Chapter 24: Nursing Services and Triggered Nursing Referrals

Chapter 24 describes the process for identifying and referring clients who may benefit from Nursing Services (NS) for all **HCS and AAA clients.** Not all will apply for **DDA clients please reference DDA policies**. This section also outlines what Nursing Services staff are responsible for: responding to referrals, performing nursing service activities (e.g., file review), and documenting their recommendations and activities.

##### Ask an Expert

If you have questions or need clarification about the content in this chapter, please contact:

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### Background

#### What are Nursing Services?

Nursing Services are nurse consultants who offer clients, who are eligible for Medicaid Long Term Services and Supports, providers, and case managers, health-related assessments, and consultation to enhance the development and implementation of the client’s plan of care. The protocols described in this chapter are critical to the health and safety of clients.

HCS Nurse Care Consultants (NCC), Area Agency on Aging (AAA) Case Managers, and RN Case Managers work closely to develop and implement an appropriate plan of care to address all triggered nursing referrals, most importantly skin integrity and to prevent pressure injuries from occurring. The [National Pressure Injury Advisory Panel](https://npiap.com/) (2022) defines a pressure injury as:

***“Localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device.*”**

**The injury can present as intact skin, skin redness or an open ulcer and may be painful. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of the soft tissue.**

**\***Licensed Practical Nurses (LPN) – AAAs can employ LPN(s) as nurse consultants to accomplish focused assessments for Skin Observation Protocol and other CARE triggered referrals for the purpose of data collection. This information will be brought back to the Registered Nurse for care planning.

For more information on LPN scope of practice: WA State Department of Health – Board of Nursing Advisory Opinion on the Registered Nurse and Licensed Practical Nurse Scope of Practice, #NCQA 3.02:

<https://nursing.wa.gov/sites/default/files/2022-07/NCAO13.pdf>

\*\*Nurse Consultants (NC) are only in the home to provide consultation and the nursing assessments listed above. If there is an emergency in the home the NC will provide guidance and skills within the nurse practice act (such as, CPR/first aid, etc.) until the emergency responders arrive.

#### Other chapters for nursing services that are available to ALTSA clients?

Skilled Nursing: COPES Waiver Skill Nursing - [Chapter 7D](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%207d.docx)

Nurse Delegation: [Chapter 13](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual)

Private Duty Nursing: [Chapter 25](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual)

Adult Day Health: [Chapter 12](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual)

#### Nursing Services Responsibilities

A NC performs the following activities in relation to skin integrity.

* Comprehensive Assessment Reporting Evaluation (CARE) review.
* For CN contractors, the case manager will send [form 13-776](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-776&title=) with all necessary data elements., CARE assessment details, service summary, ROI.
* Nursing assessment/reassessment (per the Skin Observation Protocol).
* 1:1 education and instruction for care providers and clients.
* Care and health resource coordination; and/or
* Evaluating health-related care needs service planning and delivery.

### 

### Identifying Clients for Nursing Services

#### Eligibility

Per [RCW 74.09.520 (2) (b) and (c)](http://app.leg.wa.gov/rcw/default.aspx?cite=74.09.520):

The rules shall require clients be assessed as having a medical condition requiring assistance with personal care tasks. Plans of care for clients requiring health-related consultation for assessment and service planning may be reviewed by a nurse.

The department shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review. This definition may include clients that meet indicators or protocols for review, consultation, or visit. Nursing services are available to all Title XIX clients who are eligible for MPC, CFC, CFC-COPES, RCL, RSW or NEW FREEDOM.

For MPC - [WAC 388-106-0200 (3)](https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-0200)

For COPES - [WAC 388-106-0300](https://app.leg.wa.gov/wac/default.aspx?cite=388-106-0300); [WAC 388-106-0305](https://app.leg.wa.gov/wac/default.aspx?cite=388-106-0305)

### Triggered Referral Criteria

Health-related care needs that are not identified as a critical indicator or triggered referral can still be referred to Nursing Services. If a referral is not triggered in CARE, the case manager can use their professional judgement to make a referral to a nurse if the circumstances warrant. Discuss with your supervisor and follow office policy, then document in CARE all pertinent information.

The following are considered critical indicators for Nursing Services referral criteria. **One or more** of these criteria may indicate the need for a Nursing Services referral.

