HACKETTSTOWN REGIONAL MEDICAL CENTER
ADMINISTRATIVE POLICIES
ASSESSMENT, REASSESSMENT, AND SCREENING OF PATIENTS

==========

Effective Date: October 2013	**Policy No:** AD015
Cross Referenced:	**Origin:** Nursing Office
Reviewed Date:	**Authority:** Chief Nursing Officer
Revised Date:	**Page: 1 of 13**

==========

SCOPE

Licensed Independent Practitioners (LIP); Registered Nurses (RN); Clinical Nutrition Staff; Inpatient Rehabilitation Therapy; Respiratory Therapy; Case Management; Social Worker; Pharmacy; Pastoral Care.

PURPOSE

To determine appropriate care, treatment and services to meet a patient's initial and changing needs through assessment and reassessment. Decisions regarding patient care are based on analysis of the data obtained by members of the interdisciplinary health care team.

POLICY

Every patient admitted to Hackettstown Regional Medical Center (HRMC) receives an assessment on admission and is reassessed. Reassessment is completed after initial assessment and upon any change in patient condition. The assessment and reassessment is documented in the medical record according to the timeframe outlined in this Policy.

A systematic collection and analysis of patient specific data is performed to identify the patient's relevant physical, cognitive, behavioral, emotional, psychological, social, developmental, educational, cultural, spiritual, and communication needs. The assessment of patients is an interdisciplinary process; the assessment data is used to determine and prioritize the patient's plan of care.

This policy applies to patients in Emergency Department, Critical Care (ICU/CCU), Stepdown Units (PCU), Medical and Surgical Units, Pediatrics, Childbirth Family Center, Operating Room, PACU, Minor Procdures, Wound Care, Ambulatory Care, Same Day Surgery, Interventional Radiology, Radiation Oncology, Infusion Center, Vascular Lab, Health Start Clinic and Dialysis.

PROCEDURE

I. The initial assessment of the patient is completed by a Registered Nurse in all settings where nursing care is provided.

II. Time frames for the completion of initial assessments and reassessments are specific to each care setting/unit or hours of service, and take into account anticipated length of treatment, the complexity of the care needs, and the dynamics of the patient population served.

III. Reassessment by a Registered Nurse is performed on minimum every shift or as the patient condition or setting warrants. See unit specific.

IV. The Licensed Independent Practitioner with appropriate clinical privileges completes the medical history and physical assessment, and patient reassessment as outlined in the Rules and Regulations of the Medical Staff.

V. Patient assessment and reassessment is performed to determine what kind of care is required to meet the needs of the patient initially, as well as their needs as they change in response to care. Qualified individuals assess each patient's care needs beginning with the admitting process and continuing through the discharge.

VI. The disciplines providing patient assessment and reassessment possess specialized knowledge and consider the relevant patient history, biophysical, psychological, social, behavioral, language and communicative abilities, environmental, educational, self-care and discharge planning needs of the patient. Patient assessment and reassessment are performed by the following disciplines:

a. Licensed Independent Practitioners
b. Physical/Speech/Occupational Therapists
c. Registered Nurses
d. Registered Dietitians
e. Respiratory Therapists
f. Pharmacists
g. Case Managers
h. Pastoral Care
i. Social Work

VII. As part of the initial admission, the RN asks screening questions for other disciplines in order to determine if further assessment is needed. The specialties may include, but are not limited to Nutrition, Physical Therapy, Speech Therapy, Occupational Therapy, Respiratory, Pharmacy, Counseling & Addiction, Social Services, and Case Management.

VIII. The patient's/family's cultural, spiritual and religious needs are important factors in response to illness and treatment; they are included in the assessment process.

NURSING INITIAL PATIENT ADMISSION ASSESSMENT

The Admission Assessment & Database is completed by a Registered Nurse within 12 hours of admission, or as the patient's condition warrants. The timeframe for completion depends on the type of patient, the complexity and duration of care, and the dynamics of conditions surrounding the patient's care. For example in the Critical care setting the initial physical examination portion is completed within 30 minutes of arrival to the unit.

