University Hospitals of Leicester NHS
NHS Trust

Dietetic and Nutrition Adult Service Referral UHL Policy

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

- Reviewed August 2020 : flow chart 1 wording on enteral updated, references to hostesses changed to catering assistant, reference to Nursing Associates added
- Reviewed August 2023 : roles updated, referral process added into main body, referral exclusion criterion added, references updated

KEY WORDS

Referral, Dietitian, Nutrition Nurse, Dietetic Service, Nutrition Team

1. INTRODUCTION AND OVERVIEW

1.1. This Policy refers to the Dietetic and Nutrition Service provided to adult patients across the Trusts hospital sites – Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital and off site locations where a service is provided e.g. Loughborough Dialysis Unit. It has been devised by the Dietetic and Nutrition Service to ensure appropriate, equitable and timely referral to the Dietetic and Nutrition Service.

1.2. The Dietetic and Nutrition Service assesses and advises individuals, relatives, carers, patient groups and the hospital population as a whole on therapeutic diets and artificial nutritional support packages of care in order to:

- Diagnose disease and conditions e.g. malnutrition, food allergy
- Treat diseases and conditions e.g. metabolic disease, diabetes and renal disease
- Alleviate symptoms e.g. liver disease, cystic fibrosis, gastrointestinal disease
- Reduce the risk of complications of disease e.g. coronary heart disease

1.3. The Dietetic and Nutrition Service is made up of staff who are Dietitians, Nutrition Nurses, Dietetic Assistant Practitioners and Dietetic Assistants supported by an administration team.

Dietitians use the most up to date scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate food choices and use artificial nutritional support methods. They work with a wide range of patients in every age, ethnic and disability group, helping to diagnose, treat, manage and speed recovery from a complex and varied range of conditions from gastrointestinal, liver, hepatic, diabetes, renal, metabolic, respiratory, allergies and cancer. Their scope of interventions includes therapeutic diets, oral nutritional support and artificial nutritional support e.g. enteral and parenteral nutrition. 10.8% of the UKs disease burden is associated with unhealthy diet.

Registered nurses specialising in the field of adult nutritional support lead on assessment of patients for fitness for enteral tube placement procedures and management of complications with enteral feeding tubes e.g. blocked or misplaced tubes and take a lead role in the Trust training ward nurses to care for inpatients on enteral and parenteral feeding systems.

Dietitians and Nutrition Nurses work together with other health care professionals such as Pharmacists, Consultant Gastroenterologists, Consultant Biochemists, Consultant Surgeons, Vascular Access and Infection Prevention teams commencing and monitoring adult inpatients and home care patients on parenteral nutrition as part of a wider nutrition support team called the Leicestershire Intestinal Failure Team (LIFT).

See Flow Diagram below for summary of referral routes and indications.

Flow Chart 1: Referral of Adult Patients to the Dietetic and Nutrition Service

Therapeutic Diets	All patients requiring a therapeutic diet should be referred to a **Dietitian**
Oral Nutritional Support	All patients will be nutritionally screened on admission, and rescreened weekly using the Malnutrition Universal Screening Tool 'MUST'. 1. Those who score 4 or more should be referred to **the ward Dietitian,** 2. Those who do not improve on ward first line care plan after 3 days should be reviewed and referred to **the ward Dietitian** Refer to the 'Nutritional Screening and First Line Oral Nutritional Care Policy for Adults' B26/2015.
Oral Nutritional supplements	All patients requiring prescribable oral nutritional supplements and or modular nutrition products on eMEDS should be referred to a **Dietitian.** Except those on a defined time limited nutrition pathway e.g. liver patients and #NOF patients
Enteral Nutrition	All non-cancer inpatients requiring an enteral tube feeding placement procedure e.g. stroke patient requiring PEG via Endoscopy or RIG via Imaging should be referred to a **Nutrition Nurse** for assessment of fitness for procedure
	All cancer in and outpatients requiring an enteral tube feeding placement procedure eg Head and Neck Cancer patient, Upper GI cancer patient or Bone marrow transplant patient requiring RIG or PEG via Imaging should be referred to the appropriate **Specialist Cancer Dietitian** to co-ordinate an MDT assessment of fitness for procedure.
	All patients requiring a nutritional assessment, enteral feeding regimen – pump and or bolus, care plan e.g. water flushes and ongoing clinical monitoring of an enteral tube feed +/- oral nutritional supplements and oral diet should be referred to a **Dietitian**. Nb Dietitian will interface with Home Enteral Services in other Trusts and Home Care Companies for discharge of patients.
	All patients requiring assessment and care plan for enteral tube feeding complications management e.g. blocked or leaking feeding tube refer to a **Nutrition Nurse**.

2. POLICY SCOPE – WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1. The following staff groups can use this Referral Policy: Medical teams, Nurses and Midwives, Nursing Associates and other members of the ward team such as Housekeepers, Catering Assistants, Specialist Nurses, Pharmacists, Allied Health Professionals Physiotherapists, Occupational Therapists, Speech and Language Therapists, Health Care Scientists and Macmillan Patient Information Centre. Patients, relatives and carers and outside patient groups eg Macmillan Information Centre staff can also refer patients as long as patients have given consent.

2.2. Any member of the healthcare team looking after an individual patient can refer an adult patient to the Dietetic and Nutrition Service. No specific training is required.

2.3. Adult patients can be referred to the Dietetic and Nutrition Service from any of the following patient settings: inpatients, outpatients, pre-assessment clinics, day case patients and patients requiring structured group education. Patients who are part of clinical trials and research and development programmes can be referred with funding to support professional time.

2.4. Adult patients and their relatives/carers can self-refer. We will seek confirmation of the referral with the Consultant and ensure we have sufficient medical details.

2.5. Adult patients are classified as being over 16 years of age or those over 19 years of age in special education.

2.6. We do not at this time offer a direct access service to General Practitioners. All patients referred to the Dietetic and Nutrition Dietetic Service must be under the care of a UHL Trust Consultant medical team and have a Dietetic and Nutrition Service funded as part of the overall care package.

2.7. This Policy does not cover Dietetic and Nutrition Service referrals for neonatal and paediatric patients.

2.8. This Policy does not cover Adult Dietetic Critical Care and Nutrition Support Team, Leicestershire Intestinal Failure Team (LIFT) referrals for patients on parenteral nutrition.

2.9. This Policy does not cover adult dysphagic patients requiring a modified consistency diet provision as this should be under the instruction of a speech and language therapist.

