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.

## 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.

## PC.16 A comprehensive plan of care is developed collaboratively and documented for each patient.

PC.16.1 The plan of care is developed through a collaborative approach between the healthcare team(s), patient, and family.

PC.16.2 The plan of care is based on the assessment findings and aimed to meet all patients' needs.

PC.16.3 The patient and family are involved in developing the plan of care.

PC.16.4 The plan of care contains the measurable goals/desired outcomes towards discharge.

PC.16.5 The plan of care is completed within 24 hours of admission or earlier based on the patient's condition and needs. (Nursing plan of care is completed whenever possible before the end of the shift).

PC.16.6 The plan of care is reviewed by the most responsible physician on a daily basis.

PC.16.7 The plan of care is modified as appropriate upon any significant change in the patient's condition or when new treatments are added or discontinued.

PC.16.8 The plan of care includes a provisional date of discharge set within 24 hours of admission.

PC.16.9 The plan of care is documented in the patient's medical record.

## PC.17 Patients are reassessed to ensure effectiveness of care plans.

PC.17.1 All patients are reassessed at appropriate intervals to determine:

PC.17.1.1 Response to treatment.

PC.17.1.2 Compliance with treatment.

PC.17.1.3 Complications and side effects.

PC.17.1.4 Plan for continued treatment or completion of treatment.