ORIGINAL ARTICLE

Nutrition intervention goals from the perspectives of patients at risk of malnutrition: A qualitative study

Lina Al-Adili1 | Lena Nordgren2,3 | Ylva Orreval4,5 | Jenny McGreevy6,7 | Elin Lövestam1

1Department of Food Studies, Nutrition and Dietetics, Uppsala University, Uppsala, Sweden
2Centre for Clinical Research Sörmland, Uppsala University, Uppsala, Sweden
3Department of Public Health and Caring Sciences, Uppsala University, Uppsala, Sweden
4Department of Biosciences and Nutrition, Karolinska Institute, Stockholm, Sweden
5Medical Unit Clinical Nutrition, Women’s Health and Allied Health Professionals Theme, Karolinska University Hospital, Stockholm, Sweden
6Department of Food Studies, Nutrition and Dietetics, Centre for Clinical Research Sörmland/Uppsala University, Uppsala University, Uppsala, Sweden
7Department of Dietetics, Nykoping Hospital, Nykoping, Sweden

Correspondence
Lina Al-Adili, Department of Food Studies, Nutrition and Dietetics, Uppsala University, PO Box 560, SE-751 22 Uppsala, Sweden.
Email: lina.al-adili@ikv.uu.se and lina.isaah@gmail.com

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Abstract

Background: Nutrition counselling is characterised by a collaborative approach where the patient and the dietitian establish goals that promote health and self-management. Little is known about goal-setting in nutrition interventions of patients at risk of malnutrition. The present study aims to describe the perspectives and needs of patients at risk of malnutrition regarding goals of nutrition interventions.

Methods: Semi-structured interviews were conducted with 15 patients from three primary care centres and one hospital in mid-Sweden selected through purposive sampling. Interview transcripts were analysed using reflexive thematic analysis following the six-phase guidelines of Braun and Clarke to identify patterns of shared meaning and themes in the data.

Results: The findings highlight that the participants rarely reflected on their personal goals of the nutrition intervention. Instead, they strived to maintain strength and energy, with the nutrition counselling being seen as supportive in managing nutrition impact symptoms. They described discrepancies between their perspectives and the dietitian’s regarding weight goals and the diet prescribed to gain weight.

Conclusions: The study findings suggest that elucidating patients’ goals is key to counteracting the discrepancies between the dietitians’ clinically oriented goals and patients’ perspectives. Goal-setting is part of the dietitian’s structured working process, whereas the patient’s lifeworld is complex and unstructured. To provide person-centred nutrition care, new strategies and tools are needed to facilitate collaborative goal-setting. These approaches will bridge the gap between clinical goals and patients’ individual needs, promoting better alignment and improved outcomes.

KEYWORDS
at risk of malnutrition, goal-setting, qualitative research

Key points
• Patients at risk of malnutrition described rarely considering their own goals for nutrition interventions.
• Nutrition counselling was seen as valuable in managing nutrition impact symptoms and maintaining strength and energy.
• Understanding and incorporating patients’ goals in nutrition interventions might bridge the gap between dietitians clinically oriented goals and patients’ perspectives.
INTRODUCTION

The prevalence of malnutrition is a significant concern both globally and in within the context of developed countries such as Sweden. In developed Western countries, the estimated prevalence ranges from 30% to 50% across both hospital and primary care settings. Malnutrition is characterised by deficiencies, excesses or imbalances in an individual's intake of energy and/or nutrients. Although malnutrition can arise from various factors, the present study focuses on the risk of disease related malnutrition. Patients with diagnoses such as cancer, kidney, lung, gastrointestinal and neurological diseases frequently develop disease-related malnutrition. This often leads to reduced quality of life. Various eating difficulties and nutrition impact symptoms (NIS), such as difficulty swallowing, loss of appetite, vomiting, early satiety, diarrhoea and nausea, are commonly associated with malnutrition. Disease-related malnutrition can be managed through nutritional support. Nutrition interventions for patients at risk of malnutrition aim at improving patients' nutritional status, functional status and quality of life, and include nutrition counselling involving dietary modification, oral nutritional supplements, or enteral and parenteral nutrition. Nutrition counselling is characterised by the patient and the dietitian collaboratively establishing food, nutrition and physical activity priorities, goals and individualised action plans that promote health and self-management.

