

NURSING ASSESSMENT IN THE ICF/ID

NURSING ROLES

Nursing takes on many roles¹ in the ICF/ID including:

- Liaison between the individual and health care providers
- Direct service provider
- IDT member
- Advocate
- Educator

NURSING ROLES - LIAISON

W338:2

The nurse addresses health problems, communicating with, and referring to, other health care providers as needed for follow up on abnormal findings.

NURSING ROLES – DIRECT SERVICE PROVIDER

W344:

If individuals' needs indicate, licensed nursing should be present to provide care.

NURSING ROLES – IDT MEMBER

W332:

Nursing should participate in the development and update of individual program plans as part of the interdisciplinary team process.

NURSING ROLES - ADVOCATE

W339:

Health and wellness are actively promoted, problems are promptly attended to, and steps are taken to prevent recurrence of problems.

NURSING ROLES - EDUCATOR

W340, W341, W342:

Nursing provides training to clients and staff as needed in appropriate health and hygiene methods.

Nursing provides instruction in methods of infection control.

Nursing trains staff in detecting signs and symptoms of illness, first aid, and basic skills needed to meet individuals' health needs.

SCOPE OF PRACTICE

W345, W346:

The facility must adhere to State Board of Nursing regulations³ that govern allowed nursing activities. In the state of Idaho, RN and LPN functions are clearly delineated.

SCOPE OF PRACTICE

The RN may:

- Complete comprehensive assessments.
- Identify nursing diagnoses.
- Identify objectives and develop a plan of nursing care.
- Analyze data collected and revise the nursing plan of care.
- Develop education plan for staff and individuals.
- Delegate tasks, as allowed by the State Board of Nursing, and train staff for the allowed tasks.

SCOPE OF PRACTICE

The LPN may:

- Collect data for assessments.
- Participate in identifying health issues.
- Participate in identifying objectives and developing POC.
- Complete specific nursing tasks as assigned.
- Collect and report data and nursing observations.
- Educate staff and individuals in accordance with POC.

NURSING ASSESSMENT

W334:

The assessment is an integral part of the nursing process that includes:

- Assessment
- Nursing diagnosis
- Plan
- Implement
- Reassess for effectiveness

NURSING ASSESSMENT

The components of a nursing assessment remain unchanged from assessment in other settings.

However, the nurse may need to modify the approach taken with individuals in an ICF/ID.

NURSING ASSESSMENT

Factors that need to be considered during assessment are:

- Cognitive limitations
- Communication limitations
- Mental health concerns
- Anxiety or fear
- Tactile defensiveness

NURSING ASSESSMENT

The assessment process includes four components:

- Data collection
- Health history
- Physical assessment
- Functional assessment

NURSING ASSESSMENT

When conducting an assessment, consider its purpose and extent.

There are two types of nursing assessments.

- Comprehensive assessments include all body systems and psychosocial issues.
- Focused assessments are limited in nature and directed at a specific issue or problem.

NURSING ASSESSMENT

Comprehensive assessments are done at the time of admission, on an annual basis in conjunction with the IPP, and as needed.

NURSING ASSESSMENT

Focused assessments may be done on a scheduled, daily, or emergent basis:

- Scheduled assessments include quarterly reviews.
- Daily assessments are done to monitor chronic conditions. These might include treatments, medications, or diets.
- Emergent assessments are completed when there is a change in health status such as injury, illness, hospitalization, ER visit, or behavioral changes.

DATA COLLECTION

Two types of data can be collected during an assessment.

- Objective – tangible data such as vital signs, weight, height, current medications and treatments.
- Subjective – non tangible information that is reported to you by the individual or by staff, such as descriptions of pain or symptoms.

DATA COLLECTION

Age, history, life style and habits are important data to collect.

Current lab values and diagnostic test results are also important pieces of information to include.

All data collected should be validated and documented.

PHYSICAL ASSESSMENT

Actual physical assessment can be accomplished using either a “head to toe” approach or a “review of body systems” approach.

PHYSICAL ASSESSMENT

A head to toe assessment is a visual and manual inspection of each body part starting at the head and scalp and continuing downward to the feet and toes. Any observed or functional concerns are noted.

PHYSICAL ASSESSMENT

Techniques used for evaluation during assessment should include:

Inspection – what you can see

Palpation – what you can feel

Percussion – what you can hear

Auscultation – what you can hear with the aid of a stethoscope

PHYSICAL ASSESSMENT

The body system approach includes a visual and manual inspection of the major systems of the body. Any observed or functional concerns are noted.

ASSESSMENT OF SYSTEMS

Neurological – assesses level of consciousness, gait, balance, cognition, and affect.

Cardiovascular – includes the collection of vital signs and listening to heart tones.

Pulmonary – includes respiratory rate and listening to lung sounds.

ASSESSMENT OF SYSTEMS

Gastrointestinal – includes the size and shape of the abdomen, any palpable masses, and listening to bowel sounds.

Genitourinary – includes visual inspection and collection of subjective data on external genitalia to determine the need for a more extensive exam.

Musculoskeletal – includes bony and soft tissue development and function.

ASSESSMENT OF SYSTEMS

Integumentary – includes skin appearance, hydration status, and wounds or open areas. This assessment can be done at the same time other systems are being assessed.

Metabolic – includes the person's general appearance such as swelling or bruising. Lab values can also be used in evaluating metabolic function.

FUNCTIONAL ASSESSMENT

The purpose is to evaluate a person's ability to perform ADLs and to meet their own health needs. This includes his/her ability and means of expressing pain.

This is an excellent opportunity to look at maladaptive behaviors as well as cognitive limitations and decline.

HEALTH HISTORY

A complete health history should include the individual's information about medications used, treatments performed, surgical interventions, comparative lab values and diagnostic test results, and family history that might indicate genetic predisposition to certain conditions.

PLAN OF CARE

W318:

A plan should then be developed, based on the comprehensive assessment and a practitioner's orders.

The plan provides prompt treatment for acute and chronic health conditions.

PLAN OF CARE

W338:

The plan of care includes any necessary action indicated by the assessment, resulting in changes to the individual's health care.

The plan should address the physical exam, consults, diagnostics, daily health supports and monitoring.

The plan should also direct medication management and preventive health care.

PLAN OF CARE

W321:

The plan should be included in the individual's IPP making it known and available to all staff and IDT members.

Necessary staff training programs should be developed as needed.

References

¹ First things First: Nursing Assessments in the ICF/MR. Retrieved from https://webinar.cms.hhs.gov/naicfmr_archived/

² *State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Persons With Mental Retardation.* Retrieved from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_j_intermcare.pdf

³ *Rules of the Idaho Board of Nursing - 23.01.01.* Retrieved from <http://adminrules.idaho.gov/rules/current/23/0101.pdf>

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