Psychosocial Assessment: Impacting Care Planning & Intervention

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Objectives

- Identify crucial components of psychosocial assessment
- Demonstrate how psychosocial assessments should impact the care plan

Biopsychosocial-spiritual Perspective

- Physical or medical aspects of ourselves (bio)
- Emotional or psychological aspects (psycho)
- Sociocultural, sociopolitical, and socioeconomic issues (social)
- How people find meaning in their lives (spiritual)

=Biopsychosocial-spiritual


Important Point

- “Psychosocial assessment” does not just refer to the initial assessment done upon admission
- Psychosocial assessments happen throughout the individuals’ stay

What Do Your Assessment Tools Look Like?

- Do they capture information to paint a comprehensive picture?
- Do they encourage assessment and not just regurgitation of facts?
- Do they easily allow you to impact the care plan with the information obtained?

Critical Elements of Care

- Comprehensive Assessment (F272)
- Comprehensive Care Plan (F279)
- Care Plan Implementation by Qualified Persons (F282)
- Care Plan Revisions (F280)
- Provision of Care and Services
  - Can be deficient in a number of areas depending on the issue
  - Will likely be tagged on F309 - Provide Necessary Care for the Highest Practicable Well Being

Many facilities receive deficiencies related to these critical elements of care
"Life History Provides Major Clues"

- Understanding the reasons why someone is behaving in what appears like an unusual or disruptive way makes acceptance easier for staff.
- "This isn’t premeditated, conscious mischief, this is someone responding to their environment in a way other people don’t want. We need to substitute something meaningful for behavior that might be undesirable." – American Medical Directors Association President-Elect Jonathan Evans, MD


Social Worker Role

- Help determine the reason/rationale for the person’s choice
  - What is the NEED?
- Use assessment skills
- Document
- Communicate with the team
- Update the care plan

What Is A Need?

- "A condition or situation in which something essential or desirable is required or wanted."
- Abraham Maslow’s Hierarchy of Needs
  - Must be met in order (hierarchy)
  - If not met, problems will arise

Social Worker Contributions

- Resident worked nights so that might be why he won’t go to bed when everyone else does
- Resident feels her pain is punishment from God for something she did as a young woman
- Resident worked as a nurse for 30 years and especially enjoyed the pediatric unit in the hospital. Her dementia is quite advanced but she might enjoy "caring for her patients"
- Resident’s middle daughter overdosed on prescription medication 10 years ago and died. Resident is afraid to take her Morphine routinely even though her pain negatively impacts her quality of life
- Resident raised 5 children and volunteered with many aspects of their school and activities. She is exhibiting signs of depression and might benefit from volunteering in the ice cream parlor or being the “facility greeter”

Goal Setting for Mood Problems

Too often...

- Behavior problems are addressed by reducing the frequency of a maladaptive, disruptive, and/or harmful behavior.

- Examples:
  - "Episodes of racial slurs will be reduced to 1x/day…"
  - "Tearfulness will be reduced to 3x/week…"
  - "Number of complaints will be reduced to 2x/wk…"
  - "Negative verbalizations will be reduced to 4x/wk…"
  - "Repetitive verbalizations of "Help me, Help me" will be reduced to…"

What is the Message?

- Even if the goal is met and the maladaptive, etc behavior is reduced, the resident receives the message that the behavior is STILL permissible (just not as much)
  - Racial slurs
  - Yelling
  - Hitting

Assessing Symptoms: Care Planning Causal Factors

- Mood distress expressions are a means of communication and should not be restricted or inhibited
- "What is the underlying CAUSE of these symptoms?"

- In other words, WHAT IS THE ASSESSMENT?
  - Pain, loneliness, fear, confusion, delirium, substance abuse, change in medical condition
  - Base the goal on the causal factors

Greenwald, Steven C., Social Work Policies, Procedures and Guidelines for Long-Term Care, SocialWork Consultation Group Publishing, 2002

Useful Goals for Depression

- Resident will respond positively to counseling sessions 2x/wk with social worker to identify strategies to adjust to long-term care placement
- Resident will verbalize two strengths during visits with the social worker that will help her adjust to long-term care placement
- The resident will interact in any demonstrable way with staff who visit to provide extra support 3x/wk

Accurate Recording?

- How is “per day” defined?
  - 24 hours?
  - Day shift?
- Who will follow the resident throughout the designated time period to determine number of episodes?
- Where should all the data be recorded?

Strengths Perspective
**Strengths Perspective**

- Recognizes an individual’s strengths and abilities to cope with problems
- Social workers focus on strengths:
  - Enhancing resident’s personal strengths and resources
  - Helping residents to solve interpersonal and environmental problems
  - Helping residents use their past successful choices and behaviors, skills and insights to resolve or “work through” a current crisis
  - Identify factors that contribute to growth and well-being

**Examples of Strengths: Incorporating Assessments**

- Goal setting
- Positive attitude
- Easily redirectable
- Verbalizes desire to improve/get stronger
- Feeds self
- Strong family/friend support
- Smiles
- Has overcome crisis in the past
- Has hobbies that provide comfort
- Good vision
- Participates in decision-making
- Makes needs known
- Ambulatory

**Questions to Identify Strengths**

- What do you consider your strengths?
- What makes a good day for you?
- What are the things you do each day or each week because you really prefer or choose, not because you must? What makes you get so involved that time seems to move quickly?
- What do you do well? What kinds of things did you previously do well? What has always give you confidence or made you proud?

