Interdisciplinary Admission Assessment
and Plan of Care / Problem List
for Inpatient and Ambulatory Settings

POLICY:

An Admission Assessment for each patient and family will be initiated at the time of, or prior to admission when possible, and completed within the first 24 hours on a patient care unit in order to develop a specific plan of care. All disciplines involved in the patient's care work together to perform a comprehensive patient assessment and plan of care from the collection and review of data. The patient is re-assessed throughout hospitalization as needed. Interdisciplinary assessment findings are used to make decisions about the plan of care.

Assessments for Ambulatory Clinic Patients are initiated at the first clinic appointment. Information is gathered from many sources, which may include screenings, evaluations, diagnostic procedures, and external reports. A plan of care is formulated with each patient and family based on mutually determined needs and goals. Re-assessments are performed in response to care or for a significant change in a condition or diagnosis.

PURPOSE:

The admission assessment tools support a system of data collection that promotes the creation of an effective and efficient plan of care upon admission. The data include the areas of bio-physical, psychosocial, functional, environmental, self-care, educational, and discharge planning. Teaching and special care needs/health issues are identified from the assessment and are used to develop an ongoing plan of care and a discharge plan.

The ambulatory assessment includes many of the same system areas as above, addressing the unique needs and goals for each patient and family.

PROCEDURE:

I. Admission Assessment

A. Nurses and/or health care team members initiate the admission assessment tools at the time of admission to an inpatient unit or as plans are made for hospital admission (e.g. the Emergency Department or referring clinic). If a patient is initially assessed in the Emergency Department (ED) and is subsequently admitted to an inpatient unit, the admitting residents may utilize the ED assessment(s) and add any additional information in the admission assessment tools.

B. If the planned admission is within 30 days of the clinic visit, the assessment tools, as completed, are delivered to / filed with the receiving unit charge nurse until the
day of admission. It is the responsibility of the admitting team to review, update and/or complete the assessment and plan of care.

C. Part A of the Interdisciplinary Admission Assessment tools is completed within 24 hours of admission to the unit; this includes the nutritional assessment. The physician components (medical history, physical exam, etc.) are completed within 2 hours to the acute / critical care units and within 8 hours to Rehab and Inpatient Psych Units.

D. Circumstances may arise when full data collection within 24 hours may not be possible or may be deemed inappropriate by clinical judgment. An initial assessment is still required, incorporating any significant data that is obtainable within the first 24 hours, then signed by the appropriate health care team members.

E. Any data collected after 24 hours can be added to the assessment tools and documented as a late entry, with initials and signatures.

F. Any issues or problems that are assessed in Part A of the Interdisciplinary Admission Assessment tool are first indicated by checking the “Y” box to the left of the functional area, with subsequent documentation in the patient’s plan of care / problem list.

G. Ongoing assessment includes reevaluation of patient care needs throughout the hospitalization and is documented in the nursing flow sheets, plan of care and/or progress notes.

II. Ambulatory Assessment

A. Each patient seen in an ambulatory clinic will have an initial assessment.
   1. The scope of the initial assessment will be determined by the nature of the referral, the presenting problem and the goals and individual needs of the patient and family.
   2. The initial assessment will include relevant physical history of illness or injury, physical findings, and an appraisal of the patient’s psychological needs (including developmental issues) and social situation as deemed necessary by the nature of the referral.
   3. The medical team will identify those patients who require nutritional assessment, intervention, and education and refer as appropriate.
   4. Patients at risk for developmental or functional limitations will receive a screening of present skills and developmental history.
   5. When external assessment reports have been completed prior to the ambulatory visit, every effort will be made to have those reports available at the child’s first visit.
   6. Initial assessments may also include diagnostic procedures such as laboratory or imaging.
   7. When an assessment suggests the patient may be a victim of possible abuse, the patient will be managed according to Children’s child abuse/neglect policies and procedures.

B. Assessment data will be analyzed to identify the patient’s need for care or treatment. Care decisions will be made in collaboration with the patient and family and documented in the medical record.

C. The patient’s care will be coordinated with the patient’s primary care provider so that patients are subsequently re-assessed either by their primary care provider or Children’s provider to determine their response to care or note any significant...
changes in condition or diagnosis. Re-assessments should be linked with key decision-making points in the care of the patient.

III. Plan of Care/Problem List (Inpatient)

A. Information on this tool includes primary and secondary diagnosis, names of involved services and team members, lists of problems (numbered) with dates and anticipated outcomes for this hospital admission.
   1. The problems that are documented here are identified at the time of admission and as new issues arise throughout the hospital stay.
   2. The date indicates the date that the problem was identified and recorded.
   3. The anticipated outcome indicates the expected status to be achieved at the time of discharge.

B. Data from the admission tools and interdisciplinary assessments is used to identify problems and health issues. This will serve as the patient’s plan of care and is kept in the front of the medical record, along with applicable clinical paths or guidelines of care.

C. If the patient is following a clinical pathway or guideline of care, this is indicated on the problem list, and unless otherwise stated, is the plan of care.

D. The Multidisciplinary Inpatient Follow up note may serve as the plan of care.

E. Except for non-specialty units (e.g., ICUs, Rehab, IPU) the Plan of Care/Problem List is initiated within 24 hours of admission and completed for every inpatient stay. The specialty units will document problems/health issues in the progress notes.

F. For patients transferred from the ICUs to an acute care unit, the Plan of Care/Problem List will be initiated prior to transfer.

G. Any member of the health care team may identify patient problems or health issues, discuss with a member(s) of the team and record/update an entry on this tool.

H. Identification/documentation of the problem does not indicate accountability for resolution or resolution of the problem. The attending physician is accountable for the oversight of plan of care.

I. New problems identified throughout the course of hospitalization are added to the Interdisciplinary Plan of Care/Problem List.

J. Recording of the status and progress of problems/health issues is documented in the progress notes by team members. Team members acknowledge and review other team members’ notes in addressing patient problems/health issues.

K. Discharge status is documented in the progress notes, discharge summary and Continuing Care Instructions.

IV. Plan of Care / Problem List (Ambulatory)

A. Information on the Summary List in Clinical Information System (CIS) includes primary and secondary diagnoses. In addition, the patient’s list of active problems and the plan of care is documented in each clinic visit note.

B. Data from the admission tools and interdisciplinary assessments are used to identify problems and health issues.

C. If the patient care is following a clinical pathway, guideline of care, care map or treatment protocol, this is indicated on the problem list, and unless otherwise stated, is the plan of care.
D. Any member of the health care team may identify patient problems or health issues, discuss with a member(s) of the team and record/update an entry on the summary list of CIS.

E. Identification/documentation of the problem does not indicate accountability for resolution or resolution of the problem. The attending physician is accountable for the oversight of the plan of care.

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