I. PURPOSE

To comprehensively assess and document the initial assessment and reassessments of all patients admitted to the University of California, Irvine, Medical Center, promoting processes that deliver data and information to empower staff to participate meaningfully in clinical decision making.

II. POLICY

A. All patients who receive care at UCI Medical Center are assessed by qualified individuals to determine the patient’s initial needs, changing needs, and effectiveness of care/intervention.

B. Each discipline is responsible for defining their assessment parameters. Assessments are performed by each discipline within their scope of practice, licensure laws, applicable regulations, and certifications.

C. The patient assessment performed by medical staff is done in accordance with established medical staff rules and regulations.

D. Assessment is the systematic collection and review of patient data. All assessment data from the multi-disciplinary team is utilized to determine and prioritize the care needs of the patient. The determination and prioritization of care is based upon the diverse and unique needs of the patient, including biophysiologic, cognitive, behavioral, psychological, spiritual and social/cultural data and past medical history (Problem List). Additionally, assessment data identifies facilitating factors that pose potential barriers to the patient reaching their goals.

E. The assessment process across disciplines includes the following:
   1. Collection of data through mechanisms such as: observation, interview, measurement, and diagnostic tests.
   2. The data is analyzed to create information necessary to determine the approach to meeting care needs and to identify any additional information required.
   3. Decisions are made and executed regarding delivery of care on the basis of the assessment.

F. Reassessment
   1. Reassessment across disciplines is ongoing and occurs at designated intervals during the patient’s treatment to determine the response to and effectiveness of the care and interventions.
   2. Reassessment provides ongoing data about the patient’s biophysical,
psychological, spiritual and social needs.

3. The scope and intensity of the reassessment are based upon the patient’s diagnosis, the care setting, the patient’s desire for care and consent for treatment, and the patient’s response to any previous care.

4. Significant changes in the patient’s condition or diagnosis requiring reassessment.

G. Coordination of Care

1. The RN is responsible for ensuring coordination of care among other disciplines and support staff.

2. The RN is responsible for coordination of care based on the initial patient assessment and ongoing based on interval assessments.

ACUTE CARE NURSING DIVISION

A. Initial Assessment

1. A personal interaction between patient and staff member occurs upon arrival to the unit.

2. The patient’s initial assessment consisting of vital signs, pain screening and assessment and focused system review is based upon the judgment of the RN, utilizing the admission assessment form and flow sheet, are assessed and documented by a registered nurse according to the following.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Critical Care</td>
<td>Immediately Upon Arrival</td>
</tr>
<tr>
<td>Medical Surgical</td>
<td>Within one hour</td>
</tr>
<tr>
<td>Acute Rehabilitation</td>
<td>Within one hour</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Immediately upon arrival</td>
</tr>
<tr>
<td>Step Down (PCU/4N)</td>
<td>Immediately upon arrival</td>
</tr>
<tr>
<td>Labor and Delivery</td>
<td>Immediately upon arrival</td>
</tr>
<tr>
<td>Post Partum</td>
<td>Within one hour</td>
</tr>
<tr>
<td>OBER</td>
<td>Within one hour</td>
</tr>
<tr>
<td>Newborn Nursery</td>
<td>Immediately upon arrival</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Within one hour</td>
</tr>
<tr>
<td>Pediatric ICU</td>
<td>Immediately upon arrival</td>
</tr>
<tr>
<td>Neonatal Intensive Care Unit</td>
<td>Immediately upon arrival</td>
</tr>
<tr>
<td>LSU (Limited Stay Unit)</td>
<td>Within one hour</td>
</tr>
</tbody>
</table>

3. The following/remaining information of the patient assessment must be completed and documented within 24 hours (exceptions: Neonatal Intensive Care Unit and Newborn Nursery):

- Arrival mode/ personal items with patient
- Admission Nurse
- Allergies
- Medications
- Height and Weight
The registered nurse (RN) is responsible for performing all assessment processes. The RN may delegate aspects of data collection to the LVN, Psychiatric Tech., Trauma Tech., or Senior Hospital Assistant. The RN must then analyze the data and set care priorities, formulate nursing diagnosis, plan of care, health education, and initiate referrals.

The first 24 hours when partial data is only obtainable, due to patient’s condition and lack of significant other, the admission assessment is marked appropriately in the partially completed box, and the RN signs on the line for “assessment initiated by”. Additional data is collected as soon as feasible and documented, signed and dated on the admission assessment forms.

