OASIS Alert

Discharges: Bolster Your Discharge Process with these Steps

Are you making one of these common discharge assessment errors?

An accurate discharge assessment helps ensure accurate outcome and process measures. Make sure your discharge process presents the best picture of the care you provide.

Include Care Details

Generally, a discharge assessment should be a re-evaluation of all care provided to the client during the episode of care, including changes resulting from provided services, says **Pat Jump,** with Rice Lake, Wis.-based **Acorn's End Training & Consulting**. The assessment should include any medical, nursing, rehabilitative, and social needs the patient has that may continue post-discharge.

Additionally, be sure to document the following when discharging a client, Jump says:

- Care provided, why, what happened as a result of the care.
- Progress toward established goals.
- Ability to accurately take all medications.
- Change in health status with specific notations related to primary and secondary diagnoses.
- Ability to manage at home without home care services, including functional limitations that restrict mobility. Document the medical or physical reason for the limitation as well as the impact of the limitation on the client's activity.
- Physical limitations, mental health status, significant signs and symptoms, highlights of significant problems.
- Any concerns you may have regarding the client and/or family, including any continued needs of the client.
- Date and reason for discharge.
- Discharge location and who will be responsible for care.
- Referrals made to other providers or community resources.

Remember these OASIS Specifics

When you're completing an OASIS discharge, the assessment must include OASIS documentation consistent with narrative documentation, Jump says. To give justice to changes that have occurred since the previous OASIS assessment, a full head-to-toe assessment is necessary. A comprehensive assessment helps ensure the accuracy of OASIS Outcome and Process measures.

OASIS assessment focus areas include the following, Jump reminds:

- Interventions that have been implemented and were included on the plan of care (this may involve a review of prior visits to verify implementation).
- Discharge disposition, keeping in mind that the **Centers for Medicare & Medicaid Services** defines Assisted Living as living in the community with formal assistive services and that formal assistive

services include services through an organization (such as Meals-on-Wheels) or paid helpers.

- Date of last/most recent home visit, whether or not that visit was included on the plan of care. If your agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the therapist.
- Discharge/Transfer/Death date, which is determined by agency policy or physician order.

Avoid these Mistakes.

One of the most common mistakes clinicians make when completing an OASIS discharge assessment is leaving the assessment incomplete, Jump says. Put processes in place to thoroughly review your discharge assessments to guard against this error.

Failing to complete the assessment during a home visit is another common error, Jump says. It's important to remember that the OASIS discharge assessment must report the client's status at an actual home visit not from a phone call. A hands-on comprehensive assessment is the only way to ascertain all of the details necessary for a professional assessment.

Not completing an OASIS discharge assessment when a client is no longer receiving skilled care but continues with personal care or homemaking services is also a mistake, Jump says. While you aren't required to complete a discharge OASIS assessment when a client no longer receives skilled services but unskilled care continues, it is recommended, she says. If you don't complete a discharge OASIS in situations like this, you can fail to capture a clear endpoint to the episode of care. This may have an impact on agency outcome and process measure reports.

Guard Against Unplanned Discharges

At times, unanticipated discharges occur, such as when a client moves out of the area to live with a relative without notifying your agency ahead of time. When this happens, the clinician needs to document the client's status based on the last visit by a "qualified" clinician, Jump says. Specifically, that means a clinician who is Medicare-authorized to complete an OASIS assessment an RN, PT, OT, or SLP.

Watch out: You may have more recent data regarding the patient's condition from the LPN/LVN or home health aide but that information may not be used to complete the discharge OASIS assessment, Jump says. Unfortunately, this can result in the inability to capture the most recent improvements which could negatively impact OASIS outcome and process measures.

While some unplanned discharges are unavoidable, there are several steps you can take to mitigate the frequency of unanticipated discharges, Jump says. These include:

- Regular clinician contact with the client/family, including phone calls between visits.
- Clearly communicating to the client/family the importance of notifying the agency of any changes.
- Providing a specific phone number and if possible, name of the agency person to contact. Make sure this is in a font that the client/family can easily see.
- Rapid response from the clinician when a client calls or expresses concerns.
- Consistent communication between caregivers, including instructions to the home health aide to notify the clinician of any impending changes, change in health status, physician appointments, etc.