

The Readiness Among Nutrition Support Hospital Staff for the Implementation of the Patient-Generated Subjective Global Assessment

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Purpose: To timely tackle malnutrition in hospital patients, the implementation of a new malnutrition practice is needed. We aimed to determine the readiness of nutrition support hospital staff for implementing a new malnutrition practice, using the Patient-Generated Subjective Global Assessment (PG-SGA) instrument.

Participants and Methods: A cross-sectional assessment of readiness among nutrition support hospital staff was conducted using semi-structured interviews. Interviews were scored across five dimensions of the community readiness model: Knowledge of efforts, Leadership, Community climate, Knowledge of the issue, and Resources for efforts. A general score and a dimension score (mean and standard deviation) were calculated. Scores could range from 1 (no awareness) to 9 (community ownership).

Results: In total, 11 respondents, including physicians (n=2), dietitian (n=1), physiotherapists (n=3), speech therapists (n=2), nutritional assistants (n=2), and a manager (n=1) were interviewed. The general community readiness score was 4.0±0.3, indicating the preplanning stage for the implementation of the PG-SGA. All five dimensions were in the preplanning range (3.5–4.5). Resources was lowest (3.5 ± 0.9; range 3.0–4.0), and Knowledge of efforts was highest (4.5 ± 1.9; range 2.0–7.0); the scores of the remaining dimensions clustered around ~4.0. No dimension score exceeded the preplanning stage.

Conclusion: Readiness to implement the PG-SGA was uniformly low (ie, at preplanning stage) across CRM dimensions, with resources most limited and awareness of existing efforts highest, yet still in the preplanning stage. Recommendations are directed to hospital leadership/clinical leaders and to interprofessional nutrition teams, with targeted training for all professionals involved in nutritional care to enable progression toward implementation.

Keywords: community readiness, interprofessional collaboration, organizational change, PG-SGA, implementation

Introduction

Malnutrition is a global issue among hospitalized patients, with reported prevalence rates ranging from 13% to 58%.¹⁻³ It is associated with adverse clinical outcomes, including prolonged hospital stays, increased readmission rates, and higher mortality risk.^{1,4,5} Effective management of malnutrition begins with early nutritional screening, which serves as a critical first step in identifying at-risk patients.⁶

In the Netherlands, nutritional screening is commonly performed using tools such as the Short Nutritional Assessment Questionnaire (SNAQ)² and the Malnutrition Universal Screening Tool (MUST).^{3,7} While these tools are validated, they primarily identify patients who are already malnourished, as they include criteria that indicate signs of malnutrition, such as unintentional weight loss and low body mass index (BMI).^{8–10} As such, they reflect a reactive approach to malnutrition care, where diagnosis and treatment begin only after clinical signs have emerged.

However, the distinction between malnutrition and the risk of malnutrition carries critical therapeutic and prognostic implications.⁹ Preventive interventions are essential for individuals at risk, while those already malnourished require targeted treatment addressing both the condition and its underlying causes.⁹ To enable a more proactive, risk-based approach, it is necessary to adopt screening instruments that identify early indicators of nutritional decline, before malnutrition becomes clinically apparent. This transition supports earlier intervention and has important policy implications, as it requires the formal recognition of preventive nutritional care and the allocation of appropriate resources for individualized treatment.^{8,9}

At the Dutch hospital Nij Smellinghe, nutritional risk screening was previously conducted using the validated Short Nutritional Assessment Questionnaire (SNAQ) as part of the routine patient anamnesis performed by nurses. When patients were identified as being at high risk of malnutrition, they were referred to a dietitian for dietary intervention and supportive measures such as energy- and protein-enriched meals, between-meal snacks, and oral nutritional supplements where indicated. Among high risk patients, nutritional assessment was performed by dietitians using clinical judgment. As the SNAQ primarily detects established malnutrition rather than early risk factors,⁸ it reflects a reactive approach to malnutrition care.