|  |  |  |
| --- | --- | --- |
| **1.** | **The presence of any one or combination of diagnoses that are unstable or changing.** | |
| *or* | a) | Diagnosis of insulin dependent diabetes ***and*** one or more of the following:   * ≥ 3 ER visits in the last six months-Consider if data self-reported or actual * Recurrent infections * Non-healing/deteriorating lesions * Open lesions (foot screen) * Vision impaired and the client is administering the injection(s) * The client does not adhere to the prescribed nutritional eating plan. * BMI < 19 or > 30 * Presence of diagnosis of depression * Presence of diagnosis of cellulitis * Infection (cellulitis, drainage, or infection in foot) |
| *or* | b) | Diagnosis of quadriplegia ***and*** one or more of the following:   * UTI * Current pressure injury * Recurrent infection * CPS (Cognitive Performance Score) score > 3 * Overall self-sufficiency has declined in the past 90 days * Treatment includes a ventilator or tracheotomy * Incontinence * Fecal Impaction |
| *or* | c) | In the last six months: ≥ 2 hospitalizations *or* ≥ 2 emergency room visits |
| *or* | d) | An indication on the assessment that the client has:   * “Pain daily” *or* * A pain scale rating > 4 (5 to 10) ***and*** pain impact is “limiting activity” ***and*** pain treatment is ineffective |
| *or* | e) | Treatment needs that include one or more of the following, with the listed indicators:   * Tracheotomy/suctioning * Indwelling catheter care * Injections * Wound/skin care * Passive ROM * Tube feedings ***and*** the client has: * A UTI; or * Recurrent infections; or * ≥ 3 hospitalizations OR ≥ 3 ER visits in the last six months; Consider if data self-reported or actual: or * A provider type that is not: 1) Nurse Delegator   2) Home health agency  3) Hospice  4) Facility staff  5) Waiver skilled nursing |
| **2.** | **The presence of a medication regimen that affects client assessment, service planning and delivery:** | |
| a) | A medication level that is “must be administered to person” ***and***the client.   * Is choking or gagging on medications or * Is not taking medications as prescribed |
| *or* | b) | The client is declining assistance with medications ***and***   * Is not taking medications as prescribed ***and*** * In the last six months: ≥ 2 ER visits *or* ≥ 2 hospitalizations |
| *or* | c) | The client’s medication regimen is complex ***and***   * Has multiple prescribers ***and*** * In the last six months: ≥ 2 ER visits or ≥ 2 hospitalizations or * Is not taking medications as prescribed |
| *or* | d) | The client lives alone ***and***   * Needs assistance with medications and the need is unmet ***and*** * Frequency is daily ***and*** * Classification Category is A Low or B Low |
| **3.** | **Nutritional status or weight concerns affecting service planning and delivery as evidenced by the client having (triggers could include oral problems/hygiene and dental problems):** | |
|  | a) | Weight loss or gain, ***and*** a BMI of < 18.5 or > 30, ***and*** one or more of the following:   * Chewing problem * Current swallowing problem * Non-compliant with prescribed or advised eating plan. * Poor appetite * An appetite change |
| *or* | b) | A current swallowing problem ***and*** a BMI of < 18.5 or > 30 ***and*** the client is:   * On a mechanically altered diet *or* * Using a dietary supplement |
| *or* | c) | Nutritional approaches that include:   * Enteral or * Parenteral ***and*** the provider type is one of the following: * CDWA (IP) * Home care agency worker * Informal support * Client ***and*** there is no (one or more): 1) Nurse Delegation   2) Home health  3) Self-directed care  4) Waiver skilled nursing |
| *or* | d) | A client age 2-20 with a BMI of underweight (BMI for age 5th percentile) or overweight (BMI for age > 95th 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 either: * Client or family/informal supports * CDWA (IP) * Self-directed care |
| *or* | b | The client is assessed as bladder *or* bowel incontinent most or all the time ***and***:   * Uses incontinent supplies and has leakage; or * Does not use incontinent supplies but has occasional incontinence, the client is assessed as having one or more of the following: * Diarrhea * A UTI * History of recurrent urinary tract infections * Constipation * Fecal impaction |
| *or* | c) | The client ADL self-performance code in column A is 3 or 4 for one or more of the following ADLs:   * Bed mobility * Transfer * Walk in room, hallway, and rest of immediate living environment. * Locomotion in room and immediate living environment ***and*** the client is assessed as having a fall in the last 6 months (marked in CARE as past 30 days or days 31-180) |
| **5.** | **Skin breakdown or history of skin breakdown. This may be triggered by:** | |
|  | a) | An indication in CARE that the client has one or more of the following skin problems NOT related to pressure ***and*** the status is non-healing or is deteriorating:   * Abrasions, skin tears, or cuts * Burns * Open lesions * Rashes * Skin fold / perineal rash * Surgical wounds |
| * Stasis ulcers ***and*** on the Treatment Screen one or more of the following is not there: * Application of dressing * Application of medication * Wound/skin care * Client needs treatment but does not receive it |
| *Or* | b) | Foot problems including:   * Fungus * Infection * Open lesions * Ingrown toenail ***and*** the problem is non-healing or deteriorating ***and*** on the Treatment Screen one or more of the following is not there: * Application of dressing * Application of medication * Wound/skin care * Client needs treatment but does not receive it |
| **6.** | **CARE Assessment identifies the need for the Skin Observation Protocol (SOP) and the creation of a pressure injury prevention plan. Pressure injuries are also called bed sores, decubitus ulcers, pressure sores, and pressure ulcers. The SOP:** | |
| a) | Is a pressure injury prevention plan that case managers and RN case managers will follow to prevent a pressure injury or the progression of a pressure injury. |
| b) | Specifies the responsibilities of case managers/social workers ***and*** nursing service respondents when a client meets the highest risk indicators identified in CARE. |
| c) | The SOP may be triggered by one or more of the following:   * Current pressure injury * Quadriplegia * Paraplegia * Total dependence in bed mobility * Comatose or persistent vegetative state * History of pressure injury within 1 year * Bed- and/or chairfast ***and*** cognition problems * Bed- and/or chairfast ***and*** incontinent of bladder or bowel most or all the time * Bed- and/or chairfast ***and*** insulin dependent diabetes mellitus (IDDM) * Hemiplegia ***and*** cognition problems ***and*** bladder or bowel incontinence |

Nursing Services may be used to providehealth-related expertise regarding skin care/skin integrity in coordination with home health staff during transition or discharge from a home health agency, or other health care provider.

