

	<b>INODAYA Hospitals - Kakinada</b>		Documentation code: INH/AAC.01/Doc.No:08
	Policy on Initial assessment performed by qualified personnel		Issue date: 11/11/2025
	Reference: AAC.04b. NABH Standards – 6 <sup>th</sup> Edition		Review No: 00
	Prepared date: 11/11/2025	Review Date: 10/11/2026	Issue No: 01

## AAC.4b. POLICY ON INITIAL ASSESSMENT PERFORMED BY QUALIFIED PERSONNEL

### 1. PURPOSE

To ensure that all patients receiving care at **Inodaya Hospitals** are **systematically assessed at the time of admission or first contact by qualified, registered, and credentialed healthcare professionals** to identify their physical, psychological, social, spiritual, cultural, and economic needs, enabling the development of a comprehensive and individualized care plan.

This policy promotes patient safety, continuity of care, and compliance with professional, legal, and NABH requirements.

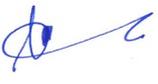
### 2. SCOPE

This policy applies to **all patients** (Outpatients, Inpatients, Day Care, and Emergency cases) assessed by:

- Medical Staff
- Nursing Staff
- Dieticians
- Physiotherapists
- PRO
- Other allied health professionals involved in patient care.

### 3. POLICY STATEMENT

- Every patient shall undergo a **complete initial assessment** by qualified personnel appropriate to their care needs and setting (OP, IP, ER, Day Care).

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- The assessment shall cover all relevant domains of patient health and well-being:
    - **Physical** (vital signs, illness, pain, functional status)
    - **Psychological** (mental status, stress, anxiety, coping ability)
    - **Social** (family structure, support systems, relationships)
    - **Spiritual** (beliefs, faith practices, spiritual distress, coping through faith)
    - **Cultural** (language, food preferences, cultural beliefs influencing care)
    - **Economic** (financial capacity, affordability of treatment, support requirements)
  - Only **qualified and credentialed healthcare professionals** shall perform assessments within their defined scope of practice.
  - All assessments shall be **documented, signed, dated, and timed** in the patient’s medical record.
  - The **treating consultant** or his/her designee shall review and **countersign the medical assessment within 24 hours** of admission.
- Assessment findings shall form the basis of an individualized, multidisciplinary Care Plan

#### 4. DEFINITIONS

##### **Initial Assessment:**

A systematic evaluation of a patient’s physical, psychological, social, and functional status to identify care needs at the time of admission or first contact.

##### **Qualified Personnel:**

Registered healthcare professionals authorized by law and the hospital’s credentialing process to conduct specific assessments within their professional scope of practice.

#### 5. RESPONSIBILITY AND QUALIFICATION REQUIREMENTS

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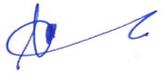
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Discipline	Qualification	Registration Requirement	Scope of Initial Assessment
<b>Medical Practitioner</b>	MBBS / MD / DNB	Registered with State / Central Medical Council	Perform detailed medical and physical assessment, diagnose condition, assess pain, mental status, and develop care plan.
<b>Nursing Professional</b>	Diploma / B.Sc / M.Sc Nursing	Registered with State / Central Nursing Council	Conduct nursing assessment covering physical, emotional, psychosocial, and spiritual aspects. Record vital signs, pain, and hygiene status. Initiate nursing care plan.
<b>Dietician / Nutritionist</b>	M.Sc in Dietetics / Nutrition	Not mandatory	Conduct nutritional assessment; identify cultural and religious food preferences; assess nutritional risk.
<b>Physiotherapist</b>	Bachelor's Degree in Physiotherapy	Not mandatory	Assess functional ability, mobility, and rehabilitation needs.
<b>pre</b>	Any Degree with 5 years of experience	Not mandatory	Evaluate emotional and psychological well-being, anxiety, depression, coping mechanisms, and spiritual distress.

## 6. PROCEDURE

### 6.1 Outpatient Department (OPD)

- Assessment by **qualified physician** within **30 minutes** of patient arrival.
- Includes history taking, physical examination, vital signs, and pain evaluation.

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- Documented in the **Outpatient Consultation Record**.

### 6.2 Emergency Department (ER)

- Assessment by **Emergency Medical Officer** within **15 minutes** of arrival (as per triage).
- Includes vital signs, chief complaints, brief history, mental status, and provisional diagnosis.
- Documentation completed within **30 minutes** in the **Emergency Assessment Form**.

### 6.3 Inpatient Areas (Ward / ICU)

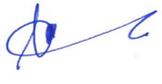
- Assessment by **registered and credentialed physician**:
  - Within **1 hour** of admission to ICU.
  - Within **2 hours** of admission to Ward / Room.
- **Nursing assessment** within **30 minutes** of admission.
- **Nutritional and functional assessments** within **24 hours**.
- **Consultant countersignature** on the medical assessment within **24 hours**.

### 6.4 Day Care Unit

- Assessment by **registered physician** within **2 hours** of admission.
- Nursing assessment within **30 minutes**.
- Care plan finalized and signed within **24 hours** by treating consultant.

## 7. DOCUMENTATION

All initial assessments shall be recorded in the **patient's medical record** using standardized hospital forms, which include:

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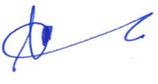
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- Initial Medical Assessment Form
- Nursing Assessment & Care Plan
- Nutritional Assessment Form
- Functional Assessment Form
- Emergency / Day Care Assessment Form
- Pre-Anesthesia Evaluation (if applicable)

Each entry must be **dated, timed, signed, and include the name and designation** of the assessor.

#### Document Revision History

DOCUMENT REVISION HISTORY		
Version	Date of issue	Reason for Revision
Original version - 1		
Revised version - 2		
Revised version - 3		
Revised version - 4		
Revised version - 5		

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