Possible victims of abuse will be identified through the assessment process and follow-up will be rendered as defined in the Administrative Policy: Mandatory Reporting of Abuse.

B. Reassessment

1. A complete assessment as defined by the nursing flow sheet must be completed and documented minimally at the beginning of each shift, by the RN. Additional reassessments will be done and documented according to the following:

   - When there is a significant change in the patient’s status and/or diagnosis or condition
   - When there is a change in the level of care
   - When an untoward event places the patient at risk for an adverse outcome
   - To determine the patient’s response to treatment and services for the patient
   - Physician orders
   - Based upon the patient’s family’s desire
   - Abnormal findings from previous assessment
   - Per specialty/population specific standards of care, pertinent policy and procedures, and legal regulatory requirements.
   - To meet the intervals specified by the hospital, course of care, treatment and services for the patient.

C. Unit Specific Assessment and Reassessment Criteria

1. Cardiac Intensive Care Unit/ Medical Intensive Care Unit/ Surgical Intensive Care
Unit/ Burn Intensive Care Unit/Neuro Intensive Care Unit
a. An assessment will be completed by the RN at the beginning of each shift, the content of which is defined by the Intensive Care Nursing Flow sheet, the Burn and Wound Therapy Form (as appropriate), the plan of care, teaching plan, and in some instances the clinical path. The pediatric population in the Burn Intensive Care Unit will be assessed according to the Pediatric Intensive Care Flow sheet, the Burn and Wound Therapy Form and other criteria as described in #8 below.
b. Reassessment
A focused reassessment occurs minimally every 4 hours, and as described in Nursing Division B-1 of this document.

2. Step Down/ Burn Acute Care
   a. Assessment
      An assessment will be completed by the RN at the beginning of each shift, the content of which is defined by the Intensive Care Nursing Flow sheet, the plan of care, teaching plan, and in some instances the clinical path.
   b. Reassessment
      A focused reassessment occurs minimally every 4 hours, and as described in Nursing Division B-1 of this document.

3. Medical/ Surgical/ Oncology/ Neuro/ Orthopedic
   a. Assessment
      An assessment will be completed by the RN at the beginning of each shift, the content of which will be defined by the Medical-Surgical Nursing Flow sheet, and the BMT Flow sheet as appropriate, the plan of care, teaching plan, and in some instances a clinical path.
   b. Reassessment
      The scope and intensity of specific reassessment occurs as described in Nursing Division B-1 of this document.

4. Labor and Delivery
   a. Assessment
      An assessment will be completed by the RN at the beginning of each shift, the content of which is defined by the Labor and Delivery Observation Record, the plan of care, and in some instances the clinical path.
   b. Reassessment
      The scope and intensity of specific reassessment occur as described in the Standard of Care for the Laboring Patient, and the Standard of Care for the Antepartum Patient with complications, and as described in Nursing Division B-1 of this document.

5. Obstetrical Emergency
   a. Assessment
      1. An assessment will be completed by the RN upon patient presentation, the content of which is defined by the pertinent standard of care and plan of care.
**b. Reassessment**
1. A focused reassessment by the RN occurs minimally every 4 hours based on chief complaint. Additional reassessments will be done as described in Nursing Division B-1 of this document.

---

6. **Post Partum/ Obstetrics**
   a. **Assessment**
   An assessment will be completed by the RN at the beginning of each shift, the content of which is defined by the Postpartum/ Antepartum Observation Sheet, the plan of care, and in some instances the clinical path.
   b. **Reassessment**
   The scope and intensity of specific reassessment occur as described in the Standard of Care for Post Partum patients and the Standard of Care for Antepartum Patients with Complications, and as described in Nursing Division B-1 of this document.

---

7. **Newborn Nursery**
   a. **Initial Assessment**
   1. The initial assessment is completed immediately upon birth in the delivery room. The scope of the assessment which is described as the individual components of the Apgar score, the assessment being the actual Apgar score.
   2. The completion of the initial assessment occurs in the nursery, the content of which is defined by the Newborn Transitional Flow sheet.
   b. **Shift Assessment**
   An assessment will be completed by the RN minimally every 8 hours, the content of which is defined by the Newborn Daily Flow sheet, the plan of care, and in some instances the clinical path.
   c. **Reassessment**
   The scope and intensity of specific reassessment occur as described in Nursing Division B-1 of this document.

