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On-Call Coverage Protocol

At this time, most On-Call shifts 11:00pm-8:30am are managed by a group of volunteer staff members and per-diem staff. Each month, the On-Call social workers schedule their shifts for the coming month. If there is an emergency, the Back-Up On-Call schedule provides appropriate coverage (see Back-Up Coverage).

Signing In / Out

- It is the Emergency Department/On-Site social worker's responsibility to sign out the pager to the On-Call social worker's pager at 11:00pm and for the ED/On-Site social worker to sign the pager over to his/her own pager at 8:30am daily.
- The On-Call social worker uses her/his own pager, the status of which should be set to "Out of Hospital-On Page" within the Partners Telephone Directory.
- If you are required to do a back-up shift and do not have your own pager, please contact Lisa Scheck to get the loaner pager in advance of your shift.

REMEMBER: DO NOT SWITCH THE PAGER OVER YOURSELF AT 11:00PM AS THIS COULD RESULT IN MISSED PAGES. IF YOU HAVE ANY QUESTIONS ABOUT THE SWITCH OVER, PAGE THE ED/ON-SITE SOCIAL WORKER BEFORE TAKING ANY ACTION.

- The On-Call social worker should reference the On-Call/On-Site Outlook calendar folder or the weekly e-mailed On-Call/On-Site Schedule prior to her/his shift. The On-Call social worker should know how to locate this information in case information needs to be handed-over to On-Site or ED social workers.
- Make sure you have a copy of the On-Call/On-Site Manual with you for reference, which can be downloaded from the Department website or SharePoint site.

On-Call Shift

Cover all services in the hospital from 11:00 PM - 8:30 AM; 7 days a week, responding to pages from home and coming into the hospital only if necessary.

If You Are Called In

You will be paid for 4 hours of work, for the first 2 times you need to come in to the hospital in a 24-hour period, even if the time spent in the hospital is less than that. If you work more than 4 hours you will be paid accordingly. If you make more than 2 trips to the hospital during a shift, you will be paid the exact hours you work after the initial 8 hours given.

When travel into the hospital is appropriate/necessary for the handling of a case, social workers will be paid at the rate of one and one half times for any time they are required to spend at the hospital while On-Call over and above 40 hours worked in a given week (pay period) Sunday - Saturday.

In the event of a Disaster, come into the hospital immediately. Report to the Emergency Department. See Disaster Protocol.

Before you complete your shift, hand over relevant case information to other staff as necessary for ongoing care of patient/family. An Inpatient Staff List by Floor is available on the Social Service Department SharePoint site.

At the End of Your Shift

Complete an On-Call Log so that you can be properly paid for your shift. If you came into the hospital while on duty, record the time on the On-Call Log. If you managed pages via phone, record that time on the On-Call Log and indicate that the page was addressed only via phone. Also, record meal tickets, parking tickets, and cash given to patients. Completed logs should be given to the Department Time-Keeper or placed in his/her mailbox. We recommend you keep a copy of the logs for your personal records.

Time taken as either scheduled or unscheduled earned time during that week (pay period) is not considered a part of those 40 hours. Those 40 hours must be actual hours worked. (Up to 40 hours are paid at straight time, according to federal wage and salary law).

Important Numbers/Helpful Hints

Page Operator: 617-726-2241

ED/On-Call pager: 26803

Child Protection Team pager: 32728

Social Work Administrator On-Call pager: 23977

It is often helpful to get consultation on difficult cases. One of the Leadership Team Members is available as the Social Work Administrator On-Call to provide consultation to workers On-Call. Call the page operator and ask to page 23977 or the Leadership Team Member by name.

Emergency Department workers sign out the ED/On-Call pager 26803 to their own pagers.

Parking for Employees While On-Call

If a social worker is a regular member of the On-Call Program and does not yet have night/weekend parking access at MGH, the Social Service Department will pay the one-time $25 dollar fee for night/weekend parking.

If a social worker is not a regular member of the On-Call Program and does not have night/weekend parking access at MGH, the Social Service Department will pay for the social worker's parking for his/her shift, though will not pay the one-time $25 fee for night/weekend parking. If a social worker comes into the hospital during her/his On-Call shift, her/his parking receipt should be submitted to the Department Time-Keeper for reimbursement along with the On-Call Log.

On-Site Coverage Protocol

Currently, most shifts are managed by a pool of volunteer staff members and per-diem staff. Although weekend shifts are usually covered by an On-Site pool member, it is possible that no On-Site pool member takes the weekend shift(s). If there are no volunteers to cover a weekend shift, back-up staff assigned to the weekend shift(s) is responsible to work their assigned back-up shift(s). Staff is required to be local and available to act as back-up even if a volunteer takes the assigned shift.

Full time staff who work a weekend shift will be paid at time and a half, as long as they have worked at least 40 hours that week (pay period). Part-time staff and those staff who are assigned a weekend shift of a holiday week, will be paid at their usual hourly rate. The Saturday hours are paid with the preceding week's hours and Sunday hours are paid in the current week's hours.

The On-Site social worker should reference the On-Call/On-Site Outlook calendar or the weekly emailed On-Call/On-Site Schedule prior to his/her shift. The On-Site social worker should know how to locate this schedule in case information needs to be handed over to On-Call or ED social workers.

On-Site Shifts

Cover all services in the hospital Saturdays and Sundays from 8:30 AM - 5:00 PM, 10:00 AM -6:30PM, and 2:30PM to 11:00 PM.

If an On-Site social worker is unable to cover his/her weekend shift

1. The social worker must page the Social Work Administrator On-Call (pager 23977).
2. The Social Work Administrator On-Call will contact the Back-Up On-Site social worker who will need to come to the hospital to cover the shift.
3. The Social Work Administrator On-Call will communicate the Back-Up On-Site coverage plan to the ED and other On-Site social workers.

On-Site Shift Logistics

Make sure you have a copy of the On-Call/On-Site Manual with you for reference, which can be downloaded from the Department website or SharePoint site.

On the day of your On-Site Shift

- Arrive by 8:30 AM, 10:30 AM, or 2:30 PM as scheduled
- Make sure your pager is on.

If you are the 8:30 AM social worker

- Transfer the ED pager 26803 to your pager (see instructions).
- Page the ED pager and your personal pager number to ensure all pages come through.
- Look up your own pager in the Partners Telephone Directory. If you have not received any pages, review "retrieve messages" button to ensure you are signed out properly and are receiving pages.
- Look up ED pager 26803 in the Partners Telephone Directory to ensure that your name is listed (the notation will be listed under the ED pager, not your personal pager).
- Cover the ED and other areas of the hospital as needed, triaging consults with the 10:00AM and 2:30PM social workers.

At the end of your On-Site shift

- Page the 2:30PM social worker to check-in/hand-over active cases.
- Hand-over relevant case information to any other staff as necessary for ongoing care of patient/family. A list of social work coverage in the hospital is available on the Social Service Department SharePoint site.
- Change your own pager status to "Not available."

Upon arrival at 2:30 PM, the On-Site social worker will

- Page the On-Site social worker(s) to check-in, then transfer the ED pager to her/himself.
- Receive all pages and page On-Site social workers via her/his pager with any Inpatient calls.
- At end of ED Shift at 11:00 PM the social worker will switch the ED pager 26803 to be covered by the On-Call social worker's pager.

To transfer the On-Call pager to the On-Site pager

Call Page Operator 617-726-2000 or follow the directions below

1. Dial 617-724-5800
2. Enter On-Call pager "26803"
3. Press "3" to change status
4. Enter password "26803" then "#"

5. System will confirm your current status and ask for new status.
6. Press “7” to forward pages
7. When asked for covering page ID number, enter your pager
8. Press “2” for indefinite timed status

Pager Numbers

On-Call pager: 26803

If you are covering an On-Call shift and do not have a personal pager, please check with Lisa Scheck for the loaner pager.

If you have any questions about these procedures, please contact Lisa Scheck or the Social Work Administrator On-Call (pager 23977) should issues arise before or during your shift.

Best Practice Guidelines for On-Site Social Workers

Goals

To enhance communication and equity of caseload amongst On-Site Social Workers

To prioritize cases in the ED and urgent cases on inpatient units such as crisis situations or cases that may impact discharge

- On-Site social workers routinely see patients in the ED and inpatient units, and occasionally in the MGH Walk-In Clinic or other AMB clinics open on the weekend. Please Note: patients must be registered in order for social workers to provide services.
- Given on-going capacity constraints throughout the hospital, priority should be given to consults that may expedite or impact discharge from the ED or inpatient admission.
- On-Site social workers should routinely check the ED SW Consult List in Epic for New Consults. Routinely checking this list will help ensure consults are not missed or delayed. On-Site social workers should request that consulting providers place an inpatient consult order “IP Consult to Social Work” in Epic if one has not already been entered.
- On-site social workers should touch base with each other throughout the day and share workload regardless of patient location. Working out of the ED office space can enhance communication.
- The triaging social worker should alternate consult pages between her/himself and the other On-Site social worker(s) as evenly as possible.

