

Assessments



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September 17, 2007



Types of Assessments

- Initial assessment
- Change of condition
- Re-admission after hospitalization, sub-acute rehab, nursing home stay etc
- Special focus assessments; fall risk, pain management, cognitive, self-medication, elopement risk, nutritional needs, skin integrity and behavioral



Initial assessments

- Must be completed by the Registered professional nurse upon admission or immediately prior to the admission
- The assessment tool must include the 18 components for evaluation under 7.2 (d)



Initial assessments (cont)

- Need for assistance with ADL's
- Cognitive patterns
- Communication/hearing patterns
- Vision patterns
- Physical functioning and structural problems
- Continence



Initial assessments (cont)

- Psycho-social wellbeing
- Mood and behavior problems
- Activity pursuit patterns
- Disease diagnosis
- Health conditions and preventive health measures, including, but not limited to, pain, falls and lifestyle



Initial assessments (cont)

- Oral/nutritional status
- Oral/dental status
- Skin conditions
- Medication use
- Special treatment and procedures
- Restraint use
- Outside service utilization



Required Reassessments

- All residents with a general service plan at least semi-annually
- All residents with a health service plan quarterly
- More often on an as needed basis, including and upon residents return to the facility from the hospital (7.4 (c)1)



Re-assessment

- Prior to changing a resident's level of care (4.1 (a) 11)
- Involuntary discharge 5.14 (a)
- Resident posing a danger to himself or others 5.13 (c)



Re-admission assessments

- Form/tool used to be determined by facility policy
- May update original assessment with changes and sign and date the change
- May use separate assessment tool; or, document in the nurse's notes etc.
- Current assessment in the resident's record must reflect the current status



Policies must be developed and implemented to ensure

- Monitoring the condition of all residents on an as needed basis
- Notification of the RN if there are significant changes in condition
- Assessment of the resident's need for referral to a physician, APN or PA, or community agencies as appropriate



Change of condition

- Resident must be assessed at time of change in condition
- Arrange for medical intervention prn
- Identify any need for nursing interventions
- Update the care plan as needed



Fall assessments

- Fall Risk Assessments
- RN to assess resident after each fall
- Gather data related to the circumstances of the fall
- Identify interventions that may reduce the potential for additional falls
- Update the care plan



Pain Assessment

- Assess on admission, at time of planned discharge, on change in condition, self-reporting of pain or evidence of behavioral cues that indicate pain
- Assessment to include intensity or severity, pain character, pain frequency or pattern, or both, pain location, duration, precipitating factors, responses to treatment and the personal, cultural, spiritual, and/or ethnic beliefs that may impact an individual's perception of pain



Pain Assessment (cont)

- Pain assessment documented in the record to include, but not limited to date, pain rating, treatment plan and resident response.
- If pain is identified a pain treatment plan shall be developed and implemented



Other Assessments

- May be used-follow facility policy
- Cognitive
- Self-medication
- Elopement risk
- Nutritional
- Skin integrity/wound care
- Behavioral