East of England Neonatal ODN
(Hosted by Cambridge University Hospitals)

Clinical Guideline: Neonatal Dietetic Referral & Triaging Criteria

Authors: London Neonatal Dietitians Working Group
(adapted for EOE by Lynne Radbone, Lead Neonatal Dietitian EOE ODN)

For use in: EoE Neonatal Units - Guidance specific to the care of neonatal patients.

Used by: Dietitians working on neonatal units within the East of England network. Other healthcare professionals on neonatal units within the network, that refer infants to Dietitians.

Key Words: Dietitian, referral, triaging, dietetic contact

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Approved by:

Neonatal Clinical Oversight Group	
Clinical Lead Matthew James	**Matthew James**

Ratified by ODN Board:

Date of meeting	

Audit Standards:

Audit points: Objectives or activities *What outcomes or activities do you want to monitor?*	**Audit methods** *How are you going to monitor the outcomes and activities for this? Will there be a re-audit?*	**Assurance** *Where will the audit results be reported to? Where does learning from the audit take place?*
Dietetic contact for qualifying infants	BadgerNet/EPR/Patient records: determine if qualifying infants receive dietetic contact. Local level: incident reporting system reports / snap shot audit at unit level Re-audit every 2 years.	East of England clinical Oversight Group East of England Dietitians
Time from referral to initial dietetic contact	Local level: incident reporting system reports. Re-audit every 2 years.	East of England clinical Oversight Group East of England Dietitians

1 Background

Dietitians are essential members of the neonatal unit MDT. They are specialists in clinical nutrition; improving & supporting the nutritional status of infants on the unit and beyond. Dietetic provision is associated with improved nutrition status (1), which in turn contributes to:

- Increased survival rates (2)
- Attenuating the effect of critical illness (3)
- Improved neurodevelopmental outcomes (4 5)
- Reduced length of stay (6)

A survey conducted in 2022 by the London ODN showed that while the majority of units in the network operate under a blanket referral pathway to dietetic input (i.e. the Dietitian screens all infants on the NNU to determine if they require input), a significant number (44%) require a referral from another healthcare professional on the unit before providing care.
Only 11% of units had dietetic referral criteria to help identify infants that require dietetic input. This was identified as a need by the majority of unit dietitians in the network, resulting in the creation of this document.
The National Neonatal Network Dietitian's Group (NatNeoRD) also identified the need for agreed, standardised, dietetic referral criteria across England, and are grateful to the London Network for permitting the use of their guideline across all networks.

2 Purpose

To promote embedded practices by ensuring timely input from dietetic services; by standardising referral and triaging criteria for infants admitted to neonatal units that require dietetic input.

To support evidence gathering that highlights areas of need for timely dietetic input (particularly in units that are under resourced). This in turn can help build cases for increased dietetic provision.

Please note:

- This guideline addresses identification and timing of initial dietetic contact, which is defined as: first contact or input that a dietitian provides to an infant. This may be direct or indirect (e.g. telephone contact/verbal conversation with family or other unit staff, ward round) and may include a full assessment or a brief summary of actions taken. This can be agreed locally and documentation is required.
- This guideline does not cover ongoing inpatient review, or outpatient follow-up criteria. Review/follow-up following initial dietetic contact at dietitians' discretion in collaboration with the wider MDT. Local implementation in relation to re-referrals and caseload management applies.

• While this is a uni-professional document pertaining to dietetics, we recognise the importance of MDT involvement and input for infants with long-term or complex needs on the neonatal unit, and support the embedding of the entire Allied Health and Psychological professional team in collaboration with the medical and nursing workforce.

3 Referral & Triaging Criteria

Table 1: Referral & triaging criteria for neonatal dietetics

High priority – initial dietetic contact* in 1-2 working days	Extreme prematurity (< 28 weeks gestation) ELBW (< 1000g) SGA (< 10th centile) with AREDF and < 35/40 Weight loss > 15% (when > 14 days old) Poor weight gain (when > 14 days old) defined as: - Preterm < 10g/kg/day for 7 days - Term < 15g/day for 7 days Establishing feeds post necrotising enterocolitis Gastrointestinal malformation or surgery (including stomas) Congenital heart defect Congenital hyperinsulinism Feed intolerance (e.g. vomiting/diarrhoea) Need for any term specialist formula (new or established) Discharging with BMF or enteral tube feeding Failure to establish/progress enteral feeds (≥ 3 days for preterm, ≥ 5 days for term)
Medium priority – initial dietetic contact* within 2-3 working days	Very premature (28-32 weeks gestation) VLBW (1000-1500g) SGA (< 10th centile) with AREDF and > 35/40 Liver disease Cleft lip & palate / other oro-pharyngeal malformation Neurological injury/impairment Any other genetic/congenital anomaly that may affect feeding or growth Uncertainty around commencing BMF Metabolic bone disease of prematurity
Low priority – initial dietetic contact* within 5 working days	Chronic lung disease Queries relating to vitamin & iron supplementation Dietary changes for lactating mothers

Adapted from references (7) & (8).

