Access to Care and Continuity of Care (ACC)

Overview

Health care organizations are pursuing a more comprehensive and integrated approach toward delivering health care. This approach is characterized by a high degree of collaboration and communication among health care practitioners. Hospitals need to consider the care provided as part of an integrated provider system of services, health care practitioners, and levels of care, which make up a continuum of care. The goal is to correctly match the patient's health care needs with the services available, to coordinate timely and high-quality services provided to the patient in the organization, and then to plan for referral, transfer, or discharge and follow-up. The result is improved patient care outcomes and more efficient use of available resources.

Information is essential for making correct decisions about the following:

- Which patient needs can be met by the health care organization
- Prioritization for patients presenting with urgent or immediate needs
- Efficient flow of services to the patient
- Access to intensive care or specialized services
- Coordination and continuity of care
- Referral, transfer, or discharge of the patient to their home or to another care setting
- Safe patient transportation

Standards

The following is a list of all standards for this function. They are presented here for your convenience without their intent statements or measurable elements. For more information about these standards, please see the next section in this chapter, Standards, Intents, and Measurable Elements.

Admission to the Hospital

ACC.01.00 Patients admitted to the hospital or who seek outpatient services are screened to identify if their health care needs match the hospital's mission, scope of care, and resources.

ACC.01.01 Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment.

ACC.01.02 The hospital considers the clinical needs of patients and informs patients when there are unusual delays for diagnostic and/or treatment services.

Patient Flow

ACC.02.00 The hospital has a process for managing the flow of patients throughout the hospital that includes the admission and registration of patients, as applicable to the patient care setting.

ACC.02.01 At the time of admission, the patient and family receive education and orientation to the patient care area, information on the proposed care and any expected costs for care, and the expected outcomes of care.

ACC.02.02 The hospital establishes criteria for admission to and discharge from units or departments providing specialized services.

Continuity of Care

ACC.03.00 The hospital provides continuous patient care services and coordination among health care providers.

ACC.03.01 There is a qualified individual responsible for the patient's care.

Discharge, Referral, and Follow-Up

ACC.04.00 The hospital develops and implements a discharge planning and referral process based on the patient's readiness for discharge.

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.

ACC.04.02 The complete discharge summary is prepared for all patients and is included in the patient's medical record.

ACC.04.03 Emergency care is documented.

ACC.04.04 Medical records contain patient profiles.

ACC.04.05 The hospital has a process for the management of patients who leave against medical advice.

Transfer of Patients

ACC.05.00 The hospital has a process to transfer patients to other health care organizations based on the patient's status and the hospital's ability to meet those needs.

ACC.05.01 The receiving organization is given a written summary of the patient's clinical condition and the interventions provided by the hospital, and the process is documented in the patient's medical record.

Transportation

ACC.06.00 The hospital's transportation services comply with relevant laws and regulations and meet requirements for high-quality, safe transport.

Standards, Intents, and Measurable Elements

Admission to the Hospital

Standard ACC.01.00

Patients admitted to the hospital or who seek outpatient services are screened to identify if their health care needs match the hospital's mission, scope of care, and resources.

Intent of ACC.01.00

Matching patient needs with the hospital's mission, scope of care, and available resources depends on obtaining information on the patient's needs and condition through screening. Decisions to treat, to transfer, or to refer are made only after the results of screening evaluations are available.

Screening for patient needs and condition may be conducted through various means, including the following:

- Triage criteria in the emergency department or outpatient urgent/immediate care clinic
- Visual evaluation

- Physical examination
- Previous physical, psychological, clinical laboratory, or diagnostic imaging evaluations

The screening may occur at various points of contact, including the following:

- At a referring source (for example, primary care visit)
- During emergency transport
- Upon arrival at the hospital

If patients qualify for admission, their care needs are identified and prioritized. These needs may include the following:

- Preventive services
- Diagnostics services
- Curative or treatment services
- Rehabilitative services
- Palliative services

The patient is admitted to the service or unit that meets the patient's most urgent needs.

When the hospital does not have the clinical capability to provide the needed services, the patient is transferred, referred to, or assisted in identifying sources of services to meet their needs. The transferring hospital must provide and document stabilizing treatment within its capacity prior to transfer.

