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§482.61(e) Standard: Discharge planning and discharge summary. The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and…

Interpretive Guidelines §482.61(e)

The record of each patient who has been discharged should indicate the extent to which goals established in the patient's treatment plan have been met.

As part of discharge planning, staff consider the discharge alternatives addressed in the psychosocial assessment and the extent to which the goals in the treatment plan have been met.

The surveyor should refer to hospital policy for discharge timeframes.

The discharge summary should contain a recapitulation of the patient's hospitalization, which is a summary of the circumstances and rationale for admission, and a synopsis of accomplishments achieved as reflected through the treatment plan. This summary includes the reasons for admission, treatment achieved during hospitalization, a baseline

of the psychiatric, physical and social functioning of the patient at the time of discharge, and evidence of the patient/family response to the treatment interventions.