- The triaging social worker will forward consult pages to another On-Site social worker who will directly respond to the consulting provider. The social worker who received the consult should communicate back to the triaging social worker if he/she did not pick up the case.
- The non-triaging social worker should send a page (or text) to the triaging social worker to inform her/him of availability. "FYI - I'm ready to take another case."
- On-Site social workers may decide to alternate who triages pager 26803. For example, a social worker deeply involved in an end-of-life case may prefer not to cover the pager if possible.
- On-Site social workers may communicate with each other via Voalte or personal cell phone text messaging regarding their status/availability, though may NOT include patient information in personal cell phone text messages.
- In the absence of consult pages or new consults on the ED SW Consult List in Epic, social workers should case find on units with vacancies or high volume, as guided by Department Leadership.
- On-Site social workers should not see patients on their own units unless responding to an appropriate On-Site Social Work Consult, or a coverage need has been identified through case finding in the absence of consults (see previous bullet point).
- At the end of the shift, page the next scheduled social worker to check-in/hand-over active cases. Hand-over relevant case information to any other staff as necessary for ongoing care of patient/family.

Back-Up Coverage

All Social Service Department MSW staff members will be scheduled for Back-Up coverage to the On-Call and ED/On-Site service. The Back-Up schedule is published twice a year. New staff will be assigned shifts after 6 months of employment.

Back-Up to holiday coverage rotates with staff being scheduled as back-up to a holiday every 3-5 years. As with other back-up shifts, when staff is assigned a holiday as part of their back-up shift, they are responsible to cover the hospital should no one volunteer to cover the holiday. If this should occur, staff is responsible for covering the ED as well as the inpatient service.

To provide effective backup to the On-Call and On-Site service, staff must be local and available by phone for their assigned back-up time. If staff is not going to be available, they must exchange their back up shift with another staff member. Staff may not give away their scheduled time, but trades can be made. Please contact Stephanie Giraldo and Lisa Scheck as soon as possible if a change is made.

For Staff who do not typically use pagers, a loaner pager is available and can be obtained by contacting Lisa Scheck in advance of the Back-up Shift.

When you are assigned the following BACK-UP shifts you may be asked to cover

Back-Up Shift	On-Site	On-Call	Holiday On-Site	Holiday On-Call
Sunday, Monday	Sunday 8:30am - 5:00pm, 10:00am-6:30pm, 2:30pm-11:00pm Monday 5:00pm-11:00pm	11:00pm - 8:30am	8:30am - 5:00pm, 2:30pm-11:00pm	11:00pm-8:30am
Tuesday, Wednesday, Thursday	5:00pm-11:00pm	11:00pm - 8:30am	8:30am-5:00pm, 2:30pm-11:00pm	11:00pm-8:30am
Friday, Saturday	Friday 5:00pm-11:00pm Saturday 8:30am - 5:00pm, 10:00am-6:30pm, 2:30pm-11:00pm	11:00pm - 8:30am	8:30am-5:00pm, 2:30pm-11:00pm	11:00pm-8:30am

Please Note: Back-Up Coverage may also be needed in exceptional circumstances such as an unexpected high volume of critically ill or injured patients requiring social work intervention.

On-Call Inclement Weather Policy

Social workers should consider their personal safety and use their best judgment when deciding whether to come to work. If a social worker decides that it is not safe to travel into the hospital in response to an On-Call page because of severe weather conditions, the social worker should page the Social Work Administrator On-Call for consultation.

Suggestions for alternative ways to manage patient care during a storm are

- The worker can take a taxi to the hospital, which may be reimbursed on a case-by-case basis.
- Child protection cases could be managed by the Child Protection Team (CPT) by telephone.
- Cases can be handled as best as possible by telephone.
- Cases may need to be deferred until someone can safely get in to the hospital.
- Consult with the Social Work Administrator On-Call regarding whether overnight accommodations near the hospital can be arranged.

We do not expect staff to compromise personal safety to get to the hospital in severe weather conditions.

Abuse

Child Maltreatment

Purpose

While many health care professionals are mandated reporters, social workers are often the primary health care team member consulted to facilitate and/or address concerns of child abuse and/or neglect. Documentation of child abuse/neglect issues should be clear and concise to ensure that involved health care providers are aware of any safety issues for the patient and/or family in order to provide the highest quality care and ensure a safe discharge plan.

Policy

As mandated reporters, social workers are required to make a report to the Department of Children and Families (DCF) whenever, in their professional capacity, they have reasonable cause to believe that a child under the age of eighteen years is suffering from abuse or neglect, or is at risk of substantial harm from abuse or neglect. This includes assessing for children's safety in situations of domestic violence. The social worker should document concerns of abuse or neglect of a child in the patient's medical record (or in the parent's medical record if the parent is the patient). In all cases in which child maltreatment is part of the differential diagnosis, the care provider or the social worker should notify the Child Protection Team (CPT). Further information about the hospital policy may be found in the *e*llucid Policy and Procedures Library and 51A forms are available on the Social Service Department Website and SharePoint site.

Unexplained Infant and Child Deaths

The State Child Fatality Review Team (CFRT) considers that all unexplained infant and child deaths establish reasonable suspicion that neglect or abuse may have contributed to the death and recommends that mandated reporters report all such events to the Department of Children and Families, pursuant to M.G.L. c.119, s.51A. Thus, a 51A should be filed in these cases. Per hospital policy, the Child Protection Team should be consulted to assist in determining threshold for this reporting mandate.

Impaired/Intoxicated Parent/Caregiver in the Inpatient Pediatric Setting

If during admission, parents or caregivers present to the hospital impaired by use of a substance (including alcohol), review the Impaired Caregiver Guidelines to assist hospital staff around how to manage these challenging cases.

Procedure

When called about a child abuse, neglect or child sexual assault case, in most instances social workers should plan to come to the hospital. There may be rare instances when your presence is not required and the On-Site social worker can pick up

the case in the hospital the following morning. You should attempt to obtain as much information as possible from the referring source at the time of the initial call regarding the presenting problem and the concerns related to the safety of the child(ren).

Child Protection Team Consultation

To consult with CPT, you can either call the pager operator at 617-726-2241 and ask to have the CPT paged, or page directly by calling 617-724-5656, pager 32728.

Assessment and Documentation

Each parent or guardian at the hospital should be interviewed separately, and apart from the child. The following information should be documented objectively and concisely:

1. Exact quotes from the patient, parent/guardian.
2. Detailed information about the injury or concern, including date, timeframe, sequence of events, people present.
3. The full name of the individual identified as the perpetrator, if available.
4. Any weapons used during the incident of abuse, including items not ordinarily thought of as weapons.
5. Prior history of accidents, injuries, or concerns of abuse and/or neglect, and any efforts made by parent/guardian to seek help.
6. Identification of the child's legal custodian or guardian.
7. Where and with whom the child lives (parent(s) or guardian(s), sibs, extended family, etc).
8. Identification of other care providers including school personnel, day care providers, extended family, etc.
9. Parent /child interaction should be observed and assessed
10. Information about the child's general functioning (development, affect, activity, behavior changes, peer relationships, etc).
11. Community agency involvement, including past/current DCF.
12. Psychotherapeutic history of child/family.
13. Substance abuse history of child/family.
14. History of domestic violence. [Note: In 40-60% of families where child maltreatment occurs, there is also domestic violence present; therefore all mothers of a child who may have been abused or neglected, should be screened for domestic violence. Please refer to the Domestic Violence policy (Page 19) for assistance with screening for domestic violence.

15. Permission (release of information form, or documented verbal authorization from a parent or guardian, to contact DCF, mental health and medical providers, school personnel, or other outside professionals involved in the care of the child, as indicated).
16. The social worker's impression of the risk of further harm to the patient and/or others based on the above information.
17. Action taken to ensure the safety of the patient and/or others.
18. Document consultation with CPT.
19. Decision if a 51A is/is not filed and the reason(s) for it. [When DCF undertakes an emergency response and comes to the hospital to meet with patient and family, it should be documented in the patient's medical record and should include DCF recommendations and/or interventions.]

Filing a 51A

Verbal Report: After CPT consultation during daytime hours, the social worker calls in the 51A to the local office of DCF where the child resides. After 5:00 PM and weekends, the social worker calls in the 51A to the Child at Risk Hotline (800) 792-5200.

Written Report: The written report (51A) must be completed and sent to the appropriate DCF area office within 48 hours of the initial verbal report.
The 51A form should not be placed in the medical record; however, a copy of the 51A should be forwarded to CPT at 175 Cambridge Street and to the Social Service Director's Assistant, WACC 037.

