



HEALTH HOLDING

HAFER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

Department:	Provision of Care		
Document:	Multidisciplinary Policy and Procedure		
Title:	Multidisciplinary Assessment and Reassessment of MCH Patients		
Applies To:	All Healthcare Provider		
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1. PURPOSE:

- 1.1 Identify patients' needs through a thorough assessment process that results in decisions about the patient's immediate and continuing needs for emergency, elective or planned care and when the patient's condition changes.
- 1.2 Ensure reassessment of all patients at intervals appropriate to their condition and level of care to determine any change in diagnosis, their response to treatment and to plan for continued treatment or discharge.

2. DEFINITIONS:

- 2.1 Patient assessment:
 - 2.1.1 It is an ongoing, dynamic process that takes place in all the maternity and children medical department.
 - 2.1.2 Patient assessment consists of three primary processes:
 - 2.1.2.1 Collecting information and data on the patient's physical, psychological, nutritional, rehabilitation and socio-economic status, and his/ her past and present health and family history. It must include complete physical examination.
 - 2.1.2.2 Analysing the data and information, including the results of laboratory and diagnostic imaging tests to identify the patient's health care needs and discharge planning.
 - 2.1.2.3 Developing a plan of care to meet the patient's identified needs.
- 2.2 The initial assessment aims to identify the general patient's medical and nursing needs and a provisional diagnosis so that care and treatment can be initiated.
- 2.3 Reassessment: Is a continuous process of data gathering to determine whether care decisions are appropriate and effective or there is need for changes or discharge. It is done by all the patient's health care practitioners.
- 2.4 Discharge planning:
 - 2.4.1 It is the process of ensuring smooth and safe transition of hospitalized patients.
 - 2.4.2 It is a multidisciplinary team work that starts on admission, with planning reassessed and updated continuously throughout the patient's hospital stay, and is finalized on discharge.

3. POLICY:

- 3.1 All patients admitted to MCH departments (Neonates, Pediatric and OBS-GYNE patients) will have their health care needs identified on admission and during their hospital stay through an assessment/ reassessment process by hospital privileged healthcare professionals to determine patient's initial and changing condition and needs.
- 3.2 Only qualified, MCH privileged healthcare workers permitted by license, applicable laws and regulations are allowed to perform assessment and reassessment.
- 3.3 The most responsible physician ensures all patients under his/her care have a complete medical assessment with all diagnostic tests and referrals as required to reach a final diagnosis.

- 3.4 Patient assessment and reassessment occurs at, but not limited to, the following hospital sites:
 - 3.4.1 Inpatient departments:
 - 3.4.1.1 Admitted patients to all hospital departments
 - 3.4.1.2 Neonatology unit and delivery rooms for neonates (refer to MCH policy on assessment and reassessment of neonates in the NICU).
 - 3.4.1.3 Before surgery and after surgery in the recovery room and on receiving the patient at his/ her treating room.
 - 3.4.1.4 On transfer of patients from one level to another
 - 3.4.1.5 One day care unit
 - 3.4.1.6 Before and after certain radiologic procedures e.g. MRI , procedures that need contrast material
 - 3.4.2 Emergency Room:
 - 3.4.2.1 All patients are triaged at their entry to emergency room to prioritize their needs based on level of acuity or high risk presentation (refer to MCH policy on triage in emergency room).
 - 3.4.2.2 Initial assessment by ER physician consists of pertinent history, relevant physical examination, needed laboratory or radiologic examinations, forming provisional diagnosis and developing a plan of care. It is documented on the emergency department assessment forms.
 - 3.4.2.3 ER nurses will document the nursing assessment on the 'initial emergency nursing assessment form'.
 - 3.4.2.4 Frequency of reassessment is determined by each patient's level of care and needs and both physicians' order and nurse's professional judgement.
 - 3.4.2.5 All admitted patients who stay in the ER until the bed is available will have full initial assessment by the concerned department medical team within maximum of 24 hours or earlier according to patient condition and needs.
 - 3.4.2.6 Assessment and reassessments in the ER are documented on designated forms and included in the patient's temporary medical record (emergency physician assessment form and obstetrician emergency assessment form).
 - 3.4.3 Outpatient department:
 - 3.4.3.1 All patients examined in the outpatient department will have their health care needs identified through an assessment/ reassessment process to determine patient's initial and changing condition and needs.
 - 3.4.3.2 Outpatient assessment requires at least initial assessment followed by focused history and physical examination as appropriate, based on the nature of presenting problems.
 - 3.4.3.3 All assessments and reassessments are documented on designated forms for different specialities and included in the patient's medical record (physician outpatient assessment form/ outpatient physician follow up form (reassessment), one day/outpatient form)
 - 3.4.3.4 Consultation and or referral to other outpatient specialty clinics can be done through the hospital outpatient appointment system.
- 3.5 Initial assessments of inpatients and outpatients should include complete history and physical examination, psychological, nutritional, socioeconomic, functional status and need for rehabilitation and spiritual/ cultural status and needs, screening for presence of pain and risk of fall. Assessments also include other special needs e.g. dental, hearing, vision problems that may need referral for further assessment and treatment. The initial assessment should be done within 5 – 15 minutes on the initial contact.
- 3.6 Patient assessment will consider the patient's condition, age and health needs as well as his/her requests or preferences. Specific initial assessment parameters vary according to the scope of practice of each clinical service.
- 3.7 Patient's medical and nursing needs identified from the initial assessment are completed and documented in the patient's medical record.
 - 3.7.1 Within the first 24 hours after admission as an inpatient,

