# A PRESCRIBING SUPPORT DIETITIAN FOR CARE HOMES

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**Prescribing Support Dietitians (PSD) have generally been employed to ensure the clinical and cost-effective prescribing of oral nutritional supplements (ONS) in the community, with the management of nutrition support patients. This role continues to grow to include a variety of settings and focus has extended to gluten-free products, infant formulas and thickeners.**

In 2013, I was offered the role of PSD for care homes, working within the Integrated Response Team (IRT) that covers care homes for adults in the northern part of West Sussex.

The IRT is made up of nurses, a pharmacist and a dietitian. It is commissioned by Crawley, Horsham and Mid-Sussex Clinical Commissioning Groups (CCGs) to work with those care homes identified as needing support by members of the IRT steering group. The group includes representatives from the CCGs, adult safeguarding team, West Sussex County Council and local GPs.

The IRT works in collaboration with care homes to improve awareness of community services and to empower staff through training and education in order to provide consistent evidence-based care. This leads to a reduction of inappropriate and unnecessary 999 calls, A&E attendances and hospital admissions. We also provide general support to all care homes in the area through our care home forums, newsletters and rolling training programme.

## SUMMARY OF THE DIETETIC ROLE

The Prescribing Support Dietitian role within the IRT aims to raise the standard of nutritional care provided within care homes through advice, training and support to all staff involved in food and fluid provision. The role focuses on the prevention of malnutrition, the early identification of those at risk and reducing complications. The role also aims to ensure the appropriate use of oral nutritional supplements.

Liaison with other healthcare professionals and teams that support care homes guarantees consistent evidence-based messages around the common nutritional concerns and nutritional management of individuals at risk of malnutrition in care homes. For example, involvement in the care home champion meetings for community nurses and presenting at tissue viability nursing team meetings.

## BACKGROUND

It is known that malnutrition and dehydration in care homes can lead to increased risk of hospitalisation, readmission and long term ill health[1].

The British Association for Parenteral and Enteral Nutrition (BAPEN) found that over 37% of residents admitted to care homes were either malnourished or at risk[1]. This highlights the need for excellent nutritional care. However, the Dignity and Nutrition report from CQC showed that one in six homes did not meet the standard set for nutritional care (outcome 5)[1].

This role provides opportunity to engage with a wide range of stakeholders linked to care homes with the aim of raising the awareness of the importance of recognising malnutrition early, preventing its development and treating the condition appropriately.

The emphasis has been around improving nutritional care in care homes, increasing knowledge and confidence in adopting a food first approach for residents who are at risk of malnutrition.

For article references please visit info@networkhealthgroup.co.uk

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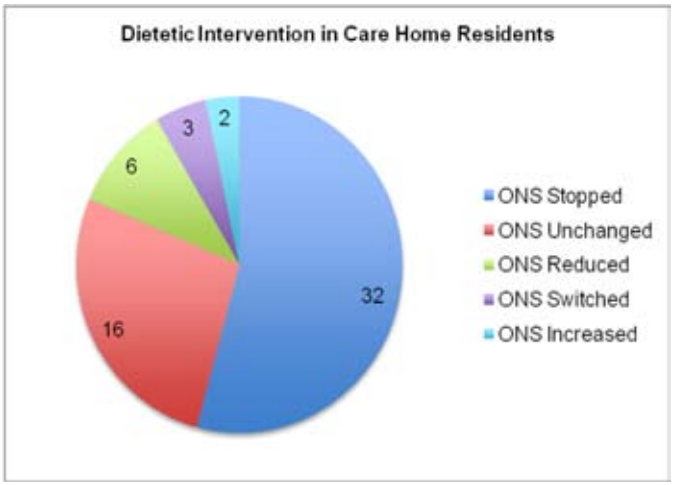
Chart 1: Resulting change in ONS prescription following dietetic intervention




Improving residents' nutritional status through food is the most appropriate way to manage the risk of malnutrition and the associated complications of this. Malnutrition brings the associated costs of an increased number of GP visits, more prescriptions, slower healing, reduced immunity and longer hospital stays which is estimated to cost the UK economy £13 billion per year[2].