To facilitate timely interventions that potentially could prevent the development of risk of malnutrition into presence of malnutrition, the hospital wanted to move from a reactive to a proactive, interprofessional strategy for managing malnutrition. This shift aligns with a growing international consensus that emphasizes early identification and prevention of malnutrition. Guidelines from both the European Society for Clinical Nutrition and Metabolism (ESPEN) and the American Society for Parenteral and Enteral Nutrition (ASPEN) advocate for screening strategies that go beyond detecting current malnutrition by also identifying patients at nutritional risk, enabling timely and preventive interventions.^{11–13}

Findings from research conducted at Nij Smellinghe support this proactive direction. A comparative study of the Patient-Generated Subjective Global Assessment Short Form (PG-SGA SF) and the routinely used SNAQ showed that, unlike the SNAQ, the PG-SGA SF could predict length of hospital stay.¹⁴ These findings underscore the added value of the PG-SGA SF in identifying patients at nutritional risk earlier and more effectively. The PG-SGA SF is a self-reported component of the full Patient-Generated Subjective Global Assessment (PG-SGA) and serves as a screening tool that can be used as a first step within a broader assessment framework.¹⁵ In this project, the aim was to implement both the PG-SGA SF and the full PG-SGA, enabling both screening for nutritional risk and identifying malnutrition. By integrating this evidence into practice, Nij Smellinghe aimed to implement a structured, forward-looking nutritional care policy that engages the full interprofessional team and supports earlier, more tailored interventions to improve patient outcomes.

Successful implementation of a new malnutrition policy requires readiness among hospital staff. The Community Readiness Model (CRM), developed by the Tri-Ethnic Center for Prevention Research at Colorado State University, provides a structured approach to assess an organization's preparedness for change by integrating social and cultural contexts.^{16,17} Originally designed to evaluate community-based interventions, CRM has been widely applied to facilitate organizational change and guide the development of context-specific implementation strategies.¹⁸

In the hospital setting, readiness entails staff awareness, interprofessional collaboration, leadership support, and resource availability. Effective adoption of the PG-SGA requires not only nurses and dietitians, who traditionally manage malnutrition screening and treatment, but also physicians, physical therapists, speech therapists, and nutritional assistants. A shared understanding of roles, a positive climate, and strong leadership alignment across hierarchical levels are critical for successful implementation.^{17–21} Additionally, sufficient resources must be secured to sustain the new policy.²²

This study applies the CRM to evaluate the readiness of nutrition support staff for adopting the PG-SGA within a proactive, interprofessional malnutrition care approach. The findings will guide the development of tailored

implementation strategies to support the successful adoption and long-term sustainability of the hospital's revised malnutrition policy.

Materials and Methods

Design and Respondents

In this cross-sectional study, the level of readiness regarding the implementation of the PG-SGA was determined in the surgery, urology, lung disease and cardiology wards of a regional Dutch hospital. Hospital staff members with a profession involved in the standard malnutrition policy, as well as new professionals who will be involved in the new malnutrition practice with the PG-SGA were considered key informants. The Tri-Ethnic Center Community Readiness Handbook recommends including at least six key respondents for the interviews.²³ However, due to the large number of healthcare profession types involved, we aimed to include a minimum of two key respondents per healthcare profession, ie, physicians, nurses, dietitians, physiotherapists, speech therapists, managers, and nutritional assistants. The nurses were contacted for inclusion by four nurses from the involved wards. These four nurses were actively involved during the preparation phase of the implementation of the PG-SGA. The other key respondents were selected together with the Head of Acute Care Rehabilitation. Representativeness of the sample was ensured by purposive inclusion of respondents from all professional groups involved in nutritional care or in the planned PG-SGA implementation. This approach is in line with the CRM Handbook, which recommends selecting key informants who are knowledgeable about the issue and the local context. All eligible respondents received an Email from the researcher with written information about the study. The key respondents had to work on the surgery, urology, lung disease, or the cardiology ward, since the PG-SGA was to be implemented on these wards. Interviews with the key respondents were performed from 10 September 2018 to 19 October 2018.

