10A NCAC 13B .5406 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After goals of care have been reached, or a determination by the interdisciplinary care team has been made to return to the setting from which the patient was admitted, or that further progress is unlikely, the patient shall be discharged to another inpatient or residential health care facility that can address the patient's needs including skilled nursing homes, assisted living facilities, nursing homes, or other hospitals. Other reasons for discharge may include an inability or unwillingness of patient or family to cooperate with the planned therapeutic program or medical complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff members, and community-based services such as home health services, hospice or palliative care, respiratory services, rehabilitation services to include occupational therapy, physical therapy, and speech therapy, end stage renal disease, nutritional, medical equipment and supplies, transportation services, meal services, and household services such as housekeeping in discharge planning.

(b) The case manager shall facilitate the discharge or transfer process in coordination with the facility social worker.

(c) If a patient is being referred to another facility for further care, documentation of the patient's current status shall be forwarded with the patient. A discharge summary shall be forwarded within 48 hours following discharge and shall include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action recommendations, and activities and procedures used by the patient to maintain and improve functioning.

History Note: *Authority G.S. 143B-165;*
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