**TOPIC: ASSESSMENT AND REASSESSMENT OF PATIENTS**

PURPOSE: In order to identify the need for care and treatment of each patient, assessment and reassessment will be performed at the initiation of service and periodically throughout the patient's care as appropriate to the condition of the patient. Assessment, planning, intervention and evaluation are ongoing processes due to the nature of outpatient services.

LEVEL OF RESPONSIBILITY:

Physicians
Advanced Practice Nurses
Registered Nurses

POLICY:

1. Assessments in the Ambulatory Care setting are to be completed by the practitioner based on the chief complaint of the patient (MD, RN, and Nurse Practitioner).

2. The patient's plan of care and treatment decisions, recommendations, and/or referrals are made upon analysis of data collected through the assessment. Such decisions/recommendations/ referrals will be documented in the EMR.

3. Assessments are individualized and appropriate to the age of the patient, neonate through geriatric. Reassessments will be performed to determine efficacy of treatment or to identify additional needs when the patient's condition or diagnosis changes.

PROCEDURE:

Initial Assessment:

1. A practitioner (physician or nurse practitioner) as clinically indicated, will assess all patients for the initial clinic assessment in the ambulatory clinic areas.

2. Initial assessment will include pertinent aspects of the following:
    * patient history interview
    * review of present symptoms
    * assessment of pain
    * assessment of current complaint
    * examination
    * review of systems
    * development of treatment plans

The assessment will be as indicated by the patient's specific needs. The assessment should be completed within the patient's first three visits to PCC.

3. The Medical Assistant performs specific tasks and procedures, including data collection (such as vital signs) as part of the assessment.

4 Ambulatory care nutrition screening may be done as part of the initial assessment, and as condition of the patient warrants.

5. When pain is identified, a more comprehensive assessment is performed when warranted by the patient's condition. Measure of pain intensity and quality (i.e. pain character, frequency, location and duration), appropriate to patient's age are recorded in a way that facilitates regular reassessment and follow-up.

Reassessment:

1. Reassessment will review and evaluate the patient's status of previously identified conditions and evaluate any newly identified conditions.

2. Patients are to be reassessed for pain, functional and nutritional assessment and discharge planning needs as indicated based on previous visit.

3. Age specific expectations will be utilized and documented (e.g. dietary review, smoking status, exercise habits, preventive health maintenance services, etc.).

4. Data will be documented in the patient's EMR.

5. Problem lists and a review of systems will be updated with each patient's visit.

6. Diagnostic testing and/or treatment will be determined by the practitioner utilizing current standards of clinical practice.

7. Follow-up of diagnostic testing will be performed accordingly.

8. Reassessment will be appropriate and indicated by the patient's specific needs. Exclusions to each guideline may exist for each unique clinic, such as for prescription refills, laboratory testing, etc.

Original: 2/96
Revised: 5/02, 5/08, 2/09
Reviewed: 9/14