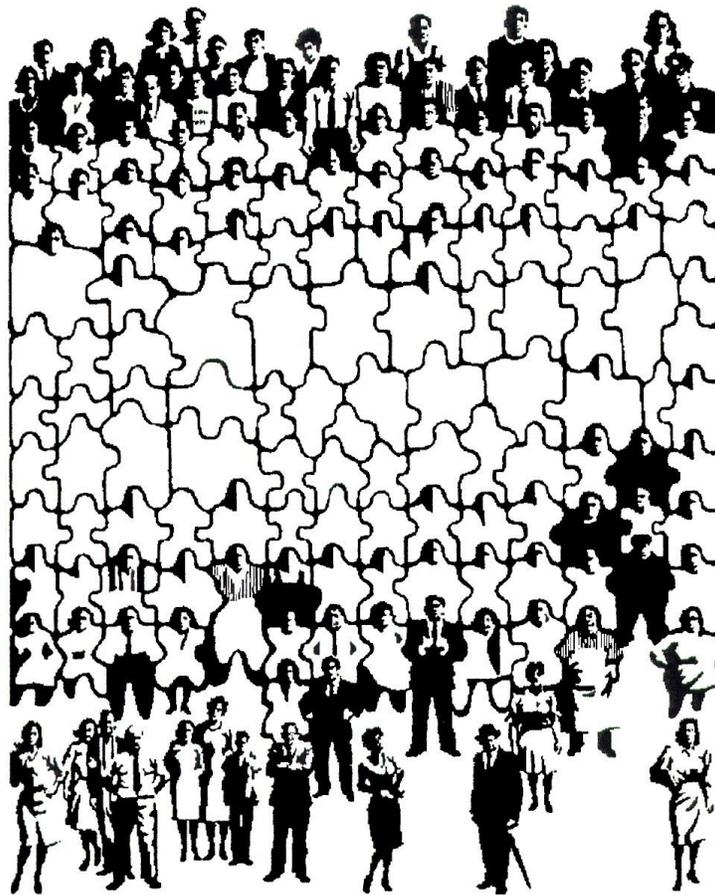


The Role Of The Social Worker In The Long-Term Care Facility



Edited by Novella Perrin and Joanne Polowy

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This booklet is dedicated in memory of Garry Thompson, MSW.

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It is hoped this publication can be used in planning and implementing a social service program in a long-term care facility and that it will stimulate and increase an awareness of the need for service integration between components of care in long-term care facilities. Such heightened awareness should enrich the quality of life for residents in the long-term care facilities -and it is toward this goal that we are striving.

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The revision of this book is the result of a team effort of practitioners, academicians, and Division of Aging* staff. Almost all of the original material has been incorporated but as there have been a number of changes in laws, regulations, and public policy, particularly on the federal level, the booklet needed to be updated. The input, cooperation, and dedication of the following people are greatly appreciated.

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Preface to the Revised Edition

The information in this booklet is intended to serve as a guide for the delivery of social services in long-term care facilities. The booklet was purposefully written in a broad manner to allow applicability to the wide range of long-term care and assisted living facilities that exist in the state. It is left to the reader to implement the information in the manner most appropriate to the individual facility.

This information should be viewed as a yardstick against which one can measure the quality and effectiveness of social service delivery. Although there are no penalties associated with noncompliance to this booklet's recommendations*, it is hoped the reader will be challenged to strive for the attainment of the highest standards. It is toward this goal of high quality social service delivery that this book has been directed.

***Many of the guidelines suggested in this booklet are based on state and federal regulations which do carry such penalties for noncompliance.**

The Role of the Social Worker in the Long-Term Care Facility

Chapter 1

General Philosophy

"Are the old really human beings? Judging by the way our society treats them, the question is open to doubt. Since it refuses them what they consider the necessary minimum, and since it deliberately condemns them to the extreme poverty, to slums, to ill health, loneliness and despair, it asserts that they have neither the same needs nor the same rights as other members of the community. In order to soothe its conscience, our society's ideologists have invented a certain number of myths - myths that contradict one another, by the way - which induce those in the prime of life to see the aged not as fellow beings but as another kind of being altogether."

Simone de Beauvoir
The Coming of Age

The writings of de Beauvoir reflect the prevailing societal view of the nineteenth century toward older persons and indeed may still represent the attitude of certain elements of today's population. However, the general philosophy upon which this booklet is based takes a more optimistic view of older adults. It is the basic premise of the authors that each person, whether living independently or living in a long-term care facility, is unique; has the same basic needs as all others; and is entitled to the same rights.

The role of the social worker in a long-term care facility is to enable each individual to function at the highest possible level of social and emotional wellness.

A social worker in a long-term care facility helps the person who is entering a facility make the transition from a previous living environment to life in an institutional setting while meeting the social/emotional comfort needs of that resident. Once the resident is established, the social worker assures the resident's continuing needs are met and that the person is given the opportunity to participate in planning for continued care in the facility, transfer, or discharge back into the

community. Although the resident is the main focus, it should be noted that much of the social worker's time may be spent working with the family.

To assure positive well-being for the resident, social workers should adopt a holistic perspective by recognizing the dynamic interplay of social, psychological, physical, and spiritual well-being. The social worker must constantly be aware of factors which may have a negative impact upon a resident's well-being and, if possible, prevent this from occurring. Further, the social worker must interact with all levels of staff within the facility as well as the residents and their families and friends; this is essential to enhancing the opportunity for the resident's positive life experience while in a long-term care facility.

The social worker's role should be guided by the following philosophy. The social worker:

1. Is aware of the worth and uniqueness of each individual
2. Treats each individual with respect
3. Creates an atmosphere of growth for the individual
4. Adopts a holistic perspective by recognizing the dynamic interplay of social, psychological, physical, and spiritual well-being
5. Provides a physical environment that is supportive rather than challenging or crippling to the individual
6. Fosters a positive self-image for the residents through continued social contact, decision-making opportunities, and independence

Specific tasks which may be a part of the social worker's duties generally include but are not limited to:

- Marketing and providing tours for potential residents and families
- Planning for pre-admission and discharge
- Providing psycho-social assessment and completion of relevant parts of the minimum data set (particularly face sheets, sections A, AA, AB, AC, E, F, Q and sometimes B)
- Utilizing the minimum data set to guide the care plan

- Participating (as a member of an interdisciplinary team) in resident care planning
- Counseling residents and their families
- Contacting and utilizing community resources on the resident's behalf and serving as a link between the resident and these resource systems when necessary
- Advocating for and protecting resident's rights
- Ensuring the social and emotional needs of each resident are met
- Stimulating social contact and interaction
- Promoting the maximum level of independence of each resident
- Promoting volunteerism for the facility



Survey research has indicated there is a limited understanding of what constitutes a comprehensive social service program in long-term care facilities. Thus, the information in this booklet is intended to serve as a guide for the delivery of social services in a long-term care facility. It has been developed to be used not only by a social worker/social service designee, but also by an administrator and others on the staff of a facility. All long-term care staff must understand and be aware of the necessary components of social work in a long-term care facility, the range of services associated with each component, and the various duties a person designated as responsible for social services may be called upon to perform. The administrator, in particular, needs to understand the complexity of what is involved in meeting a resident's social and emotional needs and should provide as much support to the social service staff as possible to assure that those needs can be met.

The components included in this booklet should be considered as basic. They include: admission, information and referral, counseling, problem-solving and complaint resolution, support services, financial resource management, and individual service delivery. For each of these basic components there is a brief explanation, a description of the range of services which may be available, and the possible associated duties. The facility social worker may be called upon to do any or all of these components.

The goals of this booklet are:

- To provide a general philosophy regarding social service delivery in long-term care facilities;
- To set forth the basic components of a social service program in a long-term care facility;
- To clarify the role of the social worker/social service designee in a long-term care facility;
- To increase awareness of the multiple duties of a long-term care social service worker/social service designee;
- To improve the quality of social services in long-term care facilities;
- To provide resources for further information on social work in long-term care settings;
- To provide a sample job description for a social worker/social service designee.

When utilizing the information presented herein, it is necessary to remember that all long-term care facilities are not alike. Long-term care facilities differ according to size, location, organizational structure, proprietorship, level of care, staff, staff background and experience, resident population and cost. Although some of these characteristics may seem unrelated to social service delivery, they all impact a resident's life and care. It is necessary for the reader to understand the information provided in this booklet must be individualized and adapted for each facility to best serve the needs of the residents in that facility. It is for this reason that a range of services or duties is presented for each of the basic components. Each of these areas

must be addressed in some way if the social and emotional needs of residents are to be met.

Organization of the Book

This book is organized in a logical progression of tasks that may be required of a social worker in providing services to residents. Following the first introductory chapter, chapter two discusses admission of the resident to the long-term care facility, the third chapter presents components of individualized service delivery to the resident after admission; and the fourth through eighth chapters detail additional services a social worker may be asked to provide or assist in obtaining. The final chapter describes the types of on-going training needed by the social worker to enhance service delivery and professional development. The concluding sections list accredited social work programs in Missouri, sample job descriptions for social workers, common abbreviations used in the service delivery system, and possible contents for an admission packet. A glossary of terms and related websites also are included.

Terminology

The terms "social worker" and "social service designee" are terms that are defined in federal and state regulations. (See section on Sample Job Descriptions). However, the terms "social service worker," "social worker," "worker," or "designee" are used interchangeably in this book.

According to RSMo 337.604, no person shall hold himself or herself out to be a "social worker" unless such person has: (1) Received a baccalaureate or master's degree in social work from an accredited social work program approved by the council on social work education; (2) Received a doctorate or Ph.D. in social work; or (3) A current baccalaureate or clinical social worker license as set forth in sections 337.600 to 337.689. No government entities, public or private agencies or organizations in the state shall use the title "social worker" or any form of the title for volunteer or employment positions, etc., unless the volunteers or employees in those positions meet the criteria set forth in subdivision (8) of section 337.600 or subsection 1 of this section.

Chapter 2

Admissions

Admission of a resident to a long-term care facility is a significant event for the new resident, his/her family, friends and facility staff. It is not an event that simply happens; it requires thorough yet individualized pre-admission planning and coordination. Ideally, each admission has pre-admission coordination that includes a tour of the facility, interaction with staff, proper screening, and explanation of services, policies and procedures. Unfortunately, in many cases the facility has only a few hours to prepare. Even with short notification, the new resident and family should be provided with as much information as possible to assist in the transition.

Marketing

The pre-admission process may begin months or years prior to the actual admission. The pre-admission process begins with marketing. Every staff member has the responsibility to market the facility. Every contact made with a person outside the facility has some impact. One never knows when a family member is looking for a facility or will recall a positive or negative interaction when seeking placement for a loved one. Although each employee is a representative of the facility, actual marketing tasks are frequently listed as a part of the social worker's job description. **If marketing is a part of the performance expectation, the following list provides key marketing concepts:**

- Know the facilities in the area and what level of care is offered in each. Other facilities may serve as "feeders" to the facility or may be a more appropriate placement for the resident.
- Stay in contact with all referral sources so that referrals will continue. Keep the referral sources informed about current vacancies and services the facility can provide. Network with other social workers in other facilities and hospitals.
- Utilize a variety of methods such as positive news releases, open houses, and educational programs, to keep the facility name constantly in the public eye.

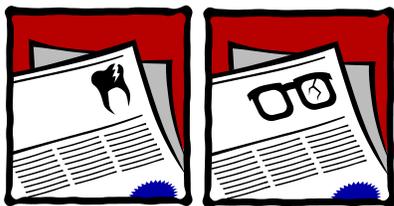
- Help keep the facility looking attractive. Although many could argue that quality of care is the most important aspect of any facility, if the facility does not look inviting, there may be no residents to whom to provide services.

Orientation to the Facility

In some facilities, “marketing” simply refers to tours of the facility. Such tours are usually hosted by the social worker. This sets the stage for an ongoing relationship between the social worker, the resident, and the resident's family (if any) as the social service worker may be the person to whom a family and the resident (if admitted) will turn for later assistance.

Literature (brochures or pamphlets) with photographs of the facility should be developed to distribute during tours or pre-admission inquiries. At a minimum the following information should be presented during a tour or in the "marketing" process:

- Facility rates - including information on services included and not included in the rate
- Description of rooms available
- Visiting hours
- Activity programs
- In-room services (i.e. television, telephone)
- Ancillary services (physical, occupational and speech therapies, dental services, beauty shop, laundry)
- Physician services
- Facility policies regarding personal property, admission, discharge, bed holding and outings into the community



Also, it is helpful to have other flyers and pamphlets available regarding Medicare, Medicaid, Social Security, and other programs which affect and assist older persons and their families. The Department of Health and Senior Services has some

excellent material available on these issues which can be obtained free of charge. This material and the facility flyer should be given to prospective residents and their families for them to take home and study.

Pre-Admission Coordination

A potential resident should always be encouraged to visit the facility **before admission** and should be encouraged to actively participate in the selection and admission process. If the person cannot visit the home, ideally, the social service worker should go to the person's home (or the hospital) to describe the facility, services and answer questions. If this is not possible and the person is coming to the facility directly from a hospital, communicating with the hospital social worker is essential. Also, meeting with family members or significant others before admission is a key factor in facilitating adjustment for the potential resident. If the resident has not already seen a brochure or videotape about the nursing home which includes pictures of rooms, floor plans of the facility and grounds, and special features of the facility, it should be given to the resident to assist in familiarization with the facility. In some cases, it may be appropriate to give the brochure or brochure to the resident's family so they may assist in the orientation process.



