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PERSON-CENTERED

PSYCHOSOCIAL SERVICES FOR ELDERS

October, 2009

A White Paper by,

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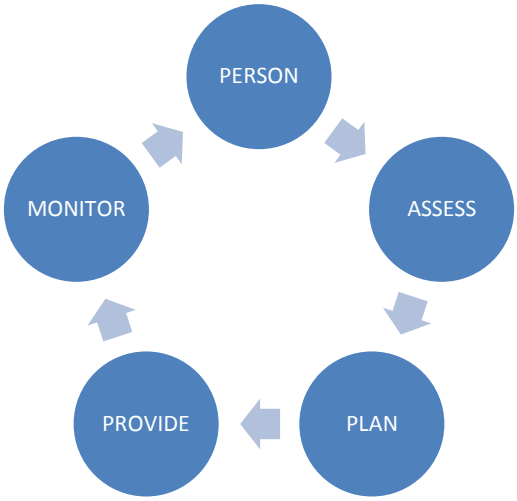
PSYCHOSOCIAL SERVICES FOR ELDERS
OVERVIEW

The provision of psychosocial services for elders in any setting - their own home, an adult day center, assisted living/personal care or nursing home - should be person-centered. This is accomplished by creating a system that focuses on the elder at each phase of service provision. When we speak of service we are speaking of one person (**servant)** providing assistance **(service)** in helping another person **(person being served)** live their life to the fullest. The service becomes an enhancement to the quality of life for the person being served **(consumer)** which is the definitive goal of person-centered care.

Person-centered psychosocial care serves the elder through a process of assessment, planning, and service provision. It is achieved by transforming old culture systems into new culture systems even though the system itself remains basic – assess, plan, provide, monitor outcome.



How we assess, how we plan, how we provide services and how we monitor the outcome of those psychosocial services provided become the **foundational areas** that need transformed in this particular system. For each of these foundational areas we will explore what constitutes person-centered assessment, person-centered planning, person-centered service provision, and outcome monitoring that promotes the psychosocial well-being of each person served. Let's unpack the foundational areas.

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FOUNDATIONAL AREA : PERSON-CENTERED ASSESSMENT PROCESS

Assessment, a definition: "The act of judging or evaluating a person, situation or event", Webster's Dictionary. There are other definitions of assessment that aren't relevant to the health care field and it makes one wonder why the term is even used. Regardless, the term IS used by professionals in all aspects of clinical care to help determine a person's health status.

Assessment, types: There are, according to Wikipedia.org, different types of assessment and even though they are referenced for educational purposes in Wikipedia.org, we, I believe, can transform them to help us better understand clinical assessment. The types sited are:

1. Formative and Summative
    a. Formative: accomplished throughout a specific indicator or timeframe
    b. Summative: accomplished at the end of a specific indicator or timeframe
2. Objective and subjective (bias is built into both)
    a. Objective: questioning that has only one answer/conclusion
    b. Subjective: questioning has more than only answer/conclusion
3. Referencing – test results measured against a specific criteria or standard
4. Informal and Formal
    a. Informal: made on the results of observations, discussions, and monitoring
    b. Formal: made on the results of a specific set of indicators and given a score

"Assessment is used by professionals to consider approaches and next steps for individuals"

So, if we look at assessment through the rose colored glasses of psychosocial assessment alone, and utilize the types and definition mentioned above, we could come up with a definition that looks like this:

Psychosocial assessment is the act of gathering, documenting and evaluating information about a person through the results of formalized testing <u>and</u> the techniques of questioning, discussing, and observing a person over the course of a pre-determined timeframe. This act of assessment would be used for the purpose of developing approaches to enhance the person's psychosocial well-being and quality of life.

The components of psychosocial assessment could then be described as:

1. Initial
    a. Timeframe: prior to inclusion in the program / community
    b. Includes formalized results, specific questions and discussions on topics about the person's life history (past life events, interests, and preferences).
    c. Used by the professional to develop approaches / interventions to insure the person's psychosocial well-being and quality of life during the adjustment period.
2. Periodic Review
    a. Timeframe: set periods during inclusion in the program / community
    b. Includes formalized results, observations, questions and discussions about the person's involvement and participation in the program / community (present life events, interests and preferences).
    c. Used by the professional to monitor the person's response to the approaches / interventions that were planned to insure enhanced psychosocial well-being and quality of life of the person.

