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| **Assessment of Patient (PSF)** | |
| **Department: Clinical Patient Care** | **ORIGINATION DATE: 6/95** |
| **CATEGORY:** | **EFFECTIVE DATE: 11/30/12** |

**SCOPE:**

Intended for inpatient and outpatient care units where patients are admitted and cared for.

**PURPOSE:**

To assure that initial and ongoing patient assessments are performed by caregivers for the duration of the patient stay.

**POLICY:**

Unless an emergent situation exists, the patient should have his/her physical, psychological, social, cultural and spiritual statuses assessed by qualified caregivers of the applicable discipline(s) based on patient’s current situation prior to planning and implementing the plan of care.

An initial assessment shall be performed to determine the patient’s immediate and emerging needs to direct appropriate assignment of care in the organization. Caregivers shall refer to initial assessment documented in the Clinical Information System (CIS) to limit duplication of assessment efforts. All assessments will be documented in the CIS or progress notes as applicable.

**PROCEDURE:**

1. Anesthesia. Assessment and reassessment responsibilities of physicians and licensed independent practitioners are contained in the Penrose-St. Francis Medical Staff Bylaws, Rules and Regulations.
2. Physicians. Assessment and reassessment responsibilities of physicians and licensed independent practitioners are contained in the Penrose-St. Francis Medical Staff Bylaws, Rules and Regulations.
3. Behavioral Health. When a patient is admitted to the Emergency Department with a psychiatric or chemical dependency complaint, a Psychiatric Emergency Triage Team (P.E.T.T.) staff member, assesses the patient within 1 hour whenever possible upon receipt of a doctor’s order for a P.E.T.T. Consult – provided the patient is conscious and able to participate in the assessment.. P.E.T.T. clinical staff members are part of an interdisciplinary team - which includes masters and doctoral level clinicians, as well as RNs with specialized training and experience with psychiatric patients. The patient assessment consists of data collection covering the areas of presenting problems, psychiatric history, chemical use history, socio-cultural history, mental status, dangerous/out of control behaviors, and admission criteria. Staff assesses patients at the time of admission to the Emergency Department in order to determine and document the most appropriate treatment plan, disposition, and level of care – should the patient require further treatment. If the patient is found to meet criteria for an M-1 Hold or emergency Commitment for Alcohol or Drugs, P.E.T.T. staff assume responsibility for finding appropriate placement once the patient has been medically cleared. For Emergency Department patients, vital signs are taken every hour for 4 hours – then every 4 hours until discontinued by the physician. The RN does the physical reassessment every 24 hours, and the remainder of the reassessment is done every waking shift (i.e., patient is not awakened at night if sleeping) by one of the following: RN, Mental Health Worker, or Emergency Department Tech In addition, P.E.T.T. staff may assess patients on medical units after receiving a doctor's order. The consultation will include assessment and documentation of psychiatric and chemical dependency treatment needs as described above. For patients with behavioral health complaints who are hospitalized on medical units, P.E.T.T. staff provides triage, assessment, and discharge planning 24 hours a day, 7 days a week. In the event of a disaster, patient assessments may be done on paper, i.e., if the power goes out. Also, non-nurses may be utilized to augment nursing staff on some assessments: for danger to self or others and/or suicidal/homicidal ideation. Depending on the scope of the disaster, patient assessments may have to be shortened and time frame for completing assessments lengthened.
4. Care Management Services.

The Care Management Service’s process of discharge planning assessment begins upon admission for all patients and is coordinated by the designated nurse case manager. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is not adequate discharge planning. Timely evaluations are completed so that appropriate post-hospital arrangements are made before discharge and unnecessary delays in discharge are avoided.

Unit nursing staff do the initial Nursing patient admission assessments, within four hours of admission, and make referrals to Care Management Services to ensure needs they identify are being addressed as part of the discharge planning process. Nursing referrals and those received from other members of the interdisciplinary care teams are acted on as appropriate within 24 hours or the next business day. Likewise, physician orders are evaluated and acted on as appropriate within 24 hours or the next business day. There are Care Management Services nurse case managers on duty seven days per week for these purposes.

