Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
RESIDENTIAL HABILITATION CENTER
STANDARD OPERATING PROCEDURE

TITLE: DISCHARGE PROCESS 103.4

PURPOSE

To establish processes for a client's safe and successful discharge from a Residential Habilitation Center (RHC).

SCOPE

This procedure applies to the discharge of a client from a nursing facility or intermediate care facility.

POLICY

A. The RHC will conduct a thorough transition process to ensure a safe and successful discharge.

B. The RHC must document in the client's chart the pros and cons and rationale for the discharge.

C. At least 30 days before a client's planned discharge date (see F623 in the State Operations Manual), the RHC must notify in writing:

1. The client;

2. The client's family;

3. The client's legal representative; and

4. The Washington State Long-Term-Care Ombudsman if the client is discharging from a nursing facility.

D. If the RHC is unable to provide 30 days' notice, the RHC must document a reason why in the client's chart.

PROCEDURES

Transition planning

A. Before a client is discharged, the RHC:

1. Must sufficiently prepare the client and the receiving entity to ensure a safe and orderly transition; and

2. May allow the receiving entity to shadow RHC employees who work with the client.

B. Before a client is discharged, the receiving entity must, when possible, complete an orientation with the client at the RHC in a manner the client can understand. The orientation may include things like pictures and social stories.

Transition meetings

A. Upon notification of a client's potential discharge, the RHC must schedule a transition meeting.

B. Transition meetings must occur regularly until the client is scheduled to leave and when possible a final meeting must occur at least one week before the discharge date.

C. Transition meetings must include:

1. The client;
2. The client's family, legal representative, or other advocate;
3. The client's case manager;
4. The client's interdisciplinary team; and
5. The receiving entity.

D. The purpose of the transition meetings is to:

1. Create a post-discharge plan of care;
2. Ensure all parties understand the discharge process;
3. Discuss the representative payee in the client's transition;
4. Determine if an assessment of the client's new home is needed;
5. Determine if a Cross-Systems Crisis Plan is needed;
6. Determine if a PASRR assessment is needed; and
7. Arrange for the client's transportation to the receiving entity's care.

E. The post-discharge plan of care must indicate where the client plans to reside, any arrangements that have been made for the client's follow-up care, and any post-discharge medical and non-medical services.

Sharing client information

Before the client leaves the facility, the RHC must give the receiving entity:

A. A list of the client's preferences;

B. Instructions for assisting the client with activities of daily living;

C. The contact information of the client's family, legal representative, and medical providers;

D. The client's adaptive equipment, instructions for using the equipment, proof of equipment lease or ownership, and whether or not the client needs to purchase the equipment;

E. The client's individual habilitation plan or individual plan of care;

F. Assessments relevant to the client's plan of care;

G. A discharge summary, which must include the client's:

1. Developmental status;
2. Social status;
3. Health status;
4. Nutritional status;
5. Current status of the objectives in the individual plan of care;
6. Customary routine or active treatment schedule;
7. Functional assessment, if the client has one; and
8. Positive behavior support plan, if the client has one;

H. A medical summary of the client's time at the facility, which must include:

1. Current diagnoses and illnesses;
2. A summary of the last three years of lab, radiology and consultations; and
3. Treatments and therapies implemented to address the client's conditions;

I. Dates for follow-up appointments scheduled with the client's community medical providers;

J. A pharmacy summary of the client's time at the facility, which must include:

1. Medications currently taken by the client and reasons for each medication's administration;

2. Medication administration instructions;

3. Known, pertinent medications taken by the client in the past, reasons for each medication's administration, and reasons for each medication's discontinued use; and

4. Drug allergies, paradoxical effects, and adverse reactions;

K. All of the client's chronic and acute nursing care plans; and

L. Employment or vocational training records for the past 6 months, if applicable.

Day of discharge

A. On the day the client is discharged from the facility:

1. The RHC reviews the client's discharge summary and post-discharge plan of care with the receiving entity.

2. The RHC and receiving entity review and sign the client's personal property inventory.

3. The RHC gives the receiving entity the client's:

a. Insurance card or cards;
b. Identification card;
c. Social Security card;
d. Birth certificate; and
e. Guardianship documents.

4. The client's medical provider gives the receiving entity:

a. The medical orders; and
b. A prescription for a 30-day supply of the client's medications.

5. The RHC pharmacy gives the receiving entity at least a one-week supply of the client's medication.

B. If the receiving entity asks the RHC for a renewed prescription, the RHC should discuss with the receiving entity ways to address the need and permanently transfer the prescriptions to a community provider.

AUTHORITY

42 C.F.R. Section 483.21	*Comprehensive Person-Centered Care Planning*
42 C.F.R. Section 483.440	*Condition of Active Treatment.*

DEFINITIONS

Cross-systems crisis plan means a plan that helps service providers deliver a coordinated and collaborative response to a person experiencing, or at risk of experiencing, a crisis involving multiple systems of care and agencies (e.g., law enforcement, mental health agencies).

Discharge means movement of a client from a certified facility to another certified facility or other community location when the client is not expected to return to the original facility.

Receiving entity means the place where the client is moving to, which may be the client's family home, another nursing facility or intermediate care facility within an RHC, or some other community setting.

SUPERSESSION

None.

Approved: _/s/ Deborah Roberts_____ Date: January 15, 2019
Deputy Assistant Secretary (Acting)
Developmental Disabilities Administration