

SOCIAL WORK ASSESSMENT TOOL

(SWAT)

Guidelines for Use and Completion



The Social Work Assessment Tool was developed by the Social Work Outcomes Task Force of the Social Work Section, National Hospice and Palliative Care Organization, National Council of Hospice and Palliative Professionals. Members of the Task Force included Mary Raymer, ACSW, Ruth Huber, Ph.D., MSW, Dona Reese, Ph.D., MSW, Stacy Orloff, LCSW, and Susan Gerbino, Ph.D., MSW. Charlotte Butler, Ph.D., had major responsibility for writing this information booklet.

INTRODUCTION

The purpose of this document is to provide practical information on the development and use of the Social Work Assessment Tool (SWAT). Hopefully you will find it a valuable guide when using the SWAT. If you have any additional questions please contact:

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SOCIAL WORK SERVICES IN HOSPICE AND PALLIATIVE CARE

Importance and Impact in the Treatment Process

There is no doubt that social work services are important in effective end-of-life care. Research has demonstrated that increased social work involvement is significantly associated with:

- ❖ Lower hospice costs
- ❖ Lower pain costs
- ❖ Fewer on-call visits by staff
- ❖ Fewer hospitalizations of patients
- ❖ Fewer nights of continuous care
- ❖ Better team functioning
- ❖ Fewer visits by home health aides, nurses, and by the agency
- ❖ Decreased staff turnover
- ❖ Increased job satisfaction for MDs, nurses, and social workers
- ❖ Higher client satisfaction and quality of life for patients
- ❖ Lower severity of problems in the case

(combined results from Cherin, 1997; Mahar, Eickman, & Bushfield, 1997; Paquette, 1997; and Reese & Raymer, 2004)

We also know that certain psychosocial and spiritual issues are associated with client outcomes (See Table 1). We know that social workers are addressing these issues, but without documentation, there is no way to demonstrate social work effectiveness in routine agency quality assurance efforts.

CREATING THE SWAT

In response to requests from all over the nation for a tool to document social work effectiveness, the Social Worker Section of the National Hospice and Palliative Care Organization's National Council of Hospice and Palliative Professionals has developed the SWAT. Our hope is that it will be used as part of the routine quality assurance activities of hospices and palliative care programs' nationally. Examining service approaches that produce higher scores can then identify best practices.

SWAT CONTENT

There are eleven individual psychosocial and spiritual issues that make up the SWAT. These issues were selected based on research results and practice wisdom about areas of major influence on end-of-life care outcomes. Table 1 lists the issues, a description of each issue, and related tasks to be accomplished with each issue. Following the table is a sample of the SWAT form and brief instructions on how to use the form.

TABLE 1

ISSUE	DESCRIPTION	TASKS TO BE ACCOMPLISHED
1. End-of-life decisions consistent with their religious and cultural norms	Patient self-determination is a key aspect of hospice philosophy and an important social work value. The ability to make one's own choice promotes self-determination. Legal and ethical questions may be involved, as well as cultural and religious beliefs and preferences regarding end-of-life care.	Social worker discusses end-of-life preferences with clients, advocates for patient self-determination with team. Helps clarify values, assesses whether there are concerns. Refers to religious leaders for specific religious questions. Provides resources if needed. Develops practice approaches and policies that make room for differing beliefs and preferences, leads the way in developing cultural competence.
2. Patient thoughts of suicide or wanting to hasten death	Practice wisdom suggests that suicidal ideation, request for assisted suicide, or a suicide attempt may be an issue for a patient. Often unmet needs, death anxiety, a need to control the circumstances of death, or other emotional distress create a desire to hasten death.	Meeting the needs leading to suicidal ideation may address the issue: counseling regarding complicated anticipatory grief, pain and symptom control, obtaining resources to support the family in caregiving, addressing financial needs, advocating for patient self-determination.
3. Anxiety about death	Elements of death anxiety are fear of loneliness, fear of personal extinction, fear of suffering, and fear of the unknown. ¹ Much of this entails questions about the afterlife, thus death anxiety may overlap with spiritual issues. Death anxiety leads to lack of awareness of prognosis, or denial.	Allow patient to openly discuss spiritual issues, clarify own beliefs. Spirituality and social support reduce death anxiety. Coming to a sense that one's own life has been valuable as it is, and a sense of oneness with all may decrease death anxiety.
4. Preferences about environment (e.g., pets, own bed, etc.)	Patient self-determination regarding preferences about the environment is an important part of hospice philosophy. Preferences may include where the bed is located, the desire for pets in the room, preferences about who visits and when, having treasured objects	Preferences should be elicited and explored. Social workers act as advocates for patient preferences with family members and the hospice and palliative care team.