Measurable Elements of ACC.01.00

1. Screening results determine if patients are accepted or admitted to the hospital, dependent on patient needs matching the hospital's mission, scope of care, and available resources.
2. Patients outside of the hospital's mission, scope of care, or available resources are assessed and stabilized within the capacity of the hospital prior to transfer.
3. The hospital transfers, refers, or assists the patient or family in identifying and/or obtaining appropriate sources of care if their needs do not match the hospital's mission, scope of care, or available resources.
4. Patients are admitted to the service or unit that meets their most urgent needs.
5. Ⓓ Assessments and treatments completed prior to transfer are documented in a record maintained by the transferring hospital. (*See also* ACC.03.00, ME 4)
6. There is a process to provide the results of diagnostic tests to those responsible for determining if the patient is to be admitted, transferred, or referred.

Standard ACC.01.01

Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment.

Intent of ACC.01.01

The hospital identifies which patients need emergent, urgent, or immediate care and prioritizes care.

Patients with emergent, urgent, and immediate care needs are identified and prioritized through the use of a recognized triage process, such as Emergency Severity Index or Canadian Triage and Acuity Scale. Staff responsible for identifying and prioritizing patient needs are trained in the selected triage process.

The triage process includes early recognition of the signs and symptoms of communicable diseases. Patients identified as having, or suspected of having, potential communicable diseases are segregated and/or isolated.

The triage process includes identifying patients who require clinical observation. The clinical observation period allows appropriate clinicians to determine whether a patient requires admission or is safe to discharge from the hospital. There is a defined process for clinical observation prior to admission to or discharge from the hospital.

Certain screenings or diagnostic tests may be required for every patient being admitted, or the hospital may identify specific screenings and tests for particular patient populations based on risk. Examples include the following:

- Screening patients with active diarrhea for *Clostridioides difficile* (*C. diff*)
- Screening patients from other health care organizations for methicillin-resistant *Staphylococcus aureus* (MRSA)

The triage process used by the hospital organization meets the following criteria:

- Is based on evidence or established by a professional organization.
- Is appropriate for the patient population (for example, pediatric vs. adult triage tools, obstetric tools).

The clinical observation process includes the following:

- Criteria for admission to or discharge from the hospital
- A time limit on the observation period
- Identification of who determines whether the patient is admitted or discharged from the hospital

Screenings and diagnostic tests required for admission are based on the following:

- Current trends in health care and current scientific evidence
- Risks specific to patient population cared for by the organization
- Risks specific to the environment and geographic region

Measurable Elements of ACC.01.01

1. Ⓓ The hospital selects and uses an evidence-based triage process, appropriate to its patient population, to identify and prioritize patients with emergent, urgent, and immediate needs.
2. The hospital has identified which specific screenings or diagnostic tests must be completed prior to admitting or registering patients.
3. The triage process includes early recognition of communicable diseases.
4. Staff are trained to use the triage process, including the early recognition of communicable diseases.
5. There is a process for holding patients for observation when clinically indicated.

Standard ACC.01.02

The hospital considers the clinical needs of patients and informs patients when there are unusual delays for diagnostic and/or treatment services.

Intent of ACC.01.02

Delays for diagnostic services and treatment may negatively impact patient condition, particularly when a patient's condition or treatment is time sensitive. Patients have a right to know and understand the potential impact of these delays on their health.

Patients are informed when there are known long delays for diagnostic and/or treatment services or when obtaining planned care may require placement on a waiting list. Examples of such delays include the following:

- Waiting for an organ transplant
- A delay in obtaining a diagnostic test due to limited appointments
- Waiting for an elective surgical procedure due to limited availability of operating theatres

Patients are informed of the associated reasons for the delay and are informed of alternatives, if available.

This requirement applies to inpatient and outpatient care and/or diagnostic services. This requirement does not apply to minor, usual, or expected waiting periods for outpatient care or inpatient care. Examples of such delays include the following:

- When a provider is behind schedule in a clinic
- When the emergency department and its waiting room are full

- When a delay is consistent with regional norms for specialized services, such as oncology treatment or organ transplant

These are reasonable examples for delays, but patients and/or their families should still be informed of delays and the reason for them. Appropriate and timely communication is essential to address anxiety and demonstrate genuine empathy for patients and/or their families.