Oral nutritional supplements (ONS) are a common treatment for malnutrition and can be inappropriately prescribed. ONS are often initiated before food fortification and dietary counselling has been trialled, frequently with no assessment or goals of treatment. Food should be a first line treatment[3, 4], although lack of knowledge, historical use and inconsistent messages promote care home staff to regard ONS as the 'magic bullet' to treat malnutrition.

By supporting care homes to provide balanced nutritious menus, providing education on the timely identification and management of malnutrition and to raise awareness of the appropriate use of oral nutritional supplements, (i.e. use of ONS only if meeting Advisory Committee for Borderline Substances (ACBS) criteria after dietary measures have been unsuccessful in achieving goals of treatment), there is a reduction in the number of oral nutritional supplements needed. This approach offers significant cost savings and cost avoidance to the Clinical Commissioning Group(s).

The IRT Prescribing Support Dietitian:

- reduces inappropriate prescribing of oral nutritional supplements through education, training and clinical assessments;
- empowers carers to support a residents' return to a balanced food intake, reducing the need for inappropriate ONS;
- empowers carers to use Food First throughout their home, thereby reducing requests for ONS prescriptions;
- improves nutritional care as described above, which can:
  - reduce admissions
  - reduce readmissions
  - reduce hospital stay
  - improve quality of life and promote independent living
  - reduce long-term dependence on ONS
  - maximise food intake facilitating long-term recovery and nutritional health[2, 5].

## KEY COMPONENTS OF THE PSD FOR CARE HOMES ROLE

### Dietetic assessments and reviews

All residents in the care home who receive a prescription for an oral nutritional supplement are assessed and then reviewed (with GP and, if possible, resident consent) by the IRT dietitian.

Exclusions:

- Those under the care of another dietitian. In this case, contact is made to inform them of IRT intervention and dietetic aims around ONS and Food First.
- Those individuals with enteral feeding tubes in situ.

59 residents were reviewed in eight care homes over a nine-month period (see Chart 1).

- 32 residents (54%) assessed did not require further prescription for oral nutritional supplements after dietetic advice, so a request to the GP was made to stop prescriptions.

- 11 residents (19%) had their prescription modified; reduced or product change or increased.
- 16 residents (27%) had no changes made to their prescription:
  - Some patients were end of life or had advanced dementia, so it would have been challenging and distressing to discontinue the prescriptions. Unfortunately prescriptions are often commenced in these groups with good intentions, but inappropriately. Perhaps to be seen to be providing nutritional support or due to challenging behaviour and repeated food refusal.
  - Some residents did meet ACBS criteria and required ONS to support their nutritional status (such as those with COPD, Parkinson's and oesophageal stricture). However, education was needed to ensure that Food First was implemented as well as ONS in order to gain the greatest benefit.

There is strong evidence to confirm that the majority (78%) of prescribing is inappropriate based on findings of:

- 19 residents having MUST scores of 0 (i.e. healthy weight and no significant weight loss).
- 42 residents on ONS not meeting the ACBS criteria for prescription.
- 13 residents prescribed only one dose daily.
- Food First advice consistently not being fully implemented.

Findings show that due to the complexities of resident's clinical condition, family, resident and carer expectations, cultural reliance and lack of knowledge that ONS is consistently used inappropriately. For example; A pudding style supplement was being used as dessert rather than using the menu options available. This was costing the CCG £3.92 per day (two items); a fortified pudding would provide greater calories (fortified mousse provides 308Kcal compared with between 170-200Kcal by standard pudding style ONS) and costs the care home ~£0.38. Ceasing ONS is therefore a challenging process.