---

8. **Pediatrics**
   a. **Initial Assessment**
   Within one hour of arrival in addition to the vital signs, and focused system review pediatric patients will also have their height and weight assessed. Pediatric patients are screened regarding their nutritional status as part of the initial assessment. The remainder of the assessment as described under A–4 of this document will be completed within 24 hours.
   b. **Shift Assessment**
   An assessment will be completed by the RN at the beginning of each shift, the content of which is defined by the Pediatric Flow sheet, the plan of care, teaching plan, and in some instances the clinical path.
   c. **Reassessment**
The scope and intensity of specific reassessment occur as described in Nursing Division B-1 of this document.

9. Pediatric Intensive Care Unit
   a. Initial Assessment
      Immediately upon arrival in addition to the vital signs, and focused system review, pediatric patients will also have their height and weight assessed. Pediatric patients are screened regarding their nutritional status as part of the initial assessment. The remainder of the assessment as described under A-4 of this document will be completed within 24 hours.
   b. Shift Assessment
      An assessment will be completed by the RN at the beginning of each shift, the content of which is defined by the Pediatric Intensive Care Flow sheet, the plan of care, teaching plan, and in some instances the clinical path.
   c. Reassessment
      A focused reassessment occurs minimally every 2 hours as described in Nursing Division B-1 of this document.

10. Neonatal Intensive Care Unit
    a. Initial Assessment
       Immediately upon arrival vital signs, a focused system review and weight and length are completed. The remainder of the assessment will be completed within 24 hours, the content of which is defined by the Neonatal Nursing Admission History and Physical Assessment.
    b. Shift Assessment
       An assessment will be completed by the RN at the beginning of each shift, the content of which is defined by the Neonatal Intensive Care Flow sheet, the plan of care, teaching plan, and in some instances the clinical path.
    c. Reassessment
       Scope and intensity of reassessments beyond shift assessment will minimally include vital signs and a focus review in keeping with the specific patient’s condition. The reassessment is performed and documented on the Neonatal Intensive Care Flow sheet. A growing neonate status is reassessed every 4 hours, an intermediate status is reassessed every 3 hours, an intensive status is reassessed every 2 hours, and as described in Nursing Division B-1 of this document.

11. Emergency Department
    a. Assessment
       An assessment will be completed by the RN upon patient presentation the content of which is defined by the Emergency Department Medical Screening Exam, the pertinent Standard of Care, Medical Screening Policy, and care path.
    b. Reassessment
       A focused reassessment by the RN occurs minimally every four hours
based on chief complaint. Additional reassessments will be done as described in Nursing Division B-1 section of this document.

**Acute Rehabilitation Unit**

A. Initial Assessment
   1. All patients are assessed within 24 hours by a multi-disciplinary team consisting of Registered Nurses, Physical Therapists, Occupational Therapists, and as appropriate Speech Therapists, Neuropsychologist, and other team members. The content of initial assessment is defined by the Interdisciplinary Admission Evaluation Form.

B. Shift Nursing Assessment
   1. An assessment will be completed by the RN at the beginning of each shift, the content of which is defined by the Rehabilitation Interdisciplinary Flow sheet, and Functional Focus List (plan of care), and in some instances clinical path.

C. Reassessment
   1. Nursing Reassessment
      The scope and intensity of specific reassessment occur as described in Nursing Division B-1 section of this document.
   2. Interdisciplinary Reassessment
      All patients will be reassessed weekly utilizing the Salient Factor Model, through the Interdisciplinary Discharge Progress Report.

**Psychiatric Services**

A. Initial Assessment
   1. Initial Nursing Assessment
      a. The patient’s initial assessment consisting of vital signs, biophysical status including pain screening, arrival mode, review for appropriate mental health legal hold, personal possessions and contraband search with documented rationale and indicators for high psychiatric and medical risks. These screening/assessment criteria are to be documented by a registered nurse within two hours of arrival on the psychiatric unit.

   2. Initial Multi-disciplinary Assessment
      a. Nursing
         The remainder of the Nursing initial assessment will be completed within the first 8 hours of admission, the content of which is described in the Neuropsychiatric Center Interdisciplinary Assessment Form Section I.
      b. Physician
         The physician will complete, within 24 hours of the patient’s admission, the Neuropsychiatric Center Interdisciplinary Assessment Form, the content of which is described as MD Assessment Form., Section II.
      c. Occupation Therapy
         The occupational therapist will complete, within 48 hours of receipt of a written physician order, the Interdisciplinary Admission, the content as described as the
Occupational Therapy Functional Evaluation, Section IV.

d. Clinical Social Worker
The Clinical Social Worker will complete, within 72 hours of the patient’s admission, the Interdisciplinary Admission, the content as described as the Social Worker Assessment Form, Section III.

