



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

PATIENT ASSESSMENT POLICY

Effective Date: June 1, 2018

Policy: TX-10

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I. PURPOSE:

- A. To outline a systematic process for gathering pertinent information about each Montana State Hospital (MSH) patient.
- B. To establish a comprehensive information base for decision making about each patient's care.
- C. To provide patients with the appropriate timely care.

II. POLICY:

- A. Patient assessment at MSH is an ongoing process which begins before the patient is admitted and continues throughout treatment.
- B. Pre-admission information as well as observations made at the time of admission are used to determine the patient's initial placement in the hospital. Pertinent information obtained during the admission process is shared with the receiving treatment program staff.
- C. Once the patient arrives in the admission area, an initial assessment is completed within the first hour to determine immediate care needs. More formal assessments to determine each patient's physical, psychiatric, social, and rehabilitation needs are conducted during the first week of hospitalization. Analysis of information from these basic assessments drives initial treatment and discharge planning, and may trigger additional assessments for nutritional, occupational, vocational, spiritual, legal, and other specialized treatment needs.
- D. For patients remaining in the hospital for extended periods, admission assessment information is updated no less than annually. All formal assessments are conducted by staff with appropriate clinical qualifications.
- E. Patient acuity and needs determine the frequency of reassessment i.e.; a patient at high risk for self-harm may be observed/assessed continually while a stable patient with a history of polydipsia may be weighed and interviewed twice per shift. Reassessment of patient care needs including treatment plan review is also initiated at the following times:
 - 1. when there is a significant change in the patient's condition and/or diagnosis,
 - 2. when a patient is transferred from one MSH treatment program to another,
 - 3. at regularly established intervals, as established by state statute, and
 - 4. at the time of discharge.

- F. Information generated through analysis of assessment information is integrated to identify and prioritize an individualized plan of care for each MSH patient.

III. DEFINITIONS:

- A. **Licensed Independent Practitioner:** An active, provisional or part-time physician or APRN and/or CNS who attends to the care of the patients at MSH.

IV. RESPONSIBILITIES:

- A. All clinical professionals are responsible for following the procedural guidelines to ensure an appropriate and timely completion of the various assessments.
- B. Health Information is responsible for tracking the timely completion of the various assessments and for notifying the responsible clinical professional in the event that required information appears to be missing or incomplete.

V. PROCEDURE:

A. Pre-admission Assessment:

1. Pre-admission assessment begins when the Admissions Coordinator or Nurse House Supervisor receives a call from a community referral source about a possible hospital admission. Information gathered at this time includes:
 - a. circumstances which precipitated the pending admission,
 - b. diagnosis(es) and medication history,
 - c. additional physical health problems,
 - d. legal status,
 - e. involvement in community mental health or other healthcare services,
 - f. mental status, and
 - g. attempted community placement.
2. This information is used:
 - a. to determine the appropriateness of the admission to MSH based on the patient's psychiatric and physical health status,
 - b. to determine the most suitable MSH treatment program placement,
 - c. as preliminary information for the receiving treatment team, and
 - d. for the utilization review process.
3. On some occasions, MSH does not have advance notice of an admission. At these times the information above is obtained as soon as possible when the patient arrives.

B. Initial Assessment:

1. An initial assessment will be completed by a Registered Nurse within one hour of the time each patient is received by the assigned treatment program staff. The Registered Nurse will evaluate initial assessment data to determine whether there

is an immediate need for further medical or psychiatric evaluation and notify the appropriate licensed independent practitioner accordingly.

2. Results of the initial assessment are documented in each patient's medical record.

C. Admission Assessments:

1. Comprehensive nursing and psychiatric assessments are completed for each patient within 24 hours of admission.
2. Each patient will receive a *physical exam* within 24 hours of the admission. Exams will be completed as soon as possible if problems are reported prior to admission or identified after arrival at the hospital.
3. The *social assessment* is completed for each patient within seven (7) calendar days of admission.
4. A *rehabilitation assessment* is also completed for each patient within seven (7) calendar days of admission.
5. In cases when patients refuse and/or acuity precludes obtaining a complete assessment, the reason for delay and plan for completion is documented in the medical record.
6. Admission assessments become a permanent part of each patient's medical record and are updated annually for patients who remain hospitalized for extended periods.
7. Admission assessments include the following:
 - a. The Admission Psychiatric Evaluation is completed by a Licensed Independent Practitioner and results in a formal report, which includes psychiatric diagnoses and an initial treatment plan.
 - b. The Nursing Assessment is completed by a Registered Nurse, although aspects of the assessment may be delegated to other nursing staff in accordance with hospital policy and procedure. The nurse must draw on critical thinking and problem-solving skills to make clinical decisions and plan care for the patient. If any abnormal findings are identified, the nurse must ensure that appropriate action is taken. This may involve communication with the Nursing Supervisor, Licensed Independent Practitioner, medical clinic and the patient's treatment team.
 - c. The Admission History and Physical includes a comprehensive medical history and is completed by the medical clinic Licensed Independent Practitioner.
 - d. Completion of preadmission information initiates the social assessment process. Initial recommendations for treatment are made utilizing available