Dietetic expertise is required to assess residents that may not require ONS, but due to a variety of factors should continue with their prescriptions. Where possible, more cost effective products are recommended, hence the reason that 54% of residents prescribed ONS had the recommendation to stop, not the 78% found to be receiving prescriptions inappropriately. This is where the importance of effective training on the identification and management of malnutrition, particularly around prevention, is vital. This role ensures engagement with the key stakeholders to promote and cascade the preventative and Food First messages, resulting in better nourished residents and fewer requests for ONS.

### TRAINING

In-house training around identifying and managing malnutrition is provided to those homes identified to the IRT. This is tailored to include case studies and documentation relevant to the home and the staff attending. The majority of staff trained are carers (i.e. not registered nurses).

All training is designed to deliver simple take-home messages that can easily be implemented in a care home, e.g. the use of fortified milk for all residents. Evaluation is consistently positive with 98% of attendees rating the training as very good or excellent.

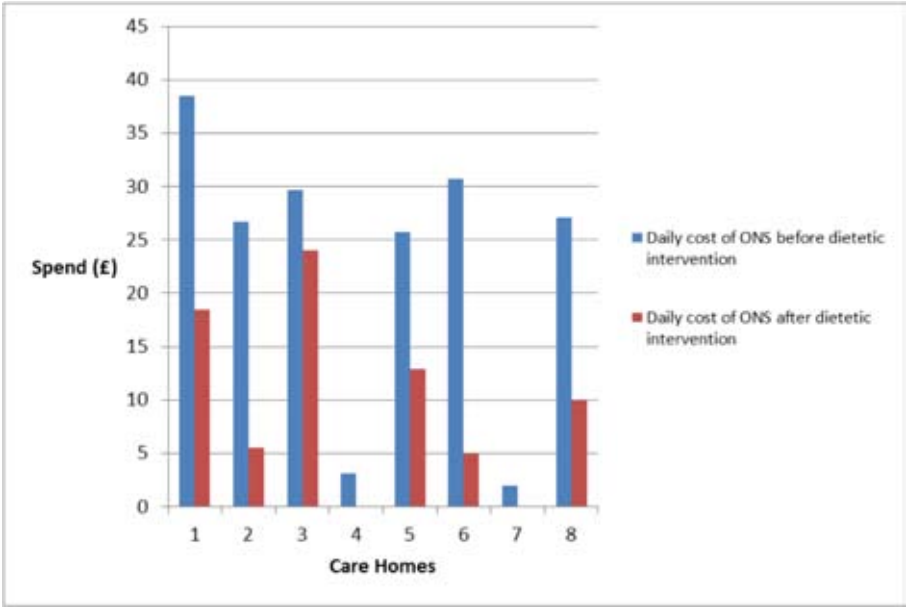
A generic nutrition training session is delivered on our rolling training programme. Common concerns encountered during the team's work have prompted the development of workshops including bladder and bowel (nutritional management of constipation), dysphagia management and 'MUST'. The importance of good nutrition and Food First messages are included in all the training delivered by the IRT.

## Resources

Listed below are the resources that have been developed to support care home staff to deliver excellent nutritional care:

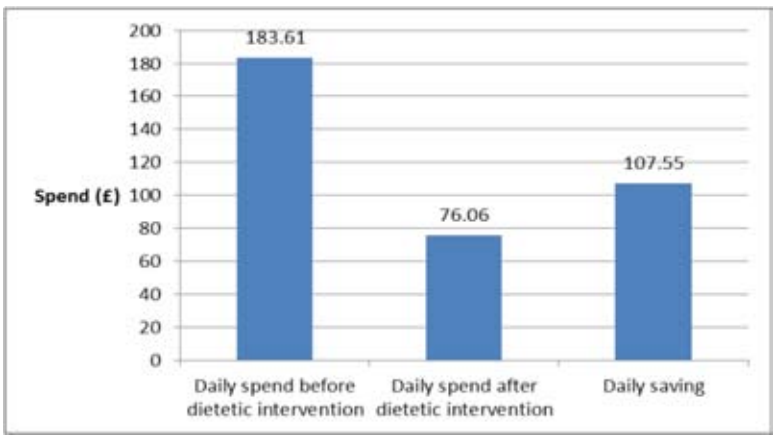
- Nutritional Care:
- Food First advice to promote weight
- Nourishing drink recipes
- Managing Constipation
- Using oral nutritional supplements
- Diabetes Mellitus and diet
- Overview of meals (catering advice)
- Core actions and minimum standards for nutrition and hydration
- MUST record sheet and actions
- Malnutrition assessment
- Dignity at mealtimes (advice when assisting individuals to eat and drink)

