

Guidelines for Nursing Home Social Workers

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Table of Contents

Chapter One	
Introductory Comments and Outline of the Text	1
<i>John McNeil, DSW</i>	
<i>The University of Texas, School of Social Work</i>	
Chapter Two	
Gerontology Basics: Biopsychosocial Changes with Aging.....	5
<i>Yvette Murray, Ph.D.</i>	
<i>Southwest Texas State University, Department of Social Work,</i>	
<i>San Marcos, Texas</i>	
Chapter Three	
Claiming Your Space: How to Earn Acceptance and Explain Your	
Role.....	15
<i>Shirley M. Haulotte, LMSW-ACP</i>	
<i>Pflugerville Care Center</i>	
<i>Peggy S. Purvis, LNHA, SWA</i>	
<i>University of Texas, Medical Branch, Galveston, Texas</i>	
Chapter Four	
Nursing Home Social Work Practice in the Regulatory Framework.....	31
<i>Loretta M. Hooper, LMSW-AP</i>	
<i>Texas Department of Human Services, Corpus Christi, Texas</i>	
Chapter Five	
Measuring Cognitive Impairment and Depression with	
Standardized Rapid Assessment Instruments.....	54
<i>John McNeil, DSW</i>	
<i>The University of Texas, School of Social Work</i>	
Chapter Six	
Social Work Ethics for the Long Term Care Setting.....	67
<i>Shirley Boothe, LMSW</i>	
<i>Living Centers of America, Houston, Texas</i>	
Chapter Seven	
End of Life Issues or "What Do We Do Now, Kemosabe?"	78
<i>Reverend Chuck Meyer</i>	
<i>St. David's Healthcare System, Austin, Texas</i>	
Chapter Eight	
Synthesis.....	91
<i>John McNeil</i>	
<i>The University of Texas at Austin, School of Social Work</i>	
Subject Index	94
Author Index.....	97

Chapter One

Introductory Comments and Outline of the Text

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The fastest growing segment of the U.S. population is comprised of individuals 65 years of age or older. This growth was quite moderate during the first half of the twentieth century, averaging less than .5% increase each decade until the second world war. The actual and projected growth until 2050 are expected to exceed 1% each decade except one. The significant is also relative to larger cohorts within age categories as the older population grows older. People are living longer as reflected by the greater numbers of persons 75 to 84 years of age and the number of persons 85 years of age and over. By the year 2000, there will be almost 5 million persons age 85 or older. These elderly individuals will account for 1.8% of the population and are projected to increase to 5.2% by the year 2050. By the turn of the century, half of the elderly population is expected to be ages 65 to 74 and half will be age 75 or older. Another figure of importance is that in 1985, approximately 25,000 persons were 100 years of age or older, and by the year 2000, there will be over 100,000 centenarians. A publication of a few years ago was aptly entitled "The Graying of America." Because females live longer than males, a disproportionately large number of these graying persons will be women.

The following are some selected aging facts:

- * In 1990 there were over 31.5 million persons in the U.S. 65 years of age or older. This accounted for 12% of the population. Within the next three decades almost 20% of the population will be age 65 or older.
- * Almost 75% of persons over age 65 live independently.
- * About 5% of persons over age 65 are in skilled nursing facilities.
- * About 23% of persons age 85 and older are in skilled nursing facilities.
- * Between 4% and 6% of persons over age 65 have dementia, but 30% of those over age 85 have dementia.
- * The incidence of chronic disease increases with age. The ten most common chronic illnesses are are:

Arthritis	Sinusitis
Hypertension	Visual Impairments
Hearing Impairments	Varicose Veins
Heart Conditions	Diabetes
Orthopedic Ailments	Arteriosclerosis

As can be surmised from the preceding facts the nursing home population is not likely to decrease over the next several decades. A more likely scenario is that even more persons will require nursing home services. Even if the 5% figure remains constant for persons residing in

nursing homes, the proportional increase in the size of the elderly population will lead to a significantly larger number of persons being institutionalized. Considering the fact that health status is not the only factor influencing decisions regarding institutionalization, there is additional evidence to support this belief. Other factors are absence of family, exhaustion of family resources, and caregiver burden reaching its endurance level. The primary factors that determine institutionalization include: age (over 85), being female, recent hospital admission, living in retirement housing, being cognitively impaired, and having one or more problems with instrumental activities of daily living (IADL) (Hooyman & Kiyak, 1996, p 339). A partial profile of the typical nursing home resident is a widowed white female, 82 years of age, with impairment in one or more IADL's, and who has lived in the nursing home for more than a year.

There is a critical need for adequately trained gerontological social workers. It is estimated that the United States will need 40,000 to 50,000 professionally trained social workers to serve older people and their families by the year 2000. According to a 1987 National Institute of Aging report, this number is expected to reach between 60,000 to 70,000 by the year 2020 (cited in Barusch, Greene, & Connelly, 1990) when the "baby boom" population peaks. Nursing homes will be the place of employment for many of these needed gerontological social workers. The present publication, *Guidelines for Nursing Home Social Workers*, is intended to help fill the training void.

OUTLINE OF THE TEXT

Chapter 1 – Introductory Comments

Chapter 2 – Gerontology Basics: Biopsychosocial Changes with Aging, provides a broad overview of the normal aging process. Dr. Yvette Murray, the author, while adhering to a holistic perspective, organizes the material relative to organ systems of the human body. Although changes can be expected in functional ability older persons are able to make adaptations and continue to age successfully.

Chapter 3 – Claiming Your Space: How to Earn Acceptance and Explain Your Role, is written jointly by Shirley M. Haulotte, a nursing home social worker and Peggy S. Purvis, a nursing home administrator. Traditional roles of the social worker are identified, and it is explicated how these roles operate within the nursing home environment. Emphasis is also placed upon the necessity for interdisciplinary functioning and respect for all members of the nursing home team.

Chapter 4 – Nursing Home Social Work Practice in the Regulatory Framework, is authored by Loretta M. Hooper. The foundations for the current regulatory standards are discussed first, followed by an explanation of how this data base has driven the development and implementation of surveyor guidelines. Insight is provided to understand better resident, staff, and surveyor behavior.

Chapter 5 – Measuring Cognitive Impairment and Depression with Standardized Rapid

Assessment Instruments (RAI's), is written by Dr. John S. Mc Neil. This chapter presents several instruments that may be used by nursing home social workers as a tool in their psychosocial assessment of residents. Strengths and weaknesses of each RAI is provided.

Chapter 6 – A Framework for Ethical Decision-Making, is authored by Shirley Boothe. As the title suggests this chapter introduces a process that the nursing home social worker may use when ethical decisions must be made. A case example is given that demonstrates and walks-through the steps.

Chapter 7 – End of Life Issues or "What We Do Now, Kemosabe?" is written by Rev. Chuck Meyer. Rev. Meyer uses the Long Ranger and Tonto analogy to forcefully, yet humorously focus attention on the many painful end of life issues. Methods of dealing with these issues in the most efficacious and least stressful manner are suggested.

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Chapter Two

Gerontology Basics - Biopsychosocial Changes with Aging

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Today, one out of every three adult Americans is over sixty-five years of age. People over eighty-five constitute the fastest growing demographic group in the United States. With projections from the Census Bureau (1993) that average life expectancy will increase to 82.6 years by 2050, the demand for health care professionals who have expertise in gerontology will intensify. As the population ages, many senior citizens become vulnerable to medical problems which tend to be progressive. Unlike traditional clients, the elderly with chronic illnesses often require protracted health care services (Rothman, 1994). The perception that the majority of older people are disabled is unfounded, however. While 80% of people over sixty-five years of age have at least one chronic illness, only 20% are limited in their activities by health problems. Furthermore, just 5% of the elderly live in institutional settings (Roff and Atherton, 1990). Although services to the elderly have typically focused on health problems, the aging experience also poses psychosocial and environmental changes which may require a diverse array of services such as counseling, financial assistance, transportation, and assistance in personal care and daily living (Rothman, 1994).

Among health care professionals, social workers are uniquely qualified to work with vulnerable populations. The value perspective in social work of treating each client as an individual is not only humanistic, but quite useful in serving the heterogeneous population of seniors who differ greatly in their personal responses to aging. Social work training in intervention which emphasizes the person in the environment perspective is also helpful in working with the elderly whose problems may be interrelated. For example, when an elderly person is suffering from hearing loss, this physical problem has other implications. The individual's inability to hear conversations may lead to the suspicion that family members are keeping secrets, which in turn, may result in paranoid behavior. Another outcome may be social isolation because the elderly person cannot hear well enough to communicate with others. The environment also poses hazards when older people cannot hear cars, smoke alarms, or the ringing of the doorbell or telephone. Unlike other health care professionals who tend to focus on physiological or psychological problems, social workers use an integrative approach which takes into account the reciprocal effects of how dysfunctioning in one area influences other areas.

Since effective helping is dependent upon a comprehensive assessment of the client's problems, this chapter will focus on psychosocial and ecological approaches to evaluating changes associated with the aging process. The psychosocial perspective has been defined by Hepworth and Larsen (1993) to include intrapersonal, interpersonal, and environmental systems. Intrapersonal systems involve cognitive functioning, behavioral functioning, and physical health. Interpersonal systems include culture and social functioning. Environmental systems encompass safety, social support, and resources. In assessing environmental systems, the ecological paradigm posited by Carel Germain (1991) is useful in evaluating the nature and quality of transactions between the person and the environment.

Cognitive Functioning

Cognitive abilities involve intelligence, learning, memory, perception, and sensory functions (Hooyman and Kiyak, 1996). As far as intelligence is concerned, some research studies have shown a decline in performance by older persons on the Wechsler Adult Intelligence Scale. Originally, this decline was attributed to age; however, the differences were not significant among age groups when level of education was taken into account. In addition, lower test scores by seniors on verbal ability, reasoning, and spatial perception are often the result of extrinsic factors (Rowe and Kahn, 1992). According to Hooyman and Kiyak (1996), physical conditions such as lighting, print size, and the tone and loudness of the instructor's voice can influence the performance of the elderly in testing situations. Other factors that inhibit performance include anxiety and time pressure.

Short term memory loss does occur with age; however, the decline actually begins at mid life. Usually, this memory loss at mid life is attributed to absentmindedness, while similar problems with recall in older persons are interpreted more ominously due to the fear of senility. Memory loss that occurs when the elderly cannot remember basic information such as the names of friends or their home address is not a normal loss associated with aging and involves some type of organic brain dysfunction.

Another area of cognitive functioning affected by aging is the nervous system. By age thirty, the brain begins to lose thousands of neurons every day. At eighty years of age, the brain will actually weigh 7% less. The loss of neurons and a corresponding decrease in the production of neurotransmitters slows reaction time and results in decreased sensory function in touch, taste, and smell (Mertz, 1995).

In addition to psychoses, a number of organic brain diseases may affect cognitive abilities producing delirium and dementia. Delirium is manifested by disorganized thinking, incoherent speech, and memory impairment. Psychomotor activity may be increased or decreased, and the individual may be disoriented to time, place, and/or person. Delirium can be reversible in some instances. Delirium may be caused by strokes; brain tumors; systemic infections; drug withdrawal; and toxicity to alcohol, drugs, or medication. Dementia is caused by a degenerative brain disorder

of unknown origin such as Alzheimer's, Pick's, or Huntington's disease. Deterioration is gradual and progressive. Symptoms include difficulty in understanding words, impaired judgment, language difficulties, inability to recognize people and objects, personality changes (Saxon and Etten, 1994).

Behavioral Functioning

Stereotypes about the elderly often portray them as dependent, withdrawn, and lacking in problem solving abilities (Harrigan and Farmer, 1992). Research studies by Neugarten, Havighurst and Tobin (In Neugarten, 1968, pp. 173-177) have refuted the notion that dependency is an inevitable outcome of old age; rather, their findings suggest that there are four basic responses to aging. The integrated individual, characterized by high self esteem and cognitive flexibility, continues to self actualize in later life. On the other hand, older people who are very defensive lack the energy to participate in self actualizing pursuits because they are busy fighting an inner battle against aging. Their behavior tends to be hostile, and they are preoccupied with losses in their life. The truly passive, dependent elderly are in the minority. These individuals react to aging with apathy and tend to withdraw socially. Disorganization is another less frequent response to aging. For the disorganized elderly, their inadequate coping abilities are the result of adult onset dementia (Hooyman and Kiyak, 1996).

When depression, social isolation, and ineffectual problem solving occur, this maladaptive behavior is usually traceable to personal losses. With increasing age, the aging person experiences losses in many areas: decreased social status, diminished privacy and autonomy, deteriorating health, and the death of loved ones. The elderly may react to these losses by social withdrawal, refusal to eat or care for themselves, or by substance abuse (Marino, 1991). In the latter case, numerous research studies indicate that there are two types of elderly drinkers. Early onset drinkers frequently suffer from depression and begin abusing alcohol in their late thirties or forties. They continue a pattern of heavy drinking into their remaining years. The reactive alcoholic does not begin abusing alcohol until age fifty or sixty. Drinking in this group of elderly alcoholics tends to be in response to events such as retirement, loss of a partner, or impaired health (Schonfeld and Dupree, 1990).

Although the elderly represent 12.5% of the population, they account for 30% of all the prescription drugs sold in the U.S. Often these prescription drugs are misused for a variety of reasons. Since older persons tend to have chronic health problems, they may take over the counter medication such as laxatives, antihistamines, analgesics, etc., which interfere with the medicinal properties of prescription drugs. Polypharmacy is another danger that occurs when an older person is seeing several physicians for multiple health problems. Adverse drug reactions may result from the combination of medications prescribed by individual doctors. These reactions may cause mental confusion, erratic behavior, and life threatening physiological problems. Misuse of medication also happens when patients inadvertently do not comply with instructions. Sensory

losses can cause the elderly to mishear or misread instructions, and forgetfulness can result in drug overdoses (Traxler, 1995).

Physical Functioning

Although only 5% of the older population is institutionalized, approximately 80% of people over 65 years of age suffer from at least one chronic health condition. The most frequent problems are arthritis, hypertension, hearing loss, heart conditions, and orthopedic impairments (Roff and Atherton, 1990). These health problems result from the effects of aging upon various systems in the human body. Since the elderly often come to the attention of social workers because of chronic illness or conditions influenced by physical dysfunctioning, a thorough health assessment is essential.

Changes in the sensory system usually begin in the forty to fifty age range; however, they usually do not significantly limit behavior until age seventy or eighty. These changes involve vision, hearing, smell, taste, touch, and balance (Saxon and Etten, 1994). Usually, the first sensory change people notice is difficulty in reading small print or seeing close objects clearly. This condition, presbyopia, results from the lens in the eye losing elasticity. Other visual changes associated with aging involve difficulty with adaptation to bright and dark light, and discriminating among the violets, blues, and greens of the color spectrum (Roff and Atherton, 1990). Common eye diseases which can lead to blindness if untreated include: cataracts, caused by clouding of the lens; glaucoma, fluid buildup which creates pressure inside the eye; and diabetic retinopathy, hemorrhages that block light receptors in the retina (Saxon and Etten, 1994).

Age related changes in hearing affect about 30% of the population over sixty-five, and 50% of people who are over seventy-five years old. One type of hearing loss, presbycusis, results from changes in the inner ear that make it difficult to hear speech clearly. Usually, this condition begins with the inability to hear higher frequency sounds. The second type of hearing impairment results from blockage from a buildup of ear wax, or damage which prevents sound waves from traveling normally through the ear. The latter problem may be caused by illness, drugs, exposure to loud noise, or head injury. With conduction deafness, the individual cannot hear speech loudly enough (Roff and Atherton). Other disorders of the ear include tinnitus, which is a ringing or buzzing noise, and disturbances in the vestibular system which cause dizziness, vertigo, and equilibrium difficulties (Saxon and Etten, 1994).

Other changes in the sensory system affect taste, smell, and touch. As the number of taste buds decrease with age, older people may complain that the food tastes bland. To enhance the flavor, they make heavy use of salt, sugar, and spices. Although the sense of smell is more affected by age than taste, research is not definitive as to the cause. Insensitivity to smell can lead to problems in personal hygiene and safety hazards when the odor of gas cannot be detected. Senses in the skin register touch, pressure, hot, cold, and pain; however, with age there is a loss

of receptors in the skin which diminishes sensitivity. This sensory loss may cause clumsiness or susceptibility to burns (Saxon and Etten, 1994).

In the skeletal system, the most significant aging change is the gradual loss of calcium beginning in the late thirties for women. The resulting condition, osteoporosis, accounts for 1.5 million fractures per year - 40%, spinal; 25%, hip; and 15% are wrist fractures. By age sixty-five, 20% of white women have experienced fractures. Men usually do not develop osteoporosis before age seventy. In addition to fractures, brittle bones from loss of calcium may cause slumped posture, backache, and diminished height. Another common skeletal problem is arthritis which affects 70% of people over 60 years of age. Rheumatoid arthritis, which can also strike young people, is a chronic inflammation of the membranes lining joints and tendons. It causes pain, swelling, bone dislocation, and severe crippling. Three times as many women are affected as men. Osteoarthritis is a gradual degeneration of the joints due to stress. The most susceptible joints are the hands, knees, hips, and shoulders. Pain and disfigurement may also occur in the fingers. Pain and inflammation from osteoarthritis may be intermittent or pervasive (Hooyman and Kiyak, 1996).

Problems of the circulatory system, heart attacks and strokes, are the leading cause of death in the elderly population. Conditions which damage the heart include hypertension, atherosclerosis, and arteriosclerosis. Hypertension occurs when the blood exerts too much pressure against the walls of the blood vessels. It may cause strokes and heart failure. Atherosclerosis is the buildup of fatty plaque inside the lining of the blood vessels. Because the passage ways in the vascular system are constricted, the heart is overworked trying to pump blood throughout the body. Arteriosclerosis is the hardening of the blood vessels due to reduction in elasticity. The condition results in loss of blood flow which may lead to angina, burning sensations, or heart attack. Another circulatory problem associated with aging is congestive heart failure. This condition is caused when the heart's pumping capacity is impaired (Roff and Atherton, 1990). The heart loses about 1% of its reserve pumping capacity per year after age thirty (Mertz, 1992).

Hypertension, atherosclerosis, arteriosclerosis, and congestive heart failure are significant factors in causing cerebral vascular accidents which may lead to paralysis or death. Strokes affecting the brain fall into three categories - thrombotic, embolic, and hemorrhagic. Thrombotic strokes are caused by fat deposits in the blood vessels leading to the brain. Embolic strokes occur when plaque breaks off and lodges in the cerebral arteries, obstructing blood flow. Hemorrhagic strokes happen when blood vessels burst in the brain. In addition to these types of strokes, transient ischemic attacks (TIAS) may precede these types of strokes. TIAS produce temporary numbness, difficulty with speech, momentary blindness, and headaches (Roff and Atherton, 1990).

The gastrointestinal system fairs better than most body systems; however, it does have age related problems as well. Hiatal hernias, a condition in which a portion of the upper stomach

bulges up through the diaphragm, is common among obese older women. Symptoms associated with hiatal hernias are difficulty in swallowing, indigestion, regurgitation of stomach acid, and chest pain. Diverticulosis is common to half of the elderly over age eighty. This problem, caused by inflamed pouches in the intestines, results in nausea, abdominal pain, bleeding, and changes in bowel function. The incidence of gall bladder disease also increases with age, and depending on the severity of pain and vomiting, surgery may be necessary (Hooyman and Kiyak, 1996). In addition, several age related problems often affect bowel functioning. Constipation from inadequate bulk in the diet, may be treated by over the counter laxatives which can become habit forming. Hemorrhoids, ruptured blood vessels near the anus, often cause pain and bleeding. A more dangerous health problem, colorectal cancer, is the most common form of cancer in people over seventy. Survival rates are high if the cancer is detected in its early stages (Roff and Atherton, 1990).

Changes in the respiratory system tend to progress slowly with age. Chronic bronchitis, fibrosis, asthma, and emphysema are all classified as chronic obstructive lung disease. Damage to the lungs from these illnesses is irreversible. Symptoms include chronic coughing, expectoration, and shortness of breath. In addition, pneumonia, which results from a bacterial infection of the lungs, is among the leading causes of death in older people. Lung cancer is another serious respiratory problem, particularly in men, although the incidence is also rising among women (Roff and Atherton, 1990).

The two most common disorders of the endocrine system in the elderly involve the thyroid gland and the pancreas. With aging, the thyroid gland sometimes either overproduces the thyroid hormone causing hyperthyroidism, or it produces insufficient amounts leading to hypothyroidism. Hyperthyroidism, which is also referred to as Graves' disease, causes weight loss, fatigue, heart palpitations, depression, and tremors. Hypothyroidism, or myxedema, affects women five times more frequently than men. Its symptoms include fatigue, depression, muscle pain, constipation, mental confusion, and loss of appetite (Saxon and Etten, 1994). When age related changes impair the ability of the pancreas to control the level of glucose in the blood, the resulting condition is diabetes mellitus. Type II diabetes may begin in middle or old age. Warning signs of diabetes are unusual thirst, frequent urination, blurred vision, unusual weight loss, and problems with wound healing (Roff and Atherton, 1990). Chronic complications associated with diabetes affect the coronary and cerebrovascular systems, the kidneys, and the eyes (Saxon and Etten, 1994).

A major problem with advanced age which involves the excretory system is incontinence. There are four common types of incontinence: stress incontinence which occurs involuntary during coughing, sneezing, or exercise; urge incontinence which is the inability to delay voiding after the feeling that the bladder is full; reflex incontinence is the sudden leaking of large amounts of urine without any sensation of urgency; and overflow incontinence resulting from prostate enlargement which causes small amounts of urine to leak, frequently or continuously. While not life threatening, incontinence can have devastating psychological and social effects on older people.

Lowered self esteem, restricted recreational activities, and reluctance to engage in interpersonal relationships may be consequences of incontinence. In addition, others may view the older adult with incontinence as being incompetent (Saxon and Etten, 1994). Aging also causes gender specific problems in the excretory system. Cystitis is an inflammation of the lower urinary tract which often occurs in older adults, especially women. This condition results in frequent urination, burning when voiding, lower abdominal pain, and blood in the urine. The majority of males over age 60 have symptoms of benign prostatic hyperplasia which include urge and overflow incontinence, difficulty in initiating urination, and pain during voiding. This urinary disorder is the result of the nonmalignant enlargement of the prostate gland (Saxon and Etten, 1994).

Another part in the body which exhibits significant changes with aging is reproductive system. Post-menopausal women may suffer from fatigue, hot flashes, and painful intercourse caused by changes in the vagina. Since these symptoms are associated with decreased levels of estrogen, hormone replacement therapy (HRT) may be prescribed to alleviate symptoms and lessen the risk of heart attacks and osteoporosis. About one-third of all post-menopausal women are on HRT (Grouse, 1995). While HRT is beneficial for most postmenopausal women, it can exacerbate the growth of estrogen receptive breast cancer tumors (Mayo Foundation, 1994). The potential risk is especially significant in view of fact that women have a one in eight lifetime chance of getting breast cancer, and the disease is fatal to over 46,000 women each year. Most breast cancer, 80%, occurs in women over age fifty. Monthly self examinations and annual mammograms for women over fifty are the most frequent means of detecting breast cancer (Love, 1995).

Another deadly form of cancer in the reproductive system of women is ovarian cancer. This disease is difficult to detect in its early stages when it is treatable. In four out of five women, when ovarian cancer is found, it is so advanced that the chance of surviving more than five years is only 0% to 30%. Over two-thirds of women who contract ovarian cancer are over fifty-five years of age (Grouse, 1995). Although more common during menopause, cancer of the cervix and uterus can occur in older women. Vaginal bleeding is the most noticeable symptom. Yearly Pap tests can usually detect cancer of the cervix and uterus in its early stages when it is very treatable (Saxon and Etten, 1994).