In the nutrition care of patients with malnutrition, goal-setting is an important process that has received limited research attention. Goal-setting is used extensively in health care to promote behaviour change; for example, in diabetes and obesity treatment. Previous studies have shown that a person-centred approach to goal-setting, such as shared decision-making, can improve patient outcomes. Shared decision-making involves collaborative discussions to identify and set goals that align with patients’ priorities and needs, ultimately enhancing the effectiveness of healthcare interventions. If patients’ personal goals are not considered, positive outcomes of healthcare interventions are less likely.

Patients with malnutrition often have complex needs and diverse underlying diagnoses, which makes goal-setting particularly challenging. In a qualitative study, dietitians highlighted a discrepancy between their clinically oriented goals and patients’ goals, and described a lack of patient participation in the goal-setting process. The quality and use of person-centred strategies that improve communication and shared decision-making in nutrition care requires improvement. Although healthcare professionals’ perspectives concerning goal-setting have been previously explored, research regarding the perspectives of patients at risk of malnutrition concerning goal-setting in nutrition interventions is currently lacking. Understanding patients’ perspectives can support the development of person-centred strategies in nutritional care.

METHODS

This is a qualitative study based on individual interviews with patients at risk of malnutrition. A phenomenological approach was used in the design and planning. Semi-structured interviews were conducted to explore the individuals’ experiences and allow them to freely describe their perspectives within the scope of the investigated topic.

Purposive sampling was used to recruit participants. Dietitians in one university hospital and three primary care settings who worked with patients at risk of malnutrition were invited to help find patients meeting the study’s inclusion criteria. They received a comprehensive video presentation during a workplace meeting, along with written instructions, including the inclusion criteria and patient letters, provided in both paper and by email. The inclusion criteria are shown in Table 1.

Patients meeting the inclusion criteria were asked by dietitians if they would be willing to share their experiences and reflections in an interview study concerning involuntary weight loss and/or eating difficulties. Voluntary participation was emphasised in the patient letters and verbally by the dietitians. Patients interested in participating provided their contact details, which the dietitian forwarded by letter or phone to the first

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<th>TABLE 1</th>
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<td>• Adult patients (&gt; 18 years)</td>
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<td>Risk for malnutrition according to the Swedish National Board of Health and Welfare's criteria:</td>
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<td>• Involuntary weight loss (signs of negative energy balance)</td>
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<td>• Eating difficulties (such as loss of appetite)</td>
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<td>• Underweight (body mass index &lt; 20 kg/m² at &lt; 70 years, &lt; 22 kg/m² at &gt; 70 years)</td>
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<td>• Patients with expected survival &gt; 3 months</td>
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<td>• Received nutrition counselling from a diettian during the past month</td>
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<td>• Primary somatic diagnosis</td>
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<td>• Assessed by the diettian to have:</td>
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<td>Good cognitive ability</td>
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investigator who telephoned the patients and informed about the study, introducing herself as a PhD student interested in the experiences of patients with nutritional problems.

A semi-structured interview guide was developed by the investigators based on their knowledge of malnutrition, nutrition interventions and dietetic professional practice, and previous scientific literature concerning patients at risk of malnutrition, goal-setting in nutrition interventions, person-centredness in healthcare, and proposed strategies to ensure quality in qualitative research.28-31 (see Supporting information, Appendix S1). The interview guide consisted of open-ended questions categorised in line with the four-circle tool developed by Lenzen et al.15 This is based on a simplified version of the four domains from the International Classification of Functioning and Disability:2 my health, my activities, my own way and my environment. It is used to explore patients’ experiences of their condition from a holistic perspective, as well as support clinicians and patients in collaboratively identifying patients’ goals.15

Participants were asked to share their thoughts and to reflect on concerns about their nutritional problems and how these affected their life, health conditions and ongoing nutrition intervention within the four domains. This strategy aimed to find meanings and understand the investigated phenomena within the patient’s lifeworld and context. This enables reflections on aspects that the participants did not consider to be connected to goal-setting. Two pilot interviews were conducted in September 2020 resulting in minor revisions to the interview guide. The structure of the interview guide and some questions were modified to encourage deeper exploration of the topic. These interviews were included in the final analysis because interesting aspects of the topic were highlighted.

