

## Referral Criteria

The following are considered Nursing Services referral criteria:

1. The presence of any one or combination of diagnoses that is unstable or changing.

This may be triggered by:

- a. Diagnosis of insulin dependent diabetes and:
  - Greater than two ER visits in the past six months; or
  - Recurrent infections; or
  - Non-healing/deteriorating lesions; or
  - Vision impaired and the client is administering the injection; or
  - The client does not adhere to the diet; or
  - BMI less than 19 or greater than 30; or
  - Presence of diagnosis of depression; or
  - Presence of diagnosis of cellulitis; or
  - Infection (cellulitis, drainage) (foot screen).
- b. Diagnosis of quadriplegia; and
  - UTI;
  - Current pressure ulcer;
  - Recurrent infection;
  - CPS score > than 3;
  - Overall self sufficiency has declined in the past 90 days;
  - Treatment includes a ventilator or tracheotomy;
  - Incontinence;
  - Fecal Impaction; or
  - Caregiver stress stability scale is >24
- c. More than one hospitalization in the last six months and more than one emergency room visit in the last six months;
- d. An indication on the assessment that the client has:
  - "Pain daily"; or
  - A pain scale rating greater than 4 (5 to 10); and
  - Pain impact is "limiting activity"; and
  - Pain treatment is ineffective.
- e. Treatment needs that may include:
  - Tracheotomy/suctioning;
  - Indwelling catheter care;
  - Injections;
  - Wound/skin care;
  - Passive ROM; or
  - Tube feedings; and the client has:
    - A UTI;
    - Recurrent infections;

- Greater than two hospitalizations in the last six months;
  - Greater than two ER visits in the last six months or a provider type that is not:
    - A Nurse Delegator;
    - A home health agency;
    - Hospice;
    - Facility staff; or
    - Waiver skilled nursing.
2. The presence of a medication regimen that has an effect on client assessment, service planning and delivery. This may be triggered by:
- a. A Medication level that is “must be administered to person” **and:**
    - The client is choking or gagging on medications; or
    - The client is not taking medications as ordered; or
  - b. The client is declining assistance with medications **and:**
    - Is not taking medications as ordered; **and**
    - Has greater than one ER visit or greater than one hospitalization in the last six months; or
  - c. The client’s medication regimen is complex **and:**
    - The client has multiple prescribers; **and**
    - The client has had greater than one ER visit or greater than one hospitalization in the last six months; and
    - The client is not taking medications as ordered.
  - d. The client lives alone **and:**
    - The client needs assistance with medications and the need is unmet; and
    - The frequency is daily; and
    - The client’s Classification Category is A Low or B Low.
3. Nutritional status or weight concerns affecting service planning and delivery. This may be triggered by indications of oral problems or oral hygiene and dental problems as evidenced by:
- a. A weight loss or weight gain and:
    - A BMI of < 19 or > 30; and the client:
      - Has a chewing problem;
      - Has a current swallowing problem;
      - Is non-compliant with their diet; or
      - Has a poor appetite; or
      - An appetite change.
  - b. A current swallowing problem; and BMI of <19 or > 30 and the client is:
    - On a mechanically altered diet; or
    - Using a dietary supplement.

- c. Nutritional approaches that include:
    - Enteral; or
    - Parenteral; **and**
    - The provider type is IP or home care agency worker; or
    - Informal support; or
    - Client; **and there is no:**
      - Nurse delegation;
      - Home health;
      - Self-directed care; or
      - Waiver skilled nursing.
  
  - d. A client age 2 – 20 with a BMI of underweight (BMI for age < 5<sup>th</sup> percentile) or Overweight (BMI for age > 95<sup>th</sup> percentile).
4. The client is bedbound, or has care needs related to immobility that affects assessment, service planning and delivery. This may be triggered by:
- a. The client is assessed as needing but not receiving:
    - ROM passive, ROM active, splint or brace assistance, transfer, or walking; and:
      - The client's overall self sufficiency has declined in the last 90 days; or
      - The provider code is client or family/informal supports, IP/agency, or self-directed care; or
  
  - b. The client is assessed as incontinent of bowel or bladder most or all of the time; and:
    - Uses and has leakage; or
    - Does not use and has leakage; and
    - The client is assessed as having:
      - Diarrhea;
      - A UTI;
      - A history of recurrent infections;
      - Constipation; or
      - Fecal impaction.
  
  - c. The client ADL self performance code is (3) or (4) in column A in the following ADLs:
    - Bed mobility;
    - Transfer;
    - Walk in room, hallway, and rest of immediate living environment; or
    - Locomotion in room and immediate living environment; and:
      - The client is assessed as having a fall in the last 30 days or the last 31-180 days.

5. Skin breakdown or history of skin breakdown. This may be triggered by:
  - a. An indication in CARE that the client has one of the following skin problems not related to pressure, and the status is not healing or is deteriorating:
    - Abrasions, skin tears, or cuts;
    - Burns;
    - Open lesions;
    - Rashes;
    - Skin folder/perineal rash;
    - Surgical wounds; or
    - Stasis ulcers; **and** on the Treatment Screen there is **NO** for:
      - Application of dressing;
      - Application of medication;
      - Wound/skin care; or
      - Treatment and the client needs treatment but does not receive it.
  - b. Foot problems including:
    - Fungus;
    - Infection;
    - Open lesions; or
    - In grown toenail **and** the problem is non-healing or deteriorating **and** on the Treatment Screen there is no:
      - Application of dressing;
      - Application of medication;
      - Wound/skin care; or
      - Treatment and the client needs treatment but does not receive it.
6. [Skin Observation Protocol](#) - The Skin Observation Protocol specifies both case manager/social worker and nursing service responsibilities when a client meets the highest risk indicators identified in the protocol. This may be triggered by any of the following:
  - Current pressure ulcer;
  - Quadriplegia;
  - Paraplegia;
  - Total dependence in bed mobility;
  - Comatose or persistent vegetative state;
  - History of pressure ulcer within one year;
  - Bedfast and/or chairfast, and cognition problems;
  - Bedfast and/or chairfast, and incontinent of bladder or bowel;
  - Hemiplegia, and cognition problems, and incontinent of bladder or bowel; or
  - Bedfast and/or chairfast, and Insulin Dependent Diabetes Mellitus (IDDM).

**You may also refer any other health-related care needs, not identified as a critical indicator, to Nursing Services.**