Intimate Partner Violence Core Competency Education_ Safety in Documentation-20250219_120018-Meeting Recording

February 19, 2025, 6:00PM

53m 37s

Jacob, Samantha, N MSW, LSCSW, LCSW 0:03

Ashley has already put in the chat the code you'll need for.
Cloud CMU to get your credit and certificate. So if you have any questions about that you can put those in the chat. But.
We will jump right in.
In case you were unaware, February is adolescent relationship abuse.
A month awareness month.
So there's also going to be ace U at the end of the month.
Which is just next week the 27th.
Um.

MK

Metz, Kelsey 0:43

You need us, Marshall.

Jacob, Samantha, N MSW, LSCSW, LCSW 0:44

Out at Kansas.
But will be also be available via teams regarding trends in adolescent relationship abuse.
So please make plans to try and attend that as well.
All right, so disclosures, I do not have any disclosures and just some housekeeping.
And kind of so that we are all have common knowledge.
I.
Pvcs for intimate partner violence, IPV can affect anyone.
And any example that I use today. Please know that pronouns can be changed.
And please share and ask questions during the presentation.
Or we will have some time at the end as well.
But please don't hesitate to raise your hand and ask a question or put a question in the chat.

I'm happy to answer those as we go along.
And then please share your experiences as well if you have them. We can all learn from each other.
So our objectives today are to understand the dynamics of IPV within the pediatric medical setting review, safe documentation strategies when working with survivors of IPV and critically analyse and discuss safe documentation and challenging cases.
So what is IP?
VIPV current or former spouses can occur between current or former spouses, boyfriends, girlfriends, dating partners or sexual partners.
Intimate partner violence.
Physical violence.
Sexual violence, stalking, psychological aggression, including course of acts by a current or former intimate partner.
They can occur between heterosexual or same sex couples.
It does not require sexual intimacy.
And can vary in frequency and severity and occurs across a continuum, ranging from a singular experience that someone may have that may have a lasting impact.
Or chronic and severe, more severe episodes over a period of years.
So dynamics within the pediatric medical setting, this 2006 study showed that.
Women that talk to their healthcare provider about experiencing abuse before times more likely to use an intervention such as advocacy counselling, protection order, shelter, other services.
So in.
The when we talk about power and control in a in this dynamics, in the case of.
IPV, even in the pediatric setting or other medical setting.
The abuser may use power and control dynamics that may not look bad on the outside, but it's important to recognize them for power and control tactics.
Many times and often we show the power and control wheel.
That talks about what those acts may look like, keeping in mind that in a pediatric healthcare setting that may look a little different, power and control for.
Survivors.
And their abusers may look like the abuser manipulating the medical record.
Using the patient portal to change appointments without.
Consulting the survivor and then the survivor not bringing the patients those appointments. And it may look like.

Accessing the patient portal to try and attempt to find their home address, their new safe address.
It may look like.
Causing a scene in an appointment that derails the appointment.
So we're no longer talking about the patient's healthcare needs, but now we're talking about the behavior of the parents.
It may look like manipulating a situation so an abuser looks like the more model parent and.
Sheds a bad light on the survivor, so some of those are just some.
Of the.
Forms of power and control that we see in the pediatric medical setting.
So what does this mean for documentation in 2020?
The 21st Century Cures Act was enacted.
Which mandates health systems ensure that clinical notes, laboratory results, and other healthcare information are available available for patient access.
Documentation in the pediatric medical record is complex and complicated.
Study finding suggest that electronic health records may confer both risks and benefits for IPV survivors and their children.
And we'll go into some of those risks and benefits here in a minute.
Research is still lacking in best practices for documentation in the EMR, but we've developed some recommendations through our core competency document, our quality improvement initiatives.
Recommendations from Child Protective service professionals, such as the safe and together.
Documents and recommendations discussion with multiple multidisciplinary teams.
Teams are partners at Rose Brooks.
Social work as well as medical staff and then case review through IPV workgroup.
So what are some of those benefits? The benefits of documentation include continuity of care, beneficial and legal proceedings, repeated pattern of abuse, and effects on the children can be documented, and the non offending caregivers efforts to address IPV and assure child safety, holding batterers accountable and document stand.
Of care and legal requirements are addressed.
When we are considering our documentation, we want to make sure it is safe that we keep our we keep our survivors safe.

