Discharge Planning Process

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Department of Health and Senior Services
Section for Long Term Care Regulation

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Discharge Planning

- **What is discharge planning?**
  - A process of identifying each resident's discharge goals and needs, and then developing and implementing interventions to ensure those goals and needs are met.
- **When does discharge planning start?**
  - Upon Admission
- **Why is discharge planning important?**
  - Ensure we know the resident goals related to discharge.
  - Identify any necessary support (caregiver, referral to local contact agencies, etc.) to meet those goals.
  - To provide education regarding post discharge care to prevent readmission and ensures resident safe transition home or to another care setting.

Meet Harriet

- Admitted from an acute care hospital
- History of falls at home
- Post hip fracture requiring surgical repair
- Diagnosis of bladder cancer with chronic pain
- Receives narcotic pain medication
- Indwelling catheter
- Physical Therapy discharging resident on Friday
- Upon discharge, plans to resume living with her daughter, who has an intellectual disability

Discharge Planning

- **Who should be included in the discharge planning process?**
  - Resident
  - Resident's representative
  - Physician
  - Nursing staff
  - Direct Care Staff
  - Dietician or nutrition staff
  - Anyone else determined by resident's needs (Home Care, Hospice, Ombudsman)or requested by the resident (primary caregiver, family)

Discharge Planning to Community

Identify the destination and ensure it meets the resident's health and safety needs

- What if the setting is unsafe but the resident is insistent that they are discharged:
  - Discuss risks and implications
  - Discuss and document more suitable location options
  - Document the resident's wishes
  - Determine if a referral to Home and Community is necessary (A/N hotline)

Discharge Planning to Community

Determine:

- **What will the resident need at home?**
  - The plan must include the identified needs and written plan to address them
- **Who will assist/support the resident once home?**
  - Consider caregiver/support person availability and capacity to provide required care

Discharge Planning to Community

Determine:

- **Who will coordinate services?**
  - Pharmacy services
  - Laboratory Services
  - Home Health Service
  - Discharge instructions/resident teaching

*The plan should include staff responsible for coordination of any planned services after discharge.

Plan ahead to prevent "Friday Night Discharge" pitfalls!

Discharge Planning to New Care Provider

- Assist the resident in choosing an appropriate care provider, by helping them find information to make an educated decision, such as:
  - Show Me Home Care and Rehab
  - Nursing Home Compare
  - Home Health Compare
  - Show Me Long Term Care

Discharge Planning

DOCUMENT!

DOCUMENT!

DOCUMENT!

Individualized Service Plan (ISP)
Minimum Data Set
Resident Record

Preparing a Discharge Summary

At the time of discharge, all certified SNFs must complete a discharge summary, which includes:

- A recap of the resident's stay
  - Describes the course of treatment while residing in the facility
  - Diagnosis, course of illness, treatment, and/or therapy, and pertinent lab, radiology, and consultation results, including pending lab results

Preparing a Discharge Summary

- A final summary of the resident's status, which includes information from the most recent comprehensive assessment, including:
  - Customary routine
  - Cognitive patterns
  - Communication
  - Vision
  - Mood and Behavior Patterns
  - Psychosocial well-being
  - Physical functioning and structural problems
  - Continence
  - Disease diagnosis and health conditions
  - Skin conditions
  - Activity pursuit
  - Medications
  - Special treatment and procedures

Preparing a Discharge Summary

- A reconciliation of medications
  - A resident's discharge medications may differ from the medications he/she took in the facility
  - If a discrepancy is found, assess and resolve
  - Ensure discharge instructions and accompanying prescriptions accurately reflect the reconciled medication list in the discharge summary

Preparing a Discharge Summary

- Create a post-discharge plan of care
  - Developed by the resident and/or representative, and the ID team
  - Include arrangements facility has made to address the resident's needs after discharge
  - Include instructions given to the resident and/or representative, in a manner they are able to understand