The Care Management Services initial discharge planning assessment is done using the Admission Screening Assessment Tool, the Risk Screening Tool, and as appropriate the Readmission Interview Tool. These tools consider physical, psychosocial, financial and other issues, including functional status, cognitive ability and family support.

Needs are re-assessed as circumstances warrant. These assessments assist the case managers to evaluate the likelihood of a patient’s capacity for self-care or return to their previous environment. Nurse case managers continually monitor patients’ progress, with special focus on those identified as high risk, and communicate with patient & family, all involved disciplines and physicians to ensure high quality care and appropriate utilization of resources.

Care Management Services nurse case manager/social worker teams function in a way that ensures there is consistent comprehensive interdisciplinary collaboration. In addition to inpatients, Emergency Department patients and outpatients, as needed, receive these services.

1. Nursing**. Specialty Areas as Applicable to Patient’s Needs.**
2. *\*Nursing: Adult and Pediatric Patients* Adult and pediatric patients are initially assessed by a RN within 4 hours of their admission, except in Critical Care, Labor and Delivery, and Emergency departments where patient dynamics require more immediate assessments. The initial assessment includes: history and physical exam, medication reconciliation, development of a plan of care, problem list, level of pain and comfort; psychosocial/emotional/spiritual needs, patient’s and/or parents’ (in the event the patient is a minor) knowledge of his/her current condition, readiness and ability to learn, preference for learning, barriers to learning; home environment and social support and discharge planning needs. In some cases, a Licensed Practical Nurse (LPN) will be involved in the patient care and will perform assessments based on scope of practice and report any new findings or abnormal findings to the primary RN assigned to the patient. Reassessment of patients by a RN occurs every 12 hours or more frequently if the patient's condition warrants. Discharge planning begins on the day of admission and is a collaborative effort by the RN with other disciplines. Prior to surgery, all surgical patients receive a pre-operative assessment by a RN.

# Knowledge, the Orders, Interventions, Notes (KOIN).

1. Knowledge: the caregiver will have the knowledge to:
2. Educate and collaborate with the patient and his/her support system about the plan of care
3. Plan the care of the patient and communicate the plan of care to other members of the interdisciplinary team.
4. Orders: the orders written by the Licensed Independent Practitioner (LIP) are a major part of the plan of care.
5. Interventions: address how care is provided, how orders are carried out, and provide documentation for the outcomes and data.
6. Notes: Notes provide additional information.

*2. \*Nursing: Birth Center Patients*. Nursing assessment of the pregnant patient in the Birth Center Triage area starts as soon as the patient presents to that area. Existence of potential emergency conditions *(i.e., imminent delivery risk or experiencing a condition that threatens the life of the patient and/or her unborn child)* are assessed within minutes. The nurse then performs a complete assessment of the patient’s condition including: medical, psychosocial, level of pain, expectations and knowledge of her condition, readiness and ability to learn and spiritual condition which is documented within 4 hours of patient’s arrival. Medication reconciliation is accomplished. Reassessment in triage occurs as patient’s condition warrants, but at least every 4 hours. Reassessment of all admitted patients *(pregnant or delivered)* is completed and documented at least every shift that indicates patient’s response to nursing interventions. Assessments of fetal heart tones and uterine activity are performed according to the Association of Women’s Health, Obstetrics, and Neonatal Nurses (AWHONN) standards.

*1\*Nursing: Critical Care*. Patients are initially assessed by a RN within one hour of their admission. The initial assessment includes all aspects included in the general nursing assessment along with MRSA screening. Reassessment of patients by a RN occurs at least every 4 hours or more frequently if the patient's condition warrants. Discharge planning and pre-operative assessment is the same as for the general nursing areas. Medication reconciliation is accomplished.