II. The scope and intensity of the 'Initial Assessment' is determined by the patient's age, condition, diagnosis, and the care setting. The assessment takes into account the patient's immediate and emerging needs, and considers those identified needs in developing the collaborative plan of care and/or problem list, that is individualized to meet the needs and care goals of the patient and family.

III. Data is collected related to each patient's health history, physical, psychological and

social status.

IV. Assessment Data Collected on Admission
- a. Demographic
- b. Reason for Admission
- c. Religion
- d. Allergies
- e. Advance Directives
- f. Environmental
- g. Current Medications
- h. Language Needs
- i. Communication Needs
- j. Self-Care
- k. Immunization Status
- l. Vaccination Status
- m. Developmental
- n. Spiritual / Cultural
- o. Diagnostic Testing
- p. Physical Exam
- q. Vital Signs
- r. Body Measurements (as needed)

Skin Assessment/Pressure Ulcer Risk Assessment

The patient's skin is assessed on admission by the RN. The Braden Risk Assessment Scale is completed as part of the initial admission assessment. Patients are at risk with a Braden Score < 15. Pressure related alterations over boney prominences or related to medical devices are staged using the National Pressure Ulcer Advisory Panel (NPUAP), Pressure Ulcer Staging System. (Refer to Pressure Ulcer Prevention and Treatment Protocol).

Fall Risk Assessment

All patients are assessed for risk factors associated with potential falls. Appropriate measures are identified to reduce risk and prevent patient falls. The RN utilizes the Morse Fall Risk Assessment Scale on admission to assess each patient's risk for falls (Refer to Fall Prevention Program Policy)

Pain Assessment

Pain is assessed in all patients on admission. A more comprehensive assessment is performed when warranted by the patient's condition and presence of pain. (See PC28 Pain Management Policy)

Functional Status

The RN assesses the functional status of all patients as part of the initial nursing admission assessment. The assessment includes patient mobility and ability to carry out activities of daily living. The RN generates a consultation to the appropriate discipline in the Rehabilitation Department, when one or more problems in the areas of functional mobility, self care, communication, swallowing and/or motor are identified.

Nutritional Screening

Assessment of hydration and patient's nutrition status is based on specific measurable screening criteria and patient triggers. The RN assesses the patient's overall nutritional status as part of the initial nursing admission assessment. Identified nutritional risk factors generate a nutrition consult with the Nutritional Care Service Department.

Patient and Family Education Needs

A learning needs assessment for each patient is performed during the admission assessment, which includes the patient's cultural, spiritual and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, barriers to communication, preferred learning method and preferred language for discussing health care. The teaching for patient/family education is documented in the Medical Record, under patient education. (Refer to Patient Education Policy)

Communication Needs

Identification of the patient's oral and written communication needs, including the preferred language for discussing health care, are identified in the admission assessment. Examples of identified communication needs include the need for personal devices, such as hearing aids or glasses, language interpreter, communication board.

Abuse/Neglect

As part of the initial assessment, it is important for the Registered Nurse to identify if a patient may have been abused, and the extent and circumstances of the abuse in order to give the appropriate care. The RN asks questions to identify abuse/neglect. The LIP may also note related information. (Refer to Abuse and Neglect Policy) If triggers are met a social services consult is requested.

Depression and Suicide Screening

Included in the psychosocial portion of the initial patient history and assessment, the RN asks the patient questions related to depression and suicide risk. The patient's LIP is notified to determine if the need for additional evaluation and intervention may be appropriate. A social services consult is requested by Nursing.

Alcohol or Drug Dependency

The patient's history of alcohol, nicotine and other drug use and treatment are included in the initial assessment. A Counseling & Addiction Center consult may be requested; LIP follow-up when indicated.

Spiritual/Cultural Screening and End of Life Care

Patients are asked about their cultural, spiritual, and religious needs as part of the assessment process and incorporated into the patients plan of care. During the initial admission assessment the RN may recognize that the patient and/or family may require spiritual support. An assessment is made to identify variables that influence the patient's/family's perception and expression of grief. Pastoral Care may be consulted.

Discharge Planning

Discharge planning is initiated on admission and is incorporated in the admission assessment. Potential discharge related needs of the patient and family are identified on admission, in order to provide for continuity of care and appropriate and timely post-discharge care. The patient/family are involved in the discharge planning process as appropriate. Case Management incorporates this information into the case management discharge planning assessment.

