

<b>Name of Policy:</b> <u>Assessment/Reassessment</u> <b>Policy Number:</b> 3364-100-45-18 <b>Department:</b> Hospital Administration <b>Approving Officer:</b> Chief Executive Officer – UTMC Chief of Staff <b>Responsible Agent:</b> Chief Nursing Officer <b>Scope:</b> The University of Toledo Medical Center and its Medical Staff	  <b>Effective Date:</b> 4/1/2024 <b>Initial Effective Date:</b> 7/14/1999
<input type="checkbox"/> New policy proposal <input type="checkbox"/> Major revision of existing policy	
<input type="checkbox"/> Minor/technical revision of existing policy <input checked="" type="checkbox"/> Reaffirmation of existing policy	

**(A) Policy Statement**

Each patient's physical, psychological, and psychosocial status are assessed upon admission, in addition to their learning and discharge planning needs. The scope and intensity of assessments are based on the patient's diagnosis, care required, and the patient's desire for and response to previous care. Reassessments are completed at regular intervals determined by patient response and significant changes in condition or diagnosis.

**(B) Purpose of Policy**

To determine the care required to meet a patient's initial needs, as well as continued needs, as the patient responds to care delivered.

**(C) Procedure**

Inpatient

1. A physician's history and physical examination shall be completed within 24 hours after admission. This history and physical includes the following:
  - ◆ Chief complaint and details of present illness
  - ◆ Past medical history, social history, and family history
  - ◆ Review of systems
  - ◆ Physical examination findings
  - ◆ Problem list (or differential diagnosis)
  - ◆ A plan of care
2. If a complete history and physical has been recorded and a physical examination performed within 30 days prior to patient's admission to the hospital or the date of the invasive procedure, a reasonably updated, legible, and signed copy of these reports may be used in the patient's medical record, provided these reports were recorded by a member of the Medical Staff. For hospitalized patients, daily progress notes will qualify as an updated examination. The physician, or other individual qualified to perform the H&P, must write and sign an update note addressing the patient's current status within 24 hours of the admission and prior to the invasive procedure.
3. All inpatient dental patients' records will contain a physical examination report by the dentist and a physical examination report by the attending physician. All inpatient podiatry patients' records will contain a physical examination report by the podiatrist and a physical examination report by the attending physician.
4. A Registered Nurse (RN) assesses the patient's needs for nursing care on admission to any area/department in which nursing care is provided and the nursing assessment will be completed within 24 hours of admission.
5. Aspects of the data collection may be delegated to qualified nursing staff members, and based upon their education and competency level, are able to assist with data collection.
6. All inpatients will be screened for nutritional needs within 24 hours of admission by the RN. Screening criteria developed and approved by Clinical Dietitians will be used. The RN will notify the clinical dietitian of any inpatient found to be at risk.

- ◆ All patients determined to be at nutritional risk will be assessed by a clinical dietician within 48 hours of receipt of nursing referral.
  - ◆ Reassessment of the nutritional plan is completed by the clinical dietician at least every seven days.
7. All patients admitted will be screened for possible functional rehabilitation needs within 24 hours of admission by the RN. Screening criteria developed and approved by rehabilitation staff will be used. The Rehabilitation department will contact the physician for orders for Rehabilitation Services as appropriate. These patients will be evaluated by a rehabilitation specialist within 24 hours of receipt of physician referral.
  8. All patients admitted will have their discharge planning needs initially assessed at the time the RN completes the nursing care assessment. Patients with identified complex special discharge planning needs will be seen by a member of the care coordination staff within 48 hours of receipt of referral.
  9. For a child or adolescent, the following are assessed and documented as appropriate to the patient's age and needs:
    - ◆ Emotional, cognitive, communication, educational, social, and daily activity needs
    - ◆ The patient's developmental age, length or height, head circumference, and weight
    - ◆ The effect of the family or guardian on the patient's condition and the effect of the patient's condition on the family or guardian
    - ◆ The patient's immunization status
    - ◆ The family or guardian's expectations for and involvement in the patient's assessment, initial treatment, and continuing care.
  10. Patients who are possible victims of alleged or suspected abuse or neglect will be assessed using criteria established in hospital policies (3364-100-45-14 and 3364-100-45-16). When appropriate, actions will be taken as identified in same policies. Patients who are suspected victims of domestic violence will be screened and assessed in accordance with hospital policy 3364-100-45-21. Appropriate actions will be taken as identified in this policy.
  11. Nursing reassessment is an ongoing process. Each patient is reassessed at regular intervals; the frequency of the reassessment shall be based upon the RN's judgment, physician order, and/or patient status.

