



CLINICAL POLICY

Patient Screening, Assessment, Reassessment and Plan of Care

A. EFFECTIVE DATE :

September 19, 2023

B. PURPOSE :

The purpose of this policy is to provide guidance for the screening, assessment, reassessment, and plan of care for patients.

C. POLICY :

1. UConn Health screens, assesses, and reassesses patients based on the patient's presenting problem, health history, and other factors described in this policy. UConn Health may use additional screenings and/ or assessments by its nursing, medical, social work, occupational therapy, physical therapy, nutrition, and other staff when the patient's condition warrants.

D. PROCEDURE :

1. Initial Screening and/or Assessment

- i. The initial screening/assessment may include the following: an initial evaluation of the patient's health and physical history, social, and psychological status of the patient, presenting symptoms and response to interventions, and appraisal of inpatient and outpatient support needs.
- ii. The extent of the screening, assessment and reassessment is based on the patient's current condition, age, and treatment setting.
- iii. With the patient's consent, alternative data sources such as family members and medical alert jewelry may be utilized.
- iv. In the inpatient setting, the initial assessment is completed within 24 hours of admission and updated with additional information throughout the patient's hospitalization as appropriate. In the emergency department, the initial assessment is completed during the patient's stay in the emergency department unless the patient's medical condition makes this assessment impracticable. In the outpatient setting, the initial screening/assessment is completed within each specific clinic during the patient's first visit. Data collected for all settings may include the following:
 - a. Vital signs
 - b. Height and weight
 - c. Allergies

- d. Chief complaint
 - e. History of current illness/injury
 - f. Previous medical/surgical history
 - g. Immunization status
 - h. Current medications
 - i. Interpreter needs
 - j. Learning needs
 - k. Fall risk
 - l. Pain
 - m. Psychosocial status
 - n. Nutrition/Food Insecurity
 - o. Functional status
 - p. Suicide risk
 - q. Abuse and neglect
 - r. Substance use
 - s. Skin
- v. Licensed practitioner history, physical, and assessments are completed according to Medical Staff Rules and Regulations for inpatient, outpatient, and ambulatory settings.

2. Reassessment for Inpatients

- i. Each patient is reassessed as necessary based on their identified problems, plan for care, changes in condition, changes in care setting, or as clinically relevant.
 - a. Reassessment may also be based on the patient's diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; discharge planning needs; and/or setting requirements.
- ii. Specific assessments related to patient diagnosis or procedure are completed per licensed practitioner order or as clinically relevant.
- iii. Reconciliation of lines, drains, and airways is performed by tracing lines, drains, and airways from the patient to the point of origin at the following times:
 - a. Every change in caregiver
 - b. Change in care setting
 - c. Change in level of care
 - d. Before connecting to or reconnecting any device or infusion
- iv. Ongoing assessment is the responsibility of direct caregivers and consultants, may include:
 - a. Current physical, social, and psychological status of the patient
 - b. Evaluation of diagnoses considering input from patient/family, consultants, and results of diagnostic testing
 - c. Patient reports and physiologic responses related to medical, nursing, and other interventions
 - d. Identification of less urgent patient needs which are not part of the inpatient plan of care but will require further follow up
 - e. Assessment of discharge plans relative to current status of the patient and family

4. Plan of Care for Inpatients

- i. The patient's plan of care is initiated within 24 hours of admission.
- ii. Existing and potential problems, goals, and interventions are evaluated once in 24 hours and updated as clinically relevant.

- iii. Active problems will have an expected end date
- iv. The Plan of Care Review (progress note) is used to summarize findings, which may include, but is not limited to:
 - a. Admission, transfers, and discharge
 - b. Improvements and/or deteriorations
 - c. Response to care/treatments
 - d. Short term plan for the patient
 - e. Significant events
 - f. Unresolved problems at time of discharge

5. Screening & Reassessment for Outpatients

- i. Each patient is screened/reassessed as necessary based on their current condition and identified problems, changes in condition, desire for care, required/recommended treatment and services, and response to previous care, treatment, and services.
- ii. At the direction of the licensed practitioner, patient care setting, standard of care, or as clinically relevant (including type of visit such as in person versus telehealth) screening/reassessment of patients may include the following elements:
 - a. Vital signs
 - b. Allergies
 - c. Current medications
 - d. Learning needs
 - e. Fall risk assessment
 - f. Pain assessment
 - g. Advanced directives
 - h. Suicide risk
 - i. Abuse and neglect
- iii. Clinicians may also conduct focused assessments specific to their patient populations.
- iv. Patients in behavioral health outpatient settings are assessed based on clinic-specific population.

6. Consult Orders

- i. Nurses are permitted to place the following consult orders per protocol (no cosign required) if services are available, based on the assessment of patient needs:
 - a) Wound Care
 - b) Social Work
 - c) Spiritual Care
 - d) Nutrition

7. Patient Education

- i. For inpatients, the Learning Assessment is completed within 24 hours of admission.

- ii. For outpatients, the Learning Assessment is completed prior to providing patient education or with a change in condition.
- iii. Ongoing patient education is provided consistent with the patient's learning needs.
- iv. Patient education may be deferred if the patient is unable to participate in learning and does not have family/caregiver available and/or present.
- v. Documentation of patient education includes the teaching method, learner's readiness, and response.

8. Discharge from the Hospital (Inpatient Status)

- i. Identified problems are addressed prior to discharge.
- ii. Unresolved problems are documented in the medical record.
- iii. Discharge instructions are reviewed, individualized, and provided to the patient, family/caregiver or accepting healthcare facility.
- iv. An interagency referral form is completed if applicable.

E. SCOPE :

This policy applies to all inpatient, outpatient, procedural and ambulatory areas of JDH and UMG.

F. DEFINITIONS :

None

G. MATERIAL(S) NEEDED :

None

H. ATTACHMENTS :

None

I. REFERENCES :

PC.01.02.01
PC.04.02.01
PC.01.03.01

J. SEARCH WORDS :

Assessment, Inpatient, Outpatient, Reassessment, Screening, Plan of Care, Discharge assessment, Patient Education

K. ENFORCEMENT:

Violations of this policy or associated procedures may result in appropriate disciplinary measures in accordance with University By-Laws, General Rules of Conduct for All University Employees, applicable collective bargaining agreements, the University of Connecticut Student Code, other applicable University Policies, or as outlined in any procedures document related to this policy.

L. STAKEHOLDER APPROVALS :

On File

M. COMMITTEE APPROVALS :

Nursing Standards Committee, Clinical Policy Committee

N. FINAL APPROVAL :

1. Bruce T. Liang, MD (Signed) 10/03/2023
Bruce T. Liang, MD Date
Interim Chief Executive Officer & EVP for Health Affairs
Dean, School of Medicine

2. Anne Horbatuck (Signed) 09/26/2023
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3. Scott Allen (Signed) 09/27/2023
Scott Allen, MD Date
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4. Caryl Ryan (Signed) 10/03/2023
Caryl Ryan, MS, BSN, RN Date
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O. REVISION HISTORY :

Date Issued: 09/19/2023

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Date Reviewed: