NutriTrans

Standardised nurse-led nutritional handover in care transitions

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Description of the initiative

Malnutrition affects >30% of older Belgian hospital patients (43% at risk, 24% well-nourished) and 29% of those in home nursing care.[1,2] Since 2014, acute care hospitals have been structurally financed to establish nutrition support teams for follow-up, including discharge preparation, yet limited financial resources mean that handover of nutritional information during transitions to home or residential care still remain highly variable.[3] Compounded by limited dietitian availability in these settings, and nurses' lower awareness of malnutrition risk, time constraints, and absent protocols, this is associated with a 20-25% higher risk of hospital readmission.[4] This project will address this gap by co-designing and testing nurse-led handover tools, training, and audit-feedback to strengthen nutritional care transitions for older patients at risk of malnutrition, including those receiving home enteral nutrition (HEN) or home parenteral nutrition, (HPN). The primary aim is to develop and pilot a flexible, nurse-led model for structured nutritional care transitions, designed for adaptation to local workflows and wider implementation across care settings and regions.

Planned activities & deliverables

- Project approach: the project will follow four steps: 1) mapping current handover practices, 2) co-designing tools and training with stakeholders, 3) piloting the intervention in selected settings, and 4) evaluating implementation outcomes (i.e., feasibility, acceptability, fidelity and adoption).
- Deliverables: A project governance plan, baseline mapping report, co-designed nurse-led handover toolkit, training package, audit-feedback framework, pilot evaluation report, and dissemination materials.
- 12 months milestones: Stakeholder engagement completed, current practices mapped, and the first version of the toolkit and training materials developed and ready for pilot testing.
- 24 months milestones: Pilot completed, intervention refined, and a transferable model for structured nutritional care transitions available for broader implementation.

Resources & enablers

- Personnel and funding: The project requires a coordinator with at least a MSc degree (10% FTE), while other stakeholders will contribute on a voluntary basis. Student involvement will be leveraged through collaboration with the project partners, via BSc in Nursing graduation projects and MSc in Nursing and Midwifery coursework projects, without incurring personnel costs. Currently, no other funding in relation to the project is planned or confirmed.
- Grant use: The grant will primarily cover the project coordinator's involvement, co-design and meeting expenses, development of training and handover tools, implementation support, and evaluation activities.
- Success factors: Strong clinical ownership, active engagement of end users, clear governance, access to participating sites, and alignment with existing discharge and follow-up pathways will be important requirements for successful implementation.

Results, expected outcomes & impact

- **How will the findings be implemented?**

The findings will be translated into a nurse-led handover toolkit, training package, and audit-feedback framework for use in routine discharge and follow-up care. Implementation will be supported through co-design, pilot testing, and refinement with stakeholders.

- **How will this project advance nutritional care in clinical practice?**

The project will advance nutritional care in clinical practice by demonstrating effective nutritional care and implementation of clinical nutrition management pathways and therapies through a scalable, nurse-led model for structured nutritional care transitions. It will also address strategies to implement and advance nutritional care in clinical practice by using co-designed handover tools, training, and audit-feedback across hospital, home care, and residential care settings. In addition, it will contribute to education of medical students or healthcare professionals through stakeholder involvement and project-based learning opportunities.

- **Is the project transferable to other care settings / geographical regions?**

Yes. The intervention will be developed as a scalable practice model that can be adapted to local workflows and transferred to other care settings and regions.

Please tick to confirm the PEN letter of endorsement is attached.
Incomplete submissions will not be considered.

[1] Geurden B, Franck E, Lopez Hartmann M, Weyler J, Ysebaert D. Prevalence of 'being at risk of malnutrition' and associated factors in adult patients receiving nursing care at home in Belgium. Int J Nurs Pract. 2015;21(5):635-644. doi:10.1111/ijn.12341
[2] Vanderwee K, Clays E, Bocquaert I, Gobert M, Folens B, Defloor T. Malnutrition and associated factors in elderly hospital patients: A Belgian cross-sectional, multi-centre study. Clinical Nutrition. 2010;29(4):469-476. doi:10.1016/j.clnu.2009.12.013
[3] Mistiaen P, Cordon A, Devriese S, et al. Organization and reimbursement of enteral and parenteral nutrition in and outside the hospital in Belgium. Published online 2019:KCE Reports 315. D/2019/10.273/40.
[4] Folven KI, Biringer E, Nilsen RM, et al. Increased risk of rehospitalisation and death in older hospital patients at risk of malnutrition: A cohort study. J Nutr Health Aging. 2025;29(2):100455. doi:10.1016/j.jnha.2024.100455