LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
- SHREVEPORT

PATIENT ASSESSMENT

Purpose:

To assure care provided to each patient is based on an assessment of the patient's relevant physical, psychological, and social needs.

Policy:

1. Each patient is assessed by qualified individuals upon admission to all LSUHSC care settings to identify the appropriate care or treatment needed and/or the need for further assessment. The physical, psychological and social status of each inpatient is assessed. The scope of assessment for each discipline is defined in departmental/hospital policies. The scope and intensity of the assessment is determined by:

    a. The patient's condition/diagnosis,
    b. The care setting,
    c. The patient's desire for care,
    d. The patient's response to any previous care, and
    e. The patient's consent to treatment.

2. The assessment process for an infant, child, adolescent, adult or geriatric patient is individualized. The following are assessed and documented as appropriate for the patient's age and needs as outlined in the Medical Records Content/Documentation policy (Hospital Policy 6.5).

    a. The patient's emotional, cognitive, language and communication needs, education, social, and daily activity needs;
    b. The patient's developmental age, length or height, head circumference, and weight.
    c. 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;
    d. The patient's immunization status, and
    e. The family's or guardian's expectations for and involvement in the patient's assessment, initial treatment, and continuing care.

3. Inpatients are assessed continuously throughout their hospital stay. An initial assessment (first 24 hours) is documented in the Electronic Health Record (EHR) by the admitting physician as the basis for the plan of care to be rendered. If a history and a physical examination have been performed within 30 days before admission, this report may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission. A RN assesses the patient's need for nursing care in settings where nursing care is provided. Inpatients are screened for nutritional/functional needs within 24 hours of admission. Services are consulted as needed. During downtime the admission progress note or the patient history form (SN 1032) and physical examination form (SN 1134) shall be utilized.

4. A duly licensed and credentialed staff physician will either perform or supervise the performance of a patient's assessment as outlined in the Medical Staff Bylaws, Rules and Regulations Section on Health Information Management.

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

6. Continued assessments are documented throughout the patient's medical record. A multidisciplinary approach is utilized for performing patient assessments based on the patient's diagnosis, the care setting, the patient's desire for care, and the patient's response to any previous care, i.e., by physicians, nursing, Nutritional Services, Rehabilitation Services, Social Services, Case Management, Cardiopulmonary Services, etc.

7. Outpatient Assessment - Outpatients are assessed during the clinic visit by the physician/APRN/PA. Each clinic's nursing standard of patient care defines assessments performed by nursing staff prior to the physician's exam. Follow-up visit assessments are performed by the physician/APRN/PA as deemed appropriate for the patient's condition.

8. Based on initial assessment of patient and established plan of care, reassessments are performed and documented throughout the care process and at follow-up appointments. Reassessment time frames are defined in departmental policy/bylaws, etc. Reassessment shall take place under a variety of conditions including, but not limited to, the following:

    a. Reassessment of the patient shall be performed at regular intervals in the course of care by medical and nursing staff. Ancillary services involved in the patient's care also perform reassessment as dictated by patient's needs.
    b. Reassessments are performed to determine a patient's response to care/treatment.
    c. Reassessment shall take place when there is a significant change in a patient's condition or a change in diagnosis.

10. Assessment and reassessment are documented in the EHR, the following paper reports shall be utilized during downtime:

    a. Medical Staff:
        1) History & Physical Examination
        2) Progress Notes
        3) Pre/Post Anesthesia Notes
        4) Consultation Reports
        5) Operative Reports
        6) Discharge Summary
        7) Outpatient Clinic Record

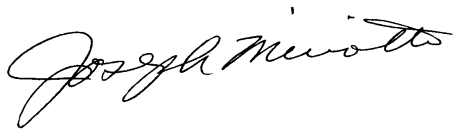
    b. Nursing Staff:
        1) Patient History/Assessment Record & Discharge Record

2) Nursing 24 hour Patient Progress Report/Plan of Care
3) Outpatient Clinic Notes

c. Other assessments are performed and documented by Nutritional Services, Rehabilitation Services, Case Management, Social Services, Home Care, Respiratory Care, Pastoral Services, Pharmacy, etc., as appropriate.

11. The plan of care will be reviewed regularly in consultation with or from written information provided by other members of the health care team and the patient/family. When warranted: The plan of care will be revised as appropriate to the patient's condition and the ongoing assessment process.

12. Discharge planning needs will be included in the initial assessment and reassessment process, throughout the patient's hospitalization. The patient/family will be involved in the discharge planning process as appropriate.



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Administrator

3/20/13
Date

Approved by Clinical Board: 9/19/00, 1/20/04, 2/20/07, 3/16/10, 3/19/13
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