

## PIC Tool Instructions

### Purpose

The PIC tool guides dietitians to see patients according to their urgency for dietitian services. It standardizes priority assignment to patients on daily caseload in order to facilitate workload prioritization. The PIC criteria are guidelines – some patient situations may not fit into the options listed. **Use clinical judgment** as to the relative risk for harm or deterioration and the relative potential for improvement to direct priority assignment.

### Tool Assumptions and Requirements

#### A. Interprofessional approach to providing care

- Dietitians are a specialized resource providing medical nutrition therapy (MNT); they acquire their caseload by referral and are not expected to conduct in-depth screening of all patients
- General monitoring of nutrition, hydration, and bowel function is best performed by point-of-care health care providers (e.g., nurse, care aide)
- Non-therapeutic care (e.g., obtaining food preferences) is not addressed by the PIC tool

#### B. Nutrition Acuity Score (NAS)

- Once assessed, dietitians assign a NAS based on the patient's nutrition problems using the NAS table
- A NAS is not assigned when:
  - No nutrition problem identified (e.g., stable and not receiving maintenance MNT)
  - Nutrition not a focus of care (e.g., MNT refused, no further treatment options available)
  - Assessment incomplete (e.g., insufficient information / unable to speak with patient)

#### C. Monitoring / Termination of services

- Given the complexity of patient care, monitoring standards are not specified; dietitians use clinical judgement to determine:
  - Need for nutrition monitoring versus termination of services
  - Frequency of monitoring / Monitoring intervals
- NAS 4 patients generally should have services terminated and not be scheduled for monitoring
- When dietitians determine monitoring is needed, it must be done as close to the predetermined timeline as possible (e.g., a NAS 3 patient at the monitoring deadline is a PIC 1 and should be seen prior to a new PIC 2 referral)

### PIC Assignment

Assign PIC values to all patients needing services that day regardless of the capacity you have to see them.

New referrals (assign a PIC value within 1 working day):

- Locate the referral reason in the table to determine the PIC value. If there are multiple reasons, assign the lowest PIC that applies (e.g., if a patient is on an unnecessary therapeutic diet (PIC 3) and has had low intakes for 6 days (PIC 1), assign PIC 1)
- When the referral reason is not provided, undertake minimal screening (less than 5 minutes) by consulting members of the health care team to determine the reason for the referral (a detailed review of the health record or consultation with the patient should NOT occur); if the reason for the referral is still not evident, do not assign a PIC value and alert the referral source that more information is required before the patient can be seen

- If the referral is related to unskilled tasks (e.g., food preferences) do not assign a PIC value

#### Patients on caseload:

- Use the monitoring deadline to determine the PIC value
- When a date range is provided, the monitoring deadline is the last day of the range

---

### See Patients According to Their PIC Value

- The goal is to see PIC 1s that day; if this target is missed, they remain PIC 1s until seen
- For PIC 1 monitoring, use the NAS to determine priorities (e.g., NAS 1s are generally seen before NAS 2s who are generally seen before NAS 3s)
- PIC 2, 3, 4 referrals related to intakes or malnutrition automatically become PIC 1 referrals as time passes as they deteriorate over time (e.g., 3 days without eating well becomes 4 days); some PIC 2, 3, or 4 referrals will not become PIC 1s over time and remain unseen until all PIC 1 monitoring and referrals are completed

---

### Definitions

**Daily Caseload:** Patients that should be seen that day; compiled from referrals requiring MNT, patients requiring monitoring and referrals that need a PIC value assigned.

**Termination of Services:** Dietitians may terminate services for a variety of reasons including:

- Accepted nutrition plan is in place (e.g., education completed, NAS 4 patients)
- Goals are achieved
- Goal of care has changed
- There are no further treatment options
- Patient refuses services

#### **Copyright Disclaimer**

The Fraser Health Authority (FHA) authorizes the use and reproduction and/or modification of this publication for purposes other than commercial redistribution. In consideration for this authorization, the user agrees that any unmodified reproduction of this publication shall retain all copyright and proprietary notices. If the user modifies the content of this publication, all FHA copyright notices shall be removed, however FHA shall be acknowledged as the author of the source publication. Reproduction or storage of this publication in any form by any means for the purpose of commercial redistribution is strictly prohibited.