Procedures

The original English interview questions were translated into Dutch by PD. HJW reviewed each phase of the translation process and provided feedback to ensure accuracy and conceptual equivalence. The final English version of the interview questions is available in [Supplemental File 1](#).

Interviews were all performed face-to-face by the primary researcher and recorded with an audio recorder. Interviews took place in the hospital, typically in consultation rooms or meeting spaces. Participants selected both the time and location of their interview to accommodate their availability and preferences. Audio records of the interviews were transcribed verbatim by the researcher PD and a Nutrition and Dietetics graduate.

The handbook includes an interview guide, with community readiness interview questions.²³ The interview guide contained a combination of closed (yes/no format) and open-ended questions, addressing the five dimensions of community readiness:

1. Knowledge of efforts: How much does the community know about the current programs and activities?
2. Leadership: What is leadership's attitude toward addressing the issue?
3. Community climate: What is the community's attitude toward addressing the issue?
4. Knowledge of the issue: How much does the community know about the issue?
5. Resources: What are the resources that are being used or could be used to address the issue?²²

Scoring and Stage Translation

Each interview was scored across the five dimensions of the Community Readiness Model (Knowledge of efforts, Leadership, Community climate, Knowledge of the issue, and Resources). Scores on each dimension were assigned using anchored rating scales ranging from 1 to 9, with higher scores indicating greater readiness for change. Importantly, each numerical score corresponds to a readiness stage that provides qualitative interpretation of the community's preparedness:

- 1 = No awareness
- 2 = Denial / resistance
- 3 = Vague awareness
- 4 = Preplanning
- 5 = Preparation
- 6 = Initiation
- 7 = Stabilization
- 8 = Confirmation / expansion
- 9 = Community ownership

For each respondent, dimension scores were averaged to calculate an overall community readiness score. These scores were then interpreted both numerically and in terms of the corresponding readiness stage, to enable clear communication of the degree of preparedness.²³

We use “low readiness” to refer to lower stages on the continuum (eg, Stages 1–4: No awareness–Preplanning).

Prior to scoring, transcripts were de-identified (removal of names, roles, dates, and other identifiers) and labeled by interview number. For each interview, raters first read the transcript in full, then reviewed it against the dimension-specific anchor statements in the CRM handbook and marked domain-relevant passages. Using the anchors, a numeric rating (1–9) was assigned for each dimension; in-between values (eg, 3.5) were used when responses exceeded one anchor but did not fully meet the next. Numeric ratings were then mapped to the nine CRM stages (1 = No Awareness to 9 = High Community Ownership).²³ The inter-rater reliability of the scoring between both researchers (PD and AD) was considered fair (intra class correlation=0.42).²⁴ After both researchers completed the scoring, the scores were discussed. When scores differed, both researchers discussed until consensus was reached.²³

Data Analyses

For each respondent, the overall community readiness score was calculated as the arithmetic mean of the five dimension scores (1–9). At both dimension and overall level, results are reported as means (SD) and ranges (min–max). To aid interpretation, we report numeric scores alongside their stage labels. Per-respondent scores were also shown per dimension. All quantitative results were descriptive.

Open-ended responses were used to contextualize the Community Readiness Model (CRM) domain ratings. Interviews followed a semi-structured guide mapped to the five CRM dimensions and included non-leading probes (eg, “Could you give an example?”; “Who is involved?”) to elicit detail. Transcripts were reviewed alongside the CRM anchor statements, dimension-relevant responses were identified, and a small set of illustrative quotations was selected to clarify how the anchored 1–9 scores were derived and to give voice to participants in the Results.²⁵

Ethics

The study was approved by the hospital’s Institutional Review Board (7233/MdH/AB) and conducted in accordance with the Declaration of Helsinki. Participants were hospital staff only; no patient data were collected. All participants provided informed consent, which included permission for the use of anonymized responses and direct quotes in publications. Participation was voluntary, and individuals could decline or withdraw at any time without consequence. Interviews were audio-recorded and transcribed verbatim; transcripts were de-identified prior to analysis (removal of names, roles, dates, and other identifiers) and labelled by interview number. Quotations are reported in anonymized form.

