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A Retrospective Review of the After-Hours Social Work Service in a Tertiary-Care Public Hospital in Australia

Purpose: After-hours social work (SW) services seem to be provided in many major healthcare centres but there appear to be no data describing these services, in terms of the number of patients seen, their characteristics, types of problems, SW interventions provided, their effectiveness or the impact of providing after-hours services on the provider. The aim of this study was to investigate the patient characteristics and types of interventions provided to patients who received an after-hours SW service and the effect of providing these services on the service-provider. **Method:** A retrospective review of data collected on patients who had received after-hours SW service for urgent/crisis scenarios over a three-year period in a tertiary-care public hospital in Australia was undertaken, with two illustrative case scenarios. **Results:** A total of 172 occasions of service were delivered, with most services provided to patients/families in the Emergency Department (ED) or Intensive Care Unit (ICU) following trauma or with a medical condition. Counselling for trauma, grief or loss were the types of interventions most often provided. Interventions were most frequently rated by the SW-provider as highly complex and imperative. At times, providing the after-hours service negatively impacted on the service-provider the following day, with tiredness and hypervigilance most frequently reported. **Conclusion:** An after-hours SW service within a tertiary-care hospital was provided approximately five times/month, predominantly involving counselling to patients/families in the ED or ICU, and rated as highly complex and imperative. These results provide evidence, albeit anecdotal, that an after-hours SW service is of value in this setting.

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Abstract

Purpose: After-hours social work services seem to be provided in many major healthcare centres, but there appear to be no data describing these services in terms of the number of patients seen, their characteristics, types of problems, social work interventions provided, their effectiveness, or the impact of providing after-hours services on the provider. The aim of this study was to investigate the patient characteristics and types of interventions provided to patients who received an after-hours social work service and the effect of providing these services on the service-provider. **Method:** A retrospective review of data collected on patients who had received after-hours social work service for urgent/crisis scenarios over a three-year period in a tertiary-care public hospital in Australia was undertaken, with two illustrative case scenarios. **Results:** A total of 172 occasions of service were delivered, with most services provided to patients/families in the Emergency Department or Intensive Care Unit following trauma or with a medical condition. Counselling for trauma, grief, or loss were the types of interventions most often provided. Interventions were most frequently rated by the social work provider as highly complex and imperative. At times, providing the after-hours service negatively impacted on the service provider the following day, with tiredness and hypervigilance most frequently reported. **Conclusion:** An after-hours social work service within a tertiary-care hospital was provided approximately five times/month, predominantly involving counselling to patients/families in the Emergency Department or Intensive Care Unit; services were rated as highly complex and imperative. These results provide evidence, albeit anecdotal, that an after-hours social work service is of value in this setting.

INTRODUCTION

After-hours social work (SW) services appear to be provided in healthcare settings in numerous countries, including Australia, Canada, Northern Ireland, United Kingdom, and the United States.[1-6] These services are most often provided for patients and/or their families in crisis situations, such as mental illness, trauma, domestic violence, suicide, and unexpected death in the setting of an emergency department (ED) or intensive care unit (ICU). Whilst we were able to identify numerous websites for these after-hours SW services, we were unable to find any published studies specifically describing after-hours SW services in these settings in terms of the number of patients seen, characteristics of these patients, types of patient problems, SW interventions provided, or the effectiveness of after-hours SW services.

Whilst after-hours SW services do not appear to have been specifically researched, there is literature available that has addressed the role of the social worker in EDs during normal working hours.[7-9] Auerbach and Mason noted that social workers based in EDs provide roles including assessing the social service needs of patients/families with the overall aim of triaging patients based on social service needs and decreasing hospital costs by reducing unnecessary hospital admissions.[7] Bywaters and McLeod suggested that SW services to ED have the potential to increase hospital efficiency (e.g., by preventing hospital admissions, enabling faster discharge home), increase ED effectiveness (e.g., by improving quality of communication and patient satisfaction), and provide better access to social care services.[8] Bywaters and McLeod noted that SW services to ED outside of normal office hours were uncommon even though the peak time for ED attendance is often after-hours.[8] Wrenn and Rice, in a retrospective case

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series of all patients seen by SWers in an urban university hospital ED over a 6-week period found that SW services were provided to 5% of ED patients.[9] Three distinct groups of patients were seen: the elderly, young adults, and children under 5-years-old, with the type of intervention depending to a large extent on the patient's age. A cost-benefit analysis by Gordon, based on various assumptions underlying service provision, concluded that the cost of 24-hours SW staffing might yield net economic benefits to a hospital system, especially in large urban centres.[10] However, as this study was based on assumptions rather than evidence per se, the validity of this conclusion is not certain.

