# Discharge Planning and Assessments

| Highlights | Policy Statement |
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| | Facility will develop and implement an effective discharge planning process that focuses on the resident's goals, the preparation of residents to be active partners and effectively transition them to post-discharge care. |

## Policy Interpretation and Implementation

Facility Admission

1. Social Services or Designee will complete a **Discharge Planning Review** in Point Click Care prior to the first comprehensive assessment.

    a This form must be updated, as needed, to reflect any changes that may have occurred until discharge status is confirmed.

Return to Community

    b Social Services will communicate with the resident about their interest in receiving information regarding returning to the community. This communication must be documented in Point Click Care. In addition, if the resident indicates an interest in returning to the community, Social Services or Designee must document any referral to local contact agencies or other appropriate entities made for this purpose. The comprehensive care plan must also reflect the resident's response.

    c If discharge to the community is determined to not be feasible, Social Services or Designee must document who made the determination and why.

Discharge Summary and Plan

2. When the facility anticipates a resident's discharge to a private residence or another nursing care facility (i.e., skilled, intermediate care, ICF/MR, etc.), the following actions must be completed, which will assist the resident to adjust to his or her new living environment.

    a Medical records or Designee to obtain a discharge order from the physician.

    b Complete the following assessments in Point Click Care:

Comprehensive Discharge Instruction Form

        1. **Comprehensive Discharge Instruction Form** (Post Discharge Plan); and

Final Discharge Summary

        2. **Final Discharge Summary**

Content of the Discharge Summaries

3. These summaries will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's:

    a. Medically defined condition and prior medical history (medical history before entering the facility and current medical diagnoses, including any history of mental retardation and current mental illness);
    b. Medical status measurement (objective measurements of a resident's physical and mental abilities including, but not limited to, information on vital signs, clinical laboratory values, or diagnostic tests);
    c. Physical and mental functional status (ability to perform activities of daily living including bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, and other communication systems. Includes determining the resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities and the resident's ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day

activities of the facility);

d. Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence);
e. Nutritional status and requirements (weight, height, hematological and biochemical assessment, clinical observations of nutrition, nutritional intake, resident eating habits and preferences, and dietary restrictions);
f. Special treatments or procedures (treatments and procedures that are **not** part of basic services provided; for example, treatment for pressure sores, naso-gastric feedings, specialized rehabilitation services, and respiratory care);
g. Mental and psychosocial status (the resident's ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood);Discharge potential (the expectation of discharging the resident from the facility within the next three months);
h. Dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances);
i. Activities potential (the resident's ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being. Activity pursuits refer to any activity outside of ADLs which a person pursues in order to obtain a sense of well-being. Includes activities which provide benefits in the areas of self-esteem, pleasure, comfort, health education, creativity, success, and financial or emotional independence, and the resident's normal everyday routines and lifetime preferences);
j. Rehabilitation potential (the ability to improve independence in functional status through restorative care programs);
k. Cognitive status (the resident's ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and
l. Drug therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident).

Notice of Discharge

4. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge plan can be developed.

Responsibility of Social Services Department

5. The Social Services Department will review the plan with the resident and family twenty-four (24) hours before the discharge is to take place.

Availability of Discharge Summary and Plan

6. A copy of the Comprehensive Discharge Instruction Form must be signed by the appropriate individuals, and all pertinent information must be presented to the resident, including a reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

| **References** | |
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| **Related Documents** | Documentation of Transfers/Discharges (*Transfers and Discharges*) |
| **Policy Revised** | Date: **3-28-2017**<br>Date: **9-5-2019** |