PC.9.4 Assessments completed within 30 days prior to admission or an outpatient visit can be used with a documented update of any significant changes.

PC.9.5 Assessments completed more than 30 days prior to admission or an outpatient visit must be repeated.

PC.9.6 Medical and nursing assessments are completed and documented for all patients prior to surgery, anesthesia or invasive procedures.

Standard Intent:

The patient's medical and nursing needs are identified from the initial assessments, which are completed and documented in the clinical record within the first 24 hours after admission as an inpatient or earlier as indicated by the patient's condition. When the initial medical assessment is conducted in outpatient setting prior to care in the hospital as an inpatient, it must be within the previous 30 days. If at the time of admission as an inpatient the medical assessment is greater than 30 days old, the medical history must be updated and the physical examination repeated. For medical assessments performed and documented 30 days or less prior to admission, any significant changes in the patient's condition since the assessment are noted at admission.

PC.10 Medical assessment is completed and documented for each patient.

PC.10.1 Each patient undergoes an initial medical assessment that includes a health history and physical examination, covering the following:

PC.10.1.1 Main complaint.

PC.10.1.2 Details of the present illness.

PC.10.1.3 Systems review.

PC.10.1.4 Past history including previous admissions and surgeries.

PC.10.1.5 Allergies and prior adverse drug reactions.

PC.10.1.6 Drug history.

PC.10.1.7 Family history.

PC.10.1.8 Psycho-social history.

PC.10.1.9 Economic factors.

PC.10.1.10 Pain (screening followed by assessment if required).

PC.10.1.11 Risk for fall (screening followed by assessment if required).

PC.10.1.12 Physical status and functionality (screening followed by assessment if required).

PC.10.1.13 Complete physical examination.

PC.10.1.14 Diagnostic test(s) as indicated by the patient's condition.

PC.10.1.15 Need for additional or specialized assessment as indicated by the patient's condition.

PC.10.1.16 Need for discharge planning as indicated by the patient's condition.

PC.10.1.17 Provisional diagnosis.

PC.10.2 The most responsible physician ensures all patients under his care have a complete medical assessment with all diagnostic tests and referrals as required to reach a final diagnosis.

PC.10.3 Medical assessment is performed by the most responsible physician or a member of the team who is qualified by license, certification, and experience.

PC.10.4 Diagnostic tests (e.g., laboratory and radiology) are available as indicated by the hospital's scope of service and the professional standards of care.

PC.10.5 Diagnostic tests (e.g., laboratory and radiology) are appropriately and timely ordered to aid in reaching a final diagnosis.

PC.10.6 The medical assessment is documented in the patient's medical record.

Standard Intent:

The patient's initial medical assessment must cover all essential basic elements such as those mentioned in the substandard 10.1.1 through 10.1.17. In addition, an appropriately ordered diagnostic tests (laboratory and radiology) must be documented and available in the patient's file. It is the responsibility of a qualified and licensed physician under the supervision of the most responsible physician.

PC.11 Nursing assessment is completed and documented for each patient.

PC.11.1 The nursing assessment is performed by a staff nurse.

PC.11.2 The nursing assessment identifies the patient's nursing needs.

PC.11.3 The nursing assessment must be timely and complete.

PC.11.4 The nursing assessment is documented in the patient's medical record.

Standard Intent:

Nursing assessments are primary to the initiation of care and may also identify a need for other assessments. The Nursing assessments are conducted by individuals qualified as registered nurse. The Nursing assessments must be completed and documented in patient's file in timely manner. Please identify timely.

PC.12 Additional and specialized assessments are performed for identified patient groups.

PC.12.1 There are criteria implemented to identify patient groups who need additional or specialized assessments.

PC.12.2 Additional assessment includes, but is not limited to, the following categories:

PC.12.2.1 Patients in severe or chronic pain.

PC.12.2.2 Children.

PC.12.2.3 Frail and elderly.

PC.12.2.4 Suspected victims of abuse, neglect, and domestic violence.

PC.12.2.5 Drug abuse.

PC.12.2.6 Psychiatric disorders.