UR MEDICINE | THOMPSON HEALTH

THOMPSON HOSPITAL
CLINICAL PRACTICE GUIDELINE

Clinical Guidelines for Social Work for Patients Undergoing Total Joint Arthroplasty

Introduction

Social Workers on the Orthopedic Center of Excellence are focused on planning for an individual's transition to home or to another level of care. The goal is to assist in the process of providing each patient with continuity of care. Continuity of Care ensures the coordination of care within an organization or across different agencies or settings to reduce duplicate services, to address goals in existing services, and to ensure consistent and continuous services for the client as they transition in care or are discharged.

RECOMMENDATIONS

Preoperative Evaluation:

1. Social Worker participates in the pre-op joint class
   a. Social Worker speaks with the patients regarding discharge plan
      i. Patients are the primary focus of care and participate in decisions regarding their discharge plan
   b. Completes necessary paperwork, indicating if the patient anticipates discharge directly home or to a skilled nursing facility upon discharge from the hospital.
   c. Social Work provides information regarding eligibility/need for skilled rehabilitation and potential coverage.
2. Social Worker initiates contact with patient and/or family members prior to admission
   - Early contact by the Social Worker ensures that the patient is considered in a biopsychosocial context and that patient and families have sufficient time to deal with the hospitalization and to plan for the transition and discharge

Screening:

1. All patients who are having a total joint replacement

Psychosocial Assessment: The following information is collected from the patient and/or family member at the pre-op joint class, on the telephone prior to surgery and/or upon admission to the hospital.

1. Personal Data
2. Health Status/Age
   a. Disease process
3. Type of Surgery
   a. Past Surgical History
4. Functional Status
5. Cognitive Status
6. Patient Support System
7. Caregiver Support System
8. Financial Status

9. Vocational Status/Potential
10. Community Reintegration
11. Home & Community Environment
12. Medical equipment in place/needed

Reassessment is an ongoing process, with a formal reassessment conducted at prescribed intervals and whenever there is a significant change in the patient's health, abilities, living situation, family involvement, etc. Reassessment includes evaluation of the type and intensity of services required, with change made to the treatment plan accordingly; contacts with therapy and other team members and at Rounds.

Intervention Methods:

1. Treatment Options
    - Home Plan
        i. Patient and/or family preference for home care provider
        ii. Verify insurance and/or County of residence for pre-determined agencies
        iii. Identify and notify home care agency
        iv. Medical equipment e.g. CPM machines, walkers, etc.
    - Rehabilitation at skilled nursing facility
        i. Patient selects at least 5 choices (and more, if needed) from list of facilities in the community provided by the Social Worker
        ii. PRI and Screen will be completed
        iii. Social Worker communicates preferences to CM/SW Administrative Assistant; referrals will be sent.
        iv. Social Worker will be alerted by the CM/SW Administrative Assistant of calls of available bed offers and/or barriers to discharge.
        v. The Social Worker confirms bed offer with patient and/or family member, Physician, and Nursing.
        vi. Social Worker facilitates discharge
2. Collaboration
    - Social Worker will collaborate with patients, family members/significant others and interdisciplinary team members informed about progress toward goals, obstacles, and changes to the plan
    - Multidisciplinary input and active collaboration in each patient's treatment and discharge planning ensure that all available information and expertise is considered as decisions are made
3. Continuum of Care
    - Social Workers are available in the rehabilitation facilities and through the home care agencies to provide re-evaluation, planning, and referrals as appropriate as required to ensure continuity of care.
4. Documentation
    - Plans of care are developed and documented in the patient's medical record
    - The patient's understanding and acceptance of the treatment plan is documented
    - Documentation focuses on new and pertinent information relevant to the current/proposed course of treatment or future planning.

- All medical record documentation is kept confidential in nature and should be treated accordingly
- Documentation is electronically signed by the Social Worker with the specific professional credentials identified (i.e. LMSW)

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