Q0310: Resident's Overall *Goal*

Q0310. Resident's Overall Goal

Complete only if A0310E = 1

Enter Code ☐

A. Resident's overall goal for discharge established during the assessment process

1. Discharge to the community
2. Remain in this facility
3. Discharge to another facility/institution
9. Unknown or uncertain

Enter Code ☐

B. Indicate information source for Q0310A

1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

Item Rationale

This item identifies the resident's general expectations and goals for nursing home stay. The resident should be asked about *their* own expectations regarding return to the community and goals for care. The resident may not be aware of the option of returning to the community and that services and supports may be available in the community to meet *their* individual long-term care needs. Additional assessment information may be needed to determine whether the resident requires additional community services and supports.

Some residents have very clear and directed expectations that will change little prior to discharge. Other residents may be unsure or may be experiencing an evolution in their thinking as their clinical condition changes or stabilizes.

Q0310: Resident's Overall *Goal* (cont.)

Health-related Quality of Life

- Unless the residents' goals for care are understood, *their* needs, goals, and priorities are not likely to be met.

Planning for Care

- The resident's goals should be the basis for care planning.
- *Great progress has been made in this area. This progress allows individuals more choices when it comes to care options and available support options to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the 1999 U.S. Supreme Court decision in Olmstead v. L.C., which states that residents needing long term services and supports have a civil right to receive services in the least restrictive and most integrated setting appropriate to their needs.*

DEFINITION

DISCHARGE
To release from nursing home care. Can be to home, another community setting, or a healthcare setting.

Steps for Assessment

1. Ask the resident about *their* overall expectations *and goals* to be sure that *they have* participated in the assessment process and *have* a*n* understanding of *their* current situation and the implications of choices such as returning home or moving to another appropriate community setting such as an assisted living facility or an alternative healthcare setting.
2. Ask the resident to consider *their* current health status, expectations regarding improvement or worsening, social supports and opportunities to obtain services and supports in the community.
3. If goals have not already been stated directly by the resident and documented since admission, ask the resident directly about what *their* expectation is regarding the outcome of this nursing home admission and expectations about returning to the community.
4. The resident's stated goals should be recorded here. The goals for the resident, as described by the family, significant other, guardian, or legally authorized representative, may also be recorded in the clinical record.
5. Because of a temporary (e.g., delirium) or permanent (e.g., profound dementia) condition, some residents may be unable to provide a clear response. If the resident is unable to communicate *their* preference either verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative.
6. Encourage the involvement of family or significant others in the discussion, if the resident consents. While family, significant others, or the guardian or legally authorized representative can be involved if the resident is uncertain about *their* goals, the response selected must reflect the resident's perspective if *they are* able to express it.
7. In some guardianship situations, the decision-making authority regarding the individual's care is vested in the guardian. But this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes.

Q0310: Resident's Overall *Goal* (cont.)

Coding Instructions for Q0310A, Resident's *o*verall *g*oal *for discharge e*stablished *d*uring *the a*ssessment *p*rocess

Record the resident's expectations as expressed by them. It is important to document their expectations.

- **Code 1, *D*ischarge to the community:** if the resident indicates an expectation to return home, to assisted living, or to another community setting.
- **Code 2, *R*emain in this facility:** if the resident indicates that *they* expect to remain in the nursing home.
- **Code 3, *D*ischarge to another facility/institution:** if the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.
- **Code 9, Unknown or uncertain:** if the resident is uncertain or if the resident is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative do not exist or are not available to participate in the discussion.

Coding Tips

- The *response to this* item s*hould be* individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident's expectations, not whether or not the staff considers them to be realistic. Coding other than the resident's stated expectation is a violation of the resident's civil rights.
- Q0310A, Code 1 "*D*ischarge to the community" may include newly admitted *residents with a facility-arranged discharge plan or those residents* with adequate supports already in place that would not require referral to a local contact agency (LCA). It may also include residents who ask to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community (Q0500B, Code 1*, Yes*).
- Avoid trying to guess what the resident might identify as a goal or to judge the resident's goal. Do not infer a response based on a specific advance directive, e.g., "do not resuscitate" (DNR).
- The resident should be provided options, as well as, access to information that allows *them* to make the decision and to be supported in directing *their* care planning.

DEFINITION

DESIGNATED LOCAL CONTACT AGENCY (LCA)

Each state has community contact agencies that can provide individuals with information about community living options and available community-based supports and services. These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

Q0310: Resident's Overall *Goal* (cont.)

- If the resident is unable to communicate *their* preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. Families, significant others or legal guardians should be consulted as part of the assessment.

Coding Instructions for Q0310B, Indicate *i*nformation *s*ource for Q0310A

- **Code 1, Resident:** if the resident is the source for completing this item.
- **Code 2, *F*amily:** if a family member is the source for completing this item *because the resident is unable to respond*.
- **Code 3, *Significant other*:** if *a significant other of the resident* is the source for completing this item because the resident is unable to respond.
- ***Code 4, Legal guardian:*** *if a legal guardian of the resident is the source for completing this item because the resident is unable to respond.*
- ***Code 5, Other legally authorized representative:*** *if a legally authorized representative of the resident is the source for completing this item because the resident is unable to respond.*
- **Code 9, *N*one of the above:** if the resident cannot respond and the family or significant other, or guardian or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0310A = 9).