B. Reassessments
1. Nursing
Additional reassessments will be done and documented according to the following:
   - When there is a significant change in the patient’s status and/or diagnosis or condition
   - When there is a change in the level of care
   - When an untoward event places the patient at risk for an adverse outcome
   - To determine the patient’s response to care, treatment, and services
   - To meet legal, regulatory or hospital requirements

All geriatric patients (age 65 and older) or patients with concurrent medical diagnosis requiring active treatment will be assessed in keeping with the physician’s orders.

2. Physician
Reassessment will occur daily in keeping with the Medical Center Staff Rules and Regulations.

3. Occupational Therapy
Reassessment occurs weekly based upon the patient’s response to their plan of care, or when there is a significant change in the psychiatric or medical condition.

4. Social Worker
Reassessment by the clinical social worker will occur weekly based upon the patient’s response to their plan of care, or when there is a significant change in the psychiatric or medical condition.

Perioperative Services

A. Pre-Op Process
1. Initial Assessment
   a. AM Admit
      Patients that are designated as an AM admit will be assessed by an RN immediately upon arrival. The scope of the assessment is defined by the age appropriate Nursing Admission Assessment Form, and the Surgical Procedure Checklist.
   b. Outpatient Admit
      Patients that are designated as outpatient admits will be assessed by an RN immediately upon arrival to the unit. The scope of the assessment is defined
by the Outpatient Nursing Assessment Form, and the Surgical Procedure Checklist.

c. Inpatients
Inpatients will be assessed by an RN immediately upon arrival to the unit. The scope of the assessment is defined by the Surgical Procedure Checklist.

2. Reassessment
The scope and intensity of specific reassessment occur when:
- There is a significant change in the patient’s condition
- To determine the response to interventions and treatments
- Abnormal findings from previous assessments
- Physician’s orders
- Any significant changes will be reported to the anesthesiologist and/or surgeon.

B. Operating Room
1. Assessment
An assessment will be completed by a RN upon arrival to the OR, the content of which is defined by the Surgical Procedure Checklist.

2. Reassessment
a. Monitored Anesthesia Care/ Regional/ General Anesthesia
Reassessments are completed by the anesthesiologist in keeping with the Medical Staff Rules and Regulations.

b. Local anesthetics
The scope and intensity of the reassessment will be completed based upon the policy for monitoring local anesthetics and when any of the following occur:
- When there is a significant change in the patient’s condition
- When there is a change in the level of care
- When an untoward event places the patient at risk for an adverse outcome
- To determine the patient’s response to treatment
- Physician orders

C. Post Anesthesia Recovery
1. Assessment
An assessment is completed immediately upon arrival to the post anesthesia care unit area by a RN, the elements which are defined on the Post Anesthesia Care Unit Flow sheet.

2. Reassessment
a. Monitored Anesthesia Care/ Regional/ General Anesthesia
A reassessment including vital signs, respirations, pulse oximetry is completed and documented every 5 minutes times three episodes, every 15 minutes x2 hours, and every 30 minutes thereafter until stabilized. A systems assessment as defined on page 2 of the Post Anesthesia Care Unit Flow sheet or unit/age specific flow sheet will be completed every 30
minutes until stabilized. Focused reassessment also occurs when any of the following occur:
- When there is a significant change in the patient’s condition
- When there is a change in the level of care
- When an untoward event places the patient at risk for an adverse outcome
- To determine the patient’s response to treatment
- Physician orders

b. Moderate Sedation
The scope and intensity of the reassessment will be completed based upon the Moderate Sedation Policy and Procedure. Reassessments are completed and documented when any of the following occur:
- When there is a significant change in the patient’s condition
- When an untoward event places the patient at risk for an adverse outcome
- To determine the patient’s response to treatment
- Physician orders

Limited Stay Unit
A. Assessment
An assessment is completed immediately upon arrival to the Limited Stay Unit by an RN. The elements which are defined by the Medical-Surgical Nursing Flow Sheet, the plan of care, teaching plan, and in some instances a clinical pathway.

B. Reassessment
The scope and intensity of specific reassessment occurs as described in Nursing Division B-1 of this document.

Ambulatory Care
A. Clinics
1. The licensed independent practitioner is responsible for the assessment and reassessment for all patients receiving care in the ambulatory clinics.

