### PURPOSE

To provide guidelines for the initial assessment of patients admitted to service and for completing the plan of care.

### POLICY

An initial patient assessment will be performed and documented in the patient’s clinical record by a registered nurse, physical therapist, occupational therapist, or speech therapist.

A comprehensive patient assessment will be completed within five (5) calendar days of the patient’s start of care.

Two patient identifiers will be used to identify the patient. Acceptable patient identifiers are:

* Patient Name
* Date of Birth
* Social Security Numbers
* Photo Identification
* Insurance Card
* Family/Caregiver verified identity
* Visual recognition

The assessment will be patient-specific and comprehensive to include the patient’s need for home care, rehabilitative care, social, and discharge planning needs. The assessment will also include the exact use of the current versions of the Outcomes and Assessment Information Set (OASIS). This assessment will measure patient outcomes from data collected at the start of care and at the following defined intervals thereafter:

1. The last five (5) days of every 60-day episode beginning with the start of care date (recertification)
2. Upon transfer
3. Significant change in condition resulting in a new case mix – Follow-up assessment
4. Within 48 hours of the patient’s return home or of the organization’s knowledge of the patient’s return from a 24-hour hospital admission for other than diagnostic testing
5. At discharge

### PROCEDURE

1. The initial assessment and comprehensive assessment must be conducted by a registered nurse unless physical therapy, occupational therapy, or speech language pathology is the only requested service for that patient. In those cases, the physical therapist or speech therapist may conduct the initial assessment and the comprehensive assessment. These assessments may be conducted by the occupational therapist if the need for occupational therapy establishes program eligibility.
2. The comprehensive assessment for each patient must be completed in its entirety by a single clinician with input from other evaluating disciplines.
3. During the initial and comprehensive patient assessment, all baseline data to be used in measuring the patient’s progress towards goals and other relevant information will be documented in the patient’s clinical record, including at least the following information, if applicable:
4. Outcomes and Assessment Information Set (OASIS) data must be collected on all patients receiving skilled services except pre and postpartum patients, patients under the age of 18, and patients whose care is reimbursed by a private insurance company. OASIS data collection is not required for patients who are receiving only personal care or support services (patients receiving only homemaker services). The OASIS data will be collected during the comprehensive assessment. The assessment tool must also include the exact use of the current versions of the OASIS data set.
5. A physical assessment, including blood pressure, temperature, pulse, respiration, skin, pain status, height/weight, nutritional status, and other relevant data related to pertinent physical findings.
6. Patient’s functional status, including but not limited to, the degree of self-care, and the amount and level of assistance needed in the following areas:
	1. Eating
	2. Meal preparation
	3. Toileting/continence
	4. Transfer
	5. Ambulation
	6. Shopping, cleaning, laundry
	7. Bathing
	8. Dressing
	9. Use of telephone
	10. Mobility
7. Patient’s medical and psychosocial history, including pertinent diagnosis and prognosis.
8. The patient’s psychosocial status, including emotional barriers to treatment, cognitive limitations, memory, and orientation.
9. The patients and family/caregiver’s educational needs, abilities, motivation, and readiness to learn.
10. Name and address of the patient’s physician.
11. Name of the hospital, other agencies, and persons involved in the past and present care of the patient.
12. An evaluation of the home environment and assessment of emergency preparedness of the patient.
13. Presence of any Advance Directives for care or discussions with patient and, as appropriate, family/caregiver, regarding the withholding of resuscitative services or the withdrawal of life-sustaining treatment.
14. Wishes regarding care, treatment and end-of-life decisions.
15. Equipment presently in the home and potentially needed by patient.
16. Any identified symptoms of pain.
17. Review of medication history, as applicable to care and service and current medication use, including prescription, over-the-counter medications and herbal medications, and identifying drug interactions, duplicative drug therapy, and noncompliance with therapy.
18. If not the patient, identify the patient’s representative if any.
19. Patient and family caregiver support systems and the type of care the family/caregiver is available, capable, and willing to provide.
20. Cultural and religious practices.
21. Involvement of family/caregiver, neighbors, or other individuals or organizations.
22. Laboratory results.
23. Medical, alcohol, and other drug history.
24. Preventive and periodic health screening, including TB screening, if appropriate.
25. Immunizations, when appropriate.
26. Specific, individualized patient needs and problems pertinent to the care being provided.
27. Past medical and surgical care including dates of onset/exacerbation.
28. Anticipated discharge needs.
29. The comprehensive assessment should determine:
	* 1. Patient problems, needs, strengths, goals and care preferences
		2. The patient’s continuing need for home care
		3. That the patient meets payment eligibility requirements (e.g., homebound status)
		4. Patient prognosis
		5. Baseline information to be used to measure the patient’s progress toward achievement of desired goals and outcomes
		6. Plan of care, including type of services, frequency, and duration
		7. The ability of the organization to adequately meet the patient’s medical, nursing, rehabilitation, social and discharge planning needs
30. A plan of care will be developed from the information gathered during the initial and comprehensive assessment. The patient’s physician is consulted for approval if additions or modifications to the plan of care are required after the assessment is completed.
31. The Clinical Supervisor or designee will be responsible for the review of the plan of care.