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Dietetic Assistant versus Specialist Renal Dietitian: Investigating efficiencies in the Dietetic workforce

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Background
Increasing demands on healthcare and the gap in workforce or funding supply mean introducing new roles and changing the skill mix of dietetic teams will continue to be necessary. The National Workforce planning guidance document1 advocates a structured systematic approach to planning, implementing and monitoring new roles or changes to skill mix. When planned effectively, new roles and skill-mixes will contribute to securing safe and sustainable care. The renal workforce document2 states that Renal Dietetic Assistants (DAs) and renal Band 5 dietitians form 7% and 5% of the renal dietetic workforce. The aim of this descriptive, scoping project was to better understand the scope of work that the renal dietetic assistant undertook and how this new skills-set impacted on the renal dietetic workload.
Method
A time and motion study was carried out to show the work activity of a dietetic assistant during their 18.75hr/1125mins working week, for 2 weeks. During the same period a Band 7 captured their work activity over the same time frame. Work duties were coded and recorded on an Excel spreadsheet, then analysed to show the impact of a DA in the dietetic workforce.
Results
Analysis of the work activities recorded in time (mins) of the DA and Band 7 shows that the DA spent 50% of their time seeing routine oral nutrition support patients. The Specialist Renal Dietitian (Band 7) concentrated on complex nutrition support reviews in ICU and renal HDU, which amounted to 55% of time spent. 25% of their time was spent on routine nutrition reviews e.g. clinic reviews. An illustrated non clinical role fell under project which totalled 7% of time for the Band 7 and 9% for the DA time. The DA was able to assist with implementation of a new nutrition screening tool by auditing ward equipment and calibration dates of weighing scales, which freed up time for the Band 7 to produce a training package to assist implementation of the screening tool. Examples of differences in activities are shown in Figures 1 & 2.
Conclusion
Incorporating a DA into the dietetic workforce did not increase the Band 7's productivity in terms of numbers of patients seen each. However, including a DA in the workforce shifted the Band 7 Renal Dietitian's caseload towards more clinical complexity, and freed up time for engaging in renal service development/QI projects such as implementing a new renal nutrition screening tool. Working together on such projects maximised value of both the DA and the Band 7 by synergistic and collaborative working.