Many residents may be cognitively impaired and unable to participate in the decision-making process. Even so, the resident should be included in as much of the process as he/she is able to understand.

In order to facilitate a resident's transition from independent living to that of living in a new environment, it is essential to gather as much detailed information as possible about the resident, background, and family. This should be completed before admission to ensure proper placement and to enable staff to provide needed services. Information that is needed before admission includes: financial data, insurance coverage, burial arrangements, responsible parties/families, religious preferences, and physician preference. It may be helpful to supply local hospital social workers with a checklist or copy of the facility pre-admission form so they know what type of information is needed. The information should not be used for any purposes other than those designated by

the policies of the nursing home or state and federal regulations. **Remember that all information regarding the resident is confidential.**

Prior to admission, *it also may be the social service worker's responsibility to obtain any ancillary equipment or services needed by a potential resident.* These may include specialized medical equipment, (i.e. special bed, wheelchair, oxygen, respirator) or external services (i.e. transportation, ambulance services).



The social service worker's involvement in this process will vary depending on the policies of the particular facility and the particular needs/requests of the resident. Some facilities, for instance, have the social service worker assign the room based on both medical and social aspects involved.

In some facilities, the administrator or director of nursing may take the lead role in the admission process. Even if this is the case, the social worker should have an opportunity to meet with both the resident and the family to let them know of ways the worker can be helpful to them after admission.

Pre-Admission Screening

Federal regulations require that all prospective residents be screened for the

Prospective residents who are potentially Medicaid eligible must be screened by Missouri Department of Health and Senior Services staff members as mandated by the Missouri Care Options Program: Level 2, according to the DA124C form.

possibility of a mental illness or developmentally disabled diagnosis. The pre-admission screen is known as PASARR which stands for Pre-Admission Screen and Resident Review. Compliance with PASARR is ensured by completion of the DA124 form. The DA124 form is divided into three parts, A, B, and C. DA124A and DA124B screen for the possibility of a mentally ill or developmentally disabled person. DA124C is establishing the future Medicaid eligibility of the person.

A pre-admission assessment is also important so that the facility may determine the appropriateness of the placement. Unfortunately, many families base the placement decision on location or cost of the facility rather than determining whether or not the

facility can adequately meet the needs of the future resident. While it may be economically tempting to do otherwise, the facility must insure it can meet the needs of the resident prior to accepting the placement.

Admission

At the first opportunity, preferably when the resident arrives in the facility, the social service worker should visit with the new resident and his or her family or support system (if available) to orient them to the facility. Take time at this early stage to find out



how the resident wants to be addressed by staff members - by first or last name (or title if that is part of the person's past). During this visit, information should be provided regarding facility policies, schedules, and services. An example of this information would be how to get to the dining room, when the next meal will be served, and salon or barber shop schedules. (See Appendix A for a complete list of possible admission packet contents.) Although these things may have been discussed prior to admission and covered in written form, review these again and allow ample time for questions.

Prior to or upon admission, each prospective resident or each resident shall be informed of the home and community based services available in this state by providing such resident a copy of the most current Missouri Guide to Home and Community Based Services, incorporated by reference, or any successor pamphlet as may be incorporated by reference in a subsequent amendment to this section. This booklet may be downloaded and printed from this website: <http://www.gcd.oa.mo.gov/pdf/GCDServices.pdf> or call 1-800-235-5503 for copies.

If admission was hurried or was directly from a hospital, some of the items listed under "pre-admission" may also need to be covered. This is particularly important if the admission was *involuntary*. The social service worker should gather all the needed information and gain an understanding not only of the resident's needs but also of his/her feelings and reactions to the admission.

It is important to realize that regardless of the circumstances of admission, the process may be as difficult for the family as it is for the resident; therefore, it is very reassuring to them to know there is someone taking a personal interest in the new resident.

It may be necessary at later dates to review the information provided during the admission process to be certain that questions were answered and information was understood. New questions often arise as the resident and the family adjust to the new setting and concerns or information may need to be discussed more than once.

If, for some reason, the resident or a family member did not have an opportunity to tour the facility, this should be conducted as soon as possible. Notification of visiting hours, care plan and guest meal procedures also should be shared with the family member. The resident as well as the family members appreciate being introduced to as many staff members as possible and a list of key staff should be provided to the family if facility policy permits. The social worker also should discuss with the family how to immediately register the assets of the new resident. This registration must be done with the local county Family Support Division (formerly Division of Family Services). Please see Chapters 4, 5, 6, 7 and 8 for additional specific intervention skills.

Advance Directives

Hospital, skilled nursing facilities, hospices, home health agencies, health maintenance organizations (HMOs), and personal care providers serving persons covered by either Medicare or Medicaid must provide information about Advance Directives. *The resident must be told about his/her legal right to have an Advance Directive and to refuse any medical care he/she does not want.*



Advance Directives are documents that state the resident's choice about medical treatment or identifies someone to make decisions about his/her medical treatment if he/she is unable to make those

Missouri law recognizes two types of advance directives: a health care directive; and a durable power of attorney for health care.

decisions. They are called advance directives because they are signed in advance to let the facility, doctor, and other health care providers know what the resident's wishes are concerning medical treatment. Long-term care facilities and other health care organizations must determine if a person has an "advance directive," but services or admission cannot be withheld if a person does not have one.

HEALTH CARE DIRECTIVE: In a health care directive (advance directive) the resident states what health care he/she wants or does not want in the event of a medical emergency that incapacitates the person either mentally or physically so that the person is not able to speak for himself/herself. It is important for the long-term care facility to have a copy of each resident's advance directive to put in his/her medical file so that his/her wishes can be followed. There is a document known as a "Living Will" recognized by Missouri Statutes. This document only goes into effect when a person is terminal in their illness. Food and hydration may not be limited or withdrawn by this document. Therefore, the Durable Power of Attorney or the health care directive, are much broader in scope when addressing these situations.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE: On August 28, 1991, a law went into effect in Missouri that allows a competent adult to designate another person to make health care and treatment decisions for them if and when they are unable to do so. The act is known as the Durable Power of Attorney for Health Care (Chapter 404 RSMo, Supp. 1991). A lawyer may be helpful in developing the advance directives, but there are no legal requirements in Missouri to involve an attorney.

The Durable Power of Attorney for Health Care:

- Must be signed by the patient and notarized;

continued:

The Durable Power of Attorney for Health Care: (continued)

- Becomes effective upon certification of the incapacity of an individual by two licensed physicians (unless the power of attorney document provides for a different number; but in any case, certification by at least one physician is required);
- Must provide a specific grant of authority to withhold or withdraw artificially supplied nutrition and hydration if the patient intends the designated person to be able to withhold or withdraw this type of medical treatment; and
- May be revoked by the adult, if competent, at any time and in any manner of communication.

Both state and federal regulations require that a person must be told about the right to make health care decisions and the various state laws related to this. This is true regardless of the person's medical condition and the necessary information should be provided in written form either before or at admission. However, the resident does not have to have one if he/she does not want one unless required by the facilities' advanced directive policies. Any change or cancellation should be written, signed, dated, and witnessed just as if it were the original. The social worker should review the material with the resident at least once after admission when the resident has had an opportunity to reflect on it.

Each facility must have policies and procedures on how to handle medical emergencies and advance directives. *The resident or the resident's legal representative must also be informed of these policies and procedures prior to or at the time of admission.* The state requires that these be reviewed annually with all residents, either individually or in a group session. This is usually a responsibility assigned to the social service worker. The Department of Health and Senior Services has a number of publications which can assist the worker in understanding the laws and issues involved. If the resident has an advance directive, the facility must have a copy on file and must adhere to the resident's wishes provided they are not in conflict with facility policy. It is imperative the resident and family understand the facility policies on advance directives so that conflicts do not arise.



The Social History

The social history should be obtained either prior to or at the time of admission. It should be made part of the medical record as soon as possible as it may provide helpful information and insight for all disciplines providing care to the resident. The social history should give an accurate account of significant events in the life of the resident. If the resident is unable to give the needed information, or if there is reason to believe that the information provided is inaccurate, the worker will need to contact a family member or significant other who can provide such information. However, it should remain the practice of the social service worker first to make an attempt to obtain the history from the resident.

Minimally, the social history should provide the following information:

- 1. Date and place of birth**
- 2. Marital status**
- 3. Childhood history**
- 4. Educational background**
- 5. Major occupation(s)**
- 6. Relationships with family and/or significant others**
- 7. Previous living arrangements**
- 8. Community involvement**
- 9. Religious preference**
- 10. Personal interests or hobbies**
- 11. Potential length of stay**
- 12. Individual providing information**
- 13. Substance use**

It is important that whenever possible, privacy during disclosure of significant events be provided to the resident. The resident also should be assured that all information will be held in the strictest confidence by the facility staff.

Resident Rights

Resident rights should be reviewed promptly on admission even if these were discussed in the pre-admission process. Every resident has basic human rights that

must be respected by the staff in the facility and there are specific rights stated in Missouri's law that a resident and resident's family should understand. *Resident rights must be prominently posted in the facility and are to be presented in written form to each resident.* A complete listing of resident rights is given in the federal and state guidelines.

Examples of Resident Rights include the right to:

A dignified existence

Self determination

Communicate with persons inside and outside the facility



Access to services inside and outside the facility



Be free of interferences, coercion, discrimination, or reprisal from the facility in exercising resident rights

Be informed of resident rights

Access own records



Be informed of own medical condition



Refuse to participate in experimental research

Be notified of Medicaid benefits

Select own physician and pharmacy

Be notified of transfer or discharge or a change in room or roommate

Manage own financial affairs



Participate in planning of own care and treatment

Privacy and confidentiality

Voice grievances and expect prompt resolution of grievances

Resident Rights continued:

Examine the results of the Federal and/or State survey of the facility

Refuse to perform work

Use the telephone, mail, and personal property



Be free of any physical and/or chemical restraints

Be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion

An environment that promotes maintenance or enhancement of each resident's quality of life



Care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality

Participate in choices about aspects of own life



Participate in an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psycho-social well-being of each resident

If the social service worker is the person within the facility who handles explaining these rights (and this is generally the case), the worker should review these in terms the resident can understand and provide as much explanatory information as possible. Current resident rights information is available in booklet form from each facility and from the designated Ombudsman for Long-Term Care. Documentation of all initial and annual reviews of resident's rights should become a part of the resident's chart. Many facilities have a form that is signed by the resident for documentation purposes; however, it is the right of the resident to refuse to sign such a statement. If this happens, the refusal to sign, or the inability to sign also should be documented. (Contact the Missouri State Long-Term Care Ombudsman Program at 1-800-309-3282 for materials regarding residents' rights.)

Residents also must be reminded that they need to respect the rights of others in the facility. This includes respecting other residents' rights and staff's right to provide care without restraint or abuse from the resident or family. Other policies developed by the facility to assure the well being of the resident. (i.e., sign out sheets) should be discussed at this time.

Discharge Planning

Surprisingly, discharge planning should begin as soon as the resident enters the facility. Discharge planning can involve both internal “within” the facility and external transfers. The ultimate goal for some residents may involve transfer to another facility, admission to alternative treatment programs or returning home to an independent level



of functioning. For others who may need to remain in the facility for indefinite periods, discharge planning may involve internal transfers within the facility's programs as the resident's care needs change. Whatever the ultimate goal, discharge planning is a critical part of the resident's overall plan of care and can be a useful tool in determining progress towards the goals identified in the care plans.

The social service worker should always encourage and support the resident's efforts to function at the highest possible level. For those residents leaving the facility to return home or to placements in other facilities, discharge plans should focus not only on the immediate care needs of the resident but also on the transition and relocation needs of both the resident and their family or support system. These may include visits to the new facility, family orientation or training to the care needs of the resident or introduction to home-based caregivers. Discharge plans for residents needing to remain in the nursing facility for long periods should be focused on increasing the residents' self-care abilities and helping them to achieve and maintain their optimal level of functioning.

Discharge planning should be an interdisciplinary assessment process that includes and encourages physician, dietary, therapy, nursing, and family involvement. The plan should be specific, relevant and individualized to the overall needs and abilities of each resident.

When actual discharge from the nursing facility occurs, it may be necessary for the social service worker to arrange support services to facilitate the transition from the nursing facility to the alternative environment. *Services such as transportation, durable medical equipment, home health services, medication system, meal delivery, or other support services need to be arranged.* These services should be coordinated to meet the requests and needs of the resident and family or significant others. Financial assistance for home care services may be available through Medicaid. In some areas of the state, there are private agencies that families may choose to assist with the discharge planning.



Facility staff also should be familiar with the MISSOURI CARE OPTIONS PROGRAM, which is an integral part of discharge planning. The Division of Senior and Disability Services and Section for Long Term Care no longer complete a post-admission screening process. This program had at one time mandated Division of Senior Services staff to screen residents receiving Medicaid payments who may be willing and capable of returning to the community or to a lower level of care. Candidates for post-admission screening included rehabilitative placements and residents with relatively low care needs and medical problems as identified by the Minimum Data Set information or referral. The Department of Health and Senior Services staff currently are not conducting a post-admission screenings as part of the annual survey and certification process. The facility social service worker should still be ready to be involved in reviewing the cases screened as well as assisting with any discharge plans for residents identified to return to the community or to a lower level of care, as this has been a popular and mandated program in the past, and may again be required by state law.

