

Joint Commission on Accreditation of Healthcare Organizations Pain Standards for 2001

Right and Ethics Functional Chapter

Assessment of Patients Functional Chapter

Care of Patients Functional Chapter

Education of Patients Functional Chapter

Continuum of Functional Chapter

Improving Organization Performance Functional Chapter

There are eleven chapters of functions or activities required of accredited health care organizations. These functional chapters contain standards which are found in the various accreditation standards manuals published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Manuals address health care organizations providing ambulatory care, behavioral health care, home care, hospice, hospital, and long term care.

The new "pain" standards and some examples are "pulled out" of the six chapters in which they appear in these six Manuals and are shown below for your information. These new standards are effective for surveys conducted after January 1, 2001. **Both the Standard and its Intent are scored during on-site surveys of an organization's performance.**

However, please note: the Examples of Implementation provided are **NOT** standards nor are they required ways to meet a standard. They are only examples of how other organizations have successfully demonstrated compliance with a standard.

Right and Ethics Functional Chapter

Standard

RI.1.2.7

The health care organization addresses care at the end of life.

Intent of RI.1.2.7

Dying patients have unique needs for respectful, responsive care. All staff are sensitized to the needs of patients at the end of life. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life.

The health care organization's framework for addressing issues related to care at the end of life provide for

- providing appropriate treatment for any primary and secondary symptoms, according to the wishes of the patient or the surrogate decision maker;
- managing pain aggressively and effectively;
- sensitively addressing issues such as autopsy and organ donation;

- respecting the patient's values, religion, and philosophy;
- involving the patient and, where appropriate, the family in every aspect of care; and
- responding to the psychological, social, emotional, spiritual, and cultural concerns of the patient and the family.

Effective pain management is appropriate for all patients, not just for dying patients (see standards RI.1.2.8 and PE.1.4).

Standard

RI.1.2.8

Patients have the right to appropriate assessment and management of pain.

Intent of RI.1.2.8

Pain can be a common part of the patient experience; unrelieved pain has adverse physical and psychological effects. The patient's right to pain management is respected and supported. The health care organization plans, supports, and coordinates activities and resources to assure the pain of all patients is recognized and addressed appropriately. This includes:

- Initial assessment and regular re_assessment of pain;
- Education of all relevant providers in pain assessment and management;
- Education of patients, and families when appropriate, regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments; and
- After taking into account personal, cultural, spiritual, and/or ethnic beliefs, communicating to patients and families that pain management is an important part of care.

Assessment of Patients Functional Chapter

Standard

PE.1.4

Pain is assessed in all patients.

Intent of PE.1.4

In the initial assessment, the organization identifies patients with pain. When pain is identified, the patient can be treated within the organization or referred for treatment. The scope of treatment is based on the care setting and services provided. A more comprehensive assessment is performed when warranted by the patient's condition. This assessment and a measure of pain intensity and quality (eg, pain character, frequency, location, and duration), appropriate to the patient's age, are recorded in a way that facilitates regular reassessment and follow-up according to criteria developed by the organization.