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Psychosocial well-being along with physical and spiritual well-being is considered to be the basis for the health of a person. Therefore, the assessment of a person's psychosocial status is pivotal in helping to determine overall health status. Tools for conducting the assessment come in a variety of types, but there are some basic considerations a professional should take in developing or selecting such a tool. Let's explore what should be included in the content of the psychosocial assessment tools and how the information gathered can be used to create an effective plan to help the person experience his/her highest level of well-being.

CHARACTERISTICS OF A PERSON-CENTERED PSYCHOSOCIAL ASSESSMENT TOOL

1. **Be Well Organized and Simple to Administer** – creates a bond between the person asking the questions and the person answering the questions and affords the person conducting the interview the ability to quickly move from one subject to another while facilitating the gathering of important planning information.
    a. Section titles that flow in a chronological order from birth to present
    b. Selection of listed answers made by the interviewer with area for comments
2. **Provide Relevant Information** – should meet the goal of supplying pertinent information that will feed into individualized planning for the provision of psychosocial services. Should be the psychosocial source of information for the comprehensive interdisciplinary assessment tool that becomes the basis for planning the provision of broad services to the person.
    a. Includes information needed for the comprehensive assessment tool – MDS/state regulated assessment tool, etc.
    b. Includes information needed for the development of individualized program components (activities, social services etc).
    c. Broad topic information that relates to what services the person prefers and how the person prefers those services are to be provided – their personal preferences.
3. **Be Strength Based** – should provide information about the person's abilities to accommodate their preferences.
    a. Included for selection by the interviewer would be major areas of interest that can be translated into individualized program components that meet their preferences.
    b. Areas on the assessment tool for ability recognition. Such as: what the person can and cannot accomplish for him/herself and the assistance needed to be provided by others in meeting their expressed preferences.
4. **Be Titled to Reflect information Gathering Reference** – could be titled as follows: Initial Assessment – Life History OR just **Life History** which would reference information about the life of the person prior to entrance into the program or community. **Program/Community Life Review** could be the title of the periodic review assessment tool used while the person is included in the program/community.
5. **Be a Permanent Document** - This typically is kept with the person's permanent record so that it can serve as a reference for future assessment and planning.
6. **Be Used to Develop a Comprehensive Assessment** – from this and pertinent information that is gathered by other professionals, a comprehensive assessment is completed and from that input is developed a multidisciplinary plan to provide services from various specialty areas within the program or community such as nursing, activities, social services and dietary to name a few.

INITIAL ASSESSMENT TOOL

The purpose of an **INITIAL ASSESSMENT TOOL** is to facilitate the gathering of personal information prior to inclusion into the program or move-in to the community. It should include the following:

1. Identifying Information
    a. name
    b. names that person has been known by (maiden name for a woman or nickname, preferred name)
    c. birth date
    d. address – where they lived prior to entering the program/community
    e. ID numbers if not found elsewhere – social security, medical insurance etc.
    f. Legal documents – living will, code status etc.
2. Life events - past
3. Life preferences and interests – past
4. Preferences and interests – within last 6 months
5. Abilities and special needs - present

REVIEW ASSESSMENT TOOL

The purpose of an **REVIEW ASSESSMENT TOOL** is to facilitate the periodic gathering of information DURING inclusion in the program or community. It should include the following:

1. Identifying Information
    a. name
    b. preferred name
    c. birth date
    d. Identifying information about where the person's lives, i.e., room number or home address
    e. timeframe for review
2. Participation and attendance in events that have been planned by the program/community (interests)
3. Person's response to the events that have been planned by the program/community (preferences)
4. Independent or small group participation in events not planned by the program/community (special interests)
5. Abilities and special needs - present

An assessment tool that captures pertinent information and facilitates the planning of individualized approaches and interventions that enhance the well-being of the person is foundational in person-centered psychosocial services for elders.

FOUNDATIONAL AREA: PERSON-CENTERED SERVICES PLANNING

Without assessment there can be no plan for person-centered psychosocial services provision. It becomes the provision of services without regard to the person being served. The provision of general services just for the sake of recognizing that certain services are offered to people who are included in the program/community is not person-centered services.