- 3.7.2 Earlier as indicated by the patient's condition as in cases of emergency medical or surgical patients, critical care patients, women in complicated labour.
- 3.8 The assigned consultant/ designee will write the orders, document any required consultation and fill the required request forms for other needed healthcare professionals and communicates with them.
- 3.9 Other assessments required by the patient's condition are performed by concerned health care practitioners and documented within the first 24 hours of receiving the consultation or sooner as required by patient condition e.g. patients with intense pain, nutritionist for high risk level nutrition, social service for victims of abuse
- 4.10 Medical, nursing and other healthcare professionals involved in the patient care will collaborate in analysing and integrating patient assessments, identifying and prioritizing patient needs. The assigned consultant is responsible for organizing the care. Collected data, in addition to results of laboratory and diagnostic imaging tests, are integrated to:
 - 4.10.1 Understand the care the patient is seeking and identify the most urgent care needs and prioritize
 - 4.10.2 Understands the patient response to any previous care
 - 4.10.3 Select the best care setting for the patient
 - 4.10.4 Form an initial primary diagnosis and associated conditions
 - 4.10.5 Develop each patient's plan of care
 - 4.10.6 Determine the need for discharge planning
- 4.11 Patients/ patient's guardian are included in the decision process as needed.
- 4.12 Reassessment:
 - 4.12.1 Healthcare professionals involved in inpatient care reassess patients all through their hospital stay. The scope and intervals of reassessment are based on patient's condition, needs, level of care, response to treatment and plan of care.
 - 4.12.2 The results of complete assessments/ reassessments of all the different healthcare professionals will be documented in the patient's medical record for the information and use of all those who deliver direct patient care.
 - 4.12.3 Conducting reassessments will include, but is not limited to the following:
 - 4.12.3.1 By physician at least daily (or more according to acuity of cases) all through patient's hospital stay including weekends.
 - 4.12.3.2 In response to a significant change in the patient's condition.
 - 4.12.3.3 If the patient's diagnosis has changed and the care needs require revised planning, and to determine if medications and other treatments have been successful, plan for continued treatment or the patient's transfer to another level of care, referral or discharge.
 - 4.12.3.4 Pre and post-surgical operations, invasive procedures.
 - 4.12.3.5 On transfer to another level of care.
 - 4.12.3.6 Nursing staff will:
 - 4.12.3.6.1 The nursing reassessment will be as follows:
 - 4.12.3.6.1.1 Every 1 hour for intensive care patients and documented on the 'Neonatal ICU flow sheet, PICU flow sheet, MICU flow sheet.
 - 4.12.3.6.1.2 Every 4 hours for intermediate care patients
 - 4.12.3.6.1.3 Every 8 hours for regular wards
 - 4.12.3.6.1.4 Whenever there is a change in patient condition.
 - 4.12.3.6.2 Record vital signs at regular intervals, as ordered and as needed.
 - 4.12.3.6.3 Pain reassessment according to policies.
 - 4.12.3.6.4 Risk for fall
 - 4.12.3.6.5 Physical examination every shift and more frequently as needed based on the patient's condition.
 - 4.12.3.6.6 Regular reassessment of central and peripheral intravenous lines, drains and airways.
- 4.13 Educational needs: the multidisciplinary care team will do initial assessment and reassessment of the educational needs of the patient and his/ her caregiver all through the admission, according to patient's needs.

