Tool: Discharge Planning Process – 483.21(c)(1)

Purpose & Intent 483.21(c)(1): To develop a discharge plan to help as many residents who want to return back to the community, to be effectively discharged from the nursing center back to the community.

To assure that the Center has followed all the required steps in the discharge planning process, AHCA staff recommend you use a checklist for each resident and keep a record to show the survey team should they ask how you assure each resident has a discharge plan developed in accordance with the new Requirements of Participation (RoP). The actual RoP language outlining the process is at the end of this Tool.

The checklist below captures the required steps broken down into (A) develop a discharge plan and (B) process for discharging a resident from the Center. You may want to customize or add additional steps, but this is intended to meet the requirements. However, please note that CMS has not yet issued its interpretative guidance for this new RoP. When they do, some of the items on this checklist may need to be updated.

The MAJOR required steps in the discharge planning process are:

- ✓ Create an interdisciplinary team which includes the resident
- ✓ Evaluate the resident's discharge potential and needs
- ✓ Document results of discharge plan
- ✓ Create a discharge plan (see below for required content)
- ✓ Update discharge plan
- ✓ Share discharge plan with the resident
- ✓ Prepare resident & their representative for discharge
- ✓ Document reason for discharge or transfer [see *AHCA Tool: Admission, Transfer, and Discharge Rights - 483.15(c)(1)*]
- ✓ Provide required information to [see *AHCA Tool: Information Accompanying Residents at Discharge or Transfer – 483.15(c)(2)*]
- ✓ Complete a discharge summary [see *AHCA Tool: Information Accompanying Residents at Discharge or Transfer – 483.15(c)(2)*]

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Suggested Checklist for Completing the Discharge Planning Process per Resident

When developing the DISCHARGE PLAN, were the following completed for each resident following admission to the Center?

- ☐ Involved an interdisciplinary team in discharge plan development, which must include the following:
  - The attending physician.
  - A registered nurse with responsibility for the resident.
  - A nurse aide with responsibility for the resident.
  - A member of food and nutrition services staff.
- ☐ Involved the resident and the resident's representative(s) in the development of the discharge plan.
  - If not, does the medical record document why their involvement was determined not practicable?
- ☐ Evaluate the resident's discharge needs:
  - Identified the discharge needs of the resident.
  - Identified the resident's goals of care and treatment preferences.
  - Assessed the caregiver/support person availability and the resident's or care-giver's/support person(s) capacity and capability to perform required care.
  - Ask the resident about their interest in receiving information regarding returning to the community:
    - If the resident indicates an interest in returning to the community, document referrals to local contact agencies or other appropriate entities.
    - If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
- ☐ Documented and dated in the clinical record:
  - How the resident was involved in discharge plan development.
  - The resident was asked about receiving information regarding return to the community.
  - The evaluation results of the resident's discharge needs and discharge plan.
  - The evaluation results were discussed with the resident or resident's representative.
- ☐ Discharge Plan as part of comprehensive care plan (see below for required content of plan and checklist to assure the discharge plan has all the required information).
  - Informed the resident and resident representative of the final plan.
- ☐ Update the Discharge Plan
  - Document and date the discharge plan when updated.
  - Was the discharge plan updated based on information received from referrals to local contact agencies or other appropriate entities?

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- ☐ Discharge/Transfer
  - Was resident (and/or representative) provided orientation about their discharge?
  - Was the resident informed of their rights prior to discharge/transfer (e.g. bed-hold policy, appeals, discharge/transfer arrangements)?
  - Was information on the quality of home health agency provided to the resident?
  - Was rationale for discharge documented in the medical record and signed by the physician?
- ☐ All the required information provided to the receiving health care organization or individual:
  - Was a discharge summary completed with all the required information?

Discharge Plan Content (Phase I)

The Discharge Plan must be included as part of the Comprehensive Care Plan. It needs to include information obtained during the required discharge planning process (see above).

Based on a review of the RoP from 483.21 and 483.15, AHCA staff suggest creating a template discharge plan that includes the following sections, which will help comply with information obtained when following the required discharge planning process.

Suggested Template for Discharge Plan Content

- ☐ Resident's goals of care and treatment preferences
- ☐ Resident's interest in being discharged or transferred
- ☐ Needs of the resident upon discharge
- ☐ Capacity of resident and caregivers to meet the needs of resident upon discharge/transfer
- ☐ Names of local referrals and agencies to provide services upon discharge/transfer
- ☐ Is discharge/transfer feasible (and who made this decision and why)
- ☐ Names of the interdisciplinary team involved in developing the discharge plan including at a minimum:
  - The attending physician
  - A registered nurse with responsibility for the resident
  - A nurse aide with responsibility for the resident
  - A member of food and nutrition services staff
- ☐ Documented and dated resident's involvement
  - How the resident was involved in discharge plan development
  - The resident's interest in receiving information regarding return to the community

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  - When the evaluation results were discussed with the resident or resident's representative
  - When the care plan was shared with the resident (and/or representative)

- ☐ Date when Discharge Plan was reviewed and updated

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Discharge Planning Process (Phase I)

(Actual RoP language)

The RoP language for 483.21(c)1 is as follows: The facility's discharge planning process must:

- ✓ Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
- ✓ 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.
- ✓ Involve the interdisciplinary team in the ongoing process of developing the discharge plan, which must include:
  - The attending physician.
  - A registered nurse with responsibility for the resident.
  - A nurse aide with responsibility for the resident.
  - A member of food and nutrition services staff.
  - 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.]
  - Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident.
- ✓ Consider caregiver/support person availability and the resident's or care-giver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
- ✓ Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
- ✓ Address the resident's goals of care and treatment preferences.
- ✓ Document that a resident has been asked about their interest in receiving information regarding returning to the community.
  - 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.
  - 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.
  - If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
- ✓ 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.
- ✓ 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

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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.

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