Subject: Discharge or Transfer of Resident

Reference: §483.20; §483.21; §483.15; F622; F623; F624

Purpose: Residents will be assessed regarding their discharge goals, preferences and care needs to meet their goals. If the resident anticipates being able to leave the facility at some time in the future, and has discharge potential, a comprehensive discharge care plan will be developed by the interdisciplinary care team.

The resident will be supported in reaching their goals to the extent practicable and will be re-evaluated periodically to identify changes. The care plan will be kept up to date regarding modifications identified based on resident condition and objectives. The resident and resident representative will be actively included in the care plan process to the extent possible and will be provided the discharge plan and any updates.

In the event that a transfer to another facility is necessary, the facility must provide sufficient preparation and orientation to residents, and to the destination facility to insure an appropriate transition.

To ensure that the resident is informed of an impending involuntary discharge or transfer and their right to appeal the discharge or transfer.

Definitions:

Anticipates: Means that the discharge was not an emergency discharge (i.e. 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 resident needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe resident/caregiver education needs and ability to meet care needs after discharge.

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

Discharge: refers to moving resident to a non-institutional setting or to home.

Transfer: refers to moving a resident from the facility to another legally responsible institutional setting.

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

Procedure:

1. When the attending physician determines that the resident's physical and mental condition warrants, and the needs can be met in the individual's own home, or in a boarding type home, the physician will recommend discharge in accordance with a plan of care, and will give order/permission for resident to be discharged, also indicating whether medications may be sent with the resident.

2. When a transfer to another facility is indicated, an order for the transfer will be obtained from the physician.

3. The facility may require that the resident transfer to another facility when:

    a. The facility can no longer meet a resident's needs.
        I. The resident's physician will document in the clinical record when the resident's needs cannot be met by Moundridge Manor. Services limitations include, but may not be limited to, residents with the following conditions/needs:
            1) Weight greater than 400 pounds
            2) Tracheostomy
            3) Nasogastric tube
            4) Peritoneal dialysis
            5) IV infusion therapy (care and transportation will be facilitated for any resident receiving routine IV infusions outside the facility).

    b. The safety and/or health of other individuals in the facility is endangered.
        I. Any physician may document when discharge is necessary because health and/or safety of other residents is endangered.

    c. The resident has failed, after reasonable and appropriate notice, to pay rates and charges
        I. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or the third party denies claims and the outstanding bill is 30 days in arrears.

d. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility

e. The facility ceases to operate.

4. The facility will minimize unnecessary and avoidable anxiety and depression for the discharging or transferring resident.

5. Identification of need for discharge care plan

   a. As part of the comprehensive admission assessment, the Interdisciplinary Team (IDT) will identify the resident's desire and preferences for discharge. Based on the comprehensive assessment of the resident, a comprehensive discharge plan will be developed.

   b. Assessment – upon admission to the facility and on an ongoing basis, the resident will be evaluated based upon a comprehensive assessment and resident choice for discharge from the facility.

6. Comprehensive Care Plan – Discharge Plan - A person-centered discharge plan will be put in place to address:
   a. Resident desires and choices
   b. Resident Representative involvement
   c. Teaching with resident/representative
      I. Caregiver support needs
      II. Medications
         1) Reason for medication
         2) Common side effects
         3) Dose, time of day, duration, route
         4) Return demonstration and evidence of understanding
      III. Resources
         1) Financial
         2) Social support
      IV. Strategies
         1) To prevent complications
         2) Interventions if complications arise
      V. Medical condition
         1) Diagnosis
         2) Signs and symptoms and when to notify physician
         3) Specific care related to medical condition(s)
         4) Lab and radiology testing explanation of results
      VI. Treatments
         1) Reason for treatment

2) Training on specific treatment
3) Return demonstration and evidence of understanding

d. Functional needs
    I. Resident specific ADL training
    II. Use of supportive devices
    III. Prevention of complications
    IV. Return demonstration and evidence of understanding
e. Advance directives
f. Supplies and Durable Medical Equipment
g. Follow up appointments (including transportation)

7. Comprehensive Care Plan – Discharge Plan Update

    a. Continual re-evaluation and updating of plan as indicated.
    b. Involvement of resident including their goals for discharge.

8. Documentation

    a. The discharge plan will be included in the medical record. If discharge to the community is determined to not be feasible, document who made the determination and reason.
    b. The resident and resident representative will be involved in and be informed of the final discharge plan
    c. An evaluation of resident's discharge needs will be documented in the resident's record on a timely basis. This evaluation will be discussed with the resident and/or resident representative.
        I. Relevant information will be incorporated into the discharge plan to facilitate implementation and avoid unnecessary delays in resident discharge.
    d. Any referrals to support agencies
        I. Include any applicable information in discharge care plan

9. Orientation for discharge

    a. The facility will provide the resident with sufficient preparation and orientation to the upcoming discharge to ensure that the discharge is safe and orderly. The orientation will be provided to the resident and resident representative in a form and manner that can be understood.
    b. The resident will be provided with information about where he/she is going
    c. The facility will work with the resident and family to ensure that valued possessions are not left behind
    d. The facility will coordinate with the financial departments to ensure the transition of resident funds to the appropriate entities. Funds will be transferred at the time of discharge.

e. The facility will minimize unnecessary and avoidable anxiety and depression for the discharging resident.
f. The facility will provide the appropriate education related to medication, treatments, medical care and services, psychosocial needs, care interventions and approaches and other applicable information for a safe transition.