But that's not the only thing we have to think about.
We do have to consider continuity of care, which can lead to challenging.
Situations when it comes to ensuring our documentation is doing both being safe and ensuring that continuity of care.
The risks we have are things like safety and the abuser may have access to the chart.
And the IPV information that's documented in it escalated violence and or death if confidentiality is broken, disruption of the safety plan, the legal ramifications changes with memory due to trauma.
So maybe you document what you believe is verbatim what a survivor has said was their experience with abuse.
But then when they go to file, their police report or they're testifying in a legal setting in a court setting, it changes and that can create problems for that survivor in their legal proceedings.
And that the child will eventually have access to their EMR.
So.
We want to keep in mind what it would look like for this information that you document to be reviewed by both the batter and then also by the child as they become an adult, is the information that's in that that you're documenting in that medical record pertaining to.
That child's healthcare, were they the victim of the abuse, or was it solely their survivor parent?
Yes, that trauma is going to have a lasting impact. But is that how they should learn about that trauma from their parents?
Should they learn about it from their parent or from their medical record?
So quality improvement process, we do have a quality improvement team here at children's mercy that reviews IPV and bridge documentation.
It is completed by a multidisciplinary team.
There are inpatient, outpatient, needy social workers that participate, as well as Ed nursing that reviews the documentation of the provider as well as the nurses and other medical professional social workers now.
Thankfully, able to only have to review the social work documentation.
The goal of Documentation Review is to ensure that we have a robust identification of IPV, including safe documentation that we monitor trends and we look for opportunities for improvement both on an individual and systems level.
I do want to say that even though we do have this great team of staff that are doing

this quality improvement, it's really all of our responsibility to ensure that we're reviewing documentation.
Within the medical records that we're accessing.
For safety, so if you notice a concern of decoded bridge language.
Or documentation of a safety plan that discloses where Survivor is going to be living or their contact information in an unsafe way.
Please share that with either somebody on the Qi team or myself as the IPV program manager.
So that we can make modifications to those medical records.
We all are leaders in this work, so if you see something.
Say something.
And if you don't feel comfortable saying something directly to that provider or your colleague, again that is an opportunity for you to reach out.
To myself or anyone else on the IPV quality improvement team.
We also would welcome any success stories if you have a case that you're proud of or have witnessed a success of a coworker, please share that with me so that we can highlight those stories in the IPV workgroup.
This well.
So we're going to talk next about kind of the nuts and bolts of documentation, the basics of the children's mercy, IPV documentation, 'cause. I do know we have a lot of new faces within the department, so.
We're going to start off by this is our new and updated IPV screening or bridge screening or domestic screening form as it's been called kind of across the hospital, different things in 2024, the IPV work group began reviewing.
And modifying the document, the domestic screening form.
Which as I mentioned, we refer to as bridge screening. Through research, we've learned that providing universal education is essential and the workgroup wanted our screening tool to reflect this as well. So we no longer ask if there are concerns for violence in the home, but rather only ask.
If a family ask a family if they would like to speak with someone about resources regarding relationship abuse or violence.
This also more closely aligns with our social work ethics and allowing for self determination.
Previously we asked if there were concerns for violence in the home, and then we asked if they would like to speak with someone now. And regardless of if they said

yes or no, if they wanted to speak with someone. Now it automatically generated a social work consult.
Those of us social workers that have participated in the IPV task force or Work Group for a while expressed that we had some challenges with that because we want families to be able to self determine.
If they need to speak with social work or not, or if they are ready for that next step, maybe they're ready to share that they do have some concerns, but they're not ready to share.
They're not ready to talk to someone directly about it.
So we wanted.
We now have taken that kind of questionable.
Step out of the process and have now aligned it more closely with that, allowing them for that self determination of yes.
I do want to talk with someone about it.
Next is our bridge St. follow Up tool which is the next step after a social work.
Consult has been done and we have completed a social work assessment in any case where a bridge, a positive bridge screen has been completed.
Or bridge concerns have been identified during an assessment, a bridge screen follow up form should be completed.
These, sorry.
This first box information wanted yes or no should be completed based on the.
Bridge screen or the domestic screening form.
It should automatically populate if it doesn't.
You can leave that blank.
You'll select the referral type, which would be that. So for you it would be that social work was consulted.
You'll select the interventions that you offered.
Or were engaged during this intervention. If you completed a safety assessment, a patient safety assessment directly related to the bridge screen positive.
And then the level of intervention, A level 1 intervention, is that the caregiver and the patient went to shelter.
Level 2 is that they went to a safe place but not shelter.
Level 3 is safety. Planning was discussed, resources given caregiver and patient return.
Home no bridge concerns would be that they truly were no bridge concerns at all,