Results

Of the 17 contacted potential respondents, six were not willing to participate. Reasons for not being willing to participate were: daily work activities are not related to nutrition (n=3), not eligible (n=1), or no cause specified (n=2). None of the nurses applied to participate in the study. In total, 11 key respondents, including physicians (n=2), dietitian (n=1), physiotherapists (n=3), speech therapists (n=2), nutritional assistants (n=2), and a manager (n=1), were interviewed. See [Table 1](#) for full characteristics. The mean duration of the interviews was 31 minutes (range: 18–53 minutes). In total, six respondents were female.

Table 1 Participant Descriptions

Characteristic	n (%)
Total participants	11
Female	6 (55%)
Male	5 (45%)
Physicians	2 (18%)
Dietitians	1 (9%)
Physiotherapists	3 (27%)
Speech therapists	2 (18%)
Nutritional assistants	2 (18%)
Manager	1 (9%)

Table 2 Stages of Community Readiness

Stage	Title	Description
1	No awareness	No awareness Issue is not generally recognized by the community or leaders as a problem (or it may truly not be an issue).
2	Denial/Resistance	At least some community members recognize that it is a concern, but there is little recognition that it might be occurring locally.
3	Vague Awareness	Most feel that there is a local concern, but there is no immediate motivation to do anything about it.
4	Preplanning	There is clear recognition that something must be done, and there may even be a group addressing it. However, efforts are not focused or detailed.
5	Preparation	Active leaders begin planning in earnest. Community offers modest support of efforts.
6	Initiation	Enough information is available to justify efforts. Activities are underway.
7	Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced.
8	Expansion/Confirmation	Efforts are in place. Community members feel comfortable using services, and they support expansions. Local data are regularly obtained.
9	Community ownership	Detailed and sophisticated knowledge exists about prevalence, causes, and consequences. Effective evaluation guides new directions. Model is applied to other issues.

Community Readiness

The mean (SD) community readiness score for all healthcare professionals was 4.0±0.3. The score of 4.0 represents the preplanning stage for the implementation of the PG-SGA (Table 2). The community readiness scores per dimension are shown in Figure 1. The highest score, ie, 4.5±1.9 (range=2.0–7.0), was observed for the “Knowledge of efforts” dimension, which indicates that the community scored between preplanning and preparation stage. The lowest score, ie, 3.5±0.9 (range=3.0–4.0), was observed in the “Resources” dimension, which indicates that the community scored between vague awareness and preplanning stage. The remaining dimensions had scores indicative for the preplanning stage.

Per-respondent CRM scores across the five dimensions are visualized in Figure 2. Ratings predominantly cluster within stages 3–4 (vague awareness–preplanning stage). The lowest score dimension score was 2 and the highest was 7. The domain Resources generally falls at the lower end of the range (score of 3–4), whereas Knowledge of efforts shows the greatest variation in scores (score of 2–7).

Healthcare professionals’ perceptions of the PG-SGA and risk of malnutrition are illustrated through representative quotes in Box 1. The quotes illustrate varying degrees of awareness and engagement. For example, while some participants acknowledged the potential value of the PG-SGA and recognized efforts such as workshops and information sharing, others highlighted limited awareness among untrained staff. Leadership was generally perceived as supportive in principle but not consistently proactive in practice, with several participants noting that concrete data (eg, on prolonged hospital stays due to malnutrition) could help prioritize the issue.

