NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES
POLICY AND PROCEDURE

SUBJECT: OUTPATIENT SERVICES ASSESSMENT

NUMBER: NN-PC-AS- 01

ORIGINAL DATE: 5/20/10

REVIEW/REVISE DATE: 3/17/11, 12/15/11

APPROVAL: ________________________________, Interim Agency Director

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I. PURPOSE

The purpose of this policy is to identify assessments completed by outpatient services at Northern Nevada Adult Mental Health Services (NNAMHS).

II. POLICY

It is the policy of NNAMHS that all consumers be assessed upon admission and be reassessed at regular intervals, as well as when their condition changes.

III. REFERENCES

MR 171 Medication Summary List

MR 267 LOCUS Adult Assessment

MR 111 Outpatient Nursing Assessment

Suicide Assessment

MR 270 Pain Assessment

NNAMHS Policy NN-PC-PL-14 Pain Management

NNAMHS Policy PC-AS-10 Suicide Risk Assessment
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IV. PROCECURE

1. Outpatient Services Psychological Assessment Services (PAS)

   A. The following assessments are completed in the Electronic Medical Record (EMR) by a licensed clinician at the time of admission to services:

      - Diagnosis
      - Presenting concerns
      - Psychiatric History
      - Legal Problems
      - Addictive Behavior
      - Anger/Aggression
      - Suicide/Self-harm
      - Mini Mental Exam
      - Mental Status
      - LOCUS (EMR and paper form) and Form MR 267
      - Consumer Self Assessment – completed by consumer
      - Abuse and Trauma
      - Summary Progress Note

   B. The following assessments are completed in the Electronic Medical Record (EMR) by the RN in the PAS at the time of admission:

      - Allergies (Nurses)
      - Medications (Nurses)
      - Nurses Assessment Bundle: including the following tabs:
      - Subjective Physical
      - Nutrition Screening
      - Objective Physical

- Pain
- General Physical Condition
- Physical/Marks/Wounds/Injuries
- Medical History, Treatment and, Health Habits
- Consumer/Family Education Record
- Summary Progress Note
- Initial Treatment Plan
- MR form 171 Summary List (paper)

2. Outpatient Services—Medication Clinic

A. Abnormal Involuntary Movement Scale (AIMS) – will be complete annually by the clinic nurse in the EMR on all consumers receiving qualifying neuroleptic medications (QNM) for longer than six (6) months. A consumer on qualifying neuroleptic medications who experiences an unexpected change in condition, or response warrants an AIMS assessment.

B. Consumers undergoing decreased dosage taper of QNM will receive an AIMS evaluation at least once every 6 months until dosage has been stabilized.

C. LOCUS – completed at the time of admission to the outpatient program and updated every three months, unless assigned to Service Coordination.

D. Outpatient Nursing Assessment – MR 111 competed for consumers presenting to the medication clinic for scheduled appointments or walk-in visits requiring evaluation.

E. Pain Assessment completed-on consumers experiencing chronic pain, updated at scheduled visits.

F. Suicide Risk Assessment - completed on intake and updated at least annually.

3. Outpatient Services – Service Coordination

A. Vocational Assessment, page 3 - completed by Service Coordination and/or Mental Health Court in the EMR if consumer indicates desire to work. It will be completed at the initial treatment planning meeting. The assessment will be updated as needed.

B. Vocational Assessment – completed by Vocational Services in the EMR at the time of admission to outpatient services and updated as needed.

C. RN Nutrition Screening – this is a screening tool to identify consumer with nutritional risk factors. It is completed by RN's in Service Coordination in the EMR as needed.

D. LOCUS Assessment, upon admission, a change in status, and every 90 days.

4. Outpatient Services – Mental Health Court

A. Family/Social. Assessment - completed in EMR by Service Coordination at initial treatment planning meeting and updated as needed.

B. Family/Social Assessment - completed in the EMR by Mental Health Court staff at initial treatment planning and is updated at needed.

C. Readiness Assessment (MR 217) – currently a paper form and completed by Mental Health Court Staff. This must be completed within 30-days of intake to Mental Health Court. The form is signed by the consumer or guardian and Service Coordinator. The MR 217 is updated every 90-days. This assessment is kept in hard copy chart.

D. LOCUS Assessment, upon admission, a change in status, and every 90 days.

5. PACT

A. The PACT assessment is documented in the Psychosocial Assessment in the EMR. PACT will complete this assessment within 30-days of the consumer's acceptance into the program. This includes the following tabs:

- Presenting Concerns
- Living Situation
- Employment/Military
- Relationships

- Suicide/Self-harm
- Anger/Aggression/Homicidal
- Predatory Behaviors
- Addictive/Behavior
- Psychiatric History
- Legal Issues
- Education
- Strengths and Weaknesses

B. In addition, the following assessments are completed upon admission:

- LOCUS Assessment, MR 267, and EMR completed at intake and updated every 90 days.
- PACT staff will conduct a pain assessment on admission and when there is a change in status
- Suicide Risk Assessment
- Completed on intake and updated at least annually

6. Counseling:

A. The following assessments will be documented in the EMR by the Psychology Department.

B. With counseling orientation group, a progress note will be entered into the EMR.

C. MR 204 – Outpatient psychology evaluation form will be completed at the first appointment.

D. A LOCUS, MR 267, and EMR upon the initial appointment and every three (3) months and as indicated by changes in acuity. (Complete only if recent LOCUS from another service is not present.)

E. A Treatment plan will be completed by the second visit.

F. Suicide Risk Assessment completed on intake if primary provider and updated as needed.

7. Psychiatric Evaluation – Electronic Medical Record

A. Completed by the prescribing clinician, MD/DO/APN at initial appointment to the medication clinic if the consumer does not have a recent evaluation completed and available.

B. The psychiatric evaluation can be dictated or entered directly into the electronic medical record.

C. The following items must be addressed in the psychiatric evaluation:

- Chief complaint
- Description of current symptoms requiring hospitalization
- Current medical history
- Psychiatric & medical history
- History of substance abuse
- Mental status
- ICD-9-CM
- 5 Axis Diagnosis
- Estimation of memory function
- Capacity for harm
- Capacity for ADLs
- Insight
- Judgment

8. Nutritional Assessment

A. A nutritional assessment can be ordered following a nutrition screening in outpatient that indicates three or more nutritional risks.

B. A request will be forwarded to the registered dietician in writing, which includes the individual's name, phone number, and the consumer's nutritional status, which warranted the referral.

C. The dietician will consult with the individual within seven (7) working days and document findings in the EMR (progress note)