Weisman Children's Rehabilitation Hospital (WCRH)

Administrative Manual

SUBJECT: PATIENT ASSESSMENT and EVALUATION NO: AM 6.29

EFFECTIVE DATE: 12/2/97 Page 1 of 12
REVIEWED/REVISED 4/9/03; 11/04; 04/05; 04/06; 04/07, 1/08; 1/09; 1/10; 1/11; 1/12; 1/13; 1/14; 1/15; 1/16; 1/17; 1/18; 1/21; 1/24

TJC: PC.01.02.01; PC.01.02.03
PURPOSE:
To establish guidelines for the assessment and reassessment of patients in order to determine the right care, treatment and services to meet the patient's initial and continuing needs.

POLICY: WCRH assesses and reassess its' patients.

- It is the policy of WCRH to begin the assessment process prior to the patient being admitted to the hospital.
- The purpose of this assessment is to determine the needs of the patient on admission and changing needs during the hospital stay.
- The hospital specifies individuals who are qualified to assess patients and the time frames in which the assessment and reassessment are carried out.
- The clinical liaison or designee collects information about each patient, including health status, physical function and psychosocial function and the information is shared among interdisciplinary team members in order to facilitate integrated and coordinated care planning.
- When the need for additional information is identified, the information is gathered by the appropriate team member.

PROCEDURE:

1. The hospital's assessment process is described in the attached chart.
2. Copies of the Assessment Tools are the EMR.
3. Nursing care is provided for in-patient and day hospital patients.
4. Nursing Services are not provided in the Out-Patient Services area.
5. The Clinical Liaison is a nurse working as marketing representative. The Clinical Liaison does not provide nursing care either within WCRH or at the referral site. The assessment that is done at the referral site by the Clinical Liaison is for admission determination and is not considered a nursing assessment.

6. Nurses in the Case Management Department are not practicing as nurses in this hospital and do not provide nursing care. The assessment that is done is a case management assessment.
7. When the Interdisciplinary Care Team assesses and identifies patient needs that cannot be met during the rehabilitation in-patient admission, those needs will be documented in the medical record, including plans for addressing those needs.
8. Individual disciplines must complete their assessments within the specified time. The assessment is part of the permanent medical record. See chart below.

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Administrator

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
PRE-ADMISSION: 1. Clinical Liaison Team	Referral Source e.g. area hospital, home, out-patient clinic	1. Clinical Liaison Nurses (RN)	Within 24 hours of referral	Assessment Tool for Pediatrics	Recommendation of Admission Team 1. When patient is not ready for discharge from acute general hospital 2. When admission canceled 3. When there is a change in diagnosis, medical or mental condition 4. When more information is required for admit decision	1. Patient 2. Case Management 3. Nursing 4. Infection Control 5. DCPP 6. Patient's family 7. Physician 8. Social Service 9. Respiratory 10. Rehab Therapies 11. Nutrition
2. Admissions	As referrals dictate in the WCRH Conference Room or other designated location	1. Admissions 2. Physician 3. Administrator 4. Therapies 5. Respiratory 6. Social Work 7. Clinical Nurse liaison 8. Case Management	Within 24 hours of completed assessment by Clinical Liaison Nurse	1. Ability to tolerate three hours of therapy 2. Diagnosis 3. Co-morbidities 4. Disposition 5. Financial issues	1. Daily until admit decision is made or admission is denied 2. Team may request further assessment from Liaison	1. Clinical Liaison to arrange admission 2. Decision to admit or deny communicated to referral source 3. Nursing obtains report from referral source 4. Pharmacy needs are identified 5. Special equipment or other needs are identified 6. Social Work needs are identified 7. Therapies needs are identified