* Nursing Service activity would occur in collaboration with the case manager to ensure home and community-based service planning and delivery is meeting the functional and cognitive care needs of the client; and
* This service would primarily be a *consultative* *role* in reviewing the service plan for adequacy in relation to the health care needs of the client and interpretation of health-related, client-specific service needs.

Clients who meet the triggered [referral criteria](#_Transferring_&_making) do not need to be referred for nursing services when their needs are being met by another resource or health care professional. Proper documentation of all the factors is important.

Note: Other resources may be available for AAA non-core clients. The referral criteria is the **minimum** set of criteria, as shown in the *Nursing Referral Indicators* screen of CARE, that you should use when considering a client for nursing services.

Examples include:

* Health-related assessment of the client being performed by home health or hospice agency staff.
* Client assessment and instruction to caregivers through Nurse Delegation.
* Clients receiving Private Duty Nursing and receiving nursing consultation from HCS or DDA Nursing Care Consultants.
* Clients residing in an Enhanced Adult Residential Care Center (EARC) or Assisted Living (AL) required to provide limited nursing services ([WAC 388-78A-2310](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-78A-2310));
* Active and recent involvement of the client’s primary care physician in the health-related assessment and service planning needs of the client.

### Transferring & making Referrals

#### Who Should I Refer the Case to?

***\**** *For HCS clients who were assessed in hospitals and skilled nursing facilities*

|  |  |  |
| --- | --- | --- |
| **New HCS**  *in-home or residential* | **New and ongoing DDA** *in-home or residential* | **Ongoing AAA**  *in-home* |
| HCS NCC (unless alternative local agreements allow you to refer it to the AAA) | Nursing Services resources. These include an AAA or a contracted agency or individual RN provider  [(DDA Policy 9.13](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy9.13.pdf)) | AAA Rn or LPN Case Manager or contractors |

#### Transferring Clients

Note that for both HCS and DDA, local agreements with AAAs may require additional referral forms or communication. Common activities across both HCS and DDA are:

* Nursing Referral Indicators in CARE are addressed.
* Skin Observation Protocol (SOP)\*

##### HCS to the AAA

1. HCS staff must utilize HCS nursing resources first, before transferring the case (unless otherwise agreed to by the AAA)
2. Complete the Case Transfer Form in Barcode when:
   * Referring the case to the AAA for nursing services (per local agreement)
   * Transferring a case from one office to another (and nursing services have already been provided)
3. As applicable, check the following boxes on the electronic Case Transfer form (if necessary, include additional information in the Comments space):
   * Nursing services
   * In-home nursing services review by AAA needed (NOTE: The AAA may assign referred cases to a case manager with a request for nursing consultation or to an AAA RN/case manager)
   * Nurse Delegation
4. Local agreements may require additional referral forms or communication.

##### DDA Clients

Please refer to [DDA Policy 9.13](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy9.13.pdf) for additional information on providing Nursing Services, including SOP. Use the DDA Nursing Services Referral Form ([DSHS Form 13-911](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-911&title=)) to check:

* The type of Nursing Service activity(s) requested.
* The Nursing Referral or SOP reason(s) for referral; and
* Any special instructions or comments for the nurse.

The DDA Nursing Services Referral form can be faxed or emailed to the local NS resources, according to regional field office procedures and HIPAA compliance requirements (particularly when sent via email).

##### Nurse Delegation- For HCS SOP Triggered Referrals

In the situation where the Nurse Care Consultant (NCC) or RN Case Manager is **unavailable**, authorized staff may refer the Nursing Trigger – Skin Observation Protocol, to **any** available Nurse Delegator, who will address ***all*** other nursing triggers at the same time.  The timeframes for Nurse Triggered referrals can be found in this document under “[Responding to all referrals](#_Responding_to_Referrals)” (p.10 & 11).  All RNDs are expected follow these timeframes.

The case manager will send out the HCS/AAA Nursing Services Form: [HCS/AAA Nursing Services Referral Form (#13-776)](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-776&title=)

**Note:**

Ensure that you receive the following forms back in the specified timeframe.

* [Basic Skin Assessment (13-780)](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-780&title=)
* [Pressure Injury Assessment and Documentation (13-783)](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-783&title=) – (Form only needs to be filled out and filed when there is an actual pressure injury is confirmed)

\* Please refer to [DDA Policy 9.13](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy9.13.pdf) for RND referral for SOP

#### Communication

##### *Contacts*

When the protocol requires communication, verification, and exchange of information with non-professional caregiver(s), the HCS/AAA social worker/nurse or case manager will contact:

* Caregiver is employed by an agency The home care agency supervisor or contact person
* Caregiver is an Individual Provider CDWA (IP)

##### Timeframes

Service referral timeframes are maximums and are intended to ensure client referrals are sent in a timely manner. Timeframes may not be medically appropriate in every situation and may need to be shortened. The Nurse professional is responsible for evaluating each client on a case-by-case basis and determining whether shortened timeframes are necessary to meet a client’s care or medical needs and implementing shortened timeframes as necessary.

#### Ineligible clients

Clients assessed for services using CARE who are determined ineligible or declining may still trigger the [Skin Observation Protocol](#_Skin_Observation_Protocol_1). You must consult with your supervisor to determine the required response based on the client’s caregiving and health care support related to their skin care needs and highest risk indicators.

