

- 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).

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.

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.

PC.20 Provision of care is continued, integrated, and coordinated.

- PC.20.1 Information about the patient's care and response to treatment is shared between medical, nursing, and other care providers (e.g., patient rounds, multidisciplinary teams, case management for patients requiring complex care).
- PC.20.2 The patient's medical record is available to the authorized care providers to facilitate the exchange of information.