2. A focused health history and physical will be completed by the licensed independent practitioner based upon the patient need.

3. The Adult or Pediatric Problem List and Medication Record will be started on the first visit and completed by the third visit.

4. Patients receive nutritional screening as described under Nutritional Services #A-4 of this document.

B. Moderate Sedation Sites
1. Assessment
   a. Patients undergoing ambulatory procedures with planned moderate sedation are initially assessed by an RN, the content which is defined by the Outpatient Nursing Assessment Form, the Moderate Sedation Flow sheet and the Moderate
Sedation Policy and Procedure.

b. Patients undergoing inpatient procedures with planned moderate sedations are initially assessed by an RN, the content which is defined by the Initial Nursing Assessment Form, the Moderate Sedation Flow Sheet and the Moderate Sedation Policy and Procedure.

2. Reassessment
   a. The scope of intensity of the reassessment will be completed based upon the Moderate Sedation Policy and Procedure.
   b. Reassessments are completed and documented when any of the following occurs:
      - When there is a significant change in the patient’s condition
      - When an untoward event places the patient at risk for an adverse outcome
      - To determine the patient’s response to treatment
      - Physician orders

C. Ambulatory Care Chemotherapy Sites
   1. Assessment
      a. Patients admitted as outpatients for chemotherapy will be assessed by an RN, the content of which is defined by the Infusion Center Nursing Assessment.
   2. Reassessment
      a. Patients are reassessed intra and post procedurally including vital signs, IV site assessment, IV site blood return, and response to chemotherapy. Reassessments are completed and documented when any of the following occur:
         - When there is a significant change in the patient’s condition
         - When an untoward event places the patient at risk for an adverse outcome
         - To determine the patient’s response to treatment
         - Physician orders

D. Burn and Wound Therapy
   1. Assessment
      a. Patients undergoing burn and wound therapy are initially assessed by an RN or Physical Therapist, the content of which is defined by the Burn and Wound Outpatient Therapy Service Record.
   2. Reassessment
      a. Patients are reassessed with each visit by a RN or Physical Therapist, the content of which is defined by the Burn and Wound Therapy Service Record.

Nutritional Services

A. Screening
   1. All patients are screened for nutritional risk within 24 hours of admission by the
RN based on the established criteria developed by an interdisciplinary team, including nursing and nutrition services. Specific nutrition-related questions are asked, and the results are entered in the TDS system.

2. The TDS system prioritizes patients into levels of nutrition risk: (high, moderate, or low risk).

3. Ongoing screening for changes in care and condition are conducted daily by the clinical dietitian. This is done by reviewing the diet order lists, and pre-albumin lists every morning.

4. Adult ambulatory care patients are screened by the Medical Assistant upon the patient’s first visit to the primary care clinic, utilizing a screening tool agreed upon by both ambulatory nursing and nutrition services. Re-screening occurs annually or at the patient’s next visit to clinic if more than one year has elapsed from the last nutritional screening.

5. Pediatric ambulatory care patients are screened utilizing height/weight growth charts at every well-baby visit (first 24 months of life) and every annual visit thereafter.

B. Assessment

1. Assessments of inpatients at nutritional risk are conducted by a clinical dietitian and documented in the medical record in the interdisciplinary note section.

2. For an ambulatory care patient, a score of 6+ utilizing the “Determine Your Nutritional Health” checklist, identifies the patient to be at nutritional risk.

3. Time frame for nutritional assessments for patients are as follows:
   - Consults: Within 24 hours of receipt of the consult
   - High Risk - Within 48 hours of admission
   - Moderate Risk - Within 72 hours of admission
   - Low Risk - Upon receipt of consult or referral or within 14 days of admission

   Ambulatory Care – Patient is notified of need for nutritional assessment.

4. Assessments involve using subjective information from the patient and/or significant other, laboratory test results, medications, height, weight, weight changes, nursing intake records, and other interdisciplinary team documentation/feedback, to make assessment of patient’s nutritional needs, intake adequacy, tolerance to diet, nutrition knowledge, and current level of nutrition risk/status. A nutritional plan of care is formulated on all patients who are assessed at moderate and high risk. Recommendations are made to physicians and other healthcare team members as appropriate.

C. Reassessment

1. Reassessment of patients are conducted at routine intervals, based on level of nutritional risk, and documented in the medical record in the interdisciplinary note section by a clinical dietitian.
2. The time frames for nutritional reassessment are as follows:
   **High Risk** - a minimum of every 5 days or more frequently, according to the patient's individual needs, from the time of the initial nutritional assessment
   **Moderate Risk** - a minimum of every 7 days or more frequently, according to the patient's individual needs, from the time of the initial nutritional assessment
   **Low Risk** - A minimum of every 14 days from the time of initial nutrition screening.