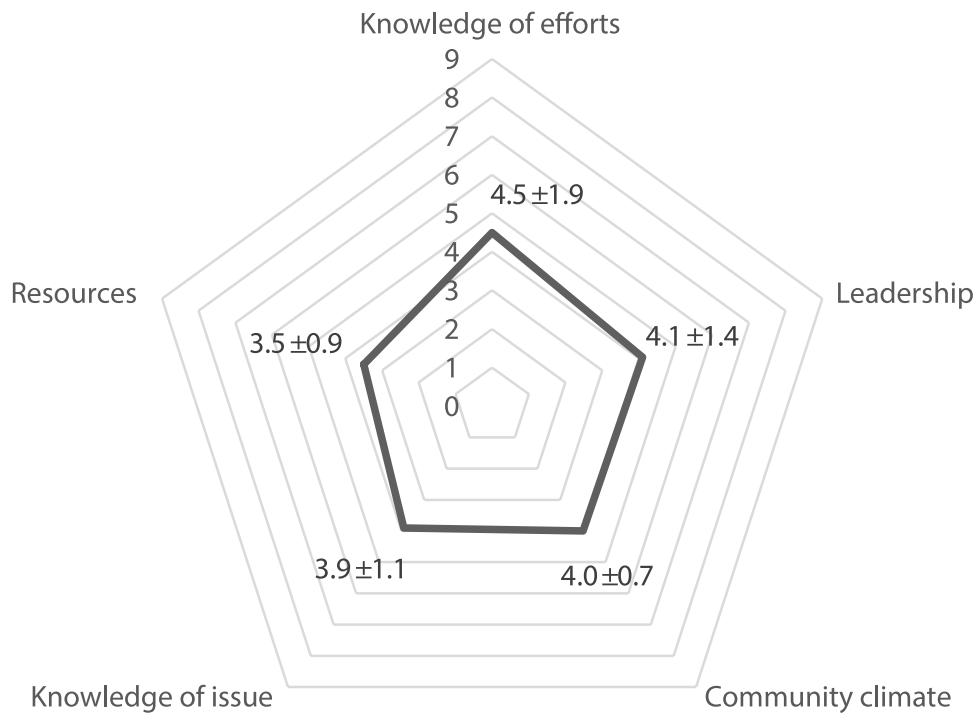


Figure 1 Cobweb chart on Community Readiness scores per dimension for hospital staff. Scores are presented as mean ± standard deviation.

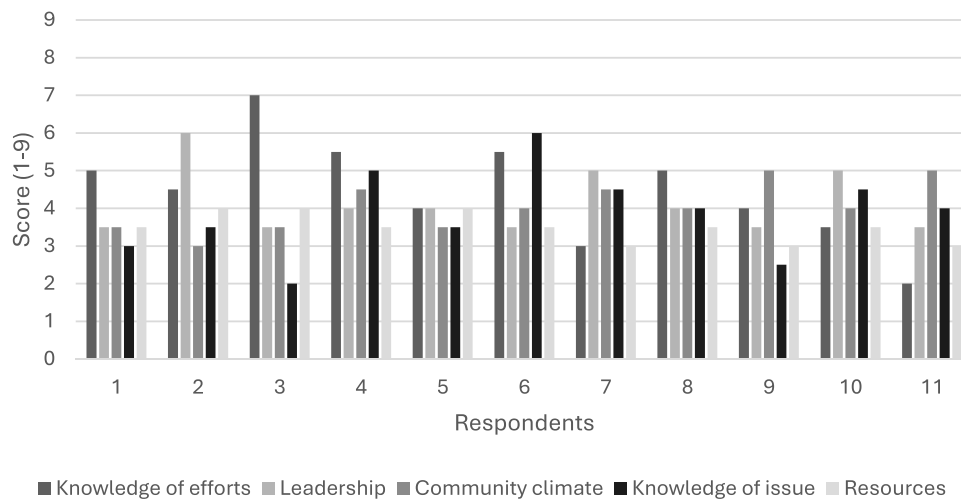


Figure 2 Per-Respondent Community Readiness Dimension Scores for PG-SGA Implementation. **Abbreviation:** PG-SGA, Patient-Generated Subjective Global Assessment.