The most lethal health problem of the reproductive system in males is prostate cancer which results in 41,000 deaths, annually. It is the second leading cause of death for men. This form of cancer is usually slow growing in older men and has a favorable prognosis if detected before it has metastasized. Prostate cancer is diagnosed by physical examination and a blood test which evaluates the amount of Prostate Specific Antigen (PSA) produced by the prostate gland. High PSA levels indicate that the prostate gland is secreting antigens to fight cancer (Ubell, 1996).

As far as sexual functioning is concerned, it is a prevalent misconception that aging greatly diminishes capacity for satisfying sexual relations. In the absence of health impairments, men can remain sexually active into their later years. When it does occur, impotence in older men is often

treatable. Frequent causes are fear of failure, overindulgence in alcohol, depression, anxiety, and other health problems. In older women, dryness of the vagina can cause intercourse to be painful; however, medication and lubricants alleviate this condition (Roff and Atherton, 1990).

Social Functioning

The elderly are often victimized by stereotypes about social functioning which portray them as socially isolated, withdrawn, and negativistic. This bleak scenario is not true for the majority of older adults. Most of the elderly remain connected to their family, and until age seventy-five, continue to live with a family member. Approximately 70% of older men live with their spouse; however, in the case of elderly women, two-thirds are widowed (Harrigan and Farmer, 1992).

When social isolation does occur in the aging population, it is usually the result of extrinsic factors such as outliving family and friends, health limitations, or transportation problems. Withdrawal and negativism are not inevitable consequences of aging, but rather, the by-products of ageist treatment of older people. Various research studies have shown that age stereotyping is pervasive in American society. The elderly are viewed as less competent, intelligent, and attractive than their younger counterparts (Levin, 1988). These attitudes contribute to infantilization where older adults are perceived and treated as if they were in their second childhood (Arluke and Levin, 1984). This ageist stereotyping often creates a self fulfilling prophecy where seniors withdraw from an environment that diminishes their self esteem and autonomy. Absence of these environmental influences and any disease pathology, the degree of social functioning tends to be consistent throughout the aging process. If an individual is optimistic and outgoing as a young person, she or he will continue to exhibit similar behavior later in life. Similarly, the ability to bond with others and relate on an intimate level is not altered with age.

Environmental Functioning

Reciprocity between the elderly and their environment is contingent upon the ability to successfully negotiate transactions, the availability of necessary resources, and quality of support systems in the family and community. Limited cognitive functioning, behavior problems, poor health, and impaired social skills all impede environmental transactions. The quality of life for older persons is also significantly affected by social systems within their living environment. Evidence from research studies indicates that social networks and support have a definite impact on morbidity and mortality among older people (Rowe and Kahn, 1987). Typically, relatives are the most frequently used support systems. About 20% of the elderly do not have any living children and must rely on spouses or siblings for assistance (Hooyman and Kiyak, 1996). While the majority of familial support systems contribute to the well being of their elderly members, research by Pillemer and Finkelhor (1988) found a rate of elder abuse cases of 32 per thousand. Spouses were the most common abusers, 58%, with adult children next at 24%. Elderly people in poor health were 3 to 4 times more likely to be abused. Elder abuse encompasses several types of

maltreatment: physical or sexual abuse, psychological abuse, exploitation involving misuse of property or money, withholding medication or health aides, and deprivation of care necessary for physical and mental health (Hooyman and Kiyak, 1996).

In evaluating the elderly population's access to environmental resources, natural helpers should not be overlooked. For older persons living in the community, natural helpers may be friends, neighbors, grocery clerks, postal workers, etc. In nursing facilities, individual volunteers, church groups, and civic organizations greatly enhance the lives of the elderly residents by providing opportunities for socialization, recreational activities, and assistance with personal tasks such as grooming or letter writing.

Since the elderly typically have chronic health problems, medical care is a vital environmental resource in the community. Emergency medical services, inpatient and outpatient care, quality nursing facilities, and health care professionals trained in gerontology are all essential resources that contribute to the ability of the elderly to survive in their environmental setting.

Culture and societal attitudes also play a pivotal role in how the elderly function in the environment. In minority cultures that revere their senior members - Hispanics, Afro Americans, Asian Americans, and Native Americans, older people are more likely to be treated with dignity and respect. Social attitudes that value youth and portray the elderly as burdens on society are destructive influences on the self esteem and emotional well being of older people.

Summary

In providing comprehensive social work services to the elderly population, a multidimensional approach to assessment which addresses cognitive, behavioral, health, social, and environmental functioning is useful in evaluating the complex changes related to the aging process. Since dysfunction in one area usually affects functioning in other areas, the psychosocial paradigm enables social workers to initiate interventions which target these reciprocal effects. In working effectively with the elderly, it is also essential for social work practitioners and other health care professionals to recognize that aging is an individual process which is affected by genetics, interpersonal skills, social support, and environmental resources. An ecological perspective to intervention allows social workers to take these factors into account as well as the heterogeneity found in the older population. Age, gender, culture, ethnicity, socioeconomic status, and lifestyle are variables which influence both how the elderly personally experience growing older, and their individual adaptation to the psychological and physiological changes inherent in the aging process.

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Chapter Three

Claiming Your Space

How to Earn Acceptance and Explain Your Role

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Social Services are critical to supporting the care of the elderly in a long term health care facility. The intervention of social services is needed for resolution of a number of concerns: physical, social, psychological and financial. Lewis (1981) makes the point that older adults are generally institutionalized for support of multiple physiological and psychosocial deficits ". . . the aged requiring institutional care are admitted to nursing homes due to the interaction and resulting exacerbation of complex social, cognitive and physical problems." (p. 16). While the residents' physiological needs are for the most part satisfied by the medical and nursing care staff, it is the social worker who has primary responsibility for addressing the residents' higher level needs such as love, belongingness, self-esteem and self-actualization (Maslow 1954). Silverstone (1979, p. 49) points out that "provision of social services in homes for the aged should begin with the admission process, carry through to the quality of life for residents, and, when called for, facilitate discharge of residents".

In the mid 1970's, studies by Linstrom (1975) and Brody & Brody (1974), suggested the greatest and most common area of neglect in our nation's nursing homes was the psychosocial aspect of care. A decade later, reforms were put in place to remedy this situation. The most significant reforms were contained in legislation passed by the United States Congress, termed the Omnibus Budget Reconciliation Act of 1987 (OBRA). Passed in 1987, enacted in 1990, and revised several times, OBRA is a collection of laws, many of which profoundly influenced nursing home reforms. Among the reforms affecting the long term care industry was one requiring nursing facilities that had over 120 beds to hire a full time social worker. Before the enactment of OBRA, most facilities utilized social work consultants – contract workers who made recommendations to meet psychosocial needs of residents. Since they had had very little contact with social workers, it is not surprising that nursing home administrators had sparse information about the roles and functions of social work. Often the mandate for a full-time, permanent social worker was seen simply as an added expense in an already tight budget. "Just what do social workers do?" and "why do we need them?" were questions asked by administrators and owners of nursing facilities.

To compound the problem, social workers were not trained to work in nursing facilities and had little idea of duties or responsibilities. It was common to have both social worker and

administrator uninformed and confused about the social worker's job description. The Federal Regulations gave only a bare sketch of the areas of responsibility (see Appendix A).

Therefore, the task of articulating social work practice in long term care within the guidelines of Federal Regulations fell to a few adventuresome planners including administrators, regulatory personnel, and social workers. Social work practice in long-term care continues to be a fluid process. The purpose of this chapter is to provide a framework for that process drawing from both the academic body of social work and social work practice wisdom.

Social Work Practice in Long Term Care

Social Work Roles

There are a number of ways to define the job of a social worker in long term care. One way is to begin with broad role definitions to clarify the ways in which a social worker interacts with residents, family and staff in the facility. There are six major roles that are appropriate to social work in the nursing facility:

Enabler	Educator
Broker	Case Manager
Advocate	Program Developer

The role of *Enabler* is one in which the social worker assists the resident to employ his or her strengths to cope in the nursing home environment. This requires evaluation and development of social support systems, which makes the social worker an integral part of the admission process. Typically, the social worker will complete assessments prior to, or shortly after, placement in the facility. Following the assessment phase, the social worker develops individual and group interventions designed to meet the psychosocial needs of the resident.

In the *Broker* role, the social worker connects the needs of the resident with the resources that are able to fill those needs. The needs may vary from an overdue eye exam to Medicaid eligibility, making it necessary for the social worker to be informed about a myriad of resources and to be creative in seeking out or developing resources not commonly known. The referral process, a basic activity of the broker, includes locating appropriate resources, gathering information about receiving services and assisting residents with service entry tasks (Schneider, 1992).

Similar to the legal profession, the *Advocate* initiates action on behalf of a resident. This may be the most significant role in the interdisciplinary setting of the nursing facility. The Federal Regulations include a Resident's Bill of Rights (see Messinger, 1981) which provides guidelines for the social worker to follow when advocating for a resident (see Appendix B for a condensed statement of the Bill of Rights). The existence of the Federal Bill of Rights for Nursing Home Residents (and similar regulations set forth by several states) provides the social worker with the necessary sanctions to be an open and assertive advocate.

The *Educator* role encompasses not only the resident, but the family, staff and community as well. The goal of the educator is to help others build additional skills and develop other resources. As with any type of learning, practice, support and feedback are integral components, at times, includes giving information about the nursing home system and empowering the resident to take control of his or her environment. Many topics, such as advanced directives, require the social worker in the role of educator to become more informed about the topic and to interact with others on micro, mezzo, and macro levels.

In the *Case Manager* role, the social worker looks at the entire client system and attempts to bring all components together. The social worker provides the resident and family a helping relationship and transactional link with the nursing home environment (Silverstone & Burack-Weiss, 1984). Tasks include identifying, organizing and supporting significant others for the resident. In a small percentage of cases, the resident may be functionally rehabilitated and returned home. This situation may require intensive casework intervention with the resident and his or her significant others in the community. When the prognosis for functional restoration or recovery is good, assessment, treatment and discharge planning should be initiated during the admission process.

From time to time, the social worker is called upon to be a *Program Developer*. Program development encompasses diverse areas such as group work, behavior management, psychoactive drug reduction, advance directives and field instruction for social work interns. Among these areas, group work is the most closely linked to social work training. The most common group treatment approaches with the institutionalized elderly are: Remotivation, Reminiscence and Validation (Burnside, 1978). Remotivation therapy is a group treatment approach used to stimulate individuals who have lost interest in the present and the future (Dennis 1978). Ebersole (1978) describes the use of Reminiscence groups that help to promote socialization skills and stimulate cognitive processes. Validation therapy groups are based on techniques developed by Naomi Feil (1983). The essence of this form of group therapy is to assist very old disoriented residents to get in touch with their inner world and help them express their feelings. The social worker provides a link between past associations and present reality. Examples of other types of groups include sensory stimulation for cognitively impaired residents and establishing a Resident Council.

Social Work Functions

In addition to various social work roles, it is valuable (and probably more precise) to view social work in long term care from a functional perspective. The National Association of Social Workers (NASW) developed standards of social work practice in long term care facilities (NASW, 1981). In the standards, the functions of the social work program are detailed. In general, the social work program should be directed toward providing services designed to identify and meet the social and emotional needs of each resident; to assist each resident and family to adjust to the

effects of the illness or disability, treatment and stay in the facility; and to assure adequate discharge planning and the appropriate use of community, social and health resources.

According to NASW, specific social work service functions include the following:

1. Preadmission services.
2. Development of individual social service plans.
3. Assistance in finding and utilizing community resources.
4. Provision of individual, family, and group services.
5. Participation in the interdisciplinary care team comprehensive resident treatment planning.
Advocacy of the rights of residents.
7. Discharge planning.
8. Orientation and supervision of volunteers when appropriate.
9. Participation in planning and policy development.
10. Participation in orientation and in-service training for staff.
11. Contribution to the development of community resources.
12. Supervision of field work when appropriate.
13. Participation in research and demonstration projects.

The Texas Department of Health Advisory Committee for Nursing Home Affairs published a guide to social work services in Texas nursing facilities (1990). Included in the guide is a chart of comprehensive social work functions and roles (see Appendix C). This chart is an invaluable resource for defining the job of the social worker. The actual job description should be a flexible, fluid tool used jointly by the administrator and social worker to define and support the role of the individual social worker in a specific facility. (An example of a job description is included in Appendix D).

The social worker's position in the social structure of the organization affects his or her role. This includes how the organization sanctions the role and how communications flow within the organization. In determining the specific job in an individual facility, there are four factors that contribute to role differentiation: *the position* itself, *the facility*, *the administrator* and *the interdisciplinary relationships*.

Generally the job is first defined by what is expected of the person in *the position*, what most people do in the position, and what the individual brings to the position. In other words, what do other social workers in similar facilities do? Besides the administrator, staff and families who have been involved in a facility may have preconceived ideas about the job of a social worker predicated on the functions of the prior social worker. For example, if the previous social worker drove the van and handled lost and found items, the same may be expected of the person currently in that position. On the other hand, families who have recently dealt with a social worker in a hospital setting may seek out the nursing home social worker only to aid with discharge planning and community referrals.

Social workers will also help define this position by their individual strengths and preferences. Workers coming from other social work positions may find they are most comfortable with duties that mirror those in their recent job. If discharge planning was a major component of their previous work then one might assume they would excel in this in the long term care facility. However, because this is only a small part of the job, social workers need to be aware of the limitations of their own preferences and remain open to developing skills in other areas.

Second, *the facility* defines the job of the social worker. Two main variables are the size of the facility and the payer source. Federal requirements state that a facility with more than 120 beds must have a full time social worker. Though not required, many smaller nursing facilities have made efforts to hire social workers. However, it is likely that the smaller the facility the more hats the social worker will wear. For example, in some facilities the social worker will oversee the activity department of the facility or perhaps be assigned to coordinate all admissions to the facility. Facilities funded mainly by Medicaid (despite their size) have limited monetary resources for staff positions. Thus it is not uncommon for social services (along with other key departments) to be given the odd job assignments (e.g., driving or accompanying residents to appointments, delivering mail, moving residents from room to room). In Medicare facilities social workers may find their role similar to the hospital setting with more need for crises intervention, family support and discharge planning.

The third factor, *the administrator*, defines the job through the perspective of what the social worker can do for the facility. This perspective incorporates the social worker as a multi-faceted asset, ranging from a mediator of conflicts to a marketing agent for the facility. Administrators are recognizing now, more than ever, the need to have as part of their team, professionals who can support the facility as well as the residents and families. Social workers are very important as they deal with the extended relationship of the facility to both families and community. Before social workers were on staff, administrators bore the brunt of disgruntled families and dissatisfied residents. Administrators now have the option of referring these cases to the social worker. Another way social workers market their facility is through interaction with other social workers in hospital discharge planning offices. Frequently, social workers are informal marketing agents as they participate in community education, family support groups and professional affiliations.

The last factor, *interdisciplinary relationships*, contributes to job definition by interactions. Nursing facilities are a unique environment of families, residents and staff. Unlike hospital settings, it is important to realize that families and residents who choose a facility are often choosing years of commitment from the staff. Thus, the interdisciplinary approach is vital to the success of the stay of that resident. Nursing, Social Services, Dietary and Activities work together to build a total plan of care for residents. Within the interdisciplinary structure, social workers are

called upon to draw on their skills of co-opting and their knowledge of organizational dynamics to build a teamwork atmosphere.

Setting and Keeping Boundaries

Due to diversity of roles, number of functions, and lack of clear definition, social workers in long term care carry many responsibilities and are often subject to professional burn out. Gleason-Wynn (1995) surveyed social workers in licensed nursing homes in Texas. Of the 326 respondents, 92.5% were satisfied with their current job. However, 36.5% indicated that they were likely to quit or look for a new job within the next year. Job stress, a significant indicator of potential for burnout, was the second highest predictor of job turnover, (the first was lack of job satisfaction). When asked what barriers exist in the nursing home that effect the provision of social work services, the following responses were given:

- 27.4% Lack of understanding by co-workers of the social worker's role and functions
- 21.8% Lack of communication and teamwork, especially with nursing staff
- 14.8% Ratio of residents to social worker is too high, limited time to meet needs
- 14.3% Dual roles (admissions/marketing/social worker); responsible for multiple duties not social work related

One way to avoid burnout while attending to the many job duties, is to have an overview of empowerment. Empowering self and others distributes the burden of work and enables the social worker to focus on meeting the essential job requirements. Empowerment is a process through which people become strong enough to participate within, share in the control of, and influence events and institutions which affect their lives (Cox; 1994). The areas of empowerment include: *empowering the resident, empowering the family, empowering the staff, empowering yourself.*

To *empower the resident* means assuming the social work perspective that clients are able to solve their own problems-- the social worker is simply a facilitator. Instead of listening to the same litany of complaints repeatedly, it is more effective to problem-solve with the resident on communicating concerns to staff members. Too often the social worker in the nursing home is placed in a position of "fixing problems" whether it is finding an item of clothing lost in laundry or a conflict with a roommate or not wanting to be awakened at 5:30AM for breakfast. When seen as a "fixer", the social worker will be overburdened with a myriad of small concerns that could be more effectively met through supporting the resident to be an assertive and effective communicator.

Empowering the family should begin before or upon admission of the resident and is similar to resident empowerment. Instead of trying to do everything to meet the family's wishes, it is more effective to solicit the family to assist with problem solving or to provide services. For example, the social worker might suggest that the family bring in special foods to make the resident's stay more pleasant. Or, the family might be encouraged to write letters for the resident,

take the resident on an outing or another activity that will be beneficial to the resident and gives the family ideas to enhance their visits.

Empowering the staff begins with consciously developing a good working relationship with all staff members. With this rapport as a foundation, the social worker is then able to educate the staff on interventions with the resident rather than responding and reacting to every incident. Ideally, the social worker becomes the support person to all other staff and intervenes in only those situations requiring professional expertise (e.g., assessment of depression, suicidal thoughts or behaviors, discharge planning).

Empowering self requires the ability to ascertain what can be reasonably accomplished in the job and being assertive in articulating the boundaries. Self empowerment also involves an open dialogue between the administrator and the social worker, and the job description should be updated as changes occur. Often social workers are more accomplished at assessing the strengths and weaknesses of others than they are at assessing their own.

Summary

The outlook for social workers in long term care is optimistic. Additional knowledge, technologies and tools will need to be developed that will more effectively meet the psychosocial needs of the residents. Social workers will be instrumental in the planning, development, implementation and evaluation of the growing body of knowledge about elderly residents in nursing facilities.

Older adults are the fastest growing age group in our society and will continue to show steady growth in the future. Within this group, the fastest growing segment is that over the age of eighty-five, many of whom will need nursing home care. Social workers in nursing homes must be appropriately trained to meet the psychosocial needs of these older adults. This training must include knowledge of social work practice with the elderly, skills for ethical decision making, and the ability to advocate for and on behalf of clients. Social workers must also accept the challenge of developing policies that are in the best interest of the elderly. Long term care offers social workers an opportunity to work in a challenging, growing, and changing career that utilizes all facets of social work from the basics to skilled interventions. It is rewarding to be part of a system dedicated to enhancing the life of older adults in nursing facilities. For many it is not only a job but a calling.

Appendix A

NURSING FACILITY REQUIREMENTS

Section 19.703. Social Services General Requirements.

- (A) The facility must provide medically-related social services to attain the highest practical physical, mental, or psychosocial well-being of each resident. See also section 19.901 of this title (relating to Quality of Care) for information concerning psychosocial functioning.
- (1) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.
 - (2) A facility of 120 beds or less must employ or contract with a qualified social (or in lieu thereof, a social worker who is licensed by the Texas State Board of Social Work Examiners as prescribed by the Human Resources Code, Chapter 50, section 50.016
 - (a) and who meets the requirements of subsection (b)(2) of this section to provide social services a sufficient amount of time to meet the needs of the residents.
 - (b) A qualified social worker is an individual who is licensed, or provisionally licensed, by the Texas State Board of Social Worker examiners as prescribed by Chapter 50 of the Human Resources Code, and who has at least:
 - (1) a bachelor's degree in social work, or a bachelor's degree in a human field, including , but not limited to, sociology, special education, rehabilitation counseling, and psychology; and
 - (2) one year of supervised social work experience in a health care setting working directly with individuals.

Section 19.704. Social Services Process

- (a) The facility must ensure that psychosocial assessment and care planning are completed and reviewed or updated as provided in section 19.801 and section 19.802 of this title (related to Resident Assessment and Comprehensive Care Plans).
- (b) If indicated by the Resident Assessment Instrument (RAI) and/or the resident's need, an in-depth psychosocial assessment is required. The social service needs of each resident must be identified and addressed by the direct provision of services or by arranging access to services.

Appendix B

Condensed Version of the Federal Bill of Rights for Nursing Home Residents

The resident is fully informed of his or her rights

The resident is informed of all available services and any related charges.

The resident is fully informed of his or her medical condition and can participate in treatment planning.

The resident is transferred or discharged only for medical reasons or nonpayment of bill.

The resident is given reasonable advance notice of any planned relocation.

The resident is encouraged to exercise his or her rights as a citizen.

The resident may lodge grievances and recommend changes.

The resident may manage his or her own personal financial affairs.

The resident is free from mental and physical abuse and from chemical and physical restraints.

The resident is assured confidential treatment of personal and medical records.

The resident is treated with consideration, respect, dignity, individuality and privacy.

The resident is not required to perform services for the facility.

The resident may associate and communicate privately with persons of his/her choice.

The resident may meet with and participate in activities of social, religious and community groups.

The resident may retain and use personal clothing and possessions as space permits.

If married, privacy is assured the resident for visits with a spouse. If both spouses are residents, they are permitted to share a room.

