

TITLE: ASSESSMENT OF PATIENTS

POLICY # B2-2

MANUAL: ADMINISTRATIVE POLICY/PROCEDURE MANUAL

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Signature /s/ Michael Glasberg

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Michael Glasberg, Chief Operating Officer

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VALUES CONTEXT:

Our value of Service assures that we respond to the needs of the whole person: body, mind and spirit.

PURPOSE/EXPECTED OUTCOME(S)

“To provide patients with the right care at the time it is needed, qualified individuals in the hospital assess each patient’s care needs throughout the patient’s contact with the hospital.”¹

POLICY

Assessment involves the components of observing (body, mind and spirit) and recording facts, reporting and recording observations, classifying data, monitoring change, predicting possible outcome, and making a decision on the needs of the patient.

Differences in the assessment process and outcome will be dictated by the purpose, the setting and the health care professional conducting the assessment. Factors that must be considered include the patient’s and family’s perception of the illness and how the patient should be treated, the degree of illness, cognition, drugs, problems with communication, cultural differences, religion, education and developmental level, role and place in the family, social and economic status, emotional status, previous experience and background, personal habit, daily activities of living, and physical and physiological status.²

The result of assessment is a personalized plan of care. The assessment and care planning process is ongoing and determines the priority of care provided.²

PROCEDURE

- A. All patients are assessed on admission to determine immediate care needs. The patient assessment is completed within 24 hours and an individualized age-appropriate plan of care is initiated.
 1. An RN is responsible for assessing patient care needs for all newly admitted patients within the time period established by the department.
 - * For patients transferring into medical-surgical areas from PACU or Emergency Department an RN takes report from the PACU/ER RN and may, based on report, assign an LVN to begin the collection of data. The RN completes the assessment process by observing the patient, analyzing, synthesizing and evaluating the data collected by the RN and LVN.

¹ Joint Commission 1996 Comprehensive Accreditation Manual for Hospitals, p. 101

² Beland, Irene, Clinical Nursing, 2nd Edition, pp. 18-22

2. Physicians are expected to have dictated the patient's history and physical within 24 hours of admission. If a physician's history and a physical examination has been performed within 7 days prior to admission, a durable, legible copy of this report may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission.

B. Assessment

1. Every inpatient has an assessment by a Registered Nurse.

Assessing the status and identifying the needs of the patient serves as the foundation for the planning, implementation and evaluation of the care plan. When appropriate, data from the patient's significant other(s) are included in the assessment.

The assessment of patient care begins with the patient's chief complaint. Commonly this occurs in the physician's office or the emergency department.

- a. Nursing Assessments

The RN is responsible for initial assessment and ongoing reassessments of the patient. Some of the data collection for initial assessment and reassessments can be delegated to an LVN or Care Partner/CNA, as defined in their job descriptions and proven competency/skills. The RN is responsible for completing the assessment process by observing the patient, analyzing, synthesizing and evaluating the data, formulating the nursing diagnosis or problem statements, identifying nursing interventions and expected outcomes and evaluating the patient's response to treatment.

- b. Clinical Professional Staff Assessments

Clinical Professional Staff (e.g. case manager, home care liaison nurse, social worker, dietitian, respiratory therapist, spiritual care, enterostomal nurse, Occupational Therapy, Speech Therapy, Physical Therapy) assess patients specific to their discipline and treatment that are referred to them. Patient care policies and procedures define when and where interdisciplinary collaboration is appropriate. The RN or LVN may make a referral to dietitian, spiritual care, enterostomal nurse; case manager, social worker or bioethics consults for further assessment without a physician order.

2. Patients are screened during initial assessments.

- a. Emotional/ Behavioral Disorders/ Alcohol or Drug Related Admission. For further information, refer to Management of Patients experiencing psychiatric problems, suicidal, combative, behavior or substance abuse, Policy #B3-22
- b. Dying Patient: for further information refer to Nursing Policy and Procedure for End of Life Care.
- c. Assessment and Identification of Abuse Victims. For more detail refer to Administrative Policy: Abuse and Assault Reporting.

