

[All records must document the following, as appropriate:]

§482.24(c)(4)(vii) - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.

Interpretive Guidelines §482.24(c)(4)(vii)

All patient medical records must contain a discharge summary. A discharge summary discusses the outcome of the hospitalization, the disposition of the patient, and provisions for follow-up care. Follow-up care provisions include any post hospital appointments, how post hospital patient care needs are to be met, and any plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted living.

The MD/DO or other qualified practitioner with admitting privileges in accordance with State law and hospital policy, who admitted the patient is responsible for the patient during the patient's stay in the hospital. This responsibility would include developing and entering the discharge summary.

Other MD/DOs who work with the patient's MD/DO and who are covering for the patient's MD/DO and who are knowledgeable about the patient's condition, the patient's care during the hospitalization, and the patient's discharge plans may write the discharge summary at the responsible MD/DO's request.

In accordance with hospital policy, and 42 CFR Part 482.12(c)(1)(i) the MD/DO may delegate writing the discharge summary to other qualified health care personnel such as nurse practitioners and MD/DO assistants to the extent recognized under State law or a State's regulatory mechanism.

Whether delegated or non-delegated, we would expect the person who writes the discharge summary to authenticate, date, and time their entry and additionally for delegated discharge summaries we would expect the MD/DO responsible for the patient during his/her hospital stay to co-authenticate and date the discharge summary to verify its content.

The discharge summary requirement would include outpatient records. For example:

- The outcome of the treatment, procedures, or surgery;
- The disposition of the case;
- Provisions for follow-up care for an outpatient surgery patient or an emergency department patient who was not admitted or transferred to another hospital.

Survey Procedures §482.24(c)(4)(vii)

- Verify that a discharge summary is included to assure that proper continuity of care is required.
- Verify that a final diagnosis is included in the discharge summary.