Preparing a Discharge Summary

- Post-Discharge Plan of Care (cont.)
  - Post Discharge Plan of Care should include:
    - Where the resident will live
    - Follow-up care the resident will receive
    - Needed medical and non-medical services
    - Community care and support services
    - When and how to contact the continuing care provider (document if efforts to assist the resident in locating a continuing care provider are unsuccessful

Preparing a Discharge Summary

- In addition, the facility must provide the following information to the receiving provider:
  - Contact information of the practitioner for the care of the resident
  - Resident representative information, if applicable, including contact information
  - Advance Directive information
  - All special instructions or precautions for ongoing care, as appropriate
  - Comprehensive care plan goals
  - All other necessary information, including a copy of the resident's discharge summary, and any other information for a smooth transition of care

What Can Go Wrong?

- Harriet- Discharged home without pain medication and no continuing care provider. Admitted to hospital to obtain necessary medication.
- Discharged to another facility without current orders for Coumadin and PT/INR monitoring.
- Resident discharged home with a manual lift and her primary care giver was 9 months pregnant and not able to operate the lift.
- Resident discharged home and primary caregiver had dementia and unable to care for the resident.
- Resident discharged home in wheelchair and home had 12 steps to get inside.
- Resident discharged home with no support system in place to provide basic care, outside what home health is able to provide.

Discharge Planning Regulations

CMS - F660 and F661
MO CSR - 19 CSR 30-85.042 (16) SNF
- 19 CSR 30-85.042 (58) SNF
- 19 CSR 30-86.047 (12) ALF
- 19 CSR 30-86.047 (31) ALF
- 19 CSR 30-86.047 (44) ALF
- 19 CSR 30-86.047 (56) (C) ALF
- 19 CSR 30-86.043 (49) RCF

- Knowing Act or Omission of Duty

Discharge Planning and Summary Wrap-Up

Questions?

Hospice Service Requirements

- A long term care facility can either:
  - Arrange for hospice services through an agreement with one or more hospices, or
  - Not. If not, the facility must assist the resident in transferring to a facility that will arrange for hospice services.

Hospice Service Requirements

If hospice services are provided, the facility must:

- Have a written agreement that addresses:
  - The services provided by hospice
  - The services provided by the facility
  - Process for communicating between hospice and the facility
  - A provision that the LTC facility immediately notifies the hospice about the following:
    - A significant change in the status.
    - A need to alter the plan of care.
    - A need to transfer the resident from the facility.
    - The resident's death.

Hospice Service Requirements

- Facility must designate a person to work with hospice representatives to coordinate care for the resident.
  - The designee must have a clinical background and be able to assess the resident or have access to someone that has the skills.
- Facility must ensure that each resident's written plan of care includes the most recent hospice plan of care, and a description of the services furnished by the facility.

Hospice Service Requirements

- Coordinated Plan of Care
  - Created by the facility and hospice, through collaboration
  - Clearly shows what care needs to be completed by hospice and what care will be the facility's responsibility
  - Include how the plan will be coordinated between the hospice and the facility

Hospice Service Requirements

- The coordinated plan of care should reflect:
  - Diagnoses;
  - Common Problem List;
  - Palliative interventions;
  - Palliative goals/objectives;
  - Responsible disciplines;
  - Responsible providers;
  - Resident choices regarding care and goals.

Hospice Service Requirements

- Surveying for compliance
  - Requested during Entrance Conference
    - Identification of residents receiving hospice services
    - Facility policy and procedures
    - Written agreements between facility and Hospice provider(s)
  - Residents receiving hospice services will be selected as part of the sample

Hospice Service Requirements

CMS - F849- Hospice Services

SNF- Contract with outside resources- 19 CSR 30-85.042 (6) and (7)

RCF and ALF- Promptly referred to outside resources or discharged

- 19 CSR 30-86.042 (30) RCF
- 19 CSR 30-86.043 (27) RCF**
- 19 CSR 30-86.047 (10) ALF

Hospice services

- 19 CSR 30-86.047 (30) ALF

Questions?
Situations?
Experiences?