Unusual delays require documentation in the patient's medical record. Documentation of unusual delays includes the reason for the delay, so the hospital and health care provider understand how it impacted patient care. Examples of unusual delays include the following:

- Insufficient staffing
- Miscommunication
- Rejected laboratory specimen

Measurable Elements of ACC.01.02

1. Patients are informed when there will be a delay in care and/or treatment.
2. Patients are informed of the reasons for the delay and provided with information on available alternatives consistent with their clinical needs.
3. The information on unusual delays and reasons for the delay are documented in the patient's medical record.

Patient Flow

Standard ACC.02.00

The hospital has a process for managing the flow of patients throughout the hospital that includes the admission and registration of patients, as applicable to the patient care setting.

Intent of ACC.02.00

Managing the flow of patients throughout the hospital improves the coordination of care, patient safety, and health outcomes. It is essential to minimize boarding of patients in the emergency department or other temporary areas in the hospital.

Patient flow is the movement of patients throughout the hospital from the point of admission to the point of discharge or from the point of registration to the point of disposition. Effective management of processes that support patient flow can minimize delays in the delivery of care. Patient flow includes the following:

- Admission and discharge of patients
- Scheduled, elective, and emergent admissions
- Assessment and treatment of patients
- Patient transfers between units or other levels of care
- Availability of staff and resources

The hospital has a process to manage patient flow. Components of the process include the following:

- Available inpatient beds in appropriate care areas
- Availability of appropriately trained and credentialed staff
- Expected patient progression and movement through all care areas, including the following:
  - Emergency department
  - Inpatient units
  - Operating theatres and procedure areas
  - Diagnostic testing areas
- Availability and efficiency of nonclinical services that support patient care, including housekeeping and transportation

Hospitals must prepare for patient overflow when patient flow does not progress as expected, and when there is an influx of patients. Preparation plans address patient and staff requirements to provide safe care to patients boarding in the emergency department or held in other temporary locations.

The hospital has a process to manage overflow patients boarding in the emergency department and other temporary areas. This process includes the following:

- Facility plans for allocation of space, utilities, equipment, medical equipment, and supplies
- Staffing plans
- Clinical resource availability and access, including the following:
  - Overflow or boarded patients receive the same level of care as admitted patients.
  - Overflow or boarded patients have the same access to clinical services as admitted patients.
  - Overflow or boarded patients have the same access to nonclinical services as admitted patients.
- An established timeline for transferring patients from temporary holding areas or the emergency department to appropriate inpatient beds

Staff from throughout the hospital can contribute to understanding and resolving problems in patient flow. The hospital establishes measures and goals to review the effectiveness of the patient flow process. These measures and goals are monitored and inform strategies to improve patient flow. The effectiveness of process improvements to patient flow is evaluated.

Measurable Elements of ACC.02.00

1. The hospital implements a patient flow process, including the following:
   - Availability of appropriate beds
   - Properly trained staff
   - Expected movement and progression throughout care areas
   - Availability of nonclinical services
2. The hospital has an admission process for patients, regardless of their origin of arrival, including a registration process for patients who do not require admission.
3. The hospital plans and provides for the care of patients who are boarded in the emergency department and other temporary holding areas, including the following:
   - Allocation of space, utilities, equipment, medical equipment, and supplies
   - Staffing plans
   - Availability of clinical resources
   - Availability of nonclinical resources
   - Provision of timely and equivalent care to meet patient needs
   - A time limit on boarding patients in the emergency department and other temporary holding areas and a process for managing patients when temporary boarding periods exceed this time limit
4. Ⓓ The patient flow processes are reviewed for effectiveness, and process improvements are identified and implemented.

Standard ACC.02.01

At the time of admission, the patient and family receive education and orientation to the patient care area, information on the proposed care and any expected costs for care, and the expected outcomes of care.

Intent of ACC.02.01

Orientation to the care environment, including equipment related to the care and services provided, is an essential component of patient safety. Patients and their families receive sufficient information to make knowledgeable decisions. Patients and clinical staff understand the scope and limits of the general consent (if used by the hospital) to protect patient autonomy and rights.

The patient and their family receive information about the proposed care, the expected outcomes of care, and any expected cost for the care when not paid for by a public or private source. This information can be provided as a written document or through verbal explanation. It must also be noted in the patient's medical record.

