Empowering the Administrator for Success: Tools & Resources to Build an Excellent Social Work Department

Developed by
2014 Arizona Long Term Care Social Work Task Force
Nursing Facility Administrators

This Toolkit is designed especially for you.

Our primary goal is to provide guidance and direction for the development of a high caliber social work department within your facility. This toolkit offers specific tools and helpful resources to assist you in reaching the highest level of social work performance possible. We believe this will serve to enhance your leadership and strengthen resident care outcomes.

The Administrator’s Toolkit 2nd Edition was completed by the Arizona Long Term Care Social Work Task Force, a group comprised of credentialed social workers, academic leaders, and professionals in the field of long term care. All demonstrate vast experience in the skilled nursing setting. In this edition, we are also pleased to make these materials available on-line. Just go to http://www.naswaz.com/?page=ltctaskforce and you will find the resources in this Toolkit available for internet viewing and downloading.

In the Table of Contents you will find an extensive list of documents, tools, and guides that demonstrate how a qualified social worker can, and should, contribute to successful resident-centered outcomes and reduce deficiencies. Use this toolkit as a dynamic source of information. If you are evaluating the social worker’s performance, take a look at the Professional Performance Evaluation and the Social Work Quality Assurance & Improvement documents for specific domains such as care planning and medically related social services. Or, if you are recruiting a new social worker, check out the document titled “Interviewing a Social Work Candidate - Questions and Suggested Responses.” Not sure what great social work documentation looks like? Check out the examples in this toolkit! Want ideas of how to involve the social worker in the QIS process or strategies to work with health plans, that’s in there too!

Thank you for your dedicated efforts, day in and day out, in serving the residents and their families of long term care facilities.

You truly make a difference!
The 2014 Arizona Long Term Care Social Work Task Force

Mission

To promote the growth and development of the long term care social work profession throughout the state of Arizona, and to enhance the strength and efficacy of facility based social service programs.

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This toolkit is available online at:

Arizona Health Care Association
(http://www.azhca.org/members/social-work/)

LeadingAge Arizona
(http://leadingageaz.org/social-worker-monthly-conference-call/)

National Association of Social Workers, Arizona Chapter
(http://www.naswaz.com/?page=ltctaskforce)

If you would like to provide feedback on this resource, please feel free to contact Paige Hector, Chair or anyone on the committee. All emails are noted on the task force member list.
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The Arizona Long Term Care System (ALTCS) is part of the Medicaid program in Arizona, also known as the Arizona Health Care Cost Containment System (AHCCCS). ALTCS provides services to the chronically ill, elderly, and physically disabled who are in need of long-term care and meet certain medical and financial criteria. With proper management of the ALTCS process in your facility, fewer patients will be denied, and large gaps in payment from ALTCS denials can be avoided.

The Impact of ALTCS in the SNF and the Avoidance of BAD DEBT

Management of the ALTCS Process

- When possible, identify the need for ALTCS before, or at the time of admission. It is an Arizona DHS regulation to provide Medicaid information upon every admission.
- **Ideal team approach for ALTCS in your building:**
  - **Admissions** - identifies the need for a secondary payer and offers education on ALTCS.
  - **Social Services** – meets with the family to discuss how they plan to pay for care and begin identifying potential issues that would cause ALTCS ineligibility. They provide education on the ALTCS program within the first week after admission. They assist in gathering documents and support the family member who is acting as the authorized representative, and discuss a program contractor with the family.
  - **Utilization review meetings** - therapists and nurse case manager discuss level of care and create a discharge plan or lower level of care needs.
  - **Case Management** – discusses care options with the family and termination of other insurances and encourages ALTCS planning.
  - **Business Office** - run insurance checks; look for term dates, other benefits, days used, and secondary information. If a payment gap exists, then pre-screening for ALTCS early is recommended.
- Designate staff (typically social services or business office) to initiate the ALTCS application and track its progress during the pending period. Regular meetings to discuss ALTCS pending individuals are necessary to ensure eligibility problems are identified and funding does not lapse. You cannot rely on the social worker to take the place of a family member to obtain proper documentation. They do not have the authority to get documentation from the bank, life insurance, or other needed areas.

Pre-Screen

- Prior to submitting ALTCS applications, pre-screen for issues that will cause ineligibility with a social worker or outside agency to reduce the risk of being denied.
- When a secondary payer or a long-term payer is needed, so is a pre-screen.
- It is better to fix issues that will cause ineligibility before the application is submitted rather than waiting until the denial comes to fix them.
Everyone does not need to submit an ALTCS application.

- Do not wait until the resident has spent down to $2,000 before applying. ALTCS applications can take over three months to process, and early intervention could allow for payments during the application processing period.
- Identify the payer source during the ALTCS pending period and also if the application is denied. Retroactive coverage will occur back to the month the client is “otherwise eligible” not the month the application was submitted. If you are counting on retroactive coverage to pay during a pending time, be mindful of not only when the application was submitted but also if the authorized representative has met spend down rules.
- Proper management of the medical portion of ALTCS is very important. Staff members should document correctly by illustrating what they are doing for the client (not what the client is doing for themselves). The 60 points necessary to obtain benefits must be obtained by proving hands on care in six areas: activities of daily living, sensory, orientation, continence behaviors, and medical conditions that impact ADL’s.
- If denied, there is an appeal process, but it is best to properly prepare for the Medical PAS.
- Align yourself with an Elder Law firm to help you manage difficult cases.

**Share of Cost/Patient Trust Accounts**

- Notify and document the resident or responsible party when the Share of Cost is due. Initiate the Representative Payee process if the resident is unable to manage responsibility for the Share of Cost.
- Apply for Representative Payee right away if there are issues with getting paid. If you wait, you will lose money! The social worker can be helpful in identifying family dynamics. Before applying for representative payee, identify other legal issues that will complicate the process (i.e. resident needing Income Only Trust.)
- The business office should keep a close eye on resident trust accounts. An approved ALTCS recipient cannot have more than $2,000 in resources. If you notice a resident reaching the $2,000 limit you may want to call in help before the client is dis-enrolled.

**Ineligibility**

Over 76% of applications are denied. Proper preparation of applications will reduce payment gaps.

- Ineligibility RED FLAGS:
  - House is in a trust
  - Over gross monthly income limits
  - Resident has given away or transferred any money or assets in the past 5 years (this includes gifting to charity or church). The penalty means no payment to your facility even after approval. The look back period for all gifts/transfers is five years.
  - Comingling of funds or additional properties
- Ineligibility start date has changed which can cause a large penalty period and a financial loss for the facility. Looking proactively at the penalty period (period of time that the resident meets all of the eligibility criteria for ALTCS, but cannot receive benefits due to gifts and/or transfers) will allow the facility to get paid during penalty period.
“Business Case” for High Caliber Social Work Services in LTC

The investment of resources in qualified and trained social work leadership in a facility will reap financial benefits, improve quality of care, and more....

- Due diligence in the admissions process will ensure the proper placement in your facility. Improper placements can lead to unsuccessful care outcomes, and unnecessary and costly litigation.

- Social work leadership in the care planning process is essential to the well-being of the resident. The social worker serves as the resident and family advocate. Happy families and improved quality of life for residents ensures census.

- Social work documentation can make or break your survey/inspection. Strong and accurate documentation will contribute to survey success, thereby preventing costly dispute resolution and enforcement.

- Social work leadership and intervention with families and residents can also prevent or reduce the incidence of complaints to the Department of Health, and ensuing regulatory costs.

- Social work leaders can work with case management within managed care/health plans to address improprieties in “level of care” designation. Funding is available for appropriate level of care, but it must be carefully documented.

- Social workers can assist in developing a wide range of services to meet the growing needs of specialty populations including persons with behavioral issues, and traumatic brain injury… to name just a few. This can be beneficial on a financial level and also assist in meeting the needs of the community.

- Social workers can be the key to a successful relationship with hospital discharge planners. To ensure subacute census, you must have capable leadership in communication with the hospitals and other acute settings.

- Social workers can educate your staff on the impact of new regulatory guidance and prevent costly errors in clinical and survey performance.

- Social workers can dramatically improve your community image by conducting appropriate outreach and education to businesses and community groups in your service delivery area.

In summary, an inexperienced social work department has a financial price tag. But more than that, it places your facility at risk... risk of costly regulatory errors, lawsuits, and poor customer satisfaction.

It is important to invest in social work leadership...hire only qualified, knowledgeable social workers and continue to support their efforts through ongoing education and training.
Hartford Geriatric Social Work Competency Scales

Recent research indicates that the Hartford Geriatric Competency Scales have underlying subscales that help differentiate between *core geriatric social work skills* and *specialized geriatric social work skills*. Administrators can help their social work staff members to strive for mastery of the core social work skills and support professional development in the specialized skills. It is not recommended to use the scales as evaluative tools as staff typically indicates they are highly competent in everything. A more appropriate use is to frame the scales as needs assessment tools.

The scales are provided in this toolkit. You can also visit the Council on Social Work Education (CSWE) at [http://www.cswe.org/](http://www.cswe.org/) to learn more about the Hartford Geriatric Competency Scales.
Geriatric Social Work Competency Scale II with Life-long Leadership Skills:
Social Work Practice Behaviors in the Field of Aging

The following is a listing of skills recognized by gerontological social workers as important to social workers effectively working with and on behalf of older adults and their families. These competences are to be developed at different levels across the social work learning continuum, from BSW, to MSW at the core and advanced levels and in life-long learning post-MSW. The Scale was designed for pre-post evaluations of education and field training. An accompanying Field Instructor Version is available.