- 4.14 The hospital identifies the following categories of patients as special population who need individualized initial assessment. They will be referred to the appropriate service:
 - 4.14.1 Neonates: refer to NICU department (assessment and reassessment of neonates)
 - 4.14.2 Children and adolescence: refer to 'Assessment and reassessment of Pediatrics patients'.
 - 4.14.3 Women in labor: refer patient to obstetric department 'Management of patient progress at labor and delivery.
 - 4.14.4 Women experiencing terminations in pregnancy: screening of psychological, social and assessment and reassessment and management according to patient's needs.
 - 4.14.5 Terminally ill/ dying patient
 - 4.14.6 Victims of abuse and neglect will be referred to concerned subspecialty e.g. Pediatrics, obstetrics/gynecology, social evaluation as required.
 - 4.14.7 Patients whose immune systems are compromised: intensive care patients including neonates, severe malnutrition, neutropenia.

4. PROCEDURE:

- 4.1 Assigned multidisciplinary team conduct assessment and reassessment as per the designated forms.
- 4.2 Physicians:
 - 4.2.1 Assessment
 - 4.2.1.1 Assigned consultant or his/ her designee conduct initial assessment and document it in the patient's medical record within the first 24 hours after admission. It includes (but is not limited to):
 - 4.2.1.1.1 History of:
 - 4.2.1.1.1.1 Chief complaint, indication for procedure, details of present illness, review of systems, pain, functional disabilities or recurrent falls, past medical and surgical history including previous admissions, relevant past social and family history, drug history and any prior adverse drug reactions and current medications (dose, route and frequency), allergies, pregnancy assessment
 - 4.2.1.1.1.2 Menstrual history: for all females in the childbearing age undergoing general anesthetic procedures, administration of chemotherapy, and/or diagnostic imaging procedures where the fetus would be within the primary radiation field, pregnancy status must be screened.
 - 4.2.1.1.1.3 Psychiatric: known illness, initial interpretation of how the patient perceives his/ her illness, if patient is depressed, angry and may harm him/her or others.
 - 4.2.1.1.1.4 Document history of socioeconomic and educational level, any illicit drug abuse or smoking.
 - 4.2.1.1.1.5 Assess the need of spiritual support e.g. for the dying patient and family, parents of patients with multiple malformations.
 - 4.2.1.1.2 Complete physical examination considering age, sex and presenting problem e.g. pregnancy, adolescence, neonates, children
 - 4.2.1.1.3 Assess the need for additional consultations e.g. cardiac, surgical or specialized assessment e.g. patients with hearing, eye or speech defects etc.
 - 4.2.1.1.4 Order needed laboratory and imaging tests as indicated by patient condition.
 - 4.2.1.1.5 Communicate the information with the nursing and other healthcare consulted professionals and analyse the data obtained to identify the patient's healthcare needs, make a provisional diagnosis and decide the plan of care.