The hospital seeks ways to minimize any financial barriers for the patient. Examples include the following:

- Providing applications for financial aid
- Identifying sources of charitable funding for health care
- Providing prescriptions for generic rather than branded medications

When used, general consents include the following:

- The scope of the general consent (for example, which tests and treatments are covered by the general consent)
- What tests and treatments require additional informed consent
- How patients receive information (for example, via patient portal or text messaging)

The hospital specifies how the general consent is documented in the patient's medical record.

The hospital may rely on implied consent or obtain a general consent for treatment when the patient is admitted or registered for the first time. Hospitals are not required to use a general consent unless required by laws and regulations. Regardless of whether general consent is obtained, all patients are informed about what tests and treatments require additional informed consent.

All patients are informed about the likelihood of students participating in their care; for example, medical students, nursing students, physical therapy students, respiratory therapy students.

Measurable Elements of ACC.02.01

1. The patient and family receive education and orientation to the patient care area.
2. The patient and family receive information on the proposed care, treatment, and services, including expected outcomes.
3. The patient and family receive information on any expected costs related to the proposed care, treatment, and services.
4. Patients and families are informed as to the scope of a general consent, if used by the hospital. (*See also* PCC.03.00, ME 3)
5. Ⓓ The hospital defines, in writing, how a general consent is documented in the patient's medical record, if used by the hospital. (*See also* PCC.03.00, ME 1)
6. All patients receive information about the likelihood of students and trainees participating in care processes.

Standard ACC.02.02

The hospital establishes criteria for admission to and discharge from units or departments providing specialized services.

Intent of ACC.02.02

Specific criteria for admission to and discharge from intensive care or specialized units or departments ensures that patients are receiving an appropriate level or type of care and encourages the efficient use of these limited resources.

Units or departments that provide intensive or specialized care are costly, use many resources, and usually are limited in space and staffing. Hospitals should restrict admission to these units or departments to ensure the appropriate use of these areas and resources. The hospital must establish criteria regarding which patients require the level and type of care provided by these specialized units or departments. Criteria must be

consistently implemented throughout the hospital and among clinical staff determining patient disposition. Examples of these units or departments and their admission criteria include the following:

- Criteria for admission to a burn unit may include a specific percentage of the burned body surface and/or whether the burn is a second- or third-degree burn.
- Criteria for admission to an intensive care unit may require that patients are intubated, need close monitoring for critical changes, or require additional equipment (for example, IV lines and pumps, feeding tubes, drains and catheters).
- Admission to a postanesthesia care unit vs. surgical intensive care unit may be determined by whether the patient remains intubated, is on vasopressors, or requires complex wound care.

The criteria are used to determine direct admission to the unit or department (for example, directly from the emergency department). The criteria are also used to determine admission into the unit or department from another clinical area within the hospital or transferred from another hospital.

Patients admitted to a specialized unit or department require periodic reassessment to determine when a patient continues to meet criteria for specialized services. Examples of patients no longer meeting criteria include the following:

- A patient admitted to an intensive care unit whose physiological status has stabilized and no longer requires continuous monitoring
- A patient whose physiological status has deteriorated, and care goals are redirected to comfort or palliative care, requiring less intensive monitoring

Whenever possible, criteria for intensive or specialized units and departments meet the following requirements:

- Use prioritization or severity-of-illness criteria.
- Are based on diagnostic and/or objective parameters.
- Use physiologic-based criteria for medical and surgical services.
- Use psychological-based criteria for psychiatric services.
- Include required lifesaving or life-sustaining technology, interventions, and medications. Examples of such technology, interventions, and medications include the following:
  - Ventilators or other respiratory support
  - Vasopressors or other medications requiring frequent or continuous monitoring
  - Frequency of direct observation of the patient
  - Frequency and complexity of wound care

Intensive or specialized units or departments establish criteria for reassessment of admitted patients, which include the following:

- When and how often patients should be reassessed for continued care or transfer to a different level of care
- Diagnostic and/or objective parameters for safe transfer to a different level of care
- Physiologic-based and/or psychological-based criteria
- Frequency and type of technology, interventions, and medications for de-escalation of treatment