Chapter 3

Individualized Service Delivery

Individualized service delivery refers to the overall social service management of each resident's care in the nursing facility. This includes maintaining individual contact with the residents, participating in resident assessment and preparing the plan of care, providing or assuring social service needs are met, and completing required documentation in the medical chart.

Resident Contact

The social service worker is responsible for maintaining regular individual contact with residents in the long-term care facility. Frequency and social context of the contact may vary due to resident needs and facility policies. However, one-on-one contact should occur with enough regularity that the ongoing social and emotional needs of a resident can be identified and a plan for meeting these needs can be implemented.

Contact should be initiated by the social service worker utilizing some technique which will fit into the facility's routine. Some workers have found that assuming responsibility for daily mail delivery provides a natural point of contact. It also alerts the social worker to those residents who do not receive mail and for whom this may signal an underlying need for help and additional support. Contact also may be prompted by a referral from other staff members, family, or friends. Because referrals tend to come sporadically, it may be necessary that the social worker prioritize them, putting those issues that are most critical first. Though time may be limited, there should be follow-up action on all referrals.



At times, staff in the facility or family members may come to the social service worker with concerns that are inappropriate for the social service worker to handle. *The worker should feel at ease in letting the person know that assistance on a specific issue cannot be given, but an effort should be made to provide help in locating the appropriate staff or agency.* The social worker also should be

familiar with the facility's complaint procedure and refer the resident and/or family to this system when appropriate.

Recognizing and Appreciating Diversity

Individuals are influenced by their religious, racial, gender, ethnic and cultural backgrounds. They are products of childhood and adult experiences related to religious or moral beliefs, racial and ethnic heritage and traditions, and cultural practices.

All staff need to be knowledgeable about and sensitive to individual differences, traditions and experiences in all these areas not only with residents but with other staff and visitors.

Without training in and appreciation and respect for these differences, a social service worker may unknowingly violate a cultural or ethnic practice, tradition or value. This may result in unintended misunderstandings or perceived insults. The social service worker should take a lead role in recognizing, respecting, interpreting and communicating cultural, ethnic, or racial differences among residents and staff. Recognition and celebration of these differences may lead to a better atmosphere in the facility and greater trust and respect among residents and staff.

Care Planning and the Minimum Data Set

A social service assessment of the resident's cognitive, affective, ancillary, discharge and psychosocial needs must be completed within seven days of admission. With this information, an initial care plan is created. The Minimum Data Set is designed to meet the federal requirement of a comprehensive, interdisciplinary assessment. The MDS must be completed upon admission, annually, and upon significant changes in the resident. Additionally, certain items are also assessed quarterly. *The social service worker is usually responsible to complete the cognition, mood, behavior and psychosocial sections of the MDS.* (Face sheets, A, AA, AB, AC, E, F, Q, and sometimes B are the sections most frequently completed by the social worker.) Because the MDS is used as a national database and for facility reimbursement it is very important to code the sections correctly. The MDS User Manual may be viewed online on the website for the Centers for Medicare and Medicaid Services. The user

manual also provides the criteria for determining a resident's change of condition. The change of condition means that the resident has had significant improvement or decline in more than one area of functioning. This observation would then trigger a comprehensive MDS assessment so that a new plan of care can be made.

The MDS assessment is also used as a part of the prospective payment system (PPS). Based upon the coding of certain sections, the facility is reimbursed for residents who utilize their Medicare A benefits. The MDS assessments for PPS are assessed at specific intervals—5 days, 14 days, 30 days, 60 days and 90 days.

The Resident Assessment Protocol (RAP) is based upon the MDS assessment and includes a summary (RAP Summary) of the areas that need further assessment by the MDS team. This further assessment is used to build a care plan for an identified need.

Federal guidelines also require the MDS team to complete a comprehensive MDS assessment if there has been a change in the resident's condition. Any significant improvement or decline in more than one area of functioning that is noted by the MDS team at the quarterly assessment or in the daily observation of the resident, constitutes a change of condition. Such a change of condition usually requires a change in the care plan. Social workers also need to be aware of the CMS database of Quality Indicators derived from the MDS data. This is available at www.cms.hhs.gov, and families need to be told how to access this information.

Identifying Individual Social and Emotional Needs

Both state and federal government regulations require that the person responsible for social services identify the social and emotional needs of residents and

Many people assume isolation and depression are inevitable for all older adults who enter a long-term care facility. If the social worker has correctly identified the social and emotional needs of the resident and is providing appropriate services this need not be the case.

provide or arrange for services to meet these needs.

To insure the social and mental health of each resident, the social worker must have an accurate social history, frequent

contact with the resident to adequately observe and accurately interpret behavior, and frequent communication with the resident to determine orientation and affect and to answer questions.

Many people assume feelings of sadness and loneliness accompany the transition into the facility. Early research on movement into a nursing facility indicated the move had negative physical and psychological effects, hence, the term "transfer trauma." More current and methodologically correct research indicates such "trauma" does not necessarily occur when the move is voluntary, the environment is supportive, and/or the resident has been prepared for the move. *Elements of a supportive environment and pre-admission preparation focus on staff members, especially social workers, answering the resident's questions, reassuring the resident that social contact and routine activities will continue, and providing opportunities for meaningful interaction with other residents.*

Contact and communication are again central to meeting the resident's social and emotional needs. This contact and communication also will help to reduce the institutional depersonalization that residents sometimes feel upon admission. Continued opportunities for interaction with staff, residents, and families must be provided with the

goal of empowering the older adult to achieve maximum functioning.

It is important to interact frequently enough with the resident to observe resident behavior because resident behavior may be an expression of socio-emotional needs. Although it is important to change the negative behavior, it also is important to understand why the behavior is occurring.

Equally important, is the realization that it is not possible to change (fix) all resident's negative behaviors regardless of the number of varied approaches that have been tried. The social service worker, however, must continue trying alternative strategies as some improvement may occur even though complete change or elimination of the behavior may not occur.

Documentation

State and federal regulations require the social service worker to keep accurate and timely records. Documentation serves as proof that contact has been maintained with each resident, that social and emotional needs are identified, that a current and individualized plan has been developed to meet these needs, and that the identified needs are being met. In addition, notes of significant changes in mood, events, or circumstances in a resident's life (i.e. death of a relative or close friend) may provide insight to other staff providing care to the resident. Documentation of progress notes should be updated quarterly along with the plan of care. However, regulations indicate that services and documentation must be given to residents **as needed**. In reality, the only way compliance with this rule can be documented is by making thorough and ongoing notes of services provided.

The social service worker is responsible for completing the following for each resident in the facility:

- 1. Social history (See Chapter 2: Admissions)**
- 2. Social services assessment**
- 3. Social services plan of care**
- 4. Social services progress note(s)**

Documentation in each of these must be objective and factual. The reporting of observable or audible events must be stated in a clear, simple, and concise manner. **It is extremely important not to allow personal feelings, thoughts, or interpretations to enter into the recorded statements.**

Social Service Assessment

The social service assessment should give a clear indication of the resident's current psycho-social state. As with the social history, the assessment should be completed and filed in the resident's medical record as soon as possible after admission.

At a minimum, the social services assessment should provide the following information:

- 1. Circumstances of admission**
- 2. Relevant medical information**
- 3. Statements made regarding placement**
- 4. Current affect and mood**
- 5. Expressed needs or concerns**
- 6. Orientation to person, place, and time**
- 7. Socialization and communication skills or needs**
- 8. Interests and hobbies**
- 9. Family or significant other support**

Completing an accurate and thorough social service assessment requires a good general knowledge of human behavior, well-developed listening and observation skills, sound interviewing techniques, and good writing and recording habits. Although some facilities have developed forms or questionnaires to use in this process, the social service worker should keep the interview as unstructured and low-keyed as possible in order to help put the resident at ease and develop a good working relationship. If facility policy requires completion of a Social Service Assessment form, it should be completed later based on complete information and thorough notes.

Resident Plan of Care

Another major responsibility of the social service worker is participating as a member of the multidisciplinary Plan of Care Team. The resident plan of care is a personalized and coordinated plan of action. *It requires the participation of*



representatives from social service, nursing, dietary, activity/recreation therapy, physical, occupational, and speech therapy as well as any other appropriate staff member(s). Each team member

utilizes skills and techniques from their own specific discipline to accurately identify individual needs and devise ways to meet those needs

in an integrated treatment care plan. A basic resident right is the opportunity to participate in this planning process. The Plan of Care team should encourage the exercising of this right by all residents. NOTE: in facilities licensed only by the state, overall plans of care are not mandated by state licensure rule, but many facilities do this as it is a beneficial process.

The social worker should actively participate in the plan of care meetings, if facility policy permits. It is during this process that specific short term goals for each discipline are set and interdisciplinary long-term goals and discharge plans are discussed.

The first step in writing a care plan is to briefly identify (1) specific needs or problems the resident is currently experiencing and (2) specific strengths the resident may exhibit either now or in the past which may help address needs or problems. The stated problem or problems should be those of the individual resident and not those of the staff working with the

resident. The second step in developing a care plan is to set goals that are focused on meeting the resident's stated need or problem and which make full use of the resident's existing strengths if possible. The goal(s) should be reasonable, stated in measurable terms and identified for a specified period of time (usually three months). The final step in writing a care plan is defining behavioral approaches the social service worker should use to help meet the stated goals.

In a federally certified facility, an initial plan of care is to be completed by the resident's physician before or immediately upon admission. Following this, members of the Plan of Care team meet and develop the Overall Plan of Care. The initial plan, with the physician's orders and preliminary directions for care, must be filed in the resident's medical record immediately and be available to all involved in the resident's care.

The various disciplines simultaneously should begin with their own assessment and goal setting processes so that within 14 days, an overall plan with the goals developed by the specialists (including the social service worker) can be combined by a care plan coordinator (usually a facility Registered Nurse) into the Overall Plan of Care. From that point on and throughout the remainder of the

resident's stay in the facility, the Plan of Care team must review and make a written record of progress made towards established goals whenever there is a change in the resident's condition or circumstances or at specific time intervals, i.e. quarterly. This review may be brief and is usually written on a facility plan of care form and notes made on the assessment instrument, i.e. the Minimum Data Set. If the review determines that the previous goals have been met, then different needs should be identified, new goals established, and the process should begin again. If the review determines that specific goals have not been met, the specific discipline team member involved (i.e. the social worker if it is a social work goal) or the entire team as a group should attempt to modify the existing plan by establishing a more realistic goal or goals and workable approaches. NOTE: *The social service worker should also record more detailed information regarding problem resolution or changes in the resident's condition or circumstances in the social services progress notes as needed or at least quarterly if it is a federally certified facility.*

The plan of care provides the social service worker with a unique opportunity to get a total picture of the resident's functioning in the facility environment. It can also be helpful in monitoring changes in the resident's level of functioning and can be used to obtain assistance from the other disciplines in achieving a social service goal (i.e. adjustment to the facility).

The information which can and should be gathered in the plan of care process can assist the social worker in determining needed support or financial services, desired counseling, appropriate room placement, and information for the discharge planning process. If appropriately done, the reader should be able to

identify the resident by reviewing the plan of care. Although computerization of plans of care has made them easier to write, such computerization may not allow for necessary individualization of each care plan for each of the residents.

Social Services Progress Notes

Progress notes serve three major purposes: (1) an official record of ongoing contact or intervention with the resident; (2) a source of documented progress towards

goals stated in the plan of care; and (3) a record of information potentially helpful for all staff involved in the resident's care and treatment.



Current state regulations require that social service progress notes be entered into the resident's medical record as needed. In federally certified facilities, **quarterly** notations are needed so that the overall plan of care can be current. The initial entry should include the observations made while gathering information for the social services history and assessment. The first entry, however, should also indicate the direction the social worker plans to take in assisting the resident in adjusting to the facility. This should be integrated into the initial plan of care, but should also be kept as a social services record.

At a minimum, routine social service progress notes should include the following information:

- 1. Nature and frequency of contact with resident**
- 2. Resident's participation during contacts and visits**
- 3. Significant comments made by the resident**
- 4. Observed changes in resident's physical and/or psycho-social functioning**
- 5. Changes in resident's expressed needs or concerns**
- 6. Changes in resident's strengths and coping skills**
- 7. Description of relevant behaviors observed**
- 8. Resident's socialization and activity involvement**
- 9. Progress made toward plan of care goals**
- 10. Effectiveness of plan of care approaches**
- 11. New goals and approaches as needed**

Progress notes need not be lengthy; however, it is necessary that they be clear and objective. The social service worker **must be as factual as possible** in reporting observations. Interpretations of a resident's behavior or expression should be done with caution and should always be identified as such. The worker should never allow

personal feelings or opinions about residents to enter into the recording process, and maintaining objectivity and avoiding subjective statements, always should be the goal.

In addition to the required notations, other entries in the social service progress notes also may be needed. The finalization of legal matters of a resident, for example, should always be documented. Particular counseling sessions and significant events occurring during the resident's stay in the facility should be written as a separate entry whenever they occur. An old cliché applies here: "If it isn't documented, it isn't done."

