Policy on Initial Assessment (ER, IP, Day Care & OP)

- **Purpose:**

To assure care provided to each patient is based on an assessment of the patient's relevant physical, psychological and social status needs resulting in care that the patient is seeking in the best setting possible.

- **Scope:**

All Patients at **Inodaya Hospitals, Kakinada**

- **Definitions & Abbreviations:**

IDT - Interdisciplinary Team

MBBS - Bachelor of Medicine and Bachelor of Surgery

MHC - Master Health Check

MRD - Medical Records Department

SOP - Standard Operating Procedures

- **Responsibility:**

Managing Director, Medical Superintendent, Consultants, Nursing Staff and every other care provider

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 inpatient shall be assessed. The scope and content of assessment shall be defined by a multidisciplinary Committee (Nursing Assessment, Inpatient History and Physicals,

Nutritional Screening Assessment, Physiotherapy Assessment, Medical Social Worker's Assessment, etc).

5.2 The scope and content of the assessment shall be determined by:

- The patient's condition/diagnosis
- The care setting
- The patient's response to any previous care and
- The patient's consent to treatment.

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

5.4 Outpatient assessment - the Physician shall assess outpatients during the clinic visit **with in 30 min of Patient arrival**.

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

In the initial assessment, patients with pain shall be identified so that they may receive appropriate treatment or referral.

5.6 **Inpatient: IP** duly registered and credentialed staff Physician shall either perform or supervise the performance of a patient initial assessment within **1 hour in ICU and 2 hours in Ward/Sharing/Single rooms.** Counter signed by primary consultant within 24 hours of admission. Initial assessments shall be valid for 30 days.

The care plan is prepared and documented based on initial assessment also includes the review plan and cross referrals if any. The above is documented in the patient's medical record to achieve desired outcomes.

The assessment and the care plan is signed by the treating consultant doctor or his designee after the assessment.

5.7 **In emergency room** the patient shall be assessed by the emergency room team with in 15min (Based on Triage) on arrival and documentation shall be completed within 30 Minutes. 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.

5.8 **Day Care Patient** Initial Assessment to be complete within 2 hours of admission by registered and credentialed staff physician will perform the initial assessment

5.9 The nursing assessment shall be performed and documented in the patient record within 30 minutes of admission in ward and (INPATENTS) in ICU it should be within 30min

5.10 The nutritional and functional assessment shall be completed within 24 hours of admission of the patient.

5.11 Continued assessments and reassessments shall be documented throughout the patient's medical record. A multidisciplinary approach shall be utilized for performing patient assessments based on the patient's diagnosis and the care setting and the patient's response to any previous care, i.e., by Physicians, Nursing staff, Nutritionist, Physiotherapist and Medical Social worker. This shall be performed in the interdisciplinary team rounds and documented in the IDT form.

5.12 The initial medical assessment shall be documented before anesthesia or emergence treatment, which shall also include a re-evaluation immediately before administration of anesthesia.

5.13 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.

- Reassessment shall take place also when there is a significant change in a patient's condition or a change in diagnosis. Reassessments shall also depend on the type of patient population.
- Nursing staff shall reassess patients as per the standards maintained in the department.

- Medical staff shall reassess patients once daily, including weekends, during the acute phase of their care and treatment.
- More frequent reassessments shall be done by both nurses and doctors as per the clinical condition of the patient.

5.14 Assessment and reassessment are documented in the following reports:

A. Medical Staff:

- Progress Record
- Pre/Post Anesthesia Record
- Consultation Referral
- Operative Reports
- Discharge Summary

B. Nursing Staff:

- Nursing Assessment & Care Plan
- Nurse' Record
- Nurse's Clinical Chart
- Flow Sheets

C. Nutritional services, Physiotherapy services as appropriate. Other assessments are performed and documented.

- The plan of care shall include preventive aspects of the care and shall be reviewed regularly in consultation with or from written information provided by other members of the health care team and the patient/family. The plan of care shall be revised as appropriate to the patient's condition and the ongoing assessment process.

Information about the patient's care and response to treatment shall be shared among medical, nursing and other care providers during each staffing shift, between

shifts and during transfers. The patient's record shall be available to the authorized care provider to facilitate exchange of information.

Discharge planning needs shall be included in the initial assessment and reassessment process, throughout the patient's hospitalization. The patient family shall be involved in the discharge planning process as appropriate.

Procedures: (Out Patient)

- The following details are considered in the initial assessment by the consultant/Junior Resident / Casualty Medical Officer

    - Present Complaint/ Symptoms
    - Medical History
    - Allergies If Any
    - Family History
    - Vital Signs
    - Physical Examination
        - Nutritional screening

Procedure for initial assessment of patients at In-Patient areas:

- All inpatient staff members greet the patient/attendants with a "Namaste"
- The patient and their attendants are explained of the process of initial assessment by Doctors and Nursing staff
- The Doctors, Nursing staff & Dieticians shall document their findings in the respective forms within the time frames defined according to the initial assessment policies
- The Doctors, Nursing staff, Dieticians & Physiotherapists shall discuss and document the preventive, promotive, curative and rehabilitative aspects related to the plan of care with the patient

Procedures:In Emergency: The following details are noted

- General Information: Patient's personal details, Date & Time of arrival, brought by and referred to

- Clinical Examination by CMO
  - Chief complaints
  - Vital signs
  - Triage Color
  - Brief History of presenting complaint
  - Past Medical and surgical history
  - Medication History
  - Mental status
  - Previous Investigation & treatment
  - Diagnosis
  - Investigation ordered
  - Treatment ordered- Drug , Dose, Frequency
  - Procedure
  - Consent obtained
  - Discharged to home / Admission to hospital-IP No, Bed No/ Transferred to other hospital / Reason:
  - Patient status: Critical/ Stable

Responsibility Matrix - Initial Assessment of the patient

Initial assessment	Reception staff	Registered medical practitioner (Consultant / Registrar / Resident Doctor)	Nurse	Dietician
After Admission – Medical		Yes		
Nursing			Yes	
Nutritional		Yes		Yes

Functional			Yes	

Responsibility Matrix - Reassessment of the patient

Reassessment	Registered medical practitioner (Consultant/Registrar/Resident)	Nurse	Dietician
Medical	Yes		
Nursing		Yes	
Nutritional			Yes
Functional	Yes	Yes	

Assessment of patient documents

Assessment	Document
Medical	Initial Patient Assessment, Progress Record, In House Transfer Forms, Pre-Operative assessment (Physician), Restraint Form, Emergency – Accident and Emergency forms
Social, Economic and Psychological	Initial Patient Record at registration
Nutritional	Nutritional Assessment Form
Nursing	Nurses Record, Flow Sheets, Nursing Assessment &Care Plan
Pre-anesthetic, Intra operative and Post operative	Surgical Record-Anesthesia Record

Qualified professionals perform assessment 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
Counselor	Master's Degree in Social work	Not required
Physiotherapist	Bachelor's Degree in Physiotherapy	Not required

Policy on care plan:

- Based on the initial assessment and result of diagnostic tests treating doctor or doctor member of treating team will arrive for a provisional diagnosis or differential diagnosis and documents the care plan.
- Care plan will be reassessed as and when required depending on the results of the diagnostic investigations.
- Care plan will be signed by the clinician in charge of the patient within 24 hrs of initial presentation.
- Care plan reflects identification of special needs like ambulation, wound care, regarding continual nursing care following discharge and rehab services if any.

Document Revision History

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