

Organisation name Site or unit		STANDARD OPERATING PROCEDURE Structured Clinical Assessment on Admission	
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Signature			

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Abbreviations

Abbreviation	Meaning
SOP	Standard operating procedure

Key points

- Every patient receives a structured clinical assessment on admission, covering every defined area, completed by a qualified clinician.
- Start with what the patient tells you, then examine, then check the record. Record the source of each answer.
- The senior clinician checks the assessment within the time set by the facility, and returns an incomplete assessment.
- Stop and get help straight away if a patient is admitted with no structured assessment, or one that does not cover the defined areas.

1. Purpose

To make sure no patient starts care with a problem missed. Most problems that are missed on admission are missed because the assessment was not done in the same way for every patient, or because the questions that matter were not asked. This SOP sets out one structured assessment, the order in which it is completed, and how it is checked. It supports criterion 1.2.

2. Scope

Element	Coverage
Who	Admitting clinicians, senior clinicians who check assessments, and the staff who support them.
Where	All wards, clinics and departments where patients are admitted or first seen.
When	On admission or first contact; and on transfer to a new area where the existing assessment is older than the time set by the facility.
Not covered	Focused emergency assessment, which is completed as soon as the patient is stable (see Safety and exceptions).

3. Definitions

Term	Meaning
Structured assessment	The facility's admission form, with each defined area completed in the order set on the form.
Defined area	A heading on the form that must be completed for every patient, such as presenting problem, medical history, medicines, allergies, mobility, cognition, nutrition, skin, continuity of care needs, and social circumstances.
Admitting clinician	The doctor or nurse who completes the assessment.
Senior clinician	The doctor or nurse in charge who checks the assessment.

4. Background

A patient who is admitted without a structured assessment may have a problem missed until it has become serious. A defined assessment gives every patient the same thorough start, and it is the basis for the care plan in CLN-SOP-002-EN. The assessment is also the first point at which the risks in CLN-SOP-003-EN, CLN-SOP-004-EN and CLN-SOP-005-EN are identified.

5. Responsibilities

Role	Responsibility
Clinical director	Approves the admission form and its defined areas, and receives the quarterly audit.
Ward or unit manager	Ensures the form is available and that staff are trained and observed.
Admitting clinician	Completes every defined area, records the source of each answer, and refers to other disciplines where needed.
Senior clinician	Checks the assessment within the set time, returns incomplete forms, and records the check.

6. Materials and equipment

Item	Requirement
Admission assessment form	The current approved form, on the electronic or paper record.
Observation equipment	Scales, a blood pressure monitor, a pulse oximeter and a thermometer, available at the bedside.

7. Safety and exceptions

- **Emergency.** In an emergency, treat first. Complete the assessment as soon as the patient is stable, and record the time the assessment was started and the time it was completed.
- **No history available.** Where the patient cannot give a history, use the record, the family and the accompanying staff, and record the source of every answer.
- **Language.** Where the patient does not speak the language used, use a qualified interpreter. Do not rely on a family member to interpret for a clinical history.

8. Procedure

Before you start

- Check that the current admission form is available and that the record is open.
- Check the handover and the referral: the reason for admission, and any alerts already on the record.

Step 1. Take the presenting history

1. Ask the patient, in open questions, why they are here, and what has changed. Record the answer in their own words.
2. Ask about the start of the problem, how it has changed, and what has helped or made it worse.
3. Ask about any previous admission for the same problem, and about any events in the past 30 days, such as a fall, a procedure or a new medicine.

Step 2. Complete each defined area

1. **Medical and surgical history:** conditions, operations, and the dates of each.
2. **Medicines:** reconcile the list against the patient, the pharmacy record and the community record. Record anticoagulants, insulin, opioids and psychotropic medicines separately.
3. **Allergies and intolerances:** record the reaction for each, not only the name of the drug.
4. **Observations:** record temperature, pulse, blood pressure, respiratory rate, oxygen saturation and level of consciousness. An abnormal observation is escalated before the rest of the assessment continues.
5. **Mobility, falls and cognition:** record the mobility aids used and any falls in the past year, and screen cognition with the facility's tool.
6. **Nutrition:** record weight, height, recent weight change and food intake, and refer as CLN-SOP-003-EN requires.
7. **Skin:** record the skin condition over the bony areas, and refer as CLN-SOP-004-EN requires.
8. **Social circumstances and carers:** record who lives with the patient, who helps them, and any need for support at discharge.

