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*Sarah Lawrence College*

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**PEDIATRIC HOSPITAL SOCIAL WORK**

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May, 2020

Sarah Lawrence College

*Submitted in partial completion of the Master of Arts Degree at Sarah Lawrence College, May 2020*

### **Abstract**

The role of a pediatric hospital social worker is very unique and the job requires a different skill set than do jobs for social workers who work outside the hospital. This thesis will provide a literature review on the history of hospital social work, hospital social work skills, social work roles and the effects of long-term hospitalization on children's development. This thesis will include a discussion of the author's experience interning as a pediatric hospital social worker, as well as a comparison between the role of a child life volunteer and that of a pediatric hospital social work intern. Additionally, this thesis will include descriptions of the author's personal experience of supervision and support while working as a pediatric hospital social work intern and of the training given prior to entering the field. Finally, this thesis will include suggestions for future training. The hope is that this thesis will provide those going into the field of social work and other medical professionals an overview of the role of a pediatric hospital social worker.

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## **Introduction**

Prior to my internship at a children's hospital in a major Northeastern city, the role of a hospital social worker was very unclear to me. It was not until I stepped into the hospital for my first day of internship that I really got a sense of what a hospital social worker's role is. My hope is that this thesis will help those going into the social work field and other medical professionals have a better understanding of the role of a pediatric hospital social worker. This thesis will begin with a literature review on the history of hospital social work, a description of hospital social work skills needed for working in a hospital, social work roles in the hospital setting, and effects of long-term hospitalization on children's development. Next, this thesis will provide a discussion on what I have learned during my experience as a hospital social work intern at an urban children's hospital in a major Northeastern city. Specifically, I will be focusing on the different types of assessments that hospital social workers may perform on a daily basis, and will provide a typology of hospital social work consultations. I will also discuss what I have learned from the research on hospital social work roles versus what I experienced as a hospital social work intern. I will be comparing and contrasting my role as a pediatric hospital social work intern with my previous role as a child life volunteer in a similar setting. I will then be reflecting back on the support and supervision that I received at my internship and the impact I think it had on my work and the work of my colleagues. Finally, I will be looking at the different types of training I believe would be helpful for future social workers entering the field.

## Literature Review

### History of Social Work in Hospital Settings

While a staple presence in hospitals today, social workers were not always present in health care settings such as hospitals. It was not until the early 1900s that social work in health care began in the United States, specifically in the Massachusetts General Hospital (Beder, 2006), when care for the sick shifted from taking place in the home to taking place in a hospital. Also during this time, physicians began realizing the impact that living conditions and personal problems can have on one's health and recovery process (Beder, 2006). The man who introduced the necessity of creating a hospital social worker position was Dr. Richard C. Cabot. Faced with immense amounts of adversity from doctors and nurses, Cabot and Ida Cannon brought the idea of hospital social workers to Massachusetts General Hospital (Ruth & Marshall, 2017). Cabot believed that social workers would help patients adjust to their hospitalization, explain the impact of the illness and detail what the hospital stay would look like (Beder, 2006). In 1905, Garnet I. Pelton was the first person to fill a hospital social work position in the United States (Beder, 2006). Pelton's job was to report the patients' domestic and social conditions to the medical team, help patients to meet doctor's orders and suggestions, and provide a link between hospital and community agencies and organizations (Beder, 2006). It was not until 1914, and the influence of Ida Cannon, that the position of a hospital social worker became recognized in hospital units in multiple hospitals around the United States (Beder, 2006)

Given the title of "Chief of Social Services," Ida Cannon further developed the role of a hospital social worker and became a leader in the profession. Cannon had three essential ideas when it came to hospital social work; the central focus must be the patients' needs, the social worker must identify and interpret the social aspects of illness and of good patient care, and there

must be teamwork among the many different hospital positions (Beder, 2006). Cabot believed that the role of the social worker was to bridge the gap between the hospital environment and the patients' everyday social environment as a way to remove barriers to medical treatment (Beder, 2006). This idea is known as person-in-environment and enhances physicians' ability to heal the patient by better understanding what the patient has to deal with when they are discharged from the hospital (Beder, 2006). It is because of Cabot and Cannon that social workers are now a vital part of how hospitals care for their patients. From one social worker in 1905 to approximately 300,000 health care social workers in 2017, hospital social work is only continuing to grow (Beder, 2006; Ruth & Marshall, 2017).

## **Social Work Skills for Working in a Hospital**

### ***Understanding of Medical Conditions***

Social workers working in hospital settings require a different skill set than social workers who work outside the hospital. Specific to hospital social work is the need for the social worker to understand the basics of a patient's disease (Gregorian, 2005). As stated by Gregorian (2005), "Not only should hospital social workers be experts about the psycho-social issues associated with illness but they also need to develop and constantly update a broader knowledge base about the physiology of disease" (p. 8). An additional skill unique to hospital social workers is the ability to accomplish multiple tasks that usually take many sessions, in a single session. Social workers working in the hospital must be extremely effective when meeting with clients because they often will only meet with their clients once (Gibbon & Plath, 2005 cited in Zimmerman & Dabelko, 2008). Because single sessions are so common, in a short period of time hospital social workers must engage clients, establish rapport, assess, provide information,

validate, challenge beliefs and behaviors, and counsel (Gibbon & Plath, 2005 cited in Zimmerman & Dabelko, 2008).

### ***Dealing with the Unknown and Working Quickly***

Hospital social workers should be comfortable dealing with the unknown and working quickly (Gregorian, 2005). When working in a hospital setting, days are usually unpredictable and there is no set schedule for when you will see patients or for how long (Gregorian, 2005). Additionally, it is not uncommon for a social worker to be consulted for a particular reason and then for that social worker to enter a patient's room and encounter an array of other issues that need to be evaluated. As stated by Gregorian (2005), "to succeed in this type of environment the social worker must be extremely flexible with the ability to prioritize work and change focus in an instant" (p. 5). It is important to be flexible because it is not uncommon for the reason for the referral given by the medical team to be vague and lack essential information (Gregorian, 2005). As a result, hospital social workers often enter a room with very little information or knowledge on what they need to assess or look for. Thus, when entering a hospital room, social workers must be able to quickly assess, "the patient's mental status, emotional state, the family dynamics, the patients' needs and the staff's agenda in seeking social work consultation" (Gregorian, 2005, p.7). While it is helpful to have a good sense of what the treatment team hopes to get out of consulting the social worker, it is common that the social worker will lack a lot of essential information when entering a patient's room (Gregorian, 2005).

### ***Anticipating Clients' and Patients' Reactions***

Patients do not often refer themselves for social work help in a hospital setting. Thus, they are oftentimes confused and/or worried when a social worker enters the room. This could be in part because people often associate social workers with Child Protective Services or for those

requiring financial assistance, which might cause them to be guarded or suspicious (Gregorian, 2005). This is something I personally observed on a day-to-day basis while interning at a children's hospital. It is important for a social worker to anticipate this reaction on their entrance in order to most appropriately respond to their clients.

