    - Dietitians then complete a nutritional assessment and supply the recommended dietary intervention.
    - Nutritionists integrate nutritional needs identified by the assessment with the other needs of the patient.
- Functional status
    - An evidence-based functional screening tool, including physical ability, vision, and hearing, may be developed by the hospital's occupational therapists.
    - Nurses and occupational, physical, and speech therapists are trained use the screening tool.
    - Occupational, physical, and speech therapists complete a functional assessment.
    - Physical medicine and rehabilitation physician orders functional therapy to address the needs identified in the assessment.

Other specialized needs may be identified through routine care; for example, clinical staff may observe that a patient has difficulty seeing or hearing and refer the patient for the necessary assessments.

Assessments are completed using evidence-based tools and used by trained clinical staff to determine the level of risk or severity of a problem and to develop specific interventions to address the risk or problem.

A screening tool is used to evaluate for the presence of a risk or a problem and generally results in a "yes or no" response.

Screening tools can be developed by a qualified individual to screen for a risk or problem. Creating a brief questionnaire for the patient is a useful screening tool, as in the following examples:

- Asking a patient "Have you lost or gained more than 2 kg in the past 30 days?" to screen for nutritional risk
- Asking a patient "Are you able to complete daily hygiene tasks without difficulty or assistance?" to screen for functional risk
- Asking a patient to complete a brief whisper test to screen for hearing deficits

Assessment tools are used to complete an in-depth assessment of patient risk or problems and are used to develop specific interventions to address the risk or problem.

Assessment tools meet the following criteria:

- Are appropriate to the risk or problem being evaluated.
- Are appropriate to the patient population being evaluated (for example, pediatric, adult, geriatric).
- Are based on evidence and validated in the population being evaluated.

Measurable Elements of AOP.01.03

1. Evidence-based screening tools are used to identify patients who require further nutritional assessment, and the tools are implemented consistently throughout the hospital.
2. Patients whose screening indicates a nutritional risk or problem receive a nutritional assessment.
3. Screening tools are used to identify patients who require further functional assessment, and the tools are implemented consistently throughout the hospital.
4. Patients whose screening indicates a functional risk or problem receive a functional assessment.
5. When the need for additional specialized assessments is identified, patients are referred within the hospital or outside the hospital.

Standard AOP.01.04

All patients are screened for pain and assessed when pain is present.

Intent of AOP.01.04

Pain greatly impacts a patient's quality of life, affects healing, and can impact physical, psychological, and social well-being.

Screening identifies those at risk or potentially in need of a further, more specialized assessment. The screening has a narrow scope, whereas the scope of assessment is more comprehensive. An assessment is a systemic process done to evaluate needs that can then be fulfilled, or a plan made around them on how to meet those needs, thus the individual conducting the assessment should have an expertise or specialty in the field being assessed.

Screening tools have a more narrow, superficial scope and are beneficial for identifying those at risk. A screening tool is used to identify patients with pain. The screening process is simple, is high level, and identifies whether a risk or problem related to pain exists. If the screening identifies a risk or a problem, an assessment is then completed. A screening for pain may consist of one or more simple questions that can be asked by trained clinical staff. The results of the pain screening are documented in the patient's medical record.

The information gathered through the screening determines if the patient needs further assessment. The assessment is then used to match the individual's needs with the appropriate type and level of care, treatment, or services.

If the planned care, treatment, or services may result in pain, this would also indicate the need for a pain assessment.

The pain assessment is appropriate to the patient, including the following:

- Patient age
- Patient condition (for example, sedated or alert)
- Any barriers (for example, inability to speak or hear or developmental delays)

The pain assessment is a more in-depth evaluation of the patient's pain and is used to develop specific interventions to address the pain. The pain assessment is documented in the patient's medical record.

The patient's pain is addressed immediately and may include referral or transfer to a different care setting. For example, an outpatient with severe pain may be admitted as an inpatient to further assess and treat their pain, or an inpatient in the general medical unit may need to be transferred to an intensive care unit for monitoring if an epidural is needed to treat their pain.

A screening tool is used to evaluate for the presence of a risk or a problem and generally results in a "yes or no" response. Examples of questions that may be used in a screening include the following:

- Are you having pain right now?
- Does pain keep you from sleeping at night?
- Does pain keep you from participating in activities?
- Do you experience pain every day?

Evidence-based tools are used to measure the severity of the patient's pain. Examples of pain severity scales include the following:

- Wong-Baker Faces Scale
- FLACC (Face, Legs, Activity, Cry, Consolability)
- COMFORT Scale
- Behavior Pain Scale
- Newborn Infant Pain Scale

The pain assessment also evaluates pain intensity and quality, including the following:

- Pain character (for example, sharp, dull, or burning)
- Frequency
- Location
- Duration

- Pain history (for example, when did the pain start, what activities cause the pain, what treatments has the patient tried to relieve the pain)
- What makes pain better or worse
- What are the patient's goals for pain relief (for example, zero pain or enough relief to complete or participate in specific activities)

Pain assessments, including which assessment tool is used, are documented in the patient's medical record to allow the care team to easily identify trends in the patient's pain and pain relief interventions.

Measurable Elements of AOP.01.04

1. All inpatients are screened for pain, and the screening is documented.
2. Outpatients whose condition, diagnosis, or situation may indicate that they are at risk for pain are screened for pain.
3. Ⓓ When pain is identified by the screening, a pain assessment is performed and documented. (*See also* COP.07.00, ME 1)
4. Patients are reassessed for pain following any pain management interventions.
5. If needed, the patient is referred or transferred to a care setting that has the capabilities and resources to treat the patient's pain.

Standard AOP.01.05

All patients are reassessed at intervals based on their condition and treatment.

Intent of AOP.01.05

Reassessment is key to understanding how patients respond to treatment and to understand if care decisions are effective.

Patients are reassessed throughout the care process at intervals based on their condition and treatment as defined in hospital policies. The results of these reassessments are documented in the patient's medical record.

Hospital policy defines how often reassessments occur by various members of the health care team. A physician must assess patients with acute care needs at least daily, including weekends, and when there is a significant change in the patient's condition.

Hospital policy defines how often patients are reassessed by a nurse. This will vary greatly based on the patient's needs, condition, and treatment. For example, newly intubated patients may require a nursing reassessment every hour, whereas a stable, chronically ill patient with an established airway may require a nursing reassessment every four hours.

Hospital policy defines how often patients are reassessed by other members of the care team, including the following:

- Respiratory therapists
- Physical, occupational, and speech therapists
- Social workers or other social services

Reassessments occur in accordance with hospital policy. Reassessments are completed and results are documented in the patient's medical record in the following instances:

- At defined intervals by various members of the care team, including physicians, nurses, and others
- Daily by a physician for acute care patients
- In response to a significant change in the patient's condition
- If the patient's diagnosis has changed and the care needs require revised planning
- To determine if medications and other treatments have been successful and the patient can be transferred or discharged