

Assessment of Patients II

1. Question:

Describe your role in conscious sedation.

Answer:

1. Before administration of conscious sedation, Confirm IV assess a immediate availability of antidotes, emergency medications/equipment, crash cart, blood pressure machine, suction, oxygen, airway/intubation equipment, pulse oximeter and equipment for monitoring vital signs (heart and respiratory rate).

Verify length of time patient has been NPO.

Review History and physical, patient's allergies and current medications.

Explain/reinforce with the patient the purpose of conscious sedation, possible pharmacologic reactions, and monitoring.

Document pulse, respiratory rate, pulse oximeter, level of consciousness, pain level, response to verbal commands, and blood pressure.

Verify completed informed consent.

2. Intraprocedure

a. Document medication dosage/times and patient response.

b. Monitor parameters listed in 1.e continuously. Document significant changes from baseline findings. Attach monitor strip to patient record.

3. Post conscious sedation, monitor and document.

Items listed in 1e. For at least 30 minutes post conscious sedation discontinuation or at least one hour post reversal agent and patient meets these criteria:

a. Stable vital signs and oxygen saturation.

b. Returns to pre-sedation level of consciousness and/or until patient is completely arousable and responsive and/or responding appropriately for age, and able to ambulate with minimal assistance if tolerated by physical status and surgical procedure. The pediatric patient's activity/mobility

- level is appropriate for age and pre-sedation physical condition.
- c. Assess patient for signs/symptoms of problems throughout conscious sedation; airway, overdose, unexpected drug effects, etc. Take appropriate actions and complete a variance report as needed.
- d. Ensure discharge instructions are given.

2. Question:

What special assessments are performed for patients receiving treatment for emotional/behavioral disorders?

Answer:

- a. For all patients:
 - History of mental, behavioral, emotional and substance abuse problems/treatments.
 - Current mental, emotional and behavioral functioning.
 - Maladaptive or problem behaviors.
 - Psychosocial assessment.
 - Mental status exam.
 - Techniques, methods, or tools that would help the patient control his/her behavior.
 - Pre-existing medical conditions or any physical disabilities and limitations that would place the patient at greater risk during Restraint or Seclusion, and any history of sexual or physical abuse that would place the patient at greater psychological risk during Restraint/Seclusion.
 - Those responsible for the patient's care determine the need for family members to participate in the patient's care
- b. As appropriate:
 - Legal assessment
 - Vocational/education assessment
- c. When indicated by patient needs:
 - Psychiatric evaluation
 - Functional evaluations of communication, self-care, and visual-motor functioning
 - Psychological assessment

3. Question:

What special assessments are performed for infants, children, and adolescents (0-18 years)?

Answer:

Effect of the family/guardian on the patient's condition and the effect of the patient's condition on the family.
Family/guardian/significant other involvement in care.
Immunization status.
Developmental age/skills.
Weight
Length, and height
Emotional, cognitive, communication, social needs
As appropriate, consideration of the patient's education needs and daily activities.

4. Question:

Nutritional Services
When do you complete a nutritional assessment on patients?

Answer:

Refer to Hospital Nutritional Care Policy 5.3.
All patients are screened for Nutritional Risk Factors within 8 hours of admit. Those meeting Nutritional Risk criteria are referred to a registered dietician for review. The Registered Dietician designs a level of care within 48 hours of admission. All patients identified at moderate – severe Risk will receive a nutritional assessment by a RD/RD app within 48 hours of admission.

5. Question:

What discharge planning screening criteria do you utilize upon admission to determine if case management should be consulted?
Do you have a patient that meets these criteria? If yes, review chart to ensure that case management was consulted and recommendations were incorporated into the plan of care.
Who is contacted for an emergency consult for discharge planning on a weekend or

Answer:

- Lacks transportation
Disabled and living alone.
Durable Medical Equipment.
Physical/Occupational/Speech Therapy after discharge.
Unable to manage self-care/prior Home Health services.
Frequent hospital admissions for poorly controlled chronic disease.
Admission from a nursing home or another state.
Teenage obstetric (<16 years).

holiday?

If patient meets any of the above criteria, was case management consulted? Were their recommendations incorporated into the plan of care?

The House Manager is contacted for emergency discharge planning consults on weekends and holidays.

6. Question:

Answer:

When diagnostic testing is ordered, what should be present on the record before the test is performed

Evidence of a diagnosis or diagnostic code for the diagnostic test requested (i.e. Imaging Services, Radiology, Nuclear Medicine, Radiation, Oncology).

7. Question:

Answer:

Do you have a CLIA license for your point of care testing?

Yes. It is maintained in the Point of Care Department.

8. Question:

Answer:

What functional screening criteria do you utilize upon admission to determine if P.T./OT should be consulted? Who is consulted for emergency consults on weekends and holidays?

Movement dysfunction
Ambulating difficulty
Cognitive impairment
Developmental involvement
Upper extremity or hand dysfunction
Difficulty in functional activities including activities of daily living.
Burn or nonhealing wounds.
Notify the MD to contact the on-call physical therapist for emergency consults on weekends and holidays.

b. Do you have a patient that meets these criteria? If yes, what do you review the chart for?

b. Was PT/OT consulted and were there plans incorporated into the plan of care?

