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Subject 9.13	General Procedures	06/20/14 - Reviewed w/ changes - Reviewed w/o changes
Policy 9.13.9	**Interdisciplinary Admission Assessment and Reassessment**	06/20/14 - Effective UTMB Health System - Author

Interdisciplinary Admission Assessment and Reassessment

Definitions

***Licensed Independent Practioner (LIP)*:** Any individual permitted by law and UTMB to provide care and services without direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

Policy

The assessment of patients is an interdisciplinary process. Assessment data is documented in a common location and shared among disciplines to enhance the continuity of care and decrease duplication of data collection.

Patients will receive care based on a documented assessment of their needs and current state. Assessment data is used to determine and prioritize the patient's need for a plan of care as addressed in IHOP Policy 9.13.8 Interdisciplinary Plan of Care.

Data received from the patient and the patient's family is included in the assessment.

Nursing

All nursing assessments will be completed by a Registered Nurse (RN) licensed by the Texas Board of Nursing. The RN may delegate subjective and objective data collection to another licensed nurse or unlicensed nursing personnel as appropriate based on their credentials and training. Delegation of data collection must be in accordance with the Texas Nursing Practice Act and the Texas Board of Nursing Rules and Regulations for the delegation of tasks to unlicensed personnel.

An RN will complete the Nursing Admission Assessment within 24 hours of admission for all patients admitted to UTMB hospital, including patients hospitalized for observation.

Nursing admission assessment based on age, condition, diagnosis and care setting will include at a minimum:

1. Vital signs
2. Allergies
3. Physical exam
4. Spiritual/Cultural Screen
5. Pain Screen
6. Abuse/neglect/assault screen

Nursing, continued

7. Functional screen
8. Nutritional Screen
9. Advance Directives/Guardianship
10. Braden Scale
11. Fall Risk Assessment
12. Sensory/Communication Screen
13. Discharge Planning Screen

Additionally, developmental, age-appropriate and patient population specific assessments will be completed as indicated.

Attempts to obtain data that cannot be obtained or assessed at the time of the initial assessment should be continued until obtained or the patient is discharged.

Admission assessments for patients admitted to the Newborn Nurseries and ISCU will be documented on the *Neonatal Nurseries Admission Flow Sheet*. For newborn infants transferred from other facilities, a Neonatal Transport Note must be filed in the medical record.

Each patient's health care learning needs, readiness to learn, and barriers to learning will also be assessed upon admission and documented.

An RN will assess each patient's care needs before delegating appropriate aspects of the patient's nursing care, and patients will be **reassessed** by an RN at least every shift to document changes in the patient's condition and/or diagnosis, and to determine the patient's response to intervention. Nursing reassessment of a patient will reflect at a minimum a review of patient-specific data, pertinent changes, and response to interventions. More frequent reassessments will be completed as appropriate for the patient population and/or individual patient need. Nursing reassessment will be documented on the appropriate unit flow sheet or on the nursing progress records.

Licensed Independent Practitioner (LIP)

A complete history and physical (H&P) examination shall, in all cases, be completed by a LIP and placed in the record within twenty-four (24) hours after admission. If a complete H&P has been obtained within 30 days prior to admission (in the office of an LIP on campus, or in an

Licensed Independent Practitioner (L.I.P) (continued)

on-campus private or staff clinic) a durable, legible copy of this report may be used in the patient's hospital medical record, provided there is documentation in the medical record of any subsequent changes in the patient's condition, or documentation that there have been no changes in the patient's condition.

This history and physical H&P examination includes at a minimum the patient's chief complaint, present illness/injury, review of systems, past history, family history and physical examination. The patient's biophysical, psychosocial, cultural, spiritual, developmental, educational, functional, nutritional, and pain/comfort needs will be addressed as appropriate.

All inpatients are **reassessed** by an LIP daily for changes in patient condition and/or diagnosis, and to determine the patient's response to interventions. LIP reassessment of a patient will reflect at a minimum a review of patient-specific data, pertinent changes, and response to interventions. More frequent reassessments will be completed as appropriate for patient population and/or individual patient need. Refer to *Rules and Regulations of the Medical Staff* and to division and departmental policies and procedures for more detailed information.

Perioperative Assessment

Day Surgery Nursing Admission Assessments will be completed by an RN on day surgery patients prior to surgery. Data collection may begin at the pre-op visit but must be reviewed and confirmed on the day of surgery. Information collected more than 30 days prior to admission must be re-collected

Before surgery, the patient's H&P is completed and recorded in the medical record. If a complete H&P has been obtained within 30 days prior to admission in a physician staff member's office or in a private or staff clinic, a durable legible copy of this report may be used, provided that on the day of the surgery, an update is documented including:

- Examination of the patient; and
- Any subsequent changes in the patient's condition, or documentation that there have been no changes in the patient's condition.

If the H&P was completed more than 30 days prior to the surgery date, a new H&P must be completed. The H&P will be on the medical record before the time of the operation.

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Perioperative Assessment, continued

A pre-anesthesia assessment is completed and documented on all patients for whom anesthesia is contemplated. This information may be collected by an anesthesia resident or Certified Registered Nurse Anesthetist (CRNA) under the direction of a faculty Anesthesiologist. For cases where deep sedation is contemplated, the preanesthesia evaluation may be conducted by an LIP with deep sedation privileges.

The preanesthesia evaluation must be completed and documented within 48 hours immediately prior to surgery or a procedure requiring anesthesia services. Some of the elements contributing to a preanesthesia evaluation may be performed prior to the 48 hour time frame, but no more than 30 days prior to surgery or a procedure requiring anesthesia services. Review of these elements must be conducted and documented immediately prior to deep sedation or anesthesia.