#### **Disclaimer of Liability**

The information contained in this publication was prepared for use by employees of, and in facilities that are owned and operated by, the Fraser Health Authority (FHA). While care has been taken to ensure the accuracy of the information as of the date of publication, FHA makes no warranty, express or implied, as to accuracy, completeness or currency. New knowledge, new technologies, clinical and research data, and clinical experiences may provide sound reasons for adopting alternative clinical practices. The ultimate judgment regarding the propriety of any specific clinical practice must be made by the health professional in light of the circumstances presented by the patient.

## Priority Intervention Criteria Tool (PIC) Acute Care – Adult

**PURPOSE:** To triage patients for dietitian services according to their degree of urgency for MNT as a risk management strategy.  
**INSTRUCTIONS:** Assign a PIC score to new referrals and patients coming due for monitoring. Patients are seen according to their PIC score – PIC 1 patients within 1 working day; PIC 2 patients next, then PIC 3, etc.  
**NOTE:** Some PIC 2, 3, 4 referrals may remain unseen.  
 Some patients may not fit into options listed; use clinical judgment as to the relative risk for harm / deterioration & potential for improvement.

PIC 1	PIC 2	PIC 3	PIC 4
High urgency for MNT	Moderate urgency for MNT	Low urgency for MNT	No urgency for MNT
<b>MONITORING</b>			
NAS 1 / 2 / 3 patients at monitoring deadline*	NAS 1 / 2 / 3 patients approaching monitoring deadline		
<b>REFERRALS – CLINICAL</b>			
Suspect malnutrition			
Suspect malabsorption			
Swallowing assessment to initiate diet†	Swallowing assessment to adjust diet†		
<b>REFERRALS – INTAKE / ASSESS DIET</b>			
New EN / PN			
EN / PN intolerance			
EN schedule change to accommodate drug bioavailability / kinetics	EN / PN schedule / system change unrelated to drug bioavailability / kinetics		
NPO for 4 days or more, or Low intake (less than 50%) for 5 days or more, or Suboptimal intake (50-75%) for 10 days or more	NPO for 2-3 days, or Low intake (less than 50%) for 3-4 days, or Suboptimal intake (50-75%) for 7-9 days	NPO for 1 day, or Low intake (less than 50%) for 1-2 days, or Suboptimal intake (50-75%) for 4-6 days	Suboptimal intake (50-75%) for 3 days or less
	Inadequate micronutrient intake that may cause harm, but not acutely		
Inappropriate nutrition that may cause acute harm	Inappropriate nutrition that may cause harm, but not acutely	Unnecessary therapeutic diet	
	Excessive / Inadequate fluid intake		
<b>REFERRALS – NUTRITION EDUCATION</b>			
Education required to prevent acute harm			
Education required for discharge today	Education required for discharge tomorrow	Education required for discharge in 2 or more days	Education best provided in clinic or outpatient settings
<b>PIC 0:</b> <ul style="list-style-type: none"> <li>▪ Nutrition intervention is inappropriate at this time</li> <li>▪ Unable to be seen due to extrinsic factors (e.g., medical intervention, not present, behavioural instability)</li> </ul>			
<b>PIC None:</b> <ul style="list-style-type: none"> <li>▪ Services not related to MNT (e.g., food preferences)</li> <li>▪ Reason for referral not clear despite screening</li> </ul>			
* Unless new clinical information indicates that monitoring deadline can be delayed.			