Chapter 4

Traditional Social Work Practice and Intervention Skills

Social workers in long-term care facilities may be called upon to provide a wide variety of services for residents. Some of these fall within traditional social services practice such as counseling and treatment planning, informal group work, networking with community agencies, assisting residents with financial matters, working with families and support groups and providing an array of information about the facility and available services. Additionally, social workers often help with less traditional services depending upon resident and facility needs. Such services include assisting with transportation arrangements, conducting resident activities, arranging and/or conducting facility tours and meeting with and/or speaking to community groups.

Traditional Social Work Practice Skills

The social service worker also must be a good observer of human behavior in general and must understand the individual resident well enough to accurately interpret the resident's behavior.

Whatever the activities and services may be, the social service worker needs to demonstrate appropriate empathy, non-judgmental acceptance, and respect for the older adult. To do this the worker must be a good listener who is capable of objective, unbiased interpretation of the information that is heard. *Confidentiality and respect for privacy are critical to developing and maintaining trust in any interpersonal relationship.* These are particularly important in long-term care facilities where maintaining privacy and confidentiality are not only good ethical practice, but required by law. Finally, as with all good communicators, the social service worker must be positive, yet realistic, in their approach to all residents and staff.

It is important when counseling or communicating with a resident that the social worker consider the total person. The social worker needs to examine the social, psychological, physical, spiritual, ethnic and cultural factors that may influence the

resident's behavior. The worker must then be able to communicate and work effectively with families and support groups, other facility staff and outside professionals involved in achieving the resident's identified goals.

Counseling Skills

Counseling is a process that **assists** individuals in learning about themselves. It assists the individual to make decisions, select alternatives, and develop coping skills. The counselor, of course, does not act as a decision-maker, but merely acts as a facilitator in the process.



Professional counseling is an applied field in which a qualified person (counselor) uses behavioral knowledge to assist the client. True counseling can only be provided by a person trained and educated in the behavioral sciences; a qualified social worker, counselor, etc. For the purpose of this manual, counseling in a long-term facility will be considered to consist of three levels: informal, formal, and clinical.

Informal counseling will normally be the level at which the social service worker functions in providing day-to-day information and communication with the residents.

Formal counseling constitutes the implementation of a formalized plan using counseling theory to change behavior, including goals and documentation of interaction and progress. This should be performed by a trained professional including a trained counselor, a master's level social worker, or a bachelor's level social worker with specialized training.

Clinical counseling uses the client/counselor relationship in a treatment program with intensive therapies. A psychologist or other specifically trained professional performs this level of counseling.

Informal or formal counseling may include the following services:

- Making routine rounds to all residents to open lines of communication;
- Helping residents understand and utilize their resident rights;
- Establishing linkages with outside agencies for services needed by residents but not available in-house (i.e. clinical counseling);

**Informal or formal counseling may include the following services:
(continued)**

- Advising residents/families of resources not available in-house (i.e. financial aid or financial services);
- Assisting residents, families, and facility staff when room changes are necessary;
- Assisting family/residents during the admission process;
- Assisting family/residents during the death and grieving period;
- Assisting trained counselors with adjustment/self-help groups;
- Counseling and assisting with discharge plans;
- Making visits on occasion to residents in the hospital to assure continuity of care.

In the area of counseling, caution and discretion must be utilized by the social service designee. Particular areas of discretion include:

- Helping the resident/family identify and effectively evaluate choices (The social service designee should not make the choice);
- Communicating with the mentally ill and their families (Try to get specific guidelines from a physician/psychologist on how to work with both the individual and his/her support system);
- Referring a problem or getting consultation about a problem (Knowing and respecting your own ability usually results in better care for the resident);
- Accepting each resident as an individual who has specific needs, strengths, experiences, knowledge, etc.;
- Maintaining confidentiality of resident/family information. Any information shared with the designee as a facility employee is confidential and should be treated as such.

Crisis Intervention Skills

Throughout the developmental cycle from infancy to adulthood, an individual experiences many stresses. At times, the impact of internal and/or external stressors is severe enough to create a "crisis". A state of crisis is not an illness, but such a struggle with life situations so as to cause emotional distress and behavioral dysfunction. Examples of such crises for older adults include: death of a spouse, retirement, loss of health or mobility, and institutionalization.

The goal of crisis intervention is to intercede with the resident before the maladaptive behavior becomes permanent. Thus, timing is critical. The social worker must recognize that the resident is experiencing a problem and must then begin implementing a plan of intervention. (Also see Chapter 5: Problem Solving and Complaint Resolution).

Facilitating Groups

Many kinds of groups are formed in long-term care facilities for purposes of stimulation, socialization, support, understanding, and information. In fact, many forms of intervention have been developed specifically for group work led by trained social service workers and therapists. This type of therapeutic intervention requires special training and experience of the social service worker. The facility social worker that does not have this specialized training may still be asked to lead non-therapeutic groups for residents, families or support groups. These groups usually come together for a common purpose, such as caregiver support, ongoing care planning, information sharing and updates, etc.

Facilitating these groups may best be accomplished by:

1. Preparing members for group interaction by helping them practice their listening and verbal skills and explaining what will happen
2. Providing an appropriate, comfortable setting
3. Limiting interruptions and distractions
4. Setting group size based on resident abilities, needs or interests
5. Establishing days and times convenient for all members



6. Defining and clarifying the group's purpose and goals
7. Providing meaningful experiences and useful information
8. Encouraging open conversation
9. Facilitating but not dominating interaction
10. Recognizing and respecting each individual's unique form of participation and contribution

Working With Residents with Special Needs: Residents with Cognitive Impairment

Many of the residents in long-term care facilities display some degree of cognitive impairment. This may result from a specific disease, a developmental disability, or physical deterioration associated with aging. The resident's confusion often presents challenges to the social service worker who is attempting to identify, understand and meet the resident's needs.

Many residents with dementia have difficulty communicating their wishes in the traditional ways. Although what they are experiencing may be very common and understandable (i.e. pain, frustration, loss, anger) their ability to express their needs clearly may be significantly impaired and the message may be garbled. Their words and behaviors may not always match. For many residents, this leads to even more frustration and anxiety.

The social service worker must be familiar with the resident so as to recognize the message without needing words or behaviors to explain. *The social service worker must demonstrate great patience in an effort to obtain needed information, and guard against the feelings of frustration that may escalate into crisis situations.* When eliciting information from residents with any

form of cognitive impairment, it is important the environment be free from distraction, there is ample time provided for interaction, the social service worker communicates in a calm manner, the interview is tailored to the individual and the social service worker is prepared to conduct more than one interview if needed. Patience and good observational skills are critical to working with special populations.

Younger Residents

Many long-term care facilities have significant populations of younger, more physically active residents. Younger residents with physical, mental or developmental disabilities may present special challenges for social service and other facility staff in long-term care facilities who traditionally work with predominantly older populations. Younger residents may have difficulty integrating well with other residents, creating their own friendship groups or finding meaning in the activities designed for older, less physically capable residents.



Younger residents, regardless of their functional capability levels, may also be experiencing many of the typical social, emotional and physical changes associated with adolescence and young adulthood. *These may be in serious conflict with the social, emotional and physical changes and service needs of the older residents.* The social service worker must be attuned to the developmental needs of these younger residents as well as those of the older residents. Common activities and services may be appropriate for some residents depending upon interests and capabilities. However, to more adequately meet the social and emotional needs of each population, the social worker should also be aware of age-related needs.

The challenge of providing activities, outside experiences, and interpersonal opportunities which are age-appropriate and geared towards these different levels of functional capability and interest will generally require creativity and persistence from the entire multidisciplinary team. Maintaining the quality of care for one group of residents should not come at the expense of another group's treatment needs.

Low-Need Residents

High-functioning residents with few day-to-day needs from facility staff may present yet another challenge to the social service worker. If the low-need individual resides in a facility associated with a residential care facility, a variety of support services and social opportunities may be available to these low-need residents through the residential care facility. *However, staff in facilities with fewer resources may find themselves focusing on the higher-need residents and abandoning the low-need resident to his or her own devices. It should be noted that it is difficult to do both ends of the continuum effectively.*

The social service worker should be alert to the low-need resident's social, interpersonal, and companionship needs as well as subtle or sudden changes in their overall functioning.

Individuals and resident couples with few apparent needs may indeed require only support services, socialization opportunities and non-obtrusive observation. Staff need not feel obligated to "find a problem" where none may exist. However, staff must be continually aware of gradual and continuing changes in functional levels which may indicate a need for changes in care plans or services. As with younger residents, the challenges of low-need residents require the full efforts of the multidisciplinary team. It is essential the lines of communication be left open. Frequent informal contacts should be maintained to establish trust.

Chemical and Physical Restraints

With the implementation of OBRA '87 and the Federal Nursing Home Reform Act, there has been an increased emphasis on minimizing the use of all chemical and physical restraints. The mentally confused or disoriented resident may display disruptive or aggressive behavior out of frustration or confusion. If the behavior becomes extreme or dangerous to the resident or others, restraints are used; often without a full evaluation of what is causing the behavior and or exploring reasonable alternative approaches. The social service worker's ability to communicate with the resident is critical as there is often some element from the person's current condition (frustration,

impaired communication skills, physical discomfort) or past history which is contributing to the wandering, screaming, disruptive or aggressive behavior. Talking with the resident and the family member to identify behavior patterns may be helpful. Recognizing such things as the time of day the resident becomes most agitated or identifying activities or sounds which are disturbing to the resident may also provide clues which may improve communication and lessen the need for restraints.

It is imperative that families understand the restraint policies of the facility. Often the family demands the resident be restrained even though there is no medical reason to do so. In recent years there has been a great quantity of material published on this subject. If the facility does not have such resources on hand, the Department of Health and Senior Services has some excellent material available free of charge.

Chapter 5

Problem Solving and Complaint Resolution

It is important to recognize that problems and complaints are **normal**. Environments in which people live, work, and interact together will always include problems, complaints and the potential for ongoing interpersonal conflict. In fact, the greatest percentage of the social service worker's time will be devoted to problem solving and complaint resolution.

Problems, complaints and interpersonal conflict will always exist even if never expressed to staff. The social service worker can save staff and residents much difficulty if the situations which lead to these problems are identified early and steps are quickly taken to problem solve at an early stage. Problems in long-term facilities rarely resolve themselves and without attention, usually get worse.

Unidentified problems are likely to lead to larger problems or at a minimum will result in a build-up of resentment and ill will. Problems that are never resolved can result in chronic emotional pain. At the point a resident's usual coping strategies fail, a growing sense of helplessness may make the search for solutions even more difficult. The original problem may no longer be the issue if an effective solution or response is not found. The actual problem becomes the failure to find an effective solution or response.

There are three principles that work against effective complaint resolution:

1. People tend to assume that if complaints are not vocalized they do not exist;
2. People tend to take complaints too personally;
3. People tend to become defensive and try to justify the behavior or intent in question, rather than working for resolution of the problem.

It is the responsibility of all facility staff to help in the early identification and effective resolution of problems and complaints. Often a family member or resident will direct the complaint to the nurse assistant, telephone operator, or dietary aide. This person may be the most accessible but not necessarily the best able to resolve the issue. If this occurs, the staff member receiving the complaint must convey the problem or complaint to the appropriate staff member.

The social service worker should take the initiative in this process and assure that there is a facility policy in effect and that all staff are aware of how to handle complaints. Missouri Statute (198.088.3 RSMo) requires each facility to establish written procedures by which complaints and grievances may be

Each facility must also designate a full-time staff member to receive all grievances. It is the social service worker's job to ensure that all residents are advised of and understand the grievance policy and procedures and that they are introduced to the staff member whose job it is to receive complaints. In fact, it is often the social service worker who is the designated grievance staff member.

Problem Identification

The first step in problem resolution is problem identification. It is impossible to solve a problem if it has not or cannot be identified. The social service worker should create an atmosphere in which the expression of grievances is possible and safe. In order to do this the social service worker should attempt to lower the hurdles a person must cross in order to get the problem heard. Methods to help accomplish this include:

1. Maintaining open communication with family and residents: Be

accessible to them. This may require initiating conversation and contact with both residents and families. It may be necessary to maintain some office hours in the evening and on weekends;



2. **Using suggestion boxes** and programs which will help identify problems that people are unable or unwilling to bring to your attention. It is also wise to have a box where people can leave a note asking for a return call. Much of the social worker's day is spent outside the worker's office making contact difficult for people;
3. **Simplifying and publicizing the formal grievance process** used by the facility;
4. **Establishing a method to allow staff to make known their problems and complaints concerning residents;**
5. **Using third party assistance, such as the Ombudsman Program:** This is often helpful in identifying and resolving problems the residents and family members are reluctant to discuss directly with facility staff. The Ombudsman Program (1-800-309-3282) is often helpful in dealing with on-going concerns. While the facility staff may not have adequate time available to sit and listen to the residents' concerns in a timely manner, the Ombudsman Program staff or volunteers can spend the time necessary to hear complaints and grievances with an objective ear. Sometimes the immediate opportunity to air grievances and discuss concerns will result in a lessening of tensions and even workable solutions.
6. **Using resident and family councils:** These may be an effective means to identifying common concerns of residents and families. (See How to Organize and Direct an Effective Resident Council published by the Missouri Long-Term Care Ombudsman Program).