Graph 1 shows the reduction in ONS usage following dietetic intervention in the IRT focus homes




*Lower savings achieved in Care Home 3 due to a large number of residents transferred from another home with complex needs and a heavy reliance on ONS. It is very difficult to reduce or cease ONS in end of life or in residents that have become dependent on ONS.*

Graph 2: Total savings on ONS across 8 IRT focus homes




## Key Performance Indicators

The dietetic role has three main KPIs attached against which the role is measured and evaluated.

### KPI 1: Reduce usage of ONS by 50%

- On average 18% of residents across the eight homes (all nursing) were prescribed ONS.
- Across the eight homes the number of ONS (as items) was reduced by 77%.
- This represents a 59% reduction in spend ONS products.

### KPI 2: 80% of target care homes are using a validated malnutrition screening tool:

- 100% of focus homes are using MUST at the end of IRT intervention.
- An audit was carried out by the team to assess nutrition screening, accuracy of the result,

documentation of results and actions if the resident is identified at risk. This local audit highlighted frequent screening, but often scores were inaccurate with little or no evidence of action in the nutrition care plan[6].
- MUST training is now provided as part of the bespoke training delivered in focus homes and is included on the rolling training programme.

### KPI 3: Reduce prevalence of malnutrition by 5.0% (from baseline assessment):

- National data suggests between 32-42% of older adults in care homes are malnourished[7].
- This is reliant on care homes screening accurately, which has been found not to be the case locally.
- Therefore, baseline data collection includes nutrition screening on 50% of residents undertaken by the team to ensure accuracy of data.
- Current data suggests prevalence in line with national reporting.
- Care homes have this repeated at the three- to six-month review.
- Data collected for one care home at the six-month review point suggested a decrease in the prevalence of malnutrition in the region of 6.0% from baseline assessment.

## COST AVOIDANCE

Dietetic intervention can reduce prevalence of malnutrition and dehydration, which in turn could prevent falls, UTIs, constipation, promote wound healing and prevent the initiation of ONS 5.

All of these factors have a significant impact on cost both in terms of quality of life and finance. This cost avoidance is difficult to measure.

The possible exception would be avoidance of ONS prescriptions; however, because only those individuals already prescribed ONS are seen, the cost avoidance linked to improved nutrition and thus preventing requests for ONS is difficult to estimate.

It is likely that as a result of the education, training and resource that is put into the focus homes and messages cascaded via the IRT newsletter and through forums and rolling training, that many residents who would have started on ONS did not, because the Food First message had been implemented and those at risk identified earlier, thus preventing deterioration.

As part of this role, liaison with the CCG's GPs, medicines management team and other teams, such as tissue viability nurses, admission avoidance and community nursing also provides opportunity to further promote the Food First message. All nurses within IRT are aware of and promote the Food First message.

## FUTURE AREAS OF WORK

- Reduce laxative prescriptions: Laxative use is widespread in care homes. There is some evidence demonstrating a reduction in laxative use by introducing fruit smoothies onto the care home menu[8].
- Reducing inappropriate use of thickeners (e.g. Nutilis, Thick and Easy, Thicken-Up): Observations suggest an over use of thickening agents, often after a 'coughing episode'. This can in fact negatively impact on the hydration status of residents by reducing fluid intake causing dehydration[9] and which, in turn, can contribute to falls, delayed wound healing, reduced cognitive function and quality of life. This inappropriate use is again at a cost to the CCG. Training and resources targeting this will aim to positively impact on the malnutrition and dehydration commonly seen in residents with dysphagia.

