BAPEN COVID-19 Service Improvement & Innovation Awards Entry Form

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Summary of the Service Improvement & Innovation:

Good nutrition and hydration is essential to support recovery and rehabilitation of many patients following hospital admission due to COVID-19 infection. During the COVID-19 pandemic the GSTT community dietetic team implemented a virtual Rapid Access Dietetic Clinic (RAC) in Lambeth and Southwark. The goal of the RAC is to optimise patient's nutritional status by streamlining nutrition care between secondary and primary care settings. The RAC enables timely dietetic review post-hospital discharge, particularly for individuals at risk of further nutritional decline in community settings resulting from COVID-19 (i.e. taste changes, muscle wasting, continued weight loss), including those who are housebound, and/or socially isolated.

The RAC runs twice weekly with two dietitians (one community dietitian and one prescribing support dietitian) undertaking 30 minute telephone reviews. Eligible patients receive dietetic review within two weeks of hospital discharge. Acute dietitians complete a RAC referral via an Electronic Patient Record (EPR) referral form. To be eligible patients must:

- be adults (≥16 years)
- be community dwelling, free living or housebound, residing in Lambeth or Southwark Local Care Partnerships (LCPs)
- require oral nutritional support (ONS) following acute admission
    - including patients requiring ONS secondary to nutritional implications of COVID-19
    - additionally, those identified as malnourished or at risk of malnutrition (including those with long term conditions, frailty, falls, dysphagia and pressure ulcers) requiring dietetic review following hospital discharge

RAC dietitians assess adherence to nutrition care plans post-discharge and modify ONS prescriptions accordingly. They identify barriers impacting nutritional intake in the community and may complete onward referrals to GSTT Integrated Local Services (community teams) and Primary Care Network (PCN) teams, including General Practitioners (GPs), district nursing, social services and the voluntary sector. Following RAC review, patients may be re-directed into specialist dietetic outpatient clinics, referred to the community dietetic team or discharged from dietetic care.

Challenges faced and how they were overcome:

1) **Caseload management and dietetic capacity**

The GSTT community dietetic team provide support to community sites in Lambeth and Southwark PCNs including care homes, rehabilitation sites, community clinics and individuals whom are housebound. The COVID-19 pandemic caused a significant increase (35-40%) in referrals. Housebound patients referred to the community dietetic team often required urgent dietetic assessment. Care homes and intermediate care sites also required a significant increase in dietetic support, for patients with or recovering from COVID-19. Implementation of the RAC helped to support caseload demand, ensuring patients received timely dietetic review post-hospital discharge.

2) Establishing and running the clinic

The RAC was designed and implemented in June 2020, during the COVID-19 pandemic. Challenges faced and actions taken are summarised below:

- Implementing a new referral pathway to establish the service required collaborative work and close communication across all GSTT dietetic teams. Through weekly COVID-19 huddles questions and concerns could be discussed and resolved. The community dietetic team collaborated with Intensive Care Unit (ICU) dietitians to ensure appropriate community support was available for patient's post-ICU admission.
- Streamlining the referral process helped to reduce time required by acute dietitians when completing RAC referrals. This was supported by the administrative team and use of the EPR system.
- The administrative team assist to ensure patients are available for their appointment, and RAC dietitians confirm patients have not been readmitted or experienced discharge delays. During acute assessment, dietitians gain patient consent for referral to the RAC and inform them of their appointment time.

3) Providing appropriate dietetic support to patients

RAC dietitians identified review within 7-14 days post-discharge was optimal. Reviews within seven days had not provided sufficient time for patients to adapt to their home setting. Reviewing patients following seven days at home ensured they could share experiences of eating, drinking, and achieving nutrition goals in their home environment, as well as highlight challenges faced and support required. For patients experiencing social issues, RAC dietitians facilitate prompt onward referrals to relevant local services including social, voluntary and local care networks. Within the appointment RAC dietitians effectively prioritise the most pertinent issues and provide a detailed handover to the subsequent dietitian highlighting key issues for follow up.

Evaluation and Outcomes:

Six weeks following implementation a snapshot sample of 10 patients who had been reviewed in the RAC were audited to evaluate whether goals of the clinic were being met. All 10 patients met the referral criteria for the RAC.

Patient's age ranged from 49-99 years and 60% were female. Body Mass Index (BMI) ranged from 14.1-29.9kg/m^2 with a median of 22.15kg/m^2. Eighty percent of patients were at medium or high risk of malnutrition and over half scored two or more on the Malnutrition Universal Screening Tool, indicating high risk of malnutrition.

Patients were reviewed on average 12 days post-hospital discharge and 80% were seen within 14 days. Half of the patients had been prescribed ONS on hospital discharge and three patients continued ONS following RAC dietitian review.

Following RAC dietitian review half of the patients were referred to the community dietetic team. One patient who had been followed up within one day post-discharge was rebooked into the RAC clinic, one was referred to their GP dietitian and three were discharged from dietetic care.

Actions completed by RAC dietitians included:

- Provision of more clinically appropriate and cost-effective ONS samples
- Education regarding high energy, high protein foods, food fortification strategies and nourishing recipes, tailored towards individual progress in the home environment
- Provision of strategies for symptom management
- Communication with community multidisciplinary teams (MDT) including GPs, allied health practitioners and GSTT Integrated Local Services
- Communication with and provision of support for patient family and carers

Future Plans:
Following initial pilot roll out, the RAC will continue for all patients whom meet eligibility criteria. Ongoing evaluation incorporating patient feedback and clinical outcomes will be used to assess effectiveness and identify areas for development. Continuing to broaden and strengthen collaboration with PCNs including GPs, social services and the voluntary sector, community MDTs, and all relevant acute teams will contribute to ongoing success of the RAC.