Examples of Implementation for PE.1.4

1. All patients at admission are asked the following screening or general question about the presence of pain: Do you have pain now? Have you had pain in the last several months? If the patient responds "yes" to either question, additional assessment data are obtained:
 - a. pain intensity (use a pain intensity rating scale appropriate for the patient population; pain intensity is obtained for pain at present, at worst, and at best or least; if at all possible, the pain rating scale is consistently used in the organization and between disciplines)
 - b. location (ask the patient to mark on a diagram or point to the site of pain)
 - c. quality, patterns of radiation, if any, character (elicit and record the patient's own words whenever possible)
 - d. onset, duration, variations and patterns
 - e. alleviating and aggravating factors
 - f. present pain management regimen and effectiveness
 - g. pain management history (including a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, manner of expressing pain)
 - h. effects of pain (impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration, etc.)
 - i. the patient/client's pain goal (including pain intensity and goals related to function, activities, quality of life)
 - j. physical exam/observation of the site of pain
2. Patient/clients often have more than one site of pain. An assessment system or tools with space to record data on each site is provided on the assessment sheet.
3. A hospital may need to use more than one pain intensity measure, depending on their patient/client population. For example, a hospital serving both children and adults selects a scale to be used with each of those patient populations. Assessment of cognitively impaired patients may also require assessment of behavioral factors signaling pain or discomfort.
4. Staff are educated about pain assessment and treatment including the barriers to reporting pain and using analgesics. Staff encourage the reporting of pain when a patient/client and/or family member demonstrates reluctance to discuss pain, denies pain when pain is likely to be present (for example, post-operative, trauma, burns, cardiac emergencies), or does not follow through with prescribed treatments.
5. Pain intensity scales are enlarged and displayed in all areas where assessments are conducted. For organizations using clinical pathways, pain assessment is incorporated in some way, into every appropriate clinical pathway.

An organization selects pain intensity measures to insure consistency across departments; for example, the 0-10 scale, Wong Baker FACES Pain Rating Scale (smile-frown), and the Verbal descriptor scale. Adult patients/clients are encouraged to use the 0-10 scale. If they cannot understand or are unwilling to use it, the smile-frown or the verbal scale is used.

A unit caring for persons with Alzheimer's disease developed a pain scale for each resident based on their long-standing knowledge of their residents and their knowledge of the common pain syndromes in elderly persons.

A pediatric hospital includes, in its introductory information for parents, information about pain and pain assessment, including parents' role in interpreting behavioral changes of their child that may indicate pain or discomfort.

Care of Patients Functional Chapter

Overview

The goal of the care of patients function(1) is to provide individualized care in settings responsive to specific patient needs.

Patients deserve care that respects their choices, supports their participation in the care provided, and recognizes their right to experience achievement of their personal health goals. The goals of patient care are met when the following processes are performed well:

- Providing supportive care;
 - Treating of a disease or condition;
 - Treating symptoms that might be associated with a disease, condition, or treatment (eg, pain, nausea, or dyspnea);
 - Rehabilitating physical or psychosocial impairment; and
 - Promoting health.
- The standards in this chapter address activities involved in these processes, including
- planning care;
 - providing care;
 - monitoring and determining the outcomes of care;
 - modifying care; and
 - coordinating follow-up.

These activities may be carried out by medical, nursing, pharmacy, dietetic, rehabilitation, and other types of providers. Each provider's role and responsibility are determined by their

professional skills, competence, and credentials; the care or rehabilitation being provided; health care organization policies; and relevant licensure, certification, regulation, privileges, scope of practice, or job description.

Standard

TX.3.3

Policies and procedures support safe medication prescription or ordering.

Intent of TX.3.3

Procedures supporting safe medication prescription or ordering address;

- distribution and administration of controlled medications, including adequate documentation and record keeping required by law;
- proper storage, distribution, and control of investigational medications and those in clinical trial;
- situations in which all or some of a patient's medication orders must be permanently or temporarily canceled, and mechanisms for reinstating them;
- "as needed" (PRN) and scheduled prescriptions or orders and times of dose administration;
- appropriate use of patient-controlled analgesia (PCA), spinal/epidural or intravenous administration of medications, and other pain management techniques utilized in the care of patients with pain;
- control of sample drugs;
- distribution of medications to patients at discharge;
- procurement, storage, control, and distribution of prepackaged medications obtained from outside sources;
- procurement, storage, control, distribution, and administration of radioactive medications;
- procurement, storage, control, distribution, administration, and monitoring of all
 - blood derivatives(2) and
 - radiographic contrast media.

Examples of Evidence of Performance for TX.3.3

1. Before initiating patient-controlled analgesia (PCA) for surgical patients, an interdisciplinary team of physicians, pharmacists and nurses reviewed the literature on PCA, drafted policies, procedures, and standing orders, obtained approval from the pharmacy and therapeutics committee and medical staff, oriented all staff, and conducted a pilot test on the general surgery patient care unit.