¹ Conte, H., Weiner, M., & Plutchik, R. (1982). Measuring death anxiety: Conceptual, psychometric, and factor-analytic aspects. *Journal of Personality and Social Psychology*, 43(4), 775-785.

	close by, music, books, etc.	
5. Social support	Informal and formal support, patient's environment, family, significant others, friends, and resources. Better social support predicts a preference for home hospice care. Spirituality increases social support.	Help promote open discussions, remove barriers to intimacy and help maintain intimacy. Provide insight into family strength, needs, and adjustment to terminality.
6. Financial resources	A major concern is the adequacy of health insurance to cover end-of-life care expenses, medications, medical equipment. Other issues may be a need for caregivers in the home and a loss of income due to the illness.	Assess how well clients' financial resources meet their needs; referring to formal supports when needed.
7. Safety issues	Client safety becomes an issue when activities of daily living become more difficult. Clients who live alone, or with family members in denial about the patient's condition, may be in danger of injury in the home.	Assess client safety and obtain informal and formal supports as needed. Provide counseling if family denial is leading to an unsafe situation.
8. Comfort issues	Patient's physical comfort is influenced by the psychosocial and spiritual dimensions. Increased social work services is associated with decreased pain control costs.	Assess for non-physical pain control interventions, including relaxation and meditation techniques.
9. Complicated anticipatory grief (e.g., guilt, depression, etc.)	Some factors interfere with resolution of anticipatory grief. These include guilt about one's past actions, anger and depression in response to the terminal illness, spiritual questions. Patient cannot die in peace.	Assess patient's beliefs and concerns, provide counseling, opportunities to resolve conflicts or ask for forgiveness, refer to religious leaders for specifically religious questions.

<p>10. Awareness of prognosis</p>	<p>Lack of awareness of terminality although being informed of it. Denial is a way of coping with death anxiety, but one cannot accomplish tasks of dying while in denial. Denial compromises patient self-determination. Denial of patient's terminality by primary caregiver can lead to unsafe home conditions or lack of support for patient end-of-life decisions.</p>	<p>Avoid confronting the patient and stripping them of their denial. A little bit of denial is considered positive. Intervene when harmful situations develop. Patients go in and out of denial, and will bring up questions about their terminality during periods when they are ready to address it. Death anxiety leads to denial; reducing death anxiety by addressing spirituality will reduce denial.</p>
<p>11. Spirituality (e.g., higher purpose in life, sense of connection with all)</p>	<p>Different concept from religion. Religion has to do with a certain belief system, affiliating with an organized religion. Spirituality applies to everyone, regardless of religious or non-religious path. Finding meaning and purpose in life, sense of connection with all (nature, others, God, ultimate reality, according to one's own belief system). Spirituality was the most frequently addressed issue in home visits to clients in a study of a Midwestern hospice. Addressed by all team members; refer to appropriate chaplain for specifically religious issues.</p>	<p>Help patient discover a higher purpose in life and a sense of connection or oneness with all. Encourage patient to resolve spiritual issues connected with the meaning of life and suffering, unfinished business, clarifying his/her belief system, relationship with the Ultimate, isolation, and transpersonal experiences. These may include reconciling with someone, praying for forgiveness, or forgiving oneself and asking for forgiveness from another.</p>

USING THE SWAT

This section provides a case scenario of a hospice patient and family and details the clinical interventions utilized by the social worker in providing care. Following the case study are instructions on using the SWAT to document client outcomes. Then a completed SWAT is provided, with the scores we would have given these clients. Finally, another case example is provided with a practice SWAT to be completed for training purposes.

CASE EXAMPLE

Mary, 70 year old seriously ill patient

David, 50 year old son, lives with mother, travels a lot

Michael, 45 year old son, lives with mother much of time

Susan, 40 year old daughter, lives in Florida

Dorothy, 35 year old daughter, lives locally, has been designated as the primary caregiver.

