Discharge Care Plan Policy and Procedure

State logo added here. If not, delete text box

DISCHARGE CARE PLAN FACILITY POLICY

PREFACE

This facility promotes and supports a resident centered approach to care. The purpose of this policy is to define and set expectations regarding discharge care planning in the facility to ensure that the process is conducted with the resident and/or resident representative as active partners, focusing on the resident's goals and preparation, as well as coordination with the interdisciplinary team and the comprehensive assessment, to prepare the resident for person-centered care following discharge.

POLICY

It is the policy of this facility that residents will be assessed for their discharge goals, preferences and care needs to meet their goals. The assessment information will be used to develop a comprehensive discharge care plan. The resident will be re-evaluated periodically to identify changes and the discharge care plan will be modified to reflect any changes. The care plan will be developed by the interdisciplinary team, including the resident's physician, a registered nurse with responsible for the resident, a nurse aide responsible for the resident, other staff or professionals in disciplines determined by the resident's needs or requested by the resident, a member of the nutrition services staff and to the extent practicable, the resident and their representative. The resident will be periodically reassessed to identify changes that require modification of the discharge plans and update the plans as needed. The resident and representative will be provided with the final discharge care plan.

CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - DEFINITIONS

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

"Adjust to his or her living environment" means that the post-discharge plan, as appropriate, should describe the resident's and family's preferences for care, how the resident and family will access these services, and how care should be coordinated if continuing treatment involves multiple caregivers. It should identify specific resident needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe resident/caregiver education needs and ability to meet care needs after discharge.

"Discharge potential" refers to the facility's expectation of discharging the resident from the facility within the next 3 months.

"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.

"Transfer and discharge" includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

"Sufficient preparation" means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence

OBJECTIVE OF THE DISCHARGE PLAN FACILITY POLICY

The objective of the discharge plan policy and procedure is to provide a framework for the completion of relevant documents by the IDT and the residents and representative that will inform the discharge process and assist the resident to reach their discharge goals(s).

OVERVIEW OF REGULATORY COMPONENTS OF THE POLICY

§ 483.20 Resident assessment.

(1) ***Resident assessment instrument.*** A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(xvi) Discharge planning.

(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts

(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§ 483.21 Comprehensive person-centered care planning.

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section

(2) A comprehensive care plan must be—

(ii) Prepared by an interdisciplinary team, that includes but is not limited to—

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

(c) ***Discharge planning*** **- 1)** ***Discharge planning process.***

The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at § 483.15(b) as applicable and—

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(iii) Involve the interdisciplinary team, as defined by § 483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative.

All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

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

(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.

***§483.15* (c)(7) Orientation for *t*ransfer or *d*ischarge.**

A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

PROCEDURE FOR DEVELOPMENT OF A DISCHARGE CARE PLAN

PURPOSE

The interdisciplinary team shall prepare a comprehensive discharge care plan with the resident and resident representative to assist the resident to reach their discharge goal.

PROCEDURE

1. **Admission and Assessment**
    a. As part of the comprehensive admission assessment, the Interdisciplinary Team (IDT) will identify the resident's desire and preferences for discharge. Based on the comprehensive assessment of the resident, a comprehensive discharge plan will be developed.
        a. The IDT will consist of
        b. The resident's physician
        c. A RN with responsibility for the resident
        d. A nurse aide with responsibility for the resident
            i. Nurse aide input for a resident's discharge plan will be documented in the medical record and included in the development of the resident's care plan.
        e. A member of the nutrition services staff
        f. Other professionals based on the resident's needs and at the resident's request
        g. The resident and representative

    b. Assessment

    Upon admission to the facility and on an ongoing basis, resident will be evaluated based upon a comprehensive assessment and resident choice for discharge from the facility. An assessment will include:
        a. Medical condition/Diagnoses

b. Functional Status
c. Cognitive Status
d. Medications
e. Treatments
f. Support Services for Care following Discharge
g. Resident's goals and treatment preferences
h. Resident's desire and preference for discharge
i. Post discharge location (if known)
j. Availability, capability and capacity of caregiver/support person
k. The resident and representative's education and skills needed for post-discharge
l. The feasibility of discharge for the resident
m. Risk factors for preventable re-hospitalization
n. Need for referral to local contact agency/ advocacy agency
o. PASARR recommendations