Standard

TX.5.4

The patient is monitored during the post-procedure period.

Intent of TX.5.4

The patient is monitored continuously during the post-procedure period. The following items are monitored:

- a. Physiological and mental status;
- b. Status of or findings related to pathological conditions, such as drainage from incisions;
- c. Intravenous fluids and drugs administered, including blood and blood components;
- d. Impairments and functional status;
- e. **Pain intensity and quality (eg, the character, frequency, location, and duration of pain), and responses to treatments; and**
- f. Unusual events or postoperative complications and their management.
Results of monitoring trigger key decisions, such as transfer to an alternative level of care due to a precipitous change in vital signs, or discharge.

Standards, Intents, and Examples for Rehabilitation Care and Services(3)

Rehabilitation is designed to achieve an optimal level of functioning, self-care, self-responsibility, independence, and quality of life. Achieving the patient's optimal level of function means restoring, improving, or maintaining the patient's assessed level of functioning. Rehabilitation services aim to minimize symptoms, exacerbation of chronic illnesses, impairments, and disabilities.

Qualified professionals provide rehabilitation services consistent with professional standards of practice. All interventions encourage the patient to make choices, to sustain a sense of achievement about treatment progress, and if necessary, to modify participation in the rehabilitation process.

Assessment (4) identifies the patient's physical, cognitive, behavioral, communicative, emotional, and social status and identifies facilitating factors that may influence attainment of rehabilitation goals. Problems may include;

- substance use disorders;
- emotional, behavioral, and mental disorders;
- cognitive disorders;
- communicative disorders;
- developmental disabilities;
- vision and hearing impairments and disabilities;

- physical impairments and disabilities; and
- **pain interfering with optimal level of function or participation in rehabilitation.**

Assessment also helps identify services and accommodations helpful to increasing the patient's readiness for rehabilitation.

The rehabilitation plan identifies goals and services and interventions to meet them. Rehabilitation provides patients with skills and supports to function in an environment with as much independence and choice and as little supervision and restrictiveness as possible. Decisions are based on regular reassessment and reliable measures of patient needs, strengths, symptoms, behavioral patterns, and goal achievement. The patient and clinician agree on care choices

Rehabilitation provides access to community resources and services that promote continued goal achievement and independence after rehabilitation concludes.

Education of Patients Functional Chapter

PF.3.4

Patients are educated about pain and managing pain as part of treatment, as appropriate.

Intent of PF.3.4

When appropriate, patients and families are instructed about understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management, when identified as part of treatment.

Examples of Evidence of Performance for PF.3.4

- Examples of patient and family educational materials
- Organization-wide policies and procedures defining responsibilities for patient or family
- Progress notes
- Flowcharts
- Referral and consultation notes
- Interviews with clinical staff

Continuum of Care Functional Chapter

Standard

CC.6.1

The discharge process provides for continuing care based upon the patient's assessed needs

at the time of discharge.

Intent of CC.6.1

Discharge planning focuses on meeting patients' health care needs after discharge.

Discharge planning identifies patients' continuing physical, emotional, symptom management (eg, pain, nausea, or dyspnea), housekeeping, transportation, social, and other needs, and arranges for services to meet them.

Discharge services may include;

- adult foster care;
- case management;
- home health services;
- hospice;
- long-term care facilities;
- ambulatory care;
- support groups;
- rehabilitation services; and
- community mental health.

Discharge planning involves the patient, the family, the practitioner primarily responsible for the patient, nursing and social work professionals, and other appropriate staff. Staff members help the patient and family adapt to the plan of care.

Improving Organization Performance Functional Chapter

Standard

PI.3.1

The organization collects data to monitor its performance.

