Medicines Optimisation Innovation Centre

HSC Health and Social Care

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Evaluation of New Models of Prescribing (NMOP):

Dietitian led direct ordering of oral nutritional supplements for care home residents

August 2022

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Overview of New Models of Prescribing project

Introduction

Northern Ireland lacks mechanisms to allow some prescribers working at interfaces between primary and secondary care to prescribe treatments directly to their patients. This means that there may be duplication of work, with the original prescriber needing to work through the patient's General Practitioner (GP) to ensure that the required treatments are prescribed.

In order to address these issues, a transformation project led by the Health & Social Care Board (HSCB) and involving extensive stakeholder engagement, was established to scope out the arrangements that need to be in place to enable prescribers working at the interface to work in a more effective and autonomous way. The stakeholder engagement established key principles to enable New Models of Prescribing (NMOP) (Figure 1).

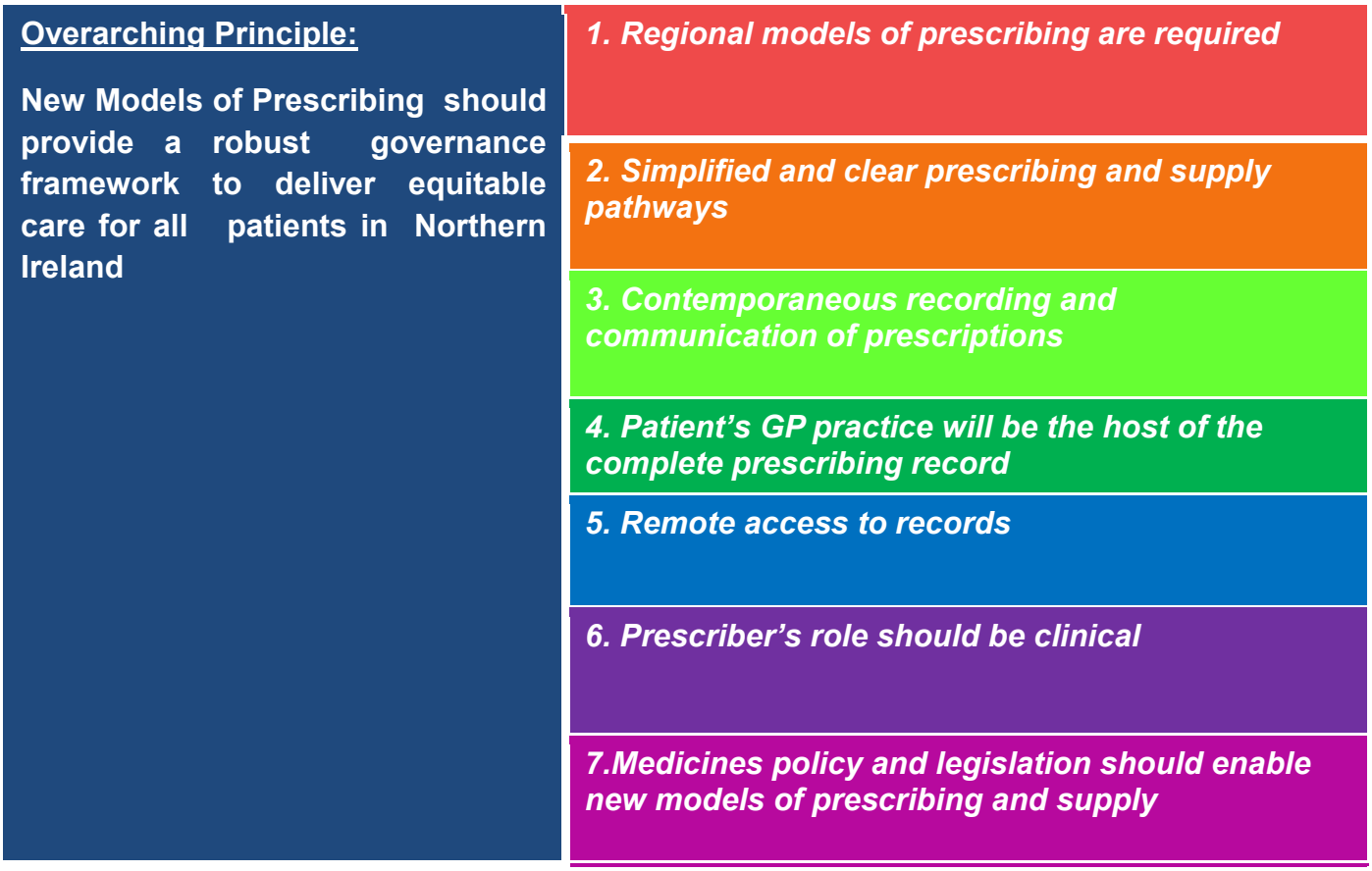


Figure 1 Agreed NMOP Principles

A number of pilot projects were initiated to explore the processes, governance and policy frameworks required for new models of prescribing (NMOP). The pilots included:

- Dietitian led direct ordering of oral nutritional supplements for care home residents
- Physiotherapist prescribing at the interface: community and outpatients
- Heart failure specialist nurse prescribing at the interface
- Mental health home treatment team: medical and non-medical prescribers

The Medicines Optimisation Innovation Centre (MOIC) is a regional centre in Northern Ireland dedicated to delivering medicines optimisation to the population. MOIC were tasked with assisting in the evaluation of the NMOP pilot studies.

One of the pilot projects focussed on dietitian led direct ordering of oral nutritional supplements for care home residents. This report will describe the evaluation of that pilot. The terms of reference for the Dietitian led direct ordering of oral nutritional supplements for care home residents can be found in Appendix 1.

Context

Care home residents, who are assessed as having additional nutritional requirements, should have a management care plan that aims to meet their complete nutritional requirements. To supplement the first step of fortified food measures, oral nutritional supplements (ONS) are often prescribed by GPs, usually on the recommendation of a dietitian. Dietitians currently do not have prescribing rights but changes to legislation have been proposed to support supplementary prescribing of medicines in secondary care by advanced dietitians. However dietitians already have the skills and expertise to assess and monitor residents for nutritional needs, recommending and stopping nutritional products as clinically indicated and it is reasonable to propose that the clinical responsibility for ordering these items can sit with them.

A MORE nutrition pilot in 2019, involving eight care homes in South Eastern Health & Social Care Trust (SEHSCT) locality, identified that waste of ONS products over a 3-month period in care homes was 24% of the prescribing costs. A key recommendation for improvement suggested by the care homes, GP practices and community pharmacists, was the direct input of dietitians to the ordering process.

NHS Tayside has successfully implemented a dietetic led stock order service for care homes in the Dundee area. The service has demonstrated improved management of residents and, prescribing savings mainly achieved from reduced wastage due to inappropriate prescribing. Additional savings have recently been identified as a result of an NHS managed supply process.

This pilot tested a similar concept through dietetic led ordering of ONS for residents in care homes in Northern Ireland, without the need for generation of a GP prescription. Monthly stock orders for the care home residents were raised by the dietitian rather than individual resident orders.

Two supply mechanisms were tested as outlined below and in Table 1:

- ONS supplied by community pharmacy contractor who normally supplies medicines to the care home
- ONS supplied by Business Services Organisation Procurement and Logistic Services (BSO PaLS) (a similar approach to NHS Tayside supply model)

Between April and June 2021, six care homes from three Health and Social Care Trusts in Northern Ireland participated in the Dietetic ONS NMOP Pilot.

Table 1. Supply mechanisms established for pilot

Process	ONS Supply by Community Pharmacy	ONS Supply by BSO PaLS
Who will order ONS?	A Trust dietitian will order ONS for the care home residents on a monthly basis, following resident assessment, using a stock order form which will be issued to the pharmacy using the secure email address.	A Trust dietitian will order ONS for the care home residents on a monthly basis, following resident assessment, using a stock order form which will be issued to BSO PaLS via eProcurement.
How will community pharmacy contractor be reimbursed?	The contractor will code the stock order form in the same way as a GP stock prescription and will then submit the prescription to BSO FPS (via a dedicated email address) to process for payment. In order to reimburse the community pharmacists participating in the supply option of the pilot, BSO has agreed to process the order forms for payment in the same way as a GP Stock form.	Community pharmacy contractor will be compensated for loss of income.
Trusts	Belfast Health & Social Care Trust and Western Health & Social Care Trust (BHSCT & WHSCT)	Northern Health & Social Care Trust (NHSCT)
Number of care homes	4	2
Dietitian's role	The dietitian will liaise with care home staff and use a digital stock management module along with nutritional requirements of all residents to generate future orders.	The dietitian will liaise with care home staff and use a digital stock management module along with nutritional requirements of all residents to generate future orders during the pilot period.

Aims and objectives of NMOP Dietetic ONS pilot evaluation

The overarching aim was to complete an evaluation of the Dietetic ONS pilot through joint working between MOIC and Health & Social Care Board (HSCB).[1]

The objectives were to:

Objective 1	Establish potential volume of ordering activity that can be shifted to dietitians
Objective 2	Identify benefits in relation to access to ONS and reducing pressure on GPs
Objective 3	Identify any risks associated with the sustainability of a new model e.g. workforce
Objective 4	Support and enhance the delivery of tailored dietetic interventions to residents, maximising professional skills at the point of care delivery
Objective 5	Support the delivery of care pathways that can be delivered by a dietitian
Objective 6	Reduce delays in residents accessing ONS
Objective 7	Support a reduction in waste of ONS
Objective 8	Support optimum use of technology in processes
Objective 9	Support improvements in resident / client concordance with taking ONS
Objective 10	To agree measures and collect relevant data to measure the outcomes for residents[2]
Objective 11	To agree and implement measures to capture the experiences of care home and dietetic staff, GPs and community pharmacists, and BSO PaLS.[2]

[1]On 31 March 2022 the HSCB was closed and its staff and functions migrated to the Strategic Planning and Performance Group (SPPG) of the Department of Health on the 1st April 2022

[2]Achieved in the project set up phase

Evaluation methodology

An analysis plan linking project objectives to the collected data was co-produced by MOIC, HSCB and clinicians participating in the NMOP pilot. Division of tasks under the plan was agreed between HCSB and MOIC (Appendix 2).

In line with the agreed analysis plan, the following outcome measurement and analysis was undertaken:

- **Stakeholder feedback**
    - **Virtual discussion:** An agenda for a virtual feedback session was co-produced by HSCB and MOIC. Mentimeter software was used to capture quantitative agreement ratings and qualitative commentary from contributors. Qualitative feedback from participants was analysed using a theming approach. Average agreement ratings from the participants on how the pilot met the project objectives were obtained. All data has been summarised and is presented in this report.
    - **Stakeholder survey**: A survey co-designed by HSCB and MOIC was launched via Citizen Space. Descriptive statistics were used to summarise responses. Qualitative feedback from participants was themed and mapped against the project objectives.
    - **General Practice Pharmacists (GPPs) feedback:** GPPs were asked to provide general feedback on the pilot service which has been included in the stakeholder feedback.
- **NMOP audit activity**: Between April and June 2021, six care homes from three Health and Social Care Trusts in Northern Ireland participated in the Dietetic ONS NMOP Pilot. Assigned dietitians from each care home collated baseline and end of pilot data through clinical audits. Audit activity was collated using Excel. Data was quality checked and re-categorised as necessary. These data were agreed by HCSB and MOIC. Descriptive statistics were used to summarise activity at the start and end of the pilot and results were tabulated. Additional supporting information were summarised in text.

- **Supply route process maps**: Clinicians participating in the NMOP pilot summarised the supply route at the start and end of the pilot. The main steps from the process at the start and at the end of the pilot were extracted from the text and summarised as a flowchart figure. Key findings were summarised.
- **Resident journeys**: Clinicians participating in the NMOP pilot summarised resident journeys which emerged during the pilot. The key findings are summarised in this report.
- **Summary of stock orders and prescribing data**: Average monthly prescribing costs pre-pilot were obtained from prescription payment data collated by BSO Family Practitioner Service (FPS) to facilitate community pharmacy dispensing payment, in conjunction with care home prescribing data systems developed by NISRA. The reported costs may be slightly different to the actual costs due to some limitations with the raw data e.g. NISRA information relies on identification of a care home resident's health and care number from a prescription which has been 2-D bar code scanned; GP practice generated prescription scan rate can vary and is not currently 100%.
    - It was anticipated that the stock order payment system used by BSO FPS would provide the data to analyse the dietetic raised stock orders. This proved challenging due to multiple factors including dates of orders and inconsistencies in submitting forms for payment. A spreadsheet was created instead to collate information from all the stock orders written by the dietitians for each care home to facilitate the cost analysis. March 2021 product price list was used to ensure consistency.
    - BSO PaLS provided costs for product they supplied during the pilot.
    - The time period for costs analysis extended beyond the pilot period to ensure results were as robust as possible; the analysis period was January to November 2021.
- **Audit of Good Nutritional Care Training delivered to care home staff:** An educational package 'Good Nutritional Care in Care Homes' was delivered to the care homes taking part in this project. Outcomes were obtained for these

sessions with the use of pre and post knowledge based polls during the sessions (Appendix 9).

- **Supplementary information:** Comments were sought from the ONS suppliers (community pharmacists or BSO PaLS), to supplement feedback from the stakeholder workshops and survey, to enhance understanding of the challenges and benefits of the two supply models.

Results

Virtual stakeholder feedback session

Data from 15 stakeholders involved in the pilot was collected at a stakeholder feedback session. During the stakeholder feedback session, agreement ratings on whether the pilot met the overall objectives of the project were collected using Mentimeter software this was analysed and presented using descriptive statistics presented in Table 2. In addition, discussion on a range of topics was documented via note takers directly into the Mentimeter software. Thematic analysis took place to analyse the results. The results are summarised within the report with additional extracts supporting the thematic analysis in Appendix 3.

Mentimeter ratings

The stakeholders were asked "how strongly do you agree or disagree to the following statement" and asked to select a score from 1-5 (5 = strongly agree and 1 strongly disagree). Overall, there was strong agreement that the pilot met the overall objectives of the project.

Table 2: Agreement ratings on whether the pilot met the overall objectives of the project

Question	Mean Score
Robust governance arrangements were put in place to ensure safe and effective ordering and supply of ONS	4.5
The pilot supported the delivery of care pathways that can be delivered by a dietitian	4.5
The pilot project maximised the use of dietetic professional skills at the point of care	4.6
The pilot project optimised the use of technology in processes to enable order and supply of ONS for care home residents	3.6
The pilot project displaced prescribing of ONS for care home residents from GP practices	3.9
This pilot project reduced delays in residents accessing ONS	4.1
This pilot project supported a reduction in waste of ONS	4.3

Stakeholder feedback survey

An online survey was developed to obtain the views and experiences of a range of key stakeholders. The survey was created by the Task and Finish Group and shared with MOIC for input. It was circulated after the stakeholder feedback workshop, to Task and Finish group Members, GPs, GP Pharmacists (GPPs) and Community Pharmacists via secure email, and care home staff via dietitians. There were 24 responses in total. Most of the responses were from GPs and GPPs (Table 3).

Table 3: Respondents to stakeholder survey

Stakeholder	Number	Percentage
GP / GPPs	11	46%
Dietitian	3	13%
Community Pharmacist	2	8%
Care Home Nursing Staff	2	8%
Dietetic Services Manager	2	8%
RQIA	1	4%
BDA	1	4%
PHA	1	4%
HSCB	1	4%
Total	**24**	100%

Most of the respondents (83%) worked in one of the three participating localities, where the pilot project was implemented.

Stakeholder survey and virtual stakeholder feedback discussion

Does dietitian-led ordering of ONS on stock order benefit residents?

The majority of respondents (92%) felt that dietitian-led ordering of ONS via stock order benefited the resident with the remaining 8% indicating that they were unsure. Just under half of the cohort provided further comment (Appendix 4). Benefits included: reducing delay in ONS supply; improved food fortification practice; more

efficient use of ONS; more streamlined communication with appropriate healthcare professionals.

There was only one negative comment from a dietitian relating to the volume of paperwork.

Feedback from the virtual stakeholder feedback discussion supported the Key Findings outlined as follows:

Key Findings: Do you feel this pilot benefits the residents?
• Reduces delay in residents accessing ONS • Increased resident choice leading to improved compliance • Reduces burden on GP practice and community pharmacy • Improved communication across disciplines • Residents have access to specialist clinician • Care home staff more informed about food first, food fortification and ONS • Reduced waste of ONS • Releases care home staff capacity to care for other needs • Comprehensive documentation to support nutritional intervention.

Do you feel that the dietetic ordering and alternative supply mechanisms were beneficial?

Most respondents (83%) indicated that the dietetic ordering and alternative supply mechanisms were beneficial. Those who were unsure (17%) highlighted reservations with the BSO PaLS supply mechanism and the need to ensure dietitians were informed of stock availability. Benefits cited included cost savings, improved mechanisms for care homes, less waste and reduced GP input required.

Feedback from the virtual stakeholder feedback discussion supported the Key Findings in relation to ordering and alternative supply outlined in this report:

Key Findings: Dietetic ordering and alternative supply
• Reduction in ONS waste • Utilisation of dietitians' skills • Reduced risk of incorrect product being supplied • Released GP capacity • Access to ONS now only takes 24-72 hours from time of ordering • Improved partnership working • BSO PaLS supply route was challenging

Were respondents happy for dietitian-led ordering of ONS for care home residents to continue?

