Midwest Care Alliance
The source for home, hospice & palliative care

Independent-Study Program ● Contact Hour Request Form

Provided by the Midwest Center for Home, Hospice & Palliative Care Education

You Will Know Me from My Story: Integrating a Comprehensive Psychosocial Assessment into a Meaningful Plan of Care (04/2013)

Objectives:
1. Describe the components of a comprehensive psychosocial assessment.
2. Discuss the use of the psychosocial assessment in developing and implementing an individualized plan of care.

Criteria for Successful Completion: Listening to the audio seminar, submitting completed Request Form (evaluation/test) with processing fee of $10, and achieving a minimum score of 80% on the post test. Upon submittal of the proper forms, this program offers 1 Contact Hour credit for nursing valid nationally *(not valid for Iowa licenses).*

INSTRUCTIONS: After listening to the seminar online, simply complete this form which includes both an evaluation and post test. Once completed, submit it along with a processing fee of $10 to request credit. In order to qualify for credit, a minimum score of 80% must be achieved on the post test.

Expiration: This program expires on 04/29/15.

Disclosure Information:
The planning committee has declared no conflict of interest. The presenter, Jean O'Leary-Pyles, MSW, LISW-S, has declared:
☒ Nothing to Disclose ☐ Disclosure:

No commercial support was received for this educational activity.

Requesting Credit For: ☐ **Nursing**
-Upon submittal of the proper forms, this program offers 1 Contact Hour credit for nursing valid nationally (not valid for Iowa licenses).

Part I - Participant Information *(please type or print legibly)*

Date Completed:	
Name:	
Employer:	
Occupation/Credentials: *(RN, LPN, SW/C)*	
Complete Mailing Address: *(Street, City, State, Zip)*	
Phone:	
Email Certificate To:	

HospiScript
a Catamaran company

Thank you to HospiScript Services for the donation of the audio recording.

Midwest Care Alliance
The source for home, hospice & palliative care

Independent-Study Program ● Contact Hour Request Form

Provided by the Midwest Center for Home, Hospice & Palliative Care Education

You Will Know Me from My Story: Integrating a Comprehensive Psychosocial Assessment into a Meaningful Plan of Care (04/2013)

Part II – Evaluation

Were the following objectives met?

1. Describe the components of a comprehensive psychosocial assessment. ☐ YES ☐ NO
2. Discuss the use of the psychosocial assessment in developing and implementing an individualized plan of care. ☐ YES ☐ NO
3. Please list 1 learning point you plan to incorporate into your practice: _____

This speaker demonstrated effective teaching on a scale of 5 (excellent) to 1 (poor):

Jean O'Leary-Pyles, MSW, LISW-S: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments:	
Questions for Speaker:	

Part III - Post Test

1. The psychosocial assessment includes:
   a. ☐ social and cultural variables
   b. ☐ patient and family coping mechanisms
   c. ☐ patient and family goals
   d. ☐ all of the above
2. The social worker is the only team member that is involved with the comprehensive assessment.The social worker is the only team member that is involved with the comprehensive assessment. ☐ TRUE ☐ FALSE
3. The Conditions of Participation require the interdisciplinary care team to update the plan of care as often as the patient/family condition changes. ☐ TRUE ☐ FALSE
4. The plan of care should reflect:
   a. ☐ patient and family goals
   b. ☐ identified problems
   c. ☐ interventions
   d. ☐ all of the above
5. The interdisciplinary care team should only use the physician referral information to develop the plan of care. ☐ TRUE ☐ FALSE
6. Who should be involved in hospice care planning?
   a. ☐ interdisciplinary team
   b. ☐ attending physician
   c. ☐ all of the above
   d. ☐ all of the above
7. Team collaboration and communication is imperative to effective care planning. ☐ TRUE ☐ FALSE
8. Physical symptoms in the patient can only be managed with the use of pharmocological interventions. ☐ TRUE ☐ FALSE
9. If patient and family needs change, the plan of care should be:
   a. ☐ thrown away
   b. ☐ updated to reflect the changeupdated to reflect the change
   c. ☐ used until the end of the hospice benefit period
   d. ☐ unchanged
10. If an intervention, based on the plan of care, is ineffective, the patient should be discharged from the hospice program. ☐ TRUE ☐ FALSE
11. Length of time (IN MINUTES) to complete this self study: _____

To Request Credit:

Send completed form *(include both evaluation and test pages)* and $10 processing fee to:

Midwest Care Alliance, 855 S. Wall St., Columbus, OH 43206

Midwest Center for Home, Hospice & Palliative Care Education (OH-248/4-01-15) is an approved provider of continuing nursing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

You Will Know Me From My Story:

Integrating A Comprehensive Psychosocial Assessment Into a Meaningful Plan of Care

Jean O'Leary-Pyles, MSW, LISW-S
HomeReach Hospice Social Worker
Hospiscript, April 2013

"It is much more important to know what sort of patient has the disease than what sort of disease the patient has."