When a person is new to a program or community, initial services will be provided according to a plan in either a formal or informal manner. The initial set of services that is provided through a program/community protocol is usually developed informally.

> For instance, an adult day services program that offers pre-planned group activity programming to all of the participants who attend on a certain day will automatically include a new person in those group activities. This new person will be encouraged to attend or will be placed, if in a wheelchair, within the group activity regardless of whether they have been assessed to prefer or possess the ability to be successful at the tasks of said group activity. In some cases this increases the new person's already existing anxiousness of being in a strange place among strangers and can lead to behavioral symptoms being displayed which could lead to drastic measures being taken to subdue the person if he/she becomes "out of control".
>
> How much better it would be for a formal "adjustment plan" to be developed for all new people. This plan could have the new person introduced to the surroundings and daily routine by a "partner" that has been assigned to spend time with the new person until they feel comfortable in the new environment. During the time spent with the new person, the "partner" could provide encouragement, reassurance and validation to help in the adjustment process and also informally assess the ability level of the new person. This would be a written plan that would be shared with all service providers within the adult day services center to alert them to the approaches/interventions outlined in the plan to insure the success of the new person's adjustment.

If there is not a formal assessment and services planning process in place in a program/community, then the provision of services of that program or community will be based on the direct service providers' perception of the person and program/community service provision practice. The danger in this type of provision of services is quite obvious and could lead to an array of problems of mis-perception and inconsistent or negligent service provision.

The format for writing the services plan varies across the spectrum of elder care service providers from plans that are generated from the assessment process and reflect a computerized response to a set of assessed values, to the handwritten plan that informally tells the direct service workers how to provide the service. Most service provision plans that are being developed include the following:

1. Problem/Need/ identified through the assessment process
2. Goal for the person to accomplish or have accomplished for him/her with help, to get rid of the identified problem or meet the need
3. Approaches/Interventions/ which are tasks to accomplish the goal
4. Who is going to provide assistance to get the task accomplished
5. The time frame for accomplishing the goal with a goal review date

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The task of developing and writing the service provision plan usually falls to a team of people representing multidisciplinary aspects of the services to be provided or offered. This multidisciplinary team convenes at pre-determined (mandated) times for the purpose of initiating or reviewing a group of service provision plans.

During their gathering they determine and document in their program's/ community's plan format which of the problems/needs that were identified should be included in the plan, what the goals should be, enumerate the approaches/interventions needed to meet the goals, the assignment of who is going to complete the tasks needed to carry out the approaches, and determine the timeframe that the team will have to review the plan again. Review of the service provision plan is usually completed by the same multidisciplinary team that wrote it. Included in the review process are the following:

1. Review of the problem/need to see if it is still an overall issue
2. If the problem/need is deemed an issue, then the goal(s) are reviewed to determine if it is still viable.
3. The approaches/interventions are reviewed to note their effectiveness in reaching the goal
4. The time frame for the next review is determined
5. Determination if any new problems/needs have developed with the person since the last review and subsequent goals, approaches that are needed for the new issue.

The written plan is retained in an individual's permanent record or grouped together with the other service provision plans in a central area. A system of accountability for carrying out the plan is rarely initiated in most program/community service provision policies and procedures. The plans are not again utilized until the next scheduled review or the status of the person changes and then the plan is changed. This is called a ***compliance plan*** for service provision. It is developed and written for the sole purpose of complying with regulations.

Person-centered psychosocial services planning looks very different and is driven by person-centered assessment. It is person-directed, which means that the preferences of the person themselves or their representative, are the basis for the determination of not just the <u>services to be provided</u> but also how those <u>services are to be provided to them</u>.

The development of an individualized plan to deliver services– referred to as the "I" Plan - depends on what the professional discovers about the person's preferences, interests and abilities through the comprehensive assessment and relationship building processes so that <u>appropriate services for that individual</u> can be initiated by the team. Typically the "I" Plan is written as if the person him/herself were speaking to the reader with "I" statements (this has also been used in preparing video plans). The following are some examples:

1. <u>Under the heading: My Typical Day</u>
    a. I like listening to my Bible tapes and would like to do that daily – preferably in the morning before breakfast
    b. I like to watch the TV – my stories in the afternoon and the news and quiz shows after dinner
    c. I would like to be able to go to the dining room for all of my meals because I like to socialize with others – I don't mind going to breakfast in my robe.
    d. I would also like to play word games, Bingo, go to hymn sings, and cooking and baking groups.