Notification to Parent/Caretaker: It is customary to notify the parent/guardian that a 51A report has been filed. In rare circumstances, a decision may be made to delay or defer notification of the 51A filing. Such exceptions should be discussed with the CPT.

Massachusetts Department of Children & Families Locations

DCF info on filing a mandated report

Child Abuse Reporting Form

The complete MGH Policy about filing a 51A form can be found in the *e*llucid Policy and Procedure Library by searching for Abuse or Neglect of Children.

Child Protection Team (CPT) Contact Information

Phone: 617-724-0285

Fax: 617-726-5961

Pager: 32728

Disabled Adult Abuse

MGH Policy

The complete MGH policy for reporting abuse of a disabled adult can be found in the ellucid Policy and Procedures Library and reporting forms are available on the Social Service website and SharePoint Site.

Procedure

The On-Call worker will be available to provide phone consultation to staff on any case of this nature and to come in to the hospital for evaluation and intervention when appropriate. The staff member most familiar with the findings of suspected abuse will submit the requested report.

It if is determined during the telephone consultation that a report will be made and the patient is admitted, the evaluating physician or nurse should submit:

1. **Verbal Report:** Call the Disabled Persons Protection Commission (DPPC) 24 hours/day a**t** 1-800-426-9009.
2. **Written Report**: Fax a completed DPPC Reporting Form to 857-403-0296 within 48 hours of the verbal report.
3. **Notice to Patient:** The patient should be promptly notified that such report has been or will be made, unless: doing so would put the patient at risk of serious harm, or notification would be to a personal representative (e.g.: legal guardian or health care proxy), whom is believed to be responsible for the abuse or neglect and notice is not in the individual's best interest.
4. **Document** the above in the patient's chart and write a request for social service assessment by the Inpatient social worker. Do not put the original or a copy of the report in the medical record.

If the patient is not admitted, or is admitted on a weekend, the ED, On-Call, or On-Site social worker may need to do an evaluation and assist with a safe discharge plan.

Elder Abuse

MGH Policy

The complete MGH policy for reporting abuse or neglect of the elderly found in the ellucid Policy and Procedures Library and reporting forms are available on the Social Service website and SharePoint Site.

Procedure

The On-Call worker will be available to provide phone consultation to staff on any case of this nature and to come in to the hospital for evaluation and intervention when appropriate. The staff member most familiar with the findings of suspected abuse will submit the requested report.

It if is determined during the telephone consultation that a report will be made and the patient is admitted, **the evaluating physician or nurse should submit**:

Online Report

The online reporting form can be found at the Mass.gov website. Print completed form before submitting and send to the Social Service Director's Assistant, WACC 037.

If you file online you DO NOT need to make a verbal report to the MA Elder Abuse Hotline (800- 922-2275) or fax the written report to the local protective service agency. Online reports will be referred to the local Protective Service Agency.

DO NOT USE the online system if any of the following apply:

- Emergency or urgent situations that require immediate attention from Protective Services as it may take more than 24 hours to process online reports.
- You do not have the name and address of the victim. The online reporting system will not allow you to file such reports.

If online reporting form is not used:

1. **Verbal Report**: Call the Elder Abuse 24-Hour Hotline at 800-922- 2275. During regular business hours, the MGH staff person will be referred by the Elder Abuse Hotline Worker to the designated protective service agency covering the area where the elder lives. After regular business hours, the Elder Abuse Hotline Worker will take the verbal report and forward the information to the appropriate agency on the next business day.

2. **Written Report**: Submit a completed Elder Abuse Mandated Reporter Form to the designated protective service agency within 48 hours of making the verbal report. Report forms are available from MGH Social Service Department or may

be obtained by fax from the designated protective service agency. Elder Abuse Form.

3. **Notice to Patient**: The patient should be promptly notified that such report has been or will be made, *unless:* doing so would put the patient at risk of serious harm, or notification would be to a personal representative (e.g.: legal guardian or health care proxy), whom is believed to be responsible for the abuse or neglect and notice is not in the individual's best interest.

4. **Document** the above in the patient's chart and write a request for social service assessment by the Inpatient social worker. Do not put the original or a copy of the report in the medical record.

If the patient is not admitted, or is admitted on a weekend, the ED, On-Call, or On-Site social worker may need to do an evaluation and assist with a safe discharge plan.

Elder and Disabled Abuse Consultation

Contact the Social Service Department Elder/Disabled Abuse Consultation Team via page 24077, 8:30 AM - 5:00 PM, Monday-Friday. For consultation after hours and on weekends, contact the Social Work Administrator On-Call via page 23977. Please send ORIGINAL Elder and Disabled abuse reports to the Social Service Director's Assistant, WACC 037.

Social Service Elder/Disabled Abuse Consultation Team (M-F 8:30 AM - 5:00 PM)
Pager: 24077

Elder Abuse Hotline (M-F after 5:00 PM and on Weekends)
Phone: 1-800-922-2275

Disabled Persons Protection Commission (DPPC)
Phone: 1-800-426-9009

Health Care Agency or Facility Abuse, Neglect, or Exploitation

Purpose

To increase MGH clinical staff awareness of the effects of abuse on patients in health care settings, to encourage an interdisciplinary team approach to addressing the

problem, and to clarify MGH clinical staff responsibilities and actions to take regarding suspected abuse or neglect of patients occurring in skilled nursing facilities, hospital, rest home, assisted living, home health, or hospice settings.

Policy

The social worker should document any suspicion that abuse, neglect, or misappropriation of funds of a patient has occurred in a skilled nursing facility, hospital, rest home, assisted living, home health, or hospice setting in the patient's health record. If it is determined that a mandated report should be filed, the social worker must inform his/her Clinical Director, consult with the Social Service Department's Elder/Disabled Abuse Consultation Team and notify the MGH Compliance Office at 617-726-5109. Please see below for procedural details.

Procedure

The following information should be documented objectively and concisely

1. Exact quotes from the patient or witnesses regarding abuse/neglect/exploitation.
2. Observations by the social worker of physical injury.
3. The full name of the perpetrator.
4. The date, time and location of any assaults.
5. Any weapons used during an assault, including things not ordinarily thought of as weapons such as boots or household items.
6. The social worker's impression of the risk of harm to the patient based on the above information.
7. Action taken by the social worker to ensure the safety of the patient and/or others.
8. Consultation with the Clinical Director, the Social Service Elder/Disabled Abuse Consultation Team and the MGH Compliance Office (617-726-5109).
9. Decision if a mandated report is or is not filed and the reasons for it.
10. The social worker or a member of the involved clinical team should notify the MGH Compliance Office that a report is being filed. MGH Compliance will ask that the reporter place a call to an administrator at the facility to notify that a report is being filed. If staff prefers that the MGH Compliance Office provide notification, the Office is available to assist.
11. If there is concern that abuse or neglect occurred in a Partners affiliated setting, the social worker or a member of the involved clinical team should first consult with the MGH Compliance Office.
12. **Verbal Report**: Call the Department of Public Health (DPH) 24 hours/day at 617-753-8150 to report suspected abuse, neglect and misappropriation of property in

a hospital, nursing home, rest home, group home, home health or hospice setting.

For facilities licensed by the Department of Mental Health (DMH) or the Department of Developmental Services (DDS), e.g. group homes call the Disabled Persons Protection Commission (DPPC) 24 hours/day at 800-426-9009 to report suspected abuse, neglect, and misappropriation of property.

If the social worker or member of the involved clinical team is informed that a DPH Investigator will visit MGH, he/she should refer the investigator to the MGH Compliance Office.

13. **Written Report:** Submit your completed report by fax 617-753-8165 to DPH immediately for suspected abuse, neglect, or misappropriation of property or death resulting from incidents. The written report is the Hospital Fax Report Form. For DMH and DDS licensed facilities submit your completed DPPC reporting form by fax to 857-403-0296 within 48 hours of making the verbal. The original report form should not be placed in the health record; however, a copy should be sent to the Social Service Director's Assistant, WACC 037 and a copy to the MGH Compliance Office.

14. **Notice to Patient** – The patient should be promptly notified that such report has been or will be made, *unless:* doing so would put the patient at risk of serious harm, or notification would be to a personal representative (e.g.: legal guardian or health care proxy), whom is believed to be responsible for the abuse or neglect and notice is not in the individual's best interest.

MGH Compliance Office

Phone: 617-726-5109

Elder Abuse Hotline (after 5:00 PM and on Weekends)

Phone: 1-800-922-2275

Ombudsman for Assisted Living at the Executive Office of Elder Affairs (Monday – Friday, 9:00 AM – 5:00 PM)
Phone: 617-727-7750

Social Service Elder/Disabled Consultation Team (Monday – Friday, 8:30 AM – 5:00 PM)

Pager: 24077

Domestic Violence

DV Assessment

The following DV assessment has been developed to help you

1. Further assess the current safety risks to patient and any children.
2. Determine whether to come in to the hospital.
3. Determine what the patient wishes to do at this time re: the domestic violence.
4. Assess and review options for helping families find a safe place to go when fleeing DV.

