

Policy Title: Patient Assessment and Reassessment		
Department/Unite: General Clinics.	Policy Number: UOJ-MSA-GC-P/03	Replaces No:
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Revision History			
Subject	Changes made	Done by	Revision date

1. **CONDITIONS:** 1.1 All staff of General Clinics.
2. **PURPOSE:** 2.1 To ensure that all patients of the MSA undergo an appropriate assessment by qualified individuals based on which a plan of care can be established.
3. **DEFINITIONS:** N/A
4. **Related Documents:** N/A
5. **POLICY:**
- 5.1 It is the policy of the MSA that all patients, receiving healthcare services, at the facility will receive a complete assessment by a qualified individual to allow development and implementation of a plan of care that will best meet the individualized health care needs of the patient.
- 5.2 Clinic physician and nurse will complete the initial assessment in an effort to provide a comprehensive, collaborative approach to patient care. The patient may be referred to other discipline, for more comprehensive assessment if needed based on the findings of the initial assessment.
- 5.3 Assessment is performed by each discipline within its scope of practice e.g. geriatric, dental, Immunization etc.
- 5.4 An initial medical and nursing assessment is completed in the first visit; then all patients are reassessed in the follow up visits according to discipline. The assessment may be extended to another visit, unless a procedure is to be performed for the patient during the first visit.
- 5.5 Trainee physicians and interns are also allowed to perform assessment, but senior member of PHC medical staff (consultant / specialist / resident) countersigns their documentation in the health record in the same clinic visit.

**6. PROCEDURES:**

6.1 On the first visit, all patients will have an initial medical / nursing assessment which will be completed by the attending physician and the clinic nurse and will consist of history & physical examination.

6.2 An initial Nursing Assessment is completed to include at least:

6.2.1 Vital signs

6.2.2 Allergies & adverse drug reaction

6.2.3 Fall risk screening

6.2.4 Pain screening

6.2.5 Nutritional screening

6.2.6 Functional screening

6.2.7 Psychosocial screening

6.2.8 Body mass index

6.2.9 Waist circumference

6.2.10 Motor activity

6.2.11 Food habits

6.2.12 Previous history of chronic disease

6.2.13 Previous family history of chronic disease

6.2.14 Smoking status

6.2.15 Psychological screening of depression

6.2.16 Psychological screening of anxiety

6.3 An initial Medical Assessment is completed to include at least:

6.3.1 Complaint

6.3.2 Present history

6.3.3 Past history (hospital admission & surgery)

6.3.4 Family history

6.3.5 Current medications

6.3.6 Immunization status (for pediatric patients).

6.3.7 Physical examination including full body systems review

6.3.8 Early and periodic examination of the targeted disease in the medical evaluation form by age group and risk factors.

6.4 General clinic nurse performs patient's nurse assessment within 10 to 15 minutes from patient's arrival to general clinics nurse and General clinic physician performs patient's medical assessment within 10 to 20 minutes from patient's arrival to general clinics physician.

6.5 As appropriately determined by the physician performing initial assessment, other disciplines will be contacted to assess the patient as needed, e.g. social worker, dietitian.

6.6 Other points for history and physical examination will be assessed in different disciplines according to their assessment forms.

6.7 The initial assessment must end with conclusions about patient condition and plan of care (including medications and investigations).

6.8 The healthcare team reassess the patients on scheduled visit/s, its times and frequencies are determined according to clinical guidelines.

6.9 The healthcare team will reassess the patients on their return to the PHC regardless if this return is scheduled or not and the reassessment include at least:

6.9.1 Diagnosis

6.9.2 New complaint

6.9.3 Relevant symptoms & signs

6.9.4 Results of investigations done

6.9.5 Results of interventions done

6.9.6 Response to treatment given

6.9.7 Compliance to treatment given

6.9.8 Complication and side effects

6.9.9 Plan for continued treatment or completion of treatment.

6.10 The plan of care may be revised and corrected based on the results of the reassessment.

## 7. RESPONSIBILITIES

7.1 MSA Supervisor: To ensure the implementation of this policy and procedure in the all clinics.

7.2 MSA healthcare team: To follow the guidelines mentioned above regarding

patient assessment and reassessment and to complete all required health record forms.

**8. Appendix:**

8.1 Assessment and reassessment forms

**9. REFERRANCES:**

9.1 CBAHI resource manual

9.2 Ministry of Health Manual for general clinic.

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