2.10. This Policy does not cover special dietary requirements for religious and cultural needs. Please refer to your ward Catering Folder and Catering Assistant for information.

3. DEFINITIONS AND ABBREVIATIONS

3.1. **Enteral nutrition** generally refers to any method of **feeding** that uses the gastrointestinal (GI) tract to deliver part or all of a person's nutritional requirements. It can include a normal oral **diet**, the use of liquid oral nutritional supplements or delivery of part or all of the daily requirements by use of an enteral tube (tube **feeding**).

3.2. **Hydration** applied to any fluid consumed. Foods that have a high fluid content eg jelly, ice cream will support good hydration.

3.3. **Malnutrition Universal Screening Tool** (MUST)

3.4. **Nutritional support** is an active measure(s) put in place to help improve nutritional intake. This could be oral and/or enteral and/or parenteral to address malnutrition. Oral Nutritional Supplements (ONS) are sterile liquids, semi-solids or powders, which provide macro and micro nutrients. They are widely used within the acute and community health settings for individuals who are unable to meet their nutritional requirements through oral diet alone.

3.5. **Oral nutrition** can be food i.e. fortified food, additional snacks, fluids and non-prescription and prescription oral nutritional supplements.

3.6. **Parenteral nutrition** (PN) refers to the provision of nutrients by the intravenous route. In general, PN should only be used when it is not possible to supply nutrition using the GI tract ie when intestinal failure is present. Total Parenteral Nutrition (TPN) implies that all macronutrient (carbohydrate, nitrogen and lipid) and micronutrient (vitamins, trace elements and minerals) and fluid requirements are met by an intravenous nutrient solution and no significant nutrition is obtained from other sources. Some patients treated with PN can absorb some fluid and nutrition taken orally and in these patients PN is a supplement to their oral intake.

3.7. **Therapeutic diet** is a meal plan that controls the intake of certain foods or nutrients. It is part of the treatment of a medical condition and is normally prescribed by a physician and planned by a dietitian. A **therapeutic diet** is usually a modification of a regular **diet**.

4. ROLES – WHO DOES WHAT

4.1. The Executive Lead for this Policy is the Chief Nurse. Who has overall responsibility for ensuring patient care and safety, including nutritional management.

4.2. **The Head of Nursing for the Clinical Support and Imaging Management Group and Lead Nurse for Nutrition, Hydration and Head of Service for**

Dietetics and Nutrition have responsibility to ensure that adequate arrangements are in place to:

a) Ensure the Trust is compliant with national and local targets.

b) Support the implementation of the Trust's Adult Dietetic and Nutrition Service Referral Policy.

4.3. **Heads of Nursing/ Deputy Heads of Nursing** are responsible for ensuring that adequate arrangements are in place to:

a) Ensure the Trust's Adult Dietetic and Nutrition Service Referral Policy is implemented in their CMG.

b) Monitor and validate the Nursing Metrics for Nutrition within their Clinical Management Group focusing on wards / units with high non-compliance with standards.

c) Sign off Serious Incidents (SI) reports and ensure actions are implemented.

4.4. **Ward Sisters / Deputy Sisters / Outpatient Lead Nurses** are responsible for:

a) Ensuring that all staff receive information, instruction and training on the key aspects of this Policy at induction and undertake the HELM adult nutritional screening training as essential to job role for all nurses. This training should be accessed on HELM and / or ward level as a minimum requirement and relevant to their working areas and duties. See section 6 for more details.

b) Investigating reported incidents / near misses and complaints linked to nutritional care and ensuring any remedial action is identified and implemented. Seeking advice from the Dietetic and Nutrition Service in the assessment of root causes and if investigation at a higher level is required.

c) Ensuring nutritional screening using the Malnutrition Universal Screening Tool (MUST) and nutritional care plans are completed with the Trust procedures and paperwork.

d) Ensuring the nutrition metrics are audited monthly using the monthly performance review tool and monitored closely on a quarterly basis.

e) Identifying a named Nutrition Link Nurse for each ward/unit and outpatient area, ensuring they have undertaken and completed the relevant training for the role.

f) Ensuring the importance of meeting the patient's nutritional needs is a focus for the ward team, and that good communication and team work are in place to ensure this is achieved. Raising ward nursing staff awareness of the need to ensure points 4.5 (a) – (i) below are followed.

g) Ensuring the correct equipment is available at ward/unit/outpatient level for anthropometric measurements e.g. weighing scales, height/length measure and that they are fit for purpose and calibrated.

h) Ensuring all of the ward/unit nursing team have undertaken the following nutrition training to be able to provide core and safe nutritional care to patients:

- E-learning on HELM for adult nutritional screening using MUST and first line nutritional care and also adult enteral tube placement also support this Policy.
  - It is called “Nutritional screening; A MUST for Hospitals”.
- Two nutrition study sessions bookable via HELM, these are provided by the dietetic practice learning lead post holder;
  - Session A “Nutritional Screening and First Line Nutritional Care”
  - Session B “Nutritional interventions and monitoring”

4.5. **Registered Nurses** are responsible for continuing to follow:

a) Weighing patient’s on admission.

b) Completing the patients’ initial nutritional screening tool on admission, weekly during the patient stay and on discharge.

c) Planning patient care in response to the initial nutritional screening results including referral to the ward Dietitian, which will need processing through an ICE order as soon as need is identified, see referral criteria – Appendix 5.

d) Referring patients for therapeutic diet advice and support. Communicating with catering staff regarding any menu’s or support menu’s required by inpatients’.

e) Initiating the first line oral nutrition care plan which is part of the standard nursing documentation. Nb ward poster available.

f) Communicating with the ward team such as Housekeepers and Health care assistants all patient nutrition needs.

g) Staff should continue to follow the first line nutritional care plan unless clinically inappropriate e.g. patient is nil by mouth or the ward Dietitian advises an alternative oral nutrition care plan.

h) Providing direct support to patients to help them meet their nutritional needs

i) Ensure patients who need assistance with feeding have the 'red tray system' in place. A red tray will be order when communicated to catering by a red RT behind the bed – see trust red tray process. Ensure all patients with meals on a red tray receive the help and assistance they need.

j) Monitoring and documenting patients' nutritional status e.g. food intake recorded on food record charts and record body weights on weight charts.

k) Assess patient's progress, looking at trends in weight (twice weekly), food intake being achieved (daily) and repeat MUST scores (weekly). Patients should be referred to the ward dietitian when the nutritional screening tool score is 4 or more, or if the 'MUST' score is 1-3 and on review after three days there is no improvement on the 1st line care plan, shown by the patient losing weight, and/ or food record charts showing poor food intake, and /or MUST score increasing.