MGH Policy

For more information on the complete MGH Domestic Violence policy, go to the *e*llucid Policy and Procedures Library and search for "domestic violence."

Guidelines for On-Call

1. Upon receiving the referral for social work assistance with a domestic violence case, obtain as much information as possible from the referring provider and then ask to speak with the patient directly.
2. Determining the nature of the referral. Because most calls will be originating from the Emergency Department, as the patient is likely to not have a private place in which to speak to you.

DV Phone Assessment

If you can speak with the patient directly, use the following questions as a guide to help you determine the patient's needs.

1. "Are you in a safe place to talk to me right now? Since you may not have privacy, I'll try to ask simple easy-to-answer questions."
2. "Did anyone explain that a social worker would be calling you?" If NOT, explain the nature of the referring provider's concerns and why you are calling: to offer support, to come in if needed, and to inform the patient of specialized services available through MGH and in the community.
3. "Let me start with a few questions about your safety right now."

Simple Safety Assessment

- "Does your partner know you are here?"
- "Can you safely leave the hospital?"

- "Does your partner have access to weapons of any kind?"
- "Do you have any children?"
- "Where are your children right now? Do you think they are safe?"
- "Do you need any help finding a safe place to go?"

4. "Are you willing to have me come in to talk with you in person?"
5. "Can you safely wait for the (time: 1 hour, ½ hour) it will take me to get to see you?"
6. "Have you been told about the HAVEN program?" (If not, explain HAVEN services)
7. "Would you like me to arrange for a HAVEN advocate to follow-up with you first thing next business day?" (If yes, see section on obtaining safe follow-up info, page 21).
8. "Do you know what you will do when you're ready to leave the hospital? Is there any way we can support you with your plan?"

Determining when to come in to the hospital

Most domestic violence calls will present a need for the social worker to come in to the hospital to further assess, provide support and make successful linkages to domestic violence services. There are, however, cases where coming in may not be in the patient's best interest.

When to come in to the hospital

1. If the patient wants to see you in person and feels it is safe to do so.
2. If you are concerned about children's safety (refer to child abuse section).
3. If patient seems too disoriented or traumatized to answer your questions and someone else can determine that it is safe for patient to wait for your arrival.
4. If, because of linguistic barriers, it is too difficult to assess patient needs over the phone and you need a trained interpreter.
5. If your clinical judgment tells you the patient needs your physical presence for support and they say it is safe to wait to see you.

When not to come in

1. When the patient says s/he does not want to talk to you.
2. When the patient says s/he has to leave and it would be unsafe to wait.
3. When the referral seems coercive on the part of the provider, and is more for the benefit of the referring provider than the patient.

If you decide not to come in, make sure to let the patient know that you will be following up with the referring provider to explain your decision. Also, offer to have someone follow up with the patient the next business day (follow the guidelines below to refer to HAVEN for follow up).

Obtaining Safe Follow-Up Information

After learning that a patient would like HAVEN or social work follow up, ask for at least two phone numbers and ask the following question of each number.

1. "Is it safe for us to call you there?"
2. "What should we say if someone besides you answers?"
3. "Can we leave a message for you there?"
4. "What should the message say?"

Document these safety instructions next to each phone number on the referral to HAVEN.

Always Call the HAVEN Program

HAVEN wants to be aware of all DV cases received by On-Call social workers. Call HAVEN at 617-724-0054 and let them know you have received a DV case On-Call whether or not you come into the hospital and whether or not the patient wants follow-up.

1. If the patient wants a HAVEN advocate to follow-up, leave the patient's name and contact numbers (including safety information as outlined above) on the HAVEN voicemail at 617-724-0054.
2. If this case was a consult only or if patient is not interested in/does not need follow-up by HAVEN, leave your extension and pager number. A HAVEN staff person will follow-up the next business day to debrief the case, review interventions and provide support.

MGH HAVEN

Phone: 617-724-0054

Working with Families Fleeing Domestic Violence

Assessment

- What are the current safety concerns?
- What led to the family seeking assistance now?
- Has the family left the abusive situation in the past? What happened then (did the abuser come looking for victim, was a restraining order violated, etc.)?

- Is this person a Mass resident? (see number 4 under “Basic Options below)
- Are there children? (See number 4 under “Basic Options” below)
- If no children, is a homeless shelter an option?
- How has the family been supporting themselves? (working, SSI, SSDI, cash assistance, SNAP, unemployment, child support, support of family, etc)
- What shelter/housing options has family looked into already?
- Does the family need a confidential location?
- Would a restraining order be safe and appropriate for this family?
- Does this person risk losing their housing if they leave the property? Can advocacy help get the abuser out of the apartment/unit?
- Can the person stay someplace until the next business day?

Basic Options (Contact Info)

1. Family or friends
2. Mass DV Shelter (Safelink 877-785-2020)
3. Other states DV Shelters (call each state individually to get a list of shelters in that state or look online for a list of DV shelters in each state)
    - New Hampshire DV hotline- 1-866-644-3574
    - Maine DV hotline: 1-866-834-4357
    - Vermont DV hotline: 800-228-7395
    - Rhode Island DV hotline: 800-494-8100
4. Emergency Housing through Department of Housing and Community Development (DHCD). The patient has to go to local Department of Transitional Assistance Office (DTA).
5. Department of Transitional Assistance Locations

    **This is only an option if it is during business hours and the person is Mass resident and has children with them.*
6. Homeless shelters (if no children)

Last resort alternatives

1. Have the child(ren) registered as patients and be seen for a check-up.
2. Involve MGH Police and Security to ask if the family can stay in the waiting area until the start of business the next day when the social worker can continue to explore options.

Community Violence

Community Violence is the exposure to intentional acts of interpersonal violence usually committed in public areas by persons not intimately known to the victim.

Purpose

The Violence Intervention Advocacy Program (**VIAP**) is a collaboration between the MGH Social Service Department and the MGH Emergency Department. The philosophy of the program is that violence is preventable and that trauma centers, like MGH, have an opportunity to engage with victims of community violence in an effort to stop the cycle of violence. The mission of VIAP is to assist survivors of community violence (assaults, gunshot wounds, stabbings, homicide) recover from physical and emotional trauma and empower patients and families with skills, services, and opportunities so they can return to their communities, make positive changes in their lives, strengthen others who have been affected by violence, and contribute to building safe communities.

Policy

Patient safety and security is paramount. Patients should be asked about their safety as an MGH patient and upon discharge. MGH Police and Security should be utilized as needed.

As MGH is a level 1 trauma center, it is imperative that we attempt to make outreach as a part of our city-wide commitment as a VIAP program, and to attempt to mitigate potential for further violence or recidivism. As with any trauma-related call, we strongly recommend that social work staff consider coming into the hospital for any community violence issues for which they are paged. Calls coming from the ED should be treated with "priority." Please see Trauma/Death/Dying section for further policy and information.

BMC Streetworker Protocol

As a part of our collaboration with Boston Medical Center we have teamed up with their Streetworkers, Rusti Pendleton and Donald Osgood. The Streetworkers are badged as MGH non-employees and may present to the Emergency Department in the event of multiple injuries or if they expect a large number of family members or community members to present to the ED. The Streetworkers only present to the ED if the patient is from the city of Boston and *already* known to the Streetworker program. Patient consent must still be obtained in order for the Streetworkers to meet with an MGH patient. While the Streetworkers have been instructed to contact the ED Coordinator prior to arrival, they may also contact social work to collaborate.

Procedure

Conducting an initial risk assessment is the essential first step in violence intervention to determine both the risk of retaliation by patient and/or his/her family members or friends and the vulnerability of the patient to re-injury.

Risk Assessment Tool

1. Do you know the person that hurt you?
2. Do you think the conflict that caused the incident is over?
3. Do you think that you will hurt anyone because of what happened today?
4. Do you think any of your friends or family will hurt anyone because of what happened today?
5. Have you reported this incident to the police or other authority?

Patients should be informed that there is a MGH VIAP advocate available to support the patient and family before and after discharge. The social worker should ask if the patient wishes to receive an outreach call from the VIAP advocate, Kate Haskins, the following business day.

If the patient consents to a VIAP referral

- Ask for the best number to contact
- Does the patient prefer text or voicemail?
- Is it okay to leave a voicemail at this number?
- Refer patient to VIAP program by completing two steps
    1. Place an **Ambulatory Referral Order** (if the patient will be discharged soon) or **Inpatient Consult Order** (if the patient will remain admitted until the next business day) in Epic. Hint: Search for “VIAP” when placing the order.
    2. **Send an Outlook email to Kate Haskins, the VIAP Program Coordinator. The email should include the Patient’s MRN, contact information, and any special considerations (such as language preferences or safety concerns).**

In cases of homicide, please see the guide for Bereaved Survivors of Homicide and follow the same process to refer to VIAP.