Most of the respondents (96%) indicated that they were happy for dietitian-led ordering of ONS for care home residents to continue. Some respondents provided additional information for example, supporting the efficiencies achieved during the pilot and detailing the value they placed on the governance arrangements which had been put in place. Some of those in support of the service continuing highlighted the need for allocation of an adequate resource. Full details of the additional comments provided can be found in Appendix 4.

One respondent, a community pharmacist from NHSCT locality was not satisfied as they didn't see the BSO PaLS supply route as a viable long-term solution.

Feedback from the virtual stakeholder feedback discussion supported the key findings:

Key Findings: Happy for pilot to continue?
• Organised and safe mechanisms in place • Withdrawal of service would be detrimental to all stakeholders and decrease use of "food first" approach • Recurrent funding required to secure appropriate dietetic input • Community pharmacy supply route should be used

Do you feel that the pilot project contributed towards a reduction in delays in residents accessing ONS?

Three-quarters of respondents agreed that the project contributed towards a reduction in delays in residents accessing ONS. One respondent, a community pharmacist from NHSCT locality disagreed, and five other respondents were unsure. Further comment can be viewed in Appendix 4.

Feedback from the virtual stakeholder feedback discussion supported the Key Findings presented:

Key Findings: Reduction in delays in residents accessing ONS
• Access to trial of ONS available from stock on day of dietetic assessment • Time to arrange delivery of stock greatly reduced with community pharmacy supply route • Stock system provided immediate access to ONS for new residents • BSO PaLS route required authorisation of eProcurement order by a Trust Pharmacy Manager

Do you feel that the pilot project reduced ONS waste?

Most of the respondents (83%) agreed that the project reduced ONS waste. Again the community pharmacist from NHSCT locality disagreed as they considered the arrangement they had already in place to deliver ONS on a weekly basis to care homes, was the reason for reduced waste.

Feedback from the virtual stakeholder feedback discussion supported the key findings as follows:

Key Findings: Pilot project reduced ONS waste
• Non-labelling of ONS facilitated use of product across a number of residents where appropriate • Stock managed according to use • No longer need to dispose of ONS if resident admitted to hospital or deceased • Easier to facilitate changes to resident ONS requirements without incurring waste • Choice of flavours reduces taste fatigue • New supplement record easily identifies the unacceptability of a particular product for specific residents

Common themes from the data collected for stakeholder feedback were extracted and are summarised in Figure 2. The themes include: enhanced communication, interface with other health professionals, resident focussed, effective use of skills, robust processes, stock supply, reduced waste, time saved, training, I.T. and Inhealthcare. The themes were mapped against each objective. A summary of the themes linked to the objectives are presented in Table 4 and further detail with supporting extracts in Appendix 3.

Table 4 Key themes identified from feedback provided at stakeholder workshop aligned with project objectives

Theme	Mapping to Project Objectives[3]
Enhanced Communication / Interface with other HPs	*Objective 1,2, 4, 5, 6*
Resident focussed	*Objective 4, 5 ,6, 9*
Effective use of Skills	*Objective 1, 5*
Processes	Objective 4,5
Stock Supply	*Objective 3, 5*
Reduced Waste	*Objective 4, 5, 6, 7, 9*
Time Saved	*Objective 2, 4, 5, 6*
Training	*Objective 1, 4, 5*
IT/ Inhealthcare	*Objective 4, 5, 8, 9*

[3] For full details of the project objectives please refer to page 9

Figure 2. Key themes identified from stakeholder feedback

What do you think were the positives of this project?

Nineteen (79%) respondents provided a response to this question. These can be viewed in Appendix 4. Responses included improved resident care, prompt access to ONS, more efficient use of care home staff resource, implementation of Inhealthcare software to assist with stock management and improved working relationships

Feedback from the virtual stakeholder feedback discussion supported these findings. In addition the virtual group discussed reduced risk, greater oversight, one point of contact for pharmacy, no resident specific labelling of products required, intervening at an earlier stage, improved collaboration and increased efficiency as key positives of this project. Further information on the virtual stakeholder feedback session can be found in Appendix 3.

Key Findings: Positives

- Improved resident care
- More timely access to ONS
- Multidisciplinary working
- Better time management within care homes, GP practices and community pharmacies
- Reduced waste
- Maximising use of dietitians' skills
- Streamlined processes
- Reduced storage space required in care homes
- Networking across organisations and UK regions
- Governance arrangements and systems

Additional feedback from the virtual stakeholder feedback discussion:

- No resident specific labelling required
- Reduced risk
- Intervening at an earlier stage
- One point of contact for pharmacists (with dietitian)
- Greater oversight
- Increased efficiency
- Improved collaboration

What do you think were the challenges associated with this project?

Three-quarters of respondents provided a response to this question. These can be viewed in Appendix 4. Responses included difficulties with introducing change, underestimation of dietetic resource required at start-up and engaging care home staff in stock management processes.

Feedback from the virtual stakeholder feedback discussion supported the Key Findings presented below. In addition the virtual group discussed the set up processes being time intensive and some issues arising from the BSO PaLS model as key challenges of this project.

Key Findings: Challenges

- Managing change
- Adequate dietetic resource
- IT literacy among care home staff
- IT software and hardware resource in care homes
- Maintaining GP records and avoiding duplication of supply
- BSO PaLS supply difficulties
- Care homes insisting on weekly deliveries
- Misinterpretation of project aims by some community pharmacy representatives
- Responding to concerns of nutrition companies regarding BSO PaLS supply

Additional feedback from the virtual stakeholder feedback discussion:

- Starting process is quite long to get up and running. Easier to maintain once up and running
- If lots of residents come through together it can be difficult to manage.
- Some of the terminology within the letters could have been explained better to families.
- Brexit and supply of food items to NI.
- BSO PaLS supply model had more limited range of ONS
- Limitations of the pilot model meant dietitian time required had to be

estimated during set up. In addition some residents who would have been discharged but kept on because of pilot.

- Storage facilities

Additional feedback from discussion with ONS suppliers

- There were unforeseen challenges with set up and implementation of the BSO PaLS supply model:
- The range of products to be supplied for the NHSCT care homes was wider than anticipated
- BSO PaLS had a restricted range of products available for supply due to limitations of the Regional Secondary Care Nutrition Framework. This led to delays in supply of products and the need for additional GP generated resident prescriptions for the two NHSCT care homes.
- Additional steps were required in the authorisation process for e-procurement
- Locally agreed existing supply arrangements between the NHSCT care homes and the participating community pharmacies hampered the BSO supply model.

What improvements/considerations should be made for full implementation?

Over half of respondents (58%) advised on improvements / considerations for full implementation. One respondent highlighted the need to involve families of the service redesign and to ensure use of appropriate terminology in resident information.

Feedback from the virtual stakeholder feedback discussion supported these findings. In addition the virtual group discussed central leadership and buy in from all HSC Trusts as key improvements / considerations for full implementation of this service.

Key Findings: Improvements / considerations for full implementation
• Raise awareness among key stakeholders • Increased dietetic resource for initial implementation • Determine dietetic skill mix • Training for care home staff on food fortification and Inhealthcare system prior to implementation • Full implementation of Inhealthcare digital platform, including stock management module • Recurrent funding • Streamline to include one supply route only • Clear nutrition strategy for care home residents • Review / implementation of NI formulary to reduce variation • Ensure buy-in from care home sector • Share outcomes of pilot with key stakeholders • Agreed reimbursement model for Community Pharmacists • Wording of resident information resources to be considered Additional feedback from the virtual stakeholder feedback discussion: • Consider introducing dietetic assistants and support workers • Ensure buy-in from all HSC Trusts • One regional system to be considered • Appropriate funding for Community Pharmacy • Care pathway • Central leadership and ownership for full scale roll out • Optimal frequency for those under active dietetic care versus in a stable maintenance phase • Clear guidance on roles and responsibilities for all of those involved

Additional comments

Less than half of respondents (46%) provided a response listing additional comments. These can be viewed in Appendix 4. Responses reflected the job

satisfaction experienced by participating dietitians, the appreciation of an integrated and collaborative approach to the project and perceived benefits to residents.

Key Findings: Additional Comments
• NMOP pilot is an example of collaborative approach • Effective project management • System-wide benefits achieved

Feedback from General Practice Pharmacists

In addition to the virtual stakeholder feedback session and the stakeholder survey, feedback from the General Practice Pharmacists (GPPs) was also welcomed for this project. The feedback from GPPs was very positive and in favour of the service. Two areas identified by the GPPs as possible areas for improvement were:

- The form looks very similar to previous dietetic letters and was nearly missed as a clinician didn't notice the difference
- If the service continues there should be more communication with GPs

GPPs involved in the project were also encouraged to participate in the survey and feedback sessions as appropriate the results of which are summarised in the sections above. Full details of the feedback from GPPs can be found in Appendix 5.

Dietetic ONS audit activity

Between April and June 2021, six care homes from three Health and Social Care (HSC) Trusts in Northern Ireland participated in a pilot of new models of prescribing (NMOP) for dietetic oral nutritional supplements (ONS). There were two care homes participating from the BHSC Trust (B1 and B2), two from the NHSC Trust (N1 and N2) and two from the WHSC Trust (W1 and W2). An audit of ONS prescribing was undertaken before and after the pilot was delivered at each care home.

Data was collected by the dietitian responsible for delivering pilot activities at each care home. A Microsoft Excel spreadsheet was completed at each care home and compiled into a pre- and post- pilot database by the NMOP project manager. All analysis was undertaken using Microsoft Excel. Frequencies and percentages were

reported to present the information. Missing or incomplete data were reported where applicable.

Care homes and residents

At the beginning of the pilot, there were 207 residents living in the pilot care homes. Some 48% (n=101) of those residents were being supplied one or more ONS items for nutritional support. By the end of the pilot, 30% (n=67) of residents at the pilot care homes were on ONS (total number of residents at the end of the pilot = 222). Tables 5 and 6 provide a breakdown of the numbers of residents at each care home and the proportion of residents on ONS before and after the NMOP pilot.

Table 5. Care home and resident characteristics

	Pre-Pilot	Post-Pilot
Total number of residents in pilot care homes at time of audit	209	222
Care home	**n**	**n**
B1	18	24
B2	64	64
N1	29	28
N2	16	22
W1	37	35
W2	45	49
Trust		
BHSCT	82	88
NHSCT	45	50
WHSCT	82	84

Table 6. Number and percentage of residents in pilot care homes who were supplied with ONS at time of audit

	Pre-Pilot		Post-Pilot	
Total	101/209	**48%**	67/222	**30%**
Care home				
B1	10	56%	9	38%
B2	28	44%	19	30%
N1	13	45%	12	43%
N2	5	31%	3	14%
W1	29	78%	13	37%
W2	16	36%	11	22%
Trust				
BHSCT	38	46%	28	32%
NHSCT	18	40%	15	30%
WHSCT	45	55%	24	29%

Prior to the NMOP pilot, not all residents prescribed ONS were under the care of the Trusts' dietetic teams. Some residents may have been discharged from the dietetic team but were continuing with ONS for review by the GP, or in other cases ONS was initiated by GP without dietetic input e.g. on request of the care home, or residents may have been awaiting assessment by dietetic services. Table 7 outlines the number and percentage of residents who were supplied with ONS and were under the dietetic care services pre- and post-pilot.

Table 7. Number and percentage of residents in pilot care homes who were supplied with ONS and were under dietetic care services at time of audit

	Pre-Pilot		Post-Pilot	
Total	49/101	**49%**	62/67	**93%**
Care home				
B1	6	60%	8	89%
B2	11	39%	19	100%
N1	8	62%	12	100%
N2	2	40%	3	100%
W1	9	31%	9	69%
W2	13	81%	11	100%
Trust				
BHSCT	17	45%	28	96%
NHSCT	10	56%	15	100%
WHSCT	22	49%	20	83%

The Dietetic ONS audit also investigated whether, or not, residents under the care of dietetic services had been reviewed within the timelines specified per their individualised care pathways. Before the pilot, 31 residents (63%) were reviewed within the set timeline and 7 residents (14%) were not. Data was missing, unknown or unspecified for 11 residents. After the pilot, all residents had been reviewed within the timelines specified in their care pathways. Figure 3 outlines the breakdown of these findings per Trust.

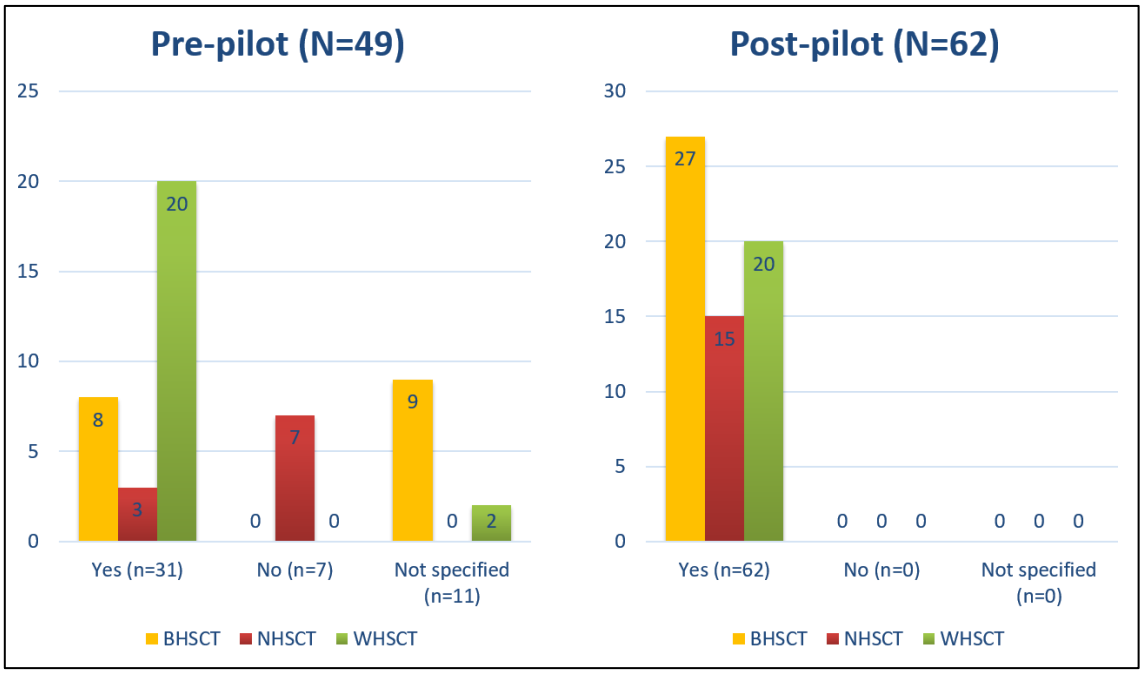


Figure 3. Resident under dietetic care reviewed within timelines as specified per care pathway

Prior to the pilot, when GPs were responsible for issuing prescriptions for ONS items, a total of 36 GP practices were prescribing for residents at the six pilot care homes. A breakdown per care home and HSC Trust is provided in Table 8.

Table 8. Number of GP practices prescribing ONS items at pilot care homes before the pilot

	Pre-pilot
Total	36
Care home	
B1	7
B2	15*
N1	3
N2	1
W1	5
W2	5
Trust	
BHSCT	22
NHSCT	4
WHSCT	10

*** GP practice 'unknown' for 4 residents**

ONS items

Information regarding the number and type of ONS items was collected; a baseline audit was completed for each care home in March 2021 and a final audit was completed in June 2021. These snapshot audits indicated the range of product types supplied to residents reduced from 134 to 81 during the pilot period (Table 9).

Table 9. Number of ONS items supplied to residents in pilot care homes

ONS data	Pre-pilot	Post-pilot
Total	**134**	**81**
Care home		
B1	15	12
B2	34	25
N1	14	13
N2	6	4
W1	44	14
W2	21	13
Trust		
BHSCT	49	37
NHSCT	20	17
WHSCT	65	27

Before the pilot, 82% (n=11) of all ONS items suppled to residents at the care homes were initiated through dietitian recommendation. At the end of the pilot, this had increased to 98% (n=79) (see Figure 4). One of the two ONS items not started by a dietitian had been initiated by the Acute Care at Home Team. There was no information about who initiated the remaining item. Notably, at the end of the pilot no ONS items were being requested by the care home or initiated by a GP.

