

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Initial Combined Assessment (CDPH 4455)

Instructions for Use

The Initial Combined Assessment (CDPH 4455) is designed to be completed by any qualified Comprehensive Perinatal Services Program (CPSP) practitioner, as defined in Title 22, Section 51179.7.

PURPOSE

The Initial Combined Assessment tool permits the CPSP practitioner to assess the client's strengths and identify her needs in the areas of nutrition, psychosocial, and health education. This information along with the information from the initial obstetric assessment is used, in consultation with the client, to develop an Individual Care Plan (ICP). The combined assessment is ideal for those practice settings in which one CPSP practitioner (versus a team of practitioners, each with their own areas of expertise) is responsible for completing the client's initial assessment; it does not, however, preclude discipline specialists from providing needed services to the client.

PROCEDURES/PROCESS

The combined assessment tool is designed to be administered by a qualified CPSP practitioner and not self-administered.

1. Familiarize yourself with the assessment questions and the client's medical history before completing the assessment.
2. The interview setting should be private and, ideally, have access to a phone.
3. At the beginning of the assessment, explain to the client that the purpose of the interview is to identify problems which may be of concern to her and to assist in their resolution.
4. Explain the confidentiality of the assessment process. Clarify that as a health practitioner you are legally required to report information regarding child or elder abuse/neglect and in some circumstances, domestic violence.
5. Focus on the client, do not read the questionnaire word-for-word. Engage the client in conversation about herself, family, and environment and use this opportunity to establish rapport and gain information for the assessment.
6. Inform the client you will write notes while you are conducting the assessment.
7. Sensitive questions should be approached in an accepting, straightforward manner. Most clients are willing to answer, especially if they understand why the question is being asked. Explain that her responses are voluntary, and she may choose not to answer a specific question.
8. Ask open-ended questions and respond to answers in a nonjudgmental manner. Be aware of your voice, body language and attitudes.
9. If the client has limited English-speaking abilities and you are not comfortable in speaking her preferred language, arrange, if possible, to have another staff member with those language capabilities complete the assessment. If such a person is not available, the practice should have the ability to make use of community interpreting services on an as-needed basis. As a last resort the client may be asked to bring someone with her to translate; it is not appropriate to use children to translate. Telephone translation services should only be considered as a last resort for very limited situations.

10. When the assessment is completed, pay particular attention to the answers that are shaded, they are ones most likely to need interventions and/or be included on the individualized care plan. Generally they will require follow-up questions by the practitioner to determine the actual need and appropriate intervention. Answers to nonshaded responses and/or open-ended questions are important in that they provide additional information about the client's strengths, living situation, and resources that will be important to consider when developing a care plan.
11. At the completion of the interview, summarize the needs that have been identified, and assist the client in prioritizing them. Work with the her to set reasonable goals on the care plan.

DOCUMENTATION

1. Make sure all questions are answered. If the question does not apply, write "N/A" (not applicable); if the client declines to answer, so note.
2. All notes and answers on the assessment should be legible.
3. All problems identified during the assessment should indicate some level of follow-up. Follow-up may range from a problem noted on the Individual Care Plan to notations on the assessment form and/or narrative that indicate immediate intervention provided or that the issue is not one that the client chooses to address at this time.
4. All assessments should be dated and signed with first initial, last name, and title of the person completing the assessment.
5. Time spent in minutes should be noted at the end of the assessment; indicate only time spent face-to-face with the client, not time spent in phone calls, charting, etc., unless the client is present during these activities.

REMINDER:

The nutrition assessment component of this revised Initial Combined Assessment will not be considered complete unless you also perform a 24-hour diet recall or food frequency and plot the client's weight on the appropriate weight gain grid.