Please use the scale below to thoughtfully rate your current skill:

0 = Not skilled at all (I have no experience with this skill)
1 = Beginning skill (I have to consciously work at this skill)
2 = Moderate skill (This skill is becoming more integrated in my practice)
3 = Advanced skill (This skill is done with confidence and is an integral part of my practice)
4 = Expert skill (I complete this skill with sufficient mastery to teach others)

<table>
<thead>
<tr>
<th>Not skilled at all</th>
<th>Beginning skill</th>
<th>Moderate skill</th>
<th>Advanced skill</th>
<th>Expert skill</th>
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Please give us any comments and/or suggestions regarding the skills in each section.

1. VALUES, ETHICS, AND THEORETICAL PERSPECTIVES (Knowledge and value base, which is applied through skills/competencies. | Skill Level (0 -4)
---|---
1. Assess and address values and biases regarding aging.  
2. Respect and promote older adult clients’ right to dignity and self-determination.  
3. Apply ethical principles to decisions on behalf of all older clients with special attention to those who have limited decisional capacity.  
4. Respect diversity among older adult clients, families, and professionals (e.g., class, race, ethnicity, gender, and sexual orientation).  
5. Address the cultural, spiritual, and ethnic values and beliefs of older adults and families. |
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<tr>
<td>6.</td>
<td>Relate concepts and theories of aging to social work practice (e.g., cohorts, normal aging, and life course perspective).</td>
</tr>
<tr>
<td>7.</td>
<td>Relate social work perspectives and related theories to practice with older adults (e.g., person-in environment, social justice).</td>
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<tr>
<td>8.</td>
<td>Identify issues related to losses, changes, and transitions over their life cycle in designing interventions.</td>
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<tr>
<td>9.</td>
<td>Support persons and families dealing with end-of-life issues related to dying, death, and bereavement.</td>
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<tr>
<td>10.</td>
<td>Understand the perspective and values of social work in relation to working effectively with other disciplines in geriatric interdisciplinary practice.</td>
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Comments

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### II. ASSESSMENT

<table>
<thead>
<tr>
<th>Skill Level (0 -4)</th>
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<tbody>
<tr>
<td>1. Use empathy and sensitive interviewing skills to engage older clients in identifying their strengths and problems.</td>
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<tr>
<td>2. Adapt interviewing methods to potential sensory, language, and cognitive limitations of the older adult.</td>
</tr>
<tr>
<td>3. Conduct a comprehensive geriatric assessment (bio-psychosocial evaluation).</td>
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<tr>
<td>4. Ascertain health status and assess physical functioning (e.g., ADLs and IADLs) of older clients.</td>
</tr>
<tr>
<td>5. Assess cognitive functioning and mental health status of older clients (e.g., depression, dementia).</td>
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<tr>
<td>6. Assess social functioning (e.g., social skills, social activity level) and social support of older clients</td>
</tr>
<tr>
<td>7. Assess caregivers’ needs and level of stress.</td>
</tr>
<tr>
<td>8. Administer and interpret standardized assessment and diagnostic tools that are appropriate for use with older adults (e.g., depression scale, Mini-Mental Status Exam).</td>
</tr>
<tr>
<td>9. Develop clear, timely, and appropriate service plans with measurable objectives for older adults.</td>
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<tr>
<td>10. Reevaluate and adjust service plans for older adults on a continuing basis.</td>
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### III. INTERVENTION

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<tbody>
<tr>
<td>1. Establish rapport and maintain an effective working relationship with older adults and family members.</td>
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<tr>
<td>2. Enhance the coping capacities and mental health of older persons through a variety of therapy modalities (e.g., supportive, psychodynamic).</td>
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<tr>
<td>3. Utilize group interventions with older adults and their families (e.g., bereavement groups, reminiscence groups).</td>
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<td>4. Mediate situations with angry or hostile older adults and/or family members.</td>
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<tr>
<td>5. Assist caregivers to reduce their stress levels and maintain their own mental and physical health.</td>
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<td>6. Provide social work case management to link elders and their families to resources and services.</td>
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<tr>
<td>7. Use educational strategies to provide older persons and their families with information related to wellness and disease management (e.g., Alzheimer’s disease, end of life care).</td>
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<tr>
<td>8. Apply skills in termination in work with older adults and their families.</td>
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<tr>
<td>9. Advocate on behalf of clients with agencies and other professionals to help elders obtain quality services.</td>
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<tr>
<td>10. Adhere to laws and public policies related to older adults (e.g., elder abuse reporting, legal guardianship, advance directives).</td>
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IV. AGING SERVICES, PROGRAMS, AND POLICIES

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<tbody>
<tr>
<td>1.</td>
<td>Provide outreach to older adults and their families to ensure appropriate use of the service continuum.</td>
</tr>
<tr>
<td>2.</td>
<td>Adapt organizational policies, procedures, and resources to facilitate the provision of services to diverse older adults and their family caregivers.</td>
</tr>
<tr>
<td>3.</td>
<td>Identify and develop strategies to address service gaps, fragmentation, discrimination, and barriers that impact older persons.</td>
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<tr>
<td>4.</td>
<td>Include older adults in planning and designing programs.</td>
</tr>
<tr>
<td>5.</td>
<td>Develop program budgets that take into account diverse sources of financial support for the older population.</td>
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<tr>
<td>6.</td>
<td>Evaluate the effectiveness of practice and programs in achieving intended outcomes for older adults.</td>
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<tr>
<td>7.</td>
<td>Apply evaluation and research findings to improve practice and program outcomes.</td>
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<tr>
<td>8.</td>
<td>Advocate and organize with the service providers, community organizations, policy makers, and the public to meet the needs and issues of a growing aging population.</td>
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<tr>
<td>9.</td>
<td>Identify the availability of resources and resource systems for older adults and their families.</td>
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<td>10.</td>
<td>Assess and address any negative impacts of social and health care policies on practice with historically disadvantaged populations.</td>
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V. LEADERSHIP IN THE PRACTICE ENVIRONMENT OF AGING

*Leadership skills are life long learning objectives for which a foundation is laid in social work education. Competence is built over years of practice and continuing education.*

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<thead>
<tr>
<th>Skill Level (0 - 4)</th>
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<tbody>
<tr>
<td>1. Assess “self-in-relation” in order to motivate yourself and others including trainees, students, and staff toward mutual, meaningful achievement of a focused goal or committed standard of practice.</td>
</tr>
<tr>
<td>2. Create a shared organizational mission, vision, values and policies responding to ever changing service systems in order to promote coordinated, optimal services for older persons.</td>
</tr>
<tr>
<td>3. Analyze historical and current local, state, national policies from a global human rights perspective in order to inform action related to an identified social problem and/or program for older adults for the purpose of creating change.</td>
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<tr>
<td>4. Plan strategically to reach measurable objectives in program, organizational, or community development for older adults.</td>
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<tr>
<td>5. Administer programs and organizations from a strength’s perspective to maximize and sustain human resource (staff and volunteers) and fiscal resources for effectively serving older adults.</td>
</tr>
<tr>
<td>6. Build collaborations across disciplines and the service spectrum to assess access, continuity, and reduce gaps in services to older adults.</td>
</tr>
<tr>
<td>7. Manage individual (personal) and multi-stakeholder (interpersonal) processes at the community, interagency, and intra-agency levels in order to inspire, leverage power, and resources to optimize services for older adults.</td>
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<tr>
<td>8. Communicate to public audiences and policy makers through multiple media including writing synthesis reports and legislative statements and orally presenting the mission and outcomes of the services of an organization or for diverse client group (s).</td>
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<tr>
<td>9. Advocate with and for older adults and their families for building age friendly community capacity (including the use of technology) and enhance the contribution of older persons.</td>
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<tr>
<td>10. Promote use of research (including evidence based practice) to evaluate and enhance the effectiveness of social work practice and aging related services.</td>
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Interviewing a Social Work Candidate

Questions and Suggested Responses

Selecting the best candidate for any position is important - time spent prior to hire may save time wasted on an improper hire. Asking the right questions to identify candidates’ knowledge and skill sets is key. The questions in this document target specific areas in which a qualified social worker must demonstrate expertise. The bulleted points provide parameters for suitable answers.

An often overlooked part of the interview process is assessment of writing skills. The social work task force recommends that in addition to the verbal interview each candidate be asked to demonstrate observation and documentation skills.

Place the candidate in a common area where several residents can be observed. Instruct the candidate to observe the residents and then write a sample medical record entry describing the resident and situation. Or, an alternate suggestion is to ask the person to write a sample record entry based on a real situation he/she handled from another setting (make certain privacy is upheld). Evaluate the written responses for clarity of thoughts, knowledge of pertinent issues, completeness, legal defensibility and grammar/legibility.