that the family really did misinterpret.
What the questions were asking.
And are reporting concerns for mental health related to the child or are asking for basic needs resources. Then you would mark no bridge concerns.
If a patient is admitted and you're not able to do a full assessment.
That you could click that the patient was admitted in disposition is pending or if a family is reporting historically had some bridge concerns, but they're in a safe place now and they are no longer involved in that relationship.
You can Mark Bridge history.
No acute concerns.
But again, that should be completed every time a bridge screen.
Is a positive bridge screen is received.
So formal bridge screening is completed in the Edu, CC inpatient and several of our outpatient clinics using that domestic screening form and some of our other outpatient clinics, they do some bridge screening, but they don't utilize that formal form that we use and.
In their response may look a little different.
For a positive bridge screen, social work should be consulted automatically.
And the bridge screen follow up forms should be completed for all positive consultations.
And then when you're completing that further documentation, consider the do's and don'ts that we're getting ready to jump into.
Also, for bridge screening, if a clinical area is completing bridge screening, it is not the responsibility of the nurses or the care assistants or any of the medical team to clarify with that family. If that is truly a positive screen or not.
They don't need to go back into the room and make sure that they understood the questions they should allow for social work to go ahead and take that next step and assess, and that may lead to even you know, even if it isn't a a true positive Br.
Screen. It can allow for a robust conversation with social work about other needs that the family may be experiencing.
OK.
So do's and don'ts.
When we're documenting, we wanna make sure that we consider when would be a good time to be descriptive, be precise and be succinct.
We wanna keep objective descriptions of interactions between parents that could

lead to a building of pattern of power and control and impact on the child.
We wanna continue to be strength based on our documentation about Nonoffending caregiver and language that holds that matter accountable.
Using words like buy or not with or between because with or between does not hold that accountable, that better or accountable it. It lends itself to.
Placing blame on both parties.
Affirming the perpetrators role on the impact of IPV to the child.
And accurately define the victim and the perpetrator.
Some of the safeguards that we can use are denied disclosures which we'll talk about a little bit more in a minute.
Coded language handoffs can be more detailed, but beware of the message center hand offs considering consider using e-mail and send securely.
Message center. Handoffs can always be saved by somebody else, even if you intend for them not to be saved to the medical record.
Somebody get can very easily hit save that is outside of social work.
And now that document is in the medical record, it can be accessed by that offender.
Alright.
We wanna make sure that we're always using coded language.
IE bridge concerns branch positive positive bridge screen throughout all documents.
Avoid using terms and phrases such as IPV or domestic violence.
Document the effects on the victim or the child.
Ongoing exposure to bridge issues in the home by Father appear to be escalating patient suicidal ideation and require.
That they be transferred to a higher level of mental health intervention as an example of how you may document those effects on the on the child document, the power control tactics that are posing a threat to the family chronic and escalating power control tactics by the parent appear.
To impact Dad's ability to seek appropriate medical care for the patient, including acquisition of medications and completion of medical appointments.
That may be with a phrase or, you know, an example.
Of how you would document that if.
A.
An abuser is manipulating appointments within the patient portal and now it's causing.
The in this case, the dad's ability to seek appropriate medical care for their child.