APPENDIX C
SOCIAL WORK IN LONG TERM CARE

FUNCTION	ROLE WITH INDIVIDUAL	ROLE WITH FAMILY	ROLE WITH FACILITY	ROLE WITH COMMUNITY
I. PRE-ADMISSION PROCESS	<p>A. Screening Process</p> <ol style="list-style-type: none"> 1. Explore alternate care 2. Assess appropriate placement 3. Assess needs <ul style="list-style-type: none"> --physical --mental --emotional --environmental --social --financial / legal <p>B. Preparation for Placement</p> <ol style="list-style-type: none"> 1. Assist and inform with <ol style="list-style-type: none"> a. planning and preparation b. understanding of LTC placement <p>C. Team Eligibility Conference</p> <ol style="list-style-type: none"> 1. Share Social Work assessment and relevant data collection with team members <p>D. Assist the applicant with planning for admission</p>	<p>A. Screening Process</p> <ol style="list-style-type: none"> 1. Explore Alternate Care 2. Discuss Appropriate Placement 3. Assess family <ul style="list-style-type: none"> --perspective --concerns --involvement <p>B. Preparation for Placement</p> <ol style="list-style-type: none"> 1. Informing / assisting family understanding 2. Plan/prepare for LTC placement 3. Promote continued involvement <p>C. Team Eligibility Conference</p> <ol style="list-style-type: none"> 1. Share family information with team <p>D. Assist the family with lanning for the admission</p>	<p>A. Screening Process</p> <ol style="list-style-type: none"> 1. Report to team 2. Development of Social Work record 	<p>A. Screening Process</p> <ol style="list-style-type: none"> 1. Interlink with current caregiver <ol style="list-style-type: none"> a. their perception of applicant needs b. recommendations of continued services or referrals to local providers <p>B. Preparation for placement concerning available resources</p> <p>C. Team Eligibility Conference</p> <ol style="list-style-type: none"> 1. Share Social Work data collection and assessment on community resources and needs <p>D. Assist in obtaining confirmation on availability of contract services</p>

FUNCTION	ROLE WITH INDIVIDUAL	ROLE WITH FAMILY	ROLE WITH FACILITY	ROLE WITH COMMUNITY
II. ADMISSION PROCESS	<p>A. Actual Admission</p> <ol style="list-style-type: none"> 1. Advocate / communicate <ol style="list-style-type: none"> a. Resident's Rights b. Facility Services c. Facility rules/regs d. Advanced Directives 2. Develop Social History and initial assessment 3. Discuss role of Social Worker and accessibility <p>B. Initial Adjustment</p> <ol style="list-style-type: none"> 1. Proactive assistance with acceptance and adjustment 2. Orientation to staff, facility, 3. Engage individual in adjustment programs/services <p>C. Social Service Plan</p> <ol style="list-style-type: none"> 1. Involve individual with assessment of Social Services Needs 2. Develop with person the Social Service Care Plan 3. Begin Implementation 	<p>A. Actual Admission</p> <ol style="list-style-type: none"> 1. Advocate / communicate <ol style="list-style-type: none"> a. Resident's Rights b. Family rights and responsibilities c. Facility services d. Facility rules and regulations e. Advanced Directives 2. Family input for social history and date collection 3. Discuss roles of Social Worker and accessibility <p>B. Initial Adjustment</p> <ol style="list-style-type: none"> 1. Promote family role in adjustment of individual 2. Promote family assistance for individualizing care plan and personalizing room 3. Engage family in facility adjustment services <p>C. Health Care Plan</p> <ol style="list-style-type: none"> 1. Communicate the direction of Care 2. Encourage support and involvement 	<p>A. Actual Admission</p> <ol style="list-style-type: none"> 1. Coordinate Admission with team 2. Documentation <ol style="list-style-type: none"> a. Social work record (informal) b. Medical record (formal) c. Advanced Directive (on clinical record) <p>B. Initial Adjustment</p> <ol style="list-style-type: none"> 1. Inservice staff common adjustment needs/issues 2. Training Specific needs of the individual <p>C. Health Care Plan</p> <ol style="list-style-type: none"> 1. Incorporate Social Service plan of Care into the overall plan of care 	<p>A. Actual Admission</p> <ol style="list-style-type: none"> 1. Determine needed contract services and availability 2. Contracted services follow-up/ initial service delivery is confirmed <p>B. Initial Adjustment</p> <ol style="list-style-type: none"> 1. Assist with maintenance of community ties for religious, civic, social and personal support systems <p>C. Health Care Plan</p> <ol style="list-style-type: none"> 1. Resource referrals for service delivery

FUNCTION	ROLE WITH INDIVIDUAL	ROLE WITH FAMILY	ROLE WITH FACILITY	ROLE WITH COMMUNITY
<p>III. ONGOING ACTION</p>	<p>A. Interventions</p> <ol style="list-style-type: none"> 1. Individual <ol style="list-style-type: none"> a. conflict resolution b. support c. referrals 2. Group <ol style="list-style-type: none"> a. support b. information 3. Crisis <p>B. Social Work and Overall Care Plan</p> <ol style="list-style-type: none"> 1. Inform/invite 2. Evaluate / monitor 3. Modify/update 4. Continue <p>C. Note: Continuation of all functions and roles previously identified involve ongoing:</p> <ul style="list-style-type: none"> *Assessment *Development *Implementation *Monitoring *Evaluation <p>****Teamwork and Collaboration on Delivery of Services</p>	<p>A. Interventions</p> <ol style="list-style-type: none"> 1. Individual <ol style="list-style-type: none"> a. conflict resolution b. support c. referrals 2. Group <ol style="list-style-type: none"> a. support b. information 3. Crisis <p>B. Social Work and Overall Care Plan</p> <ol style="list-style-type: none"> 1. Inform/invite 2. Evaluate / monitor 3. Modify/update 4. Continue <p>C. Note: Continuation of all functions and roles previously identified involve ongoing:</p> <ul style="list-style-type: none"> *Assessment *Development *Implementation *Monitoring *Evaluation <p>****Teamwork and Collaboration on Delivery of Services</p>	<p>A. Interventions</p> <ol style="list-style-type: none"> 1. Psychosocial Program Development <ol style="list-style-type: none"> a. Individual b. Group c. Family d. Other support systems e. Staff <p>C. Administrative Responsibility *Involve areas not directly related to resident</p> <ol style="list-style-type: none"> 1. Documentation 2. Policy and Procedure <ol style="list-style-type: none"> a. Evaluation b. Modification c. Continuation 3. Professional growth and Development 4. Communication and coordination with staff on overall plan of care 5. Environmental modifications and improvements 	<p>A. Interventions</p> <ol style="list-style-type: none"> 1. Networking <ol style="list-style-type: none"> a. Boards/Committees b. Resident/family community needs c. Educational and community awareness d. Promote community relations <p>C. Develop and Maintain Community Resource File As Case manager, promote continuum of care with community resources</p>

FUNCTION	ROLE WITH INDIVIDUAL	ROLE WITH FAMILY	ROLE WITH FACILITY	ROLE WITH COMMUNITY
IV. DISCHARGE FROM THE FACILITY	A. Planning 1. Identify discharge needs 2. Identify Community resources to meet those needs 3. Promote/enlist resident support and participation 4. Assist with transition and termination of placement 5. Compilation of needed resource materials	A. Planning 1. Identify discharge needs 2. Identify Community resources to meet those needs 3. Promote/enlist resident support and participation 4. Assist with transition and termination of placement 5. Compilation of needed resource materials	A. Planning 1. Documentation 2. Provide opportunity to acknowledge departure from facility, staff, residents and support systems	A. Planning 1. Coordinate smooth transition through necessary resources a. Agency b. caregiver 2. Explore additional community resources that may be beneficial 3. Connect with receiving facility and/or caregiver
V. POST DISCHARGE VI. OTHER INTERVENTIONS (Inconclusive List) *Death and Dying *Room Placements *Hospital Visits *Advanced Directives Education to staff and community *Inservices to staff	A. Followup measures for individual, family, facility and Community	A. Followup measures for individual, family, facility and Community	A. Followup measures for individual, family, facility and Community	A. Followup measures for individual, family, facility and Community

APPENDIX D
JOB DESCRIPTION - SOCIAL SERVICES DIRECTOR

Minimum Qualifications: A Licensed Social Worker with a Bachelor's Degree and one year of supervised social work experience in a health care setting

Responsibilities: The Social Services Department within the facility is responsible for:

- the identification of the resident's cognitive, emotional mental, and psychosocial needs, and
- the provision of service to meet the identified needs of the individual to attain or maintain the highest practical level of physical, mental and psychosocial well-being.

Duties: The following are the duties of the social services director:

- A. **History, Assessment, Care Plan Process**
 - 1. To develop a social history on each new resident
 - 2. To develop a psychosocial assessment as part of the comprehensive, identifying the problems, needs and concerns which may impact negatively on the resident's psychosocial functioning.
 - 3. To formulate a care plan which addresses the identified problems, needs and concerns.
- B. **Implementation and Evaluation of Social Services**
 - 1. To implement or assure the implementation of staff approaches which address the problems, needs or concerns.
 - 2. To periodically review the residents' progress toward resolution of problems, needs or concerns; evaluate the effectiveness of the staff approaches; evaluate changes in the mental and psychosocial assessment and document the above according to State and Federal requirements.
 - 3. To actively participate in the interdisciplinary reviews and revisions; to revise the resident's plan of care according to resident needs.
- C. **Pre-Admission, Admission and Post-Admission**
 - 1. To actively participate in the pre-admission screening of all potential residents.
 - 2. To actively participate in the provision of information as outlined in the admission agreement.
 - 3. To orient the resident to the long-term care environment and facilitate to placement.
- D. **Community**
 - 1. To identify and coordinate available community resources which assist in meeting resident needs.
 - 2. To develop a volunteer program when necessary for provision of needs.
- E. **Education and Training**
 - 1. To coordinate in-services for all associates in areas concerning the mental and psychosocial needs of the resident.
 - 2. To continually pursue education to increase the director's own knowledge in the area of social services in long term care.
- F. **Resident Rights**
 - 1. To inform residents and families of their rights and responsibilities.
 - 2. To educate staff about resident rights and facility implementation of those rights.
 - 3. To act as the resident's advocate.

G. Discharge Planning

1. Along with the interdisciplinary team, assess each resident's potential for discharge.
2. Together with the resident, family and interdisciplinary team plan for the resident's discharge.

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Nursing Home Social Work Practice In The Regulatory Framework

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Social workers play a vital role in the quality of life for nursing home residents. Numerous nursing home residents were interviewed in an ethnological study completed by Abt Associates, Inc. for the Health Care Financing Administration (HCFA). Based in part on the Abt study, revisions to the guidance to surveyors were completed with a stronger emphasis on quality of life. This new guidance serves to direct long term care social workers and surveyors to determine the minimum requirements for quality of life for nursing home residents. Utilization of a comprehensive assessment can be an effective tool for the social worker to maximize a resident's quality of life.

The Abt Study

As a social worker in the long term care setting, your job has been impacted by recent changes in the long term care survey protocol. Federal requirements for medically related social services have not changed but the interpretive guidance to surveyors has been changed significantly.

Why did HCFA make these changes? An ethnographic study completed by Abt Associates, Inc. revealed surveyors tended not to see quality of life problems. They also noted that when a social worker identified quality of life problems they were overruled in team discussions.

The Abt study used focused interview and observation techniques with a total of 160 residents in 40 facilities in 10 states. Interviews sought to determine what residents believed were the important factors that affected their quality of life. Responses by residents clustered into eight categories. These categories are:

DIGNITY

Staff interactions

INDEPENDENCE/AUTONOMY

Self-sufficiency in ADLs

Freedom of Choice

Maintaining or increasing the ability to walk

POSITIVE SELF IMAGE

Maintaining physical appearance

BEING LIKED

Positive interactions with staff

Being popular with other residents

HAVING A SENSE OF PURPOSE

Activities

Helping others

PRIVACY

Personal space

BEING TREATED POLITELY BY STAFF

HOMELIKE ATMOSPHERE

(Abt Associates, Inc., Draft Report, 1993, Chapter 5)

Dignity

For residents in this study who described staff as a concern in the area of dignity, the comment was "that they talk to me properly" (a dignity concern) rather than "that they know what they're doing"(a quality of care concern). For many residents, having dignity (or being treated with dignity) is associated with being independent, both in terms of living in a facility with few rules and regulations and in terms of being able to do things for oneself. An example of resident responses was "walking makes me feel less helpless."

Independence/Autonomy

Residents complained of restrictive rules such as having to sign out when leaving the facility, smoking restrictions, not being able to keep food in their rooms, not being allowed access to outside areas, having prescribed hours for visitors and not being able to order over the counter medications. Some residents admitted the need for rules but described some rules as demeaning and geared to manage confused residents.

Positive Self-Image

Dignity is also associated with a positive self image, in terms of maintaining physical appearance, being liked by others, and having a sense of purpose of life. When describing a positive self image, residents wanted to maintain a well-groomed appearance, dress in street clothes daily and have clean clothes available.

Being Liked

Residents felt liked when staff took the time to talk to them. Other responses included practicing their own beliefs, the absence of prejudice, being included in activities even if less capable and being voted onto the resident council. Being trusted with medications also added to self image.

Having a Sense of Purpose

Lack of appropriate activities contributed to having no sense of purpose. Helping others was mentioned as an important part of the residents' lives. Some volunteered in the facility helping other residents who were less capable. Residents liked to take part in activities "that amount to something." Religious activities were also considered important. Just the availability of activities per se was not relevant to issues of resident self image. The activities had to have meaning to the residents.

The importance of dignity is emphasized further in the Health Care Financing Administration (HCFA) interpretive guidelines:

- Grooming residents as they wish to be groomed
- Assisting residents to dress in their own clothes appropriate to the time of day and individual preferences
- Promoting resident independence and dignity in dining
- Respecting resident's private space and property
- Respecting resident's social status, speaking respectfully, listening carefully, treating residents with respect
- Focusing on residents as individuals when they talk to them (State Operations Manual (SOM), Transmittal 274, June, 1995, page PP-53)

Privacy

When discussing privacy, residents referred to the adequacy of space to allow for privacy and the appropriateness of other's actions that might infringe upon privacy.

Comments about privacy included:

"My room is an important place to me."

"I never liked being in a group."

"It's important to have time to be off by myself."

"It's important to me that nobody shares my toilet. I don't like that."

Many residents discussed the desire to have a private room, fewer roommates, or more adequate space in their current room.

Reasons for wanting a private room included:

- * wanting "a place of my own"
- * having the choice of whether to see people or not
- * having control over the use of the phone, TV and radio
- * having a quiet place to escape the noise and bad odors of the facility
- * having more space for possessions and to move around in and
- * not having to share a bathroom.

Most residents understood they could not have a private room, however, there was still the desire to have some place where they could go to be alone as well as a quiet private place for entertaining visitors.

Residents wanted to be able to lock doors to their rooms, bathrooms and shower rooms for privacy. Private telephones in resident rooms were suggested to enhance privacy. One resident commented, "It's too noisy to use the phone in the hall, and everybody hears your business."

Several things that staff do or do not do were mentioned as affecting residents' privacy. Most commonly mentioned was the failure to knock on doors prior to entering a resident's room.

Other issues were respecting private property, closing doors to residents' room behind them (or asking resident if they want the door closed), allowing residents to close their doors, keeping curtains around residents' bed drawn during treatments and not asking residents inappropriate or personal questions.

Residents also commented about privacy during showers. Most of these issues reflected a concern for modesty. Many residents, when asked if they have any concerns about privacy in the nursing home, assumed they were being asked about protecting modesty. Confused residents who wandered and invaded the privacy of others accounted for the largest number of complaints about invasion of personal space (Chapter 5, page 20).

HCFA guidelines on privacy indicate the facility is given flexibility in creating space. A separate room for visiting is not a requirement, however, nursing homes may designate a certain area for resident visits with family and friends. The home must provide privacy curtains in residents' rooms, but they need not provide private rooms.

Additionally, "facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene . . ." (SOM, Transmittal 274, June, 1995, page PP-24)

Being Treated Politely By Staff

When residents described interactions with staff, they grouped staff responses in two categories: personal interactions with staff and interactions with staff during care giving duties. Beyond being sensitive, patient, and kind, it is important to residents that staff see them as individuals, i.e., staff should "know my name" and "know my likes and dislikes." Residents want to be treated as adults. Staff should speak courteously and kindly. If residents request the assistance of staff, they want the staff to willingly help them and not get angry or complain (Chapter 5, page 22).

In the area of care giving interactions, residents mentioned that staff always seemed to be rushed and that there were not enough staff to do everything that needs to be done. Residents wanted nurse aides to be well-trained to perform personal assistance tasks. They wanted nurses to be qualified and knowledgeable in order to answer questions about medical care and medications.

Homelike Atmosphere

When asked about the basic physical features of their home, residents wanted adequate space, access to outside areas and a good location. Specific elements included wide hallways and doorways, large windows, a variety of common areas, space to entertain guests, common areas that would accommodate a group of people without being crowded, adequate closet space and resident rooms that were large enough to enable residents in wheelchairs to move around in them.

Most residents wanted to be in a home located near their family and friends. They also wanted the home to be in a quiet area, close to stores, restaurants and other places to visit.

They wanted the decor to be "homey." It was important for the facility be clean, have no odors and be well-maintained. Residents wanted things fixed promptly. They did not want the home to look like a hospital, rather for the nursing home to truly look and feel "like a home" (Chapter 5, page 31).

All of the information compiled in the Abt study was considered when drafting the new Guidance to Surveyors found in State operations Manual (SOM) Transmittal 274. It is recommended that you have handy a copy of your manual when reading this section.

SOM Transmittal 274

As you look at your copy of SOM transmittal 274, you will notice a vertical line beside the majority of text in the column labeled Guidance to Surveyors. This vertical line indicates new or amended material.

F tag 250 that relates to Social Services gives guidance to indicate what social services might include. F tag 251 details the qualifications of a social worker.

Your responsibilities as a professional social worker will vary with your job description and the individual demands of your employer. In order to adequately meet the needs of the individual residents in a nursing facility, an assessment of those needs must be completed. The amount of information a social worker is required to obtain is not dictated by federal requirements. The new Resident Assessment Instrument (SOM, Transmittal 272, April, 1995) calls for an in-depth assessment of resident needs. The individual(s) who complete the elements of that assessment are determined by the facility.

The current guidance states that, "It is not required that a qualified social worker necessarily provide all of these services. Rather, it is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate discipline (s)." (SOM, Transmittal 274, June, 1995)

Traditionally, activity directors have "filled in" for social workers when a facility did not have a requirement for a full time social worker. Some elements outlined in the guidance have been successfully carried out by activity directors or other assigned staff. Examples include, making arrangements for obtaining needed adaptive equipment, clothing, and personal items, making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation), dental/denture care, podiatric care, eye care, hearing services, equipment for mobility or assistive eating devices and need for home like environment, control, dignity, privacy.

Where needed services are not covered by the Medicaid State Plan, nursing facilities are still required to attempt to obtain these services. For example, if a resident requires transportation services that are not covered under a State Medicaid Plan, the facility is required to arrange these services. This could be achieved, for example, through obtaining volunteer services.

However, there are many more complex issues that face an elderly institutionalized person that the average activity director has not been trained to negotiate.

The training and skills of a social worker are best utilized in areas where the resident's assessed needs include:

- Maintaining contact with family (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;
- Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications;
- Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);
- Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangement to other facilities);
- Providing or arranging provision of needed counseling services;
- Through the assessment and care planning process, identifying and seeking ways to support residents' individual needs and preferences, customary routines, concerns and choices;
- Building relationships between residents and staff and teaching staff how to understand and support residents' individual needs;
- Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each residents' individuality;
- Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;
- Finding options that most meet the physical and emotional needs of each resident;
- Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet;
- Meeting the needs of residents who are grieving; and
- Finding options which most meet their physical and emotional needs.

Types of conditions to which the facility should respond with social services by staff or referral include:

- Lack of an effective family/social system
- Behavioral symptoms, e.g. if a resident with dementia strikes out at another resident, the facility should evaluate the resident's behavior. The resident, for example, may be re-enacting an activity he or she used to perform at the same time

every day. If that resident senses that another is in the way of his or her re-enactment, the resident may strike out at the individual impeding his or her progress. The facility is responsible for the safety of any potential resident victim while it assesses the circumstances of the resident's behavior

- Presence of a chronic disabling medical or psychological condition (e.g., multiple sclerosis, chronic obstructive pulmonary disease, Alzheimer's disease, schizophrenia)
- Depression
- Chronic or acute pain
- Difficulty with personal interaction and socialization skills
- Presence of legal or financial problems
- Abuse of alcohol or drugs
- Inability to cope with loss of function
- Need for emotional support
- Changes in family relationships, living arrangements, and/or resident's condition of functioning
- A physical or chemical restraint

(SOM, Transmittal 274, June, 1995)

Appendix A gives the Guidance to Surveyors with notations in parentheses that indicate other areas of care that are related to the residents' social service needs. The underlined letters and numbers within the parentheses relate to areas on the Minimum Data Set (MDS) 2.0 where the residents' needs may be assessed. The MDS is not a definitive listing of assessment areas or related tags; it is simply a social worker surveyor's viewpoint of what is related to a nursing home resident's medically-related social service needs.

It is very easy to get caught up in the demands of "paper compliance" when completing assessments of a resident in a nursing home; consequently, it is vital that social services stay focused on the resident as an individual. As a person who has or had a family, cared for others and lived a full life. Each resident hopes to live the rest of his/her life with that same fullness and vitality that he/she knew prior to entering your facility.

The residents are more than data entry boxes on an MDS 2.0 form. They are also more than just the "crabby old man" (depicted in the poem by Frank Warman entitled "What Do You See" that is found in Appendix C).

Try filling out an assessment for yourself or one of your family members. You will find out that there just is not enough room to adequately state what really needs to be said about that person. It is the social worker's job to help others see the resident for the person they really are and not necessarily the person the "paper" describes.

Appendix A

F250 (g) Social Services

Intent: §483.15 (g)

To assure that sufficient and appropriate social services are provided to meet the resident's needs.

Guidelines: §483.15 (g) (1)

Regardless of size, all facilities are required to provide for the medically related social services needs of each resident. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. It is not required that a qualified social worker necessarily provide all of these services. Rather, it is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate discipline(s).

"Medically-related social services" means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include, for example:

- Making arrangements for obtaining needed adaptive equipment, clothing, and personal items; (F162 - **Limitation or charges to personal funds, F246 - Accommodation of needs, G5, G6, G1Ah, H3, K5g**)
- Maintaining contact with family (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;(F152 - **In the case of a resident adjudged incompetent, F154 - Right to be fully informed, A9, P1r, P3, Q, R**)
- Assisting staff to inform residents and those they designate about the resident's health status and health care choices and their ramifications; (F154 - **Right to be fully informed, C6, D1, P**)
- Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation); (F246 - **Accommodation of needs, C, D, G1A b-f**)
- Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements); (A7, A9, A10)
 - Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents

returning home, assisting with transfer arrangement to other facilities); (F204 - **Orientation for discharge or transfer, F284 - Post discharge plan of care with participation of resident, P1r, P3, Q, R**)

- Providing or arranging provision of needed counseling services; (**E1, F2, F3, P2**)
 - Through the assessment and care planning process, identifying and seeking ways to support residents' individual needs and preferences, customary routines, concerns and choices; (F242 - **Self-determination and participation, AC1, F3, G, R**)
 - Building relationships between residents and staff and teaching staff how to understand and support residents' individual needs; (**C, D, E, F**)
 - Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each residents' individuality; (F151 - **Exercise of rights, AC, F3, G, N**)
 - Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions; (F152 - **In case of resident adjudged incompetent, F154 - Be fully informed, F155 - Right to refuse, B4, R**)
 - Finding options that most meet the physical and emotional needs of each resident; (F246 - **Accommodation of needs, C, D, E, F, G, N, P2**)
-
- Providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet; (F221 - **Physical restraints, F222 - Chemical restraints, F224 - Staff treatment of residents, C4, P2, P4**)
 - Meeting the needs of residents who are grieving; and (F319 - **Mental psychosocial well being, F2f**)
 - Finding options which most meet their physical and emotional needs. (F246 - **Accommodation of needs, C,D,E,F,G**)

Factors with a potentially negative effect on physical, mental, and psychosocial well-being include an unmet need for: (F246 - **Accommodation of needs, F310 Activities of Daily Living**)

- Dental/denture care; (F411 - **Dental care, K1, L1**)
- Podiatric care; (F328 - **Special needs, foot care, M6**)
 - Eye care; (F313 - **Vision and Hearing, D**)
 - Hearing services; (F313 - **Vision and Hearing, C2, C3, C5**)

- Equipment for mobility or assistive eating devices; and (G1A a-f, G5, G6, K5g)
- Need for home-like environment, control, dignity, privacy. (**F164 - Privacy and confidentiality, F242 - Self-determination and participation, F252 - Environment, AB, H**)

Where needed services are not covered by the Medicaid State Plan, nursing facilities are still required to attempt to obtain these services. For example, if a resident requires transportation services that are not covered under a State Medicaid Plan, the facility is required to arrange these services. Transportation could be obtained, for example, through use of volunteer services. (**F207 - Equal access to quality care**)

Types of conditions to which the facility should respond with social services by staff or referral include:

- Lack of an effective family/social system; (**F319 - Psychosocial well being, F2**)
- Behavioral symptoms; (**B5, B6, E4, P2**)
- If a resident with dementia strikes out at another resident, the facility should evaluate the resident's behavior. For example, a resident may be re-enacting an activity he or she used to perform at the same time everyday. If that resident senses that another is in the way of his or her re-enactment, the resident may strike out at the resident impeding his or her progress. *The facility is responsible for the safety of any potential resident victim while it assesses the circumstances of the resident's behavior;* (**F223 - Abuse, P2**)
- Presence of a chronic disabling medical or psychological condition (e.g., multiple sclerosis, chronic obstructive pulmonary disease, Alzheimer's disease, schizophrenia); (**I1, I2**)
- Depression; (**F319 - Psychosocial well being, F3, E1, P2**)
- Chronic or acute pain; (**J2**)
- Difficulty with personal interaction and socialization skills; (**F319 - Psychosocial well being, F1-3, N, P2**)
- Presence of legal or financial problems; (**A7, A9, A10**)
- Abuse of alcohol or drugs; (**F319 - Psychosocial well being, AC**)
- Inability to cope with loss of function; (**F319 - Psychosocial well being, AB6, AB7**)
- Need for emotional support; (**F319 - Psychosocial well being, F2,F3,I**)
- Changes in family relationships, living arrangements, and/or resident's condition of functioning; and (**F319 - Psychosocial well being, AB2, AB5, AC1, F2, G, I**)

- A physical or chemical restraint. (F221 - Physical restraints, F222 - Chemical restraints, P4, O)

For residents with or who develop mental disorders as defined by the *Diagnostic and Statistical Manual for Mental Disorders (DSM-IV)*, see §483.45, F406.