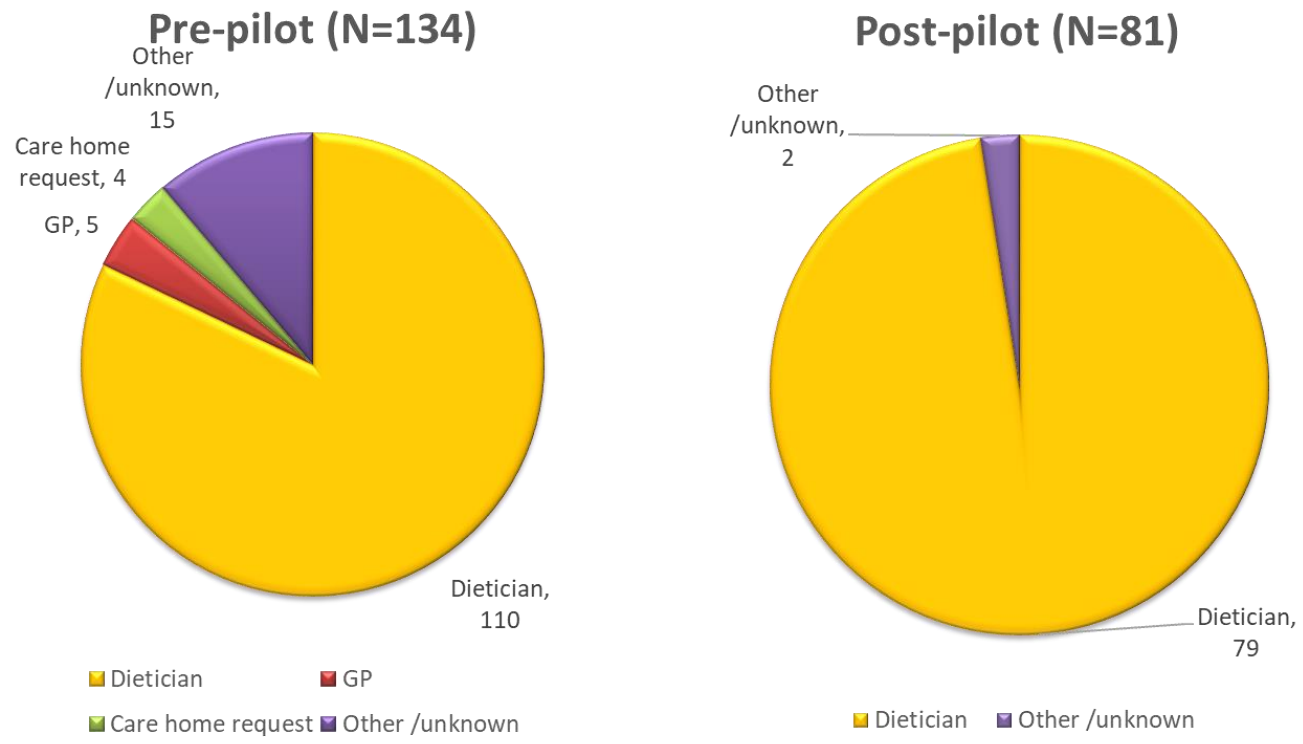


Figure 4. Initiation of ONS items

Further analysis of ONS prescribing was undertaken on those items that were prescribed under the care of dietetic services. Pre-pilot, there were 67 ONS items supplied to residents under the care of dietetic services. Some 85% (n=57) corresponded with dietetic recommendation. Eight items did not correspond with recommendations and there was missing or incomplete data for 2 items. Analysis of the information collected regarding discrepancies at the beginning of the pilot revealed the following reasons for a discrepancy:

- Incorrect frequency prescribed (n=3)
- Item omitted (n=1)
- Incorrect item prescribed (n=3)
- Unknown (n=1)

After the pilot, 75 ONS items were supplied to residents under the care of dietetic services. 88% (n=66) corresponded with dietetic recommendations. Details regarding the five items that did not correspond with dietetic recommendations were not documented. There was missing data concerning the remaining four items and

thus it is unknown whether or not these items corresponded with dietetic recommendations.

The length of time it took for ONS to be supplied after an assessment was investigated for those residents under the care of dietetic services. In general, at the end of the pilot most ONS items (n=46; 61%) were supplied to the resident within two days (see Figure 5). For the NHSCT, problems were encountered with the ordering of ONS items and therefore ONS items took longer to be issued to residents. This occurred due to delays in establishing BSO PaLS process for eProcurement and restrictions on range of products allowed to be stocked meaning that alternative supply routes (via GP prescription dispensed in Community Pharmacy) had to be utilised for some products. BSO PaLS only stock products included in the *Regional Framework for Nutritional Products for Secondary Care Health and Social Care Organisations (March 2017)*. The implications of this were not fully understood during the pilot development stages.

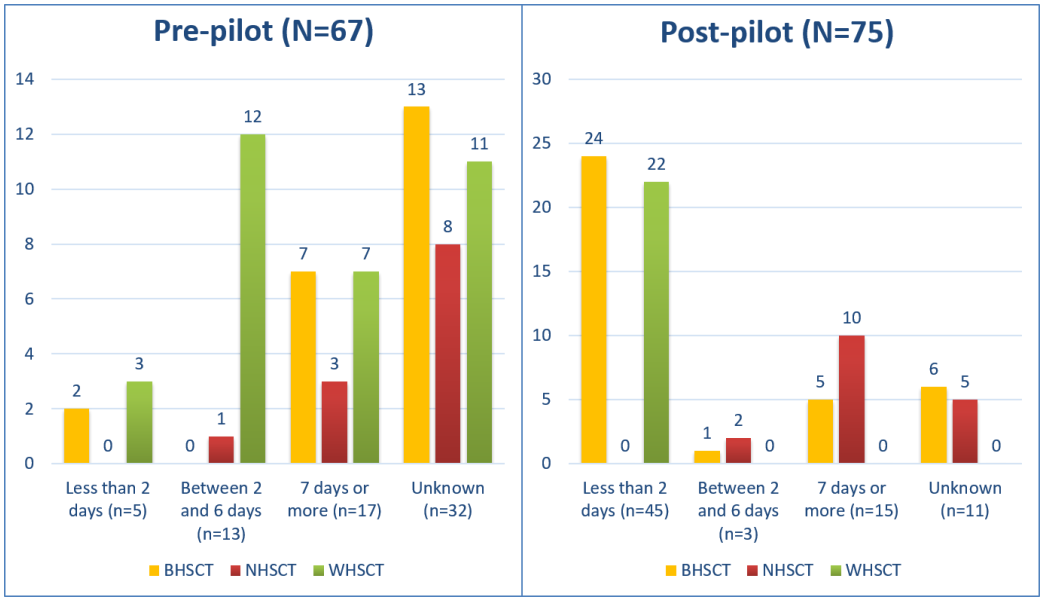


Figure 5. Length of time for initial ONS supply after assessment by a dietitian

ONS items supplied to residents before and after the NMOP pilot were examined. Table 10 lists the ONS product type and number of items supplied per product type before and after the pilot.

Table 10. ONS items per product type

ONS product type	Baseline	Final
Desserts	24	16
Dysphagia IDDSI Labelled Desserts	3	2
Dysphagia Pre-Thickened ONS	16	13
Modular Low Volume Products	27	14
ONS Compact Products	0	1
ONS Compact Products Providing Over 1.5k cal per ml	39	20
ONS High Calorie Powdered Products	0	1
ONS Juice Based Products	10	5
ONS Milk Based Products Providing 1.1 to 1.5 kcal per ml	3	1
ONS Products Providing 1.0 kcal per ml	1	0
ONS Products Providing Over 1.5 kcal per ml	5	3
ONS Standard Powdered Products	6	5

Before the pilot 64% (n=56) of ONS items supplied to residents complied with the NI Nutrition formulary. At the end of the pilot, compliance with the formulary increased to 79% (n=41). There are no formulary choices for the following ONS product types: Dysphagia IDDSI Labelled Desserts; Dysphagia Pre-Thickened ONS; Modular Low Volume Products. As such these non-formulary product types were removed from analysis. The breakdown of compliance with the formulary can be found in Table 11.

Table 11. Compliance to dietetic formulary

Did the ONS item comply with formulary?	Pre-pilot (N=88)*		Post-pilot (N=52)*	
Yes	56	**64%**	41	**79%**
No	29	33%	5	10
N/A	1	1%	3	6%
Missing data	2	2%	3	6%
*** Only items that have a listed product type in the formulary were assessed for compliance)**				

The pilot included development of a new method to record ONS consumption which enabled assessment of resident compliance with ONS. Better compliance was recorded after the pilot, with a full serving being taken for 93% of items (n=75) and no items being refused completely (see Table 12).

Table 12. Resident compliance to ONS

Amount of ONS serving taken per administration	Pre-pilot (N=134)		Post-pilot (N=81)	
None	14	10%	0	-
1/4 serving	20	15%	1	1%
1/2 serving	8	6%	3	4%
3/4 serving	6	4%	0	-
Full serving	85	**63%**	75	**93%**
Missing data	1	1%	2	3%

Clinical Data

As part of the new service being established, dietitians collated baseline clinical data from the care homes to inform set up and roll out of the service. Data collection was repeated three months after the NMOP pilot had been initiated. Extracts of the data set have been selected for analysis and are presented below.

The availability and methods of food fortification was a point of interest for this pilot. Appendix 6 outlines food fortification pre–pilot and post-pilot. There were minimal differences in the time points however all six care homes offered desserts at lunch and evening meals post-pilot as opposed to four out of six care homes at the start of

the pilot. One care home was using double cream for food fortification in the post-pilot evaluation.

Snack options between meals for the care home residents are summarised in Appendix 7a. Post-pilot one additional care home provided custard as a snack option. Mousse was also an additional snack option in the post-pilot audit for one care home. There was a reduction in the amount of cake, buns, cupcakes and savoury snacks offered between meals. Three additional snacks (soaked buns, milkshakes and smoothies) were offered by the care homes in the final audit only as snacks in-between meals.

Some care home residents require snacks with a modified texture, the full range of snacks fitting this criterion can be found in Appendix 7b which outlines the differences between what was available pre-pilot and post-pilot. Soaked buns and cheesecake with no base were two additional options that weren't available in any of the care homes pre-pilot.

Positively all of the care homes participating in the pilot kept records of food and fluid intake for all residents both pre and post pilot.

Supply route Process Map

Dietitians within each Trust area were asked to outline the current pathway for the ordering of ONS products in Care Homes at the start of the pilot and again at the end. A process map was collated for BHSCT and WHSCT areas as they were using the Community Pharmacy Supply; a separate process map was developed for the NHSCT as they were using the BSO PaLS Service.

Table 13 summarises the number of steps in each pathway at the start and end of the pilot.

Table 13. Number of steps and time taken for each process

Trust /Supply Route	Number of steps/times at start of NMOP pilot	Number of steps/time at end of NMOP pilot	Number of steps / time
BHSCT & WHSCT via Community Pharmacy	10 steps Total timescale: >2 weeks	6 steps Total timescale: 24-72 hours	↓ ↓
NHSCT Via BSO PaLS	10 steps Total timescale: 2 weeks	7 steps Total timescale: 2 weeks	↓ ↔

Resident Journeys

Clinicians participating in the NMOP pilot submitted resident journeys which emerged during the pilot. Table 14 summarises the key findings.

Table 14. Resident Journeys – Key Findings

Findings at initial dietitian assessment of resident	Following dietetic intervention
ONS prescribed to resident beyond intended duration	NMOP discontinued inappropriate ONS NMOP reduced spend on ONS NMOP supported Regional Medicines Optimisation policy
BMI in unhealthy or obese range	NMOP discontinued inappropriate ONS NMOP reduced risk of harm to resident: Obesity-related outcomes e.g. diabetes, stroke, potential reduction in BMI. NMOP reduced spend on ONS NMOP supported Regional Medicines Optimisation policy
Resident actively trying to lose weight	NMOP discontinued inappropriate ONS NMOP reduced spend on ONS NMOP supported Regional Medicines Optimisation policy
Inappropriate supplement prescribed: • **Incorrect thickness (dysphagia resident)**	NMOP reduced risk of harm to residents: Aspiration-related outcomes e.g. pneumonia, hospitalisation NMOP supported Regional Medicines Optimisation policy

Inappropriate supplement prescribed: • **Non-formulary choice**	NMOP switched to formulary choice product NMOP supported Regional Medicines Optimisation policy
End-of-life resident not tolerating or requiring supplements	NMOP discontinued inappropriate ONS NMOP reduced spend on ONS NMOP supported Regional Medicines Optimisation policy
Opportunities to fortify foods were missed	NMOP enabled catering staff to maximise opportunities to fortify food NMOP supported appropriate nutrition interventions

Summary of stock orders and prescribing data

The pilot demonstrated a reduction in average monthly cost for the majority of care homes as indicated in Figure 6 below.

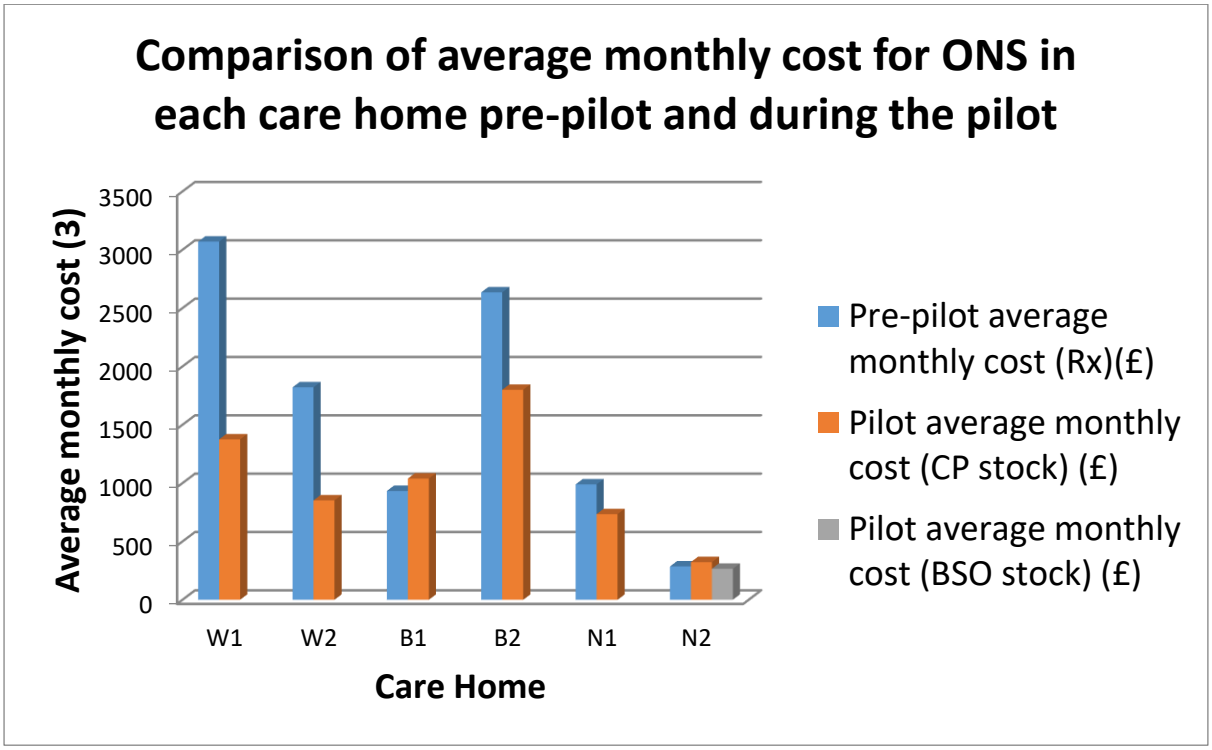
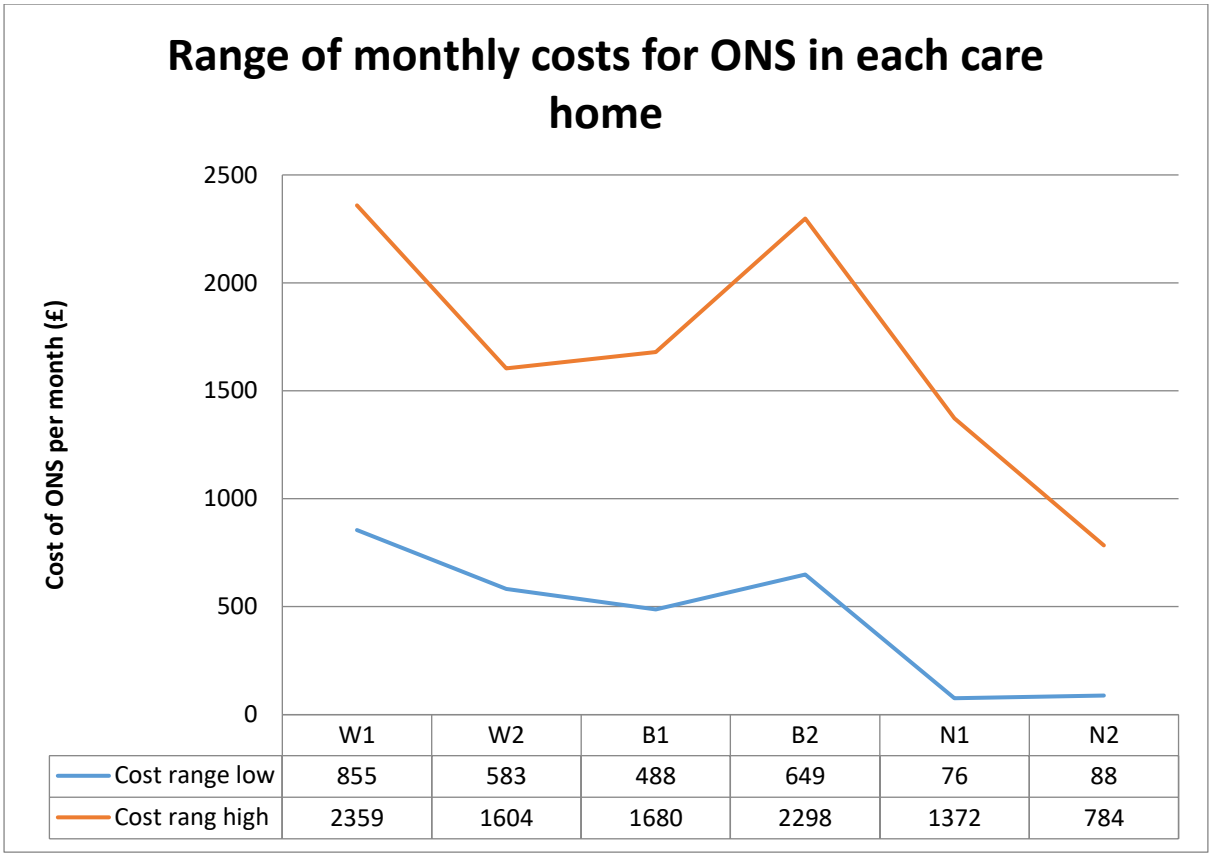


Figure 6. Average monthly cost for ONS

Dietitians reported increased caseload due to shorter referral times or identification of unmet need for nutritional support which may explain the increased costs in some homes during the pilot.