### Responding to All Referrals

#### Timeframes

#### Business Week Monday-Friday; Excludes Holidays and Weekends.

#### Time Clock starts next business day. Example: Assessment Done Friday 5/1 (2 business days clock starts) Monday 5/4.

#### All staff has the responsibility to make sure to manage the coverage to stay within timeline.

**Other Triggered Nursing Referrals (excluding SOP):**

2 business days CM is required to make referral.

2 business days Nurse is required to confirm receipt of the referral.

10 business days Nurse will review and use nursing judgment if phone contact and/or visit to client is necessary and will document all actions. \*\* **If the nurse is unable to make timeline, document all efforts and barriers, inform supervisor, case manager and review and make contact (if required), as soon as possible.**

15 business days Complete all documentation.

**29 working days Total**

**Triggered Nursing Referral SOP:**

2 business days CM is required to make referral.

2 business days Nurse is required to confirm receipt of the referral.

5 business days Nurse will review file and if SOP referral is required, they must reach out to client, family member(s), or POA/Guardian and make phone contact. \*\*\*\* **If the nurse is unable to make contact within the timeline, document all efforts and barriers, inform supervisor, case manager, and make contact as soon as possible.**

20 working days Make visit if necessary and complete documentation.

**29 working days Total**

**\*\*Some referrals may require quicker responses. Based on the information you receive and the type of referral, you will provide services in a timely manner consistent with the client’s need for care, safety, and best practice.**

HCS/AAA clients Use the table below for clients in the community (in-home or residential)

DDA clients Use [DDA Policy 9.13](https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy/policy9.13.pdf)

|  |  |
| --- | --- |
| **Situation** | **RESPONSE TIMES\*** |
| **IS** in jeopardy of imminent harm or placement in a hospital or nursing home. | * May consult with Nursing Services for *immediate* triage. * Refer the client to the most appropriate level of health care services (e.g., emergency room or physician). * Nursing Services is not designed to be an emergent or urgent home visit responder. |
| **IS NOT** in jeopardy of imminent harm or placement in the hospital or nursing facility. | * Confirm receipt of referral within two working days * Identify and verify the need for nursing services. * Initiate activities in a timely way according to the needs of the client. |

##### Exceptions

Exceptions to the requested or planned Nursing Services activity timeframes may occur only when:

* The client is not in jeopardy of imminent harm or placement in the hospital or a skilled nursing facility.
* The referral source requests a shorter or longer activity time with justification.
* The client requests a shorter or longer activity time; or
* The client is not available for consultation or visit.

If the requested/planned activity time is not met, document the reason for the delay(s) in the Service Episode Record (SER). If the referral was made to a nurse without access to CARE and they report a delay, document that information in the SER.  **This note should document the plan for follow-up on the identified care need.**

### Performing Nursing Services Activities

Once the nursing services staff (you) receive a referral, you may perform:

* A review of the CARE assessment
* Consultations (office, telephone or electronic)
* Visits (observation)
* Assessment

Collaborate with the client’s case manager to determine the frequency and the scope of all nursing service activities, which are based on individual client need.

#### CARE Assessment Reviews

Review the CARE assessment and the Service Summary report including any pertinent Service Episode Record entries. The purpose of this review is to identify health-related:

* Problems that are not addressed by service interventions.
* Client and/or caregiver teaching needs.
* Care and resource coordination needs not addressed by the Assessment Details. Examples include:
* Consultation with the physician, home health provider, and/or pharmacy.
* Education regarding available community resources.
* Phone consultation when the condition of the client changes; or
* Consultation with the case manager regarding a referral to COPES or DDA Skilled Nursing, or Adult Day Health for an unmet, intermittent, skilled nursing or rehabilitative care need.

If the CARE assessment was developed by a nurse or the assigned case manager is a registered nurse, additional review is not necessary.

#### Consultations, Assessments, and Visits

Based on the CARE assessment review, you may need to perform any of the following consultation activities:

* Nursing assessment/reassessment done in person, if unable to do in person, complete documentation of reason(s) why visit not done.
* Instruction to care providers and client given in person. If unable, complete documentation on reason(s) why not given in person and what alternative method was used.
* Care coordination.
* Evaluation of health-related care needs.

The nurse will may need to assist the client with transfer or turning during the skin assessment to assess all areas of skin and will also provide teaching and/or instruction to a client or caregiver based on the referral indicator, pertinent physical problem(s), or a service planning need.

The standards of nursing conduct or practice in [WAC 246-840-700(2)(a)(i)(A)](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-700) define the nursing process as a systematic, problem-solving approach to nursing care, which has the goal of facilitating an optimal level of functioning and health for the client. This consists of a series of phases including assessment and analysis.

* The registered nurse initiates data collection and analysis that includes pertinent objective and subjective data regarding the health status of the clients.
* Dependent on the situation, nursing assessment can be an essential method to gather relevant information.
* Coordinate with the client’s case manager if changes are needed in CARE or regarding any referrals to ensure that immediate and ongoing needs are met.

These lists are based on client circumstances and need; they are not all-inclusive but *may* include the following activities for each.

##### Assessment or Instruction

* Perform a nursing assessment as needed, including vital signs, etc.
* Skin observation protocol
* Assessment of client positioning and mobility related to care needs.

