Discharge Planning
Case Studies

Taken from actual CMS 2567’s

Patient 1

Overview:
• Patient was admitted on a 72 hour hold for psychiatric evaluation due to symptoms of psychosis, auditory hallucinations and suicidal ideation
• Patient’s diagnoses:
  – Psychotic disorder, polysubstance abuse, opioid abuse, mild mental retardation, and chronic pain
• Patient had several congenital bone and joint defects, chronic back pain and used a wheelchair to assist in mobility.
• The patient was homeless
• Patient was placed on psychiatric medications that included
  – Thorazine for a psychotic disorder
  – Klonopin for anxiety
  – Cymbalta for depression
Overview: continued

- Patient was unable to care for himself and did not have the ability to focus or concentrate
  - Had physical limitations and restrictions with mobility
  - Ability to learn was below average
  - Exhibited a high risk for psychosocial problems which included housing, living situation, isolation, and social problems

- Patient wanted to go to a group home because he forgot where he was or how to get home
- He previously stayed at an assisted living facility in the city and he wanted to go back there.
- Discharge Planner: Assist the patient with possible discharge to the assisted living facility with follow-up for after care and the facility’s outpatient clinic

Initial treatment plan:

- Evaluate the patient
  - for any concerning psychosis or mood symptoms
  - for suicidal/homicidal ideation
  - response to medication
- Discharge planner to assist with dispositional needs
  - Could benefit from group home placement, perhaps assisted living as he has been to this facility in the past
- Start medications
- Medical consult
- Consider inpatient admission for psych testing and more dispositional needs
Progress Note & Discharge

In one of the psychiatric progress notes
• There is an indication that patient wanted to go to a different state to find a group home
  – (it was also noted the patient was upset, anxious, and hearing voices)
• Physician orders that day (documented) to discharge the patient to the Greyhound bus station by taxi with a three-day supply of medications as well as Ensure and snacks with the patient for a 15 hour bus ride
• Discharge planner:
  – the patient expressed a desire to return to an assisted living facility or group home in his current city
  – indicated that he called for placement but the facility refused to accept the patient.
• The Discharge planner acknowledged no other group homes or assisted living facilities were contacted
• Patient was discharged to the Greyhound bus station via taxi with a three-day supply of medication. Discharge instructions were explained to the patient

Discharge Planning

• What do we think of this discharge plan?

• If you were the Compliance Officer, what would you do?
Record Review

• There was no documented evidence in the medical record
  – of instructions provided to the patient that included an appointment made, addresses, phone numbers, and names of physicians or how the patient could access any services.
  – how the patient could access
    • mental health services,
    • narcotics anonymous meetings
    • medication clinic
    • name of a psychiatrist/medical physician for follow-up
    • a list of housing or shelters where the patient could stay

Facility Policy

• Provide each patient with a copy of the Discharge instructions including appoints made and/or how the patient can access services
• Document (prior to discharge) all contacts and referrals with intra agency and community programs
• Document the discharge planning process with the patient and multidisciplinary treatment team
• Provide the patient with information and appointments to appropriate services in the community
• Provide appropriate nourishment for length of travel and contact the Pharmacy for providing nourishment when patient arrives at destination
• Write a discharge summary that includes:
  – Complete description of referrals to treatment and community resources
  – Description of community based housing arrangements
  – Transportation resources provided
• Confirm patient has housing/shelter available
CMS Requirements (*in part*)

- The patient’s discharge summary describes the services and supports that are appropriate to the patient’s needs and will be effective the day of discharge
- A complete description of arrangements with treatment and other community resources for the provision of follow-up services
  - A plan outlining treatment and medication regimen
  - Specific appointment dates/times and addresses of the service providers
  - Description of community housing/living arrangements
  - Economic/financial status or plan
  - A complete description of the involvement of family and significant others with the patient after discharge

Deficiencies

Facility failed to:

- ensure a comprehensive discharge plan was implemented
- ensure policies/procedures and established standard of care were followed for patients discharged from the facility
- identify if the patient who were likely to suffer adverse health consequences upon discharge with an adequate discharge plan
- provide an appropriate safe discharge plan for patient according to the physician’s orders
Deficiencies

Facility failed to:

- provide that a discharge planning evaluation was completed on patients that included the likelihood of patients needing post hospital services and the availability of the services
- include a discharge planning evaluation for patients’ medical records that established an appropriate discharge plan
- arrange for the initial implementation of patients’ discharge plans

CMS cited **Condition Level Deficiencies** related to Governing Body and Discharge Planning for these deficiencies

Patient 2

Overview:

- Patient received emergent placement of a tracheostomy after experiencing respiratory failure
- Patient was hospitalized for 25 days
- Hospital course included ICU care for most of the 25 days
- Patient’s diagnosis included multiple co-morbidities
Facts

• Patient was discharged at approximately 12:30 pm
• Shortly after discharge, the CM and RT discover that suctioning equipment has not been ordered
• Physician’s order for home suction equipment was written more than 2 hours after discharge
• The Case Manager called the patient’s home approximately 4 hours post discharge and was told by the patient’s spouse that the patient was short of breath
• The family was told to call 911
• RT called the medical equipment driver who said the equipment was delivered to the home approximately 6 hours post-discharge
• Patient expired

Record Review

• Records indicate Case management was not aware of the need for patient/spouse teaching regarding suctioning and overall care of the tracheostomy identified by respiratory therapist post discharge
• A nursing progress note the day of discharge stated the patient said “Help...help, I am so anxious I can’t breathe....” Although the note stated to continue trach training, there was no documented evidence the patient/spouse demonstrated competency with the trach care
• A late entry in the record noted that “Case Manager spoke with spouse who expressed concerns regarding patient’s inability to cough up mucus and that the suction equipment had not yet arrived
• The patient responded in the background “I can’t cough anything up and I can’t breathe”
• The patient’s spouse was instructed to call an ambulance and go to the ED if unable to breath
Patient 2

• What do you do now?

• What should have been done?

Deficiencies

Facility failed to
• Assure that
  – a comprehensive & accurate discharge plan was devised and implement prior to discharge
  – that the patient’s needs regarding trach care, including necessary equipment and demonstration of competency to complete care was completed prior to discharge to patient home
  – complete a timely evaluation for all of the post hospital needs and services prior to discharge
• Have necessary equipment available & evidence of competency to use the equipment properly
• Ensure that the patient/spouse were counseled on all aspects of post discharge treatment/care to be done at home prior to discharge

CMS: Condition Level Deficiency related to QAPI and Discharge Planning
• Failure to meet the requirements for quality improvement and related discharge planning prior to discharge
~ Thoughts ~

*TJC*

[CMS Logo] [Medicare Logo]

[Image of money] [Image of scales]