### ***Employing Cultural Competence and Understanding of Diversity***

Finally, an incredibly important set of skills that hospital social workers must employ are cultural competence and a broad understanding of diversity in the United States. As stated by the NASW (2016), "The increasing racial, ethnic, linguistic diversity of the United States requires health care social workers to strive continuously for cultural competence" (p. 22). It is important for social workers in the healthcare field to recognize cultural diversity as being critical to both the therapeutic alliance with clients and the working relationship with colleagues (NASW, 2016). Client diversity can be expressed by race, socioeconomic class, sexual orientation, gender, religion, health, cognitive ability, psychiatric ability, immigration status, education level and more (NASW, 2016). It is important that social workers working in health care acquire a cross-cultural knowledge in order to provide culturally competent and effective practice. Not only do social workers working in the healthcare field have to recognize others' culture, but they must recognize that their own cultural self-awareness is an integral component when it comes to cultural competence (NASW, 2016). One's cultural self-awareness requires an understanding of how one's cultural beliefs, values, biases, experiences and perceptions can affect interactions with clients and colleagues (NASW, 2016).

### **Social Work Roles in the Hospital**

On a day to day basis, hospital social workers may have many different roles. Some examples of different roles that a hospital social worker may undertake in a single day are:

biopsychosocial assessments, care coordination, counseling patients and their families, risk assessment of patients (self-harm, child abuse or family violence), discharge planning, and referring patients to services available in their community (Browne, 2019; Palmer, 2014 as cited in Hassan, 2016; Ross et al., 2019). Additional integral roles of hospital social workers include interdisciplinary and interorganizational collaboration, advocacy, palliative care, hospice and end-of-life care, crisis intervention, client and family education, record keeping, and maintenance of confidentiality (NASW, 2016).

### ***Biopsychosocial Assessment***

In order for a social worker to carry out different roles in a hospital setting, the first step is to carry out a biopsychosocial assessment. According to Ross et al. (2019), “The biopsychosocial assessment for the social worker is the analogical equivalent of the physical exam for the medical physician.” (p.9). It was proposed by Engel in 1977 that the biopsychosocial model looks at three aspects related to illness: biological, psychological and social (Browne, 2019). It is from the biopsychosocial perspective that the traditional medical model was expanded to not only look at the biological causes of disease. The biopsychosocial assessment, in turn, influences the questions we ask today when assessing patients. It is with the information gathered from a biopsychosocial assessment that the social worker is able to aid and implement interventions to meet client’s needs (Browne, 2019). With the biopsychosocial assessment, social workers can assess, for example, a client’s support systems, socioeconomic status, emotional problems and how these can affect that client’s ability to access resources and cope with stress related to illness (Browne, 2019). One’s socioeconomic status can impact a patient’s ability to receive appropriate medical care in multiple ways (Browne, 2019). For example, socioeconomic status can prevent a patient from buying certain medications that a

physician may prescribe or from accessing transportation to medical appointments (Browne, 2019). In regard to emotional problems, a person who has depression may be less likely to follow up with medical appointments (Browne, 2019). Additionally, when it comes to social support, more specifically family support, a child with family support to help with the challenges associated with illness will likely have a better outcome than a child facing illness without family support (Browne, 2019).

### ***Care Coordination***

Care coordination is a critical role when it comes to being a hospital social worker. The term care coordination is frequently used interchangeably with case management or care management (Ross et al., 2019). The National Quality Forum (2010) defined care coordination as “a function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time” (p.1). There are four foundational characteristics that are attributed to pediatric care coordination (Antonelli et al., 2009). The first foundational characteristic is patient and family centered, which can be explained as linking patients and families to community-based primary care medical homes that are accessible to them (Antonelli et al., 2009). Next, an important characteristic of pediatric care coordination is that there is a specific plan that is both proactive and comprehensive (Antonelli et al., 2009). In order for a plan to be both proactive and comprehensive it must support longitudinal and continuous care (Antonelli et al., 2009). Another important characteristic of pediatric care coordination is promoting self-care skills and independence (Antonelli et al., 2009). By promoting self-care, social workers provide families with the skills needed to navigate a complex health care system (Antonelli et al., 2009). Finally, pediatric care coordination

emphasizes cross-organizational relationships by ensuring effective communication and collaboration along the continuum of care for a patient (Antonelli et al., 2009).

A study by Ross et al. (2019) looked at a single urban pediatric hospital in order to quantify care coordination functions fulfilled by health care social workers in one specific hospital. This study found that social workers in this particular hospital spent over 75% of their workday working exclusively on care coordination tasks (Ross et al., 2019). From the study by Ross et al. (2019), one can see just how common the role of care coordination can be for hospital social workers. The effects of care coordination further display the importance of the role for patient outcomes in the hospital setting. For example, care coordination has been associated with shorter and less frequent hospital stays and reduction in health care costs specifically in pediatric populations (Criscione et al., 1995, Antonelli & Antonelli, 2004).

### ***Risk Assessment***

An additional essential role for hospital social workers is risk assessment with patients (Palmer, 2014, as cited in Hassan, 2016). Risk assessment can include self-harm behaviors, child abuse and/or family violence (Palmer, 2014, as cited in Hassan, 2016). Suicide risk assessments are very common at the hospital in which I was an intern, especially with the adolescent population. When it comes to risk assessment with adolescents, Rollhaus (2019) relays the importance of speaking with the adolescent alone and warning the patient about the limits of confidentiality. Additionally, Rollhaus (2019) states that when interviewing the patient, the initial questions should be open-ended and nonthreatening. Some examples Rollhaus (2019) provides of open-ended questions include: “I know that a lot of people your age have a lot going on. What kind of things have been on your mind or stressing you lately?” (slide 11). When it comes to responding to a patient who discloses suicidal ideation or past suicidal activity,

Rollhaus (2019) states that it is important to validate the patient's experience and reassure the patient that they have been heard and that you are there to get them help.

### ***Collaborative Work***

A unique role of hospital social workers is collaboration among health care team members, other colleagues, and organizations to support, enhance, and deliver effective services to clients and client support systems (NASW, 2016). When working in a health care setting, multiple practitioners are usually involved in a client's care. This makes teamwork and collaboration between all health care workers essential. As stated by Zimmerman and Dabelko (2008), "Collaborative models of patient care establish mutually beneficial partnerships among patients, family members, and health care providers through shared responsibility in the planning, delivery, and evaluation of health services" (p. 34). Mizrahi and Abramson (2003) found that the majority of physicians valued the social workers' participation in collaborative work. This shows that it is not only the social workers who feel they benefit from collaborative work but also the medical team.

There are three teamwork models commonly used in health care settings: multidisciplinary models, interdisciplinary models and transdisciplinary models (NASW, 2016). Multidisciplinary models consist of many disciplines working together while each drawing on their own professional knowledge (NASW, 2016). Interdisciplinary models can be described as different disciplines working together toward a common goal for a client (NASW, 2016). Finally, transdisciplinary models can be defined as "a team of health care professionals cooperating across disciplines to improve patient care through practice or research" (NASW, 2016, p. 31).

### ***Advocacy***

An additional critical role of hospital social workers is being an advocate. Social workers in hospital settings are responsible for advocating on behalf of their patients in regards to their needs and interest (NASW, 2016). Hospital social workers can also advocate for system-level change to increase patients' access to care and improve outcomes and the delivery of services for those who are marginalized, medically complex or disadvantaged (NASW, 2016). Finally, hospital social workers' advocacy role consists of promoting clients' self-advocacy skills and enhancing communities' capacities to support clients in all aspects of their lives.