##### Nursing Assessment/Reassessment

* Review of medical/surgical history and pertinent treatments
* Review of physical systems related to the functional or cognitive level of the client.
* Psycho-social, emotional, cognitive assessment as pertinent to potential problems and referral critical indicators
* Medication review-Based on the limited information available-Further data gathering may be needed by the nurse for specific questions.
* Identification of client problems and caregiver teaching needs not currently addressed by the plan of care.
* Client teaching

Follow CARE assessment and documentation guidelines (see LTC Manual Chapter 3 Assessment and Care Planning) for making or recommending changes in CARE. Contractors without access to CARE (such as Nurse Delegators, Private Duty Nurses, Skilled Nurses, etc.) will make recommended changes on [Department-approved forms](#_If_you_do) to be submitted to the case manager for review and revision to CARE as needed.

##### Educating Providers and Clients

You may also want to provide:

* Disease process(es) or symptoms and how to effectively manage them related to the client’s functional and cognitive ability, impacting the service plan or care delivery (i.e., incontinence, effects of immobility).
* The purpose, interactions, and side effects of medications.
* Behavioral interventions or alternatives to psychoactive medications or the use of physical or chemical restraints- this may require consulting with the client’s primary care provider (PCP).
* Safety and universal precautions.
* Health promotion and disease prevention standards of care to promote client wellness and ability.

##### Care and Resource Coordination

* Consult and coordinate with all pertinent members of a client’s health care team and facilitate health-related referrals.
* Provide education regarding available community resources and programs related to the health care needs of the client.
* Offer phone consultation or client reassessment related to a health care need.

##### Evaluating Health-Related Functional/Cognitive Needs or Interventions

If there are health-related needs affecting service planning and delivery, you may need to:

* Observe, monitor, and reassess the client based on the referral critical indicator or other health-related needs identified.
* Evaluate the client’s caregiver training need when deficits are identified in skills required to meet the client’s functional and cognitive service plan.
* Enhance the plan of care, defining the services provided to the client through formal and informal supports based on assessment information, and with approval of the case manager.
* Identify need for additional nursing services activities.

#### Prohibited Activities

You are not allowed to perform or to provide *skilled treatment* except in the event of an emergency (e.g., CPR or first aid). *Skilled treatment* is care that would require authorization and/or prescription and supervision by an authorized practitioner prior to a nurse providing it (e.g., medication administration or wound care). Refer clients with these needs to home health agencies or other appropriate health care professionals.

#### Documenting Results of Nursing Services Activities

Document the results of your activities (file review, office/telephone consultations, and visits) in CARE and client files, including any communication or service coordination required. \*\* Note, it is required that all nurse referrals are reviewed when the nurse is doing a triggered referral.

Follow these guidelines [(Chapter 3 LTC Manual)](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) for documenting in CARE based on how the Nursing Referral Indicator is marked. If you do not have access to CARE, please use the approved [Department-approved forms](#_If_you_do).

|  |  |
| --- | --- |
| **Yes** | Observations, instructions, or recommendations to the Critical Indicators List in CARE, regardless of the findings. |
| **No** | Observations, instructions, or recommendations **if** findings inconsistent with the current CARE information *or* new findings not previously assessed.   * If there are no new findings for the indicator(s) marked “no” during the provision of the nursing activity, document “no new findings” for the Nursing Referral Indicator. |
| **Blank** | Consult with the SW/CM for clarification of client assessment and Nursing Service activity need. |

##### Department Approved Forms

If a referral is sent outside the agency, department approved forms should be sent to the contracted nurse or Registered Nurse Delegator for the purpose of documenting Nursing Service(s) activities. Using DSHS approved forms allows for consistency in the information given and reported.

* [Nursing Services Basic Skin Assessment (13-780)](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-780&title=)
* [Pressure Injury Assessment and Documentation (13-783)](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-783&title=)

You are expected to safeguard client information per confidentiality policies established in the [LTC Manual](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual), state and federal rules (e.g., HIPAA), AAA, and contract requirements. All emails of forms and requests should be sent through secure email accompanied by a copy of the client’s signed consent, [DSHS 14-012](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=14-012&title=).

### HCS/AAA Skin Observation Protocol

The following protocol outlines what to do when the protocol is triggered. The triggered referral could mean that a nurse is going to review the file or contact the client or visit the client. Once there is a triggered referral for SOP, the assessor needs to determine if the client has a:

1. Pressure injury; *then*
2. Caregiver who is treating the pressure injury; *then*
3. Professional or family/informal caregiver.

After determining these factors and it is deemed necessary, a referral is sent to an AAA RN, HCS NCC, or the contracted entity for Nursing Services. When a referral is sent the *nurse* will write the necessary documentation and the home visit note if a visit occurred. If the referral is not sent, due to no current pressure injury per the protocol, documentation for the SOP visit will be done by the *assessor*.

There are five scenarios for SOP documentation, depending on the presence/absence of a pressure injury and who is providing care/treatment when one exists.

1. A non-professional is providing treatment. – Example: CDWA IP, Agency HCA, Family Member, Informal Caregiver/support
2. A professional is providing treatment. – Example: Physician, Wound Care Clinic, ARNP, PA-C, RN or LPN, HHA Nurse, PT
3. A non-professional with a prevention plan in place, the caregiver is checking all pressure points, ***and*** there is no reported skin problems.
4. A non-professional is providing care and the caregiver is not checking all the pressure points or it is not known if a skin problem exists.
5. No one (neither professional nor non-professional) is providing skin care that has been verified as meeting the client’s needs (visit required)

For more information on patient education, visit the [Nursing Services Website](https://www.dshs.wa.gov/altsa/home-and-community-services/nursing-services).

