

Tool- Discharge Care Plan Policy and Procedure Checklist

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New York



Tool: Discharge Care Plan Policy and Procedure Checklist

As it relates to developing a discharge plan of care, there are several areas of the Requirements of Participation that relate to this process.

§ 483.20 Resident assessment.

(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(xvi) Discharge planning.

(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts

(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§ 483.21 Comprehensive person-centered care planning.

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section

(2) A comprehensive care plan must be—

(ii) Prepared by an interdisciplinary team, that includes but is not limited to—

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) 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.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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(c) Discharge planning - (1) Discharge planning process.

The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, 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 facility's discharge planning process must be consistent with the discharge rights set forth at § 483.15(b) as applicable and—

- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
 - (ii) 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.
 - (iii) Involve the interdisciplinary team, as defined by § 483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
 - (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
 - (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
 - (vi) Address the resident's goals of care and treatment preferences.
 - (vii) 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.
- (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.
- (viii) 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.
 - (ix) 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.

(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:

(iv) 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 where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

§483.15 (c)(7) Orientation for transfer or discharge.

A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

**See also resident rights, admission transfer discharge, dignity and comprehensive resident assessment sections*

CMS Definitions

"Anticipates" means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition) or due to the resident's death.

"Adjust to his or her living environment" means that the post-discharge plan, as appropriate, should describe the resident's and family's preferences for care, how the resident and family will access these services, and how care should be coordinated if continuing treatment involves multiple caregivers. It should identify specific

"Discharge potential" refers to the facility's expectation of discharging the resident from the facility within the next 3 months.

Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.



“Sufficient preparation” means the facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident’s family in selecting the new residence.

Purpose and Intent of § 483.21 Comprehensive person-centered care planning – Preparation for Discharge

The facility policy guides the practices that promote a resident’s right to participate in a comprehensive care plan that includes a discharge plan, if desired by the resident and educates and informs staff practices for the development of a comprehensive discharge care plan. The policy defines the facility’s Interdisciplinary Team’s (IDT) actions to determine the resident’s discharge potential, goals and preferences and use the assessment information to develop a care plan and prepare and orient the resident for discharge.

To assure that the individual facility has followed all the required steps for the development and implementation of a comprehensive discharge plan of care policy in accordance with the new Requirements of Participation (RoP), the following checklist captures specific action items for successful completion. The far left column represents the actual RoP language and the right column indicates specific leadership strategies for successful completion and implementation of the revised RoP. When preparing updated policies and procedures, it is recommended to include actual RoP language as applicable. Please note that CMS has not issued its interpretative guidance for the new RoP, therefore additional updates may be necessary once the guidance is released.

**Suggested Checklist:
Discharge Care Plan Policy and Procedure**

Regulation	Recommended Actions
<p>§ 483.20 Resident assessment. (1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident’s needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (xvi) Discharge planning. (xviii) Documentation of participation in assessment. (1) Incorporating the recommendations from the PASARR level II determination and the PASARR</p>	<p><input type="checkbox"/> Review, revise and implement the Resident Comprehensive Assessment and Care Plan Policy and Procedures in accordance with the new RoP respective to the updated discharge process.</p> <p><input type="checkbox"/> Ensure that the policy contains provisions to develop a comprehensive discharge care plan or document the reason that discharge is not feasible.</p>



Regulation	Recommended Actions
<p>evaluation report into a resident’s assessment, care planning, and transitions of care.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Review and revise information provided at admission to residents and representatives about participating in development and updating of the residents’ comprehensive care plans and discharge plan. Ensure that the information includes participation in development of the discharge care plan. <input type="checkbox"/> Review and revise the admission assessment process and documents to ensure that they include a process for identifying the resident’s <ul style="list-style-type: none"> • discharge goal • desire and preference for discharge • post-discharge residence location, if known <ul style="list-style-type: none"> ○ known potential physical obstacles, such as stairs • availability, capacity and capability of caregiver/support person • education and skills needed • risk factors for preventable re-hospitalization • need for referral to local contact agency/ advocacy agency • PASARR recommendations <input type="checkbox"/> Review and revise staff education for orientation and annual training to reflect the changes in requirements for admission assessment.
<p>§ 483.21 Comprehensive person-centered care planning. (A) The resident’s goals for admission and desired outcomes. (B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Review, revise and implement the Resident Comprehensive Assessment Care Plan Policy and Procedures in accordance with the new RoP respective to the discharge process and IDT roles and responsibilities



Regulation	Recommended Actions
<p>community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section</p>	<ul style="list-style-type: none"> □ Ensure that the policy contains provisions to develop a comprehensive care plan that reflects: <ul style="list-style-type: none"> • the interdisciplinary team’s assessment of the resident ‘s desire to discharge • the feasibility of discharge • the resident’s goals for admission • the resident’s preference for potential discharge • post-discharge residence location, if known <ul style="list-style-type: none"> ○ known potential physical obstacles, such as stairs • availability, capacity and capability of caregiver/support person to provide care after discharge • education and skills needed by resident and caregiver/support person • risk factors for preventable re-hospitalization • need for referral to local contact agency/ advocacy agency • PASARR recommendations • Referrals made to local contact agencies and other appropriate entities • Resident, resident representative and receiving entity orientation prior to discharge for a safe transition of care □ Develop a transition of care policy and procedure that incorporates the new admission, transfer discharge protocols as well as facility specific requirements per State, partner agreements, transfer agreements, clinician agreements, etc. utilizing standards of practice available through AMDA, AHRQ and other sources.