The net average reduction in cost per month across the six care homes was £3621. This could be extrapolated to over £43K annually for the care homes participating in the pilot.



	W1	W2	B1	B2	N1	N2
Cost range low	855	583	488	649	76	88
Cost rang high	2359	1604	1680	2298	1372	784

Figure 7. Range of monthly costs for ONS

Figure 7 shows the highest and lowest monthly cost for dietetic order for each care homes. The wide range of costs indicates orders were tailored monthly to meet the stock needs of the care home for that month; this would contribute to a reduction of waste.

There is considerable difference in expenditure from home to home but the care homes have different bed numbers and each resident has individual nutritional needs.

Due to the volume of prescribing and stock order data it is not included in the report; spreadsheets used for analysis have been retained by DoH SPPG[1].

[1]On 31 March 2022 the HSCB was closed and its staff and functions migrated to the Strategic Planning and Performance Group (SPPG) of the Department of Health on the 1st April 2022

Audit of Good Nutritional Care Training delivered to care home

As part of the new models of prescribing project an educational package namely 'Good Nutritional Care in Care Homes' was delivered via 4 x 1.5hr online training sessions to staff at the care homes taking part in this project. The objectives of the training are as follows:

- To understand the importance of nutritional screening
- Be able to assess risk of malnutrition
- Know the steps required to introduce a nutritional action plan for treating under nutrition
- Have an understanding of underlying conditions / factors that affect intake including fluid and how best to manage these

Outcomes were obtained for these sessions with the use of pre and post knowledge based polls during the sessions. As presented in Figure 8 the training demonstrated an improvement in knowledge before and after the educational sessions.

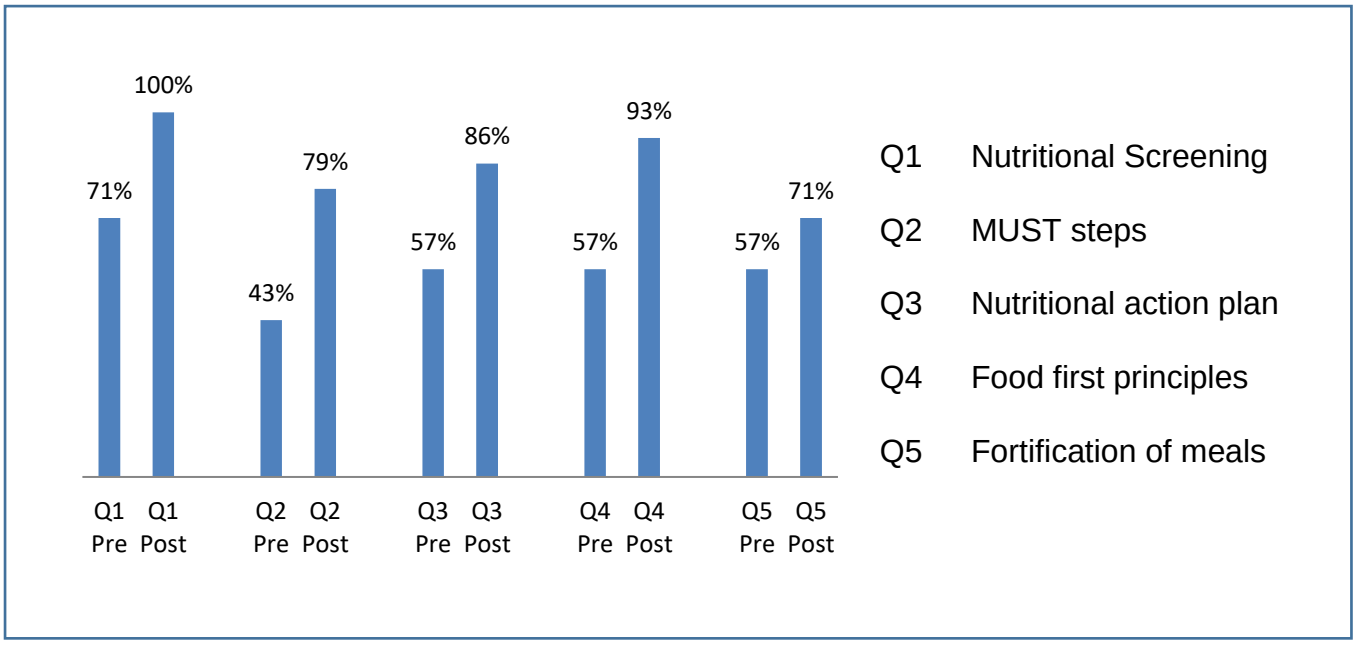


Figure 8: Pre and post educational training knowledge polls

Participants were trained on calculating risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). Of those who attended training 96% were able to correctly calculate MUST scores at the end of the session.

Conclusion

Overall the data presented in the stakeholder feedback indicates that the objectives of the pilot project were met.

Data presented from the stakeholder feedback indicated dietitian-led ordering of ONS via stock order benefited the residents within the care homes. In particular, the project contributed towards a reduction in delays in residents accessing ONS. Most of the stakeholders indicated that the dietetic ordering and alternative supply mechanisms were beneficial. Benefits cited included cost savings, improved mechanisms for care homes, reduced ONS waste and reduced GP input required.

The positives for the project as outlined in the stakeholder feedback included: improved resident care, prompt access to ONS, more efficient use of care home staff resource, implementation of Inhealthcare software to assist with stock management and improved working relationships. Reduced risk, greater oversight, one point of contact for pharmacy, no requirement for resident specific labelling of products, dietitian intervention at an earlier stage, improved collaboration and increased efficiency were among other benefits reported by stakeholders.

The challenges identified through the stakeholder feedback included: difficulties with introducing change, underestimation of dietetic resource and time required at start-up and engaging care home staff in stock management processes. Issues arising from the BSO PaLS model were seen as a key challenge of this project.

Key themes of the dietitian led ordering of ONS and identified from the stakeholder feedback included: enhanced communication, interfaces with other health professionals, resident focussed, effective use of dietitians' skills, robust processes, stock supply, reduced waste, time saved, training, I.T.provision and Inhealthcare software.

The Dietetic ONS audit activity clearly showed that the number of ONS items supplied to residents which complied with the NI Nutrition formulary increased. By

the end of the pilot nearly all of the ONS items supplied to the residents at the care homes were initiated through dietician recommendation. There was also a substantial increase in the number of residents reviewed within the timelines specified in their individual care pathways. By the end of the pilot most ONS items were supplied to residents within 2 days with the exception of ONS supplied via the BSO PALS model.

The BSO PaLS model experienced delays in the setup of the eProcurement process. Restrictions on the range of products allowed to be stocked also meant that alternative supply routes (via GP prescription dispensed in Community Pharmacy) had to be utilised for some products. BSO PaLS only stock products included in the *Regional Framework for Nutritional Products for Secondary Care Health and Social Care Organisations (March 2017)*. The implications of this were not fully understood during the pilot development stages.

There is considerable difference in expenditure on ONS from home to home as care homes have different bed capacity and each resident has individual nutritional needs. However, overall the pilot demonstrated a reduction in average monthly cost for the majority of care homes participating.

As part of the new models of prescribing project an educational package namely ‘Good Nutritional Care in Care Homes’ was delivered. The training demonstrated an improvement in knowledge before and after the educational sessions.

It should be noted that this pilot project was implemented during the COVID-19 pandemic which was a challenging time with a constantly changing healthcare landscape. Moving forward to full implementation areas for consideration include the need for central leadership and buy in from all stakeholders with the inclusion of all five HSC Trusts, and further logistical requirements to enable successful implementation of a regional supply model.

Appendices

Appendix 1: Terms of Reference

New Models of Prescribing: Dietetic Ordering of Oral Nutritional Supplements in Care Homes

Task and Finish Group Terms of Reference

1.0. Background to New Models of Prescribing

Northern Ireland lacks a mechanism to allow many prescribers working at interfaces between primary and secondary care to prescribe medication directly to the patient that can then be dispensed in the community. This can result in duplication of work, with the original prescriber needing to work through the residents GP to ensure that the required medicines are prescribed.

A transformation project involving extensive stakeholder engagement was established to scope out the arrangements that need to be in place to enable prescribers working at the interface to work in a more effective and autonomous way. The project considered new and transformative processes to allow prescribers to prescribe directly to patients, rather than going through a third party, and proposed mechanisms to enable new models of prescribing (NMOP). A business case has been developed and sets out a proposal to invest in the development of an Electronic Care Record (ECR) solution, to enable the production of HS21 prescriptions at interfaces between Primary and Secondary care. Northern Ireland currently has no technology solution to enable the printing of HS21 prescriptions at these interfaces. The proposed ECR solution will enable qualified medical and non-medical prescribers working in for example, Outpatient Clinics, and Intermediate Care Units, to issue prescriptions directly to patients rather than relying on the patient's GP to implement the recommendations.

A number of pilot projects will be initiated to test process, governance and policy frameworks required for NMOP in a small number of sites. One of the pilot projects will focus on dietetic led ordering of oral nutritional supplements (ONS) for residents in care homes.

2.0. Background to Dietetic Prescribing

Residents who are assessed as having additional nutritional requirements should have a management care plan that aims to meet their complete nutritional requirements. To supplement the first step of fortified food measures, oral nutritional supplements (ONS) are often prescribed by GPs on the recommendation of a dietitian. Dietitians currently do not have prescribing rights but changes to legislation have been proposed to support supplementary prescribing in secondary care. Further changes would be required to support this in primary care.

Following a post graduate qualification, supplementary prescribing will allow advanced dietitians to prescribe prescription only medicines (POMs) within a clinical management plan as agreed with an independent prescriber. This will facilitate

prescribing for specific conditions and enhance the role of the dietitian e.g. in management of patients at an IBS or diabetic clinic

However ONS and other ACBS nutritional products are not POMs and currently a prescription is not legally required for prescribing; it is legally required to allow HSC supply in primary care under the Pharmaceutical Services Regulations.

All dietitians already have the skills and expertise to assess and monitor patients for nutritional needs, recommending and stopping nutritional products as clinically indicated and it would be reasonable to propose that the clinical responsibility for ordering these items should sit with dietitians.
Models of dietetic led ordering of nutritional supplements have been established in other areas of the UK. For example, in Rotherham a service has been established since 2006 and reported benefits included:

- GPs no longer being requested to prescribe products they are unable to review or monitor
- Improved supply of ONS to residents
- Improved compliance with NICE guidance on treating malnutrition
- In 2010/11, when compared to national trends, the cost savings were estimated to be £1,165,194.

A MORE nutrition pilot in 2019 identified that ONS waste over a 3-month period in care homes was 24% of the prescribing costs. A key recommendation for improvement suggested by the care homes, GP practices and community pharmacists, was the direct input of dietitians to the ordering process.

This pilot will test the concept of dietetic led ordering of ONS for residents in care homes in Northern Ireland without the need for generation of a GP prescription.

3.0. Aims and Objectives of the Dietetic Ordering Pilot Task and Finish Group

The aims of the pilot will be to:

- Facilitate the issuing of an order by a qualified dietitian for ONS, where the need has been identified in line with the recommendations of the *Suggested 7 Steps to Appropriate Prescribing of Adult Oral Nutritional Supplements (ONS)*[1],
- Explore options for individual resident vs stock ordering
- Explore the potential for links with technology to support resident review e.g. *In-Healthcare*
- Develop options for supply via community pharmacy and BSO PaLS
- Develop processes for reimbursement of suppliers

[1] https://niformulary.hscni.net/formulary/9-0-nutrition-and-blood/9-4-oral-nutrition/

- Explore existing barriers in policy and legislation to dietetic ordering and alternative supply mechanisms in the community, working closely with the Policy and Legislation Task and Finish group to overcome these barriers
- Develop robust governance arrangements to ensure safe and effective ordering and supply practice
- Develop processes that address existing logistical challenges re: communication with primary care, timely updating of clinical records, and interface with community pharmacy.
- Establish an effective funding mechanism, which is not directly linked to a GP Cipher code, to permit dietitians to order for residents from multiple practices.
- To determine the impact of changes on patients and healthcare professionals

The objectives of the pilot project are to:

- Establish potential volume of ordering activity that can be shifted to dietitians
- Identify benefits in relation to access to ONS and reducing pressure on GPs
- Identify any risks associated with the sustainability of a new model e.g. workforce
- Support and enhance the delivery of tailored dietetic interventions to residents, maximising professional skills at the point of care delivery
- Support the delivery of care pathways that can be delivered by a dietitian
- Reduce delays in residents accessing ONS
- Support a reduction in waste of ONS
- Support optimum use of technology in processes
- Support improvements in resident / client concordance with taking ONS
- To agree measures and collect relevant data to measure the outcomes for residents
- To agree and implement measures to capture the experiences of care home and dietetic staff, GPs and community pharmacists, and BSO PaLS.

3.1. Chair

The dietetic ordering pilot task and finish group will be chaired by Paula Cahalan, AHP Lead BHSCT.

3.2. Frequency of Meetings

The dietetic ordering pilot task and finish group will meet monthly.

3.3. Pilot Locations

The pilot will run across the Belfast, Northern and Western Trust areas.

4.0. Dietetic Ordering Pilot Task Membership

The membership is as follows:

Name	Title	Organisation
Paula Cahalan Andrea Linton	AHP Lead (Chair until Sep '21) NMOP Co-ordinator (Chair from Oct '21)	BHSCT HSCB
Mo Henderson	AHP Consultant	PHA
James McAuley	NMOP Project Manager	HSCB
Emer McLean	PMMT Pharmacy Adviser	HSCB
Lucy Hull Jill Curry Anne Gormley Siobhan McCaffrey/ Warren Edwards (From August 2021)	Trust Dietetic Head of Service Trust Dietetic Head of Service Trust Dietetic Head of Service Acting Assistant Dietetic Manager Community Team Lead Dietitian	BHSCT NHSCT WHSCT
Monique Kritzinger Jemma Jackson (until June 2021) / Elizabeth Armstrong (from June 2021) Linda Trimble/ Laura Drumm (until August 2021)/ Louise Roulston (from August 2021)	Trust Dietitian	BHSCT NHSCT WHSCT
Brenda Rushe	Representative for Independent Health and Care Providers	RCN
Rachel Lloyd	Pharmacist Inspector	RQIA
Ciara Haughey	GPP	GP Federation
Dr Stephen Bradley	GP	GP
Peter Rice	Community Pharmacist	CPNI
Jonathan Semple	Head of Logistics	BSO PaLS
Ruth Balmer	Policy Officer	BDA

Appendix 2: Analysis Plan

Overview of project aims and objectives:

This pilot will test the concept of dietetic led ordering of ONS for residents in care homes in Northern Ireland without the need for generation of a GP prescription.

The objectives of the pilot project are to:

- Establish potential volume of ordering activity that can be shifted to dietitians
- Identify benefits in relation to access to ONS and reducing pressure on GPs
- Identify any risks associated with the sustainability of a new model e.g. workforce
- Support and enhance the delivery of tailored dietetic interventions to residents, maximising professional skills at the point of care delivery
- Support the delivery of care pathways that can be delivered by a dietitian
- Reduce delays in residents accessing ONS
- Support a reduction in waste of ONS
- Support optimum use of technology in processes
- Support improvements in resident / client concordance with taking ONS
- To agree measures and collect relevant data to measure the outcomes for residents
- To agree and implement measures to capture the experiences of care home and dietetic staff, GPs and community pharmacists, and BSO PaLS.

In addition: to evaluate

- whether or not the aims and objectives of the project have been met using various data collection methods e.g. surveys, audits, residents stories, correspondence and a stakeholder workshop.

