1.0 Conditions:

This policy applies to all Physicians, Nursing Staff, Social Workers and Clinical Dieticians.

2.0 Purpose:

To ensure a comprehensive and timely patient assessment. This assessment will help the medical, nursing as well as other staff to understand the type of medical, nursing, preventive, palliative, curative and rehabilitative services needed by the patient.

3.0 Policy:

Patient’s assessment and reassessment has to be continuous throughout the patient’s hospitalization by the admitting/attending physicians, nursing staff and other health care professionals, and must be documented in the patient medical record.

4.0 Procedure:

4.1 At the time of admission

4.1.1 Healthcare professionals will introduce themselves to the patient before the assessment.

4.1.2 The admitting physician will complete an initial physical, psychological social, nutritional and pain assessment.

4.1.2.1 Following disciplines will be contacted if required to assess the patient:

a) Social Service
b) Clinical Dietician
c) Health Education
d) Physiotherapy.
4.1.2.2 The assessment of patients by these supportive disciplines when requested should be within:

a) 8 – 12 hours of admission to unit/ floor
b) 2 – 4 hours of admission to obstetrical floor
c) Within an hour of admission to critical care

4.2 Time of attending to the patient:

4.2.1 The consultant must see all admitted patients under his/her name according to the following time frame:

- Routine admission: within 24 hours
- Urgent admission: 4 hours
- Emergency admission: As soon as possible

4.2.2 For 1st on-call (Resident/ Senior Resident as applicable)

- Routine admission: 1 hours
- Urgent admission: 30 minutes
- Emergency admission: 10 minutes

4.3 Patient assessment will be done as following:

4.3.1 Initial history and physical examination: By admitting physician.

4.3.1.1 The admitting physician will do complete assessment of the patient that will include:

a) Current detailed history
b) Previous history and care
c) Cultural and family assessment
d) Physical examination

4.3.2 Psychological assessment: By admitting physician & Nursing Staff

4.3.2.1 All patients will need to be screened for psychological needs.

4.3.2.2 Screening may require further comprehensive assessment based on established criteria.

4.3.2.3 Patients requiring further assessment has to be identified during daily rounds (see below).

a) Findings must be documented in the patient medical record.
b) If further assessment is required, a psychiatry consultation has to be performed.
4.4 **Social Assessment: By admitting physician, nursing staff and social worker**

4.4.1 Patients needs to be screened for social needs at the time of admission.

4.4.2 Based on developed criteria, patients may require further screening and assessment by social worker, at the time of discharge.

4.4.2.1 The patient who might need further assessment should be identified during daily rounds. These patients are:

a) Old patients  
b) Re-admitted patients within 3-7 days  
c) Previous discharge against medical advice  
d) Extended length of stay  
e) Oncology patients  
f) Patients after loss of organ/ fetus  

4.4.2.2 All patient’s findings must be documented by the physician and the social worker.

4.4.2.3 The social worker will collaborate with physicians and nurses and help them in the following:

a) Identifying the psychosocial needs of the patients  
b) Develop plan of care  
c) Educate the patient on the available agencies which might help him/her  
d) Find financial support for the patient  
e) Identify home situation and need for support  
f) Identify patients self care ability and needs.  
g) Assists in discharge planning

4.5 **Medication Assessment**

4.5.1 The patient and, as appropriate, his/her family and/or support individuals will be involved in the discussions regarding the medications that the patient is currently taking.

4.5.2 A complete list of medications that the patient is currently taking will be entered in the assessment form and the Medication Reconciliation Form and forwarded to the Pharmacy Department.

4.5.3 Attending physicians shall make every effort to obtain a complete list of medications taken by the patient. Failure to obtain a complete medication list shall only be due to patient-specific factors (i.e., patient is comatose and no family or support individuals are available), and those factors shall be clearly documented in the medical record.

4.6 **Nutritional Assessment: By admitting physician, nursing staff and clinical dietician**

4.6.1 Upon admission the admitting physician will assess the patient for nutritional needs.
4.6.2 A clinical dietician will perform nutritional assessment when required for those who are at nutritional risk.

4.6.3 Assessment of patients for nutritional needs will be done throughout the patient hospitalization by the health care team.