OK.
I think beyond safety to the survivor story and we will what we want to honor and empower them to share their story, how they want to.
So that it go is reflective of looking at their documentation through the eyes of the survivor, the better of the patient, the defense attorney, and who may see this document.
We want to know that we're documenting in a way that the survivor is going to feel like they were seen and heard and empowered.
To act in the way that they feel is safest for them and their child.
And then remember in the in just keeping in mind that in the event that the notes get into the hands of the batter with this note, allow the survivor to deny that they disclosed any IPV.
Some do's when we're complaining assessments and speaking with a survivor is involving them in that shared decision making regarding how that document, how you're going to document in the medical record and communicating with the team that goes into, you know, when we're talking with Rose Brooks what?
Does that caregiver?
Want how?
How does they?
How do they want that conversation to go?
How do they want you to share with the medical team everything that they have disclosed to you during your social work assessment?
Is everything pertinent to the medical team to know that they've shared, or can we give some more high level information?
This really gives that power back to that survivor and increases their safety.
And making sure that we're keeping in mind where we're talking with the medical team outside of the medical or if we're talking with them outside of the medical record, even if we're talking with them in person.
Like, what are our surroundings and who is hearing what we're saying?
Use our core competency as a guide for how to document as well as examples.
There is that core competency document that was updated, I believe October of 2024.
So using that as a place to look for examples and how, and a great guide.
Reach out to your Co worker if you feel like you need to just process through. How should I document this best?

I always say when you meet with a survivor.
Get a lot of information and it's a lot of really heavy, hard information to hear and not being able to document all of it in detail can sometimes feel really inappropriate. But at the same time, we know that it's not necessary for that child's medical record to have all of that information, and it would be a safety concern for that survivor if we did share every piece of that information that they shared with us in the medical. Records.
Alright.
So make sure that you're processing that with someone else. If you feel if you're feeling how comfortable or you're unsure of what that next step is, you're always welcome to call myself the IPV program manager or your manager if you need them to review your documentation before you.
Finalize it.
Denied disclosures are something that we can really only do on the back end.
For staff that have been here a long time, this was not always the process.
Yes, but we currently are not able to preemptively enter a denied disclosure form.
So if the document is requested and we do feel like it's going to put a survivor at greater risk for their well-being, we can complete that denied disclosure form.
Just remember that if you do complete that denied disclosure form, the abuser will see it.
If they're the ones requesting the record.
Alright, so now we'll hop into some of the dots.
We want to never document the address of a victim that does not want it disclosed.
This example would be like Mom is currently living with maternal grandpa or grandparents. Dad is aware of the grandparents address and mom's current location. Dad requested that the current address not be listed in the patient's EMR, so those are some of the things that we can.
We want to make sure that we're trying to keep that safe place safe.
We want to make sure that we're not documenting safety plans details including the name of the Bridge Advocate Shelter.
Things like that that we want to.
An example might be mom and patient secured a safe discharge plan.
I know it's vague.
I know it doesn't include a lot of information for that continuity of care, but it does ensure safety.

And then Mom received supportive services to ensure safety. That doesn't.
Even that doesn't, you know, in that example they may not have gone to shelter, but they received all the information that they needed to receive to keep them safe or get the services and support that they need.
Do not document detailed accounts of the abuser by.
The child or the victim patient disclosed what appears to be bridge positive in the home by Mom. That includes emotional and physical elements of power and control.
So in this case, if the child is reporting a having witnessed a domestic violence in the home or IPV, we don't want to report child set this and reported this abuse.
That can not only put that.
Survivor at risk?
But it also could put that child at risk for safety from that abusive parent or partner for the survivor.
Other languages to other language to avoid dysfunctional family.
Father allows or enables the violence.
Mother failed to protect the children.
All of this language really blames the victim for the perpetrator's violent abuse of behavior.
So we want to make sure that we're not placing that blame on the shoulders of that survivor.
And then a big thing is to be careful to not decode our coded language.
So an example of decoding that language would be mothers noted to have a broken arm and disclosed due to bridge positive.
Yes, we didn't say that.
Branch meets IPV, but we did say that it that broken arm as a result of a bridge and an abuser could probably put that together.
Father reported safety concerns due to bridge positive again.
A foreign abuser that could be.
Well, what are your safety concerns?
And is and then if we're using that coded language throughout in other ways, they may determine, oh, you're saying I'm abusive?
Patient was open and shared relevant information regarding witnessing mother and his stepfather fighting when stepfather was drunk, indicated bridge.
Positive relationship. All of that defines what a bridge positive relationship is that mother and stepfather were fighting when stepfather was drunk.