NURSING REASSESSMENT

Patients are reassessed by the Registered Nurse every shift or as the patient's condition warrants. Each discipline involved in the patient's care, reassesses the patient based on population and specific needs as stated within this policy. Reassessment occurs at least as follows:

- During and following any invasive procedure
- Following a change in the patient's condition or level of care
- During and following the administration of blood and blood products
- Ongoing reassessment in response to medication, pain and treatment
- Following any adverse drug reaction or allergic reaction
- During and following any use of physical restraints or seclusion
- During and following implementation of interventions to address skin integrity related to pressure, friction, shearing, moisture, incontinence and local treatment
- Ongoing reassessment of educational needs of all patients and families

The Braden Risk Assessment Scale is completed daily, when there are changes in the level of care, and when the patient's physical condition increases the level of skin integrity risk.

The Morse Fall Risk Assessment is completed once every shift, and as the patient condition warrants (following any change in medical status).

The patient is reassessed for pain, relief from pain, and response to treatment at regular intervals. The frequency of pain reassessment is dictated by the intensity of the patient's pain and the effectiveness of pain relief strategies, as specified in the Pain Assessment and Management Policy.

Patient reassessment determines if care decisions are appropriate and effective. Patients are reassessed throughout the care process and at regular intervals. In addition to specified time intervals for reassessment, all patients are reevaluated to determine response to specific treatment, and when a significant change occurs in the patient's condition or diagnosis.

The Interdisciplinary Patient Plan of Care is reviewed regularly in consultation with or from written information provided by other members of the healthcare team and the patient/family; it is revised as appropriate to the patient's condition and the ongoing assessment and reassessment process. (Refer to Interdisciplinary Plan of Care Policy)

UNIT-SPECIFIC NURSING ADMISSION ASSESSMENT AND REASSESSMENT

Emergency Department

The RN performs an initial assessment on all patients admitted to the Emergency Department immediately upon arrival. The initial patient assessment consists of a rapid Triage to determine the level of acuity based on the Emergency Severity Index (ESI) Five-Level Triage System. This includes airway, breathing, circulation and presenting complaint. (Refer to Emergency Department Triage Policy)
The frequency of patient reassessment is determined by the patient's acuity level as determined by the Emergency Severity Index (ESI) Five-Level Triage System, or any changes in condition as stated in the Emergency Department Triage Policy.

Critical Care Units (ICU/CCU and PCU)

The RN begins the initial physical assessment of the patient's needs immediately on admission to the Critical Care Units. A full systems assessment is completed by a RN within 30 minutes of arrival to the unit.
Information is collected on an ongoing basis to reflect the patient's current status and care needs. The RN reassesses the patient at a minimum of every 4 hours. Because of the complex nature of the patient's condition, reassessment may occur more frequently.

Medical/Surgical

The RN begins the initial physical examination of the patient's needs on admission to the unit. The full patient assessment is completed within 12 hours.
Information is collected on an ongoing basis to reflect the patient's current status and care needs. Each patient is reassessed at a minimum of every eight hours by an RN and with any significant change in the patient's condition. The RN completes the patient's post-operative assessment/reassessment, when applicable, upon arrival to the unit.

Pediatric Patients

The RN begins the initial assessment of the patient's needs on admission an assessment is completed within 12 hours. The assessment process for an infant, child or adolescent patient is individualized appropriately to age and needs. The family or guardian's expectations for, and involvement in the patient's assessment, initial treatment and

continuing care is assessed.
The initial patient care assessment includes as appropriate: Developmental age; Height, length and weight; Head circumference of all children under the age of 2 years; Evaluation of emotional, cognitive, communication, educational and social needs; Daily activities; Immunization status.
Information is collected on an ongoing basis to reflect the patient's current status and care needs. Each patient is reassessed at a minimum of every shift by a RN.