10. Discharge or Transfer Summary

a. A discharge summary will be completed upon discharge to include:
    I. A recapitulation of the residents stay in the facility (diagnosis, course of illness/treatment, therapy, lab, radiology and consultation reports)
    II. A final summary of resident's status
    III. Medication reconciliation
    IV. A post-discharge plan of care developed with the resident and resident representative
        1) Location where the resident will reside
        2) Arrangements for care, medications and services post-discharge
        3) Arrangements for follow-up communication post-discharge
    V. Copy of discharge summary will accompany the resident

11. Transfer to another facility (other than transfer to hospital with anticipated return)

a. Documentation in clinical record will include
    I. The basis of the transfer
    II. The specific resident needs that cannot be met
        1) Facilities attempts to meet those needs
    III. Service available at the receiving facility to meet the need(s).

b. Moundridge Manor staff will provide orientation to receiving facility staff about the medical and psychosocial care needs, daily patterns and preferences of the resident. Information provided to the receiving facility will also include:
    I. Primary care physician and other consulting practitioners as well as their respective contact information.
    II. The resident's representative's contact information
    III. Advance directives
    IV. Special instructions or precautions for ongoing care
    V. Comprehensive Care plan including goals
    VI. Current MDS
    VII. Care certificate
    VIII. Legal Representative authorization
    IX. Medication / Treatment administration Records

X. Insurance / Medicare papers
XI. Transfer Sheet
XII. History and physical
XIII. Physician's order sheet
XIV. Immunization Record
XV. Recent lab / test reports
XVI. Discharge summary

12. Discharge or Transfer Follow Up Process

a. After discharge or transfer social services or designee will complete 2 follow up calls or visits with the resident, resident representative and/or receiving location, within first week after discharge, for an appropriate transition of care.
b. If problems with the transition are defined / recognized, the facility team members will assist in further interventions as indicated.
c. Documentation of discharge follow up will be included in the resident's medical record.

13. Notification of Discharge and Transfer

a. When possible, notification of transfer or discharge shall be provided in writing to resident and/or representative 30 days before the resident is transferred or discharged.
b. Notice must be made as soon as practicable before transfer or discharge when
    I. The safety or health of individuals in the facility would be endangered
    II. The resident's health improves sufficiently to allow a more immediate transfer or discharge
    III. An immediate transfer is required by the resident's urgent medical needs.
c. The contents of the notice will include
    I. The reason for the transfer or discharge
    II. The effective date of transfer or discharge
    III. The location to which the resident is transferred or discharged
d. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available

14. State Agency Contact Information Related to Transfer and Discharges

The following information must be included in the discharge notice according to Kansas regulations:

KDADS Complaint Program

503 South Kansas
Topeka, Kansas 66603
1-800-842-0078
KDADSCOMPLAINTHOTLINE@ks.gov

LTC Ombudsman
Landon State Office Building
900 SW Jackson Street, Suite 1041
Topeka, Kansas 66612
1-877-662-8362
LTCO@ks.gov

The Office of Administrative Hearings
1020 South Kansas Avenue
Topeka, Kansas 66612-1327
785-296-2433

For residents who have developmental disabilities or who are mentally ill:
Disability rights Center of Kansas
214 SW 6th Avenue, Suite 100
Topeka, Kansas 66603
1-877-776-1541

15. The resident will not be transferred or discharged during an appeal process unless the health and/or safety of the resident or other individuals in the facility will be affected.

16. Transfer or Discharge against Medical Advice

If a resident chooses to leave the facility against medical advice, include documentation of the following:

a. Capacity: this term refers to the resident's medical ability to make a decision.
b. Signs and Symptoms and the provider's concerns.
c. Extent of Care and Services
d. Current Plan of Care
e. Risk of Foregoing Services
f. Alternatives and options
    I. Document alternatives discussed and the resident's response
g. Explicit statement of what the resident is refusing.
h. Questions, follow-up, medicines and instructions. All possible interventions to limit potential negative outcomes.

17. Transfers to Hospital

a. Communication to the admitting hospital to ensure safe and effective transfer of care will include:
    I. Transfer form
    II. Advance Directives
    III. EMAR, ETAR
    IV. Physicians orders
    V. Verbal report – to include baseline cognition and ADL status
    VI. Bed Hold policy
    VII. Medicare / Insurance information
    VIII. Face sheet
    IX. Legal Representative
b. All hospital transfers will be reported monthly to the state ombudsman

18. Quality Assurance

a. All discharges will be tracked per Quality Assurance Program to evaluate effectiveness of process and outcomes.