

DELEGATION RELATED TO A MEDICAL DISCHARGE SUMMARY
Position Statement
West Virginia Board of Examiners for Registered Professional Nurses

The West Virginia Board of Examiners for Registered Professional Nurses (Board) has determined that it is within the scope of practice of an Advanced Practice Registered Nurse (APRN) holding Announcement of Advanced Practice from the Board to perform a Discharge Summary as delegated by a medical doctor or doctor of osteopathy (MD/DO). The Board has further determined that it is not within the scope of practice for a registered nurse who is not an APRN to perform a Discharge Summary as delegated by an MD/DO. *However*, it is within the scope of practice for a registered professional nurse who is not an APRN to extract, collect and compile from the client's medical plans of care, progress notes, and laboratory/diagnostic reports and document or dictate this information to be reviewed and validated by the attending MD/DO. The RN cannot determine a medical diagnosis, medical plan of care, or substitute his/her judgment for that of the MD/DO. In both cases it is expected that the APRN and RN have the required competencies to perform these requirements and that evidence of the competencies is documented and maintained by the nurse and the health care facility in which they have privileges. This fits within the Board's Scope of Practice Model for RNs and APRNs.

The Board supports the CMS Interpretive Guidelines that provide:

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. (Emphasis added)

CMS Interpretive Guidelines §482.12(c)(1)(i) the MD/DO provide the following:

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 42CRFR 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. (Emphasis added)