

## Discharge Critical Element Pathway

Use this pathway for a resident that has been or is planning to be discharged to determine if facility practices are in place to ensure the resident's discharge plan meets the needs of the resident.

### Review the Following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – Discharge Status (A2100), C – Cognitive Patterns, G – Functional Status, and Q – Participation in Assessment and Goal Setting.
- Physician's orders (e.g., medications, treatments, labs or other diagnostics, and the discharge order – planned or emergent).
- Pertinent diagnoses.
- Care plan (high risk diagnoses, behavioral concerns, history of falls, injuries, medical errors, discharge planning to meet the resident's needs including but not limited to resident education and rehabilitation, and caregiver support and education).

### Observations:

- Does staff provide care for the resident as listed in the discharge plan? If not, what is different?
- How are staff providing education regarding care and treatments in the care plan?
- How does the resident perform tasks or demonstrate understanding after staff provides education?

### Resident, Resident Representative, or Family Interview:

- What are your discharge plans?
- What has the facility discussed with you about returning to the community or transitioning to another care setting?
- Were you asked about your interest in receiving information regarding returning to the community? If not, are you interested in receiving information?
- What was your involvement in the development of your discharge plan?
- What has the facility talked to you about regarding post-discharge care?
- Ask about any discrepancies between the resident's discharge plan and the facility's discharge plan.
- If discharge is planned:
  - How did the facility involve you in selecting the new location? Did you have a trial visit, if feasible? How did it go;
  - How were your goals, choices, and treatment preferences taken into consideration;
  - What are your plans for post-discharge care (e.g., self-care, caregiver assistance);
  - What information did the facility give you regarding your discharge (e.g., notice, final discharge plan)? When was it given? Was the information understandable; and
  - What discharge instructions (e.g., medications, rehab, durable medical equipment needs, labs, contact info for home health, wound treatments) has the facility discussed with you? Were you given a copy of the discharge instructions? If applicable, did the facility have you demonstrate how to perform a specific procedure so that you can do it at home?

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### Staff Interviews (Nurses, DON, Social Worker and Attending Practitioner):

- What is the process for determining whether a resident can be discharged back to the community? How do you involve the resident or resident representative in the discharge planning? Do you make referrals to the Local Contact Agency when the resident expresses an interest in being discharged?
- How often are the discharge needs of the resident evaluated and is the post-discharge plan of care updated?
- What is the resident's discharge plan, including post-discharge care?
- Why is the resident being discharged (i.e., for the resident's welfare and the resident's needs cannot be met in the facility, because the resident no longer required services provided by the facility, because the health or safety of the individual was endangered, or due to non-payment)?
- For residents being discharged to another healthcare provider: What did the facility do to try and provide necessary care and services to meet the resident's needs prior to discharge? What does the new facility offer that can meet the resident's needs that you could not offer?
- Where is the resident being discharged to? How was the resident involved in selecting the new location? Was a trial visit feasible?
- What, when and how is a resident's discharge summary, and other necessary healthcare information shared with staff at a new location?
- For discharge summary concerns are noted, interview staff responsible for the discharge summary.
- How does the facility provide education to the resident or care provider regarding care and treatments that will be needed post-discharge?

### Record Review:

- Did the facility ask the resident about their interest in receiving information regarding returning to the community? If not, why not?
- If the resident wants to return to the community, was there a referral to the local contact agency or other appropriate entities?
- If referrals were made, did the facility update the discharge plan in response to information received?
- If the resident cannot return to the community, who made the determination and why?
- Did the facility identify the resident's discharge needs and regularly re-evaluate those discharge needs?
- Does the care plan adequately address the resident's discharge planning? Does it address identified needs, measurable goals, resident and/or resident representative involvement, treatment preferences, education, and post-discharge care? Has the care plan been revised to reflect any changes in discharge planning?
- Who from the IDT was involved in the ongoing process of developing the discharge plan?
- What are the circumstances and basis for the discharge? Was the discharge necessary? Was the reason for the discharge documented by a physician, as appropriate?
- Is there documentation of the specific needs that could not be met, the attempts the facility made to meet the resident's needs, and the specific services the new facility will provide to meet the resident's needs?

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- If the resident went to a SNF, HHA, IRF, or LTCH, did the facility assist the resident and the resident representative in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH available standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available that is relevant and applicable to the resident's goals of care and treatment preferences.
- If this was a facility-initiated discharge, was advance notice given (either 30 days or, as soon as practicable, depending on the reason for the discharge) to the resident, resident representative, and a copy to the ombudsman:
  - Did the notice include all the required components (reason, effective date, location, appeal rights, Ombudsman, ID and MI info as needed) and was it presented in a manner that could be understood; and
  - If changes were made to the notice, were recipients of the notice updated?
- Did the facility provide a discharge summary to the receiving provider, which includes all required components at F661?
- Does the discharge summary include a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications? If not, describe what is missing.
- For residents discharged to the community, does the medical record have evidence that written discharge instructions were given to the resident and if applicable the resident representative?

### Critical Element Decisions:

- 1) Did the facility:
  - Involve the IDT, resident and/or resident representative in developing a discharge plan that reflects the resident's current discharge needs, goals, and treatment preferences while considering caregiver support;
  - Document that the resident was asked about their interest in receiving information about returning to the community;
  - Assist the resident and/or resident representatives in selecting a post-acute care provider if the resident went to another SNF (skilled nursing facility), NH (nursing home), HHA (home health agency), IRF (inpatient rehab facility), or LTCH (LTC hospital); and/orIf No, cite F660
  
- 2) Did the facility:
  - a. Develop a discharge summary which includes a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications?
  - b. Develop a post-discharge plan of care, including discharge instructions?If No, cite F661

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- 3) Does the resident's discharge meet the requirements at 483.15(c)(1) (i.e., for the resident's welfare, the resident's needs could not be met in the facility, the resident no longer required services provided by the facility, the health or safety of the individuals in the facility was endangered, non-payment, or the facility no longer operates)?  
If No, cite F622
- 4) Was required discharge information documented in the resident's record and communicated to the receiving facility?  
If No, cite F622
- 5) If this was a facility-initiated discharge, was the resident and resident representative notified of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge? Did the notice meet all requirements at 483.15(c)(3) through (6) and (c)(8)?  
If No, cite F623

**Other Tags, Care Areas (CA) and Tasks (Task) to Consider:** Participate in Care Plan F553, Notification of Change F580, Professional Standards F658, Medically Related Social Services F745, Resident Records F842, QAA/QAPI (Task), Orientation for Transfer or Discharge F624.