### ***Record Keeping and Confidentiality***

Finally, a critical role of hospital social workers is record keeping and maintaining confidentiality. As stated by the NASW (2016), "Social workers practicing in health care settings shall maintain timely documentation that includes pertinent information regarding client assessment, and intervention, and outcomes, and shall safeguard the privacy and confidentiality of client information" (pp. 34-35). It is important for social workers in health care settings to have clear, concise and ongoing documentation in order to facilitate effective communication with other health care providers and organizations (NASW, 2016). Good quality social work documentation should include: biopsychosocial assessments; client care plan; what services were provided; referrals made to other practitioners and/or organizations; date, times and descriptions of contact with the client, the client support system and other health care providers or organizations (NASW, 2016).

### ***Effects of Long-Term Hospitalization on Children's Development***

It is evident from the research that long-term hospitalization can have a negative effect on children's development (Mrazek, 1984). A review by Mzraek (1984) concludes that children

hospitalized during preschool years often undergo emotional stress from the hospitalization. However, it is evident that after the age of four or five there is a decrease in the child's vulnerability to negative consequences as a result of hospitalization (Mzraek, 1984). Mzraek (1984) proposes that this difference is because at the age of four or five the child begins to master the Piagetian stage of concrete operations, which means it is likely that the child at this age can better understand that the painful treatments they are receiving will benefit them in the long run. Additionally, from a social-emotional perspective, at the age of four or five, a child is better able to turn to peers and adults for reassurance and a sense of security. Furthermore, at earlier stages of social-emotional development, children tend to seek security only from primary attachment figures (Mzraek, 1984).

A monumental study by Douglas (1975), found that a single hospital admission longer than a week or repeated admissions before the age of five are both associated with an increased risk of behavior disturbance and poor reading in adolescents. Some of these behavior disturbances include troublesome behavior in class, delinquent behavior and unstable job patterns (Douglas, 1975). An additional study by Quinton and Rutter (1976), done as an attempt to replicate the findings from the study by Douglas (1975), further confirmed Douglas' finding that repeated hospital admissions are significantly associated with disturbances in later childhood. Additionally, the study by Quinton and Rutter (1976) further confirms Douglas' (1975) finding that a single hospital admission for children carries no increased risk for later emotional or behavioral disturbance. From the research, it is evident that the age of the child and the duration of hospital stay has an effect on a child's development.

A limitation to this literature is that it is from the 1900s. From my research, it is evident that further research on the duration of hospital admissions and the effect it has on child

development is very limited. The literature seems to focus more specifically on specific diagnoses that children may face and the effect the diagnosis and/or forms of treatment may have on child development. Evidently, more research needs to be done on the negative consequences of long-term hospitalization on children's development. I hope to be able to do research related to this topic in the future.

## **Experiences as a Pediatric Hospital Social Work Intern**

### **Form of Assessments**

As a social work intern at an urban children's hospital in a major Northeastern city, I learned that there is not one type of assessment performed for each patient. Whenever someone from the medical team believes that a social worker is needed, they will put in a request for a social work consult. The medical team will, most of the time, clarify the reason for the consult. Otherwise the social worker would need to reach out to the resident directly for more information. It is important that the social worker knows the reason for the consult before meeting the patient because the social worker's assessment is tailored specifically to that reason. On the Inpatient Infant and Toddler floor where I interned, there were about 11 different reasons that a consult may take place, which I have experienced. However, there are other reasons that a consult may take place that I did not have experience with. The reasons for a social work consult that I had experience with included: brief resolved unexplained event (BRUE), failure to thrive (FTT), ingestion, suspected child abuse or neglect, foster care, shelter system, psychosocial support, insurance, reinstatement or referral for home services, transportation coordination, and length of stay. The questions that the social worker may ask during an assessment depend on the reason for the consult given by the medical team.

### **A Typology of Hospital Social Work Consultations**

#### ***Medical Conditions of the Child***

**Brief Resolved Unexpected Event (BRUE).** BRUE is defined by Tieder et al. (2016) as: an event occurring in an infant younger than 1 year when the observer reports a sudden, brief, and now resolved episode  $\geq 1$  of the following: (1) cyanosis or pallor; (2) absent,

decreased, or irregular breathing; (3) marked change in tone (hyper- or hypotonia); and (4) altered level of responsiveness. (p. e1)

When someone from the medical team requests a BRUE consult, there are specific questions that the social worker should ask during their assessment. These questions include but are not limited to: when did the episode occur and what did the child present with? How many times did the episode occur before the patient was brought into the hospital? Was the episode during or after feeding?

The purpose of these specific questions is to assess whether or not the parent took immediate action once the episode occurred and brought the child to the emergency room for evaluation, whether or not the event was a result of feeding, and to gather information to determine if the event was preventable by the parent and/or guardian. The overall purpose is to make sure the parent reacted in a responsible fashion and that the parent is not causing any harm to the child. For example, if a parent were to have seen the patient stop breathing and turn blue for an extended period of time or if the parent witnessed the event occur multiple times before bringing the patient to the emergency room, the social worker may be concerned that there is medical neglect.

**Failure to Thrive (FTT).** FTT is defined as slowed or halted physical growth and is also associated with abnormal growth and development (Children's Hospital of Philadelphia, n.d.). An FTT consult requires the social worker to ask very specific questions during their assessment around patient feeding. During an FTT assessment, the social worker is trying to assess if the parent is feeding the patient appropriately, if the patient is taking his feeds well, how the parent is feeding the patient, and how often the patient is being fed. From these questions, the social worker can get a sense of the feeding behaviors that take place in the home. From there, the

social worker will inform the medical team and the registered dietician of the information that he/she gathered. The medical team and registered dietician can then conclude whether or not the patient's inability to gain weight is due to inadequate feeding practices at home (Children's Hospital of Philadelphia, n.d.). From there, the medical team can determine if genetic testing is necessary and rule out other potential reasons for why the patient may be failing to thrive (Children's Hospital of Philadelphia, n.d.).

**Ingestion.** An unfortunately common situation that is dealt with at the hospital where I was an intern is ingestion. Often patients come in after ingesting their parents' medication or cleaning products, e.g. Whenever a child is admitted to the hospital due to ingestion, a social worker is required, at the hospital where I interned, to consult with that patient and his/her family. When doing an assessment due to ingestion, the social worker is trying to discover how the patient was able to access the item ingested and who was watching the patient during the time of ingestion. For example, if a patient comes in having ingested a caregiver's aspirin, the first thing we would find out is where the aspirin was and who was watching the patient at the time. The goal is to assess whether or not the patient's access to the ingested item was due to neglect on the parent's part or if it was a genuine accident. The social worker is also assessing why the parent was not with the child at the time of ingestion and able to stop it before it occurred.

Depending on what the social worker discovers during the assessment, he/she will decide if a call needs to be made to the local child welfare agency. This decision will not be made solely based on the social worker's assessment, but also on the medical team's and social work supervisors' thoughts as well. From there, dependent upon whether or not the local child welfare agency is called or accepts the case, the social worker will work with the parent and/or guardian

to think of alternative places where medicine and/or objects that the child might ingest could be placed in the house so as to be out of the child's reach. Educating parents on the importance of having all medications and cleaning supplies in a place not accessible to children is a major part of the social worker's job in this situation.