<table>
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<tr>
<th>QUESTION</th>
<th>APPROPRIATE ANSWERS</th>
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| **You have 5 computer assessments due, 3 new admissions, 2 discharges and care plans today. How do you prioritize your day?** | • Organize day into related activities to increase efficiency  
• Do all related tasks at once, i.e. gather all charts to complete MDS assessments at one time  
• Determine what time the residents will be discharging and ensure all services are arranged to facilitate a safe d/c plan (all this should have already been arranged prior to the day of d/c but now it’s just making sure it all falls into place)  
• Since care plans are at scheduled times, all other activities must take place around those  
• Save the new admissions for the end of the day unless intervention is needed sooner  
• Remain focused on the task at hand  
• Minimize interruptions |
| **What is your understanding of a grievance policy?** | • Grievance reports are written whenever an issue/complaint cannot be immediately resolved (and sometimes then as well)  
• Important to understand the facility policy and follow it exactly  
• Usually, the social worker is responsible for maintaining the grievance log and reporting issues/trends at the quality meeting  
• Risk management is anything related to reducing the possibility of loss or injury; it requires excellent communication and teamwork as well as ongoing training, especially in areas of customer service  
• Look for evidence that the candidate has critical thinking skills |
| **How do you know when to write a grievance report?** |  |
| **How do you describe risk management?** |  |
| **Describe the components of a care plan for a resident with depression.** | • The Problem Statement needs to be resident specific and describe HOW depression impacts his/her quality of life  
• The goal should: 1) offer positive value to the resident, 2) improve his/her life somehow, 3) be measurable and realistic & 4) **address causal factors and not symptoms** such as tearfulness or combativeness |
The approaches or interventions describe *what the staff will do* to assist the resident in achieving the goal, i.e. provide 1:1 visits weekly by the social worker to discuss feelings r/t cause of depression and resident strengths, facilitate a date night with husband, refer to a psychiatrist, etc.

**What are the components of a comprehensive biopsychosocial assessment?**

- Focus on resident strengths throughout the entire interview and assessment process
- Identifying information (ethnicity, spirituality, appearance, payer source, etc.)
- Reason for admission and presenting problems, prior living arrangements and level of assistance needed with ADLs and IADLs
- Advance directives and need for advance care planning
- History of physical and/or psychosocial problems
- Mental health and psychological treatment
- Personal and family history
- Support system
- Education and employment history
- Interests/hobbies
- History of substance abuse
- Cognitive functioning
- Discharge plan, if appropriate
- Impression and assessment

**How do you prepare to interview a new resident/patient?**

- *Comprehensive chart review to identify: (not going in “cold”)*
  - Advance directives
  - Responsible parties
  - Diagnoses and impact on mood/behavior
  - Discharge planning issues or placement issues if for long term care
  - Issues from the hospital such as mood or behavior challenges
  - Review of nursing assessments, especially fall, pain and elopement risks – ensure care plans are started
  - Identify areas that the social worker can contribute to an interdisciplinary approach to care plans
  - Therapy evaluations to get information on the prior level of functioning and goals

**How do you explain code status to a resident and/or family member?**

- First ask if they have questions regarding advance directives or code status
- Ask them to explain their understanding of the choice, either full code or do not resuscitate (DNR)
- Ensure accuracy of understanding
- If education is needed, explain full code in the same way that any other treatment or procedure is explained which includes discussion of risks (broken ribs, punctured lungs, probably decreased quality of life). Inform that Full Code includes many procedures, i.e. intubation, cardiac compression, artificial ventilation, etc.,
- Take the orange card to the meeting as a visual aid
- If education is needed for DNR, explain that comfort care is always provided, i.e. oxygen, pain management
<table>
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<tr>
<th><strong>Describe your experience with care plan conferences.</strong></th>
<th>• If code status is changed, must communicate with the charge nurse to get appropriate orders and follow facility procedures</th>
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</table>
| **Do you facilitate the meetings?** | • Review the actual care plan during the conference  
• Invite participation from resident/family/responsible party  
• Facilitate an efficient and productive conference  
• Facilitate conference calls if family/responsible party unable to attend, schedule conferences at bedside if resident is unable to get out of bed  
• Keep group focused – if conference turns into a “complaint session” schedule a separate meeting with necessary staff  
• Social worker reports on: mood, behaviors, room changes, roommate changes, how resident is adapting to facility life or if admitted for a rehab stay, the discharge plan, advance directives, emergency contact and relationship |
| **How do you keep them on track?** | • Review the actual care plan during the conference  
• Invite participation from resident/family/responsible party  
• Facilitate an efficient and productive conference  
• Facilitate conference calls if family/responsible party unable to attend, schedule conferences at bedside if resident is unable to get out of bed  
• Keep group focused – if conference turns into a “complaint session” schedule a separate meeting with necessary staff  
• Social worker reports on: mood, behaviors, room changes, roommate changes, how resident is adapting to facility life or if admitted for a rehab stay, the discharge plan, advance directives, emergency contact and relationship |
| **What information do you report on?** | • Review the actual care plan during the conference  
• Invite participation from resident/family/responsible party  
• Facilitate an efficient and productive conference  
• Facilitate conference calls if family/responsible party unable to attend, schedule conferences at bedside if resident is unable to get out of bed  
• Keep group focused – if conference turns into a “complaint session” schedule a separate meeting with necessary staff  
• Social worker reports on: mood, behaviors, room changes, roommate changes, how resident is adapting to facility life or if admitted for a rehab stay, the discharge plan, advance directives, emergency contact and relationship |
| **What is your experience in discharge planning?** | • Referrals to community resources – must demonstrate knowledge of most common resources, i.e. home health, medical equipment, Title 19, Meals-on-Wheels, mental health services  
• Discharge planning starts with the pre-admission process  
• Comprehensive documentation of all activities related to discharge planning, including name and time of any phone calls, meetings or interactions  
• Communication with interdisciplinary team, resident and family  
• Coordination of home health and equipment to coincide on day of discharge or earlier if training is necessary on a new piece of equipment, i.e. 4-wheeled walker, glucometer, etc. |
| **How do you give report to a health plan case manager?** | • Be prepared with updates from all disciplines (nursing, rehab, dietary) Focus on progress to justify skilled stay  
• Keep conversation short and focused on patient issues  
• Keep case manager updated on all discharge planning barriers/challenges  
• If not sure how to answer a question, get someone to help |
| **A patient admitted for rehabilitation has declined therapy for two days. What is the role of the social worker?** | • Assess reason(s) why resident is declining therapy, i.e. depression, confusion, pain  
• Identify possible interventions to facilitate participation  
• Explain insurance benefits and skilled stay requirements  
• Involve family if appropriate  
• Consider writing a care plan for “refusal of care”  
• Communicate with staff at PPS or stand-up meeting |
| **Two roommates are not getting along. What do you do?** | • Interviewee must demonstrate knowledge of resident rights and roommate regulations  
• Talk to both residents, individually and possibly together  
• Help them generate creative solutions  
• If a solution is not possible and a room change is necessary, the resident that initiated the “complaint” is the one who must make the room change  
• Document in both residents’ medical records all interventions attempted as well as the outcomes  
• Make sure families are kept informed as appropriate |
| What is the role of the social worker with pain management? | • Be familiar with the Federal regulations for pain management in F309 Quality of Life  
• Assessment using tools like the “faces” scale, the “number scale 1-10” or scales for advanced dementia  
• Assessment by asking about: aggravating and alleviating factors, impact of pain, meaning of pain, and most importantly, the resident’s goals for pain management  
• Education regarding: misconceptions related to pain, challenges to achieve adequate pain management, the relation of pain to behaviors/mood, definitions of tolerance, addiction and dependence  
• Identification of non-drug interventions and techniques to relieve anxiety (guided imagery, visualization, muscle relaxation) |
|---|---|
| A resident’s daughter comes into your office in tears. Her mother is quite ill and probably won’t make it through the week. What do you do? | • Invite her to sit down  
• Shut the door to ensure privacy,  
• Put phone on Do Not Disturb  
• Start where the daughter is – if she needs to cry, let her cry; if she needs to talk, let her talk (about topics she feels necessary)  
• Encourage her to share her feelings, concern, worries  
• Do not offer false hope or meaningless comments like “I’m sure things will be just fine” or “At least she won’t be suffering.”  
• If she is receptive, talk about ways staff focuses on her mom’s comfort  
• Determine if any action is necessary  
• Ask if there is anything else she would like staff to do  
• In some circumstances, suicide assessment might be necessary |
| A resident is admitted to your facility with advanced cancer. How do you approach her on this topic? | • Start with very general discussion and ask her what she knows about her medical condition or why she is in the facility  
• Determine if she needs more information or to have information repeated and then facilitate getting the information to her  
• Involve other members of the IDT as necessary, i.e. physician, nurse  
• Use active listening techniques  
• Initiate or update the care plan with social work interventions such as 1:1 visits to allow resident to share feelings r/t diagnosis and prognosis |
| Tell me about your communication skills. | • Communication is vital to a successful facility  
• Must be comfortable speaking up in a group, being assertive even if the group does not agree with the content, i.e. room change conflicts, patient discharge decisions  
• Ability to listen to other peoples’ points-of-view and use reflective statements, i.e. “What I hear you saying is…” or “It’s important to you that…”  
• Ability to remain professional, mediate disagreements |
| How do you employ them in the interdisciplinary team? What personality traits do you have that help you communicate effectively? | • Interviewee must be able to describe a complicated situation and demonstrate skill and critical thinking in achieving resolution  
• Listen for terms like: residents rights, assessment, documentation, involvement of the IDT, family meetings, physicians orders, advance directives, ombudsman and care plans |
| What did you learn from it? | • The candidate should demonstrate ability to incorporate learned knowledge into daily practice and possibly modify current practices based on such experience  
• Important traits include flexibility, self-confidence (not ego) |
| What are your strengths? |  
| Weaknesses? | • Interviewee should be able to express how strengths and weaknesses impact his/her performance in the work setting  
• How does the interviewee adjust or compensate for weaknesses? |
| What is something you have failed at? | Must demonstrate ability to learn from mistakes and to use the knowledge positively  
Assess ability to identify when it is time to ask for help, to utilize other resources |
| What did you learn? |  
| Are you using this knowledge now? How? |  
| What areas would you like more education? | • Ability and willingness to be honest about areas that need work or that the person wants to become more proficient  
• Of concern would be the interviewee who does not feel additional education is necessary |
| What do you do to prevent burnout? | Hobbies/interests  
Family, friends, social supports  
Leave work at work  
Know limits  
Maintain a sense-of-humor  
Talk to supervisor if feeling stressed or overwhelmed  
Exercise and eat a balanced diet  
Get enough sleep |
| What would you do if you were feeling overwhelmed? | Speak to supervisor  
Communicate regarding unfinished tasks  
Develop action plan to address unfinished areas  
Ask for help! |
| What makes you competent to do this job? | Someone who exudes confidence but not arrogance  
Someone comfortable jumping into new environments but also willing to ask for help  
Skills – be specific  
Training – be specific  
Experience – be specific  
Personality, personal goals, passion – describe |
| Why do you want to work here? | Assess for sincerity  
Did interviewee do research on the facility prior to the interview, i.e. number of beds, clientele, rating on nursing home compare? |
“The standards may be regarded as a basic tool for social work practice in long-term care facilities, although practice priorities may vary among settings. NASW recognizes the need to integrate knowledge of long-term care services into social work practice. The standards outlined in this document are the results of that recognition.”