Problem Resolution

Once the problem or complaint is identified there is a good chance of resolution. Results from the Ombudsman Program indicate that approximately 75% of the complaints received are totally or partially resolved.

Often the social service worker's most important role in the problem-solving effort will be in identifying various alternatives in resolving the problem. Many people only take the time to think of one possible solution. If they find that it is not workable, they may give up on the problem. The social service worker must be creative in problem-solving and willing to consider and incorporate as many resources for resolution as possible. Engaging the family in problem-solving may uncover resolutions not previously considered. The effective problem-solver must remember that there is usually more than one solution to a problem.

The following steps represent one approach to problem-solving:

- S**tate your problem
- O**utline your response
- L**ist your alternatives
- V**iew the consequences
- E**valuate your results



The final step of evaluating your results is extremely important as it will signal whether the problem is truly resolved or only that a new solution must be found.

It is important to keep the resident and/or family member(s) informed of the progress on the complaint issue. Although steps may be taking place that will lead to resolution, if the progress is not communicated in a timely fashion the complainant will assume nothing is being done. This sense of abandonment may lead to frustration, aggression, depression or some other negative behavior.

The social service worker also may play an important role in developing effective and constructive complaint resolution and problem-solving skills in residents and family members. Guidelines for family members include:

- 1. Speak up.** Do not be afraid to voice your concerns. Do not assume people should know how you feel; they do not. Facility staff and administration are not mind readers. They cannot solve problems that they do not know exist.
- 2. Start intervention with the staff member most directly involved,** but be prepared to move up the chain of command if the problem is not solved.

- 3. Remain calm while discussing the problem.** Avoid anger, sarcasm, or threats. State the facts as clearly and succinctly as possible. Do not attack the other person, question their intentions or challenge their sincerity.
- 4. Discuss and document.** Serious complaints or repeated minor or unresolved problems should be discussed with the person in charge and documented in writing.
- 5. Seek outside assistance.** If internal efforts are ineffective, consider contacting the long-term care ombudsman or the state regulatory office.



The time, effort, and dedication directed to effective problem solving and complaint resolution will be beneficial. Successful problem solving in long-term care facilities results in better care, an improved atmosphere, happier residents, less stress among staff members, and improved public relations.

Chapter 6

Support Services

The social service worker frequently acts as an intermediary between the resident and support services. These support services may be found inside or outside the facility. The social service worker may simply provide information to the resident or family support members regarding these services or it may be necessary to intercede on behalf of the resident. The role a social service worker takes in this process will depend upon the needs and requests of the particular resident or family and the policies of each facility. *Residents may have needs of varying complexity and in some cases the resident may be unwilling or feel unable to utilize the needed available support services.* If so, the resident's wishes must be respected. The social service worker should not exert pressure or be coercive. However, if a good working relationship between the social service worker and the resident has been established, the social service worker may be able to help the resident understand the need for the service.

Physical Abuse, Psychological Abuse, Neglect, or Financial Exploitation

Older adults are often vulnerable to abuse, neglect, or exploitation by a variety of people close to them. Although an abusive situation may be evident to the social service worker or other staff member, the older adult may not always perceive the behavior in the same way or may be reluctant to express his or her concerns. Unless it is an emergency situation, care must be taken to investigate before accusations are made or any potentially intrusive action is taken.

If a social service designee encounters a situation which raises any suspicion of physical or psychological abuse, neglect, or financial exploitation of a resident, whether caused by a facility employee or someone else, the social service worker must act as an advocate for the resident.

Definitions and examples of abuse/neglect include:

- **Physical abuse** - conduct that results in bodily harm.

Examples: the infliction of physical pain or injury, physical coercion (confinement against one's will) slapping, sexually molesting, cutting, burning, or physically restraining.

- **Psychological abuse** – threats that result in mental distress, fear, fright, and/or emotional disturbance.

Examples: the infliction of mental anguish, name calling, treating as a child, insulting, ignoring, frightening, humiliating, intimidating, threatening, or isolating.

- **Negligence** - breach of duty or careless conduct that results in injury to an older person or in a violation of resident rights.

Examples: Passive neglect: the unintentional failure to fulfill a care-taking obligation with no conscious or willful attempt to inflict physical or emotional distress; failure to provide care based on lack of knowledge. Active neglect: the intentional failure to fulfill a caretaking obligation, conscious and willful attempt to inflict physical or emotional stress or injury, or deliberate denial of food, eyeglasses, hearing aids or dentures.

- **Financial exploitation** - theft or conversion of money or property belonging to the older person by relatives or caregivers, sometimes accomplished by threat, deceit, or battering.



Examples: The illegal or unethical exploitation and/or use of funds, property, or other assets belonging to the older person.

State law **mandates that any facility employee** suspecting abuse or neglect of a resident must report or cause a report to be made to both the appropriate facility staff member and/or to the Missouri Department of Health and Senior Services. The **Missouri Department of Health and Senior Services Elder Abuse and Neglect Hotline (1-800-392-0210)** is a statewide toll-free number which should be called in such cases. In most facilities the administrator would be expected to handle these situations

and initiate an investigation. In that case, the social service worker should immediately bring the situation to the administrator's attention. Although the administrator generally makes the report, in some instances the worker may be asked to make the call. A Department of Health and Senior Services staff member will promptly investigate the complaint, determine if it is substantiated, and take appropriate steps to remedy the situation. The facility also will investigate the situation so that if the complaint is valid a remedy is immediately enacted. The social service worker may play an important role in alleviating the stress residents or families may experience during the initial situation or as the investigation proceeds.

Financial Assistance:

Medicare, Medicaid, Private Insurance and Long-Term Care Insurance

Financial assistance and/or handling a resident's business affairs is/are the most frequent request(s) for assistance. It may be necessary for the social service worker to assist the resident or family in applying for financial assistance and understanding the resources available. Therefore, a separate chapter on Financial Resource Management is included in this book (See Chapter 7). The social worker will need to discuss with the resident and family the available payment options and insure appropriate forms are completed.

Many changes in financial assistance have occurred in the past decade. As an example, a number of changes have occurred in financial assistance with and insurance coverage for long-term care. New private insurance options are available and there have been changes in the traditional public health care insurance programs. These should be discussed with the resident, appropriate family member, or the resident's

administrator to make certain that resources and benefits are clearly understood.

Many people are surprised to learn that Medicare does not pay for their nursing home care. Medicare is a hospital and medical insurance program of the federal government that covers people over the age of 65, or persons of any age who have been

disabled for at least two years. Contrary to popular opinion, Medicare does NOT cover most of the costs of nursing home care. *It will pay a limited number of days of nursing home care provided the person has had a hospital stay of at least three days immediately prior to the nursing home admission and if the person is admitted to the nursing home for skilled nursing or rehabilitative services.* Medicare will not cover nursing home expenses if the service needed is primarily custodial care. Custodial care is assistance with personal needs that could be provided by persons without professional skills. (See the most recent Medicare and You available from the Social Security Administration.)

Medicaid is a federal government program administered by each state to provide medical services for persons with little or no income. *Medicaid will pay for nursing home services provided the person meets income and medical eligibility requirements.* In order to accept Medicare or Medicaid residents, long-term care facilities must be participants in the Medicare and/or Medicaid program. Not all facilities participate in these programs.

Private health care insurance plans and long-term care plans vary in their terms and benefits. It is important to explain the government programs, eligibility, and payment issues to the resident and family as well as to direct them to their insurance agents for complete information on benefits and coverage provided by their individual private plans. A complete picture of the resident's financial resources must be determined at the time of admission. Current information is crucial. *See Chapter 2 regarding the DA124C form.*

Legal Issues

When a resident is having difficulty handling personal affairs, financial assets or business matters, it may be necessary for another party to act on the resident's behalf. Frequently the social service worker will be the first one to become aware of problems in this area. The selected alternative will depend on the resident's level of functioning and the issues involved.

If the resident is sufficiently capable, he/she may need to grant someone a **Power of Attorney** or establish a **Trust** at a bank to be administered by one of their officers. Another option is that the resident could designate a **Personal Custodian** (established

by the Missouri Adult Personal Custodian Act of 1986). This process has some additional safeguards for the resident over a Power of Attorney or Durable Power of Attorney.

For the protection of the resident, an attorney should draw up the documents and assist the resident. However, the social service worker may need to assist a resident in obtaining a lawyer and following through with the process. Regardless of the individual's need, as the resident's advocate, the social service worker should become familiar with the alternatives and the advantages and disadvantages of each approach.

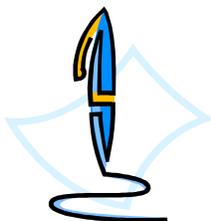
When a resident does not have the mental ability to understand all relevant information and cannot reach or carry out appropriate decisions, it may be necessary to arrange for legal protection through a court appointed guardian (to handle matters related to the person), or conservator (to handle matters related to property.)

The involvement may be as simple as providing information to the resident's family so they can take the necessary legal steps. If, however, the resident does not have a family or someone else to initiate the proceedings, the social service worker may be more heavily involved. Contact should

be made with the County Probate Court to obtain forms and instructions on initiating the process. As Missouri law provides for limited Guardianships or limited Conservatorships, a judge will indicate after a hearing what, if any, rights a resident will retain. A facility should keep a copy of the court order with the resident's records and if the resident retains some rights, these should be protected. (For further information see [Guide to Guardianship and Conservatorship in Missouri](#), Missouri Department of Health and Senior Services). PLEASE NOTE: Guardianship should be utilized only as a last resort.

Witnessing Forms

A social service worker may be asked to witness a resident's signature on a document or to assist in getting a resident to sign a document. **The policies of each facility should be strictly adhered to in these instances.** By signing as a witness on a



document, a social worker is attesting to the fact that the signature on the document belongs to the resident who is addressed by the document. If a worker believes a resident is being forced or coerced into

signing a document or that the resident does not understand the meaning or consequences of signing the document, the worker should consult the administrator before proceeding to act as a witness. *The social service worker should never force a resident to sign a document.*

If a resident does not speak, understand, or read English well enough to understand the nature and consequences of the document which he/she is being asked to sign, an appropriate interpreter or objective family member who can interpret should be asked to assist before any further action is taken. It may be wise for the facility administrator to maintain a resource file of community residents who may be called upon to act as interpreters when the need arises. The social service worker may even consider acquiring basic skills in another language common to the local area.

When a resident is physically unable to put his/her signature on a document because of limited eyesight or other disabilities, it may be necessary for the resident to make an "X" and have two other persons witness the "X".

Again, if there is some question about the resident's willingness to sign the document or ability to understand the nature and consequences of what is being signed, the nursing facility's administrator should be consulted before proceeding with this activity. *All events of this nature, in which the social service worker is a participant, should be recorded in the medical record.*

Interdepartmental Staff Meetings/In-service Training

The social service worker may participate in interdepartmental staff meetings or be asked to assist in staff training sessions. Each facility determines what type of interdepartmental staff meetings is appropriate for the residents and the staff. In-service training may be interdepartmental or departmentally specific, but the social service worker should be involved on a regular basis to help facility staff understand residents' rights and other issues related to the personal lives of residents.

Chapter 7

Financial Resource Management

The goal for the social worker assisting with financial resource management is not to act as a financial advisor but to act as a source of information regarding available governmental or private funding sources and to assist in the completion of the associated paperwork. Whether handled by the social worker or the resident, financial resource management may have beneficial effects both for the resident and the facility in that it:

- Prolongs financial independence of the resident;
- Preserves resident dignity;
- Provides comfort and security for the resident who wishes to leave his/her estate for heirs or does not wish to become a financial burden for children;
- Preserves equitable payment for care received from the nursing home.



The person providing these services in the facility need not be a social worker at the bachelor's or master's level, but needs to be someone with a working knowledge of the more common government programs such as Medicare, Medicaid, Social Security, and the Veterans Administration. It is important to establish a contact person in each of these offices to whom referrals can be made and from whom reliable information can be obtained easily.

If the social service worker is responsible for assisting residents in financial resource management, some of the typical specific functions include:

1. Assisting in the maintenance of the resident's personal funds: When appropriate and if the resident is entitled, governmental and private sources should be contacted in order to maintain personal funds. For example:

- a. The social history reveals that the resident is a WWII veteran and may be eligible for increased benefits if nursing facility care is required. The social service worker would connect the family

with the appropriate VA benefits officer and assist with paper work if necessary.

- b. The resident may have additional private insurance which may help cover medications or doctor visits. The family may need help in completing forms, determining eligibility, or interpreting policy.

2. Assisting in completing applications for financial aid: The first step would be to determine eligibility regulations for the program, then link the resident or resident's family, with the appropriate agency. Because paperwork may be confusing and difficult for the resident or the family to read or understand, the social service worker may be needed to explain information requested and see that the applications are complete. The paperwork may be an overwhelming problem for an older person with poor eyesight and no previous experience in completion of financial aid applications.

3. Assisting in filing Medicare and/or insurance claims: Some facilities may have staff in the business office who handle these tasks. Because of the potential workload involved with assisting in these tasks, residents and/or their families should be encouraged to learn to file claims themselves. However, they may need help from the social service worker for initial instruction or help with special problems. The social service worker may also direct specific problems or questions to the appropriate agency for a solution. (The CLAIM Program is a resource which the social service worker will want to become familiar. CLAIM is the health insurance counseling program, 1-800-735-6776.)

