

Assessment of Patients I

1. Question:—Ask Patient

Answer:

Describe your involvement in planning your care.

Patient should describe that the plan of care was discussed with them; that they are working to improve health status by..., etc.

2. Question:

Answer:

What is your discipline's scope of assessment? Is it defined in writing?

Staff should verbalize what assessments they perform and locate a policy that reflects this.

Social Services

3. Question:

Answer:

When do you request a social service/case management consult on patients?

Refer to Hospital Social Service Policy 5.38. All patients are screened for Social Service Risk factors (discharge planning, abuse/neglect, etc.) within 8 hours of admit. Those meeting high-risk criteria are referred to social services for a more in-depth assessment. These patients receive in-depth social services assessment within 48 hours of admit, if deemed necessary by the administrative house manager. An administrative house manager is available for emergency consults after hours, weekends & holidays.

4. Question:

Answer:

What are high-risk criteria that would indicate a referral to Speech-Language Pathology is required?

Education related to speech – language disorder
Swallowing evaluation – (Bedside and Videofluoroscopy)
Head and neck cancer preoperative counseling.
Voice restoration following total laryngectomy
Fitting voice prostheses
Stroke evaluation/rehabilitation

Traumatic brain injury / Closed head injury
evaluation /Rehabilitation
Other concerns within the scope of practice of
Speech-Language Pathology
The physician must order the consult.
Refer to Hospital Speech-Language Pathology
Services Policy 5.36.

5. Question:

What are high-risk criteria that would indicate
a referral to Audiology Services is required?

Answer:

Decreased hearing
Decreased speech understanding
Failed hearing screening
Tinnitus
MD must order consult. Refer to Hospital
Audiology Services Policy 5.28.

6. Question:

- a) Which waived/point of care tests do you
perform on this unit?
- b) How were you trained/retrained to perform
these tests?
- c) Where are policies/procedures located?
- d) Explain the quality control you perform for
each test. Show me your quality control
logs.

Answer:

- a) Answer may include urine ketodiastix,
urine ketostix, urine dipstick, blood glucose,
clinitest, fecal hemocults, gastric ph,
gastrocults, Strep A screens, or urine
pregnancy tests. Other point of care tests
may include hemachron (ACT) or I-stat.
- b) Oriented and annual reassessment of
competence.
- c) Polices/procedures should be available for
all tests performed.
- d) Staff should explain quality control and
show logs. I-stat, ACT and blood glucose
do not have manual logs – the logs are
automated and maintained in the Point of
Care Office.

7. Question:

How would you identify possible victims of
abuse/neglect?

Answer:

- Discrepancies between history and/or
injury
- Physical Abuse
- Inconsistencies in the history in

conjunction with the criteria listed

- unusual or unexplained bruising
- head injuries, especially in infants
- retinal hemorrhages infants/children
- fractures
- burns
- repeated injuries
- Sexual Abuse
 - genital injuries
 - unexplained loss of developmental milestones
 - repeated UTI unrelated to other causes
 - depression
 - STD's in child
 - pregnancy in the very young
 - sexual knowledge that exceeds the level of maturity
- Neglect
 - poor hygiene and/or lack of appropriate clothing
 - lack of heat/running water
 - undernourished
 - malnourished/dehydrated
 - over/under medicated
 - lack of immunization
 - failure to thrive
 - lack of medical care
- Emotional
 - withdrawn
 - suicidal
 - excessively aggressive
 - conduct disorder
 - inappropriate parent/child interaction
 - depression
 - Domestic violence - Refer to criteria listed above as appropriate to the situation.

Refer to Hospital Abuse/Neglect Policy 5.5

8. Question:

What should you do if you suspect abuse/neglect?

Answer:

Document findings. Notify MD. Report as mandated by law to appropriate authorities and LSUHSC Social Service Department.

Refer to Hospital Abuse/Neglect Policy 5.5.

9. Question:

What would you do if you identified a patient with possible drug/alcohol dependence?

Answer:

Document findings. Notify MD and Case Management. Case Management will inform patient of local agencies/treatment programs and assist patients to contact agencies if they so desire. Refer to Hospital Substance Abuse Policy 5.29. Note: LSUHSC has no identified treatment program for substance abuse.

10. Question:

What would you base the scope of intensity of further assessment on?

Answer:

The patient's condition/diagnosis, the care setting, the patient's desire for care, the patient's response to previous care, and the patient's consent for treatment.

11. Question:

a) What special assessments and interventions are made for terminal patients?

Answer:

a) Social, spiritual, and cultural factors that influence the perceptions and expressions of grief by the patient, family, and significant others. To the extent possible, as appropriate to the patient's and family's needs and the hospital's services, interventions address: patient and family comfort, dignity, and psychosocial, emotional, and spiritual needs about death and grief.

b) Who would you consult if needs were identified?

b) Pastoral Services or Social Services, Case Manager, Pain Services, or others as needed.

12. Question:

What special assessments are required prior to moderate (conscious) sedation?

Answer:

- assessment of mental status
- examination specific to the procedure and any co-morbid conditions
- examination of the heart and lungs by auscultation

- airway evaluation
 - allergies
 - family history of anesthesia/sedation problems
 - medication history
 - abnormal lab results
 - pain level and assessment
 - evaluation of blood/blood component requirements, as applicable
- Refer to Medical Records Content/Documentation Policy #6.5. and Moderate (Conscious) Sedation Policy 5.26.