Sir William Osler, MD

"You matter because you are you. You matter to the last moment of your life."

Dame Cicely Saunders, MD

2

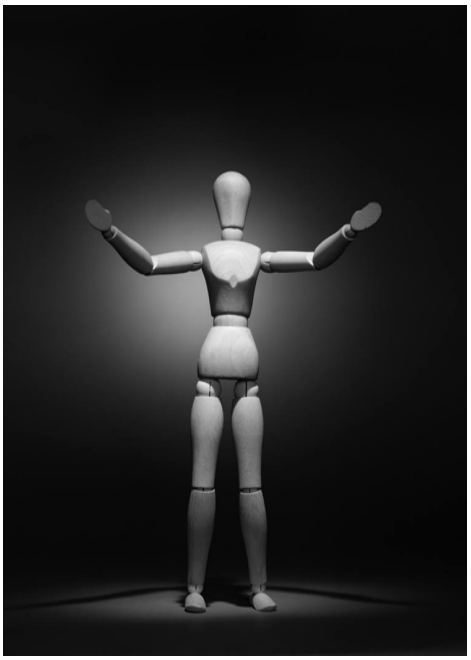
Knowing the person who

stands before you

~~~

and honoring

his life story



3

- Describe the components of a comprehensive psychosocial assessment

  (LISTENING TO THE STORY)

- Discuss the use of the psychosocial assessment in developing and implementing an individualized plan of care

  (HEARING THE STORY)

4
~~~

COP Requirements Related to the Comprehensive Assessment

- Medicare Hospice Conditions of Participation contain federal regulations that govern all Medicare certified hospice programs
- Mandate an initial and ongoing assessment of the physical, psychosocial, emotional and spiritual needs of the patient, including complications and risk factors (interdisciplinary management of the patient and family)

5

Interdisciplinary Whole Person Care

6

Listening to the Story

- Comprehensive assessment begins at time of referral, continues through the admission process and expanded as additional information is obtained by team members.
- Information is gathered from the referral source. A nurse completes an assessment within 48 hours of election of the hospice benefit, followed by other discipline assessments within five calendar days.

7

Meet Beth

- Referral received from local hospital:
  - *38 yo*
  - *Metastatic breast cancer*
  - *Divorced with two children, ages 12 and 14*
  - *Uncontrolled pain*
  - *Family tension*
  - *Goal is to prepare patient and family for transition from the hospital to a home setting with continued hospice care*

8

Listening to the Story

How, when and whether a patient shares his story is in part dependent on the listener response.

- Key for all team members, in all interactions

Active listening, time and seeking clarification are crucial to "hearing the voice" of the patient and family

Narrative medicine: philosophy/practice used in medicine which encourages the assessment of a patient through the interpretation of his/her story

Raminsky, Oprah 2012

9

Beth….

- Assessment/admission visit, completed by a nurse prior to hospital discharge, leads to initial assessment of needs and development of the initial plan of care:
  - *Manage pain, nausea and anxiety*
  - *Support patient and family (patient not yet ready to reveal prognosis to children)*
  - *Develop caregiver plan for hospice at home*
  - *Admit to inpatient unit*
  - *Prepare patient and family for transition from the hospital to a home setting with continued hospice care*

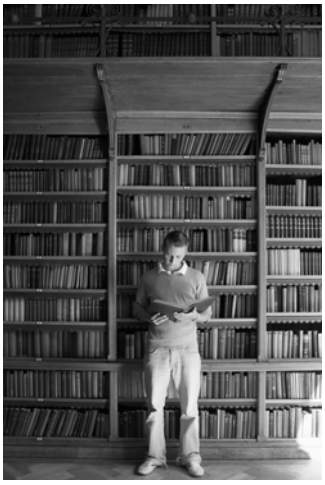
10

Psychosocial Assessment

Although the comprehensive assessment is initiated on the day of admission and includes psychosocial information, the psychosocial assessment is completed by a social worker and is a more specific and in depth exploration of the patient/family experience

11

Seeking An Individual's Story (aka The Psychosocial Assessment)



