Supplementary Table: Practice Points for Collaborative Client-Centred (Nutrition Education

Exploring One's Perceptions of the Nature and Purpose of Nutrition Education
Self assessment:
1. Recognize and assess one's beliefs, attitudes, knowledge, and skills, and how these affect approaches to nutrition assessment and nutrition education (NE).
2. Identify one's expectations for and beliefs about the nature and purpose of NE. Questions to guide self-reflection to identify one's assumptions about the nature and purpose of NE: i. Why do you think people eat what they do? ii. How does food intake relate to physical, mental, spiritual, or social well-being? iii. What is considered to be 'dietary change'? (How much of a change in what, how, why, when or where one eats is intended to be considered dietary change? For example, if a person does not change what they eat but they become less anxious about eating, is that considered dietary change?) iv. What is involved in changing eating behaviour? v. How easy or hard do you think it is to change eating behaviour? vi. What is a nutrition educator's role in bringing about dietary change? vii. Consider other reasons people might seek nutrition advice beyond an interest in changing their eating behaviour.
Practice Points:
3. Nutrition education may: i. involve supporting and guiding clients in whatever way they want to be helped to assist them to achieve their personal goals. ii. be about clients' relationships with others expressed through food. iii. be about addressing guilt, regret and other emotions associated with food choice/eating behaviour. iv. be a time to explore clients' myths, fears, barriers, misconceptions, and challenges. v. not always be about eating behaviours, or nutrients/food intakes. vi. offer opportunities to identify and address sources of dietary cacophony.[1]
4. Depending on a client's situation, it is sometimes best practice to **not** impart nutrition information.
5. Recognize that one's focus/approach will differ for each individual, family, or community.
6. Be compassionate, caring, nonjudgmental, and infinitely flexible to accommodate a diversity of learners.
7. 'Compliance' is a non-issue, and counter to client-centred goal setting. Aim to guide learner to their goal safely, not to command or direct. Recognize that one may aim for risk reduction rather than 'ideal' outcomes (e.g., if a client wants to lose a large amount of weight in a short time, or if a client wants to adopt an extreme diet restriction to cure their diagnosis).
8. Consideration of the 3CNE components is compatible with and may be used in conjunction with other counselling theories or approaches (such as motivational interviewing or Stages of Change).

[1] 'Dietary cacophony': The 'noise' people encounter about what, where and how they 'should' eat (1); this can be external to the person (in the media, through conversation or consultations) (2) or based on personal values and beliefs (3).

Context/Setting
Practice Points:
1. The approach taken and information shared will depend on the environment in which one works.
2. Learn about the community/context in which one works including: • determinants of health as these relate to income, literacy, and employment. • community resources and services.
3. Know the expectations (purpose and goals) of the program or service in/for which one works.
4. Determine whether or not one's work setting is appropriate for NE. Where it is not, advocate for context-appropriate NE services (e.g., if it is determined that the acute care setting[2] may not be an effective location for NE, consider options/alternatives and strategically present these to instigate change. One service should not be 'dropped' without ensuring a suitable alternative).
5. When planning to change the approach to NE to better address clients' needs/preferences, determine the receptivity in one's work setting.
6. Be aware of the NE services and programs available in your community. In some communities, effort may be required to enhance support services to improve client access to/preparation of food.
7. In the counselling/education space, resolve potential distractions such as lighting, distracting sounds, unpleasant smells, etc.
8. Dress appropriate to the location, setting, and client group.

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- In an acute care setting with limited time and opportunity for NE, dietitians may need to focus on supporting clients toward adequate food intake to aid recovery rather than on providing NE.
- Find out if a client is interested in discussing/able to discuss food, eating, or nutrition.
- Clarify that NE provided in an acute care setting is only survival education and that follow-up is recommended/required, then ensure follow-up is available.

Interpersonal Communication: Learning From and About Others to Work Collaboratively

Self assessment:

1. Self-assess one's preferred learning approach.
2. Self-assess one's communication strengths/weaknesses.
3. Consider how one might inadvertently express 'power over' rather than working collaboratively.

Practice Points:

4. Understand the value that people place on consulting with a dietitian. Attendance may be in response to a desire to learn, a referral, or obligation, and how that might impact the consultation.
5. Prepare for the emotional challenges often associated with offering NE. One often learns about life circumstances that are shocking or upsetting. It is important to develop personal coping strategies to be able to continue in the role.
6. Be aware of clients' schedules and plan time with them accordingly (respect appointment times; do not keep people waiting).
7. Develop skills in seeking client input including:
    a. establishing rapport
    b. framing questions to invite conversation
    c. active listening
    d. using open ended questions
    e. not interrupting
    f. appreciating clients' motives for seeking nutrition consultation
8. Develop NE approaches appropriate to clients' learning styles.
9. Be aware of verbal and non-verbal communications, particularly how one conveys beliefs in client abilities to self manage/make decisions.
10. Be dependable and honest.
11. Maintain confidentiality.
12. Instructional considerations:
    i. Make information meaningful (whatever it means to the client).
    ii. Create conditions for people to succeed; focus on what clients can eat rather than outlining all foods that they should avoid or limit.
    iii. Work with clients to break long term goals into workable steps (realistic, short term goals).
    iv. Integrate interactive/visuals/exercises into individual counselling and group presentations.
    v. Recognize that clients may ask for cooking tips and recipes in the absence of knowing how to phrase their question or concern. Clients may not know how to express their needs other than to ask for something tangible (e.g., recipes/cooking tips); seeking tangible information is one way to begin to make sense of the complexity of nutrition and what a person can do to alter intakes. This request can be a point of entry into a conversation and more meaningful interactions. Getting the basics sorted out gives people a chance to ask more questions.