Measurable Elements of ACC.02.02

1. Ⓓ The hospital has established written admission criteria, based on prioritization, diagnostic, and/or objective parameters, for specialized units or departments.
2. Ⓓ The hospital has established written discharge and/or transfer criteria from specialized units or departments to a different level of care.
3. The medical records of patients who are admitted to specialized units or departments contain evidence that they meet the criteria for care, treatment, and services. (*See also* GLD.06.00, ME 3)
4. The medical records of patients who are transferred or discharged from specialized units or departments contain evidence that they meet criteria for discharge. (*See also* ACC.03.00, ME 1; ACC.05.00, ME 1; GLD.06.00, ME 4)

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

Measurable Elements of ACC.03.01

1. A qualified individual responsible for the coordination of the patient's care is available through all phases of inpatient care and is identified in the patient's medical record.
2. There is a process for transferring the responsibility for coordination of care.
3. Ⓓ The process identifies how transferred responsibility is assumed, and the participation or coverage is documented.

Discharge, Referral, and Follow-Up

Standard ACC.04.00

The hospital develops and implements a discharge planning and referral process based on the patient's readiness for discharge.

Intent of ACC.04.00

Effective and early discharge planning can decrease the risk of hospital readmission, improve recovery, ensure safe medication practices, and help prepare patients and/or families in having safe, posthospital care.

Discharge planning is a process used to help determine what types of continued care and services a patient may need after leaving the hospital. Improvements in hospital discharge planning significantly improve outcomes for patients as they move to the next level of care. Early initiation of the discharge planning process is paramount to maximizing outcomes. The discharge planning process includes assessing and identifying the patient's need for continuing care or services. The patient's principal health care provider determines readiness for referral or discharge.

Referring or discharging a patient to a health care provider outside the hospital, another care setting, home, or family is based on the patient's health status and readiness for discharge. The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. An organized process is required to ensure that any continuing needs are met.

Patients not directly referred or transferred to another health care practitioner receive clear instructions on where and how to receive continuing care. This is essential to ensure that all care needs are met. The instructions include the name and location of sites for continuing care, any return to the hospital for follow-up, and when urgent care should be obtained. The process includes referring patients to sources of care outside the region when required.

The hospital begins to plan for the continuing needs as early in the care process as possible. The discharge planning process begins with the initial assessment and is updated throughout the care process as the patient's discharge needs become clearer. Discharge planning includes any special education the patient may require related to continuing care outside of the hospital. The patient, the patient's family, health care practitioners, and others involved in the patient's care participate in planning the patient's discharge or transfer.

The hospital establishes a method to determine a patient's readiness for discharge. This includes the use of the following:

- Relevant criteria
- Clinical indications
- Clinical guidelines/protocols

The hospital establishes a process to ensure that patients receive any continuing care or support services they need following discharge. Continuing care needs include the following:

- Referral to a medical specialist
- Rehabilitation services

- 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.

The hospital has defined situations when a patient will be given a copy of the discharge summary. Examples include the following:

- When required by hospital policy
- When required by local laws or regulations
- When the health care provider responsible for the patient's follow-up care is unknown

The summary includes the following:

- Reason for admission, diagnoses, and comorbidities
- Significant physical and other findings
- Diagnostic and therapeutic procedures performed
- Medications at time of discharge, including last date/time administered
- All medications to be taken at home
- Therapeutic equipment at time of discharge (for example, nebulizers, glucometer, ambulation devices)
- The patient's condition at the time of discharge (examples include "condition improved," "patient at baseline condition")
- Follow-up instructions

Measurable Elements of ACC.04.02

1. A discharge summary is prepared by a qualified individual.
2. The discharge summary contains at least the following:
   - Reason for admission, diagnoses, and comorbidities
   - Significant physical and other findings
   - Diagnostic and therapeutic procedures performed
   - Medications at time of discharge, including date/time of last dose given while hospitalized
   - All medications to be taken at home
   - Therapeutic equipment at time of discharge
   - The patient's condition at the time of discharge
   - Follow-up instructions
3. A copy of the discharge summary is provided to the health care provider responsible for the patient's continuing or follow-up care.
4. The patient or caregiver is provided with a copy of the discharge summary.
5. A copy of the completed discharge summary is included in the patient's medical record at the time of discharge.

Standard ACC.04.03

Emergency care is documented.

Intent of ACC.04.03

Emergency care is documented to ensure continuity of care and to permit providers at the next level of care to understand the emergency services provided.