Data/info sources to consider:

- Care Home Data:
  - Pre Project Data
  - Post Project Data
  - Resident Overview Template
- Audit of Good Nutritional Care Training delivered to care home staff
- Summary of Stock Orders
- Stakeholder Feedback Session – Mentimeter® software
- Stakeholder Feedback Survey
- Resident stories
- Supply route process maps
- Supplementary information

Analysis mapped to aims and objectives:

Objective	Suggested analysis	Data processing to completed to perform analysis
Establish potential volume of ordering activity that can be shifted to dietitians	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion Quantitative analysis of care home data and summary of residents Quantitative analysis of baseline and final audit data Analysis of process map steps	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. MOIC to analyse and summarise prescriber and resident data into suggested results tables. MOIC and HSCB to analyse and baseline and final data into suggested results tables. Process maps steps to be compared from baseline to final.
Identify benefits in relation to access to ONS and reducing pressure on GPs	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion Analysis of Process map steps	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to

		be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Process maps steps to be compared from baseline to final - Change in number of steps on pathway to be identified.
Identify any risks associated with the sustainability of a new model e.g. workforce	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion Quantitative analysis of care home data and summary of residents Quantitative data analysis of baseline and final audit data	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. MOIC to analyse and

		summarise prescriber and resident data into suggested results tables. MOIC and HSCB to analyse and baseline and final data into suggested results tables.
Support and enhance the delivery of tailored dietetic interventions to residents, maximising professional skills at the point of care delivery	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion Quantitative analysis of care home data and summary of residents Quantitative data analysis of baseline and final audit data	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. MOIC to analyse and summarise prescriber and resident data into suggested results tables. MOIC and HSCB to analyse and baseline and final data into suggested results tables.
Support the delivery of care pathways that can be delivered by a	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review

dietitian	Quantitative data analysis of baseline and final audit data Analysis of Process map steps	themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. MOIC to analyse and summarise prescriber and resident data into suggested results tables. MOIC and HSCB to analyse and baseline and final data into suggested results tables.
Reduce delays in residents accessing ONS	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion Quantitative data analysis of baseline and final audit data Analysis of Process map steps	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to

		be reached between MOIC and HSCB on Themes and categorisation of data. MOIC and HSCB to analyse and baseline and final data into suggested results tables.
Support a reduction in waste of ONS	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion Quantitative data analysis of baseline and final audit data Analysis of Process map steps	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. MOIC and HSCB to analyse and baseline and final data into suggested results tables.
Support optimum use of technology in processes	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion Quantitative data analysis of baseline and final audit data	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to

		be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. MOIC and HSCB to analyse and baseline and final data into suggested results tables.
Support improvements in resident / client concordance with taking ONS	Qualitative thematic analysis of stakeholder survey and stakeholder workshop discussion Quantitative data analysis of baseline and final audit data	Stakeholder workshop data to be analysed and themed by MOIC. HSCB to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. Mentimeter ratings to be summarised by MOIC. Stakeholder survey data to be analysed and themed by HSCB. MOIC to review themes. Agreement to be reached between MOIC and HSCB on Themes and categorisation of data. MOIC and HSCB to analyse and baseline and final data into suggested results tables.
To agree measures and	N/A – this formed part of the project set up phase	

collect relevant data to measure the outcomes for residents		
To agree and implement measures to capture the experiences of care home and dietetic staff, GPs and community pharmacists, and BSO PaLS.	N/A – this formed part of the project set up phase	

Suggested results table templates

Table 1. Care home and resident characteristics

	Pre-pilot	Post-pilot
Total number of residents in pilot care homes at time of audit		
Care home Trust	**n**	**n**

Table 2. Number and percentage of residents in pilot care homes that were supplied with ONS at time of audit

	Pre-pilot		Post-pilot	
Total Care home Trust	**n**	%	**N**	**%**

Table 3. Number and percentage of residents in pilot care homes that were supplied with ONS and were under dietetic care services at time of audit

	Pre-pilot		Post-pilot	
Total Care home Trust	**n**	%	**N**	**%**

Table 4. Number of GPs prescribing ONS items at pilot care homes before the pilot

	Pre-pilot
Total Care home Trust	

Table 5. Number of ONS items supplied to residents in pilot care homes

ONS data	Pre-pilot	Post-pilot
Total Care home Trust	**n**	**n**

Table 6. ONS items per product type

Pre-pilot	ONS product type	Post-pilot
n		**n**

Table 7. Compliance to dietetic formulary

Did the ONS item comply with formulary?	Pre-pilot (N=88)*		Post-pilot (N=52)*	
Yes No N/A Missing data * Only items that have a listed product type in the formulary were assessed for compliance)	**n**	**%**	**n**	**%**

Table 8. Resident compliance to ONS

Amount of ONS serving taken per administration	Pre-pilot (N=134)		Post-pilot (N=81)	
None 1/4 serving 1/2 serving 3/4 serving	**n**	%	**n**	%

Full serving Missing data				

Table 9: Agreement ratings on whether the pilot met the overall objectives of the project

Question	Mean Score

Table 10

Objective	Key Themes	Extract to support achievement	Challenges

Table 11: Respondents to stakeholder survey

Stakeholder	Number	Percentage

Table 12: Resident Journeys – Key Findings

Findings at initial dietitian assessment	Following dietetic intervention

Appendix 3: Extracts to support

**A full report from the Stakeholder feedback session generated by the Mentimeter software is available on request from DoH Strategic Planning and Performance Group.*

Objective 1	Establish potential volume of ordering activity that can be shifted to dietitians
Objective 2	Identify benefits in relation to access to ONS and reducing pressure on GPs
Objective 3	Identify any risks associated with the sustainability of a new model e.g. workforce
Objective 4	Support and enhance the delivery of tailored dietetic interventions to residents, maximising professional skills at the point of care delivery
Objective 5	Support the delivery of care pathways that can be delivered by a dietitian
Objective 6	Reduce delays in residents accessing ONS
Objective 7	Support a reduction in waste of ONS
Objective 8	Support optimum use of technology in processes
Objective 9	Support improvements in resident / client concordance with taking ONS
Objective 10	To agree measures and collect relevant data to measure the outcomes for residents*
Objective 11	To agree and implement measures to capture the experiences of care home and dietetic staff, GPs and community pharmacists, and BSO PaLS.*

*Achieved in the project set up phase.

Common themes from across the data collected for Stakeholder feedback were extracted. The themes include: enhanced communication, interface with other health professionals, resident focussed, effective use of skills, robust processes, stock supply, reduced waste, time saved, training, I.T. and Inhealthcare. The themes were mapped against each objective. A summary of the themes linked to the objectives are presented in the table below with supporting extracts.

Theme	Sub themes	Extracts
Enhanced Communication / Interface with other HPs *(Objective 1,2, 4, 5, 6)*	• One point of contact at community pharmacy • One point of contact at care home • All communication has improved – with dietitian, care home, manager, Community Pharmacy and GP • Just having one interaction per month instead of at lots of time points • Named link person in the care home	• Able to work with dietitian to resolve any issues. • Communication was good. • Good communication to manager and dietitians • Communication was already good • Having a named person to ring...."Can I speak to...." is really helpful • Only having to link in with one pharmacist to chase rather than lots of people • Enhanced communication • Improved communication and collaboration • Beneficial in collaboration and communication pathways that didn't exist previously between dietitians/GPs/Community pharmacy • Improvement in interacting with community pharmacy. Direct communication to dietitian instead of going through care home etc. makes it easier. • Just having one interaction in a month with the pharmacy rather than several interactions at different time points is an improvement. From their perspective they also only have one point of contact. They have rung and emailed if any issues. • Contact would have been minimal prior to this with community pharmacy - it has really improved • Nursing homes - good feedback, improved relationships as there more often. • Improved relationships, point of contact and working together to sort out. • Having a named link person in the nursing home is helpful • Community pharmacy had direct access to the dietitian. Usually have to go through GP and Nursing home. Great to be able to phone or email the dietitian. Just one order with direct communication. No complaints. • Community pharmacy has been very helpful. • Streamlined and sped communication up. Plans were being put in place straight away. We were keeping GPs informed rather than waiting on them • Not sure if it improved communication - communication was good already.

Resident focussed *(Objective 4,5, 6, 9)*	• Efficiency of changes • Reduced risk • Speech and Language • Immediate access to ONS stock when required • Improved frequency of reviews • Resident increased compliance • Able to wean people quicker • Reduce supplement fatigue	• Resident was able to get any changes required in place quickly. • Speech and language recommendations can be added on • Staff were able to access and use ONS stock immediately for a new resident • Allowing intervention at earlier stage • Greater oversight of resident s • Reduces risk • Reduce chance of incorrect scripts • Taste fatigue - being able to deal with timely • Able to wean people quicker • Increase compliance, reducing supplement fatigue • Reviewing resident s quicker every 2 weeks instead of 6-8 weeks. • Reduces risk to resident s • Huge benefit in reducing risk. • Overall improved resident care and given nurses reassurance
Effective use of Skills *(Objective 1,)*	• Assessing, reviewing and monitoring • Dietitian has greater oversight of the process	• Reflects much more effective use of dietetic skills and advanced practice • [Dietitian has] greater management and oversight of process • Assessing people more regularly, reviewing and monitoring. • Intervene at an earlier stage • Lot of support from dietitian • Much more effective use of dietitian skills • [Dietitians] are well embedded within the homes and governance arrangements in place.

Processes (Objective 4,5)	• Intensity of service set up • Robust arrangements • Payments from BSO • Stock forms • Cypher numbers • Established communication to GP, BSO and Community Pharmacy	• Starting process is quite long to get up and running. Easier to maintain once up and running • A lot of work to set up - setting up the cipher codes for example • A lot of work initially • Setting up stock forms, getting dietitians cypher numbers, communication to GPs/Community Pharmacy/ BSO. • Robust arrangements in place • Robust arrangements were good • Systems very streamlined • Processes were clear • How to link in with pharmacists, who needed what and how to get that through. We had GP letters there to let them know too. Nothing jumped out as missing in terms of what needs put in place • No issues from governance (N) no concerns nothing to be done differently • No concerns from Community Pharmacy - worked smoothly. Clear schedule for order, supply etc. Need to consider this for scale up. • Happy with what was put in place. • In normal circumstances even though we are the ones suggesting we have to jump through hoops to get them prescribed • No issues. Great project to be initiated. • No issues with processes or getting payments from BSO. Streamlined process • Submitting to BSO for payments was a straightforward process. Massively streamlined and saved a lot of time. • Support from the centre has been really important to making this work. A great example of collaborative leadership and what that can achieve.

Stock Supply *(Objective 3, 5)*	• Brexit and food supply to NI • Reduced Delivery times of ONS • Community Pharmacy - if get order wrong could deliver in the afternoon.	• Issue with parallel imports - linked to Brexit and supply of food items to NI. Obtaining some ONS became difficult. Things were labelled incorrectly. It got dealt with appropriately but could be an issue • Reduced delivery times of ONS • Community Pharmacy - If they get an order in morning they could deliver in afternoon or next morning • Speech and Language Therapy recommendations - May already have in stock so quick supply
Reduced Waste *(Objective 4, 5, 6, 7, 9)*	• Reduction in waste • Able to reuse stock • Training with chefs re: fortification of food	• Wastage has cut back • Reduction in waste • Able to reuse stock • Notice wastage has cut down massively • Zero waste since it started • Zero wastage in one care home • ONS wastage - cut back, better range of flavours, focusing on fortifying food • Massive benefits in reduction of waste • If someone went into hospital there wasn't a build-up of stock that wasn't used • Different flavours of ONS is good • Training completed with chefs re fortification of food

Time Saved *(Objective 2, 4, 5, 6)*	• Decreased time spent chasing • Only spending 10% of time at community pharmacist end. Not having to spend time chasing up and labelling. • From GP perspective – actioned right away.	• Less work at GP end. Time spent chasing prescriptions and labelling has reduced time • Waiting on GP - that step has been sped up. • From a Dietetic point of view - no difference in records being updated but from a GP and pharmacy point of view it has been sped up as it has been actioned right away. • Where we save time somewhere we lose time somewhere else • CP time saving, much more efficient. One order. No labelling. Comparison with other care homes - may take 10-14 days for prescription, chasing prescription, care home etc. No delay of in stock with wholesaler • Not sure if it improved communication - communication was good already. It streamlined and sped communication up. Plans were being put in place straight away. We were keeping GPs informed rather than waiting on them. • Less work on the community pharmacist end only spending 10% of the time. Can only say positive things. Not having to spend time chasing and labelling orders. It's just one order. • Community Pharmacy response very timely and responsive. Time saved in chasing GP prescriptions relieving dietetic time. • Community Pharmacy - one single order streamlines processes instead of 30/40 scripts. Much more efficient and not having to label all drinks etc. Saved massive amount of time. • Streamlined process, impacted timeliness, residents were able to get any changes required in place quickly. • Nursing homes have saved time by not having to order repeat prescriptions • Has reduced delays substantially • If something is in stock they can get it there and then. • Time saved in chasing up GP scripts • Care Home perspective: massive benefit to home. No need to wait for ages • Massive benefit to the home. Reduce risks for benefits and not having to wait. • Previously dietitians had to do a lot of chasing • Time has been spent ordering instead.

Training *(Objective 1, 4, 5)*	• General knowledge and confidence has improved • Excellent and well delivered • Good update of training	• Training was excellent and presented well • Good uptake on food first training and uptake of ONS. • In general knowledge and confidence has improved • One nursing home said that they couldn't release staff for training due to COVID. One nursing home they had done a lot of training prior to the pilot. • The training may just depend on the nursing home at a given time • In NHSCT because of COVID there had been a lot of training provided • Training for chef and all team.

IT/ Inhealthcare *(Objective 4, 5, 8, 9)*		*Inhealthcare:* • Monthly monitoring would give more enhanced dietetic monitoring • Monthly monitoring would have been useful - more enhanced level of service • Really good engagement with Inhealthcare and collaboration • Continues to provide monitoring • Constant oversight of resident needs. • Invaluable in care home. • Inhealthcare great for regular monitoring by care home etc. • Concerns of use of word 'malnourished' in letter, explanation could have been better to families • Letter to families could have been improved (letter was adapted as a result) • Need to have it established - need lead time to get established. Need to be engaged with regular submission of info • In WHSCT limited use of Inhealthcare. In time, will see shortening of pathways but bigger numbers in case load • Had the old Inhealthcare but didn't have the new revised one. • It has really helped reduce the time for the nurses and has really helped the nurses • Inhealthcare - Belfast already had in homes but WHSCT has an issue getting it rolled out to the homes as didn't already have it. So difficult to get the balance in not overloading the nursing homes. • Had the old version of Inhealthcare too. • Some care homes have recently got Inhealthcare; other care homes haven't got it. There hasn't been a comparison.
NHSCT Specific	Communications	• Communication was needed more frequently. • BSO PaLS may not have fully understood what they were signing up to at the outset.

	Processes	• When ONS product was available in the care home, staff were able to reuse, access immediately for new resident. • Nothing has changed with recording processes. Have processes in place already to record in a timely way – this new model has not changed that process. • Maintenance and adhering to already good standards of record keeping
	Stock supply	• Delays in obtaining stock had an adverse impact on cost-effective prescribing. • NHSCT has had to rely on Community pharmacy to fill in some of the gaps in terms of stock that BSO PaLS were unable to supply e.g. new products • Care homes had an existing arrangement in place to get weekly delivery of ONS from CP contractors and BSO PaLS couldn't facilitate this. Care home didn't have space to hold stock for 4weeks. • Only able to order what is on BSO PALS list.
	Waste	• This supply route experienced increased Waste • NHSCT had increased waste. • Some things issued by PALS and some things issued by CPs.
	Time Management	• It took time to place the order and get item in stock. • The initial ordering of product took extra time. Once in stock it was much more quickly delivered to the care home • Supply often took longer with this method when compared with model used prior to the pilot. • Timeframe was prohibitive but once item was in stock in care home it worked well and you could see the potential.

Appendix 4: Survey data

Do you feel this pilot benefits the residents?

Please provide further details
timely and most appropriate prescribing by most knowledgeable person
- Improved food fortification across the nursing home (NH) to help prevent the need for ONS in the first instance. This allowed staff to see that ONS should not always be first line treatment for malnutrition and food fortification can be extremely beneficial on its own. Especially when ONS is not tolerated. - Ensure getting oral nutritional supplements (ONS) that are tolerated and that long term prescriptions are monitored to avoid excess weight gain or loss that may increase risk of other health problems - Prevent long term prescriptions of ONS that are not tolerated but continue to be offered to residents. - Less prescribing freed up carer/nurse time to be able to cater to other resident needs
patient receives the supplement in a timely manner and there is a stock available for the patient to try different flavours
Absolutely
All patients in one setting have one point of contact with a dietitian.
More direct consultations will provide better quality of care for the patients. Although, multiple issues regarding paperwork have been found when dispensing supplements to the nursing homes. Regular updates need to be sent to the dispensing pharmacy to keep supply and paperwork up to date.
Yes if full cooperation between dietitian, GP and supplier e.g. community pharmacist and ongoing follow up.
It enabled closer contact and feedback with dietitian regarding compliance and trial to be more suited to the resident as well as quicker turn around with receiving stock
Tailored dietetic intervention promoting food first. Timely access to appropriate oral nutritional supplements with greater range of flavours available from a stock system therefore reducing taste fatigue and hence increased compliance and improved patient outcomes meeting nutritional requirements for weight gain, wound healing etc.
Pilot demonstrates efficiencies for the patient; ensuring get ONS they require by trained health care professionals (dietitians) with supplementary prescribing rights in a timely manner, relieving capacity of GPs and Pharmacy and overseeing the process. Increased oversight of supply which in turn results in saving and less wastage to the public purse.
Patients have enhanced nutritional oversight by a dietitian, oral nutritional products were supplied in a timelier manner and product flavour choice was expanded to support compliance. New records developed to record the amount of each supplement consumed along with a food record chart helped provide comprehensive information for the dietitians to support their clinical assessment of the patient and tailor products to support the patients' needs.

Training provided to catering staff on food first fortification should lead to more nutritious options for patients who require additional nutrition support.

Do you feel that the dietetic ordering and alternative supply mechanisms were beneficial?

