THE POWER OF SOCIAL WORK DOCUMENTATION

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OBJECTIVES

Recognize and address at least 3 common barriers and pitfalls to creating effective social work documentation

Identify 3 criteria of an effective and practical social work palliative care note

Assess 2 ways in which documentation can impact the clinical care of patients receiving palliative care as well as the perception of the social work role on a palliative care team
THE PALLIATIVE CARE SOCIAL WORKER

Psychosocial Provider

Palliative Care Clinician
RELEVANT PALLIATIVE SOCIAL WORK COMPETENCIES

- **Knowledge**
  - Social work/biopsychosocial theory
  - Real world needs, challenges, strengths of clients/community resources
  - Health and care systems, insurance
  - Symptoms: physical and emotional
  - Behavioral/mental health
  - Cultural and spiritual concerns
  - Ethical and legal principles
  - End of life care
  - Grief and bereavement
RELEVANT PALLIATIVE SOCIAL WORK
COMPETENCIES CONT’D

- Skills
  - Assessment
  - Treatment planning and interventions (e.g. advocacy, communication, counseling)
  - Interdisciplinary teamwork and education
  - Supervision, training, and leadership

(Gwther, Altilio, Blacker et al.)
- Provides assessment and planning
- Describes relevant psychosocial and family dynamics
- Records service delivery
- Tracks care coordination
- Assists in supervision
- Enhances accountability and worker protection

(Reamer, 2005)
PALLIATIVE SOCIAL WORK DOCUMENTATION...

- All of the previous

AND

- Describes goals of care
- Assesses decision-making/communication
- Focuses on patient/family-defined quality of life
- Identifies symptom burden and other areas of potential suffering
- Relates to issues of anticipatory grief and bereavement
- Provides recommendations
When done well:

- Enhances communication
- Models interdisciplinary work and palliative language in the SW and medical record
- Aides in collaboration with existing psychosocial providers
- Assists in clarification of palliative social work role
- Displays the relevance of SW theory and interventions in palliative medicine
What we say matters.

How we say it matters.

Documentation is often taught in-setting, with some evidence new social workers feel unprepared and untrained (Kane, 2001).

Palliative Social Workers can play a role in helping shape the language of the medical record.
We see patients and families at their most vulnerable and at their highest level of need.

An enhanced level of care requires enhanced written communication.
“Similar to scalpels for surgeons, words are the palliative care clinician’s greatest tools. Surgeons learn to use their tools with extreme precision, because any error can be devastating. So too should clinicians who rely on words.” (Eric Cassell, MD)
Words and language are the tools of palliative care.
They “define, clarify, and communicate experience” (Wolfe, Hinds, Sourkes, 2011).
Their potential for positive and negative impacts are substantial.
This is particularly true in a permanent written record.
LANGUAGE PROBLEMS

- Vague
  - E.g. “provided support”, “offered care”
- Passive
  - E.g. “remained a supportive listening presence”
- Judgmental
  - E.g. “patient is splitting”, “family enmeshed”
- Drawing Conclusions
  - E.g. “he was confused”, “she is angry”

Problematic language detracts from depth of social work and weakens our role.
BARRIERS TO DOCUMENTATION

Personal?

Professional?

Institutional?
BARRIERS TO EFFECTIVE DOCUMENTATION

- **Time Management**
  - Detracts from ‘real’ work
  - Good notes take thought

- **Institutional Challenges**
  - “Politics”
  - Technical challenges
  - Regulations

- **Ethical Risk**
  - What’s relevant?
  - Confidentiality v. important detail

- **Lack of Guidance/Tools**
  - Level of training/supervision
  - Availability of templates, forms, etc.
ETHICAL RISK

- Fear that “too much” documentation or detail violates confidentiality OR puts provider at risk

- Including all relevant information: ultimately protective of client and clinician

- Assessment v. drawing unexplained conclusions

- Writing smarter not necessarily longer

- Writing for an audience/ patient and family access to records

(Reamer 2005; Cumming et al. 2007)
WHAT NEXT?
INFORMED BY EACH OTHER

Documentation

Assessment
CONSIDERATIONS FOR STRUCTURE

- Gives the assessment/narrative a useful backbone
- Hits all salient points, addressing concerns
- Helps with ethical risk
- Guides shape of note which can help with time management concerns
- Gives narrative a predictable and useful structure
- Creates a blend between structure and well-written narrative
# Social Work Assessment Tool (SWAT)

Complete after each social work visit. Rate the patient on how well s/he is doing on concerns regarding each issue. Rate the primary caregiver on how well s/he is doing on each issue, or on how well s/he is coping with patient concerns regarding the issue. If there are no concerns in an area, circle 5 ("extremely well"). Each issue should be assessed during each client contact.

