DEPARTMENT: Nursing Services **POLICY: DCP 1815**

SUBJECT: Comprehensive Assessment of the Skilled Care Patient

PURPOSE: To outline the process for completing a comprehensive, detailed assessment of skilled care/swing bed patients' needs

RESPONSIBILITY:

- Inpatient nursing services, DCP/UR/Social Services
- Hospitalist, Dietitians, PT/OT, Pharmacy
- Members of the multidisciplinary care team: Hospitalist, DCP, Pharmacy, Nursing, Infection Control, Dietitians, Respiratory Therapy, and Physical Therapy (PT)/Occupational Therapy (OT).

DEFINITIONS:

1. A comprehensive assessment of the skilled/swing bed patient will include a standardized, reproducible assessment of each patient's functional capacity, physical, social and cognitive needs, disease processes and health condition, nutritional, dental and skin conditions, medications and discharge potential, as well as any other special treatment or procedures.

POLICY:

1. Within 14 days of admission a comprehensive assessment will be completed on each swing bed/skilled care patient, with input from the patient themselves, a multidisciplinary care team that includes the hospitalist (MD/DO), Social Service personnel, Staff RN, Dietitian, PT/OT, Pharmacy and patient family if available or their representative.

2. An ongoing assessment of the patient's social and activity preferences will be completed on a weekly basis to ensure their social needs and preferences are provided for
    a. Following a comprehensive assessment a comprehensive care plan will be developed within 7 days and include measurable objectives and timetables to meet a residents medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The patient's physical and occupational therapy needs will be assessed and managed by the PT director and his designees, which includes OT.
    b. Comprehensive assessment will be completed not less than every 12 months and within 14 days after it is determined there has been a significant change in the resident's physical or mental condition.

PROCEDURE:

1. On admission the patient will have a history and physical completed by the hospitalist. The admission screening, admission history, surveillance assessment, vaccination screening, code status, including advanced directives, fall risk, Braden skin assessment will be completed by the admitting RN.
    a. Include in these assessments are the patients identified, primary language, ability to understand instructions, suicide risk screening, abuse screening, spiritual, cultural and religious preferences and issues that may affect the care provided,

functional assessment, use and or need for adaptive equipment, any current or future need or use of community services including but not limited to meals on wheels, home care services or home O2, any adaptive equipment such as hearing aids, glasses or dentures, sleep habits and use of sleep aids. Additionally, a vaccination screening and health history are completed.

b. Multidisciplinary care rounds are held daily, Monday – Friday. Progress toward meeting goals will be addressed and changes in plan of care will be made accordingly.

c. Prior to day 14 a comprehensive assessment will be completed in addition to the previously stated assessments. The comprehensive assessment will include patient preferences in:

1. Daily routines include wake and bedtimes, clothing choices, activities such

as preferences in reading material, television viewing, games and desired level of social interactions and activity level

2. Dental and nutritional issues will be addressed on admission and as needed based on patient complaint and dietary intake.
   Dietary preferences are sought for each meal daily by the dietary staff.
3. Visual assessment will be completed on admit or within 7 days.
4. The comprehensive assessment will be completed not less than every 12 months or within 14 days of significant change in the resident's physical or mental condition.

Significant change is defined by:

i. Deterioration in 2 or more areas of ADL's
ii. Communication
iii. Cognitive abilities that appear permanent (pronounced deterioration in function and communication following a stroke, loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself, deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic and staff conclude that these changes in patient psychosocial status are no likely to improve without staff intervention)

REVIEW PROCESS:

This policy will be reviewed annually by Discharge Planning/Social Service designee, Director of Nursing Services, Director of Physical Therapy, Medical Staff, and Chief Executive Officer.