4.6. **Health Care Assistants and Housekeepers** are responsible for:

a) Being aware of patients' nutritional care plan requirements and providing direct support to patients to help them meet their nutritional needs

b) Ordering and providing first line oral nutrition support interventions e.g. snacks, milky drinks, Aymes Shakes, Soups and Smoothies and providing these to the patient when indicated by the 'MUST' score (1+)

c) Assist patient's with therapeutic dietary needs using ward Catering Folder as a resource, and liaising with catering. Prompt ward nursing staff to refer to the ward dietitian for further support and guidance when this is required.

d) Ensure patients can order suitable meal choices, using a weekly meal planner if there are communication difficulties.

e) Ensure patients who need assistance with feeding have the 'red tray system' in place - see trust red tray process. Ensure all patients with meals on a red tray receive the help and assistance they need.

f) Monitoring and documenting patients' nutritional status e.g. food intake recorded on food record charts and body weights and report changes and escalate any concerns to the Registered Nurse in charge of the patients care

g) Undertaking stock control at ward level of first line oral nutritional support interventions e.g. snacks, Aymes Shakes, Soups and Smoothies, milk and ordering top up supplies using the daily ward requisition form and submitting to Catering Services

4.7. The **Medical Team** are responsible for:

a) Ensuring the nutritional status of patients is assessed as part of admission, board rounds, ward rounds and on discharge where applicable.

b) Acting upon concerns raised by healthcare professionals if the patient's oral nutritional intake is insufficient to meet their nutritional needs.

4.8. **The ward Catering Hostess** is responsible for the:

a) Advising patients to use the standard codes on the standard menus (adult, renal, ethnic Asian and afro Caribbean) to inform on suitable menus choices for higher energy, healthy eating (including diabetes, coronary heart disease and hypertension), soft and vegetarian diet needs.

b) Provision of specific therapeutic diet menus to inpatients in order for them to order meals and snacks from the catering folder using support menus such as:

- Gluten free menu
- Low lactose menu
- Low fibre menu
- Peanut and tree nut free menu

c) They should communicate to ward nursing staff and the ward Dietitian if a patients therapeutic dietary requirements cannot be met by any of the standard menus e.g. cow's milk, egg and nut allergic patient.

d) Provision of supplies to the wards of first line oral nutritional support interventions e.g. milk, snacks and provision of non-prescription oral nutritional supplements e.g. Aymes Shakes, Soups and Smoothies via daily ward requisitions.

e) They should communicate with ward nursing staff to ensure red trays are provided where needed – Described in the trust wide 'Red Tray Process', red trays should be ordered when there is a red RT behind the patients bed.

f) Red trays should not be cleared at the end of a meal service, until nursing staff have documented what the patient has eaten on the food record charts.

g) The ward hostess should also communicate with ward nursing staff if an inpatient opts not to order any food or their food order is minimal i.e. soup only.

4.9. **Dietitians** are responsible for:

a) Providing Trust wide training on the use of the adult Dietetic and Nutrition Service Referral Policy as part of Trust wide training programmes such as: Nursing Associates, Preceptorship nurses, HCA induction, International nurses and Mealtime Volunteers.

b) Providing Trust wide training on the valid use of the nutritional screening tool and first line nutritional care plan as part of Trust wide training programmes such as: Nursing Associates, Preceptorship nurses, HCA induction, International nurses and Mealtime Volunteers.

c) Providing Clinical Management Group (CMG), speciality and ward based training on the Adult Dietetic and Nutrition Service Referral Policy and valid use of the nutritional screening tool and first line nutritional care plan when requested.

d) Acting upon dietetic referrals from ward nursing staff and nutritionally assessing the patient and providing an individualised care plan

e) Undertaking a nutritional assessment of patients referred using factors such as weight, weight history, height, body mass index, history of recent intake, hydration, blood biochemistry and influence of disease state on nutritional status.

f) Providing an individualised nutrition care plan for patients referred after nutritional assessment and documenting this in medical and nursing notes at ward level

g) Interpreting and monitoring the nutritional documentation e.g. food record charts and body weights held at ward level.

h) Escalating concerns with patients who are not meeting nutritional requirements to the medical team.

i) Providing supplementary clinical audits on nutritional screening and first line nutritional care to the nursing metrics as part of a fresh pair of “eyes and ears” approach.

j) Referring patients that require complex enteral nutrition feed assessment e.g. patients requiring small bowel access for feeding and some patients with short bowel /high output fistulae/chronic malnutrition to the Leicestershire Intestinal Failure Team.

4.10. **Specialist Nurses** are responsible for:

a) All specialist nurses should ensure as a patient’s key worker that nutritional care has been considered in the patients care plan

b) Nutrition specialist nurses and Tissue Viability specialist nurses need to ensure nutritional screening and first line nutritional care is

covered in nutrition and tissue viability link nurse training and education sessions.

4.11. **Allied Healthcare Professionals (AHP's) are responsible for providing support to the meal time experience :**

a) **Speech and language therapists (SLT)** provide a referral-screening tool for patients suspected of having difficulties swallowing their food or drink. The SLT team will undertake a swallow assessment. SLT recommendations will aim to reduce risks of aspiration and choking and promote safe eating and drinking.

b) **Occupational Therapists (OT)** will undertake an OT assessment that will be carried out at meal times in order to determine whether the patient is independent or having difficulties with feeding. Aspects such as environment, cutlery and kitchen practice will form part of the assessment.

c) **Physiotherapy (PT)** can provide input in terms of assessments of mobility and transfer, posture ability and positioning and upper limb range of movement and strength.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS – WHAT TO DO AND HOW TO DO IT

5.1. The Dietetic and Nutrition Service for adult patients is provided Monday to Friday 8.00am to 4.00pm (excluding bank holidays). Please note some post holders will adopt flexible job plans around patient and service needs e.g. Board rounds and Multidisciplinary outpatient clinics starting at 8.00am and others finishing at 6.00pm after clinics.

5.2. To refer an adult inpatient or emergency department patient please follow Appendix 1 outlining Procedure using Appendix 2 ICE referral. All inpatient referrals must be made using the electronic referral forms on ICE. Areas exempt from referral due to operating a blanket referral system for all inpatients on the ward/unit include:

Adult Intensive Care Units

Adult Bone Marrow Transplant Unit

If referrals are made verbally face to face with the ward Dietitian or Nutrition Nurse, verbally via bleep/pager to the ward Dietitian or Nutrition Nurse, answerphone message left in Nutrition and Dietetic Department, on Ward Rounds/Board Rounds or written in medical case notes they should always be supported by an ICE referral.

