Dietitians of Canada
Les diététistes du Canada

Standard of Care:
Clinical Nutrition Prioritization Matrix

Clinical Nutrition Leaders Action Group (CNLAG) Ontario

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Background

The Dietitians of Canada Clinical Nutrition Leaders Action group (CNLAG) Ontario is comprised of clinical nutrition practice leaders and managers in Ontario. The CNLAG identified the need for a Standard of Care for the prioritization of clinical nutrition care. Decreased staffing over the years and growing acuity, particularly in acute care settings, prompted the need to develop triaging guidelines. Consultation with registered dietitians within the leaders' organizations revealed that consensus building around prioritization of cases was very much needed to better manage caseloads and reduce risk to patients.

The team applied the College of Dietitians of Ontario's framework for Developing Professional Practice Standards to create a Prioritization Matrix.[1] A literature search and review of College documents revealed that the need was warranted, but that guidelines were lacking in this area.[2-4] The team searched two electronic databases up to October 15, 2015: Medline (OVID SP) and CINAHL (EBSCO) for which the subject headings and keywords pertaining to Dietetics or Allied Health were combined with Triage or Patient Prioritization (refer to search strategy in Appendix A). Relevant gray literature, websites of dietetic organizations, relevant nutrition and dietetics journals, the web via Google and Google Scholar, as well as references and citations of seminal articles, were reviewed.[2-18] An environmental scan of standards of participating organizations revealed inconsistencies in and the need to update preexisting standards.

Purpose Statement

The purpose of the Prioritization Matrix (PM) is to prioritize patients/clients for screening and assessment by the Registered Dietitian. The matrix helps to ensure that *the right patient/client receives the right care, at the right time*, and serves to better manage the allocation of time and resources, support safe provision of patient care and clinical cross-coverage, and facilitate transfer of accountability.

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Use of the Prioritization Matrix

The matrix classifies three levels of nutrition risk: Priority 1: High Nutrition Risk, Priority 2: Moderate Nutrition Risk, and Priority 3: Low Nutrition Risk. The matrix is a decision-making tool to be used in conjunction with professional judgment.[5] Past experience with patients/clients and the importance of recognizing individual risks and vulnerabilities cannot be underestimated when applying the matrix. The recommended time frames for assessment and follow-up, and also, whether a patient/client is even assessed by a dietitian, may differ according to organizational risk management policies, as well as, health care setting and resource constraints. Organizations are encouraged to adopt and adapt the matrix to best serve their patient population needs and safety priorities.

Sustainability Plan

CNLAG members will review and update the standard of care every three years and post on the Dietitians of Canada CNLAG website.

CLINICAL NUTRITION PRIORITIZATION MATRIX

NUTRITION CARE LEVEL	***PRIORITY 1***	***PRIORITY 2***	***PRIORITY 3***
Nutritional Risk	High	Moderate	Low
Patient profile & disease activity	Acute or active chronic disease/increased metabolic needs. Nutrient losses (vomiting/diarrhea) Malnutrition Needs close monitoring of intake or tolerance to diet and nutrition support therapy. Discharge pending nutrition education	Acuity resolved, degree/risk of malnutrition stabilized. Stable patient receiving therapeutic diet requiring: a) nutrition education for discharge plans; and/or b) referral for follow-up care.	No known acute or active nutrition-related problems. Patient receiving appropriate diet that is well tolerated and is able to meet nutritional needs.
Role of Nutrition	Plays a critical role in the patient's medical situation - central treatment and will influence the outcome (recovery and survival) of their medical problem.	Aims to decrease progression and or prevent the reoccurrence of their medical problem. Maintenance or improvement of their nutritional status will have a direct impact on their recovery.	Focuses on: • maintenance of a stable condition; • maintenance/cultivation of good nutritional status/quality of life; and/or • primary and secondary disease prevention.
Weight Status[9-12]	Less than 75% Usual Body Weight (UBW) Weight change (unintentional): 1 to 2% in 1 week 5% within 1 month 7.5% within 3 months 10% within 6 months	75-84% UBW Weight change (unintentional)	85-95% UBW
Subjective Global Assessment	C	B	A
Malnutrition screening tool[13-19]	High malnutrition risk	Moderate malnutrition risk	Low malnutrition risk
Suggested Time Frame[10]	Assessment and intervention initiated within 1 to 2 working days after patient screened and determined Priority 1 Follow-up occurs every 1 to 2 working days.	Assessment and intervention initiated within 2 working days after patient screened and determined priority 2. Follow-up occurs every 2 to 3 working days.	Assessment and intervention initiated as time permits after patient screened and determined priority 3. Monitor every 3-5 working days or as required, or as time permits. Referral made to an alternative or external registered dietitian when warranted.

Examples	• Intake less than 50% of meal tray • Poor intake less than 25% of needs for 3 days or more. • Commencing texture modified foods or fluids. • Abnormal nutrition-related labs or Refeeding Syndrome • Newly initiated EN or PN therapy • Intolerance to enteral nutrition • Electrolyte abnormalities while on nutrition support therapy. • Newly Rx's insulin (Type 1 or 2 or steroid-induced) for frequent hypoglycemic episodes • ARF/AKI, initiation of dialysis • Acute/flare IBD • Discharge pending nutrition education	• Intake less than 50% nutritional needs for 3 to 5 days. • Existing texture-modified diet • Post-op diet teaching (ileostomy, myotomy, GI stent) • Monitoring existing EN or PN therapy • Stable CKD • Stable IBD	• Adequate intake • Regular texture diet & fluids • Previous abdominal surgery with no changes in intake • Food preferences • HIV without malnutrition • Weight management • Pre-existing chronic medical conditions (e.g. DM, CHF, CAD) with therapeutic diet teaching in the past

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APPENDIX A: LITERATURE SEARCH STRATEGY

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) less than1946 to Present›

1 exp Nutritionists/ (191)
2 exp Dietetics/ (5315)
3 exp Nutritional Status/ (25735)
4 exp Diet Therapy/ (44863)
5 exp Nutrition Disorders/ (281268)
6 exp Malnutrition/ (103393)
7 exp Diet/ (212049)
8 dh.fs. (42304)
9 (diet* or nutrition*).ti. (218886)
10 or/1-9 (607917)

NUTRITION

11 exp Allied Health Occupations/ (45847)
12 exp Physical Therapists/ (547)
13 exp Physical Therapy Modalities/ (134897)
14 exp Allied Health Personnel/ (44091)
15 allied health.tw. (4859)
16 physiotherap*.tw. (17296)
17 speech Language*.tw. (3297)
18 occupational therap*.tw. (9946)
19 or/11-18 (238451)

ALLIED HEALTH

20 exp Triage/ (8691)
21 (prioritiz* or prioritis*).ti. (2299)
22 (patient* adj2 flow).ti. (1358)
23 waiting list*.ti. (1249)
24 triag*.mp. (16309)
25 exp *Health Care Rationing/ (5948)
26 exp *Waiting Lists/ (3723)
27 exp *Resource Allocation/ (7946)
28 or/20-27 (31161)

TRIAGE

29 **10 and 28 (196)** NUTRITION AND TRIAGE
30 **19 and 28 (678)** ALLIED HEALTH AND TRIAGE
31 limit 30 to yr="2012 -Current" **(145)**
32 29 or 31 (340) (NUTRITION OR ALLIED HEALTH) AND TRIAGE
33 limit 32 to english language (315)
34 remove duplicates from 33 (308)

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