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.

    - 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.