4. Assisting with verification for Veterans Administration, railroad retirement, and other pensions: This task involves outside agencies which request resident information in order to verify need. Because of the social worker's knowledge of the resident and the facility, they may be the appropriate facility contact person to handle these inquiries. It is important to check facility policy regarding the sharing of information with outside agencies.

5. Obtaining signatures on monthly income checks: Pension, Social Security or other checks need resident signatures before the business office can credit the resident's account. Checks for residents signing with an "X" must be co-signed by witnesses. Residents with cognitive impairment or mental disabilities may need special assistance with their income. The social worker may assist effectively in all these situations.

Chapter 8

Volunteers

The use of volunteers will enhance the services that are offered in a facility. Volunteers often can help dispel myths surrounding the facility, misperceptions of older adults in general. They also bring additional personal contact to the resident, provide needed and/or new services to the residents as well as serve as a liaison between the facility and the community. Volunteers may also be recruited for specific purposes such as serving as interpreters or readers for non-English speakers. The presence and efforts of volunteers may add in many subtle ways to the quality of life for the residents and to the overall environment and atmosphere of the facility. Volunteer programs generally have the following four objectives:

1. To improve and increase services for the residents;
2. To assist professional and paraprofessional staff by providing non-technical services for residents, thus allowing regular staff more time for individual care requiring their expertise;
3. To facilitate meaningful involvement between community members and residents both within the facility and in the community;
4. To enhance mutual understanding and respect among the facility staff, residents and the larger community.

A regular staff member should be designated as the Volunteer Coordinator. This is often the social service worker or activities director. The coordinator should personally interview potential volunteers to determine their particular interest(s), capabilities, skills, or background experiences. The level of commitment and the importance of reliability and confidentiality should be discussed at the outset. A regular schedule of contact between the volunteer(s) and the Volunteer Coordinator should be in place to make sure the volunteer(s) remains current about their assigned duties and is satisfied and comfortable with the resources available and the tasks being assigned.



Volunteer Services

Although volunteers can serve in every department in a long-term care facility, possible assignments should be cleared with the administrator and the appropriate department head. Duties should be clearly defined and time should be allotted for orientation and continuing in-service training. If the Volunteer Coordinator is not the social worker, then the social worker must inform the Volunteer Coordinator of the Social Service Department's needs. Other disciplines may not recognize the substantial contribution volunteers can make to the Social Service Department.



The facility should have in its policies and procedures manual a specific section dealing with volunteers. This section should include information and policies on recruitment, screening procedures, the volunteer orientation program, ongoing in-service training, and a current list of duties appropriate for volunteers assigned to the various departments. Consideration also should be given to some form of volunteer recognition program or ceremony. Some facilities present certificates of appreciation; others hold special recognition dinners or teas which may include the residents and their families; others give periodic public recognition in the news media.

Good planning is the key to success. Before attempting to initiate a full-scale volunteer program, test the system. Sometimes a family member or other person who frequently visits a resident in the facility will agree to help. If the volunteer has a positive experience the word will spread. The state or regional ombudsman could also be a starting point. For information about the Missouri Long-Term Care Ombudsman Program, contact the Missouri Department of Health and Senior Services or the local Area Agency on Aging office.

The importance of screening and training can not be overemphasized. State regulations require that volunteers be screened through the Elder Disqualification List.

Chapter 9

Staff Training and Development

Staff training and in-service development is very important for the social service worker. *This area cannot be over-emphasized.* Because the social service worker routinely interacts with many people and encounters a variety of problems and situations all requiring a general knowledge of many disciplines, training in a variety of areas is not only helpful but *essential*.

The formal education, background and professional experiences of individuals filling social service positions in long-term care facilities are quite varied. The formal education level may range from a high school diploma or GED to a doctoral degree in a field other than social work.

The background and professional experience of the social service worker in long-term care facilities also varies greatly. It may range from a dietary or housekeeping person familiar with the facility to a minister or retired military officer embarking on a post-retirement career. While some of these individuals perform well in the social service role, rarely can this be sustained without additional and ongoing training, development, and in-service support.

Administrators and supervisors should recognize the value of ongoing training, professional development and organizational affiliation as necessary for all staff to sustain effective job performance. As with all staff, training, development, and professional affiliation generally lead to better job performance and higher levels of personal satisfaction for the social service worker. The social worker should actively seek in-service and training opportunities and discuss staff development leave time or compensation with the administrator. The social service worker should also be aware of and encouraged to take advantage of development and training opportunities within their own professional organizations or staff affiliations (i.e. National Association of Social Workers, Social Services Association of Missouri-SSAM). Membership in professional associations offers a rich array of resources, training, networking, and advocacy opportunities for both experienced and new social service workers.

Critical Areas of Training Needed by the Social Service Worker

Although there are no limits to how much the social worker needs to learn about human interaction, there are areas which are crucial to effective job performance in the long-term care facility. Among these are:

- **The Physiology of Older Adults**

The physiology of aging is a vital area of information for the social service worker as there are many physiological problems and disease processes which effect the behavior of aging persons. Knowledge of the etiology (causes) and natural courses of diseases which affect these age groups will help the social service worker to interact more effectively and to more thoroughly understand some of the individual resident behaviors. Training in infection control and disease prevention is also crucial in the long-term care facility.

- **Mental Health of Older Adults**

Many residents in long-term care facilities display varying degrees of mental confusion and/or depression which may affect their behavior. There is also a growing population of long-term care residents with significant mental health problems and/or diseases. While appropriate professional medical and psychological services are critical in evaluating, developing and carrying out treatment plans for these individuals, it is very important for the social service worker to be knowledgeable about many types of mental health problems and to have appropriate training in recognizing behaviors, understanding needs and barriers, communicating effectively, and providing appropriate services for these residents. Specific training in working with special populations, such as Alzheimer's residents, is crucial.

- **Social Gerontology**

Social gerontology as a field relates to the study of the social behaviors of older adults as a client group. The social service worker can provide better services to this group if there is some understanding of the social life and interaction with others.

- **Funding Sources for Long-Term Care**

Because payment for the services provided to residents of long-term care facilities comes from many sources, the social service worker needs to have knowledge of all these resources. These sources may be state or federal, public or private. Some of the usual funding sources are: (1) State Family Support Division; (2) State Department of Mental Health; (3) Veterans Administration; (4) Social Security (on a limited basis); (5) private pay by the resident, and (6) insurance benefits.

- **Information Referral and Networking**

Training in the area of information and referral is crucial for the social service worker. Good discharge planning, treatment planning, and effective service delivery all require knowledge of the available services and resources of other agencies. The social service worker then is able to provide better service for the resident should referral to outside services become necessary.

- **Government and Industry Regulations**

The challenge of staying current on changes in government, industry, or accreditation regulations and policies (e.g. HIPAA regulations, Missouri Department of Health and Senior Services policies, licensure regulations, etc.) can seem overwhelming. The social service worker needs specific and ongoing training in new regulations and policies. He/she also needs training on how to implement these new practices and how they will affect his or her individual job duties, facility, and resident care.

- **Communication and Leadership Skills**

Social service workers must communicate with families, residents, other staff and outside professionals on a daily basis. Learning how to express needs and concerns clearly, how to listen effectively, and how to ask questions will facilitate good and accurate communication. The social service worker may be expected to lead many small group sessions or major projects within the facility. Solid communication, leadership, organizational and motivational skills are invaluable to the effective social service worker.

- **Individual and Group Counseling**

The social worker should receive training in formal and informal individual and group counseling. An important part of the social worker's role may involve these types of counseling opportunities. Many problems and issues that arise in the daily life of residents in long-term care facilities (i.e. conflict resolution, roommate concerns, interpersonal communication) are best addressed in groups. Generally this type of individual and group work does not require highly developed therapeutic skills or professional training, but the social service worker does need a general knowledge of techniques in group and individual communication, problem identification, and problem resolution. If the social service worker suspects that more significant problems are present, referral to a trained therapist or counselor should be initiated.



- **Types of Community Placement**

Social service workers need training in the types of community placements and service alternatives available for their residents. State and federal laws and regulations mandate that clients be placed in certain facilities depending upon treatment needs, their physical and mental levels of functioning and their functional capabilities. Current knowledge of available facilities and services will help the social service worker assist the administrator with decisions about accepting a new resident, redirecting and/or referring the resident to a more appropriate facility and/or suggesting transfer.

- **The Multidisciplinary Team**

The social service worker generally works as a member of a multidisciplinary team. In addition to the social service worker, the team may include therapists, nurses, doctors, nursing assistants, clergy, dietitians, activity directors and volunteer coordinators. Social service workers need a good working knowledge of each member's role in the team and the specific expertise he/she brings to the treatment planning process in order to meet the residents' total needs.

- **Advocacy Role**

Social workers are often the frontline advocate for the resident. Very often they are the only voice for a resident with crucial needs. Social service workers should be trained in effective advocacy techniques so that the resident's individual needs are met within the facility's policies, guidelines and resources.

- **Medication**

Social service workers should have formal, organized training in recognizing the potential side effects and complications of drugs commonly prescribed for residents. The material included in Medication Technician or Level I Medication Aide training manuals should be made available to social service staff for reference to assist in understanding a resident's behavior.

The preceding by no means represents an all-inclusive list of areas needed in staff development and training for the social service worker. However, it does cover most of the crucial areas needed in training. There are many educational institutions, agencies, organizations and professional groups which offer topical training for personnel who are working with older adults. Such training also may be available through professional organizations and interest groups.

The social service worker, as well as every other staff member, needs to attend professional meetings which will allow him/her to share ideas and gain new knowledge and insight into the issues confronting the older adult. Every effort should be made to allow and encourage social service workers to attend professional meetings, participate actively in their professional organizations and to bring new information back to the facility and other staff. Sharing this new information may be accomplished through in-service training or briefings by staff members who have attended meetings or conferences. The same sharing may be accomplished through informal groups meeting to discuss particular issues within the facility. Although enabling staff to attend and participate in professional activities is very difficult for long-term care facilities which are often short of staff, time and money, the long-term benefits of encouraging participation far outweigh the immediate sacrifices necessary to get staff to meetings.

Stress Management for Social Service Workers/Designees

The issue of stress management is being handled separately because of its importance as an area of training and development for a social service worker. It is probably the most critical area of needed training.



The social service worker wears many hats in a long-term institution; a few of which may be recreational therapist (or assisting in that process), clothing shopper, transportation person, counselor, and mediator. The stress of many job functions, many needs of residents, and many different people giving directions may become overwhelming. To help manage some of this ongoing stress, the social service worker needs as much training in time management and stress management as possible. Since many administrators admit they know very little about the area of social services, a social work consultant may be a valuable asset to both the facility and the resident social worker. This is particularly true if the social worker is new to the field. A professional social work consultant can link the worker with a support network within the field of social work. In addition, the worker will have someone with whom to discuss and examine problems and frustrations and at the same time get some evaluation of personal effectiveness.

Whether or not a consultant is available, the social service worker needs the assistance and support of his/her administrator and supervisor in order to eliminate or more effectively handle some of the stress on the job. One way this may be accomplished is by examining the functions of the worker then evaluating them according to priority and time needed.

- **Workload/Caseload** - Can the worker effectively perform the job as assigned or is the workload too heavy or too varied to do a good job?



If there are more than 60 residents per social worker, the workload is probably too great.

- **Job Description** - Does the social service worker have a job description on file in the personnel office? Can the worker prioritize his/her time?

- **Job Status** - Is the worker viewed as an important part of the health care team and respected by administration and others?
- **Accountability** - To whom is the worker responsible and for what? It should be clear to the worker who the "boss" is and to whom the worker is accountable.
- **Scheduled Hours to Work and Rate of Pay** - How many hours is the worker required to work and what is the rate of pay to be received for that work? This needs to be clear and in writing when a person takes the position of social service worker.

The administrator, the worker, and other facility staff need to be clear on the social service worker's role in the facility. In smaller facilities with limited staff, the social service worker may find himself/herself being asked or expected to perform duties far outside his/her field simply because he/she is the only additional staff person available.

For some social workers, this is not particularly stressful. However, for others, it may present a number of problems including time away from traditional social service tasks. Consistent, clear and open communication by all involved is vitally important to maintain good

working relationships. When this has been established, the social service worker and the administrator need to establish what is referred to as the worker's "comfort zone". The comfort zone is the amount of work which the worker can perform and perform effectively within the allotted time frame.