Participants could choose the setting for the interviews; all chose to be interviewed by phone or video meeting due to Covid-19 restrictions. The main investigator (LA) conducted the interviews from her home office. Demographic data were collected at each interview using a short questionnaire developed by the research team. The Short Form of the Scored Patient-Generated Subjective Global Assessment (PG-SGA SF) was used to evaluate nutritional status.33 This instrument consists of four parts: weight history, changes in food intake, symptoms that prevent adequate food intake and perceived functional ability. It also contains questions about the amounts and types of food eaten and an assessment of symptoms. The interviews were audio-recorded and transcribed verbatim by a professional transcriber. Participants were given a small gift in appreciation of their participation.

Ethical approval was obtained by the Swedish Ethical Review Authority (Dnr 2019-02568).

All participants received verbal and written information about the study. Verbal informed consent (recorded) was obtained from all participants.

Reflexive thematic analysis with an inductive approach was used, where themes were data-driven.34,35 The process of analysis was ongoing during and after data collection, which stopped after 15 interviews because no new information on the topic was collected.36 Each interview was given equal attention during the coding process (conducted by the first investigator). The six-phase guidelines of Braun and Clarke were used to identify patterns of shared meaning and themes in the data.34,35 First, all data extracts were coded in Nvivo.37 Second, meaning units were collected, shortened and grouped into reflexive themes by the first author who conducted and analysed all the interviews (Appendix S2).

Third, reflexive themes connected to goals were selected and categorised; themes not related to the study purpose were omitted. All transcripts were read several times by the first investigator (LA), once by a co-investigator (EL) and partly by the other co-investigators, to ensure that the themes were coherent, consistent and distinctive. Coding and themes were discussed and confirmed by all co-authors. Descriptive statistics were used to summarise participant characteristics.

Reflexivity is central to the approach used in the present study.34,35,38 This entails researchers continuous reflecting on their preconceived ideas and the meanings of the phenomena described. In qualitative studies, researchers are considered a tool for data collection.34,35 The investigators’ backgrounds and combined experience therefore informed the method used in this study. The investigator (LA) who conducted the interviews has clinical experience with patients at risk of malnutrition and training in interview techniques. All of the investigators have experience in qualitative research and knowledge about nutrition interventions for patients with malnutrition. The study was designed by all of the investigators and several meetings were held to design and pilot the interview guide, discuss data analysis, and review the manuscript.

RESULTS

Interviews with 15 participants, living at home, recruited from three primary care centres and one hospital in mid-Sweden were conducted between September 2020 and December 2021. All participants contacted by the researcher agreed to participate. The interviews were conducted by phone (n = 13) or video meeting (n = 2), each lasting on average 40 min (excluding answering the PG-SGA SF). Males (n = 5) and females (n = 10) aged between 23 and 81 years (median 76 years), from primary care (n = 7) and hospital outpatient clinics (n = 8), participated. Four of the participants had employment, of whom one was on sick leave, two were students and nine were retired. Eight participants lived alone and seven shared a household. Three had parents born abroad. Nine participants had a cancer diagnosis, such as ovarian, kidney,
colon, abdominal, breast or head and neck cancer; for some, these were combined with other diagnoses. Six had other diseases, such as chronic obstructive lung disease, heart failure, celiac disease, lung emboli, rheumatic disease, osteoporosis, diabetes or gastrointestinal diseases. All had nutritional problems, consumed food orally and had received nutrition counselling.

Three themes connected to goals of nutrition interventions was highlighted: (i) participants’ desires; describing the driving force behind making dietary changes; (ii) participants’ needs; reflecting on the role of nutrition counselling in supporting them in managing NIS; and (iii) participants’ views; highlighting differences in perspectives and weight goals. These themes are described and illustrated with key quotes from participants (using pseudonyms).

The driving force behind making dietary changes

The first theme the driving force behind making dietary changes comprises aspects that are meaningful to participants; their ultimate desires within the context of malnutrition. It also captures participants’ reflections on goals of the nutrition intervention. All participants expressed being driven to make dietary changes to help maintain strength and energy, and by a fear of disease and deterioration in health.