All referrals must be supported with the Malnutrition Universal Screening Tool (MUST). In the event of no MUST score being on the referral ward nursing staff will be requested to complete and then refer. The ICE referral will be declined in the interim. In the event of a MUST score

being between 1 and 3 the ward nursing staff should implement the first line oral nutritional support care package. If the MUST score is 4 or more, the first line oral nutritional support care package should be implemented in parallel with the referral.

In the event of IT Major Incident Failure use manual adult dietetic referral form Appendix
3.

5.3. To refer an adult, outpatient, pre assessment outpatient, daycase or patient requiring access to a structured education group please follow Appendix 4 outlining Procedure.
Outpatients must be referred in writing using either the clinic report letter from Consultant to GP eg Dit 3 report letter stating in the main text of the letter "by copy of this letter to the Nutrition and Dietetic Service I will request a referral for the patient to be seen for xxxx". The clinic report letter should be cc'd to the Dietetic and Nutrition Service Booking Programme, Leicester Royal Infirmary. If there is a delay between clinic outpatient appointment with the Consultant medical team and the referral letter being delayed then use manual referral form. This form should also be used in the event of IT failure. See Appendix 3.

Outpatients referred to the Dietetic and Nutrition Service will mainly be seen as part of multi-disciplinary Consultant clinics as the Dietitian will be present as a core member of the MDT. Other referrals received will be booked into Dietetic dedicated outpatient clinics via our Booking Programme which are held on all referrals will three hospital sites. Home visits are carried out on a needs assessment basis only.

5.4. Use Referral Criterion to ensure appropriate referral of the patient. For Dietetic Referral Criterion see Appendix 5 and for Nutrition Nurse Referral Criterion see Appendix 6.

5.5. Associated documents which support ward medical and nursing staff in and out of hours include:

a) Nutritional Screening and First Line Oral Nutritional Care Policy for Adults (B26/2015).

b) Enhancing Patient Mealtimes Guideline (B43/2006).

c) Guideline for Commencing Out of Hours Enteral Tube Feeding (Nasogastric) in Adult Inpatients. (Including Management of Re-feeding Syndrome). Trust Ref: B55/2006.

d) Out of hours Enteral tube feeding (Nasogastric) Starter Regimen for an Adult Inpatient with Renal Failure. (Including Management of Re-feeding Syndrome) Guidance for practice Trust Ref: C2/2015

e) Guideline for Commencing Nasogastric Feeding in Adult patients in Critical Care. Trust Ref: B42/2016

f) Policy for the Dietary Management of Adult and Paediatric Neutropenic Patients Trust Ref: B28/2008

g) Clinical Guideline for the Nutrition and Dietetic Management of Adult In-patients with Chronic Liver Disease B19/2017

h) Clinical Guidelines for the Nutrition and Dietary Management of Adult Bariatric Surgical Patients C56/2015

i) Good Practice in Discharge Planning for adult patients leaving hospital Trust Ref: B20/2009

6. EDUCATION AND TRAINING REQUIREMENTS

6.1. Training is available to support the use of this clinical Policy and Procedures via the Dietetic and Nutrition Service. Staff will need to be able to:

- Refer a patient to the ward Dietitian as per Appendix 1 detailing Procedure
- Accurately complete the 'MUST' nutritional screening tool
- Implement an appropriate nutritional care plan according to the MUST score, including initiating 1st line oral nutritional care plans and referral to the ward Dietitian when appropriate
- Monitor patient's nutritional progress, and review nutrition care plan as necessary
- Advise and assist patients to manage different diseases / conditions treated by diet treatment
- Discharge planning including nutritional care for patients

6.2. Elements of these areas are currently included in UHL Nursing Associate, Healthcare Assistant induction sessions, preceptorship training, and international nurse training, and these sessions should include clear reference to this Policy.

Other trust-wide training such as dementia training, older person champion training, tissue viability study days, and mealtime assistant volunteer training should all make reference to this Policy.

Catering staff should also receive training that refers to this Policy.

6.3. E learning on HELM for adult nutritional screening using MUST and first line nutritional care and also adult enteral tube placement also support this Policy.

It is called “Nutritional screening; A MUST for Hospitals”.

6.4. Ward staff have access to two nutrition study sessions bookable via HELM, these are provided by the dietetic practice learning lead post holder;

Session A “Nutritional Screening and First Line Nutritional Care”
Session B “Nutritional interventions and monitoring”

6.5. Results from nutrition audits; the nursing metrics – nutrition metrics, and the CQUIN unintentional weight loss audit may highlight areas of the trust where further training in nutritional screening and nutritional support would be beneficial, at present this can be delivered by the Dietetic practice learning lead post holder.

6.6. Student nurses on placement within the Trust, should be supported in learning these key nutritional skills and sessions on nutrition will be delivered as part of the IPL programme by the dietetic practice learning lead post holder making clear reference to this Policy.

6.7. Trainee nurse associates within the trust are supported in learning these key nutritional skills as part of their course by the Dietetic practice learning lead post holder.

6.8. Ward staff have access to two nutrition study sessions bookable via helm; session A ‘Nutritional screening and First line nutritional care’ and session B ‘ Nutritional interventions and monitoring’. These are provided by the dietetic practice learning lead post holder.

6.9. For those looking to advance their nutritional knowledge further, the Trust now runs a Nutrition Module once a year which has been accredited for 30 credits by De Montfort University. Sessions within this course are delivered by the Dietetic and Nutrition Service, within a session on malnutrition the practice and processes within this policy will be covered in detail. This course is organised by the trust’s education and practice development team.

6.10. Other helpful training can be accessed on line through the National skills Academy for Health, This is interactive and the learner can develop at their own pace and can save their learning and return later. Staff will need to register with an NHS e-mail, but there after can access outside NHS premises. See https://elearning.nsahealth.org.uk, currently modules are available on

a) Introduction to food and nutrition

b) Under nutrition and dehydration

c) Facilitating and supporting eating and drinking

d) Assisting with eating and drinking

e) Best practice benchmarking for nutrition care

f) Basics of nutrition and hydration

7. PROCESS FOR MONITORING COMPLIANCE

7.1. Audit standards or key performance indicators that will be used for monitoring this Policies compliance and effectiveness and the frequency of monitoring / audit are set out in the Policy Monitoring table set out below.