**Strengths → Approaches**

- Provide resident with opportunities to make simple, no-lose decisions
- Ask the resident to try to calmly communicate what he wants to say
- Ask the resident how he would feel if someone spoke to him that way
- Distract her during the shower with conversation about favorite topics such as family, cherished hobbies, or past employment
- Engage the resident in singing or humming
- Help resident develop a simple list of things that she knows have a calming effect
- Work with the CNA’s to assist the resident in having a positive personal appearance
- Ask the resident to think of how she could make her cigarettes last, such as having someone hold them for her, rationing herself, or buying more with her trust funds

**Now, What Do We Do With Strengths?**

- Use them in the care plan
- Incorporate them in the approaches
- Teach staff about resident strengths
- Empower the individual to use his/her strengths

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**Interdisciplinary Approach Example**

- “When the resident expresses sad thoughts, listen attentively and acknowledge that the admission process often evokes strong feelings. Afford her a kind ear. Do not attempt to talk her out of her feelings. She has every right to feel whatever she feels. Later, ask her what she might do to start feeling better. Help her recognize that she is not alone in feeling upset or distraught. Admission to the long-term care facility evokes many emotions and it often helps to talk about one’s experience.” (SW/ACT/NURSING/CNA)

Demonstration of Impacting the Care Plan Based on a Thorough Psychosocial Assessment

Case Scenario

- Mrs. T is an 81 year old married female, admitted to the nursing home due to multiple falls in her assisted living community. She has one daughter who lives locally who accompanied her. Her husband has lived in the nursing home 3 years prior.

Insight into daily habits to assist with adjustment to the nursing home

- What time is she used to waking up and going to bed?
- When and what does she normally like to eat?
- Did she sleep in the same room as her husband?
- What does she like to wear?

Assists staff to understand the prior level of functioning

- Why does she now require a nursing home level of care?
- How did Mrs. T perform ADL's and IADL's at home?
- What services were used at home?

Provides an understanding of family dynamics

- Who does Mrs. T rely on?
- Who wants to be involved with her care and adjustment?
- What is the relationship between Mrs. T and her husband? Her daughter?

Insight into mental health issues, lifetime coping skills and patterns, and emotional well-being

- Does Mrs. T have any history of psychiatric care?
- Is Mrs. T taking any medications for mood or behaviors? If so, have there been any changes or adverse effects either recently or in the past to medications?
- How does Mrs. T's family describe her history of coping skills and emotional well-being?
- Has Mrs. T had any losses in the past year? The past 5 years? Any unresolved losses?
Assess mood and any changes that may have occurred since the last review

- Has Mrs. T had any changes in her mood or behavior medications since her last review? What were they and why?
- Have there been any changes for which the physician is following Mrs. T - medication management or counseling?
- Has Mrs. T had any physical changes that could contribute to her mood or behavior either acutely or chronically?
- Was there a death or change within her family?
- Is there another loss Mrs. T is coping with?

Identify Trends & Precipitating Factors: Assess Beyond the 7 day observation

- What do staff say about Mrs. T's mood and behaviors? Is she better, worse, or the same in the past 3 months?
- When do the staff say her mood and behaviors occur? Is there a pattern?
- Were there changes to her medications that could have affected her mood or behaviors?
- Were there environmental factors that might contribute to her mood and behaviors?

Mrs. T's Care Plan:
Personalize Approaches – Take Credit!

- Mrs. T is very private and does not like to ask for help or have male caregivers. Female caregivers assigned when able and staff to check on her frequently to provide assist as needed.
- Do not “educate” Mrs. T on proper ADL techniques as she views this as lecturing and belittling by the staff. Guide Mrs. T through conversation when assisting with ADL’s to ensure safe techniques.
  - When staff “catch” Mrs. T in the bathroom and she did not ask for assistance to transfer, instead of stating “how did you get here?” or “why didn’t you put on your call light?” state to Mrs. T “I see that you need to use the restroom (or are finished), let me help you finish up.” As you are assisting her, discuss with her the techniques you (not her) are using to ensure safety (i.e. “Please hold on to the grab bar as this will help me make sure you are secure” rather than “don’t forget to hold on to the grab bar so you don’t fall.”)

Personalized Care Plan cont.

- Mrs. T misinterprets humor. Do not joke with Mrs. T when providing care and remain professional.
- Mrs. T has a private room due to rooming with spouse and other residents escalate her episodes of mood and behavior.
- Mrs. T prefers not to each lunch. She prefers to have most of her breakfast and dinner meals out of the facility.
- Mrs. T likes to sleep late.
- Mrs. T has psychology follow-up weekly. Psychiatry follow-up for medication management as needed.

Personalized Care Plan cont.

- Phrase Mrs. T when she is observed socializing with peers, spending time out of her room, exhibiting positive affect and comments, and cooperating with staff.
  - When staff observe that Mrs. T is having a “good day” (i.e. smiling, conversing with staff without accusations), state to her “I like to see you when you smile, you look happy.” This encourages her to talk about what is making her happy today rather than dwell on the negative. On the flip side, if you state “you look happy today” the word “today” emphasizes to her that other days she is not happy and she will perceive what you intend as a positive comment as more of a negative comment and set a negative tone with her for the rest of the day.
- Encourage Mrs. T to personalize her bedroom to her liking.
- Assist Mrs. T with putting any appointments or things of importance on the calendar in her room for her to refer to.
- Maintain contact with daughter for updates on any changes, positive or negative, that daughter may have observed.

Questions?