Advanced Practice RN/Physician Assistant

13. Question:

What is your discipline's scope of assessment?

Answer:

The assessment includes, but is not limited to, performing an initial/ongoing patient assessment to determine need for medical attention, obtaining patient histories, performing exams and requesting and interpreting laboratory/diagnostic studies. In addition, the Advanced Practice RN/Physician Assistant identifies normal and abnormal findings, monitors the effectiveness of therapeutic interventions, and takes actions within their scope of practice.

Refer to Hospital Patient Assessment Policy 5.9.

14. Question:

What is the role of the staff physician in patient assessment?

Answer:

A duly licensed and credentialed staff physician will either perform or supervise the performance of a patient assessment as outlined in the Medical Staff Bylaws, Rules and Regulation Section on Health Information Management and the Hospital Patient Assessment Policy #5.9.

15. Question:

What is the content of the History and Physical for outpatient surgery patients?

Answer:

The history and physical information for outpatient surgery may be completed by a qualified physician or oral surgeon, but the individual performing the procedure MUST document (at minimum):

An evaluation note regarding the patient's overall condition and information regarding the operative/procedure site.

The history and physical must be completed within 30 days prior to the procedure unless an unstable medical condition exists. If the patient is medically unstable, the history and physical examination must be completed within 72 hours of the procedure.

The outpatient history must include the following for outpatient surgery:

Indications/symptoms for surgical procedure;

Current medications (dosages/frequency)

Any known allergies, including medication reactions, latex

Existing co-morbid conditions, if any.

The extent to which the patient's physical status must be documented is to be reflective of the type of anesthesia planned and/or given, according to the following:

No Anesthesia or Local/Topical or Regional Block:

Assessment of mental status; and an examination specific to the procedure proposed to be performed and any co-morbid conditions.

Moderate Sedation:

Assessment of mental status; and an examination specific to the procedure proposed to be performed and any co-morbid conditions.

Examination of heart and of lungs by auscultation.

Allergies

Family History of Anesthesia problems

Medication History

Abnormal lab results

General, Spinal or Epidural Anesthesia:

Complete Physical Examination

Refer to Sections 1.B & 2.B for Pediatric & Adolescent requirements.

Note: Anesthesia combinations require a physical relevant to the highest level of anesthesia provided.

In addition, these assessments are required for Pediatric/adolescent records

- Evaluation of patient's developmental age
- Immunization status
- Family/guardian's expectation for and involvement in, the assessment, treatment and continuous care of the patient
- Length/weight within the past 7 days
- As appropriate to the pediatric/adolescent patient's age and needs
- Consideration of education needs and daily activities
- Head circumference until fontanelles close as appropriate to patient's age and needs.

Refer to Hospital Medical Records Content/Documentation Policy #6.5.

16. Question:

What is the content of the history and physical for emergency surgery patients?

Answer:

Refer to Hospital Medical Records Content/Documentation Policy 6.5.
A preoperative note
Preoperative diagnosis
Indicated diagnostic tests

17. Question:

a) What does the preanesthesia assessment consist of?

Answer:

Refer to Hospital Anesthesia Care Policy 5.9.2.
a)-Preanesthesia Evaluation Record
-Data gathered through patient interview
-Pertinent physical examination
-Review of diagnostic data
-History of previous anesthetics (including adverse family history)
-Drug allergies
-Medications
-Tobacco, drug and alcohol usage

- Dental or airway anomalies
- Presence of intercurrent disease processes capable of affecting anesthesia
- Physician's recommendations regarding anesthesia and premedication, ASA risk classification, and an anesthetic plan
- Anesthesia risks/alternatives
- Immediately before anesthesia, a licensed independent anesthesia practitioner reevaluates the patient to determine suitability for the planned anesthesia
- Pain level

b) Who performs the preanesthesia assessment?

b) An Anesthesia provider performs the assessment with review by a licensed independent anesthesia practitioner.

Anesthesia

18. Question:

Answer:

Describe intraoperative monitoring?

Staff should describe intraoperative monitoring as outlined in policy and as noted on the anesthesia form.

19. Question:

Answer:

Describe the process for discussing anesthesia options and risks with the patient or family prior to administration.

Anesthesia should describe this process. Refer to Hospital Anesthesia Policy 5.9.2.

20. Question:

Answer:

Describe your training in the criteria for assessing possible victims of abuse/neglect.

Staff should describe their training in these criteria. The criteria focus on observable evidence and not on allegation alone. Refer to Hospital Abuse/Neglect Policy 5.5.

21. Question:

Answer:

How do you integrate information from the assessment process to identify and assign priorities to the patient's care needs?

During rounds/reports, we discuss information from various disciplines. In addition, we review consults/progress notes/nursing

records/other pertinent documents to plan and prioritize patient care.

22. Question:

Where has the need for a discharge planning assessment been addressed?

Answer:

In the initial patient assessment and ongoing assessments. Social Services/Case Management is consulted if the patient meets high-risk criteria. (Refer to Patient Assessment Form for criteria).

23. Question:

Are there reports of required diagnostic testing?

Answer:

Yes. For example, _____ test was ordered on this patient and the results are recorded in the medical record.