Labor and Delivery
The RN performs a complete patient/fetal assessment immediately on admission to the Labor & Delivery Unit. Information is communicated to the LIP for development of a plan of care.
Reassessment of the patient in labor is ongoing to confirm the five (5) components of fetal heart rate and uterine activity and with clinical status changes. A full reassessment is performed every shift.
Routine Intrapartum Surveillance: Reassessment of the patient at least every 30 minutes in the 1st stage of labor, and at least every 15 minutes in the 2nd stage of labor.
Heightened Intrapartum Surveillance: (Loss of moderate fetal heart variability and/or fetal heart accelerations; variable late or prolonged decelerations; at risk antepartum and intrapartum patients). Reassessment occurs at least every 15 minutes in the 1st stage of labor and at least every 5 minutes in the 2nd stage of labor.

Newborn Care
The RN begins an initial assessment immediately on admission. The assessment is completed within 2 hours.
Information is collected on an ongoing basis to reflect the infant's current status and care needs. Each infant is reassessed 2 hours after a bath and at a minimum of every shift (every 12 hours) by the RN and with any significant change.
Temperature stabilization is monitored every 30 minutes until stabilized; then at a minimum of every 4 hours during the first 24 hours of care. Continued monitoring of the temperature is maintained at least every 12 hours.

Operating Room
The RN completes a preoperative assessment during the time the patient is in the Holding Area. This assessment includes a physical assessment of the patient's mental status, limitations, presence of prosthetic devices, evaluation of the operative site, skin condition, known infectious diseases, NPO status, and allergies.
The procedure/location is verified verbally and with the consent form. Other information is obtained from the history and physical on the chart, laboratory or x-ray reports and EKG. The RN verifies that medications have been given and documented, vital signs charted, and the presence of any lines documented, i.e., IV, drains, foley catheter.
The circulating RN in the operating room verifies the allergies, and all members of the OR Team confirm the operative site. Assessments of the skin and tissue integrity are

performed prior to the application/use of any equipment in the operating room, such as tourniquets, electrocautery pads, or warming units.

Anesthesia staff performs an assessment on patients related to anesthesia care. Anesthesia staff continuously monitors the patient in the operating room and during transport to the PACU. The RN reassesses the skin and tissue integrity for the effect of any equipment, i.e., tourniquet site and extremity, electrocautery pad site, or area warmed by the warming unit. Pressure points and bony prominences are also assessed.

Post Anesthesia Care Unit
Immediately upon arrival to the PACU, the RN completes the initial assessment of the patient's condition and needs. (Refer to 'The Standards of PeriAnesthesia Nursing Practice, ASPAN Guidelines')
Information is collected on an ongoing basis to reflect the patient's current status and care needs. Each patient is reassessed according to the Standards of PeriAnesthesia Nursing Practice, ASPAN Guidelines, the patient's surgical procedure, and changing needs.
In the instance of critical events, the reassessment occurs more frequently. A complete discharge assessment is completed prior to transfer to another level of care.

Minor Procedures
Upon arrival of the patient to Endoscopy, the RN completes a patient assessment. The assessment addresses level of consciousness, Aldrete scoring, prep results if applicable, ability to move extremities, skin, pain and abdomen. Confirmation of NPO status is obtained. Vital signs are obtained, including pulse oximetry. The data collected is utilized to plan patient care and implement appropriate interventions.

The RN or Anesthesia Care Provider continuously monitors the patient during the procedure, including vital signs, cardiac monitoring, level of consciousness, and comfort. For procedures performed under Monitored Anesthesia Care (MAC), an Anesthesiologist is present and responsible for monitoring the patient. (Refer to Conscious Sedation/Analgesia Policy)

At the completion of the procedure and prior to transfer, the RN reassesses the patient with Aldrete scoring, skin, abdomen, vital signs, and how the patient tolerated the procedure. Prior to discharge, the RN reassesses the level of consciousness, by mouth (P.O.) status, pain, skin and abdomen. The IV site is monitored for patency, and the total amount of fluids infused is documented.

Wound Care Center
The RN begins an initial assessment of the patient's needs on admission to the Wound Center. The initial assessment is initiated within 1 hour of the patient's arrival.

Information is collected on an ongoing basis to reflect the patient's current status and care needs. Ongoing reassessments occur additionally whenever needed in response to medication, pain, treatment, etc. Each patient is reassessed each week with MD and RN, and with any change in condition by a RN.

