Policy on the initial assessment is performed with in a time frame based on the needs of the patient

1.Policy:
The initial assessment shall be performed within a time frame that is appropriate to, and based upon, the needs, condition, and acuity of the patient.

2. Purpose:

To provide a standardized process for conducting initial patient assessments in order to:

- Ensure prompt and accurate evaluation of each patient's condition.
- Prioritize care based on clinical urgency.
- Facilitate the development of individualized care plans.
- Promote patient safety and quality outcomes.

.3.**Scope:**

All Patients at Inodaya Hospitals, Kakinada

4. **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

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5. **Responsibility:**

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

6.0 NURSES:

The nurse may delegate subjective and objective data collection to another licensed nurse as appropriate based on their credentials and training.Delegation of data collection must be in accordance with the hospital based on below category.

a. ICU - within 30 minutes
b. WARDS – within 60 minutes.
c. EMR- within 15 minutes documentation in 30 minutes

Nursing admission assessment based on age, condition, diagnosis and care setting will include at a minimum:

1. Vital signs

2. Spiritual/Cultural Screen

3. Pain Screen

4. Abuse/neglect/assault screen

5. Cognitive and Functional screen

6. Nutritional Screen

7. Advance Directives/Guardianship

8. Sensory/Communication Screen

9. Discharge Planning Screen

Additionally, developmental, age-appropriate, and patient population specific assessments will be completed as indicated. These will include physical assessment, skin integrity screening, and fall risk screening.

- The time frame for completing the initial assessment will be determined by the urgency of the patient's condition.
- Emergency or high-acuity patients shall be assessed immediately upon presentation.
- Non-urgent or routine cases shall be assessed within the organization's established standard time frame (e.g., within 24 hours of admission or initial contact).

All assessments must be documented promptly and accurately in the patient's record

1. Emergency and Critical Care Patients

- Patients presenting to the **Emergency Department (ED)** or **Critical Care Unit (CCU/ICU)** with life-threatening or urgent conditions must undergo an **immediate assessment upon arrival**.
- The triage nurse shall perform an **initial rapid assessment** to determine the severity of the patient's condition and prioritize care accordingly.
- The **primary physician** and **nursing staff** shall conduct a **comprehensive assessment** once the patient's condition is stabilized.
- Key assessment elements include:
  - Airway, breathing, and circulation (ABC) status.
  - Vital signs and pain assessment.
  - Level of consciousness and neurological status.
  - Immediate review of presenting complaint, allergies, medications, and past medical history.

- All findings must be promptly documented in the **Emergency Department Record** or **Critical Care Chart**, and immediate interventions must be initiated based on assessment results.

2. Inpatients (Non-Emergency Admissions)

- **Every patient admitted to any inpatient unit of Inodaya Hospital shall undergo an initial nursing and medical assessment within 24 hours of admission, or sooner if the patient's condition necessitates it.**

Nursing Assessment:

- **Conducted by the assigned staff nurse upon admission.**
- **Includes evaluation of vital signs, physical condition, psychological status, nutritional status, level of independence, and social factors.**
- **Risk assessments for falls, pressure injuries, infection control, and pain management must be completed.**
- **Nursing diagnoses and care plans should be initiated based on identified needs.**

Medical Assessment:

- **Conducted by the admitting physician or designated medical officer.**
- **Includes a thorough medical history, review of systems, and physical examination.**

- **Diagnostic tests, investigations, and treatment plans are ordered as per findings.**
- **Both assessments should be documented in the patient's admission file or Electronic Medical Record(EMR) and verified by the nurse in charge or medical officer**

3. Outpatients

- **Patients attending the Outpatient Department (OPD) shall be assessed at the time of their visit, prior to the initiation of any diagnostic, therapeutic, or procedural intervention.**
- **The assessment process includes:**
  - **Verification of patient identity and chief complaint.**
  - **Review of medical history, allergies, and current medications.**
  - **Measurement of vital signs and initial nursing assessment.**
  - Consultation and physical examination by the attending physician.

• All findings are to be recorded in the **OPD record** or **electronic system** to ensure continuity of care.

4 Assessment Components.

The initial assessment is a **comprehensive evaluation** covering the following domains:

- **Physical Assessment:** Vital signs, body systems review, pain assessment, nutritional status, mobility, and functional capacity.

- **Psychological Assessment:** Mental status, mood, anxiety, stress level, and coping mechanisms.
- **Social Assessment:** Living conditions, family support, socioeconomic factors, and cultural or spiritual needs.
- **Risk Assessment:** Identification and documentation of potential risks such as:
  - Fall risk
  - Pressure injury risk
  - Infection risk
  - Nutritional deficiency
  - Violence or self-harm risk (if applicable)
  - The outcome of each assessment shall guide the plan of care, treatment priorities, and referrals to other healthcare professionals as needed.

Document Revision History:

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