Discharge Summary and Plan

Highlights

Policy Statement

When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment.

Policy Interpretation and Implementation

Discharge Summary and Plan

1. When the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/MR, etc.), a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. This tool is incorporated into PCC and should be used for all planned discharges.

Content of the Discharge Summary

The Discharge Summary will be completed within 14 days of a residents discharge and

2. The **discharge summary** 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);
   h. Discharge potential (the expectation of discharging the resident from the facility within the next three months);
   i. 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);

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j. 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);
k. Rehabilitation potential (the ability to improve independence in functional status through restorative care programs);
l. Cognitive status (the resident's ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and
m. 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).

Content of Post Discharge Plan

3. The **post-discharge plan** will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will contain, as a minimum:

a. A description of the resident's and family's preferences for care;
b. A description of how the resident and family will access such services;
c. A description of how the care should be coordinated if continuing treatment involves multiple caregivers;
d. The identity of specific resident needs after discharge (i.e., personal care, sterile dressings, physical therapy, etc.); and
e. A description of how the resident and family need to prepare for the discharge.

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 post-discharge plan and summary will be provided to the resident and receiving facility, and a copy will be filed in the resident's medical records.

References	
OBRA Regulatory Reference Numbers	483.20(1)(1); 483.20(l)(2); 483.20(l)(3)
Survey Tag Numbers	F283; F284
Related Documents	Documentation of Transfers/Discharges
Policy Revised	Date: **4-4-2016** By:_____ Date:_____ By:_____ Date:_____ By:_____ Date:_____ By:_____