And just as a reminder, message center is not a safe place to discuss bridge concerns. If required to discuss bridge concerns and consider e-mail and having more dialogue with verbal dialogue with your team mates about what the updated history is, or updated concerns or safety plan is.
So that we're not documenting it and the medical record where it could be accessed by that abuser.
So we're getting ready to jump into some case studies or examples, but I wanted to leave some time take some time to see if you have any questions regarding the do's and don'ts and our safe documentation so far.

Hancock, Susan, C LMSW 29:14
Samantha.
This is Susan.
I jumped on a few minutes late. A lot of times I see in the pars like.
In the clinical section of not domestic violence bridge positive regarding father regarding somebody.

Jacob, Samantha, N MSW, LSCSW, LCSW 29:34
None.

Hancock, Susan, C LMSW 29:34
To identify who that is, regarding previous boyfriend. Is that something that we just need to?
Completely do away with and just say you know history of rich positive or bridge positive.

Jacob, Samantha, N MSW, LSCSW, LCSW 29:50
Yeah, I would recommend.
I would recommend more of if it's not a a biological caregiver of the patient or step parent, like if it's an ex-boyfriend. I think in that case where it's not somebody that can get access to the medical record.
That is different, but in the cases of a you know a step parent that could potentially try and get access to the medical record or biological parent. I would really hesitate to put to identify who like.
Like it in that way, I think it would be appropriate to say.

Mother reports bridge history or mother reports. Bridge positive because then it identifies who the person was that disclosed that information.
Versus placing that putting the alleged perpetrator or the abuser's information in there.

Hancock, Susan, C LMSW 30:48
Thank you.

Jacob, Samantha, N MSW, LSCSW, LCSW 30:49
Yeah.
Looks like Ashley, you have a question.

F

Falbo, Ashley, M LCSW, LMSW 31:00
Come on, that real quick that we've always been told on our team like.
Regardless of their relationship of that person, assume that person could access the mental cracker at any time.
Like even if it is an ex-boyfriend, I think the point of their abuse is probably to try to get back with that person.
And you know, they could end up getting married at some point and be a step parent.
So just like that's what we've been told, at least if it doesn't really matter their relationship, they could at some point access it.

Jacob, Samantha, N MSW, LSCSW, LCSW 31:26
Yeah.
Yeah, yeah, I think it's always best and safest just to assume that anyone can get access to the medical record as much as we can try and prevent it.
Thank you, Ashley.
Sarah.

SE

Shaffer, Sarah, E 31:46
Yeah, I don't know if I'm jumping the gun, but I know that we've kind of had a situation where a provider has mentioned bridge positive in the family, living in a shelter, in their notes.

Is there any good guidance that other than like us telling them not don't do that?
Is there any other good guidance you can give us?

Jacob, Samantha, N MSW, LSCSW, LCSW 32:09
Yeah, I would definitely.
You can share those concerns with me.
We have Doctor Randall Kim Randall has created, and Jesse Fazel. Have created a document that we share with providers that when we see those concerns of document, those concerning documentation notes in a patient's medical record that we can then share with them, that gives them kind of.
Those best practice guidelines and.
And talks with them about how.
To either protect that note or modify or remove that note so that they can address the current situation as well as hopefully not have that in the future.
So you're welcome to send those to myself.

Shaffer, Sarah, E 32:58
OK.
Thank you.

Falbo, Ashley, M LCSW, LMSW 32:58
This is random and something we just found out. I think Chelsea Hilton was the one who noticed this, but apparently psycho psychosocial nursing notes are immediately available in the patient portal.
I don't know if that is just the ER ones, because those notes are under like the ER visit or and like the inpatient ones are under a completely different folder.
But that was something that she identified, I think over this past weekend that any.
Any of those notes are going straight to the patient portal, so if they're documenting, you know this happened, they could be able to see it.
So I think that's something being followed up on though.