### *Clinical Assessments of the Child's Environment*

**Suspected Child Abuse or Neglect.** At the hospital where I interned, it is mandatory for a hospital social worker to meet with a patient who may have past or present child welfare involvement and/or diagnosis that is suspicious for abuse and/or neglect. If a patient already has a current case with the local child welfare agency, it is the role of the social worker to find out the name of the case worker assigned to the case in order to ensure a safe discharge and hospital stay for the patient. Once the name of the case worker has been acquired, the social worker will contact the case worker and find out who is allowed to be at the bedside with the patient and visitation rights of those involved in the case. For example, if the child welfare case is placed due to concerns of abuse by the patient's father, that father may legally not be allowed to be around the patient and, therefore, the medical team and security must be made aware. On the other hand, if the patient has a past child welfare case that has been closed, it is the job of the social worker to assess the client's safety as well as any current abuse or neglect.

A non-accidental trauma (NAT) is the leading cause of death and childhood traumatic injury in the United States (Paul & Adamo, 2014). Some of the general presentations of children with NATs include: bruising, burns, fracture, abusive head trauma (AHT) and ocular manifestations (Paul & Adamo, 2014) At the hospital where I was an intern, there is specific protocol for social workers if a patient comes in with a diagnosis that the medical team may deem a NAT. In this situation, a hospital worker is required to perform an assessment. If there is

a concern of a NAT from the medical team, the assessment the social worker will perform will include a specific array of questions. Depending on what the patient is admitted for and the concern from the medical team, each assessment for suspected child abuse or neglect will look different.

The social worker will perform a biopsychosocial assessment in order to look at all aspects of the patient's life. Some of the questions the social worker may ask include: who lives in the home, who watches the child, how the parent/guardian believes the incident or illness occurred, any past child welfare involvement, the reason for any previous admissions, and questions about family dynamics. Here, the goal of the social worker is to get a general picture of what life is like at home for the patient and find out why the patient has been admitted to the hospital. For example, if the patient comes in with a broken limb, the social worker will want a detailed description of how the patient got hurt, who was watching the patient when he/she got hurt and what that person did immediately after the patient was visibly in pain.

**Foster Care.** At the hospital where I interned, it is also required for social workers to do an assessment for any patients in the foster care system. It is the role of the social worker to find out what agency the patient belongs to and the name of the case worker at the agency that is in charge of the patient. From there, the social worker must contact the case worker and find out: visitation rights of the biological parents, who the patient is allowed to be discharged with, where the patient should be discharged to, and who has medical decision-making rights for the patient. Additionally, the case worker from the agency might request that the social worker fax the patient's discharge summary to the agency for their records at discharge. The social worker's role is to ensure that the people who are at bedside with the patient are legally allowed to be at bedside, ensure the patient goes home to the appropriate home/facility and determine who has

medical decision-making rights for the patient. If a biological parent is not allowed to visit the patient at bedside, it is the job of the social worker to make the medical team and security aware.

**Shelter System.** A majority of the patients we receive at the hospital where I interned live in the shelter system. When a patient is in the shelter system, the social worker should find out the location of the shelter (unless it is a domestic violence shelter) and the case worker that the patient's caregiver works with at the shelter. It is then the job of the social worker to contact the case worker to notify them that the patient is in the shelter and will not be able to sign in and out of the facility at this time. The social worker will then provide the patient and/or guardian of the patient with paperwork stating the date of admission and date of discharge when the patient is medically cleared to leave the hospital. The parent and/or guardian will give the paperwork that excuses the parent and/or guardian from signing in and out of the facility during those specific dates to the facility.

**Psychosocial Support.** It is common that a social work consult will be put in for psychosocial support. These cases can include, but are not limited to, parents and/or guardians who are extremely anxious about their child's admission, parents and/or guardians who need someone to talk to after receiving news about their child's diagnosis, parents and/or guardians who need information on resources they can access in their communities, and parents/or guardians who would like an outpatient mental health referral for themselves or their child. The social worker will then look up mental health clinics in the area in which the patient lives and schedule an appointment. If the parent and/or guardian wishes to seek mental health treatment for themselves or their child, the social worker will then provide the patient or parent and/or guardian with the information of the time, date and location of the appointment.

### ***Administrative Responsibilities***

**Insurance.** When a patient is admitted to the hospital, the type of insurance they have is entered into their chart upon arrival. However, if the patient does not have insurance, a social work consult is usually required. At the hospital in which I interned, there is a Medicaid office located in the building. Medicaid is

a joint federal and state program that, together with the Children's Health Insurance Program (CHIP), provides health coverage to over 72.5 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities.

("Eligibility", n.d., para 1)

If a patient does not have insurance, the social worker will make a referral to the Medicaid office for the patient. Once a referral has been made, the case worker at the Medicaid office will contact the parent and/or guardian directly and arrange to set up insurance if the patient qualifies.

**Reinstatement or Referral for Home Services.** When working in a children's hospital, one will often encounter patients with complex medical conditions and/or developmental disabilities. It is common that children with complex medical conditions and/or developmental disabilities will require or already receive home health services. As the hospital social worker, it is our job to ensure that either these services continue when the patient leaves the hospital- even though they were put on hold during the hospitalization- or these services are put in place for the child to receive once he/she returns home if he/she did not have these services before being admitted to the hospital. Some examples of home services can include early intervention (EI), a home health aide, private duty nursing, or consumer directed personal assistance program (CDPAP).

EI is a program in which children under three years old can receive therapeutic and support services in their home (“Early Intervention Program”, n.d.). Some of the services that one can receive from EI are speech pathology and audiology, occupational therapy and physical therapy (“Early Intervention Program”, n.d.). If a patient is admitted who already receives EI services in the home, the first step is for the hospital social worker to get the name of the EI Coordinator from the caregiver of the child. The hospital social worker will then reach out to the EI Coordinator to inform them of the patient’s hospital admission in order to put the patient’s services on hold. The hospital social worker will then contact that same EI Coordinator when the child is ready to be discharged to let them know that the child can continue receiving services. If the child does not already receive EI services, the medical team may suggest a referral. In this case, it is the hospital social worker’s job to send the EI referral form to the county in which the child lives. It is important for the social worker to know the child’s county as each county has different requirements as to where the referral form is sent and what is required. The hospital social worker will then let the patient’s parent and/or guardian know that the EI referral was made and to expect a phone call arranging for the evaluation.

Additionally, a client could have a home health aide. Merriam-Webster (n.d.) defines a home health aide as a trained, certified health care worker who aids a patient in the home including personal care, light household duties and monitoring of the patient’s condition. In 2007, 160,700 home health and hospice aides were providing assistance in activities of daily life (ADLs) and were employed by agencies providing home health and hospice care (Berkovitz et al., 2011).

It is also common for children with complex medical conditions to have a private duty nurse (PDN). If a patient has a PDN, he/she receives nursing services at home from either a

Registered Nurse (RN) or Licensed Practical Nurse (LPN) (Private Duty Nursing Services, 2003). If the patient already receives PDN services prior to being admitted to the hospital, it is the hospital social worker's job to contact the company that provides the PDN and let them know the patient has been admitted to the hospital. Additionally, at discharge, the hospital social worker will contact the PDN company to let them know the patient is being discharged and will inform them of the medical team's recommendations as to if the patient should resume PDN services.

