The Social Work Alert System: An account of a new initiative in the emergency department at Middlemore Hospital

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Abstract

This article discusses a new initiative within the Emergency Department and the wider Middlemore Hospital in South Auckland, namely a Social Work Alert System (SWAS) that enhances delivery of quality care for patients. The SWAS is defined as a social work process that identifies patients who may be at risk due to past or present circumstances so that they may be reviewed and psychosocially assessed by a social worker. For the purposes of this article, a scenario is used to illustrate how the SWAS operates involving a pregnant mother who came to hospital through the Emergency Department.

Introduction

The need to identify and respond adequately and promptly to potentially at-risk patients within the hospital is an on-going area of development. In response, Counties Manukau District Health Board (CMDHB) supported a social work initiative to set up a process to identify at-risk patients coming through the Emergency Care at Middlemore hospital. This article will explore the background surrounding the set up of this new initiative and how it links to social work practice in Emergency Care. A case scenario will be used to illustrate how the SWAS works and relates to practice in the Emergency Care and other areas of the hospital. This scenario focuses on how the SWAS applies to potentially at-risk pregnant mothers coming to Middlemore.

Background to the Social Work Alert System

The SWAS was created as a result of social workers' concerns about potentially at-risk patients not being identified and seen by social workers on admission to hospital. The set up of this new social work process involved extensive negotiations and efforts by social workers within the Counties Manukau Acute Allied Health Service. In leading this project the

social workers took a collaborative and partnership approach which involved meetings and consultation with various divisions and personnel such as the Family Violence Prevention Co-ordinator; Child Protection Service; Patient Information Services; Acute Allied Health Service and Administration Managers. It was decided that the Social Work Alert would be modelled on the already in place Child Protection Alert System and then modified as needed to fit a social work emphasis.

The SWAS guidelines and procedures came into effect in February 2008 after extensive development work carried out by Saloshni Ayiar. CMDHB supported the resourcing of this new initiative by social workers who were informed by the increasing body of research that reflects the link between family violence and neglect, and health care utilisation and costs (Rivara, et al., 2007; Fanslow & Robinson, 2004). This support allowed the opportunity for Acute Allied Health social workers leading the initiative to form the Social Work Alert Committee in March 2008 and invite key stakeholders such as the Family Violence Prevention Co-ordinator to be members in order to oversee the development of the SWAS and its administrative pathway. The next section focuses on the administrative pathway to creating a new alert system.

Identification of potentially at-risk patients

Prior to the alert system, the way of identifying potentially at-risk patients was dependent on a number of pathways: self-referral by patient with disclosure of risk by patient to clinicians; the clinician identifying the need for social work input; and, if non-accidental injuries (such as severe facial bruising) are apparent, by an automatic referral to social worker. Apart from the above avenues leading to referral to social workers, social workers can also actively screen for new admissions of potentially at-risk patients. Therefore, social workers and health clinicians need to be aware and understand about potentially at-risk patients because this will increase the likelihood of referring these patients to social workers and for them to receive appropriate support services. One of the responses to this gap was the development of the SWAS, its purpose being to increase the likelihood of capturing potentially at-risk patients entering the hospital by identifying them through an alert system visible to clinicians on the intranet. To complement this effort, the Family Violence Prevention Screening Programme involves CMDHB health clinicians being trained to screen patients for family violence. On disclosure of abuse under this programme, referral to social workers would occur and other support services provided.

The SWAS was designed to focus on key areas of need and risk for patients where the social worker plays a significant role in identifying socially at-risk patients coming into the hospital environment and coordinating responses. By creating an alert system specific to social work within the wider hospital patient information system, it therefore reinforces the social worker's role in addressing the link between hospital admissions and underlying social risks (Fanslow & Robinson, 2004). With risk being so broadly defined, social workers in Acute Allied Health at Middlemore developed the five guiding risk categories for the Social Work Alert System: (1) family violence (2) pregnant mothers living in high risk situations (3) elder abuse (4) transient patients and (5) DNA – did not attend appointment.