The patient, a Caucasian protestant widow, is diagnosed with end stage chronic obstructive pulmonary disease and has a history of asthma. She has shortness of breath with minimal exertion, and uses oxygen most of the time. Two years ago she was on a ventilator after respiratory arrest, but now has a living will that states her wish for comfort care only - she doesn't want any death delaying procedures. She also has a Do Not Resuscitate Order, and has designated her son David as power of attorney for health care decisions and finances. Her physician predicts she has six months or less to live, according to concrete guidelines developed for determining prognosis.

Mary lives with her son David, who travels a lot and isn't home much. Her other son Michael also lives with her much of the time. The patient feels that she lives in an unsafe neighborhood, and keeps a gun in the house for that reason. The Dept. of Aging has provided an aide to do housework 2 hours per week. She has two daughters, one is Susan in Florida whom she doesn't see very often. The other daughter, Dorothy, lives close by, but works, and visits on Mondays. Dorothy is the primary caregiver and has slowly been taking over her mother's care and responsibilities. Mary's husband died many years ago when he was in his 20's, and she appears to have coped well with this loss. She was divorced due to her alcoholism. She raised four children alone, and now enjoys her grandchildren. She was an LPN, but became disabled and retired on Social Security Disability at age 62. She has Medicare and the Medicare Hospice Benefit.

Her children say that due to her alcoholism, she was not there for them as children. The patient complains that her son David insults her, but Dorothy reported that the patient has

always insulted David. Dorothy is resentful about her mother's abuse toward her children and their father. Dorothy also complains of a lack of support from her siblings, who leave the care of the mother to her. She is glad, though, that her sister Susan has been looking into hospices in Florida.

Mary states that she wants to stay at home and die in her own bed, but has been afraid she will panic when she gets short of breath. She has had difficulty with the idea of calling hospice instead of 911 at times like this. She has expected that she would want to go to the hospital, and would be afraid to be home alone during respiratory arrest. Her family also is not used to the hospice philosophy of dying at home. Dorothy was able to make an agreement with hospice staff, though, that she would call the hospice nurse first, before calling 911. If the nurse is not able to be there immediately, and she is really afraid her mother will choke to death, she will call 911.

Mary has portable oxygen tanks, a wheelchair, bedside commode, and a home alert system. She states that her home is arranged the way she wants it. She is obese and has diabetes. She takes medications for shortness of breath and anxiety. She says she has been shaky on her feet lately, feeling "hyper" from all the meds, and has difficulty breathing. Staff is concerned that she smokes. She is concerned about finances. She has many unpaid medical bills, and wants to be able to keep her house so that her children can sell it to pay for her funeral.

Mary needs help with bathing, dressing, feeding, transfers from bed to wheelchair, and ambulation to the commode. She complains that her children will assume no responsibility for her. She wants to be able to get out of the house for outings. She went to a nursing home temporarily in 2/07, and did well there according to staff, but did not consider it good quality of life and would not stay. She does not want to return to the nursing home. Mary is fearful of thinking about death, but is capable of open discussion of thoughts and feelings. She has discussed dying a peaceful death in bed. Funeral plans have been discussed - patient knows funeral home, wants cremation, wants private memorial service only.

She copes through focusing on the positives, and staying involved with her children's lives. She does worry about leaving her children behind. Although she takes medication for anxiety, she has coped fairly well and denies any thoughts of ending her life.

She felt close to God the last time she was sick. She says she is not religious, though, and has no belief in life after death. Her philosophy of life has been to have fun all her life. Her life has been carefree, she has partied, drunk alcohol, she says she has basically done whatever she wanted in her life. Her one regret is that she wishes she could have been a better mother. She recognizes that she did the best she could - has forgiven herself.

When Dorothy was asked about her beliefs, she stated that she no longer believes in God. If there was a God, He wouldn't have let her be abused, let her father die so young, and let her mother die in this painful way.

INSTRUCTIONS

The Social Work Assessment Tool (SWAT) was designed for use by social workers to document and assess outcomes achieved by the patient and/or caregivers. The above case example presents the history of a patient who can typically be seen in any hospice environment. The instructions provided in this section will detail how to effectively document and assess the patient's outcome.

Following these instructions, a sample SWAT is provided which has been completed based on the case example of Mary.

