**Policy**: Discharge Planning

**Procedure**: On admission, the interdisciplinary team will assist the resident in developing a customary routine as well as identifying each resident’s discharge goals and needs. The facility will implement an effective discharge planning process that focuses on the resident’s discharge goals, evaluates these goals throughout the resident’s stay, 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 Discharge Planning process must include the following:**

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

2. 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.

3. Involve the interdisciplinary team in the ongoing process of developing the discharge plan.

4. Consider the availability as well as the capacity and capability of the caregiver/support person to perform required care, as part of the identification of discharge needs.

5. The resident and the resident representative will be involved in the development of the discharge plan and inform the resident and resident representative of the final plan.

6. Address the resident’s goals of care and treatment preferences.

7. 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 (Section Q of the MDS).

(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.

8. For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist resident and their resident representative 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.

(A) Identify needs that must be addressed before the resident can be discharged, such as resident education, rehabilitation, and caregiver support and education.

(B) Re-evaluate the plan regularly and updated when the resident’s needs or goals change.

9. 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.

**When the facility anticipates discharge, a resident must have a Discharge Summary that includes the following:**

1. A summary of the resident's stay that includes, but is not limited to:

(A) Diagnoses

(B) Course of treatment or therapy

(C) Pertinent lab / diagnostic results and consultation reports

(D) Resident/Resident representative education provided

2. A final summary of the resident's current status and discharge instructions from members of the Interdisciplinary team.

3. Reconciliation of all pre-discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter).

4. 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:

(A) Where the individual plans to reside,

(B) Follow up appointments and any arrangements that have been made for the resident’s follow up care.

(C) Post-discharge medical and nonmedical services.

5. Within 7 days of discharge, a designated member of the interdisciplinary team will conduct a follow up call to inquire about the resident’s current status and re-adjustment to the community/new facility.