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
IN-PATIENT: 1. Nursing	In-patient nursing unit Day hospital	1. Licensed registered nurses 2. LPN (only those areas appropriate to the Practice Act)	Comprehensive Assessment within 24 hours of admission Physical Assessment within 8 hours of admission	Completion of Assessment 1. Initial Physical Assessment 2. Nursing Daily Flow sheet 3. Initial Interview 4. Basic Developmental Screen 5. Present on Admission 6. Falls assessment 7. Skin assessment 8. Pain assessment	1. With a change in status 2. Each shift by nursing PRN 3. Pain every shift Weekly a. Falls b. Skin	1. Patient/Caregiver 2. Physician 3. Pharmacy 4. Dietitian 5. Materials Management 6. Therapies 7. Case Management 8. Patient's family 9. Infection Control 10.Respiratory 11. Social Work
2. Infection Control	Nursing Unit	1. Infection Control Practitioner	Within 1 week of admission or sooner if notified of special circumstances by nursing	1. Reviewed medical record	1. At least weekly 2. Review of medical record including lab studies.	1. Patient 2. Physician 3. Nursing 4. Pharmacy
3. Dietitian	Nursing Unit	1. Registered Dietitian Nutritionist	1. Within 72 hours 2. For DH within 72 hours of consult	1. Assessment Tool 2. Initial Team Conference	1. With a change in nutritional status 2. Identified nutrition diagnosis - weekly 3. No identified nutrition diagnosis - every 2 weeks 4. Weekly Team Conference	Day Hospital consult only 1. Patient 2. Physician 3. Nursing 4. Speech Therapy 5. Pharmacy 6. Family 7. Social Work 8, Food service (as indicated)

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
4. Case Management	Conference room	Registered Nurse	Team Evaluation wrap up within 24-72 hours (if over weekend) of admission	All assessments and eval wrap up goals for rehab Physicians documentation of medical necessity	1. Daily documentation of level of care in CPSI 2. Weekly team conference	1. Patient 2. Physician 3. Nursing 4. Patient's family 5. Therapies 6. Insurance Case Managers
4A. Social Work	1. Nursing Unit 2. Social Work office 3. Conference room	masters prepared and licensed by the Division of Consumer Affairs of the NJ Dept. of Law and Public Safety	Within 72 hours of admission SW assessment and learning needs assessment	1. Eval wrap up/ assessment tool 2. Evidence of abuse 3. Disposition 4. Emotional / Cognitive issues 5. Initial Team conferences	1. Weekly Team Conference 2. Change in medical status 3.Change in disposition 4. All changes requiring an update	1.Patient 2.Physician 3.Nursing 4.Patient's family 5.Therapies 6.Respiratory 7.DHS/DCPP 8.Referring hospitals 9.Outside agencies to whom referrals are being made 10. School, case management and Dietitian
5. Physician	Nursing Unit	1. Licensed physician with current admitting medical staff privileges	1.History and Physical within 24 hours of admission	1. Review of records from referral source 2. Evidence of abuse 3. Diagnostic testing needed 4. Consultation as needed and weekly 5. Initial Team Conference	1. Immediately with change in diagnosis, medical or mental status 3. 24 hrs/day coverage by attending physician 4. Weekly Team Conference Progress Note	1. Patient 2. Patient's family 3. Nursing 4. Pharmacy 5. Case Management 6. Dietitian 7. Therapies 8. Social Work

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
6. Physical Therapy	1. Patient Room 2. Therapy gym 3. Private Treatment room	Licensed Physical Therapist	1. Initial screen within 24 hours of admission 2. Complete evaluation within 48 hours of admission	1. Assessment Tool for Adults and Peds 2. Eval wrap up 3. Comprehensive chart review 4. Initial Team Conference	1. Immediately with change in diagnosis, medical or mental status 2. Scheduled Interdisciplinary Team Conference 3. Daily medical rounds PRN 4. Progress note	1. Patient 2. Patient's family 3. Physician 4. Nursing 5. Respiratory Therapy 6. Case Management 7.Materials Management 8.Orthotic/ Prosthetics 9. Other therapies 10. Wheelchair Vendors
7. Occupational Therapy	1. Patient room 2. Therapy gym 3. Private Treatment Room 4. Sensory Integration rooms 5. Computer room 6. ADL Kitchen 7. Community	Licensed Occupational Therapist	1. Initial screen within 24 hours of admission 2. Complete evaluation within 48 hours of admission	1. Assessment Tool for Adults and Peds 2. Eval wrap up 3. Comprehensive chart review 4. Initial Team Conference	1. Immediately with change in diagnosis, medical or mental status 2. Scheduled Interdisciplinary Team conference 3. Daily medical rounds PRN 4. Progress notes	1. Patient 2. Patient's family 3. Physician 4. Nursing 5. Respiratory Therapy 6. Case Management 7.. Materials Management 8.Orthotics/ Prosthetics 9.Other therapies 10.Dietitian 11. Wheelchair and assistive technology vendors

