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.

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.

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* **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.