POLICY MONITORING TABLE

The Trusts Nutrition and Hydration Assurance Committee will support the implementation and monitoring of this Policy.Element to be monitored	Lead	Tool	Frequency	Reporting arrangements Who or what committee will the completed report go to.
Appropriateness of adult inpatient referrals	Head of Service – Dietetic and Nutrition Service	Dietetic and Nutrition Scorecard	Monthly	Trust Dietetic and Nutrition Service Business and Quality and Safety meeting CSI CMG Assurance report and monthly meetings as indicated
Appropriateness of outpatient, pre assessment, day case and Structured Education Group referrals via Nutrition and Dietetic Booking Programme	Head of Service – Dietetic and Nutrition Service	Internal spreadsheet and Tiara reports	Monthly	Trust Dietetic and Nutrition Service Business and Quality and Safety meeting CSI CMG Assurance report and monthly meetings as indicated

Response times to inpatient referrals	Head of Service – Dietetic and Nutrition Service	Dietetic and Nutrition Service Scorecard	Monthly	Service Assurance report to CSI CMG Exec team CSI CMG Metrics
Response times to outpatient referrals	Head of Service – Dietetic and Nutrition Service	Dietetic and Nutrition Service Scorecard	Monthly	Service Assurance report to CSI CMG Exec team

8. EQUALITY IMPACT ASSESSMENT

8.1. The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Standards and Guidelines for Nutritional Support of Patients in Hospitals, British Association Parenteral and Enteral Nutrition (BAPEN), 21 December 2012

Nutrition Support for adults: Oral nutrition support, enteral tube feeding and parenteral nutrition, NICE, CG 32, last updated 04 August 2017

Care Quality Commission: Nutrition Standards 2017

10. PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trust's PAGL system.

For inpatients a Dietetic and Nutrition Service is available to all wards/units Monday to Friday from 8.00am to 4.00pm (except bank holidays). Areas exempt from referral due to operating a blanket referral system for all inpatients on the ward/unit include:

- **Adult Intensive Care Units**
- **Adult Bone Marrow Transplant Unit**

All inpatient referrals must be made using the electronic referral forms on ICE. See Appendix 2. In the event of IT failure please use manual referral forms. See Appendix 3.

- If referrals are made verbally face to face with the ward Dietitian or Nutrition Nurse, verbally via bleep/pager to the ward Dietitian or Nutrition Nurse, answerphone message left in Nutrition and Dietetic Department, on Ward Rounds/Board Rounds or written in medical case notes they should always be supported by an ICE referral.

All referrals must be supported with the Malnutrition Universal Screening Tool (MUST). In the event of no MUST score being on the referral ward nursing staff will be requested to complete and then refer. The ICE referral will be declined in the interim. In the event of a MUST score being between 1 and 3 the ward nursing staff should implement the first line oral nutritional support care package. If the MUST score is 4 or more, the first line oral nutritional support care package should be implemented in parallel with the referral.

For Referral Criterion to Dietitians please refer to Appendix 5.

For Referral Criterion to Nutrition Nurses please refer to Appendix 6.

Referrals should be made at the time of decision making on the same day to avoid delay.

Response to referral standards are set within 1 day of receipt of referral and within 2 days of receipt of referral.

The standard for an inpatient to be seen within 1 day of receipt of referral applies to the following groups:

- Risk assess a patient for a known or suspected food allergy to be able to advise ward and catering staff
- Triage of patients for enteral nutrition
- Inherited Metabolic Disease patients
- Patients requiring a therapeutic diet where a menu does not exist, is appropriate or safe so that bespoke meals can be ordered from Catering Food Service

We will aim to see all other inpatients within 2 days of receipt of referral.

Wards/Units will be able to assess and start artificial nutritional support prior to being assessed by the Dietetic and Nutrition Service by using the following support Policies and Guidelines:

- Guideline for Commencing Out of Hours Enteral Tube Feeding (Nasogastric) in Adult Inpatients. (Including Management of Re-feeding Syndrome). Trust Ref: B55/2006.
- Out of hours Enteral tube feeding (Nasogastric) Starter Regimen for an Adult Inpatient with Renal Failure. (Including Management of Re-feeding Syndrome) Guidance for practice Trust Ref: C2/2015

If using a **Modified Consistency Diet menu** e.g. puree, fork mashable based on a Speech and Language Therapists assessment a referral to the Dietetic and Nutrition Service should be considered to ensure nutritional adequacy. When these diets are used they are inherently low in energy.

