Long-Term Care Survey Alert

Survey Management: DOES YOUR DISCHARGE PLANNING ENSURE A SAFE TRANSITION?

Nursing home providers who think their job ends when the resident goes out the door may be setting their facility up for survey woes and even malpractice litigation. For example, think of what would happen if a facility discharged a resident to a house in the winter without adequate heat, food or supervisionwhen a simple phone call would have flagged the situation. And if staff don't pass along critical clinical information and medications to the home health agency or assisted living facility, the resident may suffer a bad outcome.

Surveyors can tag a facility under F204 for failing to prepare the resident or coordinate care to ensure a safe and orderly transfer or discharge."Deficiencies in discharge planning could also show up under an F309 tag, which is a catch all tag for quality of care issues," notes **Gail Polanski**, a consultant with **MG Healthcare Solutions** in Orchard Park, NY.

How Surveyors Catch Shortfalls

Surveyors may catch shortfalls in discharge planning through acomplaint from residents' families or a provider in the community or as a part of closed record review, including Section Q of the MDS (to review this section, see Section Q art).

"Surveyors are supposed to look at closed records as part of their sample, including residents who have been discharged home or to another health care setting to see if the facility provided adequate support and helped the resident make the transition," explains **Beth Klitch**, principal, **Survey Solutions** in Columbus, OH. As additional follow-up, surveyors may contact the resident at home to ask him to evaluate the job the facility did in preparing him for dischargeor they might contact the home health agency or hospice to see if the facility facilitated continuity of care.

Under F204, surveyors are also directed to check social service notes to see if facility staff made appropriate referrals for the resident and provided resident counseling, if required.

Mariner Post-Acute Network has addressed Section Q requirements by revising its social service assessments. "These now have a back section of discharge assessment/planning to coincide with the MDS," reports **Darla Watson**, vice president of beneficiary support for the Atlanta-based nursing home chain.

"Social services does a discharge plan on admission (within 14 days) that includes short-term and long-term assessment planning," Watson explains. Staff then updates the discharge plan every time the facility does an MDS.

"The MDS nurses can then take the social services assessment form and determine whether they're dealing with a short- or long-term discharge and if appropriate caregivers are available in the home or in another care setting," Watson adds.

Mariner facilities also start discharge planning upon admission by getting the wheels in motion to help residents achieve an optimal level of care, whether that be a safe transition home or to assisted living. In addition, the rehab therapists make home visits in many cases to assess the resident's home environment before discharge. "They also train the caregivers and help the resident and caregiver prepare in terms of getting in place the right equipment and home adaptations," Watson reports. **Tip**: Your facility can count home visits under the Medicare RUG system, including travel time, if the rehab therapist spends time in transit teaching the resident or family member or discussing the transition or care requirements.

For residents discharged to home health, check the date when home health services are supposed to start and make sure providers show up on that date, advises **Debbie Glass** with MG Healthcare Solutions.

Pay special attention to those Friday discharges where home health or hospice services might not start until Monday. "Confirm that a family member or other responsible person will be checking in with the resident and there will be food in the house," Glass advises. Document all of your calls and conversations in the resident's record.

Klitch also advises facilities to call residents within 24 to 72 hours after discharge/transfer and talk to a designated family member to see how things are going and whether they have any needs or questions. Staff should also call home health or assisted living providers to see how former residents are doing and whether the provider needs any additional information.

Follow-up is good for customer relations,Watson notes. Mariner does a survey to find out how former patients/residents are doing at home and how they felt about their care in the facility.