Across interviews, knowledge gaps regarding malnutrition and its risk factors were reported by respondents from multiple professional groups, indicating that this limitation was not confined to a single discipline. These accounts were sometimes accompanied by misconceptions (eg, equating malnutrition exclusively with low body weight) and variable familiarity with PG-SGA procedures, see illustrative quotations in [Box 1](#).

Also, recurring barriers concerned insufficient time, competing priorities, and limited staffing; participants commonly anticipated an increased workload with the new protocol. Uncertainty about concrete next steps and variable motivation were also noted across professional groups ([Box 1](#)). Taken together, dimension ratings generally clustered between Stages 3–4 (vague awareness–preplanning).

Box 1 Selected Comments from Interviews with Hospital Staff from Hospital Nij Smellinghe in the Netherlands

Knowledge of efforts: How informed do you think healthcare professionals are about programs/activities that seek to reduce or treat malnutrition and its risk factors? "So we had a kind of workshop, and you also shared some information on the ward."
 "The PG-SGA is a good tool that might even replace the SNAQ, as it is more sensitive."
 "Regarding the PG-SGA, I think those who have been trained are indeed familiar with it, but those who haven't been trained probably aren't. No, because I wasn't aware of it (of the implementation process with the PG-SGA) either."

Leadership: What are leaders (management or head of hospital departments) doing to reduce malnutrition?
 "Management says it is important, but I do not expect them to be actively involved."
 "I would say yes, if we are given time for it."
 "Direct management often focuses on other issues, but once you make it concrete, for instance, by stating that a severely malnourished patient stays three days longer, it suddenly becomes a financial concern."
 "Management is involved, but it feels somewhat like a vacuum".
 "Resources are allocated for training and time is made available for informational meetings."

Community climate: Do you think that addressing malnutrition and its risk factors is important for healthcare professionals?
 "It's yet another new thing to learn."
 "They (nurses) think it's a hassle in the patient records, or they say: this patient is heavier, so it's not necessary."
 "Those who are no longer open to innovation will likely see the PG-SGA as an obstacle."
 "I think there's still unfamiliarity and questions like: what kind of work will it bring, how will it be implemented, and what does it mean for us?"
 "There is some resistance to implementation; people often assume it will create extra work."

Knowledge of issue: How much do healthcare professionals know about malnutrition and its risk factors?
 "There is a lack of knowledge, simply not knowing."
 "I think it's (malnutrition) underestimated."
 "Overweight people are not malnourished. Yes, a major misconception."
 "I notice there is still little direct intervention."

Resources: What resources are available to address malnutrition and its risk factors? Would healthcare professionals and leadership support using these resources to address malnutrition and its risk factors?
 "There is support, such as adjustments in HIX (electronic health record), but it's unclear how many resources are available."
 "No, no idea." (*In response to whether funding for working with the PG-SGA is known*)
 "I think if something comes out of your study, they will likely support it."
 "As far as I know, there are no resources available to address the issue of underestimating malnutrition, such as volunteers, financial donations or grants, or experts."

Abbreviations: PG-SGA, Patient-Generated Subjective Global Assessment; SNAQ, Short Nutritional Assessment Questionnaire.

The Community climate appeared mixed, with a combination of openness and resistance to change. Concerns about increased workload, lack of familiarity, and misconceptions, such as associating malnutrition exclusively with low body weight, were frequently mentioned. Knowledge gaps were evident, as was uncertainty about the availability and accessibility of resources to support malnutrition interventions.

Discussion

This study found that the overall readiness of hospital nutrition support staff for implementing the PG-SGA SF was limited, with an average community readiness score of 4.0, indicative of the preplanning stage. All five CRM dimensions fell within the 3.5–4.5 range. Within this narrow band, Knowledge of efforts was highest (4.5 ± 1.9) and Resources lowest (3.5 ± 0.9); however, no dimension exceeded preplanning. This pattern indicates early recognition of the need to act, without concrete plans, roles, or resourcing in place.