*2\*Nursing: Emergency Department.*  Nursing assessment in the Emergency Department starts as soon as the patient presents to the triage area. Visual assessment includes determining if a potential emergency condition *(i.e., threat to life or limb)* exists. The triage nurse then performs a full triage assessment, which includes but is not limited to the chief complaint, symptoms, vital signs, affect, current medications, medical history, and allergies. Based on the triage assessment, the nurse assigns an acuity level based on the 5 level systems. The acuity level helps determine which patients need to be seen immediately and which can wait without threatening life or limb. Fully triaged patients in the waiting room are to be reassessed hourly. A qualified RN in the Emergency Department will complete the nursing assessment using the department-specific nursing documentation record. On-going, focused reassessments are to be documented which indicate the patient's response to nursing interventions. A statement indicating state of wellness at discharge will be documented in the nursing record. Care management will be notified if there is a need for their services in the discharge planning process. Medication reconciliation is accomplished.

In the event of an emergency: If a disaster is declared by the charge nurse (in consultation with the attending physician), the charge nurse will activate the Code Grey process. Depending on the scope of the disaster, a disaster triage plan will be put in effect. This plan is based on resources available and utilizes the red (emergency), yellow (urgent), green (minor), and black (expectant death) color card system for rapid triage. Also depending on the scope of the disaster, the ED disaster plan will be activated which could involve moving patients out of the ED into other areas of the hospital and relying on other nursing care resources within the facility to provide care.

*3 \*Nursing: Flight for Life.* An appropriate assessment of each patient’s physical, psycho/social, and spiritual condition is achieved by the flight registered nurse through the gathering of any of the following:

Historical background provided by the client, significant other, bystander or medical personnel;

Environmental survey;

Existing written data; and

Performance of a physical exam using a systems approach.

Emergency conditions are assessed within the first 30 seconds of encountering the patient. The secondary survey is achieved within the first 10 minutes of encountering the patient (in the event of a disaster this should be completed within 5 minutes). A prioritized nursing care plan is formulated from the assessment data and implemented according to practices prepared by the physician advisor for Flight for Life. Reassessment is systemic and ongoing for the duration of the transport. Ongoing reassessments are performed as warranted by patient response. Vital signs are assessed every 10-15 minutes, or more frequently as needed. During disaster/mass casualty situations care of patients with probable non-survivable injuries will be deferred to care for those patients who have a better chance of surviving.

*4.\*Nursing: Infection Control.* All patients are assessed for presence of infection by a RN as part of the initial nursing assessment using the time frames specified by nursing. The RN will assess for infection throughout all body systems and implement any Isolation Precautions appropriate for suspected or diagnosed disease (Infection Control Manual; Isolation Precautions pages 9-15). The initial assessment will include TB admission screening. Reassessment of the patient for ongoing or developing infection by a RN occurs every 24 hours or more frequently as the patient’s condition warrants. Check Meditech for history of MRSA or Vancomycin-resistant enterococci (VRE) or other Multi-drug resistant organism (MDRO), pneumavax history and influenza assessment.

1. *Nursing: Inpatient Rehabilitation.* The Inpatient Rehab Unit is a Diagnosis Related Group (DRG) exempt acute rehabilitation program governed by the Centers for Medicare and Medicaid Services (CMS), Inpatient Rehabilitation Facility (IRF), and Prospective Payment System (PPS). All patients admitted to this program from PH or SFMC are discharged from the acute medical unit and a new admission/episode is begun. Adult and adolescent patients meeting CMS criteria for comprehensive rehabilitation services are assessed by a qualified Registered Nurse and therapy team The nursing assessment is initiated within one hour of admission. Vital signs, including pulse oximetry, weight and pain level are assessed within 1 hour and the RN completes a head to toe physical and functional assessment within 8 hours of admission. CMS requires the initial assessment be completed within 72 hours to address the required fields in the CMS mandated Inpatient Rehab Facility Patient Assessment Instrument (IRF/PAI). The scope of an evaluation or assessment is based on the discipline as well as the patient’s needs and may include, but is not limited to : history, age, assessment of previous and current physical condition, activities of daily living, impairments, equipment needs, cognition, perceptual, physical tests or planning needs. Discharge planning begins upon initial assessment and with ongoing reassessments throughout the episode of care. Reassessment of the physical/medical/functional issues occur at least once each shift or more frequently if the patient’s condition warrants. In addition to the individual discipline assessments, the team meets initially within four days of admission and a minimum of weekly to conduct an interdisciplinary team conference to develop an interdisciplinary plan of care and discharge plan/goals, perform ongoing reassessment and modifications to the interdisciplinary plan. Documentation is to be completed according to IDP and CIS guidelines. Medication reconciliation is accomplished.

