



ESRD Network #15

TIP SHEET #1 – PATIENT ASSESSMENT

One of the most important actions that can impact patient outcomes, satisfaction, and compliance is the completion of a thorough assessment of your patient's needs. You cannot create an individualized and comprehensive plan of care that your patient understands and follows if you don't:

- ***Know who the patient is***
- ***Know what they know and don't know***
- ***Know what the patient hopes for and wants for him/herself***
- ***Know who the patient counts on in times of need***
- ***Know the patient's mental and emotional strengths & challenges***
- ***Know their medical and psychosocial history***
- ***Know their current health and medical issues.***

Keys to a thorough patient assessment:

- Studies show that **the quality of the relationship between the care provider and the patient is an important determinant in adherence behaviors.** Quality relationships require time and energy to build and maintain. Ensuring there is enough time to sit down with your patients and conduct a thorough assessment will not only provide you with information that you and the patient can use to create an individualized treatment plan, it can be invaluable in letting the patient know you care enough to take the time to get to know him/her and listen to what s/he thinks and feels.
- **Review the medical record prior to assessing your patient.** This can lead to questions for the patient you might not have thought about. If you find information of concern by reviewing the medical record such as patient or family history of substance abuse or mental illness, do you discuss this with the patient in your assessment? Do all professional members of your care team read a patient's medical record? Does your team place a high value on gathering medical records from other providers to keep your patient's files as current and complete as possible? History adds important depth to a comprehensive assessment.
- **Patient readiness to engage in the assessment process should not be minimized.** The patient's current physical, emotional, and mental states, as well as facility environmental factors, can all impact patient readiness to fully engage with you.
- **Set aside enough time to sit down with your patient without interruptions.** If this is a challenge, speak with your supervisor or facility manager to problem solve this. Be creative. For example, ask the secretary not to page you during the time you are assessing a patient. If you're an RN, ask for nursing coverage of your duties during the time you are assessing a patient. Remember to acquire interpreter assistance or other specialized services for patients who need them so they can actively participate in the assessment process.
- **Ask questions that will add depth and meaning to the assessment .** For example, asking the patient about the quality of relationships among siblings provides more information than simply knowing the number of siblings. This could be valuable information in identifying patient support at a time when the patient is having difficulty adjusting and/or adhering to treatment.

- **Actively explore with the patient his/her hopes, fears, strengths and challenges.** From this you may uncover barriers to adherence such as ethnic or cultural issues, literacy concerns, locus of control, etc. You may be surprised by what you learn.
- **Be honest with your patient about your assessment.** Information gathering is only part of the assessment process. The other significant part of this process is using your professional knowledge and experience to critically think about that information in order to identify areas of improvement that will enhance the patient's experience of treatment and his/her quality of life. In this way, you and your patient can create a treatment plan that utilizes the strengths of both the patient and the treatment team.

Below is language from the new Conditions for Coverage that should be used to guide your assessment practice. They become effective October 14, 2008. Visit our website home page at www.esrdnet15.org for the link to the complete text.

“The interdisciplinary team is responsible for providing each patient with an *individualized and comprehensive* assessment of his or her needs.” Specifically, “the patient’s comprehensive assessment must include, but is not limited to, the following:

- Evaluation of current health status and medical condition, including co-morbid conditions.
- Evaluation of the appropriateness of the dialysis prescription, blood pressure & fluid management needs.
- Laboratory profile, immunization history, and medication history.
- Evaluation of factors associated with anemia, such as hematocrit, hemoglobin, iron stores, & potential treatment plans for anemia, including administration of erythropoiesis-stimulating agent(s).
- Evaluation of factors associated with renal bone disease.
- Evaluation of nutritional status by a dietitian.
- Evaluation of psychosocial needs by a social worker. *
- Evaluation of dialysis access type & maintenance (for example, arteriovenous fistulas, arteriovenous grafts, and peritoneal catheters).
- Evaluation of the patient’s abilities, interests, preferences, & goals, including the desired level of participation in the dialysis care process; the preferred modality (hemodialysis or peritoneal dialysis), & setting (for example, home dialysis), and the patient’s expectations for care outcomes.
- Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for non-referral must be documented in the patient’s medical record.
- Evaluation of family and other support systems.
- Evaluation of current patient physical activity level.
- Evaluation for referral to vocational & physical rehabilitation services.”

(*) There is also a new regulation regarding the assessment of your patients’ psychosocial status. “The interdisciplinary team must provide the necessary monitoring and social work interventions. These include counseling services and referrals for other social services to assist the patient in achieving and sustaining an appropriate psychosocial status as measured by a standardized mental and physical assessment tool chosen by the social worker, at regular intervals, or more frequently on an as-needed basis.”