Improving resource availability should be the top priority before implementing any changes. Staff acknowledged the importance of addressing malnutrition, but lacked clarity on actionable steps and expressed low motivation. A recurring barrier was insufficient time and staffing to screen, assess, and treat patients identified via the PG-SGA SF. Staff anticipated an increased workload from the new protocol. This concern is supported by other studies, which identified time constraints and competing priorities as common barriers to nutritional screening in clinical settings.^{26–28} A systematic review reported that having to deal with competing priorities is one of the most perceived barriers to nutritional risk screening.²⁶

Hospital staff exhibited limited knowledge about risk of malnutrition, its prevalence, causes, and consequences. This knowledge gap is likely linked to minimal nutrition education in professional training programs for healthcare workers.^{29–31} While the PG-SGA SF is generally considered user-friendly for patients,^{32–36} the professional section of the PG-SGA, particularly the physical exam, is often perceived as complex by dietitians, nurses, physicians, and physiotherapists.^{33–37} However, evidence suggests that with adequate training, the comprehensibility and usability of the full PG-SGA can significantly improve,³⁷ highlighting the importance of ongoing education.

Leadership engagement is essential to embed nutritional care practices into daily clinical routines. In this study, hospital leaders recognized malnutrition as an issue, yet their active support in driving improvements was limited. Previous research shows that managerial leadership, through prioritization and visible support, is crucial for integrating nutritional screening into routine care.³⁸ For example, support from ward managers has been linked to higher screening rates and more positive staff perceptions.³⁹ However, leadership does not only come from formal management roles. Sustained improvements often rely on professional leadership from within clinical teams. Although many healthcare settings use multidisciplinary teams, these often work in parallel, each within their own domain.⁴⁰ In contrast, interprofessional collaboration, marked by shared goals, joint decision-making, and mutual accountability, is essential for delivering high-quality nutritional care. As the World Health Organization states, this collaboration thrives when professionals, patients, and carers work closely together.⁴¹ In this context, dietitians are well-positioned to provide internal leadership, coordinating initiatives and promoting best practices.³⁹ Combining both managerial and professional leadership appears critical for lasting change in clinical nutrition practice.

Although the CRM has been used for the implementation of new practices regarding various types of health issues,¹⁸ this is the first study in which the CRM has been used in the context of the implementation of a new malnutrition practice in a hospital. The model was originally developed in response to the limited effectiveness and sustainability of interventions that failed to consider the target community's readiness for change.²² Prior efforts often lacked alignment with local needs and priorities; for example, discrepancies between the agendas of community leaders and members, or insufficient community engagement, frequently hindered the success of otherwise well-conceived initiatives.²¹ The goal of the CRM is to collect knowledge on how ready the community is at a certain time-point, and to get that community to a stage where implementing a new practice is feasible. Performing the community readiness assessment allows the implementation staff to tailor strategies based on the community's readiness to change. Involving hospital staff and leadership in identifying barriers and facilitators can enhance the relevance of malnutrition care strategies and foster greater ownership and integration of the PG-SGA into routine practice.¹⁸

Consistent with the results, knowledge gaps regarding malnutrition were observed across professional groups. Although Knowledge of efforts received the highest score in our data, responses still clustered within the preplanning–preparation range, indicating low awareness without consistent application in daily practice. This indicates that, despite some level of awareness, understanding of malnutrition and its risk factors remains insufficient and has not yet led to consistent application in daily practice. Similarly, one systematic review identified limited knowledge as a barrier among both nurses and general practitioners, reinforcing the persistence of this issue across disciplines.⁴² These findings underline the need for more than general awareness: targeted, practice-oriented education is crucial to enable actual change in nutritional care.