Patients are reevaluated immediately before the induction of anesthesia by a provider qualified to administer anesthesia. This information must also be documented.

Perioperative Nursing Assessment is completed by the circulating Registered Nurse and documented on the *Perioperative Assessment Form* in the Electronic Health Record (EHR).

The postoperative status of the patient is assessed by the anesthesia provider on admission to the Post Anesthesia Care Unit (PACU), during the patient's PACU stay if indicated, and upon the patient's discharge from the PACU. A post-anesthesia evaluation must be performed and documented by someone qualified to administer anesthesia, and should not begin until the patient is sufficiently recovered from the acute administration of anesthesia so as to participate in the evaluation. Although the evaluation should begin in the designated recovery area, it may be completed after the patient has moved to another location. This post-anesthesia evaluation must be completed within 48 hours. For those patients who are unable to participate in the post anesthesia evaluation, an evaluation should be completed and documented within 48 hours with a notation that the patient was unable to participate along with the reasons why. For those patients whose regional anesthetic effects are expected to continue beyond the 48 hour time frame, a post- anesthesia evaluation must be

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Perioperative Assessment, continued

completed within 48 hours, with notation that full recovery has not occurred and is not expected within the stipulated timeframe but that the patient was otherwise able to participate in the evaluation.

For deep sedation cases, the post-anesthesia note may be documented by an LIP with deep sedation privileges. A post-anesthesia note is not required for moderate sedation cases.

The PACU RN documents the nursing assessment on the PACU nursing record. A nursing assessment is performed on admission and discharge to the PACU and as indicated.

Care Management

A Care Management assessment is an evaluation of the patient's social functional care needs as these impact his/her health, and is used as the basis to initiate appropriate discharge planning. The Care Manager or Social Worker will complete a Social Functional Assessment for assigned patients. The assessment should be completed within 48 hours or as soon as possible.

The reassessment will occur as indicated and/or when there are changes in the patient's condition or treatment goals and during the discharge process.

Care Management assessments are also completed upon consultation from any member of the health care team and when needs are identified by the care manager from case findings or rounds.

Nutrition Services

Nutrition screening is the process of using criteria pre-established by registered dietitians to identify patients at nutritional risk. A nutrition screening is conducted on all inpatients as part of the Admission Assessment. Nutrition screenings will be completed by an RN.

Nutrition assessment is the comprehensive analysis of nutritional risk factors to determine the severity of risk/potential risk as well as to initiate appropriate treatment and intervention to maintain or improve nutritional status. Nutrition assessment is performed by dietitians who are registered/registry-eligible by the Commission on Dietetic Registration of The American Dietetic Association and are licensed/licensure-eligible by the Texas State Board of Examiners of Dietitians.

The collection of data to be used in a nutrition assessment may be performed by a variety of members of the health care team including

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Nutrition Services, continued

dietetic technicians.

Renal patients will be assessed by renal dietitians who meet the qualifications established by the Texas Department of Health.

Completion of nutrition assessments will be prioritized based on severity of risk factors. The assessment will be documented in the consult or in the progress notes section.

Reassessment will occur at intervals established in standards of care and unit/service policies as well as when results of routine monitoring indicate changes in condition or treatment goals. Reassessment will be documented in the progress notes.

Physical Therapy

Physical Therapy assessments are initiated by a qualified healthcare practitioner's referral. This includes physicians, dentists, chiropractors, podiatrists, physician assistants and advanced nurse practitioners. The assessments are performed by a physical therapist who is licensed to practice in Texas. Assessments are based on referral, patient diagnosis, and clinical presentation.

Reassessments will occur informally with each patient interaction, and formally if the patient has a significant change in status, the patient undergoes a surgical procedure, a new problem is identified, and/or prior to discharge.

Occupational Therapy Assessment

Occupational Therapy assessments are initiated by a physician's referral, and may be performed by an occupational therapist who is licensed to practice in Texas.

Reassessment will occur informally with each patient interaction, and formally if the patient has a significant change in status, the patient undergoes a surgical procedure, a new problem is identified, and/or prior to discharge.

Speech Pathology Services

Speech Pathology assessments are initiated by physician order.

All assessments for communication and/or swallowing deficits are performed by speech-language pathologists licensed to practice in Texas.

Reassessments are performed and documented in the patient progress

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Speech Pathology Services, continued

notes if a significant change in status occurs, when a new problem is identified, and/or prior to discharge.

Audiology Services

Audiological assessments are initiated by physician order.

Formal audiological assessments are performed by audiologists licensed to practice in Texas.

At the Angleton Danbury campus neonatal hearing screens are performed by nurses.

Reassessments are performed and documented in the patient progress notes if a significant change in status occurs, when a new problem is identified, and/or prior to discharge.

Respiratory Care Service

Formal assessments are performed by respiratory care practitioners licensed to practice in Texas.

The initial assessment will be performed at the first encounter with the patient and prior to the initiation of therapy by a Respiratory Therapist (RT).

Reassessments will be performed with each scheduled treatment, and must reflect a minimum review of the patient current orders, pertinent changes, patient-specific data, and response to treatments. RT assessment/reassessment will be documented on the appropriate unit flow sheet or on the RT flowsheet.

Pastoral Care Services

Spiritual screening is conducted by an RN upon admission as part of the initial nursing admission assessment.

Pastoral Care may also be consulted upon request and contacted directly by the patient, the patient's family, or staff.

Assessments may vary slightly based on religious/spiritual orientation.

Assessment data will be documented in the chaplain's discretion.

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Pharmacy

A Pharmacy assessment will occur informally with each patient interaction, and formally when requested by a healthcare team member. Assessments will include a review of patient-specific data, pertinent clinical changes, and response to the initial intervention.