2. **Comprehensive Care Plan – Discharge Plan**

A person-centered discharge care plan will be put in place to address:

a. Resident desires and choices
b. Resident Representative involvement
c. Teaching with Resident/resident representative and Care Giver Support Needs
d. Medical Condition
    i. Diagnosis
    ii. Signs and Symptoms and when to notify physician
    iii. Specific care related to medical condition(s)
    iv. Lab and radiology testing and explanation of results
e. Medications
    i. Reason for Medication
    ii. Common side effects
    iii. Dose, time of day, duration, route
    iv. Return Demonstration and Evidence of Understanding
f. Treatments
    i. Reason for Treatment
    ii. Training on specific treatment
    iii. Return Demonstration and Evidence of Understanding
g. Functional Needs

i. Resident specific ADL training
ii. Return Demonstration and Evidence of Understanding

h. Advance Directives
i. Supplies and Durable Medical Equipment
j. Urgent/Emergency contacts
k. Follow up Appointments (including transportation)

3. Comprehensive Care Plan – Discharge Plan Update

a. The Interdisciplinary Team will re-evaluate the Discharge Care Plan on a regular basis at a minimum via the RAI process or more often as needed, with the resident and resident representative, to identify any need for modifications and will update the plan of care to reflect changes

4. **Discharge**

a. If the resident is being discharged to a lower level of care within the facility, the facility will document the discharge plan and approaches as developed via the comprehensive care planning process (See Discharge Transfer Policy).

b. If the resident desires returning to the community, document any referrals to Local Contact Agencies or other appropriate entities for the purpose of discharge (if applicable).

c. Update the resident's comprehensive care plan and discharge plan (if applicable) with any information received form referrals to local contact agencies or other appropriate entities.

d. If a resident is planning to be discharged to another Skilled Nursing Facility, Home Health Agency, Inpatient Rehab Facility, Assisted Living, or a Long Term Care Hospital, assist resident and resident representative in selection of a post-acute care provider using standardized data on quality measures and data on resource use as available.

a. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

5. Documentation

a. The resident needs and discharge plan must be documented in the medical record. If discharge to the community is determined to not be feasible, document who made the determination and reason.

b. The resident and resident representative will be informed of the final discharge plan. Proper Notice of Discharge will be provided per Discharge Transfer Policy and Procedure *(Insert Facility Specific information here)*

c. An evaluation of the residents discharge needs will be documented in the resident record on a timely basis. The results of this evaluation will be discussed with the resident or resident representative.

a. Relevant resident information will be incorporated into the discharge plan to facilitate implementation and avoid unnecessary delays in resident discharge or transfer.

d. The Discharge Care Plan as part of the comprehensive care plan and correlating documentation will be maintained in the medical record per policy

6. **Orientation for transfer/discharge**

The facility will provide the resident with sufficient preparation and orientation to the upcoming discharge to ensure that the discharge is safe and orderly. The orientation will be provided to the resident and resident representative in a form and manner that can be understood.

a. The resident will be provided with information about where he/she is going.

b. The facility will work with the resident and family to ensure that valued possessions are not left behind

c. The facility will coordinate with the financial departments to ensure the transition of resident funds to the appropriate entities. Funds will be transferred at the time of discharge

d. The facility will orient the staff in the receiving facility about the care needs of the resident, the daily patterns and preferences

e. The facility will minimize unnecessary and avoidable anxiety or depression for the discharging resident.

f. The facility will provide the appropriate education related to medication, treatments, medical care and services, psychosocial needs, care interventions and approaches and other applicable approaches for a safe care transition

7. Information for the Receiving Provider

The facility will share relevant information with the post-discharge care provider, including:

a. The resident's primary care physician and other consulting practitioners as well as their respective and contact information
b. The resident representative's contact information
c. The resident's Advance Directives
d. All special instructions or precautions and for ongoing care as appropriate
e. The resident's comprehensive care plan goals
f. A copy of the discharge summary
g. Any other necessary or relevant information or documentations to facilitate safe and effective transition of care
h. (Insert facility and state specific requirements here)

8. Discharge Summary

a. A discharge summary will be completed upon discharge to include:
    a. A recapitulation of the residents stay in the facility (diagnoses, course of illness/treatment, therapy, lab, radiology and consultation reports
    b. A final summary of resident status
    c. Medication reconciliation
    d. A post-discharge plan of care developed with the resident and resident representative
        i. Location/Agency/Facility where resident will reside
        ii. Arrangements for care, medications and services post-discharge
        iii. Arrangements for follow up communication post-discharge

9. Discharge Follow Up Process

a. Upon discharge (internally or externally), social services or designee will complete follow up calls or visits with the resident, resident representative and receiving location (insert facility and state specific information here) for an appropriate transition of care.
b. If areas of additional care coordination are needed, the facility representative and applicable team members will assist in the care coordination process. (insert transition of care policy information here)
c. Documentation of discharge follow up will be completed per policy. (insert transition of care policy information here)

Cross Referenced Policies and Procedures

Admission
Transfer Discharge Process
Discharge Summary
PASARR
Transition of Care

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

State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities, 06/10/16:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

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
www.ihi.org/topics/adesmedicationreconciliation/Pages/default.aspx