For patients who did not receive PDN services prior to being admitted to the hospital, the medical team may still believe that PDN services are necessary. In this case, it is the hospital social worker's job to make that referral. First, at the hospital I interned, the hospital social worker will need a letter of medical necessity from the medical team stating what services the PDN will perform in the home and how many hours of care the patient will need. The hospital social worker will then send the letter of medical necessity to the patient's insurance company to receive approval. If the insurance company approves the PDN, the insurance company will specify how many hours the patient will have nursing services in the home covered by insurance. If the insurance company does not approve the PDN, then the patient will not receive the services unless they can pay for them.

Finally, patients with complex medical conditions may receive services from a CDPAP. CDPAP is a Medicaid program that provides services to the chronically ill or physically disabled who need help with activities of daily living (ADLs) or skilled nursing services (Consumer Directed Personal Assistance Program, n.d.). The CDPAP can be chosen by the recipient but cannot reside in the patient's home (Consumer Directed Personal Assistance Program, n.d.).

From my experience interning in a children's hospital, it appears common for patients' CDPAPs to be family members.

**Transportation Coordination.** Hospital social workers will often meet with patients in order to coordinate transportation at discharge for the patient and his/her parent and/or guardian. Oftentimes, patients who have Medicaid insurance are entitled to free transportation from the hospital to their home at discharge (Department of Health, 2015). The hospital social worker will coordinate with the transportation company to arrange for transport at discharge to take the patient and his/her parent and/or guardian home from the hospital.

Additionally, patients with Medicaid insurance are often also entitled to any medical transportation that may include doctors' appointments. Medicaid transportation is defined as "a federally-required State-Plan-approved service managed and administered by the Department of Health to ensure that enrollees have access to approved medical services." (Department of Health, 2015, slide 2).

**Length of Stay.** At the hospital in which I was an intern, when a patient is in the hospital for seven days, it is required that a social worker performs an assessment. At this hospital, a general biopsychosocial assessment will usually be done with the addition of an inquiry into the psychosocial support for the family. The social worker will inquire about life at home for the patient and the family, whether or not the parent and/or guardian works and how being in the hospital is affecting their ability to work, any other children that may be in the home and how they are being cared for during this admission, and family support systems. It is common during Length of Stay assessments for parents and/or guardians to ask for a letter for their employer stating that they had to be with the patient in the hospital to make medical decisions from the

admission date to the discharge date. Parents will often want documentation to provide to their employers on why they were out of work for so long.

### **The Everyday Routine of a Pediatric Hospital Social Work Intern and Case Examples**

For the purpose of this thesis, I will provide case examples on three specific reasons for consults: BRUE, FTT and foster care. Prior to presenting the three case studies, I will provide a description of what a typical day looked like at my internship.

#### ***Everyday Routine of a Pediatric Hospital Social Work Intern***

While interning at an urban children's hospital in a major Northeastern city in an Infant and Toddler Inpatient Unit, I got to see what the everyday role was of a hospital social worker, more specifically a pediatric hospital social worker. At the hospital in which I interned, the patients were broken up by teams. A different social worker was dedicated to each team which consisted of about 10-15 patients. Each morning I would come into work and log into the online portal, which gave me a list of all the patients on my team. Before diving deeper into each patient, the overall list automatically displayed the patient's name, age, gender, diagnosis, room number, insurance, days admitted to the hospital and whether or not they have an open social work consult or have already been seen by a social worker. It was common that patients would be sent to the Infant and Toddler Inpatient Unit after already being admitted into the pediatric intensive care unit (PICU). Therefore, it was likely that those patients were already seen by the designated social worker in the PICU. However, if there was a patient that had an open consult, that meant that it was my responsibility to see the patient. Sometimes the order for the consult included a small description of why the social worker was needed. However, this was not the case for every patient and if there was a description it was usually very vague.

Next, I would participate in interdisciplinary team (IDT) rounds. IDT rounds took place every morning on every floor and those usually in attendance were the resident, social worker, registered dietician, and nurse. The residents, like the social workers, were assigned to specific teams. The resident for my team would then go over each patient on the floor. For the social workers, I believe, IDT rounds were extremely beneficial. If the patient had a social work consult in place, the resident would further explain the reason the consult was ordered and any additional information they acquired having already met with the patient. This would allow me to get a sense of what type of consult each patient may have and allow me to somewhat prepare what I would ask when I entered the room. As mentioned earlier, it is not uncommon for hospital social workers to enter a room for a particular reason and come out with an array of other issues that must be taken care of (Gregorian, 2005). This was a very common occurrence for me during my time as a hospital social work intern. Additionally, during IDT rounds the hospital social worker could ask the nurse and resident questions regarding expected discharge dates, insurance and patient diagnosis in order to get a better overall picture of the patient's reason for admission. IDT rounds were also a time for me to ask the resident to put a social work consult in if one was not already in place for specific patients. For example, if there was a patient admitted who was in foster care, it was required at the hospital in which I interned, that a social work consult would be ordered. Therefore, if a social work consult was not already in place, it was my job to let the resident know that an order needed to be put in.

After IDT rounds ended, I would return to the office and begin diving deeper into the charts of the patients that I had to see that day. I would look into any old notes that the patient had from the medical team or nurses and would look to see if there were any old notes from previous social workers who may have seen the patient. I was also able to see previous social

work notes from past admission if the patient was previously admitted to the hospital at which I interned. This allowed me to get a sense of the patients' needs prior to entering the room.

I would then begin seeing patients and undergoing my assessments. Depending on each patient's needs, I would have different tasks each day. A majority of the time, I was assisting patients with complex medical conditions who needed the social worker to: reinstate services that they may have been receiving at home or at school that were on hold due to the admission, contact shelters to let them know the patient had been admitted to the hospital, contact foster agencies to let them know the patient had been admitted to the hospital and find out information regarding visitation rights for foster parents and biological parents, assist with patient discharge transportation and provide patients and their families with psychosocial support. These are the tasks that I most often performed while being a social work intern.

Once I met with my patients and completed all my necessary tasks, I then began documenting everything that I had done with each patient. My documentation had to be extremely specific to each patient and most of the time included phone numbers of people I spoke to regarding the patient and thorough descriptions of what services and of information I provided to the patient. However, the most important part of the documentation was to conclude that I performed a risk assessment for either the patient or the parent and/or guardian depending on age. A patient could be discharged if they or their parent and/or guardian state that they are a harm to themselves or to others.

### *Case Examples*

**BRUE Case Example.** An eight-month-old baby was admitted to the infant and toddler inpatient unit presenting with BRUE. According to the baby's mother, it was one specific

incident in which the baby stopped breathing and began turning blue, although after a few seconds, his coloring returned to normal.

My role here was to do an assessment and gain information on everything that happened before, during and after the incident. My first step was to ask the baby's mother to explain exactly what happened and when. I then inquired as to how much time elapsed between the event and bringing the baby to the Emergency Room (ER), and whether or not she believed the event was related to feeding or occurred during or after a feed. Within this context, the mother explained to me that the baby had been admitted to the NICU after birth. She also reported that during the baby's time in the NICU and since he had been discharged, it was not uncommon for him to briefly stop breathing while asleep. However, the mother explained that these events usually did not last for long nor did the baby usually turn blue. Additionally, the mother reported that she brought this concern up to the medical team when the baby was in the NICU and that the medical team stated that the events were probably related to leftover fluid from birth clogging the baby's airway.