Participants had rarely articulated their goals, however they emphasised the desire to “have more energy” and “feel stronger”:

I don't really care about my weight. I'm happy with my weight, that's not the problem. It's more that I need the energy to cope, to get stronger … that's why I have to eat (Anna)

Although some described goals to prevent weight loss, most participants seemed unsure about the main goals of the nutrition intervention. Few described reading their patient records. When asked if they had any specific goal for the next meeting with the dietitian, Gabriella answered: “No, nothing”. Some participants, for example Sara, described the dietary advice received in the nutrition counselling, implying a perception that goals are set by the dietitian10:

No, only that she prescribed oral nutritional supplements for me, which … she wanted me to drink them and then I should eat more fat. Fat, butter, cream, the usual stuff that makes you fat. Hamburgers and pizzas and, stuff like that. That's about it (Sara)

Using dietary changes to counteract a deterioration in health and to support medical treatment or planned surgery were particularly important. Participants reflected on the severity of their condition, and contemplated their role in taking control. Although not all participants received medical treatment, Emma, who has cancer, emphasised her responsibility to support the medical treatment by finding strategies to facilitate eating:

So, I think it's partly that I'll cope with the treatments much better if I can manage to eat, and also be more active (Emma)

Participants with cancer described how their struggle to take control was driven by fear, expressed for example by “I try because I don't want to waste away”. Losing weight was emphasised as a sign of gradually disappearing, deterioration, and reflecting a loss of control. Several participants considered preventing weight loss to be particularly important:

It's also to do with the importance of the whole thing, that you don't want to waste away. Hopefully I'll stay feeling about the same, it's maybe sometimes better or sometimes worse and so on. That's the only outlook I have really. So it’s … my condition is serious, so … I do what I can to hang on in there, so to speak (Christopher)

Some participants described a weight goal, for example getting back to the weight they had before their disease, reflecting an effort to gain control over their body. However, focusing on weight goals during the nutrition counselling was problematised:

But my weight, I want to get up to about 50, 52, 53 kilos, back to my old weight. [pause] But then … when I told the dietitian … she said: “you shouldn't have that as a goal, the goal should be to feel better”, and she's right (Isabell)

The role of nutrition counseling

The second theme the role of nutrition counselling refers to participants’ reflections on the supportive role of the nutrition counselling in the management of NIS. It captures participants’ needs from the nutrition intervention. They described aspects such as the dietitian being “supportive”, “receptive” and “inclusive”, reflecting person-centred care.14 An encouraging and individualised approach was emphasised as crucial for implementing the dietary advice. Some stressed the need for support and feedback, and some the need for dietary advice adapted to their preferences and health situation.
Most participants had been referred by their physicians or encouraged by family members to consult a dietitian for help concerning their food intake and weight. Having a professional evaluate their intake and nutritional status, and regularly measure their weight, was described as helpful when managing NIS through dietary changes. Anna discussed her needs from the nutrition counselling:

I just need someone to check up on me really, and you get a bit of a “kick in the butt”; “Do this and that”, and: “Do the right thing”, and … Yes, I don’t know really. I just need to be pushed, I think, a lot (Anna)

The dietitian’s supportive approach was highly valued and described as helping participants deal with their struggles. Receiving positive feedback encouraged them to make dietary changes. Participants stressed the need to be informed, supported and respected by the dietitian. Lena (87 years old), acknowledged her physical limitations, yet stated that:

And their whole attitude that: “It's okay, you can manage this and we'll help you as much as we can …”. This helps you to cope with all the difficulties, you feel supported all the time. I have never experienced this before (Lena)

She described feeling “empowered” when the advice was adapted to her situation and needs. Practical and simple dietary advice was highly appreciated. Isabell emphasised how such advice had helped her in her struggle with eating:

But then she said: “Cut it up (the food) and then just take a small piece”. […] it helped me a lot, because you get this little kick that you need when, for example, you start cooking and everything. Yes, I've received a lot of advice from her, little things like that, which have made everything easier (Isabell)

Although many described forcing themselves to eat, finding strategies that facilitated eating was highlighted as key to managing NIS and maintaining dietary changes:

But if it's not nice, then I'd rather skip it. I don't force myself, apart from these oral nutritional supplements which I do actually force myself to take. Otherwise, I skip things that I don't think are nice (Sara)

Differences in perspectives and weight goals

The final theme differences in perspectives and weight goals comprises participants’ views of a healthy diet and ideal weight for individuals at risk of malnutrition and highlights discrepancies between the dietician’s and participants’ perspectives. Advice about how to facilitate eating, increase protein intake, and manage NIS was highly appreciated by participants (described above). However, some participants were critical of the diet prescribed by the dietitian to gain weight, involving increased intake of sugar and fat which they described as harmful; some were also unwilling to gain weight. These participants described resistance to implementing dietary changes according to the dietitian’s recommendations.