Intent for PI.3.1

Performance monitoring and improvement are data driven. The stability of important processes can provide the organization with information about its performance. Every organization must choose which processes and outcomes (and thus which types of data) are important to monitor based on its mission and the scope of care and services it provides. The leaders prioritize data collection based on the organization's mission, care and services provided, and populations served (see LD.4.2 for priority setting). Data that the organization considers for collection to monitor performance include the following:

- Performance measures related to accreditation and other requirements;
- Risk management;

- Utilization management;
- Quality control;
- Staff opinions and needs;
- Behavior management (5) procedures, if used;
- Outcomes of processes or services;
- Autopsy results, when performed;
- Performance measures from acceptable databases;
- Customer demographics and diagnoses;
- Financial data;
- Infection control surveillance and reporting;
- Research data;
- Performance data identified in various chapters of this manual; and the appropriateness and effectiveness of pain management.

Organizations are required to collect data about the needs, expectations, and satisfaction of individuals and organizations served. Individuals served and their family members can provide information that will give an organization insight about process design and functioning. The organization asks them about;

- their specific needs and expectations;
- their perceptions (6) of how well the organization meets these needs and expectations; and
- how the organization can improve.

The organization can use a number of ways to get input from these groups, including satisfaction surveys, regularly scheduled meetings held with these groups, and focus groups.

One Final Note: If the health care organization does not know how well it is managing pain, leaders should be sure that questions relating to pain assessment and management are included on the tool used to collect data about how well the organization is meeting the specific needs and expectations of the individuals served by that organization.

Notes

1. function A goal-directed, interrelated series of processes, such as continuum of care

or management of information.

2. blood derivative A pooled blood product, such as albumin, gamma globulin, or Rh immune globulin, whose use is considered significantly lower in risk than that of blood or blood components.
3. Effective January 1, 2000.
4. Described in the "Assessment of Patients" chapter of this manual.
5. The use of basic learning techniques, such as biofeedback, reinforcement, or aversion therapy, to manage and improve an individual's behavior.
6. To better measure the performance of organizations on how well they meet the needs, expectations and concerns of individuals, the Joint Commission is moving from the term satisfaction toward the more inclusive term perception of care and service. By using this term, the organization will be prompted to assess not only individuals' and/or families' satisfaction with care or treatment, but also whether their needs and expectations are met by the organization.



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The decision-making process is applied consistently, and the lines of accountability are clear. To ensure this, it is vital that a guiding process be formally adopted by the hospital's medical staff and approved by the governing body.

Examples of Evidence of Performance for RI.1.2.5 and RI.1.2.6

- Interviews with patients and families
- Interviews with hospital leaders
- Interviews with clinical staff
- Policies and procedures or other processes concerning
 - patient rights and responsibilities
 - informed consent
 - advance directives
- research, investigation, or clinical trials
- resolution of conflict in care or treatment decisions
- withholding resuscitation, and forgoing or withdrawing life-sustaining treatment
- pain management
- Patient medical records

Standard

RI.1.2.7 The hospital addresses care at the end of life.

Intent of RI.1.2.7

Dying patients have unique needs for respectful, responsive care. All hospital staff are sensitized to the needs of patients at the end of life. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of life.

The hospital's framework for addressing issues related to care at the end of life provide for

- providing appropriate treatment for any primary and secondary symptoms, according to the wishes of the patient or the surrogate decision maker;
- managing pain aggressively and effectively;
- sensitively addressing issues such as autopsy and organ donation;
- respecting the patient's values, religion, and philosophy;
- involving the patient and, where appropriate, the family in every aspect of care; and
- responding to the psychological, social, emotional, spiritual, and cultural concerns of the patient and the family.

Effective pain management is appropriate for all patients, not just for dying patients (see standards RI.1.2.8 and PE.1.4).

Examples of Implementation for RI.1.2.7

1. The patient, family, or surrogate decision makers are involved in every aspect of the patient's care at the end of his or her life. The hospital uses a formal process to support this involvement. Policies and procedures guide clinicians in the appropriate format for medical record entries.
2. The hospital may use as its basis acute pain management guidelines that reflect the state of knowledge on pain management and are published by the Agency for Health Care Policy and Research.