Glossary

- Activities of Daily Living (ADL).** Activities of daily living required for people to live on their own. These include such tasks as bathing, getting in and out of bed or a chair, using the toilet and dressing.
- Advance Directive (AD).** Sometimes called Advance Medical Directives (AMDs), a legal document authorizing decisions to be made, typically involving the withholding of lifesaving medical treatment, should circumstances arise in which a person has lost the capacity to make those decisions for himself or herself.
- Assisted Living Facility (ALF).** Residential facilities that provide limited supportive care and permit a high degree of independence.
- Case Manager.** An individual who coordinates and oversees other health care workers in finding the most effective methods of caring for specific patients or residents.
- Centers for Medicare and Medicaid Services (CMS).** The federal agency within the Department of Health and Human Services (DHHS) established to administer the Medicare, Medicaid, and State Children's Health Insurance Programs. The agency was formerly known as the Health Care Financing Administration (HCFA).
- Coinsurance.** A provision in a member's insurance coverage that limits the amount of coverage by the plan to a certain percentage, commonly 80%. Any additional costs are paid out-of-pocket by the member.
- Conservator/Conservatorship.** In law, the appointment of an individual (custodian) with legal responsibility for another person's welfare, specifically matters related to property.
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).** A federal law (P.L. 99-272), that requires all employer-sponsored health plans offer certain employers and their families the opportunity to continue, at their personal expense, health insurance coverage under the group plan for up to 18, 24, or 36 months, depending on the qualifying event, after their coverage normally would have ceased (e.g. due to the death or retirement of the employee, divorce or legal separation, resignation or termination of employment, or bankruptcy of the employer).
- Continuing Care Retirement Community (CCRC).** A type of residential facility that offers a combination of housing and health or supportive services at various levels of care. Residents generally pay a monthly fee for food, rent, utilities, housekeeping, and nursing care.
- Co-payment.** A specified amount that the insured individual must pay for a specified service or procedure (e.g. \$10 for an office visit).
- Discharge Planning.** A part of the resident management guidelines and the nursing care plan that identifies the expected discharge date and coordinates the various services necessary to achieve the goal.
- Diagnosis Related Groups.** Distinct categories of diseases that are the basis for Medicare's financial reimbursements to hospitals.

Durable Power of Attorney for Health Care (DPA). (Chapter 404 RSMo).

A legal document in which a competent adult may authorize another competent adult to make his or her health care decisions should he or she become incapacitated or otherwise unable to make those decisions independently.

Guardian/Guardianship. In law, the appointment of an individual (guardian) with legal responsibility for another person's welfare, specifically matters related to the person.

Health Insurance Portability and Accountability Act (HIPAA) (Title II, Subtitle F).

Title II, Subtitle F of HIPAA gives the Department of Health and Human Services (DHHS) the authority to mandate (*require*) the use of standards for electronic exchange of health care data (*how personal health care information is transferred from one agency to another electronically*); to specify what medical and administrative code sets should be used within those standards (*which codes you should use*); to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information (*what you have to do to ensure privacy and confidentiality*).

Health Maintenance Organization. A managed care company that organizes and provides health care for its enrollees for a fixed pre-paid premium regardless of service usage.

Hospice. An organization that provides health services to dying persons and their families and support groups. Hospice is a service covered by Medicare.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A national organization of representatives of health care providers: American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and consumer representatives. The JCAHO offers voluntary inspection and accreditation on quality of operations to hospitals, nursing facilities, continuing care retirement communities, and other health care organizations.

Managed Care. A health service approach that combines insurance, care providers, and facilities within a single system designed to reduce costs.

Medicaid. A joint federal/state/local program of health care for individuals whose income and resources are insufficient to pay for their care, governed by Title XIX of the federal Social Security Act, and administered by the states. Medicaid is the major source of payment for nursing home care of the elderly.

Medicare. A federal entitlement program of medical and health care coverage for the elderly and disabled, and persons with end-stage renal disease, governed by Title XIX of the federal Social Security Act, and consisting of two parts:

Part A: for institutional and home care including hospice care

Part B: for medical care

Medi-Gap Insurance. Also known as Medicare Supplemental Insurance, a type of private insurance coverage that may be purchased by an individual enrolled in Medicare to cover certain needed services that are not covered by Medicare Parts A and B (i.e., "gaps").

Missouri Association for Social Welfare (MASW). A citizen membership organization founded in 1910 to promote social causes and public welfare. MASW has evolved into an organization advocating for changes in public policy to improve social conditions.

Missouri Care Options Program (MCO). A state program implemented in 1992 by the Department of Health and Senior Services which works to promote quality home and community-based long-term care, moderate the growth in Medicaid payments to nursing homes by offering choices for home and community-based care, and to enhance the integrity, independence and safety of Missouri's seniors and adults with disabilities.

Missouri Long-Term Care Ombudsman Program (1-800-309-3282).

A federal/state program of staff and volunteers serving residents of nursing and residential care facilities to provide support and assistance with any problems or complaints. Individual volunteers are recruited by the Area Agencies on Aging or their service providers. Following screening and training, the volunteer is assigned to a facility. The volunteer receives orientation to the facility and its procedures prior to making regular contact with the residents.

National Association of Social Workers (NASW). With a membership of 150,000, NASW is the largest organization of professional social workers in the world.

The organization works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies.

Omnibus Budget Reconciliation Act of 1987. Federal budget legislation that included the Nursing Home Reform Act.

Personal Custodian. A legally appointed individual who holds, manages and invests property for another individual who has requested custodianship.

Power of Attorney. A power of attorney is created by a written document naming the "principal" (person desiring the power of attorney) and the "attorney in fact" (person who will act in the principal's name) along with the specific powers given to the attorney in fact.

Public Administrator. County elected official who, as part of their job, may be appointed as guardian and/or conservator in certain cases.

Residential Care Facilities. Small group homes that provide mainly custodial care for individuals who do not need the intensive support of a nursing home.

Substituted Judgment. The process of making health care decisions for an incapacitated person based on an effort to determine what that person would want under the circumstances at hand.

Supplemental Security Income. A federal benefit program that provides at least a minimum income to low-income individuals who are aged, blind, or disabled.

Witnessing a Document or Signature. By signing as a witness on a document, the individual is attesting only to the fact that the signature on the document belongs to the individual who is addressed by the document. The witness may further attest to the fact that any information recorded on the document in front of the witness was indeed provided by the individual who is addressed by the document.

Will. A legal declaration of a person's desires concerning the disposition of his or her assets after death; usually written and signed by the person and witnessed by two or more witnesses.

Useful Websites

Centers for Medicare and Medicaid Services (CMS)

<http://www.cms.hhs.gov>

U.S. Official Government Medicare Site

<http://www.medicare.gov>

Missouri Association for Social Welfare (MASW)

<http://www.masw.org>

Missouri Bar Association

<http://www.mobar.org>

Missouri Home and Community Services: Division of Senior & Disability Services

<http://www.dhss.mo.gov/HomeComServices/>

Missouri Department of Health and Senior Services

<http://www.dhss.mo.gov/>

Missouri Long-Term Care Ombudsman Program

<http://www.dhss.mo.gov/Ombudsman/>

National Association of Social Workers

<http://www.naswdc.org>

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Community Resources for Long-Term Care Social Workers

Area Agency on Aging (AAA)

Community Mental Health Center

Department of Social Services

 Family Support Division (formerly Division of Family Services - DFS)

Department of Health and Senior Services

 Division of Senior and Disability Services

Department of Mental Health (DMH)

Home Health Care Agencies

Homemaker Agencies

Hospital Social Services Director or Discharge Planner

Legal Aid

Long-term Care Organizations (National and state)

Ministerial Alliance

Ombudsman For Long-Term Care

Social Security Office

Support Organizations (Blind, Alzheimers, Arthritis, Diabetes, CVA)

Transportation Providers

Veteran's Administration

Missouri Colleges and Universities With Social Work Programs

**Accredited by
The Council on Social Work Education**

Avila College, Kansas City - BSW

Central Missouri State University, Warrensburg - BSW

Columbia College, Columbia - BSW

Evangel University - BSW

Missouri Western State College, St. Joseph – BSW

Park University – Candidacy BSW

Saint Louis University, St. Louis - BSW/MSW

Southeast Missouri State University, Cape Girardeau - BSW

Southwest Missouri State University, Springfield – BSW/MSW

University of Missouri, Columbia - BSW/MSW

University of Missouri, Kansas City - MSW

University of Missouri, St. Louis – BSW/MSW

Washington University, St. Louis – MSW

William Woods University, Fulton - BSW

Sample Job Description Social Service Designee/Worker

Job Summary:

- Responsible for delivery of social services to residents and their families.
- Handles preadmission and admission interviews, informing resident and family of available services and resident rights and responsibilities.
- Prepares social histories for use by professional facility staff and participates in resident care conferences. May be involved in in-service training of aides and staff related to resident rights and social services.
- Handles problems of adjustment to the long-term care facility environment and maintains frequent contact with residents and their families, and serves as their advocate.
- Establishes working relationships with community health, welfare, and volunteer groups to promote cooperative assistance in meeting the social welfare needs of residents and families.
- Assists with arrangements, if needed, for out of facility health care, transportation, and counseling services.
- Handles discharge planning and provides assistance to residents and families on request.

This is an entry level social work position working under the supervision of a facility social worker or, if supervised by the administrator, with regular consultation from a degreed social worker.

Required Knowledge, Skills, and Abilities:

- Knowledge of long-term care facility environment and the effects of disease and disability upon the resident and the resident's family.
- Knowledge of available community resources.
- Ability to work independently and exercise good judgment in problem solving and networking within the facility and community.
- Interest in and appreciation of older adults and chronically ill individuals.
Positive, pleasant, understanding attitude.
- Ability to communicate effectively with good verbal and writing skills.

Qualifications:

Social Worker:

Master's Degree in social work (M.S.W.)

Bachelor's Degree in social work (B.S.W.) or a concentration in the social sciences and at least one year's experience in some capacity working with older adults.

Designee:

Graduation from high school with at least three years experience in some capacity working with older adults, with at least one year of the experience being in a long-term care facility. College course work in sociology, psychology, gerontology, or social work may be substituted for up to two years' experience.

SUGGESTED ADMISSION PACKET CONTENTS

The following list is provided as possible suggestions for inclusion in an admission packet. You may choose to place some of these items in a Resident Handbook or you may prefer individual brochures and leaflets. The purpose of this draft list is to suggest content rather than format.

- Abuse/Hotline Phone Numbers
- Acknowledgement of Resident Policies
- Activity Calendar
- Activities of Daily Living Assessment
- Admissions Checklist
- Admissions Questionnaire (about facility)
- Advance Directive admission Interview
- Advance Directive Informational Brochure
- Ambulance Policy
- Ancillary Service Fees
- Application/Admission/Agreement/Contract
- Assignment of Benefits and Payment Responsibility agreement
 - Bed Hold Policy
- Authorization for service utilization
- Bibliography of Learning Tools for Families
- Billing Information
- Care Plans
- Chaplain Services
- Client Assessment, Referral, and Evaluation Process
- Compliant Process
- Computer Policy (Resident Owned)
- Consent Authorizations and Releases
 - Activities Consent
 - Authorization to Treat
 - Bed Rail Release
 - Code Status Policy—Do Not Resuscitate Orders
 - Emergency Medical Treatment
 - Influenza Immunization
 - Informed Consent
- Isolation Rooms
- Leave of Absence Policy
- Mail Consent
- Notification of Change in Condition
- Personal Clothing, Furnishings, Electrical Appliances, and Carpeting
- Pharmacy Services
- Photograph and Media Release
- Physician services
- Podiatry Consent Form

- Release of Information
- Self-Administer Medications
- Tetanus/Diphtheria Booster Informed Consent
- Tuberculosis Screening
- Definition of Health Care Treatment Terms
- Disaster Policy
- Drug Distribution Policy
- Environmental Services
- Facility Newsletter
- Fall Assessment Tool
- Financial Statement
- Fire and Disaster Policy
- Freedom in Choice of Caregivers
- Funding Options
 - HMO's
 - Medicaid
 - Medicare
 - Private Insurance Coverage
 - Private Pay
- Funeral Plans
- Grievances Procedures
- Guardianship and Conservatorship
- Health Care Services Definitions
 - Long-Term Care
 - Respite Care
 - Short-Term Care
- History and Physical
- Hospice Services
- Important Addresses and Phone Numbers
 - Hospital
 - Pharmacy
 - Physicians
- In-Home Services Brochure
- Instrumental Activities of Daily Living assessment
- Inventory List
- Investigation of Complaints
- Invitation to Care Plan Conference
- Layout/Diagram of Facility
- Levels of Care Offered (explained)
- Listing of Administrative Staff
- Long-Term Care Ombudsman Program Explanation and Directory
- Loss and Theft Handbook—Prevention Tips for Residents
- Mail/Incoming and Outgoing
- Meal Times
- Medicaid Eligibility & Benefits
- Medical Records
- Medicare Benefits
- Medicare Secondary Payer Screening
- Memorial Services
- Minimum Data Set Assessment
- Mission Statement
- MSP Screening Questionnaire
- Nutritional Programming

- Nursing Home Checklist, Guide for Prospective Residents and Their Families
- Organizational Chart
- Patient's Bill of Rights/Resident Rights
- Philosophy of Facility
- Physical Restraint Information
- Policy and Procedures
- Pre-Admission Assessment
- Pre-Admission Assessment for Medicare
- Prices of all Medical, Incontinence, and Personal Supplies
- Privacy of Statement for Health Care Records
- Record of Complaint
- Recreation Services
- Refund Policy
- Rehabilitation Programs
- Resident Billing Guidelines for Credit/Refunds
- Resident and Family Council Information
- Resident Handbook
 - Clothing
 - Communication Suggestions and Concerns
 - Complaints of Patient Abuse and/or Neglect
 - Consideration of Others
 - Dental Services
- Eye, Hearing, and Foot Care Services
- Filing a Grievance of Complaint
- Housekeeping and Laundry
- Introduction
- Items Not Included in Per Diem Medicaid Rate
- Pastoral Care
- Payment Policy
- Personal Possessions/ Inventory of Personal Effects
- Personalizing Your Room
- Pharmaceutical Services
- Physical Therapy
- Physician Services
- Postage and Stationery
- Recreational Programs
- Rehabilitation Program
- Resident Council Meetings
- Resident Personal Funds
- Resident Rights
- Smoking Policy
- Respiratory Therapy
- Restorative Therapy

- Spiritual Needs of Residents
- State Survey Results
- Transportation
- Visiting Hours
- Resident Voting
- Responsibilities of Resident
- Room Hold Acknowledgement/Agreement
- Room Rates
- Salon Information/Prices
- Sample Dietary Menu
- Smoke-Free Facility Policy Statement
- Social Services
- Special Care Unit/Behavioral Unit
- Social Security and SSI Recipient Information
- Survey Results
- Tax Return Assistance/Property Tax Credit Program/Circuit Breaker
- Telephone Policy
- Therapy Payment Form
- Welcome Page
- Videos/Listing of Resources

Role of the Social Worker in Old vs. New Culture

Social workers play a crucial role in the lives of elders. Many of us are working at trying to change the prevailing nursing home culture from merely delivering services to sustain life, to one of infusing life with the warmth of the living. Because the differences may not yet be clear, I have attempted to outline them and give some examples of where we are now juxtaposed with where we ought to be. We learn in our education that we must engage with the person where (s)he is, and use ourselves purposefully to help those we work with to discover and build on their individual strengths. But is there coherence between these values we are taught and our actual practice?