Version date: July 16 2020

†Note: only applicable when standard practice is for RDs to conduct formal swallow assessments

**PIC Operational Definitions and/or Examples | Acute Care – Adult**  
(refer to white box under each PIC item)

PIC 1	PIC 2	PIC 3	PIC 4
High urgency for MNT	Moderate urgency for MNT	Low urgency for MNT	No urgency for MNT
To be seen first to avoid the onset or deterioration of a condition, or to address a situation identified in the column	To be seen after PIC 1s to avoid the onset or deterioration of a condition, or to address a situation identified in the column	To be seen after PIC 1s and 2s to avoid the onset or deterioration of a condition, or to address a situation identified in the column	May require maintenance MNT, but can be monitored by point-of-care team member rather than dietitian
MONITORING			
NAS 1 / 2 / 3 patients at monitoring deadline	NAS 1 / 2 / 3 patients approaching monitoring deadline		
The last day the patient can be seen before becoming overdue for planned monitoring <b>Note:</b> PIC 1s not seen remain PIC 1s until seen	Within the monitoring plan dates, but will not be overdue if not seen (i.e., not at the last day of the monitoring deadline range)		
REFERRALS – CLINICAL			
Suspect malnutrition			
Based on anthropometric data, visual examination, report of involuntary weight loss, being at malnutrition risk according to a validated screening tool (e.g., two 'YES' answers using CNST; or a score of 2 or more using MST) <b>Note:</b> requires RD assessment to determine whether malnutrition actually present, and the severity of malnutrition if it is present			
Suspect malabsorption			
For example: high output ileostomy / fistula			
Swallowing assessment to initiate diet	Swallowing assessment to adjust diet		
NPO or cannot safely tolerate current diet	Tolerating current diet but potentially ready for upgrade		
REFERRALS – INTAKE / ASSESS DIET			
New EN / PN			
EN / PN considered "new" until at goal rate / volume			
EN / PN intolerance			
For example: nausea, vomiting, diarrhea, abdominal pain / cramping, bloating, aspiration, allergic reaction			
EN schedule change to accommodate drug bioavailability / kinetics	EN / PN schedule / system change unrelated to drug bioavailability / kinetics		
For example: patient switching from IV to on oral Dilantin	For example: change from continuous to intermittent schedule or closed to open system		
NPO for 4 days or more, or Low intake (less than 50%) for 5 days or more, or Suboptimal intake (50-75%) for 10 days or more	NPO for 2-3 days, or Low intake (less than 50%) for 3-4 days, or Suboptimal intake (50-75%) for 7-9 days	NPO for 1 day, or Low intake (less than 50%) for 1-2 days, or Suboptimal intake (50-75%) for 4-6 days	Suboptimal intake (50-75%) for 3 days or less
<i>(definition not needed)</i> <b>Note:</b> percent intakes are in relation to estimated nutrition needs			
	Inadequate micronutrient intake that may cause harm, but not acutely		
	For example: increased thiamin needs with high dose Lasix; increased calcium / vitamin D needs with long-term prednisone; increased B12 needs with long-term metformin		

Inappropriate nutrition that may cause acute harm	Inappropriate nutrition that may cause harm, but not acutely	Unnecessary therapeutic diet	
For example: has dysphagia and not on a therapeutic diet; introducing nutrition support too quickly in presence of refeeding syndrome risk; end stage liver disease at risk for hypoglycemia if they don't have a bedtime snack; altered nutrition-related lab values that require <u>urgent</u> initiation, discontinuation or change of MNT (e.g., refeeding syndrome, AKI with elevated potassium)	For example: restrictive therapeutic diets that require customization (e.g., dysphagia / renal); tissue weight changes while on EN / PN; altered nutrition-related lab values that require non-urgent initiation, discontinuation or change of MNT (e.g., repeated hypoglycemic events, hyperphosphatemia with renal failure without the presence of calciphylaxis)	For example: on a diabetic diet without diabetes	
	Excessive / Inadequate fluid intake		
	<i>(definition not needed)</i>		
<b>REFERRALS – NUTRITION EDUCATION</b>			
Education required to prevent acute harm			
For example: hyperkalemia, dysphagia, short bowel syndrome, celiac disease, fluid restricted, ileostomy diet			
Education required for discharge today	Education required for discharge tomorrow	Education required for discharge in 2 or more days	Education best provided in clinic or outpatient settings
Nutrition education necessary and ready for discharge	Nutrition education necessary and ready for discharge tomorrow	Nutrition education necessary, but not ready for discharge	For example: hyperlipidemia hyperphosphatemia, chronic hyperglycemia

Version date: July 16 2020

## Nutrition Acuity Score (NAS) Acute Care – Adult

**PURPOSE:** To describe patients according to their need for initiation of or change to MNT to avoid the deterioration or onset of nutrition problems (i.e., nutrition acuity).

