Recording
Psycho-Social Care

Documenting Individualized
and Measurable Patient Care Data

Objectives

- Name the top five deficiencies in SW
documentation
- Discuss general guidelines and verbiage for
documentation of social work care in hospice
- Describe Ira Byock's end-of-life developmental
tasks
- Develop interventions for use with patients with
dementia/Alzheimer's

Objective:
Empower you to document
from your professional
expertise, experience, and pride...
...rather than documenting to complete a form.
Federal Conditions of Participation

- 418.54(c) “...provided by a qualified social worker, under the direction of a physician... based on the patient’s psychosocial assessment and the patient/family’s needs and acceptance of these services.”
- 418.54(b) “...must complete the comprehensive assessment within five calendar days after the election of hospice care.”
- 418.54(c) “Content of the comprehensive assessment...must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness...in order to promote the patient’s well being, comfort, and dignity throughout the dying process.

COPs continued...

418.54(c) continued...

- Content of comprehensive assessment:
  - (1) Nature and condition causing admission
  - (2) Complications and risk factors that effect care planning
  - (3) Functional status, including patient’s ability to understand and participate in his/her own care
  - (4) Imminence of death
  - (5) Severity of symptoms

COPs continued...

- 418.54(c)(7) Bereavement “Initial bereavement assessment...focusing on the social, spiritual, and cultural factors that may impact ability to cope...”
- 418.54(c)(8) Referrals and further evaluation by appropriate health professionals
- 418.54(d) Update of the comprehensive assessment “...by the IDT and must consider changes that have taken place since the initial assessment...include information on progress toward desired outcomes and reassessment of response to care...no less than every 15 days.”
COPs continued...

- 418.54(e) Patient outcome measures
  - (1) "assessment must include data elements for measurement of outcomes...documented in the same way for all patients
  - (2) "data elements must be part of the comprehensive assessment...must be retrievable...used in individualized patient care planning and coordination of services...must be used as part of the aggregate for hospice's QAPI program

COPs continued...

- 418.56 IDT, care planning, and coordination of services
  - (a) "hospice must designate an IDT...composed of...doctor, registered nurse, social worker, pastoral or other counselor
  - (b) "...all care and services must follow an individualized written plan of care...each patient and care giver must receive education and training appropriate to their responsibilities for the care and services identified in the plan of care

COPs continued...

- 418.56(c) "must develop an individualized written plan of care for each patient...must reflect patient/family goals and interventions based on assessments:
  - (1) detailed statement of the scope and frequency of services
  - (3) measurable outcomes anticipated from implementing the plan of care
  - (d) Review of plan of care: "...must review, revise, and document...no less than every fifteen calendar days...must include information from the updated comprehensive assessment and note patient's progress toward outcomes and goals specified in the plan of care.
COPs continued...

- 418.114(b)(3) Social worker personnel qualifications
  - (i)(A) has an MSW from an accredited school of SW, or
  - (B) has a baccalaureate degree in SW from an accredited school; or a baccalaureate degree in psychology, sociology, or other field in sociology and is supervised by an MSW; and
  - (ii) has 1 year of social work experience in a healthcare setting; or
  - (iii) has a baccalaureate degree,... is employed by the hospice before Dec 2, 2008, and is not required to be supervised by an MSW.

COPs continued...

- 418.26(d)(2) Discharge from hospice; discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged...

Interpreting the Regulations

- Your IDT must include a qualified SW. Without your presence, there is NO IDT meeting.
- Comprehensive assessment must be completed within 5 days of admission. Must include all elements identified in the COPs.
- If you identify a need for referral, you must follow up and document.
- Update to the comprehensive assessment must be done every 15 days by visit or phone call.
Interpreting...continued

- Outcomes and interventions must be documented in measurable outcomes. Must document progress toward goals.
- Plan of care must be individualized...no “cookie cutter” documentation. Check boxes are only the beginning.
- Frequencies in the POC must be according to Patient/family need. Visits must match the frequency documented in the POC. No stand alone PRN frequency.
- Updates to the plan of care must be made every fifteen days.
- SW must document discharge planning at least 5 days before discharge.