Radiation Oncology

The Radiation Oncology Nurse completes an Initial Patient Assessment and History at the Consultation Appointment. At this time the patient is also given Site Specific Education regarding their treatment area along with written self-care instructions. A Learning Needs Assessment is reviewed to address any areas that may impact teaching and learning such as physical disability, cognitive changes, language barriers or any religious/cultural needs. This Assessment also includes a review of pathology dates and reports, pertinent diagnostic scans and reports, and a review of prior radiation therapy and chemotherapy status.

Information is collected on an ongoing basis to reflect the patient's current status and care needs. Ongoing assessments occur weekly by the RN and Radiation Oncologist for patients under active treatment and as needed for any condition changes.

A Discharge Assessment is completed on the last day of radiation treatment and Written Discharge Instructions are given. Patients are seen for a one month post treatment follow-up. Routine follow-ups continue every 3-4 months for the first two years, every 6 months for years 3 through 5 and then yearly.

Counseling and Addiction Center

Assessment:

A licensed clinician/counselor assesses all clients referred to the outpatient program. The Center has admission criteria and provides treatment services for adolescents, ages 13 to 18 years of age and to adults, 18 years and older. The Assessment is an evaluation that includes a complete and comprehensive biopsychosocial and supervised urine drug screen. Clients admitted to the outpatient program must meet the diagnostic DSM IV TR diagnosis of Deferred (799.9), substance abuse or substance dependency.

Reassessment:

The initial treatment plan is developed with the client. The client's progress is reviewed by the client and his/her primary counselor fourteen (14) calendar days after the client's first day in treatment. Both individuals provide input into how the client is progressing and sign the Master Treatment plan Review. Revisions to the Client's Treatment Plan are made as new problems arise necessitating a change during treatment or removing problems listed as goals are achieved or no longer apply. The client's progress is reviewed by the client and primary counselor every twenty eight (28) calendar days and documented on a Master Treatment Plan Review.

Ambulatory Care: Same Day Surgery, Infusion Center, Pain Management

The RN completes a 'Short Stay' initial assessment on all Ambulatory Care patients upon arrival to the specific unit. The patient's present and past health history and physical assessment is completed based upon the patient population, needs, goals, treatment, care, and services provided. (Refer to Short Stay Initial Nursing Assessment Policy)

Information is collected on an ongoing basis to reflect the patient's current status and care needs. Each patient is reassessed by the guidelines specific to the patient's procedure and changing needs. A discharge assessment is completed prior to the patient's discharge.

Interventional Radiology

The Radiology RN performs a patient assessment prior to beginning an Interventional Radiology Procedure. The assessment includes a review of pertinent laboratory data; pregnancy evaluation, as appropriate; level of consciousness; review of medications and past medical history. Vital signs are obtained including pulse oximetry and cardiac rhythm strip. Assessment of pulses, skin color and temperature of the extremity are included as applicable. The data collected is used to plan patient care and implement appropriate interventions. Every patient receives Post Procedure instructions.

The RN monitors the patient continuously during the procedure, including vital signs, cardiac monitoring, level of consciousness, and comfort. The IV site is monitored for patency and the total amount of fluid infused is documented. At the completion of the procedure and prior to transfer, vital signs, and how the patient tolerated the procedure. Pulses, skin color and temperature of the extremity are included when applicable.

INTERDISCIPLINARY PLAN OF CARE

Upon completion of the full Initial Patient Care Assessment the Registered Nurse:

- Confirms information collected by other nursing staff members.
- Reviews the patient's health history to ensure that all information given is accurate and complete.
- Completes patient identification, and collection of valuables and medications for proper handling.
- Analyzes the collected data to produce information about the patient's care needs, and to identify additional information required. Data analyzed include:
  - □ Need for further assessment by other disciplines
  - □ Admission assessment data assessed by the RN
  - □ History and Physical
  - □ Diagnostic Test Results ordered by the Physician
  - □ Consults
- Functions collaboratively with health care professionals from varying disciplines to plan patient care based on the analysis of the findings from the assessment process.