Examples of Evidence of Performance for RI.1.2.7

- Interviews with patients and families
- Interviews with hospital leaders
- Interviews with clinical staff
- Policies and procedures or other processes concerning
 - patient rights and responsibilities
 - informed consent
 - advance directives
- research, investigation, or clinical trials
- resolution of conflict in care or treatment decisions
- withholding resuscitation, and forgoing or withdrawing life-sustaining treatment
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- Patient medical records

Standard

RI.1.2.8 Patients have the right to appropriate assessment and management of pain.

Intent of RI.1.2.8

Pain can be a common part of the patient experience; unrelieved pain has adverse physical and psychological effects. The patient's right to pain management is respected and supported. The health care organization plans, supports, and coordinates activities and resources to assure the pain of all patients is recognized and addressed appropriately. This includes

- initial assessment and regular reassessment of pain;
- education of all relevant providers in pain assessment and management;
- education of patients, and families when appropriate, regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments; and
- after taking into account personal, cultural, spiritual, and/or ethnic beliefs, communicating to patients and families that pain management is an important part of care.

Examples of Implementation for RI.1.2.8

1. Pain is considered a "fifth" vital sign in the hospital's care of patients. Pain intensity ratings are recorded during the admission assessment along with temperature, pulse, respiration, and blood pressure.
2. Every patient is asked a "screening" question regarding pain on admission. Patients and families receive information verbally and in an electronic or printed format at the time of initial evaluation that effective pain relief is an important part of treatment.
3. Competency in pain assessment and treatment is determined during the orientation of all new clinical staff.
4. The following statement on pain management is posted in all patient care areas (patient rooms, clinic rooms, waiting rooms, etc):

Statement on Pain Management: All patients have a right to pain relief.

 - Inform patients at the time of their initial evaluation that relief of pain is an important part of their care and respond quickly to reports of pain.
 - Ask patients on initial evaluation and as part of regular assessments about presence, quality, and intensity of pain and use the patient's self report as the primary indicator of pain.
 - Work together with the patient and other health care providers to establish a goal for pain relief and develop and implement a plan to achieve that goal.

Review and modify the plan of care for patients who have unrelieved pain.
5. The hospital demonstrates its commitment to pain management by inclusion in educational programs for staff awareness events regarding pain assessment and treatment.
6. The hospital supplies educational materials about pain to all patients. For outpatient surgery patients, information is mailed to patients prior to the day of surgery.
7. Any telephone follow-up (for example, outpatient surgery, short stay obstetrics, evaluation of discharge planning) includes asking the patient about their pain status.

Examples of Evidence of Performance for RI.1.2.8

- Interviews with patients and families
- Interviews with clinical staff
- Policies and procedures, practice standards or other processes for addressing effective pain management
- Records and content outlines of staff educational offerings
- Educational materials for patients and families
- Patient rights or other statements delineating the organization's commitment to effective pain management

Example of Implementation for PE.1

The following example regarding the use of seizure precautions illustrates the interrelationship of the safety program, risk management, and patient care activities. During a seizure (the sudden onset of convulsive movements spreading throughout the body), the patient is in a state of clouded awareness. After the seizure, the patient may have no recollection of the event.

A hospital determines the scope and content of each clinical intervention that is of special interest and concern to the safety committee, including those that require special documentation. The hospital provides for an assessment of patients who's safety may be at risk when seizure precaution intervention services are required. For example,

- patients with Alzheimer's disease, dementia, seizure disorders;
- patients with head trauma or who have taken medication overdoses;
- patients at risk for skin breakdown; and
- patients who are comatose or require thrombolytic therapy or anticoagulant therapy.