The record of each patient receiving emergency care includes the arrival and departure times. This information is captured for all emergency department patients, including those who are discharged from the hospital, transferred to another facility, or admitted as inpatients. Departure time may be when the patient physically leaves the emergency department to go home or to another facility, or the time at which the patient is moved to another unit as an inpatient. For patients discharged from the emergency department, the medical record includes conclusions following completion of emergency treatment, the patient's condition at discharge, and follow-up care instructions.

Measurable Elements of ACC.04.03

1. The medical records of all emergency patients include arrival and departure times.
2. The medical records of patients discharged from the emergency department include conclusions following completion of treatment.
3. The medical records of patients discharged from the emergency department include the patient's condition at discharge.
4. The medical records of patients discharged from the emergency department include any follow-up care instructions.

Standard ACC.04.04

Medical records contain patient profiles.

Intent of ACC.04.04

Patient profiles provide a summary of a patient's condition and treatments and are available to all members of the patient's health care team across the continuum of care. Patient profiles provide a "snapshot" of the patient and their care.

The hospital creates patient profiles or similar brief overviews for all patients, including inpatients and outpatients, as part of the patient medical record. A profile makes updated critical information quickly and easily available to health care providers, particularly when there are multiple providers involved in the patient's care. Patient profiles are particularly helpful when patients have complex diagnoses and care, multiple problems, or multiple care teams. Because a health care occurrence is dynamic, the patient profile must be kept up to date and current with patient information as any changes occur. The profile summary should be available within one document for efficient access by any health care provider.

A patient profile is required for both electronic and hard-copy medical records.

The process for creating patient profiles includes defining what information is part of the patient profile. Examples of such information include the following:

- Patient age, weight, height
- Active problem list
- Past medical and surgical history
- Current treatment information
- Allergies

Additional considerations include creating a format that is easy for clinicians to retrieve and review and evaluating the process to verify that the profile meets the needs of the clinicians.

The patient profile may be structured differently or contain different information between care areas to meet clinician needs; however, the profile must be consistent within care areas, as in the following examples:

- Inpatient and outpatient profiles may be structured differently, but all inpatient and outpatient profiles are consistent.
- Medical and surgical patient profiles may be structured differently but all medical and surgical patient profiles are consistent.
- Psychiatric and physical rehabilitation patient profiles may be structured differently, but all psychiatric patient physical rehabilitation profiles are consistent.

Measurable Elements of ACC.04.04

1. All patient medical records contain a patient profile or similar overview.
2. Ⓓ The hospital identifies necessary information to be included in the profiles.
3. The patient profile is easy to access and review and is consistent within care areas.
4. The process is evaluated to ensure that the implementation is consistent with the policy and provides clinicians with an accurate overview of the patient.

Standard ACC.04.05

The hospital has a process for the management of patients who leave against medical advice.

Intent of ACC.04.05

Patients leaving against medical advice are at risk of inadequate treatment, which may result in permanent harm or death. The hospital must have a process to manage patients leaving against medical advice and to inform them of the risks related to this decision.

"Leaving against medical advice" means leaving the hospital after an examination has been completed and a treatment plan has been recommended. Leaving against medical advice also includes patients who do not complete or return for complex or lifesaving treatments in the outpatient setting.

Inpatients and outpatients, including patients from the emergency department, have the right to refuse medical treatment and to leave the hospital against medical advice. However, these patients may be at risk of inadequate treatment, which may result in permanent harm or death.

When a competent patient requests to leave the hospital without medical approval, the risks must be explained by the provider recommending the treatment plan or their designee, and the conversation should be documented in the medical record. If the patient allows it, normal discharge procedures should be followed. Patients leaving against medical advice do not leave the facility without receiving information on their medical care. Health care providers attempt to identify why the patient is choosing to leave against medical advice to improve communication and identify potential process improvements. When a patient leaves the hospital against medical advice without notifying anyone or does not return for treatment, the hospital must try to contact the patient to inform them of potential risks.

If the patient has a documented primary care provider, they must be notified of the patient's decision to leave against medical advice. When applicable, the hospital reports cases of infectious disease and provides information regarding patients who may harm themselves or others to local and national health authorities as required.

If the patient is at risk of self-harm or harming others, the hospital should restrain the patient from leaving if allowed by local laws and regulations.

The hospital may develop a process to allow patients to leave the hospital for a defined period (such as on a weekend "pass") if approved by the patient's attending physicians and permitted by local laws and regulations. Such a temporary absence is not considered leaving against medical advice.

