HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Rehabilitation Centre		
Document:	Departmental Policy and Procedure		
Title:	Patient Assessment		
Applies To:	All Rehabilitation Staff		
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1. PURPOSE:

1.1 To measure and document the patient's condition before and during the rehabilitation program.
1.2 Follow-up the improvement of the patient's condition by monitoring the achievement of the goals in the rehabilitation program.
1.3 Reassessment done by therapist or rehabilitation physician to measure the efficiency of the treatment plan and prognosis.

2. DEFINITIONS:

2.1 ROM: Range of Motion.
2.2 MMT: Manual Muscle Test.
2.3 SOAP: Subjective, Objective, Assessment, Plan of treatment.

3. POLICY:

3.1 Ensure the child's health condition before the session.
3.2 The therapist/physician must explain to the parents about the child's condition and the goals of treatment.
3.3 Re-evaluation should done by the therapist every month, and after 3 months re-evaluation is done by the rehabilitation physician to determine the extent to which treatment goals have been achieved.
3.4 Discharge of the patient from the department depends either on achieving the goals set for treatment or the lack of improvement in the case after 3 months of treatment

4. PROCEDURE:

4.1 At the patient's first visit, the patient receives an initial evaluation from the rehabilitation physician.
4.2 After evaluating the patient, the doctor explains the condition to the parents and determines the type of service and the goals of the rehabilitation program
4.3 The specialist also describes the exercises to the parents and explains how to do them at home, their frequency, and the number of sessions scheduled for the child.
4.4 The assessment follows the subjective, objective, assessment, plan of treatment (SOAP) methodology.
- 4.4.1 Subjective (S) evaluation: present information from the patient regarding:
  - 4.4.1.1 Complaints (pain, Site and radiating).
  - 4.4.1.2 Functional disability.
  - 4.4.1.3 Pain scale.
  - 4.4.1.4 Pertinent medical history.
  - 4.4.1.5 History and treatment.
  - 4.4.1.6 Medical history.
  - 4.4.1.7 Any red flag.
- 4.4.2 Objective (O) results of therapist observation, palpation and examination
  - 4.4.2.1 Posture, supporting devices.
  - 4.4.2.2 Functional level.

4.4.2.3 Skin condition, soft tissue examination.
4.4.2.4 Special tests, examination.

4.4.3 Assessment (A)

4.4.3.1 The therapist assesses the situation and list of problem, identifies factors not within normal limits (ROM, muscle power, MMT, etc)

4.4.3.2 The therapist discusses with the patient's parents about setting treatment goals

4.4.4 Plan of treatment (P)

4.4.4.1 The treatment plan (P) depends on the diagnosis of each patient and on the goals set for him, and the methods differ, whether it is manual therapy, exercise, electrotherapy, etc.

4.4.4.2 The therapist should educate the patient's parents about the home program instructions and clarify the goals of the treatment plan.

4.4.4.3 Any significant change in the patient's condition necessitates an immediate reassessment with changes in the plan of care reflecting the change in diagnosis or condition.

4.4.4.4 The patient is re-evaluated after 3 months of treatment to determine the extent of improvement from the treatment sessions

4.4.4.5 If the patient needs other services in a rehabilitation centre (OT, speech), the physical medicine doctor can refer them

4.4.4.6 The therapist should write a progress note at each patient session.

4.4.5 Discharge

4.4.5.1 Discharge plan, which depends on the goals that will be determined at the first visit.

4.4.5.2 The evaluation is done every month by the therapist and after 3 months of treatment by the physical medicine doctor, and the procedure is determined based on this evaluation as follows:

4.4.5.2.1 If the patient reaches the goal within 3 months, he will be discharged from the department by the treating therapist with the opinion of the rehabilitation physician.

4.4.5.2.2 If the patient does not reach the goals set by the therapist within 3 months, and there is stability in the condition, and after conducting a case study by the therapist and the physical medicine doctor, it is classified as a chronic condition and is followed up monthly by the department.

4.4.5.2.3 If there is a noticeable improvement, but it takes longer, the treating physician may, at his discretion, increase the number of sessions for a period of more than 3 months.

4.4.5.3 Discharge summary should include

4.4.5.3.1 Date of the first and last session, and total number of sessions.

4.4.5.3.2 Whether the goals have been achieved or not

4.4.5.3.3 Reassessment.

4.4.5.3.4 If there are any comments, e.g. Home program instruction and rationales for discharge or suggestion regarding the patient condition, it should be written down on the discharge form and sign.

4.4.5.3.5 The therapist should write her/his name down on the discharge form and sign.

5. MATERIALS AND EQUIPMENT:

5.1 Referral form. (Electronic)
5.2 All types of assessments forms (PT, OT, Speech) (Electronic)
5.3 Follow up notes. (Electronic)
5.4 Discharge form. (Electronic)
5.5 Education form. (Electronic)

6. RESPONSIBILITIES:

6.1 All staff in Rehabilitation centre

7. APPENDICES:

8. REFERENCES:

8.1 Polices & procedures of rehabilitation centre in KKGH-Hail.
8.2 Polices & procedures of rehabilitation centre in KKGH- Hafer-Albatin.
8.3 Polices & procedures of Physiotherapy Department MCH- Al-jouf.

9. APPROVALS:

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