Jacob, Samantha, N MSW, LSCSW, LCSW 33:39
Yeah, like I said, we do have nursing just in the last. I want to say six months, maybe 9.
Now we have gotten nursing on board with completing those IPV quality reviews as

well.
I will say those numbers are small of the nurses that are able to do it and they are all in the Ed, so their workload is heavy and their time for that is slow.
So if you.
This is my open call for anybody if you'd like to be involved in any of this work.
Your well please reach out to me about joining the IPV workgroup or if you know any nurses that are interested in advanced points for themselves or interested in this work as well, we would love to have them on the IPV workgroup or even on just the IPV data.
Review task force if that's something that they're interested in so that we have kind of two sets of eyes on that.
And those are things that, yeah, the nursing team may know that those notes get released or they may not.
And then they're charting things in there and we've tried to provide that education to them as well about using that coded language and not decoding it by saying things like.
You know, patient reports.
That.
Dad is abusive towards mom and then puts that patient.
And survivor at greater risk too, yeah.
Any other questions before we jump into some of these case studies?
Alright. And this part is interactive. I want you guys talking and sharing.
And I'm going to ask some questions and I'd love to hear some feedback.
Patient pregnant caregiver present to a clinic for an appointment, an outpatient appointment. During the appointment, the caregiver gets multiple calls from a partner, patients, other parent.
Your team witnesses caregiver answering multiple calls, saying we're at the doctor's office. We'll come straight home.
I'm not sure how much longer we'll be.
And then caregiver seems to be growing in anxiety and then asks to put partner on speaker phone to be able to hear the visit.
So tell me, what are some of your red flags here?

BA **Basaure-Carrington, Jorge, A** 36:12
Couple other things that stand out to me are definitely the power and control the

checking up on the caregiver.
And also just kind of how she?
'S How she's exhibiting her anxiety.
How that's growing.

Jacob, Samantha, N MSW, LSCSW, LCSW 36:32
Yeah, great.
Thank you.
And then as you.
Meet with this parent or caregiver and what would be some of your steps to ensure patient safety and caregiver safety in completing kind of your completing your your assessment.

F

Falbo, Ashley, M LCSW, LMSW 37:10
You could probably write some things on a piece of paper and just hold it up for the parent instead of asking them out loud since there's someone on the phone listening.

Jacob, Samantha, N MSW, LSCSW, LCSW 37:18
Yeah.
Yeah, that I also think about sometimes.
You know, when we find those moments where we can be alone with the caregiver.
I know in my outpatient setting I've used situations like lab when the patient needs to go to lab and I can step aside with the parent or caregiver to see if there's something going on that they'd like to share but don't feel comfortable sharing in front of their.
Child.
And maybe we've kind of disconnected from that call with that caregiver.
That's causing this increased anxiety, but ensuring that we're able to kind of do some of that safety discussion with that.
Survivor in a Safeway that doesn't put them at further risk because it's being disclosed in front of the child.
We didn't explicitly discuss this, but bridge assessments and screenings should never be completed in front of a child.
They may not understand that what they hear.

And then could repeat at home may cause.
Their parents, for their risk, and so above the age of two, we should really not be discussing any of this in front of a child.
Alright, move to the second one.
Mother has screened bridge positive in the past due to concerns related to physical abuse and manipulation from patient's other parent.
Mother has separated from father and mother has a protection order in place, but patient is not listed on that protection order and the parenting plan allows for both parents have legal and physical custody of the patient.
Patient is scheduled for upcoming surgery and mother denies concerns for physical abuse, but is concerned about how to ensure her safety while patient.
Is admitted.
Talk me through kind of what? How how would you as a social worker talk with this mom or what steps would you take to help ensure her and her safety while patient is admitted?

Paske, Kaysie, M 39:48
I think I'd be interested to know what would help make her feel safe, like from her end.

Severin, Ashley, N 39:49
Oh.

Paske, Kaysie, M 39:53
What would that look like?
And then kind of go from there and what we can do.

Severin, Ashley, N 40:00
Yeah, I agree with that.
And I'll piggyback off of what Casey said too.
I know like in our clinic sometimes.
I mean, I know this is like a surgery, but making sure that the door stays open.
Or like we if there's enough room or putting like the father in a separate room from the mother and the patient and the patient can kind of go back and forth.
But making sure that the medical team goes back and forth between the the two

teams, I know that's always or the two rooms I know that's always difficult and hard asking the parent like the mother if she wants to bring like a.
Like a support system and encouraging her to bring like a support support person with her as well.