#### What are the Skin Observation Protocol requirements?

The Skin Observation Protocol is a **mandatory** protocol that must be completed for each client who has triggered a highest risk indicator. The protocol must be responded to, and all protocol activities provided according to the client’s skin integrity and caregiver status. An observation is when an in-person visit to assess the skin integrity is required.

The protocol directs the case manager and/or nurse to:

* Determine whether an observation visit is required or not by a nursing resource.
* What activities must be completed by the case manager and/or the nurse; and
* The documentation requirements for case management and nursing staff.

If the skin protocol is triggered, certain steps will be indicated to determine whether a Skin Observation visit is:

* [Not Required](#_HCS/AAA_SOP_Visit)
* [Required](#_SOP_Visit_Required)
* [Delayed](#_SOP_Visit_Delayed)

##### HCS/AAA SOP Visit Not Required

Use the [Skin Observation Protocol](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/SOP%20Sample%20Documentation.doc)  for each of the following situations:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. | A **non-professional** is providing skin care treatment for a client who has a pressure injury.   * The HCS/AAA case manager must make the referral to the nurse on the same day as the assessment. (**Special medical circumstance that requires a same day referral to nurse**) | | | |
|  | a) | Review the treatment with the caregiver(s) and client and decide if visit is necessary; | | |
|  | b) | Document what is being done and who authorized treatment; | | |
|  | c) | Verify by asking the caregiver(s) that they are checking **all** pressure points; | | |
|  | d) | Distribute [educational materials](https://www.dshs.wa.gov/altsa/home-and-community-services/nursing-services) and prevention plans as appropriate related to pressure points to both the caregiver(s) and client (colored pictures with text); | | |
|  | e) | Revise the plan as needed; | | |
|  | f) | Document all activities in CARE; | | |
|  | g) | HCS/AAA social worker will follow-up on RN recommendations. | | |
|  |  | | | |
| 2 | A **professional** is providing skin care treatment for a client who has a pressure injury.   * HCS/AAA case managers/nurses or other contracted nursing resources must: | | | |
| a) | Obtain name and contact information of Health Care Professional (HCP) and verify with the HCP that: | | |
|  | i. | | There is a treatment plan in place; ***and*** |
|  | ii. | | The client’s skin has been seen by the HCP responsible for treatment according to timeframes recommended in the treatment plan or within the last 7 days. |
| b) | Communicate with the HCP as soon as possible: | | |
| i. | | Verify that all pressure points are being checked and discuss response to treatment. | |
| ii. | | Request to be notified when client is discharged from care for pressure injury. | |
| iii. | | Document all activities in CARE | |
| **Exception:** If you determine that the HCP does not have a treatment plan in place and/or has not been observing pressure points as part of the plan, a nurse **must** make an [observation visit](#_SOP_Visit_Required), assess the client, and revise CARE as necessary. | | | |
| **Note:** The activities in this section of the protocol also apply to clients being assessed for in-home or residential services while receiving care from professionals in a hospital or skilled nursing facility (SNF). The Skin Observation Protocol must be completed for clients who are in a hospital or SNF at the time of the CARE assessment triggering the protocol. | | | |
| 3. | A non-professional is providing skin care with a prevention plan in place, the caregiver is checking all the pressure points, and there is no reported skin problem.   * The HCS/AAA case manager/nurse or other contracted nursing resource must: | | | |
|  | a) | Verify that: | | |
|  |  | i. | The caregiver(s), or the client with assistance as needed, is checking all the pressure points and all the pressure points have been checked within the last 7 days: | |
|  |  | ii. | The prevention plan is meeting the client’s needs, and the client and caregiver(s) have been advised of skin care issues; | |
|  | b) | Document what is being done as a prevention plan and who is providing the prevention plan in CARE; | | |
|  | c) | Use the color pictures included with the protocol as a resource to ask the client or the caregiver(s) regarding the presence of any pictured skin conditions or change; | | |
|  | d) | Revise the care plan as needed; ***and*** | | |
|  | e) | Document all activities in CARE | | |
|  | **Exception:** If you determine that the non-professional care being provided through the prevention plan is inadequate or is not meeting the needs of the client, a nurse must make an [observation visit](#_SOP_Visit_Required) and revise CARE, as necessary. | | | |
| 4. | A non-professional is providing skin care, the caregiver(s) is **not** checking all the pressure points, it is not known if there is a problem, the client is cognitively intact, ***and*** the client declines observation: | | | |
| a) | Probe for reasons the client doesn’t want skin observed. | | |
| b) | Suggest appropriate alternatives (such as asking if the client has checked their pressure points themselves or if another support person is reliable, have they checked?). | | |
| c) | Use the color pictures included with the protocol as a resource to ask the client or caregiver regarding the presence of any of the pictured skin conditions or changes. | | |
| d) | Document in CARE ***and***: | | |
| i. | | Refer to the HCS/AAA nurse or other contracting nursing resources for follow up; or | |
| ii. | | Contact the client’s primary care provider as soon as possible, discuss skin concerns and document; or | |
| iii. | | Advise the client of skin care issues, educate and document | |
| e) | Do not complete the skin observation. | | |
| f) | Document in CARE, on the appropriate screen(s), that the client has declined skin observation and follow CARE assessment and service planning procedures. | | |
| g) | Discuss with your supervisor. | | |

##### SOP Visit Required

Observation is required when the client meets the highest risk indicators and ***no one*** (neither a professional nor a non-professional) is providing skin care that has been:

* Documented and verified as meeting the client’s needs as above in the “Not Required” steps 1, 2, and 3; *or*
* **All** pressure points are *not* being observed.