Probes: §483.15 (g) (1)

For residents selected for a comprehensive or focused review as appropriate:

- How do facility staff implement social services interventions to assist the residents in meeting treatment goals?
- How do staff responsible for social work monitor the resident's progress in improving physical, mental, and psychosocial functioning? Has goal attainment been evaluated and the care plan changed accordingly?
- How does the care plan link goals to psychosocial functioning/well being?
- Have the staff responsible for social work established and maintained relationships with the resident's family or legal representative?
- (NF) What attempts does the facility make to access services for Medicaid recipients when those services are not covered by a Medicaid State Plan?

Look for evidence that social services interventions successfully address residents' needs and link social supports, physical care, and physical environment with residents' needs and individuality. (SOM, Transmittal 274, June, 1995 ; SOM, Transmittal 272, April, 1995)

Appendix B

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) – VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION	
1. DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date. <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> — <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> — <div style="border: 1px solid black; width: 40px; height: 20px; text-align: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> Month Day Year </div>
2. ADMITTED FROM (AT ENTRY)	<div style="display: flex; gap: 10px;"> <div style="width: 45%;"> 1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other </div> <div style="width: 5%; text-align: center;"> a. b. c. d. e. f. g. h. </div> </div>
3. LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility
4. ZIP CODE OF PRIOR PRIMARY RESIDENCE	<div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> </div>
5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	<i>(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above.)</i> Prior stay at this nursing home Stay in other nursing home Other residential facility — board and care home, assisted living, group home MH/psychiatric setting MR/DD setting NONE OF ABOVE
6. LIFETIME OCCUPATION(S) (Put "1" between two occupations)	<div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> </div>
7. EDUCATION (Highest level completed)	<div style="display: flex; gap: 10px;"> <div style="width: 45%;"> 1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school </div> <div style="width: 45%;"> 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree </div> </div>
8. LANGUAGE	<i>(Code for correct response)</i> a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other, specify
9. MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes
10. CONDITIONS RELATED TO MR/DD STATUS	<i>(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)</i> Not applicable — no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition related to MR/DD MR/DD with no organic condition
11. DATE BACKGROUND INFORMATION COMPLETED	<div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> — <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;"> </div> — <div style="border: 1px solid black; width: 40px; height: 20px; text-align: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> Month Day Year </div>

SECTION AC. CUSTOMARY ROUTINE	
1. CUSTOMARY ROUTINE	<i>(Check all that apply. If all information UNKNOWN, check last box only)</i> CYCLE OF DAILY EVENTS (In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)
	Stays up late at night (e.g., after 9 pm) a. Naps regularly during day (at least 1 hour) b. Goes out 1+ days a week c. Stays busy with hobbies, reading, or fixed daily routine d. Spends most of time alone or watching TV e. Moves independently indoors (with appliances, if used) f. Use of tobacco products at least daily g. NONE OF ABOVE h.
	EATING PATTERNS Distinct food preferences i. Eats between meals all or most days j. Use of alcoholic beverage(s) at least weekly k. NONE OF ABOVE l.
	ADL PATTERNS In bedclothes much of day m. Wakens to toilet all or most nights n. Has irregular bowel movement pattern o. Showers for bathing p. Bathing in PM q. NONE OF ABOVE r.
	INVOLVEMENT PATTERNS Daily contact with relatives/close friends s. Usually attends church, temple, synagogue (etc.) t. Finds strength in faith u. Daily animal companion/presence v. Involved in group activities w. NONE OF ABOVE x. UNKNOWN — Resident/family unable to provide information y.
	END

SECTION AD. FACE SHEET SIGNATURES			
SIGNATURES OF PERSONS COMPLETING FACE SHEET:			
a. Signature of RN Assessment Coordinator			Date
b. Signatures	Title	Sections	Date
c.			Date
d.			Date
e.			Date
f.			Date
g.			Date

= When box blank, must enter number or letter
a. = When letter in box, check if condition applies
 Code "NA" if information unavailable or unknown.

NOTE: Normally, the MDS Face Sheet is completed once, when an individual first enters the facility. However, the face sheet is also required if the person is reentering this facility after a discharge where return had not previously been expected. It is not completed following temporary discharges to hospitals or after therapeutic leaves/home visits.

Resident _____

Numeric Identifier _____

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION	
1.	RESIDENT NAME <input type="text"/> a. (First) b. (Middle initial) c. (Last) d. (Jr./Sr.)
2.	ROOM NUMBER <input type="text"/>
3.	ASSESSMENT REFERENCE DATE a. Last day of MDS observation period <input type="text"/> - <input type="text"/> - <input type="text"/> b. Original (0) or corrected copy of form (enter number of correction)
4a.	DATE OF REENTRY Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) <input type="text"/> - <input type="text"/> - <input type="text"/> Month Day Year
5.	MARITAL STATUS 1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated
6.	MEDICAL RECORD NO. <input type="text"/>
7.	CURRENT PAYMENT SOURCES FOR N.H. STAY (Billing Office to indicate; check all that apply in last 30 days) Medicaid per diem a. Self or family pays for full VA per diem Medicare per diem b. Medicare resident liability or Medicare co-payment Medicare ancillary part A c. Private insurance per diem (including co-payment) Medicare ancillary part B d. Other per diem CHAMPUS per diem e.
8.	REASONS FOR ASSESSMENT a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 0. NONE OF ABOVE b. Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required 1. 5 day assessment 2. 30 day assessment 3. 60 day assessment 4. Quarterly assessment using full MDS form 5. Readmission/return assessment 6. Other state required assessment
9.	RESPONSIBILITY/LEGAL GUARDIAN (Check all that apply) Legal guardian a. Durable power of attorney/financial Other legal oversight b. Family member responsible Durable power of attorney/health care c. Patient responsible for self NONE OF ABOVE
10.	ADVANCED DIRECTIVES (For those items with supporting documentation in the medical record, check all that apply) Living will a. Feeding restrictions Do not resuscitate b. Medication restrictions Do not hospitalize c. Other treatment restrictions Organ donation d. NONE OF ABOVE Autopsy request e.
SECTION B. COGNITIVE PATTERNS	
1.	COMATOSE (Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G)
2.	MEMORY (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem2 b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem2
3.	MEMORY/RECALL ABILITY (Check all that resident was normally able to recall during last 7 days) Current season a. That he/she is in a nursing home Location of own room b. NONE OF ABOVE Staff names/faces c. are recalled
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only2 2. MODERATELY IMPAIRED—decisions poor, cues/supervision required2 3. SEVERELY IMPAIRED—never/rarely made decisions2, 5B
5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS (Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time.] 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) 2 = 1, 17* b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)2 - 1, 17* c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) 2 = 1, 17* d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)2 - 1, 17* e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) 2 = 1, 17* f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not) 2 = 1, 17*
6.	CHANGE IN COGNITIVE STATUS Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated1, 17*
SECTION C. COMMUNICATION/HEARING PATTERNS	
1.	HEARING (With hearing appliance, if used) 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting4 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly4 3. HIGHLY IMPAIRED/absence of useful hearing4
2.	COMMUNICATION DEVICES/TECHNIQUES (Check all that apply during last 7 days) Hearing aid, present and used a. Hearing aid, present and not used regularly b. Other receptive comm. techniques used (e.g., lip reading) c. NONE OF ABOVE d.
3.	MODES OF EXPRESSION (Check all used by resident to make needs known) Speech a. Signs/gestures/sounds d. Writing messages to express or clarify needs b. Communication board e. American sign language or Braille c. Other f. NONE OF ABOVE g.
4.	MAKING SELF UNDERSTOOD (Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts4 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests4 3. RARELY/NEVER UNDERSTOOD4
5.	SPEECH CLARITY (Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words
6.	ABILITY TO UNDERSTAND OTHERS (Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message2, 4 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communications4 3. RARELY/NEVER UNDERSTANDS2, 4
7.	CHANGE IN COMMUNICATION/HEARING Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated17*

= When box blank, must enter number or letter.
 = When letter in box, check if condition applies
 Code "NA" if information unavailable or unknown.

Resident

SECTION D. VISION PATTERNS	
1. VISION	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2. VISUAL LIMITATIONS/DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of the following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE
3. VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes

SECTION E. MOOD AND BEHAVIOR PATTERNS	
1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily
VERBAL EXPRESSIONS OF DISTRESS	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions 1 or 2 = 8
a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" 1 or 2 = 8	i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry/dressing, relationship issues 1 or 2 = 8
b. Repetitive questions—e.g., "Where do I go; What do I do?" 1 or 2 = 8	j. UNPLEASANT MOOD IN MORNING 1 or 2 = 8
c. Repetitive verbalizations—e.g., calling out for help; "God help me!" 1 or 2 = 8	k. Insomnia/change in usual sleep pattern 1 or 2 = 8
d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received 1 or 2 = 8	l. APATHETIC ANXIOUS APPEARANCE
e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" 1 or 2 = 8	m. Crying, tearfulness 1 or 2 = 8
f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others 1 or 2 = 8	n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking 1 or 2 = 8, 17*
g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack 1 or 2 = 8	o. LOSS OF INTEREST 1. Withdrawal from activities of interest—e.g., no interest in longstanding activities or being with family/friends 1 or 2 = 7, 8 2. Reduced social interaction 1 or 2 = 8

2. MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators present 1. Indicators present, not easily altered 2. Indicators present, easily altered
3. CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated 3, 17*
4. BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered (A) (B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) A = 1, 2, or 3 = 9, 11	
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) A = 1, 2, or 3 = 9	
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) A = 1, 2, or 3 = 9	
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or directing in public, smeared/threw food/fees, noisiness, rummaged through others' belongings) A = 1, 2, or 3 = 9	
e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating) A = 1, 2, or 3 = 9	

Numeric Identifier

5. CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated 3, 17*
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SECTION F. PSYCHOSOCIAL WELL-BEING	
1. SENSE OF INITIATIVE/INVOLVEMENT	At ease interacting with others At ease doing planned or structured activities At ease doing self-initiated activities Establishes own goals Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) Accepts invitations into most group activities NONE OF ABOVE
2. UNSETTLED RELATIONSHIPS	Cover/open conflict with or repeated criticism of staff Unhappy with roommate Unhappy with residents other than roommate Openly expresses conflict/anger with family/friends Absence of personal contact with family/friends Recent loss of close family member/friend Does not adjust easily to change in routines NONE OF ABOVE
3. PAST ROLES	Strong identification with past roles and life status Expresses sadness/anger/empty feeling over lost roles/status Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community NONE OF ABOVE

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS	
1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)	
0. INDEPENDENT—No help or oversight—OR—Help/oversight provided only 1 or 2 times during last 7 days	
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days	
2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days	
3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support —Full staff performance during part (but not all) of last 7 days	
4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days	
8. ACTIVITY DID NOT OCCUR during entire 7 days	
(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)	
0. No setup or physical help from staff	
1. Setup help only	
2. One person physical assist	
3. Two+ persons physical assist	
8. ADL activity itself did not occur during entire 7 days	
a. BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed A = 1-5A; A = 2, 3, or 4 = 5A; 16; A = 8-16
b. TRANSFER	How resident moves between surfaces—to/from bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) A = 1, 2, 3, or 4 = 5A
c. WALK IN ROOM	How resident walks between locations in his/her room A = 1, 2, 3, or 4 = 5A
d. WALK IN CORRIDOR	How resident walks in corridor on unit A = 1, 2, 3, or 4 = 5A
e. LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair A = 1, 2, 3, or 4 = 5A
f. LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair A = 1, 2, 3, or 4 = 5A
g. DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis A = 1, 2, 3, or 4 = 5A
h. EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) A = 1, 2, 3, or 4 = 5A
i. TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes A = 1, 2, 3, or 4 = 5A
j. PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers) A = 1, 2, 3, or 4 = 5A

Resident _____

Numeric Identifier _____

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). Code for most dependent in self-performance and support. A = 1, 2, 3 or 4 = SA (A) BATHING SELF-PERFORMANCE codes appear below. 0. Independent—No help provided (A) (B) 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days (Bathing support codes are as defined in Item 1, code B above)		
3.	TEST FOR BALANCE (See training manual)	(Code for ability during test in the last 7 days) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help a. Balance while standing b. Balance while sitting—position, trunk control 1, 2, or 3 - 17*		
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury) (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT 0. No limitation 1. Limitation on one side 2. Limitation on both sides a. Neck b. Arm—including shoulder or elbow c. Hand—including wrist or fingers d. Leg—including hip or knee e. Foot—including ankle or toes f. Other limitation or loss		
5.	MODES OF LOCOMOTION	(Check all that apply during last 7 days) Cane/walker/crutch Wheeled self Other person wheeled	a. Wheelchair primary mode of locomotion b. NONE OF ABOVE c. NONE OF ABOVE	d. e. f.
6.	MODES OF TRANSFER	(Check all that apply during last 7 days) Bedfast all or most of time 16 Bed rails used for bed mobility or transfer Lifted manually	a. Lifted mechanically b. Transfer aid (e.g., slide board, trapeze, cane, walker, brace) c. NONE OF ABOVE	d. e. f.
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes		
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs SA Direct care staff believe resident is capable of increased independence in at least some ADLs SA Resident able to perform tasks/activity but is very slow Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings NONE OF ABOVE	a. b. c. d. e.	
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION H. CONTINENCE IN LAST 14 DAYS
(Code for resident's PERFORMANCE OVER ALL SHIFTS)

1. CONTINENCE SELF-CONTROL CATEGORIES
(Code for resident's PERFORMANCE OVER ALL SHIFTS)
0. CONTINENT—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)
1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. INCONTINENT—Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed 1, 2, 3 or 4 - 16	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed 2, 3 or 4 - 6	

2. BOWEL ELIMINATION PATTERN

	Bowel elimination pattern regular—at least one movement every three days		
a.		Diarrhea	c.
b.	Constipation 17*	Fecal impaction 17*	d.
		NONE OF ABOVE	e.

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan Bladder retraining program External (condom) catheter Indwelling catheter Intermittent catheter	a. b. c. d. e.	Did not use toilet room/commode/urinal Pads/briefs used Enemas/irrigation Ostomy present NONE OF ABOVE	f. g. h. i. j.
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated			

SECTION I. DISEASE DIAGNOSES
Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	(If none apply, CHECK the NONE OF ABOVE box) ENDOCRINE/METABOLIC/NUTRITIONAL Diabetes mellitus Hyperthyroidism Hypothyroidism HEART/CIRCULATION Arteriosclerotic heart disease (ASHD) Cardiac dysrhythmias Congestive heart failure Deep vein thrombosis Hypertension Hypotension 17* Peripheral vascular disease 16 Other cardiovascular disease MUSCULOSKELETAL Arthritis Hip fracture Missing limb (e.g., amputation) Osteoporosis Pathological bone fracture NEUROLOGICAL Alzheimer's disease Aphasia Cerebral palsy Cerebrovascular accident (stroke) Dementia other than Alzheimer's disease	a. b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u.	HEMATOLOGIC Hemiplegia/Hemiparesis Multiple sclerosis Paraplegia PARKINSON'S DISEASE Parkinson's disease SEIZURE DISORDER Seizure disorder Transient ischemic attack (TIA) Traumatic brain injury PSYCHIATRIC/MOOD Anxiety disorder Depression 17* Manic depression (bipolar disease) Schizophrenia PULMONARY Asthma Emphysema/COPD SENSORY Cataracts 3 Diabetic retinopathy Glaucoma 3 Macular degeneration OTHER Allergies Anemia Cancer Renal failure NONE OF ABOVE	v. w. x. y. z. aa. ab. ac. ad. ae. af. ag. ah. ai. aj. ak. al. am. an. ao. ap. aq. ar.
2.	INFECTIONS	(If none apply, CHECK the NONE OF ABOVE box) Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection	a. b. c. d. e. f.	Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days 14 Viral hepatitis Wound infection NONE OF ABOVE	g. h. i. j. k. l. m.
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	Dehydration 276.5 - 14	a. b. c. d. e.		

SECTION J. HEALTH CONDITIONS
(Check all problems present in last 7 days unless other time frame is indicated)

1.	PROBLEM CONDITIONS	INDICATORS OF FLUID STATUS Weight gain or loss of 3 or more pounds within a 7 day period 14 Inability to lie flat due to shortness of breath Dehydrated; output exceeds input 14 Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days 14 OTHER Delusions	a. b. c. d. e.	Dizziness/Vertigo 11, 17* Edema Fever 14 Hallucinations 17* Internal bleeding 14 Recurrent lung aspirations in last 90 days 17* Shortness of breath Syncope (fainting) 17* Unsteady gait 17* Vomiting NONE OF ABOVE	f. g. h. i. j. k. l. m. n. o. p.
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Resident _____

Numeric Identifier _____

2. PAIN SYMPTOMS	(Code the highest level of pain present in the last 7 days) a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating		
3. PAIN SITE	(If pain present, check all sites that apply in last 7 days) Back pain Bone pain Chest pain while doing usual activities Headache Hip pain	a. Incisional pain b. Joint pain (other than hip) c. Soft tissue pain (e.g., lesion, muscle) d. Stomach pain e. Other	f. <input type="checkbox"/> g. <input type="checkbox"/> h. <input type="checkbox"/> i. <input type="checkbox"/> j. <input type="checkbox"/>
4. ACCIDENTS	(Check all that apply) Fell in past 30 days 11, 17* Fell in past 31-180 days 14, 17* Hip fracture in last 180 days 17* Other fracture in last 180 days NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/>	c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/>
5. STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem End-stage disease, 6 or fewer months to live NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/>	

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS	Chewing problem Swallowing problem 17* Mouth pain 15 NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/>	
2. HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes. a. HT (in.) <input type="text"/> <input type="text"/> b. WT (lb.) <input type="text"/> <input type="text"/>		
3. WEIGHT CHANGE	a. Weight loss—5% or more in last 30 days; or 10% or more in last 180 days 0. No 1. Yes 12 b. Weight gain—5% or more in last 30 days; or 10% or more in last 180 days 0. No 1. Yes 12		
4. NUTRITIONAL PROBLEMS	Complains about the taste of many foods 12 Regular or repetitive complaints of hunger Leaves 25% or more of food uneaten at most meals 12 NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/>	c. <input type="checkbox"/> d. <input type="checkbox"/>
5. NUTRITIONAL APPROACHES	(Check all that apply in last 7 days) Parenteral/IV 12, 14 Feeding tube 13, 14 Mechanically altered diet 12 Syringe (oral feeding) 12 Therapeutic diet 12 a. Dietary supplement between meals b. Plate guard, stabilized built-up utensil, etc. c. On a planned weight change program d. NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/>	f. <input type="checkbox"/> g. <input type="checkbox"/> h. <input type="checkbox"/> i. <input type="checkbox"/>
6. PARENTERAL OR ENTERAL INTAKE	(Skip to Section L if neither 5a nor 5b is checked) a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day		

SECTION L. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night 15 Has dentures or removable bridge Some/all natural teeth lost—does not have or does not use dentures (or partial plates) 15 Broken, loose, or carious teeth 15 Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes 15 Daily cleaning of teeth/dentures or daily mouth care—by resident or staff Not - 15 NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/> f. <input type="checkbox"/> g. <input type="checkbox"/>
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SECTION M. SKIN CONDITION

1. ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.] a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Number of Sites <input type="text"/>
2. TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue 1 = 18; 2, 3, or 4 = 12, 18 b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3. HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS 0. No 1. Yes 16	
4. OTHER SKIN PROBLEMS OR LESIONS PRESENT	(Check all that apply during last 7 days) Abrasions, bruises Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure 16 Skin tears or cuts (other than surgery) Surgical wounds NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/> f. <input type="checkbox"/> g. <input type="checkbox"/> h. <input type="checkbox"/>
5. SKIN TREATMENTS	(Check all that apply during last 7 days) Pressure relieving device(s) for chair Pressure relieving device(s) for bed Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/> f. <input type="checkbox"/> g. <input type="checkbox"/> h. <input type="checkbox"/> i. <input type="checkbox"/> j. <input type="checkbox"/>
6. FOOT PROBLEMS AND CARE	(Check all that apply during last 7 days) Resident has one or more foot problems—e.g., corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/> f. <input type="checkbox"/> g. <input type="checkbox"/>

SECTION N. ACTIVITY PURSUIT PATTERNS

1. TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: 10B only if BOTH N1a = <input checked="" type="checkbox"/> and N2 = 0 Morning 10B a. <input type="checkbox"/> Afternoon b. <input type="checkbox"/> Evening c. <input type="checkbox"/> NONE OF ABOVE d. <input type="checkbox"/>
(IF RESIDENT IS COMATOSE, SKIP TO SECTION O)	
2. AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 10B 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 10A 3. None 10A
3. PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred) Own room a. <input type="checkbox"/> Day/activity room b. <input type="checkbox"/> Inside NH/off unit c. <input type="checkbox"/> Outside facility d. <input type="checkbox"/> NONE OF ABOVE e. <input type="checkbox"/>
4. GENERAL ACTIVITY PREFERENCES (Adapted to resident's current abilities)	(Check all PREFERENCES whether or not activity is currently available to resident) Trips/shopping g. <input type="checkbox"/> Cards/other games h. <input type="checkbox"/> Walking/wheeling outdoors i. <input type="checkbox"/> Crafts/arts j. <input type="checkbox"/> Watching TV k. <input type="checkbox"/> Exercise/sports l. <input type="checkbox"/> Gardening or plants m. <input type="checkbox"/> Music d. <input type="checkbox"/> Talking or conversing e. <input type="checkbox"/> Reading/writing f. <input type="checkbox"/> Spiritual/religious activities l. <input type="checkbox"/> NONE OF ABOVE m. <input type="checkbox"/>

Resident _____

Numeric Identifier _____

5.	PREFERS CHANGE IN DAILY ROUTINE	Code for resident preferences in daily routines 0. No change 1. Slight change 2. Major change a. Type of activities in which resident is currently involved 1 or 2 - 10A b. Extent of resident involvement in activity 1 or 2 - 10A
SECTION O. MEDICATIONS		
1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)
2.	NEW MEDICATIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No 1. Yes
3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long acting meds used less than weekly) (NOTE: For 17 to actually be triggered, 04a, b, or c, MUST = 1-7 AND at least one additional item marked 17* must be indicated. See sections B, C, E, G, H, I, J, and K.) a. Antipsychotic 1-7 - 17 b. Anti-anxiety 1-7 - 11, 17 c. Antidepressant 1-7 - 11, 17 d. Hypnotic e. Diuretic 1-7 - 14
SECTION P. SPECIAL TREATMENTS AND PROCEDURES		
1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days TREATMENTS: Ventilator or respirator, Chemotherapy, Dialysis, IV medication, Intake/output, Monitoring acute medical condition, Ostomy care, Oxygen therapy, Radiation, Suctioning, Tracheostomy care, Transfusions PROGRAMS: Alcohol/drug treatment program, Alzheimer's/dementia special care unit, Hospice care, Pediatric unit, Respite care, Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) b. THERAPIES—Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily) [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days a. Speech-language pathology and audiology services b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by any licensed mental health professional)
2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days—no matter where received) Special behavior symptom evaluation program Evaluation by a licensed mental health specialist in last 90 days Group therapy Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage Reorientation—e.g., cueing NONE OF ABOVE
3.	NURSING REHABILITATION/RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.) a. Range of motion (passive) b. Range of motion (active) c. Splint or brace assistance d. Bed mobility e. Transfer f. Walking g. Dressing or grooming h. Eating or swallowing i. Amputation/prosthesis care j. Communication k. Other