The hospital designs this process to be consistent with applicable laws and regulations. The process for managing patients who leave against medical advice includes the following:

- Inpatients who leave with or without informing hospital staff
- Patients who have absconded
- Patients receiving complex treatment who do not complete or do not return for treatment ("no shows")

The process includes contacting the following individuals:

- The patient (if possible) to inform them of the potential risks of leaving against medical advice
- The patient's family or caregivers, as applicable
- The patient's primary care provider if one is known
- Local and national health authorities, as required, if the patient has a known or suspected reportable infectious disease
- Local authorities, as required, if the patient is at risk for harming themselves or others

The process defines expectations for documenting "leaving against medical advice," patient absconded, and no shows.

The process includes the following:

- Permitting patients to leave for a defined period of time during the planned course of treatment
- Identifying clinical criteria for patients to leave. Examples of criteria include the following:
  - Physical status
  - Mental status
  - Patient's ability to care for themselves or the family's ability to care for the patient
- Including the treatment team, the patient, and the patient's family (if applicable) in the decision

Measurable Elements of ACC.04.05

1. Ⓓ There is a written process for managing patients who leave against medical advice; this process includes the following:
   - Inpatients who leave with and without informing hospital staff
   - Patients who have absconded
   - Patients receiving complex treatment who do not complete or do not return for treatment ("no shows")
   - Documentation requirements
2. There is a process to inform the patient of the medical risks of inadequate treatment.
3. The patient is discharged according to the hospital discharge process.
4. There is a process to notify the patient's primary care provider if a patient leaves against medical advice.
5. The process is consistent with applicable laws and regulations, including requirements for reporting cases of infectious disease and when patients may be a threat to themselves or others.
6. When consistent with regional laws and regulations, the hospital develops a process for allowing patients to leave the hospital during the planned course of treatment for a defined period of time.

Transfer of Patients

Standard ACC.05.00

The hospital has a process to transfer patients to other health care organizations based on the patient's status and the hospital's ability to meet those needs.

Intent of ACC.05.00

Transferring a patient to an outside organization is based on the patient's status and need for continuing health care services. Criteria help to identify when a transfer is necessary to ensure that the patient's needs are met.

Transfer may be in response to a patient's needs. Examples of needs include the following:

- Specialized consultation and treatment
- Urgent services
- Less intensive services (such as subacute care or long-term rehabilitation)
- Patient or family request

The hospital must determine if the receiving organization provides services to meet the patient's needs and has the capacity to receive the patient. This advance determination ensures continuity of care and that the patient's care needs will be met. Transfer requirements are described in formal or informal affiliations or agreements. However, transfers may occur to other specialized treatment or services without formal or informal agreements.

A consistent process for patients is required to ensure that patients are transferred between health care organizations safely.

The condition and status of the patient determine the required qualifications of the staff member monitoring the patient and the type of medical equipment needed during transfer.

The hospital evaluates the quality and safety of the transfer process to ensure that patients are transferred with qualified staff and the correct medical equipment for the patient's condition.

The patient transfer process specifies the following:

- How and when responsibility is transferred between providers and organizations
- Criteria for when transfer is necessary to meet the patient's needs
- Who is responsible for the patient during transfer
- Qualifications of the staff caring for the patient during transfer
- What medications, supplies, and medical equipment are required during transport
- Follow-up mechanism that provides information regarding the condition of the patient during transfer and upon arrival to the receiving organization
- What is done when transfer to another source of care is not possible

Measurable Elements of ACC.05.00

1. Ⓓ The hospital develops a written transfer process based on patients' needs for continuing care and ensures that the receiving organization meets the needs of the patient to be transferred. (*See also* ACC.02.02, ME 4; ACC.03.00, ME1; GLD.06.00, ME 4)
2. The transfer process addresses how and when responsibility for continuing care is moved to another provider.
3. The transfer process identifies who is responsible for monitoring the patient during transfer and the staff qualifications required for the type of patient being transferred.
4. The transfer process identifies the medications, supplies, and medical equipment required during transport.
5. The transfer process addresses a follow-up mechanism that provides information about the patient's condition upon arrival to the receiving organization.
6. The transfer process addresses the situations in which transfer is not possible.