Jacob, Samantha, N MSW, LSCSW, LCSW 40:37
Yeah, those are great.
Thank you Casey and Ashley.
I think one thing that I would want to ask Mom is, what does Dad know?
Does Dad have your contact information or do we need to take steps to keep that safe as well?
Does he have your address or your phone number?
Do we need to be careful about ensuring that that's not on?
Discharge documents that we're handing to both of you.
And making sure that we're.
This isn't specifically about her safety.
But also making sure that we're communicating those discharge plans to both parents so that they're hearing them at the same time too. So there isn't that power and control of trying to manipulate well, this is what they told me.
Kind of dynamic going on.
Hey.
Next is John is a patient followed by Beacon, Orthopedics, GI and ENT. During John's last Beacon clinic appointment, his mother presented with a black eye and initially denied bridge concerns.
Upon further assessments with social work, mother disclosed that John's biological father is physically abusive towards her and has restricted her access to financial resources. After meeting with the Bridge Advocate, Mother has chosen to move in with her mom, so maternal grandmother.
And plans to continue to work with the Advocate for legal needs.
Talk through how would you document your interaction in this situation?

Mozqueda, Anna, K 42:37
One of the things I would do would be the bridge screen follow up note.
Kind of giving the synopsis of that. She's doing level 2 and connecting to her resources, things like that.

Jacob, Samantha, N MSW, LSCSW, LCSW 42:58

I think this is one of those times where we now we have a lot of information and our heads in our hearts and how do we.
Not put all of that down on paper, you know, as social workers, we always have this like we're taught in school.
Like if you didn't document it, it didn't happen, but we can't document all of that, right?
Like but it says he's a biologist.
It's the biological father.
And so he could definitely have access to the medical records.
And so for me, like in my progress note may look like.
Bridge positive.
Resources provided.
And it could be even just as simple as that.
Connected to resources, it really can.
Sometimes, especially if in this case biological father isn't physically abusive towards the child.
It it can be pretty bare bones which.
Can be difficult to do.
And that leads into that second question of what are the future concerns?
Can we anticipate regarding that limited documentation?
I see we've got a question from Alexis.

Andrews, Alexis, M LSCSW, LCSW 44:26

Yeah, I just had a question.
So because documentation can potentially be like bare minimum like in that progress note. Essentially what we potentially put in that progress note can be answered by the bridge screen follow up.
Do we have to document that twice?

Jacob, Samantha, N MSW, LSCSW, LCSW 44:45

I don't necessarily think that you do.
No, I think if there's additional information that you've you've gathered through that assessment, that is not bridge related, then yes, I would go ahead and document in

there.
You could.
You could just say like bridge positive connected to resources in addition to all of the rest of your note. But you're right, if it is, if like you can document everything in that bridge screen, follow up template.
Then no, I don't think you necessarily need to include a full progress note.
It just says essentially that exact same thing.
It's not indicated that you do both.
But how could that lead to future concerns if we're only doing that bridge screen, follow up template and we know that she's discharged to or that they're leaving to go to a safe place.
How can we anticipate?
What do we anticipate? Some of those problems maybe being especially in this case with this complex kid?

Mozqueda, Anna, K 45:48
With.
I was just gonna say with getting needed supplies for the patient often becomes an issue in these scenarios.

Jacob, Samantha, N MSW, LSCSW, LCSW 46:00
Yeah, for sure.
Yeah.

SE

Shaffer, Sarah, E 46:04
Just I've had some providers not really understand what bridge is also so.
Just not knowing what that is and disclosing information that they probably shouldn't.
And then also with patient access, just maybe providing more information than they should as well.

Jacob, Samantha, N MSW, LSCSW, LCSW 46:25
Yeah.
Yes, I will say that patient access does take does take feedback pretty well, at least when I've had to have those conversations about like this is jeopardizing safety.

