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USE OF PATIENTS KNOW BEST AS A TOOL TO IMPROVE PATIENT ENGAGEMENT AND DELIVER A DIGITAL DIETETICS SERVICE TO KIDNEY PATIENTS

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Patient initiated follow up is being supported by NHS England and NHS Improvement[1] to offer flexibility with follow up care and promote self-management and enable shared decision making. As a means of undertaking this, citizen held health records via web passed portals have become a new feature within clinical services, especially during the Covid-19 pandemic. It has been discussed elsewhere[2] what benefits may be gained from using digital web based portals to improve patient engagement and self-management by patients with kidney disease. As a team of kidney dietitians, the citizen health held record known as Patients Know Best (PKB) was adopted as the portal of choice for use with patients as a means of patient initiated follow up and service improvement.
A six month pilot phase was undertaken between September 2020 - March 2021 in which willing and interested patients had the opportunity to register on to the Kidney Dietitians' PKB page. Upon registering the patients were able to use a two way message function which means direct access to their kidney dietitian, a full library of information ranging from YouTube tutorials, departmental information leaflets, links to charity websites, free cook books available on the internet and links to other platforms such as Humber Health Apps and Patient View. Dietitians had the ability to electronically undertake nutritional screening, bowel assessment questionnaires using PKB and could also send 24hr food recalls and 5 day food diaries (known as consultations) for completion ahead of booked appointments via telephone or video. PKB is also being used as a teaching aide during face to face and remote consultations to promote patient empowerment and self-care[3].
Data from the pilot phase showed that 49 patients had registered with the platform. In terms of instant messaging, 43% of messages had been instigated by the patient. Approximately 90% of messages received by the dietitians were read and responded to with 24 hours. Data also revealed that 100% of consultations initiated by the dietitian had also been completed within 24 hours enabling timely intervention.
Due to the success of the pilot phase, a mail shot has now been sent to all dialysis patients (circa 400) offering them the opportunity to register with the Kidney Dietitians PKB site and a further consultation has been designed and added to PKB for audit data collection purposes.

References

1. 'Patient initiated follow up: Giving patients greater control over their hospital follow up care' *Last accessed from*https://www.england.nhs.uk/outpatient-transformation-programme/patient-initiated-follow-up-giving-patients-greater-control-over-their-hospital-follow-up-care/ *02.07.2021*
2. The role of patient portals in enhancing self-care in patients with renal conditions (2020) Hazara, A. M., Durrans, K., Bhandari, S. *Clinical Kidney Journal*; Vol 13; 1-7.
3. 'The 'future is bright' for patients of the kidney dietetics service' Patients Know Best *last accessed from* https://patientsknowbest.com/2021/04/26/hull-kidney/ *on 02.07.2021*

AN EVALUATION OF NUTRITIONAL STATUS AND SPECIFIC NUTRITIONAL ISSUES DURING A REHABILITATION PERIOD POST COVID-19 INFECTION

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Patients recovering from COVID-19 infection are at a high risk of malnutrition, reduced nutritional intake and decline in muscle mass and strength.[1]
The aim of this service evaluation is to describe baseline characteristics, quantify risk of malnutrition, provide an overview of nutritional status and nutritional related outcomes for patients recovering post COVID-19 infection on rehabilitation wards.
Data collection occurred between the 1st of February and the 1st of July 2021. This cohort included all patients who were recovering from COVID-19, who were referred to dietetic service and transferred to a rehabilitation ward. Demographic data and nutritional parameters were gathered from electronic records, and dietetic assessments.
A total of 54 patients were included: 59% male, 41% female. Ages ranged from 46 to 95 years with average age of 79.9 years and average length of hospital stay of 92 days. One fifth of those included had an ICU stay. Where data was available on sarcopenia risk, 50% were identified as at risk of sarcopenia. Of those where serum 25-hydroxyvitamin D was checked, 45% had insufficient vitamin D levels. A nutrition focused physical exam was completed for 18 patients (one third of the cohort). Using this exam, 61% were diagnosed with moderate or severe malnutrition. At least 15% of patients experienced significant weight loss between their admission to the hospital compared to their weight on admission to post COVID-19 rehabilitation ward. Of those where Malnutrition Screening Tool was completed on admission to COVID-19 rehabilitation ward, 33% were identified as at risk of malnutrition. On discharge from the dietetic caseload, the proportion of those identified at risk of malnutrition using this tool decreased to 18%. During the period from admission to COVID-19 rehabilitation ward and discharge from dietetic service, 42% gained weight, 54% maintained their weight, 4% lost weight.
Of those with data available regarding nutritional intake on admission to COVID-19 rehabilitation ward, 28% met energy requirements and 44% met protein requirements. On discharge from dietetic service these proportions increased to 66% meeting energy requirements and 74% meeting protein requirements. The average kcal intake on admission to COVID-19 rehabilitation increased from 1531kcal to 1778kcal on discharge and the average protein intake increased from 67g on admission to post COVID-19 rehabilitation to 75g on discharge.
These results demonstrate the high prevalence of malnutrition and high risk of sarcopenia in patients admitted for rehabilitation post COVID-19 infection. With dietetic input, improvements were observed in patient's nutritional intake, and nutritional outcomes such as weight and malnutrition risk. These results illustrate the need for early dietetic input in those recovering post COVID-19 infection to optimise nutritional status and nutritional outcomes.
References: 1. Anker M. S., Landmesser U., von Haehling S et al. Weight loss, malnutrition, and cachexia in COVID-19: facts and numbers. Journal of Cachexia, Sarcopenia and Muscle, 12, 9– 13. https://doi.org/10.1002/jcsm.12674

IMPLEMENTATION OF THE ROYAL PHARMACEUTICAL SOCIETY PROFESSIONAL STANDARDS FOR HOMECARE TO INVOICE MANAGEMENT OF HOME PARENTERAL NUTRITION

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Home Parenteral Nutrition (HPN) is a high tech homecare service. Patients are under the care of specialist Intestinal Failure teams, and funding for homecare is provided by NHS England. The Hackett report in 2011[1] sought to improve financial and clinical governance arrangements for patients receiving medicines via the homecare route. A workgroup developed Professional Standards for Homecare Services (Royal Pharmaceutical Society, 2013[2]). Standard 9.2 refers to Financial governance, and states "payments due to that contractor under the homecare service are not unreasonably withheld or delayed", and "product access and contract pricing is in accordance with their service specification".
In this large specialist centre, the process to manage invoices was seen to add delays in making payments to homecare providers. In addition, there was little check in place to give assurance that the homecare providers were invoicing according to the framework contract prices, and according to the prescription.
When a prescription was prepared, the HPN pharmacist would update a spread sheet with the details of that prescription. On receipt of every