Nursing Home Discharge Planning Checklist
MDS 3.0 Section Q

Disclaimer: Our facility is completing this information in accordance with MDS 3.0 Section Q regarding transition back into the community. We understand that the resident has a right to receive the needed long term care services in the least restrictive and most integrated setting. This information is true and correct to the best of our knowledge based in the information received from the resident during an interview.

Date Section Q Interview Conducted: ____

Person Conducting Interview: ____

Personal Information

Resident Name:	Room Number:
Primary Contact Person:	Relationship to Resident:
Medicare #	Medicaid #

Has the resident been adjudicated incompetent by a court of law? **Yes** ☐ **No** ☐

Has the resident been placed in the facility by DHR? **Yes** ☐ **No** ☐

If yes, was the placement by DHR:

Court Ordered/Protective Placement **Yes** ☐ **No** ☐

Please attach a copy of the Court Order

Has the resident been placed in the facility by a Court Order other than from DHR?

Please attach a copy of the Court Order **Yes** ☐ **No** ☐

Is the discharge medically contraindicated by a physician? **Yes** ☐ **No** ☐

The physician progress note can be located:

____

If the discharge is medically contraindicated by a physician, please explain ____________

____

If yes to any of the above questions, please stop the discharge planning process with respect to MDS 3.0 Section Q because it has been determined that discharge to the community is not feasible at this time. Before automatically stopping the discharge planning process, the nursing facility must document in the resident's medical record why it has been determined that discharge is not feasible at this time. If the resident persists and can feasibly be discharged, the discharge planning process should continue and include collaboration with the physician, guardian or court system.

Communication

Discharge Planning Start Date:	Local Contact Agency Assigned:
Has coordination been established with the Local Contact Agency?	When did the initial conversation occur with the Local Contact Agency? Date: Time: Name of person contacted: Title of person contacted:
Anticipated date and time of visit/call by Local Contact Agency: Date: Time:	Briefly describe the initial conversation with the Local Contact Agency:
What type of visit is expected from the Local Contact Agency. i.e., phone call, face-to-face?	Dates and times of additional follow-up contact made with the Local Contact Agency: Date: Time: Date: Time: Date: Time:

Signature of Facility Representative: ____

Date Signed: ________________________

Printed Name and Title of Facility Representative: _____________________________________

Housing – RAI Manual Q0400

What type of residence has the resident indicated that they wish to be discharged, i.e., another nursing facility, assisted living facility, private home, etc.?	Anticipated New Address:
Have any barriers and/ or challenges been identified by the Local Contact Agency?	List the barriers and/or challenges identified by the Local Contact Agency:

Assistive Technology - RAI Manual Q0400

Does the resident require assistive technology (Hardware and software that help people who are physically impaired)? Examples include, but are not limited to: eyeglasses, hearing aids, large print books, translating devices, TDD/TYY for phone service, etc. If so, what does the resident require? List all that apply	Has the facility communicated to the Local Contact Agency that the resident requires assistive technology: Date: Time: Name of person contacted:

Medical Needs/Referrals - RAI Manual Q0400

Is the resident enrolled in a managed care plan?	Name of managed care plan:
Has the resident been referred for Hospice services?	Name of Hospice Date of Referral
Has the resident been referred for Home Health services?	Name of Home Health Date of Referral

Has the resident been referred for other services?	Name of Other Services Date of Referral Name of Other Services Date of Referral Name of Other Services Date of Referral

Durable Medical Equipment - RAI Manual Q0400

Does the resident require any durable medical equipment, i.e., hospital bed, wheelchair, walker, etc.? If so, what does the resident require? List all that apply	Has the facility communicated to the Local Contact Agency that the resident requires durable medical equipment: Date: Time: Name of person contacted:

Medical Support - RAI Manual Q0400

On the day of transition, the following information has been communicated with the Local Contact Agency:

Type of transportation used to transition into the community:	Name of transportation Date set up Name of person contacted	Date Completed

Are medication orders written?	Medication orders requested and written Date set up Name of physician	Date Completed
Are treatment orders written?	Treatment orders requested and written Date set up Name of physician	Date Completed
Are special diet orders written?	Special Diet orders requested and written Date set up Name of physician	Date Completed
Does the resident have any allergies or reactions to medications?	Known allergies or reactions to medications	Date Completed
Are special nursing needs required?	Special nursing needs requested Date set up Name of Provider	Date Completed

Does the resident need Mental Health support?	Mental Health needs requested Date set up Name of Provider	Date Completed
Does the resident require assistance with Activities of Daily Living?	Activity of Daily Living needs requested Date set up Name of Provider	Date Completed
Does the resident require therapy?	Therapy needs requested Date set up Name of Provider	Date Completed
Have any medical or special appointments been pre-arranged for the resident upon discharge?	List of pre-arranged appointments Date set up Name of Provider Date set up Name of Provider Date set up	Date Completed

	Name of Provider Date set up Name of Provider	
Has the resident/responsible party received medication education?	Medication education provided for (list drugs): Date medication education provided Name and signature of Educator	Date Completed
Has the resident/responsible party received prevention and disease management education?	Prevention and disease management education provided for (list diseases): Date education provided Name and signature of Educator	Date Completed

Medical Support - RAI Manual Q0400

The following medications and/or scripts have been sent with the resident/responsible party upon discharge:

Name of Medication and/or Script	Dosage Instructions	Amount of Medication Distributed	Certification and Signature of Receiving Party
			Facility RN Signature Receiving Party Signature
			Facility RN Signature Receiving Party Signature
			Facility RN Signature Receiving Party Signature
			Facility RN Signature Receiving Party Signature
			Facility RN Signature Receiving Party Signature

Medical Support - RAI Manual Q0400

<u>Attach a copy of the medical records release form dated and signed to this document!</u>

The following documents have been sent with the resident/responsible party upon discharge:

Name of Document/Information	Certification and Signature of Receiving Party
Advance Directive	Facility Signature and Date Receiving Party Signature and Date
Brief Medical History	Facility Signature and Date Receiving Party Signature and Date
Medication Education	Facility Signature and Date Receiving Party Signature and Date
Post Discharge Plan of Care	Facility Signature and Date Receiving Party Signature and Date
Prevention and Disease Management Education	Facility Signature and Date Receiving Party Signature and Date
List of resident preferences and needs for care and supports	Facility Signature and Date Receiving Party Signature and Date
Name and phone number of who to call in case of an emergency or if symptoms of decline occur	Facility Signature and Date Receiving Party Signature and Date

	Facility Signature and Date Receiving Party Signature and Date
	Facility Signature and Date Receiving Party Signature and Date
	Facility Signature and Date Receiving Party Signature and Date
	Facility Signature and Date Receiving Party Signature and Date
	Facility Signature and Date Receiving Party Signature and Date

Date Discharge Completed: ______________________________

Signature of Facility Representative: ____

Date Signed: _______________________________

Printed Name and Title of Facility Representative: ____

Signature of Local Contact Agency Representative: ____

Date Signed: _______________________________

Printed Name and Title of Local Contact Agency Representative: __________________________________

Signature of Resident or Responsible Party: ____

Date Signed: _____________________________________