12

Psychosocial Assessment

- History of the patient and family system and relationships
- Patient and family support system (formal and informal)
- Patient/family understanding of situation
- Patient/family strengths
- History of illness and events leading to hospice admission
- Adjustment to hospice philosophy and care
- Language/educational needs or barriers
- Cultural/ethnic influences, values/belief system

13

Psychosocial Assessment

- Cognitive and mental assessment
- Coping mechanisms
- History of mental illness
- History of substance use/abuse
- History of losses, life adaptations
- Religion and spirituality
- Military history
- Patient /family strengths
- Care giving needs
- Practical or concrete needs
- Financial/legal concerns

14

Psychosocial Assessment

- Safety concerns (neighborhood or home)
- Abuse or neglect concerns
- Areas of distress
- Unresolved issues
- Bereavement risk
- Goals of care

15

Beth…

- *Married 9 years, divorced for 5 years*
- *Had not worked outside of home since marriage*
- *Diagnosed seven years ago, with remission and recurrence*
- *Beth was dating a man for one year*
- *Provided care for her children during the week, and on weekends, the children moved to their father Mark's home*
- *Beth was hopeful, with goal of living for a long time; protective of children*
- *Religion present but not a strong source of support*
- *Cognitively intact, anxious, avoidant*
- *Minimized pain to remain alert (and possibly in attempt to mimic sense of normalcy, minimizing gravity of situation)*

16

Beth….

- *Mark was involved peripherally, primarily related to children's care and routine tasks*
- *Vague history verbal abuse from Mark toward Beth*
- *Children unaware of Beth's prognosis*
- *Parents and a sister were present and supportive but reside out of state*
- *Parents and sister were realistic but concerned for the children*
- *Identified tension toward Mark and fear for children's future on the part of Beth's parents*
- *Unidentified care giver*
- *Family strengths included flexibility, honesty, presence, communication*

17

Beth…

- *Advance directives not completed*
- *Funeral planning/will not explored*
- *Anticipated high risk bereavement*
- *Identified goal - Beth: symptom relief and home going (Beth seemed unengaged and non committal)*
- *Identified goal – parents and sister: symptom relief, relationship reconciliation, encourage sharing of prognosis, supported preparation for death, death in inpatient unit*

18

COP Requirements Related to the Plan of Care

Per Medicare Hospice Conditions of Participation, each patient must have an individualized plan of care that reflects patient and family goals, as well as interventions based on problems identified in the initial and ongoing comprehensive assessment.

*Key area of deficiency

19

Be intentional!

20

Hearing the Story

- Intentional and meaningful care planning
  - Incorporate psychosocial aspects of the patient and family system. It is within the goals of care and the interventions that the story is reflected…
  - Incorporate all disciplines (multidimensional)
  - Ideas and perspectives need to be shared and considered through the eyes of the patient and family
  - Narrative competence: the ability to acknowledge, absorb, interpret and act on the stories and plights of others

Charon, JAMA 2001

21

Bellhop vs. Concierge Approach to Care Planning

22

Whole Team Care and Engagement

- Identified problems involve whole team response
  (just because the social worker identifies a problem does not mean he/she is solely responsible for intervention; physical problems involve whole team response, spiritual problems involve whole team response…..)
- Avoid compartmentalizing problems and interventions
  -for example, no BM may be a care giving issue; "non compliance" with medication may be based on fear of addiction or inability to afford medicine

  Team members should always be teaching one another about their individual discipline's approach to identified problems

23

Intentional Care Planning

- The plan of care should be
  - documented
  - user friendly
  - accessible to all team members
  - easily adaptable
  - meaningful
  - Updated as the patient and family situation changes

24

When disagreement arises, keep in mind the importance of truth, necessity and kindness when talking with each other

25

Beth…

- POC development
  - *Identified problems, patient and family driven*

PAIN:

Goal: Patient will experience symptom relief to patient preference (2-3 on scale of 10).

Intervention: adjust medication, time meds around visits to maximize social support, educate about psychosocial factors in pain management, encourage calm environment, offer opportunity to identify and process feelings, offer counseling related to adjustment to illness and supporting the children, explore psychosocial triggers

ANXIETY:

Goal: Patient will experience symptom relief to patient preference (2-3 on scale of 10).

Intervention: adjust medication , encourage calm environment, offer team facilitated meetings with patient and family, offer opportunity to identify and share thoughts and feelings, offer counseling related to adjustment to illness and supporting the children, offer relaxation and guided imagery techniques, explore psychosocial triggers

NAUSEA:

Goal: Patient will experience symptom relief to patient preference (2-3 on scale of 10.).