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Regulation	Recommended Actions
	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure that the policy and procedures for comprehensive care planning reflect the circumstances and frequency for care plan updates, review of discharge plan and applicable requirements <input type="checkbox"/> Review and revise staff education for orientation and annual training to reflect the policy and procedures for comprehensive assessment and care planning including the discharge plan and staff roles and responsibilities. <input type="checkbox"/> Review the admission, transfer, discharge updates with the Medical Director as well as correlating revised policies and procedures.
<p>(2) A comprehensive care plan must be—</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to—</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) 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.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Review, revise and implement the Resident Comprehensive Assessment Care Plan Policy and Procedures in accordance with the new RoP respective to discharge care plan and process <input type="checkbox"/> Ensure that the policy contains provisions to develop a comprehensive care plan that reflects the input from a nurse aide responsible for the resident and a member of the food and nutrition services staff. <ul style="list-style-type: none"> • If nurse aides or nutrition services staff will not attend care plan meetings, develop a process to document their input for development of the residents’ care plans. <input type="checkbox"/> Ensure the resident and/or representative participate in the development of and updating the comprehensive care plan and the discharge plan/process.

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Regulation	Recommended Actions
	<ul style="list-style-type: none"> • Develop and implement a process to document the explanation the resident and their representative do not participate in the development of the care plan. <input type="checkbox"/> Review and revise staff education for orientation and annual training to reflect the policy and procedures for comprehensive assessment and care planning including the discharge plan.
<p><i>(c) Discharge planning - (1) Discharge planning process.</i></p> <p>The facility must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, 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 facility’s discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-</p> <p>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.</p> <p>(ii) 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.</p> <p>(iii) Involve the interdisciplinary team, as defined by § 483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.</p> <p>(iv) Consider caregiver/support person availability and the resident’s or caregiver’s/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Review, revise and implement the Resident Comprehensive Assessment Care Plan Policy and Procedures in accordance with the new RoP. <input type="checkbox"/> Ensure that the policy contains provisions to document that the resident was asked about their interest in returning to the community and if the resident is interested in discharge, facility staff has made and documented referrals to local contact agencies and other appropriate entities. <input type="checkbox"/> Ensure that the policy contains provisions for regular reevaluation of the resident to identify changes that require modifications of the discharge plan. <ul style="list-style-type: none"> • Develop and implement a process to update the residents discharge care plans, as needed, to reflect the changes. Discharge plan must be updated as needed. • IDT roles and responsibilities related to keeping the resident’s discharge plan updated on an ongoing basis

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Regulation	Recommended Actions
<p>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.</p> <p>(vi) Address the resident’s goals of care and treatment preferences.</p> <p>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.</p> <p>(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.</p> <p>(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.</p> <p>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.</p> <p>(viii) 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.</p> <p>(ix) 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.</p>	<ul style="list-style-type: none"> ● Review caregiver support and training needs to perform required care and included in the discharge plan of care ● Resident and Resident Representatives involvement in the discharge care plan process ● Include resident’s goals of care and treatment process ● Documentation of resident and resident representative’s response to staff’s interview related to interest in receiving information regarding return to the community and IDT response (i.e. returning to the community, referrals to local agencies or other appropriate entities. ● Update the comprehensive care plan and discharge plan to reflect information received from those referrals <p><input type="checkbox"/> Implement a process to inform the resident and representative of the final discharge plan.</p> <p><input type="checkbox"/> Develop and implement a process to provide relevant standardized assessment, quality measure and resource utilization data for residents who elect to be referred for post-discharge care at a LTCH, HHA or SNF.</p> <p><input type="checkbox"/> Review and revise staff education for orientation and annual training to reflect the policy and procedures for comprehensive assessment and care planning including periodic updates to the discharge plan and sharing quality data about HHA, LTCH or SNFs identified by the resident and representative for post-discharge care.</p>

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Regulation	Recommended Actions
<p>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.</p>	
<p>§483.15 (c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Review and revise the policy and procedure for issuing a discharge notice and orientation prep for discharge to ensure that the policy stipulates that <ul style="list-style-type: none"> • The facility will provide the resident with sufficient preparation and orientation to the upcoming discharge to ensure that the discharge is safe and orderly. (insert facility specific information) • Provide the discharging resident with information about where he/she is going. • The facility will work with the resident and family to ensure that valued possessions are not left behind <input type="checkbox"/> Review and revise the policy and procedure for issuing post discharge follow up process and documentation. <input type="checkbox"/> Develop a comprehensive transition of care policy and procedure to include processes for safe care transitions – (i.e. INTERACT, AMDA, Bridge Model, REDD, etc.) and the facilities roles and responsibilities related to care transition, communication, etc.) <input type="checkbox"/> Be sure to include a provision in the policy to provide timely notification of the state Ombudsman office of the resident discharge.

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The below areas serves as a cross reference for facility leaders to conduct addition policy and procedure review across departments to incorporate the changes set forth in **§ 483.20 Resident assessment** and **§ 483.21 Comprehensive person-centered care planning** This listing is not all encompassing however should serve as a resource for leaders as they update their internal policies, procedures and operational processes.

Cross Reference

- Resident Rights
- CMS Definitions
- Employee Orientation
- Annual Training Requirements
- Resident comprehensive assessment
- Resident comprehensive care planning
- Admission, transfer, discharge
- Discharge Summary
- Medically related Social Services
- Dignity
- Quality Assurance and Performance Improvement
- Staff Training and Education
- Physician Services
- Transitions of Care
- Readmission process and protocols
- Admission and Preadmission Policy and Procedure
- PASARR
- Medical Director Services

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