

DISCHARGE PLANNING In the LONG TERM CARE SETTING Overview

REGULATIONS

Multiple federal and state regulations address discharge planning. Most notably are:

F 204 – Orientation for Transfer or Discharge

F 242 – Self- Determination

F 272 – Comprehensive Assessment

F 279 – Care plans

Additionally, the new MDS 3.0 places a great deal of emphasis on discharge planning, namely Section Q of the MDS 3.0 Assessment and #20 CAA -Care Area Assessment (previously known as RAPs) called Return to Community Referral.

Intent of the Return to Community Referral in MDS 3.0*

1. All individuals have the right to choose the services they receive and the settings in which they receive those services (American Disabilities Act 1990 and the Olmstead vs. L.C. US Supreme Court Decision of 1999).
2. An individual in a nursing home can choose to leave the facility at any time. An individual can request to someone about returning to the community at any time.
3. The return to community referral CAA focuses on residents who want to talk to someone about returning to the community and enables nursing home staff to directly open the discussion about the resident's preferences for service settings.
4. The discharge assessment process requires nursing home staff to apply a **systematic and objective protocol** so that every individual has the opportunity to access meaningful information about community living options and community service alternatives.

Expectations...

1. That the individual or surrogate is fully informed and involved in the discharge process,
2. Staff will identify the individual strengths,
3. Staff will assess risk factors,
4. Staff will implement a comprehensive resident-specific plan of care directed toward a successful discharge.
5. That rehabilitative programs will be instituted as needed,
6. Staff will foster the resident's independent functioning, and
7. Staff will utilize appropriate community referrals and health care agencies in the discharge process.

**Adapted from CMS Long-Term Care Resident Assessment Instrument, User's Manual, Version 3.0*

SUGGESTED SYSTEMATIC DISCHARGE PLANNING PROTOCOL

INITIAL CONSIDERATIONS

I. Predictors of Poor Post-Discharge Outcomes¹

- a. Age>80
- b. Multiple, active medical conditions
- c. Multiple hospitalizations in the past 6 months\
- d. Hospitalization in the past 30 days\
- e. History of depression
- f. Moderate-to-severe functional impairment
- g. Inadequate support system
- h. "Fair" to "Poor" self-rating of health status
- i. History of non-compliance

II. Premature Discharge can leave the Resident:²

1. with some unmet needs;
2. poorly prepared household;
3. with the likelihood of readmission (to hospital or nursing home);
4. using inappropriate or more costly services.

III. Protracted Length of Stay increases the Risk of:³

1. Infection or other negative outcome;
2. Depression/low mood;
3. Boredom, frustration;
4. Loss of independence and confidence, and
5. Financial resources or benefits being used inappropriately.

IV. Resident Choice

- Resident "choice" differs from "consent. "Consent" is the granting of permission. "Choice" is selecting from available and appropriate options.⁴

V. Discharge Planning must be applied equably to all and follow a specific process

- All healthcare disciplines involved in the resident's care should be involved in discharge planning.
- Distinct timelines need to be established for a) implementation of the internal care and services focused towards discharge and b) feedback on the resident's progress.
- Disciplines and the resident/family may need to meet frequently to discuss progress.
- Use of checklists, algorithms, or care maps are helpful in maintaining a systematic approach to discharge planning.

VI. The Discharge Planner serves as the Resident's Advocate in the Discharge Process

¹ Green, A MD and Lyons B MD, Discharge Planning for the Geriatric Patient: Pearls and Pitfalls, University of California San Francisco Academic Geriatric Resource Center. Retrieved June 24, 2009, from http://www.ucop.edu/aprg/docs/sf_displan.ppt.

² Department of Health, United Kingdom. (2010, February) *Ready to Go?* Planning the discharge and transfer of patients from hospital and intermediate care. pg 4. Retrieved June 24, 2010 from <http://www.npci.org.uk/blog?p=1354>

³ Ibid

⁴ Birmingham, J. (2009). Patient Choice in the Discharge Planning Process. *Professional Case Management*, 14(6) 296-309. Retrieved June 24, 2010 from <http://www.nursingcenter.com/library/JournalArticle.asp?article>.

10 KEY PRACTICES for DISCHARGE PLANNING

#1. Discharge Planning begins on Admission to the Facility

- Is there a clear goal of returning home or lesser level of care? REMEMBER: Most want to go back home. Is that realistic? Too early to know? Is the family in agreement?
- Are care processes in place to support and encourage the resident's wishes?
- Are practitioners (MDs, nurses, therapist, dieticians) clear about their roles and contributions towards a discharge goal?

#2. Determine if the Resident has Simple or Complex Discharge Planning Needs

- Simple = can return home with minimal support.
- Complex = requires multiple professional resources and community agencies to maintain self in home or residential care setting and willing require extensive planning

#3. Develop an initial Clinical Plan of Care within 24 Hours of Admission

- Isolate key care/needs areas that should be addressed early to prevent negative outcomes and "jump-start" progress towards discharge.
- Develop person-centered immediate needs plan of care

#4. Co-ordinate the Discharge Plan with Those Responsible for the Resident's Care

- Ensure that one person takes charge of monitoring the resident's progress.
- Communicate with all departments and agencies involved, such as consultants, diagnostic laboratory, pharmacy, etc to expedite internal services and meet timelines.

#5. Set an Expected Discharge Timeframe Early in Admission

- Consider resident's and family's preferences as well as the resident's condition
- Establish as early as possible to discharge or transfer setting

#6. Review the Resident's Plan of Care and Discharge Plan with the Resident and Family

- Determine how resident and family feel about the discharge plan
- Be frank about progress in the resident's condition and functional abilities.
- Assess caregiver's response and understanding of his/her role upon discharge.

#7. Involve the Resident and Family in Important Decisions Regarding Facility Care as well as Selecting Community Resources and Agencies

- Ensure that the resident is fully aware of his/her circumstances and can give informed consent OR that there is a DPOA.
- Consider entire range of services required upon discharge and the financial resources to obtain them.
- Make a list of community resources and agencies available to the resident and family. Invite them to add to the list based on personal experience or preferences

#8. Keep Resident and Family Informed of any Changes to the Discharge Timeline

- No one likes surprises. Prompt notification reduces confusion, anger and disappointment.
- Take the initiative to follow-up on the resident's medical progress especially as the discharge approaches as well as availability of selected community services as originally planned.

#9. Review the Discharge Checklist 24-48 prior to Discharge

- Make sure EVERYTHING has been done, including notifications, phone calls, diagnostic work, appointments, etc. per physician order and resident's request.

#10. Review Medical Record for Proper Discharge Orders and Instructions the Day of Discharge.