PC.12.2.7 Women in labor.

PC.12.2.8 Terminally ill and dying patients.

PC.12.3 Specialized assessment includes patients with dental, hearing, eye or speech defects.

PC.12.4 When additional or specialized assessments are required, they are completed and documented in the patient's medical record.

Standard Intent:

The information gathered at the initial medical and/or nursing assessment, may indicate that the needs further or more in-depth assessment such as dental, hearing, vision and/or specialized additional assessment in some categories of patients. These assessments must be completed and documented in patient's file.

PC.13 The hospital has a process to manage patients of suspected abuse, neglect, or domestic violence.

PC.13.1 The hospital has a policy and procedure that defines the initial screening criteria and subsequent assessment of cases subjected to abuse, neglect, or domestic violence.

PC.13.2 The screening criteria are developed by qualified individuals.

PC.13.3 The policy defines the staff members responsible for assessment and management of such cases in accordance with the applicable laws and regulations.

PC.13.4 Staff members are aware of the relevant laws and regulations and are educated about managing cases of abuse and neglect.

Standard Intent:

The assessment of patients subjected to abuse, neglect, or domestic violence are shaped by the culture of the patient population. These assessments are not intended to be proactive case-finding processes. Rather, the assessment of those patients responds to their needs and condition in a culturally acceptable and confidential manner. The assessment process is modified to be consistent with local laws and regulations and professional standards related to such populations and situations and to involve the family when appropriate or necessary.

PC.14 Patients are assessed, reassessed, and managed for pain.

PC.14.1 The hospital addresses pain (acute/chronic) assessment and management as a patient's right.

PC.14.2 The hospital implements a policy that clearly defines:

PC.14.2.1 Requirements for a comprehensive pain assessment and management.

PC.14.2.2 Frequency of pain re-assessment.

PC.14.2.3 Role of staff in pain assessment and re-assessment.

PC.14.2.4 Items included in pain assessment (intensity, type, duration, frequency, location, and progress).

PC.14.2.5 Pain relieving measures, including medications and their dosage, frequency, and route.

PC.14.3 Patients in pain receive pain assessment and management according to the policy.

PC.14.4 The process of pain assessment and management is documented in the patient's medical record.

Standard Intent:

Pain can be a common part of the patient experience and may be associated with the condition or illness for which the patient is being treated. Pain may also be an expected part of certain treatments, procedures, or examinations. As part of care planning, whatever the origin of pain, unrelieved pain has adverse physical and psychological effects. Thus, patients in pain have the right to appropriate assessment and management of pain. Based on the scope of services provided, the hospital must develop to clearly define its process to assess and to manage pain appropriately, Including the requirements for pain assessment, the frequency of pain re-assessment, the role of staff in pain assessment and re-assessment, the items included in pain assessment and the pain relieving measures. The pain assessment and re-assessment must be documented in the patient's medical record.

PC.15 In-hospital patients have their overall care managed and coordinated by one qualified physician.

PC.15.1 Each patient has one qualified physician responsible for the overall care rendered to that patient and is referred to as the most responsible physician (MRP).

PC.15.2 The most responsible physician must have the privilege to admit patients and to be a most responsible physician.

PC.15.3 The most responsible physician carries the overall responsibility and accountability for the outcome of care provided to the patient.

PC.15.4 The most responsible physician provides the principal care plan and coordinates when required for additional plans of other healthcare providers.

PC.15.5 Transfer of patient responsibility from one physician to another is guided by a hospital policy and is documented in the patient's medical record.

Standard Intent:

Each patient admitted to hospital must be under care of one physician (MRP) who is privileged to deliver required care to patient and will be accountable for outcome of care through developing an appropriate care plan and coordinate with other care providers if additional care required. Hospital must have a policy to guide patient care transfer from physician to other physician to ensure proper and continuum of care provided to patient.