To download this resource, go to: http://socialworkers.org/practice/standards/NASWLongTermStandards.pdf
Code of Ethics

Every social worker should follow the Code of Ethics. Download the Code at http://www.socialworkers.org/pubs/code/default.asp
Nursing Home Social Services Directors’ Opinions About the Number of Residents They Can Serve

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An appropriate number of qualified staff is a key factor contributing to quality of care and quality of life for nursing home residents. While much of the literature focuses on the importance of adequate nursing ratios, this descriptive study is the first to focus on the social services staff ratio. Nationally representative survey results from over 1,000 nursing home social services directors reveal that the mean number of residents per full-time equivalent social worker in the United States is 89.3 and the median is 79 residents (note that this figure includes both long-term and subacute residents). Furthermore, although the federal government requires nursing homes with more than 120 beds to employ 1 full-time qualified social worker to meet resident psychosocial needs, when asked their opinion, the majority of respondents indicated that 1 full-time social worker could handle 60 or fewer long-term care residents or 20 or fewer...

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Address correspondence to Mercedes Bern-Klug, PhD, John A. Hartford Geriatric Social Worker Faculty Scholar, School of Social Work, and Director, the Aging Studies Program, Room 308, North Hall, University of Iowa, Iowa City, IA 52242, USA. E-mail: Mercedes-bern-klug@uiowa.edu
Encourage social workers and social service staff to join this free listserv. People across the country are involved and often the discussion is guided by experts and researchers in the field. Participants share ideas and offer resources and tools in a variety of areas such as behavior monitoring, sensitivity training, psychotropics, resident rights, policies, interpretation of regulations and so much more. As an added benefit, listserv members can participate in free, live webinars on topics targeted to nursing home social workers like ethical decision-making, psychosocial assessments, documentation, patient-centered care and end-of-life care.

For more information go to: http://clas.uiowa.edu/socialwork/nursing-home/nursing-home-social-workers-listserv
Or Google Nursing Home Social Workers’ Listserv.

Please encourage your staff to participate in this invaluable service.
Position Summary for a Long Term Care Social Worker

- Serve as a resident advocate
- Educate staff on when to make a referral to the social worker (reference F250)
- Be knowledgeable about relevant federal and state regulations
- Maintain a current department policy and procedure manual and demonstrate the ability to operationalize the procedures
- Conduct and document a biopsychosocial assessment
- Provide and/or arrange for social work services to meet resident needs including dental/denture care, podiatric care, eye care, hearing services, equipment for mobility or assistive eating devices and the need for a homelike environment, control, dignity and privacy according to F250. Provide psychosocial interventions such as supportive counseling and support group facilitation
- Facilitate communication with resident/patient/responsible party regarding resident needs, discharge planning, transfers and changes in care
- Contribute to the comprehensive care plan based on the biopsychosocial assessment, develop measurable goals and provide as well as document stated interventions
- Identify, care plan and communicate nonpharmacological interventions to address residents' mood and behavioral needs
- Complete assigned sections of the Minimum Data Set (MDS) – appropriate sections include C (Cognitive Patterns), D (Mood), E (Behavior) and Q (Participation in Assessment and Goal Setting)
- Conduct quarterly biopsychosocial updates
- Document progress notes that address changes in biopsychosocial needs or status
- Maintain an up-to-date list of community resources and make referrals as needed to facilitate a successful discharge
- Make resource referrals for residents and family members during the resident's stay in the facility
- Attend and actively participate in interdisciplinary team meetings
- Assist residents to complete advance directives
- Facilitate advance care planning discussions
- Provide palliative care assessments
- Facilitate discharge planning starting from admission
- Educate resident/patient/family about financial benefits and initiate referrals
- Assist residents and families with financial and legal matters
- Initiate performance improvement projects related to enhancing quality of care
- Provide mandated inservices such as Resident Rights and Abuse & Neglect
- Identify educational opportunities for staff related to biopsychosocial issues and provide training or help facilitate training
- Maintain a grievance log and report findings at the Quality Assurance and Performance Improvement meeting

Demonstrates knowledge of:
- Systems perspective
- Group process/dynamics
- Disease processes
- Medical terminology
- Family systems
- Aging and related developmental stages
- Resident rights
- Federal and state regulations

Demonstrates skills:
- Develop rapport with residents and family members
- Active listening and problem solving
- Provide mood and behavioral interventions
- Delegation and teamwork
- Interpersonal communication
- Prioritize and organize
- Leadership and assertiveness
- Facilitate group meetings and care conferences
- Crisis intervention
The Quality Indicator Survey Process:
The Role of the Social Worker

The social worker in your facility can and should be an integral part of not only preparing for the QIS Process but for maintaining regulatory compliance all year long. Outlined below are specific ways in which the social worker can impact positive resident outcomes and help achieve a deficiency-free survey.

The social worker can:

- Serve in the most important role for residents and the facility – as Advocate
- Conduct interviews with resident and family members using the QIS interview tools
- Compile findings and identify issues and Performance Improvement Projects (PIPs)
- Work with the interdisciplinary team to develop PIPs
- Provide detailed biopsychosocial assessments that contribute to a comprehensive care plan
- Complete proactive and defensive documentation to protect the facility from economic losses
- Identify potential risk management problems before they escalate into crises
- Be a team leader for environmental rounds to help ensure resident self-determination, dignity and choice
- Provide inservices on abuse reporting, resident rights, and many other topics
- Provide inservices on handling difficult situations such as challenging resident and family behaviors
- Foster a climate of outstanding customer service
- Help prepare residents for the survey so they know what to expect
- Complete the Critical Element Pathway for Behavioral & Emotional Status to assist in evaluating compliance with regulatory requirements
- Be a source of knowledge on F-tags such as Quality of Life, Dignity, Self-Determination, Home-like Environment, Abuse, Discharge Planning and Medically-Related Social Services
Recommended Resources/Reading for Social Workers & Clinical Operations

(Check book availability at www.amazon.com and www.barnesandnoble.com unless otherwise indicated.)

Defensive Documentation for Long-Term Care, Strategies for creating a more lawsuit-proof resident record by Tra Beicher, RNC, ARM, HRM, CWS  Contact: Nina Cronan at 1-800-328-0293, ext. 3794

Overcoming Secondary Stress in Medical and Nursing Practice by Robert Wicks

Critical Thinking and Clinical Judgment. A practical Approach to Outcome-Focused Thinking by Rosalinda Alfaro-LeFevre

The New Care Plan Answer Book for Activity, Psychosocial and Social Work Programs: MDS 3.0 Edition by Steven C. Greenwald, LCSW, Traci Pareti, CTRS and Esther J. Davis, CTRS

Revolutionary OBRA & JCAHO Formatted Care Plans - Customized MDS/CAA Based Care Plans by Health Care Partnership, a division of SocialWork Consultation Group Publishing http://swcginc.com/store/manuals-c-1


Social Work Documentation – A Guide to Strengthening Your Case Recording by Nancy Sidell


The Social Work Ethics Casebook Cases and Commentary by Frederic Reamer


A Facility-Based Risk Management Program: A Practical Guide for LTC Providers by Tra Beicher, RNC, ARM, HRM, CWS  Contact: Nina Cronan at 1-800-328-0293, ext. 3794


A Dog Walks into a Nursing Home by Sue Halbern
National Resources for Long Term Care Social Workers

American Health Care Association [Link]

LeadingAge [Link]

ConsultGeriRN.org and Try This:@ [Link]

Portal of Geriatrics Online Education [Link]

Boston University School of Social Work Center for Aging and Disability Education and Research [Link]

National Consumer Voice for Quality Long-term Care [Link]

Advancing Excellence in America’s Nursing Homes [Link]

The National Association of Social Workers (NASW) [Link]

The National Association of Social Workers (NASW) Web ED [Link]

National Center for Gerontological Social Work Education [Link]

American Geriatrics Society [Link]
University of Iowa
Resources for Nursing Home Social Workers

http://clas.uiowa.edu/socialwork/nursing-home/other-resources

RESOURCES FOR NURSING HOME SOCIAL WORKERS

Other Resources

Free guide discussing comfort care for people with dementia living in care facilities. Produced by the Alzheimer’s Association—Greater Illinois Chapter.

