Discharge Care Plan Policy and Procedure

Interdisciplinary Team Training

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Discharge Care Plan

Objectives

- Obtain a basic understanding of the updates in regulations related to the discharge care plan to include: assessment, care planning, coordination of care, notifications and documentation.
- Review the Discharge Care Plan Policy and Procedure

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Introduction

- The nursing home Requirements of Participation (RoP) are the regulations that set minimum standards for nursing homes.
- The RoP were rewritten in October 2016.
- The changes in regulations go into effect over the next three years, in phases.

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Overview of the Regulation

§ 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.

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Overview of the Regulation

§ 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

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Overview of the Regulation

§ 483.21(c)(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.

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Overview of the Regulation

- (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.

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Overview of the Regulation

§483.21(c)(2) Discharge Summary

When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

- A recapitulation of the resident stay
- A final summary of resident status
- Medication Reconciliation

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Overview of the Regulation

§483.15(c)(7) Orientation for transfer or discharge.

- 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.

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Procedure

- Comprehensive admission assessment
  - 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.

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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.

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Discharge Plan

- Resident desires and choices
- Resident Representative involvement
- Teaching with Resident/Resident Representative and Care Giver Support Needs
- Medical Condition
- Medications
- Treatments
- Functional Needs
- Advance Directives
- Supplies and Durable Medical Equipment
- Urgent/Emergency Contacts
- Follow up Appointments (including transportation

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Procedure

- 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).
- 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.

Documentation

- 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.
- Document resident and resident representative notification of the final discharge plan
- The Discharge Care Plan needs to be maintained in the medical record

Orientation

- Resident
  - Resident Representative
  - Form and Manner of Understanding
  - Education
- Receiving Entity
  - Information needed
  - Transition of Care process
- Signs and Symptoms of Relocation Stress

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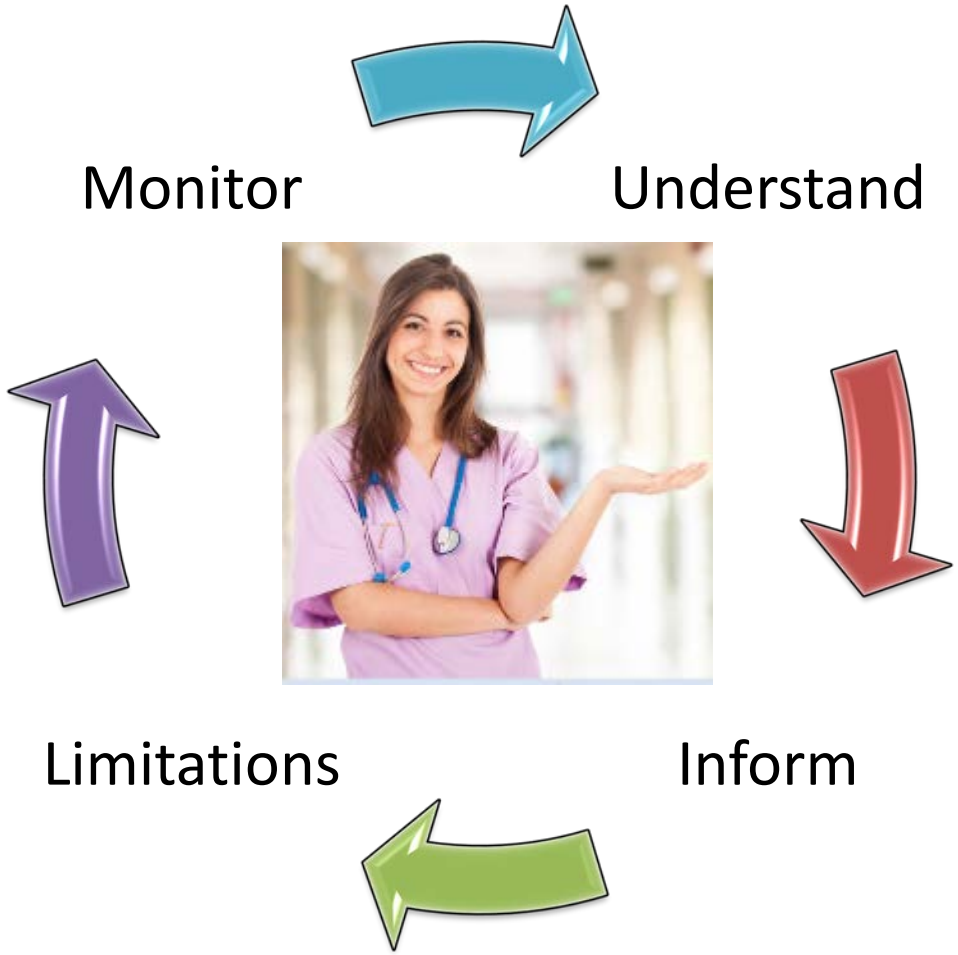
Facility Response

- Understand
- Inform
- Limitations
- Monitor



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Understand –Assessment Process for Discharge Care Plan

Assessment process includes:

- History and Physical
- Preadmission information
- Resident choice/preferences
- RAI Process (MDS, CAA's, Care Plan)
- Facility Ancillary Assessments

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Understand – 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.

