Olive View-UCLA MEDICAL CENTER

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

Policy Title:			
Category:	1 - Provision of Care	**Policy No.:**	107
Originally Issued:	2/28/1996	**Update (U)/Revised (R):**	1/23/2018
Distribution:	**Hospital-Wide** ☒	**If not Hospital-Wide, Other:**	

PURPOSE:

To define the scope, time frame of interdisciplinary assessment and reassessment of patients, and screening criteria for further assessments that are used by each member of the interdisciplinary care team.

DEFINITION(S):

Assessment is the systematic collection and review of patient specific data.

Data are uninterrupted material, facts and/or clinical observations collected during an assessment activity.

Diagnostic testing covers operative and other procedures including laboratory, radio logic, electrodiagnostic, and other functional tests and imaging technologies.

Family refers to the person (s) who plays a significant role in the patient's life. This may include an individual (s) not related to the patient. This person (s) is often referred to as a surrogate decision maker if authorized to make care decisions for a patient should a patient lose decision-making capacity.

Information is interpreted sets of data that can assist in decision making.

Operative and other procedures include operative, other invasive, and noninvasive procedures such as, CAT scan, and MRI that place the patient at risk.

Screening is the process of examining or testing a group of individuals to separate those who are well from those who are at high risk.

POLICY:

1. All patients receiving care at Olive View-UCLA Medical Center will be assessed by a licensed member of the health care team.

2. Each interdisciplinary department specific policies and procedures shall be contained in the Policy and Procedure Manual (PPM). The standards and policies shall comply with all regulatory requirements and are summarized on the attached grid.

3. Time frames for assessment and reassessments are determined by each discipline and will depend on the type of patients, the complexity and duration of their care, and the dynamics of conditions surrounding their care.

4. Further assessment is based on the patient's diagnosis, the care he or she is seeking, the care setting, the patient's response to any previous care, and his or her consent to treatment.

5. An admission history and physical examination shall be recorded within 24 hours of admission. This report shall include all the pertinent findings. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the hospital, a reasonable durable, legible copy of these reports may be used in the patient's medical record in lieu of the admission history and report by a member of the Professional Staff. In such instances, an interval admission note which includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

6. A completed history and physical and consent for surgery must be in the patient's chart or electronic record before anesthesia is begun.

7. The medical staff will determine diagnostic testing to be performed when the patient enters the service and the appropriate clinical data or background information (at a minimum, the patient's admitting diagnosis) to be included in the request or referral. Results from these tests will be used to determine the patient's health care and treatment needs.

8. All patients will be screened upon admission for identification of immediate nutritional needs using the validated Malnutrition Screening Tool (MST). At risk patients are referred to a registered dietitian. Nutritional status and needs are assessed and reassessed according to established protocols.

9. Patients are screened upon admission to identify those who require functional assessment. Functional status is assessed and reassessed according to established standards. Patients referred for rehabilitation services receive a functional assessment by a licensed Therapist.

10. Discharge planning assessment is initiated on all patients in the inpatient setting upon admission to the unit.

11. Possible victims of abuse will be assessed as per hospital policy.

12. The patient will be reassessed by each discipline:

    - To determine the response to care, treatment and interventions
    - When there is a change in the patient's condition
    - When there is a significant change in diagnosis
    - At specific intervals related to the care setting and course of treatment

13. All patients will be screened upon admission for advanced directive information. If any additional information is needed, nursing staff will refer to the Social Work Department.

The Interdisciplinary Departments:

- Medicine
- Nursing
- Wound Ostomy Care
- Respiratory Therapy
- Food and Nutrition
- Rehabilitation Services
  - Occupational Therapy
  - Orthotics/Prosthetics
  - Physical Therapy
  - Recreation Therapy
  - Speech Therapy
- Social Services
  - Medical
  - Mental Health
- Continuity of Care
- Pastoral Services
- Admission
- Pharmacy

PROCEDURE:

Clinical staff will utilize the criteria outlined in the grid below to ensure a comprehensive and interdisciplinary approach to the assessment, reassessment, and care of patients.

OVERVIEW OF DISCIPLINE SPECIFIC POLICIES AND CRITERIA (GRID)

DISCIPLINE	INITIAL ASSESSMENT TIME FRAME	REASSESSMENT TIME FRAME	LOCATION IN MEDICAL RECORD	HOW TO REFER	WHEN TO REFER (HIGH RISK "FLAG")
Medical Staff	Within 24 hours of admission: history and physical	Ongoing process based on patient's needs.	History and Physical and Progress Notes electronically.	Phone Beeper Number	Patient's complaints, any changes in the patient's condition, laboratory critical values, results of diagnostic tests, and responses to treatments.