Arizona State University Training Modules (courtesy of Dr. Robin Dorlay and her students).

Motivational Interviewing

- Powerpoint, including bibliography
- Case study

Suicide Assessment

- Powerpoint
- Annotated bibliography
- Case Study

Dementia-related Behaviors and Environmental Changes

- Powerpoint
- Annotated bibliography
- Case Study

Books & Reports


Contains the following agencies:

- Nursing Home Residents’ Psychosocial Needs: Social Work Perspective
- Office of Inspector General Report: Psychosocial Services in Skilled Nursing
- NASW Standards for Social Work Services in Long-Term Care Facilities
- AOS/AAGP Consensus Statement on Improving US Nursing Home Mental Health
- Social Worker Functions in Long-Term Care Settings (Department of Veterans)
- A4F
- NASW Clinical Indicators for Social Work and Psychosocial Services in Nursing Homes
- Quality of Life Measurement Domains

2) Measuring Long-Term Care Work: A Guide to Selected Instruments to Examine Direct Care Worker Experiences and Outcomes


3) Social Work Services in Nursing Homes: Toward Quality Psychosocial Care NASW

4) Market Survey of Long-Term Care Costs: The 2008 Medi8 Market Survey of Nursing Home, Assisted Living

Social Work Role Responsibilities

- List of 15 “Best Practice Social Work Role Functions in Long-Term Care Facilities”
- What activities and processes are social services departments engaged in?
- State Operations Manual Describing the Role of Nursing Home Social Services (used by surveyors)
- National Association of Social Workers Long-Term Care Standards
- CMS Psychosocial Severity—Guide for Surveyors
Sample Admission Note #1

The admission note is a crucial first entry by the social worker in the medical record. In this narrative note, there should be clear documentation regarding the events leading to admission, initial observations (mental status, appearance, adjustment, etc), identification of immediate problems and needs as well as a social work plan (which should also be on the care plan). This first visit should occur with 48 hours of admission.

Mr. Larson is a 69 y/o male admitted on 5/31/13 from Northwest Medical Center to Room 210A. Diagnosis for this admission is s/p right THA following a fall from a curb at the shopping mall (he was carrying a large package and didn’t see the lip of the curb). Pt admitted for PT/OT. Co-morbid diagnoses include CHF and lung Ca, although per pt, the cancer is not a present concern. He underwent chemo 3 years ago and has not had a recurrence. Pt accepts the need to be in facility for rehab and voiced he is ready to work hard and get home. This writer explained skilled need as well as the factors that determine the length of stay, i.e. medical status, improvement in therapy. Resident is dressed in a hospital gown but wife plans to bring his clothes from home, including shoes for therapy. Resident makes own decisions and is goal-oriented. Pt states that his pain has been well-controlled but when he does have pain, the current medication regimen relieves it. Mr. Larson said his pain tolerance is very high and he prefers to endure some pain rather than side effects of medications, especially drowsiness. At this time, he rates his pain as 4/10. His goal is to remain under a 5/10. His past coping skills include distractions such as reading and going out with friends. Denies depression. The couple has three children: son in Tucson, dtr in New York and a son in Phoenix. His daughter is expecting a baby this summer and he and his wife are planning a trip back east. Prior to hospitalization he was independent with all ADLs and very active with friends and various social clubs. He retired 5 years ago from the Phoenix police department and jokingly stated he is “enjoying his freedom!” D/C plan is home with wife who is able to provide some hands-on care but expressed concerns regarding heavy lifting should husband require such help. SW explained that the goal is for Mr. Larson to return to his prior level of functioning and be independent. As he progresses in therapy, Mrs. Larson will be invited to participate in caregiver training so she is comfortable with his abilities/needs. Although limited, she stated they do have some funds should they need to hire assistance at home. Wife is independent with all activity, including driving. Pt does not have any medical equipment at home although his son could install grab bars and other equipment if needed. Pt has not completed advance directives and was agreeable to reading some materials and scheduling a meeting this week to complete the documents. This writer also offered to assist Mrs. Larson with completing her directives at the same time. Both expressed appreciation. Informed them that if pt has not been discharged in approx two weeks, he would receive an invitation to a care plan conference. SW to assist with discharge planning, arrangements for home health or outpatient therapy if ordered, and DME. No further questions at this time.

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Julie Brown, BSW
Jane Trevor is a 42 year old Caucasian female admitted on 7/16/13 from Mercy General to Room 115B. Diagnosis for this admission is s/p PE. Pt admitted for PT/OT/pain control/IV ABT. She had a sitter at the hospital d/t severe agitation and pulling at the IV line. According to hospital records, two days prior to transfer, her cognitive status improved and she no longer required the sitter. Co-morbid diagnoses include bipolar disorder, chronic fatigue syndrome, diabetes and a-fib. Level II PASRR will be initiated if patient is still in facility closer to the 30th day. She has two weeks left for IV ABT and the anticipated d/c plan is home alone. Community psychiatric case manager is Christa Simmons at La Frontera, 520-555-4437. Pt sees her monthly and obtains her psychiatric medications from the clinic. Pt taking Abilify and Paxil. Met with patient to discuss the d/c plan. She was dressed in loose fitting clothes and somewhat disheveled. She lost her train of thought easily and had to be redirected to the conversation several times. Although A&OX3, she revealed that her “memory has not been so good.” Described difficulty remembering simple tasks. Feelings of depression worse since hospitalization but denies SI/HI. Has been having trouble sleeping and her appetite is poor, “has no interest in eating.” Denies ETOH use but admits to “periodic cocaine use.” Pt is unemployed and receives disability but is unable to make her rent as well as other expenses. Check is mailed to her home address on record. One week prior to hospitalization she began having shortness of breath and then when leaving her apartment building, a neighbor witnessed her collapse and called 911. Stated she “hates nursing homes” and wants to “get out of here as soon as she can.” She is single but has a significant other, Bill, but his level of support is unknown. Pt. thinks they have broken up. Has one son who lives in Oregon but no contact. Pt identified no other support. She is determined to go home but is not sure if she’ll still have her apartment. Explained skilled need and that her insurance will cover her stay for the course of the ABT Tx. Social Work Plan: 1) Identify options for living arrangements upon discharge, 2) Contact psychiatric case manager, 3) Utilize strengths for plan of care – goal oriented and able to participate in decision-making.

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Paige Hector, LMSW
Sample Social Work Progress Notes

Progress notes should capture:

- Involvement with the resident or family
- Discharge planning
- Behavioral intervention
- Progress toward care plan goals
- Resources and referrals

Example #1
Spoke with resident’s daughter to provide update regarding therapy. Resident ambulates 50’ with her FWW which is the same distance as this time last week. She does require limited assist to go from a sitting to standing position as well as verbal cues for safety. She tends to leave her walker at times and ambulate around the room by holding onto furniture. Discussed the significant risk for falls, both at the facility and at home. Daughter verbalized understanding and agreed that Mom really does require 24-hour care and supervision. She has toured adult care homes and although she really wanted Mom to return home, knows that the ACH is the best option. This writer will request that the physical therapist invite the care home owner in for caregiver training. Resident would benefit from home PT/OT given her new living environment. Daughter will talk to Mom tonight about the move.

Example #2
Celexa dose increased for target behaviors of isolation and irritability. Resident continues to show signs of depression on a daily basis. She is receptive to 1:1 visits from this writer to discuss strategies to adapt to LTC environment – visits will continue. Will ask husband to bring family dog in weekly to visit resident.

Example #3
Observed resident tucking pack of cigarettes in side of wheelchair. Met with resident to review facility smoking policy for the second time this month. Her boyfriend brings the cigarettes and lighter to her despite staff requests to give all smoking materials to the charge nurse. Resident has demonstrated poor safety awareness as she lights two cigarettes at once and has burned her clothing multiple times. Now, she is on a supervised smoking schedule 5x/day. Advised resident that her continued non-compliance with facility smoking policy would be discussed with the interdisciplinary team. Resident gave this writer the cigarettes and lighter which were then given to charge nurse.

Example #4
Resident declined overnight and is no longer arousable. According to the charge nurse, resident’s breathing is irregular with periods of apnea. Daughter from out-of-state due in today. This writer met with local daughter, Mary, at bedside. She was holding Mom’s hand and singing quietly. Receptive to a visit and starting crying. Provided support and encouraged Mary to talk about her grief over Mom’s imminent death. Will check on daughter later this morning.

Example #5
Referral made to Steve at Sunrise Home Health for PT/OT and RN for wound care. Patient will be discharged home with son 9/4/09 and home health scheduled to start 9/5/09. Facility will provide first two days worth of dressing change supplies. Son has patient’s home O2 at his house and has already made contact with Preferred Home Care to order more E-tanks. Private duty caregiver has completed caregiver training and will be with patient while son is at work from 8:30 AM to 4:30 PM. Pt has a FWW and wheelchair at son’s house. No further needs at this time.
The quarterly note can also suffice for a care plan conference note as long as it is comprehensive and clearly explains all pertinent issues. If the social worker is writing a summary of the actual care conference, this entry should reflect details from all disciplines at the meeting.