General Instructions

1. Complete the SWAT immediately after each patient and/or primary caregiver visit. Do not complete it after phone calls or other kinds of interventions in the case. Rate the patient and primary caregiver on how they are doing on each issue listed on the SWAT. Each of these issues is an important factor in hospice outcomes, and should be assessed on every visit. Assessment on each visit will allow documentation of progress in the case, and ensure that clients are not having difficulty in these areas.
2. Questions should not necessarily be read to the client, because it is possible clients are not ready to face issues that openly. The social worker should use assessment skills with the patient and/or family members to come to an understanding of the clients' progress on these issues, and then complete the SWAT after the session, based on the social worker's own judgment.
3. Fill in the date of the contact – note the month, day, and year.
4. Rate the patient on how well s(h)e is doing on concerns related to each issue, and rate the primary caregiver on how well s(h)e is doing on his/her own related to the issue (or on how well s(he) is coping with the concerns of the patient regarding the issue, whichever seems to apply). Circle 1 if, in comparison to most cases in your experience, the client is having far more difficulty than usual. Circle 2 if the client is having some difficulty but not to a severe level. Circle 3 if the client is not having difficulty with the issue but is not doing well either. Circle 4 if the client is doing reasonably well compared to most clients, but not as well as some clients. If there are no concerns at all regarding the issue, circle 5 for "extremely well." There should be no responses of "not applicable". It is not possible to use the SWAT with unresponsive patients. In that case the social worker could still use the SWAT with the primary caregiver.
5. There is no one correct rating in a case. Social workers will vary somewhat in their ratings, but there will be a trend toward general agreement overall.

6. After rating the clients, calculate a total score for the patient by adding the individual item scores in the patient column. Calculate a total score for the primary caregiver by adding the individual item scores in the primary caregiver column.
7. If there is more than one social work visit in a case, there will be a SWAT completed on the first visit and one completed on the last visit. When the case is closed, compare the scores from the SWAT completed on the first visit to the scores on the last visit to determine whether the clients experienced progress on the issues included in the SWAT. The hospice or palliative care program may want to record these scores in an additional file as a part of their quality assurance efforts. The total scores can be compared for an overall summary of social work outcomes. Individual item scores can be compared as well. Usually total scores will show general improvement on the part of clients, even if clients did not experience resolution of certain individual issues.

Our SWAT ratings based on the case example

1. End-of-life decisions consistent with their religious and cultural norms

Mary and her primary caregiver have been struggling with end of life decisions. Mary does not want to be placed on a respirator, and wants to die peacefully in her bed. On the other hand, she is afraid of the process of dying of respiratory distress and is more used to the idea of dying in the hospital. Dorothy, the primary caregiver, has made an agreement with the hospice nurse. She will call the nurse before calling 911, but if Dorothy is fearful about Mary's symptoms and feels she needs help immediately, she will call 911. There do not appear to be cultural or religious concerns about the ethics involved in the decision. Since Mary has worked on this issue and is making progress toward a decision, we did not give her a rating of 1. She has not made a decision, however, and still feels quite anxious and confused about these issues. Thus, we gave her a rating of 2.

Dorothy has been able to make a decision despite expressing some discomfort with the possibility of not calling 911, so we did not give her a negative rating of 1 or 2. On the other hand, Mary was not involved in this decision and thus it is not clear that the plan will uphold Mary's wishes. Thus, we do not consider this issue resolved, and did not give Dorothy a positive rating. We gave her a rating of 3, Neutral, indicating neither a negative nor a positive rating.

2. Patient thoughts of suicide or wanting to hasten death

Although the patient keeps a gun in the house, she has denied any suicidal ideation. Since no concerns have been noted about this issue in this case, we have given Dorothy a rating of 5. Mary's history of alcohol abuse is a risk factor, however. Thus, we gave her a rating of 4.

3. Anxiety about death

Mary is afraid she will panic when she becomes short of breath. She is fearful of thinking about death, and takes medication for anxiety, but is capable of open discussion of thoughts and feelings and has coped fairly well by focusing on the positives and staying active in her children's lives. Death anxiety is difficult to rate; a client may appear to be calm when in reality s(h)e is too anxious to acknowledge his/her feelings and copes through denial. Since Mary is experiencing a significant amount of anxiety and needs medication as a result, we would not give her a positive rating of 4 or 5. However, she is handling her anxiety well enough that she is able to discuss issues openly rather than resorting to a significant degree of denial. Thus, we gave her a rating of 3 for this issue.

Dorothy does not exhibit any signs of death anxiety or significant concern about her mother's anxiety. She is somewhat concerned about end of life decisions, though, so we gave her a rating of 4.

