



HEALTH HOLDING

HAFER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

Department:	Pediatrics		
Document:	Multidisciplinary Policy and Procedure		
Title:	Assessment and Reassessment of Pediatric Patients		
Applies To:	All Pediatrics Staffs		
Preparation Date:	January 12, 2025	Index No:	PED-MPP-001
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1. PURPOSE:

- 1.1 To identify and prioritize patient care needs within the appropriate time frame.
- 1.2 To develop plan of care for the patient.
- 1.3 To collaborate other health team members in discharge planning activities.
- 1.4 To obtain and enhance the continuity of care to patient.

2. DEFINITIONS:

- 2.1 Initial Assessment- The first process of gathering patient's data and information relevant to care for both outpatient and in-patient during the beginning of health care worker -patient's contact before commencement of plan of care.
- 2.2 Reassessment- Is the continuous process of gathering patient's data and information related to patient's condition, respond to treatment and/ any patient care rendered during subsequent length of stay in hospital.

3. POLICY:

- 3.1 Initial assessment and reassessment must be carried out within established time frame.
- 3.2 All patients carted for will have their health care needs identified through documented assessment and reassessment process.
- 3.3 Initial assessment by the consultant/ physician including history and physical examination will be completed within maximum of 24 hours or earlier according to patient condition and needs.
- 3.4 Assessment and reassessment should be performed by individuals having special education, training, knowledge skills permitted by licenser, applicable laws and regulation or certification at the time of admission.

4. PROCEDURE:

- 4.1 Stabilize and attend to patient's needs in an emergency situation.
- 4.2 Initiate the assessment by collecting, organizing, validating and documenting patient data accordingly in accordance with: interview the patient and/ or family.
- 4.3 Conduct initial assessment which includes information as follows:
 - 4.3.1 Patient identification by two nurses
 - 4.3.1.1 Check and verify patient identification procedure by two nurses and affix both signatories in initial nursing assessment form for documentation.
 - 4.3.1.1.1 Confirm identity of patient with the witnessing nurse using two identifiers.
 - 4.3.1.1.2 Patient's name (four names for Saudi and complete name for Non-Saudi).
 - 4.3.1.1.3 Medical record number
 - 4.3.1.2 Ask patient to tell his/ her name for unconscious or pediatric patients, relative/ guardian are to be present for confirmation of correct patient identification.

- 4.3.2 Admission:
 - 4.3.2.1 The route of entrance on admission or transfer in
 - 4.3.2.2 Transport and source of information
 - 4.3.2.3 Patient's complaint
 - 4.3.2.4 Source of information
 - 4.3.2.5 Current medication
 - 4.3.2.6 Any allergies
 - 4.3.2.7 History of past major illness, medical/ surgical
 - 4.3.2.8 Valuables and belongings
 - 4.3.2.9 Special assistive devices
- 4.3.3 Vital signs, weight, height, Glasgow Coma Scale.
- 4.3.4 Pain
- 4.3.5 Psychological status
- 4.3.6 Psychosocial status
- 4.3.7 Gastrointestinal
- 4.3.8 Genito-urinary
- 4.3.9 Respiratory needs
- 4.3.10 Sensory Perceptual- vision, hearing and speech
- 4.3.11 Eyes, Ears, Nose, Oral cavity, Throat/ Neck and Teeth.
- 4.3.12 Sleep pattern
- 4.3.13 Functional/ activities of daily living
- 4.3.14 Nutritional assessment
- 4.3.15 Special needs
- 4.3.16 Physical examination
 - 4.3.16.1 Head to toe examination
 - 4.3.16.2 Trace the tube or any contraptions attached to the patient from the point of origin if any.
- 4.3.17 Risk assessment- pressure ulcer
- 4.3.18 Risk assessment- fall assessment
- 4.3.19 Discharge planning indicators and referrals
- 4.3.20 Special needs patient indicators
- 4.4 Initiate assessment within 5-15 minutes and complete documentation within four (4) hours from the time of arrival/ contact.
- 4.5 The staff will perform an in-depth analysis for patients with special needs. Key assessment criteria are as follows:
 - 4.5.1 Paediatric patient
 - 4.5.2 Developmental history
 - 4.5.3 Functional abilities
 - 4.5.4 Nutritional abilities
- 4.6 Reassessment
 - 4.6.1 The reassessment procedure is to perform for in-patient receiving subsequent nursing care and medical care.
 - 4.6.2 The information of reassessment includes a minimum review of patient specific data, pertinent changes in condition/ diagnosis
 - 4.6.3 Reassessment of patient are required according to the following:
 - 4.6.3.1 Every beginning of eight (8) hour shift for patient in regular ward and documented thru careware system.
 - 4.6.3.2 Every 1 hour for intensive care patients and documented on the sheet, PICU flow sheet.
 - 4.6.3.3 Every 4 hours for all cases under intermediate care.
 - 4.6.3.4 Whenever there is a change in patient's condition
 - 4.6.3.5 Any change in the nursing care plan
 - 4.6.3.6 Response to treatment and interventions
 - 4.6.3.7 Before sending patient to OR for surgery

