SC.3 Patients with psychosocial risk have an appropriate plan that meets their needs.

SC.3.1 The social worker works collaboratively with clinical staff (physicians, nurses, and other clinical staff) to develop a suitable plan of care that meets the psychosocial needs of the patient and ensures the continuity of care.

SC.3.2 Patients are reassessed by social worker at regular intervals, their response to the plan of care is monitored, and adjustments are made accordingly.

SC.3.3 The plan of care is documented in the patient's medical record as part of multidisciplinary team planning.

Standard Intent:

The social worker works collaboratively with clinical staff (physicians, nurses, and other clinical staff) to develop a suitable plan of care that meets the psychosocial needs of the patient and ensures the continuity of care with regular reassessment to monitor their response to plan. The plan of care must be documented in the patient`s medical record.

SC.4 The hospital ensures the provision of effective social care services for inpatients and outpatients.

SC.4.1 Social worker helps patients cope with illness, treatment, and recovery.

SC.4.2 Social worker helps patients subjected to abuse, neglect, or violence.

SC.4.3 Social worker assists patients and families communicating meaningfully with healthcare teams.

SC.4.4 Social worker assists patients and families during grief and bereavement.

SC.4.5 Social worker assists patients in job-related and school concerns.

SC.4.6 Social worker assists patients to gain access to hospital and other community-based services including home health care and financial assistance.

SC.4.7 Social worker participates with the treating team in discharge planning.

Standard Intent:

The hospital ensures the provision of effective social care services for inpatients and outpatients including all mentioned sub-elements.

SC.5 The social worker documents all relevant patient information in the medical record.

SC.5.1 The social worker documents relevant information in the patient's medical record, which include:

SC.5.1.1 Reason for referral.

SC.5.1.2 Patient/family assessment and reassessment findings.

SC.5.1.3 Plan of care including goals and interventions such as counseling, education, and facilitation of resources.

SC.5.1.4 Evaluation of the plan of care.

SC.5.1.5 Regular progress notes that include the patient/family understanding, care progress, and needs for different or additional services.

Standard Intent:

The social worker documents relevant information in the patient's medical record, which include the reason for referral, patient/family assessment and reassessment findings and the evaluation of the plan of care. In addition, regular progress notes that include the patient/family understanding, care progress, and needs for different or additional services.