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.