PC.7.1 The hospital implements a policy that defines the criteria and process for screening patients for pain, functional limitations including risk for fall, and malnutrition.

PC.7.2 Screening criteria are developed by qualified individuals.

PC.7.3 When pain is present from the initial screening, the patient receives a comprehensive pain assessment.

PC.7.4 Patients with functional impairment are referred for functional assessment.

PC.7.5 Patients identified as malnourished or at risk for malnutrition are referred for a nutritional assessment.

Standard Intent:

The patient's initial assessment should include screening for the pain, functional needs and nutritional needs. The hospital should develop the appropriate screening criteria for staff to follow during the assessment. Such criteria should be developed by the appropriate staff (for example, screening for nutritional needs to be developed by a dietician). Patients' that screen positive should be referred to the appropriate specialty for a full assessment (for example, patients' that are at risk for nutritional needs are further assessed by a dietician).

PC.8 The initial assessment includes the need for discharge planning.

PC.8.1 The hospital has criteria to identify patients requiring discharge planning before or upon admission.

PC.8.2 A proposed discharge date is set soon after admission.

PC.8.3 Staff members are aware of the discharge planning process particularly for common cases with predictable outcome.

Standard Intent:

The hospital must have criteria to identify patients requiring discharge planning before or upon admission. The discharge planning must be part of all patient initial assessment and include a proposed discharge date is set soon after admission. Staff members are aware of the discharge planning process particularly for common cases with the predictable outcome.

PC.9 Initial assessment of patients is completed and documented in the medical record on a timely manner.

PC.9.1 The hospital implements a policy that defines the time frame for completing the medical, nursing, and other assessments required for different care settings and services.

PC.9.2 Medical and nursing assessments are completed and documented within the first 24 hours of admission for routine elective cases.

PC.9.3 Medical and nursing assessments are completed and documented earlier whenever indicated by the patient's condition and the hospital policy.

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.