- 4.2.1.1.6 Selects measurable realistic time based goals.
- 4.2.1.1.7 Document the plan of care on the 'Multidisciplinary plan of care form' and the planned orders on the physician order sheet.
- 4.2.1.2 Assess the patient's needs at admission and initiate discharge planning as needed.
- 4.2.1.3 Assess and document the needed education for patient and family.
- 4.2.1.4 The initial assessment of patients admitted for surgery or invasive procedures will be recorded prior to surgery and will include in addition to the above:
 - 4.2.1.4.1 The patient's pre-operative diagnosis, the results of relevant investigations and the pre-anesthetic assessment and discharge needs.
 - 4.2.1.4.2 Pre-induction assessment occurs immediately prior to the induction of anesthesia and focuses on physiological stability and readiness of the patient for anesthesia.
 - 4.2.1.4.3 The anesthetist documents the 'pre-anesthesia/ sedation assessment form'.
 - 4.2.1.4.4 The anaesthetists reassess the patient post operatively, on admission to the recovery room, during the patient's discharge from the recovery room.
 - 4.2.1.4.5 The receiving unit physician and nurse reassess the patient upon arrival from the operating theatre to the unit.
- 4.2.1.5 Initial assessment in emergency room is based on patient's needs and condition; analysis of the reason for visit, objective findings from a targeted physical examination and conclude with a treatment plan.
- 4.2.1.6 Patients requiring individualized assessment will be referred (4.14) will be referred to the specialized appropriate service.
- 4.2.1.7 Patients referred from other organizations will have their referral criteria evaluated and any discrepancy between current assessment and the previous one documented in the medical records.
- 4.2.1.8 For assessments done by a consultant in an outpatient visits within 30 days before admission, the findings are reviewed and decision about its verification is made at admission by assigned physicians as appropriate to:
 - 4.2.1.8.1 The time between the outside assessment and admission
 - 4.2.1.8.2 The critical nature of the findings
 - 4.2.1.8.3 The complexity of the patient
 - 4.2.1.8.4 The planned care and treatment
 - 4.2.1.8.5 A copy of this report may be included in the patient's medical record, provided that any changes that may have occurred in the patient condition are recorded in the medical record at the time of admission.
- 4.2.1.9 If the medical assessment is greater than 30 days old at the time of admission or prior to an outpatient procedure, the medical history must be updated and the physical examination repeated.
- 4.2.2 Physician Reassessment
 - 4.2.2.1 Reassessment will be completed regularly:
 - 4.2.2.1.1 At least once a day including weekends and holidays by a member of the assigned medical staff and documented in the medical records.
 - 4.2.2.1.2 In intensive care units, it is additionally done upon the change of each shift.
 - 4.2.2.2 In addition, reassessment will be performed:
 - 4.2.2.2.1 Whenever there is a change in the patient's condition or diagnosis
 - 4.2.2.2.2 To document medication/ procedure response, complications or side effects, compliance with treatment, need for continued treatment or discharge
 - 4.2.2.2.3 Pre and post-operative
 - 4.2.2.2.4 Upon transfer from one service or level of care to another. ICU physician conducts patient assessment before transferring the patient. Both the

intensive care and receiving physicians sign the 'ICU physician transfer/ Discharge form'

4.2.2.3 Reassessment of patient may result in changes in the plan of care

4.2.2.4 Document reassessment on designated form as needed on the multidisciplinary progress notes.

4.3 Nursing staff :

4.3.1 Initial assessment:

4.3.1.1 Vital signs: pulse, blood pressure, temperature, respiration and pain is conducted on arrival, followed by a full assessment that must be completed within 24 hours of admission and documented on designated forms.

4.3.1.2 The assessment will include the following:

4.3.1.2.1 Physical status: head to toe examination and documentation on designated forms

4.3.1.2.2 Nutritional risk screening: use criteria on the nurse's initial assessment forms.

4.3.1.2.3 Psychosocial status

4.3.1.2.4 Functional status

4.3.1.2.5 Pain :

4.3.1.2.5.1 All patients are screened for pain on admission, in the emergency room and in the outpatient clinics.

4.3.1.2.5.2 If pain is detected, conduct pain assessment and inform physician. Provide pharmacologic and non-pharmacologic management.

4.3.1.2.5.3 Do reassessment using the appropriate pain scale and with accordance with age and condition of the patient.

4.3.1.2.6 Risk of fall:

4.3.1.2.6.1 All neonates are high risk for fall

4.3.1.2.6.2 For pediatric patients perform 'Humpty dumpty fall risk assessment'.

4.3.1.2.6.3 For adults perform 'MORSE' fall risk assessment.

4.3.1.2.7 Skin risk assessment; perform 'Braden scale' and look for presence of pressure ulcers.

4.3.1.2.8 Allergy

4.3.1.2.9 Cultural and spiritual needs

4.3.1.2.1 Assess for discharge planning e.g. socioeconomic, rehabilitation needs

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4.3.1.3 Patient specific population assessments will be completed as indicated e.g.