Examples

1. *Resident* F is a 55-year-old married *individual* who had a cerebrovascular accident (CVA, also known as stroke) 2 weeks ago. *They were* admitted to the nursing home 1 week ago for rehabilitation, specifically for transfer, gait, and wheelchair mobility training. *Resident* F is extremely motivated to return home. *Their spouse* is supportive and has been busy adapting their home to promote *their* independence. *Resident F's* goal is to return home once *they have* completed rehabilitation.

   Coding: Q0310A would be **coded 1, *D*ischarge to the community**.
   Q0310B would be **coded 1, Resident**.

   Rationale: *Resident* F has clear expectations and a goal to return home.

2. *Resident* W is a 73-year-old *individual* who has severe heart failure and renal dysfunction. *They* also *have* a new diagnosis of metastatic colorectal cancer and *were* readmitted to the nursing home after a prolonged hospitalization for lower gastrointestinal (GI) bleeding. *They* rely on nursing staff for all activities of daily living (ADLs). *They* indicate that *they are* "strongly optimistic" about *their* future and only want to think "positive thoughts" about what is going to happen and need to believe that *they* will return home.

   Coding: Q0310A would be **coded 1, *D*ischarge to the community**.
   Q0310B would be **coded 1, Resident**.

Q0310: Resident's Overall *Goal* (cont.)

Rationale: *Resident* W has a clear goal to return home. Even if the staff believe this is unlikely based on available social supports and past nursing home residence, this item should be coded based on the resident's expressed goals.

3. *Resident* T is a 93-year-old *individual* with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about *their* care preferences, *they are* unable to voice consistent preferences for *their* own care, simply stating that "It's such a nice day." When *their adult child* is asked about goals for *their parent*'s care, *they* state that "We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints, the level of care that she needs, and other work and family responsibilities we cannot adequately meet her needs at home. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort and for us to spend as much time as we can with her." The assessor confirms that the *adult child* wants care oriented toward making *their parent* comfortable in *their* final days, in the nursing home, and that the family does not have the capacity to provide all the care the resident needs.

   Coding: Q0310A would be **coded 2, *R*emain in this facility**.
   Q0310B would be **coded 2, Family**.

   Rationale: *Resident* T *does* not respond *appropriately to the question of their care preferences*, but *their adult child* has clear expectations that *their parent* will remain in the nursing home where *they* will be made comfortable for *their* remaining days.

4. *Resident* G, an 84-year-old *individual* with severe dementia, is admitted by *their adult child* for a 7-day period. *Their adult child* stated that *they* "just need to have a break." *Their parent* has been wandering at times and has little interactive capacity. The *adult child* is planning to take *their parent* back home at the end of the week.

   Coding: Q0310A would be **coded 1, *D*ischarge to the community**.
   Q0310B would be **coded 2, Family**.

   Rationale: *Resident* G is not able to respond but *their adult child* has clear expectations that *their parent* will return home at the end of the 7-day respite visit.

5. *Resident* C is a 72-year-old *individual* who had been living alone and was admitted to the nursing home for rehabilitation after a severe fall. Upon admission, *they were* diagnosed with moderate dementia and *were* unable to voice consistent preferences for *their* own care. *They have* no living relatives and no significant other who is willing to participate in *their* care decisions. The court appointed a legal guardian to oversee *their* care. Community-based services, including assisted living and other residential care situations, were discussed with the guardian. The guardian decided that it is in *Resident* C's best interest that *they* be discharged to a nursing home that has a specialized dementia care unit once rehabilitation was complete.

   Coding: Q0310A would be **coded 3, *D*ischarge to another facility/institution**.
   Q0310B would be **coded *4*, *Legal* guardian**.

Q0310: Resident's Overall *Goal* (cont.)

Rationale: *Resident* C is not able to respond and has no family or significant other available to participate in *their* care decisions. A court-appointed legal guardian determined that it is in *Resident* C's best interest to be discharged to a nursing home that could provide dementia care once rehabilitation was complete.

6. *Resident* K is a 40-year-old with cerebral palsy and a learning disability. *They* lived in a group home 5 years ago, but after a hospitalization for pneumonia *they were* admitted to the nursing home for respiratory therapy. Although *their* group home bed is no longer available, *they are* now medically stable and there is no medical reason why *they* could not transition back to the community. *Resident* K states *they* want to return to the group home. *Their* legal guardian agrees that *they* should return to the community to a small group home.

Coding: Q0310A would be **coded 1, *D*ischarge to the community**
Q0310B would be **coded 1, Resident**

Rationale: *Resident* K understands and is able to respond and says *they* would like to go back to the group home. *Their* expression of choice should be recorded. When the legal guardian, with legal decision-making authority under state law, was told that *Resident* K is medically stable and would like to go back to the community, *the legal guardian* confirmed that it is in *Resident* K's best interest to be transferred to a group home. *Small group homes are considered community settings.* This information should also be recorded in the individual's clinical record.