Based on the literature, there is no exact way to determine the specific full-time equivalents (FTEs) for clinical dietitians, and most articles and studies are from the 1990s and earlier. This literature review focuses on articles from 2001 and more recent.

Historically, staffing ratios have been determined by type of diet ordered and type of dietary service that was provided, ratio of staff to patient beds or hospital census, evaluation of patients’ nutritional statuses and medical diagnoses, and amount time spent on Medical Nutrition Therapy (MNT), among other factors. The key theme among much of the literature is that each hospital and facility is different and staffing needs will reflect accordingly.

In 2001, Kwon et al assessed “changes in clinical dietetics due to cost-reduction activities in healthcare systems” while focusing on acute care hospitals in “ADA Area 2 states” which included Iowa, Michigan, Minnesota, Missouri, Nebraska, North and South Dakota, and Wisconsin. These authors found that staffing patterns had undergone changes due to cost reduction, meaning that many dietitians’ (RDs) caseloads had increased and RDs had gained additional responsibilities that may not directly relate to RD tasks such as administrative or clerical duties, and dietetic technician duties. The authors stated that staffing needs should be determined based on patient need for MNT rather than the ratio of patients to RDs.

While there is “no cookie-cut answer” for determining an equation for staffing needs, several articles have cited the American Dietetic Association book Christina Biesemeier, MS, RD, FADA wrote titled Achieving Excellence: Clinical Staffing for Today and Tomorrow. Biesemeier says there are 5 focus areas when assessing staffing needs at any facility: determine your facility’s mission and vision, the population that is served, and any planned new services; what department services and operations are provided; what legal requirements are needed for staff, patient care, and scope of practice; accreditation standards of the facility and how they affect staff and patient care; and any professional practice issues and guidelines that need to be followed, such as the Code of Ethics and Standards of Professional Practice. Using a staffing model, though not generalizable for each facility, can be advantageous for administrative purposes because it easily quantifies staffing. Biesemeier urges dietetics professionals and managers to advocate for their departments and have other health professionals advocate for the department to ensure staffing requirements are met and to show the consequences of understaffing.

The most recent study for inpatient staffing needs was published in the April 2015 issue of the Journal of the Academy of Nutrition and Dietetics, in which the authors were looking to develop a predictive model for determining inpatient RD staffing in acute care facilities. RDs were asked to track the total time spent per patient encounter and the patient care tasks that were performed during each encounter. It was found that “patient complexity, type or assessment required, and whether or not the patient was seen in the ICU as the best predictors of RDN time required,” with nutrition assessment as the primary predictor of RD time spent on patient care. Unfortunately, the study was not able to provide a gold standard staffing model, but it was able to provide “baseline data on RDN staffing levels” and created a “model that focused on easily obtainable patient characteristics, while adjusting for average hospital and RDN effects.”

What are we to do? Based on some of the literature, it has been suggested that a combination of using a staffing model, benchmarking models, and self-assessment may be the best approach for establishing RD staffing needs in individual facilities.
References