Our SW department has provided an after-hours service at the Royal Adelaide Hospital (RAH), a tertiary-care public hospital, for approximately 15 years, allowing referrers access to the SW service outside of usual working hours (i.e., 1700 to 0900 weekdays and 24 hours per day on weekends and public holidays) for urgent, acute, and crisis scenarios. Anecdotally, this service is delivered on 1-10 occasions/month, with referrers usually being medical or nursing staff, and most frequently provided to ED or ICU patients and/or their families in crisis situations. Summary data have been collected on a per-patient basis since the inception of this after-hours SW service, but to date there has been no formal evaluation of these data or the after-hours SW service. The current study, by formally reviewing the data that have been collected regarding the after-hours SW service at the RAH, including the impact of providing the service on the service-provider, will provide useful insights into this service, including how it has changed over time and potential areas for future modification and/or research. We believe this retrospective review is particularly important given the lack of information describing and assessing the effectiveness and impact of an after-hours SW service in an ED/ICU setting.

Thus, the aim of this study was to undertake a retrospective review of data concerning the after-hours SW service provided at the RAH in order to describe the number of patients seen, their characteristics, reason for referral, and types of services provided. Additionally, the impact of providing the after-hours SW service on the service-provider the following day was investigated.

METHODS

Design

A retrospective review was undertaken of summary data concerning the after-hours SW service at the Royal Adelaide Hospital. Additionally, two illustrative case scenarios are provided. The study was approved by the Royal Adelaide Hospital Research Ethics Committee as a quality assurance activity and registered with the Australian New Zealand Clinical Trials Registry.

Setting, Participants and Timeline

The Royal Adelaide Hospital is a 650-bed, tertiary-care, public hospital in Australia. The participants comprised all patients who had received after-hours SW service between January 2013 and December 2015 and for whom the SW data form had been completed.

Interventions

The SW Department at the Royal Adelaide Hospital comprises approximately 37 staff in total, of whom five provide the after-hours SW service on a rotational basis. Staff participation in this after-hours service is volitional, usually involves those staff who have experience working as part of the trauma team, and requires that they have at least eight hours break between call-backs and return to work. Referrals for the after-hours SW service are made to a designated after-hours mobile phone by medical staff and/or nurse manager. Based on the information provided by the referrer, the on-call social worker decides whether after-hours service is necessary. Priority is given to crisis situations deemed as requiring urgent assessment/intervention that cannot be delayed until the next normal working day. Patients who are admitted to ED with a primary psychiatric diagnosis are ineligible for the after-hours SW service. Once the referral is deemed appropriate, the on-call social worker makes his/her way to the hospital and relevant clinical area. After speaking with the referring staff member and reviewing the patient's medical records, the social worker meets with the patient and/or family to assess their needs and provide the appropriate intervention, which may include counselling, mediation, conflict resolution, and consideration of welfare requirements (e.g., domestic violence, child protection, discharge destination). Theories and models that might be used in these interventions included crisis intervention, the psychosocial model, systems theory, and task-centred casework. The duration of the intervention is highly variable depending on the requirements of each individual case. Once the after-hours visit is finished, the SW service-provider completes a data summary form at that time or the following day, and in virtually all cases, a verbal handover and further SW follow-up is provided on the next working day.

Outcomes

Since the inception of the after-hours SW service at the RAH, the SW staff providing this service have collected summary data on a per-patient basis. These data include referral details (e.g., date/day/time of service), perceived complexity and necessity of the service (rated by the service-provider on a 5-point scale [1 = not complex/unnecessary and 5 = highly complex/imperative]), patient details (e.g., gender, age, primary diagnosis), intervention type (e.g., counselling, welfare), and the effect of the call-back on the SW-provider the following day (e.g., tiredness, irritability).

