LOS ANGELES GENERAL MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

Subject: **INPATIENT ASSESSMENT / REASSESSMENT**	Original Issue Date: 04/05	Policy # **801**
	Supersedes: 06/21	Effective Date: 03/24

Departments Consulted:	Reviewed & Approved by:	Approved by:
	Professional Practice Committee Nurse Executive Committee Attending Staff Association Executive Committee	(signature on file) Nancy Blake Chief Nursing Officer

PURPOSE

To describe the process for assessing and reassessing inpatients within the Los Angeles General Medical Center.

POLICY

The provision of care, treatment, and services to patients includes the assessment of a patient's condition and needs, the reassessment of the patient's condition, and his/her response to interventions. The assessment process includes a collection of objective and subjective data that focuses on the patient's physical, psychosocial, spiritual, and developmental needs.

PROCEDURE

Registered Nurses conduct assessments/ within the scope of their licensure, certification, regulations, and applicable law.

The Registered Nurse utilizes the assessment data to formulate a plan of care and make necessary referrals to other departments.

The primary source of information is the patient, but if the patient is unable to communicate, a family member or significant other may be utilized as a resource for history information.

I. Admission History Assessment

The Admission History assessment:

- Is documented in the Admission History in the electronic health record (EHR) for all units- Adults, Adult ICU, Pediatrics, Pediatric ICU, and Neonatal ICU.

The Admission History documentation must be initiated within:

- 4 hours of admission to an acute care unit
- 1 hour of admission to a critical care unit
- 1 hour of admission to a pediatric unit

Refer to nursing policies:

- Inpatient Documentation Guidelines
- Documentation of Ambulatory Care, Emergency Room and/or Urgent Care Areas

The following systems assessments include:

- Physiologic systems assessment
- Neurological Assessment (refer to Addendum A- Neurological Assessments for Ischemic Stroke Patients)
- Medical device use assessment
- Pain assessment
- Nutrition Risk
- Falls Risk Assessment (using the age-appropriate scale) (see Nursing Policy, "*Fall Prevention").*
- Suicide Risk Screen (see section below)
- Skin Assessment (using the age-appropriate scale)
- Skin Assessment including injuries related to medical device use
- Initial weight
- Pediatric: (height/length and head circumference, if applicable for age).
- Patient and Family Education
- Referrals/teaching needs
- Discharge planning
- Or any other applicable assessment

II. Reassessment

Reassessments are completed as follows:

- Every 4 hours for adults and pediatrics; and every 8 hours for perinatal
- To assess a patient's response to care
- With the change in the patient's condition

Changes noted during reassessment are reflected in the IPOC (Interdisciplinary Patient Care Plan).
Any pertinent findings including a significant event that occurs shall be reported to the provider and documented under the Notes or Documentation section in the EHR.

Suicide Risk Screening and Assessment

Suicide risk screening is done all patients able to verbalize responses upon admission. If patient is unable to verbalize responses, check the N/A box in the EHR.

Suicide Risk Assessment is done:

- For patients who answer "yes" to the suicide risk screen. If answered "yes":

- Notify provider
- Refer to Patient's At Risk for Suicide Nursing Clinical Standard

REFERENCE

Los Angeles General Medical Center Policy #800: Pain Assessment
Nursing Clinical Standard: Physiologic Monitoring/Hygiene/Comfort – Adults Acute Care Units
Nursing Clinical Standard:Physiologic Monitoring/Hygiene/Comfort –ICU's/Progressive Care Unit
Nursing Clinical Standard: Physiologic Monitoring/Hygiene/Comfort—Newborn/Pediatric
Nursing Clinical Standard: Pain Management
Nursing Clinical Standard: Patient's At Risk for Suicide
Nursing Policy, Inpatient Documentation Guidelines
Nursing Policy, Documentation – Ambulatory Care, Emergency Room and/or Urgent Care Areas
Unit Structure Standards

REVISION DATES

04/05, 09/08, 02/11, 07/12, 10/12, 01/14, 12/18, 06/21, 03/24

Addendum A: Nursing Policy #801 Patient Assessment/ Reassessment: Neurological Assessments for Ischemic Stroke Patients

First 24hr (ICU/ED) Post thrombolytic Administration
• First 2 hours every 15 minutes • Next 6 hours every 30 minutes • Next 16 hours every hour Assessments include: • Neurological Assessment • Vitals • Mental Status • Pupils assessment • Neuromuscular / Extremities assessment • Glasgow Coma Assessment • The National Institutes of Health Stroke Scale (NIHSS) (every 12 hours)

ICU Post Thrombectomy Assessment
• First hour every 15 minutes • Next hour every 30 minutes • Hourly times 5 hours Assessments include: • Neurological Assessment • Vitals • Mental Status • Pupils Assessment • Neuromuscular / Extremities Assessment • Glasgow Coma assessment • Neurovascular Checks • Incision/ Wound/ Skin Abnormality (of site accessed)

Addendum A: Nursing Policy #801 Patient Assessment/ Reassessment: Neurological Assessments for Ischemic Stroke Patients

Baseline assessment (ICU/ED) Every 4 hours

• Mental Status
  - Level of consciousness
  - Orientation assessment
• Language
  - Fluent/Speech
  - Follows commands
  - Facial symmetry
• Cough reflex
• Gag reflex
• Glasgow Coma Assessment
• Pupil assessment
  - PERRL
  - Right pupil description
  - Left pupil description
  - Right pupil reaction
  - Left pupil reaction
  - Right pupil size
  - Left pupil size
  - Pupil Accommodation, Right
  - Pupil Accommodation, Left
• Neuromuscular assessment
  - Right Upper Extremity Strength
  - Left Upper Extremity Strength
  - Right Lower Extremity Strength
  - Left Lower Extremity Strength
• NIHSS (every 12 hours)

Addendum A: Nursing Policy #801 Patient Assessment/ Reassessment: Neurological Assessments for Ischemic Stroke Patients

Baseline assessment (Med/Surg) Every 4 hours

• Mental Status
    - Level of consciousness
    - Orientation assessment
• Psychosocial assessment
    - Affect/behavior
    - Appearance
• Language
    - Fluent/Speech
    - Follows commands
    - Facial symmetry
• Cough reflex
• Gag reflex
• Pupil assessment
    - PERRLA
    - Right pupil description
    - Left pupil description
    - Right pupil reaction
    - Left pupil reaction
    - Right pupil size
    - Left pupil size
    - Pupil Accommodation, Right
    - Pupil Accommodation, Left
• Neuromuscular assessment (every 12 hours)
    - Right Upper Extremity Strength
    - Left Upper Extremity Strength
    - Right Lower Extremity Strength
    - Left Lower Extremity Strength

Revision:

06/21. 03/24