<table>
<thead>
<tr>
<th>Patient I.D.#</th>
<th>Date of social work visit</th>
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</thead>
</table>

| ISSUE: | | | | | | | | |
|--------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| 1. End of life decisions consistent with their religious and cultural norms | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 2. Patient thoughts of suicide or wanting to hasten death | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 3. Anxiety about death | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 4. Preferences about environment (e.g., pets, own bed, etc.) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 5. Social support | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 6. Financial resources | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 7. Safety issues | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 8. Comfort issues | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 9. Complicated anticipatory grief (e.g., guilt, depression, etc.) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 10. Awareness of prognosis | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 11. Spirituality (e.g., higher purpose in life, sense of connection with all) | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

**TOTAL Patient Score:** __________  **TOTAL PCG Score:** __________

NOTE: To calculate total scores: add the score for each item in the patient column to get a total patient score. Add the
<table>
<thead>
<tr>
<th>SOCIAL WORK ASSESSMENT TOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 item questionnaire, Likert scales</td>
</tr>
<tr>
<td>Basis to develop categories and organize psychosocial issues to assess patient and caregiver needs</td>
</tr>
<tr>
<td>Researched-based, philosophical framework for hospice social work documentation</td>
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<tr>
<td>Brief and useful format</td>
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<tr>
<td>Reminder of key concepts</td>
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<tr>
<td>Assigns numerical values to complex issues</td>
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<tr>
<td>Consistent instrument</td>
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</tbody>
</table>

(Reese et al., 2006)
## Table 1: SWAN Psychosocial Assessment Guide

<table>
<thead>
<tr>
<th>SWAN Areas</th>
<th>Issues to Assess by Psychosocial Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Care Needs and Safety Concerns</td>
<td>- Current and changing care needs, ability to perform ADLs, obstacles to patient safety, need for additional resources or alternative placement, current and potential future caregiver limits, need for help with planning, impaired decision making or need for capacity screening, risk or existence of abuse/neglect/exploitation, need for intervention or referral to APS/CPS.</td>
</tr>
<tr>
<td>2. Financial Needs</td>
<td>- Need for financial assistance and referral to internal agency or community resources.</td>
</tr>
<tr>
<td>3. Awareness and Understanding of Prognosis</td>
<td>- Knowledge and understanding of prognosis, disease process, issues of denial, and acceptance of hospice care and philosophy. Need/desire for accurate information, EOL education, and facilitation of open discussion/meeting.</td>
</tr>
<tr>
<td>4. Sense of Well-Being and Adjustment</td>
<td>- Quality-of-life issues, ability to enjoy regular activities, impact of illness on lifestyle; sense of autonomy and control; satisfaction with environment and living situation; preferred place of death; regrets; unfinished business; fulfillment of needs/desires for intimacy, including sexual expression; intense sadness and depression. Anxiety related to terminal illness, physical decline, loss of independence, need for caregivers or alternative living arrangements, fear of burdening others, and fear of impending death. Current and past coping, any past trauma affecting current situation. Need for relaxation and anxiety reduction techniques, supportive counseling, and EOL education.</td>
</tr>
<tr>
<td>5. Interpersonal Issues and Level of Social Support</td>
<td>- Family dynamics/conflict, existing support system, mental health issues, factors that impede healthy communication, divergent expectations, substance abuse issues, isolation, available emotional support, and desire for resolution/reconciliation.</td>
</tr>
<tr>
<td>6. Coping Related to Loss and Anticipatory Grief</td>
<td>- Emotional factors related to impending death: guilt, anger, unresolved issues, past loss, and past trauma affecting current grief. Paradox of holding on and letting go, impending changes to the family system, ability to acknowledge the reality of death and to share the pain of grief. Coping strategies, need for EOL education, counseling, and support.</td>
</tr>
<tr>
<td>7. Suicidal Ideation and Potential for Suicide Risk</td>
<td>- Identifying presence of suicidal ideation and distinguishing between the readiness for life to end and the desire for an end to suffering. Finding of risk results in completion of suicide risk assessment and planned interventions.</td>
</tr>
<tr>
<td>8. Cultural Values</td>
<td>- Identifying, seeking understanding of, honoring, educating, and advocating for needs related to beliefs and cultural values. May include communication style and preferences, space, role of family members, and special traditions. Addressing cultural, religious, spiritual, familial organization/processes and preferences related to issues such as pain control, decision making, and death.</td>
</tr>
<tr>
<td>9. Decision Making and Advance Planning</td>
<td>- Need/desire for information, education, and assistance with health care options such as advance planning and decision making, advance directives, final arrangements, and other legal issues.</td>
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</tbody>
</table>

