

Important Information for Authors

If you are a student author and do not supply your supervisor's name and contact details, your abstract will be automatically rejected.

Authors must seek the approval of all authors before submitting an abstract for consideration and supply all names and contact details. All authors will receive email confirmation of abstract submission.

Please be reminded that abstracts will no longer include graphical elements (figures or tables) and will move to plain text format.

Submission

Abstracts must be submitted through the online submissions system, Ex Ordo. You will be required to register with Ex Ordo to establish your username and password. All communications including acknowledgement, acceptance or otherwise will be electronic via Ex Ordo using the email address you have registered with. Authors must complete all required fields.

The maximum length of an abstract is 450 words (excluding references). References will be limited to 50 words.

You can alter your abstract any time up to the submission deadline – after this date, changes will not be possible.

Themes

Authors must select which Society Theme their research falls within; *Food Systems, Nutrition and optimum life course, Nutrition in the treatment, management and prevention of disease or Novel nutrition research methodologies and technologies*. Correct classification is important as it ensures that submissions are assessed by the correct reviewer and speeds up the review process. If you are unsure which Theme you should select, please visit the Theme Lead section on the Society website: <https://www.nutrition society.org/about/themes>

The review process

Before being accepted for presentation, abstracts are reviewed by a scientific and editorial committee consisting of conference organisers, Society Theme Leads and Trustees. Abstracts will be considered based on the quality of the communication in terms of its relevance to nutritional science, the substance of its results, and its originality.

Abstracts will be rejected for any of these following reasons:

1. Lack of data/statistics/results
2. Lack of co-author or supervisor agreement
3. No objectives/conclusion/methodology
4. Unoriginal work (previously presented/published)
5. Not sufficiently supported by references
6. Results not clearly presented
7. OC unclear and confusing
8. Concern about ethics
9. Failure to follow the instructions to authors

Presentation by oral or poster communications are given equal weight and are not differentiated upon publication in *Proceedings of the Nutrition Society* (PNS).

When submitting an abstract, authors will be asked if they would like to present a poster or an oral presentation. Where possible, the author's preference will be taken into account when arranging the programme.

Preparation of abstracts

Title: Use an initial capital letter only for the first word and for proper nouns. Abbreviations should not be used in the title.

Statistics: Indication should be given of the variability of replicated results and significance of any stated differences. A brief account of any statistical methods should be provided.

References: References should be presented as shown in the examples below. Citations should be numbered consecutively in the order in which they first appear in the text of your abstract using superscript Arabic numerals in parentheses i.e. ⁽¹⁾. The name of the journal should be abbreviated (<http://bit.ly/journalabbreviation>) and in italics.

Reference example

1. Collins A, Azqueta A & Langie S (2012) *Eur J Nutr* 51, 261-279
2. Normanton H, Houdijk JGM, Jessop NS et al. (2007) *Br J Nutr* 97, 104–110
3. United Nations Children's Fund (UNICEF) World Health Organization, International Bank for Reconstruction and Development/The World Bank (2020) _Geneva: World Health Organization. [Available at: <https://data.unicef.org/resources/jme-report-2020/>]

Author and Institution: Please list all authors initials, surnames and institutions as below. If there is more than one name and address they should be related by superscript numbers.

Author and Institution example

J. Jess¹, H. Taylor¹ and P. Hickford²

1. Faculty of Health & Social Sciences, Bournemouth University, Bournemouth, UK and 2. The Royal Bournemouth NHS Trust, Bournemouth, UK.

Please find below abstracts examples.

For publishing queries, please email: pns.edoffice@cambridge.org

For conference queries, please email: conferences@nutritionssociety.org

Abstract Examples

A year in the public life of COVID-19 and vitamin D: representation in UK news and social media and implications for future health communications. By R. Innes¹, E. Miyake², D. Pennington³ and A. Mavroeidi¹ 1. *Physical Activity for Health Research Group, School of Psychological Sciences and Health, University of Strathclyde, Glasgow, UK*, 2. *Department of Journalism, Media and Communication, University of Strathclyde, Glasgow, UK* and 3. *Department of Computer and Information Sciences, University of Strathclyde, Glasgow, UK*.

The scientific basis for the potential relationship of vitamin D status with COVID-19 is mainly based upon the association of low serum concentration of 25(OH)D with increased susceptibility to acute respiratory tract infections⁽¹⁾, which are prevalent within the COVID-19 pathology. As such, especially at the beginning of the pandemic, vitamin D was at the centre of media attention, often portrayed as a potential therapeutic agent in the combat to slow down the rate of the infection⁽²⁾.

The aim of this investigation was to examine how the relationship between vitamin D and COVID-19 was presented in different media sources (traditional e.g. UK newspapers vs. social e.g. Twitter) and assess the level of misinformation associated with this issue by comparing media content to evidence-based guidelines.

Data were collected over the first year of the pandemic (February 2019–20), from the social medium Twitter and 5 of the most widely read UK based newspapers using the keywords “vitamin D” and “COVID”. An inductive thematic analysis was carried out on the data to identify themes and subthemes. Quality control of the coding was conducted on a sample of the dataset (20%). Data were also compared to the “ground truth” identified as the NICE report titled “COVID-19 rapid guideline: vitamin D”⁽³⁾ to explore the accuracy of media outputs.

