POLICY FOR REASSESSMENT

1. Purpose:
To standardize the process for Reassessment for patients cared for by our hospital

2. Definitions:

a. **OPD:** Out Patient Department
b. **IPD:** In-Patient Department
c. **ED:** Emergency Department
d. **In-Patient areas:** Wards, ICUs & HDUs
e. **Day Care Patient:**

3. Distribution:
In-Patient areas, Outpatient Department, Day care patient& Emergency Department

4. Responsibilities:
IP, OPD & Casualty Nursing staff, Casualty Medical Officer, Junior Residents &Consultants

5.0 Policy:

5.1 Each patient upon admission to **Inodaya Hospitals, Kakinada** shall be assessed by qualified individuals for appropriate care or treatment needs / need for further assessment. The physical, psychological, social and economic status of each in-patient shall be assessed.

5.2 The patient shall be assessed and the records shall be documented as appropriate to the patient's age and needs.

5.3 Outpatient assessment - the Physician shall assess outpatients during the visit. Out patients are informed of their next follow – up, where appropriate.

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Medical Director	Accreditation Coordinator	Managing Director

5.4 The physician as deemed appropriate for patient condition shall perform follow-up visit assessments.

5.5 A duly registered and credentialed staff Physician shall either perform or supervise the performance of a patient assessment within 24 hours. The assessment shall include documented plan of care with preventive aspects of care.

5.6 In emergency room the patient shall be assessed by the emergency room team with in 15min of arrival and documentation shall be completed. In the mean time the patient shall be given appropriate treatment to stabilize him/her. The concerned doctor shall be immediately informed about the patient arrival.

5.7 The nursing assessment shall be performed and documented in the patient record within 24 hours of admission (which includes Dietician, functional Assessment)

5.8 The nutritional assessment shall be completed within 24 hours of admission of the patient.

5.9 Continued assessments and reassessments shall be documented throughout the patient's medical record.

5.10 Reassessment of the patient shall be performed at regular intervals in the course of care by medical and nursing staff.

A. Reassessments shall be performed to determine a patient's response to care/treatment.
B. Reassessment shall take place also when there is a significant change in a patient's condition or a change in diagnosis.
C. Nursing staff shall reassess (Every 8 hours) patients as per the standards maintained in the department.
D. Medical staff shall reassess patients once daily (24 hours)
E. More frequent reassessments shall be done by both nurses and doctors as per the clinical condition of the patient.

F. At a Minimum, the documentation shall include vitals, systemic examination findings and medication orders.

G. Reassessment for daycare patients as on when required (based on clinical condition) and before discharge time

5.11 Assessment and reassessment are documented in the following reports:

A. Medical Staff:
B. Nursing Staff:
C. Nutritional services as appropriate.
D. Functional Assessment
E. Psychological Assessment

Qualified professionals perform assessment& Reassessment are Registered as applicable under the law of the land:

Professional	Basic Qualification	Registration
Medical	M.B.B.S	Registered with the Centre / State Medical Council
Nursing	Diploma / Degree in Nursing	Registered with the Centre / State Nursing Council
Dietician	Master's Degree in Dietetics	Not required
Physiotherapist	Master's Degree / Degree	Registered with Physiotherapy council

6.0 Multidisciplinary approach

6.1 Qualified individuals shall form a multidisciplinary team and shall be responsible for the patient's care.

6.2 Information shall be shared among the staff while giving hand off's.

6.3 The patient's record shall only be available to authorized personnel who are the care givers.

6.4 Referral policies and procedures shall be followed.

7 Procedures:

a. All patients undergoing reassessments are explained of the reassessment process and greeted with a "Namaste"
b. Modified Morse fall risk assessment is used for assessing patient fall risk
c. Braden scale is used for prevention of bed sore/pressure ulcers
d. Nurse Inpatient record is used for documenting the reassessments
e. Doctors progress notes columns are used by doctors to document the response to treatment & modify the plan of care as and when necessary

8. Reference documents:

a. Modified Morse Fall Risk Assessment
b. Braden scale
c. Nurse In-patient assessment records
d. Plan of care form

MEWS chart has the scoring system for all vital parameters. The nurse assesses each parameter and gives the score, which helps to assess the level of patient deterioration. Based on the scoring, intervention is taken to prevent the further deterioration of the condition. RRT is a first phase of intervention, it consists of Duty Doctor and Nurse Manager, and they have exclusive contact number. If MEWS score falls 1-2, need to

perform every 2 hrs observation. If score is 2-3 inform the Nurse Manager and every hour observation. If score is 4 and more, inform RRT and ½ hourly observations required.

Document Revision History

DOCUMENT REVISION HISTORY		
Version	**Date of issue**	**Reason for Revision**
Original version - 1	10/03/2022	Prepared 5th edition
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