After the assessment, the hospital makes recommendations about ensuring the patients' safety. The policies and procedures that govern the use of seizure precautions are approved in writing by the chief executive officer and the current medical staff's chief officer or their designee. The hospital's use of seizure precautions addresses

- patient comfort and safety as indicated by regular staff efforts to maintain a patient's personal needs;
- safety of room design, privacy, and other environmental conditions;
- staff training and supervision;
- proper protection on the sides of hospital beds; and
- other factors that contribute to avoiding undue physical discomfort, harm, or pain.

Standards

PE.1.2 Nutritional status is assessed when warranted by the patient's needs or condition.

PE.1.3 Functional status is assessed when warranted by the patient's needs or condition.

PE.1.3.1 All patients referred for rehabilitation services receive a functional assessment.

Intent of PE.1.2 Through PE.1.3.1

In its initial patient assessment, the hospital identifies patients at risk for nutritional problems, according to criteria developed by dietitians and other qualified professionals. The hospital refers such patients to a dietitian for further assessment.

During the initial assessment, the hospital also identifies patients who require a functional assessment using criteria developed by rehabilitation specialists and other qualified professionals. This functional assessment, in turn, identifies any patients who will need rehabilitation services. Any patients who are currently receiving rehabilitation services at the hospital have had a functional assessment.

Some patients coming into the hospital setting may need special nutritional care and some patients may need rehabilitation services or other services addressing their ability to function. These patients will require specialized assessments. Therefore, it is important for the hospital to identify patients with special needs.

Standard

PE.1.4 Pain is assessed in all patients.

Intent of PE.1.4

In the initial assessment, the organization identifies patients with pain. When pain is identified, the patient can be treated within the organization or referred for treatment. The scope of treatment is based on the care setting and services provided. A more comprehensive assessment is performed when warranted by the patient's condition. This assessment and a measure of pain intensity and quality (eg, pain character, frequency, location, and duration), appropriate to the patient's age, are recorded in a way that facilitates regular reassessment and follow-up according to criteria developed by the organization.

Examples of Implementation for PE.1.4

1. All patients at admission are asked the following screening or general questions about the presence of pain: Do you have pain now? Have you had pain in the recent past? If the patient responds "yes" to either question, additional assessment data are obtained:
 - Pain intensity (use a pain intensity rating scale appropriate for the patient population; pain intensity is obtained for pain at present, at worst, and at best or least; if at all possible, the pain rating scale is consistently used in the organization and between disciplines);
 - Location (ask the patient to mark on a diagram or point to the site of pain);
 - Quality, patterns of radiation, if any, and character (elicit and record the patient's own words whenever possible);
 - Onset, duration, variations and patterns;
 - Alleviating and aggravating factors;
 - Present pain management regimen and effectiveness;
 - Pain management history (including a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, manner of expressing pain);
 - Effects of pain (impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration, etc);
 - The patient's pain goal (including pain intensity and goals related to function, activities, quality of life); and
 - Physical exam/observation of the site of pain.
2. Patients often have more than one site of pain. An assessment system or tools with space to record data on each site is provided on the assessment sheet.
3. A hospital may need to use more than one pain intensity measure, depending on their patient population. For example, a hospital serving both children and adults selects a scale to be used with each of those patient populations. Assessment of cognitively impaired patients may also require assessment of behavioral factors signaling pain or discomfort.
4. Staff are educated about pain assessment and treatment including the barriers to reporting pain and using analgesics. Staff encourage the reporting of pain when a patient and/or family member demonstrates reluctance to discuss pain, denies pain when pain is likely to be present (for example, post-operative, trauma, burns, cardiac emergencies), or does not follow through with prescribed treatments.

5. Pain intensity scales are enlarged and displayed in all areas where assessments are conducted. For organizations using clinical pathways, pain assessment is incorporated in some way, into every appropriate clinical pathway.
- An organization selects pain intensity measures to insure consistency across departments; for example, the 0–10 scale, Wong Baker FACES Pain Rating Scale (smile-frown), and the Verbal descriptor scale. Adult patients are encouraged to use the 0–10 scale. If they cannot understand or are unwilling to use it, the smile-frown or the verbal scale is used.
 - A unit caring for persons with Alzheimer’s disease develops a pain scale for each resident based on their long-standing knowledge of their residents and their knowledge of the common pain syndromes in elderly persons.
 - A pediatric hospital includes, in its introductory information for parents, information about pain and pain assessment, including parents’ roles in interpreting behavioral changes of their child that may indicate pain or discomfort.