Step 3. Refer to other disciplines

1. Refer where the presentation needs it, for example to physiotherapy for a mobility problem, to pharmacy for a complex medicine list, or to social work for safeguarding concerns.
2. Record the referral, the reason, and the date. The referral is not complete until the receiving discipline has acknowledged it.

Step 4. Check the assessment

1. The senior clinician checks each defined area within the time set by the facility.
2. Return an incomplete assessment to the admitting clinician, with the missing areas listed. The admitting clinician completes it and records the time.
3. Record the check, the date, and the name of the senior clinician.

9. Worked example

Situation	What to do
A 71-year-old man is admitted with confusion. His wife is with him. The medicine list on the record has eight items, and he cannot say which he takes.	Ask his wife about the medicines and the pharmacy supply, and reconcile the list with the community pharmacy. Record the source of each entry. Record the cognition screen and the falls history. Refer to pharmacy for a medicines review, because the confusion may be drug-related. Check that the assessment covers every defined area before the senior clinician reviews it.
A woman is admitted in the early hours with breathlessness. She has no record and no one with her.	Treat first: observations, oxygen and the medical team. Complete the assessment when she is stable. Record the time the assessment was started and completed, and the source of each answer. Do not leave the defined areas blank; record "not obtained" with the reason.

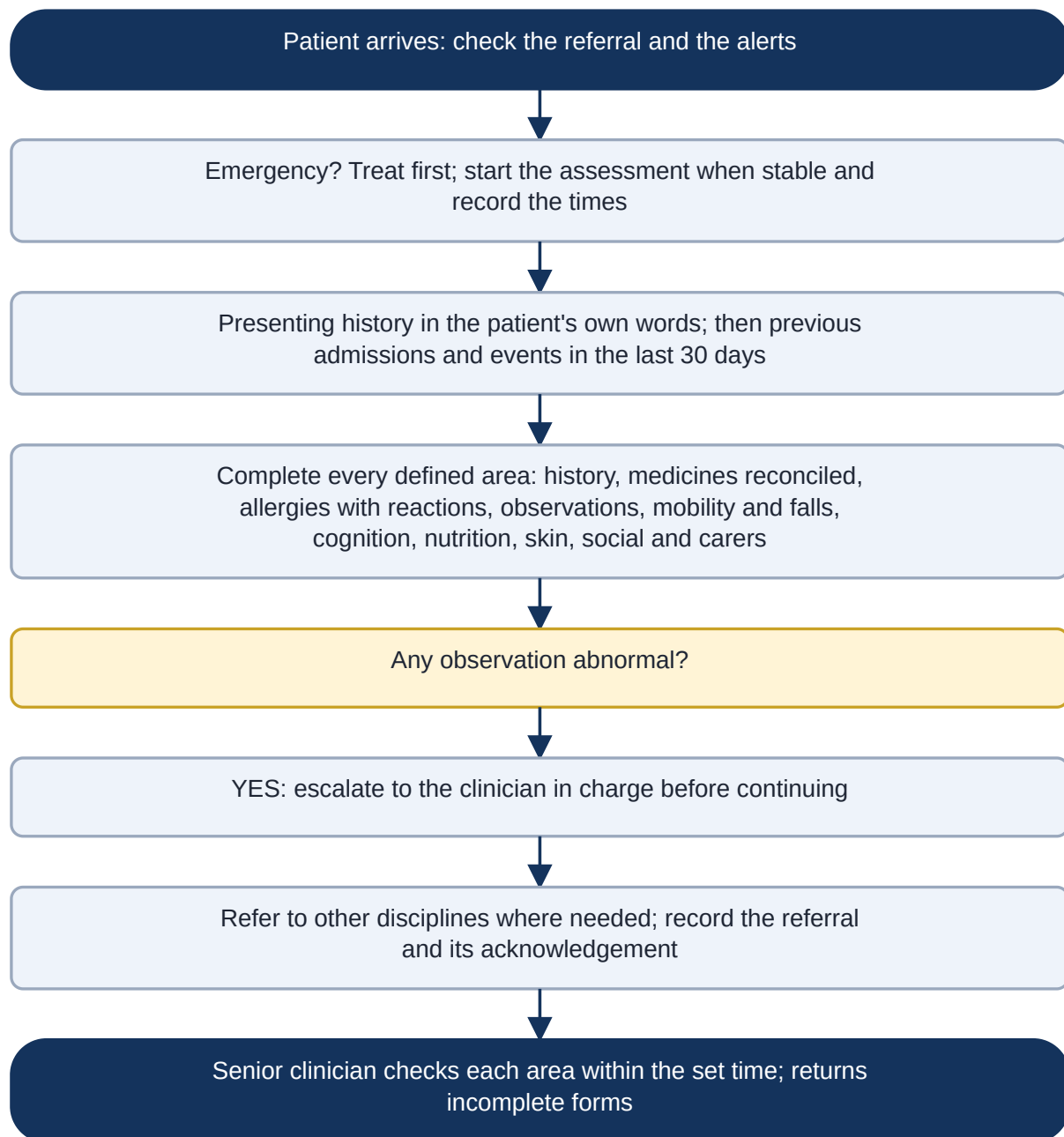


Figure 1. Admission assessment pathway

10. Decision points

If	Then
Assessment is complete	Senior clinician checks it; the care plan starts (CLN-SOP-002-EN).
A defined area is missing	Complete it before the check. If the patient is unstable, complete it as soon as possible and record the time.
An observation is abnormal	Escalate to the clinician in charge before continuing.
A referral is needed	Refer, and record the referral, the reason and the date.

11. Escalation

Event	Inform	Timescale
Patient admitted with no structured assessment	Senior clinician	Immediately
Abnormal observation during the assessment	Clinician in charge	Immediately
Assessment not checked within the set time	Ward or unit manager	Same shift