In the event of a recognized local, regional or federal disaster resulting in an increased demand for acute beds, CMS recognizes that some facilities in the emergency area may take a higher number of admissions outside of the 13 qualifying conditions to meet the demands of the crisis. Based on a decision made by key hospital and rehab personnel, the Inpatient Rehab Facility (IRF) may temporarily convert available exempt beds to acute care beds to accommodate the needs of the disaster plan. The IRF staff should clearly indicate in the medical record where an admission is made to meet the demands of the crisis during the emergency period. This conversion should be viewed as a short term solution, and efforts must be made to return non-qualifying patients to an acute floor within 96 hours.

1. *\*Nursing: Medical Oncology Outpatient.* Patients are assessed by a RN at the time of initial consultation. Assessment includes vital signs, medications and brief history. Teaching is performed regarding disease process, treatment regimen, nutritional needs and management of side effects. Medication reconciliation is accomplished. The nurse is responsible for treatment administration including hydration, antiemetics, blood products, injections for support of blood counts, and chemotherapy. Ongoing assessment is performed while patient is receiving chemotherapy. Assessment and care of those patients includes: issues of pain control, adverse side effects, emotional/spiritual needs, lab results, and quality of life issues. The RN refers patients to ancillary and support services as needed orrequested.
2. *\*Nursing: \*Neonatal Intensive Care and Well Baby Nurseries.* Well newborns and Newborns requiring intensive care are assessed by a qualified RN using their department-specific admission assessment and reassessment tools. Patients in the NICU and Well-Baby Nursery are assessed within 2 hours of admission.
3. *\*Nursing: Outpatient Nursing Care.* (Radiology Care, Outpatient Surgery, GI Lab, Special Procedures, Wound Clinic, Cardiac Cath Lab). Patients are initially assessed by a RN prior to the procedure for which they are being seen in the department, and again upon return to the department post-procedure. If the procedure is performed in the department, an assessment is made by a RN immediately following the procedure. Medication reconciliation is completed.

The initial assessment will include: for ambulatory patient presenting for invasive procedures, pertinent elements of the history and physical exam relative to the planned procedures should be recorded prior to the procedure, specified body area as appropriate, development of priority nursing diagnoses, level of pain and comfort; psychosocial / emotional / spiritual needs, patient’s knowledge of his/her current condition, readiness and ability to learn, preference for learning, barriers to learning; and presence of a caregiver for the recovery period at home (8 - 24 hours, depending on anesthesia administered) following discharge. The patient undergoing a cardiac catheterization will be shown the informational “Cath Film” as part of their pre-op preparation. Patients requiring conscious sedation for their procedure (endoscopy, bronchoscopy, interventional radiography and such) will require a history and physical as delineated in the Moderate Sedation Policy S-01-e). All discharge instructions are reviewed prior to the procedure due to carryover effects of sedation/anesthesia post-procedure. Reassessment by a RN occurs at least every hour and prior to discharge if the patient is present longer than 1 hour post procedure. Post cardiac catheterization, the patient is monitored per “Post Catheterization Orders”, that is every 15 minutes for the first hour with increasing intervals thereafter. The nurse will notify care management if the assessment identifies a need for further discharge planning.