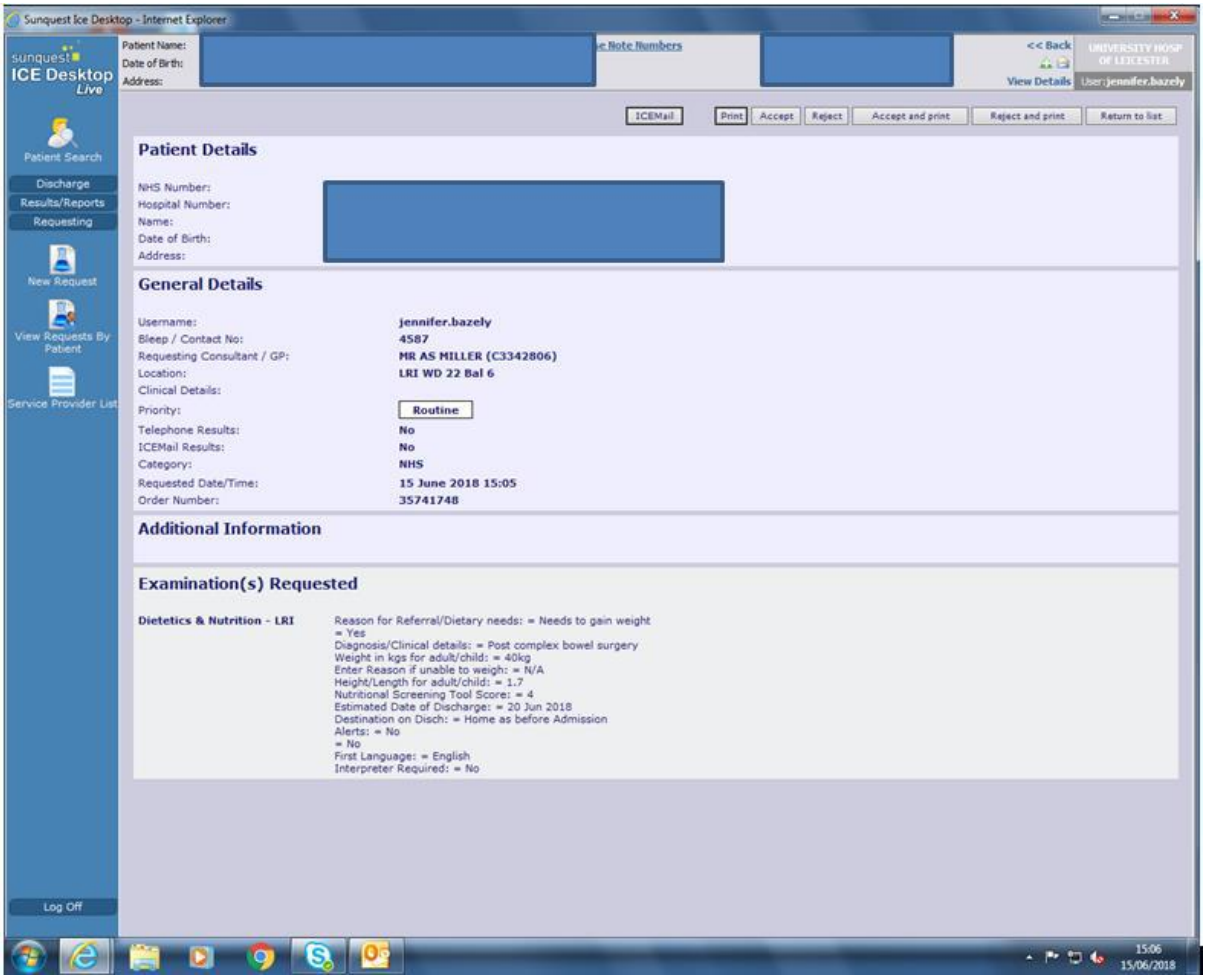
Inappropriate referrals that will be declined include:

- Patients were referral reason cited is poor appetite with no food record charts completed highlighting poor food intake e.g. <50% of meals consumed and/or weight loss with no actual evidence of actual weights with weight loss clinical trend.
- Patients for first line oral nutritional support where clinical needs can be catered for via food and drink e.g. snacks, extra milk, Aymes Shakes, Soups and Smoothies non prescribable nutritional supplement drinks as part of first line oral nutritional support care plan to be implemented at ward/unit level. Referrals for a patient with a MUST score of 1 to 3 that do not indicate that the first line oral nutritional care pathway has been implemented at ward level for at least 3 days will be declined.
- Patients with food preferences and self-imposed diets not supported by a medical diagnosis e.g. certain likes and dislikes. These patients should be referred to the Catering Food Service staff via the ward Catering Hostess.
- Patients with cultural diet requirements e.g. vegetarian, vegan, fruitarian with no impact on nutritional status. These patients should be referred to the Catering Food Service staff via the ward Catering Hostess.
- Patients with religious diet requirements e.g. kosher. These patients should be referred to the Catering Food Service staff via the ward Catering Hostess.
- Patients requiring bowel preparation diet. Please use dedicated bowel preparation menu for 2 days.
- Patients requiring weight management. They should be referred via the Making Every Contact Count Programme (MECC).
- Patients with menu fatigue. These patients should be referred to the Catering Food Service staff via the ward Catering Hostess. Use of the restaurant pass facility should be considered as long as the inpatient meets the criterion.
- Patients on end of life care pathway, please keep patient comfortable. Dietetic assessment and care planning is inappropriate in these cases.

For information on Catering – Food Services see your Ward Catering Folder and InSite section Patient Catering and Trust website www.leicesterhospitals.nhs.uk Patient Catering available for menus.

Following Dietetic and Nutrition assessment a treatment care plan and or advice will be discussed with the patient, relatives /carers and appropriate members of the ward health care team. Documentation will be made into the patient's medical case notes and where indicated nursing notes, patient bed end records. Documentation will also be made into the relevant electronic system e.g. Nervecentre, Somerset, Proton. In some cases documentation will be made into MDT documentation e.g. Stroke.

Appendix 2: Electronic ICE Referral



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

DIETETIC and NUTRITION SERVICE REFERRAL FORM

PATIENT DETAILS (or addressograph label):	**REFERRER DETAILS**
Patient No:	Consultant:
Surname:	Speciality / Sub speciality:
Forename(s):	Contact details: Ext: …….. Bleep: ……..
Address:	Patient Location: Outpatient Daycase Clinic …… Site ……
Postcode:	
DOB:	
Gender:	Signed …… Date ……
NHS No:	Please PRINT name in case further details required:
Tel No:	……

GP DETAILS
Name :
Address:

Post Code:
Tel No:

DIETETIC and NUTRITION SERVICE REFERRAL DATE
……..

Priority:
Reason for referral / Dietary needs:
Diagnosis / Clinical Details:

Weight in kgs for adult / child:
Height / Length for adult / child:
Nutritional Screening Tool Score:
Alerts:
Allergies:
First Language / Interpreter required:
Transport required for outpatients / daycase patients:

Referral to Treatment (18 week monitoring) - Please complete if the patient is on an 18-week Pathway and you are referring them for definitive treatment

Is the patient	**If Yes**	
on an 18 week	Unique pathway Identifier*	
pathway?	This referral is the: *(Select ONE only)*	
Yes / No	Start of a new pathway (New condition or change of treatment)	
	Continuation of an active pathway (1st definite treatment not given)	
	Date of decision to refer to receiving organisation:	
	RTT Clock Start date	
	(The date the patient started on the existing pathway of the date of this referral if it starts a new pathway)	
	If No: This referral is the continuing treatment for a stopped pathway (i.e. 1st definitive treatment already commenced)	

FOR COMPLETION BY DIETETIC AND NUTRITION SERVICE ONLY	
Received date and time: ……..	
Received by: ……	
Date and time input onto Tiara: ……	
NHS Confidential: Personal Patient Data	**Version 2 / 2020**

For outpatients a Dietetic and Nutrition Service is available to all outpatients Monday to Friday from 8.00am to 4.00pm (except bank holidays).

For Referral Criterion to Dietitians please refer to Appendix 5.

For Referral Criterion to Nutrition Nurses please refer to Appendix 6.

