



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 be 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:

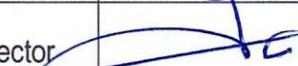
- 6.1 All staff in Rehabilitation centre

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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