AAC 4e. Policy on Initial Assessment of In-Patients and Documented Care Plan

1. Purpose

To ensure that every in-patient admitted to Inodaya Hospital receives a **timely, comprehensive, and documented initial assessment**, leading to the formulation of an **individualized care plan** that promotes safe, effective, and continuous patient care.

2. Scope

This policy applies to:

- All in-patients admitted to Inodaya Hospital
- All clinical departments and units
- Medical officers, consultants, nursing staff, and allied healthcare professionals

3. Definitions

- **Initial Assessment:** A structured clinical evaluation of the patient's physical, psychological, social, and functional status conducted at the time of admission.
- **Care Plan:** A documented, patient-specific plan outlining identified problems, goals, interventions, responsibilities, and review timelines.
- **In-Patient:** Any patient admitted to the hospital for observation, diagnosis, or treatment for more than 24 hours or as defined by hospital policy.

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4. Policy Statement

Inodaya Hospital ensures that:

- Every in-patient undergoes a **complete initial assessment** within defined timelines after admission.
- Findings from the assessment are **clearly documented** in the patient medical record.
- An **individualized care plan** is developed, implemented, reviewed, and updated based on the patient's condition.
- Care is delivered through a **multidisciplinary approach** ensuring continuity and quality of care.

5. **Responsibility:**

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

6.0 NURSES:

A. Intensive Care Unit (ICU)

Procedure Followed in ICU

1. On admission to the ICU, the patient is received by trained ICU nursing staff and immediate life-saving measures are initiated as per clinical condition.
2. A rapid initial assessment is performed focusing on airway, breathing, circulation, disability, and exposure (ABCDE approach).
3. Vital signs, oxygen saturation, cardiac rhythm, neurological status, and urine output are assessed and continuously monitored.

4. The ICU nurse completes a comprehensive nursing assessment at the time of admission and documents findings including pain score, sedation score, pressure injury risk, infection risk, and device-related risks.
5. The treating intensivist or duty doctor conducts a detailed medical assessment **immediately on admission** and documents clinical findings, provisional diagnosis, and critical care management plan.
6. Necessary investigations and imaging studies are ordered and treatment is initiated without delay.
7. An individualized ICU care plan is formulated based on the patient's condition and includes ventilatory support, medication plan, nutrition, fluid management, infection prevention, and nursing interventions.
8. The care plan is reviewed and updated **at least once every shift or whenever the patient's condition changes**.
9. Multidisciplinary inputs from anesthesia, cardiology, physiotherapy, dietetics, and pharmacy are incorporated into the care plan and documented.
10. All monitoring, interventions, and patient responses are accurately documented in the ICU flow charts and medical records.

B. Emergency Department

Procedure Followed in Emergency Ward

1. On arrival at the Emergency Department, the patient is immediately triaged based on severity using the hospital-approved triage system.
2. Emergency nursing staff initiates rapid assessment and stabilization focusing on airway, breathing, circulation, and neurological status.
3. Vital signs and pain score are recorded immediately and repeated as per patient condition.

4. The emergency medical officer conducts an initial medical assessment **at the earliest possible time** and documents presenting complaints, brief history, and clinical findings.
5. Life-saving interventions are initiated simultaneously with assessment as per emergency protocols.
6. Provisional diagnosis, investigations, and emergency treatment orders are documented in the patient record.
7. Once stabilized, a preliminary care plan is prepared outlining further management, observation, admission, referral, or discharge.
8. If the patient is admitted, the emergency assessment and care plan are communicated to the receiving ward or ICU to ensure continuity of care.
9. All assessments, treatments, and patient responses are documented clearly with date, time, and signature.

C. Procedure Followed in Wards – Inodaya Hospital

1. On admission to the ward, the patient is received by the nursing staff, and patient identity is verified as per hospital policy.
2. The nursing staff ensures patient safety, comfort, orientation to the ward environment, and explains ward routines to the patient and attendants.
3. An initial nursing assessment is conducted **at the time of admission or within two hours**, and findings are documented in the nursing assessment form.
4. The nursing assessment includes recording of vital signs, pain assessment, nutritional screening, fall risk assessment, pressure injury risk assessment, level of consciousness, and psychosocial status.
5. Any abnormal findings identified during the nursing assessment are immediately communicated to the duty doctor or treating consultant.
6. The treating doctor or medical officer conducts a comprehensive initial medical assessment **within 24 hours of admission** and documents the findings in the patient medical record.

7. The medical assessment includes presenting complaints, history of present illness, past medical and surgical history, medication and allergy history, and relevant family and social history.
8. A complete physical and systemic examination is performed and documented.
9. Based on the assessment, the doctor records a provisional diagnosis, orders investigations, and prescribes treatment.
10. An individualized, documented care plan is prepared based on the medical and nursing assessment findings.
11. The care plan identifies patient problems, treatment goals, planned interventions, monitoring requirements, and patient education needs.
12. Nursing staff implements the nursing interventions as per the care plan and documents all care provided, including medication administration and procedures.
13. The treating consultant reviews the patient daily, assesses progress, and updates the treatment plan and care plan as required.
14. Any significant change in the patient's condition prompts reassessment and revision of the care plan, which is documented with date, time, and signature.
15. Allied health professionals such as physiotherapists, dieticians, and pharmacists provide care as required and document their inputs in the patient record.
16. Patient and family education regarding diagnosis, treatment, medications, and safety measures is provided and documented.
17. All documentation is completed in real time, is legible, dated, timed, and signed by the responsible healthcare provider.
18. Discharge planning is initiated early during the hospital stay and updated as per patient progress.
19. At the time of discharge, a final assessment is documented, discharge instructions are explained to the patient and attendants, and continuity of care is ensured.
20. Compliance with this procedure is monitored through regular ward rounds, internal audits, and medical record reviews.

D. Compliance and Monitoring

1. All clinical documentation related to initial assessment and care planning shall be completed **in real time or within 24 hours of the event**, and shall be legible, dated, timed, and signed by the responsible healthcare provider.
2. Compliance with this procedure shall be monitored through **scheduled internal audits conducted at least once every quarter**.
3. **ICU rounds** shall be conducted **daily,** and compliance with assessment and care plan documentation shall be reviewed during these rounds.
4. **Emergency case reviews** shall be carried out **monthly** to evaluate adherence to initial assessment and emergency care planning protocols.
5. **Ward medical record audits** shall be conducted **once every quarter** to ensure completeness and accuracy of assessments and care plans.
6. Any non-compliance or gaps identified during audits or reviews shall be documented and reported to the Quality and Patient Safety Committee **within 7 days**.
7. **Corrective and Preventive Actions (CAPA)** shall be initiated **within 15 days** of identification of the gap and their effectiveness shall be reviewed **within 30 days**.

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Prepared By:	Verified By:	Approved BY:
Dr.Gowthamkrishna	Mrs.G.Lakshmi Lavanya	Dr.G.Rammohan
Medical director	Chief Executive officer	Managing Director

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Prepared By:	Verified By:	Approved BY:
Dr.Gowthamkrishna	Mrs.G.Lakshmi Lavanya	Dr.G.Rammohan
Medical director	Chief Executive officer	Managing Director