

Standards and Intent Statements

Following are the standards and intent statements for this function. This section is divided by grid element. Footnotes further clarify terms and other issues.

Standards and Intent Statements for Initial Assessment

Standards

PE.1 Each patient's physical, psychological, and social status are assessed.

PE.1.1 The scope and intensity of any further assessment are based on the patient's diagnosis, the care setting, the patient's desire for care, and the patient's response to any previous care.

Intent of PE.1 and PE.1.1

When a patient enters a hospital service, staff members first need to find out the reason why the patient was admitted. The specific information the hospital requires at this stage, and the procedures for getting it, depend on the patient's needs and on the setting in which care is being provided. Hospital policy defines how this process works.

The initial assessment takes into account the patient's immediate and emerging needs, and considers those needs broadly—that is, not only physiological status but psychological and social concerns too. This initial assessment helps staff determine what care the patient needs as well as any further assessments. A patient's cultural and family* contexts and individual background are important factors in his or her response to illness and treatment; families can be of considerable help in these areas of assessment.

The information gathered at the first patient contact may indicate that the patient needs a broader or more detailed assessment. Precisely what further assessment is needed will depend, at least in part, on

- the patient's diagnosis;
- the care he or she is seeking;
- the care setting;
- the patient's response to any previous care; and
- his or her consent to treatment.

The hospital has a policy that addresses these issues and defines what areas to include in reassessments.

For dying patients, an assessment is made of the social, spiritual, and cultural variables that influence the perceptions and expressions of grief by the individual, family members, or significant other(s).

* **family** The person(s) who plays a significant role in the individual's life. This may include a person(s) not legally related to the individual. This person(s) is often referred to as a surrogate decision maker if authorized to make care decisions for an individual should the individual lose decision-making capacity.