#### Behavior and Mental Health Services

1. The content of the assessment and reassessment of patients receiving treatment for mental and behavioral disorders includes at least the following elements:
  - ◆ A history of mental, emotional, behavioral, and substance use problems, their co-occurrence, and treatment
  - ◆ Current mental, emotional and behavioral functioning including a mental status examination
  - ◆ Maladaptive or problem behaviors
  - ◆ A psychosocial assessment.
2. Additional assessments are conducted when appropriate.

#### Emergency Department

1. A licensed independent practitioner with appropriate clinical privileges determines the scope of assessment and care for patients in need of emergency care.
2. Each patient presenting to the ED will be bypassed to a treatment room or triaged by an RN within 15 minutes of arrival to the ED.
3. An RN will reassess each patient at regular intervals; the frequency of the reassessment shall be based upon the RN's judgment, physician order, and/or patient status.

#### Operative and Other Procedures

1. Operative and other procedures, whether being done on an inpatient or outpatient basis, may only be performed after an assessment of the patient by a physician has been completed, to determine if the patient is an appropriate candidate for the procedure. This assessment includes:
  - ◆ History & physical examination
  - ◆ Review of results of diagnostic tests, as indicated (if undergoing an operative procedure)
  - ◆ A pre-operative diagnosis completed and recorded in medical record.

2. In cases of emergency procedures, the above requirements may be suspended.
3. Any patient for whom anesthesia is contemplated receives a pre-anesthesia assessment. This assessment consists of two parts including:
  - ◆ Before anesthesia, the patient is determined to be an appropriate candidate for the planned anesthesia
  - ◆ The patient is re-evaluated immediately before anesthesia
4. The patient's postoperative status is assessed on admission to and discharge from the post-anesthesia care area.

#### Diagnostic Services

1. Radiologic diagnostic testing necessary for determining the patient's health care needs is performed upon the written or electronic request of a physician order. All requests shall contain a reason for the examination as well as any relevant clinical information related to the test being performed. All tests will be clinically interpreted with a dictated report within 24 hours of completion of exam.

#### Ambulatory Services

1. All new patients are assessed by the physician or appropriate licensed independent practitioner.
2. The patient's summary list is completed by the patient's third visit and updated on each subsequent visit.
3. The patient is reassessed on each subsequent physician visit.

#### Respiratory Care

1. Respiratory care assessments are performed upon physician's order for respiratory care services and are based on American Association of Respiratory Care Clinical Practice Guidelines, within 24 hours of initiation of therapy.
2. Other respiratory assessments are performed per request of physician or nurse for any patient regardless of whether or not receiving respiratory care services.
3. Reassessment of patients will be performed per the triage guidelines identified in Respiratory Care policy, with the start of therapy.

#### Spiritual Care

1. Chaplains will make an assessment of a patient's family's spiritual, religious, or emotional needs upon request by the patient/family or members of the health care team.

#### Rehabilitation Therapy Services

1. Each professional discipline will initiate an assessment upon receipt of a physician's order (when required, i.e., no physician's order required for social work, therapeutic recreation). The assessment will determine each person's impairments, activity limitations, and participation restrictions. Assessments will be completed within the scope of practice as defined by national and state practice acts. The assessment will be used to develop a treatment plan in collaboration with the person served to meet their rehabilitation needs.

#### Additional Assessments/Reassessments

1. Policies within clinical departments further delineate the responsibilities of members of the health care team in assessment/reassessment of patient care needs.
2. Medical Staff Bylaws further delineate physician responsibilities for assessment/reassessment.

<p><b>Approved by:</b></p> <p><u>/s/</u> <u>03/27/2024</u> Richard Swaine Chief Executive Officer - UTMC Date</p> <p><u>/s/</u> <u>03/27/2024</u> Puneet Sindhwani, MD Chief of Staff Date</p> <p><i>Review/Revision Completed By:</i> Nursing Administration Chief of Staff Operating Room</p>	<p><b>Review/Revision Date:</b> 3/13/02 4/29/05 4/23/2008 6/11/2011 6/1/2014 6/1/2017 5/1/2020 5/1/2021 4/1/2024</p> <p><b>Next Review Date:</b> 4/1/2027</p>
<p><b>Policies Superseded by This Policy:</b> 7-45-18</p>	