AAC.4d. Policy on the initial assessment for day care patients

1. Purpose

The purpose of this policy is to ensure that all day care patients at Inodaya Hospital undergo a **timely, safe, and comprehensive initial assessment** to determine fitness for the planned procedure, ensure patient safety, and provide appropriate care throughout the day care stay.

2. Scope

This policy applies to:

- All day care patients receiving diagnostic or therapeutic procedures
- All departments providing day care services
- Medical officers, consultants, nursing staff, and allied healthcare professionals

3. Policy Statement

Inodaya Hospital ensures that every day care patient receives a **documented initial nursing and medical assessment** prior to any procedure. The assessment findings are used to formulate an **individualized care plan**, ensure patient safety, and facilitate appropriate discharge or admission when required.

4. Responsibility

- **Consultants / Medical Officers:** Conduct medical assessment, confirm fitness for procedure, and document care plan.

- **Nursing Staff:** Perform nursing assessment, monitoring, documentation, and patient education.
- **Day Care In-charge:** Ensure adherence to this policy and completeness of documentation.

- **Allied Health Professionals: Provide support services as required and document care**

5. Procedure Followed by Inodaya Hospital

1. All day care patients reporting to Inodaya Hospital are registered as per hospital registration policy and assigned a unique patient identification number.
2. Patient identity is verified using at least two identifiers before initiation of assessment or procedure.
3. On arrival at the day care unit, the patient is received by trained nursing staff and oriented to the unit and planned care.
4. An initial nursing assessment is conducted **prior to the procedure**, and findings are documented in the day care assessment record.
5. The nursing assessment includes recording of vital signs, pain assessment, allergy status, current medications, fasting status (where applicable), and general physical condition.
6. Risk assessments such as fall risk, procedure-related risk, and infection risk are carried out as applicable.
7. Any abnormal findings identified during the nursing assessment are immediately communicated to the treating doctor for evaluation.
8. The treating consultant or duty medical officer conducts a focused medical assessment **on the same day prior to the procedure**.
9. The medical assessment includes review of presenting condition, relevant past medical and surgical history, current medications, allergy history, investigation reports, and fitness for the planned procedure.
10. Based on the assessment, the doctor confirms the provisional diagnosis, orders required investigations, and determines patient suitability for day care management.
11. An individualized, documented care plan is prepared outlining the planned procedure, medications, monitoring requirements, and post-procedure care.

12. Informed consent for the procedure is obtained and documented as per hospital consent policy.
13. During the day care stay, nursing staff monitors vital signs, comfort level, and patient response to treatment, documenting all observations and interventions.
14. Any change in the patient's condition during the day care stay

Document Revision History:

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Revised version - 2		
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