4. Preferences about environment (e.g., pets, own bed, etc.)

Mary states that her home is arranged the way she wants it. She has some concerns about her environment, however, since she feels that her neighborhood is unsafe and she is afraid of dying alone. Thus, we gave her neither a positive nor a negative rating. We gave her a 3.

Dorothy does not appear to have any concerns regarding her mother's environment or her mother's coping with this issue. Thus, we gave her a 5.

5. Social support

Both the patient and primary caregiver have some forms of support and are lacking others. Mary has resources provided for her by the Department of Aging, and has a home alert system. She feels that she is involved in her children's lives and states that she enjoys her grandchildren. Her daughter Dorothy has shown support in agreeing to serve as the primary caregiver, and has been providing some care and taking over responsibilities. Her son David has been supportive in allowing Mary to live with him, and has agreed to serve as power of attorney. On the other hand, David isn't home much and Mary is afraid to be home alone during respiratory arrest. She feels that her neighborhood is unsafe. Her relationships with her children seemed strained, and she feels that her children are not assuming responsibility for her. She has lived for many years without the support of a husband. It is unclear whether she has supportive friendships. Since Mary has some supports, both formal and informal, we did not give her a rating of 1 or 2. Since her physical needs are great and she is spending much of her time alone, however, we also did not give her a positive rating of 4 or 5. Since the pros and cons seem to weigh equally for Mary, we gave her a rating of 3.

Since Dorothy feels some support from her sister Susan, who is looking into hospices in Florida, we did not give her a rating of 1. She feels, however, that most of the care of her mother has been left to her, and has felt a lack of support from her mother due to alcoholism and abuse. We gave her a rating of 2, since she seems to lack the support she needs.

6. Financial resources

Mary has resources from the Social Security administration, and has the medical equipment and medications she needs. She has her financial affairs in order, as she has designated David as power of attorney for financial decisions. Thus, we did not give her a rating of 1 or 2. She is concerned about unpaid bills, however, and concerned about being able to keep her house in order to pay for her funeral. Thus, we did not give her a positive rating of 4 or 5. We gave her a 3. Dorothy does not express concerns about finances; thus, we gave her a rating of 5.

7. Safety issues

There seem to be some safety concerns in this case. Mary states that the neighborhood is unsafe. Although she needs quite a bit of help with activities of daily living, her primary caregiver works. Mary uses oxygen and smokes. We gave her a rating of 2 for safety issues. Dorothy is not adequately addressing these concerns, thus we also gave her a 2. We have seen more unsafe situations, for example extremely unsanitary conditions or abuse, or patients without primary caregivers. Thus, we did not give them a rating of 1.

8. Comfort issues

Mary appears to be fairly uncomfortable and fairly anxious about her symptoms – she has shortness of breath with minimal exertion, is afraid she will panic when she gets short of breath, is afraid to be home alone during respiratory arrest. She is shaky on her feet lately and feeling “hyper.” Since we have seen patients in more severe discomfort, we would not give her a rating of 1, but since she seems to need work in this area, we gave her a 2.

Dorothy is also anxious about her mother’s symptoms, stating she is afraid her mother will choke to death. Thus, she is not exhibiting a sense of peace and comfort with her mother’s dying process. Still, we have seen other primary caregivers with far more anxiety about their loved one’s symptoms. Based on this reasoning, we also gave her a rating of 2.

9. Complicated anticipatory grief (e.g., guilt, depression, etc.)

Mary and Dorothy have both expressed elements of complicated anticipatory grief. Mary’s one regret is wishing she had been a better mother, and she worries about leaving her children behind. She states though that she did the best she could and forgives herself. Since she has come to peace about this issue, we have given her a rating of 4. We did not give her a rating of 5 because she has not resolved this issue directly with her children.

Dorothy expresses resentment toward her mother about not being there for them as children, being abusive toward them and their father. She has not shown a resolution of these issues. Thus, we gave her a rating of 2. We did not give her a rating of 1 since we have seen much worse cases.

10. Awareness of prognosis

Both Mary and Dorothy have a realistic awareness of Dorothy’s prognosis, and are able to openly discuss it. Mary has made funeral plans, designated a power of attorney, has openly discussed end of life decisions. Dorothy also has openly discussed her mother’s terminality

and plans for end of life treatment decisions. We rated both of them as 5 for this issue.