3. A nutritional reassessment will consist of: any changes in care and condition, response to nutrition interventions, current level of nutritional care, nutritional care plan and recommendations to physicians and other healthcare team members as appropriate.

**Pastoral Care**

A. Initial Referral/ Interview
   1. All patients are evaluated for their desire of Pastoral Care Services within 24 hours of admission by a RN.

2. A pastoral visit is a priority when a referral is initiated by a staff member or requested by patient/ family, or obtained via the DNAR referral list.

3. The initial interview is completed and documented by a staff chaplain. The interview may include the following:
   - Religious/ Sacramental needs
   - Spiritual support and counseling
   - Grief and bereavement counseling
   - Crisis intervention
   - Bioethical intervention
   - Staff counseling and support

B. Follow-up/ Evaluation
   1. Is conducted based upon the spiritual needs of the patient/ family and findings at the initial interview.

2. Follow up includes evaluation of the effectiveness of previous intervention and the need for subsequent intervention/ support.

**Social Work**

A. Assessment
   1. Referrals are responded to within 48 hours from initial request.

2. Assessments are performed by a Clinical Social Worker

3. Social workers perform Psychosocial evaluations related to any of the following:
   - Difficulty coping with new disability/ terminal illness diagnosis/ trauma
   - Rape/ suspected domestic/ gang related violence
Alleged child/ elder/ dependent adult abuse/ neglect
Overdose
Teen pregnancy: age 14 and under
Grief/ loss issues
Extreme non-compliance resulting in multiple admissions
Maternal substance abuse
Risk Management legal-ethical issues
Acute symptoms of clinical depression/severe mood disorders/ suicide attempt
Pending adoption

4. Data is gathered from interviews with patient/ family/ significant others, medical record, review and staff consultation.

5. Psychological assessment may include but is not limited to:
   Living and economic situations
   Family relationships, communication
   Support systems; significant others, agency involvement
   Cultural factors
   Patient / family view of situations/ concerns/ needs
   Coping with and adapting to situation
   Impression of person-problem-situation and a plan for intervention

B. Reassessment
   1. Reassessments are completed upon re-consult or referral.
   2. All reassessments are performed by a Clinical Social Worker.

Case Management

A. Screening
   1. All patients are screened by a Case Manager for Case Management Services within 72 hours of admission.
   2. Screening criteria may include:
       Inadequate family/caregiver support
       Unsafe home situation/abuse/neglect
       No residence/homeless
       Chemical or substance abuse
       Attempted suicide/psychiatric issues
       Unidentified or lack of payor
       Inadequate financial resources
       Terminal prognosis
       Life altering diagnosis
       Chronic or intractable pain
       Greater than 80 years of age and lives alone
       Multiple co-morbid conditions
       High risk pregnancy
       Failure to thrive
Lack of transportation
Transferred from a caretaking facility
Need alternative living situation
Forensic patient
Identify unknown
Re-admission within 30 days

3. Screenings are done in collaboration with the Clinical Social Workers.

B. Assessment
1. A case management assessment is completed on all patients within 48 hours of admission.
2. Case Managers are Registered Nurses
3. Case Managers initial assessments may include but are not limited to:
   - Discharge Planning
   - Transfer to other acute care facilities, sub-acute and skilled nursing facilities
   - Home care needs
   - Insurance, benefits and coverage
   - Hospice
   - Patient Care Conferences
   - Location of family members, or other supportive persons
   - Community resource and referrals
   - Resources not covered by insurance
   - Durable medical equipment
4. Data is gathered from interviews, medical record review, multi-disciplinary teams, financial records, insurance companies, and health care information gathered using the (ECIN) electronic case management system.

C. Reassessment
1. Reassessments are an ongoing process as needs change frequently.
2. Reassessments are performed by the Registered Nurse Case Manager.

Respiratory Care Services

A. Assessment
1. An assessment is performed within 24 hours for all initial medication treatment orders.
2. An assessment is performed to determine and monitor effectiveness and appropriateness of ordered therapies.
3. Criteria assessed upon review of new order includes:
   - Diagnosis
   - Current respiratory issues, including presence/absence of pain
   - Vital signs
   - Breath sounds
   - Specific respiratory complaints

B. Reassessment
1. The reassessment in keeping with the symptomology and therapeutic intervention
is conducted with each patient interaction. Additional documented reassessment will occur and be documented in the following situations:

To determine the response to interventions and treatments
Change in patient condition
Abnormal finding from previous assessment
Request for more frequent assessment in accordance with established policy/procedure requirement.

