Patient Assessment Protocol

Purpose

The purpose of the patient assessment protocol is to provide an objective methodology for determining the appropriateness of respiratory therapy modalities prescribed by a physician. This methodology will ensure that each patient will receive therapy based on predetermined criteria to achieve positive therapeutic outcomes.

Audience

Respiratory Care Services Respiratory Care Practitioners.

Scope

- Initial assessments will be performed within 24 hours of initiation of therapy.
- Follow up assessments will be performed at 72 ° or sooner if deemed necessary.

Guidelines

On the initial assessment, the patient's medical record is reviewed; the patient is examined and assessed for clinical necessity of ordered therapy.

The assessment is documented on the patient assessment portion of the treatment card.

A "SOAP" note is documented in the physician progress notes.

The physician is contacted if there is a recommendation for changing therapy or discontinuing the therapy.

72° after initiation of therapy the patient will be reassessed to determine if therapeutic goals have been met or whether the patient has a continued need for therapy.

The reassessment will be documented on the patient assessment protocol form and a "SOAP" note will be written in the progress notes.

If the goals of therapy have been met, a "SOAP" note will be documented in the physician's progress note stating that the therapy has been discontinued.

Addendum

Patient treatment card

References

Donald F. Egan (Editor), et al Egan's Fundamentals of Respiratory Care, Eighth Edition, Mosby; 8th edition, June 2, 2003

Clinical Application of Respiratory Care, 2nd Edition, Shapiro, Harrison and Trout.

Technical Assistance Document, Respiratory Care; 26, 459 - 478.

Medical Necessity Program Document, Blue Cross & Blue Shield.

Nielson-Tietsort, J; Poole, B; et al. Respiratory Care Protocol: An Approach to In-Hospital Respiratory Therapy. Respiratory Care; 26, 430-436.