4.6.4 The assessment will include:

4.6.4.1 Monitoring patient’s response to the diet
4.6.4.2 Making adjustment in the care plan of nutritional care
4.6.4.3 Further referral to the dietician if required

4.6.5 All findings needs to be documented in the patient medical record and has to be conveyed to the patient and family.

4.6.6 The clinical dietician when requested is responsible for following:

4.6.6.1 Nutritional status
4.6.6.2 Eating habits
4.6.6.3 Food allergies
4.6.6.4 Developing nutritional care plan
4.6.6.5 Highlight food and drug interaction and discuss with the healthcare team.
4.6.6.6 NPO Monitoring.
4.6.6.7 Make recommendations as related to dietary needs.
4.6.6.8 Participate in patient education.

4.6.7 Those patients who have orders for therapeutic diet, clinical dietitians must reassess the patient within 48 hours of ordering. This assessment should include:

4.6.7.1 Need for continuing therapeutic diet
4.6.7.2 Difficulties related to food intake
4.6.7.3 Need for supporting equipments.

4.7 Pain Assessment: By admitting physician & nursing staff

4.7.1 Pain assessment has to be considered as the fifth vital sign
4.7.2 Every patient has to be assessed for pain.
4.8 Abuse: By admitting physician & nursing staff

4.8.1 Every patient especially children, female and elderly patients has to be assess for abuse.

4.8.2 Upon suspicion of abuse, the observing physician/nurse must report immediately and follow the policy for abuse.

4.9 Spiritual needs

4.10 Provisional Diagnosis/ Final Diagnosis

4.10.1 It is the responsibility of the admitting physician to reach a provisional diagnosis for the admitted patient.

4.10.2 The provisional diagnosis has to be documented in the patient medical record.

4.10.3 It is the responsibility of the consultant to make sure that “Final Diagnosis” is made and documented.

4.11 Specific Assessment

4.11.1 All departments must develop further specific assessment needs and requirements as applicable to their specialty.

4.11.2 Each department must identify the information that has to be taken from inpatient and ambulatory patients for specific assessments.

4.12 Reassessment

4.12.1 Any change in the patient’s condition shall require an immediate reassessment with changes in the plan of care reflecting the change in the condition if needed.

4.12.2 Patient care staff will verify and reset, if necessary, the alarm parameters of any medical equipment used on the patient at the beginning of each shift.

4.12.3 The plan of care will be reviewed regularly.

4.12.4 Discharge planning will be initiated at the time of admission and will be reassessed continuously throughout the patient’s hospital stay. The patient/family will be involved in this process as appropriate.

4.12.5 The patient/significant other will be assessed for educational needs at the time of admission and throughout the hospital stay. As teaching needs arise, a teaching plan will be formulated.

4.12.6 All data collected shall be recorded in the assessment record and shall be available to all those disciplines involved in the care of the patient. Portions of the initial assessment form include screening information related to other disciplines. Based on the outcome of
screening data, other disciplines will be contacted to perform a more comprehensive assessment of the patient as needed. This data shall be used by the multidisciplinary teams to establish the information necessary to provide the most comprehensive plan of care for the patient.

4.12.7 Consultation with those disciplines, shall be determined by the initial data collection screening information and the ongoing reassessments and collection of data.

4.13 Nursing Responsibilities:

4.13.1 Patient assessment

4.13.1.1 The nurse assigned at the time of admission must document comprehensive written nursing assessment within eight (8) hours of admission this assessment must include:

- a) History of patient and main complaint
- b) Patient allergies
- c) Patient physical condition
- d) Patient psychological condition
- e) Patient pain assessment
- f) Patient nutrition assessment
- g) Care plan

4.13.2 Assessment for risk of fall

4.13.2.1 The nurses must assess all patients for fall risk as follows:

- a) Use scale of risk to indicate the patient potential for fall.
- b) Identify the factor/s that may lead to fall.
- c) Inform the attending physician about the possible risk.

4.14 Documentation

4.14.1 Attending nurse must complete initial assessment of patient within 8 hours of admission for routine admissions, 4 hours for urgent and 30 minutes in emergency case.

4.14.2 All entries must be dated, time and signed by the attending nurse.

4.14.3 The attending nurse must enter all findings including suspicious of abuse/neglect.
5.0 References:

5.1 MCN Guidelines
5.2 Hospital Rules and regulation
5.3 CBAHI Standard
5.4 Canadian Standard