**INSTRUCTIONS:** Based on nutrition problem(s) identified during the assessment, assign a NAS value. If there are multiple problems located in different columns, the column closer to the left determines the NAS. If no nutrition problem exists, do not assign a NAS.

**NOTE:** Some situations may not fit options listed; use clinical judgment as to relative risk for harm / deterioration & potential for improvement.

NAS 1	NAS 2	NAS 3	NAS 4
Highest need for MNT	Moderate need for MNT	Lowest need for MNT	Maintenance MNT
<b>CLINICAL</b>			
Severely malnourished (SGA C)	Mildly/Moderately malnourished (SGA B)		
Malnourished on MNT - no clinical improvement	Malnourished on MNT - improved intakes and weight stable	Malnourished on MNT - improved intakes and weight gain	Malnourished with / without MNT, but no further RD services
Involuntary severe / significant weight loss: -5% or more in 1 month, or -10% or more in 6 months <sup>1</sup>		Involuntary weight loss: -less than 5% in 1 month, or -less than 10% in 6 months <sup>1</sup>	
		Involuntary weight gain on EN / PN	
Swallowing difficulty prohibiting oral intake	Swallowing difficulty impairing oral intake		
	Biting / Chewing difficulty impairing oral intake		
Altered GI function resulting in malabsorption and/or electrolyte abnormalities	Altered GI function affecting oral intake		
Altered nutrition related lab values requiring urgent MNT	Altered nutrition related lab values requiring non-urgent MNT		
Food-medication interaction that has immediate negative impact on drug bioavailability / kinetics		Food-medication interaction increasing micronutrient needs	
<b>INTAKE</b>			
Inadequate oral intake or inadequate EN / PN infusion: -less than 50% for 5 days or more <sup>2</sup> -50-75% for 10 days or more	Inadequate oral intake or inadequate EN / PN infusion: -less than 50% for 4 days <sup>2</sup> -50-75% for 7-9 days	Inadequate oral intake or inadequate EN / PN infusion: -less than 50% for 3 days <sup>2</sup> -50-75% for 4-6 days	
Oral diet / EN / PN composition or administration inconsistent with needs that may cause acute harm	Oral diet / EN / PN composition or administration inconsistent with needs that may cause harm, but not acutely	Oral diet / EN / PN composition or administration inconsistent with needs unlikely to cause harm	
Excessive EN / PN infusion			
		Meeting 75% or more of estimated nutrition needs from PN	Meeting 75% or more of estimated nutrition needs from oral diet / EN
	Inadequate carbohydrate intake increasing risk for hypoglycemia		
	Excessive fluid intake in presence of organ failure	Excessive fluid intake without the presence of organ failure	
Inadequate fluid intake			
Inadequate vitamin intake that may cause irreversible harm	Inadequate vitamin / mineral intake <b>with</b> physical signs / symptoms of deficiency or low serum value	Inadequate vitamin / mineral intake <b>without</b> physical signs / symptoms of deficiency or low serum value	
<b>BEHAVIOURAL-ENVIRONMENTAL</b>			
Food & nutrition related knowledge deficit - Education required to prevent acute harm	Food & nutrition related knowledge deficit - Education required to prevent non-acute harm		
<b>NAS 0:</b> <ul style="list-style-type: none"> <li>▪ No nutrition problem identified (e.g., stable and not receiving maintenance MNT)</li> <li>▪ Nutrition is no longer the focus of care (e.g., terminal/imminent death, MNT refused, no further treatment options available)</li> <li>▪ Assessment incomplete (e.g., insufficient information / unable to speak with patient)</li> </ul>			

Version date: July 15 2021

<sup>1</sup> White JV, Guenter P, et al. Consensus Statement: AND and ASPEN: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Under-nutrition). JPEN. 2012; 36:275-283