Many described weight as being the main focus of the nutrition intervention:

The main focus has been around these oral nutritional supplements and that I'll put on weight (William)

Participants’ views of an ideal weight varied. Several female participants described wanting to be slim. They expressed resistance to increasing their energy intake to gain weight, highlighting a discrepancy between their weight goals and the dietitians’ goals:

No, she talked about BMI, that at my height I should be 62 kilos and I weighed 57 at the time. She thought I could easily gain a few kilos (Sara)

Interviewer: What do you think about that, do you have any goals …

No, my weight is fine as it is. … I don't feel the need to gain a couple of kilos (Sara)

Some participants with cancer described the oral nutritional supplements as particularly unhealthy. This is illustrated by Marie:

Even these … especially this X (oral nutrition supplement), it's really sweet. So, … sugar isn’t good for anyone, least of all if you have cancer (Marie)

Although some participants described wanting to gain weight, some were against eating energy-dense food. They reported avoiding food items high in sugar and fat, describing the advocated diet as “junk food” and potentially harmful to their condition. Marie said that the food recommended “does not seem right”:
But I think [...] doctors should advise their patients to eat as sugar-free as possible. But now, you have to eat this white bread and pasta and things like that which are converted into unhealthy carbohydrates, so it doesn't feel right (Marie)

Discussions between the participants and dietitians on hospital wards were described as being limited by short interaction times:

It feels like (the dietitian) just runs in and gives out a brochure and then runs out again (at the hospital). So I don't really know how much help I actually got there. Although, I guess I didn't ask for much either (Daniel)

DISCUSSION

The aim of the present study is to describe the experiences, perspectives and needs of patients at risk of malnutrition regarding goals of nutrition interventions. Our findings highlight that participants rarely reflected on their personal goals of the nutrition intervention. Instead, they described striving to maintain strength and energy, with nutrition counselling being seen as supportive in managing NIS. However, discrepancies were highlighted between participants’ perspectives and those of the dietitians regarding weight goals and the diet prescribed to increase weight.

Person-centredness implies a shared responsibility between patients and healthcare professionals in working towards goals defined by patients. Previous studies have discussed and categorised patients’ goals from a professional viewpoint. However, the present study highlights that participants rarely reflected on their personal goals of the nutrition intervention. Instead, they described striving to maintain strength and energy, with nutrition counselling being seen as supportive in managing NIS. Although participants might not have reflected on goals, the dietitian’s working process entails goal-setting. The dietitian has a structured working process, whereas the patient’s lifeworld is complex and unstructured. Studies have stressed the need to develop person-centred strategies that facilitate identification of patients’ goals during nutrition counseling. Supporting patients in explaining their goals is key to balancing healthcare professionals’ clinically oriented goals with patients’ perspectives, priorities and needs.

Setting SMART (Specific, Measurable, Achievable, Relevant and Time-framed) goals for nutrition interventions is recommended. Melin et al. suggest a new approach to identifying goals that are meaningful to patients: MEANING (Meaning, Engage, Anchor, Negotiate, Intention-implementation gap, New goals and Goals as behaviour change). In person-centred care, patients are acknowledged as being capable and vulnerable. The MEANING approach entails adjusting the goals to patients’ capabilities and resources, which is in line with person-centred care. Combining the use of SMART goals and the MEANING approach in nutrition counselling might facilitate person-centred goal-setting.

Different tools and strategies are used in health care to support the identification of what is meaningful to individuals, such as the four-circle tool developed for nurses by Lenzen et al. or the goal hierarchy tool developed by Berntsen et al. Motivational interviewing can be used to enhance the communication of goals. However, to enable person-centred use, Melin et al. argue that these tools and strategies should be integrated into clinical reasoning. Hence, educating dietitians on how to use a MEANING approach and adapt and use existing goal-setting tools and strategies might support the implementation of shared decision-making in goal-setting.

Melin et al. emphasise that some patients might have difficulty expressing their needs and perspectives, and identifying future goals. However, the philosophy of person-centred care is that patients are seen as capable individuals who can influence their health positively. Although the participants in the present study had different conditions and diagnoses, all described a degree of willingness to make dietary changes and improve their condition. Positive consequences and avoiding deterioration were the main driving forces for implementing dietary changes. Herlitz et al. highlight that persons with complex diseases might have limited capabilities and resources to make behavioural changes in healthcare.
interventions. Patients might therefore be willing to make dietary changes yet face physical, mental and practical challenges in doing so. Herlitz et al.⁴⁵ suggest focusing on how patients view their choices, how they adopt goals and what emotional feedback they receive to support them in making behavioural changes. Involving patients in goal-setting might be one way to help them identify feasible goals.