- 4.6.3.8 Upon receiving patient from OR. or other procedure done
- 4.6.3.9 Before patient can be transferred or discharged
- 4.6.3.10 Before going to out on pass.

- 4.6.4 The assessment and reassessment time frame and the responsibilities: refer to 'Multidisciplinary assessment and reassessments of MCH patients (PC-MPP-003)
- 4.7 Record and document all the obtained data/ information including special and individualized assessment in the assessment form or reassessment form appropriately
- 4.8 Review of laboratory/ radiology reports
- 4.9 Formulate a plan of care from the obtained assessment information in determining and prioritizing the actual and potential patient needs/ problems for planning, implementation and evaluation of care that is rendered to the patient.
- 4.10 Initiate and facilitate specific discharge planning from the information obtain in the initial assessment data/ information by referring and coordinating other health care team members in the provision of patient care fulfilling the collaborative nursing role in discharge planning.
- 4.11 Document in the designated forms the patient's condition, all the treatment given and nursing care rendered and patient's tolerance to procedure.

5. MATERIAL AND EQUIPMENT:

- 5.1 Gloves
- 5.2 Pen
- 5.3 Watch
- 5.4 Forms
 - 5.4.1 Paediatric Physician Admission Assessment Form
 - 5.4.2 Paediatric Physician Emergency Assessment Form
 - 5.4.3 Infant/ Paediatric Nursing Daily Reassessment Form
 - 5.4.4 Pain Assessment and Reassessment Flow Sheet
 - 5.4.5 Fall Risk Assessment Form
 - 5.4.6 Nutrition Screening Assessment Form
 - 5.4.7 Multidisciplinary Plan Of Care Form
 - 5.4.8 Patient/ Family Education Record Form

6. RESPONSIBILITIES:

- 6.1 Paediatric Physician
- 6.2 Paediatric Nurses


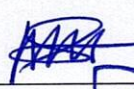

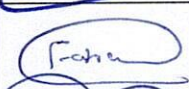
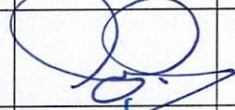

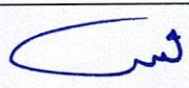
7. APPENDICES:

N/A

8. REFERENCES:

- 8.1 Ministry of Health, General Directorate of Nursing, Manual of Nursing Policy and Procedure, 2nd edition, 2011.
- 8.2 Joint Commissions International standards, 2011.
- 8.3 Janice L Hinkle, Kerry Cheever, Brunner and Siddhartha's Textbook of Medical Surgical Nursing, Lippincott Williams and Wilkins, Philadelphia, 13th edition, 2014.

9. APPROVALS:

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