4.3.1.3.1 Neonates, infants and children: the following are assessed and documented as appropriate to the patient's age and needs:

4.3.1.3.1.1 Length/ height, weight and head circumference and plotted on growth charts

4.3.1.3.1.2 Developmental age

4.3.1.3.1.3 Immunization status

4.3.1.3.1.4 The effect of the family or guardian on the patient's condition and the effect of the patient condition on the family or guardian.

4.3.1.3.1.5 Family involvement in the care and treatment of the patient

4.3.1.3.1.6 Child's communication and daily activity needs.

4.3.1.3.2 Assigned nurse should be aware of the steps of assessment of patients who are possible victims of alleged or suspected abuse or neglect policies and forms and assist physician as requested.

4.3.1.3.3 Women experiencing terminations in pregnancy: screen for psychological, psychiatric, social and spiritual status. Any unusualities

- 4.4.1.1 Patients found to have nutritional risk at the screening done by nurses on the initial assessment will be reviewed by the assigned physician who will order a consultation to the clinical dietician within 24 hours of admission.
- 4.4.1.2 Clinical dietician will perform initial nutritional assessment within 24 hours of receipt of referral or earlier according to patient condition. An in-depth assessment will include the following:
 - 4.4.1.2.1 Review of screening information
 - 4.4.1.2.2 Diet prior to admission, adequacy of intake, weight history
 - 4.4.1.2.3 History of nausea, vomiting, diarrhea, tube feeding, food allergy, psychological eating disorder, metabolic disorder
 - 4.4.1.2.4 Medications identified to have pertinent effects on nutritional status
 - 4.4.1.2.5 Anthropometric measurements and its percentiles
 - 4.4.1.2.6 Review related laboratory data
 - 4.4.1.2.7 Make nutritional diagnosis
 - 4.4.1.2.8 Decides on nutritional goals, develop nutritional plan of care and communicates with the assigned physician.
- 4.4.1.3 Clinical dietician documents the assessment on the 'nutritional risk screening forms' and in addition to the 'Multidisciplinary plan of care form'.
- 4.4.1.4 Patient education about recommended nutrition
- 4.4.2 Reassessment:
 - 4.4.2.1 Clinical dietician performs planned reassessment, the frequency and scope of which according to patient's nutritional risk level.
 - 4.4.2.2 Dietician will monitor and evaluate the progress of the nutrition plan of care and whether the nutrition related goals and expected outcomes are being met.
 - 4.4.2.3 Updated plan of care is documented on the 'Multidisciplinary plan of care form'.
- 4.5 Rehabilitation service/ Physiotherapy:
 - 4.5.1 Assessment:
 - 4.5.1.1 Consultation by the responsible physician is sent for patients found on the initial nurses screening or systematic evaluation by physician to be in need for rehabilitation therapy
 - 4.5.1.2 Patients with acute needs are screened, assessed and treated within 24 hours of receipt of consultation. Patients with chronic needs are screened within 24 hours of receiving consultation, assessed and treated within 72 hours on weekends.
 - 4.5.1.3 Further history is taken as needed e.g. of functional ability, previous physiotherapy treatment and response, results of related investigations/ X-rays
 - 4.5.1.4 The assessment is individualized to ensure different populations are treated in a safe and appropriate manner, such as pediatric, elderly, terminally ill and victims of abuse or neglect
 - 4.5.1.5 Evaluation may include, but not limited to:
 - 4.5.1.5.1 Physical performance (including muscle strength, joint range of motion, muscle excursion, balance, mobility, sensation, coordination and motor control)
 - 4.5.1.5.2 Functional performance including bed mobility, transition between positions, transfer, functions in the upright position and gait
 - 4.5.1.5.3 Nature, location and factors affecting the patient's pain/pain perception
 - 4.5.1.5.4 Use of mobility devices such as gait assist devices, wheelchairs, lifts and transfer aids.
 - 4.5.1.6 Assessment is documented on the 'Physiotherapy assessment form'. The plan of care is documented on the 'Multidisciplinary plan of care form'.
 - 4.5.2 Reassessment:
 - 4.5.2.1 Inpatients are reassessed:
 - 4.5.2.1.1 Every visit (or a minimum of once daily if the patient is seen for treatment twice daily)