Outpatients must be referred in writing using either the clinic report letter from Consultant to GP eg Dit 3 report letter stating in the main text of the letter "by copy of this letter to the Nutrition and Dietetic Service I will request a referral for the patient to be seen for xxxx". The clinic report letter should be cc'd to the Dietetic and Nutrition Service Booking Programme, Leicester Royal Infirmary. If there is a delay between clinic outpatient appointment with the Consultant medical team and the referral letter being delayed then use manual referral form. This form should also be used in the event of IT failure. See Appendix 3.

Outpatients referred to the Dietetic and Nutrition Service will mainly be seen as part of multi-disciplinary Consultant clinics as the Dietitian will be present as a core member of the MDT. Other referrals received will be booked into Dietetic dedicated outpatient clinics via our Booking Programme which are held on all referrals will three hospital sites. Home visits are carried out on a needs assessment basis only.

Please do not refer to individual Dietitians via email as your referral will not be going through a recognised service process with governance arrangements.

We also offer pre assessment outpatient clinic appointments with certain specialities eg cancer surgery.

As of our outpatient Booking Programme we also offer patients access to **structured education group sessions** for the following specialities:

Adult Coeliac disease – newly diagnosed and refresher

Adult Diabetes

- DAFNE Pre Assessment
- DAFNE 5 Day
- DAFNE 5 x 1 day
- Refresher
- Foundation
- Follow Up
- Pump Group Pre Assessment
- Pump Group Start
- Pump Group Follow Up
- Pump Group Adult Exchange
- Diabetes weight management

Adult Cancer

- Breast Cancer

All patients for therapeutic diet assessment, care planning and monitoring. See table below for indications for referral.

All patients must have a nutritional screening score calculated using the Malnutrition Universal Screening Tool ('MUST'). Patient should be referred to the Dietitian if they have a 'MUST score of 4 or more.

All patients who have been on the first line oral nutritional care plan for three days or more and on review there is concern about their nutritional progress (indicated by serial weights showing a downward trend and completed food record charts highlighting poor food intake e.g. <50% of meals consumed).

All patients requiring prescribable oral nutritional supplements by the ward Dietitian on eMeds.

All cancer in and outpatients requiring an enteral tube feeding placement procedure fitness for procedure assessment.

All patients requiring a dietetic individual nutritional assessment and enteral feeding care plan including enteral feed prescribed on eMeds and regimen – pump and or bolus and rate mls of feed and hours of delivery including water flushes, drug nutrient interactions considere all outlined in enteral tube feeding care plan. Also enterally tube fed inpatients requiring a discharge plan and referral to the Home Enteral Nutrition Service for the local area the patient resides in for training and ongoing community feed and anxil supplies.

All patients in the following groups should be referred regardless of MUST score under local blanket referral policy (as part of pre-determined clinical care pathways). Those marked with an * do not need to be referred via ICE, discuss directly with the ward Dietitian:

- Intensive care patients *
- Patients with C Diff
- Patients with grade 3 and 4 pressure ulcers (on admission and hospital acquired)
- Bone marrow transplant patients*
- Pancreatic cancer patients*
- Head and neck cancer patients*
- Gastro-oesophageal cancer patients*
- End stage renal failure on or about to start dialysis
- Acute renal failure
- Cystic Fibrosis*
- Primary Ciliary Dyskinsia*

The chart that follows identifies referral indications for many of the common diseases, conditions and problems encountered, please note that this is not an exhaustive list.

Disease/Condition/Problem	Referral Indications
Anaemias	Diet related Iron, Vitamin B12 and/or Folate deficiency
Antenatal	Crohn's Disease, Ulcerative Colitis, Pancreatitis, Coeliac Disease, Patients with BMI <18, Diabetes, Metabolic Disorders, Food hypersensitivity, HIV, Cystic Fibrosis, Hyperemesis, Food allergies
Bone Health	Rheumatoid Arthritis, Osteoporosis, Osteomalacia, Osteopenia
Cancer and Haematology*	All Gastro-oesophageal, Head and Neck and Pancreatic cancer patients should be seen by a Dietitian at diagnosis and nutrition should be considered in their treatment plan along their cancer journey. All bone marrow transplant patients from decision to transplant should be seen by a Dietitian and nutrition should be considered in their treatment plan along their cancer journey. The following patients with cancer of the Pancreas should be referred to the Dietitian if: Patient has unexplained or sudden unintentional weight loss of over 2kg Patient requires insulin or pancreatic enzymes Nutritional problems can be anticipated Patient is being considered for prescribed nutritional support Patient is already being prescribed nutritional support Patient is already following a therapeutic diet Patient / carer has expressed a wish for nutritional information and / or dietetic support Other cancer and acute Leukaemic patients should be referred to the Dietitian if: Patient has unexplained or sudden unintentional weight loss of over 2kg Patient has a BMI below 19 Patient has a reduced dietary intake for over 7 days excluding patients who have been Nil by Mouth for investigation/surgery. Nutritional problems can be anticipated Patient is experiencing swallowing problems Patient is being considered for prescribed nutritional support Patient is already following a therapeutic diet

Disease/Condition/Problem	Referral Indications
Coeliac Disease	Positive Serology and/or Biopsy
Cystic Fibrosis*	Positive Sweat test and/or two CF mutations on genotyping.*
Dermatological conditions	Dermatitis Herpetiformis, severe/unexplained eczema or urticaria where a dietary link is suspected.
Diabetes	Those deemed urgent outpatients to be seen within 4 weeks: Newly diagnosed with Type 1 diabetes Patients with Type II diabetics converting onto insulin treatment Gestational diabetes Diabetes and underweight or at risk of malnutrition with a BMI of <18.5kg/m2 or unintentional weight loss greater than 10% within the last 3-6 months Diabetes and newly diagnosed with Coeliac disease Those deemed routine to be seen within 18 weeks: Pre-pregnancy for people with Type 1 and 2 diabetes Breast feeding ladies with diabetes Diabetes with complications or poor control thought to be related to diet Those experiencing excessive weight on commencement of oral hypoglycaemic agents and or insulin (may need input re dose change and glucose self-monitoring) Obesity with a BMI > or equal to 30 or > or equal ethnic minority group Diabetes and cardiovascular risk with 10% risk of CVD in the next 10 years, MI or Cardiac Surgery in the last 4 months, or diagnosed Metabolic Syndrome Diabetes and at risk of malnutrition with a BMI of 18.5-20kg/m2 or unintentional weight loss of 5-10% within the last 3-6 months Diabetes and liver disease with Non-alcoholic steatohepatitis (NASH) Hyperglycaemia and pancreatitis/post pancreatectomy Diabetes and Coeliac Disease for annual review or if nutritional deficiencies are suspected
Drug nutrient interactions	

