



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

NURSING ASSESSMENT

Effective Date: April 6, 2020

Policy: NS-03

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I. PURPOSE:

- A. To systematically collect relevant data about the patient as the initial step of the nursing care process.
- B. To continually collect and review patient specific data throughout the patient's hospitalization.
- C. To accurately document assessment findings on an approved form in the Medical Record.
- D. To identify and prioritize the appropriate nursing diagnosis(es) which provide the focus for the development of the patient's plan of care and discharge plan.

II. POLICY:

- A. The standard of care at Montana State Hospital (MSH) is that patients receive nursing care based on a documented systematic assessment of their needs, strengths, and treatment expectations.
- B. Assessments will be completed by registered nurses (RNs) and documented on a standardized form. Assessments will be completed: 1) within 24 hours of admission to the hospital; 2) whenever there is a significant change in the patient's physical and/or mental status; 3) no less than yearly.
- C. To the degree possible, the patient and significant others will collaborate with the registered nurse in the completion of the assessment.
- D. The nursing assessment is an integral part of the multi-disciplinary treatment planning process for each individual patient.
- E. Registered Nurses will perform a head to toe assessment for patients reporting actual or potential physical health problems throughout their hospital stay. This assessment information and ongoing assessment data will be documented on the Nursing Health Assessment form.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

- A. Registered Nurses - Complete nursing assessments.

V. PROCEDURE:

- A. Select an appropriate place to perform the assessment.
- B. Inform the patient of their mutual roles and responsibilities in the assessment process and encourage the patient's participation.
- C. Utilize interview, behavioral observation, and physical and mental status assessment skills to achieve a thorough and accurate assessment of patient care needs.
- D. Assess each patient at the time of admission and continuously throughout the patient's hospitalization as warranted by changes in the patient's care needs through the systematic collection of data in the following areas: biophysical, psychosocial, risk/environmental, educational, and discharge planning.
- E. As possible, seek out and utilize information pertinent to the assessment from not only the patient, but also from family members, significant others, and other health care providers.
- F. Document assessment findings in the patient's progress notes. (reference Patient Treatment Plan Policy).
- G. Participate and collaborate with the patient's treatment team in the formulation of the treatment plan.
- H. Document ongoing day-to-day assessments related to the patient's treatment plan in the progress notes of the patient's medical record.
- I. If, at the time of admission, sufficient assessment data is unable to be collected due to the severity of the patient's symptoms, the patient will be re-assessed within 48 hours of admission. Completion of the admission assessment must be coordinated by RNs assigned to the unit where the admission occurs. Nurse Supervisors are available to assist with the assessment when necessary.
- J. Completion of the admission assessment will be coordinated by all RNs assigned to the unit where the admission occurs. Nurse Supervisors are available to assist with the assessment when necessary.

VI. REFERENCES: M.C.A. 53-21-162. MSH policies *Patient Treatment Plan* and *Patient Assessment*; MSH Nursing Procedure *Nursing Physical Health Assessment*.

VII. COLLABORATED WITH: Medical Director.

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- VIII. RESCISSIONS:** NS-03, *Nursing Assessment and Diagnosis* dated December 11, 2013; NS-03, *Nursing Assessment and Diagnosis* dated February 3, 2011; NS-03, *Nursing Assessment and Diagnosis* dated January 25, 2008; NS-03, *Nursing Assessment and Diagnosis* dated October 24, 2003; NS-03, *Nursing Assessment and Diagnosis* dated February 14, 2000; HOPP NS-01-01, *Nursing Assessment and Diagnosis* dated June 15, 1996.
- IX. DISTRIBUTION:** All hospital policy manuals.
- X. ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.
- XI. FOLLOW-UP RESPONSIBILITY:** Director of Nursing.
- XII. ATTACHMENTS:** None.

Signatures:

Kyle Fouts
Hospital Administrator

Tiona Juarez, RN
Director of Nursing