4.	DEVICES AND RESTRAINTS	(Use the following codes for last 7 days:) 0. Not used 1. Used less than daily 2. Used daily Bed rails a. Full bed rails on all open sides of bed b. Other types of side rails used (e.g., half rail, one side) c. Trunk restraint 1 - 11, 18; 2 - 11, 16, 18 d. Limb restraint 1 or 2 - 18 e. Chair prevents rising 1 or 2 - 18
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)
7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes
SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS		
1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes b. Resident has a support person who is positive toward discharge 0. No 1. Yes c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 2. Discharge status uncertain
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support
SECTION R. ASSESSMENT INFORMATION		
1.	PARTICIPATION IN ASSESSMENT	a. Resident: 0.No 1.Yes b. Family: 0.No 1.Yes 2.No family c. Significant other: 0.No 1.Yes 2.None
2.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	
a.	Signature of RN Assessment Coordinator (sign on above line)	
b.	Date RN Assessment Coordinator signed as complete Month Day Year	
c.	Other Signatures	Title Sections Date
d.		Date
e.		Date
f.		Date
g.		Date
h.		Date

TRIGGER LEGEND

- | | | | |
|-----------------------------|--|---------------------------|--|
| 1 - Delirium | 5B - ADL-Maintenance | 10A - Activities (Revise) | 14 - Dehydration/Fluid Maintenance |
| 2 - Cognitive Loss/Dementia | 6B - Urinary Incontinence and Inwelling Catheter | 10B - Activities (Review) | 15 - Dental Care |
| 3 - Visual Function | 7 - Psychosocial Well-Being | 11 - Falls | 16 - Pressure Ulcers |
| 4 - Communication | 8 - Mood State | 12 - Nutritional Status | 17 - Psychotropic Drug Use |
| 5A - ADL-Rehabilitation | 9 - Behavioral Symptoms | 13 - Feeding Tubes | 17* - For this to trigger, 04a, b, or c must = 1-7 |
| | | | 18 - Physical Restraints |

Resident Name: _____

Numeric Identifier: _____

SECTION S. TEXAS SPECIFIC ITEMS

Activities of Daily Living

<p>A. SELF PERFORMANCE provided in the facility 60% of the time over the last 30 days.</p> <p>0. Independent—No help or oversight provided.</p> <p>1. Supervision—Oversight, encouragement, cueing.</p> <p>2. Limited Assistance—Resident highly involved; received physical, guided maneuvering of limbs or other non-weight-bearing assistance.</p> <p>3. Extensive Assistance—Resident performed part of activity, but help of the following type was provided: 60% of time weight-bearing support or full staff performance during part, but not all, of last 30 days.</p> <p>4. Total Dependence—Full staff performance during entire 30 days.</p> <p>8. Activity Did Not Occur</p>				
<p>B. SUPPORT provided in the facility 60% of the time over the last 30 days.</p> <p>0. No Setup or Physical Assistance From Staff</p> <p>1. Setup Help Only</p> <p>2. One Person Physical Assistance</p> <p>3. Two + Persons Physical Assistance</p> <p>8. Activity Did Not Occur</p>			A	B
S.1	BED MOBILITY—How resident moves to and from lying position, turns side-to-side, positions while in bed.			
S.2	TRANSFER—How resident moves between surfaces—to and from: bed, chair, wheelchair, standing position (EXCLUDE: to and from bath and toilet).			
S.3	EATING—How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).			
S.4	TOILET USE—How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy, catheter, adjusts clothes.			
S.5	PRIMARY SOURCE OF NUTRITION—Primary source (50%) of nutrition calorically over last 30 days is enteral or parenteral.	0. No	1. Yes	
S.6	TERMINAL ILLNESS—Six month terminal prognosis per physician.	0. No	1. Yes	

Rehabilitation—Enter number of days of rehabilitation received over the last 30 days (excluding skilled therapy services for wound care, splinting, positioning, or staff training).

<p>A. PHYSICAL THERAPY</p> <p>B. OCCUPATIONAL THERAPY</p>			A	B
S.7	How many days was skilled therapy (for at least 15 minutes per day) received in the last 30 days?			
<p>Items S.8 through S.12—Enter the number of days of restorative care provided (15 minutes or more per day) following a skilled therapist's written plan.</p>			A	B
S.8	Training and skill practice in BED MOBILITY.			
S.9	Training and skill practice in TRANSFER.			
S.10	Training and skill practice in WALKING.			
S.11	Training and skill practice in DRESSING or GROOMING.			
S.12	Training and skill practice in EATING or SWALLOWING.			

FOR DHS USE ONLY

CASEMIX (1)	(2)
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Rev. 1/96

Health Status Problems

S.13	SEIZURES (one or more)—Check only if occurred and treated in facility during the last 30 days.		
S.14	DEHYDRATION—Check only if acute, symptomatic and treated during the last 30 days.		
S.15	URINARY TRACT INFECTION—Check only if acute, symptomatic and treated during the last 30 days.		
S.16	AMPUTATION—Resident has had an amputation of a limb within the last 6 months.	0. No	1. Yes
S.17	QUADRIPLEGIA WITH EXTENSIVE ASSISTANCE—Neurologic disorder causing paralysis of all four extremities, with Self-Performance of 3 or 4 in S1, S2, and S4.	0. No	1. Yes

Therapeutic Interventions

<p>A. FREQUENCY OF INTERVENTIONS during the last 14 days.</p> <p>0. Not Receiving</p> <p>1. Less than Daily</p> <p>2. Once a Day</p> <p>3. Two Times a Day</p> <p>4. Three or More Times a Day</p> <p>5. Continuously 6–23 Hours</p> <p>6. Continuously Throughout the Day</p>				
<p>B. NUMBER OF DAYS TREATMENT received in last 14 days.</p>			A	B
S.18	INTAKE and OUTPUT (Analysis of I/O).			
S.19	BLADDER REHAB (Individualized plan to regain bladder control and continence).			
S.20	WOUND DRESSINGS (Applied to an open wound).			
S.21	DECUBITUS CARE (Code only for treatments of Stage III or IV).			
S.22	SUCTIONING (Oral, nasal, tracheal).			
S.23	TRACHEOSTOMY CARE (Exclude self care).			
S.24	OXYGEN ADMINISTRATION			
S.25	RESPIRATORY THERAPY			
S.26	VENTILATOR or RESPIRATOR			

Behavior Status—Check only behaviors during the last 30 days that required immediate staff intervention on a daily basis.

S.27	WANDERING (Oblivious to needs or safety).		
S.28	VERBAL AGGRESSION		
S.29	PHYSICAL AGGRESSION		
S.30	SOCIALY INAPPROPRIATE/DISRUPTIVE		

I CERTIFY that, to the best of my knowledge, the above information is true and correct.

DON Name	License No.
Signature—DON	Date

FNA Name	License No.
Signature—FNA	Date

Resident _____

Numeric Identifier _____

SECTION T. SUPPLEMENT -- CASE MIX DEMO													
1.	<p>SPECIAL TREATMENTS AND PROCEDURES</p> <p>a. RECREATION THERAPY—Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)</p> <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">DAYS</td> <td colspan="2">MINS.</td> </tr> <tr> <td>(A) = # of days administered for 15 minutes or more</td> <td>(A)</td> <td>(B)</td> <td>(B)</td> </tr> <tr> <td>(B) = total # of minutes provided in last 7 days</td> <td></td> <td></td> <td></td> </tr> </table> <p>Skip unless this is a Medicare 5 day or initial admission assessment</p> <p>b. ORDERED THERAPIES—Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?</p> <p>0. No 1. Yes</p> <p>If not ordered, skip to item 2</p> <p>c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.</p> <p>d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered.</p>	DAYS		MINS.		(A) = # of days administered for 15 minutes or more	(A)	(B)	(B)	(B) = total # of minutes provided in last 7 days			
DAYS		MINS.											
(A) = # of days administered for 15 minutes or more	(A)	(B)	(B)										
(B) = total # of minutes provided in last 7 days													
2.	<p>WALKING WHEN MOST SELF-SUFFICIENT</p> <p>Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0, 1, 2, or 3 AND at least one of the following are present:</p> <ul style="list-style-type: none"> • Resident received physical therapy involving gait training (P.1.b.c) • Physical therapy was ordered for the resident involving gait training (T.2.b) • Resident received nursing rehabilitation for walking (P.3.f) • Physical therapy involving walking has been discontinued within the past 180 days <p>Skip to item 3 if resident did not walk in last 7 days</p> <p>(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)</p> <p>a. Farthest distance walked without sitting during this episode.</p> <table border="0"> <tr> <td>0. 150+ feet</td> <td>3. 10-25 feet</td> </tr> <tr> <td>1. 51-149 feet</td> <td>4. Less than 10 feet</td> </tr> <tr> <td>2. 26-50 feet</td> <td></td> </tr> </table> <p>b. Time walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 1-2 minutes</td> <td>3. 11-15 minutes</td> </tr> <tr> <td>1. 3-4 minutes</td> <td>4. 16-30 minutes</td> </tr> <tr> <td>2. 5-10 minutes</td> <td>5. 31+ minutes</td> </tr> </table> <p>c. Self-Performance in walking during this episode.</p> <p>0. INDEPENDENT—No help or oversight</p> <p>1. SUPERVISION—Oversight, encouragement or cueing provided</p> <p>2. LIMITED ASSISTANCE—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance</p> <p>3. EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking</p> <p>d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).</p> <p>0. No setup or physical help from staff</p> <p>1. Setup help only</p> <p>2. One person physical assist</p> <p>3. Two+ persons physical assist</p> <p>e. Parallel bars used by resident in association with this episode.</p> <p>0. No 1. Yes</p>	0. 150+ feet	3. 10-25 feet	1. 51-149 feet	4. Less than 10 feet	2. 26-50 feet		0. 1-2 minutes	3. 11-15 minutes	1. 3-4 minutes	4. 16-30 minutes	2. 5-10 minutes	5. 31+ minutes
0. 150+ feet	3. 10-25 feet												
1. 51-149 feet	4. Less than 10 feet												
2. 26-50 feet													
0. 1-2 minutes	3. 11-15 minutes												
1. 3-4 minutes	4. 16-30 minutes												
2. 5-10 minutes	5. 31+ minutes												
3.	<p>CASE MIX GROUP</p> <p>Medicare <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> State <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>												

SECTION U. MEDICATIONS

List all medications that the resident received during the last 7 days. Include scheduled medications that are used regularly, but less than weekly.

1. **Medication Name and Dose Ordered.** Record the name of the medication and dose ordered.
2. **Route of Administration (RA).** Code the Route of Administration using the following list:

1 = by mouth (PO)	5 = subcutaneous (SQ)	8 = inhalation
2 = sublingual (SL)	6 = rectal (R)	9 = enteral tube
3 = intramuscular (IM)	7 = topical	10 = other
4 = intravenous (IV)		
3. **Frequency (Freq.).** Code the number of times per day, week, or month the medication is administered using the following list:

PR = (PRN) as necessary	2D = (BID) two times daily	QO = every other day
1H = (QH) every hour	(includes every 12 hours)	4W = four times each week
2H = (Q2H) every two hours	3D = (TID) three times daily	5W = five times each week
3H = (Q3H) every three hours	4D = (QID) four times daily	6W = six times each week
4H = (Q4H) every four hours	5D = five times daily	1M = (Q month) once every month
6H = (Q6H) every six hours	1W = (Q week) once each week	2M = twice every month
8H = (Q8H) every eight hours	2W = two times every week	C = continuous
1D = (QD or HS) once daily	3W = three times every week	O = other
4. **Amount Administered (AA).** Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water.
5. **PRN-number of days (PRN-n).** If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
6. **NDC Codes.** Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength, and form. The NDC code must match the drug dispensed by the pharmacy.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Numeric Identifier _____

Resident's Name:	Medical Record No.:
------------------	---------------------

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
 - Describe:
 - Nature of the condition (may include presence or lack of objective data and subjective complaints).
 - Complications and risk factors that affect your decision to proceed to care planning.
 - Factors that must be considered in developing individualized care plan interventions.
 - Need for referrals/further evaluation by appropriate health professionals.
 - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
 - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP Problem Area	(a) Check if Triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	<input type="checkbox"/>		<input type="checkbox"/>
2. COGNITIVE LOSS	<input type="checkbox"/>		<input type="checkbox"/>
3. VISUAL FUNCTION	<input type="checkbox"/>		<input type="checkbox"/>
4. COMMUNICATION	<input type="checkbox"/>		<input type="checkbox"/>
5. ADL FUNCTIONAL/REHABILITATION POTENTIAL	<input type="checkbox"/>		<input type="checkbox"/>
6. URINARY INCONTINENCE AND INDWELLING CATHETER	<input type="checkbox"/>		<input type="checkbox"/>
7. PSYCHOSOCIAL WELL-BEING	<input type="checkbox"/>		<input type="checkbox"/>
8. MOOD STATE	<input type="checkbox"/>		<input type="checkbox"/>
9. BEHAVIORAL SYMPTOMS	<input type="checkbox"/>		<input type="checkbox"/>
10. ACTIVITIES	<input type="checkbox"/>		<input type="checkbox"/>
11. FALLS	<input type="checkbox"/>		<input type="checkbox"/>
12. NUTRITIONAL STATUS	<input type="checkbox"/>		<input type="checkbox"/>
13. FEEDING TUBES	<input type="checkbox"/>		<input type="checkbox"/>
14. DEHYDRATION/FLUID MAINTENANCE	<input type="checkbox"/>		<input type="checkbox"/>
15. ORAL/DENTAL CARE	<input type="checkbox"/>		<input type="checkbox"/>
16. PRESSURE ULCERS	<input type="checkbox"/>		<input type="checkbox"/>
17. PSYCHOTROPIC DRUG USE	<input type="checkbox"/>		<input type="checkbox"/>
18. PHYSICAL RESTRAINTS	<input type="checkbox"/>		<input type="checkbox"/>

B. _____
 1. Signature of RN Coordinator for RAP Assessment Process

3. Signature of Person Completing Care Planning Decision

2. - -
 Month Day Year

4. - -
 Month Day Year

Appendix C
WHAT DO YOU SEE?

What do you see, people, what do you see?
What are you thinking when you're looking at me?
A crabby old man, and not very wise
Uncertain of habit-with far away eyes.
Who dribbles his food and makes no reply
When you say in a loud voice "I do wish you'd try."
Who seems not to notice the things that you do
And forever is losing a stocking or shoe.
Who resisting or not, lets you do as you will,
When bathing and feeding the long day to fill.
Is that what you're thinking? Is that what you see?
Then open your eyes, you're not looking at me.
I'll tell you who I am
as I sit here so still,
As I rise at your bidding, as I eat at your will.
I'm a small child of ten with a father and mother.
Brothers and sisters who love one another.
Young boy of sixteen with wings on his feet.
Dreaming that soon now a lover he'll meet
A husband at twenty, my heart gives a leap,
Remembering the vows that I promised to keep.
At twenty-five now I have young of my own
Who need me to build a secure happy home.

A man now of thirty, my young they grow fast,
Bound to each other with ties that should last.
At forty my young sons are grown and are gone.
But my woman's beside me to see I don't mourn.
At fifty once more babies play at my knee,
Again we know children, my loved one and me.
Dark days are upon me, my woman is dead.
I look at the future, I shudder with dread.
For my young are all rearing young of their own,
And I think of the years and the love I have known.
I'm an old man now, nature is cruel
'Tis her jest to make old age look like a fool.
The body it crumbles, grace and vigor depart.
Now there is a stone where I once had a heart.
But inside this old carcass a young man still dwells,
And now and again my battered heart swells.
I remember the joys, I remember the pain,
And I'm loving and living life all over again.
I think of the years all too few--gone too fast,
And accept the stark fact that nothing can last.
So open your eyes, people--Open and see...
Not a crabby old man, look closer...
SEE ME!

(Frank Warman, PhD, Lyrics from Video Look at Me, permission for use granted by Area Council on Aging,
Corpus Christi, Texas)

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Chapter Five

Measuring Cognitive Impairment and Depression with Standardized Rapid Assessment Instruments

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Assessment technology of the past two to three decades has produced test instruments that can be used by social workers who work with elderly individuals. Previously, all psychological testing was the exclusive domain of the clinical psychologists. Administration, scoring, and especially interpretation required extensive specialized training. The development of Rapid Assessment Instruments (RAIs) has made it possible for professionals, with minimal instruction, to include these standardized procedures in their work with clients of all age groups. Numerous publications have appeared in the past two decades that disseminate this information. Prominent among these are Kane and Kane (1981) *Assessing the elderly: A practical guide to measurement* and Fischer and Corcoran (1994) *Measures for clinical practice: A sourcebook*. Increasing numbers of articles are appearing in the professional literature. Knowledge regarding RAIs is readily accessible to the professional motivated to stay current with practice. The instruments discussed in this paper are only a very small sample of the potential benefits of this emerging practice area. Although RAIs cannot be used to definitively establish a diagnosis, they alert the practitioner to the need for additional assessment and trigger thinking about possible intervention strategies. Secondly, they are convenient and efficient for establishing client baseline levels which facilitate the ability to monitor and evaluate practice. Rapid Assessment Instrument technology has the potential for greatly enhancing the professionalism of the gerontological social worker.

Assessment is the crucial first step toward assuring that high quality care is provided for all patients, including the elderly. Assessment goes beyond establishing a medical diagnosis, but encompasses gaining an understanding of the bio-psycho-social situation of the individual(s) who are the target(s) of attention. Additionally, assessment is of value only to the extent that it guides efficient and effective treatment. As a member of a treatment team in nursing homes, social workers must have knowledge and skills to assist in arriving at a comprehensive evaluation of the resident. In order to assess adequately the social domain, which has traditionally been a social work role, it is necessary to evaluate also for mental impairment. It has been documented that changes in mental status are often the first indications of changes in psycho-physiological functioning. The incidence of delirium among older hospitalized patients ranges between 40% and 50%, and dementia is also prominent (Yazdanfar, 1990). Considering these factors, a need existed for valid and reliable rapid assessment instruments that test for mental impairment which do not

require extensive training to administer and to score. These RAIs can be used by any member of the care providing team. Within the past 25 years, a number of instruments have been developed that can be used in this manner. Most of them can be used by the social worker in the nursing home because they are appropriate for "bedside evaluation" in that they can be administered in a few minutes, are minimally taxing on the patient, and can be scored easily.

Five of these instruments will be discussed:

1. Mental Status Questionnaire (MSQ)
2. Short Portable Mental Status Questionnaire (SPMSQ)
3. Cognitive Capacity Screening Examination (CCSE)
4. "Mini-Mental State" (MMS)
5. Geriatric Depression Scale (GDS)

Mental Status Questionnaire (MSQ)

The Mental Status Questionnaire (MSQ) can be considered the grandfather of RAIs and was developed to determine the mental status of the aged. Originally presented at a 1960 mental health conference by Kahn, Goldfarb, Pollack, and Peck, the MSQ was to set the stage for the development of additional tests that appeared over the next two decades. Kahn, et al. (1960) state that the questions were drawn partly from standard mental status examination procedures and partly from special investigations of patterns of altered behavior with cerebral dysfunction. A total of 31 questions were initially compiled that covered orientation, memory, calculation, general, and personal information. From these 31 questions ten were eventually selected as the most discriminating, and these became the MSQ. The ten questions require spoken responses with each correct response earning one point. Questions test orientation to time, place, knowledge of birth date, age, and past and current presidents (Nelson, Fogel, & Faust, 1986). The latter two questions regarding presidents are designed to test awareness of current events, as well as memory of past events (Kane & Kane, 1981). It can be argued, however, that retaining knowledge about presidents would be a low priority concern of many residents of hospitals or nursing homes.

Scoring is straightforward, providing a quantitative measure that supposedly allows for determination of the degree of the severity of cognitive impairment. The greater the number of errors, the more severe the degree of impairment. A score of 9-10 errors indicates severe impairment, 3-8 moderate, 0-2 none or minimal.

Validity and reliability studies have been reported, but a consistent criticism is that improvement is needed in both dimensions (Brink et al, 1986; Nelson et al, 1986). Brink et al (1986) argue persuasively regarding the poor level of validity of the MSQ. Validity was established by correlating its results with that of other commonly used measures of dementia such as staff ratings or formal psychiatric examinations (Brink et al.). They point out that the MSQ has a pattern of false positives, especially when used with immigrant populations, poorly educated

individuals, racial minorities, or those persons living in an "unstimulating environment." In a similar vein, Nelson et al. (report that in a review of three validation studies, two showed that less than 5% of patients without clinically diagnosed cognitive impairment made more than two errors, the cutoff point for pathology. By contrast, only 55% of patients with clinically diagnosed organic mental disorder were correctly classified. Brink et al. find serious problems when the MSQ is used with special populations, while Nelson et al. find that it fails to accurately diagnose half of the patients with organic impairment. Suggestions are made, however, to decrease false positives by the use of double administration. During the first administration, the patient is given the correct answer to any questions which are missed. After the MSQ trials are completed, the patient is re-asked the items missed and the score is raised by one point for each correct answer given on retrieval (Brink). In these instances, the interpretation is that the failure on the first administration was not due to organicity, but to an insufficiently stimulating environment. Another complaint about the MSQ is that it does not have a serial subtraction component, and thus, registration, retention, and cognitive processing are not tested (Baker, 1989) (see Table 1)

Table 1
Mental Status Questionnaire (MSQ)

<i>Give one (1) point for each correct answer</i>	Earned Score
1. What is the name of this place?	_____
2. Where is it located (address)?	_____
3. What is today's date?	_____
4. What is the month now?	_____
5. What is the year?	_____
6. How old are you?	_____
7. When were you born (month)?	_____
8. When were you born (year)?	_____
9. Who is the President of the United States?	_____
10. Who was President before him?	_____

SCORING. Score shows severity of brain syndrome
 0-2 errors = none or minimal
 3-8 errors = moderate
 9-10 errors = severe

Note: Kahn, R.L., Goldfarb, A. L., Pollack, M., & Peck A. (1960). Brief objective measures for the determination of mental status in the aged. *The American Journal of Psychiatry*, 117(4), 326-328.

Test-retest reliability, as reported by Kahn, the developer of the test, is better than .80 and another study using the same data report Alpha reliabilities of .84 (Kane & Kane, 1981). Inter-rater reliability has not been published, but simplicity of the items would seem to ensure satisfactory results (Nelson et al., 1986). Nelson and his colleagues report another study that tested 55 elderly clinically stable patients four times at three week intervals. At the times of the re-administration, there was a change of at most one point in 75% of the patients. Although these reports are reasonably positive, reliability has to be considered cautiously if there are serious validity problems. In spite of its shortcomings, the MSQ is used widely and is believed to be a useful measure of cognitive impairment (Lautenschlaeger, Meier, & Donnelly, 1986).

Short Portable Mental Status Questionnaire

The Short Portable Mental Status Questionnaire (SPMSQ) was first reported in 1975 by Pfeiffer (see Table 2). It is a ten-item instrument that is similar in many ways to the MSQ, but yet differs in some significant ways. Questions test orientation to time, place, age, and memory, but in addition include a serial subtraction item which was one of the criticisms of the MSQ. Although the names of the current and past Presidents are asked for, the patient is also asked to give her/his mother's maiden name. This question addresses criticism about relevancy of the names of presidents for individuals living in institutions (Kane & Kane, 1981), whereas using the mother's maiden name is something the person is most likely to have known in the past. Patients are also asked to subtract 3 from 20 and continue backwards by series of 3s. A question asking for the telephone number or street address is a test of practical survival skills (Kane & Kane, 1981). The SPMSQ is thought to be more difficult than some of the other tests because the patient must answer all components of a question in order to get credit for a correct answer. For example, if the question asks for month, day, and year all must be given correctly in order to be considered accurate.