Top Five Deficiencies

- Frequency written in the plan of care does not match the number of visits made
- Plan of care is not individualized
  - No individualized problems
  - No measurable interventions and goals/outcomes
  - No documentation of progress toward goals
- Care is not delivered according to the plan of care
  - Did you do what you said you would do?
  - Updates are not made to the plan of care at least every fifteen days (Must update the comprehensive assessment q 15d by phone call or visit.)
- Initial visit is not made within 5 calendar days of admission

Documentation is an art, not a science. Write what you know, what you see, what you did, whether or not it worked, and what you will do next.
Putting it all together…

- Assessment, including...
  - Pain
  - Safety
  - Communication style and effectiveness
  - Teaching
  - Care giver support and resources
  - Imminence of death
  - Financial/legal assessment
  - Psychosocial/emotional assessment, including suicide assessment
  - Coping mechanisms
  - Bereavement risk assessment

Documentation Cycle

- Initial Assessment
- Change Plan of Care, progress toward goals
- Documentation of assessment, goals, interventions
- Re-assess: what works, what doesn’t
- Create Plan of Care based on Assessment
- Change Plan of Care, progress toward goals

Questions to Think About…

- What are your future hopes (in next days/weeks/months)? What would you like to see happen?
- What is left undone?
- What are the things you worry about?
- What are some of your immediate problems? Your family’s?
- If you could talk about anything, what would you talk about?
- Wish list/bucket list
- How can we journey together?
- “I don’t know.” If you did know…
How is the Patient different today from your last visit? A week ago? Two months ago?

Compare the Patient with a healthy person of this age. What are her/his limitations?

Dr. Ira Byock
End-of-life developmental tasks:

- Task #1 “Please forgive me.”
- Task #2 “I forgive you.”
- Task #3 “Thank you.”
- Task #4 “I love you.”
- Task #5 “Goodbye.”


Problem/ Intervention/ Goal

Patient 87 y/o lifelong Roman Catholic female who is tearful during assessment. Through skillful interview and reflective listening you learn that she is sad over an abortion she had at age 17. She has never shared this story with anyone.

- Problem: sadness over abortion at age 17 as evidenced by withdrawn behavior and tearful episodes.
- Interventions:
  - reflective listening
  - encouragement to tell personal story
  - referral to chaplain for follow up
- Goals:
  - decreased episodes of crying; increased peace
  - verbalized feelings of acceptance/relief, etc.
  - opportunity to ask forgiveness, say goodbye
Problem/ Intervention/ Goal

Patient is 93 y/o male NF resident with diagnosis Alzheimer’s. He is non-responsive. There is no family of record to assist in developing the Plan of Care.

- Talk w/ facility staff to ascertain Patient history. (This in itself could be a problem/intervention/goal.)
- Problem: due to disease process, Patient is unable to interact with his environment, or assist in development of plan of care
- Intervention: read, sing, tell stories; guided imagery; facilitate relaxation response. (Presence...means WHAT?)
- Goal: provide companionship; promote Patient’s comfort; alleviate sense of isolation

List of Potential Problems...AEB...

- Altered ability to: focus attention; formulate ideas, thoughts; make decisions; solve problems
- Inability to handle stress, deal with emotional/psychological demands
- Altered communication – reading, writing, speaking, holding conversations
- Inability to perform tasks: livelihood/loss of employment, pay bills, ADLs, social activities, household tasks, yard work, home and car maintenance
- Interference with inter-personal relationships – loss/grief; estrangement; unfinished business
- Advance Directives; funeral planning; will

List of Possible Interventions

- Provide support (what kind), offer acceptance (how)
- Encourage expression of feelings
- Teach....
- Encourage verbalization of personal story
- Identify support systems
- Make referral to...make sure to follow up and document
- Respect racial, cultural differences
- Assist with completion of...
List of Possible Interventions

- Facilitate communication (how) between (whom)
- Reflective listening
- Explore attitudes of... to alleviate/promote...
- Facilitate respite care/ move to alternative living
- Assess... what and how
- Provide grief support by...
- Inform of resources for...
- IDT conference with...
- Naomi Feil's Validation Therapy
- TimeSlips – story telling with people with dementia

Possible Goals...

- Promote Patient comfort
- Alleviate... (what - stress, discomfort, sadness, etc.)
- Increase knowledge about... (what)
- Complete long range planning
- Improve quality of life (must be defined according to Patient)
- Facilitate death with dignity
- Facilitate family communication, peace, reconcile interpersonal relationships, etc.
- Facilitate healthy grief
- Acceptance of loss/ limitation, terminal illness, EOL, etc.

Resources

http://www.who.int/classifications/icf/en/
WHO's International Classification of Functioning

WHO's Disability Assessment Schedule

http://www.who.int/substance_abuse/research_tools/whosqolbref/en/
WHO's Quality of Life Scale
Resources...cont

- [http://www.dyingwell.org/](http://www.dyingwell.org/)
  Dr. Ira Byock

- [http://www.youtube.com/watch?v=CrZXzioFcVM](http://www.youtube.com/watch?v=CrZXzioFcVM)
  Naomi Feil's Validation therapy

- [http://www.timeslips.org/](http://www.timeslips.org/)
  Using story telling with Patient's with dementia

Resources...cont


  The Advanced Certified Hospice and Palliative Social Worker (ACHP-SW) from National Association of SWs

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