Name of Policy:	**Assessment/Reassessment**
Policy Number:	3364-110-07-06
Department:	Nursing Service
Approving Officer:	**Interim Chief Nursing Officer (CNO)**
Responsible Agent:	**Interim Chief Nursing Officer (CNO)**
Scope:	The University of Toledo Medical Center (UTMC)

THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Effective Date: 6.1.21
Initial Effective Date: June, 1981

_____ New policy proposal
_____ Major revision of existing policy
_____ Minor/technical revision of existing policy
__X__ Reaffirmation of existing policy

(A) Policy Statement

Admission data with history will be completed by a Registered Nurse (RN) on all new admissions within 24 hours. The RN will report assessment and screening data as appropriate to other members of the health care team.

(B) Purpose of Policy

To collect physical, psychological, and social status information regarding the patient and the family so that problems may be identified when planning care.

(C) Procedure

1. A nursing admission assessment will be completed on all new admissions within 24 hours. There should be an indication of the source of information if it is someone other than the patient.

2. Unscheduled and emergency admission patients will be immediately assessed and evaluated upon arrival in a nursing unit. If a patient exhibits any signs of distress, the physician will be called immediately. Distress includes, but is not limited to, the following: abnormal vital signs, abnormal skin color, decreasing level of consciousness, respiratory difficulty, uncontrolled bleeding, excessive edema, excessive bladder or abnormal distention, uncontrolled pain, nausea/vomiting causing discomfort, severe anxiety, and danger to self or others.

3. Observation status patients are considered outpatients and do not require a complete in-depth admission assessment; screening should be completed which includes pain, discharge planning needs, nutritional needs, function needs and abuse screen. These patients should however be observed/assessed frequently with emphasis on the reasons for their stay (presenting signs, symptoms, etc.).

4. All inpatients will have the following admission screens completed, and action taken as indicated, within 24 hours of admission.
   a. Pain - patient found to have "pain" will have the entire assessment completed by the RN.
   b. Discharge Planning Needs — patients found to have complex or special discharge planning needs will be referred to the Care Coordination Staff.
   c. Nutritional Needs — the dietitian will be notified of any patient found to be at risk for nutritional concerns.
   d. Functional Needs — this screening will be documented in the medical record and used by the physician to determine need for referral to Rehabilitation Services for an in-depth assessment.
   e. Victims of alleged or suspected abuse will be assessed using criteria established in hospital policies *(3364-100-45-14; 3364-100-45-16)*. Action will be taken as identified in same policies.

5. The assessment of infants, children and adolescent patients is individualized to the patient's age and needs.

6. End of life/dying patients will be assessed for social, spiritual, and cultural needs.

7. The scope and intensity of any further assessment will be based on the patient's diagnosis, the care setting, the patient's desire for care, and the patient's response to any previous care.

8. Aspects of data collection for the assessment may be delegated to qualified nursing staff members who, based upon their education and hospital/unit orientations, are able to assist with data collection

9. The responsibility of the RN includes review and analysis of the assessment data, establishing nursing care planning goals based on individualized assessment findings, implementation of the plan of care, and the initiation of the discharge plan.

10. The RN integrates, prioritizes, and coordinates the implementation of the patient's care with the physician, other disciplines, and patients and their families based upon assessment findings

11. Reassessment is an ongoing process. Each patient is reassessed at regular intervals and as needed.
    a. The frequency of the reassessment shall be based upon the RN's judgment, MD order and/or the patient status.
    b. All reassessments will be at minimum every 12 hours in med-surg and stepdown settings and at least every 8 hours in a critical care setting. Focused assessments should be completed as needed.
    c. Reassessment data is used to determine a patient's response to care.
    d. Significant change in patient status or diagnosis will result in reassessment.

12. Included in the assessment process is the responsibility for overseeing or conducting the patient teaching and implementation of patient education to assist patients with their needs. Each patient will have learning needs, abilities, preferences, and readiness to learn assessed. The nature and complexity of the patient's learning needs as they relate to infection control and safety, age, and cultural needs are considered.

13. Prior to discharge, continuing patient care needs are assessed and documented, and appropriate referrals are made to meet the identified needs, using the community and patient's available resources.

Approved by: /s/ Todd Stec, RN Interim Chief Nursing Officer *Review: Policy & Standard Committee 8/2010, 9/13, 5/15, 6/18, 6/21* *Revision Completed By:* *Nancy Gauger, MSN, RN* Date	**Review/Revision Date:** 1982 3/1993 5/2005 1983 6/1996 7/24/2008 5/1984 9/1998 8/31/2010 1985 9/1999 9/10/13 1986 1/2000 5.22.15 1987 5/2001 6/2018 1988 12/2001 6/2021 1989 1/2002 1990 8/2002 **Next Review Date:** 6/2024
Policies Superseded by This Policy: 7-06	