Please provide further details
Good for homes and also for patients. cost saving and minimising waste also
- Quicker turnaround of supply of ONS to NH- supplied within 24hours by community pharmacy -Dietitians have the best knowledge when it comes to ONS products and we understand the difference between the types and flavours etc. - Dietetic ordering removed room for error as some ONS have very similar names and this previously resulted in the wrong ONS being ordered via GP. - removed need for GP input that would have taken longer. Sometimes >1week and this freed up GP time for other tasks.
there is a stock available and less wastage
prevent wastage and steam line processes while patients still receiving what they need
Once issues are sorted out, I can see this being beneficial. If dietitians were aware of availability of certain supplements, it would run much smoother.
Unsure that regional ordering (BSO PALS) was successful.
Dietitian is able to place a stock order for ONS directly to community pharmacy without the previous requirement of a GP script for each individual patient. NH no longer have to order repeat prescriptions – previously a 4 week cycle from ordering to delivery of ONS. Community pharmacy will deliver ONS within 48-72 hours of order. Stock supply of ONS means that wastage is no longer generated from long term hospital admissions / patients deceased / patients requiring a change of ONS mid-script i.e. SLT assessment requiring immediate change to IDDSI level recommendations.
- Patient benefits - Care home benefits - less wastage and governance of ONS in the home. - Flexible systems working and increased partnership working with pharmacy / Dietitians / BSO and supply chains.
Definitely, the dietitian is the expert in choosing appropriate nutritional products and additional steps i.e. via GP letter of recommendation to prescribe, were not required to ensure orders were raised. Having stock supply allowed patients to access new products in a significantly more timely way. Care homes and community pharmacists only had to liaise with one dietitian rather than multiple GP practices to ensure orders were prepared. The BSO PaLS supply mechanism was however challenging and multiple barriers were identified during the pilot. Only one care home trialled the method. However the pilot provided valuable learning to inform a specification for scale up - though restrictions would have to apply and it is unlikely this service could be as comprehensive and reactive as community pharmacy supply.

Do you feel this pilot benefits the care home residents?

Please provide further details
it is a great system, well organised with robust safety mechanisms with great benefit to all stakeholders
I feel that not continuing the pilot would result in return to old issues i.e. longer inappropriate prescriptions, increased time getting prescriptions filled by GPs, increased time for NH and GPs spent adding prescription scripts and chasing prescriptions. I also feel that the implementation of food fortification advice has resulted in reduced reliance on ONS and this may return if dietetic ordering doesn't continue.
Recurrent funding is required asap
happy for it to continue with appropriate resources
with additional dietetic staffing could be rolled out widely
Original dispensing system via prescriptions from Doctor was much easier to manage to dispense and manage stock. I don't see this as a long term solution.
Via CP as during pilot
Huge potential for system redesign with Dietitians working at advanced practice to support a critical issue; supporting nutritional needs of older people, ensuring efficiencies in the system, reliving capacity into the systems and reducing wastage in a domain where waste of ONS is common practice.
Yes there are benefits for patients, care homes, GP practices, dietitians, community pharmacists and economic benefit to the HSC. However the necessary dietetic support would be need to be adequately resourced.

Did the pilot project contribute towards a reduction in delays in residents accessing ONS?

Please provide further details
Reduced from previously over one week from time dietetic letter was sent by dietitian to GP to when ONS was prescribed and then a further up to 2days for ONS to deliver to NH.
in some instances the delays can be very long so this greatly reduced that
instantly available instead of potentially weeks or months
Waiting for response from Dietitians have stalled dispensing to nursing home but were able to sort out before supply had run out.
Question for care home
Supplements were provided much quicker and even shortfalls were addressed quickly
Delays in accessing ONS minimised as patient can commence ONS / trial of ONS on the day of dietetic assessment from a stock supply / if not in stock, within 48 - 72 hours from order placed with community pharmacy.
Dietitians are trained professionals with expertise in nutrition. With extra support they were able to oversee, govern and support the use of ONS in the care home setting. Looking at diverse approaches including food first.
The stock system provided immediate access for new patients or alternative products for existing patients. Dietetic direct ordering removed the need to write to the GP with a prescribing recommendation enabling the dietitian to raise an order immediately if a new product was required. However community pharmacy had the ability to supply products within 24 hours whereas BSO PaLS had a number of challenges to prevent this e.g. products had to be listed in the secondary care framework and ordering in products took several weeks. In addition, to meet the requirements of the HSCT e-procurement system, the dietitian had to get the order authorised by a pharmacy manager before the products were supplied. This added an additional step to the process.

Did the pilot reduce ONS waste?

Please provide further details
Very much so, one of the main core benefits.
Not labelling ONS allowed for ONS to be used with other residents if a patient admitted to hospital or passed away. Previously all ONS individually labelled and all thrown out if that resident unable to use.
Significant benefit
Appropriately adjusted depending on patient compliance. not disposing of ONS if pt. in hospital / deceased etc. has saved a significant amount
Supplies to our nursing home are sent on a weekly basis regardless of changes so waste is reduced via these means.
Question for care home
Very much so in many cases at times it identified that staff were over using and following old prescriptions causing a shortfall which was easier identified as there was no excess stock
Stock supply of ONS means that wastage is no longer generated from long term hospital admissions / patients deceased / patients requiring a change of ONS mid-script i.e. SLT assessment requiring immediate change to IDDSI level recommendations. Able to stock a greater range of flavours increasing compliance and reducing supplement fatigue hence reduction in wastage.
Yes, I know from previous work that significant waste is generated from individual patient prescriptions and a stock system will prevent this waste. The new supplement record sheet will easily identify if a patient doesn't like a product or flavour and alternative can be recommended subsequently preventing waste.

What do you think were the positives of this project?

What do you think were the positives of this project
A very obvious project that will only be to the benefit of patients, homes and cost savings to health service
1. Improved patient care as food fortification made a priority and reduced the need for ONS overall 2. If ONS needed then this was provided within a short space of time and allowed for short trials etc. and quick use of ONS when needed 3. Reduced time spent by NH filing prescriptions, completing orders, chasing GP for ONS scripts and proving ONS to residents 4. Implementation on Inhealthcare allowed for changes to SLT recommendations to be picked up quickly and ONS changed to appropriate volume quickly. The implementation of Inhealthcare has also helped to reduce the risk of inappropriate ONS prescriptions continuing as all patients prescribed has their weights, dietary intake and ONS tolerance monitored for this. This ensured that those not under active review by dietitian could be reviewed and ONS altered as needed. The removal of this could result in return to long term inappropriate prescriptions being continued 5. Improved relationship between dietitian and NH by working together with a system that worked efficiently
as above - improved access to ONS, less waste, better access to a range of flavours reducing flavour fatigue and improving compliance, easier for care homes and improved working relationship with Dietetics
Potential reduced over ordering of ONS
the length of time from when supplements are advised to when the patient got a supplement which they like was greatly reduced and less wastage
Maximised effective and timely management of ONS in care homes.
Direct communication between dietitian and Nursing Home and ensures appropriate & timely treatment
It definitely would have reduced time delays for patients receiving their supplements and reduced our work load
Direct involvement of the Dietitian to continually review patient adherence and tolerance of ONS
Helped reduce waste
Cost saving processes stream lined patients receive appropriate ONS in a timely manner more frequent dietetic monitoring of patients wider range of flavours , increasing pt. compliance
eliminated red tape paperwork from primary care
- Better engagement between dietitian and patients to fit patient needs. - Personalised supplement care for each patient.
faster access to products prescribed, closer working dietitians and care homes - better end result for patient Potential reduction in waste

It allowed closer contact with dietitian to discuss supplement compliance especially those that were transferred from community or hospital and non-compliant care carried across very quickly and those non-compliant supplements were discontinued
Saves nursing home time as no longer ordering repeat prescriptions for individual patients. **Saves dietitian time as no longer requesting GP script changes and can facilitate ONS trials with patients from a stock system.** **Saves GP time as no longer completing ONS scripts.** **Saves community pharmacy time as no longer labelling ONS for individual patients.** **Reduced space needed for ONS in NH using a stock system.** **Reduced cost of ONS adhering to a preferred ONS list.** **Timely access to ONS and reduction in waste.** **Patient benefit – poor compliance/tolerance/unsuitability of ONS addressed promptly with the reduced delay in accessing ONS, improving patient outcomes overall.**
Dietetic Advanced practice working to support the nutritional needs of people on ONS. Fresh evaluation of their nutritional needs and care plan including food first approaches. **Taking people off ONS if no longer needed.** **Reduced wastage** **Relieve capacity into the system for GPs**
The benefits of this project have been beneficial to residents and nursing staff within the home. Residents are being reviewed and getting supplements in timely manner and nursing staff have been saved time as they no longer chase supplements up. The project has stopped wastage of supplements and this makes sense financially.
Enhanced dietetic support for patients, nurses and catering staff in the care homes **Faster access to nutritional products** **Reduced waste of nutritional products** **New collaborative working: between the community pharmacists and dietitians, good networking at Task & Finish Group level, collaboration with dietetic colleagues in local Trusts and nationally with Scottish colleagues, access to care home manager opinion via RCN, collaboration with BSO PaLS.** **Collaborative working across dietetic teams in different Trusts.** **New governance arrangements: records for administration of nutritional supplements** **Development of systems to support stock ordering and supply via community pharmacy** **Development of specifications for technology to support dietetic monitoring of patients**

What do you feel were the challenges/negatives of the pilot?

What do you feel were the challenges/negatives of the pilot
Getting the time for the meetings!
1. Some staff were reluctant to change previously ways of working and continued to try and label ONS when delivered to NH. This reduced when they saw the benefits to having unlabelled ONS i.e. reduced wastage and ability to use spare ONS as trials with residents under supervision of dietitian 2. The dietetic time to initially implement the pilot was grossly under estimated and this resulted in extra hours etc. to try and ensure smooth implementation 3. Unlabelled ONS made it easier for staff to provide trials of ONS to residents without guidance from dietitian resulting in extra use of ONS 4. Difficult to implement Inhealthcare as NH had never previously used and struggled to get NH on board with updating every month
IT within care homes Funding approval for project Staffing
If patient discharged from hospital and change made to ONS, unclear if supply to be made by GP.
setting up the systems e.g. in health
Dietetic capacity to be involved with and deliver on the project.
None
Ensuring all primary care GP team members aware not to prescribe ONS in primary care - while this was done effectively there is room for duplication of prescribing if automatically reordered by either the Pharmacy or Nursing Home
knowing which nursing homes were currently taking part in pilot
stock monitoring initially until processes in place GP's still prescribing prescriptions
ensuring that records updated and no prescription issued in error
-Multiple issues regarding paperwork have been found when dispensing supplements to the nursing homes. -Regular updates need to be sent to the dispensing pharmacy to keep supply and paperwork up to date. - Some pharmacists not happy about checking off paperwork provided and would prefer prescriptions
BSO PALS supply difficulties Homes only willing to accept weekly delivery Changes in homes in pilot Variations across Trusts
Junior nursing staff at times found the ordering system hard to follow and how to access dietitian as at that time access to email for all nursing staff was limited which has now resolved as due to system changes within the home all nurses now have access to email
Establishing roles of NH for carrying out stock check and receipting stock delivery. Implementing Inhealthcare remote monitoring due to lack of IT within NH.

Implementing new documentation i.e. ONS administration chart. **Patients discharged from hospital with GP script generated for ONS not on preferred ONS list.**
Supply chains with BSO **Staffing in care homes to support additional pressures placed on dietitians.** **Communicating to GPs successful outcomes**
At the beginning of project it was quite challenging to get the project up and running and a lot of preparation work was required by the home and dietitian, it did take a lot of patience and hard work to get running smoothly. Nurse also require training and support at the start to reassure then that the system would benefit them.
Development of ordering and supply system via BSO PaLS **Misunderstanding of project aims by ICP pharmacists though following meetings to explain the project background, the outcome was positive** **Addressing concerns of nutrition companies regarding BSO supply system**

What improvements/considerations should be made for full implementation?

What improvements/considerations should be made for full implementation?
Very little, it just requires advertisement to all involved, nursing homes, community dietitians and GP practices. Up-scaling given original set-up should be hassle free, I would imagine.
1. More dietetic time allocated for initial implementation. This can be reduced after the initial introduction in each NH when processes are well established after 2-3 months. 2. Education around food fortification and Inhealthcare set up should be provided before pilot introduced. The updates for my NH were done during the pilot and I feel more benefits would have been seen earlier if these had been done in advance.
Appropriate staffing and grades and WTE/bed numbers Roll out of Inhealthcare with stock order module
In health to be fully implemented with stock ordering system included. scope the resource required to full implement
Additional permanent funding needs to be identified. Dedicated permanent dietetic hours needs to be identified.
Ensure all ONS Rx are managed via the same process and that care homes will not request any ONS from GP for example while awaiting dietetic review
would be great if rolled out to all nursing homes
Additional Dietitians / Dietetic support workers would be required roll out of In Health more widely Stock management system as part of In Health
ensuring that it is very clear that the medicine has been supplied as part of the scheme
One supply system
Ensure all NH's have IT available to facilitate use of Inhealthcare care. Inhealthcare updated with stock management facility.
Lack of strategic nutritional strategy targeting malnutrition in care homes Recognition of system wide need for dietitians in care homes working at advanced practice levels Review of formulary to reduce variation across settings, primary and secondary care.
All nursing homes, care homes need to be fully on board with the project and have support and training from the Trust. It may need to be a requirement as some homes may want to opt out of the project as it is so much work and takes up a lot of nurses or nurse managers time to get up and running
Identification of appropriate dietetic team skill mix and adequate resourcing of required staff Care Home catering staff training and qualification to support the needs of patients at risk of malnutrition Share outcomes with wider care home stakeholder group e.g. care home managers forum

Stock order system that can be easily used by the dietitians and community pharmacists and processed by BSO FPS; agreement on reimbursement of community pharmacists **In-healthcare digital platform upgrade to include stock management process** **Trial in a locality in each HSCT area** **Share outcomes with RQIA and raise awareness of appropriate nutritional support interventions; agreement for regional approach to assessing nutritional support during inspections**

Do you have any final/additional comments?

Do you have any final/additional comments
A very well organised and thought out system that from the start was been meticulous from the start. From original idea to implementation has been driven along by a great team.
It had been a pleasure to be a part of this pilot as I have been able to witness the first hand benefits to patients and all staff. The system of ordering via the CP works extremely well and all stakeholders in the NH I covered were completely on board with the pilot once they seen the benefits as set out above.
Personally I have been very impressed with how this pilot project has been managed. It has been a great opportunity for team working especially between pharmacy and dietetics. I sincerely hope the project is mainstreamed.
Very beneficial service both for patients as well as healthcare professionals
Great project with significant benefits for patients while still providing significant cost savings
Only had one patient involved. Hard to say if any benefits
- Original Project from March 2021 - June 2021 did not work - Updated project from August 2021 is much better
Good to be involved
Excellent pilot with scope for system wide changes and benefits.
It is important that families are involved and made aware of the project and the benefits of this project, as some families had got concerned when we started the project thinking their loved one was very malnourished, the wording on letters to families should be thought about and read in a simple effective way that they can understand.
It was a great opportunity to work collaboratively on this pilot with the dietetic teams, CPNI, GPP, RQIA, RCN, GPs, and BSO FPS & PaLS.

Survey Data

Please select which stakeholder group you are responding from		
	Number	**Percentage**
Practice Based Pharmacist	8	33%
GP	3	13%
Dietitian	3	13%
Dietetics Services Manager	2	8%
Community Pharmacist	2	8%
Care Home Nursing Staff	2	8%
Other*	2	8%
BDA	1	4%
RQIA	1	4%
Total	**24**	**100%**

Please select which Trust locality you work in?		
	Number	**Percentage**
Western	12	50%
Belfast	6	25%
Regional Org	3	13%
Northern	2	8%
Other	1	4%
Total	**24**	**100%**

I feel this pilot benefits the resident		
	Number	**Percentage**
Yes	22	92%
No		
Unsure	2	8%
Total	**24**	**100%**

Do you feel that the dietetic ordering and alternative supply mechanisms were beneficial?		
	Number	**Percentage**
Yes	20	83%
No		
Unsure	4	17%
Total	24	100%

Happy for pilot to continue		
	Number	**Percentage**
Yes	23	96%
No	1	4%
Unsure		
Total	24	100%

Did the pilot project contribute towards a reduction in delays in residents accessing ONS?		
	Number	**Percentage**
Yes	18	75%
No	1	4%
Unsure	5	21%
Total	24	100%

Did the pilot reduce ONS waste?		
	Number	**Percentage**
Yes	20	83%
No	1	4%
Unsure	3	13%
Total	24	100%

Appendix 5: GPP Feedback

NMOP Dietetic Ordering of ONS supplements in care homes GPP Feedback

- Feedback from GPPs regionally has been very positive
- GPPs can see the benefit of the pilot.
- Benefit is patients receiving ONS quicker.
- GPPs report they spoke with dietitian in advance of the pilot which was beneficial.
- GPPs have commented that they do think there is good scope for this type of dietitian intervention to prevent overstock of ONS in nursing homes and also continual review of ONS for patients to ensure no patient is continuing on a product longer than necessary.
- More Efficient
- GPs informed on prescribing in a timely manner
- ONS issued to patient quicker
- Two GPPs commented to have more communication with GPs if it's to continue
- One criticism from one practice was that the form looks very similar to old dietetic letters and one was missed as clinician didn't notice the difference.
- Several GPPS audited patients and stated letters were very clear as all were actioned appropriately in the patients that were identified.
- All GPPS involved were encouraged to submit stakeholder feedback.