1. \*Nursing: Perioperative. Nursing assessment for procedural safety and individual needs occurs immediately before surgery and includes, but is not limited to: Patient identity to include two identifiers, written history and physical dated, signed and timed, surgical site verification via written consent, patient understanding as in patient verbalizing what is to be done, and surgical site marked by the surgeon; allergies; skin integrity; current medications, metal or other implants; NPO status; blood availability with signed consent, anesthesia consent signed, lab reports; mobility; emotional status; family support; vision problems, and any impairments dealing with communication. Medication reconciliation is accomplished.

There is continuous intra-operative monitoring for patient safety, physiological functions, and infection control issues. The patient is assessed post-operatively for airway maintenance, skin integrity, pain and the achievement of the Perioperative Standards of Care. The patient in the Cardiac Catheterization Lab is monitored as above as well as normally occurs in the Cath Lab.

1. *\*Nursing: Post Anesthesia.* An immediate assessment is done on all patients arriving in PACU by a RN for airway and respiratory management, circulation, LOC, vital signs, anesthesia used, surgical site, level of pain and comfort, safety needs, and pertinent medical history. Medication reconciliation is accomplished. Ongoing reassessment continues every 5 – 15 minutes until the patient meets discharge criteria and is transferred to Phase II.
2. Nutrition Services. Upon admission, all inpatients are assessed for nutrition risk by a RN within 24 hours. Using the CIS an RN will notify Nutrition Services of each patient’s risk level: none, mild, moderate, or severe. Patients screened at no risk or mild risk are re-screened by Nutrition Services every 5 - 7 days. Patients identified at moderate or severe risk are assessed by the dietitian within 48 hours of risk level notification. A nutrition care plan is implemented and documented in the medical record. Those patients are reassessed by a dietitian every 5 - 7 days or sooner when notified of changes in the patient’s condition or as requested by the physician.
3. Pharmacy and Nutritional Support. Inpatients receiving parenteral nutrition (PN) are assessed either upon initiation of parenteral nutrition therapy or, per physician order, prior to initiation of parenteral nutrition therapy. A review of the patient's parenteral nutrition requirements is conducted by the registered dietitian, with input from the clinical pharmacist regarding electrolytes and any other additives, if needed. The initial assessment includes an evaluation of the protein and calorie needs of the patient along with a review of the available laboratory data. The PN assessment and recommendations are recorded in the progress notes as soon as possible. Weekly follow-up reassessments of the PN therapy are done by the registered dietician and recorded in the progress note section of the medical record.

A review of selected parenteral and oral medication therapy is conducted daily by decentralized pharmacists assigned to specific patient care units. Targeted medications/tracer drugs are reviewed for appropriate dose and dosage interval, possible adverse drug reactions, appropriate route, etc. Recommendations for changes in therapy are communicated either orally or in writing to the attending physician as soon as possible.