9. Question:

Answer:

What discharge planning screening criteria do you utilize upon admission to determine if social services should be

- No source of income
Adoption case
No place to live

consulted?

Medication assistance
Lack clothes
Crisis and/or supportive
counseling
Abuse/neglect cases

Do you have a patient that meets these criteria?

Yes, if patient meets any of the above criteria, social services is consulted and recommendations incorporated into the plan of care.

Who is contacted for emergency consults on weekends and holidays?

The House Manager is contacted for emergency consults on weekends and holidays.

10. Question:

Answer: (for adults)

What screening criteria do you utilize upon admission to determine if a patient needs a nutritional consult?

-Unintentional weight loss of greater than 10 pounds/month
Multiple trauma, burns, stress
HIV/AIDS
Cachexia, Malnutrition
DKA/New Onset
Pressure Ulcers
Vomiting and/or diarrhea > 4 days
Hepatic Encephalopathy
Burns greater than 10% of the body
Tube Feedings
Dysphagia
Acute or Chronic Renal Failure
Refer to Hospital Nutritional Care Policy 5.3 and Nutritional Assessment Policy.

Do you have a patient that meets these criteria? If yes, review chart to ensure that consult was initiated and recommendations were incorporated into the plan of care.

11. Question:

Answer:

What is the time frame for initial patient assessment?

MD completes history and physical within 24 hours of admission. Nurses complete the Patient History and Assessment Form within 8 hours of admission.

12. Question: Answer:
What does the initial patient assessment consist of? Assessment of the Patient's Physical, Social and Psychological status.
13. Question: Answer:
When do you reassess a patient? For general care units:
At least twice in an eight hour shift.
Vital signs every (answer according to your unit practices)
Pain score post procedure and when the patient complains of pain.
Also, patients are reassessed:
To determine response to treatment
When there is a significant change in patient condition/diagnosis
After surgery/invasive procedures
14. Question: Answer:
Explain how you plan a patient's care. From the initial assessment, an RN plans patient care in conjunction with the patient and other caregivers. The plan of care is prioritized to meet patient needs. Various disciplines discuss patient care/review written documentation to integrate care.
15. Question: Answer:
How have you addressed the special needs of patients who are possible victims of alleged or suspected abuse/neglect? Evidence is handled as per Hospital Policy 7.10
Consents are required as per Hospital Abuse/Neglect Policy 5.5.
Authorities are notified and information released as per Abuse/Neglect Policy 5.5.
Social Services are consulted and referrals are made to public/private agencies as appropriate.
16. Question: Answer:
When the report of diagnostic testing should include clinical interpretation, is adequate clinical information included with the request? Yes.

17. Question:

Describe how your hospital provides pathology and clinical laboratory services and consultation, whether on the premises or in a reference or contract lab.

Answer:

Refer to lab policy manual. Follow policy. Obtain results via Invision or contact Clinical Laboratory office for direction if results no longer in Invision System.

18. PT/OT Question:

Explain the functional assessment you perform when consulted.
When do you perform the initial assessment?
When do you reassess patients

Answer:

Staff should explain assessment as outlined in departmental policy.
The initial functional assessment is performed within 48 hours of consults.
Reassessments are performed as outlined in departmental policy.

19. Question:

Does a Registered Nurse assess the patient's need for nursing care?

Answer:

Yes.

20. Question:

Describe the process for assessing the patient's postoperative status on admission to and discharge from the recovery area.

Answer:

Answer is specific to unit policy.

Refer to Hospital Anesthesia Care Policy 5.9.2.

Post Anesthesia Assessment Conducted by Nursing Staff for patients admitted to the ICU from the OR.

Respiratory status

Vital signs (BP, pulse, respirations, O2 saturation, pain level, etc.) taken every 15 minutes x 1 hour or as ordered by MD. Then, vital signs will be assessed as per unit policy.

Temperature within 30 minutes

Continuous cardiac monitoring.

21. Question:

If you deliver conscious sedation, explain how you were trained.

Answer:

I reviewed conscious sedation information and took a written test. My skills and knowledge are evaluated and documented in my file prior to administering/monitoring patients receiving conscious sedation. These include:
Trained to administer pharmacologic agents to achieve desired level of sedation,
To administer pharmacologic agents to reverse the level of sedation, and
To monitor patients carefully to maintain them at the desired level of sedation,
Evaluating patients prior to performing Conscious Sedation,
Competent to manage a compromised airway and to provide adequate oxygenation and ventilation,
Rescue patients who unavoidably or unintentionally slip into a deeper than desired level of sedation.
Annual Competency established along with current ACLS certification
Hospital Policy 5.26

22. Question:

Describe the process for preoperative assessment of the patient including preanesthesia assessments.

Answer:

History and Physical/pre-op diagnosis completed by M.D.
Preanesthesia assessment completed by anesthesia provider (pertinent physical exam, review of pertinent diagnostic data, pain level, history of previous anesthetics, drug allergies, current medications, tobacco, drug, alcohol use, dental or airway anomalies, presence of intercurrent disease processes capable of affecting anesthesia).
Indicated diagnostic tests completed.
Nursing assessment and plan of care.

Hospital Policy 5.26