The test can be administered in 5 to 10 minutes, and it is easy to score. Low scores reflect the lack of impairment, with higher scores being suggestive of a higher level of impairment. Scores are adjusted for race and education. Patients with only a grade school education are allowed one more error as are African-American patients, while patients with a high school education are allowed one less error. Zero to two errors indicate no impairment, while 10 suggests severe impairment.

Norms were established using a broad spectrum of elderly individuals; community residents, nursing home residents, and persons utilizing a multipurpose clinic.

Three forms of reliability have been reported. Test-retest reliability reported by Pfeiffer (1975) is 0.80 to 0.83. Inter-rater reliability reported by Fillenbaum and Smyer (1981) is 0.62 to 0.87. Internal consistency reliability of 0.89 has been reported (Yazdanfar, 1990). Yazdanfar (1990) also reports on validity studies of the SPMSQ. Criterion validity is 0.63 when scores are correlated with clinical diagnoses of organicity, but when correlated with global impairment the figure increases to 0.71. When compared with the "Mini Mental State" and the Cognitive Capacity Screening Examination, the SPMSQ had the lowest criterion related validity. Construct validity of the Short Portable Mental Status Questionnaire is reported to be 0.84, similar to that reported for concurrent validity. True positive rates range from 88% to 92% when Pfeiffer's correction for race and education are incorporated. SPMSQ scores correlated significantly with the results of the Bender Gestalt Test (Yazdanfar, 1990) (see Table 2).

Table 2
Short Portable Mental Status Questionnaire (SPMSQ)

Give a zero (0) point for each correct answer. Question must be completely answered in order to earn the zero. If answer is incomplete or incorrect, score one (1) point.

		Earned Score
1.	What is the date today (month/day/year?)	_____
2.	What day of the week is it?	_____
3.	What is the name of this place?	_____
4.	What is your telephone number? (If no telephone, then street address?)	_____
5.	How old are you?	_____
6.	When were you born (month/day/year)	_____
7.	Who is President of the United States now?	_____
8.	Who was President just before him?	_____
9.	What was your mother's maiden name?	_____
10.	Subtract 3 from 20 and keep subtracting 3 from each new number, all the way down.	_____

Scoring

0-2 errors = intact

3-4 errors = mild intellectual impairment

5-7 errors = moderate intellectual impairment

8-10 errors = severe impairment

Allow one more error if subject had only a grade school education

Allow one fewer error if subject has had education beyond high school

Allow one more error for Black subjects, using identical education criteria

Note: Reprinted with permission from the American Geriatrics Society. Pfeiffer, E. (1975). A short portable mental status questionnaire of organic brain deficit in elderly patients. *Journal of the American Geriatrics Society*, 23(10), 433-441.

Cognitive Capacity Screening Examination (CCSE)

Rapid Assessment Instruments discussed thus far have included only those that were designed for the evaluation of psychiatric patients. In contrast, the Cognitive Capacity Screening Examination (CCSE) (see Table 3) was "adapted specifically to diagnose diffuse organic mental syndromes on busy medical wards" (Jacobs, Bernhard, Delgado, & Strain, 1977). Although the test is not specific for a geriatric population there is no contraindication for its use with elderly persons. Questions were constructed relating to orientation, serial sevens, verbal short-term memory, abstraction, digit recall, and arithmetic. The test itself is an easily administered 30 item questionnaire which can be completed in 5 to 15 minutes. Each of the 30 items receives one point for a correct answer. There is a clinical cutoff point of 20, which is suggestive of the presence of cognitive deficits.

Table 3
Cognitive Capacity Screening Examination (CCSE)

Give one (1) point for each correct answer.

	Earned Score
1. What day of the week is this?	_____
2. What month?	_____
3. What day of the month?	_____
4. What year?	_____
5. What place is this?	_____
6. Repeat the numbers 8, 7, 2.	_____
7. Say them backwards	_____
8. Repeat these numbers	_____
9. Listen to these numbers 6, 9, 4. Count 1 through 10 out loud, then repeat 6, 9, 4. (Help if needed, Then use numbers 5, 7, 3.	_____
10. Listen to these numbers 8, 1, 4, 3. Count 1 through 10 out loud, then repeat 8, 1, 4, 3.	_____
11. Beginning with Sunday, say the days of the week backwards.	_____
12. 9+3 is _____	_____
13. Add 6 (to the previous answer of 12)	_____
14. Take away 5 ("from 18")	_____
Repeat these words after me and remember them, I will ask for them later: HAT, CAR, TREE, TWENTY-SIX:	
15. The opposite of fast is slow. The opposite of up is _____	_____
16. The opposite of large is _____	_____
17. The opposite of hard is _____	_____
18. An orange and a banana are both fruit. Red and blue are both _____	_____
19. A penny and a dime are both _____	_____
20. What are those words I asked you to remember? (HAT)	_____
21. (CAR)	_____
22. (TREE)	_____
23. (TWENTY-SIX)	_____
24. Take away 7 from 100, then take away 7 from what is left and keep going: 100 minus 7	_____
25. Minus 7	_____
26. Minus 7	_____
27. Minus 7	_____
28. Minus 7	_____
29. Minus 7	_____
30. Minus 7	_____

SCORING
Total correct (maximum score = 30)
Scores below 20 are suggestive of cognitive deficits

Note: Reproduced with permission, from Jacobs et al., Screening for organic mental syndromes in the medically ill. *Annals of Internal Medicine*, 86(1), 40-46.

Validity and reliability studies have been reported more comprehensively by Foreman than by other writers (Foreman, 1987). Foreman compared the CCSE with the "Mini-Mental State" and

the Short Portable Mental Status Questionnaire and found the Cognitive Capacity Screening Examination to have the highest level of internal consistency of the three, 0.969. Criterion validity was reported to be 0.87 and the convergent validity was significant at $P < .001$. Additionally the CCSE was the most comprehensive of the three tests. Throughout the comparison with the other tests, the CCSE was the only one to exceed consistently acceptable standards (Yazdanfar, 1990).

"Mini-Mental State" (MMS)

Folstein, Folstein, and McHugh (1975) developed the "Mini-Mental State" (MMS) examination as a relatively simple means of measuring mental status in a geriatric population. "Mini" is emphasized because it is a test only of cognitive impairment, but Kane and Kane (1981) report that it was designed to be thorough. It has 11 questions and takes between 5 and 10 minutes to administer. There are two sections to the test, neither of which is timed. Section 1 requires verbal responses, addresses sensorium, memory, and attention. Section 2 measures reading and writing and the ability to name, follow verbal and written commands, write a sentence, and copy a complex figure, such as one taken from the Bender-Gestalt Test (Yazdanfar, 1990). Scoring is easy and direct, based upon the number of correct answers, with 30 being a perfect score. The cutoff point is 24, which distinguishes between cognitively impaired and unimpaired patients. Scores of 20 or less indicate severe impairment.

Reliability and validity studies, although variable, have tended to be reasonably good. Test-Retest reliability has ranged from 0.56 to 0.98 for patients with dementia, depression, and affective disorders. Internal consistency has been reported as high as 0.95. Criterion validity is reported to be 0.78 (Yazdanfar, 1990).

Some problems have been reported when the MMS has been used with Hispanic individuals in Los Angeles. They had difficulty with specific test items: naming the county of residence, subtracting by serial sevens, and repeating the phrase, "no ifs, ands or buts" (Baker, 1989). This finding suggests that another test may be more suitable for Spanish-speaking subjects. It has also been found that persons with less than 8 years of education tend to score lower on the MMS (Baker, 1989) (see Table 4).

Table 4
"Mini Mental State" (MMS)

Maximum Score	<i>Give one (1) point for each correct answer</i>	Earned Score
	Orientation	
5	What is the (year) (season) (date) (day) (month)?	_____
5	Where are we: (state) (county) (hospital) (floor)?	_____
	Registration	
3	Name three objects: One second to say each. Then ask the patient all three after you have said them. Give one point for each correct answer. Repeat them until he learns all three, Count trials and record number. Number of trials _____.	_____
	Attention and calculation	
5	Begin with 100 and count backwards by 7 (stop after 5 answers). Give one point for each correct answer. Alternatively, spell "world" backwards. Record spelling _____.	_____
	Recall	
3	Ask for the three objects repeated above. Give one point for each correct answer	_____
	Language	
2	Show a pencil and a watch and ask subject to name them (2 points)	_____
1	Repeat the following: "No ifs, ands, or buts." (1 point)	_____
3	Follow a three-stage command: "Take a paper in your right hand; fold it in half; and put it on the floor." Give one point for each correct response.	_____
1	Read and obey the following: (show subject the written item) CLOSE YOUR EYES (1 point)	_____
1	Write a sentence (1 point)	_____
1	Copy a design (complex polygon, as in Bender-Gestalt) (1 point)	_____
	SCORING	
	30 = Total score possible (perfect score)	
	24 = cutoff point which distinguishes between cognitively impaired and unimpaired.	
	20 or less = indicates severe impairment	

Note: Reprinted from the *Journal of Psychiatric Research*, 12, Folstein, M. F., Folstein, S. E., & McHugh, P. R. "Mini-mental state" A practical method for grading the cognitive state of patients for the clinician, pp. 189-198, (1975), with kind permission from Pergamon Press Ltd., Headington Hill Hall, Oxford OX3 OBW, UK.

Cognitive Impairment Conclusion

These four assessment instruments are by no means an exhaustive listing of measures designed to elicit symptomatology suggestive of dementia. Several tests have been developed to aid the physician in general practice to screen for signs of dementia. Among these is the Kokmen Short Test of Mental Status. It tests for eight components of the mental status exam: orientation, attention, learning, arithmetic, calculation, abstraction, information, and construction. The test can be scored in approximately five minutes; no time limits are set for performance, however administration time will vary depending on the level of impairment of the testee (Kokmen & Offord, 1987). Another relatively unfamiliar instrument is The Set Test, developed in the 1970's in Glasgow, Scotland (Issacs, & Kennie, 1973). Its developers describe it as a "test that is

performed by asking the subject to name as many items as he can recall in each of four successive categories or sets." The four sets are colors, animals, fruits, and towns. A point is given for each correct item, with a maximum of 10 in each set, allowing therefore for a total score of 40. A score below 15 is considered pathological and suggestive of cognitive impairment. No data is provided regarding validity, reliability, sensitivity, or specificity and the study sample is of such a restricted nature generalizability to other populations is questionable. A third Rapid Assessment Instrument is the Short-Orientation-Memory-Concentration Test, which is a six item test whose validity has been corroborated by the "gold standard" of autopsy. The six items are: What year is it now?; What month is it now?; (Memory phrase: John Brown, 42 Market St., Chicago); Count backwards from 20 to 1; Say the months in reverse order; Repeat the memory phrase. Each item is weighted such that a total score of 28 can be achieved. Weighted error scores of 10 or more are indicative of dementia (Katzman, Brown, Fuld, et al, 1983).

Geriatric Depression Scale (GDS)

The Geriatric Depression Scale (GDS) has been in use for approximately 10 years. It was developed specifically to measure depression in the elderly. Originally, the scale contained 30 items (Yesavage et al, 1983), but was reduced, subsequently, to 15 items that indicate the presence of depression in the elderly individual (Sheikh & Yesavage, 1983). As with other Rapid Assessment Instruments, it is a screening device and when depression is elicited with the GDS the diagnosis must be firmly established through the use of other diagnostic procedures. The GDS is written in a simple, easily understood language and can be administered orally or in a written format. Questions are constructed so that they can be answered in a Yes/No response (Yesavage et al, 1983). Translations are available in Spanish and French (Fischer & Corcoran, 1994). The GDS has been administered successfully to both physically healthy and ill groups of elderly persons. It can be administered in 5 to 7 minutes. One point is scored for each depressive answer. If answered positively, questions 2, 3, 4, 6, 8, 9, 10, 12, 14, & 15 are depressive answers. Questions 1, 5, 7, 11, & 13 if responded to negatively are depressive answers. The clinical cut-off point is 10. Scores of 0-10 are within the normal range and scores of 11 or above are indicative of depression.

Reliability has been determined to be excellent. Internal consistency is 0.94 and split-half reliability similarly is 0.94. Excellent stability is also shown with a one week test-retest correlation of 0.85.

Validity measures are also high. Concurrent validity, when correlated with the Zung Self-Rating Depression Scale, is 0.83 and with the Hamilton Rating Scale for Depression it is 0.84. The GDS distinguishes among elderly persons without depression, those mildly depressed, and those severely depressed. Concurrent validity was measured with the same two scales and was found to correlate between scales and was statistically significant at $P > .001$.

Conclusion

The Rapid Assessment Instruments described here are indicative of the tools available to the nursing home social worker and social workers should become familiar with one or two of them. This is consistent with the acceptance of the need for multi-dimensional assessment.

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Chapter Six

Social Work Ethics For The Long Term Care Setting

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Ethical concerns are integrally involved in the health care of our residents. As health care professionals, we are accustomed to analyzing risks and benefits and weighing options, since these are intrinsic components of diagnosis and treatment. However, social work practitioners, in the long-term care setting are confronted by situations that, while possibly similar in some ways, differ in critical dimensions from previous experiences as reflected in the professional knowledge base. The ethical concepts available to decisionmakers in long term care are often drawn from bioethics paradigms designed for the problems of hospital-based and acute care facilities (Colloby, Dubler, & Zuckerman, 1991). Although, ethics is crucial to the social work profession, and articles are often written about ethical dilemmas, there is limited available literature addressing the social worker and ethical issues in long-term care. Even in the acute care setting, according to Proctor, Howell, & Lott (1993), only three empirical studies on the topic of ethics had been published. Furthermore, the authors found virtually no research had addressed the frequency with which social workers, in acute care, encounter ethical dilemmas, or the issues related to their occurrence.

These new situations challenge practitioners to present an ethical response that must be derived from something other than the clear guidance of an established but incomplete knowledge base (Klein & Bloom, 1995). Social workers can utilize a problem-solving process that combines the best available information with the highest development of personal and professional ethics in an effort to resolve issues. Social work practice within the long-term care setting has a definable nature that includes essential tasks, skills, knowledge, ethical issues, and policy concern.

In the long-term care setting, social workers often find themselves in the middle of disputes that involve even those more "settled" issues. For example, a resident has executed a valid living will, but family members pressure the health care providers not to honor the directive. Situations that involve the withholding or termination of treatment or services, are increasingly receiving wide attention, ie. removal of feeding tubes and ventilators. "Quality of life" issues are being debated, and in its most extreme current form, the issues of assisted suicide brought to the public's attention by Dr. Jack Kevorkian (Buss, 1994). All these issues cause serious challenges for the care team members of long-term care facilities. The social service department is a key component of the Interdisciplinary Team (IDT). With the availability of extraordinary life-sustaining technology, limited resources, and a health care industry in change, ethical dilemmas have become more than "tough" in the long-term care industry-they are complex.

Traditionally, the issues of medical ethics and bioethics have been of primary concern to acute care facilities (Besdine 1985). In the acute care setting, social workers are accustomed to case reviews, ethics committees, and grand rounds. At least ethical dilemmas are discussed in some arenas. However, these same mechanisms utilized by the acute care setting, are almost non-existent in the long-term care facilities (Kane, 1990). In the long-term care setting, the American Health Care Association in their publication "Commitment to Ethics (1995), suggest that long-term care facilities have a modest appreciation of the ethical implications of many events occurring in long-term care. Also, that providers fail to understand the high degree of ethical difficulty inherent in such issues as termination of treatment, assessment of a resident's capacity to make decisions, privacy, and confidentiality.

Elderly persons are the fastest growing segment of our population, and those over 65 account for 12% of the population (Rosen, Fanshel, & Lutz, 1987). According to Galambos (1989), advances in medical technology have increased the number of medical options available to this population. As an elderly person copes with decreases in mental and physical function, the number of decisions pertaining to medical treatment increases. These options may be overwhelming for the individual who may not understand or have been exposed to these advances in medical technology. The majority of ethical dilemmas are linked to the high prevalence of dementia and other disorders that affect decisional capacity (Hofland & David, 1990). Moreover, nursing homes are generally viewed by society as institutions with routines and programs with environmental factors subverting autonomy. The coercive power of the institution where one "lives" can be more pervasive than that of the hospital where one only "stays" (Colloby, et al 1991). Few long-term care facilities in Texas provided for social services prior to the Omnibus Budget Reconciliation Act of 1987 (OBRA), requirements. In addition, the implementation of OBRA, 1990, with its emphasis on autonomy, rights of residents, and the moral responsibilities of facilities, assisted with the emergence of social workers in the field of geriatrics. The long-term care setting experienced a shift from the traditional, "medical model" to the "person in the environment", or a more "holistic" attitude towards wellness. Not only the medical aspect of care is assessed and treated, but emphasis is also on assuring that the resident receive services and care needed to provide the medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being (Engleman, 1995).

The change has been slow, and at times difficult for the integration of the social worker into a setting that has changed paradigms. Social workers address issues, and bring attention to issues that impact the resident's rights and choices, some of which include, but not limited to, life and death questions about tube feeding, administering do-not-resuscitate orders, the right of a resident to refuse treatment, as well as the day to day issues of personal autonomy.

Defining Ethics

Ethics can be defined as a system of moral principles and perceptions about right versus wrong and the resulting philosophy of conduct that is practiced by an individual, group,

profession, or culture (Barker, 1988). The facility setting creates the need for mediating processes to ensure that the legitimate concerns, interests, and convictions of all are addressed and decision-making can go forward. The literature acknowledges that social workers have loyalties to multiple parties, further contributing to potential conflicts (Blumenfield and Lowe, 1987; Gelman, 1986; Levy, 1980). Likewise, Abramson (1981), discussed the multiple and potentially conflicting parties, to whom the social worker has loyalty, in the context of the acute care setting. As viewed in the context of the long-term care setting, these may include the resident, the resident's family, the facility (which depends on the census for financial solvency), and society (for whom health care providers strive to justly allocate the scarce resources of health care).

A social worker in the long-term care setting is then faced with the challenge of facilitating communication that involves a diverse group of individuals, ie. resident, family members, staff, etc. that often have very different values and convictions. Ethical decision-making is difficult because "doing the right thing" means something different to everyone (Jerstad, 1994).

Social Work Roles

Social workers may assume various roles in the long-term care setting when addressing ethical issues. Clearly, one of the key roles of nursing home social workers is to provide residents' with opportunities and circumstances that reinforce their independence and enhance the residents rights to self-determination (McDermott, 1989). Social workers must respect the dignity and uniqueness of each individual, and they have a responsibility to preserve this dignity throughout the life cycle of a person. The social worker is in an excellent position to educate or to facilitate education regarding the rights of the residents and availability of instruments that allow the resident to convey his/her choices in end-of-life issues. Educating the staff is essential to promote resident autonomy and ensure that staff have an understanding of the impact of nursing home placement on the resident, and end-of-life decision-making available to the resident. Community education is essential to allow for discussions about advance directives, resident rights, current regulations and policy. Education of resident, family, and staff in these areas is imperative if the coordination of medical care in the facility is to allow for a more inclusive view of the resident's overall well-being. The social worker can also fulfill a counseling role in this area. Social workers may use clinical technique to counsel the individual and significant others and facilitate the resident's best choice in understanding what makes the most sense given the resident's medical condition, core values, prognosis, and preferences. In addition, the social worker may refer a resident/family member to various community resources to assist with decision making, e.g., legal services, clergy. The social worker may also assume the role as mediator and/or advocate. According to Parsons and Cox (1989), what distinguishes the mediator role from the clinical or advocate role is that the mediator intervenes in a process of interaction between systems as a neutral facilitator to assist those systems to reach agreement about disputed issues. Elderly residents must be viewed on a continuum of capacity to incapacity. Adhering to the principle of empowerment of residents toward self-determination the resident should be involved in the mediation process to the

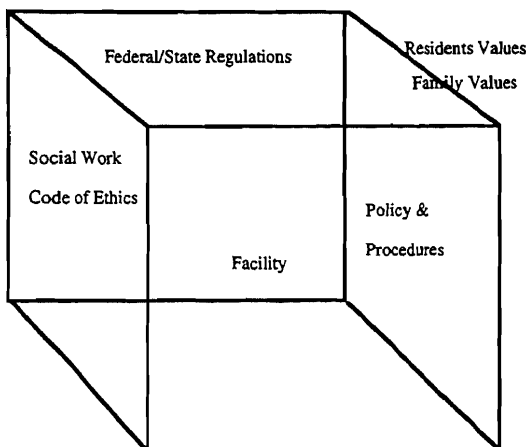
extent that they are able and willing to participate. A major challenge is the determination of decision-making capacity. Decisional incapacity is the principle, for overriding a resident's wishes and for vesting others with surrogate responsibility. For this reason, assessments of mental capacity carry such enormous weight. The resident who cannot manage his/her finances might be able to decide about major surgery or whom they want as a roommate. Residents may, for example, experience fluctuating or intermittent capacity. When the resident is unable to participate in the decision making process, the social worker may shift roles and assume the role of advocate. Advocacy then can be best summed up to be the intervention on behalf of an individual client or identified client group with one or more institutions to secure or enhance a needed service, resource, or entitlement (McGowan, 1987). Social workers can assume a planning role in the development of policies and procedures for implementing options within the facility and community agencies to reflect the best interests of the residents we serve.

Sources of Ethical Standards

Whether in business, government, or the long-term care industry, public demands for standards of practice have increased media attention on ethical issues in these arenas. The discussion by the news media about ethics' committee review by the U.S. Senate or some other regulatory agency, is almost a daily occurrence. The media coverage of scandals involving the most shocking kinds of abuse and neglect have inevitably reinforced the negative image of nursing homes. Nursing homes are subject to closer governmental scrutiny and more detailed regulation than any other health care institution (Collopy, et al 1990).

Establishing perimeters can assist the social worker, facility staff, resident, and family members in making ethical issues more manageable. "While each individual has a conscience, a world view, and a set of values to pursue, the resident is situated within a complex rubric of laws, regulations, institutional and agency policies, professional ethics, and the personal values of individual caregivers" (American Health Association, 1995, p.6). An understanding of how each of the components comprising the rubric impacts the decision-making is crucial to the process.

Figure 1
Establishing Perimeters



Standards usually mean laws, policies, and guidelines of conduct adopted by some policy making authority, ie: legislature, the courts, agencies, professional boards (Eutis, et al. 1984)

Laws and regulations are important and worthy of respect. Good practice and good ethics go hand in hand. The Health Care Financing Administration (HCFA) is directly responsible for establishing standards and regulations for the long-term industry,

but relies on the states to oversee and implement and implement. Through the state regulatory mechanism HCFA, monitors the quality of care provided within the facilities. Industry trade organizations include the American Association of Homes for the Aging (AAHA) and the American Health Care Association (AHCA), each have qualifications to which their members adhere. These standards attempt to allow the industry to self-regulate through quality assurance (QA), and continuous quality improvement (CQI). In addition, many nursing homes wish to be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) for recognition that they meet high quality standards. JCAHO mandates a mechanism be in place to address ethical issues (Joint Commission on Accreditation of Healthcare Organization, 1988).

Beyond legal regulation, professions rely on self-regulation through a variety of procedures, such as, mandatory continuing education as prerequisite for license renewal, peer review, and consultation with colleagues.

Staff personnel who are members of professional organizations such as the National Association of Social Workers, and the American Nurses' Association, have codes of conduct. Professional ethics seek to standardize the behavior to make more reliable and accountable the actions of its members. Basically the common interest of the group reflects consensus of policy makers in determining a group's "standards" (Eutis, et al. 1984)

Codes of ethics, in particular, offer standards whose potential violations may provoke both informal and formal discipline. Through membership in a professional organization, the member pledges to abide by a set of ethical standards that helps reassure the public that he or she will demonstrate sensible and responsible behavior. According to Proctor, Howell, and Lott (1993), the Code of Ethics (NASW, 1990) requires conformity to multiple principles. For example, several principles are set forth regarding the social worker's responsibility to clients, including the primacy of client's interest, maximization of self-determination, respect for privacy, and the confidentiality of information. Furthermore, "the social worker is expected to take into consideration all the principles in the code that have a bearing upon any situation in which ethical judgment is to be exercised" (p.iii).