Rogers et al.⁵⁰ developed a theory on the efficacy of persuasive communications in health-related behaviour changes. That certain behaviour can protect against the perceived threat of a disease is described as an aspect that affects the probability of behaviour change. Correspondingly, participants described fear of deteriorating health and acknowledged the importance of eating “healthy food”. This was more prominent among those with cancer who described the fear of “wasting away” and a struggle to gain control over their bodies. A key concept emphasised by Rogers et al.⁵⁰ is self-efficacy, the belief in one’s abilities to carry out a certain behaviour effectively. Although individuals might have limited capacities and resources, their self-efficacy is vital to achieving goals. Motivation may vary between individuals and is another aspect described by Rogers et al.⁵⁰ as significant for the probability of making behaviour changes. Participants described feeling empowered when the dietitian was supportive and confirming. This is in line with previous research that emphasises the role of person-centred care in motivating and promoting self-management.¹⁶,⁴⁰

In a qualitative study of patients’ perspectives on goal-setting in neurological rehabilitation, patients described negative aspects connected to goal-setting.⁴² Some emphasised the unpredictability of their disease as a barrier to the goal-setting process.⁴² Participants with chronic conditions expressed uncertainty about the future and had difficulty articulating their goals. Support and positive feedback were highly appreciated by participants in the present study and described as encouraging in the management of NIS. Identifying and setting short-term goals adapted to the person’s preferences, situation and needs, and providing regular feedback might increase the person’s self-efficacy, give them a sense of control and motivate them to reach goals.

Participants discussed the dietary advice they received. According to previous qualitative studies with clinical dietitians, weight goals appear to be central in nutrition interventions for patients at risk of malnutrition.⁹,¹⁰ In the present study, participants’ views of an ideal weight varied. Although some described a desire to increase their weight, others wanted to be slim. Hence, addressing individuals’ views on ideal weight is essential when tailoring the nutrition intervention. Nutrition literacy is “the degree to which individuals can obtain, process, and understand nutrition information and the skills needed to make appropriate nutrition decisions”.⁵¹ Informing patients about how their weight status and muscle mass loss can impact their health is one way of encouraging them to make dietary changes. However, perceptions of ideal weight are influenced by social norms that are difficult to change solely through information. Considering the person’s nutrition literacy might support them in elucidating their priorities and thoughts, and reflecting on different perspectives. Focusing on weight as the main goal is problematic because other aspects might be more important to individuals.⁹,¹⁰,⁴⁴ Lack of time with the dietitian on the hospital ward precluded a nuanced dialogue about these perspectives. If goals that matter to individuals (e.g., maintaining strength and energy) are not discussed, monitored and evaluated, identifying progress in the nutrition intervention might be difficult.

Rogers et al.⁵⁰ describe how the perceived effectiveness of a preventive behaviour can determine the probability of behaviour change. Response efficacy is the belief that implementing a certain behaviour change can prevent a threat.⁵⁰ Some described the advocated energy-dense food as harmful to their health. Such discrepancies affect the individual’s response efficacy and the chance of achieving intervention goals. Fear is an important aspect to consider in health-related behaviour change because it can affect adherence.⁵⁰ Addressing an individual’s fear connected to food and eating is therefore important when tailoring the information provided in nutrition counselling. Moreover, a qualitative study revealed that misconceptions about appetite, weight loss and healthy eating are prevalent among older people at risk of malnutrition. Beliefs such as equating thinness with health and viewing snacking as unhealthy hinder their understanding of the importance of addressing malnutrition.⁵²

Many studies stress the need for shared decision-making in goal-setting to address disparities in perspectives.¹⁴,²⁰–²⁴ Hence, discussing discrepancies and collaboratively agreeing on goals is important for good quality person-centred nutrition interventions. The investigators in the present study have a broad knowledge of qualitative research and malnutrition, which supported nuanced discussions in the analysis and promotes the credibility and dependability of the findings. The first investigator’s (LA) experience in interview techniques, the open-ended questions, and the flexible interview guide (based on the four-circle tool developed by Lenzen et al.¹⁵ and questions in line with a phenomenological approach²⁶) allowed participants to discuss what was most important to them from different perspectives. The phenomenological approach supported the formulation of open-ended questions and directed our attention to capturing individuals’ subjective perspectives and lived experiences. Instead of focusing on participants’ past experiences, we aimed at capturing descriptions of their current experience concerning goals of nutrition interventions using the questions and probes.
The strengths of the present study include the utilisation of sampling from both hospital and primary healthcare settings, which enhances transferability by ensuring a more diverse and representative sample. Additionally, participants were given the option to conduct interviews either by phone or through Zoom, allowing for flexibility in data collection.