vi. Use food in NE:

   a. providing food seems to have universal appeal.
   b. note that any food used has to look, smell, and taste good.
   c. sampling is enhanced when foods are simple to prepare, eaten in company with others, and where eaters can ask questions.
   d. provides opportunities to promote local foods.
   e. provide information during sampling provides a way to provide nutrition information simultaneously; this practice is adaptable to the varied dietary needs of different client groups.

vii. When asked to make presentations to groups, if you find that groups do not have topics to be covered in mind, have generic presentations available (based on the interests of previous groups).

Collaborating With Individuals, Families, and Groups

Practice Points:

1. Identify who the client is.

   Clients' may be/are not limited to individuals or family members attending a clinic or appointment, and participants in regularly scheduled groups or one-time-only sessions.
2. Learn about clients' expectations/goals/purpose/wishes/needs regarding NE (if desired outcome is physical, social, behavioural, functional, psychological, economic, other).
3. Assessment includes nutritional, narrative, and educational assessment
   a. Nutritional assessment includes:
      i. Macro and micronutrient needs
      ii. Proportion and timing of nutrient intake
      iii. Interpretation of biochemical measures
      iv. Clinical signs and symptoms
      v. Evaluation of anthropometric data (as appropriate)

   b. Narrative assessment includes:
      i. A typical day
      ii. Phrases/terms used to guide own terminology use (e.g., refer to 'roughage' instead of 'fibre')
      iii. Access to food including ability to shop
      iv. Cooking ability
      v. Cooking facilities
      vi. Health beliefs including:
         a. Cultural beliefs; how they think about their disease (3)
         b. Knowledge of the human body; use of food/nutrients
      vii. Relationship with food/eating
      viii. Relationships with others connected to or expressed through food/eating/feeding
      ix. Age-related issues or concerns
      x. Required supports

   c. Educational assessment
      - Interest in learning about food/nutrition
      - Health literacy
      - Literacy (ability to read, work with numbers, and problem solve)
      - Ability to conceptualize about nutrition (influences whether one offers concrete or abstract ideas about nutrition)

4. A client's diagnosis and symptoms are not always predictive of their NE needs and preferences whereas health status[3] does affect these needs and preferences. The more a client's medical condition affects their abilities to participate in regular daily activities, the more likely they are to prefer one-on-one, personalized consultations.
5. Blend/synthesize information from nutritional, narrative, and educational assessments in formulating a NE plan.
6. Share assessment findings and emerging plan with client(s) to co-create a plan.
7. Assess comprehension/engagement throughout any session for individuals, families or groups. Recognize 'ah-ha' moments or when a person is overwhelmed or distracted and address issues of importance to them. Don't continue on with the education session if it is obvious clients are not engaged or participating.
8. Sum up at the end of sessions as a reminder of what was covered (storytelling approach).
9. Collaborate to articulate troubleshooting strategies.
10. Determine need for and timing of follow up/monitoring/ongoing support (may be based on risk reduction, risk of malnutrition, etc.). Advocate for opportunities for follow up if this will reduce harm and offer other benefits to client(s), the community, or the health care system.
Notes/considerations about eating behaviour: • Providing information alone is not sufficient for behaviour change. • Recognize the complexity of eating and the multiplicity of actions needed to change one's diet (get information, shop, cook, serve, consume). Recognize that there are many ways where eating may go awry or pose challenges. • One cannot predict what it might take for a person to make change. • Figure out what it might take for behaviour change to happen, offering to serve as a guide/resource person. • Personalize information to optimize behaviour change. • Be realistic about the time required for people to change their behaviour (changes in shopping/cooking take sustained effort). • Prepare for relapses. Recognize that just because someone does not change their diet, it does not mean that they are a failure. • Recognize that you have not failed as a dietitian if your client does not change their diet.

References

1. Fischler C. Food, self and identity. Soc Sci Med. 1988;27(2):275–92. doi:10.1177/053901888027002005.
2. Morley C. Women's experiences of eating with changed health status. Doctoral dissertation. University of Calgary; 2002.
3. Wright L, Watson W, Bell J. Beliefs: the heart of healing in families. New York: Basic Books; 1996.

[3] Health status categories are: 1) Those living without acute or chronic medical conditions. We used the term 'well' (W) to refer to this group recognizing that people living with chronic conditions frequently consider themselves 'well' (3); 2) Those living with chronic, asymptomatic medical conditions whose activities of daily life (ADLs) were not affected (referred to as the 'life the same' (LS) group). People living with these conditions do not or only occasionally experience symptoms affecting abilities to shop, prepare food and to eat; eating activities at and outside of home are similar to their experiences before diagnosis (2); 3) Those living with life-altering (LA) or life-threatening (LT) medical conditions whose ADLs were affected. Consumers in this group experienced symptoms affecting eating on a daily basis; eating activities at and outside home were profoundly altered (2).