During an assessment, my role is to listen carefully to the parents report and adjust the questioning accordingly. Thus, I went on to ask the mother if the events only occurred when the baby was asleep or if they also occur at different times during the day. The mother of the baby reported that the events only occur when he is napping or sleeping for the night and not during, after or in the middle of feeds. From this information, I was able to conclude that the events were not occurring as a result of a feeding issue or due to the baby's inability to swallow the formula properly.

After the assessment is finished, the next step is to draw a conclusion and present my findings to the medical team. If my assessment had led me to conclude that the baby was having

these events during or after feeds, the medical professionals from speech and swallow would be sent to evaluate the baby and form a conclusion. However, swallowing issues did not present as the cause. I relayed this information to the medical team, and they decided to perform genetic tests on the baby to see if he had any genetic conditions that could be causing these episodes. From there, the medical team continued further investigating the reason for the episode with the patient and the parent and/or guardian. Once a conclusion was formed, the medical team let me know that it was a genetic condition that the baby was born with and that they were going to move further and develop a treatment plan.

**Failure To Thrive Case Example.** A four-month-old baby was admitted to the hospital for FTT. The patient came in presenting with low birth weight and no evidence of weight gain since his three-month check-up. When I met with the baby's mother, I introduced myself and explained that I was coming in to find out more about life at home for the baby and to learn about his daily feeding schedule. The baby's mother reported that she feeds the baby five times a day and only uses formula. His mother reported that the baby has no intolerance to the formula and that the baby does not normally vomit after feeding. I then asked the mother how she feeds the baby, and she reported that she holds the baby in a football position and holds the bottle up for him. She stated that the baby burps most of the time after feeding and that he normally finishes the whole bottle. The baby's mother reported that he does not wake up in the middle of the night and that she does not wake him either for a feed.

My role here, in addition to the assessment, was to provide psychoeducation to the mother. I educated her on the importance of waking the baby during the night for a feed, especially when he is still very young. The baby's mother appeared to understand this information. From here, my role was to relay all the information that I had gathered to the

medical team, who then relayed the information to the registered dietician. Then, the registered dietician was able to meet with the patient and his mother and conclude that the patient was not getting enough formula for his size and weight.

**Foster Care Case Example.** A five-year-old patient in foster care was admitted to the Infant and Toddler Inpatient Unit with pneumonia. When a patient is admitted to the hospital from the foster care system, it is essential to know exactly who can visit the patient. Therefore, when I entered the room, the first step I took was to ask the person at the bedside what her relation was to the patient. The person revealed that she was the maternal foster aunt. The foster mom reported that she, the maternal foster aunt, acts as a back-up caregiver in the patient's care.

For the first part of my assessment, I explored who lives in the home with the patient and whether or not the patient has a bed in the home. The child's maternal foster aunt reported that the patient lives with her foster mother, maternal foster aunt and her three biological sisters. I then asked the maternal foster aunt if the patient was in school. The maternal foster aunt reported that the patient was in school, but that she did not know the name of the school. I then asked the maternal foster aunt the name of the foster care agency that the patient is from and the name of the case manager at the agency that looks over the patient's case. As it is essential when working with foster care families that the appropriate adults are in the room, I asked the foster mom in a conversation over the phone to clarify the address, insurance information, primary care provider and telephone numbers that were listed in the chart. I then informed the maternal foster aunt that I would be contacting the patient's case worker at the foster care agency in order to ensure that the patient is cleared to leave the hospital with her and return to the apartment address that she gave me.

Another part of my role as a social work intern was to facilitate patients' care by providing help to their parents and/or guardians. For example, in this situation, the patient's maternal foster aunt informed me about the job she was missing in order to be at the hospital with her foster niece. I offered to provide the foster aunt with a letter stating that she had been in the hospital in order to make medical decisions for the patient and to include the date of admission and the date of discharge.

Inter-agency communication is an important part of the role of a social worker when working with patients involved in the foster care system. Thus, after meeting with the maternal foster aunt, I returned to the office and called the foster care agency and requested to speak with the case worker assigned to the specific case. Once I got in touch with the case worker, I confirmed that the patient could be discharged to the maternal foster aunt and return to the family home address that the foster aunt gave me. The case worker assured me that the patient could leave with the maternal foster aunt as she was listed as a back-up caregiver in the patient's file. Additionally, I asked the case worker what the visitation rights are for the patient's biological parents. The case worker reported that the patient is only allowed to have supervised visitation with the biological mother at the foster care agency. From here, I informed the medical team that the biological mother could not visit the patient in the hospital and that if the biological mother were to come to the hospital, security must be called.

Once the patient was medically cleared for discharge by the medical team, I set up transportation for the patient and her foster aunt to return home in a taxi that was covered by the patient's Medicaid insurance. Next, I faxed the discharge summary to the foster care agency to ensure they had the records for the patient's file. Finally, I gave the patient's foster aunt a letter

to give to her employer that documented the need for her to be in the hospital between the date of admission and the date of discharge.

## Discussion

### My Interest

From this experience, I have learned how diverse the role of a pediatric hospital social worker can be and how many different opportunities there are in this field. Although it is a very large field of practice, finding information online about the role of hospital social workers, specifically pediatric hospital social workers, was very limited and difficult to access. Therefore, the aim of this thesis was to gather in one place the information that I found in regard to hospital social worker roles, not only to be helpful for me when deciding on what career path I aspire to take, but also for undergraduate students considering applying to graduate school for social work.

What I have found to be most challenging here is seeing just how much work is put into discharge planning alone, which may include arranging for transportation and reinstating home services. However, I have found it extremely interesting that the role of a pediatric hospital social worker may be to set a child up with early intervention services, arrange for a child to have outpatient mental health treatment and arrange for a child to go to a rehabilitation facility.

A statement by Carranza (2013), really stood out to me in regard to why I wanted to become a hospital social worker in the first place. Carranza (2013) states “The social worker is trained to help patients and families help themselves” (p. 108). Carranza (2013) goes on to explain that social workers assist in teaching patients and families how to cope with troubling situations like traumatic and chronic illness, financial and emotional strain of caring for a disabled family member, family relationship problems due to illness/hospitalization, domestic violence, and bereavement/death. This is what I hope to do as a hospital social worker and more specifically with the pediatric population. I want to help patients and families be able to manage

a stressful situation in order to better help themselves and their family in the long run. I do not want to do the work for the patients and families, I want to allow them to realize their potential and strength in their ability to overcome stressful and sometimes traumatic situations.

### **Literature versus My Experience in the Hospital**

Prior to my internship working at a children's hospital in a major urban city, I had often researched what exactly the role of a hospital social worker was. What I have concluded, both from my experience as an intern and from the research I have found, is that the typical role of a hospital social worker seems to be very much dependent on the unit in which you work and the patients that you see. However, I have seen that the skills mentioned such as discharge planning, insurance management, and care coordination are all very much a part of any social work role regardless of the unit. Prior to coming into the field, I thought that there was one role of a hospital social worker. What I did not know was that at many hospitals the social workers are assigned to a certain unit or floor and work with patients who may have a specific diagnosis. For example, at the hospital at which I was an intern, there are many different hospital social workers that work on completely different tasks throughout the day. In my office alone, there was a dialysis social worker who only worked with patients on dialysis both inpatient and outpatient, an eating disorder social worker who solely worked with children and adolescents diagnosed with an eating disorder, and an infant and toddler social worker who only worked with infants and toddlers with an array of diagnoses. At my internship, my supervisor was the infant and toddler social worker and therefore that became my role as well.

