Recording Psycho-Social Care

Documenting Individualized and Measurable Patient Care Data

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Federal Conditions of Participation

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

418.54(c) continued...

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

- 418.54(c)(7) Bereavement “initial bereavement assessment...focusing on the social, spiritual, and cultural factors that may impact ability to cope...”

- 418.54(c)(8) Referrals and further evaluation by appropriate health professionals

- 418.54(d) Update of the comprehensive assessment “...by the IDT and must consider changes that have taken place since the initial assessment...include information on progress toward desired outcomes and reassessment of response to care...no less than every 15 days.”
418.54(e) Patient outcome measures

(1) “assessment must include data elements for measurement of outcomes...documented in the same way for all patients

(2) “data elements must be part of the comprehensive assessment...must be retrievable...used in individualized patient care planning and coordination of services...must be used as part of the aggregate for hospice’s QAPI program
COPs continued...

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

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

(i)(A) “has an MSW from an accredited school of SW, or

(B) has a baccalaureate degree in SW from an accredited school; or a baccalaureate degree in psychology, sociology, or other field in sociology and is supervised by an MSW; and

(ii) has 1 year of social work experience in a healthcare setting; or

(iii) has a baccalaureate degree..., is employed by the hospice before Dec 2, 2008, and is not required to be supervised by an MSW.”
COPs continued...

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

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

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

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

- ICF = International Classification of Functioning – an outline (classification) of the whole person in her/his own environment
- Adopted by WHO in 2001
- Assists in documenting a picture of the patient “in their world”
- Goes beyond diagnosis and physical symptoms
- Categorizes whole person, including domains of:
  - Activities
  - Participation
  - Environmental factors
  - Personal factors
ICF continued...

- Domains are further subdivided:
  - Body functions
  - Structure functions
  - Activity and Participation
  - Environmental factors
ICF continued...

- i.e. Activity and Participation is classified:
  - Learning and applying knowledge
  - General tasks and demands
  - Communication
  - Mobility
  - Self-care
  - Domestic life
  - Interpersonal interactions and relationships
  - Community life, social and civic life
ICF continued...

- i.e. Environmental factors:
  - Products and technology
  - Natural environment and human-made changes to environment
  - Support and relationships
  - Attitudes
  - Services, systems, and policies
ICF continued...

The ICF classification system provides a template for use in your initial and subsequent assessments.

Whether you use the ICF or not, assessment and documentation must “go beyond the diagnosis,” must “paint the picture,” and must demonstrate that the Plan of Care is “reasonable and necessary.”

The ICF can give you a structure from which to create your plan of care and build your documentation.
Dr. Ira Byock

End-of-life developmental tasks:

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

Stages of Psychosocial & Moral Development

- **Erik Erikson’s Stages of Psychosocial Development:**
  - Generativity vs. Stagnation – “How can I contribute to the world?”
  - Ego integrity vs. despair – “Did my life have meaning?”

- **Robert Peck:**
  - Task 2 - Body transcendence vs. body preoccupation
  - Task 3 - Ego transcendence vs. ego preoccupation

- **Daniel Levinson:**
  - “mid-life crisis”
  - Final Season – “old” vs. “venerated elder”

- **Ravenna Helson:** “social clock”
Psychosocial/Moral Development...continued

- Lawrence Kohlberg’s Moral Development:
  - Pre-conventional – rewards and punishments
  - Conventional – pleasing others/ good members of society
  - Post-conventional – individual rights/ democratically accepted law; universal ethical principles

- Carol Gilligan’s Moral Development (girls/women):
  - Individual survival
  - Goodness as self-sacrifice
  - Morality of non-violence
Documentation is an art, not a science. Write what you know, what you see, what you did, whether or not it worked, and what you will do next.
Putting it all together...

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

- **Initial Assessment**
- **Create Plan of Care based on Assessment**
- **Documentation of assessment, goals, interventions**
- **Change Plan of Care, progress toward goals**
- **Re-assess - what works, what doesn’t**
Questions to Think About...

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

Compare the Patient with a healthy person of this age. What are her/his limitations?
Patient 87 y/o lifelong Roman Catholic female who is tearful during assessment. Through skillful interview and reflective listening you learn that she is sad over an abortion she had at age 17. She has never shared this story with anyone.

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

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

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

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

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

- Facilitate communication (how) between (whom)
- Reflective listening
- Explore attitudes of... to alleviate/promote...
- Facilitate respite care/ move to alternative living
- Assess... what and how
- Provide grief support by...
- Inform of resources for...
- IDT conference with...
Possible Goals...

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

1. How do I document "presence?"

2. Identify appropriate needs/interventions/goals for patients with dementia.
Resources

http://www.socialworkers.org/credentials/credentials/achp.asp
The Advanced Certified Hospice and Palliative Social Worker (ACHP-SW) from National Association of SWs

http://www.youtube.com/watch?v=CrZXz10FcVM
Naomi Feil’s Validation therapy

http://www.timeslips.org/
Using story with Patient’s with dementia

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

WHO’s Disability Assessment Schedule

http://www.who.int/substance_abuse/research_tools/whoqolbref/en/
WHO’s Quality of Life Scale

http://www.dyingwell.org/
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