11. Spirituality (e.g., higher purpose in life, sense of connection with all)

Mary's philosophy of life has been to have fun, drink, do what she wants. She is not religious and does not believe in life after death. She regrets that she was not a better mother, but she has forgiven herself for this. Based on this, we would say that Mary's purpose in life was focused more on her own pleasure than on a higher purpose that included the welfare of others. She regrets that now, implying that she is now concerned about a higher purpose; however, she has come to a sense of peace about it. In the sense of connection dimension, Mary does not appear to feel close to her children, saying they will take no responsibility for her and that David insults her, but she does feel close to God. We have seen cases in which the patient seems to have a deep sense of meaning and purpose in his/her life, or is taking action at the end of life that will promote a sense of purpose in life or in the process of dying. Also, we have seen patients with a deep connection to others, mankind, and the universe, or taking steps to reconcile and reconnect with those whom they have hurt. Thus, we would not give Mary a 5 on this issue at this point in the case. Since she has some positive resolution in both dimensions of spirituality, however, we would give her a rating of 4.

When Dorothy was asked about her beliefs, she stated that she no longer believes in God. If there was a God, He wouldn't have let her be abused, let her father die so young, and let her mother die in this painful way. Dorothy has lost her belief system, and we don't have an indication that she has developed a new philosophy of life that represents a higher purpose. She does not express signs of strong connection with others or with a spiritual dimension. She is expressing spiritual concerns that need to be addressed. Thus, we would give her a rating of 2 for this issue. We would not give her a 1 since we have seen clients with more intensity of emotion about these concerns.

SWAT COMPLETED FOR CASE EXAMPLE

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

Date of social work visit: _____

ISSUE:	HOW WELL ARE PATIENT AND PRIMARY CAREGIVER DOING?									
	PATIENT					PRIMARY CAREGIVER				
	1 Not well at all	2 Not too well	3 Neutral	4 Reasonably well	5 Extremely well	1 Not well at all	2 Not too well	3 Neutral	4 Reasonably well	5 Extremely well
1. End of life decisions consistent with their religious and cultural norms	1	2	3	4	5	1	2	3	4	5
2. Patient thoughts of suicide or wanting to hasten death	1	2	3	4	5	1	2	3	4	5
3. Anxiety about death	1	2	3	4	5	1	2	3	4	5
4. Preferences about environment (e.g., pets, own bed, etc.)	1	2	3	4	5	1	2	3	4	5
5. Social support	1	2	3	4	5	1	2	3	4	5
6. Financial resources	1	2	3	4	5	1	2	3	4	5
7. Safety issues	1	2	3	4	5	1	2	3	4	5
8. Comfort issues	1	2	3	4	5	1	2	3	4	5
9. Complicated anticipatory grief (e.g., guilt, depression, etc.)	1	2	3	4	5	1	2	3	4	5
10. Awareness of prognosis	1	2	3	4	5	1	2	3	4	5
11. Spirituality (e.g., higher purpose in life, sense of connection with all)	1	2	3	4	5	1	2	3	4	5

TOTAL Patient Score: _____ TOTAL PCG Score: _____

NOTE: To calculate total scores: add the score for each item in the patient column to get a total patient score. Add the score for each item in the primary caregiver column to get a total primary caregiver score.

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PRACTICE EXAMPLE

INSTRUCTIONS: Complete the practice SWAT for this case.

The Case of Frances

Frances, a 50-year-old African American woman with breast cancer, lived with her 30-year-old son David, who was designated as her primary caregiver. She was a widow, her husband having died under hospice care three years earlier. David was very close to his mother and a lay minister at their church. He was married with two children and was designated as the primary caregiver. Frances stated she preferred to die at home in her own bed and not go to the hospital if she could avoid it. Based on this treatment preference as well as the prognosis that this patient would most likely die within six months, Frances' primary care physician referred her to hospice.

Frances' sister Annie had taken a leave of absence from her job and was able to stay with Frances during the day; the nurse was confident that Annie was attentive to the patient's needs. Frances preferred to stay in her private bedroom with her favorite belongings by her bedside, and did not choose to lay in the living room with the family. Annie made sure to let her little dog into the bedroom in accordance with Frances' wishes. The nurse suggested that a hospice volunteer could sit with Frances occasionally and give Annie a break. Annie welcomed this idea, although she said that since church members sat with Frances quite often she would only need this occasionally.

Frances said that although she did not want to be put on a ventilator and wanted to die at home, she felt uncomfortable with a Do Not Resuscitate (DNR) Order and didn't want a living will. The patient and family said their financial needs were taken care of with the help of their Southern Baptist Church.

