- Pain history (for example, when did the pain start, what activities cause the pain, what treatments has the patient tried to relieve the pain)
- What makes pain better or worse
- What are the patient's goals for pain relief (for example, zero pain or enough relief to complete or participate in specific activities)

Pain assessments, including which assessment tool is used, are documented in the patient's medical record to allow the care team to easily identify trends in the patient's pain and pain relief interventions.

Measurable Elements of AOP.01.04

1. All inpatients are screened for pain, and the screening is documented.
2. Outpatients whose condition, diagnosis, or situation may indicate that they are at risk for pain are screened for pain.
3. Ⓓ When pain is identified by the screening, a pain assessment is performed and documented. (*See also* COP.07.00, ME 1)
4. Patients are reassessed for pain following any pain management interventions.
5. If needed, the patient is referred or transferred to a care setting that has the capabilities and resources to treat the patient's pain.

Standard AOP.01.05

All patients are reassessed at intervals based on their condition and treatment.

Intent of AOP.01.05

Reassessment is key to understanding how patients respond to treatment and to understand if care decisions are effective.

Patients are reassessed throughout the care process at intervals based on their condition and treatment as defined in hospital policies. The results of these reassessments are documented in the patient's medical record.

Hospital policy defines how often reassessments occur by various members of the health care team. A physician must assess patients with acute care needs at least daily, including weekends, and when there is a significant change in the patient's condition.

Hospital policy defines how often patients are reassessed by a nurse. This will vary greatly based on the patient's needs, condition, and treatment. For example, newly intubated patients may require a nursing reassessment every hour, whereas a stable, chronically ill patient with an established airway may require a nursing reassessment every four hours.

Hospital policy defines how often patients are reassessed by other members of the care team, including the following:

- Respiratory therapists
- Physical, occupational, and speech therapists
- Social workers or other social services

Reassessments occur in accordance with hospital policy. Reassessments are completed and results are documented in the patient's medical record in the following instances:

- At defined intervals by various members of the care team, including physicians, nurses, and others
- Daily by a physician for acute care patients
- In response to a significant change in the patient's condition
- If the patient's diagnosis has changed and the care needs require revised planning
- To determine if medications and other treatments have been successful and the patient can be transferred or discharged

Some nonacute patients may not need daily physician assessments (for example, a stable psychiatric patient receiving group therapy sessions, or a patient who is past the acute phase of illness or surgery and who is receiving only rehabilitative treatment). Hospital policy identifies patients who do not require daily physician assessments.

Measurable Elements of AOP.01.05

1. Ⓓ Hospital policy defines, in writing, how often patients are reassessed by various members of the health care team and other circumstances when a reassessment is required, including the following:
   - Defined intervals by various members of the care team, including physicians, nurses, and other clinical staff (for example, therapists, social workers)
   - When there has been a significant change in patient condition
   - When the diagnosis has changed and plan of care needs to be revised (*See also* COP.01.01, ME 3)
   - To determine if the patient is ready for transfer or discharge
2. A physician reassesses patients at least daily, including weekends, during the acute phase of their care and treatment.
3. Ⓓ Hospital policy identifies, in writing, patient populations who may not require a daily assessment and defines the minimum reassessment interval for these patients.
4. Reassessments are documented in the patient's medical record.

Patient Falls

Standard AOP.02.00

The hospital develops and implements a process to reduce the risk of falls, and patient harm resulting from falls.

Intent of AOP.02.00

Many injuries in hospitals to both inpatients and outpatients are a result of falls, so a comprehensive falls prevention program is needed to prevent injuries to patients.

The risk for falls is related to the patient, the situation, and/or the location. Risks associated with patients include but are not limited to the following:

- Age
- Medical history
- Patient history of falls
- Medication use
- Substance consumption
- Other comorbidities
- Gait or balance disturbances
- Visual impairments
- Altered mental status
- Environmental hazards (for example, slippery floors, poor lighting, cluttered rooms)

Patient falls are a significant safety concern and can result in serious injuries such as fractures, head injuries, lacerations, and death.

Patients who have been initially assessed to be at low risk for falls may have a change in fall risk during hospitalization or between outpatient visits. Reasons for change in fall risk include the following:

- Surgery and/or anesthesia
- Sudden changes in patient condition
- Adjustment in medications