

Quality Improvement Organization Support Center (QIOSC)

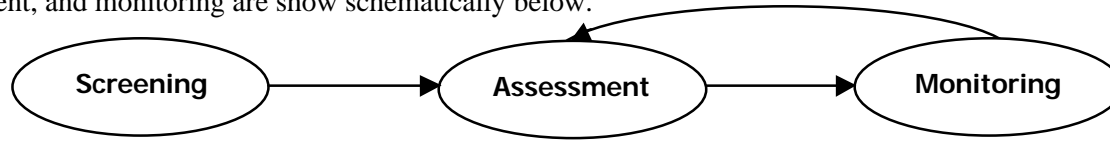
**Key Terms**

Screening, assessment, and monitoring are each defined in relation to their objective, rationale, and outcome.

<b>Term</b>	<b>Definition</b>	<b>Objective</b>	<b>Rationale</b>	<b>Outcome</b>
<b>1) Screening</b>	A question or test to determine if a person may or may not need further evaluation for a problem or condition (e.g., “Skin exam at admission to see if the resident has a pressure ulcers)	To quickly evaluate whether a resident may be have a clinical condition	To determine whether a resident should undergo in-depth assessment of a clinical condition	Triggers a comprehensive assessment of a resident’s clinical condition if the result is positive, and to periodic re-screening if a resident is negative
<b>2) Assessment</b>	A more in-depth evaluation, or more testing, to collect additional information as to why a resident screened positively (e.g. evaluation of the pressure ulcer and risk factors associated with the pressure ulcer).	To verify the screening question/test or to determine the underlying cause(s) or reason(s) for the positive screen or severity of the condition.	To gather enough information to begin an appropriate treatment or management plan that will reduce the severity of, or halt the progression of the clinical condition.	Leads to treatment and monitoring of the resident’s clinical condition
<b>3) Monitoring</b>	A question or test to used to track the effectiveness of treatment or the progression of the condition (e.g., weekly assessment of the size and condition of the PU).	To maintain careful observation of a resident under treatment for a previously identified clinical condition	To assess the resident’s response to treatment, to track changes in a resident’s clinical condition over time, and to modify the care plan to best address the resident’s clinical condition	Allows providers to assess periodic re-assessment of a resident’s clinical condition as indicated by resident’s response to monitoring

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**Diagram.** Screening, assessment, and monitoring are show schematically below.



**Clinical Topic Key Terms**

Clinical Topics	Screening	Assessment	Monitoring
<b>1) Pain</b>	At admission and regular intervals, ask resident about the presence of pain (e.g. “Are you having pain?”) and/or look for signs of pain (e.g. grimacing or change in behavior).	Assess pain severity (e.g., location, intensity, duration, frequency, quality, etc.) and causes.	Ask about response of pain to treatment using a standard pain rating scale (e.g., “How bad is your pain on a scale of 1-10”)
<b>2) Pressure Ulcers</b>	At admission and regular intervals, perform quick physical examination to determine whether or not a resident has a pressure ulcer	Evaluate the pressure ulcer (e.g., location, size, stage, appearance, pain, etc.) as well as any risk factors for pressure ulcers (e.g. immobility, incontinence, or poor nutrition)	Measure stages of healing and re-assess wound presence and description using standard tool if possible (e.g., PUSH tool).