- d. Discharge Planning - patients at risk include: lives alone, psychological diagnosis, homeless, physical barriers at home, abuse/neglect, over 70 years of age, elderly frail spouse, transfer from Board and Care/Home Care, inadequate support system. Referral may be made to case management, or home care liaison nurse. (See administrative policy #B5-2 for discharge planning.)
 - e. Diagnostic/Clinical - patients at risk include: abnormal lab tests, chemotherapy, surgery, significantly altered or abnormal vital signs, etc. Contact physician or follow patient care protocols as appropriate.
 - f. Functional status/safety - patients at risk include: recent fall, elderly, MVA, swallowing problems, arthritis. Discuss referral to physical or occupational therapy with physician.
 - g. Nutrition - patients at risk include: recent weight loss (> 12 pounds in 3 months), thin or cachectic, poor oral intake, change in appetite or eating patterns, special dietary needs, multiple allergies, tube feeding and total parenteral nutrition, problems and skin breakdown. Referral is made to Nutrition Services.
 - h. Surgery - Physical exam and history, pre anesthesia assessment with appropriate reevaluation before induction, post-op orders, admission and discharge criteria to PACU.
3. CARE PLANNING
- a. Based on assessment data, nursing and medical diagnosis, an RN develops a written plan of care specific to the patient that identifies the patient's needs and priorities for care. The plan reflects current standards of patient care practice. All plans are individualized to the patient. LVNs may contribute to the written care plan under RN supervision.
 - b. All health care providers (e.g. social worker, dietitian, respiratory therapist, spiritual care, enterostomal nurse, Occupational Therapist, Speech Therapist, Physical Therapist) also contribute to the patient care plan as needed.
 - c. Any member of the health care team may request or may coordinate a patient care conference when deemed appropriate (Procedure for Patient Care Conference).
 - d. The care plan is available in the patient's chart as a framework for providing patient care. Elements of the care plan include:
 - i. Patient Outcomes (Goals): Whenever possible, patient outcomes are mutually set with the patient and the patient's family or other representative(s). These goals are realistic, measurable and consistent with the medical care plan prescribed by the physician. They include consideration of biophysical, psychosocial, environmental, self-care, educational, cognitive status, and discharge planning aspects. The process to involve the patient and family begins on admission and is on going.

- ii. Patient care goals and interventions include three aspects of care: diagnostic, therapeutic and educational interventions. The RN may utilize patient teaching protocols or develop a teaching section of care plan to educate patient/significant other(s) prior to discharge. (See Administrative Policy regarding Patient and Family Education.) Discharge planning begins upon admission and is incorporated throughout the plan. Development of discharge plans may be delegated to the department's case manager.
 - iii. Responsibility and Documentation: RNs are responsible for developing, reviewing and updating the care plans of their assigned patients as well as patients co-assigned to non-RN staff. Each patient has a care plan initiated within 24 hours of admission by the RN. It is reviewed every shift and updated as needed.
4. Reassessment
 - a. While the initial nursing assessment is total system review, subsequent assessments are problem-oriented, therefore, the assessment data is collected consistent with the medical diagnosis and medical plan for care, the patient's presentation, acuity, patient's desire for care, and the patient's response to care. Ongoing assessments are performed according to department standards.
 - b. In all departments these routine assessments are superseded by protocols, physician order, and/or changes in patient's diagnosis and/or condition. Reassessments by Clinical Professional Staff are based on department standards and as patient condition changes.
 - c. Patients are reassessed when the patient is transferred into a new patient care area according to that department's standards.
 - d. The physician is notified in the event of significant changes in patient condition.
 - e. Long term patients in medical-surgical are weighed once a week unless otherwise ordered by the physician.
 - f. The RN evaluates the patient's response to the care relative to the planned patient outcomes. This evaluation determines the need to revise or continue the plan of care. The method and process of evaluation is defined by protocols, policies and procedures

5. Patient Care Interventions

The RN is accountable to assure the implementation of the patient care interventions. He or she is also responsible for directing the care provided by LVNs, Care Partners, students or other staff. Interventions are derived from procedures, protocols and policies, the medical plan of care, patient care priorities and professional judgment. Patients and their families or significant others are

provided with education, knowledge and skills specific to their health care needs. Patient care is documented by the caregiver providing the care.

6. Documentation:

The initial physical assessment is documented as defined by department standards. The patient care staff member who obtains data (within their scope of practice) documents on the form. Admission database documents non-physical assessment i.e. psychosocial, medical history, learning needs, etc., which are not specifically addressed on the nursing record. The plan of care is initiated within 24 hours of admission and is updated as patient’s needs/treatment changes.

Every shift the RN documents his/her assessment of the patient’s acute problems and responses to treatment plan. The RN’s assessment is based on the RN’s observation of the patient, analysis, synthesis and evaluation of data collected (some of which may be collected by the LVN or care partner within their scope of practice and after demonstrated competency).

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References:		
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