- 4.5.2.1.2 Chronic patients treated by a physiotherapy assistant will be reassessed at least once weekly by the responsible physiotherapist.
- 4.5.2.1.3 As necessary to evaluate the progress or change in the patient's status, modify the plan of care accordingly.
- 4.5.2.2 Reassessment is documented on the physiotherapy assessment form and updated plan of care on the Multidisciplinary plan of care form.
- 4.6 Social services
 - 4.6.1 Socioeconomic assessment:
 - 4.6.1.1 Consultation by the responsible physician is sent for patients found on the initial nurses screening or evaluation by physician to be need for social services. All unknowns, victims of abuse or neglect and police cases are referred to social services
 - 4.6.1.2 Patients will be seen within 24 hours of receiving the consultation during regular working hours (Sunday to Thursday) and 72 hours on weekends or earlier according to condition.
 - 4.6.1.3 The initial assessment for nurses is divided into 3 categories:
 - 4.6.1.3.1 Socioeconomic needs:
 - 4.6.1.3.2 Environmental Needs:
 - 4.6.1.3.3 Psychological Needs:
 - 4.6.2 Reassessment:
 - 4.6.2.1 Reassessment will be an ongoing process, performed according to the requirements of each case
 - 4.6.2.2 Social worker documents the initial assessment, follow up and reassessment on the 'Social worker assessment form' and on the 'Multidisciplinary plan of care form'.
- 4.7 Assessment and reassessment of patient and family educational needs:
 - 4.7.1 All members of the healthcare professionals should include identification of the educational needs of the patient and his/her family as part of the initial assessment and of the reassessments e.g. current knowledge of the patient about his/her illness, consent, safety, use of own medications, nutrition, diagnostic tests, procedures etc.
 - 4.7.2 Health education plans are based on the assessment/ reassessments by the multidisciplinary team.
 - 4.7.3 The multidisciplinary team documents the education needs and information taught on the 'Interdisciplinary patient/ family education record form'.
- 4.8 Pharmaceutical care services:
 - 4.8.1 Assessment/ reassessment:
 - 4.8.1.1 Assessment for drug related issues by the clinical pharmacist may be requested by assigned consultant in the following, but is not limited to:
 - 4.8.1.1.1 When more information or clarification regarding medications history is necessary e.g. allergies, any symptoms or adverse responses to medication, the clinical pharmacist may interview the patient and his/her family member
 - 4.8.1.1.2 Certain medication regimen e.g. anticoagulants, multiple drug used, total parenteral nutrition
 - 4.8.1.1.3 Monitoring of drug blood levels or drug related complications e.g. drugs affecting renal or hepatic function, bleeding etc
 - 4.8.1.1.4 Assessment is done within 24 hours of receiving the consultation or earlier according to condition. Reassessment as required to each case.
 - 4.8.1.1.5 Recommendations are documented on the consultation form and plan of care on the 'Multidisciplinary plan of care form'.
 - 4.8.1.2 Patient's own medications:
 - 4.8.1.2.1 When taking medication history by assigned physician or clinical pharmacist, it is preferable to ask the patients to make their home medications available to get a complete and accurate list of home used

- 4.12.2 Reassessment of the patient's discharge needs and required equipment or supplies is an ongoing process performed by the multidisciplinary team throughout the patient's stay and includes information gathered from patient medical record review, the health care team and the patient and family. It is done at least weekly or sooner as indicated by the patient's condition.
- 4.12.3 The patient/ family will be involved in the discharge planning process as appropriate.
- 4.12.4 Involved healthcare worker documents the section of the form relevant to his/ her scope of work.

