based to provide a means for measuring progress and outcomes related to the plan of care.

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.

PC.17.2 Medical reassessment must be performed at least once daily, including weekends and holidays, and in response to any significant change in the patient's condition.

PC.17.3 Nursing reassessment must be performed on every shift with a frequency dictated by the patient's condition, response to treatment, and physician's order.

PC.17.4 Reassessments are documented in the patient's medical record.

PC.17.5 The hospital defines situations where re-assessments are performed more infrequently (e.g., long stay patients mainly requiring a nursing care).

Standard Intent:

Reassessment by all the patient's health care practitioners is key to understanding whether care decisions are appropriate and effective. Patients are reassessed throughout the care process at intervals based on their needs and plan of care or as defined in hospital policies and procedures. The results of these reassessments are noted in the patient's record for the information and use of all those caring for the patient. Reassessment by a physician is integral to ongoing patient care. A physician assesses an acute care patient at least daily, including weekends, and when there has been a significant change in the patient's condition. Reassessments are conducted and results are entered in the patient's record

- At regular intervals during care.
- Nursing staff reassessment at every shift or as needed based on the patient's condition.
- Daily by a physician for acute care patients or as needed based on the patient's condition.
- 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; and to determine if medications and other treatments have been successful and the patient can be transferred or discharged.

PC.18 Clinical practice guidelines, pathways, and protocols are developed or adopted to guide priority clinical care services.

PC.18.1 The hospital implements the national clinical practice guidelines, pathways, and protocols that are consistent with current evidence- based practice.

PC.18.2 Clinical practice guidelines, pathways, and protocols are updated at least every two years and as required with emphasis on the most common diagnoses.

PC.18.3 Clinical practice guidelines, pathways, and protocols are documented in the patient's medical record.

Standard Intent:

The hospital should identify priority clinical care services or areas for whom standardization of care is critical, for example, management of patients presenting with chest pain, abdominal pain, stroke and etc. The use of practice guidelines, clinical protocols or pathways, that are evidence based, for those priority services enables staff to provide safe integrated patient care with the least available resources and time and ensures better outcomes. Such guidelines and protocols should be reviewed at least every 2 years to ensure its relevance and up to date status. The use of practice guidelines, pathways and protocols should be documented in the patients' files.

PC.19 The hospital ensures uniform patient care processes during invasive interventions.

PC.19.1 The hospital implements a policy for the assessment and management of patients undergoing invasive procedures.

PC.19.2 The policy defines all essential requirements that must be documented in the patient's medical record including, but are not limited to:

- PC.19.2.1 Date and time of the procedure.
- PC.19.2.2 Name, designation and signature of the physician performing the procedure and the names of all assistants.
- PC.19.2.3 Location of the procedure.
- PC.19.2.4 Nature and indication of the procedure.
- PC.19.2.5 Any anesthesia or analgesia used with dosage and type.
- PC.19.2.6 Patient monitoring.
- PC.19.2.7 Procedure outcome.
- PC.19.2.8 Complications
- PC.19.2.9 Laboratory specimens.
- PC.19.2.10 Specific post procedural orders.

PC.19.3 Invasive procedures are documented in the patient's medical record (or in an appropriate form) as per the policy.

Standard Intent:

Because invasive intervention carries a high level of risk, the hospital must develop a policy to guide the process from the planning till the end of the procedure, including