Recommended Resources

Boston Public Health Commission
Helpful brochures about “Healing After Trauma” offered in several languages

The Violence Intervention Advocacy Program (VIAP) provides on-going support and community referrals to victims of community violence and homicide survivors.

MGH Violence Intervention Advocacy Program (VIAP)
Kate Haskins, Mon. – Fri. 8:30 AM – 5:00 PM
Office Phone: 617-643-4303
Cell Phone: 617-816-9017 (call or text)
Pager: 27341

Sexual Assault of a Child

Please page Child Protection Team (CPT) by either calling the pager operator at 617-726-2241 and asking to have the CPT paged, or page directly by calling 617-724-5656, pager 32728.

Social workers must come in to the hospital for the sexual assault of a child.

Child Protection Team Contact Information
Phone: 617-724-0285
Fax: 617-726-5961
Pager: 32728

Sexual Assault of an Adult Patient

First check if there is a Psychiatric RN in the ED at the time, as they generally handle sexual assault cases. If the Psychiatric RN is not in the ED at the time, BARCC (Boston Area Rape Crisis Center) should be called at 800-841-8371 and a SANE RN and an advocate usually comes to the hospital. Typically, nursing staff know to call BARCC. If the patient declines a SANE evaluation, social work may become involved. If there is any confusion about what should be happening, ask to talk to the ED Charge Nurse about the case.

Accommodations

Patients and Families can make reservations for MGH affiliated facilities (Beacon House). The On-Call social worker cannot, under any circumstances, make reservations at these facilities after the hours listed below.

Beacon House

Reservations can be made at Beacon House & Beacon House Annex (617-726-7679) Monday-Friday 9:00 AM – 4:00 PM, Saturday 10:00 AM – 3:00 PM.

The Beacon House and Beacon House Annex are restored historic buildings in Beacon Hill, which provide permanent housing to a mixed use community. MGH leases 22 units for patients and families traveling from out-of-town. It is located at 19 Myrtle St., and is a ten-minute walk to the hospital.

Most Beacon House rooms can accommodate two guests; have a private kitchenette and bathroom. Rooms in the Annex are private, but share a kitchen and two full bathrooms. Each room is air conditioned, and has cable TV and phone with voicemail. Rooms are cleaned for each new guest and weekly for ongoing guests. Cots are available, but limited. There is no smoking allowed in the Beacon House or at the Annex.

If there is an emergency or problem concerning a guest after hours call the EMERGENCY LODGING PAGER 26872.

A guard is available on-site until midnight, and has keys to rooms for patients who have confirmed reservations. Please note guests are told that check-in is until 11:00 PM, although the guard is there until midnight.

The MGH Accommodations list can be found on the Social Service Website and SharePoint site.

MGH Beacon House
Mon-Fri 9:00 AM – 4:00 PM, Sat, 10:00 AM – 3:00 PM
Phone: 617-726-7679
Pager: 26872 (Emergency Lodging Pager)

Crisis Intervention

Definition

Patient and/or family are extremely distressed and unable to organize themselves or solve problems. Staff attempts to calm the situation or help patient and/or family problem solve.

Procedure

1. The On-Call social worker will assess whether it is appropriate to offer phone consultation and recommendations to referring provider or to come in to see the patient or family.
2. APS or the appropriate psychiatric consult should be contacted for behavioral management of patients.

At times, it is difficult to determine if the patient's, family's, and /or staff's needs require you to come into the hospital or if the consultation can be provided over the telephone. Many times the contact is initiated to help the staff diffuse a frustrating, stressful situation. After speaking with the key multidisciplinary team members (i.e., nurse, doctor, patient, and/or family) assess the situation. Then use your best judgment as to whether you need to come in. Feel free to contact the Social Work Administrator On-Call (pager 23977) for consultation as needed.

Impaired/Intoxicated Parent/Caregiver in the Inpatient Pediatric Setting

Admission of a child or adolescent to the hospital often leads to increased stress for parents or caregivers. During the admission, parents or caregivers may present to the hospital impaired by use of a substance (including alcohol). This can present several issues for staff, patients, or other families that can be difficult to manage. Please review the Impaired Caregiver Guidelines to assist hospital staff around how to manage these challenging cases.

Emergency Resources/Ancillary Relief Funds

Clothing

For sweat suits, t-shirts, and socks, have the floor nurse or ED nurse contact MGH Policy & Security to access clothing located in ACC 037. We have no other access to clothing. We do not have shoes.

Purpose

To define the role of social workers assisting MGH patients who are in need of, one-time only, emergency clothing items while ensuring the most efficient and effective use of limited Social Service Department funds.

Policy

Emergency clothing items should only be used when family members are unable to supply clothing for patients. Qualifying need for emergency clothing items is defined as

a patient without clothing or whose clothing was cut, blood-soaked, or soiled to the point that they are not wearable.

Procedure

Emergency clothing (t-shirts, sweat-shirts, sweat-bottoms, and socks) is stored at the ACC Social Service Department, Bigelow 10, and Founders House 6 offices, and should be signed out by a social worker for his/her individual use with patients.

An entry must be completed in the Emergency Clothing & Meal Ticket Resource Log for every resource taken. Logs are located in each office location.

Meal Tickets

Purpose

To support MGH patients and families in need of temporary nutritional support while ensuring the most efficient and effective use of limited Social Service Department funds.

Policy

A meal ticket is a resource available to assist financially needy individuals with the cost of a meal while they are visiting an MGH patient or are themselves an Outpatient who is having an unexpectedly long MGH appointment(s). Meal tickets are intended to defray the cost of food, not necessarily to cover the cost of a meal in its entirety. Meal tickets are not intended for an Inpatient's meal. If Inpatients or families have concerns related to the hospital meals, then the Nutrition Department should be consulted.

Procedure

Meal tickets are stored at the ACC Social Service Department, Bigelow 10, and Founders House 6 offices, and should be signed out by a social worker for his/her individual use with patients and families.

Meal tickets are available in the denomination of $5.

Meal tickets are intended for individuals with financial need only and should not be routinely offered to patients. Determination of financial need is based on the social worker's clinical judgment; documentation of financial need is not necessary.

Emergency Food Packs

Description

The Social Service Department, with help from the Department of Nutrition and Food Services provides a supply of easy to prepare, nutritious, familiar and tasty foods -

enough for 6-8 meals - for financially needy Inpatients who are being discharged with no access to food.

Eligibility

Eligibility is based on both the patient's financial situation and access to food. Social workers make the decision about eligibility, but need to complete the form so that the Department can track usage.

MGH Emergency Food Packs Form

online fillable or print and write

Instructions

1. Call 617-724-3663 to order and arrange for On-Site delivery (or pick-up at Blake basement) AT LEAST one hour's notice is required, but as packs are assembled as needed, as much notice as possible is appreciated. Hours: 8:00 AM to 7:30 PM.
2. Complete form. If ALL eligibility criteria are not met, please explain extenuating circumstances. Make a copy of the completed form.
3. Give the original, signed form to the staff member who delivers the meal.
4. Send the copy of the form to Ellen Forman. No pre-approval required.
5. Please refer patient to appropriate community resources as soon as possible.

Catering
(for On-Site Delivery or pick-up at Blake basement)
Phone: 617-724-3663

Petty Cash

Petty Cash is available after hours in the strong box located in the closet in the ACC mail room area. Petty cash cannot be used for medications or co-pays.

Forms

See MGH Social Service website for patient care forms.

Examples include

Child Abuse Reporting Form (51A)

Disabled Abuse Reporting Form

Funeral Homes

See MGH Social Service website for information about Final Arrangements and funerals

Homeless Shelters

When first consulted by the medical team regarding a homeless person, we recommend speaking directly with the patient and/or to his/her nurse. Assess how able the person is to obtain his/her own housing. If the patient is able to contact the shelters on his/her own, you should provide him/her with several numbers of shelters to assist with this. Telephones are available for patient's use in the ED. If the patient requires assistance, you or a provider who is in the hospital should contact the shelters. In most cases, it is not necessary for you to come into the hospital to locate a shelter bed for a patient.

See MGH Social Service website for details on shelters

The Health Care for the Homeless Team can be consulted via the pager number above in instances where the social worker or case manager is having difficulty placing patient at Barbara McInnis House or if patient has passed away and the Homeless Team may have access to information about the patient's relatives. The Homeless Team should not be consulted for locating a regular shelter bed.