DISCIPLINE	INITIAL ASSESSMENT TIME FRAME	REASSESSMENT TIME FRAME	LOCATION IN MEDICAL RECORD	HOW TO REFER	WHEN TO REFER (HIGH RISK "FLAG")
Nursing Staff	Inpatient: Within 24 of admission DEM/PER/ Ambulatory Care: Upon entry in the department Early Discharge: If patient is D/C before initial time frame, assessment will stop and will be deemed unable to complete initial admission/discharge assessment.	Inpatient: Unit Specific DEM/PER: Unit Specific Ambulatory Care: Each clinic Visit	All electronic documentation in orchid. During downtime will be located under Assessment Tab Nursing Notes section and Progress Notes. Inpatient Clinical Pathway forms are under Nursing Notes Primary filing is under Assessment in electronic patient chart. Until all disciplines are using electronic charting, copies may be made for the paper medical record	N/A	N/A
Wound Care Ostomy Nurse	24-96 hours (based on priority) Majority patients are seen within 24 hours.	Weekly, or more frequently as needed.	Documented in the Electronic Medical Record (ORCHID) under Wound Care	Through Electronic Medical Record, ORCHID, or message by phone (727) 210-3751, or pager (818) 529-1533	Wound that is not responding to standard care or a complicated wound or a pressure ulcer.
Respiratory	Within two (2) hours of admission or notification of physician's orders	Unit specific dependent on change in patient's status, condition and diagnosis. Each time therapy delivered.	Primary filing is under Assessment in electronic patient chart. Until all disciplines are using electronic charting, copies may be made for the paper medical record	Document in EMR	Hyperventilation, hypoventilation, dyspnea, labored breathing, diminished/absent breath sounds, wheezing, cyanosis of lips or nail beds.
Food and Nutrition	All inpatients will have an initial nutrition screening done by NURSING within 24 hours. Inpatient: High Risk patients seen within 24-48 hours – as defined by Depart. P&P D006.	High Risk/ Within 48 hours after initial assessment or 2x/week Patients are re-evaluated using clinical judgment to ensure their ongoing	Primary filing is under assessment in electronic patient chart.	HIS	Patients who appear emaciated; malnourished with unintentional weight loss of >10 lbs. in last month; presence of stage 3 or 4 decubitus ulcer/impaired skin integrity; GI symptoms for 2 weeks or more; enteral/parenteral feedings or supplemental source of nutrition; swallowing/chewing difficulties; pediatrics diagnosis of failure to thrive; and high-risk pregnancy (gestational diabetes mellitus and/or less than 18 years old).

DISCIPLINE	INITIAL ASSESSMENT TIME FRAME	REASSESSMENT TIME FRAME	LOCATION IN MEDICAL RECORD	HOW TO REFER	WHEN TO REFER (HIGH RISK "FLAG")
	All other patients will be seen regularly by hospitality assistants and other FNS staff during meal delivery, nourishment rounds, and patient visitations	nutritional needs are being met.			
Social Services (Clinical Social Work)	Based on priorities of patient's referrals. Inpatient: Within 72 hours of receipt of the referral. *On- call social worker available through the ANO during off hours. Outpatient: Appointment scheduled according to acuity – Walk-in and telephone consultation services available during office hours.	Reassessment is determined by the patient and/or family needs, level of functioning and healthcare team evaluations.	Primary filing is under assessment in electronic patient chart.	HIS	Concern or need for: ▪ Psychosocial Evaluation ▪ Adjustment to Illness ▪ Situational Depression or Anxiety ▪ Threat to Life or End of Life ▪ Bereavement ▪ New Life Changing Diagnosis ▪ Inadequate Support System ▪ Substance abuse ▪ Homelessness ▪ Out of Home Placement or Concern for Safety at Home – ▪ Positive Maternal or Newborn Toxicology ▪ Domestic Violence ▪ Young or Hindered Parent ▪ Overwhelmed Caregiver ▪ Child Abuse ▪ Elder/Dependent Abuse
Social Services (Mental Health)	Inpatient: Within 72 hours of admission. As soon as possible for patients admitted in the Psychiatric Emergency Room.	Inpatient: As needed based on patient and family needs. PER: Daily	Inpatient: Progress Notes under documentation in orchid. PER: PER chart	N/A	Inpatient: All psychiatric patients receive an adult psychosocial evaluation.
REHAB SERVICES: **Occupational Therapy** (Mental Health)	Within 72 hours of admission to the inpatient Mental Health Unit	Weekly.	Primary filing is under assessment in electronic patient chart.	Written physician order. Notification of order by orchid.	Mental Health inpatients that need a functional Occupational Therapy assessment.
REHAB SERVICES: Occupational Therapy (Physical Disabilities)	Outpatient: Appointment scheduled according to acuity. Inpatient: Within 72 hours of the receipt of the referral.	Inpatient: Brief reassessment with each treatment. Outpatient: Monthly	Primary filing is under assessment in electronic patient chart. medical record.	Written physician order. Notification of order by orchid.	Post-surgical hand patients requiring immediate splinting; traumatic hand injuries and deformities, which may include orthopedic/soft tissue, cumulative trauma disorders, congenital anomalies, arthritis and pain. Patients with decreased ROM/strength, impaired sensation and coordination of the upper extremities, and ADL's. Patients who have neurological conditions, stroke and cognitive deficits. Adaptive equipment or home equipment may be needed for the above conditions.