So can we?
You know, I mean if phone number has previously already been included, can we please just list the phone number and not list an address?
So I think though the important piece is that we're kind of the holder of all of that information.
Information, so making sure that we're communicating it in safe ways.
So by e-mail, face to face conversations, things like that with the care team.
And that we kind of try to anticipate as many of those needs and concerns as we can before they become an issue that could result in a barrier to care.
Any other thoughts or comments on this one?
Alright.
This is our last one and it's lengthy.
This is kind of a situation for a 10 month old male that is transferred to the Ed from an outside hospital due to injury during an IPV incident.
So this means that this this 10 month old male was injured during this incident and mother shares the following regarding this incident.
Mother reports that patient's Father returned home from running errands with food.
Father, through the bag of food at her and mom, put the food to the side.
Father became upset that mother did not appear to want the food, and things escalated quickly.
Mom stated she attempted to leave the patient. However, Father got in the car and began driving around mother stage to call 911. Prior to leaving the home, but was placed on hold for approximately 15 minutes.
During this time, Father was threatened, was threatening to kill Mom's family, mom and patient.
Mom stayed at 911, finally picked up.
So she was able to start giving information for their whereabouts by asking Father.
Why? He was on certain streets to be discreet, and that 911 was on the phone.
Father asked several times who mom was talking to, and Mom indicated she was praying.
Father then pulled into an abandoned parking lot. Mom attempted to climb into the front seat, but father began pulling mom's hair.
Father then hit mom several times with a gun and instruct patient several times.
Mom tried to shield patient but was unsuccessful.
The patient was struck.

Father began driving again and Mom tried getting.
Other cars attention.
They came to a stoplight and mom verbalized this. So 911 could hear.
Which stoplight they were at and asked Father to just pull over and alert the officer so that they could give patient to them.
This prompted 911 to know their location.
Officers then pulled father over once out of the car. Mom and patient barricaded themselves behind. The officers and father was apprehended.
Mother stated father was combative with the officers. Mom expressed extreme fear for her and her family and that father would get out of jail and find them.
Mom expressed intention to take action to ensure family safety of note, Mom stated she was summarizing the incident.
How would you document this?
Knowing that this child was injured in this incident.

Falbo, Ashley, M LCSW, LMSW 50:03
I think this might have been my case or I just like know it well enough because I was here.
But we always wanted to document like what happened to the child. Like if the child was injured.
We cannot not document, or at least in my opinion, we can't not say like child was struck or whatever it was that happened. But you just have to say bridge incident.
Unfortunately it seems horrible. But yeah, in your hotline you can.


Jacob, Samantha, N MSW, LSCSW, LCSW 50:25
Bye.
Yeah.

Falbo, Ashley, M LCSW, LMSW 50:32
Write all that stuff.


Jacob, Samantha, N MSW, LSCSW, LCSW 50:34
Yeah.
Yeah, I think.
That is really hard to not be able to write all of those things that Mom has shared.

But yes, Susan also put in the chat complete of par and notified the CPS and obtained police report number.
All of those things definitely need to happen.
But.
Yeah, I think you could definitely include the part about where.
Father hit mom.
Hit struck patient with a gun several times.
And you can.
There are pieces of this that you can share, but why?
What would be a concern?
In documenting all of this, separate from, it could put you know, the survivor at greater risk. Separate from that, what could be another concern that we talked about?
As it relates to maybe legal proceedings.

Basaure-Carrington, Jorge, A 51:43
I would definitely leave out the part where she was combative with police.
For example.

Paske, Kaysie, M 51:51
You get the problem.

Anderson, Alison, R 51:53
We're getting a protection order.

Jacob, Samantha, N MSW, LSCSW, LCSW 51:57
Yeah.
I think for me the thing that stands out is the mom shared that she's summarizing the sense in it. If we document all of this in this way and then her report changes.
Now she has conflicting reports to different entities.
And I would be hesitant to document everything so specifically that it could put her at risk of having those conflicting.
Reports to different.
To police or DCF or CD or to children's mercy.
Yeah.

Well, are there any other questions or concerns?
And yeah, somebody mentioned that you would have to testify on everything that you documented your subpoena so.
Keeping that in mind, as always.
Helpful.
Any other questions or concerns or comments or success stories that you've experienced here at Children's Mercy?
I can share.
We've had a family out in Wichita that we asked a bridge screen.
We completed a bridge screen with them and they denied concerns during the appointment.

◉ **Falbo, Ashley, M LCSW, LMSW** stopped transcription