Health Care for the Homeless Team

Pager: 781-221-6565

Homeless Families

Homeless families cannot directly access homeless shelters the way that homeless adult individuals can.

Accessing Family Shelter

Families apply to the Department of Housing and Community Development (DHCD) either by phone (866-584-0653, Monday through Friday 8:00 AM to 4:00 PM) or at certain designated Department of Transitional Assistance (DTA) offices. Families are assessed for eligibility and then placed directly from the office if eligible.

Before qualifying for family shelter, some families need to show they stayed at least one night in a "place not meant for human habitation". If the family is allowed to stay the night, it would help their case if this is documented in the discharge paperwork.

There are a very limited number of family shelters that do not require a DTA or Department of Children and Family (DCF) referral. A list is available in the Information for Homeless Families document (on Social Service Website) and families have to call themselves. There are different criteria, space is extremely limited, and there are often long waiting lists.

DCF is the only other way to access most family shelters **for families already involved with DCF**. Please note that homelessness is not considered neglect and is not a reason to file a 51A if it "is solely due to inadequate economic resources". DCF will not respond to a 51A for homelessness alone, and a filing will NOT result in families being placed from the ED. If there are other abuse/neglect concerns apart from the homelessness, please consult further with the Child Protection Team and/or Administrator On-Call.

Social workers have NO ABILITY to find a family a homeless shelter. We urge families to call 866-584-0653 or go to a participating DTA office first thing in the morning to apply.

If you are paged before 8:00 PM regarding a homeless family

Allowing a family presenting with the primary concern of homelessness to stay overnight becomes particularly challenging when:

- The Pediatric Emergency Department has a high census
- It is a weekend or holiday when DTA is not open the following morning
- And/or when a family presents from out of state and is not eligible for DTA

Boston Healthcare for the Homeless may be able to assist some homeless families in the above situations. If you are paged by the ED before 8:00pm on any day of the week regarding a family experiencing homelessness and all other options have been exhausted, contact **Georgia Thomas**, Homeless Program Family Team Director for Boston Healthcare for the Homeless.

Families may be able to be temporarily housed at a Boston Healthcare for the Homeless space at 780 Albany Street in Boston. This is not a shelter, or long-term solution, but a place where the family can stay, shower, rest and eat, before connecting with DTA when it next opens. The family will be assisted into this temporary space, and Boston Healthcare for the Homeless will follow up with them to connect them with DTA

and/or other resources. This could be a better option for families than sitting in the waiting room of the hospital, or in the ED when they don't have medical issues.

Georgia Thomas
Homeless Program Family Team Director for Boston Healthcare for the Homeless
7 days a week, 8:30 AM – 8:00 PM
Email: gthomas@bhchp.org **Pager:** 781-221-6565

If you are paged after 11:00 PM regarding a homeless family

- Suggest that the family try to find friends or family that could house them for the night.
- See if they have money for a motel.
- If the ED allows them to stay, and the family does stay the night in the ED, they should be directed to call 866-584-0653 or go to a participating DTA office as soon as it opens in the morning. If calling, access to a scanner and e-mail or a fax machine can facilitate application.
- Offer the family the Information for Homeless Families document (on Social Service Website) to find a participating DTA office and other shelters that they can call themselves.

Department of Housing and Community Development (DHCD)
Monday through Friday, 8:00 AM – 4:00 PM
Phone: 866-584-0653

Obstetrics & NICU Coverage

Adoption

If a pregnant patient comes in requesting assistance in finding an adoption agency for her baby, the On-Call social worker will need to assess whether this patient would need to work directly with a private adoption agency or with the Department of Children and Families (DCF). It is important to consult with the Child Protection Team (CPT) to assist in this determination. The medical team will do an automatic toxicology screen if a patient had no or limited prenatal care. If toxicology screen is positive a 51A will need to be filed. If during your social work assessment, you find out there are other significant substance abuse history and/or psychosocial stressors, it is likely that a 51A will need to be filed.

Along with the On-Call social work psychosocial assessment, it is important to understand the psychosocial circumstances and the meaning of the adoption to the mother (and father, if he is involved). Other Inpatient Social Work responsibilities are to assist with inpatient management and discharge planning for mother and baby

(including signing of infant discharge release form), to assist mother in contacting a licensed adoption agency if she has not already done so and to act as a liaison with the licensed adoption agency.

Other issues to keep in mind

- The birth mother/father is aware of their rights as a birth parent (contact Office of the General Counsel [Legal] if there are any questions about rights).
- Social workers can tell parents that the prospective adoption agency will go over their rights and the legal issues. The social workers can help with any specific treatment needs the parents request specific to their adoption related assessment.
- The social worker asks the nurse whether the memory box has been offered.
- The Adoption Agency initiates health insurance for the baby.
- Please call and leave a message for the MGH Birth Certificate Office 617-724-1905 with the patient's name and medical record number and let them know this is an adoption case.

Paperwork from the Adoption Agencies must be photocopied and placed in baby's chart

1. Copy of Foster Care Agreement (the adoption agency brings this piece of paperwork).
2. Copy of Authorization for Medical Release Forms (The release form is available on the Social Service Department's website).
3. Copy of Adoption Agency License / Agency Photo ID.

MGH Social Worker's paperwork must be scanned in both mom's and baby's charts

1. Authorization for Release of Protected or Privileged Health Information giving permission for us to communicate with Adoption Agency (Form is an authorization for release of medical information and can be found on the Social Service Department's website. The form should be put in mother and baby's chart.
2. Infant Discharge Release Form Adoption/Foster Care (located on Blake 13 in filing cabinet where the Operations Associates sit).

Recommended Adoption Agencies

Adoptions With Love

http://www.adoptionswithlove.org/

1-800-722-7731

Available 24 hours a day, 7 days a week

Wide Horizons for Children

28 Edge Hill Road, Waltham, MA 02451

http://www.whfc.org/

1-781-894-5330

1-800-729-5330

Voicemail will direct you to who is On-Call.

Mary Fournier

WHFC Domestic Adoption Program Manager

Cell Phone: 860-543-2918

Perinatal Mood Disorders / Postpartum depression (PPD)

Postpartum depression is a mood disorder that can affect women after childbirth. Mothers with postpartum depression experience feelings of extreme sadness, anxiety, and exhaustion that may make it difficult for them to complete daily care activities for themselves or for others. Postpartum depression is a broad term which can include antenatal mood disorders, such as OCD, anxiety, or depression as well as more severe experiences of postpartum psychosis. Postpartum depression can be diagnosed anytime within 1 year from birth.

Baby Blues

Onset in the first 2-3 days from delivery and usually dissipates after 1-2 weeks. May include mood swings, crying spells, anxiety and difficulty sleeping. Baby blues is associated with adjustment and hormonal changes.

PPD

Delayed onset. Symptoms can be more persistent, more frequent and more significant. PPD is treatable with a variety of modalities including talk therapy and/or short term medication.

If a mother received her prenatal care through MGH, or one of the MGH Community Health Care Centers, she may have access to ambulatory (outpatient) OB social work for up to 6 weeks postpartum. To access OB social work, mothers should contact their Obstetrician's office and ask to schedule an appointment with social work.

MGH Main Campus Ambulatory OB Social Workers
Nancy Leventhal, LICSW 617-724-1307
Nina Stewart, LICSW 617-724-3177

Recommended Resources

Postpartum Progress

http://www.postpartumprogress.com/

Patient Handout Post Partum Depression
*Note: this handout includes a section "What can my husband do to help?" Use discretion- may not be appropriate for all families.

Fetal/Neonatal Loss & Bereavement in the NICU

Social work is offered after any prenatal/ neonatal loss.

Miscarriage or Spontaneous Abortion (loss prior to 20 wks)

The baby is born with no signs of life. Family receives death certificate only (which is completed by physician).

Intrauterine Fetal Demise (IUFD) or Stillbirth (loss between 20wks and full term)

The baby is born with no signs of life. Family receives death certificate only (which is completed by physician).

To obtain a Certificate of Birth Resulting in Stillbirth (BRS), contact
State Registry of Vital Records and Statistics Attn: CBRS Registrar
150 Mt. Vernon Street 1st Floor, Dorchester, MA 02125
(617) 740-2606

Neonatal loss (after delivery)

The baby is born with some, or all, signs of life. Family receives birth and death certificates.

Bereavement in the NICU

When a 'redirection' or loss of an infant is identified the staff is asked to have SW paged regardless of family wishes. Anticipatory conversations with the unit SW may have occurred but please use your own clinical skills to support the family and identify their needs. The social worker's role in the NICU during this process:

- Use the NICU Bereavement checklist to help guide you in supporting the family. The nurse caring for the infant will have a copy; the resource nurse or ARN can also assist you.