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| 1. | Refer the client to the HCS/AAA nurse or other contracting nursing resources to complete the observation. | | |
| 2. | Arrange to have a third-party present if you know in advance that there is a likelihood that you will need to observe the client’s skin, or as requested by the client. | | |
| a) | When possible, involve the client in determining who this third party should be. Parental, guardian, or client representative consent must be obtained for those individuals with designated decision makers. | |
| 3. | Complete the observation (visit). | | |
| a) | Explain to the client what is involved in the skin observation and obtain their permission. | |
| b) | Tell the client where the pressure points are. | |
| c) | Help, or have the caregiver(s) help, if the client needs to partially undress. Be sure that there is privacy for the client, and the client remains covered except for the area being observed. | |
|  | d) | Look at the back of the head, ears, shoulder blades, elbows, inside of the knees, “sitting” bones, tailbone area, hips, sides of ankles, and both heels. | |
|  | e) | Observe for specific conditions as directed in the CARE assessment using the “Skin Problem” screen and skin observation descriptions as a guide. Includes: | |
|  |  | i. | Skin intact |
|  |  | ii. | Persistent redness |
|  |  | iii. | Abrasion |
|  |  | iv. | Boils |
|  |  | v. | Open lesion |
| 4. | If **no skin problem** is observed, document and revise CARE to include prevention plan(s) as appropriate. | | |
| 5. | If a **skin problem is observed**: | | |
|  | a) | Determine if there are any health professionals aware of or involved with treatment of the client’s skin problem. | |
|  | b) | Contact any health professionals involved with treatment of the client’s skin problem. Or contact the family representative if no health professionals are involved, the client is refusing treatment, *or* the health professional is not treating the problem. | |
|  | c) | Document in CARE all observations and activities provided in the Service Episode Record or progress note. For those who do not have CARE access, use 1 each of [Form #13-783](https://www.dshs.wa.gov/office-of-the-secretary/forms?field_number_value=13-783&title=) for **each** pressure injury described. | |
|  | d) | Revise/Update CARE | |
|  | e) | The HCS/AAA case manager must follow up with any RN recommendations. | |

##### SOP Visit Delayed

* Anticipate barriers as much as possible and plan prior to the visit to have a caregiver, assistant, or family member present to help the client.
* Be sure to document all activities including conversations/discussions.
* Skin observations can be delayed when any of the following exist:

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| 1. | It is unsafe *(e.g., threatening animals, sexually inappropriate or threatening behavior);* | |
| 2. | It is unsanitary (due to soiling or unhygienic conditions) ***and*** no caregiver is present to assist; | |
| 3. | It is difficult to observe because of the client’s physical condition (immobile, needs transfer or position assistance, or client is without consistent or permanent housing) ***and*** no caregiver is present to assist; *or* client is in pain; | |
| 4. | Impossible to observe because the client refuses to allow observation, has an unreliable provider, ***and*** will not let anyone else in, and/or refuses services related to skin integrity over pressure points. *For the above scenarios, you must:* | |
|  | a) | Discuss other resources and approaches with your supervisor within 1 working day ***and*** follow usual CM response times­­­ depending on results of conversation with supervisor. Use collateral contacts (e.g., family, health care provider) for information and assistance; |
|  | b) | Reschedule observation within 2 business days: |
|  | c) | Follow the usual CM time frames per the LTC manual, [Chapter 3](https://www.dshs.wa.gov/sites/default/files/ALTSA/hcs/documents/LTCManual/Chapter%203.docx), under Timeframes. |
|  | d) | Refer to APS, CPS, or CRU if abuse, neglect, or self-neglect is suspected; ***and*** |
|  | e) | Document ALL your activities including any arrangements or referrals made, or discussions had. |
| 5. | The client is cognitively intact and declines skin observation over pressure points ***and*** there is evidence of negative skin outcomes (foul odor, staining on clothing over pressure points or other visible signs). *Determine and provide any or all the following activities as appropriate to the client’s situation.* ***Document all activities and conversations.*** | |
| a) | Call 911 if emergency medical care is required; |
| b) | Refer to APS, CPS, or CRU as mandated and as appropriate if a negative skin outcome is believed to be the result of abuse and/or neglect; Refer to [RCW 74.34](https://app.leg.wa.gov/rcw/default.aspx?cite=74.34) |
| c) | If HCS case manager or AAA Case Manager is not a nurse, immediately make a referral to the nurse or Nursing Services for an observation visit as soon as possible; |
| d) | Verify and document the observation visit was done; |
| e) | Make a referral for a home health nurse or to the primary care provider if treatment is needed; |
| f) | Educate the caregiver by reviewing the section in the service plan that describes skin care over pressure points including prevention plans for skin breakdown over pressure points |
| g) | Identify someone else to observe skin and all pressure points (caregiver, family member, or person with whom the client feels comfortable); |
|  | h) | Collect collateral information re: skin problems over pressure points from health care providers, caregiver(s), family, or other involved parties; |