## CONCLUSION

A Prescribing Support Dietitian for care homes is proving to be an effective and high quality intervention for improving the nutritional care of residents in care homes and reducing inappropriate prescribing of oral nutritional supplements.

The role is far reaching through liaison with other community based teams, GPs and medicines management to promote 'Food First'. Without the dietetic role, malnutrition in care homes would continue to be under recognised, under treated and inappropriate prescribing of ONS would continue.

## Working with care homes

**Challenges encountered in raising awareness of malnutrition and its management**

- The assumption that the elderly do lose weight and this is normal. This has been found elsewhere[10].
- Poor communication between staff - care staff do not routinely read care plans and are not encouraged to inform the plan[10]. Care staff often know their residents in great detail, but this is not reflected in the documentation.
- Poor care planning with generic statements such as 'to provide Mr X with a balanced and varied diet'; no detail as to what this means to them or how to deliver this.
- Food and fluid charts that are poorly completed, therefore, potentially suggesting that residents have not been offered food or drink at certain times of the day. Often staff are not clear as to why a resident is on a food and fluid chart and the charts are never evaluated, further impacting on their completion[11].
- MUST is a tick box exercise - it often seems not to matter what the MUST score is; there is no difference reflected in the care plans and MUST is simply something that 'CQC expect to see'[6].
- Lack of awareness about how to manage 'challenging behaviour' in people with dementia. Often this means residents are malnourished and may be prescribed ONS for the sake of doing something.
- 80% of people living in care homes have dementia or memory problems[12]. Some care home staff may not understand how to communicate with or manage those with dementia[13].
- Residents at end of life are prescribed oral nutritional supplements because the resident is not eating and/or for the sake of doing something.

**Our solutions**

- Assumptions and 'myth busting' around weight loss, 'normal' weight for older persons and use of ONS is always included in nutrition training and all related training.
- The importance of good documentation is thread through all IRT training and a workshop (includes care planning, food and fluid charts and screening tools) specific to this topic is now included on the teams rolling training programme.
- Basic information and awareness raising around dementia is discussed during training, resources provided and care homes are signposted to the specialist dementia care teams in the area.

**Key points to remember when working with care homes**

**General**

- It may be obvious, but remember to work with the care home and consider what is important to them, what the barriers are and what can they change and implement.
- Consider who your stakeholders are. It may be obvious to engage with the manager and catering staff, but there may be a member of staff who has a particular interest, works daily and could be your nutrition champion. Other members of staff soon 'role model' and your suggestions become part of the daily routine.
- Do not assume that your advice 'to provide homemade fortified milkshakes' will be carried out. Be specific - maybe ask the chef about their ideas, where they can source dried milk powder/egg white powder from, suggest specific amounts to add to different food and drinks. Discuss how this can be implemented, when and by whom?

**Training**

- Staff will always benefit from training even if it is a refresher, a reminder on MUST and the benefits of detailed personalised care plans and good documentation.
- Keep your key messages SMART - provide only a few specific key messages; you may be able to build upon these if you visit the home regularly. If someone doesn't understand, it is likely not to be done.
- Use the care homes own documentation for examples if possible, e.g. their food and fluid charts. Also, try to use some of the residents as case studies - this relates the training to the home and helps staff engage.
- Add in some information about managing some of the behaviours associated with dementia, such as distracted from eating or wanting to walk/restless at mealtimes. The Caroline Walker trust has published an excellent resource which can support you with this. 'Eating Well: supporting older people and older people with dementia'[14].
- Several short 'bite-sized' training sessions may be better to deliver key messages to staff than trying to deliver one three-hour session. Always encourage the manager and catering staff to attend.
- Make any training very interactive. All the training IRT delivers almost 100% of attendees state that their favourite part is the discussion, games or practicals.
- One size does not fit all - focus on the areas that can be improved in that particular home, even if it is just one thing.
- Do not get frustrated! Sometimes the care home is not in the 'right place' - it may be a better use of your time to postpone intervention until the new manager is in place, for example.