information.

For each patient admitted to the hospital for the first time, a comprehensive *Initial* Social Assessment is completed. An *Interim* Social Assessment is completed at the time of each readmission. The interim assessment updates areas that have changed. The family history will be reassessed at that time. Social Assessment information is evaluated resulting in recommendations for further assessment, treatment and discharge planning.

- e. The Rehabilitation Assessment is administered to patients admitted for inpatient services at MSH. The assessment will evaluate and offer treatment recommendations on the social and leisure domains. Recommendations will be shared with the patient as well as the treatment team for inclusion in the treatment plan.

D. Additional Assessments:

1. Admission assessment procedures may trigger a need to further examine actual or potential areas of need for treatment. Trigger criteria, content and procedural guidelines for internal referrals are described in separate policies (i.e., the Nutritional Assessment).
2. Additional patient assessments are initiated by a Licensed Independent Practitioner's order and accomplished by:
 - a. internal referral and/or
 - b. referrals to outside specialists/consultants.
3. Internal Referrals: Focused assessments administered by MSH clinical and education staff include:
 - a. nutritional - registered dietitian
 - b. dental - licensed dentist
 - c. functional - licensed occupational therapist
 - d. psychological - psychology staff
 - e. abuse/neglect - designated professional staff
 - f. social service - social services staff
 - g. substance abuse - certified chemical dependency professional
 - h. legal - designated professional staff
 - i. vocational – vocational specialist

Routine internal referrals will be completed in seven (7) days of the date ordered unless otherwise specified by the Licensed Independent Practitioner.

4. Outside Referrals: In addition to the above assessments, outside referrals to medical/dental specialty areas are made when a patient's physical condition requires further consultation. See MSH Policy TX-05, "*Consultation Services*" re: procedural guidelines for outside consultative services.

5. The patient will be reassessed upon return from other care facilities; i.e., medical hospital, to include nursing assessment and an update to the treatment plan as per MSH Policy, “*Patient Treatment Plan, TX-12.*”
 6. Analysis of additional assessment results will assist the treatment team to:
 - a. identify care needs, and
 - b. prioritize and refine the plan of care.
- E. Assessment Tools and Documentation:
1. Assessment tools and formats for documentation will be developed by the clinical disciplines responsible for the specific evaluation. All evaluation tools will be approved by the department director/chief/supervisor prior to use with patients. Health Information will review new paper-based forms for proper format design, then number the form prior to use. Formats for the Admission Assessments (nursing, psychiatric, physical health, social, and rehabilitation) will be standardized throughout the hospital.
- VI. REFERENCES:** MSH hospital policies: Physical Health Assessment, Nursing Assessment, Psychiatric Assessment, Social Assessment, Rehabilitation Assessment, and Nutritional Assessment.
- VII. COLLABORATED WITH:** Medical Director, Director of Nursing, Director of Clinical Services, Social Work Supervisor, Director of Health Information, and Rehabilitation Department Manager.
- VIII. RESCISSIONS:** TX-10, Patient Assessment dated August 1, 2012; TX-10, *Patient Assessment*, dated July 6, 2012; TX-10, *Patient Assessment*, dated June 7, 2012; TX-10, *Patient Assessment*, dated April 9, 2009; TX-10, *Patient Assessment* dated November 17, 2004; TX-10, *Patient Assessment* dated February 14, 2000; HOPP 13-01. A 112691, *Patient Assessment Policy*, dated November 26, 1991.
- 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:** Medical Director.
- XII. ATTACHMENTS:** None.

Signatures:

Jay Pottenger
Hospital Administrator

Thomas Gray, MD
Medical Director