<sup>2</sup> National Collaborating Centre for Acute Care, February 2006. Nutrition support for adults oral nutrition support, enteral tube feeding and parenteral nutrition. National Collaborating Centre for Acute Care, London. Retrieved February 22, 2016 from <https://www.nice.org.uk/guidance/cg32/evidence/full-guideline-194889853>

**NAS Operational Definitions and/or Examples | Acute Care – Adult**  
(refer to white box under each NAS item)

NAS 1	NAS 2	NAS 3	NAS 4
Highest need for MNT	Moderate need for MNT	Lowest need for MNT	Maintenance MNT
Highest need for initiation of or change to MNT to avoid the deterioration or onset of a nutrition problem identified in the column	Moderate need for initiation of or change to MNT to avoid the deterioration or onset of a nutrition problem identified in the column	Lowest need for initiation of or change to MNT to avoid the deterioration or onset of a nutrition problem identified in the column Note: RDs need to follow-up when monitoring planned (as per college regulations); NAS 3s may require one final review prior to becoming NAS 4 and services terminated	Dietitian services no longer required (e.g., stable on MNT, or MNT no longer needed / wanted) Note: new patients (i.e., never followed by a dietitian) who do not have a nutrition problem and do not require MNT are not assigned a NAS value
<b>CLINICAL</b>			
Severely malnourished (SGA C)	Mildly/moderately malnourished (SGA B)		
<i>(definition not needed)</i>	<i>(definition not needed)</i>		
Malnourished on MNT - no clinical improvement	Malnourished on MNT - improved intakes and weight stable	Malnourished on MNT - improved intakes and weight gain	Malnourished with / without MNT, but no further RD services
Malnourished and receiving some form of MNT, but intakes remain inadequate and no tissue weight gain or continued weight loss (i.e., not enough time on MNT has elapsed, or require more MNT)	Malnourished and receiving some form of MNT with improved intakes from any source and weight stable	Malnourished and receiving some form of MNT with tissue weight gain	For example: MNT no longer consistent with goals of care, MNT declined, no further MNT options available
Involuntary severe / significant weight loss: -5% or more in 1 month, or -10% or more in 6 months <sup>3</sup>		Involuntary weight loss: -less than 5% in 1 month, or -less than 10% in 6 months <sup>3</sup>	
<i>(definition not needed)</i>		<i>(definition not needed)</i>	
		Involuntary weight gain on EN / PN	
		Unintended non-fluid tissue weight gain trend while on EN / PN	
Swallowing difficulty prohibiting oral intake	Swallowing difficulty impairing oral intake		
For example: RD leading / participating in decision-making conversations about starting enteral nutrition support	<i>(definition not needed)</i>		
	Biting / Chewing difficulty impairing oral intake		
	For example: poor dentition requiring diet texture downgrade		
Altered GI function resulting in malabsorption and/or electrolyte abnormalities	Altered GI function affecting oral intake		
For example: (for malabsorption) short bowel syndrome, untreated celiac or Crohn's disease and not receiving nutrition support; (for electrolyte abnormalities) diarrhea, high output ileostomy or bowel obstruction with high GI losses	For example: constipation, nausea, diarrhea		
Altered nutrition related lab values requiring urgent MNT	Altered nutrition related lab values requiring non-urgent MNT		
For example: refeeding syndrome; elevated potassium	For example: hyperglycemic on continuous EN warranting change to intermittent feeds, hypo/hypermnatremia, hyperphosphatemia with renal failure without the presence of calciphylaxis		
Food-medication interaction that has immediate negative impact on drug bioavailability / kinetics		Food-medication interaction increasing micronutrient needs	
For example, on EN and Dilantin therapy changed from IV to po		For example: on prednisone with inadequate vitamin D / calcium intake; on Dilantin with inadequate folic acid / vitamin D intake; on metformin with inadequate vitamin B12	

<sup>3</sup> White JV, Guenter P, et al. Consensus Statement: AND and ASPEN: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Under-nutrition). JPEN. 2012; 36:275-283

