Measurable Elements of AOP.01.01

1. Ⓓ All patients have an initial assessment that is consistent with the requirements defined in hospital policy.
2. The assessment includes the following:
   - Physical examination
   - Health history
   - Medication history and known allergies
   - Initial psychological assessment as indicated by the patient's condition
   - Initial social and economic assessment, when indicated by the patient's needs
   - Initial spiritual and cultural assessment, when indicated by the patient's needs

   (*See also* AOP.01.00, MEs 1 and 2)
3. Ⓓ The hospital outlines requirements about who is responsible for the initial assessment and the timeliness of the assessment, including the following:
   - What parts of the initial assessment each discipline is responsible for completing
   - Minimum content for the initial medical assessment
   - Minimum content for the initial nursing assessment
   - Minimum content for other assessments (for example, physical therapy, speech therapy, social services)
   - Time frame for completion of the initial assessment
   - Documentation requirements for the initial assessment

   (*See also* AOP.01.00, ME 3)
4. Ⓓ The hospital identifies, in writing, those patient groups and populations it serves that require modifications to their initial assessment.
5. The initial assessment for special patient populations is modified to reflect their needs.
6. The initial nursing assessment is completed within 8 hours, and the medical assessment is completed within 24 hours of admission to the hospital.
7. The initial assessment results in an initial diagnosis or diagnoses that require treatment and monitoring.
8. The initial nursing assessment results in a list of specific nursing needs or conditions that require nursing care, interventions, or monitoring.
9. Preoperative diagnosis is documented for patients requiring emergency surgery.

Standard AOP.01.02

The hospital has a process for accepting initial assessments from outside sources.

Intent of AOP.01.02

There must be a process to accept initial assessments from outside sources that includes validation of the information included in the assessment because correct and current information is needed to provide safe patient care.

An initial assessment may be conducted by an outside source. Examples of outside sources include the following:

- Health care practitioner's office
- Primary care or ambulatory care center
- Consulting or referring practitioner

Common reasons for initial assessments by outside sources include the following:

- Referral to a specialist employed by the hospital
- Direct or scheduled admissions to the hospital
- Referral for a scheduled outpatient or same-day procedure

The initial assessment completed by an outside source must be within the previous 30 days.

When an assessment is partially or entirely completed by an outside source, the information in the assessment is reviewed and verified by a qualified individual. If there are any changes to the assessment, the medical record is updated and identifies any additional testing that may be needed related to the change.

If the initial assessment is greater than 30 days old at the time of admission or registration, the medical history must be updated and the physical examination repeated.

For initial assessments performed and documented 30 days or less prior to admission or registration, the information in the history and assessment is reviewed and verified. This review includes the following:

- Patient's medical history and assessment findings
- Laboratory and other diagnostic test results
- Proposed plan of care and treatments

Any changes in the patient's condition since the assessment, or "no change" if appropriate, are documented at admission.

Measurable Elements of AOP.01.02

1. Initial medical assessments accepted are less than or equal to 30 days old.
2. For initial assessments less than or equal to 30 days old, the assessment is reviewed and validated; any changes in the patient's condition since the assessment or "no change" are documented in the patient's medical record at the time of admission or registration.
3. If the initial assessment is greater than 30 days old at the time of admission or registration, the medical history is updated and the initial assessment is repeated in accordance with the hospital's initial assessment policy.

Standard AOP.01.03

Patients are screened for nutritional, functional, and other special needs and are further assessed when indicated by the screening.

Intent of AOP.01.03

Initial screenings for nutritional, functional, and other special needs identify patients who may require additional interventions for safe, high-quality care.

These screenings may be conducted at the initial medical or nursing assessment. The hospital uses a screening tool to screen patients for nutritional, functional, and other special needs. The information gathered through the screening determines if the patient needs further assessment.

The screening process is very simple and high level and identifies whether a risk or problem exists. If the screening identifies a risk or a problem, an assessment is then completed. The hospital refers the patient for further assessments, either within the hospital or through the community, to address risks or problems identified by the screening.

The screening tools are implemented consistently throughout the hospital and are used by trained clinical staff.

The screening tools are developed by qualified individuals able to further assess any identified risks. Various clinical staff may be trained on how to use the tools and complete screenings with patients. When indicated by the screening, qualified individuals complete the assessment and identify interventions or a plan to address the patient's needs. Examples include the following:

- Nutritional risk
  - An evidence-based screening tool for nutritional risk may be developed by the hospital's nurses.
  - Nurses, physicians, and dietitians are trained to use the tools.