A day in the life of a social worker

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Rebecca Gleeson is the Senior Social Worker at the Bendigo Hospital, Victoria, Australia. She graduated from LaTrobe University Bendigo, with a Bachelor of Social Work and Bachelor of Human services. Rebecca joined Bendigo Health in 2009 to take up a clinical social work role and has had the pleasure of working in diverse programs areas. She has worked across all Acute Campus units (including the Emergency Department), and currently works and specialises in the Medical Units, Intensive Care and Coronary Care Units. Rebecca has been involved in a diverse range of policy work within Bendigo Health ranging from Vulnerable Children, Residential Care, Bereavement, Discharge Planning, and abuse protocols. She is passionate in working with people who have chronic and complex medical illnesses and has extensive experience with assisting patients and teams with navigating their way through the complex discharge planning process.

Editor: Elizabeth Campbell

Samuel L Jackson, Stedman Graham, and Alana De La Garza – what do these famous people have in common? They practised as Social Workers. Even Martin Short began his Social Work degree. When I was asked to write about 'a day in the life of a Social Worker' I was very humbled and honoured, but then the big stormy clouds set in. As social work is so varied, and no one day is ever the same, how could I write about a typical day?

I am a Senior Social Worker at a large regional hospital. I work in every acute ward of the hospital, including our Emergency Department.

I don't know why I studied Social Work. I've now been doing it for almost 10 years, and I enjoy my job. The role of social workers in acute hospital settings cannot be easily summarised, but I'm going to describe a day that happened to me not so long ago, and hopefully this will give you an insight into my role and the sorts of things that social workers are able to assist junior doctors with.

Morning handover with the medical teams and allied health

My day normally starts with a morning handover at 8am with the medical teams and allied health. It's an opportunity for the entire team to meet, discuss cases, and look at treatment pathways and discharge plans for patients. However, today is not the same. I receive a phone call from the bed manager explaining that she has 20 people in ED needing to be admitted. 'Mr Smith' in ED is not being admitted as there is no medical need, and he needs to go to respite. The bed manager asks whether I can make it
happen. My first thought is “why have I turned my phone on early”, closely followed by “I haven't even had my coffee”.

I go to ED to speak with family members who were on their way to a holiday, and as such report that they couldn't possibly look after their dad Mr Smith. After multiple phone calls to Residential Aged Care Facilities, GPs, and a pharmacy, I had arranged emergency respite. Mr Smith's daughter approached me, and asked “so do we send the bill to you?”. I can't tell you what I wanted to say, instead, I put on my professional voice and explained that Mr Smith or family will need to pay for his respite, and I provided carer's information and other payment options.

Frequent flyers

On the way to get my morning coffee I received a call from a nurse on the medical ward: a patient who is a frequent visitor of our hospital had requested to see a social worker. Mrs Jones has had many admissions over the years, due to her lifestyle choices impacting on her health. Mrs Jones has also had extensive child protection involvement, been exposed to family violence and is in transient housing. When I approached Mrs Jones her major concern was that she needed $20 for cigarettes. I politely said no, then proceeded to ascertain where Mrs Jones will be discharged to.

As she is a ‘frequent flyer’ to the hospital I knew a bit about her background, including that she was currently homeless and at this stage didn't have a suitable discharge destination. On reviewing her current progress notes I found out her family court hearing was today, within an hour in fact. She also needed to report her earnings to Centrelink and attend a corrections appointment, none of this information was in my initial referral, it was all discovered after the fact. After spending time contacting everyone and informing them that Mrs Jones was medically unwell and would be unable to attend any appointments and rescheduling these for the future, Mrs Jones responded with “Thanks love, I don't need that $20 anymore, I found a smoke”.

Arranging family meetings as a social worker

I then get my coffee, but whilst in line I get a call from ICU. Mrs May, a 30-year-old female I saw yesterday for intentional overdose is being made palliative and we need an urgent family meeting to discuss her end of life wishes, and the treating teams end of life plan. I attend ICU and begin the process of setting up her family meeting, which involves getting her family and friends together as well as the rest of the current treating team. It was decided during this meeting that she would be extubated and allowed to die with dignity. It was expected that she would die quickly in the unit surrounded by her loved ones. After this I spent some time with the family and began the process of bereavement providing them with information and contacts.

At lunch I sit with my colleagues, and we debrief from the morning's events - I hear that one of my colleagues has been in the children's ward, assisting with a non-accidental injury, whilst the others have been assisting with an unexpected death on a ward.

Elder abuse in the community takes many forms
After lunch, I get a call from one of the nurses on the medical ward wanting some assistance. I get to the ward to see one of my patients Mr Davies, who is severely cognitively impaired. Just yesterday we received a referral due to potential elder abuse from someone within the community. The ‘friends’ that have attended the ward are requesting to have the patient's wallet and house keys from the nurse - she is reluctant to give these as this is not our normal procedure, and the patient is unable to identify them and give us any direction into how to proceed.

I spend some time sitting with Mr Davies’ ‘friend’ and explain that no personal belongings are going to be released. I am then informed by this ‘friend’ that Mr Davies has just “signed his bank authority over to me and I am able to manage his financial affairs”. I liaise with the doctors for a capacity assessment, have a discussion with our legal team, and arrange for the documents to be destroyed.

**There can also be joy in social work**

My day rarely ends on time, as I usually stay to complete paperwork, make follow-up calls or check on patients and their family members. My job isn't all doom and gloom. One of my fondest memories is when I coordinated a wedding on one of the wards. I arranged for decorations and a chaplain to officiate at the bedside of an elderly couple who had been together for a long time. The groom was palliative. The couple was so happy to be getting married.

It helped me from the beginning to realise that there can be joy. Since then, I have seen joy in the smallest things. This job has given me a new appreciation for the people and things in my life that are important.

**On being a social worker**

I see the role of the social worker as standing at the helm of the intervention from a multidisciplinary team. However, we are often seen by others as the profession at the end of intervention who just facilitate discharge to a residential care facility. I'm here to tell you we are so much more than that.

Social workers unite the curiosity in the team and bring a level of social intelligence, in the most unlikely of places. We are the profession that the team turn to when families are distraught, angry, and demanding.

We are the profession that support the team by having the difficult conversations with patients and families about death, dying, abuse and no longer returning home. We are the ones who stay with the patient and family long after the rest of the team has gone. We sit with the tears, the fear, the joy. It's not uncommon that we also provide a supportive presence to the staff. Days that we experience multiple traumas and deaths can be unbearable, and we are often turned to for support.

My message is that timely and accurate intervention is the most important part of ensuring that I am able to assist and do my job to the best of my abilities, thereby increasing positive outcomes for the organisation, and most importantly, for patients.
Please note names have been changed to protect patients' privacy.

Tags: #A day in the life,#allied health,#emergency department,#multi-disciplinary team,#palliative,#Residential Aged Care Facilities,#social worker