The same four themes were identified from both traditional and social media sources, ‘association of vitamin D with COVID-19’, ‘politically informed views’, ‘vitamin D deficiency’ and ‘vitamin D sources’. All but two of the sub themes were also identical. However, the content within each subtheme differed across sources. For example, newspapers regularly recommended 10 microgram supplements, whereas Twitter users frequently stated that this dose was “grossly underestimated”. When relevant codes were compared to the NICE report, 72% of the codes from newspaper articles were ‘correct’, whereas 81% of the codes from Twitter relating to were ‘incorrect’.

Although the same types of information were shared across media sources highlighted by the identical main themes, the representation of the relationship of vitamin D with COVID-19 differed. This study highlights that health-related misinformation remains a prevalent issue especially on social media platforms, despite attempts from companies such as Twitter to combat the issue⁽⁴⁾. The amount of misinformation was notably lower in the newspaper articles, but still present. Future research should focus on the accuracy of media outputs to further investigate health misinformation as an issue (in both traditional and social media) and how that may affect public health. Attempts should be made to improve journalistic integrity through more rigorous and standardised regulations enforced across all media outlets so that public knowledge on current events is based on evidence rather than conjecture.

References:

1. Ilie P, Stefanescu S & Smith L (2020) *Aging Clin Exp Res* 32, 1195–1198
2. Carter S, Baranauskas M & Fly A (2020) *Obesity* 28(7), 1176–1177
3. National Institute for Health and Care Excellence. (2020) [Available at: <https://www.nice.org.uk/guidance/ng187/resources/covid19-rapid-guideline-vitamin-d-pdf-66142026720709>]
4. COVID-19 misleading information policy. (2021). [Available at: <https://help.twitter.com/en/rules-and-policies/medical-misinformation-policy>]

Improving inpatient assessment of nutritional status using the Malnutrition Universal Screening Tool (MUST). By R.A. Shah¹, Z. Soo¹, L. Thornhill², J. Martin² and A. Montagu² 1. *John Radcliffe Hospital, Oxford University Hospitals NHS Foundation Trust, Oxford, UK and 2. Department of Geratology, John Radcliffe Hospital, Oxford University Hospitals NHS Foundation Trust, Oxford, UK.*

Up to a third of patients admitted to hospital are at risk of malnutrition, leading to longer inpatient stays and increased risk of complications and readmission⁽¹⁾. Early assessment of nutritional status is therefore crucial to minimise morbidity and mortality. The most commonly used validated screening tool in the UK is the Malnutrition Universal Screening Tool (MUST). The MUST is designed to assess nutritional risk and, if detected, triggers further action such as referral to a dietician. Oxford University Hospitals NHS Foundation Trust guidelines state that a MUST should be completed within 6 hours of admission and should be repeated weekly in prolonged admissions.

Aims:

1. Assess the accuracy, timing and frequency of MUST recorded for patients admitted to 4 long-stay medical wards
2. Assess and improve staff awareness of the MUST to improve recognition of patients at risk of malnutrition.

A spot audit of MUST assessments of all inpatients on 4 long-stay medical wards on a single day in October 2020 was undertaken. Following this, a pre-intervention staff questionnaire was carried out across the same wards to assess understanding and awareness of the MUST. Subsequently, an educational poster on the MUST was produced, and a brief face-to-face small group educational session was performed with staff on one of the 4 wards. A post-intervention staff questionnaire was undertaken to re-assess understanding, and a re-audit of MUST screening of patients on the same ward was carried out the following month.

79 inpatients from 4 long-stay medical wards were included in the initial audit. Only 3% (2/79) of MUST screening was completed within 6 hours and 81% (64/79) completed at all during admission, with 50% (24/48) of patients with an admission >7 days receiving weekly MUST screening. 17 staff of various roles across all 4 wards completed the pre-intervention questionnaire, of which 71% (12/17) were able to identify all 3 components of the MUST. Following the educational intervention on one ward, this improved to 91% (10/11; $p = 0.35$). A re-audit on the same ward demonstrated 5% (1/20) of patients met the 6-hour MUST target ($p = 0.50$), but overall improved completion of MUST for 95% (19/20) of inpatients during their admission ($p = 0.18$). A statistically significant improvement was demonstrated with repeat MUST screening, with 100% (10/10) of patients with an admission >7 days having weekly screening ($p = 0.0034$).

We have demonstrated that a brief face-to-face educational intervention can have a positive impact on improving staff understanding of the MUST and its usage in keeping with local guidelines. We plan to carry out the intervention across the remaining long-stay medical wards, and to consider involving the short-stay medical wards. In addition, electronic reminders and/or repeat educational sessions would be beneficial to improve long term impact, considering staff turnover on the wards.

Reference:

1. BAPEN. Introduction to Malnutrition: Who is at risk of malnutrition? [Available at: <https://www.bapen.org.uk/malnutrition-undernutrition/introduction-to-malnutrition?start=1>]