Appendix 6: Food Fortification

	Pre-Pilot		Post-Pilot	
		N= No of Care homes		N= No of Care homes
Is fortified milk available with meals?	Yes No	6/6 0/6	Yes No	6/6 0/6
Are additional hot and cold nourishing drinks offered?	Yes No	5/6 1/6	Yes No	5/6 1/6
Are desserts given at lunch and evening meals?	Yes No	4/6 2/6	Yes No	6/6 0/6
How frequently (per day) are snacks offered to residents	x3 per day x 4 per day Care homes who did not provide information	4/6 1/6 1/6	x3 per day x4 per day Care homes who did not provide information	4/6 1/6 1/6
Are milk powder, butter & (double) cream available for fortifying foods & drinks in kitchen?	Milk Powder Butter (Double) Cream	5/6 4/6 4/6	Milk Powder Butter (Double) Cream	5/6 4/6 5/6

Appendix 7a: Snack Options between meals

	Pre-Pilot		Post-Pilot	
	Item	**N= No of Care homes**	**Item**	**N= No of Care homes**
What snacks are available for residents between meals?	Yogurt	4/6*	Yogurt	4/6*
	Custard	1/6	Custard	2/6
	Biscuits	5/6	Biscuits	5/6
	Fruit	3/6	Fruit	3/6
	Cake/ Bun Cupcakes/	4/6	Cake/ Bun Cupcakes/	2/6
	Mousse	1/6	Mousse	2/6
	Buttered Pancakes	1/6	Buttered Pancakes	1/6
	Tray bakes	3/6	Tray bakes	3/6
	Scones	2/6	Scone	3/6
	Sandwiches	1/6	Sandwiches	1/6
	Ice cream	1/6	Ice cream	1/6
	Shortbread	1/6	Shortbread	1/6
	Ready brek	1/6	Ready brek	1/6
	Range of savoury Snacks	1/6	Range of savoury Snacks	0/6
			Soaked buns	1/6
			Milkshake	1/6
			Smoothies	1/6
	*1 care home did not provide details			

Appendix 7b: Snack Options - modified texture

		Pre-Pilot	Post Pilot
	Item	N=	N=
What snacks are available for residents who require a modified texture diet?	Yogurt	4/6*	4/6*
	Custard	3/6	3/6
	Angel delight	1/6	2/6
	Mousse	1/6	1/6
	Rolo Deserts	1/6	1/6
	Milky bar puddings	1/6	1/6
	Milkshakes	0/6	1/6
	Smoothies	0/6	1/6
	Pureed kiwi and banana	0/6	1/6
	Modified soaked pancakes	1/6	1/6
	Biscuits	1/6	1/6
	Biscuits soaked in tea	1/6	1/6
	Puree Porridge	1/6	1/6
	Soaked buns	1/6	2/6
	Cake soaked in thick & easy	1/6	2/6
	Mashed banana	1/6	1/6
	Cheesecake (no base)	0/6	1/6
***1 care home did not provide details**			

Appendix 8: Process Maps

Dietetic Ordering of Oral Nutritional Supplements in Care Homes

Potential Start Date

- February 2021for baseline assessment and resident reviews
- End February/March 2021 for change to order mechanism

(caveats outlined below)

Communication

Care Homes in Belfast and Northern areas were contacted before Christmas and expressed an interest in participating in the pilot. Given current pressures all homes will be contacted again with a view to establishing a potential date for a baseline assessment and initial resident reviews. This date may be different in each area. Dietetic resource is still to be confirmed in Western Trust area.

Letters have been drafted for all community pharmacists (2 versions) and comments received on behalf of CPNI; the final version has not yet been agreed. The letters will be issued following approval by CPNI and confirmation from the specific care homes that they are in a position to participate.

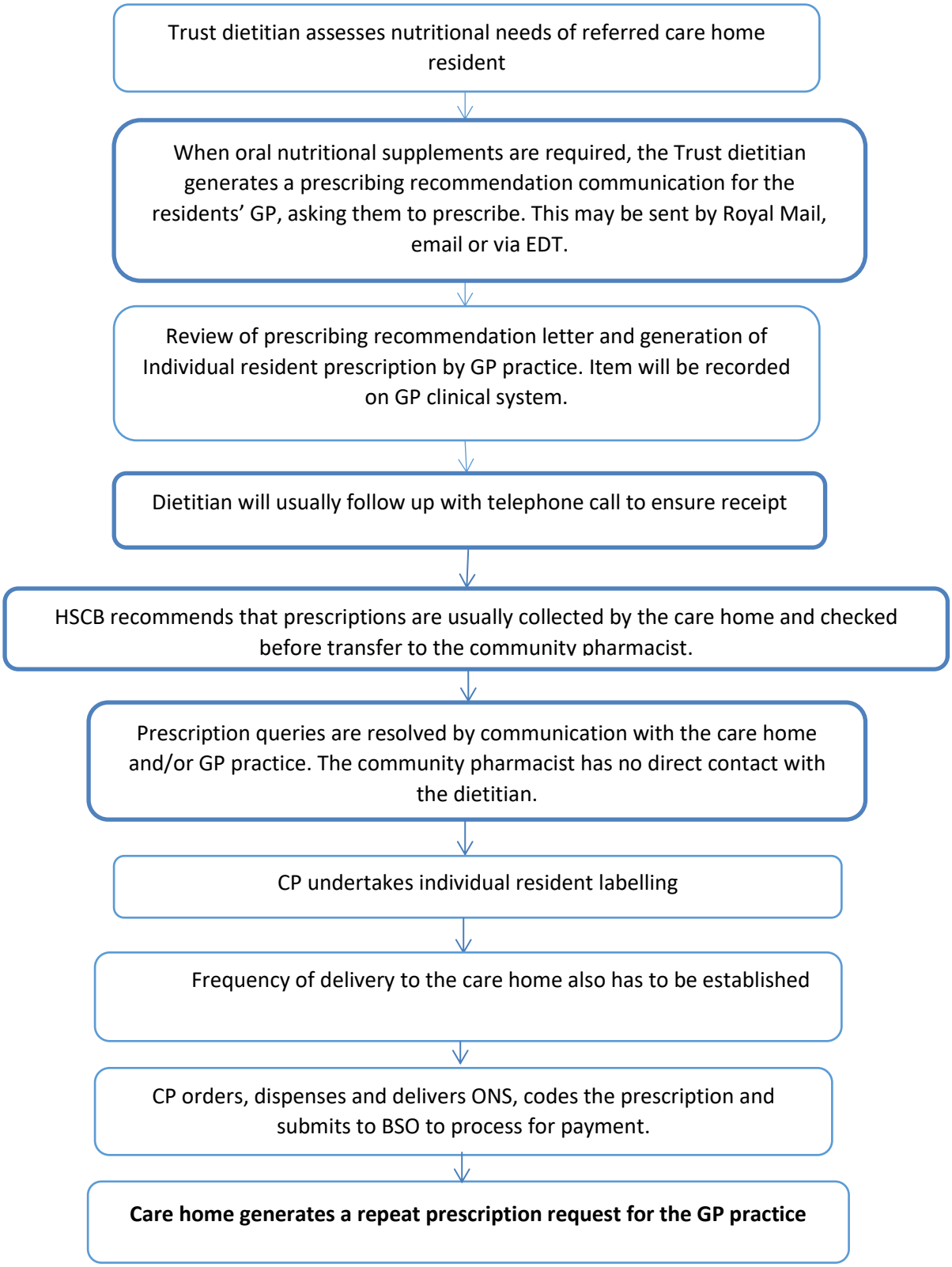
Relevant GP practices will be contacted at the same time.

Pilot Locations

Care homes were chosen using a number of criteria including overall costs for ONS, average cost per bed, number of beds and local knowledge. Additionally in the Northern area, the location within an existing BSO PaLS route was required as this model is being tested without additional capacity.

The pilot would not have been possible without the cooperation and support of the participating care homes, community pharmacies, GP practices and BSO PaLS. The Task & Finish Group also acknowledges support from BSO FPS and NISRA to enable a stock supply system and provision of prescribing data.

Process Map – Pre-pilot Community Pharmacy Supply (all HSCT areas)



Process Map – Community Pharmacy Supply (Belfast & Western HSCT areas)

A Trust dietitian will assess nutritional needs of **all referred care home residents**; focus will be on fortified food first with ONS where clinically appropriate.

↓

The Trust dietitian will generate **FIRST** stock order of ONS based on those needs for one month. NB taking account of stock in the home & any prescriptions due

↓

Stock order submitted to community pharmacy via secure email. Dietitian will follow up with telephone call to ensure receipt

↓

CP will dispense and deliver ONS, code stock order and submit to BSO to process for payment* via dieteticpilot@hscni.net before date specified by BSO for payment that month

↓

Trust dietitian will liaise with care home staff and use In-healthcare stock management software to generate stock orders for subsequent months. This will take into consideration remaining stock, changes in nutritional needs etc. Orders will be forwarded to community pharmacy as above

↓

The trust dietitian generates a communication for the resident's GP to record ONS ordered by the dietitian on the repeat prescribing screen o the GP clinical system.

↓

Mid-cycle orders may be occasionally necessary e.g. new residents admitted to care home, change in nutritional requirements of existing resident (s). In these circumstances a mid-cycle stock order will be generated and submitted in same way as monthly order. Dietitian will follow up by telephone to indicate when order is required.

*BSO has agreed to process the order forms for payment in the same way as a GP Stock form i.e. 25% on-cost of the gross ingredient cost plus a 2% expensive item payment if the ingredient cost is >£100. **This is solely for the duration of the pilot and without prejudice to any potential roll-out following evaluation**

Any HS21 prescriptions for ONS, for residents in the participating care home, issued in error by the practice during the pilot **should not be dispensed,** and coded "88888/1" and submitted to BSO in the appropriate amended bundle[1] . GP practice should be contacted to indicate that item has not been dispensed.

Dietetic Ordering of Oral Nutritional Supplements in Care Homes

Process Map – BSO PaLS Service (Northern HSCT area)

A Trust dietitian will assess nutritional needs of all care home residents; focus will be on fortified food first with ONS where clinically appropriate.

↓

A Trust dietitian will create an order ONS using a stock order form and forward to Trust Pharmacy Manager for authorisation. NB taking account of stock in the home & any prescriptions due

↓

A Trust dietitian will forward the approved order to BSO PaLS via eProcurement.

↓

BSO PaLS will process the order and deliver the order to selected care homes on the agreed weekly schedule.

↓

Trust dietitian will liaise with care home staff and use In-healthcare stock management software to generate stock orders for subsequent months. This will take into consideration remaining stock, changes in nutritional needs etc. Orders will be forwarded to pharmacy manager and BSO PaLS as above

↓

The trust dietitian generates a communication for the resident's GP to record ONS ordered by the dietitian on the repeat prescribing screen o the GP clinical system.

↓

Mid-cycle orders may be occasionally necessary e.g. new resident admitted to care home, change in nutritional requirements of existing resident (s). In these circumstances a mid-cycle stock order will be generated and submitted in same way as monthly order.

Compensation will be provided to the affected pharmacies for potential loss of income during the pilot (TBC - discussion with CPNI representative has focused on loss of dispensing fees & loss of profit, based on residents receiving ONS each month within the pilot)

Any HS21 prescriptions for ONS, for residents in the participating care home, issued in error by the practice during the pilot **should not be dispensed,** and coded "88888/1" and submitted to BSO in the appropriate amended bundle[1] . GP practice should be contacted to indicate that item has not been dispensed.

Appendix 9: Resident Journey Examples

Example	Problem	Impact	NMOP intervention
Resident reviewed by dietetic services 3 years ago and discharged on high protein ONS to support wound healing. Prescribed ONS: Fresubin 3.2kcal BD	At time of NMOP dietitian review wound was healed in excess of 2 years, however, resident remained on high protein ONS inappropriately	Resident continued to receive the unnecessary prescribed ONS for 27 months/814 days post wound fully healed at a cost of £4.70/day, total cost £3825.80. .	Inappropriate ONS was discontinued
Gentleman with a BMI indicating significant obesity* was prescribed a high protein/high energy specialist modular product Prescribed ONS: ProSource 30mls three times daily ** a BMI of 18.5 - 25kg/m² is considered to be within the healthy range*	This gentleman was actively trying to lose weight and was already making significant efforts to modify his dietary habits to this end. This prescription was adding an additional 300kcal to his total daily calorie intake.	This prescription was adding to his total daily calorie intake, hindering his weight loss efforts and potentially increasing his risk of obesity associated illnesses (diabetes, stroke, MI, certain cancers) as well as affecting his quality of life. ProSource liquid 30mls three times daily at a cost of £33.15/day, £1146.60/year.	Inappropriate nutritional product was discontinued
Lady was prescribed a high protein/high energy ONS product despite actively trying to prevent further weight gain. Prescribed ONS: Altraplen Compact	Resident was limiting her intake of high fat/sugar foods as she was unhappy that she was gaining weight yet was continuing to receive a	This prescription was adding to residents total daily calorie intake, hindering weight loss efforts and was prescribed for 2 months prior to the dietetic intervention	Inappropriate ONS product was discontinued

125mls OD	prescribed supplement providing 300kcal per day.	Altraplen Compact 125mls OD (cost of £1.33/day, £484.12/year)	
Lady was prescribed a powdered ONS product BD but she had swallowing difficulties and the SLT recommendations were for IDDSI Level 2 thickened fluids SLT recommendation was either not received by, or not implemented by the GP practice. SLT recommendation was either not identified, or the significance of the incorrect product not understood by the Care Home Prescribed ONS: Ensure Shake 57g BD	This supplement is not level 2 thick and thickening of prescribed supplements is not routinely recommended as these products do not thicken consistently. This prescription presented a resident safety risk	This prescription presented a resident safety risk – putting this lady at risk of aspiration (and subsequent chest infections/aspiration pneumonia which could result in need for antibiotic prescription/hospital admission/overall decline in clinical condition and quality of life or even death).	Inappropriate ONS product was discontinued. Supplements were changed to SLO Milkshake IDDSI Level 2 following dietetic assessment – in line with SLT recommendations.
Resident not referred to dietetics. Commenced onto supplements by hospital medical team and then discharged home on same prescription. Continued on Ensure compact three times daily	This would have met 80% of their energy and protein needs. Resident gained 18% of their body weight in 4months and moved from normal BMI of 23.5kg/m2 to overweight BMI of 28.3kg/m2.	This resident may have continued on this same inappropriate level of supplements and may have led to other issues associated with excess weight gain.	On assessment, all supplements were stopped as he was meeting his nutritional needs orally.

and Altrashot 40mls three times daily= total 1320kcal & 44.4g protein for four months.	Nursing home had contacted GP to discontinue but they were still being prescribed and they therefore felt obliged to give them.		
Resident recommended level 3 fluids from speech and language therapist. Not known to dietitian. Prescribed appropriate pre-thickened supplement but also had low volume shot prescribed that was not at an appropriate IDDSI level added to her prescription.	Had low volume shot prescribed that was not at an appropriate IDDSI level added to her prescription.	This is unsafe and could have resulted in aspiration in this resident	Inappropriate product was discontinued

Appendix 10: Stock Orders

New Models of Prescribing
Oral Nutritional supplement
Stock Order Request Form (Dietetic Care Home Project)

BSO Form Type: STOCK

Contractor No.

Pharmacy Contractor (Name and Full Address)

For supply to Care Home:

Product Description (please specify flavour)	Quantity	Code numbers (for community pharmacist use only)

Dietitian details (Name and address)

Date

Contact Telephone No.

Cipher No.

Name and phone number of dietitian if other than one named: _____

_____

To be completed by Pharmacist prior to Submission to FPS

I hereby claim payment in accordance with my terms of service for drugs and listed appliances ordered on this form and supplied, to the best of my knowledge and belief, by me.

Name of Pharmacist: _____ Date of Dispensing: _____

Information for Community Pharmacist: Once supply is completed code, complete declaration and submit the form by email to dieteticpilot@hscni.net for payment as per guidance. This form should **NOT** be submitted with your normal monthly submission.