Resident unable to participate d/t advanced dementia. Dtr (Sally) present and son (John) on conference call. During the past quarter, resident had a UTI and was treated with ABT. She is ambulatory without an assistive device and resides in the secured neighborhood d/t being an elopement risk. She continues on the antidepressant and engages easily with staff, sleeps well and expresses no negative verbalizations. She is oriented to person and still recognizes dtr but often confuses her son with her deceased husband. She requires verbal cues for most ADLs and is usually cooperative with care. She will push at staff when they attempt to provide care in the late afternoon as this is the time she gets fatigued from ambulating much of the day. Staff encourages her to rest during the day and sometimes she is receptive to sitting in her easy chair. When agitated, staff approaches her slowly and gives her simple explanations of all care being provided. Dtr added that when Mom was living at her home, dtr would hum her favorite songs which helped Mom relax. Resident is continent of bowel and bladder but does not verbalize when she needs to use the restroom. Resident has underwear in her dresser but she prefers to wear adult depends according to dtr. Resident had one fall this quarter when she tripped over the wheelchair leg rest of a resident sitting in the hallway. No injury sustained. Son asked how often the physician visits and was informed every second month but that he is available should resident have a problem that needs to be addressed. Resident weight down 4 lbs but still within IBWR. Appetite good and dtr brings her favorite meals from home at least once a week. Recent lab values WNL. She receives supplements with med-pass. Resident carries on conversations with her roommate but flow of conversation is tangential. She smiles easily and loves to hug staff. Often she plants kisses on their cheeks too. She attends activities both on and off the neighborhood and really enjoys the cooking class and anything that allows her to work with her hands. Old movies are one of her favorite activities and she laughs hysterically at The Three Stooges! Resident attends the weekly church service and participates at appropriate times, i.e. moments of silence and prayer. Her pastor from Good Sam Family Church visits 1x/wk. Resident is a DNR and the dtr is MPOA along with son as second agent. Although resident does not have a living will both dtr and son are in agreement that Mom would not want to be kept alive on life support of any kind. Their goal for her is comfort measures and that she not be hospitalized. Charge nurse to obtain order for DNH. Consent form signed by dtr during conference. Both dtr and son expressed satisfaction with care at facility and thanked staff for their time.

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Paige Hector, LMSW
Social Service Professional Performance Evaluation

Employee:  Job Title:  Date:

Evaluation Key:  1-Poor  2-Below Average  3-Average  4-Above Average  5-Excellent

Performance Responsibilities

1. Consistently available to meet and welcome new residents upon admission. 1 2 3 4 5

2. Documentation is completed on a timely basis (in accordance with state, federal and facility requirements). Content is strong with clear descriptions. 1 2 3 4 5

3. Documentation clearly emphasizes objective information, staff interventions and resident response or other outcome. 1 2 3 4 5

4. Routinely interviews residents, family members, community agency representatives and significant others to become knowledgeable about the individual resident. 1 2 3 4 5

5. Regularly attends the Care Plan Conference and contributes information about the resident’s social and emotional needs. 1 2 3 4 5

6. Demonstrates strong “observational” and “active listening” skills. Establishes and maintains a supportive counseling relationship with residents and families. 1 2 3 4 5

7. Documents discharge planning information and works with residents, families and significant others to facilitate discharge planning, when appropriate. Takes an active role in discharge planning. 1 2 3 4 5

8. Attends special meetings within the facility and community (such as Family Night, Family Council, Health Fair) or other special events, as requested by the Director. 1 2 3 4 5

9. Contacts community agencies for the purpose of resident advocacy and referral. Maintains professional relationships. 1 2 3 4 5

10. Attends and actively participates in continuing education programs. 1 2 3 4 5

11. Available to meet and work with the Social Work Consultant as a component of the continuing education program. 1 2 3 4 5

12. Completes the admission process competently, including a clear explanation regarding the resident’s right to formulate an Advance Health Care Directive. 1 2 3 4 5

13. Develops and follows a daily work schedule. Consistently uses time efficiently and constructively. Establishes necessary priorities. 1 2 3 4 5

14. Regularly attends weekly/monthly Department meetings and contributes relevant information. 1 2 3 4 5

15. Demonstrates professional/mature interpersonal relationships. 1 2 3 4 5

16. Speaks to residents, families, staff and agency personnel in a dignified, respectful and professional manner. 1 2 3 4 5

17. Completes tasks within reasonable time, as allotted by supervisor. 1 2 3 4 5

18. Maintains standard business hours, as established by supervisor. 1 2 3 4 5

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<tr>
<td>S Available on occasion, to offer additional assistance when necessary and requested by supervisor (i.e., nights, weekends, pre-survey)</td>
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<tr>
<td>20. Maintains a neat, clean and professional appearance.</td>
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<td>21. Demonstrates solid organizational, planning and implementation skills.</td>
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<tr>
<td>22. Supervises subordinates in a clear, organized and professional manner.</td>
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<tr>
<td>23. Available to help resolve resident/representative concerns and demonstrates strong problem-solving skills</td>
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**Overall Rating (115 points maximum):**

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Employee’s Strengths:

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**Areas Requiring Improvement** (Attach short/long-term goals):

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**Employee Signature:**

**Date:**

**Supervisor Signature:**

**Date:**
### Social Work Quality Assurance Improvement Form VI

**Adjustment/Orientation Counseling Services**

**Questionnaire Codes:**
1 = not acceptable  
2 = not satisfactory  
3 = somewhat satisfactory  
4 = satisfactory  
5 = very satisfactory

*Review all applicable documentation to determine the competency and success of interventions provided to facilitate the adjustment process.

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluator(s):</strong></td>
<td><strong>Room #:</strong></td>
</tr>
</tbody>
</table>

1. How satisfactory have social work services been with regard to...  
   - The resident’s psychosocial adjustment to the long-term care setting?
   - The involved family members’ adjustment to the long-term care setting, as applicable?
   - The documentation concerning provision of adjustment counseling?
   - The documentation providing measurable evidence of the resident’s specific coping strategies/methods?
   - The description on the MDS of “Psychosocial Well-Being” and “Mood/Behavior” elements related to the adjustment process?
   - The follow through in the Social Service notes concerning issues assessed on the MDS?

**MSW Consultant:** How satisfactory have counseling services been with regard to...  
- Identification of adjustment/well-being problems?
- The resident’s improvement (progress) since adjustment counseling services were initiated?

*Add the numerical scores and divide by 8 items. Review the first 8 items only for the average. This will provide the average. Follow the recommendations below for appropriate follow-up intervention.*

<table>
<thead>
<tr>
<th>Average</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0 - 5.0</td>
<td>The high average indicates apparent success in assessing and addressing adjustment problems. No specific recommendation.</td>
</tr>
<tr>
<td>2.5 - 3.9</td>
<td>Carefully review notes made during the QA/QI study. Identify problem patterns and determine a reasonable solution. Identify program weaknesses in the delivery of active “mental and psychosocial” intervention and establish goals to improve the delivery of such services.</td>
</tr>
<tr>
<td>1.0 - 2.4</td>
<td>Review the department’s protocols and procedures for adjustment counseling. Ascertain, the most significant deficiencies. Identify immediate goals for (3 month), 6 month goals and 12 month goals for improvement. Re-evaluate the program every 90 days. Utilize this Quality Assurance form every quarter.</td>
</tr>
</tbody>
</table>
Review the resident’s comprehensive care plan to make the following determinations. N.I. represents “needs improvement.” *NO answers need to be addressed immediately upon completion of the QA study:

<table>
<thead>
<tr>
<th>Evaluator:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident:</td>
<td></td>
</tr>
</tbody>
</table>

1. The social work staff are involved in the interdisciplinary care plan conferences.  
2. The care plan contains clearly stated social work interventions/approaches.  
3. The care plan information is current (i.e., revised within the 90 day time frame).  
4. Any social/psychological/psychosocial needs are clearly identified.  
5. The goals are measurable and promote enhanced adjustment and well-being.  
6. The care plan clearly reflects the resident’s individuality.  
7. The care plan is consistent with the MDS and triggered RAP summaries.

Number of “YES” Responses

Comments:

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# Social Work Quality Assurance & Improvement - Form I

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Room Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluator:</strong></td>
<td><strong>Date:</strong></td>
</tr>
</tbody>
</table>

**Medically-Related Social Services (F 250)**
Survey Procedures And Probes: §483.15 (g) (1)

Review the resident’s medical record to make the following determinations:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Nil</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have the resident’s rights have been explained to the resident or his/her representative in an understandable language?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How did facility staff implement social service interventions to assist the resident in meeting treatment goals?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) through 1:1 counseling/intervention?</td>
<td>a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) through group intervention?</td>
<td>b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) through professional consultation?</td>
<td>c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) other:</td>
<td>d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How did staff responsible for social work monitor the resident’s progress in improving physical, mental and psychosocial functioning?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) through assessment/ reassessment?</td>
<td>a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) through progress note documentation?</td>
<td>b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) through care plan documentation?</td>
<td>c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) other:</td>
<td>d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Has goal attainment been evaluated and the care plan changed accordingly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Does the care plan link goals to psychosocial adjustment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have the staff responsible for social work established and maintained relationships with the resident’s family or legal representative?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do social work interventions successfully address the resident’s needs and link social supports, physical care and physical environment with his/her need for individuality?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Has the resident experienced an “avoidable decline” in psychosocial functioning that might have been prevented through the provision of medically-related social work services?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Number of “YES” Responses**

<table>
<thead>
<tr>
<th>Scoring</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 to 8+ = 100% Compliance</td>
<td>Conduct an informal study (review 10-25 random residents) to determine if facility continues within the 85-100% range</td>
</tr>
<tr>
<td>6 to 7 = 70-85% Compliance</td>
<td>Conduct a formal review of 50% of the resident population. Identify social work program weaknesses and establish departmental goals to improve the delivery of social work services.</td>
</tr>
<tr>
<td>&lt;5 = Compliance less than 65%</td>
<td>Review the social work program with the MSW consultant. Identify immediate departmental goals targeted for 3, 6 and 12 months.</td>
</tr>
</tbody>
</table>
Social Work Quality Assurance & Improvement ♦ Form IX
Discharge Planning

Review the clinical record to make the following determinations. *NO answers need to be addressed immediately upon completion of the QA study. N.I. represents “needs improvement.”