Intervention: adjust medication, encourage calm environment, offer nutritional options, offer opportunity to share thoughts and feelings, explore psychosocial triggers

26

Beth….

ADJUSTMENT to ILLNESS:

Goal: Patient and family will have increased ability to cope with illness.

Intervention: provide opportunities for trust building, offer opportunity to identify and process thoughts and feelings, assist in identifying coping skills, encourage connection with sources of support, encourage family meeting to share feelings, encourage communication within family system

PATIENT PREPARATION FOR DEATH:

Goal: Patient will have self determined life closure.

Intervention: Offer opportunity to discuss feelings related to illness, provide counseling support related to preparing for death, provide education about disease process and s/s of dying process, offer opportunities to complete legacy work, assist in life review, encourage end of life communication with loved ones, offer opportunity to plan for end of life care and funeral planning

FAMILY PREPARATION FOR DEATH:

Goal: Family will have the knowledge and support needed to prepare for patient's death.

Intervention: Provide education about disease process and s/s of dying, provide education about grief and coping mechanisms, offer opportunity to identify and process thoughts and feelings, offer family meeting with patient for end of life conversation, offer art therapy and bereavement referrals

CAREGIVING:

Goal: Patient will reside in environment of choice.

Intervention: Assess for patient environment of choice, assess care giving options, provide information about care giving options

27

Beth…

SPIRITUAL ISSUES :

Goal: Patient will feel spiritually supported.

Intervention: Assess religion and spiritual belief system, offer opportunity to discuss spiritual beliefs, offer chaplain visits, link with community church prn, provide prayer/meditation, assist in life review, offer opportunities to explore meaning

LEGAL ISSUES:

Goal: Patient will identify a legal decision maker.

Intervention: provide education about legal decision making, offer opportunity to complete advance directives

28

Team consensus and communication are imperative – ALL HANDS IN!

29

Beth…

POC updated as problems resolved and new problems arose

- *Children informed, art therapist became involved to complete legacy work with Beth*
- *Grief counselor/art therapy referrals provided for children*
- *Ex-husband began to seek guidance about how to support the children*
- *Parenting education/skills for father*
- *Medication needs decreased*
- *Family more engaged*
- *Gentle introduction of education about dying process*

30

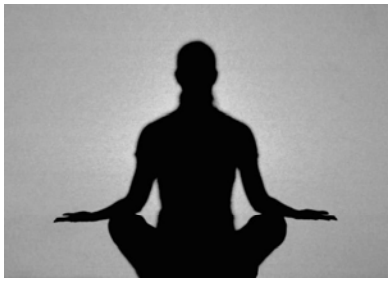
Beth…

- *Continued symptom management, with continued decline*
- *Legacy work completed (letter to children)*
- *Ongoing support to family*
- *Continued education and support around preparation for death and life closure*
- *Funeral planning*
- *Grief support*
- *Beth died in the inpatient unit*

31

Team Care

- For particularly challenging situations, need to consider care of the team members
  - Open/honest communication
  - Attention to team dynamics
  - Opportunities for debriefing
  - Ethics consultation
  - Formal and informal support
  - Self care
  - Acknowledge learnings…



32

References

- Hawkins, J, and Lindsay, E. We Listen But do We Hear? The Importance of Patient Stories. Wound Care Magazine. 2006; Sept, S6-S14. Available at www.awma.com.au/publications/2010_nsw_ellie_linday_legclub.pdf.... Accessed January 14, 2013.
- Hospice Quickflips. 2006. The Corridor Group. The Corridor Group, INC. reference.
- Lovelady, B, and Sword, T. Hospice Care Planning: An Interdisciplinary Roadmap. Journal of Hospice and Palliative Nursing. 2004; 6(4).
- National Hospice and Palliative Care Organization. Compliance Tip Sheet, CMS FY 2010 Top Ten Hospice Survey Deficiencies, Compliance Recommendations. Available at www.nhpco.org/files/public/regulatory/Tip_Sheet.pdf. .... Accessed January 12, 2013.
- Pollack, B. The Art of Healing: Listening to Patient's Stories Develops Empathy. Columbia Magazine. Available at www.columbia.educu/alumni/Magazine/Fall2003/artofhealing.html ....Accessed January 12, 2013.
- The Patient-Physician Relationship. Narrative Medicine: A Model for Empathy, Reflection, Profession and Trust. JAMA 2001, Oct 17; 286(15): 1897-902.
- Rasminsky, A. The Story Doc. Oprah Magazine, July 2012.

33