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
8. Speech Therapy	1. Patient rooms 2. Private treatment rooms 3.Therapy gym	Speech/Language Pathologist - Certified Clinically Competent	1. Initial screen within 24 hours of admission 2. Complete evaluation within 48 hours of admission	1. Assessment Tool for Adults and Peds a. Peds - interaction with parents and referral facility b. Adults - family screens 2. Eval wrap up 3. Comprehensive chart review 4. Initial Team Conference	1. With change in diagnosis, medical or mental status 2. Scheduled Interdisciplinary Team Conference 3. Daily for a. Pediatric feeding program b. Adult dysphagia program 4. Daily medical rounds PRN 5. Progress note	1. Patient 2. Patient's family 3. Nursing 4. Dietitian 5. Respiratory Therapy 6. Physician specialist 7. Case Management 8. Materials Management 9. Other therapies 10.Physician
9. Therapeutic Recreation	1. Patient's room 2. Play room 3. Teen room	Certified Therapeutic Recreation Specialist and / or certified child life specialist	1. Initial screen within 24 hours of admission 2. Complete evaluation within 48 hours of admission	1. Assessment Tool a. Adults b. Peds 2. Eval wrap up 3. Initial Team Conference 4. Comprehensive chart review	1. With change in diagnosis, medical or mental status 2. Scheduled Interdisciplinary Team Conference 3. Daily medical rounds PRN 4. Progress note	1. Patient 2. Patient's family 3. Nursing 4. Dietitian 5. Respiratory Therapy 6. Physician 7. Case Management 8. Materials Management 9. Other therapies

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
10. Respiratory Therapy	1. Referring hospital 2. Bedside 3. Team Conference	Licensed; certified or registered respiratory therapists	1. Initial assessment of a ventilator patient is conducted at the referring hospital at the request of the Admissions Team within 48 hours of request 2. In-patient assessment is conducted within 24 Hours of admission	1. Pre-admit initial assessment: a. Current respiratory status b. Pre-hospital status c. Chest x-ray d. ABG's e. Weaning history f. Disposition 2. Pre-admission assessment 3. Admission assessment a. Short/long term respiratory needs b. Rehab goals c. Patient resources d. Equipment needs e. Discharge needs 4. Initial Team Conference	1. Ongoing 2. Immediately with change in medical or mental status 3. Weekly Team Conference 4. Daily for a. Pediatric feeding program b. Adult dysphagia program	1. Patient 2. Patient's family 3. Physicians 4. Nursing 5. Therapies 6. Case managers 7. Referral sources 8. Community resources/agencies
11. a. Neuropsychology	1. Bedside	1. Licensed Psychologist 2. Graduate Psychologist with temporary permit - under supervision of Licensed Psychologist	1. Within 48 to 96 hours of consultation request	1. Review of medical record 2. Diagnostic interview 3. For patient requiring cognitive evaluation, Cognistat is the assessment tool	1. With change in mental or emotional status and order for re-consultation	1. Patient 2. Patient's family 3. Nursing 4. Therapies 5. Physician 6. Case Management