INTAKE			
Inadequate oral intake or inadequate EN / PN infusion: -less than 50% for 5 days or more <sup>4</sup> -50-75% for 10 days or more	Inadequate oral intake or inadequate EN / PN infusion: -less than 50% for 4 days <sup>4</sup> -50-75% for 7-9 days	Inadequate oral intake or inadequate EN / PN infusion: -less than 50% for 3 days <sup>4</sup> -50-75% for 4-6 days	
(no definition needed)			
<b>Note:</b> percent intakes are in relation to estimated needs			
Oral diet / EN / PN composition or administration inconsistent with needs that may cause acute harm	Oral diet / EN / PN composition or administration inconsistent with needs that may cause harm, but not acutely	Oral diet / EN / PN composition or administration inconsistent with needs unlikely to cause harm	
For example: not on a therapeutic diet and has dysphagia; intolerance (nausea, vomiting, diarrhea, abdominal pain / cramping, bloating, aspiration, allergic reaction); need EN / PN adjusted for other reasons such as transitioning to different nutrition support; need to fully inform patients of the risk of harm when they refuse MNT (e.g., refusing potassium restriction / dysphagia diet)	For example: newly started EN / PN; patient requires protein or phosphorus restriction for chronic kidney disease; therapeutic diet interfering with quality of life; renal formula no longer necessary	For example: on a diabetic diet without having diabetes, on a potassium restriction while also getting potassium repletion; changing to fibre-containing formula; changing to intermittent nutrition support for quality of life	
<b>Excessive EN / PN infusion</b>			
For example: overfeeding calories and/or dextrose on PN resulting in or increasing risk for hyperglycemia or cholestasis; EN / PN infusion resulting in or increasing risk of delayed weaning from ventilator related to increased carbon dioxide production from overfeeding calories			
		Meeting 75% or more of estimated nutrition needs from PN	Meeting 75% or more of estimated nutrition needs from oral diet / EN
		Stable on PN, but requires ongoing bloodwork monitoring	Stable on MNT and monitored by point-of-care team members
	Inadequate carbohydrate intake increasing risk for hypoglycemia		
	For example: end stage liver disease at risk for hypoglycemia if they don't have a bedtime snack		
	Excessive fluid intake in presence of organ failure	Excessive fluid intake without the presence of organ failure	
	For example: heart failure with fluid overload, liver failure with ascites, renal failure with fluid overload	Fluid intake exceeds estimated needs; or no organ failure, but need fluid restriction (e.g., SIADH)	
<b>Inadequate fluid intake</b>			
On oral diet / EN / PN and showing signs / symptoms of dehydration			
Inadequate vitamin intake that may cause irreversible harm	Inadequate vitamin / mineral intake <b>with</b> physical signs / symptoms of deficiency or low serum value	Inadequate vitamin / mineral intake <b>without</b> physical signs / symptoms of deficiency or low serum value	
For example: serum vitamin B12 level below 150 pmol/L; history of alcohol dependence requiring thiamin supplementation; refeeding syndrome risk	For example: serum vitamin B12 below reference range, but greater than 150pmol/L, vitamin D below reference range	For example: presumed osteoporosis following a fracture	
BEHAVIOURAL-ENVIRONMENTAL			
Food & nutrition related knowledge deficit - Education required to prevent acute harm	Food & nutrition related knowledge deficit - Education required to prevent non-acute harm		
For example: hyperkalemia, dysphagia, home EN, short bowel syndrome, celiac disease, fluid restricted, ileostomy diet <b>Note:</b> Education required during hospitalization or upon discharge	For example: high protein high calorie diet; protein or phosphorus restriction for kidney failure; heart healthy diet for dyslipidemia		

Version date: July 15 2020

<sup>4</sup> National Collaborating Centre for Acute Care, February 2006. Nutrition support for adults oral nutrition support, enteral tube feeding and parenteral nutrition. National Collaborating Centre for Acute Care, London. Retrieved February 22, 2016 from <https://www.nice.org.uk/guidance/cg32/evidence/full-guideline-194889853>