Ethical codes, then, define standards of conduct subscribed to by the members of the profession, aiding members in their decision-making with resident/clients whenever possible areas of conflict arise. Conflict, according to Parsons and Cox (1989), usually surfaces when participants have different data, disparate interpretation of the same data, or disagreement on procedures. The facility staff have both legal and moral responsibilities to ensure that these interactions correspond with its values and those of the community, as expressed in professional codes and regulations.

Steps in the Process

A solid understanding of the process will guide the social worker in assisting a diverse group of individuals in making ethical decisions. Viewed in this context, ethics is a process of going about doing the right thing and becomes a clinical tool. What should occur is an intensive,

reflective process of communication in which an in-depth assessment is made of the action to be taken, the implications of that action for the individual, and the impact of the decision on the decision makers. This process should include as many perspectives as possible. To give an example of the complexity of an issue we will exam a case that was referred to a social service consultant. Some of the issues in this case will be reflected in the "steps in the process". The "set of principles of ethical actions" will be easily identified as you read the case study. The social worker assumes various roles, and the sources of ethical standards will have their influence upon any decision.

SCENARIO

Mrs. L. has lived for the past eleven months at XYZ facility. Mrs. L. is 77 years old. Her diagnosis indicate: dementia, history of gastrointestinal problems, and some frequent knee problems. Her husband died five years ago. She has two children. Her daughter visits weekly and staff report, until this past Saturday, the son had never visited. A notice to discharge had been given to the family, due to an unpaid bill, twelve days before Mrs. L. pulled out the G-tube. The resident has a Living Will and Durable Power-of-Attorney for Health Care (DPOA) on the chart; neither of which is specific concerning the feeding tube. The son, Carl, has Power of Attorney for financial and the daughter, Patsy is the agent on the DPOA. The physician had given orders for the resident to be hospitalized for re-insertion of the tube on Saturday after nursing attempted the re-insertion of the tube and was unsuccessful. The ambulance was called for resident's transfer to the hospital. Before the ambulance arrived, the physician had called back and discontinued the order to send the resident to the hospital. The physician stated that he had spoken with the family and that they did not want the resident hospitalized; no other order/s given. The son showed up at the facility Saturday afternoon threatening a lawsuit if they sent his mother to the hospital. He emphasized that he was himself a practicing attorney. The daughter was in tears and stated she did not want her mother to die, but her brother thought it was time for her to "go".

According to Cassell (1988), a systematic approach using five steps can assist in the resolution of ethical dilemmas. These same five steps can be utilized by the social work practitioner in the long-term care setting.

1. Define the situation/problem and collect all factual data available
This may include, but not be limited to information about the resident's current condition, rehabilitation potential, mental state, and personal wishes regarding life support. From observations, conversations, and team members expertise this data can be obtained.
2. Establish the motives of everyone involved
Having the factual information does not mean a decision is ready to be made. The facts should also be used to examine the possible motives of everyone involved. For example: Is the resident resisting nutrition because he/she wants to end their life without more suffering or is it related to depression? Is the son/daughter resistant to following the resident's directive because of unresolved family issues? Is the physician reluctant to follow the wishes of the resident, because he/she feels that if the patient died he/she would

have failed as a doctor? Is the physician reluctant because of possible litigation? Does the administrator of the Nursing Home want treatment and hospitalization because he/she doesn't want residents to die in the facility and trigger the regulatory agency to look at number of deaths.

3. Apply a set of principles of ethical actions

While each challenge may be unique, we can identify certain common elements/principles that should be a part of all ethical decision-making and taken into consideration.

- **Autonomy:** each individual has a right to make decisions based on his/her own value system. (The right of autonomy is the basis for informed consent. (Hofland and David, 1990).
- **Nonmaleficence:** refers to the prevention of harm to others or do no harm. Ethical issues related to this principle include questions of due care versus negligence, and risks versus benefits (Callahan, 1987).
- **Beneficence:** principle of helping others further their legitimate interests. A problem commonly associated with this principle is that of "paternalism", the "I-Know-Best" syndrome (Abramson, 1989).
- **Justice:** a person has a right to what is due or owed him/her. Ethical issues related to this principle include equal services regardless of pay, and allocation of scarce resources, e.g. heart transplantation (Cassel, 1988).
- **Informed consent:** must be based on the knowledge of the risks and alternatives. One of the greatest risks in professional malpractice suits is failure to achieve informed consent (Beauchamp and McCullough, 1984). Informed consent is predicated on the intellectual and emotional capacity of the resident to comprehend the information.

4. Review the consequences of every course of action.

Evaluate each option in terms of its probability of success and possible limitations. Sometimes procedures are too burdensome to be justified or the risks are unacceptable.

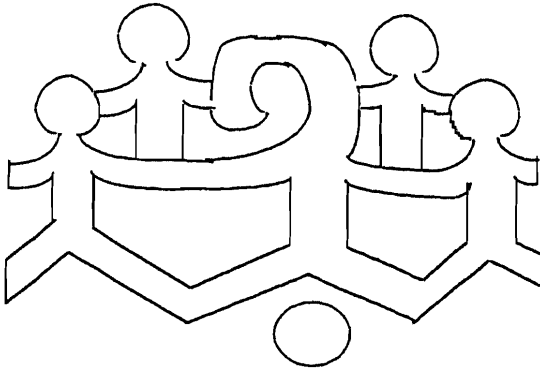
5. Plan

Decide on a course of action and determine how it should be implemented. Even to indefinitely postpone a decision is to ultimately decide. Kane and Caplan (1990), remind us that the real impact of a decision lies in the quality of its implementation.

Out of the process should emerge a consensus, albeit tentative, about the action to be taken.

Although the process might be time consuming, and emotionally draining, it would provide for careful and painstaking scrutiny and minimize the need to involve the courts as exclusive choice makers in these difficult situations (Gelman, 1986).

Figure Two



Is there anyone else that can assist with providing another perspective on the issue? Looking at the whole picture and what the end result will be is often the key to maintaining a sense of balance when dealing with ethical dilemmas. The real challenge is to ascertain that the resident, surrogate, and/or family members have a clear understanding of the course of treatment, why it is being considered, the alternative therapies available, and that they have considered these in relation to their own values.

Don't make decisions in a vacuum. Ask: "Is there anyone else who can assist with providing another perspective on the issue"? Look to outside resources e.g. consultant/s, corporate medical director, facility medical director, ombudsman, risk management, clergy. Utilize mechanisms that you may currently have available to assist you, ie. UR committee, QA/CQI councils, support groups, hospice, etc. We must not forget that the primary mechanism for the resolution of ethical dilemmas is already in place in most long-term care settings in the form of the interdisciplinary team responsible for resident care.

Resources for Resolving Ethical Dilemmas

Ethical behavior is everyone's responsibility. According to Englehardt (1986), to avoid ethical behavior becoming no one's responsibility, it is important to establish and use certain structures. Facilities and agencies have found ethics committees, grand rounds, as well as a variety of in-service programs, consultations, lectures, and other activities, useful (Buss, 1994). They are viable tools in assisting the facility staff in addressing ethical dilemmas (Miles, 1994).

Ethics committees have become a very important institutional reality within hospitals and other health care facilities during the last 20 years since the New Jersey Supreme Court recommended them in the Karen Ann Quinlan case in 1976 (McCartney, 1992). The establishment of ethics committees in long-term care facilities has progressed slowly. In a survey conducted by Miller and Cuglian (1990), the findings indicated that only 2% to 27% of nursing homes had ethics committees. However, a properly functioning ethics committee can assist a facility in developing sensitivity to the implications of its practices, help develop a collective ethical wisdom in addressing complicated issues, provide a resource for facility departments to use in addressing ethical issues, and review policies and procedures (Buss 1994). Additionally, ethics committees also may serve as a resource to residents, caregivers, and families.

When considering the formation of an ethics committee, the composition of its members is important. It should be composed of competent, interested individuals, from a myriad of backgrounds. They might include physicians, social workers, nurses, dieticians, pharmacists, ethicists, cleryperson. According to Miles (1992), ethics committees have three basic functions:

1) To educate its own members, the facility staff, and the residents/families, 2) Develop policy/guidelines, 3) Case review and consultations.

In grand rounds, a designated individual presents a case to those in the facility who have an interest in the particular case, as well as, those who might contribute to or learn from the resulting discussion. The designated individual acts as a consultant to the group. The principal benefit of this approach is the development of personal and community sensitivity toward and skill in ethical application (Miles, 1992).

Case reviews, in-service programs, videos, conferences, etc. can all be utilized as mechanisms in order to facilitate discussion of situations that have ethical implications. Discussion with peers provides the opportunity to examine the wisest possible resolution to complex issues and receive support and knowledge from professionals whose business it is to serve the geriatric population. All of these provide an opportunity for evaluation, learning, and planning by the facility care team.

Conclusion

Expectations of high-level performance and competence will continue to increase in the long-term care setting. Facilities will require that social workers conform to industry standards and maintain professional credentials. Because social workers, in the long-term care setting, touch people in moments of great dependency and often in the final stage of life, we play a major role in helping residents and their loved ones cope with physical, emotional, and spiritual needs. Many decisions are part of multiple decisions that have to be made over time. There are opportunities to educate the resident, family, and staff all along the way. As social workers we must be proactive and involved from the beginning when placement of the resident into the nursing home occurs. To the extent possible, we must obtain a comprehensive social history and get to "know" the resident. The social worker can facilitate discussion and attempt to build an ethical sensibility. An ethical sensibility does not mean unanimity. It does not mean people are all thinking the same way. We must remain true to our own values while respecting the values of others. It means there is a degree of awareness, of sensitivity to ethical issues.

Intervention through facilitating, raising consciousness, and through advocacy the social worker can ensure that the larger social structure through formal integration of ethics into policies, procedures, and daily decision-making enhances the resident's autonomy.

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Chapter Seven

End Of Life Issues

Or

"What We Do Now, Kemosabe?"

by

*The Reverend Chuck Meyer
Assistant Vice President, Patient Services
St. David's Healthcare System*

Social workers are often the first people brought in to help deal with decisions at the end of life, whether that end is imminent or long term. Residents, families, and other staff members are likely to perceive social workers as having the combination of empathy and counseling expertise that both personifies the profession - and overwhelms you from time to time! So it is extremely important to know the basic issues to address (Where Are The Bad Guys?), how to address them (The View From Silver), and where to get help (How To Find Tonto When You Feel Like The Lone Ranger.)

WHERE ARE THE BAD GUYS? - We all know that the bad guys are always in a hideout in the mountains, which is where they are right now because they are definitely not in your nursing home. People will try to tell you (and believe) that the bad guys are the doctor, the family, the patient, the nurse, the system, or even you; the bad guys are the ones who obstruct the best interests or the will of the patient, demand treatment be continued or stopped and generally get in the way.

But the truth is *there are no bad guys*. There are only people with differing interests, fears, emotions, and beliefs, all coming together trying to do the right thing regarding treatment at the end of life, with varying degrees of experience and few clear guidelines.

The truth is that we are in the middle of a major learning curve, transitioning from a model of medical practice where we believed we had to do everything to everybody for as long as possible to a model that strives, imperfectly, to determine the most appropriate treatment for the individual patient given his or her own standards for quality of life and realistic prognosis. Such decisions are not conflict-free; often the opposite is true and your job will be to mediate the best solution. And in working out solutions, it helps knowing you generally do not have to worry about bad guys.

Once they are out of the picture, you can get on with addressing the needs of the residents/patients as they deal with their end of life treatment decisions. The primary way to make everyone's job easier when the crisis comes is to raise the issue of Advance Directives.

Advance Directives

The key word here is ADVANCE. Federal law (New York State Task Force on Life and the Law, 1990) requires any institution dealing with Medicare/Medicaid to provide information regarding these directives, to ask if incoming patients/residents have them, and to document on the chart whether or not they do. While directives cannot be required for admission, they can certainly be part of an intake process that begins when someone expresses interest in your facility. Hospital studies have shown that when patients are given this information at pre-admission, there is nearly a forty percent higher completion rate before they hit the front door (New York State Task Force on Life and the Law, 1990). Many people (perhaps even you) have "been fixin' to" fill them out. Providing the material to peruse before admission allows time for discussion and unhurried consideration.

In Texas there are currently four kinds of Advance Directives: a. Living Will (Directive to Physicians), b. Durable Power of Attorney for Healthcare, c. Organ Donor Card, and d. Out-Of-Hospital DNR (Do Not Resuscitate.)

LIVING WILL - Also known as **DIRECTIVE TO PHYSICIANS**, this document allows a person certified by two physicians to be in a "terminal condition" to have life sustaining "procedures withheld or withdrawn and be permitted to die naturally."

It is very important to remember the words "terminal condition" because they include terminal illness but are not limited only to terminal illnesses. A terminal condition is

"an incurable or irreversible condition caused by injury, disease or illness that would produce death in a relatively short time without the application of life-sustaining procedures, according to reasonable judgment, and in which the application of life sustaining procedures serves only to postpone the moment of the patient's death." (Texas Health and Safety Code, Chapter 672, Section 002. Natural Death Act.)

Patients whose conditions are incurable or irreversible qualify for inclusion under this act. But no one can execute a Living Will for another person. The patient must have the capacity either to sign the document (even with an X) or to verbally state his/her wishes in the presence of two witnesses. The witnesses cannot be relatives, healthcare providers or persons who are potential beneficiaries of the resident's estate (for obvious reasons, speaking of bad guys.) It need not be notarized and the forms are free.

The limiting factors of the Living Will are:

1. the resident's terminal condition must be documented by two physicians, a difficult task in a hospital much less a nursing home or a rural Texas setting.
2. the document only takes effect when the resident is diagnosed to be in a terminal condition.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE - This allows the person to designate three people (an "agent" and two alternates) who will direct all healthcare decision

making when the person is unable to do so. The only things the agent cannot do are approve a psychiatric hospital admission or give consent for electro-convulsive therapy.

Because there is no mention of "terminal condition" or physician requirements, the DPAH is thought to be an easier, more direct and legally powerful document. The person simply must be unable to communicate his or her treatment choices for it to take effect. If the first "agent" on the form is unwilling or unavailable, the power to decide defaults to the second and on to the third.

Again the person must have capacity to sign, and the document must be witnessed by two persons who are not relatives, healthcare providers, or inheritors. Unlike the Living Will, this one cannot be verbal.

Remember that you, as an employee of a healthcare provider - the nursing home - cannot witness for your patients. You can usually find visitors, vendors or even other patients with capacity willing to witness.

When the resident executes either or both of these documents, make four or five copies. Attach one copy to the front of the chart. Put one or two in the medical file that would accompany the person to the hospital. Give copies to the resident to keep or give to the family/guardian. Remind them not to put the papers in a safe deposit box where they will be inaccessible when needed. You may want to keep a copy in their social service file.

Please keep in mind that it is entirely possible, and even legal, to die in Texas without Directives. They are meant to be helpful and permissive, not burdensome and restrictive. They have more to do with patient rights than with treatment decisions, enabling capable people to put their wishes in writing or direct their decision-making to trusted friends. As patient advocates, social workers can provide information, discuss options, and assist in the preparation of documents that will help their patients get what they want regarding healthcare, and concentrate on living fully until such time as the documents take effect.

ORGAN DONOR CARD - Most people know about this but mistakenly think it affects only younger citizens. In fact, the organ/tissue donor criteria are constantly changing and broadening to meet the growing need. Best advice here is to check with your local procurement agency (call the medical society and ask them who it is) to see what criteria apply to the population of your facility. Kidneys, corneas and tissue have been transplanted from persons in their eighties.

OUT OF HOSPITAL DNR - Passed in 1995, the actual forms are not yet finalized by the Texas Department of Health. This law outlines the procedure (involving a written document and a wrist band) for a physician to designate a patient DO NOT RESUSCITATE outside a hospital, at home, or in your nursing home facility.

Basically following the "terminal condition" language, its purpose is to prevent unfortunate situations where EMS is called by a panicked neighbor or distant relative to resuscitate someone who does not wish to be resuscitated.

All of these Advance Directives can be extremely helpful to your patients/residents and are tools to support their rights and safeguard their wishes. Having the papers in place, or even just

the opportunity to have discussions so that some wishes are known can provide a sense of relief and satisfaction for patients and families. Social Workers are in the best position to use these Directives both as an end in themselves but also as a means to beginning discussion of deeper end of life treatment issues.

The View From Silver

The Lone Ranger's horse, Silver, was huge. Sitting atop his mount at the crest of a canyon was more than a classic pose. It also gave The Masked Man a view of the situation below that was far superior to anyone else involved in the fray. This must also be the Social Work view, the broader perspective that sees beyond the present problem or conflict, that looks back at the quality of life of the patient/resident before this point and forward to the kind of meaningful life that may or may not lie ahead. Three components of this view are: A Good Death, Coercive Language, and Comfort Care.

A Good Death - As the age and acuity of our population increases, one of the primary questions we will have to consider with patients/residents is: What is a good death for you? Responses to this question all over the country are nearly identical. Most people want their death to be quick, painless and at home, or in familiar surroundings. Yet 85% of deaths in the U.S. occur in healthcare institutions such as hospitals and skilled nursing facilities where, by definition these high-tech deaths are anything but quick, painless and in comfortable surroundings (Nuland, 1995). They frequently are in ICU's with tubes, machines, high drama and higher cost (Nuland, 1996).

The earlier the social worker begins piecing together the elements of a good death with the resident/patient, the better the chance that it will actually happen. An appropriate time to discuss end-of-life wishes is when broaching the more benign and less threatening subject of Advance Directives, when the worker can ask related questions in a relaxed manner.

- While we're talking about these Advance Directive issues, I'm wondering if you have any strong opinions about the use of tubes or machines if you suddenly become seriously ill?

- What are your thoughts or feelings about artificial nutrition and hydration, or a ventilator machine that breathes for you? What about transfer to a hospital intensive care unit?

- Many people have told me what a good death would look like for them, including such things as quick, painless or at home. If you were to suddenly become seriously ill, are there any guidelines or wishes you would like us to follow?

The goal here is to enable residents to feel a sense of control about the rest of their lives. The view from Silver includes casting out over the broad plains of the person's life to examine

their values, their wishes, their quality of life standards, and to help put guidelines or Directives in place that will enable those values, wishes and quality standards to be honored all the way to the end.

Coercive Language - Social workers are in extremely influential positions regarding resident decisions about end of life treatment. You must be able to discuss these issues in terms they will understand, using accurate descriptions, metaphors and language that will clarify rather than coerce. This part of the view from Silver means that we must listen from a higher, wider perspective that enables us to hear what we are saying, evaluate our effectiveness, and alter our language as appropriate. The most commonly used phrases that can be coercive are:

LIFE SUPPORT

FOOD AND WATER

STARVE TO DEATH

DO EVERYTHING/NO CODE

EFFECT VS. BENEFIT.

The phrase "life support" conveys to a resident or family that what is being supported is, indeed, "LIFE" with the implication that it should stay supported and not have treatment withdrawn. People (staff, workers, families) cavalierly invoke the word "life" as though there is a common understanding about its meaning. In fact, we know nothing about what life means until we know what life means or meant to this resident - and is this it? Is this the quality of life acceptable to the person, or can we through medical treatments restore the person to the quality of life previously acceptable to him or her? If not then what is it we are continuing to "support" and why? Rather than talking about "life support" the worker can discuss "medical treatments," all of which may be withdrawn or withheld since they are not supporting life as the patient/resident defined it, and may in fact be prolonging dying.

Artificial nutrition is not food. Artificial hydration is not water. To call the mechanical device a "feeding tube" is to evoke in patients/residents/families the images of occasions involving meals, usually with an emotional overlay of nurturing, caring, supporting, feeling good and full from a meal, surrounded by loved ones. So of course no family members would remove a "feeding tube" if they thought it was nurturing their loved one; this would be a cruel and unethical act, akin to taking a meal away from a person. We call the tube that goes down the nose a nasogastric tube; why not call this medical treatment a "stomach tube" or "gastric tube" or "intestinal tube" for accuracy? And the substance used is (until we develop better language) "artificial nutrition/hydration" or "chemical nutrition" or "chemical support" which is mechanically administered in the same manner that ventilatory support is mechanically administered.

Furthermore, when "food and water" language is used, family members often are afraid their loved one will starve to death if the tube is removed. Social workers are in a prime position to educate and tell the truth to patients/families making these decisions. And the truth is we do not starve to death. We dehydrate first. With a condition called azotemia, dehydration begins, waste

products build up in the body and naturally insulate the person from pain as he/she goes into a coma and dies. If there is any pain or discomfort along the way, it is ethically obligatory to provide whatever narcotic or other medications are necessary to quell the pain or suffering (Abrams, 1987).

Workers furthermore need to encourage clients to ask what happens not only if artificial nutrition/hydration are withdrawn (azotemia), but what happens if these medical treatments are continued or started. Studies have shown that the provision of AN/H in terminal patients causes clinical sequelae that are normally not present with azotemia (McCain, Hall, & Groth-Juncker, 1994). Thus the nurse may have to catheterize the patient as well as suction due to increased fluids. If renal failure occurs, fluids may build up in the tissues and cause further pain (McCain, Hall, & Groth-Juncker, 1994). Artificial nutrition can cause patients to wake up so they can fully appreciate their suffering and death. Continuing these treatments forces preoccupation with the technology of treatments instead of focusing on the physical and emotional comfort demands of the dying patient and family.

Many people argue that continuing AN/H in terminal patients creates a worse death, causes more suffering and pain, and detracts from the real needs of the patient. Social Workers (along with the rest of us in health care) have an ethical obligation to accurately describe these treatments and to encourage families/decision makers to think through the outcomes of withdrawing/withholding or continuing them.

When families ask the doctor or worker to do everything they are often reacting to a suggestion to make their loved one a no code. In these instances, or when a patient/resident is hospitalized, it is important to explain to the decision makers the difference in code status, and just exactly what it means to "do everything."

Often families/decision makers are unaware of what happens when "everything" is ordered. What they are saying when making this request is that they don't want their loved one to die. What they may not realize is that the consequence of ordering a Category I Full Code on a patient may result in cracked or broken ribs, punctured lungs, electric paddles to the chest, intubation with a ventilator, and transfer to the relative isolation of an ICU. Social workers can explain that there is a difference between doing "everything possible" and "everything appropriate" to support the quality of life important to the patient.

Furthermore, workers can advocate for changes in Code Status policy in their institutions. In Austin, Texas, the Travis County Medical Society helped develop a single code status policy in the three major center city hospitals. Many nursing homes have also adopted these categories.

Category I – Full Support. Everything necessary is done to prevent mortality.

Category II – Intermediate Support. No intubation or chest compressions. Medicines and nonintubated ventilatory support are permitted.

Category III – Comfort Support. All treatments are aimed at the goal of patient comfort, dignity and security.

Again note the importance of language describing Category III. Rather than requesting a NO CODE status, which terrifies families by connoting abandonment or doing nothing, we recommend using the accurate description of COMFORT SUPPORT. This designation conveys that the proper goal now is comfort, that we still continue to treat for comfort, and that treating the family as well as the patient is part of the goal of comfort. Social workers may address the code status with the resident/family at preadmission/admission, or when an event occurs with the patient that means reviewing the patient's status, long term prognosis and quality of life concerns.

There is currently much debate over the efficacy of CPR, especially in nursing homes. Even in hospitals, we know that we should not be doing CPR on ICU patients over age 70 with cancer, sepsis, renal failure or GI hemorrhage, because the survival to discharge rate is zero. And the survival rate in nursing homes is even more dismal. Survival for a resident receiving CPR for cardiac arrest in a nursing home is between zero and two percent (Applebaum, King, & Finucane, 1990).

