Appendix E-1

Policy Number 1.17

TITLE: ASSESSMENT AND REASSESSMENT OF PATIENTS

PURPOSE

A. To describe the process by which initial patient assessment and reassessments are dome by members of the healthcare team at San Francisco General Hospital Medical Center.

B. To provide the necessary information to plan, coordinate, delegate and supervise the care of the patient.

STATEMENT OF POLICY

A. It is the policy of San Francisco General Hospital Medical Center (SFGHMC) to assess patients for actual or potential healthcare problems or needs. The assessment is conducted by members of the health care team, through an interdisciplinary and collaborative approach, to ensure continuity of care and compliance with Joint Commission on Accreditation of Health Care Organizations (JCAHO) standards and Title 22 regulations.

B. Each admitted patient's initial assessment is conducted within a timeframe identified by the service. Reassessment occurs throughout the care process and the purposes, key reassessment points and/or time intervals are defined.

C. An assessment is performed by each discipline within its scope of practice, state licensure laws, applicable regulations, or certification.

D. A registered nurse shall assess the patient's need for nursing car in all setting where nursing care is provided based on individual patient requirements and area needs.

E. Care decisions will be based upon data and information gathered in assessments and reassessments. This data will be utilized in prioritizing patient care needs and selecting appropriate interventions.

PROCEDURE

I. NURSING

A. Initial Assessment

1. Assessment will be performed by a Registered Nurse (RN) and include the following:

    a. Physical status (Medication history and allergies)
    b. Psychological status
    c. Social status
    d. Spiritual status
    e. Cultural status
    f. Risk for Injury (fall risk assessment)
    g. Nutritional status screen
    h. Functional screen
    i. Skin assessment
    j. Functional/Environmental needs
    k. Anticipated educational needs and any barriers to learning
    l. Pain
    m. Abuse/Neglect screening

2. Infants, children, and adolescent patient assessments will include:

    a. Emotional, cognitive, communication, educational, social, and daily activity needs
    b. Immunization status
    c. Family's expectations for and involvement in the care and treatment of the patient
    d. Developmental age, height, and weight
    e. Effect of the family or guardian on the patient's condition and the effect of the patient's condition on the family or guardian.

3. Family involvement in the admission process will be encouraged/facilitated by the admitting RN whenever possible.

4. The RN can delegate data gathering aspects of the admission process to Licensed Vocational Nurse (LVNs), Licensed Psychiatric Technicians (LPTs), and Certified Nurse Assistants (CNAs), according to their practice

guidelines, but the RN must analyze the data and formulate a nursing diagnosis and plan of care in collaboration with the patient and other clinical disciplines.

5. The admission assessment will be documented on the Admission Database and integrated into the medical record.

   The scope and intensity of the assessment will be determined by:

   a. Patient's diagnosis
   b. Care setting to which the patient is admitted
   c. Patient's desire for care and interventions
   d. Patient's response to treatments, procedures, and interventions

B. Reassessment

1. The patient will be reassessed:

   a. To determine response to treatment/procedures
   b. When there is a significant change in condition
   c. When there is a change in diagnosis
   d. When there is a change in the level of care
   e. Minimally every shift and at unit specified intervals related to the care setting and course of treatment (see appendix)

2. Documentation of the reassessment will be located on the unit specific nursing flowsheet and/ or progress note.

3. Reassessments are completed by RNs. Data may be collected by the LVN/LPT. Abnormal data obtained by an LVN/LPT will be reviewed and assessed by an RN. Additionally, information for reassessment will be gathered from patients, families, other healthcare professionals and physician input.

INTEGRATION OF ASSESSMENT AND REASSESSMENT

1. Data, gathered from the various clinical disciplines, is integrated into the patient medical record to assure that the patient needs are appropriately identified and service is effectively coordinated.

2. The patient's plan of care is based on the integration of assessments and prioritization of the patient problems identified by members of the healthcare team.

II. **RESPIRATORY CARE SERVICES**

A. INITIAL ASSESSMENT:

Patient assessment occurs at the time any form of therapy or diagnostic procedure is initiated. Initial assessment is performed within 30 minutes of request for service or as soon as possible for stat requests. Criteria for assessment are outlined for each therapy or diagnostic procedure.

B. CRITERIA FOR ASSESSMENT INCLUDE:

1. Diagnosis
2. Medical history
3. Physical assessment: vital signs, appearance, level of consciousness
4. Clinical data: blood gases, spO2, CXR
5. Patient's ability to perform or tolerate ordered therapy or procedure
6. Patient's educational needs: knowledge and understanding of the ordered therapy of procedure
7. Response to prior therapy or procedure

C. REASSESSMENT:

Following any form of therapy or diagnostic procedure, reassessment should occur within 30 minutes. Routine reassessment of patient's receiving continuous oxygen therapy occurs within 24 hours; within 4 hours for patients requiring continuous mechanical ventilation. Frequency of reassessment is based on patient acuity and response to therapeutic interventions. Criteria for reassessment are outlined for each therapy or diagnostic procedure

D. DOCUMENTATION

Assessment and reassessment are documented in different sections of the medical record depending on the patient's location.

Intensive Care Units: CareVue Information System

ED, PACU, 4B, 6H, and Special Procedure Areas: RCS Cardiopulmonary flowsheet.

All other Med/Surg Areas: RCS Therapy Record or Progress Notes Section

III. PHARMACY

A. INITIAL ASSESSMENT

Assessment will be performed by a pharmacist for all patients receiving medications. Patient demographics such as height, weight, body surface, age, allergy information, and laboratory values are used to assist in the assessment.

