ORIGINAL DATE: 11/96
REVISION DATE: 10/15

Home Health VNA, Inc.

SUBJECT: PATIENT ASSESSMENT/REASSESSMENT

PURPOSE: To ensure that initial, ongoing, and discharge assessments are comprehensive and completed in a timely manner.

Policy

The assessment of the patient is an ongoing process from the start of care through discharge. Care plans are revised and service plans are updated according to the patient's needs as identified during the assessment and reassessment processes. A comprehensive assessment of the patient is completed as soon as possible but no later than the 5th calendar day from the start of care. For those patients requiring collection of Outcome and Assessment Information Set (OASIS) data, the OASIS assessment will be performed as part of the Comprehensive Assessment (refer to *Policy #1930 – Outcome and Assessment Information Set*).

Procedure

A. Initial Assessment

The initial patient assessment is completed on the physician ordered start of care date or within 48 hours of the inpatient facility discharge date. Home Health VNA ensures that the physician, patient and referral sources are informed if the initial assessment is delayed. This communication is documented in the patient's medical record.

Whenever nursing care is ordered, a registered nurse will perform the initial assessment on all multidisciplinary cases to establish eligibility for coverage. If the patient's care requirements indicate a Physical Therapist to perform the initial assessment on a multidisciplinary case, the documentation will support that need; a manager will supplement the clinical documentation in a call log when needed.

The therapist will perform the initial assessment for cases in which therapy is the only discipline ordered.

Upon first/initial patient encounter, the clinician shall verify the patient's identity using two patient identifiers:

1. patient statement of name (family member may state patient name if patient unable); and
2. patient statement of date of birth. If the date of birth information is not reliable or available, patient statement of correct address or phone number is acceptable.

For Medicare patients, the initial assessment includes verification of the patient's eligibility for the Medicare Home Health Benefit, including homebound status and the need for skilled care.

B. Comprehensive Assessment

A system-based, problem-oriented comprehensive assessment is completed according to regulations and time frames set forth in the Conditions of Participation and will include the following elements

1. Systems review – all systems reviewed within clinician's scope of practice
2. Vital signs
3. Height and weight
4. Medication review and reconciliation
5. Pain assessment (using the standard pain scale)
6. Safety assessment
7. Functional status
8. Timed Up and Go (TUG) and/or Tinetti Balance Screening (Physical Therapy only)
9. Fall risk assessment – Missouri Alliance for Home Care (MAHC-10) – PHQ 2 or 9 when indicated - All disciplines
10. Pressure Ulcer risk (using the Braden scale)
11. Socio-economic assessment (including caregiver availability)
12. Mental health status assessment

All findings are documented in the medical record.

Each discipline will develop a patient plan of care based on the skilled needs identified through the comprehensive assessment incorporating patient centered goals of care with the discipline specific assessment. Documentation will include communication, patient teaching, and plan for next visit. The narrative note will include specific areas for potential outcome improvement.

C. First Visit – Delayed OASIS Assessment

Based on the patient's needs, the time of day, and available resources, a manager may make the decision to admit a patient to service and delay the comprehensive assessment. The manager confers with other sites to determine staff availability prior to scheduling a **First Visit Delayed OASIS Assessment**. The initial assessment and follow-up visit that includes the OASIS Assessment must be done by a registered nurse or physical therapist. The following tasks are completed during the First Visit – Delayed OASIS:

1. Notice of Acceptance Form signed;
2. medication verification and begin medication teaching as appropriate;
3. completion of clinical note including vital signs and care performed;
4. documentation of visit frequency as 1 day 1 to assure the next visit is assigned; and
5. manager will assure visit remains on tracking.

After the first visit, the following tasks are completed by the registered nurse:

1. code as "patient visit" on the DAR (daily activity record);
2. report is left via e-mail or voice mail to primary clinician, if known, otherwise to Clinical Manager and/or Clinical Support Coordinator (CSC); and
3. memo in "next scheduled visit" indicates "complete admit with OASIS".

The Scheduling Department will assign the OASIS visit to Assessment Specialist or primary clinician whenever possible.

D. Reassessment

Patients will be reassessed at each visit to identify effectiveness of current plan of care and need to modify the plan to meet ongoing needs and/or address new needs.

Comprehensive reassessments are completed for all patients at least every 60 days to determine:

1. effectiveness of the current plan of care;
2. patient's progress towards established goals; and
3. patient's continued need for home care intervention and recertification.

For Medicare beneficiaries, a qualified physical, occupational or speech therapist (excluding Physical Therapy Assistant/Certified Occupational Therapy Assistant) performs the required therapy reassessments at least every 30 days for each discipline during the therapy patient's course of treatment. This reassessment visit will include:

1. performing the needed therapy service;
2. assessing the patient;
3. measuring progress using objective measurements for comparison; and
4. documenting updated objectives and goals.

Clinicians will communicate assessment findings to other team members as needed to facilitate coordination and appropriate management of all areas of patient care.

E. Discharge Assessment

When the patient is discharged from the agency, a comprehensive assessment is completed.

References

1. CFRs – 484.18(a), 484.30, 484.32, 484.55, 484.55(a)1, 484.55(a)2, 484.55(b)1-3, 484.55(c)
2. Joint Commission Standards PC 01.02.01
3. Joint Commission National Patient Safety Goals
4. American Physical Therapy Association Comprehensive Summary of the 2011 Home Health Prospective Payment System: Final Rule Page 3.

Responsibility: Professional Visiting Staff
Distribution: Leadership

Nature of Change	Updated to reflect current policy.
Approved PAC	10/15/15
CCO Signature:	_____ _____/____/____ Date
CEO Signature:	_____ _____ /____/ ____ Date