Chapter 9

The Art of Paperwork

PAPERWORK IS A FACT OF LIFE FOR A SOCIAL WORKER IN A NURSING HOME. Lest the reader misunderstand the importance of timely and accurate paperwork in the overall scheme of things, this chapter focuses on the subject of documentation and suggests a method for managing this important aspect of the nursing home social worker's responsibilities. There are many ways to organize one's paperwork, but the benefit of this particular method is that it involves an effective way to conceptualize clinical information about one's clients.

As I've mentioned before, I have found that the best time to do the assessment of a new resident is immediately after their arrival. This is especially beneficial because it gives the social worker the opportunity to meet with the family, if they are present, and obtain from them psychosocial information that the new resident might not be able to provide due to cognitive limitations. Sometimes the social worker is not notified when a new admission arrives. This can be remedied by working with the admissions director, MDS coordinator, or nurse unit manager to arrange to be informed of new arrivals.

Whatever forms are used by your facility, I have found that there is no substitute for a good old-fashioned narrative (it does not have to be long) reporting the following information (at minimum):

Name and nickname(s) that the resident prefers to be called
Marital status (and existence of a significant other, if this is the case)
Ethnicity (important and often neglected in social service assessments)
Religion (including comments on formal church/synagogue attendance and/or other spiritual practices)
Major diagnoses
Place of birth
Number of siblings
Military history
Occupation
Children

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Hobbies and interests (very important for future care plans)

Basic support network (family members and significant others on whom the person counts for emotional sustenance as well as possible physical assistance)

Comments on the patient's understanding and response to medical condition and placement

Comments on mood and mental status

Finally, a sentence or two about how the social worker plans to address this particular resident's needs based on the above noted information.

Here's an example of how these elements can take on the form of a narrative.

Case study

Mildred Goldstein (who prefers to be called "Millie") is an eighty-four-year-old widowed Jewish woman of Russian descent. She was admitted to Sunny Valley Nursing Home from General Hospital with a diagnosis of right-sided stroke, coronary artery disease, depression, and arthritis.

Millie was born in New York, the oldest of three children. Her siblings have been deceased for more than ten years now. Millie completed high school and married Paul at age twenty. She had five children: John, Stephen, Esther Cohen, Sarah Goldstein, and Bob. All are highly successful in the fields of law, medicine, and business. She worked as an administrative secretary in the clothing industry. Her husband Paul, a tailor, died twenty years ago, and she moved to elderly housing, where she lived until being admitted to this facility. There she had Meals on Wheels from the Elderly Commission and homemaker services to assist with housecleaning, laundry, and transportation to doctors' appointments. She had a cat, Puff, now staying with a friend. She has been estranged from her children for many years, but recently Sarah and Bob, who live locally, have become involved with her care. She expresses positive feelings about their recent visits at the hospital but is concerned about "being a burden," because they "have their own lives and careers." Millie enjoyed playing canasta with a group of friends in her building. She is alert and oriented to person and place and knows the season and the year but not the month. Her mood is irritable and angry at times. She states that she wants to go home but has limited motivation for therapy, according to the hospital reports. She denies any concerns about her physical limitations, including inability to transfer from bed

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to chair and incontinence of the bladder. The staff express concerns about her ability to return home safely. The social worker is to provide support to the resident around adjustment to losses of health and independence and placement in the facility, encourage her to participate in care and the discharge-planning process with her family and interdisciplinary team, and help her process her feelings about recent stressors and major life changes.

Developing an Initial Care Plan from the Patient's Point of View

This basic information already tends to suggest a care plan by the picture it paints, in broad narrative outlines, of the client and her situation. Medical care plans are usually organized, for better or for worse, into three parts: problem, goal, and approaches. Since we are obligated to take this somewhat negative approach to addressing this woman's situation, we will, of course, do so, but we will also be sure to include her strengths and supports in the care plan, and, above all, we will write it from her point of view.

Her "problem," as she sees it, is that she wants to go home, but is not allowed to, which naturally makes her angry—angry at her body, for refusing to cooperate with her any more, angry at the nursing home, at her caregivers there, and possibly angry at her children, to whom she has feels she dedicated her life in order to make them independent and highly successful, but who now appear too wrapped up in their own families and busy, fast-paced lifestyles to bother with her.

Trying to put ourselves in her shoes, we can sense the client may have some denial about the extent of her medical condition. This is probably necessary for her protection against being overwhelmed by her many losses. She should not, of course, be disabused of her hopes, although the social worker and team should be careful to present the realities of her situation gently. The social worker should monitor her mood and mental status for symptoms of clinical depression, and since she already has this diagnosis (it appears that this condition was diagnosed at the hospital following her stroke), the social worker should advocate for referral to formal psychiatric services at the nursing home to monitor her conditions and psychotropic medication.

One caveat: always write your care plans as if the patient and her family will read them. That way, in care-plan meetings, communication will be more straightforward and forthright. As well, you will not have to worry about potential problematic situations where the family requests to see the chart for one rea-

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son or another. Here, for example, is how the narrative of Mrs. Goldstein's basic information can be fit into the Procrustean bed of the care-plan formula.

Case study

Problem: Mrs. Goldstein is coping with adjustment to multiple recent stressors, including health and independence losses related to recent stroke, nursing home placement, and separation from her cat. She very much wants to go home, but staff members have concerns about her ability to do so safely, due to difficulty with transfers and bladder incontinence. Also related to her stroke, Mrs. Goldstein is experiencing symptoms of depression, irritability, and lack of motivation. Mrs. Goldstein is an independent woman who is proud of her achievements in having a career and raising capable, successful children. In the past, she has been reluctant to ask her children for assistance, but since her illness, she has needed to do so, and her children have been available and are openly supportive. Millie has a strong Jewish faith and many friends in her building.

As the reader can see, the social worker has made a point of emphasizing the client's biographical information in an ongoing effort to educate staff members about who this person is and to encourage them to interact with her based on that information. This also prompts us all to follow up on this information in planning for her care. Since we have discovered that she has a strong Jewish faith, we need to consider the possibility that she may require a kosher diet and to check with her to see if this is the case. If it is, we must work with the dietary department to provide this. In her case, it turned out that she did not keep kosher but did not eat shellfish or any pork products. In exploring her religious and spiritual preferences, we should also determine if she would like visits from her local rabbi. If so, the social worker can help to arrange this. As we'll see, all of these interventions will go in the "Approaches" section of the care plan.

In the "Goals" section, we will again consider the situation from the patient's point of view.

Case study

Goals: Mrs. Goldstein will achieve and maintain her maximum level of independent functioning in the least restrictive setting. She will maintain her ties with her family, her community, and her cat to the extent