POLICY STATEMENT: The comprehensive assessment identifies the physical, psychosocial, emotional and spiritual needs of the patient related to the terminal illness that must be addressed in order to promote the patient’s well-being, comfort, and dignity throughout the dying process. The comprehensive assessment builds on the initial assessment.

PROCEDURES:

1. The comprehensive assessment of the patient consists of the following factors:
   a. the nature and condition causing admission (including the presence or lack of objective data and subjective complaints);
   b. complications and risk factors that affect care planning;
   c. functional status, including the patient’s ability to understand and participate in his or her own care;
   d. imminence of death;
   e. severity of symptoms;
   f. A review of the patient’s prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
      i. effectiveness of drug therapy;
      ii. drug side effects;
      iii. actual or potential drug interactions;
      iv. duplicate drug therapy; and
      v. Drug therapy currently associated with laboratory monitoring.
   g. an initial assessment of the bereavement needs of the patient’s family and other involved individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient’s death; and
   h. The need for referrals and further evaluation by appropriate health professionals.

2. HHPC’s assessment tools are designed to support the documentation of information related to the patient’s history, current status, problems, and needs and contain data elements for the collection of information related to patient outcomes. Comprehensive assessments are documented in the patient’s medical record.

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3. If needs are identified that are not related to the terminal illness and related conditions, the need(s) is documented including noting who is addressing the need(s) as part of the comprehensive assessment.

4. The comprehensive assessment update is accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days (see Assessment-Updates to the Comprehensive Assessment). The content related to the updated comprehensive assessment, includes, but is not limited to:
   i. Patient’s progress toward desired outcomes;
   ii. Reassessment of the patient’s response to care;
   iii. Changes in the patient/family condition or needs;
   iv. Collaboration with the attending physician, if any; and
   v. Discipline specific updated assessments based on the plan of care.

5. Staff participation in visiting the patient for the purpose of the comprehensive assessment is based on the following:
   i. The RN who did the initial assessment, in consultation with the other members of the core IDG, considers the information gathered from the initial assessment and the IDG determines who, besides the RN, should visit the patient/family during the first 5 days of hospice care;
   ii. At a minimum, the discipline specific assessments based on in person visits with the patient and or family member(s) are completed as follows:
      a. HHPC social worker (SW) makes the first social worker psychosocial assessment, including the comprehensive bereavement assessment and risk factors;
      b. HHPC chaplain makes the first chaplain spiritual assessment of hospice care; and
      c. Other disciplines, based on the plan of care, provide discipline specific assessment as part of the first and/or updates to the comprehensive assessment;
   d. Based on the plan of care for frequency of services; and
   e. Visits are made in accordance with the patient/family needs and desires and approval of IDG. The patient has a right to refuse to have an in person visit; however at the minimum an HHPC RN must visit the patient at least once every fifteen days unless extended by the core IDG.
   iii. The HHPC RN case manager, social worker, chaplain and physician employee are responsible for reviewing the data and providing input into the comprehensive assessment within the scope of his/her practice. Other members of the IDG may also provide input into the comprehensive assessment within the scope of his/her practice as indicated for the specific patient focused comprehensive assessment and requested by the RN Case Manager.

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6. The IDG uses information obtained from the comprehensive assessment to develop a written plan of care that specifies the HHPC care and services necessary to meet the patient and family-specific needs related to the terminal illness and related conditions. (See Plan of Care-PC P35).

Initial IDG approval date: 2/23/09

Review/updated/ and reapproved by IDG without changes 2/15/2011, 11/13/2012