



HEALTH HOLDING

HAFER ALBATIN HEALTH  
CLUSTER  
MATERNITY AND  
CHILDREN HOSPITAL

<b>Department:</b>	Provision of Care		
<b>Document:</b>	Multidisciplinary Policy and Procedure		
<b>Title:</b>	Out On Pass Policy and Procedure		
<b>Applies To:</b>	All Healthcare Provider		
<b>Preparation Date:</b>	January 05, 2025	<b>Index No:</b>	PC-MPP-013
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## 1. PURPOSE:

- 1.1 To establish a procedure for temporary absence of any patient from Maternity and Children Hospital, Hafer Al Batin.

## 2. DEFINITIONS:

- 2.1 **Out On Pass** – is a temporary permission of a patient to leave the hospital in a specified time.

## 3. POLICY:

- 3.1 Patient must pass through the admission procedure and completed pre – operative work up before being allowed to leave the hospital.
- 3.2 A patient is allowed to leave the hospital for 2 – 4 hours maximum and comes back within the agreed time frame.
- 3.3 A written physician order is required stating the exact hours and date that patient is allowed to leave the hospital.
- 3.4 Failure to return after the allowed time is considered discharge.

## 4. PROCEDURE:

- 4.1 Inform the attending physician about the patient is requesting to leave the hospital.
- 4.2 Attending physician or his designee shall write his/her order in the patient file.
- 4.3 Prepare the out pass form indicating the following:
  - 4.3.1 The name of the patient (4 names for the Saudi/complete name for the Non – Saudi and Medical Record Number)
  - 4.3.2 Record number
  - 4.3.3 Date
  - 4.3.4 Physician's name and signature
  - 4.3.5 Date and time patient allowed coming in
- 4.4 Full assessment of the patient before he is allowed to leave the hospital.
- 4.5 Explain to the patient regarding the routine procedure of out on pass.
- 4.6 Give patients oral medicine during his/her leave from the hospital.
- 4.7 Instruct patient to come back for due IV medications if present.
- 4.8 Remove the patient IV cannula.
- 4.9 Document in the nurse progress notes the time patient left on pass condition, accompanied by whom and medications provided.
- 4.10 When the patient returns from pass:
  - 4.10.1 Carry out physician order.
  - 4.10.2 Perform the pre – operative care procedure for patients scheduled for surgery
  - 4.10.3 Update the diet list.
- 4.11 Document in the nurses progress notes, patient returns, the time and patient condition. Any pertinent changes in patient condition, nursing supervisor and physician must be notified.



- 4.12 If the patient did not return after 4 hours, he/she shall be considered absconded.
- 4.13 The social worker will be informed if the patient did not return and they shall attempt to contact the patient to find the reason for not returning to the hospital and document it in the file.
- 4.14 The nurse shall inform the treating physician that his/her out on pass patient, did not return, document it in the nurse's progress notes, and shall write an incident report. The treating physician team shall also document this in the physician's progress notes.
- 4.15 Should the patient intend his/her out on pass to be extended, it is a must that patient shows – up to the physician and nurse for re – assessment, and to decide if the patient requires to stay in the hospital, extend out on pass or to be discharged.

## 5. MATERIALS AND EQUIPMENT:

N/A

## 6. RESPONSIBILITIES:

- 6.1 Physician
- 6.2 Nurse

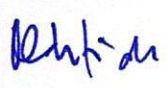





## 7. APPENDICES:

- 7.1 Out on Pass Form


## 8. REFERENCES:

- 8.1 Ministry of Health Policies and Procedure, 2013.
- 8.2 Prince Mutaib Bin Abdulaziz Hospital, 1439.

## 9. APPROVALS:

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<b>KINGDOM OF SAUDI ARABIA</b>  <b>وزارة الصحة</b> <b>Ministry of Health</b>		MRN: _____ Name: _____ Nationality: _____ Age: _____ Date of Birth: _____ / _____ / 14 _____ H _____ / _____ / 20 _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Hospital: _____ Region: _____ Dept./Unit: _____		العمر: _____ سنة _____ شهر _____ يوم تاريخ الميلاد: _____ / _____ / 14 _____ H _____ / _____ / 20 _____ الجنس: <input type="checkbox"/> ذكر <input type="checkbox"/> أنثى	
<b>OUT ON PASS</b>			
Upon my own request to get out of the Hospital for these reasons: _____ _____ _____ I am: <input type="checkbox"/> Patient <input type="checkbox"/> Legal Guardian for <input type="checkbox"/> Next of Kin (specify relation) _____ Obligated to come back to the Hospital on the time frame decided by my treating team, and to follow the Medical instructions prescribed during the leave. I am responsible for any change in medical condition outside the Medical City as it is released from all responsibilities during this absence. I know that the patient's bed will be cancelled if the patient does not return at the ordered time as each leave of absence should not exceed 48 hours. Date Out: _____ / _____ / _____ Time Out: _____ Date In: _____ / _____ / _____ Time In: _____ Total Allowed Hours: _____ Patients Contact Numbers: _____ Patient / Legal Guardian / Next of Kin Name: _____ Signature: _____ Date: _____ / _____ / _____ Head Nurse Name: _____ Signature: _____ Date: _____ / _____ / _____ Attending Physician Agreement: <input type="checkbox"/> I Agree <input type="checkbox"/> Not Agree Physician Name: _____ Signature: _____ Date: _____ / _____ / _____ Notes of Admission Office: _____ _____ Admission Officer Name: _____ Signature: _____ Date: _____ / _____ / _____		بناء على طلبي بالخروج المؤقت من المستشفى للأسباب التالية: _____ _____ _____ صلة القرابة: أنا <input type="checkbox"/> المريض <input type="checkbox"/> ولي الأمر <input type="checkbox"/> القريب الثاني أتعهد بالعودة إلى المستشفى في الوقت المحدد من قبل الفريق العلاجي كما أتعهد بالالتزام بالخطة العلاجية المحددة خلال فترة المغادرة، وأتقبل مسئولية ما يحدث خارج المستشفى من تغيرات صحية. أفهم أن المستشفى غير مسئولة خلال فترة الغياب. وأعلم أنه سيتم إلغاء سرير المريض تلقائياً في حالة عدم العودة في الوقت المحدد كما أعلم أن إذن الغياب لا يتعدى بأي حال من الأحوال مدة 48 ساعة من وقت الخروج. تاريخ الخروج: _____ / _____ / _____ وقت الخروج: _____ تاريخ العودة: _____ / _____ / _____ وقت العودة: _____ عدد الساعات المصرح بها: _____ أرقام هواتف المريض: _____ توقيع المريض/ ولي الأمر/ القريب الثاني: _____ التوقيع: _____ التاريخ: _____ / _____ / _____ إسم مسئول التمريض: _____ التوقيع: _____ التاريخ: _____ / _____ / _____ موافقة الطبيب المعالج: <input type="checkbox"/> أوافق <input type="checkbox"/> لا أوافق اسم الطبيب: _____ التوقيع: _____ التاريخ: _____ / _____ / _____ ملاحظات مكتب الدخول: _____ _____ إسم موظف مكتب الدخول: _____ التوقيع: _____ التاريخ: _____ / _____ / _____	