<table>
<thead>
<tr>
<th>Evaluator:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Yes</th>
<th>No</th>
<th>N.I.</th>
</tr>
</thead>
</table>

Are the following elements properly documented?

1. Anticipated discharge date.
2. The new place of residence.
3. The resident’s financial status.
4. The primary caretaker.
5. In home support system and outside supports.
6. The resident’s motivation/compliance with the discharge plan.
7. Special Activity needs profile.
8. Psychosocial functioning profile.
9. Dietary needs and concerns.
10. Nursing needs and care profile.
11. Rehabilitation needs and services profile.

<table>
<thead>
<tr>
<th>Number of “YES” Responses</th>
</tr>
</thead>
</table>

Comments:

<p>| | | | |</p>
<table>
<thead>
<tr>
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## Social Work Quality Assurance & Improvement Form I

<table>
<thead>
<tr>
<th>Resident:</th>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

Medically-Related Social Services (F 250)  
Survey Procedures And Probes: §483.15 (g) (1)  
*Review the resident’s medical record to make the following determinations:*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Nil</th>
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<tbody>
<tr>
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<td></td>
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<tr>
<td>3. How did staff responsible for social work monitor the resident’s progress in improving physical, mental and psychosocial functioning?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) through assessment / re-assessment?</td>
<td>a)</td>
<td>b)</td>
<td></td>
</tr>
<tr>
<td>b) through progress note documentation?</td>
<td>b)</td>
<td>c)</td>
<td></td>
</tr>
<tr>
<td>c) through care plan documentation?</td>
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<td>4. Has goal attainment been evaluated and the care plan changed accordingly?</td>
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<td></td>
<td></td>
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</tbody>
</table>

**Number of “YES” Responses**

<table>
<thead>
<tr>
<th>Scoring</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 to 8+ = 100% Compliance</td>
<td>Conduct an informal study (review 10-25 random residents) to determine if facility continues within the 85-100% range</td>
</tr>
<tr>
<td>6 to 7 = 70-85% Compliance</td>
<td>Conduct a formal review of 50% of the resident population. Identify social work program weaknesses and establish departmental goals to improve the delivery of social work services.</td>
</tr>
<tr>
<td>&lt;5 = Compliance less than 65%</td>
<td>Review the social work program with the MSW consultant. Identify and establish departmental goals targeted for 3, 6 and 12 months.</td>
</tr>
</tbody>
</table>
# Social Work Quality Assurance & Improvement Form II

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Room Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluator:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**Mental and Psychosocial Functioning (F319 & F320)**  
Survey Procedures And Probes: §483.25 (f)  
Review the resident’s medical record to make the following determinations (No I. represents “needs improvement”):  

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
</table>

1. Is there documented evidence that the facility has made accommodations for the resident’s usual and customary routines?

2. Has the resident been involved in specific programs/activities to remotivate him/her to improve and maintain maximum mental and psychosocial functioning? Please identify some of these programs:
   a) 
   b) 
   c)

3. Has the resident’s mental and psychosocial functioning been maintained or improved (e.g., increased exhibition of appropriate behavior)?

4. Have treatment plans and objectives been re-evaluated?

5. Has the resident received a psychological or psychiatric evaluation to evaluate, diagnose, or treat his/her condition, if necessary?

6. Is the resident currently receiving any psychological therapy (i.e. counseling from a Licensed Clinical Social Worker/Psychologist)?

7. Does the resident trigger any of the following Care Area Assessments (CAAs): Activities, Mood State, Psychosocial Well-Being, Behavior, Psychotropic Drug Use and/or Physical Restraints?

8. Are mental and psychosocial adjustment difficulties addressed in the care plan with a thorough, specific and unique “problem/need” statement, short-term goal and interdisciplinary approaches?

---

### Scoring

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 – 100% Compliance</td>
<td>Conduct an informal QA study (review 10-25 random residents) to determine if facility continues within the 85-100% range</td>
</tr>
<tr>
<td>6 to 75-85% Compliance</td>
<td>Conduct a formal review of 50% of the resident population. Identify program weaknesses in the delivery of “mental and psychosocial” intervention and establish departmental goals to improve the delivery of social work services.</td>
</tr>
<tr>
<td>&lt; 5 – Compliance less than 65%</td>
<td>Review the overall delivery of “mental and psychosocial” interventions with the MSW consultant and the Quality Assurance team. Identify immediate departmental objectives for (3 month), 6 months and 12 months for improvement. Re-evaluate the program every 90 days. Implement this QA form every 90 days.</td>
</tr>
</tbody>
</table>
# Social Work Quality Assurance & Improvement - Form V

**Progress Note Content**

Review the resident’s comprehensive care plan to make the following determinations: *“NO” responses need to be addressed immediately upon completion of the quality assurance study. N.I. represents “needs improvement.” Quarterly progress notes should contain...*

<table>
<thead>
<tr>
<th>Evaluator:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Y</th>
<th>N</th>
<th>N.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cognitive functioning: including level of awareness, orientation, memory and changes from previous progress notes.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Ability to make competent decisions; guardianship matters/legal status.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Issues or changes regarding financial affairs, health care directives.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Compatibility with roommate, peers and staff.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Behavioral and/or psychosocial adjustment issues/problems.</td>
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<td></td>
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</tr>
<tr>
<td>6. The resident’s involvement in the life of the facility/interaction patterns.</td>
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</tr>
<tr>
<td>7. Family involvement (visits, care conferences, special programs).</td>
<td></td>
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</tr>
<tr>
<td>8. Significant issues, problems and/or concerns raised during rounds, interviews, conferences, etc.</td>
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<td></td>
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<tr>
<td>9. The resident’s involvement/participation in his/her Care Plan Conference.</td>
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<tr>
<td>10. Religious/Pastoral Care interest and participation.</td>
<td></td>
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</tr>
<tr>
<td>11. Discharge potential and discharge planning issues.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12. Staff carrying out the care plan interventions and the resident’s response.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Discussion of normal daily patterns (when possible, related to the resident’s lifestyle prior to admission). Accommodations to enhance the resident’s quality of life.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of “YES” Responses</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
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<tbody>
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Social Work Quality Assurance & Improvement • Form III
Social History and Assessment

Evaluator:                Date:

Review the clinical record to make the following determinations. N.I. represents “needs improvement.” *NO answers need to be addressed immediately upon completion of the QA study:

<table>
<thead>
<tr>
<th>Resident:</th>
<th>Yes</th>
<th>No</th>
<th>N I</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Psychosocial History and Assessment was completed within fourteen (14) days of admission.</td>
<td></td>
<td></td>
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<tr>
<td>2. Clear, concise updates are documented at least annually.</td>
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<tr>
<td>3. The information is complete (thorough), accurate and specific.</td>
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</tr>
<tr>
<td>4. The History and Assessment communicates significant information about the resident’s background, life experience and support system.</td>
<td></td>
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</tr>
<tr>
<td>5. The History and Assessment communicates significant information about the resident’s psychosocial adjustment and coping mechanisms.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. The information is consistent with the interdisciplinary team’s view (as indicated on the MDS and RAP reviews).</td>
<td></td>
<td></td>
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<tr>
<td>7. The form/narrative is signed and dated.</td>
<td></td>
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</tr>
<tr>
<td>8. The History and Assessment contains relevant information about advance health care directives.</td>
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</tbody>
</table>

Number of “YES” Responses

Comments:

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Social Workers and Facility Policies & Procedures

Current, accurate facility policies and procedures are crucial to the health of the facility. Policies should be reviewed yearly in the facility quality assurance and performance improvement meeting. In order to help ensure a successful social work department, there are several policies that the social worker should understand and demonstrate competence in operationalizing. Below is a list of recommended policies that social workers should have in the department office. Please keep in mind, this is only a recommended list and that your facility may have additional policies that directly involve the social worker.

- Abuse and neglect
- Admission, transfers and discharges
- Care plans and conferences
- Elopement
- Grievances
- Psychosocial assessments
- Quality of life issues
- Resident rights
- Room changes
- Smoking
- Suicide
Social Workers & Federal Regulations

The role of the social worker in ensuring regulatory compliance is crucial, not just for the facility but for the well-being of the residents, patients, and families. Below is a list of federal regulations that social workers must understand and demonstrate competence in operationalizing. Social workers should have copies of the most recent versions of these regulations.

