- 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.