Standard ACC.05.01

The receiving organization is given a written summary of the patient's clinical condition and the interventions provided by the hospital, and the process is documented in the patient's medical record.

Intent of ACC.05.01

To ensure continuity of care, patient information is transferred with the patient.

The receiving organization needs to understand any patient care provided before and during transfer. Without this information, there is a risk that vital patient information will not be communicated or that interventions, treatments, or medications are repeated or omitted. A copy of the written clinical or discharge summary is provided to the receiving organization with the patient. The patient's medical record contains documentation of the transfer.

The written clinical or discharge summary includes at least the following:

- Patient's clinical condition or status
- Procedures and other interventions provided
- Patient's continuing needs and reason for transfer

The transfer documentation includes the following:

- Name of the health care organization and the name of the individual agreeing to receive the patient
- Reason(s) for the transfer

- Any serious changes in the patient's condition or status during transfer
- Any other documentation required by hospital policy (for example, a signature of the receiving nurse or physician, the name of the individual who monitored the patient during transport)

Measurable Elements of ACC.05.01

1. Ⓓ A written clinical summary is transferred with the patient and includes at least the following:
   - Patient's condition or status
   - Procedures and other interventions provided
   - Patient's continuing needs and reason for transfer
2. Ⓓ The transfer documentation includes at least the following:
   - Name of the service provider and the name of the individual agreeing to receive the patient
   - Reason(s) for the transfer
   - Changes in the patient's condition or status
   - Other documentation required by hospital policy

Transportation

Standard ACC.06.00

The hospital's transportation services comply with relevant laws and regulations and meet requirements for high-quality, safe transport.

Intent of ACC.06.00

Patients may require transportation at the time of discharge or transfer; the hospital is responsible for assessing patients' transportation needs and arranging safe transportation when necessary.

Assessing patients' transportation needs and ensuring safe transportation for those patients who require assistance is the hospital's responsibility. Transportation services may be provided by the following:

- Hospital-owned service
- A contracted transportation service
- The Ministry of Health
- Other entity

The hospital has a process for assessing patients' transportation needs at the time of discharge or transfer. A patient's transportation needs may change from admission to discharge. Examples of these changes may include change in their physical or mental condition or use of sedation during a same-day procedure.

The required equipment, supplies, and medications for transport are determined by the type of patient and the patient's condition at the time of transport. The hospital determines the staff qualifications and level of monitoring required based on the type of patient and the patient's condition at the time of transport.

The hospital identifies transportation situations that have a risk of infection and implements strategies to reduce infection risk.

The hospital ensures that transportation services meet all applicable laws and regulations related to their operation, condition, and maintenance. The hospital evaluates the quality and safety of transportation, including complaints about the transportation services.

Depending on hospital policy and the laws and regulations of the region, the cost of the transportation may or may not be the responsibility of the hospital.

The hospital has a process to evaluate transportation needs of its patients. This includes the following:

- Identifying which patients require transportation

- Identifying which type of transportation is needed (for example, ambulance, air transfer, another vehicle)
- Defining staff qualifications for transportation
- Defining what equipment, supplies, and medications are needed for transportation
- Defining criteria for patient monitoring during transportation

The hospital has a process to ensure the safety and quality of transportation services. This includes the following:

- Ensuring that transportation services comply with local and regional laws and regulations
- Identifying infection risks and implementing strategies to reduce the infection risks (transportation services are part of the hospital's infection prevention and control program)
- Evaluating the quality and safety of services provided by the hospital or others, including receiving, evaluating, and responding to complaints about the transportation services provided or arranged

Note: If transportation services are not provided by the hospital, the hospital has a process to provide feedback about safety and quality to the responsible organization.

Measurable Elements of ACC.06.00

1. The process for discharging or transferring patients includes an assessment of patient transportation needs.
2. Transportation services, including contracted services, and transport vehicles owned by the hospital meet relevant laws and regulations and the hospital's requirements for high-quality and safe transport.
3. All vehicles used for transportation, contracted or hospital owned, comply with the hospital's infection prevention and control program.
4. All vehicles used for transportation, contracted or hospital owned, have appropriate medical equipment, supplies, and medications to meet the needs of the patient being transported.
5. The transportation provided or arranged is appropriate to the needs and condition of the patient.
6. There is a process in place to monitor the quality and safety of transportation provided or arranged by the hospital, including a complaint process.