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		
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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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