- Initiates the Individualized Plan of Care based on the patient's identified problems or needs from the assessment information.
- The Plan of care is reviewed every shift by a Registered Nurse and updated based on patient reassessments.

OTHER DEPARTMENT-SPECIFIC ASSESSMENTS AND REASSESSMENTS

Rehabilitation Therapy: Physical, Occupational, Speech

Upon receipt of a consultation request, the initial assessment for Physical Therapy and Speech Therapy is completed within 24 to 48 hours; for Occupational Therapy 48 to 72 hours.

All patients being seen by the Rehabilitation Department receive a partial reassessment of their functional level at every therapy visit. The reassessment is outlined in the therapists' documentation, detailing the patient's current level of function and progress. A full reassessment is completed according to the time frame set in the short-term goals.

Nutritional Care Service

The Clinical Dietitian reviews consults received from Nursing, and determine whether the patient requires a complete assessment or a brief intervention or education. Patients are assessed using the clinical practice guidelines. Nutritional assessments are performed based on Level of Care Criteria defined by the Department. All patients for whom a nutrition consult is ordered by a LIP are assessed by a Dietitian within 24-48 hours of receipt of the consult. The Clinical Dietitian reassesses all consulted patients as defined in the Nutritional Care Services established guidelines.

Respiratory Care

The Respiratory Care Practitioner performs an initial patient assessment upon receipt of an order for Respiratory Care. The findings are documented on the Respiratory Care or the Ventilator Flowsheet.

Patients receiving Respiratory Care are reassessed every day or when there is a change in the patient's status. The reassessment is documented in the patient's medical record on the Respiratory Care or Ventilator Flowsheet.

Case Management

Every patient, whether admitted or in the Observation status is assessed for discharge needs. A screen is completed in Cerner documenting the initial assessment, with follow up notes describing the individual patients needs, and their preferences for agencies. The completed plan is documented in the case management consultation notes.

The Case Manager's assessment is an evaluation of the patient's psychosocial care needs as these impact his/her health, and is used as the basis to initiate as appropriate a discharge treatment plan. The Case Manager completes the patient assessment within response time and guidelines established in the Case Management Department. Reassessment occurs as indicated by department guidelines and/or when there are changes in the patient's condition or treatment goals.

Pastoral Care

Pastoral Care may be consulted by any staff member, patient and/or family. Consultations may vary based on cultural, religious and spiritual orientation. Data is documented by Pastoral Care as determined appropriate.

Documentation

Documentation for patient assessment and reassessment is recorded in the following reports:

1. Medical Staff:
   - History & Physical Examination
   - Interdisciplinary Progress Notes
   - Wound Care Physician Progress/Procedure Record
   - Pre/Post Anesthesia Notes
   - Consultation Reports
   - Operative Reports
   - Discharge Summary
2. Nursing Staff:
   - Patient Admission History & Assessment Record
   - Daily Patient Care Record
   - Daily Patient Flow Record
   - Interdisciplinary Progress Notes
   - Interdisciplinary Patient Plan of Care
   - Critical Care 24-Hour Nursing Assessment
   - Interdisciplinary Patient/Family Education Record
   - Short-Stay Patient History and Assessment Record
   - Emergency Department 'Emergisoft' Electronic Medical Record
   - Wound Care Weekly Nursing Reassessment & Treatment Record
3. Other Department Clinical Staff:
   - Interdisciplinary Progress Notes
   - Interdisciplinary Patient Plan of Care
   - Other departmental forms throughout the medical record

REFERENCES:

2010 Hospital Accreditation Standards, The Joint Commission. PC.01.02.01; PC.01.02.03; PC.01.02.05; PC.01.02.07; PC.01.02.08
The Standards of PeriAnesthesia Nursing Practice, Aspan Guidelines, 2008-2010

CROSS REFERENCES:

Rules and Regulations of Medical Staff
Pressure Ulcer Prevention 8620.048b
Fall Prevention Policy PC10
Pain Management Policy PC28

Abuse or Neglect, Suspected Victims of Policy PC03
Emergency Department Triage Policy 7010.000 addendum12
Interdisciplinary Plan of Care Policy PC15
Moderate Sedation Protocol 8620.157b