Given these numbers, a group of people from around the state came together representing nursing homes, oversight committees, reviewers, aging and disability groups, pastoral care and social services to discuss the appropriate policy standards for nursing homes. The result was a recommendation that, while the assumption for acute care hospitals should be that any patient who has an undesignated code status ought to be considered a Category I and receive resuscitation unless they requested otherwise upon admission, the assumption for nursing home patients should be nonresuscitation - Category III - unless they requested otherwise upon admission.

This is an issue that needs much more discussion and advocacy, especially from social workers, as the goals of a good death and appropriate end of life treatment are raised with patients/residents and administrators.

Another useful distinction with patients/families when evaluating treatment options is that of EFFECT AND BENEFIT. We may be able, through some medical treatment or technology, to produce an effect on the patient - lower blood pressure, increase cardiac output, dialyze kidneys, facilitate oxygen exchange, lower temperature. But the real question is whether or not the treatment produces a net benefit for the patient, as the patient would define it, whether it would extend or increase the quality of life.

The problem with language is that our biomedical technology has outpaced not only our ethical system but our vocabulary to talk about it. We continue to use old metaphors (food, water, life support, tube feeding) to describe new treatments and the old metaphors not only do not accurately describe what is being done - they give inaccurate or even misleading information, with which we then expect patients/families to make reasonable decisions. As social workers raise the issues of end of life treatment, you must be extremely attentive to the language you use, so as not to inadvertently coerce clients into making decisions based on inaccurate information or emotional reflexes.

Comfort Care - The view from Silver allows us to see beyond "the way we've always done it." As resident/family advocates, social workers must assist caregivers in diligently guarding the interests of the dying patient. This may mean suggesting new and definitive policy and procedure for Category III patients. Without procedure, workers must use common sense to support the goal of comfort care in their patients, asking questions about lab work (why are we sticking dying patients?), cardiac monitoring, ICU transfer, any invasive procedures (PEG, amputation, tracheotomy), hyperalimentation (AN/H), or antibiotics. A Category III in a nursing home should mean not only Comfort Care, but also Do Not Transfer (to a hospital emergency room.)

Otherwise standard nursing procedures that should be modified to support the goal of comfort include bathing, turning, dressing changes, weighing, and taking vital signs. Medications should be reviewed as to benefit (not just effect) and discontinued as appropriate.

It is immoral, unethical, unnecessary and just plain stupid for people to die in pain, discomfort, or suffering, given the incredible pharmacology we have at our disposal. But the reason many people do die such deaths is not because anyone purposely lied about outcomes or misled through language or optimism about efficacy of treatments. The problem, again, is that we are in the middle of a huge learning curve.

We used to practice medicine and provide healthcare under the technological imperative, which meant that if we had the technology we had to use it. If the ventilators, dialysis machines, antibiotics, and artificial nutrition/hydration methods were available, we felt obligated to apply them. But now we are learning that those treatments may be nonbeneficial, useless, or even harmful and that they may not be ethically or medically obligatory, especially in patients with a terminal condition.

To address this issue, an option for which social workers can advocate, is a Comfort Care Unit at the nursing home. While it may be enough to enable residents to become Category III and change the goal to comfort anywhere in the facility, it may also be useful (depending on the size of the home) to designate a particular section, or a specific number of beds on a section (or in the skilled section) as a Comfort Care Unit. Residents would be moved here when the goal of their treatment/care plan became comfort only. Many hospitals and nursing facilities are looking to this kind of unit to allow people to be comfortable as they die.

Ideally, it would seem reasonable that people should die on the unit/section on which they have lived for years, with the staff they know and other residents around who know them. But for some facilities, it will be better to reserve an area, enhance it with carpet, homelike amenities, and staff who are particularly trained in dealing with dying patients and their grieving loved ones. Such a unit would be quiet, have access to windows and perhaps a garden, have extra audio-visual equipment such as a VCR or stereo in each room, and policies and procedures that focused on a pain-free death without suffering or indignity.

The final view from Silver is one of a broad look at the dying process, with a special emphasis on comfort care as we nurture people all the way to their final breaths.

HOW TO FIND TONTO WHEN YOU FEEL LIKE THE LONE RANGER - People forget that The Lone Ranger was not The Alone Ranger. Kemosabe always had his faithful Indian companion Tonto close by to come to his rescue when things got tough, to talk with around the campfire, to strategize plans for defeating the bad guys yet again, to toss him one liners and believe in him when the world thought he was a bad guy himself, what with that mask and all.

You also have Tonto close by, though you may have to make a few phone calls to locate him (or her - Tanta?) Even if you are located out in the boonies it is important to network, to call upon other people in or around your community to assist you in your work and your feelings about it. More than any other group, social workers know this to be true. By the nature of your jobs, you are networked into community agencies, people and institutions that can help. Tonto is out there - you just have to find him. If he's not, invent him.

One of the places to find him, to find assistance in dealing with end of life decisions, is with chaplains and community clergy. If your client is transferred to a hospital, call the chaplain and make a referral. Hospital chaplains deal with end of life decisions daily and can begin to approach the patient/family regarding code status and treatment issues. If the resident/patient has had any affiliation with a denomination or specific congregation in town, the clergy (pastor, priest, minister, rabbi) from that organization may be useful in initiating a discussion of treatment issues (either at the hospital or in the nursing home.)

Social workers are already networked with the myriad agencies in every community which work together for the aged or disabled. These too are your Tontos. Be sure to think of accessing other resources such as Hospice and aging agencies which may provide volunteer guardians or help to seek a guardian as more and more of our patients/families have no one to help make decisions.

If Tonto doesn't exist, create him. Even if you do have a host of community agencies (especially Hospice) who can help keep residents/families together by discharging to home until death occurs, or who will assist in visiting your residents at the nursing home until the resident dies, you still may need help in determining the ethical nature of end of life treatment. One of the best resources for such Tonto-like assistance with those deliberations is an ETHICS COMMITTEE. Like Texans used to say about oil wells: "If you don't have one, get one." (Or borrow someone else's.)

Though an entire chapter could be written on ethics committees, a quick sketch will provide most of the information you need. Most hospital ethics committees now consist of two groups. The first is a large, deliberative body comprised of representatives from various interests and professions. A typical group will include a physician, nurse, social worker, chaplain, administrator, psychologist, educator, ethicist, attorney, layperson with no medical background, and a disability group person, among others. There should be a balance of age, sex, ethnicity, and religion, and the majority of the committee should be made up of community volunteers, not

persons paid by the institution. This committee meets periodically to discuss business, but may be called to deal with a particularly difficult ethical issue that the second group has referred to it.

This second group is an Ethics Consult Group and is made up primarily of in-house people. The group can be called on short notice to provide consultation for day to day ethical dilemmas that arise in the hospital, usually dealing with end of life treatment or withdrawal issues. To maintain credibility, the group either consults an outside member by phone for input, or invites them in for the meeting (or has them present by speakerphone.)

One of the easy ways for nursing homes to access local hospital ethics committees is to have an in-house consult group (which may be trained by the hospital committee members) that refers particularly difficult cases to the larger hospital committee when necessary. Your in-house group should still have two or three community people accessible by phone or in person so as to avoid the accusation of self-serving decision making.

In any case, the service of an ethics group can greatly relieve the deliberations of families/staff/physicians by sharing the process with a relatively informed and objective group of concerned people. It can be your Tonto in your hip pocket to pull out when you need it. And given the age, acuity level and other demographics of our society - you will need it.

Another place to find Tonto is in the eyes, hands and voices of your co-workers. Dealing with the stresses of end of life decisions on a regular basis will require that you take care of yourself as well as you take care of others. It may mean talking to someone you trust at work from time to time about the feelings engendered in you as you assist people with these issues. Or it may mean having some one or some group outside of work (perhaps at another facility) with whom you can level, blow off steam, laugh, cry and talk.

The most important thing you can do to help your residents turns out to be the very same thing that is most helpful to yourself - and that is to address your own death.

- What would a good death look like for you?
- What are your own quality of life standards?
- What are you willing to live with? Without?
- When is it okay for your significant other to withdraw artificial nutrition/hydration? A vent? Antibiotics?
- Do you have a:
 - Living Will?
 - Durable Power of Attorney for Healthcare?
 - Organ Donor Card?
 - Will?

There are two reasons to address the issue of your own death. The first is personal. Because 80% of deaths in the U.S. occur in healthcare settings (hospitals, nursing homes) (Nuland, 1995), there is an 80% chance your death will be decisional - not accidental or natural, but decisional. Someone will very likely have to decide when and how you die. If in the next

thirty minutes your significant other is called to a local emergency room to find you comatose with an aneurysm, does he or she know what you want done? Why not? If you get a phone call on that person in the next fifteen minutes, do you know his or her wishes regarding end of life treatment and resuscitation? Why not?

So the first reason to have this conversation tonight is that it takes a burden off of you and that person, whoever that is. When (not if) one of you is called on by the other one, you will have some guidelines about what to do, so you will not end up talking to a social worker and an ethics committee about code status and end of life treatment deliberations!

The second reason to examine your own end of life wishes and get your advance directives in place is professional. You will be a far better caregiver of those in your charge who come to you seeking clarity on ethical and personal issues if you have examined these issues for yourself.

To listen to another person talk about his or her death or the death of a loved one is to raise the issue of your own. To assist a resident or family to understand and make critical end of life decisions is to raise the issue of someone doing that for you, or you doing it for your own family member. If you have not addressed your own issues in some manner, if you have not considered what you would want in your own situation or that of your loved one/significant other, then one of several things may happen:

- you may avoid or put off bringing up these issues with residents until very late in the process when not much can be done, thereby preventing residents from experiencing the kind of death they want
- you may, due to your own anxiety, deal with the issues too hastily, thereby not allowing for good process to come to the best decision for the resident
- you may, through your language and inferences, inadvertently influence or coerce residents or families into making end of life treatment decisions that make you feel comfortable, rather than listening to and supporting the wishes of those in your charge.

It is extremely important, then, for social workers to carefully think through the issues and to discuss them with whoever it is that will be at the bedside making the decisions when you can no longer speak for yourself. By doing so you vastly increase the chance that you, your loved ones, and those residents/families who look to you for guidance will be able to have a good death.

POP QUIZ

1. Where are the bad guys?
 - A. There aren't any - or darned few. We're all in this together, learning new language and inventing new metaphors to address new biotechnical, ethical issues. Social workers, residents, physicians and nurses can learn from each other as we struggle to do the right thing together.
2. What exactly is The View From Silver?
 - A. High on a mesa, atop a huge, rearing stallion, you can see the broader spanse of territory than others. It is the view that takes seriously the patient/resident's past, who they were, what values they held, the quality of life they enjoyed and wanted, as well as the present reality and the future outcome. It is a view that sees not just the individual, but also the larger society, asking how these decisions impact the provision of services for all of us, considering allocation of resources and advocating for some system of just distribution as a social justice issue. Finally, it is a view that carefully attends to accurate language so as not to mislead or coerce, and that values maximum comfort care when that becomes the ultimate goal of treatment.
3. How Do You Find Tonto When You Feel Like The Lone Ranger?
 - A. The Lone Ranger was not The Alone Ranger. Annie Oakley was not Annie Only. Tonto and Wild Bill were always nearby. Your support group or individual is available if you look (or shout) hard enough. These end of life decisions should not be made alone, but in the context of community, whether that community is the in-house treatment team, an ethics consult group with outside members, or the referral to or involvement of other community agencies from Adult Protective to Volunteer Guardians to Hospice.

Finally, none of this will happen if you as the social worker have not examined your own values, quality of life standards, and preferences for end of life treatment. Only then will you be able to be fully present with the residents/patients and families who come to you seeking advice and counsel about their end of life decisions. Only then will you be able to leave their room with "the sound of hooves, a cloud of dust, and a hearty `High-O Silver!'"

Away.

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Chapter Eight

Synthesis

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This book has been written as a guide to the nursing home social worker. Although the material contained in the book may be of interest and value to others, each chapter has the nursing home social worker primarily in mind. Underpinning this stated focus, several recurring themes emerge in the text. Among these themes are:

1. The need for accurate knowledge regarding the normal aging process.
2. The importance of the nursing home being a humanitarian organization.
3. The recognition that ethical behavior must be an integral part of all interactions with residents, staff, and self.
4. The attempt to clarify and establish the professional role of the social worker in the nursing home.

Accurate Knowledge

Chapter One specifically, and other places in the text, point out the rapidity with which the 65+ population is increasing. Additionally, the fastest growing segment of the population is comprised of those persons over the age of 85. Considering that most nursing home residents are more than 80 years of age, these figures portend the great need for nursing home beds for the next several decades. Increased services will be required for both institutionalized elderly as well as for those elderly remaining in the community. A continuum of services ranging from meeting the needs of the well elderly, to the frail elderly who can remain in the community with adequate in-home based services, to assisted living residences, to placement in a nursing home will be required. At the present time there is a critical shortage of adequately trained gerontological social workers. Without a serious effort to recruit and train individuals interested in working with older adults, the situation will become worse over the next two decades as the "baby boomers" reach the ranks of the elderly. To efficiently and effectively meet the needs of this large and growing population the social worker must have a solid grasp of the normal aging process.

Illness and abnormal conditions can not be assessed appropriately unless the practitioner understands what to expect in the normal course of life. Murray, in Chapter Two, delineates normal

life cycle changes as well as predictable pathological conditions.

Humanitarian Organization

Society has not yet decided the role of older adults in the age of technology. Unfortunately, this ambiguity is sometimes expressed through negative stereotypes, devaluing attitudes, and an outright lack of respect for the dignity of the older person. These attitudes, as one would expect, permeate the walls of the nursing home. Humanitarian values must take a prominent place in the operational culture of the nursing home. Recent regulatory standards have attempted to incorporate these values in survey guidelines. Hooper's chapter, which focuses on the regulatory framework, provides information from a large scale research project which seeks to evaluate the nursing home experience from the perspective of the resident. From the resident's perspective a primary missing ingredient is "evidence of an acceptable respect for the dignity of the individual." The findings from this study led to an emphasis upon attempting to meet the psychosocial needs of residents. This plea to respect the dignity of the resident is reflected in practically every chapter in the book. Nursing homes may in some ways resemble "total institutions," but this does not give a license to ignore the fact that the resident is a person first and foremost.

Ethical Behavior

Two chapters in the book deal specifically with ethical issues and behavior. However, ethics must be interwoven into the very fabric of the nursing home if residents are to be treated with dignity. Uninformed persons may be inclined to have a limited view of ethical behavior, i.e. being exercised when end-of-life issues are involved. Every action taken, at some level, involves ethical behavior. This obviously includes each seemingly mundane activity that takes place each hour of the day in interactions with residents, staff, and discipline of one's self. Appropriate ethical behavior is the hallmark of good care in a quality nursing home. End-of-life issues are important, and it behooves the facility to have a well thought out process for handling these crises. No ethical decisions, including end-of-life decisions, should be made in a vacuum because the decisions always affect significant others. Even the Lone Ranger recognized the need for a Tonto.

Professional Role

The other recurring theme is the search for one's professional role and gaining professional respect. While the chapter by Haulotte and Purvis addresses this issue directly, each contributor alludes to the need for establishing one's role and meeting the challenge in a professional manner

that garners respect. Several social work roles have been developed by the profession over the years, and these have pertinent applicability in the nursing home environment. Similarly, experience has taught that several functions are appropriate for social work intervention. The mandate for social services in nursing homes is of relatively recent origin (1987). Considerable progress has been made, but much, however, still needs to be accomplished.

This textbook is intended to help fill the educational void in meeting the increasing need for competent gerontological social workers. Each chapter has been written by knowledgeable professional gerontological practitioners.

Subject Index

A

- Abt study · 31
- Abuse · 7
 - alcohol · 6
 - elder abuse · 12
 - substance · 7
- Advance Directives · 17
 - do not resuscitate · 79
 - durable power of attorney · 79
 - living will · 79
 - organ donor card · 80
- American Association of Homes for the Aging (AAHA) · 71
- American Health Association · 70
- American Health Care Association (AHCA) · 71
- Arthritis · 1, 8
 - osteoarthritis · 9
 - rheumatoid · 9
- Assessment · 54

B

- Behavioral Functioning · 6
- Being Liked · 31
- Being Treated Politely by Staff · 31
- Breast Cancer · 11

C

- Cancer · 11
 - breast · 11
 - colorectal · 10
 - lung · 10
 - ovarian · 11
 - prostate · 11
- Census Bureau · 5
- Chronic Obstructive Lung Disease · 10
- Circulatory System · 9
- Code of Ethics · 71
- Code Status · 83
- Coercive Language · 81
- Cognitive Capacity Screening Examination (CCSE) · 55, 58
- Cognitive Functioning · 6
- Comfort Support · 83
- Cystitis · 11

D

- Delirium · 54
- Dementia · 54, 55, 60, 61, 68, 72
- Diabetes · 10
 - millitus · 10
 - Type II · 10
- Diabetic Retinopathy · 8
- Dignity · 13, 23, 31, 32

E

- Effect and Benefit · 84
- Elder Abuse · 12
- Empowerment · 20
 - family · 20
 - resident · 20
 - self · 21
 - staff · 20
- Endocrine System · 10
- Environmental Functioning · 12
- Environmental System · 6
- Ethics · 67
 - bioethics · 67
 - defined · 68
 - medical ethics · 68
 - source of standards · 70
 - systematic approach to dilemmas · 72
- Ethics Committees · 86
- Excretory System · 10, 11
- Eye Sight
 - cataracts · 8
 - diabetic retinopathy · 8
 - glaucoma · 8
 - presbyopia · 8

F

- Federal Bill of Rights for Nursing Home Residence (Condensed) · 22

G

- Gastrointestinal System · 9, 72
 - colorectal Cancer · 10
 - constipation · 10
 - diverticulosis · 10
 - gall bladder disease · 10
- Geriatric Depression Scale (GDS) · 62

Good Death · 81
Group Treatment · 17
Guidance to Surveyors · 31

H

Having a Sense of Purpose · 31
Health Care Financing Administration
(HCFA) · 33, 70
Hearing Loss · 5, 8
 conduction deafness · 8
 presbycusis · 8
 tinnitus · 8
Heart Conditions · 8
 arteriosclerosis · 9
 atherosclerosis · 9
 congestive heart failure · 9
 heart attack · 11
 hypertension · 8, 9
Hemorrhoids · 10
Hiatal hernias · 9
Homelike Atmosphere · 34
Hyperthyroidism (or myxedema) · 10

I

Incontinence · 10
 reflex · 10
 stress · 10
 urge · 10
Independence/Autonomy · 31, 32
Integrated Individual · 7
Interpersonal Systems · 6
Intrapersonal Systems · 6

J

Job Description - Social Services Worker ·
 28
Job Satisfaction · 20
Joint Commission on Accreditation of Health
 Care Organizations (JCAHO) · 71

K

Kokmen Short Test of Mental Status · 61

L

Lung Cancer · 10

M

Mental Status Questionnaire (MSQ) · 55

Minimum Data Set (MDS) · 37

N

Natural Helpers · 13
Nursing Facility Requirements · 22
Nursing Home Population · 1

O

Omnibus Budget Reconciliation Act of 1987
(OBRA) · 15, 68
Osteoporosis · 9
Ovarian Cancer · 11
Over the Counter Medication · 32

P

Physical Functioning · 8
Pneumonia · 10
Poem
 What Do You See? · 52
Polypharmacy · 7
Positive Self-Image · 32
Prescription Drugs use · 7
Privacy · 33
Prostate Cancer · 11
Psychosocial Perspective · 5

Q

Quality of Life · 31, 67, 81

R

Rapid Assessment Instruments (RAIs) · 54
Reproductive System · 11
 hormone replacement therapy (HRT) · 11
 post-menopausal · 11
Resident Council · 17, 32
Respiratory System · 10

S

Sense of Smell · 8
Sensory Losses · 8
Set Test · 61
Sexual Functioning · 11
Short Portable Mental Status Questionnaire
(SPMSQ) · 55
Short term memory loss · 6

Skeletal System · 9
 arthritis · 9
 osteoporosis · 11
Social Functioning · 6, 12
Social Isolation · 12
Social Work Function in Long Term Care
 admission process · 16
 discharge · 17
 ongoing action · 19
 pre-admission · 28
Social Work Functions · 17
Social Work Practice in Long Term Care · 16
Social Work Roles · 16, 69
 advocate · 16, 69
 broker · 16
 case manager · 16
 educator · 17, 86
 enabler · 16

 planning · 75
Stereotypes · 7
Strokes · 9
 embolic · 9
 hemorrhagic · 9
 thrombotic · 9
Substance Abuse · 7
Support Systems · 83

T

Taste Buds · 8
Technological Imperative · 69
Transient Ischemic Attacks (TIAS) · 9

W

What Do You See? (poem) · 52

Author Index

A

Abrams, 1987 · 83
Abramson · 69, 73
Anderson · 63
Applebaum · 84
Arluke · 12
Atherton · 5, 8, 9, 10, 12

B

Baker · 60
Baker, F.M. · 56
Barker · 69
Barusch · 2
Beauchamp · 73
Bernhard · 58
Besdine · 68
Bloom · 67
Blumenfield · 69
Brink · 55, 56
Brody, E.M. · 15
Brody, S. · 15
Brown · 62
Burack-Weiss · 17
Burnside · 17
Buss · 67, 74

C

Callahan · 73
Caplan · 73
Cassell · 72
Census Bureau · 5
Collopy · 67, 68
Collopy · 70
Connelly · 2
Corcoran · 54, 62
Cox · 69, 71
Cuglian · 55, 74

D

David · 68, 73
Delgado · 55, 58
Dennis · 17
Dorr · 55
Dubler · 67
Dupree · 7

E

Ebersole · 17
Englehardt · 74
Engleman · 68
Etten · 7, 8, 9, 10, 11
Eutis · 70, 71

F

Fanshel · 68
Farmer · 7, 12
Faust · 55
Feil · 17
Fillenbaum · 57
Finkelhor · 12
Finucane · 84
Fischer · 54, 62
Fogel · 55
Folstein, M.F. · 60, 61
Folstein, S.E. · 60, 61
Foreman · 59
Fuld · 62

G

Gallo · 63
Gelman · 69, 73
Germain · 6
Gleason-Wynn · 20
Goldfarb · 55, 56
Greene · 2
Groth-Juncker · 83
Grouse · 11

H

Hall · 83
Harrigan · 7, 12
Hepworth · 6
Hofland · 68, 73
Hooyman · 2, 6, 7, 9, 10, 12, 13
Howell · 67, 71

I

Issacs · 61

J

Jacobs · 58, 59
Joint Commission on Accreditation of
Healthcare Organization · 71

K

Kahn · 6, 12, 55, 56
Kane · 54, 55, 57, 68, 73
Katzman · 62
Kennie · 61
King · 84
Kiyak · 2, 6, 7, 9, 10, 12, 13
Klein · 67
Kokmen · 61

L

Larsen · 6
Levin · 12
Levy · 69
Lewis · 15
Linstrom · 15
Lott · 67, 71
Lutz · 68

M

Maslow · 15
McCain · 83
McCartney · 74
McDermott · 69
McGowan · 70
McHugh · 60
Mertz · 6, 9
Messinger · 16
Miles · 74, 75
Miller · 74

N

NASW · 17, 71
Nelson · 55, 56
Neugarten · 7
Nuland · 81, 87

O

Offord · 61

P

Parsons · 71
Peck · 56
Pfeiffer · 57
Pollack · 56
Proctor · 67, 71

R

Reicher · 63
Roff · 5, 8, 9, 10, 12
Rosen · 68
Rothman · 5
Rowe · 6, 12

S

Saxon · 8, 9, 10, 11
Schneider · 16
Schonfeld · 7
Sheikh · 62
Silverstone · 15, 17
Smyer · 57
Strain · 58

T

Traxler · 8

U

Ubell · 11

Y

Yazdanfar · 54, 57, 60
Yesavage · 62

Z

Zung · 63