

Discharge Summary Policy and Procedure

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DISCHARGE SUMMARY FACILITY POLICY

POLICY

It is the policy of this facility that residents who have a planned discharge from the facility will have a completed discharge plan and recapitulation of stay completed to facilitate continuity of care after discharge. Post-discharge continuity of care is well known to improve health outcomes for discharged residents and to help prevent readmissions to the hospital. While the healthcare system searches for a computer-based solution to information sharing challenges, facilities must continue to provide relevant information about discharging residents to their care providers and to the residents and representatives.

A comprehensive discharge summary will describe for the next provider the resident's course of stay, medical conditions and diagnoses, the results of relevant laboratory and other diagnostic testing completed in the facility, consultations completed in the facility and medications prescribed at discharge. A Discharge Plan of Care (Reference "*insert facility name of Discharge Plan of Care Policy*") is the second critical element of continuing care documents and is addressed in a separate document. When written in layman's terms, the discharge summary and plan of care can also be used by the resident and care givers at home to deliver the proper care and identify when to call the community health care provider about changes or progress.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - DEFINITIONS

Resident representative. For purposes of this subpart, the term resident representative means any of the following:

- (1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
- (2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
- (3) Legal representative, as used in section 712 of the Older Americans Act; or.
- (4) The court-appointed guardian or conservator of a resident.
- (5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.



“Anticipates” means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition) or due to the resident’s death.

Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician’s admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points¹ (Reference - Institute for Health Care Improvement Medication Reconciliation to Prevent Adverse Drug Events)

OBJECTIVE OF THE DISCHARGE SUMMARY POLICY

The objective of the discharge summary policy and procedure is to provide a framework for the completion of relevant documents to be shared with post-discharge health care organization, care providers, the resident and the care givers at home.

OVERVIEW OF COMPONENTS OF THE POLICY FROM THE REGULATIONS

§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 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.

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PROCEDURE FOR DISCHARGE SUMMARY

PURPOSE

The facility shall prepare and provide a discharge summary including a recapitulation of stay and reconciliation of pre and post-discharge medications, with the resident's consent, with the people and agencies providing care to the resident after discharge and with the resident. The final discharge summary will include a separate discharge plan of care which will assist post-discharge care providers and the resident in the transition of care process. See the facility Discharge Plan of Care protocols for reference. *(insert facility specific Discharge Plan of Care policy information here)*

PROCEDURE

1. Upon decision of discharge from the facility, the interdisciplinary team (IDT) will communicate regularly with the resident and the representative about the resident's preferences for discharge and necessary steps for the appropriate transition of care.
 - a. Communication regarding discharge plan and coordination will begin at the time of the resident's admission to the facility.
 - b. Frequency of ongoing communication about discharge planning will be determined by the resident's preferences, the resident's progress toward discharge goals and the complexity of the needed discharge plan.
 - a. At a minimum the individualized resident discharge plan will be reviewed during the comprehensive care plan process with the resident and resident representative.
2. When the resident nears their discharge goals, the interdisciplinary team will gather the information needed for post-discharge care and complete a discharge summary. Each member of the interdisciplinary team involved in the resident's care will contribute to the summary. ***(Insert facility specific process)*** The summary will include, but is not limited to, the following components:
 - a. Reason for the transfer or discharge
 - a. Document the reason for transfer or discharge and disposition location
 - b. If the entity to which the resident is being discharged is another skilled nursing facility, evaluate the extent to which the discharge summary and

the resident's physician verify the discharge

- b. Recapitulation of stay which that includes, but is not limited to, the following:
 1. The resident's diagnoses and conditions
 2. The course of their illness and treatment in the facility
 - i. Identify follow-up care and post-discharge medical and non-medical services as identified in the Discharge Plan
 3. Pertinent lab
 4. Other diagnostic test and results
 5. Documented consultations
 6. Physician verification for discharge and/or transfer
 7. If a return to the community, identify if the resident triggered the CAA for return to community referral
 8. Other pertinent information for continuing care, which includes:
 - i. ***(Insert facility specific information listed here based upon facility Discharge Summary tool)***
 - ii.
 - c. Medication reconciliation will be completed comparing pre-discharge and post-discharge medications, including over the counter and prescribed medications.
 1. Provide listing of medications per order, correlating diagnosis and education as indicated
 2. Notify the attending provider for clarification of medication orders if there are discrepancies identified in the reconciliation, prior to releasing post-discharge medication information.
- 4. *Insert steps for accessing and using the facility's electronic health record software as part of the discharge summary***
5. The final discharge summary will be completed and ready to release to post-discharge care providers and the resident before the day of discharge.
 - a. Share the discharge summary with the community physician who will be caring for the resident after discharge as well as agencies and other providers as needed.
 - b. The resident will consent to release of the final discharge summary to post-



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discharge care givers.

- c. Document the resident's consent in the medical record
 - d. Record the documents released to post-discharge care providers and the date of release.
6. Retain the discharge summary in the resident's medical record.

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REFERENCES

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities 10/04/16:

- <https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

CMS Memo Ref: S&C 17-07-NH: Advance Copy – Revisions to State Operations Manual (SOM), Appendix PP- Revised Regulations and Tags, 11/09/16:

- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-07.pdf>

Institute for Healthcare Improvement: Medication Reconciliation to Prevent Adverse Drug Events

- <http://www.ihl.org/topics/adesmedicationreconciliation/Pages/default.aspx>