Continuity of Care

Standard ACC.03.00

The hospital provides continuous patient care services and coordination among health care providers.

Intent of ACC.03.00

Care coordination and continuity among health care practitioners improves patient safety and outcomes. Coordination is accomplished through access to patient information that is imperative to these processes. Therefore, health care practitioners who are part of the patient's care, treatment, and services are provided access to relevant information.

Patients are transferred within the hospital between various services and units or departments. The hospital identifies individuals for coordinating patient care and services. Many health care practitioners care for patients throughout the hospital. Throughout all phases of care, patient needs are matched with required level of care and resources for care. When necessary, patients are transferred or referred to resources or services outside the hospital. The hospital establishes criteria or policies to determine appropriateness of transfers within and from the hospital.

Continuity is enhanced when all health care practitioners have the information needed from the patient's current and past medical experiences to make decisions about the patient's care. When multiple decision-makers are providing care, these decision-makers agree on the care and services to be provided.

The hospital implements processes for continuity and coordination of care among physicians, nurses, and other health care practitioners in all settings, including the following:

- Emergency services and inpatient admission
- Diagnostic services
- Surgical and nonsurgical treatment services
- Outpatient care programs
- Other organizations and other care settings

The patient's medical record is a primary source of information for patient care and is an essential communication tool. The medical record must contain current information and be available during inpatient care and for outpatient visits. Medical, nursing, and other patient care notes are available to all the patient's health care practitioners who need them for patient care.

The patient's complete health care record is transferred with the patient when changing care teams or settings within the hospital so treatments, medications, and other interventions may continue without interruption. When a patient is transferred to an outside organization, the hospital provides the care team receiving the patient with a copy of the patient's medical record or a summary of essential information from the patient's health care record.

When transferring a patient to an outside organization, the hospital may transfer a copy of the patient's medical record or send a transfer summary with the patient. The transfer summary contains the following information from the patient's health care record:

- Chief complaint(s)
- Significant findings
- Diagnosis
- Procedures performed
- Medications
- Other treatments
- Patient condition at time of transfer

Care coordination and continuity processes are supported by the following:

- Guidelines
- Clinical pathways
- Referral forms
- Checklists

Measurable Elements of ACC.03.00

1. Ⓓ Hospital leaders implement processes that support the continuity and coordination of care across all care settings. (*See also* ACC.02.02, ME 4; ACC.05.00, ME 1; GLD.06.00, ME 4)
2. The patient's medical record is available to those practitioners who are authorized to have access and need it for the care of the patient. (*See also* MOI.01.01, ME 4)
3. The patient's medical record is up to date with the patient's latest information.
4. The patient's medical record or a summary of patient care information is transferred with the patient to another service or unit in the hospital. (*See also* ACC.01.00, ME 5)
5. Ⓓ The written transfer summary of the patient's medical record contains, at minimum, the following:
   - The reason for admission
   - Significant findings and test results
   - Diagnosis
   - Procedures performed
   - Medications administered during hospitalization, including last time of administration and current medications (*See also* MMU.04.02, ME 2)
   - Other treatments
   - Patient condition at time of transfer
6. Care coordination and continuity are supported using various tools, such as care plans, guidelines, or protocols.

Standard ACC.03.01

There is a qualified individual responsible for the patient's care.

Intent of ACC.03.01

A clearly identified individual overseeing a patient's entire hospital stay improves continuity, coordination, patient satisfaction, quality, and clinical care outcomes.

The individual with responsibility for the patient's overall care coordination is clearly identified, for all the different phases of patient care. This individual may be a physician or another qualified individual. The individual responsible is identified in the patient's medical record. This individual collaborates and communicates with the other health care practitioners. When more than one individual is responsible for coordination of care, there is a higher likelihood of uncertainty and a lack of effective coordination. Hospital policy defines the process for the transfer of responsibility to another individual during vacations, holidays, and other periods.

The hospital creates a policy that guides the process for patient oversight, including the following:

- Identifying the individual overseeing all phases of patient care; for example, a physician or other advanced provider
- Defining the process for transfer of oversight responsibility during off days; for example, vacations, sick days, holidays
- Identifying consultants, on-call physicians, locum tenentes, or others who take responsibility
- Defining how transfer of responsibility occurs and what documentation is required to ensure coordination and documentation of their participation or coverage; for example, when a patient moves from one phase of care to another