**Transition Care**

**Competency**

Suggested Implementation Checklist

**Suggested Implementation Checklist: Transition Care**

| **Regulation** | **Recommended Action** |
| --- | --- |
| **F660**  §483.21(c)(1) **Discharge Planning Process**  “The facility must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility’s discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and—   1. Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. 2. Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. 3. Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. 4. Consider caregiver/support person availability and the resident’s or caregiver’s/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. 5. Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. 6. Address the resident’s goals of care and treatment preferences. 7. Document that a resident has been asked about their interest in receiving information regarding returning to the community.   (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.  (B) Facilities must update a resident’s comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.  (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.  (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident’s goals of care and treatment preferences.  (ix) Document, complete on a timely basis based on the resident’s needs, and include in the clinical record, the evaluation of the resident’s discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident’s representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident’s discharge or transfer.”[[1]](#footnote-1) | * Review, revise and institute an effective transition/discharge planning process with policy and procedure that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions * Educate all staff and the interdisciplinary team about transition care/discharge planning process policies and procedure * Educate staff on how to complete medication reconciliation. * Update staff education materials for orientation, annual education, and agency staff orientation, as needed * Educate residents and resident representatives about transition care/discharge planning * Conduct updated training for Case Manager, nursing leaders about supervising and monitoring for compliance transition care/discharge planning policy and procedures. * Review transition care/discharge planning policy and procedure with the Medical Director and Pharmacy Consultant in conjunction with the Quarterly Quality Assurance Committee meeting * Ensure qualified case Manager (if used) and staff * Quality Assurance Performance Improvement e.g., readmission follow-up calls or visits, medication reconciliation (discharge medication with admission medication list), MD appointments medication questions etc. * Involve resident /resident representative in transition care /discharge planning. Ensure goals and interventions are appropriate and revise as needed. |
| **F745: Provision of Medically Related Social Services**  “§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.”[[2]](#footnote-2)  • “Transitions of care services (e.g., assisting the resident with identifying community placement options and completion of the application process, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities)”[[3]](#footnote-3) | * Ensure medically related social services are provided for each resident. (There is not a requirement that a qualified Social Worker must provide all these services unless it is required by State Law. |
| **F552 Right to be informed and make treatment decision**  “Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment”[[4]](#footnote-4) | Provide resident with information of transition care/discharge planning procedure, medical information, risks/benefits of treatment.  Include resident/resident representative in the care planning process |
| **F624**  §483.15(c)(7) Orientation for transfer or discharge.  “A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.”[[5]](#footnote-5) | * Review/revise process to address immediate orientation and preparation for transfer to the hospital emergency room or for a therapeutic leave |
| **F756 Drug Regimen Review**  “Transitions in care such as a move from home or hospital to the nursing home, or vice versa, increase the risk of medication-related issues. Medications may be added, discontinued, omitted, or changed. It is important, therefore, to review the medications. Currently, safeguards to help identify medication issues around transitions in care and throughout a resident’s stay include:   * The pharmacist performing the medication regimen review, which includes a review of the resident’s medical record, at least monthly; * The pharmacist reporting any irregularities in a separate written report to the attending physician, medical director, and director of nursing; and * The attending physician reviewing and acting on any identified irregularities.”[[6]](#footnote-6) | * Review/Revise process for medication regimen reviews at least monthly, reporting of irregularities in a separate written report to the attending physician, medical director and the DON * Review process for attending physician review and action of any irregularities |
| **F578** Right to refuse  “The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.”[[7]](#footnote-7) | Resident has the right to refused once information on the risks, benefits and specifics of the procedure/skill |
| **F561** Advance Directives  “The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.”  483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.  §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.”[[8]](#footnote-8)  **F578 “**§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).”[[9]](#footnote-9) | If resident does not have an Advance Directive, provide education and offer assistance in formulation of an Advance Directive   * Establish, review and maintain policies and procedures in the facility regarding these rights. * Inform and educate residents about your policies/procedures and about how they can exercise their rights. * Help/assist the resident in exercising their rights. * Ensure that the resident choices are incorporated in their treatment, plan, care and services |
| **F580** Notification of change | Policies and procedures for notification of change of condition |
| **F659**  “The services provided or arranged by the facility, as outlined by the comprehensive care plan, must— (ii) Be provided by qualified persons in accordance with each resident's written plan of care.”[[10]](#footnote-10)  **F 725** Sufficient and Competent Staffing  “The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population”[[11]](#footnote-11) | Licensed Nurse/Case Manger training on:   * Transition care/Discharge Planning * Provide Staffing consistent with resident need as identified with census, acuity and facility assessment * Develop in collaboration with resident/resident representative regarding person centered transition care/discharge plan of care |
| **F686 Pressure ulcer**  “Based on the comprehensive assessment of a resident, the facility must ensure that— (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and  (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.”[[12]](#footnote-12) | Licensed Nurse and CNA training on facility policy and procedure for monitoring of skin integrity |
| **F692 Nutrition and Hydration**  “Based on a resident's comprehensive assessment, the facility must ensure that a resident—  §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident’s clinical condition demonstrates that this is not possible or resident preferences indicate otherwise”[[13]](#footnote-13) | Collaborate with IDT, including physician and resident diet related to hydration needs/restrictions/orders |
| **F 757 Unnecessary Medications**  “Each resident’s drug regimen must be free from unnecessary drugs.”[[14]](#footnote-14) | Policies and Procedures with education on unnecessary medications |
| **F841 Medical Director**  “The facility must designate a physician to serve as medical director.  §483.70(h)(2) The medical director is responsible for— (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility.”[[15]](#footnote-15) | Medical Director to collaborate, review and approve all policies, procedures and protocols for transition care/discharge planning |
| **F842 Medical Records**  “Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized”[[16]](#footnote-16) | Documentation in the Medical Record to include:   * Resident care and services * Change of condition and follow up * Communication between the nursing facility and resident/resident representative and community * Care Plan and revisions * Physician orders * All pertinent charting |

**Reference**

* Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

1. Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-1)
2. 2,3,4,5 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)
5. [↑](#footnote-ref-5)
6. 6,7,8,9,10  Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-6)
7. [↑](#footnote-ref-7)
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11. [↑](#footnote-ref-11)
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16. [↑](#footnote-ref-16)