DISCIPLINE	INITIAL ASSESSMENT TIME FRAME	REASSESSMENT TIME FRAME	LOCATION IN MEDICAL RECORD	HOW TO REFER	WHEN TO REFER (HIGH RISK "FLAG")
REHAB SERVICES: Occupational Therapy (Pediatrics)	Outpatient: Appointment scheduled according to acuity. Inpatient: Within 72 hours of the receipt of the referral.	Outpatient: Prior to expiration of OT order, after six months of treatment, or as indicated by the patient's level of function. Inpatient: Weekly and as indicated by changes in patient condition or level of function.	Primary filing is under assessment in electronic patient chart.	Written physician order. Notification of order by HIS.	Child physically passive, does not move much, prefers sedentary activities; unable to feed self independently by age 3; unable to dress self by age 3; unable to dress self by age 4; unable to sit still for 1-2 minutes. Missed or delayed milestones. Awkward and uncoordinated movement, deficiencies in upper extremity ROM, strength and coordination. Child with difficulty taking the bottle, chewing or swallowing solid food. Visual perceptual problems. Child's parents feel unable to control child's behavior, or have difficulties dealing with the child.
REHAB SERVICES: Orthotics/ Prosthetics	Emergent: within 24 hours Routine: Scheduled in Orthotic/ Prosthetic Clinic with prioritization for acuity	Dependent upon equipment used, new referral from physician or patient having problem with equipment	Primary filing is under assessment in electronic patient chart.	Durable Medical Equipment Form signed by California Licensed Physician Signature. Additional forms and documentation may be needed based on patient's insurance.	Conditions or diagnoses which require bracing, external support or prosthesis. Diabetic and orthopedic shoes.
REHAB SERVICES: Physical Therapy	Inpatient: Within 72 hours of receipt of referral Outpatient: Prioritized according to acuity.	Ongoing process performed each session. Monthly	Primary filing is under assessment in electronic patient chart.	Written physician order. Notification of order by HIS.	Decreased muscle strength or impaired range of motion (ROM) of any extremity or trunk; abnormal muscle tone; loss or disuse of limb; Pain (neurological or musculoskeletal); impaired ambulation or movement; facial weakness; developmental delay; compromised endurance; edema; advanced wound care; impaired circulation; neurological disorders; stroke, congenital or acquired deformities; brain injury; orthopedic dysfunction; and need for durable medical equipment.
REHAB SERVICES: **Recreation Therapy**	Within 72 hours after admission to the inpatient Mental Health Unit	Weekly	Primary filing is under assessment in electronic patient chart.	Written physician order. Notification of order by HIS.	All Mental Health inpatients are assessed for Recreation Therapy Services.
REHAB SERVICES: Speech	Inpatient: Within 72 hours of receipt of referral	Ongoing process performed each session	Primary filing is under assessment in electronic patient chart.	Written physician order. Notification of order by	Conditions or diagnoses which may trigger a Speech Therapy consultation/referral: ▪ Difficulty swallowing (dehydration or mal-nutrition secondary to dysphagia)

DISCIPLINE	INITIAL ASSESSMENT TIME FRAME	REASSESSMENT TIME FRAME	LOCATION IN MEDICAL RECORD	HOW TO REFER	WHEN TO REFER (HIGH RISK "FLAG")
	Outpatient: Prioritized according to acuity			electronic system.	▪ Difficulty swallowing, feeding problems, PO aversion, failure to thrive (pediatrics) ▪ Stuttering ▪ Throaty, hoarse voice or no voice at all ▪ Slurred speech or decreased communicative ability with or without clear etiology ▪ Tracheotomy patients on or off ventilator ▪ Pre- and post-oral or laryngeal surgery patients (e.g., laryngectomy, polyp removal) CVA ▪ Head Trauma ▪ Neurological disease with apparent communication deficit (e.g., ALS, MS, Parkinson's, CP, etc.)
Continuity of Care	Within 72 hours of consultation request	After visit by home health agency staff and as needed	Progress Notes	Telephone call	Patients requiring referral for home care services
Pastoral Care	Within 72 hours* of consultation request *Clergy from the "Clergy Call List" available at Nursing Stations may be available during off hours.	By request by patient or staff	Progress Notes under documentation in orchid.	Telephone call or face to face	Patients, family members or staff requesting pastoral services

ATTACHMENTS/FORMS:

None

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APPROVED BY:

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