



INODAYA HOSPITAL-KAKINADA		Documentation code: INH/AAC.04.a:Doc No:07
Policy on OP , Day care, In patients, and ER patients Initial Assessment		Issue date: 11/11/2025
Reference: AAC.4.a. NABH Standards – 6 th Edition		Review No: 00
Prepared date: 11/11/2025	Review Date: 10/11/2026	Issue No: 01

AAC. 4a. Policy on OP, Day care, In patients, and ER patients Initial Assessment

1. Purpose:

To standardize the process for initial assessment at the outpatient department

2. Definitions:

- a. **OPD:** Out Patient Department
- b. **IP:** Inpatient
- c. **ER:** emergency patient
- d. **Day Care:** day care patient
- e. IDT - Interdisciplinary Team
- f. MBBS - Bachelor of Medicine and Bachelor of Surgery
- g. MHC - Master Health Check
- h. MRD - Medical Records Department
- i. SOP - Standard Operating Procedures

3. Distribution:

Outpatient Department, Front office staff & Executives, OPD nursing staff

4. Responsibilities:

OPD Nursing staff, Casualty Medical Officer, Junior Residents & Consultants

5. Policy:

Patient assessment at our hospital is an ongoing process that begins before the patient is admitted and continues throughout the care process

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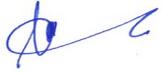
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- a. Initial assessment of the OP patient is carried out in the **OPD within 30 minutes of the patient presenting at our OPD and entering to the consultant room time**, any delay in the initial assessment is informed to the patient/attendant concerned.
- b. For Patients who are with critical conditions or with exacerbated symptoms, the patient is transferred to casualty and the initial assessment is carried out in the casualty
- c. Information generated through analysis of assessment information is integrated to identify and prioritize an individualized plan of care for each OP patient
- d. The OP registration form is filled by the patient, the form contains all demographic details to register the patient for further care

6. Procedures:

- a. The following details are considered in the initial assessment by the consultant/Junior Resident/Casualty Medical Officer
 - i. Present Complaint/ Symptoms
 - ii. Medical History
 - iii. Allergies If Any
 - iv. Family History
 - v. Vital Signs
 - vi. Physical Examination
 - vii. Nutritional screening

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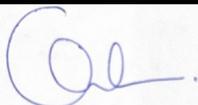
1. EMERGENCY ROOM (ER) POLICY AND PROCEDURE:

- Each patient arriving at the Emergency Department shall be **assessed within 15 minutes** of arrival, based on **triage priority**.
- The **emergency room team** shall perform the assessment and complete **documentation within 30 minutes**.
- The patient shall receive **immediate stabilization treatment** while documentation is in progress.
- The **concerned doctor** (primary consultant / specialty consultant) shall be **informed immediately** about the patient's arrival and condition.

Scope of Assessment

- General Information: Patient's personal details, date & time of arrival, brought by, referred to
- Chief complaints
- Vital signs
- Triage color code
- Brief history of presenting complaint
- Past medical & surgical history
- Medication history
- Mental status

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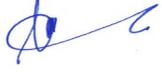
- Previous investigations & treatments
- Clinical examination by CMO
- Diagnosis (provisional)
- Investigations ordered
- Treatment ordered (drug, dose, frequency)
- Procedures performed
- Consent obtained (as applicable)
- Disposition: Discharged / Admitted (IP No., Bed No.) / Transferred to other hospital (with reason)
- Patient status: Critical / Stable

Responsibility Matrix (ER)

Activity	CMO / ER Doctor	Nurse	Support Staff
Initial Assessment	Yes	Yes (vitals, documentation)	Assist
Stabilization & Immediate Care	Yes	Yes	Yes
Documentation	Yes	Yes	-
Communication to Consultant	Yes	-	-

INPATIENT INITIAL ASSESSMENT (IP)

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POLICY STATEMENT

- All inpatients shall undergo an **initial assessment by qualified and credentialed personnel** immediately after admission.
- Assessment includes **medical, nursing, nutritional, and functional components**.
- Time frames for completion:
 - **ICU:** within **1 hour** of admission
 - **Ward/Private/Sharing Rooms:** within **2 hours** of admission
- The **primary consultant** shall **countersign the assessment within 24 hours** of admission.
- The **care plan** based on the assessment shall be prepared, documented, and signed by the treating consultant or designee within 24 hours.

PROCEDURE

Step 1: Admission Process

- After registration, the patient is assigned a **Unique Hospital Identification Number (UHID)** and **Inpatient Number (IP No.)**.
- Patient is escorted to the allotted bed by the ward staff.
- The nurse receives the patient, greets them with a “Namaste”, and orients them and their attendants to ward facilities and procedures.

