- Admission to a long-term care facility
- Home care services
- Psychological services
- Social services
- Home medical supplies or equipment
- Education related to continuing care needs

Patients discharged home are provided with at least the following information:

- Name and location of a site(s) for continuing care; for example, ambulatory care clinic, rehabilitation center, nearest emergency department
- Written instructions regarding any follow-up visits or care
- When and how to obtain urgent or emergent care

Discharge planning and instruction are documented in the patient's medical record and provided to the patient in writing.

Measurable Elements of ACC.04.00

1. The patient's discharge and/or referral is consistent with relevant criteria, indications, or guidelines.
2. The discharge planning process begins with the initial assessment and includes care, treatment, equipment, and services that meet the continuing needs of the patient.
3. Patients not directly referred or transferred are provided with the name and location of a site(s) for continuing care.
4. Patients not directly referred or transferred are provided instructions, in writing, on when to return to the hospital for continued care, treatment, and service, and when and how to obtain urgent care.
5. Patients, family as appropriate, and staff involved in the patient's care participate in the discharge planning process.
6. Discharge planning and instructions are documented in the patient's medical record and provided to the patient in writing.

Standard ACC.04.01

The hospital's discharge process includes patient and family education related to the patient's ongoing need for continuing care, treatment, and services.

Intent of ACC.04.01

Patient and family education is an important component of the discharge plan and supports the patient's return to previous functional levels and maintenance of optimal health.

The discharge process addresses the patient's and family's need for education on how to manage the patient's continuing care needs at home or for education on how to support the patient's continuing care needs in another setting. Standardized materials and processes are used to educate patients on topics related to their ongoing care and treatment after discharge. Patient education and follow-up instructions are provided to the patient in a form and language the patient understands.

Based on the patient's identified continuing care needs, discharge education and instructions may include but are not limited to the following topics:

- Review of all medications to be taken at home
- Safe and effective use of all medications, including potential medication side effects
- Potential interactions between prescribed medications and other medications (including over-the-counter preparations) and food
- Diet and nutrition
- Pain management

- Safe and effective use of medical equipment
- Rehabilitation activities and services

Patient education and follow-up instructions are provided to the patient in a form and language the patient understands. It is recommended that education and instructions are provided in writing to the patient and family, so they can refer to these materials as needed. However, not all patients and families have even basic reading skills. If education and instructions are provided in other forms, this must be documented in the patient's medical record. Education and instructions may be provided in the following forms:

- In writing (recommended method)
- Verbally
- Media (for example, videos, photographs, pictograms)

Measurable Elements of ACC.04.01

1. Ⓓ Patients and families are provided with a complete written list of medications to be taken at home and are educated on their safe use, including the following:
   - Potential side effects
   - Potential interactions between medications
   - Potential interactions between medications and foods
2. Patients and families are educated about proper diet and nutrition.
3. Patients and families are educated about pain management. (*See also* COP.07.00, ME 3)
4. Patients and families are educated about safe and effective use of medical equipment and rehabilitation activities and services.
5. Patient and family education is documented in the patient's medical record and includes the following:
   - What information and education were provided
   - How the information and education was delivered (for example, in writing, verbally, by demonstration)
   - Confirmation that the patient and/or family understood the information and education provided

   (*See also* PCC.04.01, MEs 2 and 3)

Standard ACC.04.02

The complete discharge summary is prepared for all patients and is included in the patient's medical record.

Intent of ACC.04.02

The discharge summary provides an overview of the patient's care and is intended to be used by the health care provider(s) caring for the patient following discharge.

A summary of the patient's care is prepared prior to discharge from the hospital. Any qualified individual can compile the discharge summary, such as the patient's physician or a house officer. A copy of the discharge summary is provided to the practitioner who will be responsible for the continuing or follow-up care of the patient.

A copy is to be given to the patient when indicated by hospital policy or when required by local laws or regulations. When the provider responsible for follow-up care is unknown (for example, patients who are visiting from a different region or country), a copy of the discharge summary is given to the patient or family. The expectation is that the patient provides the copy of their discharge summary to their primary care or general practitioner responsible for their care.

A copy of the discharge summary is included in the patient's medical record.

The hospital has a process to provide a copy of the discharge summary to the health care provider responsible for the patient's continuing or follow-up care.