2. If a patient remains on service after 72 hours (3 days) a comprehensive reassessment, equivalent to the initial assessment will occur.

Rehabilitation Services

Physical Therapy

A. Initial Assessment

1. All inpatients receive a functional assessment screening within 24 hours of admission by the RN based on the established criteria developed by a multi-disciplinary team between nursing and rehabilitation services. Specific functional questions are asked, and the results are entered in the TDS system.

2. The Physical Therapy assessment is conducted within 48 hours of receiving a physician order on all inpatients.

3. Criteria for recommendation of a physical therapy assessment on an outpatient is based on initial assessment by the physician, podiatrist and/or dentist. The physical therapy assessment is conducted within 30 days of receiving an authorization on all outpatients.

4. Assessments are performed and documented by a Licensed Physical Therapist.

5. The criteria assessed may include:
   - Prior functional status
   - Cognitive status/ mental condition
   - Strength/ function
   - Range of motion
   - Gait ability
   - Transfer ability
   - Absence/presence pain (level)
   - Sensation
   - Weight bearing status
   - Wound status

B. Reassessment

1. Data is collected with each inpatient visit at the initiation of treatment by a Physical Therapy Technician, a Licensed Physical Therapy Assistant, or a Licensed Physical Therapist. Inpatient reassessment occurs within eight (8) days...
of the initial assessment, or when a significant change occurs in medical or surgical conditions.

2. Data is collected with each outpatient visit at the initiation of treatment by a Physical Therapy Technician, a Licensed Physical Therapy Assistant, or a Licensed Physical Therapist. Outpatient reassessment occurs no greater than 45 days or 18 visits from the initial assessment, or when a significant change occurs in medical or surgical condition.

**Occupational Therapy**

A. Initial Assessment

1. All inpatients receive a functional assessment screening within 24 hours of admission by a RN based on the established criteria developed in a multidisciplinary team between nursing and rehabilitation services. Specific functional questions are asked, and the results are entered in the TDS system.

2. The Occupational Therapy Assessment is conducted within 48 hours of receiving physician order on all inpatients.

3. Criteria for recommendation of occupational therapy assessment on outpatients is based upon an initial assessment performed by a physician. The occupational therapy assessment is conducted within 30 days of receiving an authorization on all outpatients.

4. The assessment is performed and documented by a Registered Occupational Therapist.

5. Criteria assessed may include:
   - Social history
   - Range of motion
   - Prior functional status
   - Sensation
   - Mental status/ cognition/ Neuro-behavioral responses
   - Strength/ Functional/ Motor control and development
   - Transfer ability
   - Memory/ Orientation
   - Functional ability
   - Absence/presence pain (level)
   - Weight bearing status
   - Reflexes
   - Oral motor status and feeding
   - Parenting needs/ skills
   - Response to handling and environmental stimuli

B. Reassessment

1. Data is collected with each inpatient visit at the initiation of treatment by an
Occupational Therapy Technician, a Licensed Occupational Therapy Assistant, or a Registered Occupational Therapist. Inpatient reassessment occurs within eight (8) days of the initial assessment, or when a significant change occurs in medical or surgical condition.

2. Data is collected with each outpatient visit at the initiation of treatment by an Occupational Therapy Technician, a Certified Occupational Therapy Aid or a Certified Occupational Therapist. Outpatient reassessment occurs no greater than 45 days or 18 visits after the initial assessment, or when a significant change occurs in medical or surgical condition.

Speech Therapy

A. Initial Assessment
1. The Speech Therapy Assessment is conducted within 72 hours of receiving a physician order on all inpatients.

2. The assessment is performed and documented by a Licensed Speech Therapist.

3. Criteria for recommendation of Speech Therapy Assessment on outpatients is based upon an initial assessment performed by a physician.

4. Criteria assessed:
   - Auditory and reading comprehension
   - Verbal and written expression
   - Pragmatic skills
   - Cognitive status
   - Communication status
   - Oral motor skills and swallowing status
   - Voice status
   - Hearing screening

B. Reassessment
1. Data is collected with each inpatient visit at the initiation of treatment by a Speech Therapist. Inpatient reassessment occurs within eight (8) days of the initial assessment, or when a significant change occurs in medical or surgical condition.