- Assist the family in identifying a funeral home.
    - There is a list of funeral homes in the binder if the family needs help finding one. Offer to call the funeral home for the family
- Consider reaching out to Child Life (Weekdays Page #12416/Weekends #14678) for specific sibling concerns.
- Document your visit in Epic in both Mother and Baby's charts.
- Send follow up email to the assigned social worker following.
    - Reach out to Marisa Iacomini, LICSW (page #32657/phone 726-2611) if you have further questions/feedback.

Social Work Role in Pregnancy Loss

Pregnancy loss is experienced as an acute crisis and should be treated as such. Families may not be able to process much and may have difficulty retaining information. Printed information should be offered where possible. Social worker should offer empathy and validate feelings. Social worker should work with RNs and MDs to ensure that the patient/family is offered a memory box (RN) and that disposition of fetal remains form is signed (MD). Social worker and RN's should discuss what resources are appropriate for the family given the specific circumstances around their loss.

Presence of the baby in the room

Depending on circumstances of death/delivery, parents are offered the opportunity to spend time with the baby. The baby may be present in the room at the time of SW consultation. The baby can be kept with family for a short time without affecting the autopsy, though autolysis (decomposition or break down) does start immediately. The baby can be stored in the morgue (or in pathology) for days without affecting the autopsy as cooling slows autolysis.

Autopsy

Autopsy/fetopsy can help to determine cause of death and assess risk for future pregnancies. The results can also offer a sense of closure for families. Most autopsies are completed within 24 hours of the loss and special requests can be honored (Open casket is still possible after an autopsy has been completed). Families who consent to an autopsy on the fetal remains should be reminded that the findings will be provided to them by their OB provider in approximately 4-6 weeks.

Assisting Families with Disposition of Fetal Remains

A family is given two options for how they want to handle the arrangements of a deceased fetus or baby

1. By having MGH care for the remains.

2. By contacting a funeral home and making their own funeral arrangements. If a family elects to take care of the remains themselves, a funeral home must be involved.
    - Families should default to a funeral home that they are familiar with. If they have no specific connection, families should be encouraged to reach out to local funeral homes in their community (funeral homes will usually offer free, or low cost services, for residents of their own cities).
    - The Catholic Cemetery Association offers free burial plots for babies (a marker is offered, though sites are not specifically marked). Oak Lawn Cemetery in Roslindale is another option.

If fetus is under 20 weeks or under 300 grams

Unless the family makes their own funeral arrangements, the hospital will dispose of the remains along with any other hospital surgical specimen.

If the fetus is over 20 weeks or over 300 grams

If the family wishes MGH to take care of the remains, MGH (who works with the Brady Fallon Funeral Home in Boston) will have the remains buried. Access to the gravesite is limited and graves are not marked.

On the rare occasion that the family asks if the remains can be discharged to them directly

Justin Susterich (617-726-2976) from Pathology states that, by law, any fetus (unless cause of death is by elected termination) at any gestational age can be discharged directly to the family. For the family to have the remains given directly to them, they will need to present a burial permit to the Pathology lab. The family can purchase a burial permit in Boston (the city where the loss occurred). The family will need to have a check or money order for $31 and a copy of the Report of Fetal Death or Letter for Burial. Families must be able to offer a dignified mode of transportation for the remains as well as a dignified burial process.

The Deaner (staff member in the MGH morgue) is only available Monday through Friday. Unless it is urgent that the fetus be discharged to the family over the weekend, he prefers that these matters are completed during the work week as the pathology resident or weekend per diem pathologist are not familiar with handling these issues.

Boston Public Health Commission

1010 Massachusetts Ave, 6th Floor, Boston, MA 02118

Phone: (617) 534-5395

Burial Permit Office
Phone: 617-534-4758 or 617-534-2361

Financial Hardship

Families who identify financial hardship should be directed to their local DTA office as they may be eligible for burial financial assistance (the family does not have to be receiving benefits from DTA prior to the loss).

- There is a $1,100 benefit maximum- any assets of a financially responsible relative (i.e., parent in this case) would be deducted from the amount they would pay. One accesses this benefit through a funeral home.
- If it seems as though a family may attempt to apply for funding, please ensure that the Obstetrician completes the long-form death certificate (4 pages), if possible.
- There are some charities, such as Catastrophic Illness in Children Relief Fund, that help with finances for "final arrangements" when a child dies. Advise the family do an internet search or consult Community Resource Specialists on a case-by-case basis.

MGH Main Campus Inpatient OB Social Workers
Marisa Iacomini, LICSW (NICU) 617-726-2611 | Pager: 32657
Sandra Stokes, LICSW 617-726-2628 | Pager: 27171
Martha Southworth, LICSW 617-726-5889 | Pager: 26856

Substance Use/ NAS (neonatal abstinence syndrome)

ALL women are screened for substance use prenatally. Any mother who admits to substance use within the past two years will be asked to consent to random urine drug testing prenatally as well as upon admission for delivery. Mothers must consent for themselves to be urine tested. However, newborn babies can be tested without their mother's consent.

RN's will collect baby's first urine and first poop (meconium). Urine results are typically available within hours, where as meconium results take 4-5 days. If the result is "presumptive positive," they will be sent for additional testing which adds about an extra week.

In most cases, both mother and baby's urine toxicology tests should have a V-PAIN or pain management panel added to the standard urine toxicology test; the additional panel breaks down "opiates" into specific metabolites.

When to file a 51A on the OB Service including Special Care Nursery, Neonatal Intensive Care Unit

A 51A will need to be filed when a mother who delivers is on Methadone, Suboxone, or Subutex. Please find out who prescribes and obtain contact information to pass along to DCF.

A 51A will need to be filed if mom and/or baby tests positive for drugs at birth. DCF expects that a 51A report for Substance Exposed Newborn be made on behalf of **any positive urine result** (including marijuana and prescribed opioids). Please look in the mother and/or baby's Epic chart for any other toxicology screens done during the pregnancy which will need to be passed along to DCF. Please see page 37 for instructions.

SW will conduct full psychosocial assessment with specific attention to substance use history. SW and the treatment team will assess child protective concerns and collaborate with CPT as needed. Filings should be noted in mom and baby's Epic charts. Copies of the 51A forms can be found on the MGH Social Service SharePoint site. Families should also be connected with psychiatry and addiction services, as needed.

On nights and weekends, 51A reports should be called into the DCF Child-At-Risk Hotline at 800-792-5200; cases will be forwarded to the area office that covers the city where mom/ baby plan to live.

FYI – If a family has an on-going DCF case open, any new 51A filed will be managed through the same office, regardless of the family's current address.

MGH Child Protection Team (CPT)
available 24 hours a day, 7 days a week
Pager: 32728

Psychiatry Consult Liaison Service
Phone: 617-726-2984

Addictions Consult Team (ACT)
Phone: 617-724-SUDS

Recommended Resources

MGH Best Practice Guidelines for the Management of Substance Exposed Newborns

Patient Handout: Post Partum Depression
*Note: this handout includes a section "What can my husband do to help?" Use discretion- may not be appropriate for all families.

MGH Bridge Clinic
Transitional outpatient addiction clinic as bridge to ongoing care

Massachusetts Department of Children & Families Locations

Other issues to consider when assessing child protective concerns

Homelessness, domestic violence, significant/problematic psychosocial stressors, being unprepared both financially and emotionally for a baby, substance abuse history and significant mental health and/or cognitive/developmental delay that could affect ability to care for baby. Other things to be aware of are if patient had limited or no prenatal care or late transfer from another prenatal care facility.

Note: If parents have never been married to each other, the baby's mother is the only one who has legal rights to make medical decisions for the baby unless she has given the father rights either verbally or through the courts.

If DCF takes custody of the child

1. Ask that DCF fax a letter or legal document defining the custody arrangements. This may be a Mittimus and/or B3 letter (DCF's "letter of intent" to take the baby). Any document of custody needs to go into the front of the baby's chart and also be scanned into the baby's electronic medical record.
2. Get clarity from DCF regarding who is able to visit baby, for how long and if there are any visiting restrictions and MGH Police & Security as needed.
3. If DCF has custody, only DCF can consent for medical procedures and treatments and/or sign the child out of the hospital at discharge. Clarify with DCF who from DCF will be responsible for making medical decisions regarding the care of the child. Carefully document the name and the phone number of that individual in the Medical Record and if possible, who from DCF should be contacted if that person is not available.
4. Please document all information pertinent to items 1, 2, and 3.

5. Please hand off to floor social worker for follow up (Marisa Iacomini for NICU, Sandra Stokes and Martha Southworth for all other).

Toxicology Results in Epic

Please defer to the medical team for tox screen results. In addition, it is strongly recommended to connect with CPT before filing on the word of the team regarding tox results.

Parking for Patients and Families

Refer patients and families with parking issues to the Parking and Commuter office at 617-726-8886. The parking supervisor is able to reduce parking fees when appropriate.

