Long-Term Care Survey Alert

Psychosocial Services: GET YOUR PSYCHOSOCIAL CARE ON TRACK WITH THIS 11-POINT PLAN

Nursing homes are back in the hot seat in the wakeofan **HHS Office of Inspector General** report alleging serious shortfalls in their provision of psycho-social care. And when the OIG speaks , the **Centers for Medicare & Medicaid Services** listens so you can bet surveyors will be honing in on how well your facility is doing in this area of care. (For details on the report, see the story Survey Trends.)

Experts highlight for **Eli** 11surefire strategies for keeping your facility on track with its psychosocial assessments,care planning and interventions.

1. Take a new look at MDS sections that are critical to understanding a resident's psychosocial needs and how these create the "big picture." Start with Section B (cognitive patterns).That's where the road forks in terms of meeting the person's psychosocial needs,explains **Cheryl Field**,director of clinical and reimbursement services for **LTCQ Inc**.in Lexington, MA. If the person is cognitively intact,you can talk to him about his personality and motivation in the past and now. "But if the resident has cognitive impairment,staff must enlist family and friends to help them understand the resident's history and personality," Field says. By so doing, the staff can better understand what the resident with dementia is commu-nicating through his behaviorsand which approaches the resident is likely to find most meaningful.

Sections E (mood and behavior patterns) and F (psychosocial well-being) provide the linchpins for psychosocial assessment.So make sure everyone has input in completing these sections.To complete SectionF1, it'simpor-tant to know how various members of the team have viewed the resident interacting in different settings, such as rehab, the dining room, activities, withroom-mates, etc.

Section E identifies potential mood problems and sadness,which the nursing or social work staff can use as a trigger for more in-depth assessment. (For some quick assessment tools to differentiate between depression and grief,see the December2002 Long-Term Care Survey Alert, p. 115.)

Tip: **Green Acres Nursing and Rehabilita-tion Center** in Gettysburg, PA has its LPNs complete a 30-day flow sheet to document residents' mood patterns.The social services staff then uses that information to complete appropriate sections of the MDS and to monitor residents who may require treatment plan changes.

2. Don't separate residents' physical and psychosocial problems. "All problems are interrelatedthat's the ticket,"emphasizes **Deborah Ohl**, principal of **Ohl & Associates** in Cincinnati, OH.And while everybody agrees that's the case, the trick is to look and see if you're really viewing the resident that way, she advises. In other words, are you connecting the dots between the various things going on with the person? For example, depressed or grieving people often have poor appetites and weight loss and dehydration can lead to pressure ulcers.By the same token,an inactive resident with a poor appetite due to physical illness is more likely to feel lethargic and depressed.

3. Search for and address the root causes of psychosocial distress rather than focusing on and treating its symptoms. Pain is often an unrecognized cause of a resident's depression, agitation, anxiety and aggression or even resistance to care, Ohl notes.Or a resident's depression might stem from his grief over loss of physical function,which restorative nurses could help by setting measurable goals with the resident and renewing his sense of hope.

4. Ask the resident what motivates him, and use his responses to help him set and achieve goals that will improve his functional status, independence and self-esteem.But keep it simple. It's the little pleasures and achievements that get people on their feet.For example,a resident might be motivated to participate in speech therapy so she can tape record

herself reading of a book as a gift for a special child in her life,Fields offers.A coffee-loving resident might participate in speech and occupational therapy to regain the ability to swallow and manage her morning coffee.

Residents who claim they aren't motivated by anything should be assessed for depression.

5. Identify and tap into the resident's strengths. "Ask the person how they met tough challenges in the past,"Field suggests.Then help the person use those same strengths to deal with challenges now, such as tough rehab sessions, pain and loss, or adapting to a new life in the nursing home.

"A resident might say, for example,'I used to cope by doing the hardest thing in the day first,'"Field notes. In that case, he might want to do his rehab therapy or wound care first thing in the morning. Or if a facility-bound resident says he always found strength in attending his church, see if the former minister or members will conduct services or a prayer group at the facility.

