

RN Assessment (NDP 8)

The use of the form is optional; the performance and documentation of the RN assessment in the medical record is not optional. ABN Regulation 610-X-7-.06 ADMH Residential Community Programs states:

(3) *“The RN is accountable for determining the tasks that may be safely performed by the unlicensed assistive personnel in residential community mental health settings following appropriate training and demonstration of competency.”*

The method used by a RN to make this determination is the performance of a comprehensive assessment as defined by ABN Regulation 610-X-2-.06(2):

“the systematic collection and analysis of data including the physical, psychological, social, cultural and spiritual aspects of the patient by the RN for the purpose of judging a patient’s health and illness status and actual or potential health needs. Comprehensive assessment includes patient history, physical examination, analysis of the data collected, and development of the patient plan of care, implementation and evaluation of the plan of care.”

The agency and/or RN may use the form of choice as directed by the agency’s policies and procedures to document the required elements of the Comprehensive Assessment. The RN Assessment form NDP 8 was developed to meet the elements required by the ABN regulation.

The ABN regulations governing the Practice of Practical Nursing (LPN Practice), 610-X-6-.05(1) (e) states:

“The practice of practical nursing includes, but is not limited to conducting and documenting data elements of the comprehensive assessment.”

This allows the LPN to assist the RN in the comprehensive assessment by the completion of pages 1-5 of form NDP 8. The LPN must sign and date at the noted place on the form. The last page of NDP 8 must be completed by the RN as noted on the form.

The outcome of the RN Assessment determines if the consumer can be safely cared for by a MAC Worker or if the consumer’s needs are so complicated that they require skilled nursing services.