<table>
<thead>
<tr>
<th>F-Tag #</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>F250</td>
<td>Medically Related Social Services</td>
</tr>
<tr>
<td>F251</td>
<td>Qualified Social Worker</td>
</tr>
<tr>
<td>F319</td>
<td>Mental and Psychosocial Functioning</td>
</tr>
<tr>
<td>F320</td>
<td>Change in Mental or Psychosocial Adjustment</td>
</tr>
<tr>
<td>F309</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>F223 &amp; F226</td>
<td>Abuse and Neglect</td>
</tr>
<tr>
<td>F240 – F247</td>
<td>Quality of Life Issues (Self-determination, dignity, accommodation of needs, room/mate change, participation)</td>
</tr>
<tr>
<td>F279</td>
<td>Comprehensive Care Plans</td>
</tr>
<tr>
<td>F177 – F208</td>
<td>Admission, transfers and discharges</td>
</tr>
<tr>
<td>F150 – F177</td>
<td>Resident Rights</td>
</tr>
<tr>
<td>F411</td>
<td>Dental Services</td>
</tr>
</tbody>
</table>

**Strategies for Working with Health Plans in Managed Care Long Term Care**

- Assist in creating an effective partnership with the Health Plan. Their assistance and leadership in meeting the care needs of the residents you serve is critical. Don’t be adversaries… be allies.

- Understand the facility’s relationship with all Plans. Is there a contract? Are they non-contracted, but still serve the facility? What are the terms for the contract and how does the reimbursement work? Are there per diems? Non-Inclusive items in the contracted rate? Learn the specific outline of the facility’s relationship with each Plan. The pre-admissions process should verify specifics of payer sources, and residents and families should be educated in this regard.

- Understand how each Plan’s case management system works. They are all different. Some have specific behavioral health case managers, others do not. Caseloads differ; visiting time-lines differ as do documentation and level of care change requirements. Reach out to the case management supervisor in each Plan to make sure you understand their unique model of operation and identify yourself as a key contact in the facility.

- Become familiar with the assigned case managers from the Plan and work with them to involve them in facility-based care plans and necessary level of care changes.

- Understand the appeals and grievance process for health Plans so that you may assist in filing those when there are conflicts about levels of care and care transitions.

- Invite the Plan leadership to tour your facility and include them in written communication and newsletters etc…

- Be familiar with the limitations on marketing “choice”, and educating residents and families on the various health Plans. There are strict guidelines from the AHCCCS administration on this conduct. For more information, go to [http://www.azahcccs.gov/commercial/Downloads/Solicitations/BiddersLibrary/YH04-0001/Policies/401MarketingPolicy.pdf](http://www.azahcccs.gov/commercial/Downloads/Solicitations/BiddersLibrary/YH04-0001/Policies/401MarketingPolicy.pdf)

- Invite case managers to resident council meetings and share positive outcomes on the most recent Department of Health Services survey.

- Ask for Plan assistance on Share of Cost and/or Co Pay collections as needed. They are not required to collect this but will often assist.

- Be aware of any Pay for Performance initiatives the Plan may be conducting, and understand the mission/purpose of this effort.
Summary of Nursing Home Social Work Research  
By Robin Bonifas


What factors foster the ability of social workers and social services professionals to deliver effective psychosocial care in nursing homes?

- Lower levels of facility ownership turnover.
- More years of experience providing nursing home social services.
- Greater personal identification with the helping or caregiving role.
- Equal balance between the time spent providing psychosocial assessment and psychosocial intervention.

What does this mean for facility administrators? You can take active steps to minimize barriers to effective psychosocial care:

- Strive to promote work environment stability and reduce employee stress following ownership change.
- Foster retention and longevity of social work personnel.
- Offer competitive wages, benefits, and work opportunities to attract experienced social workers.
- Support the involvement of social workers in activities that promote positive role identity: membership in professional organizations, collaboration with colleagues in other facilities, and participation in continuing education and professional development events.
- Structure social work job responsibilities to allow a dual focus on both psychosocial assessment and intervention; minimize involvement in non-psychosocial tasks such as providing transportation or hunting for missing laundry.


Nursing home social workers tend to be skilled and knowledgeable in the following areas:

- The difference between dementia and delirium in terms of the onset of symptoms and clinical prognosis.
- The harmful effects of using physical restraints to address wandering or other problematic behaviors.
- The nature of sundowning behaviors among individuals with dementia.
- Strategies to communicate effectively with residents who are confused.
- How physical health problems can negatively affect mental health.

Nursing home social workers tend to need additional support and mentoring in the following areas:

- Understanding and addressing the needs of residents with dementia in the earlier stages.
- Understanding the cognitive and communication abilities of residents with dementia.
- Linkages between cognitive deficits associated with dementia and resistance to personal care.
- Limitations of reorientation as an intervention approach for residents who are confused and agitated.
- Linkages between medical conditions such as hypothyroidism and depression.
What does this mean for facility administrators? Encourage and support social work and social services staff to utilize continuing education resources to build skills and knowledge for addressing the needs of residents with dementia and understanding geriatric mental health conditions such as depression.


Best practice social work functions in long-term care facilities (p. 190.e14)

1. Psychosocial assessment of residents and family members as a basis for interdisciplinary care planning and intervention.
2. Resident and family education related to illness, including teaching coping and problem-solving skills to maintain or enhance psychosocial functioning.
3. Provision of, or referral for, mental health services.
4. Coordination of discharge planning and follow-up with the resident, family, interdisciplinary team, and community service providers.
5. Documentation of resident’s psychosocial status, initial and ongoing, progress notes, review of treatment goals, and so forth.
6. Case management services to facilitate coordination and continuity of care and to assist residents and families with obtaining necessary services in the home or in the community.
7. Psychosocial interventions with individuals, families, and groups related to a range of health, social, and emotional needs.
8. Crisis intervention.
9. Liaison to family members, including coordination-of-care planning meetings.
10. Advocating with and for residents within the long term care facility and system to ensure greater choice, quality of life, and quality of care. This may include consultation with the facility ombudsman.
11. Assisting with end-of-life planning, including legal and health-related matters.
12. Serving as a staff resource for training staff in nonpharmacological approaches to managing problem behaviors.
13. Participation in resident and family council as requested.
14. Supervision of fieldwork students.
15. Participation in independent or collaborative research projects.

What does this mean for nursing home administrators? Devise job descriptions for social work and social services professionals that reflect the above roles; assess familiarity with the above roles during the recruitment, interview, and hiring process; foster continuing education participation to strengthen professionals’ skills and knowledge in the above areas.

Nursing home social workers assume multiple roles in managing resident to resident aggression including:

- **Assessment**
  - Gathering information, for example through ad-hoc individual interviews
  - Ruling out potential causal factors, for example through examining environment factors and past triggers
  - Determining psychosocial impact of victimization

- **Intervention**
  - Determining appropriate psychosocial or behavioral interventions, often by employing a person-centered approach
  - Engaging in preventative approaches to minimize the occurrence of aggressive incidents, for example by making thoughtful roommate assignments or completing pre-admission screenings
  - Delivering psychosocial interventions such as negotiating roommate difficulties and developing behavioral contracts

- **Interprofessional collaboration with nursing colleagues**
  - Consultation to determine behavioral triggers
  - Intervention planning through team-based discussions to develop overall plan of care
  - Collaborative intervention delivery for effective care coordination
  - Capitalizing on one another strengths by assuming distinct and reciprocal roles.

*What does this mean for nursing home administrators?* Include social workers and social services professionals as active members of the behavioral management team; promote facility processes that maximize collaborative opportunities between nursing and social services.
Top 10 Reasons a Qualified Social Worker Makes the Administrator’s Job Easier

1. Resident and family crises are handled competently and efficiently. Most often crises are diffused BEFORE they reach your door.

2. The highest RUG level is obtained by utilizing a biopsychosocial perspective, thereby optimizing reimbursement.

3. Expeditious and safe discharge planning with necessary services and resources.

4. The medical record will be defensible from a social work perspective and documentation will support the care plan.

5. Impact a deficiency-free survey with strong social work presence.

6. Increased resident and family satisfaction with latent benefit of decreased number of lawsuits.

7. Longer lengths of stay for skilled patients when appropriate.

8. Maintain compliance with mandatory inservices and regulations, i.e. resident rights and abuse, which positively impact HOW care is provided.

9. A qualified social worker can increase the facility star rating.

10. Because an unqualified social worker can make the facility look bad!
Training Recommendations for Social Workers

The training topics below are recommended for social workers new to long term care as well as social workers with experience. A social worker (by degree or experience) might have previous long term care experience but that is no guarantee of competency.

In general, monthly (one full day per month) mentorship is recommended. For the less experienced/trained individual, more structured and consistent oversight is necessary, perhaps weekly.

- Federal and State Regulations
- Facility Policies and Procedures
- Ethical issues and resolution
- Residents Rights
- Culture change and person-centered values and practices
- Crisis Management
- Advance Directives, requirements, surrogate law, guardianship/conservatorship
- End-of-life, advance care planning, palliative care and hospice
- Resident Assessment Instrument Process – Assessments, documentation, care planning
- Discharge planning – from pre-admission to actual discharge, community resources
- Behavioral Care – diagnoses, care planning, behavioral interventions, petitioning process
- Clinical Social Work – pain assessment/management, restraint reduction, pressure sores
- Documentation – what and how much to document, defensive documentation skills
- Assessments – admission, psychosocial, psychosocial updates, progress notes
- Risk Management – handling complaints, de-escalation of crises, facilitating positive outcomes
- Customer Service and Service Recovery
- Abuse and Neglect – identification, reporting and documentation
- Admissions and discharge planning – for the skilled patient and the LTC resident
- Managing the Skilled Stay – Medicare and managed care, case management
- PASRRs upon admission and throughout stay
- Financial Management – payer sources, Medicaid benefits, other income-eligible benefits
- Burnout prevention, responsible delegation, advocating for oneself
- Cultural Competency – how different cultures handle admission, privacy issues, death and dying, spirituality, etc
- Survey Management - Quality Indicator Survey Process and tools, e.g. Critical Element Pathways