6. Give residents a choice wherever possible. That simple strategy goes a long way toward enhancing the resident's sense of dignity and autonomy. For example, **Neville Center** in Cambridge, MA,allows residents to decide when to get up and go to bed in keeping with their own lifestyle pattern."It's one thing if the resident is still in bed at 2 p.m. if he's depressed and no one has addressed that and the resident is getting pneumonia,"says the facility's executive director, **Paul Hollings**. "Surveyors should cite a facility for that," he says. But if the resident normally stays up until 2 or 3a.m.and sleeps until the afternoon, Neville staff supports his right to do that.

7. Use activities to promote residents' emotional, social and spiritual well-being. That's where comparing Sections B, E and F of the MDS to Section N (activities) can be very helpful. "If you identify someone who seems psychosocially ready to be involved in activities and engaged more with othersand that's not happening, figure out why,"Field advises.

Did the resident try an activity once and didn't like it or something happened to discourage him from trying again? Are the activities geared to his interests? Is pain or fear of incontinent episodes getting in the person's way of attending or enjoying activities?

Activities can provide a bridge to the resident's past roles and enhance the person's self-esteem and sense of meaning in life.

8. Identify and use all available resources to help you meet residents' psychosocial needs. Post a list of everyone you think might help, including the social worker and chaplain. Volunteers are another invaluable resource. "These individuals are focused more on offering residents companionship, which is important in a task- and goal-oriented environment," Field emphasizes. A good volunteer program where people spend time with elderly residents listening to them reminisce can even help reduce residents'need for psychoactive and pain medication, notes **Marilyn Mines**, a nurse consultant with **FR&R Healthcare Consulting** in Deerfield, IL.

Keep in mind that PartB-reimbursed mental health providers, including psychiatrists and clinical psychologists,can help SNF and other residents who need more individualized attention to resolve emotional or behavioral issues. In conjunction with the OIG report, CMS released a provider program memo outlining Medicare payment for Part B mental health services(PMAB-03-037).(Read the memo at http://cms.hhs.gov/manuals/pm_trans/AB03037.pdf)

Tip: Ask residents' Part B mental health providers to work collaboratively with the interdisci-plinary team.Steer clear of psychiatrists who insist on ordering a lot of anti psychotic medications.

9. Provide ways to help residents maintain positive relationships with their families. Your facility no doubt provides family orientations and hosts regular picnics or other family events but do you take credit for those interventions on care plans by individualizing them to each resident? Optimize the use of e-mail as a way for residents to communicate on a regular basis with their loved ones. "Some facilities are putting video capability on computers so residents can see family members," says **Francis Battisti**,a psychiatric social worker in Binghamton, NY.Many residents/families may be willing to pay for this extra service. **Tip:** Did the resident used to clip grocery store coupons? Maybe she'd like to do this again each week and give the coupons to her family.

10. Look for residents with unresolved family or peer conflicts to see if they'd like some assistance. The OIG, in fact, found that 13 percent of residents reviewed have "unsettled relationships" (see chart in this article). "But you have to take cues from what the resident identifies as a problem and what he wants to deal with," says **Colleen Brems**, a nurse practitioner who works with geriatric patients the **University of Iowa Hospital and Clinics**.

If residents do want to work on unresolved issues with family or other people in their lives or past, simple strategies can help. Help the resident write a letter or make a tape saying what he wants to say to an estranged family member or friend, even a deceased one. "Some people work on a letter or tape that they don't intend to send,"which is therapeutic, Brems adds.

Tips : If the resident declines to work on unsettled relationships,document that in the clinical record and continue to follow-up to see if he's changed his mind. Ask the social worker to provide an inservice on basic family dynamics and how to identify and work with troubled families.

11. Let the QIs be your guide. Use the quality indicators to track your facility's performance in the psychosocial realm of care. For example, Neville Center compares its QI reports to look for negative and positive trends in untreated depression,behavior issues and activities participation. Physically related QIs may also improve as psychosocial care picks up speed. Studies show that emotionally satisfied people have better immunity, heartier appetites and less pain than those with unmet pyschosocial needs.