5. MATERIAL AND EQUIPMENT:

- 5.1 Vital signs monitor
- 5.2 Stethoscopes
- 5.3 Weight scales
- 5.4 Measuring length and height equipment
- 5.5 Various assessment and reassessment forms
 - 5.5.1 Physicians :
 - 5.5.1.1 Physician admission assessment form
 - 5.5.1.2 Physician newborn assessment form
 - 5.5.1.3 Newborn form
 - 5.5.1.4 Estimation of gestational age by maturity rating (Ballard score)
 - 5.5.1.5 Maternity physician admission assessment form
 - 5.5.1.6 Pediatric physician admission assessment form
 - 5.5.1.7 ICU reassessment notes form
 - 5.5.1.8 Pre-anesthesia or sedation assessment form
 - 5.5.1.9 Emergency department assessment form
 - 5.5.1.10 Obstetrician emergency assessment form
 - 5.5.1.11 Pediatric physician emergency assessment form
 - 5.5.2 Nurses :
 - 5.5.2.1 Initial assessment:
 - 5.5.2.1.1 Newborn nursing initial/ admission assessment form
 - 5.5.2.1.2 ICU adult nursing initial/ admission assessment form
 - 5.5.2.1.3 Labor and delivery nursing initial admission assessment form
 - 5.5.2.1.4 Pediatric/Adult nursing initial admission assessment form
 - 5.5.2.2 Reassessment and shift handover:
 - 5.5.2.2.1 Newborn nursing daily reassessment form
 - 5.5.2.2.2 Infant/ pediatric nursing daily reassessment form
 - 5.5.2.2.3 Adult nursing daily reassessment form
 - 5.5.2.2.4 SBAR nurse shift report for labor patients
 - 5.5.2.3 Intensive care
 - 5.5.2.3.1 Neonatal ICU flow sheet
 - 5.5.2.3.2 PICU flow sheet
 - 5.5.2.3.3 Maternity intensive care unit flow sheet
 - 5.5.2.3.4 ICU daily nursing flow sheet
 - 5.5.2.4 Pain: pain assessment and reassessment flow sheet
 - 5.5.2.5 Fall: Fall risk assessment and reassessment tools
 - 5.5.3 Nutritionist:
 - 5.5.3.1 Nutrition screening and assessment form
 - 5.5.3.2 Initial nutrition assessment from outpatient note
 - 5.5.4 Social workers assessment form
 - 5.5.5 Physiotherapy assessment form
 - 5.5.6 Respiratory care assessment and reassessment form
 - 5.5.7 Multidisciplinary :
 - 5.5.7.1 Multidisciplinary plan of care form
 - 5.5.7.2 Interdisciplinary patient/ family education record form
 - 5.5.7.3 Multidisciplinary progress notes form

6. RESPONSIBILITIES:

- 6.1 Consultants, Specialists And Residents
- 6.2 Nursing Staff
- 6.3 Respiratory Therapist
- 6.4 Clinical Dietician
- 6.5 Physiotherapist Staff
- 6.6 Social Worker
- 6.7 Pharmacist
- 6.8 Religious Services

7. APPENDICES:

- 7.1 Inpatients Assessments and Reassessments Time Frame and Responsibilities
- 7.2 Special Circumstances Assessment and Reassessment Time Frame
- 7.3 Minimum Assessment and Reassessment Content

8. REFERENCES:

- 8.1 MOH, Directorate of health affairs holy capital, Maternity and Children Hospital.
- 8.2 Joint Commission International Accreditation Standards for hospitals, 6th edition, 2017. Assessment of patients.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Rhodora Nativdad	Document Management Control Coordinator		January 05, 2025
Prepared by:	Dr. Shaimaa Bayoumi Emara	Asst. Medical Director Medical Quality		January 05, 2025
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 06, 2025
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		January 12, 2025
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hazam AlShammari	Hospital Director		January 19, 2025



