Name of project: Dietetic care home nutritional support pathway review

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Kent Community Health NHS Foundation Trust

What was our aim?

The aim of the project was to increase dietetic staff capacity, without having a negative effect on patient outcomes and quality of care.

Why is it important to service users and carers?

The Kent Community Health Foundation NHS Trust (KCHFT) Dietetics Service recognises the need to use staff resources in the most efficient and effective way to meet the service demands. A review of the nutrition support patient pathway for care home patients was undertaken. It was identified that many patients remained on the caseload for long periods of time. Patients often plateaued with ongoing visits not translating into positive changes in nutritional status. Patients taking oral nutritional supplements (ONS) long term were not discharged from the service and received ongoing reviews, although the care plan remained the same. Dietetic staff reported having large caseloads sometimes felt overwhelming. Working in a manner where patients were discharged appropriately in a timely manner would reduce the number of patients on each clinician's caseload overall and could improve staff motivation and job satisfaction. Staff well-being is important at KCHFT.

It was felt that quality interventions could be achieved in a shorter time if patients were given a robust initial assessment and early follow up appointments to monitor progress. It was also felt that patients taking ONS could be discharged if clear parameters were set for re-referral.

Ideas and tests of change

Dietitians, associate practitioners and assistants generated ideas. Two pilot studies were developed.

1 – Front loading of dietetic advice

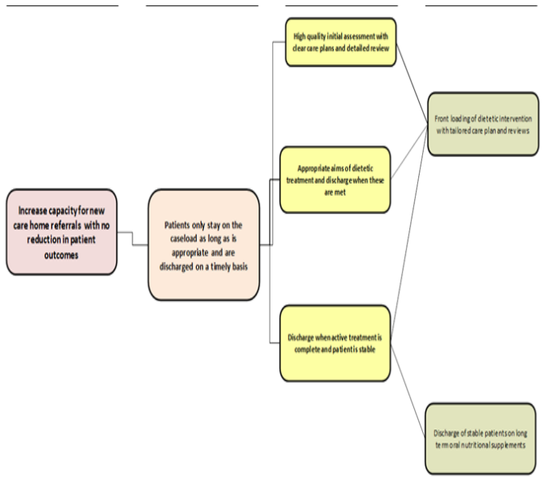
Initial visits were extended to 60 minutes from 30 minutes, with reviews scheduled for 30 minutes. A comprehensive initial assessment would be undertaken to devise a clear individualised nutrition care plan which would be left with the care home staff on the day of assessment. Goals for review and discharge would be set at the first visit. A detailed review against the goals and care plan would be undertaken monthly with appropriate adjustments made. Patients would be discharged when the care plan was fully implemented and their goals met.

2 – Discharge of stable patients on oral nutritional supplements

Criteria were developed to identify patients deemed appropriate to discharge. The clinicians would communicate the discharge plan clearly with the patient and care home staff. A report would be sent to the GP and copied to the care home with clear parameters for rereferral relating to weight loss or gain. For the purposes of the pilot it was planned to carry out a weight check of patients six months post discharge and review whether they had been rereferred.

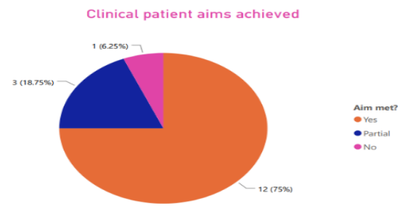
The tools we used

For the project, stakeholders were identified and a project team created. A brainstorming session was held to generate ideas. The patient pathway was processed mapped and baseline data identified. A driver diagram was formulated. Once the pilot studies were identified a PDSA cycle was used to make any changes needed to the pilots as they were carried out, although the changes made were minimal.



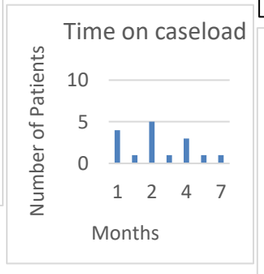
Results/How did we do/Anticipated outcome

Front Loading: Aimed for more than 25 patients to complete dietetic treatment but due to Covid this did not happen, 32 patients started the pilot and 16 completed treatment.

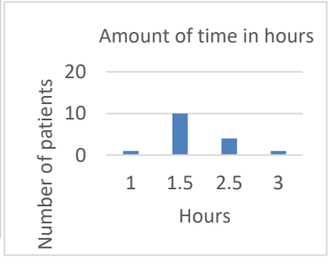


Quality of assessment assessed: aim of treatment, requirements, intake and deficit calculated, detailed care plan, reviews against care plan. All patient's notes met these quality indicators

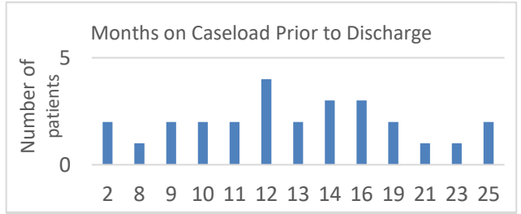
Current pathway more than seven visits over two years. Many patients were seen monthly or two.

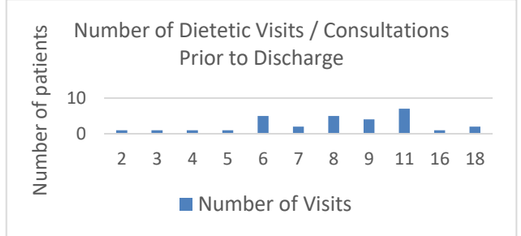


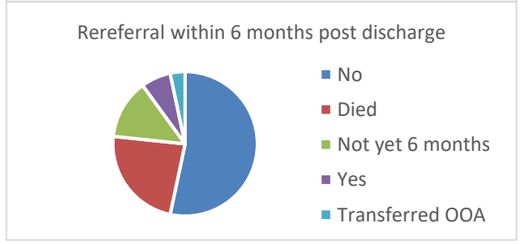
Current pathway estimated 30 minutes for a new assessment and 15 for a review. Pilot allocated 60 minutes for an initial assessment and 30 for a review.



Discharge on Oral Nutritional Supplements: 30 patients included in the pilot,







What we learned and what's next

Front Loading of Dietetic interventions:

Patients received high quality assessments and detailed visits. They had fewer visits and were on the caseload for a shorter time. Fifteen out of 16 of the patients that were discharged during the pilot had less or equal time with dietetic staff. This would indicate that in the future referral to treatment times would be reduced, confirming the potential for fewer long-term patients on the caseload.

The care home pathway has been reviewed and rewritten and is being incorporated into the reset plans for the Dietetic Service.

Discharge on Oral Nutritional Supplements:

Stable patients on ONS could be discharged from dietetic care without detriment to their nutritional status as long as clear rereferral criteria were set.

At six months post pilot, two patients had been re-referred and one of these was not appropriate. The other was reassessed and their ONS was increased appropriately.

Discharge of stable patients on ONS has been introduced across the Dietetic community team.

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