### PURPOSE

To provide guidelines for the comprehensive assessment.

### Policy

### Ohio Living hospice admits patients whose care needs can be met and ensures continuity of care through a comprehensive assessment and service coordination.

An initial comprehensive assessment is completed by the hospice registered nurse within 48 hours after the election of hospice care unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours. The initial comprehensive patient assessment will be performed by the interdisciplinary group no later than 5 calendar days after the election of hospice care, unless requested by the patient/family, and in consultation with patient’s attending physician, if applicable.

### PRocEDURE

1. The registered nurse will identify the patient/family/caregiver needs related to the terminal illness.
2. During the comprehensive patient assessment, all baseline data and other relevant information will be documented in the patient's clinical record, including the following information, as relevant:
3. An assessment of pain, including the origin, location, duration, severity, and relief measures
4. An assessment of severity of secondary symptoms, such as nausea, vomiting, respiratory distress, and nutritional status
5. Nature and condition causing admission (including the presence or lack of objective data and subjective complaints)
6. Alleviating and exacerbating factors for physical symptoms
7. Current treatment, patient response to that treatment, to include non-pharmacological interventions.
8. An assessment of the patient's response to palliative treatment
9. A physical assessment, including blood pressure, temperature, pulse, respiration, skin, and other relevant data related to pertinent physical findings and the patient's terminal illness
10. Imminence of death
11. Patient's current functional status including, but not limited to, the degree of self-care and the amount and level of assistance needed and ability to understand and participate in care
12. Functional decline over the past several months
13. Complication and risk factors that affect care planning
14. Patient's past and present medical, mental, and psychosocial status and history including pertinent diagnosis, history of substance abuse, any co-morbid conditions, and risk for drug diversion.
15. Name and address of the patient's attending physician
16. An evaluation of the home environment and assessment of emergency preparedness of the patient.
17. Presence of any Advance Directives for care and/or discussions with patient and family/caregiver regarding the withholding of resuscitative services or the withdrawal of life-sustaining treatment
18. Equipment presently in home and potentially needed by patient
19. Review of current and related past medications, including prescription, over-the-counter medications, herbal remedies, and other alternative treatments that could affect drug therapy. Review allergy history and other medication information, including but not limited to identification of the following:
    1. Effectiveness of drug therapy
    2. Unwanted side and toxic effects
    3. Drug interactions (actual or potential)
    4. Duplicate drug therapy
    5. Drug therapy currently associated with laboratory monitoring
    6. Whether the medication is unrelated to the terminal illness or related conditions
20. Patient and family/caregiver support systems and the care the family/caregiver is available, capable, and willing to provide, including applicable strengths of patient, physical, psychosocial, and/or spiritual resources available
21. Assessment of support and/or counseling needs related to the terminal illness.
22. The patient’s psychosocial status will be assessed to, included preferred style of communication including expressing emotions, emotional barriers to treatment, cognitive limitations, memory and orientation, preferred pronouns, family relationships, social history, source and adequacy of environmental and other resources, coping mechanisms, and the patient’s and family/caregiver’s reaction to illness.
23. An assessment of the patient's and family/caregiver's spiritual orientation, including, as appropriate, any involvement in a religious group such as a church or synagogue or a support group such as Alcoholics Anonymous and spiritual concerns or needs such as despair, suffering, guilt, etc.
24. Involvement of family/caregiver, neighbors, and/or other individuals/organizations, including involvement in any support groups
25. An assessment of the need for volunteer services to offer support or respite to the patient and family/caregiver
26. An initial bereavement assessment of the needs of the patient’s family and other individuals focusing on:
27. The nature of the relationship to the patient
28. Circumstances surrounding the illness/prognosis
29. Behaviors prior to and after the illness/prognosis
30. Survivor needs (social, spiritual and cultural) that may impact coping skills
31. Potential for pathological grief reactions
32. Laboratory results
33. Medical, alcohol, and other drug history
34. COVID vaccination history
35. Specific, individualized patient needs/problems pertinent to the hospice care being provided
36. The patient’s and family/caregiver’s educational needs, abilities, motivation, and readiness to learn and their ability to self-administer drugs and biologicals at home.
37. The need for referrals and further evaluation by appropriate health professionals
38. The assessment should determine:
39. Probable prognosis of six (6) months or less
40. Patient problems and needs related to the terminal illness
41. Patient goals related to the terminal illness
42. Type of services, frequency, and duration needed to meet patient care needs
43. Anticipated discharge needs, including bereavement and funeral needs
44. Survival risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, and availability of coping mechanisms and potential for pathological grief reactions
45. The need for an alternative level of care
46. The Clinical Team Leader or designee will be responsible for assuring that the documentation of clinical findings supports the terminal diagnosis.
47. The comprehensive assessment is updated by the interdisciplinary group as frequently as the patient’s condition requires but at a minimum every 15 days. This includes:
    1. The interdisciplinary group will update those sections that require updating indicating a change occurred since the initial assessment was completed
    2. If no changes are needed, then that must be documented
    3. Patient’s progress toward outcomes and goals
    4. Review/reassess patient’s response to care