PC.5.3 The hospital has a process to minimize language barriers by communicating with patients in their primary language or have interpreter services provided at all times.

PC.5.4 The hospital ensures effective communication with patients having special communication needs (e.g., sign language for the hearing impaired patients, and assistance modalities for sight impaired patients).

Standard Intent:

The hospital must ensure easy physical accessibility of all hospital departments to all patients. In addition, the hospital must identify any barriers and implemented processes to eliminate or to reduce them such as:

- Adopting an appointment system.
- Providing special communication needs to minimize Language barriers.

PC.6 The hospital has a systematic process for the initial assessment of patients.

PC.6.1 The hospital implements a policy and procedure that defines the assessment process and its scope and content for all care settings (inpatients, outpatients, critical care and emergency room).

PC.6.2 The hospital implements a policy and procedure that defines the assessment process and its scope and content for all categories of patients (adults, geriatrics, pediatrics, pregnant women, trauma patients and others).

PC.6.3 The hospital implements a policy and procedure that defines the assessment process and its scope and content for all disciplines (physicians, nurses, physiotherapists, social service and others).

PC.6.4 The policy defines the staff categories qualified by license, certification, and experience to assess patients.

PC.6.5 The initial assessment aims to identify the general patient's medical and nursing needs and a provisional diagnosis so that care and treatment can be initiated.

Standard Intent:

An effective patient assessment is an ongoing, dynamic process results in decisions about the patient's treatment needs. The scope of assessment policy and procedure must address the following:

- All hospital settings
- All patient categories
- All disciplines (healthcare workers)
- Only qualified individuals conduct the assessments
- The main aim of the assessment

PC.7 The initial assessment includes screening patients for pain, functional limitations, and malnutrition.

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.