*__Initial dietetic contact__ is defined as: first contact or input that a dietitian provides to an infant. This may be direct or indirect (e.g. telephone contact/verbal conversation with family or other unit staff, ward round) and may include a full assessment or a brief summary of actions taken. This can be agreed locally and documentation is required.

Review/follow-up following initial dietetic contact at dietitians' discretion. Local implementation in relation to re-referrals and caseload management applies.

4 Process following identification of dietetic input needed

As dietetic provision varies between units within the network, the process will vary when an infant is identified as requiring dietetic input.
Table 2: Process following identification of need

Units with no dietetic provision	• • Unit staff to share patient identifier number requiring dietetic input (table 1) with named unit HCP who will collate information. • Named unit HCP to report unmet need of collated infants on local incident reporting system on a weekly, fortnightly or monthly basis.
Units with limited dietetic provision (<50% of maximum national recommended staffing) (9)	• • Unit staff to follow established pathway for referring identified infants (table 1) to dietetic services. • Dietetics to triage and provide input to identified infants (table 1). • Dietetics to collate identified infants who breach and report on local incident reporting system on a weekly, fortnightly or monthly basis.
Units with adequate to optimal dietetic staffing (≥50% of maximum national recommended staffing (9)	• Blanket referral system: • Dietetics to screen all infants admitted according to table 1 at established frequency. • Dietetics to triage and provide input to identified infants (table 1). • Dietetics to collate identified infants who breach and report on local IRS on a weekly, fortnightly or monthly basis. • No blanket referral system: • Unit staff to follow established pathway for referring identified infants (table 1) to dietetic services. • Dietetics to triage and provide input to identified infants (table 1). • Dietetics to collate identified infants who breach and report on local IRS on a weekly, fortnightly or monthly basis.

5. References

Acknowledgement – thanks go to the working group from the London Neonatal Network for allowing the use of their original work in the construction of this document.

1	Olsen IE *et al*. Dietitian involvement in the neonatal intensive care unit: more is better. *J Am Diet Assoc*. 2005; 105(8):1224-30. doi: 10.1016/j.jada.2005.05.012.
2	National Audit Office. Caring for Vulnerable Babies: The Reorganisation of Neonatal Services in England. 2008. The Stationary Office: London.
3	Ehrenkranz, RA *et al.* Early Nutrition Mediates the Influence of Severity of Illness on Extremely LBW Infants. *Pediatr Res.* 2011; 69:522–529. https://doi.org/10.1203/PDR.0b013e318217f4f1.
4	Ehrenkranz RA *et al*. Growth in the neonatal intensive care unit influences neurodevelopmental and growth outcomes of extremely low birth weight infants. *Pediatrics*. 2006; 117(4):1253-61. doi: 10.1542/peds.2005-1368.
5	Isaacs EB *et al*. Early diet and general cognitive outcome at adolescence in children born at or below 30 weeks gestation. *J Pediatr.* 2009; 155(2):229-34. doi: 10.1016/j.jpeds.2009.02.030.
6	Carvalho-Salemi J *et al*. Malnutrition among hospitalized children in the United States: Changing prevalence, clinical correlates, and practice patterns between 2002 and 2011. *J Acad Nutr Diet*. 2018; 118:40-51. e7. doi: 10.0.3.248/j. jand.2017.02.015.
7	Johnson MJ *et al*. Developing a new screening tool for nutritional risk in neonatal intensive care. *Acta Paediatr*. 2015; 104(2):e90-3. doi: 10.1111/apa.12855.
8	King's College Hospital Neonatal Unit dietetic referral criteria for use during periods of limited cover [Accessed May 2022].
9	British dietetic Association. Dietitian Staffing on Neonatal units – Neonatal Sub-Group Recommendations for Commissioning. (2022) https://www.bda.uk.com/static/ab614d3e-e095-4e4f-96ae1458204e8810/391a27be-69a0-4b43-a52d54a731da7f01/BDA-Formatted-Staffing-Recc.pdf

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