However, it is important to note some limitations. Face-to-face interviews were not conducted, which may have limited the depth of discussions and insights that could have been gained. Moreover, because of the severity of illness in some participants, the interview time was kept short to minimise their burden. Another limitation is that the study did not explore participants’ experiences with parenteral or enteral nutrition, which hinders a comprehensive understanding of the challenges and requirements of patients receiving these forms of nutrition support. Future research is recommended to address this gap.

Although the inclusion of participants with different diagnoses and symptoms represents patients at risk of malnutrition in general, it should be acknowledged that the dominance of participants with cancer may limit the applicability of the findings to other patient populations. Nevertheless, this generic study gives a broad picture of the applicability of the nutrition interventions. Goal-setting is key to balancing the dietitian’s clinically oriented perspectives, in addition to achieving person-centred nutrition interventions. Education for dietitians, new strategies and tools that support shared decision-making in the goal-setting in nutrition interventions are warranted.

CONCLUSIONS

The findings highlight that patients rarely reflect on goals of nutrition interventions. Goal-setting is part of the dietitian’s structured working process, whereas the patient’s lifeworld is complex and unstructured. A dialogue about goals during nutrition counselling might support individuals in identifying their perspectives and needs in nutrition intervention. Elucidating the person’s goals is key to balancing the dietitian’s clinically oriented goals with the individual’s perspectives, in addition to achieving person-centred nutrition interventions. Education for dietitians, new strategies and tools that support shared decision-making in the goal-setting in nutrition interventions are warranted.

TRANSPARENCY DECLARATION

The lead author affirms that this manuscript is an honest, accurate and transparent account of the study being reported. The reporting of this work is compliant with COREQ guidelines. The lead author affirms that no important aspects of the study have been omitted and that any discrepancies from the study as planned have been explained.

AUTHOR CONTRIBUTIONS

Lina Al-Adili, Lena Nordgren, Ylva Orrevall, Elin Lövestam and Jenny McGreevy were involved in the conception and design of the study. Lina Al-Adili was responsible for data collection and transcription. Lina Al-Adili took a leading role in the analysis process and had the main responsibility for writing and revising the manuscripts, in collaboration with co-authors. All authors contributed with critical revisions during data analysis and manuscript writing.

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CONFLICTS OF INTEREST STATEMENT

The authors declare that there are no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in Uppsala University at https://doi.org/10.1016/j.pec.2022.02.015.

ORCID

Elin Lövestam http://orcid.org/0000-0001-6428-5701

PEER REVIEW

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AUTHOR BIOGRAPHIES

Dr Lina Al-Adili, a postdoctoral researcher, conducted extensive research on monitoring and evaluation of nutrition interventions for patients at risk of malnutrition. Her thesis delved into the perspectives of both dietitians and patients. Dr Al-Adili’s interests lie in implementation research and the advancement of person-centred care to enhance healthcare practices.

Dr Lena Nordgren is a research advisor at the Centre for Clinical Research Sörmland. With a background in nursing and a passion for improving healthcare, Lena’s research has focused on enhancing the well-being and outcomes of individuals living with heart failure.

Dr Ylva Orrevall is a Registered Dietitian and Research & Development Manager at Women’s Health and Allied Health Professionals Team, Karolinska University Hospital, Stockholm, Sweden and has an interest in improving professional practice for dietitians, as well as nutrition for patients with cancer.

Jenny McGreevy, RD, Med. Lic., is a practicing registered Clinical Dietitian working on the acute stroke ward at Nyköping Hospital, Sweden and has a research interest in the evaluation of dietetic interventions for patients who have had a stroke, as well as the translation of research instruments and nutrition terminology.

Dr Elin Lövestam is a Registered Dietitian and an early adopter of the Nutrition Care Process and Terminology. Research interest considers the professional approach and identity of the dietetic practitioner. Her doctoral thesis which was published in 2015 focused on language and content in clinical dietitians’ electronic health record notes. Currently, Elin leads a project aiming to develop person centred tools that can be used in evaluation of dietetic interventions for patients at risk for malnutrition.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.