Furthermore, our study identified several barriers to implementing the PG-SGA in routine practice. The dimension scores were closely clustered and uniformly insufficient to support successful implementation, making it challenging to prioritize one specific area. Nevertheless, the dimension Resources should be the primary focus, as hospital staff were positioned between the vague awareness and preplanning stages of change. This finding suggests staff recognize the importance of the PG-SGA but either lack clarity about the required actions or sufficient motivation to initiate change.²³ Training could significantly address this barrier,³⁷ as increased knowledge and familiarity with the PG-SGA may enhance staff motivation and readiness to implement it effectively. Additionally, emphasizing that the PG-SGA is a low-budget intervention, requiring minimal professional time, no specialized equipment, and potentially even providing time savings by allowing patients to complete parts of the assessment independently,⁴³ may further enhance staff engagement and acceptance. Moving forward, it is essential to engage both hospital staff and leadership in systematically enhancing

community readiness dimensions and collaboratively identifying practical solutions to overcome implementation barriers.

A key strength of this study is the use of the CRM, a research-grounded framework that bridges theory and practice by offering structured insight into a community's preparedness for change. This enables the design of stage-specific, targeted interventions and provides a clear framework for identifying and addressing barriers to implementation.²³ The use of the CRM in this study offers valuable guidance for both future research and strategic action in advancing the adoption of the PG-SGA. A limitation of this study is the absence of nurses in the study population, which affects representativeness. Given their central role in patient care, it is critical to include nurses when developing and evaluating implementation strategies. Previous studies have identified nurse-specific barriers such as lack of time, training, and organizational support, which are relevant to the PG-SGA context but require further exploration based on the perspective of nurses on working with the PG-SGA.²⁸

Our readiness assessment followed the validated five-dimension CRM.¹⁷ While this scope is appropriate for our aim and supports comparability across studies, other healthcare implementation frameworks identify additional organization-level domains (eg, structure/governance, managerial and accounting systems, ICT infrastructure, HR policies).⁴⁴ These determinants fall outside the CRM's measurement scope, but may influence how readiness manifests locally; recognizing them can help tailor actions that move the implementation forward.

Future studies should also focus on the patients' perspective on a proactive malnutrition policy, their living environment, and social network. It is essential to identify facilitators and barriers that patients may encounter concerning the new malnutrition policy. Prior studies have highlighted psychosocial factors, such as loneliness and reluctance to be screened, as significant barriers to the implementation of malnutrition screening and treatment in community settings.⁴⁵ Additionally, understanding patients' experiences with nutritional care both before hospital admission and after discharge is crucial for optimizing continuity and quality of care. Research indicates that inadequate involvement of patients and their caregivers in nutritional care planning during transitions between hospital and home can negatively affect the quality of care.⁴⁶ Furthermore, individualized nutritional follow-up after discharge, including home visits by dietitians, has been shown to reduce hospital readmissions and improve nutritional status.⁴⁷

Conclusion

Hospital nutrition support staff showed uniformly low readiness (preplanning stage) on all community readiness dimensions to implement the PG-SGA SF. All five CRM dimensions fell within the 3.5–4.5 range; Resources was lowest and Knowledge of efforts highest, yet no dimension exceeded the preplanning stage. Several domains contributing to this limited readiness were identified, including insufficient Resources, low Leadership engagement, limited awareness of current initiatives, inadequate Knowledge of the issue, and an unsupportive Community climate. To address these barriers, recommendations are primarily directed toward hospital management and clinical leaders, who play a central role in ensuring sufficient resources and prioritization, as well as toward interprofessional nutrition support teams, who are responsible for improving collaboration and awareness. In addition, education and training initiatives should be targeted to all healthcare professionals involved in nutritional care, in order to strengthen knowledge and facilitate the successful implementation of the PG-SGA SF in hospital settings.

Data Sharing Statement

The data used to support the findings of this study are available from the corresponding author upon request.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

H. Jager-Wittenaar was co-developer of the PG-SGA-based Pt-Global web tool. The author(s) report no other conflicts of interest in this work.

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