The five guiding risk categories were established from the influence of three valuable knowledge sources: (a) research (b) the local community & population in Counties-Manukau and (c) CMDHB policy. A brief discussion of these three knowledge sources follows.

The research

Research indicates a high rate of child abuse and abuse-related deaths of children in New Zealand and it is also known that battered women have three times the rate of hospital admissions than non-battered women (Bergman and Brismar, 1991). Furthermore, there is research identifying the impact of physical and emotional abuse to persons and the health implications on them (Goodyear-Smith, 2004). A growing body of research (for example, Campbell, 2002; Goodyear-Smith, 2004) also indicates that:

> …partner abuse can have a wide range of long-term physical health effects (e.g. chronic pain, gastrointestinal and cardiac symptoms, sexually transmitted diseases, vaginal bleeding and infection, chronic pelvic pain, and urinary tract infections), and mental health effects (e.g. depression, post traumatic stress disorder, alcohol & drug abuse' (Goodyear-Smith, 2004, p.1).

Furthermore, the link between admission to hospital by those experiencing family violence is increasingly emphasised (Fanslow & Robinson, 2004), and the need for health care providers to identify and intervene in such cases following admission (Loughlin, Spinola, Stewart, Fanslow, & Norton, 2000). Therefore, innovative systems and practices which focus on risk factors within the public health system are gaining support (Barker, Ricardo & Nascimento, 2007). We developed three risk categories that reflect the growing research on social risk factors of violence and the link to the patient's admission to hospital. They are: 1) family violence, 2) pregnant women living in high-risk situations and 3) elder abuse. Research is an essential tool in justifying the allocation of resources and funding to progress such systems. Addressing social issues as they relate to a person's health is a key hospital social work role.

Characteristics of the local community in Counties Manukau

The second type of knowledge that informed the project is consideration of the diverse nature of Counties Manukau's population. According to the 2006 Census, the population within the Counties Manukau catchment area is not only culturally diverse but also very youthful and highly represented in the lower socio-economic sector (Wang & Jackson, 2008). The research by Paediatric Society, March, 2008 (A Health Status Document) also confirms birth rates are higher among teenagers in Counties Manukau and admission to hospital for injuries are likely to occur from assaults (Craig, Jackson & Han, 2007). These statistics and characteristics of Middlemore Hospital's population informed Acute Allied Health social workers on areas of need and potential risk about teenage pregnant mothers, admissions for family violence and culturally appropriate resources in responding to the socio-economic and socio-cultural needs of patients. The diversity of Counties Manukau's population was therefore an inducement to seek out representation from Counties Manukau staff from the Maori and Pacific Island community sectors, among others, to be part of the Social Work Alert Committee. In summary, because of the dynamic nature of population changes in CMDHB, and how health services are provided now and for future planning (Wang & Jackson, 2008, p. 2), Acute Allied Health social workers did not overlook the importance of these aspects in developing the five guiding risk categories.

Policy

The final of the three sources of knowledge used in the development of the five guiding risk categories has roots in some of CMDHB's policies. Examples include the Family Violence, Elder/Adult Abuse & Neglect Intervention Policy and Child Protection Policy, which acknowledge and respond to potentially at-risk populations within the hospital. Within these policy frameworks, the social worker is able to implement the five risk factors into the SWAS. Being part of the hospital setting the social worker is empowered to utilise networks and professional relationships to bring the alert system into effect. If the social worker was not part of this process, they would not be able to negotiate and advocate for the five chosen risk categories to be included in the SWAS. An example is the incorporation of the DNA – 'Did Not Attend' appointment risk category which responds to the CMDHB Cultural Policy (Cultural Support for Pacific Inpatients at Middlemore Hospital Policy, May 2006) which recognises patients may not access health services due to cultural issues.

The above three knowledge sources have guided the decision to choose the five categories (family violence, elder abuse, pregnant women in high-risk situations, transience and DNA – Did Not Attend Appointment) which make up the SWAS. How this operates in practice will now be looked at in the following scenario within the Emergency Care.