INPATIENT ASSESSMENTS AND REASSESSMENTS TIME FRAME AND RESPONSIBILITIES

	Intensive ICU/PICU/NICU	Intermediate Care Unit	Labor & Delivery Room	Postpartum	Pediatrics, Obstetrics Medical, Surgical & Gynaecology Wards	Day Care Unit
Consultant	Initial assessment including history and physical examination will be completed within 24 hours of admission					
Assessment	As Soon As possible within 24 hours					ASAP within work hrs.
Reassessment	At least daily & PRN	Daily & Per Required Needs (PRN)				
Dept. Physician; Specialist/ Resident	Initial assessment including history and physical examination will be completed within a maximum of 24 hours of admission					
Assessment	Initiate within 15 minutes of patient arrival & complete within 4 hours			Within 1 hour of arrival & complete 4 hour	Within 1 hour of arrival & complete within 8 hours	On admission & within 4 hours
Reassessment	Q 8 hours & PRN	Twice Daily	According to stage of labor	Daily & PRN	Daily & PRN	PRN
NURSE						
Assessment	Initiate within 15 minutes and complete within 4 of admission			Initiate Within 30 minutes	Initiate within 1 hour and complete within 8 hours of admission.	
Reassessment	Q 1 hour or as ordered & PRN	Q 4 hour or as ordered & PRN	According to stage of labor	Q30 min. x2 Q 1 hour x1 then as per MD orders & PRN	Reassessment every 8 hours & PRN	Every 4 hours & PRN
NUTRITIONIST						
Assessment	Within 24 hours of receiving referral/ consultation on working days (Sunday to Thursday) & within 72 hours on weekends (except in urgent cases within 24 hours).					
Reassessment	According to level of nutritional risk; as condition dictates.					
SOCIAL WORKER						
Assessment	Within 24 hours of receiving referral/ consultation on working days (Sunday to Thursday) & within 72 hours on weekends (except in urgent cases within 24 hours e.g. child abuse....).					
Reassessment	As condition dictates.					
REHABILITATION/PHYSIO THERAPY						
Assessment	In patient with acute needs are screened, assessed and treated within 24 hour of receiving request. Patient with chronic needs are screened within 24 hour of receiving request & assessed and treated within 72 hours on weekends.					
Reassessment	Inpatient are reassessed each visit (or minimum of once daily if the patient seen for treatment twice daily). Chronic patients are reassessed according to needs of each case with a minimum of once weekly.					
RESPIRATORY THERAPIST						
Assessment	Within 4 hours of referral for the general wards & within 30 minutes for emergency & intensive care patients.					
Reassessment	As needed or per pulmonary hygiene guidelines.					



SPECIAL CIRCUMSTANCES ASSESSMENT AND REASSESSMENT TIME FRAME

	EMERGENCY DEPARTMENT	PRE-INDUCTION ANESTHESIA	RADIOLOGY PROCEDURE	BLOOD BANK
CLINICIAN				
ASSESSMENT	At the time of care	Immediately prior to anaesthesia	Immediately prior to transfer to radiology	On presentation for donation
REASSESSMENT	As condition dictates	Throughout Procedure	As Necessary	As Necessary
NURSE				
SCREENING	Immediately at presentation			
ASSESSMENT	At time of care	Upon presentation to OR	Upon presentation to Radiology	Upon Presentation to donation
REASSESSMENT	As ordered and PRN	Throughout Procedure	Every 15 minutes and PRN	As needed



MINIMUM ASSESSMENT AND REASSESSMENT CONTENT

	ASSESSMENT										REASSESSMENT	
	Out Patient	H&P	VS	PAIN	Nutritional Risk	Emotional Status	Functional Status	Social Status	Discharge Planning	Education	Related To Status	VS
Physician	Chief Complaint + Specialty Exam	Complete		★	★	★	★	★	★	★	★	
Nurses	Reason for visit	Nursing Specific	★	★	★	★	★	★	★	★	★	★
Nutritionist	Reason for visit	Specialty Specific			★				★	★	★	
Social Workers	Reason for visit	Specialty Specific				★		★	★	★	★	
Physical Therapy	Reason for visit	Specialty Specific		★			★		★	★	★	
Respiratory Therapist	N/A	Specialty Specific	★				Respiratory Status		★	★	★	★

H&E: Physical Examination

VS: Vital Signs

N/A: Not Applicabl