At first Frances and David had said they didn't need spiritual care from the hospice; that they would rather talk with their own pastor. After gaining an understanding of the hospice philosophy and team approach and having the role of their own pastor respected, however, the family agreed to chaplain visits as part of the hospice approach.

After the family agreed to work with the chaplain, she privately assessed the spiritual dimension with David. David said his mother had given up on life and wanted to die in order to be with her husband in the afterlife. He thought his mother's acceptance of her terminality was a sign of a lack of faith. He believed that if she just had enough faith, God would perform a miracle and cure her. He had urged his aunt to call 911 if his mother had respiratory arrest. The chaplain then spoke privately with Frances, and found that she felt guilty about her lack of faith and that her son was so upset with her. Despite David's concerns, the chaplain did not see any evidence of suicidal ideation in Frances. His view was that Frances was in agreement with hospice philosophy; she had after all served as the primary caregiver when

her husband was a hospice patient. She was not interested in hastening death, but she was accepting of it occurring naturally.

The home health aide, an African American woman, visited the next day. She was able to assess more of the social dimension since Frances confided in her that she had a general mistrust of the health care system. She had heard stories of mistreatment of African Americans by doctors. Despite this fear, however, she was even more afraid she might panic and ask her sister to call 911. She said she had not signed a DNR order because she was frightened about the idea of white doctors wanting to let her die.

Social Work Assessment Tool (SWAT)

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

Patient I.D.# _____

Date of social work visit: _____

ISSUE:	HOW WELL ARE PATIENT AND PRIMARY CAREGIVER DOING?									
	PATIENT					PRIMARY CAREGIVER				
	1 Not well at all	2 Not too well	3 Neutral	4 Reasonably well	5 Extremely well	1 Not well at all	2 Not too well	3 Neutral	4 Reasonably well	5 Extremely well
1. End of life decisions consistent with their religious and cultural norms	1	2	3	4	5	1	2	3	4	5
2. Patient thoughts of suicide or wanting to hasten death	1	2	3	4	5	1	2	3	4	5
3. Anxiety about death	1	2	3	4	5	1	2	3	4	5
4. Preferences about environment (e.g., pets, own bed, etc.)	1	2	3	4	5	1	2	3	4	5
5. Social support	1	2	3	4	5	1	2	3	4	5
6. Financial resources	1	2	3	4	5	1	2	3	4	5
7. Safety issues	1	2	3	4	5	1	2	3	4	5
8. Comfort issues	1	2	3	4	5	1	2	3	4	5
9. Complicated anticipatory grief (e.g., guilt, depression, etc.)	1	2	3	4	5	1	2	3	4	5
10. Awareness of prognosis	1	2	3	4	5	1	2	3	4	5
11. Spirituality (e.g., higher purpose in life, sense of connection with all)	1	2	3	4	5	1	2	3	4	5

TOTAL Patient Score: _____

TOTAL PCG Score: _____

NOTE: To calculate total scores: add the score for each item in the patient column to get a total patient score. Add the score for each item in the primary caregiver column to get a total primary caregiver score.

The Social Work Assessment Tool was developed by the Social Work Outcomes Task Force of the Social Work Section, National Hospice and Palliative Care Organization, National Council of Hospice and Palliative Professionals. Members of the Task Force included Mary Raymer, ACSW, Dona Reese, Ph.D., MSW, Ruth Huber, Ph.D., MSW, Stacy Orloff, Ed. D., LCSW, and Susan Gerbino, Ph.D., MSW. Further information can be obtained from the Social Worker Section, National Council of Hospice and Palliative Professionals, National Hospice and Palliative Care Organization, (703) 837-1500.

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WEB SITES

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www.abhpm.org

American Hospice Association
www.americanhospice.org

Association of Oncology Social Workers
www.aosw.org

Caring Connections
www.caringinfo.org

Hospice Net
www.hospicenet.org

Hospice Service-Medicare and Medicaid
www.cms.hhs.gov/center/hospice.asp

Hospice Service-Medicare
www.medicare.gov

International Association of Hospice and Palliative Care
www.hospicecare.com

National Association of Black Social Workers
www.nabsw.org

National Association of Puerto Rican and Hispanic Social Workers, Inc.
www.naprhsw.org

National Association of Social Workers
www.naswdc.org

National Hospice and Palliative Care Organization
www.nhpc.org

The Social Work in Hospice and Palliative Care Network
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