NR.10.2.1 History of the patient's main complaint.

NR.10.2.2 Drug allergies.

NR.10.2.3 Physical condition.

NR.10.2.4 Psychosocial status.

NR.10.2.5 Pain assessment.

NR.10.2.6 Nutritional Status.

NR.10.2.7 Discharge planning.

NR.10.2.8 Skin assessment.

NR.10.2.9 Fall risk assessment.

NR.10.3 The nursing assessment identifies nursing care needs for each patient upon admission.

NR.10.4 All patients are reassessed at appropriate intervals (at least on every shift) to determine their response to treatment and to plan for continued treatment and discharge.

NR.10.5 The nursing assessment is documented in the patient's medical record.

Standard Intent:

Patient assessment is an ongoing, dynamic process that takes upon admission. Patient assessment consists of three primary processes

1. Collecting information and data on the patient's physical, psychological, and social status, and his or her health history
2. Analyzing the data and information, to identify the patient's health care needs
3. Developing a plan of care to meet the patient's identified needs

When a patient has been admitted to a hospital for inpatient a complete assessment needs to be performed related to the reason(s) the patient has come for care. The primary outcome from the patient's initial assessments is an understanding of the patient's nursing needs so care and treatment can begin. To accomplish this, the hospital determines the minimum content of the initial nursing assessments (NR.10.2), the time frame for completion of assessments, and the documentation requirements for assessments

Patients are reassessed throughout the care process at intervals based on their needs and plan of care or as defined in hospital policies and procedures. Reassessments are conducted and results are entered in the patient's record

- at regular intervals during care or at least every shift;
- in response to a significant change in the patient's condition