|  |  |  |  |
| --- | --- | --- | --- |
|  | i) | Explore other appropriate services such as residential placement, different caregiver, community clinic, or other community-based resources (discuss with supervisor); | |
| j) | Discuss with all involved parties and come to consensus with concrete criteria about when or whether to terminate services (follow protocols established by the Challenging Cases Workgroup within your area); | |
| k) | Document all activities; | |
| l) | Incorporate recommendations in the [LTC Manual Chapter 5](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual) “Case Management” and “Challenging Cases Protocol” as appropriate: The case may be kept open to CM services. | |
| 6. | Client is cognitively impaired (CPS score >3) ***and*** meets the highest risk indicators ***and*** declines skin observation once *or* mildly objects to the observation. | | |
| a) | Using skilled interview and assessment techniques, request permission a second time. | |
| b) | Be sure the client understands as much as possible what you are requesting. | |
| c) | If the client has a legal representative, contact that individual for assistance with consent and to assist the client with the needed observation. | |
| d) | Document all activities and conversations. | |
| 7. | Client is cognitively impaired (CPS score >3), meets the highest risk indicators, consistently refuses skin observation, ***and***: | | |
| a) | The client’s skin condition over pressure points is unknown; and | |
| b) | The client has a provider who won’t let anyone else in; and/or | |
| c) | The client refuses services related to skin integrity over pressure points, d*o the following:* | |
|  | i. | Refer to the “Challenging Cases Protocol” ([LTC Manual Chapter 5](https://www.dshs.wa.gov/altsa/aging-and-long-term-support-administration-long-term-care-manual)) |
|  | ii. | Refer to and consult with your supervisor regarding other services; |
|  | iii. | Offer alternative services, a different provider, a residential placement, or a change in the way services are delivered; |
|  |  | iv. | Using skilled interview techniques to understand the basis of refusal |
|  |  | v. | Refer to APS, CPS, or CRU as mandated if there are allegations of abuse and/or neglect; Refer [to RCW 74.34](https://app.leg.wa.gov/rcw/default.aspx?cite=74.34); |
|  |  | vi. | Refer to 911, ER, or Designated Crisis Responder (DCR) if appropriate for [involuntary treatment](http://app.leg.wa.gov/RCW/default.aspx?cite=71.05.150); |
|  |  | vii. | If there are guardianship, capacity, or DPOA questions staff with your supervisor who may refer to Assistant Attorney General for consult; |
|  |  | viii. | Document all activities and conversations. |
| 8. | Client meets the highest risk indicators, but an observation was not completed due to culture or gender. *Be sure to document all activities and conversations.* | | |
| a) | Consult with your supervisor as soon as possible to find a reasonable solution. A reasonable solution is: | |
|  | i. | Timely; |
|  | ii. | Respecting of personal and professional boundaries; ***and*** |
|  | iii. | Results in someone observing the skin and documenting what was done for the client |

### Reporting Requirements

Additional information on Nursing Services program utilization may be requested for program management needs related to strategic planning, program utilization and evaluation, and long-term care coordination with other state agencies providing Medicaid-funded care.

#### AAA’s & Contractors & HCS Requirements

Each AAA office and HCS office providing Nursing Services should check with their respective leadership to see what reports may be required for internal use. **No** report is required to be sent to the ALTSA/DSHS Nursing Services Program Manager.

### resources

#### Related WAC

##### Nursing Services

[WAC 388-106-0200 (3)](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0200) MPC Services

[WAC 388-106-0300 (1 - 11)](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0300) COPES – own home

[WAC 388-106-0305 (6)](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0305) COPES – residential facility

[RCW 74.09.520(2)(b) and (c)](http://app.leg.wa.gov/rcw/default.aspx?cite=74.09.520) MA service and funding limitations

##### Standards of Nursing Conduct / Nurse Practice

Everyone, upon entering the practice of nursing, assumes a measure of responsibility and trust and the corresponding obligation to adhere to standards of nursing practice and follow best practice. You are individually responsible and accountable for the quality and timeliness of nursing service you provide to clients.

[18.79 RCW](http://app.leg.wa.gov/rcw/default.aspx?cite=18.79) Nurse Practice Act

[18.130 RCW](http://app.leg.wa.gov/rcw/default.aspx?cite=18.130) Uniform Disciplinary Act

[WAC 246-840-700](http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-700) Standards of nursing conduct or practice

[WAC 246-840-710](http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-710) Violations of standards of nursing conduct or practice

#### Acronyms in this Chapter

AAA Area Agency on Aging

ADL Activities of Daily Living

AL Assisted Living

ALTSA Aging and Long-Term Support Administration

APS Adult Protective Services

CARE Comprehensive Assessment and Reporting Evaluation

CDWA Consumer Direct of Washington

CFC Community First Choice

COPES Community Options Program Entry System

CM Case Manager

CPS Cognitive Performance Scale (when used with “score”) *or* Child Protective Services

CRM Case Resource Manager

CRU Complaint Resolution Unit

DDA Developmental Disabilities Administration

EARC Enhanced Adult Residential Care

HCP Health Care Provider

HCS Home and Community Services

HIPAA Health Insurance Portability and Accountability Act

IP Individual Provider

MPC Medicaid Personal Care

NC Nurse Contractor

POA Power of Attorney

RND RN Delegator

SOP Skin Observation Protocol

UTI Urinary Tract Infection

WPC Waiver Personal Care