I was able to see from working in an office with social workers focusing on many different specialties just how different our roles were depending on the types of patients we see. For example, the eating disorder social worker would rarely see an infant or toddler with

insurance issues - that would be my role. Additionally, it was evident that the research I read did not address the difference in roles between an inpatient and outpatient social worker. I now know that it is completely different being an inpatient versus an outpatient social worker specifically with relationship formation. For example, I worked in an inpatient unit with infants and toddlers and sometimes I would only interact with a patient or a parent and/or guardian of a patient once and then they would be discharged a few days later. Conversely, when a hospital social worker works in outpatient it is likely that they will see the same patient over and over again and therefore be able to form a relationship with the patient and/or his/her family.

From this experience, I have learned that I would prefer to work with patients that I can see both inpatient and outpatient. I found it difficult to see patients and their families once, provide them with the necessary resources and then most likely never see them again. My role consisted of very short-term intervention while interning as a hospital social worker in the Infant and Toddler Inpatient Unit. From my previous work with children with cancer and other chronic illnesses, I have been able to see just how impactful relationship building is for these patients and their families who are constantly in and out of the hospital. I want to be that familiar face for patients and families and be there for them throughout their illness.

What I also did not know prior to my internship and even after researching hospital social worker roles was that just because my internship was in a children's hospital, that did not mean I would be interacting with children directly. Specific to the unit in which I worked, a majority of the patients were too young to answer any questions or participate in an assessment in any capacity. Originally, I thought that as a hospital social worker working in a children's hospital, I would be interacting with children directly on a daily basis and hearing first-hand experiences from them. That was not the case and something that I learned very quickly. However, when I

shadowed other hospital social workers in other units like the adolescent unit, my role did involve talking to patients about their feelings and emotions. This further reiterates the idea that the experience one has is completely dependent on the unit in which one works. This is something I do believe is neglected in the literature regarding hospital social worker roles and more specifically pediatric hospital social workers.

### **Pediatric Hospital Social Worker versus Child Life Specialist**

I have learned from working in the hospital as both a child life volunteer and as a pediatric hospital social work intern how different the roles really are. The mission statement for the Child Life profession is

We, as child life professionals, help infants, children, youth, and families cope with the stress and uncertainty of illness, injury and treatment. We provide evidence-based, developmentally appropriate interventions including therapeutic play, preparation and education to reduce fear, anxiety and pain. (“Mission, Values, Vision”, n.d., para. 1)

As stated by the National Association of Social Workers (NASW) (2017), the mission of social workers is “to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.” (Preamble section, para. 1). It is evident from the two mission statements just how different the missions of each profession are. The Child Life profession’s mission is solely focused on infants, children, youth and families coping with stress related to illness, while the Social Work profession’s mission is focused on all people with particular attention to those who are vulnerable, oppressed and living in poverty. However, in regard to pediatric hospital social workers, the population that we serve can be different from those served by Child Life specialists. It has been evident from my experience both as a Child Life volunteer and as a

Pediatric Hospital Social Work intern the ways in which the roles may overlap and the ways in which the roles differ.

### ***Child Life Volunteer***

Before becoming a Pediatric Hospital Social Work intern, I spent three consecutive summers serving as a Child Life Volunteer in various pediatric hospitals in a major Northeastern city. My day-to-day role as a Child Life Volunteer consisted of: cleaning toys that were in patient's rooms or touched by patients while in the playroom, completing daily rounds to find out which patients were able to leave their rooms to enter the playroom and which patients had isolation restrictions, playing with patients with isolation restrictions at bedside, playing with patients in the playroom, sitting with patients whose parents were not around, and assisting nurses in acquiring necessary equipment. Additionally, my job was to bring items for the children to play with to the bedside of patients who were on any form of isolation. This was done to ensure that the children placed on isolation restrictions still received play materials and interaction from the child life volunteers and/or specialists. My role, essentially, was to distract patients and families and try to make their time in the hospital less stressful in some way given the circumstances. My role was about the here and now and focusing on reducing distress in the given moment.

### ***Hospital Social Work Intern***

Working as a hospital social work intern was different from that of a child life volunteer because of the population that I served and the overall role that I had. As a hospital social work intern, underpinning my work was always the mission of social work: "to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty." (NASW,

2017, Preamble section, para. 1). More specific to the mission of hospital social work is the idea that social workers continue to focus on the issue of health care inequality in the United States (NASW, 2016). It is evident that people living in poverty and communities of color experience disproportionately higher rate of acute and chronic illness for many reasons such as unequal access to health care services, discrimination and lack of insurance coverage. As stated by the NASW (2016), “Social workers recognize that reducing health disparities can only be accomplished by addressing the biopsychosocial-spiritual needs of individuals and families, as well as the systemic issues that contribute to poor health outcomes” (p. 5).

Throughout my internship, I worked with oppressed, vulnerable and poor populations rather than just sick individuals. I worked mainly with parents and/or guardians of sick children who were suffering both financially and emotionally due to the hospitalization of their child. Rather than playing with patients, my role was to help people access resources in their community once they were discharged from the hospital. My goal was to help these families better care for themselves and their families once they were out of the hospital. Additionally, my role was not about short-term changes; my role was to change the family’s life in the long run, not just while they were admitted.

### ***Similarities within Child Life Volunteer and Hospital Social Work Intern Roles***

Overall, I believe the similarity in the roles of a hospital social work intern and a child life volunteer is the desire to help people deal with stress related to illness. Whether it be parents’ stress due to a child’s illness or a child’s stress due to their own illness, the ultimate goal is to try and alleviate stress in some way, shape or form. Both the social work and child life profession, from my perspective, want to help those during times of intense stress and make the situation more manageable if possible. In my opinion, a combination role that encompasses the mission of

both child life and social work would be extremely beneficial in children's hospitals. I hope to explore this further throughout my professional career.

### **Support and Supervision**

While interning, I was able to see just how important support and supervision are when working in a hospital setting. At my internship, I worked in a small office with six social workers. Each social worker was designated a different population, but it was evident that a lot of the tasks and roles among the social workers overlapped. The social workers worked together and provided each other with support regarding different clients or experiences they were dealing with. They supported one another in decision making and discussed difficult situations they encountered. I found this environment to be extremely conducive to the work in that the support from colleagues was immense. I believe that if any of these social workers would have been isolated it would have been much harder for them to deal with the stress that comes with working in a pediatric hospital setting. Allowing the social workers to relate to one another and express their feelings regarding a case seemed to allow them to better help their clients and remain professional. When I had any questions or concerns and brought them up in the office, all the social workers would give their input and allow me to hear different perspectives regarding our work. No social worker in my office ever felt alone in making a decision that may affect their patient and/or their family.

Additionally, I believe that the supportive environment that I and the social workers that I worked with experienced is beneficial in regards to preventing burnout. Burnout refers to job-related stress occurring over time that can result in emotional exhaustion, irritability, withdrawal, and inefficacy (Maslach, 2017). Workers who are experiencing burnout are often unable to cope, feel overwhelmed, unmotivated and have poor performance (Maslach, 2017). Additionally, it has

been found that social workers are likely to experience burnout (Siebert, 2005). As a result, there can be negative effects for clients and the social work professional overall (Siebert, 2005).