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Data Analysis

Raw data were transposed from hard copies into an Excel spreadsheet and imported into SPSS for analyses. Interval data were examined for normal distribution and expressed as mean (standard deviation [SD]) or median (interquartile range[IQR]) for normally and non-normally distributed data respectively. To investigate the influence of the year of service provision (i.e., 2013, 2014 or 2015) and day of intervention (i.e., weekday or weekend), selected outcomes were compared using Chi Square tests (categorical data) or one-way ANOVA (interval data), and p values less than 0.05 were considered significant.

RESULTS

Over the 3-year study period, after-hours SW services were provided on a total of 172 occasions by 14 social workers, equating to a mean of 4.8 referrals/month. The spread of services was relatively even between years over the data collection period, as was the day of the after-hours service (i.e., weekday after-hours vs weekend) with the most frequent time of day for the after-hours service being before midnight on a weekday (Table 1). The clinical area involved was most often the ED followed by the ICU. On 126 (73.3%) occasions, the service was for a single case, whereas on 40 (23.3%) occasions, it was recorded as being one of multiple after-hours services.

Patient characteristics are summarised in Table 1. There was an even mix of genders and the median age was 45 years. The majority of patients referred for the after-hours SW service had been involved in trauma or had a medical condition.

Table 1. Referral and patient information for the 172 occasions of after-hours SW services

Referral information	
Year of after-hours service, number (%)	
2013	58 (33.7)
2015	63 (36.6)
2015	51 (29.7)
Day of after-hours service, number (%)	
Weekday after-hours	96 (55.8)
Weekend	76 (44.2)
Time of after-hours service, number (%)	
Weekday	94 (54.7)
Before midnight	75 (43.6)
After midnight	19 (11.0)
Weekend	73 (42.4)
During day (0900 to 1700)	39 (22.7)
Overnight (1700 to 0900)	34 (19.8)
Missing data	5 (2.9)
Clinical area, number (%)	
Emergency Department	122 (70.9)
Intensive Care Unit	39 (22.7)
Other	6 (3.5)
Missing data	5 (2.9)
Patient characteristics	
Gender, number (%)	
Female	84 (48.8)
Male	83 (48.3)
Missing data	5 (2.9)
Age, years, median (interquartile range)	45.0 (28.5 – 62.5)
Primary condition, number (%)	
Trauma	90 (52.3)
Medical condition	66 (38.4)
Other	16 (9.3)

Data relating to the interventions provided are summarised in Table 2. The complexity of the after-hours service was most frequently rated by the SW provider as highly complex, and the necessity of the service was most often rated as imperative. On 132 of the 172 (76.7%) occasions of service, the intervention was provided not only to the actual patient but also to family members

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and/or significant others. On four occasions (2.3%), more than 30 people were involved in the after-hours occasion of service. The interventions provided by the social worker most often involved counselling for trauma, grief, or loss.

Table 2. Interventional details for the 172 occasions of after-hours SW services

Interventional details	
Transit time, minutes, mean (standard deviation) [n = 143]	33.8 (15.5)
Intervention time, minutes, mean (standard deviation) [n = 163]	201.8 (94.8)
Complexity of after-hours service, number (%)	
1 = not complex	15 (8.7)
2	26 (15.1)
3	41 (23.8)
4	28 (16.3)
5 = highly complex	56 (32.6)
Missing data	6 (3.5)
Necessity of after-hours service, number (%)	
1 = unnecessary	4 (2.3)
2	21 (12.2)
3	37 (21.5)
4	30 (17.4)
5= imperative	72 (41.9)
Missing data	8 (4.7)
Others attending (apart from the patient), number (%)	
0	24 (14.0)
1-5	87 (50.6)
> 5	45 (26.2)
Missing data	16 (9.3)
Type of intervention provided, number (%)	
Counselling	
Trauma	128 (74.4)
Grief and loss	90 (52.3)
Conflict	16 (9.3)
Mediation	11 (6.4)
Welfare	
Accommodation	13 (7.6)
Travel	7 (4.1)
Other	49 (28.5)