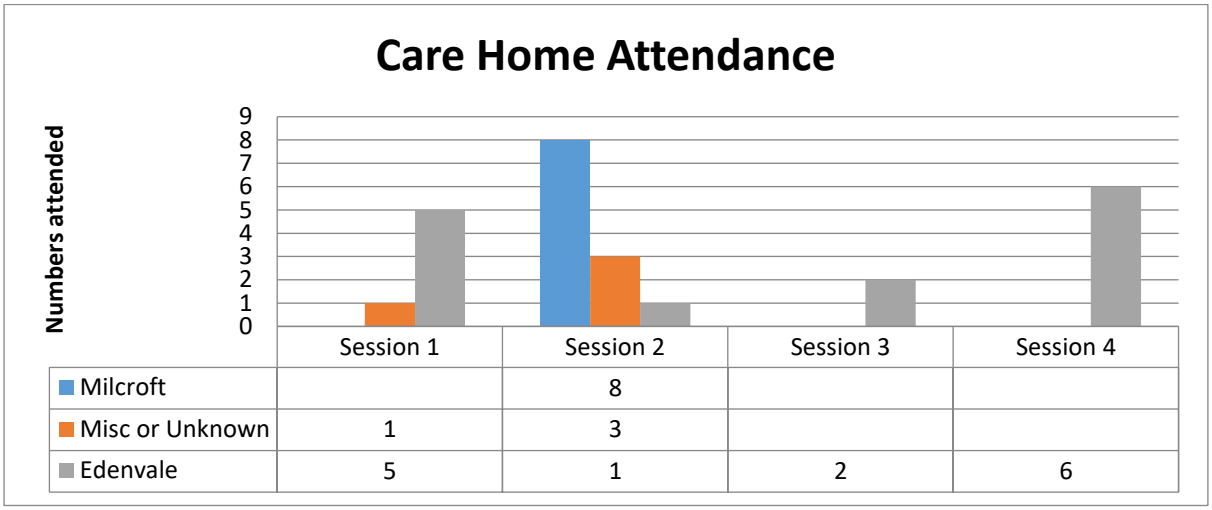
Appendix 11: Good Nutritional Training Report

Audit of Good Nutritional Care Training

Outcomes

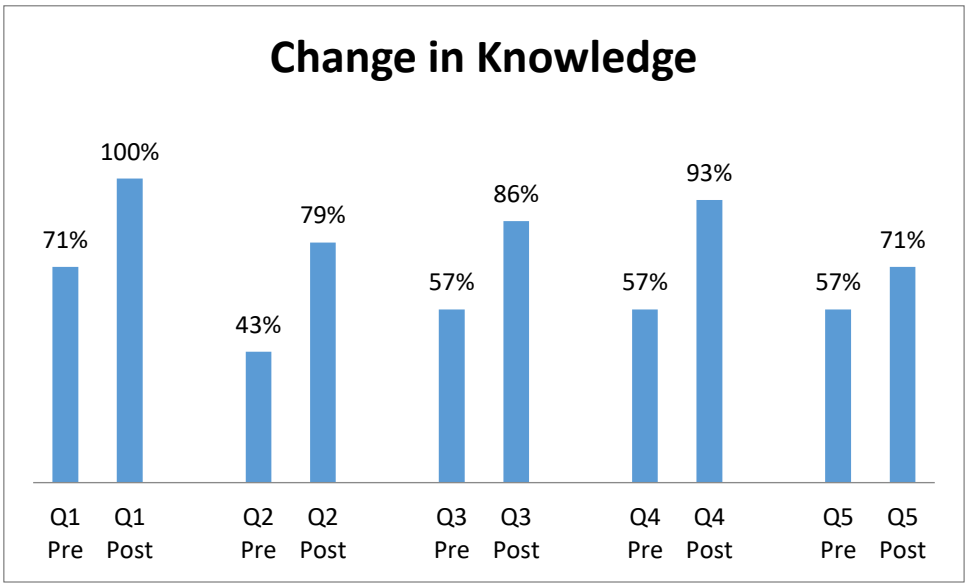
This section details the outcomes obtained from these sessions;

The numbers attended for each care home are as follows;



Outcomes were obtained for these sessions with the use of pre and post knowledge based polls during the sessions and via a survey on citizen space after the event.

The following are the results obtained;

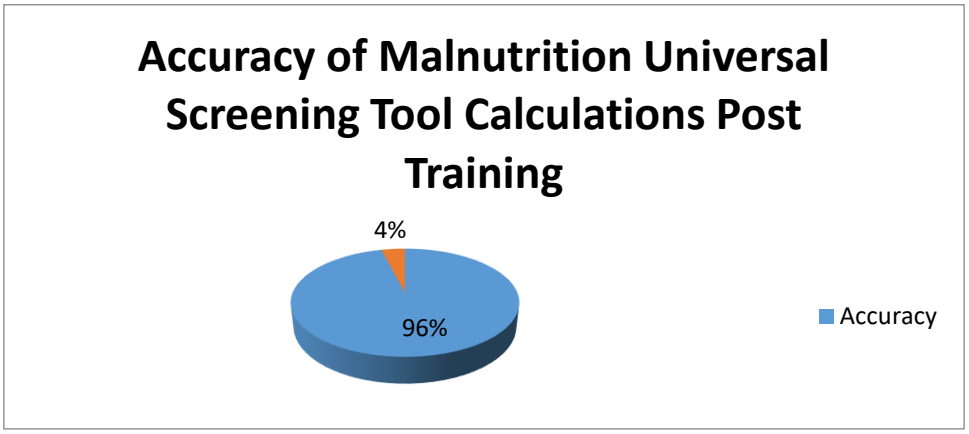


Question No.	Content
Question 1	When should nutritional screening be completed
Question 2	The number of steps required to complete MUST
Question 3	What a nutritional action plan is
Question 4	Knowledge of food first principles

Question 5	Being able to fortify meals using PHA guidance for care homes

Over all this represents a 29% increase in the ability to correctly know when to screen for malnutrition, the numbers of steps required to complete MUST, what a nutritional action plan is, how to treat malnutrition using the food first principles and being able to fortify meals using the PHA guidance for care homes.

Nutritional Screening

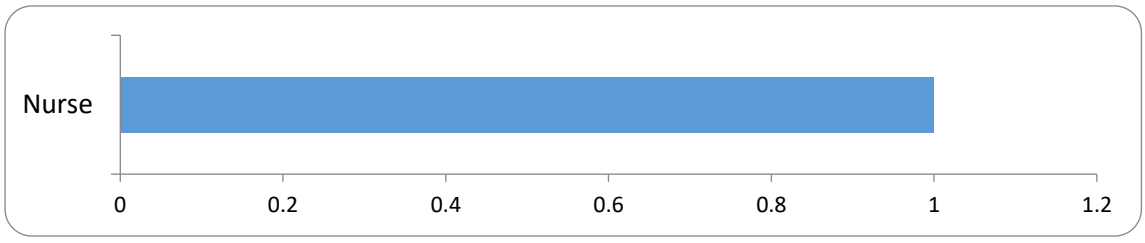


96% of those attending were able to correctly screen using the MUST tool post the training.

Citizen space Results

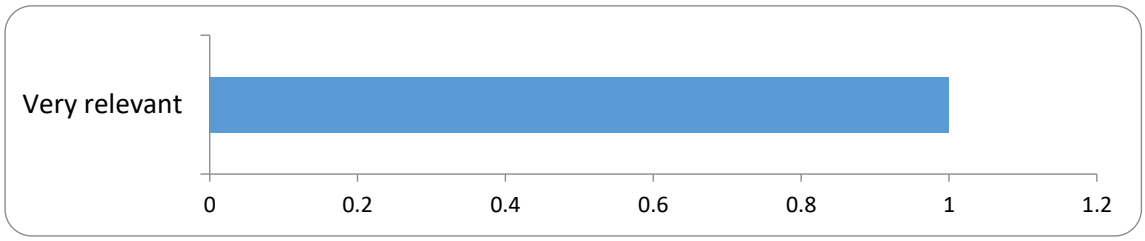
Only one person responded to the survey and so the power of these results are limited.

What is your job role in your nursing home?



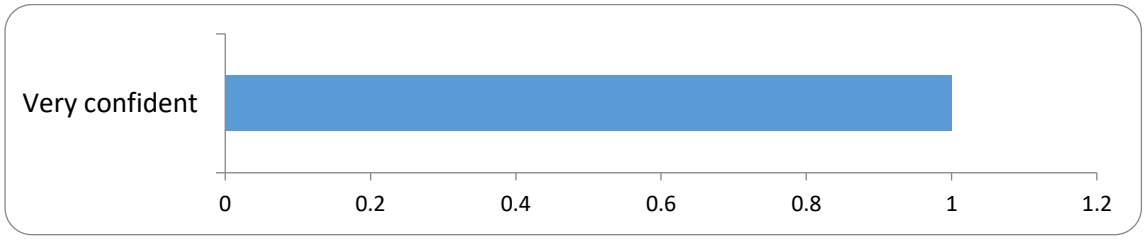
Option	Total	Percent
Carer	0	0.00%
Nurse	1	100.00%
Chef / caterer	0	0.00%
Care Home manager	0	0.00%
Other	0	0.00%
Not Answered	0	0.00%

How relevant was this training to your job role?



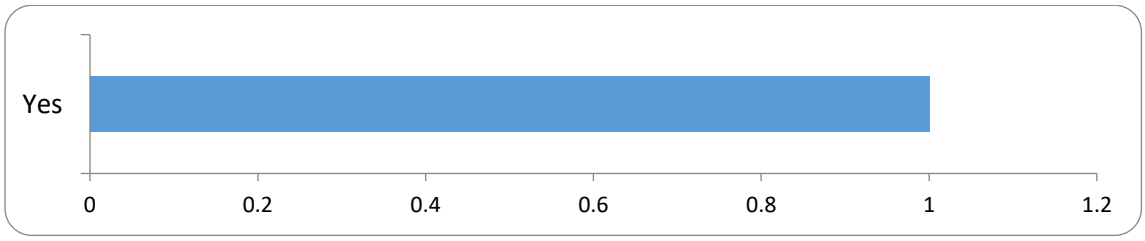
Option	Total	Percent
Very relevant	1	100.00%
Relevant	0	0.00%
Neither relevant or not relevant	0	0.00%
Not relevant	0	0.00%
Not at all relevant	0	0.00%
Not Answered	0	0.00%

How confident do you feel about applying your learning in your job role?



Option	Total	Percent
Very confident	1	100.00%
Confident	0	0.00%
Neither confident or unconfident	0	0.00%
Not Confident	0	0.00%
Not at all confident	0	0.00%
Not Answered	0	0.00%

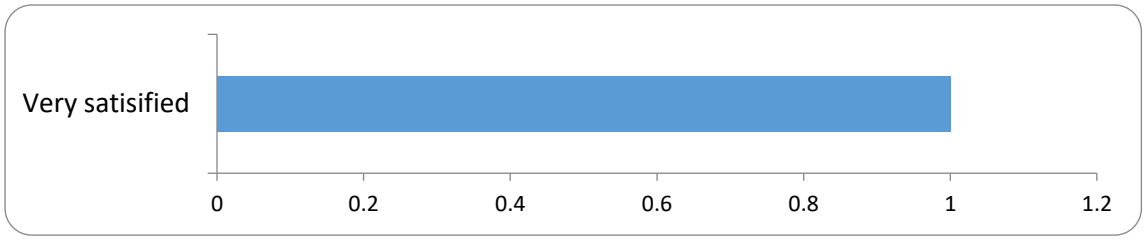
Do you feel that 1 or more aspects of your practice will change as a result of today?



Option	Total	Percent
Yes	1	100.00%
No	0	0.00%
Unsure	0	0.00%
Not Answered	0	0.00%

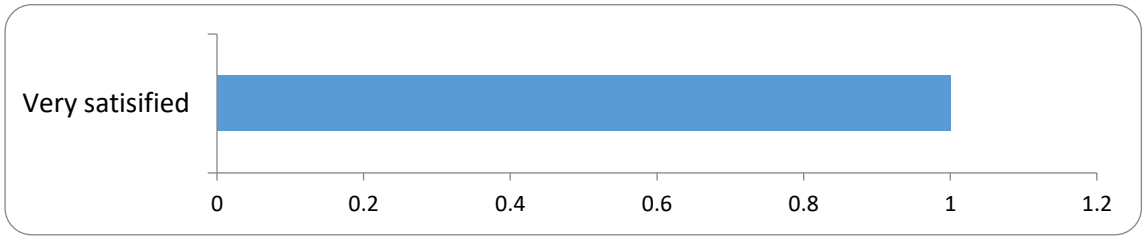
How satisfied you were with the following in helping you to learn?

Rating resources - Teaching / Powerpoint



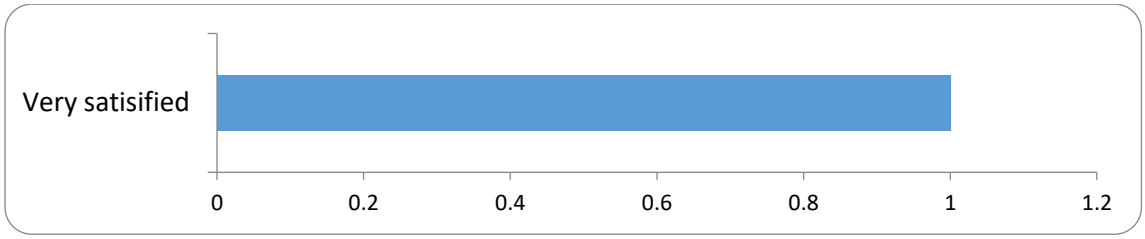
Option	Total	Percent
Very satisfied	1	100.00%
Satisfied	0	0.00%
Neither dissatisfied or satisfied	0	0.00%
Dissatisfied	0	0.00%
Very dissatisfied	0	0.00%
Not Answered	0	0.00%

Rating resources - MUST Workshop



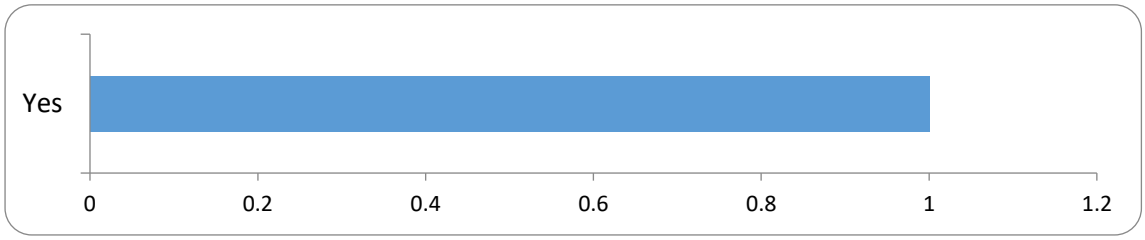
Option	Total	Percent
Very satisfied	1	100.00%
Satisfied	0	0.00%
Neither dissatisfied or satisfied	0	0.00%
Dissatisfied	0	0.00%
Very dissatisfied	0	0.00%
Not Answered	0	0.00%

Rating resources - Videos



Option	Total	Percent
Very satisfied	1	100.00%
Satisfied	0	0.00%
Neither dissatisfied or satisfied	0	0.00%
Dissatisfied	0	0.00%
Very dissatisfied	0	0.00%
Not Answered	0	0.00%

Was the program length appropriate to cover the subject?



Option	Total	Percent
Yes	1	100.00%
No	0	0.00%
Too long	0	0.00%
Too short	0	0.00%
Not Answered	0	0.00%

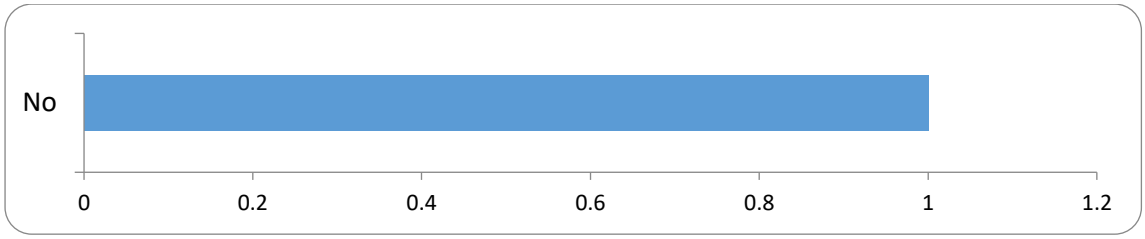
What did you find most beneficial about this training and why?

There was 1 response to this part of the question- Weight monitoring, nutrition and supplements sections.

Please give 2 suggestions of how we could improve this education program

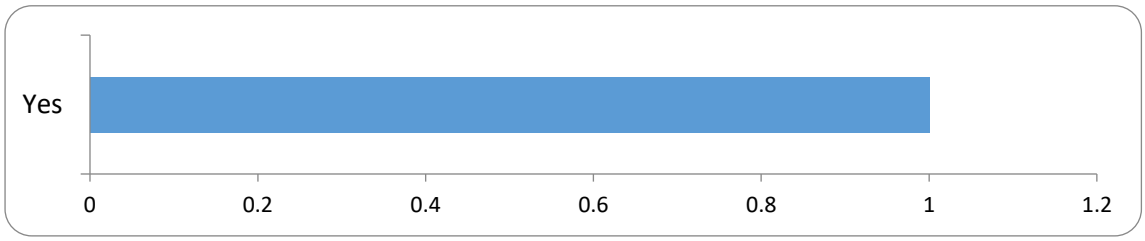
There were 0 responses to this part of the question.

Have you identified any further learning or development needs as a result of this program?



Option	Total	Percent
No	1	100.00%
Not Answered	0	0.00%

Would you recommend this program to a friend or colleague?



Option	Total	Percent
Yes	1	100.00%
No	0	0.00%
Not Answered	0	0.00%

Any further comments?

There were 0 responses to this part of the question.

Risk and considerations

To minimise devolving resident information each attendee was requested to limit questions that could reveal a client. Privacy notes are required within the Northern trust and if shared with other trusts this may need to be reviewed.

Lessons Learned / Barriers to knowledge attainment and results obtained

For session 2 due to information technology difficulties the results were not saved with the exception of accuracy for calculating the Malnutrition Universal Screening tool (MUST) score. Also of note there was limited interaction during the 3rd session and the benefits obtained were not as positive compared to other sessions. The

care home manager for the staff who attended reported difficulty with logging on, audio and connectivity this was not reported or noticed by the facilitator on the day. If the project was rolled out then further thought re potential IT support and solutions within the homes is required.

Some of the care homes within the new models of prescribing did not attend any sessions run. We are aware that within the Northern Health and Social Care Trust that significant investment in training had been completed in the year prior to these sessions and may explain the low numbers in this area. The reasons for low numbers attending should explored along with the comparing the outcomes for the homes with greater numbers attending.

Due to the limited feedback obtained via citizen space additional polls / training workshop could be considered if the project was rolled out to continually enhance the program provided.

The benefits of pooling dietetic resources to deliver training have not been fully seen within this project as most in attendance were from the WHSCT. If this project was scaled up significant dietetic time could be saved, sessions could be run in line with care homes wishes and needs (more frequently due to a large turnover of staff) and the content could be regionally agreed.

For Further queries re this audit or training delivered contact;

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