County of Los Angeles **Department of Health Services**

OLIVE VIEW-UCLA MEDICAL CENTER
CLINICAL SOCIAL WORK
POLICY & PROCEDURE

NUMBER: 1319
VERSION: 2

SUBJECT/TITLE: **ADULT DISCHARGE PLANNING BY SOCIAL WORK STAFF**

POLICY: Clinical Social Work will assess all patients referred for discharge planning and facilitate out of home placement of appropriate patients.

PURPOSE: To provide guidelines for staff regarding discharge planning requirements for adult patients.

DEPARTMENTS: All

DEFINITIONS: Adult discharge planning.

PROCEDURE:

1. Educate patient care staff to refer all appropriate patients for discharge planning assistance.

2. Participate with Medicine, Nursing, Continuity of Care, UR, OT, PT, RT etc in collaborative discharge planning involving the patient and when appropriate with the family or significant others. Utilize collaborative care rounds and multidisciplinary documentation to facilitate communication and coordination.

3. Receive referrals from the ward staff through Orchid system and discharge rounds or from patients, family or others directly. Patients should also be identified for referral through the initial assessment process conducted by the inpatient nursing staff.

4. Clinical Social Work staff will respond to these referrals by the end of the next business day.

5. The Clinical Social Work assessment for discharge planning will include the following: the likelihood of a patient to need post-hospital services and the availability of those services, the likelihood of the patient to have capacity for self-care or to have someone else in his environment who can provide the care that is needed, the patient’s understanding of his probable health care needs upon discharge, the need for referrals to other ancillary services for additional discharge planning (e.g. financial services, continuity of care, PT, OT, RT), and the patient’s understanding and degree of agreement with the clinical social work assessment.

6. If the patient consents, family and others who may be involved in the implementation of the discharge plan should be consulted and informed of the potentially needed care. The patient and the family are always encouraged to participate in the discharge plan.

7. The social work discharge assessment and any interventions or problems must be documented in the patient's medical record.

8. When the patient is approaching discharge the discharge plan should be reassessed for appropriateness and reconfirmed with the patient as well as the current and potential caregivers.

9. If the patient does not agree to a plan deemed appropriate by the treating physician, the patient may be discharged to his/her own plan. Any possible intervention or encouragement to achieve a good outcome for the patient should be provided and no punitive action taken. Ours is a resource of last resort and our patients must not be discouraged from returning for care when they are in need.

10. When the patient is being referred to community resources, both verbal and written information should be provided to the patient or family in an appropriate language whenever possible. If needed, and with consent to release, appropriate medical information should also be provided.

11. When a patient is being transferred to a skilled nursing facility appropriate medical information must be provided to that facility.

12. If a patient, family or a SNF should contact the clinical social work staff after discharge, appropriate assistance will be provided when possible.

References: CMS Standard 482.43	
Approved by: Patricia Evans (Clinical Social Work Chief I)	Date: 06/19/2017
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