Examples of Evidence of Performance for PE.1.4

- Observation of assessment interview
- Interviews with patients and families
- Review of assessment forms or protocols
- Review of clinical records
- Interviews with clinical staff
- Policies and procedures, practice standards, or other processes regarding pain assessment
- Records and content outlines of staff educational offerings
- Educational materials for patients/clients and families

Standards

PE.1.5 Diagnostic testing necessary for determining the patient’s health care needs is performed.

PE.1.5.1 When a test report requires clinical interpretation, any relevant clinical information is provided with the request.

Intent of PE.1.5 and PE.1.5.1

Diagnostic testing is integral to the physical, psychological, and social assessment of the patient. Diagnostic testing covers operative and other procedures,[†] including laboratory, radiologic, electrodiagnostic, and other functional tests and imaging technologies. To appropriately care for patients, the results of these tests are used to determine the patient’s health care or treatment needs. The hospital’s clinical staff determines which of these tests, if any, will be performed when the patient enters the setting or service.

To be interpreted appropriately, some tests require additional clinical data or background information. A clinician who requests such a test provides, in writing, any information needed to perform and interpret the test properly.

[†] **operative and other procedures** Includes operative, other invasive, and noninvasive procedures, such as radiotherapy, hyperbaric, CAT scan, and MRI, that place the patient at risk. The focus is on procedures and is not meant to include medications that place the patient at risk.

Standard

PE.1.6 The need for a discharge planning assessment is determined.

Intent of PE.1.6

The hospital has a way of identifying those patients for whom discharge planning is critical. When indicated, hospital staff identify when planning for a patient's post-hospital care and other needs is to be conducted. This discharge planning is initiated early in the treatment process, based on requirements of the plan of care or other written guidelines. Criteria for discharge or terminating treatment are stipulated and may vary based on age and disability considerations and treatment objectives. Criteria for discharge may also vary according to treatment settings, as set forth in the hospital's policies and procedures.

Standards

PE.1.7 Each admitted patient's initial assessment is conducted within a time frame specified by hospital policy.

PE.1.7.1 The patient's history and physical examination, nursing assessment, and other screening assessments are completed within 24 hours of admission as an inpatient.

PE.1.7.1.1 If a history and a physical examination have been performed within 30 days before admission, a durable, legible copy of this report may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission.

Intent of PE.1.7 Through PE.1.7.1.1

The initial assessment of a patient is performed and documented within a reasonable time frame, as defined by the hospital. Precisely what the time frame is will depend on a variety of factors, including the types of patients treated by the hospital, the complexity and duration of their care, and the dynamics of conditions surrounding their care. With that in mind, a hospital may establish different time frames for the initial assessment in different areas or services.

However, some elements of the assessment must be performed and documented—by all hospitals and for all patients—within 24 hours of admission, even on weekends and holidays. These elements are

- medical history and physical examination;
- nursing care assessment; and
- other screening assessments, as needed.

Some of these elements may have been completed ahead of time, though no more than 30 days before the patient was admitted or readmitted, and only by the appropriate, qualified professionals. Specifically,

- a medical history and physical examination by a physician or oral and maxillofacial surgeon who is a member of the medical staff and
- a nursing care assessment completed by a qualified registered nurse.

Reports from these assessments may be used in place of new assessments, provided

- durable, legible copies (or originals) of the report are in the patient's record and
- any significant changes in the patient's condition since the report are recorded at the time of admission.

Note: See IM.7.6 and IM.7.8 regarding timely documentation and authentication of histories and physical examinations.