



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 the ESRD patient's needs.

A social worker can create an individualized and comprehensive Plan of Care that the patient understands and follows only if the social worker:

- **Is familiar with who the patient is**
- **Knows what the patient may know and may not know**
- **Knows what the patient hopes for and wants for him/herself**
- **Knows who the patient counts on in times of need**
- **Knows the patient's mental and emotional strengths and challenges**
- **Knows the patient's medical and psychosocial history**
- **Knows the patient's current health and medical issues.**

KEYS TO A THOROUGH PATIENT ASSESSMENT

1. **MAXIMIZE THE QUALITY OF THE PATIENT-PROVIDER RELATIONSHIP**

Studies show that the quality of the relationship between the care provider and the patient is an important determinant of adherence behaviors. Quality relationships require time and energy to build and maintain.

2. **SET ASIDE ENOUGH TIME TO SIT WITH YOUR PATIENT WITHOUT INTERRUPTIONS**

Ensuring that there is enough time to sit with your patients to conduct a thorough assessment will facilitate your gathering the information necessary for you and the patient to utilize in order to create an individualized treatment plan. Spending time in itself can be an invaluable intervention because it communicates to the patient that you care enough to take the time to get to know him/her and to listen to what he/she expresses. If being interrupted during your assessment is a common challenge, think of creative solutions such as asking the administrative assistant to refrain from paging you during the time you are assessing a patient. (RNs can ask for coverage of nursing duties during the time they are assessing a patient.) Remember to acquire interpreter assistance or other specialized services for any patients who may require them so the patients can actively participate in the assessment process.

3. **REVIEW THE MEDICAL RECORD PRIOR TO ASSESSING YOUR PATIENT**

This can guide your questioning. You may find information of concern by reviewing the medical record, such as patient or family history of substance abuse or mental illness. History adds important depth to a comprehensive assessment.

4. **FOSTER PATIENT READINESS TO ENGAGE IN THE ASSESSMENT PROCESS**

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.

5. **ASK QUESTIONS THAT ADD DEPTH AND MEANING TO THE ASSESSMENT**

For instance, asking the patient about the quality of relationships among siblings provides more information than asking about the number of siblings. This could be valuable information for identifying patient support at a time when the patient is having difficulty adjusting and/or adhering to the prescribed treatment frequency.

6. **ACTIVELY EXPLORE THE PATIENT'S HOPES, FEARS, STRENGTHS AND CHALLENGES WITH HIM/HER**

This may lead to identifying barriers to adherence such as ethnic or cultural issues, literacy concerns, or locus of control.

7. **BE HONEST WITH YOUR PATIENT ABOUT YOUR ASSESSMENT**

Gathering information amounts to only part of the assessment process. The other significant piece of this process is applying your professional knowledge and experience to critically consider the information in order to identify areas of improvement that will enhance the patient's experience of treatment and his/her quality of life. Use your clinical tools to create a treatment plan with your patient that utilizes the strengths of both the patient and the treatment team.

THE NEW CONDITIONS FOR COVERAGE

Language from the new Conditions for Coverage should be used to guide your assessment practice. (Visit the Network #17 website at www.esrdnet17.org for a 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. 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 under the CMS ESRD Conditions for Coverage 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."

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