2. Data is collected with each outpatient visit at the initiation of treatment by a Speech Therapist. Outpatient reassessment occurs no greater than 45 days or 18 visits after the initial assessment, or when a significant change occurs in medical or surgical condition.

Pharmacy Services

A. Initial Assessment
The following is reviewed by the Pharmacist prior to the first dose of any medication being dispensed (exception: emergency cases).
1. Patient name
2. Patient age, sex
3. Height and weight
4. Medication allergies, sensitivities, past untoward reactions
5. Current medications
6. Clinical diagnosis and secondary diagnoses, clinical conditions, significant and past history
7. Relevant laboratory values, clinical diagnostic studies
8. Significant elements of past history
9. Name of attending physician and ordering physician
10. Pregnancy and lactation status
11. Any other information required for safe medication management

B. Reassessment
1. The pharmacist reviews daily all drug orders for potential drug allergies and/or appropriateness of doses in relation to height/weight, age, diagnosis, and laboratory indices, drug interactions and incompatibilities.

Child Life

A. Screening
1. All pediatric patients are screened by a Child Life Specialist for Child Life services within 72 hours of admission.
2. Screening criteria may include:
   - Potential for developmental delay or regression due to hospitalization
   - Educational needs of patients, siblings, and families
   - Academic needs
   - Terminal prognosis
   - New or Life altering diagnosis
   - Diagnosis teaching
   - Family having difficulty coping
   - Traumatic injury
   - Sibling responses and coping

B. Assessment
1. Referrals are responded to within 48 hours from initial request.
2. Assessments are performed by a Child Life Specialist
3. Child Life Specialists perform Psycho-social evaluations related to any of the following:
   - Difficulty coping with hospitalization
   - Developmental needs
   - Grief/loss issues
   - Non-compliance resulting in multiple admissions
   - Social difficulties with peers
Family support systems
Potential loss of parent or significant adult (adult patients)
Educational and academic needs
Sibling responses and coping

4. Data is gathered from interviews and observations with patient/family/significant others, medical record, review and staff consultation.

C. Reassessment
1. Reassessments are completed weekly or more often if circumstances change.
2. All reassessments are performed by a Child Life Specialist.

References
JCAHO, 2006
Title 22

Related Policy and Procedure/Standards:
Bylaws Rules and Regulations, UC Irvine Medical Center Medical Staff
Hospital Policy: Mandatory Reporting of Abuse
Hospital Policy: Care of the Patient Receiving Moderate Sedation Agents
Perioperative Care of the Adult and Pediatric Patient
Postoperative Care of the Adult and Pediatric Patient
UCIMC Emergency Nursing Standards of Care
Emergency Dept. - Triage Policy B-100
Emergency Dept. - Emotional Management of Emergency Department Patients F-502
Emergency Dept. - Services for Substance Abuse F-504
Emergency Dept. - Guidelines for the Use of the E.D. Nursing Record G-608
Emergency Dept. - Psychiatric Triage S-1806
Emergency Dept. - Triaging of OB/GYN Patients B-109
Radiology Department Standard of Radiologic Nursing Practice 7.3
UCIMC Radiology Nursing Procedures
Rehabilitation Services Policy: Evaluation Form - Physical Therapy
Rehabilitation Services Policy: Re-evaluation of Patients
Rehabilitation Services Policy: Protocol for General Evaluations/ Occupational Therapy
ARU Salient Factor Model – V
Perinatal: OBER Patients, Standard of Care
Perinatal: Laboring Patients, Standard of Care
Perinatal: Post Partum, Standard of Care
Nutrition Services Policy and Procedures
Neonatal ICU: Basic Care and reassessment Routines, Standard of Care
Pediatrics/Pediatric ICU: Standard of Care: Pediatric & Pediatric Critical Care

Author: Laura Bruzzone, RN
Nursing Administration

Approvals:
<table>
<thead>
<tr>
<th>Reviewed, No Changes</th>
<th>August, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Standards Committee</td>
<td>August, 2006</td>
</tr>
<tr>
<td>Nursing Leadership Committee</td>
<td>June, 2007</td>
</tr>
<tr>
<td>Performance Improvement</td>
<td>July, 2007</td>
</tr>
<tr>
<td>Med Exec</td>
<td>July, 2007</td>
</tr>
<tr>
<td>Governing Body</td>
<td>July, 2007</td>
</tr>
</tbody>
</table>