**Appropriate Resident Discharges**

# Date Implemented:

**Review/Update Dates:**

# Policy

In order to maintain the resident’s overall health and wellbeing, **[Enter Provider Name]** will ensure that all residents receive appropriate discharge planning, preparation, and services upon discharge. Resident discharges will incorporate the resident, responsible party, designated caregivers, and any others according to the resident’s preferences. Discharge planning begins on the day the resident is admitted and includes the resident’s desires for discharge.

# Purpose

Provide guidance to interdisciplinary staff members who assist with discharge planning for residents on appropriate discharge procedures.

**Definitions:**

**Discharge Planning** is a process that generally begins on admission and involves identifying each resident’s discharge goals and needs, developing and implementing interventions to address them, and continuously evaluate them throughout the resident’s stay to ensure a successful discharge.

**Home Health Agency** is a public or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services in the resident’s home and meets the requirements of the Social Security Act.

**Transfer and Discharge** includes movement of a resident to a bed outside of the certified nursing home 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 nursing home. Specifically, transfer refers to the movement of a resident from a bed in one nursing home to a bed in another nursing home when the resident expects to return to the original nursing home. Discharge refers to the movement of a resident from a bed in one certified nursing home to a bed in another nursing home or other location in the community when return to the original nursing home is not expected.

**Procedures**

**[Enter Provider Name]** will permit residents to remain in the nursing home and not transfer or discharge them unless –

1. The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met at the nursing home. The residents’ needs will be determined at the time the discharge or transfer notice is issued. If a resident is currently at a hospital seeking treatment for a medical/mental condition, the resident’s needs will be evaluated when the hospital determines the resident is appropriate for discharge.
2. The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the nursing home. Documentation in the resident’s medical record will support the improvement in the resident’s condition such as improvement in functional status and/or stabilized medical conditions.
3. The safety of individuals in the nursing home is endangered due to the clinical or behavioral status of the resident.
4. The health of individuals in the nursing home would otherwise be endangered.
	1. If the resident is transferred to the hospital for treatment due to a condition that places other individual’s health or safety at risk, their status will be assessed when the hospital determines the resident is appropriate for discharge to determine if other resident’s remain at risk.
5. The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Medicare or Medicaid). Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. If the resident becomes eligible for Medicaid after admission, the nursing home may only charge the allowable charges under the Medicaid plan. The resident’s record will contain sufficient documentation of attempts and support the nursing home provided to assist the resident in paying for their stay.
6. The nursing home ceases operating. (See Nursing Home Closure policy).

If the resident or their representative appeals the discharge or transfer, **[Enter Provider Name]** will not discharge the resident until a decision is rendered unless the failure to discharge the resident will endanger the health or safety of other residents. The resident’s medical record will contain sufficient documentation identifying how the failure to discharge will place other residents in danger.

At a minimum, documentation supporting the transfer or discharge will include but not limited to:

1. The basis for the transfer.
2. Specific needs that cannot be met and the service available at the receiving provider that will accommodate the need.
3. If the resident is transferred or discharged due to **[Enter Provider Name]** being unable to meet the needs of the resident or the resident’s condition has improved supporting documentation from the resident’s physician will be included.
4. If the resident is transferred or discharged to protect the health or safety of other individuals in the nursing home, a physician (not necessarily the resident’s personal physician) will document supporting evidence.

**[Enter Provider Name]** will provide the resident with preparation and orientation on the transfer or discharge in a form and manner the resident understands. This may include, but is not limited to:

1. If the resident is transferred on an emergency basis, the resident will be informed of their condition that is resulting in a transfer (such as the need to be evaluated in a hospital setting) and which hospital they will be transferring to. Support will be provided to the resident to help ease any possible anxiety.
2. If the resident is transferred to another nursing home, the resident’s preferences will be honored as much as possible. The nursing home will provide adequate records and information to ensure the receiving location can maintain continuity and safe care to the resident.
3. Upon admission to the nursing home, the resident will be asked about their desire to discharge from the nursing home. Their preferences will be incorporated into the comprehensive care plan. If the resident desires to transfer to a lower level of care, the interdisciplinary care team will conduct ongoing discharge planning meetings to identify the location the resident prefers to discharge to, progress towards reaching their discharge functional/medical goals, services that are available currently at the discharge location, identification of services that may be necessary in addition to what is provided, potential barriers to a successful discharge, and identifying a potential time frame as able. These meetings will include the resident’s representative, caregivers, and others that the resident would like to be present.
	1. If additional service providers are necessary for the resident’s discharge to be successful, the resident and/or their representative will be asked their preferences for providers (i.e. home health, hospice, therapy).
	2. Referrals will be made as appropriate to additional service providers and representatives included in the interdisciplinary care team to ensure a smooth discharge process.
	3. Interdisciplinary staff will determine if the resident needs assistance with arranging follow up appointments such as their primary care physician or specialists.
	4. Interdisciplinary staff will determine the resident’s preference for pharmacy services and ensure that accurate medications are available upon discharge.
	5. Teaching of resident needs will be conducted with the resident, responsible party, or caregivers as appropriate prior to discharge.
	6. If necessary or appropriate, the nursing home interdisciplinary team will refer residents to services that can assist with community placement such as residents with intellectual or mental disabilities.
	7. Adequate and appropriate information from the resident’s record will be provided to the resident upon discharge and/or service providers such as relevant laboratory reports, social determinants of health to coordinate care to other health care providers, care plans, medications, treatments, and any additional necessary information.

**[Enter Provider Name]** will ensure that residents are appropriately discharged. Inappropriate discharges may include discharges to a location that is unable to meet/provide the residents care needs, with a caregiver who is not trained to assist with cares as necessary, without adequate supplies such as medications, and without appropriate communication to receiving location.

A physician’s order will be obtained for all discharges and transfers.

See also policies and procedures on Bed Hold, Against Medical Advice Discharge, Involuntary Discharge

**Resources**

CMS. (18 Nov. 2024). *Revised Long-Term Care (LTC) Surveyor Guidance: Significant Revisions to Enhance Quality of Oversights of the LTC Survey Process or QSO-25-07-NH*. <https://www.cms.gov/files/document/revised-long-term-care-ltc-surveyor-guidance-significant-revisions-enhance-quality-and-oversights-ltc.pdf>