**Notes:** SWAN = Social Work Assessment Notes; ADLs = activities of daily living; APS = Adult Protective Services; CPS = Child Protective Services; EOL = end of life.
SOCIAL WORK ASSESSMENT NOTE (SWAN)

- Evolved from SWAT
- Allows for both numerical ratings and narrative
- Two note templates: initial psychosocial assessment and ongoing psychosocial assessment
- 9 broad psychosocial assessment areas
- Creates opportunity for ongoing/evolving assessments during visits and across relationships

(Hansen et al, 2015)
EXPERIENCE WITH TEMPLATES

Positive?

Negative?
- What is the mission/goal of your team?

- What psychosocial information is most helpful in driving a treatment plan?

- What psychosocial information does your medical team rely on finding in your note?

- What information needs to be communicated to other team members caring for the patient?
**WHAT MIGHT OUR TEMPLATE LOOK LIKE**

<table>
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<td>Cultural/Spiritual Formulation</td>
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<tr>
<td>Worries/Concerns</td>
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<tr>
<td>Hopes/Goals</td>
</tr>
<tr>
<td>Clinical Impression</td>
</tr>
<tr>
<td>Plan</td>
</tr>
</tbody>
</table>
1. Tell me about your child
2. What do you understand about your child’s illness?
3. Given what we know about your child’s illness, what are your hopes?
4. Given what we know about your child’s illness, what worries you most?
5. Where do you find your strength?
1. TELL ME ABOUT YOUR CHILD

- Quality of life
- Baseline function/ADLs
- Ideas to improve hospital quality of life
- Living situation/family composition
- School life
- What is important to child and family
- Acknowledgement of child as a child
2. WHAT DO YOU UNDERSTAND ABOUT YOUR CHILD’S ILLNESS?

- Family’s understanding of disease process/illness trajectory
- Family’s state of processing/coping
- Family’s education/cognition level
- Which providers/services does family identify with rely on for information
3. WHAT ARE YOUR HOPES?

- Family’s understanding of disease process/illness trajectory
- Family’s priorities/goals of care
- Child’s priorities/goals of care
- Align with family/build rapport
- Invention plan/strategy
4. WHAT WORRIES YOU MOST

- Family’s understanding of disease process/illness trajectory
- Family’s priorities/goals of care
- Child’s priorities/goals of care
- Identification of distressing symptoms
- Align with family/build rapport
- Invention plan/strategy
5. WHERE DO YOU FIND YOUR STRENGTH?

- Religious/spiritual preferences
- Sources of family support/resources
- Sources of support for child
- Family’s relationship with medical providers
GIVING THE NOTE SHAPE: POSSIBLE HEADERS

- Reason for Palliative Care Consult:
- Participants:
- Family Composition:
- Coping and Support:
- Cultural/Spiritual Formulation:
- Communication and Decision-Making:
- Hopes/Goals:
- Worries/Suffering:
- Clinical Impressions:
- Plan:
INFORMED BY EACH OTHER

Assessment

Documentation

Language
### HELPFUL LANGUAGE WHEN DOCUMENTING

- **Vague vs. Descriptive**
  - **Vague**: “provided support”, “offered care”
  - **Descriptive**: “met with family to discuss stressors involved with extended hospitalization”