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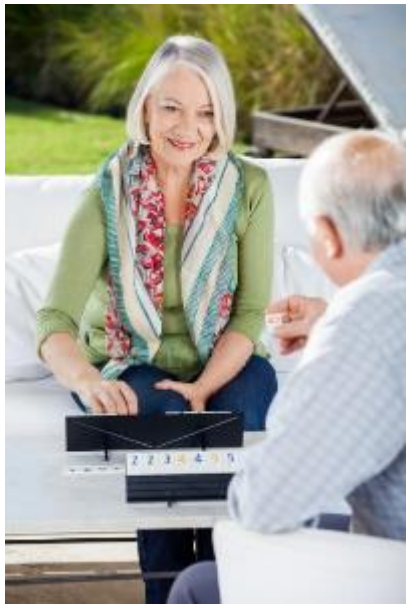
Understand – Definitions

“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



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Understand – Definitions

“Discharge potential” refers to the facility’s expectation of discharging the resident from the facility within the next 3 months.

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Understand - Definitions

“Resident representative”

- (1) An individual chosen by the resident to act on behalf of the resident
- (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
- (3) Legal representative
- (4) The court-appointed guardian or conservator of a resident

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Understand - Definitions

- **“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

Inform – Communication

- Resident
- Resident Representative
- Front line staff
- Interdisciplinary Team
- Physician
- Referral's to Local Contact Agencies
- Other entities as indicated with consent (i.e. home health agency, etc.)

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Inform-Communication

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Limitation or Obstacle

EXAMPLES:

- Resident desires to be discharged home and has not progressed to goal
- Resident is unable to perform return demonstration for medications, treatment and health care needs

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Monitor – Discharge Follow Up

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Monitor

- Admission Process
- Social Service Assessment
- Nursing Documentation
- MDS 3.0 RAI Process
- Observations
- Re-evaluation
- QAPI

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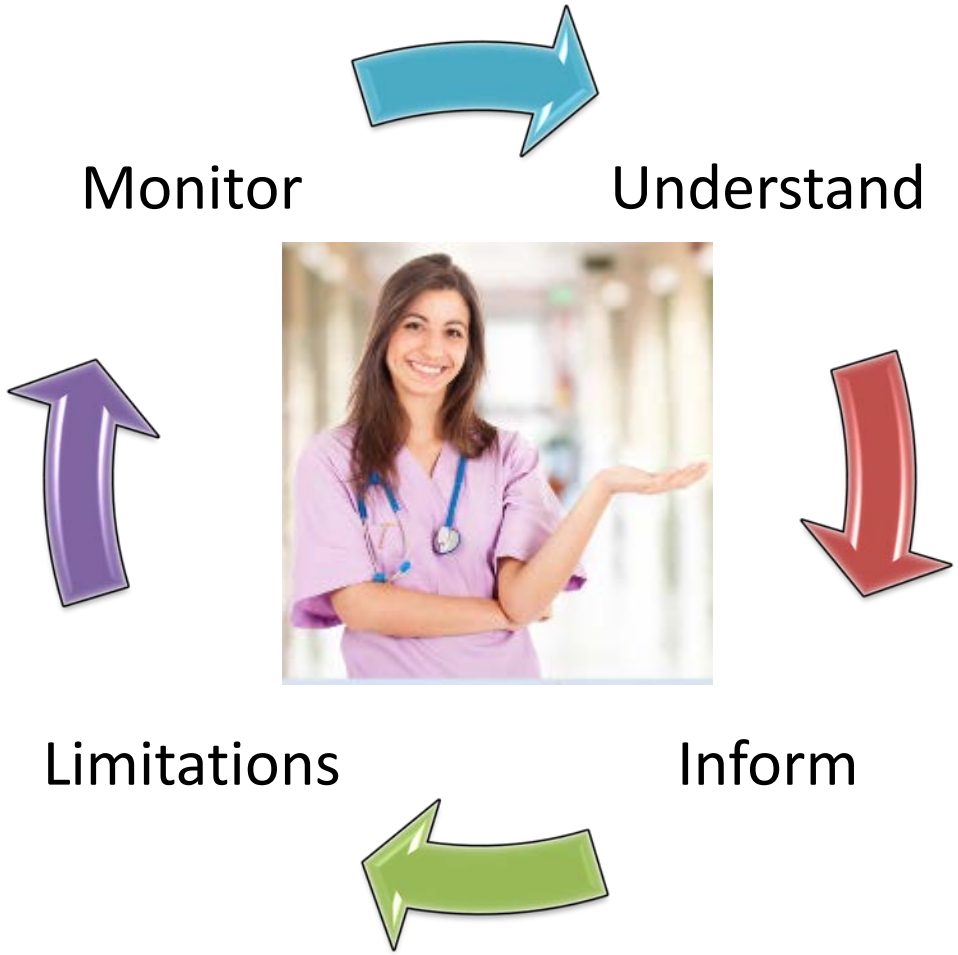
Summary

- Understand
- Inform
- Limitations
- Monitor



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Questions?

Resources:

- 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
-
- CMS, MDS 3.0 RAI Manual:
- https://www.cms.gov/Medicare/Quality-Initiatives-patient-assessment-instruments/NursingHomeQualityInits/MDS30RAIManual.html

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THANK YOU FOR PARTICIPATING IN THIS EDUCATION SESSION!

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