On 68 (39.5%) occasions, the SW provider noted that they felt tired before the call-back for reasons such as having had another call-back the previous day or interrupted sleep (Table 3). The most frequently reported impacts of providing the after-hours SW service on the SW provider the following day were increased tiredness and hypervigilance (Table 3). Approximately one-third of SW providers reported that it impacted on their next day's work/activities, for example, by making them feel unmotivated and/or tired, having to sleep most of the day as they were feeling very lethargic, needing to start work late the next day, and/or needing to cancel social activities because of tiredness.

Table 3. Effect of the 172 occasions of after-hours SW services on the provider

	Number (%)
Tired pre-call back, yes	68 (39.5)
Post-call back, yes	
Increased tiredness	90 (52.3)
Sleep disturbance	55 (32.0)
Increased irritability	25 (14.5)
Increased hypervigilance	75 (43.6)
Impacted on next day's work/activities, yes	57 (33.1)

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Factors affecting outcomes

The year in which the after-hours SW service was provided influenced the complexity of the after-hours service as rated by the SW provider (p = 0.001 [Chi Square]), with complexity appearing to increase over time, and with 52.0% of the after-hours services classified as highly complex in 2015 compared to 15.8% in 2013 (Table 4). The year of service did not influence the day of the after-hours service (i.e., weekday vs weekend, p = 0.125 [Chi Square]), the provider-rated necessity of the after-hours service (p = 0.174 [Chi Square]), or involvement time (p = 0.781 [one way ANOVA]). The day of the after-hours service (i.e., weekday vs weekend) did not influence the provider-rated complexity of the after-hours service (p = 0.595 [Chi Square]), necessity of the service (p = 0.466 [Chi Square]), or involvement time (p = 0.763 [one way ANOVA]).

Table 4. Complexity of the after-hours service according to the year of service provision

Complexity of after-hours service	2013 (n = 57) n (%) *	2014 (n = 59) n (%) *	2015 (n = 50) n (%) *
1 = not complex	3 (5.3)	4 (6.8)	8 (16.0)
2	10 (17.5)	10 (16.9)	6 (12.0)
3	20 (35.1)	16 (27.1)	5 (10.0)
4	15 (26.3)	8 (13.6)	5 (10.0)
5 = highly complex	9 (15.8)	21 (35.6)	26 (52.0)
* percentages are expressed relative to the number of occasions of service within each year			

Case scenarios

Based on actual cases, the following two scenarios illustrate the after-hours SW service with potentially identifying information changed or omitted to ensure anonymity.

Case scenario 1

The after-hours social worker was phoned at 2300 by an ED nurse manager seeking assistance for a female who found her partner after his attempted suicide by hanging. The couple were on a working holiday from overseas and spoke very limited English. The patient's prognosis was extremely poor with the possibility of impending brain death. As ED staff were unsuccessful at accessing any after-hours interpreter services (either in person or via telephone) despite repeated attempts, the social worker was asked to help regarding communication with the partner and contacting the next-of-kin overseas. After an on-line search, the social worker arranged for a priest with their cultural background to attend and help with translation regarding the patient's critical condition, possible organ donation, and identifying and obtaining contact details for the next-of-kin. The social worker then contacted the Department of Foreign Affairs and Trade who assisted in locating the next-of-kin via police in the patient's home country. This intervention facilitated essential communication and enabled informed clinical decisions in a much more timely fashion than would otherwise have occurred, thus reducing stress for the partner and next-of-kin in an extremely distressing scenario and avoiding unnecessary prolongation of the medical process.