Old: In our social work education we are taught to know and respect each individual and her/his right to decision-making, but in the nursing home the person takes second, or little or no place at all. We don't "begin where the person is" anymore. The nursing home environment makes care, services and treatment the foci [focus] of elders' lives, rather than the elder and what matters to her/him. Care is concerned primarily with ensuring physical health and safety, and meeting basic physical needs. People come to be treated as objects because the focus is on different body parts, systems and functional limitations. Elders have little, if anything to say about how their care is delivered and their role is reduced to merely receiving it. Care is always problem focused, derived from what people cannot do.

We are also taught about the value of relationships, but, too often, it seems like we become census takers, i.e., just getting answers to specific questions in order to complete documentation. We seem to have lost interest in listening to people's stories. Our jobs, too, often have become mechanical and monotonous.

An unspoken assumption in this environment is that we professionals know what is best and the goal is for elders to fit into what we plan for them, to accept the predetermined routines and programs of the facility. As with every other discipline, we call elders patients or residents (thus setting up an "us vs. them" model) and we, too, label by disability and diagnosis, neatly pigeon holing people by slipping into the all-pervasive medical approach. What becomes the most important thing is the accomplishment of tasks because there is so much more "care" needing to be delivered. We forget about the PERSON.

The message to all who live in the nursing home is that they are expected to be obedient and to defer to the professionals. It is conveyed by work, attitude, and distancing on the part of those who have status and power, i.e., staff. (Example: Staff person has no patience for another staff member talking with an elder when she needs to speak with that staff member. She has trouble understanding why she needs to wait, not the resident.) The outcome is social death, manifested in the helplessness, hopelessness, loneliness, boredom, alienation, and feeling of impotence so often seen in people who live in nursing homes. We social workers slip into the prevailing view that most of them are incompetent, dependent, and childlike, and after all, have incurable diseases, so little can be done for or with them.

Taking risks, a mark of adulthood, is actively discouraged. (Example: An elder wants to continue walking even though he falls with some regularity. Both he and his wife are aware of the potential problems. Each ask me why there are continual meetings to try to convince them that their attitudes will most likely result in a fracture at some point. Another example: An elder begins walking arm in arm tenderly with a friend on the same floor who cares about her. When the head nurse sees this, she bellows that he will cause both of them to fall and quickly puts her in a wheel chair.) Emotional and spiritual suffering are neglected because people are absorbed in physical problems. Elders are always on the receiving end with little opportunity to give back. Even we social workers are taught to set aside our own concerns, feelings, and vulnerabilities. "Don't become emotionally involved" we hear. Teams are organized for the most part to meet the needs of the nursing home and regulatory agencies and it is with them that our loyalties lie.

New: People's physical strength may be winding down, but this does not mean one stops living. As social workers our challenge is to normalize life, celebrate life, create opportunities for people to live life to the fullest; figure out ways to make lives better; help people grow to become all that they can be. It's recognizing that relationships are the building blocks of life; they must be alive and vigorous. They are the stimulus for growth as we draw nourishment from one another. We emotionally invest ourselves in the lives of others. As social workers we are taught it is the right and need of people to increase control of their lives, make their choices and decisions.

It is our responsibility to build relationships to help people exercise choice at every opportunity. It's encouraging people to take risks, challenge the status quo, strongly advocate for what elder wants or needs or is in his best interest regardless of real or perceived roadblocks. It is challenging the system when their scripted words don't make sense. (An example is being told that HIPAA requires no postings of deaths. After encouraging people to think about the implications for residents, staff and families, this was changed to just not posting the date of death. The overriding value is that people are known, that they are not forgotten after death, not privacy issues as had been interpreted initially. In the interests of trying to promote/protect privacy, we forgot about the PERSON.) It's listening to people's stories and help them see the value in and of their life experiences. It's enabling people to direct their own care; valuing the person over the task to be performed; advocating and figuring out how to make things happen for that person; truly valuing the autonomy, independence and self determination of each person. The only way this can happen is by getting detailed stories, talking about and discovering feelings; engaging and partnering with the person.

We need to learn all we can about each person (elder, staff and family), build on strengths and capabilities, affirm life at every opportunity. Every person is unique with rich histories, interests, talents, skills, needs, wants and wishes. We need to

give people opportunities to give and repay, not just be on the receiving end. We need to build a community that excludes no one; i.e., we must teach others that

everyone is part of the community; no one is selected out; everyone has a voice and everyone is affirmed; emphasize our common humanity and refer to each other as people or elders; draw on our feelings, emotions, intuition, spontaneity, faults, insecurities, individuality, sharing, giving, receiving, nurturing one's spirit, etc. It is our job as social workers to give voice to those who are silent and those who are ignored. It is our job to encourage people to exercise their constitutional rights of life, liberty and the pursuit of happiness.

Following are some examples of new culture where social workers and elders in a nursing home infused their lives with meaning.

Example: Mr. Perel, staff learned, was a prominent music teacher who came to this country from Russia some 15 years earlier than his admission to the nursing home. A major stroke left him blind, often confused, sometimes not able to express himself. A friend, with our encouragement, let his former students know what had happened. Word spread and his students came from far and wide regularly to visit with him. One man visited quite frequently and we got to know him as well and learned he was soon to conduct the orchestra for his first time at one of the Lincoln Center theaters. Staff talked with Mr. Perel about a group going with him to cheer his student on. He reluctantly agreed, staff got tickets for a van load of residents, nearly all in wheelchairs, and some of their wives and went that beautiful Fall evening to NYC. With a staff person on each side of Mr. Perel in the theater, each described the theater, set, and orchestra. Mr. Perel was very tense that evening. The curtain went up as the orchestra began. The staff on either side could feel the tension leaving him as those first measures sang out and tears streamed down his face as he took such pride in his student. Can you picture the reunion of student and teacher after that performance?

Example: In a weekly discussion group it became apparent that we deprive elders of things that give each of us who live outside nursing homes great pleasure, e.g., giving to others and expecting nothing in return except satisfaction of having done a good deed. In talking about the meaning of Thanksgiving, an elder who had a rare blood disorder, severe congestive heart failure, periods of confusion and both legs amputated said "giving to others less fortunate than I." From this a lively discussion ensued about how the community can give to others by sponsoring a food drive that the entire institution would participate in. Many in the community detested another elder in the community, not part of this particular discussion group, because he not only wandered in the rooms of others, but also slept in their beds and searched their belongings. The social worker in learning all she could about this person from his daughter, found out that he was the head of shipping and receiving at a major company. At the weekly meetings when the group unpacked the huge receptacles filled with foodstuff to pack into the boxes they beautifully decorated, the social worker enlisted the help of this man to teach the group about packing. Though he was able to speak very little, his face

lit up when he saw the cans and boxes and realized what the group had undertaken. He then taught everyone the best way to pack. Everyone in that room looked in amazement and, spontaneously, his most severe critic went over to shake his hand. He beamed with pleasure, finally feeling good about himself.

No one was calling him names or cursing at him anymore. And the group learned that each of us has strengths, we need only to search. He became a PERSON again in his life, no longer an annoyance. People viewed him differently. The weekly packing sessions leading up to Thanksgiving became a very special time for the community not only to celebrate what this man taught everyone, but the wonderful time everyone had singing together, doing arm and hand exercises with the cans, telling jokes, and writing personal notes in each box that would be delivered to families in need at a church in the neighborhood. That community celebration on the unit took on new meaning as it inspired everyone to also think about how they wanted their own meal to look and feel. Families brought in tablecloths and flowers, another made beautiful individually decorated place cards for each person, staff and residents rearranged the tables in the dining room and people dressed up. Before the meal was a moving non-denominational service that affirmed each person as each in his or her own way expressed reasons for giving thanks.

Example: A group of elders, staff and families meet to plan a memorial service for a man who was the friend of another. The friend who was alive was admitted with significant “behavior” problems as the floor was informed even before he arrived. When he got angry, which was quite often, he threw things and overturned chairs and tables. He was not able to form complete sentences, so was not able to talk about what was bothering him. The staff, in its weekly meetings to problem solve and get to know all they could about residents, learned that all of his life he loved playing the piano. Even though he never took a lesson, his wife reported that he could play anything by rote.

At this planning meeting, Abe (as he preferred to be called, told simply, in few words, that his newfound friend in a nearby room who had died was a veteran and he thought we should end the service with Taps. But there was no bugler and no one had any idea how to get one. A staff person quickly suggested that Abe play it on the piano. Both he and his wife, who was also part of the planning meeting, were overwhelmed because he had not been able to focus on playing anything for well over a year. The group gently encouraged him to try and his wife movingly offered to help him. They practiced together for long periods each day that week as his wife patiently sat with him and put tape on the keys to help him remember. On the day of the service, there was not a dry eye in the room as Abe played Taps for his friend. Perhaps those with the most tears were Abe and his wife.

Example: The weekly group with elders on this unit did many enjoyable activities together like cooking together food like potato pancakes from scratch and the wonderful aromas inviting others not involved to come and eat with them. They planted outside in large planters with bare hands having much fun with a

hose, at times squirting each other and taking off shoes and socks to feel the refreshing water. Then someone donated two sewing machines and two elders in particular were ecstatic when they saw them. They began with simple fabric pocketbooks but quickly the idea developed to make a quilt. More and more people joined the excitement, including those who had no idea how to sew. Soon everyone had a job; everyone could do something to help create a beautiful

quilt. One could thread, another stuff, another cut fabric, another sew on the machine while another person held the fabric, etc. All the while elders talking, joking, singing, telling stories about life, and having a wonderful time together. The quilt didn't have to be perfect, just as the plants didn't have to be perfectly planted. This did not matter. There was no judgment, nothing critical—just people engaged and enjoying themselves while helping each other. Many of the elders had been non communicative and described as having “vacant looks”. They saw the fun, felt the excitement and wanted to be part of it. Building on success, the group worked for months to make quilts for each other for their beds. The unit became a community.

Example: A 98 year old woman entered the nursing home with a label of dementia and depression. She lashed out, refused to talk with anyone without shouting and cursing that she was still alive. She could not even remember the names of her children and certainly not her grandchildren. She rebuffed everyone, including the social worker. Getting to know all she could about this woman, the social worker persistently tried various ways to enter this woman's life. After weeks of being turned away, there began a few short conversations. Then it seemed to grow each day as the social worker talked with her about her family, the richness of her own life and her contributions. Very slowly a relationship developed and the social worker built on this. Helping this woman see that her many physical problems did not have to mean she could no longer live life, she became eager to tell her story. And someone was there to listen. The social worker taught her about “ethical wills” and she became excited and started to talk about the value of her life. Together they worked for months on her ethical will which she came to see as her *raison d'être*, that this was the reason God continued to give her life. She talked about it pulling her out of her despair. She began focusing and remembering, determined to leave her family and unborn generations her lifetime of values that made her the person she was. Before long she began speaking with other elders, both formally and informally and met with the social work department and its students to talk about the value of this experience that “resurrected” her from death. This entire experience was not just transforming for her, but for the social worker as well who learned yet again the rewards of the richness in giving of herself to another person and the benefit of receiving wisdom and friendship. Soon after her 100th birthday, her ethical will was published in a quarterly —the first time in her life that anything of hers was published.

The social worker's role is pivotal in modeling new culture; to teach that professionals must listen and help people grow based on their needs and interests, not the nursing home's; to demonstrate that relationships are the key to everything, not giving care; (s)he must be a catalyst to create opportunities for all people to grow, regardless of where they are on the cognitive spectrum, because everyone has the capacity to grow and meaningfully contribute; to create communities where people feel they matter to each other, regardless of faults, problems, because this, too, is part of being human; to help shape this current home into a haven, a refuge in which to seek shelter from the harshness that

sometimes surrounds us; it's learning who each person is as a unique person, rich with history, life experiences, talents, needs, wants, etc; to give people choices, building on strengths; being inclusive; to enhance and live life to the fullest. Ultimately each of us wants to know that we live a life that matters. It is the job of social workers to ensure that the forces of life, not death, prevail.

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