

## British Columbia Nephrology Social Work Scope of Practice

This scope of practice was developed by the British Columbia Nephrology Social Work Professional Practice Council (BCNSWPPC) in 2008 to identify, establish, and promote provincial nephrology social work standards of professional practice. The BC Nephrology Social Work Professional Practice Council was originally comprised of social workers from Chronic Kidney Disease practice and later expanded to include all modalities of nephrology social work practice. This scope of practice was approved by social workers attending Nephrology Days conference in 2008 and will be reviewed in two years time.

### MISSION

- Nephrology social work services support and maximize the psychosocial functioning and adjustment of patients<sup>1</sup> experiencing Chronic Kidney Disease<sup>2</sup> (CKD) or End-Stage Renal Disease (ESRD). This service is extended to families, caregivers, and support networks.
- Support services are provided to ameliorate social and emotional stresses resulting from the interacting physical, psychological and social factors for a person living with CKD or ESRD. This includes shortened life expectancy and an altered lifestyle.
- Social work functions as a part of the interdisciplinary team and is responsible for fostering positive treatment environments, policies, and routines that respect diversity including individual, cultural, gender, religious and ethnic differences.
- Nephrology social work fosters and facilitates quality of life as perceived by patient, family and caregivers by respecting values of individuality, independence and choice. We promote overall wellness through all stages of care: prevention, diagnosis, chronic illness management, treatment, and end-of-life care.

### EDUCATIONAL STANDARD<sup>3</sup>

We, the BC Nephrology Social Work Professional Practice Council, advocate that nephrology social workers preferably have a Masters of Social Work degree (MSW) from an accredited School of Social Work. In situations where MSW trained persons maybe difficult to recruit due to supply or geographical factors, a Bachelor of Social Work degree (BSW) with substantial related experience should be considered. Furthermore, educational standards for social workers should be consistent with those set by the British Columbia College of Social Workers and the appropriate employers.

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<sup>1</sup> "Patients" has been used to refer to people with renal disease or clients in recognition that this is a formally recognized term used by the medical system.

<sup>2</sup> CKD refers to the predialysis/ pretransplant stage of the disease whereas ESRD or ESRF refer to the initiation of dialysis or transplant treatment.

<sup>3</sup> BC Provincial Renal Agency is not responsible for regulating professional credentials or hiring practices for BC Health Authorities unless otherwise specified.

## **ETHICAL PRACTICE**

The nephrology social worker is to practice with accountability, confidentiality, ethical guidelines, and without conflict of interest. In BC, registered social workers (RSW) must follow the Code of Ethics and Standards of Practice as outlined by the B.C. College of Social Workers (BCCSW). Other useful resources which support nephrology social work ethical practice are the British Columbia Association for Social Workers (BCASW), Canadian Association of Social workers (CASW), and the Canadian Association of Nephrology Social Workers (CANSW).

## **PROFESSIONAL PRACTICE STANDARDS**

### **1. Referrals, Assessment and Continuity of Care**

- Aim for positive health outcomes by reducing the risk of psychosocial complications, delaying disease progression, promoting wellness, and facilitating links to appropriate resources.
- Accept referrals from patients, families, health care providers, community partners or any other party involved in care.
- Triage, assess, and manage high-risk and complex cases.  
Examples of psychosocial risks and issues, which may be screened, are as follows:
  - Abuse, Neglect, Safety
  - Activities of Daily Living
  - Advance Care Planning
  - Caregiver Stress
  - Cognitive Deficits
  - Coping, Anxiety, Depression
  - Grief, Bereavement and Loss
  - Education and Vocation
  - Family Stress and Conflict
  - Finances
  - Health Consent Complexities
  - Home Environment
  - Illness Management
  - Immigration and Settlement
  - Isolation
  - Language and Cultural Needs
  - Legal Resources
  - Medical Benefits
  - Mental Health
  - Rehabilitation
  - Self Image
  - Sexual Health
  - Shelter
  - Social Support
  - Substance Misuse
  - Transportation
  - Treatment Decision Support
  - Other Complex Care Needs
- Facilitate continuity of care by completion of timely, comprehensive and concise psychosocial assessments, updating chart correspondence, reporting to team members, and transferring relevant information to key service providers for seamless transfer of care.

## **2. Counselling and Advocacy**

- Counsel patient and family regarding coping, crisis management, problem solving, health management, decision-making, resources, and other psychosocial needs by utilizing appropriate therapeutic interventions.
- Share information about peer support resources with patient and family to complement emotional support and education needs.
- In collaboration with the health care team, ensure patients, families and caregivers have accurate and adequate information about diagnosis and prognosis so that they are able to make the appropriate health care decisions.
- Provide help with negotiating the complex health care system and advocate for patient and family rights within the health care system.

## **3. Cultural Competence**

- Collaborate and work effectively in diverse multicultural, socioeconomic, demographic, and geographic environments.
- Advocate for fair and equal access to service for all human beings.
- Practice respectful interventions regardless of gender, age, ethnicity, language, culture, sexual orientation, financial status, spiritual, physical and mental abilities.
- Explore and include patient and family cultural beliefs, values, and needs in care provision.

## **4. Chronic Disease Management and Self-Management**

- Educate and support patient and family about chronic disease management, delaying disease progression and maintaining a healthy lifestyle.
- Foster self-management, engagement and motivation for positive outcomes such as improved confidence, commitment to behaviour change, problem solving capabilities, and self-advocacy skills. Encourage participation in community based self-care programs.
- Collaborate with complementary chronic illness programs for comprehensive and integrated health care.

## **5. Advance Care Planning**

- Educate and counsel patient, family and healthcare team members regarding Advance Care Planning and Advance Medical Directives.
- Facilitate and identify patient's future health care values, wishes, decisions, proxy designate, legal and financial planning, and review for change as needed.
- Coordinate Palliative Care and End-of-Life care services with patient, family, interdisciplinary teams, and community resources, which honour the patient's Advance Care Plan.

## **6. Education, Teaching and Leadership**

- Develop and provide individual or group education for patients, families, and community partners on such issues as coping, illness management, wellness, treatment, resources, and other renal or psychosocial topics.
- Develop education materials in the areas of renal care, social work and interdisciplinary practice for presentation to health professionals, trainees, students, and community partners.
- Provide mentorship, training, supervision, and leadership to social work students and staff and all other multidisciplinary health professionals.

## **7. Data Management and Program Development**

- Collect data and submit service trends to appropriate health care administrators for adequate social work resource allocation, program development, policy guidelines, and health infrastructure.
- Develop, implement, and evaluate programs for safe, effective, efficient, and high quality patient care.
- Collaborate with key stakeholders on building programs, which aim for optimal health outcomes and best clinical practice.
- Advocate for adequate, comprehensive and progressive health resources at local, regional, provincial, national, and international levels.

## **8. Research**

- Participate in the promotion, implementation, and evaluation of renal health and social work practice research.
- Develop and conduct research for the advancement of patient, family, community, and social health.

## **9. Community Partnerships**

- Build and foster ongoing strong working relationships with Provincial Renal Agency, Provincial Health Authorities, government agencies, and community partners such as The Kidney Foundation of Canada, ethnic organizations, cultural associations, and other key groups and agencies.

## **10. Personal and Professional Development**

- Pursue lifelong personal and professional learning and development.
  - Stay current with clinical practice, theoretical applications, social changes, research, policies, resources and health information.
  - Promote affiliation with national and regional health networks, renal organizations, social work groups, and other key associations.
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