The scenario and the Social Work Alert System

This section discusses how the SWAS applies to a potentially at-risk patient such as Paula in the following scenario.

Paula is four months pregnant and was admitted to the Emergency Department (ED) with facial lacerations from an alleged assault by her partner. She has two young children whom her parents were looking after temporarily while she was in hospital. Paula stated that she was 'fed up' with her partner because of his ongoing abuse and assault on her. After Paula was medically examined by the doctor, she was referred to the social worker for an assessment.

The above scenario underlines a typical case presentation to ED and how a person enters the hospital system and, via the medical team, receives a social work referral. This pathway to social work input regulates the professional relationships and functional interactions between the social workers, medical team and patients. Within this referral process it is important for health clinicians to refer Paula to enable her to access other support options. The introduction of the SWAS gives greater prominence to the need for the clinical team to refer her to a social worker if indicated. Health clinicians all have a common interest and duty to perform for the benefit of patients in their care and thus the SWAS would assist them in responding to patients needs.

Previously, if Paula had a history of admission to Middlemore for family violence or any of the other risk categories there would not have been a system in place to indicate these historical or current risk factors. However, with the development of the SWAS, clinicians can now view an alert on the computer system which gives a brief summary of potential risk factors pertaining to Paula and instructs the viewer to make a referral to a social worker when there is an alert in place.

Inherent in the scenario is the need to address other factors such as the safety of the children and support for Paula which may include: referral to the Victim Support agency and the Police; notification to Child Youth and Family (CYF); access to a lawyer for an application for a protection order; provision of information on domestic violence resources; and the involvement of other agencies such as Women's Refuge; budgeting services; Family Start. These referrals need Paula's consent, except the notification to CYF where the Children, Young Persons and their Families Act 1989 enables referral without consent when acting in the best interests and safety of the child.

Planning referrals for Paula and her children is the social worker's first priority. The next stage utilises opportunities within the hospital system which now allows social workers to create an alert for Paula. This recognises the findings in research that indicate health service utilisation of those who experience family violence is higher (Fanslow & Robinson, 2004). Therefore, by creating an alert within the Middlemore Hospital internal system for Paula would allow her access to social work services if she were to be readmitted. Furthermore, recognising Paula's unborn child and current family violence, the social work alert created will include two of the five categories, family violence and pregnant mothers living in a high risk situation (unborn risk). The second category, of unborn risk, is vital as Paula is likely to be readmitted to Middlemore's maternity ward in the near future for the birth of her child. When this happens, social work intervention would therefore be warranted in light of Paula and her newborn's social context, potential risks and needs. A summary of steps and actions taken by social workers or CMDHB staff in creating an alert is included in Table one below.

Table one. Procedure for Social Work Alert.

| Steps	Actions
1	Social workers or CMDHB staff in assessing/treating patient to identify risks as follows: (1) Identification of family violence – pregnant woman living in high-risk situations (2) identified elder abuse situations (3) transient families avoiding contact with essential services (4) adult patients at risk of not attending health appointments;
2	Staff member to make a referral for a social work alert by completing the Social Work Alert Referral form;
3	Send the referral form to the Social Work Alert Committee who is responsible for approving or declining alert requests. Supply any supporting documents or referrals to substantiate application for the social work alert;
4	The form can be e-mailed, faxed or sent via internal mail (details on the form);
5	The Social Work Alert Committee will place an Alert on the patient's file or update the existing alert. The Committee will contact the referrer in the event that the alert request is declined;
6	A social work alert is removed when the risk to the patient is no longer prevalent and/or their circumstances are deemed to be safe. This would occur after a review by the social worker. The social worker must complete a 'Social Work Alert Referral Form' requesting the Committee must be able to adequately substantiate declining any alert removal request.

In this case scenario the social worker was able to complete a safe discharge plan with Paula including: the exploration of her trauma issues; discharge to Women's Refuge; a follow- up appointment with a lawyer for a protection order; and arrangement for a Victim Support

visit. To ensure the safety of the children and her unborn child, a notification to CYF was made. Paula has also indicated she will be giving birth at Middlemore Hospital.

