SOP: Patient Assessment and Documentation Routines

This SOP details the **patient assessment and documentation routines**, covering systematic approaches to conducting accurate patient evaluations, recording vital signs, noting clinical observations, ensuring thorough medical history intake, and maintaining precise and compliant documentation of all patient interactions. The goal is to enhance patient care quality, support effective communication among healthcare providers, and ensure legal and regulatory standards are met through consistent and reliable documentation practices.

1. Purpose

To establish clear and consistent routines for assessing patients and documenting all care-related activities to ensure high standards of patient safety, communication, and legal compliance.

2. Scope

This SOP applies to all healthcare personnel involved in direct patient care and documentation within the facility.

3. Responsibilities

- **Healthcare Providers:** Conduct thorough assessments and ensure prompt and accurate documentation.
- **Nursing Staff:** Record vital signs and clinical observations as per protocol.
- **Medical Records Staff:** Maintain, audit, and archive patient records in compliance with legal standards.
- **Supervisors:** Monitor adherence and provide training as needed.

4. Procedure

4.1 Initial Patient Assessment

- Greet the patient and verify their identity using two identifiers (e.g., name and date of birth).
- Explain the assessment process and ensure patient consent.
- Conduct a comprehensive assessment, including:
    - Chief complaint and presenting symptoms
    - Past medical, surgical, family, and social history
    - Medication and allergy history
    - Physical examination by system (e.g., cardiovascular, respiratory)

4.2 Recording Vital Signs

- Obtain and document:
    - Temperature
    - Pulse
    - Respiratory rate
    - Blood pressure
    - Oxygen saturation
    - Pain score (if relevant)

- Document findings immediately after assessment in the patient's chart or electronic health record (EHR).

4.3 Clinical Observations

- Note all relevant clinical findings, interventions performed, and patient responses.
- Use standard abbreviations and terminology approved by the facility.
- Document subjective (reported by patient) and objective (observed/measured) data distinctly.

4.4 Documentation Standards

- Record information promptly, legibly, and accurately.
- Include date, time, and signature (or electronic authentication) for each entry.
- Never erase or destroy medical records; use proper correction methods if necessary (e.g., single line through error, initialed, date/time added).
- Ensure all documentation meets local, state, and federal legal requirements and facility policy.

4.5 Ongoing Assessments

- Reassess and document condition changes, interventions, and responses at intervals determined by patient acuity or facility protocol.
- Communicate significant changes to appropriate team members in a timely manner.

5. Documentation Audit & Quality Assurance

- Medical records will be audited periodically for completeness, accuracy, and compliance.
- Feedback or retraining will be provided if deficiencies are identified.

6. Related Documents

- Patient Medical Assessment Form
- Vital Signs Record Chart
- Facility Documentation Policy
- Legal Compliance Manual

7. Review and Revision

- This SOP will be reviewed annually or as required by changes in standards and regulations.

8. Approval

Name	Title	Signature	Date
[Approver Name]	[Approver Title]	[Signature]	[Date]