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
OUT-PATIENT: 1. Physical Therapy	1. Out-patient Services gym 2. Treatment rooms	Licensed Physical Therapist	Complete evaluation within 48 hours of admission	1. Assessment Tool for Pediatrics 2. Direct physician contact if appropriateness of referral is questioned 3.Assess for immediate treatment needs	1. Immediately with change in diagnosis, medical or mental status 2. As needed to maintain a current prescription thru treatment duration.	1. Patient 2. Patient's family 3. Specialty Physician 4.External Case Manager 5. School Nurses 6. Employers 7. Speech Therapy 8. Psychological support 9. Orthotic/Prosthetics 10.Other therapies 11. Early intervention programs 12. Wheelchair Vendors
2. Occupational Therapy	1. Out-patient Services gym 2. Treatment rooms 3. Sensory Integration room 4. Computer and pre-driver room 5. ADL kitchen	Licensed Occupational Therapist	Complete evaluation within 48 hours of admission	1. Assessment Tool for Adults and Peds 2. Direct physician contact if appropriateness of referral is questioned 3. Assess for immediate treatment needs	1. Immediately with change in diagnosis, medical or mental status 2. As needed to maintain a current prescription thru treatment duration.	1. Patient 2. Patient's family 3. Specialty Physician 4.External Case Manager 5. Neurooptometrist 6. School Nurses 7. Employers 8. Speech Therapy 9. Psychological support 10.Orthotics/ Prosthetics 11.Other therapies 12. Early intervention programs

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
3. Speech Therapy	1. Out-patient Services gym 2. Treatment rooms	Speech/Language Pathologist - Certified Clinically Competent	Complete evaluation within 48 hours of admission	1. Assessment Tool for Adults and Peds 2. Direct physician contact if appropriateness of referral is questioned 3. Assess for immediate treatment needs	1. Immediately with change in diagnosis, medical or mental status 2. Immediately with change in oral functional communication or swallowing status 3. As needed to maintain a current prescription thru treatment duration	1. Patient 2. Patient's family 3. Specialty Physician 4.External Case Manager 5. School Nurses 6. Employers 7. Dietitian 8. Psychological support 9.Orthotics/ Prosthetics 10.Other therapies 11. Early intervention programs
4. A. Neuropsychology	1. Neuropsych offices 2. Treatment rooms	1. Licensed Psychologist 2. Graduate Psychologist with temporary permit - under supervision of Licensed Psychologist	1. Within 2 weeks of referral for first appointment 2. Evaluation completed within 2 weeks (2 visits)	1. Review of medical record 2. Diagnostic interview 3. Neuropsych battery, depending on functioning levels	1. Immediately with change in emotional status 2. Routine is bi-monthly	1. Patient 2. Patient's family 3. Nursing 4. Therapies 5. Physician 6. Case Management 7. School personnel 8. Employers
Initial Team Conference	Nursing Unit	1. Case Management 2. Physician 3. Therapies 4. Primary Nurse 5. Dietitian 6. Neuropsychology when appropriate 7. Respiratory Therapy when appropriate 8. Resident 9. External Case Manager	1. Within 4 working days of admission	1. Completed assessments by all team members	1. Weekly	1. Patient 2. Patient's family 3. External Case Manager 4. Referring facility 5. School

ASSESSMENT PROCESS	SETTING	QUALIFIED INDIVIDUAL(S)	COMPLETION TIME FRAME	CRITERIA	REASSESSMENT	INTERACTION
Weekly Team Conference	Nursing Unit	1. Case Management 2. Physician 3. Therapies 4. Primary Nurse 5. Dietitian 6. Neuropsychology when appropriate 7. Respiratory Therapy when appropriate 8. Resident 9. External Case Manager	1. Within 7 days of the initial team conference, unless stipulated by team at initial conference	1. Progress toward goals 2. Change in disposition 3. Change in patient or family goals 4. Education needs of patient and family 5. Change in medical or mental status	1. Weekly until discharge	1. Patient 2. Patient's family 3. External Case Manager 4. Referring facility 5. School