1. Imaging Services. Upon receipt of a physician's orders, all patients having invasive studies are assessed as to the appropriateness of the exam by the radiologist who will perform the exam. The history already available on the chart and/or in the Electronic Medical Record (EMR) of the CIS, pertinent laboratory results, clinical history gathered by referring physician and prior imaging results are reviewed to determine appropriateness of exam. The dictated report is stored in RIS (*Radiology Imaging System)* and a copy is available through the CIS.
2. Radiation Oncology. All outpatients are assessed by a RN at the time of the initial teaching which is after the initial consultation with the radiation oncologist. This assessment includes: history, physical, vital signs, functional health patterns, pain assessment using a 1 to 10 scale, psychosocial/emotional/spiritual needs, ability for self-care, transportation needs, knowledge of disease and treatment process, end of treatment and discharge planning. Patients are reassessed by a RN, as their condition warrants. All patients are reassessed by a RN and the radiation oncologist at least weekly and as their condition warrants. All patients are seen daily, Monday through Friday, by radiation therapists and referred to a RN if needed. The RN refers patients to ancillary services as needed or requested. All patients are assessed at least weekly by a radiation oncologist. For those radiation patients who are inpatients, a modified assessment is done using information from the inpatient chart. The modified assessment includes: pain assessment, knowledge of disease and treatment process, psychosocial/emotional/spiritual needs.
3. Rehabilitation Services. Upon an (inpatient) IP acute care admission, all inpatients will receive an initial screening assessment of their functional needs as part of the nursing assessment. The physician is responsible for ordering whatever rehabilitation services he/she deems appropriate for the patient. Any Rehabilitation Therapy evaluation or treatment for an IP requires a physician order. Upon receipt of a physician order, a discipline specific evaluation is performed and documented by a qualified professional within a maximum of 48 hours on an IP basis, although every effort is made to initiate care as soon as possible based on patient’s salient factors and in accordance with the discipline’s scope of practice policy and program specific triage guidelines. Patients admitted to the IP Rehab Unit are screened by a rehab physician prior to admission and must have a medical need to remain in an IP hospital setting and have functional needs for rehabilitation therapy prior to admission, based on Medicare and Unit admission guidelines. OP's are scheduled as appointments are available based on triage criteria for OP. The scope of the evaluation is based on the discipline as well as the patient’s needs and may include but is not limited to: history, assessment of previous and current activities of daily living, impairments, equipment needs, cognition, perceptual, physical tests, mobility, speech language and communication, swallowing, hearing, social support, discharge planning needs and treatment recommendations as appropriate by the involved discipline. When a treatment plan is indicated, it is designed in conjunction with input from the patient and/or family and other disciplines as appropriate to promote and facilitate optimal functional improvement for the current care setting in order to transition the patient to the next more appropriate setting. Discharge planning begins at the time of the initial evaluation and is a collaborative effort with other disciplines as well as the patient and family or other caregivers. Reassessments of the patient by a qualified professional will take place at a minimum of weekly for inpatients and monthly for outpatients, or more frequently if the patient's condition or progress warrants.
4. Respiratory Care Services. All patients receiving bronchial hygiene procedures (e.g., medication nebulizer, metered dose inhaler) are initially assessed and are reassessed during each visit to assure that criteria for treatment are met, that the objectives of treatment are achieved and that there are no adverse reactions to the treatment. The Department of Respiratory Care practices provide for the performance of reassessments according to clinical indicators. Assessments are documented on the Respiratory department patient admission screening assessment and placed in the chart under the patient assessment tab. In the event of a disaster patient assessments, treatments given and vent data would be documented after the fact depending on local conditions.
5. Spiritual Care. Spiritual assessments are initiated by Chaplains upon referral from physicians and/or patient care associates or upon request from patient and/or family. These assessments address the spiritual/emotional needs of patients and families and are done within 24 hours of the referral or request. High-risk patients are responded to immediately. Patient status is reassessed when there is a change in Advance Directive information, evidence of grief/loss/death issues, family concerns or other indications of spiritual distress. Spiritual care interventions with patients and/or families are provided based on these assessments and implemented in a timely manner with appropriate follow through sessions. Spiritual Care assessments and interventions are documented in the CIS or progress notes as appropriate. Spiritual Care referrals may include hospital support services and, with the patient’s knowledge and approval, referral to community clergy, churches or other human service agencies.
6. Trauma/Merit Team. See Trauma Guidelines for Trauma & Merit *(Minor Emergent Response in Trauma)* Team Activation for list of duties for the multidisciplinary team.

**DEFINITIONS: NA**

**REFERENCES AND SOURCES OF EVIDENCE:**

Medical Staff Bylaws. (2012). *Rules and regulations*

Provision of care, treatment and services. In (2012). *Hospital Accreditation Standards*

Oakbrook Terrace, Il: Department of Publications and Education Joint Commission

Resources.

(*Provision of care*, 2012)

**POLICY VIOLATION**

Any Centura associate who fails to abide by this policy may be subject to disciplinary action, including termination.

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| **REVIEW/REVISION DATES:** 12/97, 5/98, 6/99, 2/02, 2/06, 9/09 | **CNO, CMO Initial;** |
| **Approval Body (IES): IDPC, MEC**  *(If applicable)* | **APPROVAL DATE:** |