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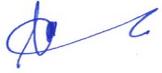
- **Initial Assessment:**

- Performed by **registered and credentialed staff physician:**
 - Within **1 hour** for ICU admissions
 - Within **2 hours** for Ward / Single / Sharing room admissions
 - Within **2 hours** for **Day Care** patients
- **Countersigned by the primary consultant** within **24 hours** of admission.
- **Nursing assessment** completed and documented **within 30 minutes** of admission.
- **Nutritional and functional assessments** completed within **24 hours** of admission.
- **Validity of Initial Assessment:** 30 days (unless condition changes).
- **Pain assessment** included during initial evaluation.
- The **care plan** is based on the initial assessment and includes review plan and cross referrals if needed.

Continued Assessment

- **Reassessments** performed throughout hospitalization by:
 - Physicians – **daily including weekends** during acute phase
 - Nurses – **as per department standards**
 - Dieticians, Physiotherapists, Medical Social Workers – as required
- Reassessment also when:

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- There is a significant change in condition
- Change in diagnosis
- Before anesthesia or emergency treatment
- Immediately before administration of anesthesia

Multidisciplinary Team (MDT) Assessment

- Performed in **interdisciplinary team (IDT) rounds**
- Includes: Physicians, Nurses, Nutritionists, Physiotherapists, Medical Social Workers
- Documented in the **IDT form**

Discharge Planning

- Initiated at the **time of initial assessment** and updated during reassessments.
- Patient’s family is involved in planning for:
 - Continuing care needs (wound care, ambulation, rehab)
 - Follow-up requirements
 - Home care instructions

Responsibility Matrix (Inpatient & Day Care)

Assessment Type	Physician	Nurse	Dietician	Physiotherapist
Initial Medical Assessment	Yes			
Nursing Assessment		Yes		

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Nutritional Assessment			Yes	
Functional Assessment		Yes		Yes
Reassessment – Medical	Yes			
Reassessment – Nursing		Yes		
Reassessment – Nutritional			Yes	
Reassessment – Functional	Yes	Yes		Yes

Documentation (Inpatient / Day Care)

PROCEDURE

Step 1: Admission and Registration

- Patient registers for Day Care services at the reception desk.
- A **unique hospital identification number (UHID)** and **Day Care Admission Number** are generated.
- The patient is escorted to the Day Care Unit, and all relevant case sheets are opened.

Step 2: Nursing Assessment (within 30 minutes)

- Performed by a **registered nurse** immediately after admission.
- Includes:

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- Verification of patient identity and consent
- Recording of vital signs (Temperature, Pulse, Respiration, BP, SpO₂)
- Assessment of pain (Numeric Rating Scale or Wong-Baker Faces)
- General appearance and comfort level
- Allergies (drug/food/latex)
- Functional status and mobility
- Any special care needs
- Findings documented in **Nursing Assessment and Care Plan Form.**
- Report handed over to the attending physician.

Step 3: Medical Assessment (within 2 hours)

- Conducted by a **registered and credentialed physician.**
- Includes:
 - Chief complaints / reason for Day Care admission
 - Relevant medical, surgical, and medication history
 - Review of systems and past investigations
 - Physical examination findings
 - Pain and mental status assessment
 - Provisional or confirmed diagnosis
 - Investigations ordered, if any
 - Planned procedure or treatment
 - Identification of special risks (e.g., anesthesia, allergy, infection control)
 - Provisional **care plan** documented.

Step 4: Nutritional and Functional Assessment (if applicable)

- **Nutritional screening** done within 24 hours of admission by dietician for chemotherapy, transfusion, or post-operative cases.

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- **Functional assessment** by physiotherapist for cases requiring mobilization, post-anesthesia recovery, or physical support.

Step 5: Care Plan Development

- Based on assessment findings, the **treating consultant** or their designee prepares a **Day Care Care Plan** including:
 - Planned treatment/procedure
 - Pre-procedure and post-procedure instructions
 - Medications
 - Pain management
 - Discharge criteria and follow-up instructions
- The care plan is **signed within 24 hours** by the consultant in charge.

Step 6: Pre-procedure Verification (as applicable)

- Before any procedure, the patient's identity, consent, allergies, and investigations are verified.
- **Pre-anesthetic evaluation** done (if anesthesia is planned).
- Immediate re-evaluation performed prior to anesthesia or treatment.

Step 7: Documentation

All assessment findings must be documented in:

- Day Care Initial Assessment Form
- Nursing Assessment and Care Plan
- Pre-Procedure / Post-Procedure Records
- Progress Notes
- Discharge Summary (at completion of care)

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Step 8: Communication and Handover

- Assessment findings and care plan are communicated to all members of the care team.
- Any abnormal findings or complications are immediately reported to the treating consultant.
- Handover occurs during staff shift change using standardized communication protocols.

Document Revision History

DOCUMENT REVISION HISTORY		
Version	Date of issue	Reason for Revision
Original version - 1	10/03/2022	Prepared 5 th edition
Revised version - 2	05/07/2023	Periodic revision and update
Revised version - 3		
Revised version - 4		
Revised version - 5		

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