- **Passive vs. Active**
  - **Passive**: “remained a supportive listening presence”
  - **Active**: “identified and discussed strategies of coping with frustration”
HELPFUL LANGUAGE (CONTINUED)

- Judgmental vs. Nonjudgmental
  - Judgmental: “patient is splitting”, “family enmeshed”
  - Nonjudgmental: “patient benefits from consistent communication from a continuity provider”, “family appears reliant on each other in medical decision-making”

- Drawing Conclusions vs. Making Clinical Assessments
  - Drawing Conclusions: “he was confused”, “she is angry”
  - Clinical Assessment: “given her questions, further discussion with patient around her prognosis would be helpful”
THOUGHTS ON A TREATMENT PLAN

- Nonspecific interventions and plans are less helpful

- Be specific about WHAT you are working on with WHOM and WHEN it will be carried out
  - Helpful to use time frames and objectives
  - Consider being as specific with the plan as you are in assessment

- Identify what team members you are collaborating with (ie: primary social workers, medical team members, etc.)
  - May consider the culture of your institution
GOALS TO ENHANCE SW PALLIATIVE CARE VIA DOCUMENTATION

- Sets the stage for care and helps develop palliative care narrative
- Helps deepen our work: we internalize our external template (our documentation) to frame social work interview
- Communicates the richness of the human experience in facing illness and death for patient and family
- Shares the underpinnings of family decision-making and individual themes with other caregivers and family
- Establishes a platform on which palliative care can evolve
Referral Information:

- Lisa – 26 Y/O with advanced CF referred by primary pulmonologist to address issues of anxiety and claustrophobia
- Diagnosed at age 2 following brother’s diagnosis
- New to BCH – followed pulmonologist from other institution
- Has much beloved 7 year old son, Ben
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Family History and Composition
- Lives with son, Ben, and fiance, Jack and her mother
- Complex family situation – mother and step father; father and his girlfriend, Jack’s parents
- Brother died of CF when she was 15 – at home unexpected
- HX substance and alcohol misuse for Lisa and her parents

Coping and support
- Intermittent and fluctuating support from parents/step families
- Changing allegiances
- Maintaining control important
- Close and complex relationship with hospital nurses and care team
- **Cultural/Spiritual Formulation**
  - Describes her brother as her “guardian angel” for herself and for Ben.
  - Catholic and has family church but does not actively seek support there. Looks for spiritual guidance and healing through faith and spiritual practices such as her aunt/Tarot cards/Reiki, guided meditation.

- **Communication/Decision Making**
  - Wants control of all decision making.
  - Complicated relationship with family members and earned trust issues - health care proxy a “moving target.”
  - Does not want to be a burden to her family.
  - Protection and care of her son is of utmost importance.
Worries/Concerns
- Biggest worry is protection of Ben - that she won’t be alive long enough to raise him properly
- Fiancé then husband, Jack – more friend than father
- Her money would be protected to care for Ben after she’s gone
- Pain/suffering - intractable anxiety
- Trauma of her brother’s death not repeated when she dies

Hopes/Goals
- To live as long as possible to raise her son
- To avoid lung transplant
- To be home as much as possible to be with her son
- To develop memory making for her son to carry her “voice into the future after she dies” – continue to raise him after her death
**Clinical Impressions**
- Strong willed and strong personality
- Vulnerabilities: anxiety and fears
- Complicated support system
- Great support by nurses but complicated
- History of substance misuse often misunderstood
- Admitted for pain/asks for opioids/Nursing distress (“drug seeking”)

**Plan**
- Ongoing QOL/Memory Making supports for Ben: journals, tickets for special events, etc
- Pain and symptom mgmt: ongoing education to nursing and pulm team
- Support in home
- Social Work guidance: financial, family relationships, changing proxy, reinforcing resilience
**LISA’S PALLIATIVE CARE THEMES**

- Protection of son and family her priority
- Seeks control of life and relationships: challenged during lengthy hospitalization
- Adult cared for in the pediatric setting
- Guided by her experience with her brother
- Anxiety and pain ongoing symptom issues: inpatient/outpatient
- Communication complicated by complex family, multiple teams and relationships with nursing and staff
- PACT considered primary support
QUESTIONS? COMMENTS?
BIBLIOGRAPHY


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