Repeated gaps on one unit	Clinical director and quality team	Within one week

12. Monitoring and compliance

Indicator	Target	Method	Frequency	Owner
Admissions with every defined area completed	100% of admissions	Audit of 20 records per unit	Monthly	Ward manager
Assessments checked within the set time	100% of assessments	Audit of 20 records per unit	Monthly	Ward manager
Source of history recorded	100% of assessments	Audit of 20 records per unit	Monthly	Clinical lead

13. Records

Record	Kept in	Retention
Admission assessment form and check record	Patient record	As set by the institutional retention policy

14. Training and competence

- **Induction:** the form, the defined areas, medicine reconciliation, and the escalation of abnormal observations. Competence is assessed on two supervised assessments.
- **Annual update:** a case review of three audited assessments per clinician.

15. Related documents

ID	Title	Relationship
CLN-SOP-002-EN	Individualised care planning	Uses the assessment
CLN-SOP-003-EN	Nutritional risk screening and therapeutic diets	Nutrition step
CLN-SOP-004-EN	Pressure injury risk assessment and prevention	Skin step
CLN-SOP-005-EN	Venous thromboembolism risk assessment and prophylaxis	VTE step

16. References

1. ASF Accreditation Standards, Standard 1 (Assessment, Care Planning and Safety), criterion 1.2. No external clinical guideline was cited; the defined areas are set by the facility's admission form and must be confirmed by the clinical director.

17. Change history

Version	Date	Summary of change	Approved by
1.0		First approved version.	ASF Expert Committee
1.2		Substantive revision: step-by-step history and examination, medicine reconciliation, abnormal observation rule, emergency handling and worked examples.	

Annex A. Admission assessment audit record

Use this record for each audit session. Record one line per patient or task observed. Enter Y, N or NA as shown in the column heading.

Date	Unit	Patient reference	Assessment complete (Y / N)	Defined areas covered (Y / N)	Checked within set time (Y / N)	Referral made (Y / N / NA)	Comment

Annex B. Monitoring chart

The unit records its monthly result on this chart and reviews it at the monthly meeting. Plot each month as a point or a bar, and note the actions taken beside it.



Figure B.1 Complete admission assessments by month. Target as set by the facility (see the monitoring table).