Social Work Alert System application to wider Middlemore Hospital

The SWAS alerts the social work service when a patient comes to Emergency Care or to the maternity ward for the birth of their child. Prior to implementation, for women like Paula with two risk categories (family violence and pregnant mothers at high risk), there was no process for screening pregnant women for an alert on their admission to the maternity ward. Therefore, this led to the creation of an additional process within the SWAS to be piloted on the maternity ward. The new system would allow active screening of all patients admitted to the maternity ward for a social work alert. Alert information would then be passed on to the social worker to allow earlier intervention, support and planning with the patient. The alert committee achieved this additional process by training the ward clerk how to screen for social work alerts on all new admissions, and implement daily checking by the maternity social worker. Therefore, because of the new additional process in the maternity ward when Paula comes to the maternity ward at Middlemore Hospital for the birth of her baby, there will be a clear indication of the need for social work input. Figure one below further summarises the process referred to in this section.

**Figure one.** Innovative practice: Social Work Alert System.
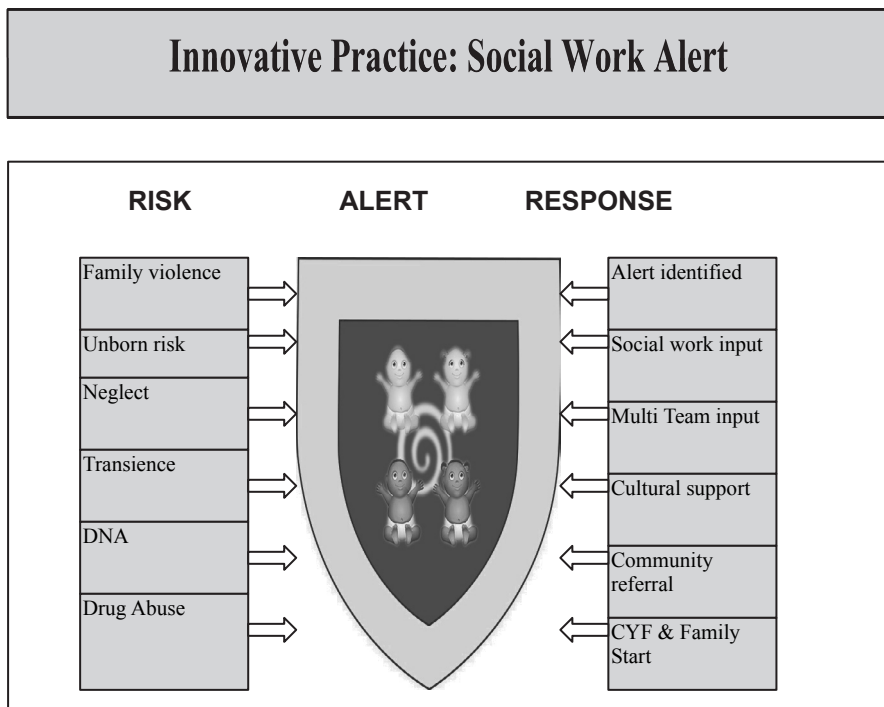
 The above diagram is a visual illustration of the Social Work Alert process enabling patients needing social work input to be identified earlier. This helps to monitor pregnant women with risks in their lives to ensure mothers and their babies have timely intervention offered.

The advantages of the development of a Social Work Alert process within the hospital includes not only identifying safety and risk faster and more effectively, but also allows increased opportunity for support and resources.

(By Angela Todman – Social Work Department, 2009).

The graph below shows the number of alerts the Social Work Alert Committee approved between 2008 and 2009. The majority of referrals received and approved relate to pregnant women living in high-risk situations. The graph also indicates an upward trend in social work alerts being referred to the Social Work Alert Committee.