Case scenario 2

The after-hours social worker was phoned at 0130 by an ED nurse manager following a multi-vehicle, high-speed crash resulting in non-life-threatening injuries for a person in their 30s and the death of several others. Assistance was sought with trauma counselling for the surviving patient's family/friends and those of the deceased people who were not yet aware of their deaths. Approximately 100 family/friends were present in the ED, with considerable tension and simmering verbal/physical violence between the different groups, which was impacting on ED staff and other patients. Through a complex process of negotiation and counselling, the social worker divided people into their separate groups of family/friends, locating them in different meeting rooms, and narrowing these down to essential family/friends only, whilst being aware of the vulnerability of all present. The family/friends were then informed of the deaths and support provided to them and the family/friends of the surviving person. Considerable liaison was required with the Major Crash Investigation Unit and South Australia Police. These interventions were extremely complex, lasting approximately 7 hours, and successfully defused an inflammatory situation and provided appropriate support in a crisis scenario. Whilst the social worker involved had the option of calling for back-up to cope with this complex scenario, he chose not to do so as he felt in control of the situation as a result of his management decisions.

DISCUSSION

The current study retrospectively reviewed data pertaining to patients who received an after-hours SW service at a major tertiary-care public hospital in Australia and provided two illustrative case scenarios. We found that over the last three years, an after-hours SW service for urgent and crisis scenarios was used approximately five times/month, with most services provided to patients/families in the ED or ICU following trauma or with a medical condition. Crisis interventions involving counselling for trauma,

grief, and/or loss were the types of input most often provided, and interventions were most frequently rated by the SW provider as being highly complex and imperative. Along with the two illustrative case scenarios, these data provide evidence, albeit anecdotal, that this after-hours SW service was of value. However, providing the after-hours service at times negatively impacted on the SW provider, with tiredness and hypervigilance the following day most frequently reported.

Because there is no previous research specifically describing after-hours SW services, there are no data available with which we can directly compare our findings. However, our findings regarding the types of SW interventions provided after-hours are similar to the SW services provided to EDs and ICUs that have been reported during normal working hours, with counselling interventions frequent.[7-9] Our median intervention time of 201.8 minutes was considerably longer than the median of 50 minutes reported by Wrenn and Rice in their retrospective case series of patients seen by social workers in an ED.[9] The reasons for our longer intervention time are not clear, but may reflect the added complexity of patients seen after-hours. The apparent increase in the complexity of cases seen over time in our study is most likely due to a change in the referral criteria over time, whereby in 2015 a stricter priority system was introduced, tightening the staff who were eligible to refer for after-hours SW service, and restricting cases to those that were not able to be managed by other on-site staff.

Our study had a number of limitations including its retrospective nature, and that it involved a single site only. Additionally, as the data form was completed by the person providing the SW service, and not an independent person, the information generated was subjective and open to bias. Another important limitation was that no data were collected regarding the actual effectiveness or cost-benefit of the after-hours SW service.

Whilst the specific results of this study are not generalisable, we believe they will be of interest to other similar healthcare centres as they provide, for the first time, a description of an after-hours SW service to ED/ICU in terms of the number of patients seen, their characteristics, reason for referral, types of services provided, and impact on the service-provider. These findings may be useful for centres seeking to establish a similar service. The current study also highlights areas where future research could be undertaken. In particular, prospective evaluation of the effectiveness of an after-hours SW service would be of value. Whilst a randomised controlled trial would be the most robust design to do this, the ethics of including a control group that received no after-hours SW intervention, despite referral for the same, would be questionable in these crisis scenarios. Instead, a prospective study where outcomes related to the effectiveness of the service are measured may be more appropriate. Such outcomes could include, for example, documenting the specific aims of the after-hours SW intervention on a case-by-case basis (e.g., identifying/contacting next-of-kin; identifying/establishing social support systems) and assessing whether these aims are achieved and their potential impact (e.g., prevented/resolved conflict that could have led to litigation and/or patient/family complaints; establishing social support systems allowing discharge home and avoiding hospital admission), or seeking the opinions/perceptions of the patient/significant other/referrer regarding whether the after-hours SW service fulfilled their needs.

In conclusion, this retrospective review found that an after-hours SW service was provided approximately five times/month, predominantly to patients/families in the ED or ICU following trauma or with a medical condition. Counselling for trauma, grief, or loss were the interventions most often provided, with interventions rated by providers as highly complex and imperative. The provision of the after-hours SW service had, at times, negative impacts on the service provider the following day, with tiredness or hypervigilance most often noted

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