Chemotherapy orders are assessed by a pharmacist verifying the order with the protocol, laboratory data, patient's weight and ideal body weight.

Clinical drug monitoring programs such as pain management, critical care, nutritional assessment, geriatric, and psychiatric care are performed by clinical pharmacists during rounds with care providers or upon referral. Assessment will be reviewed within one hour of referral.

Assessment and reassessment are documented in the medical record, the chemotherapy admix profile, or in the pharmacy computerized profile.

B. REASSESSMENT

Reassessment by the pharmacists are performed to assure appropriate and safe outcomes to medication use and are ongoing throughout the patient's stay.

IV. SOCIAL SERVICES

A. INITIAL ASSESSMENT

1. Acute Care:

Medical Social Workers screen patients for high-risk criteria. In addition, referrals are made by medical staff, nurses, patients, families, and community services. Documentation will be located in the medical record progress notes.

Intervention will be performed by a Medical Social Worker within 24 hours for patients meeting the following high-risk criteria:

a. Crisis intervention for major trauma
b. Suicide indication or attempt
c. Adoption
d. Abuse

Patients will be seen within 48 hours for moderate risk criteria including:

a. Homeless
b. Over 70 living alone
c. Need for placement at another level
d. Diagnosed catastrophic illness
e. Financial concerns
f. Advanced Directive issues
g. Substance Abuse

2. **Skilled Nursing Facility:**

   All residents are assessed within 5 days of admission. A psychosocial treatment plan is developed, incorporating short and long term goals with the participation of the resident, family, significant other, and members of the interdisciplinary team. Documentation will be located in the medical record progress notes.

3. **Psychiatry:**

   Patients admitted to adult psychiatric units are assessed within 48 hours of admission. Documentation will be located in the psychiatric medical record “Social Work Assessment” notes.

B. REASSESSMENT

1. Reassessment by the Medical Social Worker is ongoing with each session to determine the patient’s response to interventions.

2. Information for reassessment will be gathered from patients, families, other healthcare professionals, and physician input. Reassessment documentation will be located in the progress notes.

V. **REHABILITATION SERVICES**

A. INITIAL ASSESSMENT

A functional screening is completed within 24 hours of admission by nursing. Patients needing further assessment for functional limitations will be assessed by the appropriate discipline in Rehabilitation upon receipt of the physician's order. Information for assessments will be gathered from patients, families, other healthcare professionals and physicians as necessary and appropriate. All assessments will include goals and treatment plans. Documentation will be located in the medical record progress notes.

1. **Physical Therapy**

Initial assessments may include the following:

a. Patient interview
b. Medical record review
c. Evaluation of:

- Balance
- Coordination
- Bed Mobility
- Transfers
- Gait
- Strength
- Range of Motion
- Neurological Status
- Posture

2. **Occupational Therapy**

Initial assessments may include the following:

a. Patient interview
b. Medical Record review
c. Evaluation of

- Activities of Daily Living (ADLs)
- Upper Body Function
- Functional Transfers
- Cognitive-Visual Perceptual Motor Skills
- Range of Motion (ROM)

- Strength
- Coordination
- Neurological Status

3. Speech Therapy

Initial assessments may include the following:

a. Patient interview
b. Medical Record review
c. Evaluation of :

- Dsyphasia
- Dysphagia
- Cognition
- Communication

B. REASSESSMENT

Functional status and needs are reassessed with each treatment to determine the patient's response to interventions. Formal reassessment will be performed every two weeks for inpatients and monthly on an outpatient basis, or when the patient's condition changes unexpectedly, or the patient is transferred to a higher level of care. Documentation will be located in the medical record progress notes. Reassessment will include:

1. Present status of patient
2. Improvements or declines made since last assessment
3. Goals
4. Plans

VI. **NUTRITIONAL SERVICES**

A. INITIAL ASSESSMENT

1. The purpose of the nutritional assessment is to evaluate the patient's nutritional status, develop a plan of nutritional care, and evaluate the efficacy of nutritional support. The need for a nutritional assessment is determined following a nutritional screening process completed by nursing during the initial patient assessment (Food and Nutrition Services Policy CL004).

2. All inpatients are screened within 24 hours of admission and prioritized by nutritional risk level, which triggers a referral to a Registered Dietitian (RD) who will assess patients in a time frame according to highest, high, moderate, or low risk identification.

    a. Highest risk patients are seen within 24 hours (see criteria in Food and Nutrition Policy CL004).
    b. High risk patients are seen within 24 hours of referral.
    c. Moderate risk patients are seen within 48 hours of referral.
    d. Low risk patients are seen within 7 days of admission.

B. REASSESSMENT

1. Patients will be reassessed by the Registered Dietitian:

    a. Highest risk patients every 3 days
    b. High risk every 5 days
    c. Moderate risk patients every 7 days
    d. Low risk patients every 10 days and will be followed by the Dietary Technician
    e. If ordered by a physician
    f. When significant change in the patient's diagnosis/condition occurs
    g. Goals of nutrition therapy are not being achieved

2. The reassessment will document the patient's response to care. At the time of reassessment, the dietitian may determine that the patient is no longer at a certain nutritional risk level. This change of nutritional risk will be documented in the medical record.

3. All patient reassessments are documented in the patient's medical record.

Signed by: Gene O'Connell, Executive Administrator, SFGHMC; J. Renee Navarro MD, SFGHMC, Chief of Medical Staff; Sue Currin RN, MS, Chief Nursing Officer

Date Adopted: 4/20/99
Reviewed:
Revised: 10/99, 01/02, 03/02