Figure two. Social Work Alert referrals approved.
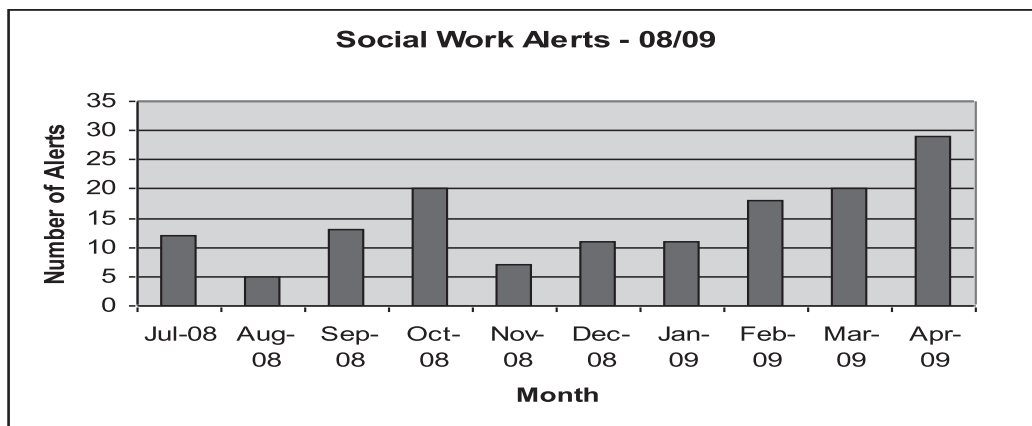
In the next section, we will explore the ethical considerations of creating an alert for patients such as Paula as referred to in the scenario.

Ethical considerations

The development of the SWAS brought to the fore the issue of confidentiality, recognising that sensitive information was involved. Rigorous procedures were put in place to ensure patient information was respected, by restricting access to social work alert summaries to approved staff only. It is important to stress here that the alert is part of an internal hospital system which sits alongside various other alert systems (such as child protection and clinical health alerts) and contributes to the management of patient information within a large hospital system. Consent is obtained from patients to gather information on risk factors, among others, and it is explained to patients by social workers that information received from them is confidential to the patient information hospital database. However, we do explain that if serious safety concerns become known social workers may need to pass information on to others outside of the hospital system, such as CYF. In the case example of Paula the information on her file documented by the social worker, including the alert, can also be accessed by other clinicians involved with Paula's care.

Theoretical implications

The SWAS has characteristics which embrace theoretical underpinnings of an ecological framework developed by Bronfenbrenner (1979) and Germain and Gitterman (1980) recognising the mutually influential systems between patients and their hospital environments. For example, the five guiding categories of the SWAS address elements of the ecological situation in which a patient is located on admission. Paula has been assessed on a wider basis which recognises not just her physical needs, but also her emotional and social needs. The assessment also took into account the need for the safety of her children. Therefore, the SWAS also draws out aspects espoused by the Whare Tapa Wha approach (Durie, 1998) which highlights the patient's physical, mental, emotional, social and spiritual beings from a holistic perspective. A social worker's knowledge of cultural diversity within the hospital also influences their decisions to refer patients to appropriate cultural services for their benefits.

Treaty of Waitangi policies promote Tikanga in Practice and bicultural approaches that CMDHB has in place. Complementing this are other cultural awareness initiatives (such as Pacific competence courses) that recognise the need for staff to respond to patients' needs holistically and in a culturally appropriate manner. In other words, the SWAS cannot be treated in isolation from these theoretical sources of knowledge when working with patients and their families.

Conclusion

The SWAS was developed to respond more adequately to potentially at-risk patients in receiving social worker input and contribute significantly to the delivery of quality care for patients. Paula's case example demonstrates that the application of an alert identifies the potential needs and risks for her and her children on future admissions. The development of the SWAS within the maternity ward has resulted in a faster and more efficient response to potential at-risk patients. However, based on our experience and recommendation, further research is needed to confirm the extent to which the system impacts on patients' quality of care and their health needs. Ethical considerations are fundamental in working with at-risk patients and should be explored further to aid greater understanding of the implications of the alert system on patients. This innovation, as a recent initiative, has the potential to enhance and make a difference to quality of care for patients.

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