

2003

J C A H O

News, tips, info, details, and ideas brought to you by the
Clinical Center JCAHO Work Group

Volume 1 - 2003

Patient Assessment

When a patient is admitted to the Clinical Center (CC), the first goal is to determine the kind of care that is required to meet the immediate needs of the patient as well as to prepare for any changing conditions and eventually discharge.



The initial patient assessment is conducted by the interdisciplinary team (social work, nutrition, medical staff, etc.). This assessment should address the patient's psychological, social and medical needs. The timeframe of these assessments are determined by CC policy or departmental policy. The results of these assessments are documented for review by the care team.

Some assessments must be performed and documented for **all patients within 24 hours of admission, even on weekends and holidays**. These elements include, but not limited to:

- ❑ **Medical History and Physical Examination**
- ❑ **Nursing Care Assessment**
- ❑ **Pain Assessment**
- ❑ **Screening assessments as needed – nutrition, functional, communicable disease, advanced directives, teaching/learning assessment.**



Routine reassessments and follow up are performed according to the policies of the Clinical Center and/or the department, but minimally, whenever the condition of the patient changes.

Test yourself...in the area where you work, do you know which team members perform an initial assessment when a patient is admitted? Do you know when they perform this assessment?. Surveyors are likely to ask:

- **When is a nutritional assessment performed?**
- **What are the screening questions for functional assessment?**
- **Does Social Work see every patient on the unit, and within what time frame from admission?**
- **When is a social work/nutrition/nursing reassessment done for a patient?**

See other side→

Patient Education:

What is Our Responsibility to Our Patients?

The goal of patient and family education is to improve the patient's health outcomes by promoting healthy behavior. What is our obligation to help patient achieve the best possible health outcome? It all begins with **ASSESSMENT** of the patient/family learning needs. When prioritizing and planning patient education outcomes, all members of the health care team need to consider the patient and family's:

- preferred method of learning
- cultural and religious practices
- emotional barriers
- desire and motivation to learn
- physical and cognitive limitations
- language barriers
- financial implications of care choices

Assessment of the patient's learning needs must include the following key areas:

- medication use
- medical equipment use
- potential drug-food interactions
- rehabilitation techniques
- pain
- language barriers
- community resources
- follow-up care

Did you know that, health care providers are also responsible for assuring patients understand their responsibilities. These responsibilities include providing information on matters pertaining to their health, asking questions, following instructions, accepting the consequences of not following instructions, following hospital rules and regulations, and acting with consideration and respect. This information is in the Patient Rights and Responsibilities pamphlet and is distributed by the admission office or by Patient Representative Program volunteer.

We are responsible for using our assessment in the **PLANNING** and **IMPLEMENTATION** of patient education. Sometimes a single discipline is responsible for assisting the patient to meet the mutually agreed upon outcomes. But when several disciplines are involved in assisting the patient to meet the same outcomes, the delivery of care must be coordinated and communicated among the disciplines involved. The final step in the education process is **EVALUATION** of the patient and family's learning. How has what the patient and family learned changed their behavior?

We use many patient education **RESOURCES** in the Clinical Center. Access the Patient Information Resources website (http://www.cc.nih.gov/cc/patient_education/resource.html) through the Education and Training icon on your Standard Clinical Desktop and find an assortment of materials available from the CC and institutes.

DOCUMENTATION The old cliché, "if it isn't documented, it didn't happen" holds true for patient education. It is generally agreed that patient teaching is an area of excellence for CC health care providers, however we must work together to ensure that all the education provided is documented in the patient record.