I believe that the supportive environment that I experienced at my internship definitely had a positive effect on the consequences related to burnout. It has been found that social support reduces the negative effects of job-related stress (Karasek & Theorell, 1990 as cited in Kim & Stoner, 2008). An additional study by Um and Harrison (1998), found that having a coworker support group is preferable as a way to prevent burnout from advancing toward job dissatisfaction. It was common for social workers to take cases from each other in order to lighten the load for someone who was overwhelmed. This was the kind of supportive environment that took place at my internship. I think that having a supportive environment is important in all environments in order to prevent burnout, but is especially important in the medical field where an abundance of stressful situations occur each and every day.

When it comes to supervision, I believe that my supervisor did an excellent job at guiding me and supporting me through cases that were more difficult. One skill that my supervisor used that I found to be extremely effective for me working with this population was scaffolding (Sullivan, 2020). My supervisor started off by figuratively holding my hand and then easing back the support as I became more comfortable. In the beginning, my supervisor would go over every client with me and would discuss step by step what I would have to do next for that client. For me, this was extremely effective and allowed me to feel comfortable and competent in my role. Other people enjoy being thrown into situations and that is the best way that they learn. It is evident from this experience how important it is to let your supervisor know the best way in which you learn in order to get the most out of the experience. I know that if I am to ever be a supervisor, I will make sure to ask my supervisee how he/she learns best.

My supervisor was a huge support for me throughout my internship. Working in a children's hospital, emotionally distressing cases are inevitable. Whenever my supervisor knew I was dealing with a harder case, she made sure to make time for us to speak that day and supported me throughout my work with the client. Additionally, if there was a case that my supervisor believed might be too emotionally distressing for me as an intern, she would allow me to accompany her as she led the conversation. This permitted me to observe how she approached a client when the situation was tense and therefore gave me insight into how I may approach a client one day if a similar situation were to come up. My supervisor gave me the space to feel each and every emotion and to experience the pain and suffering that my clients were feeling. I never felt like I had to hold anything back and I believe that made me better at doing my job. I knew that no matter how challenging the case may present to be, I had someone to support me and help me be there in the best possible way for my client.

Finally, as stated by Hirst (2019),

Supervision can provide a safe and private space in which social workers can stand back and look at ourselves in our work: where it is okay not to know and to ask for help, to make mistakes and learn from them and to process emotions arising in the work (p. 124)

My supervisor made me feel like internships were places of learning and that I was not going to know what to do at every moment and that that was okay. Knowing that I was not going to immediately know what to do in every moment allowed me to feel comfortable making mistakes and learning from those mistakes rather than allowing them to discourage me and hold me back from helping my clients.

## **Training**

Prior to my internship, I received very little training in regard to the work that I would be doing. Prior to actually meeting with patients, my supervisor gave me a tour around the hospital and spent days going over the hospital social work orientation checklist. The checklist included brief overviews of: patient's rights, case management, documentation, discharge planning, rehabilitation services, home care, durable medical equipment (DME), pharmacy, transportation, hospice/end of life, placement, PEDS subspecialty programs, charitable organizations, federal state and local resources for children, hospital services, insurance types, computer programs, policies and procedures, shelters/foster care, abuse, psychiatric services, and entitlements. My supervisor and I briefly went over each section on this checklist.

The first month of my internship, I shadowed my supervisor on a variety of cases and would help her achieve necessary tasks for each patient such as arrange discharge transportation, communicate with shelters and foster care homes, and deliver paperwork to patient's parents and/or guardians. In addition, I would sit with my supervisor as she typed her notes for her clients, which allowed me to learn the documentation process. I found this to be extremely helpful. It was not until my second month interning that I began to have my own patient and see any patients on my own.

In the beginning, I had a two-day training at another facility on how to use the database EPIC, which was used at the hospital where I was an intern. I was not allowed to have access to EPIC or make any documentation until I had the training. I found the EPIC training to be extremely beneficial and really help me understand the system that I was using to find information about my patients and to document my assessments.

Finally, throughout my internship I shadowed different unit social workers. Every few weeks, I would shadow a social worker assigned to a different population and/or different unit in the hospital. For example, I shadowed the adolescent eating disorder social worker, the PICU social worker, the dialysis social worker and the hematology/oncology social worker. This allowed me to see how different diagnoses and populations require different work and forms of assessment from the social work staff. This was eye opening for me as I originally thought all hospital social workers - despite the unit they are assigned or population they were working with - performed similar roles.

### ***My Recommendations***

Looking back on my experience, I believe that more training would have made the transition into the hospital social work field a lot easier. When I began my second-year internship, I had no idea what my role in a hospital setting was going to be. However, I had an abundance of experience working in multiple children's hospitals in many different units prior to graduate school and was prepared for what I was going to witness on the floors. I found this to be a significant advantage for me. I feel that if I had not had that prior experience, it would have been extremely difficult for me. It is one thing to see a patient connected to tubes and machines, it is another to then enter that room and be able to be a support to that patient and the family.

One major element of knowledge that I felt uninformed about prior to my internship was insurance. I believe that having a good understanding of insurance and the benefits people have is extremely important, especially when working with oppressed populations.

I also believe that it is important for hospital social work interns to shadow a variety of social workers working in different units. I found this to be a huge learning experience and has helped me when thinking about applying for certain job positions. Additionally, this experience

allowed me to see how unique everyone's style of assessment is when working with patients. It was evident that no two social workers whom I shadowed had the same assessment process. From this, I was able to take bits and pieces of my experiences and form what I believed to be the best way to perform an assessment.

Finally, I wish that I had gotten more experience with palliative and end-of-life care during my internship. I think the concept of death when working in a children's hospital is more common than we think and something that every hospital social worker will experience at some point in their career. I feel that this would have better trained me for the death of my patients in the future, as I hope to work in a children's hospital and more specifically with children with cancer and other chronic illnesses.

## Conclusion

As the role of a social worker in a children's hospital is constantly changing, it is a challenge for those new to the field to understand their role within this large institution. From this thesis, it is my hope that the role of pediatric hospital social workers is better understood by those looking to pursue a career in this field. In addition, I believe that knowing the role of hospital social workers is important for other medical professionals in order to get a better understanding of what hospital social workers are capable of in these institutions. I have seen first-hand the lack of knowledge other medical professionals have on what the role of the social worker is in a hospital setting.

Additionally, I hope that from this thesis people develop a better understanding of the skill set that is required of a hospital social worker. The set of skills required of a hospital social worker are different from social workers who work in different settings. It is important that social workers entering this field are aware of the need to work quickly and deal with the unknown that is often not expected from social workers in other settings. I feel that throughout my education, I learned about acquiring all the facts that I could before meeting with a client. What is not spoken about is when that information is not readily accessible prior to meeting with clients. This is something that is extremely common when working in a hospital setting. It is not uncommon to get minimal amounts of information regarding a client prior to meeting with them when working in this setting.

It is my hope that this thesis will spark interest in researchers regarding not only the role of pediatric hospital social workers in specific hospitals, but also the effects of long-term hospitalization on children's development. Furthermore, I hope that this thesis reaches students like me who were struggling between the career path of becoming a hospital social worker

versus a child life specialist. There are extremely limited resources regarding the similarities and differences between these roles and I think that oftentimes they are seen as the same thing. It is from my experience that I have seen just how different the role of a hospital social worker and child life volunteer are and this has opened my eyes to my opportunities going forward.

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