Disease/Condition/Problem	Referral Indications
Eating disorders –inpatients only	Anorexia Nervosa, Bulimia Nervosa, Binge Eating disorder, night eating syndrome, eating disorders not otherwise specified (EDNOS) after input from a Clinical Psychologist from Leicestershire Partnership NHS Trust in order to develop a food and nutrition care plan in keeping with the overall plan
Food Allergy	Immune mediated food allergic reactions e.g. Milk, egg, fish, shellfish, nut, peanut, seed allergy, Oral Allergy Syndrome
Food Hypersensitivity/Intolerance	Non-immune mediated reactions e.g. Pharmacological-amines and migraine Irritant- caffeine, chilli, sulphites and asthma Enzyme deficiency- lactose intolerance
Gallstones	Gallstones with pancreatitis or acutely unwell e.g. impacted or intrahepatic stones or if BMI <19
Gastro-intestinal disorders	Inflammatory Bowel Disease e.g. Crohn's Disease, Ulcerative Colitis Pancreatic Insufficiency, Pre and post op gastro surgery Constipation, Diverticular Disease, Irritable Bowel Syndrome
Gout	If control poor on medication
Hepatobiliary disease	Acute or chronic liver disease – ascites, encephalopathy, malabsorption (steatorrhea/diarrhoea)
HIV/AIDS	All HIV/AIDS positive: all newly diagnosed HIV patients patients with a history of decreased appetite, diarrhoea, vomiting or poor intake for more than 4days. in-patients with a history of weight loss for more than 1 week. out-patients with a history of unintentional weight loss for more than 2 weeks. patients with CD4 count <200 patients with a poor quality dietary intake. patients with co-morbidities (such as Diabetes, Hyperlipidemia and Hepatitis C) requiring nutritional advice. adult patients requiring nutritional support. patients with BMI's > 30kg/m^2 requiring healthy eating or weight-loss advice.

Disease/Condition/Problem	Referral Indications
Cardiology/Cardiothoracic	Patients with: Cardiac cachexia Hypercholesterolaemia – cholesterol >5.0mmol/l with other CHD risk factors present eg BMI >25kg/m2, Diabetes, Hypertriglyceridemia, Hypertension Renal Disease Hypertriglyceridemia – if triglyceride levels over 2mmol/l with other CHD risk factors Familial hyperlipidaemia Post MI patients
Hypertension	Patients on medication with other co-morbidities present e.g. Obesity, Renal disease, Diabetes, combined Hyperlipidaemia
Inborn errors of metabolism	Phenylketonuria Maple Syrup Urine Disease (MSUD) Galactosaemia Disorders of Propionate metabolism Medium Chain acyl-CoA Dehydrogenase Deficiency (MCADD) HMG CoA Lyase Deficiency Homocystinuria Tyrosinemia Type I Urea cycle disorders
Malnutrition	'MUST' score 4+, Or have been on a 1st Line nutritional care plan for three days (or more) and on review there is concern about their nutritional progress (indicated by serial weights showing a downward trend and completed food record charts highlighting poor food intake).
Neurological diseases	All patients with Motor Neurone Disease should be referred on diagnosis. If a Stroke patient is NBM by day 3 post stroke nutritional support should be considered Stroke patients should also be referred if: Swallowing problems, nutritionally at risk, patient being considered for enteral nutritional support, cholesterol of 5mmol/l for secondary prevention, obesity with BMI>25kg/m2 Other patients e.g., Multiple Sclerosis, Parkinson's, Guillain-Barré, Huntingdon's Disease, Epilepsy should be referred if: Swallowing problems, nutritionally at risk, patient being considered for enteral nutrition, including patients on a modified consistency diet (including feeding at risk/have swallowing difficulties)

Disease/Condition/Problem	Referral Indications
Obesity	Pre-operative BMI 30+ particularly pre-Gastroplasty, pre-balloon placement. BMI 25-30 with no weight loss in last 6/12 and/or co morbidities e.g. Diabetes, Hyperlipidaemia, Hypertension
Pancreatic disease*	Chronic pancreatitis and cancer of the pancreas malabsorption/steatorrhea, anorexia, glucose intolerance/diabetes
Pre-conceptual	High maternal risk e.g. Diabetes, inborn errors of metabolism, IBD. Infertility due to obesity or underweight
Renal* Patients with progressive renal failure should be referred for dietetic advice for phosphate, potassium, sodium, lipids, health promotion, diabetic control and nutritional support as appropriate. All end stage patients receiving renal replacement therapy should be referred for review Patients with nephrotic syndrome who are symptomatic should be referred	Patients with Stage 4 and 5 chronic kidney disease who also have one of the following should be referred to the Dietitian: • Evidence of progressive renal failure • Serum phosphate outside of the normal range &/or are on phosphate binders • Serum potassium outside of the normal range (not due to another correctable factor) • BMI of greater than 25 and with the agreement of the patient that they wish to lose weight • Diminishing nutritional status as evidenced by a poor appetite, unintentional weight loss and/or BMI less than 19. • Cholesterol concentration above 5mmol/L – if other heart risk factors present and above 5.2mmol/L - if no other heart risk factors • Receiving renal replacement therapy In addition, patients with nephrotic syndrome who are symptomatic should be referred irrespective of the stage of their renal failure. Patients with Acute Renal Failure should be referred as indicated. Patients with a new kidney transplant should be given information packs as inpatients and can be referred as indicated
Respiratory/Thoracic	Chylothorax post thoracic surgery bronchiectasis and COPD patients
Wound healing	Acute and chronic wounds, all grade three and 4 pressure ulcers

*This overlaps with blanket referrals mentioned in appendix 5, page 22.

Appendix 6: Adult Nutrition Nurse Referral Criterion

University Hospitals of Leicester NHS
NHS Trust

Patients who require referral to the Specialist Nutrition Nurse team include:

All non-cancer in and outpatients requiring an enteral tube feeding placement procedure fitness for procedure assessment e.g. neurology, stroke and also adult Leicester, Leicestershire and Rutland (LLR) patients in the community with long term enteral feeding tubes who have a complication(s) related to their route of access.

Complications indicating referral may include:

- Feeding tube misplacement (including peritonitis)
- Feeding tube blocked
- Damaged feeding tube e.g. end fallen off
- Leakage from tube insertion site
- Infection around the exit tube site
- Poor care management e.g. buried bumper