Social Service Department Policy regarding Inpatient Parking is as follows

Purpose

To define the role of social workers assisting MGH patients, with an Inpatient stay of 30 days or longer, in securing discounted parking, which is available through the MGH Parking and Commuter Service office.

Policy

Although parking at MGH can be expensive for many patients and families, the Social Service Department is not able to defray this expense. Only patients and families with an Inpatient stay of 30 days or longer are eligible for discounted parking, which is available through the MGH Parking and Commuter Service office located in the Wang building, room 232.

Procedure

Social workers sign the Reduced Rate Parking Form verifying that the Inpatient length of stay is 30 days or longer.

Reduced Rate Parking Forms are available in filing cabinets in Founders House 6 and Bigelow 10 Social Service offices. This form cannot be posted online as each copy has a unique identifying number.

Patients or families issued a Reduced Rate Parking Form will need to visit the MGH Parking and Commuter Services office located at Wang 232 to retrieve a key card for discounted parking.

If a patient or family presents to the parking cashier as unable to pay for parking, the cashier will either refer the patient or family to the Customer Service Representative, or offer them a non-payment form, which may result in the patient being billed.

For questions or concerns, please contact the MGH Parking and Commuter Services Customer Service Coordinator at 617-724-2968.

MGH Parking and Commuter Services

Pager: 617-724-2968

Transportation

Transportation to leave the hospital is the responsibility of the patient. There are occasions, however, when the patient does not have any transportation options for him/her to return home. When such a situation occurs, please refer to the section below to determine how best to send the patient home.

Discharge Transportation

Case Management is responsible for all discharge transportation (e.g. particularly from inpatient units).

Taxis through the Emergency Department

If all resources have been exhausted and a patient is in need of taxi transportation, the Emergency Department may have taxi vouchers between the hours of 8:00 AM – 8:00 PM.

Detox Patients

The Acute Psychiatry Service has some transportation resources available for detox patients. If the detox is outside of reasonable distance from Boston, a chair car can sometimes be used. Ask an RN to call for a chair car in these cases.

Charlie Cards

If the patient is capable of taking the T, the Social Service Department has Charlie Cards available in the strong box located in the closet in the ACC mail room area.

Town Taxi

Town Taxi is a limited resource through the Social Service Department for transportation and should only be accessed as a last resort after all other resources have been exhausted. To book a taxi for a patient, call 617-562-4401 and identify yourself as a social worker in the MGH Social Service Department.

The Social Service Department's website has information about transportation resources in the community for non-emergent transportation needs

Contact the Social Work Administrator On-Call (pager 23977) for consultation as needed.

Substance Abuse / Addiction

Detox

Due to insurance and bed availability constraints, we do not assist in discharges to detox during the On-Call shift (11:00 PM – 8:30 AM). You can, however, assist staff in planning for discharge to detox the following day. See the Social Service Department website for information and resources.

Opioid Overdose

In effect as of July 1st, 2016, the new Massachusetts Opioid Bill includes, but is not limited to

- Requires substance abuse evaluation within 24 hours to those presenting to the ED suffering from opioid overdose.
- Limits first time prescriptions for opioids for acute pain to 7 days.

Policy

A person presenting in an acute-care hospital or a satellite emergency facility who is reasonably believed by the treating clinician to be experiencing an opiate-related overdose, or who has been administered naloxone (i.e. Narcan) prior to arriving to the hospital or facility, shall receive a substance abuse evaluation within 24 hours of receiving emergency room services. The evaluation would include diagnosis and treatment recommendations.

A patient who does not wish to remain in the emergency department after stabilization, but before a substance abuse evaluation has taken placed, can be released (It is up to the patient to consent to the substance abuse evaluation).

Procedure

A substance abuse evaluation is required within 24 hours for patients presenting to the ED with an opioid overdose or who have been administered Narcan prior to arriving to the hospital.

MGH has created a new virtual pager "Overdose Evaluation" pager 28777 which is covered by various MGH mental health providers who have been trained to complete a specific evaluation for these patients. Emergency Department and On-Site Social Workers will cover the Overdose Evaluation pager Saturdays and Sundays from 9:00 AM – 11:00 PM, and on other agreed upon times when coverage is needed for ED addiction staff who typically cover the pager from 9:00 AM – 11:00 PM Monday-Friday.

On-Call Social Workers are not responsible for completing these evaluations. If you receive any pages while On-Call requesting an overdose evaluation for one of these patients, please refer the consulting provider to the "Overdose Evaluation" pager 28777.

If you are covering the Overdose Evaluation pager and completing a Substance Use Disorder Evaluation for an opioid overdose patient, it is necessary to follow the Substance Use Disorder Evaluation (SUDE) workflow which can be found on SharePoint.

Trauma / Death / Dying

Pediatric and Adult Trauma/Death/Dying (calls from the ED)

Policy

As a Level One trauma center, the Mass General Hospital ED sees many of the most critically ill and injured patients. We strongly recommend that social work staff consider coming into the hospital for any trauma/death/dying issues for which they are paged. Calls coming from the ED should be treated with "priority." The ED may be a family's first entrance, and/or only connection to the hospital setting. If the medical staff has initiated a call to have social work present at this time, we ask that you assume that there are psychosocial needs that warrant your attention.

Before coming in, try to determine from an ED staff member

- What is the medical status of the patient?
- Is family present and will they remain at the hospital for at least one hour, allowing the On-Call Social Worker time to come in?

Pediatric Trauma Alert Group Pages

The Emergency Department pager automatically receives pedi trauma stat group pages (for most critical traumas) and pedi trauma alert group pages (for any pedi trauma). Although the Emergency Department social workers automatically respond to

these pages, On-Call social workers can take these pages as an "FYI." However, providers might still send a separate page specifically requesting social work.

Adult or Pediatric Trauma / Death / Dying (calls from Inpatient Floors and ICUs)

While calls regarding Adult and Pediatric Trauma are less common on the inpatient units than from the ED, On-Call Social Work assistance may still be required. Before coming in, try to determine from an inpatient staff member

- What is going on now that requires a social worker to come into the Hospital?
- What is the patient's medical status? Has the patient's status changed suddenly/unexpectedly?
- If you are being asked to meet with family, is the family present and will they remain in the hospital for at least an hour, allowing the On-Call Social Worker time to come in?

Requests to Accompany Families to the Morgue

Staff may offer to families or families may request to view the body of their deceased loved one in the hospital morgue. The morgue is a clinical area not designed for the viewing of a deceased patient. If culturally appropriate, families should be encouraged to make arrangements with the funeral home of their choice to view their deceased loved one's body, rather than viewing the body in the morgue. If families insist on viewing their loved one's body in the hospital morgue, staff should inform family members as to what they will see. Social workers should only accompany families to the morgue along with other staff, such as the patient's nurse and MGH Police and Security. The social worker's role is to provide emotional support to families. The social worker should NOT participate in preparing the deceased body to be viewed. If questions/concerns arise regarding social work involvement in a morgue visit, please page the Social Work Administrator On-Call (23977) for consultation.

Bereaved Survivors of Homicide

The Social Service Department's Staff Access site has a guide for Bereaved Survivors of Homicide, which includes common feelings of grief, tips for survivors, and resource information.

Also consider downloading the Louis D. Brown Peace Institute's Survivor's Burial and Resource Guide (http://www.ldbpeaceinstitute.org/content/burial-guide)

Recommended Resources

Office of the Chief Medical Examiner, Headquarters

617-267-6767 or 800-962-7877 (toll free)

The Massachusetts Victim's Compensation Fund

617-727-2200 ext. 2160

www.mass.gov/ago

Massachusetts Office for Victim Assistance (MOVA)

617-586-1340

www.mva.state.ma.us/resources

Center for Homicide Bereavement (CHB)

617-792-7830

Provides bilingual/bicultural services free of charge to those who have experienced the loss of a loved one to murder.

The Children's Room (TCR)

1210 Massachusetts Ave., Arlington, MA 02476

Liz Cavano 781-367-5461

Helps grieving children, teens, and families in our communities after the unexpected loss of a loved one.

Louis D. Brown Peace Institute

15 Christopher St, Dorchester, MA

617-825-1917

Serves as a center of healing, teaching, and learning for families and communities dealing with murder, trauma, grief and loss.

North Suffolk Mental Health Association

301 Broadway, Chelsea, MA

617-889-3300

Provides community-based counseling.

For additional referrals and support, the Violence Intervention Advocacy Program (VIAP) provides on-going support and community referrals to victims of community violence and homicide survivors.

MGH Violence Intervention Advocacy Program (VIAP)
Kate Haskins, Mon. – Fri. 8:30 AM – 5:00 PM
Office Phone: 617-643-4303
Cell Phone: 617-816-9017 (call or text)
Pager: 27341