

# Tool- Discharge Summary Policy and Procedure Checklist

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## **Tool: Discharge Summary Policy and Procedure**

**§483.21 (2) Discharge summary.** When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

- (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
- (ii) A final summary of the resident's status to include items in paragraph (b)(1) of § 483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
- (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
- (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

### **Purpose and Intent of 483.21(2)**

The purpose of the discharge summary policy and procedure is to develop guidelines and a comprehensive approach to information provided to the resident, the representative and post-discharge care providers. These policies apply to residents being discharged as a result of a planned process.

To assure that the individual facility has followed all the required steps for the development and implementation of a discharge summary policy in accordance to the new Requirements of Participation (RoP), the following checklist captures specific action items for successful completion. The far left column represents the actual Requirements of Participation (RoP) language and the right column indicates specific leadership strategies for successful completion and implementation of the revised RoP. When preparing updated policies and procedures, it is recommended to include actual RoP language as applicable. Please note that CMS has not issued its interpretative guidance for the new Requirements of Participation (RoP), therefore additional updates may be necessary once the guidance is released.

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## Suggested Checklist: Discharge Summary Policy and Procedure

Regulation	Recommended Actions
<p><b>§483.21(c)(2) Discharge Summary</b></p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:</p>	<p><input type="checkbox"/> Review and revise the discharge summary policy and procedure to ensure that the required components are included and given to the post-discharge provider and the resident at discharge.</p> <p><input type="checkbox"/> Review options for the discharge summary, or some portion of the information, to be written and printed from the clinical software. Include instructions for software use in the procedure.</p>
<p>(i) A recapitulation of the resident’s stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p>	<p><input type="checkbox"/> Review and revise the current procedure for documentation of a recapitulation of stay. The recapitulation must include:</p> <ul style="list-style-type: none"> <li>• The resident’s diagnoses at admission and at discharge</li> <li>• The course of illness or description of the resident’s progress through their stay at the facility</li> <li>• Pertinent labs, x-rays and consultation reports</li> </ul> <p><input type="checkbox"/> Define who is responsible for writing the recapitulation of stay and when the document must be completed in reference to the resident’s date of discharge.</p> <p><input type="checkbox"/> Provide education about the recapitulation of stay to appropriate staff.</p> <p><input type="checkbox"/> Identify where the recapitulation of stay will be stored in the resident’s medical record.</p> <p><input type="checkbox"/> Initiate a monitoring system to ensure that the recapitulation of stay is complete and timely.</p>

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<p>(ii) A final summary of the resident’s status to include items in paragraph (b)(1) of § 483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident’s representative.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review and revise the current procedure for completion of a final discharge summary.</li> <li><input type="checkbox"/> Review and revise the facility policy and procedure for obtaining the consent of the resident to release the final discharge summary to post-discharge providers and the method for recording to whom and when the document was released.</li> <li><input type="checkbox"/> Refer to Post Discharge Plan of Care for additional documentation requirements.</li> </ul>
<p>(iii) Reconciliation of all pre-discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter).</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review and revise the current procedure for pre and post discharge medication reconciliation.</li> <li><input type="checkbox"/> Define steps to take if the reconciliation finds inconsistencies.</li> <li><input type="checkbox"/> Identify how the reconciliation will be documented in the resident’s medical record.</li> <li><input type="checkbox"/> Educate the nurses about the procedure for pre and post discharge medication reconciliation and documentation of the process.</li> <li><input type="checkbox"/> Implement a monitoring system to ensure that the reconciliation of medications is completed and is timely.</li> </ul>
<p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident’s consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review and revise the current procedure for development of a resident’s post-discharge plan of care.</li> <li><input type="checkbox"/> Ensure that the post-discharge plan of care includes               <ul style="list-style-type: none"> <li>• the location where the resident will live</li> </ul> </li> </ul>

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Regulation	Recommended Actions
resident's follow up care and any post-discharge medical and non-medical services.	<ul style="list-style-type: none"><li>• arrangements made for follow-up care</li><li>• arrangements made for medical services</li><li>• arrangements made for non-medical services</li><li>•</li></ul> <p><input type="checkbox"/> Review the process for including the resident and representative in development of the discharge plan of care.</p> <p><input type="checkbox"/> Review and revise the document(s) provided to the resident and the representative at the time of discharge.</p> <p><input type="checkbox"/> Provide education about the discharge plan of care to all staff involved in the discharge process. Consider education for the social worker, nurse leaders, staff nurses, unit clerk and medical records staff.</p> <p><input type="checkbox"/> Identify standards for the completion timeframe of the post-discharge plan of care in relation to the resident's day of discharge.</p> <p><input type="checkbox"/> Develop and implement a monitoring system to ensure that the post-discharge plan of care is complete and timely and provided to the post-discharge care provider and resident/representative.</p>



The below areas serves as a cross reference for facility leaders to conduct addition policy and procedure review across departments to incorporate the changes set forth in **§483.21(c)(2) Discharge Summary**. This listing is not all encompassing however should serve as a resource for leaders as they update their internal policies, procedures and operational processes.

Cross Reference: (additional areas for review)

- Resident Rights
- Resident Postings
- CMS Definitions
- Admission Agreement
- Admission Policy
- Resident Education
- Resident Representative Education
- Transitions of Care Policies and Procedures
- Admission, transfer, discharge policies and procedures
- Change of Condition policies and procedures
- Notification policies and procedures
- Individualize Resident Assessment policies and procedures
- Comprehensive Person Centered Care Plan policies and procedures
- Physician Policies
- Medical Director Policies
- Resident Care Policies
- Hospital Transfer Agreements
- Medical Records and Retention
- Employee Orientation
- Annual Training Requirements
- Quality Assurance and Performance Improvement

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