2. Under the heading: How you can help me
    a. Be patient with me, please.
    b. I am an intelligent person and can make decisions for myself when I have all of the information. It may take me a little time to think about what has been said, but that doesn't mean I'm not interested - it just means I am thinking about it. Give me time to decide, please…. This is new since my stroke.
    c. If you will discuss events with me first and let me ask questions about it so that I can have a better understanding, then I can make a decision about what I want to do. It really helps me to have things planned ahead of time – please don't just ask me on the spur of the moment if I want to do something – I don't respond very positively to that approach. I prefer to have things scheduled and in visible sight so that I can prepare myself for them. I do like simple reminders – you can write on my wipe-off board.
    d. I prefer to be called Margie or Marge
    e. I like to know your name so please introduce yourself to me - sometimes I can't read name tags – however, once I know your name I won't forget it.

These are just a couple of preference "heading" areas that can be included in an "I" Plan for service provision. There can be preference headings for meal time, personal hygiene completion, taking medications, movement, etc. They would include the person's preferences for service provision and how the services would be carried out.

FOUNDATIONAL AREA: PERSON-CENTERED SERVICES PROVISION OUTCOME MONITORING

Through a monitoring process, the person's response to the services provided is observed and documented. Because the goal of service provision is to provide services according to the personal preferences of individuals, their response to what is provided or offered is the most important consideration.

Therefore the observations made by those providing the services should be focused on the psychosocial demeanor of the person who receives the services. Does the service produce for the individual personal well-being or personal ill-being? Is the outcome of what is being provided or offered positive or negative for the person served? The answers to those questions will reveal the success or failure of the services provided.

The personal outcomes or responses to the services provided should dictate to the service providers what changes, if any, need to be made to the services and how they are provided. If for instance, a person demonstrates total displeasure through their words or actions that the service is not wanted, then the direct service provider should consider changing the service OR how it is provided. In this example the direct service provider would immediately discuss with the person (in the case of someone with advanced dementia, the service would be stopped and an alternative approach would be attempted). This would then lead to a positive outcome for the person being served regardless of whether the service was provided or not.

The information about this particular exchange would then be discussed with the service team and the person/representative and an alternate service provision would be planned. This is done so that other direct service providers wouldn't use the negative producing approach putting the person being served at risk for continual negative experiences.

To be avoided are the three plagues described by the Eden Alternative as: loneliness, helplessness, and boredom which can lead to a diminished quality of life for those being served. Cultivating positive interactions and experiences is what person-centered service provision is all about. It is conducted at the service provision level by direct service providers on a daily basis. These providers need to be equipped with a service provision plan and approaches/interventions that will provide the positive outcomes needed for an individual's psychosocial well-being.

By regarding the personal response to the service provision as the marker for service performance, the program/community will be able to utilize outcome monitoring as the culmination for the service provision planning process. Tools would be developed for the direct service providers to use for that very purpose – to monitor responses to what is being provided or offered. The reports from those tools could then used to change and improve the quality of service provision to help maintain a person's highest level of psychosocial well-being bringing the cycle back to the beginning – the person.

CONCLUSION

We have explored the provision of psychosocial services for elders utilizing person-centered strategies in the foundational areas of assessment, service provision planning, service provision, and service provision monitoring. We have delved into assessment as a person-centered process with tools that reflect the person's preferences, interests and abilities. Using the person-centered assessment process as the cornerstone, we discussed what an individualized service provision plan would look like and how the plan would be carried out through person-directed approaches and interventions. Monitoring person-focused outcomes and responses to the provision of services was the last foundational area that we looked at. We discovered how the outcomes/responses of the person being served become the basis for change in the provision of those services.

Recognizing that person-centered strategies are not yet permeating the services being provided to elders in all settings, we look forward to the day when these strategies will be utilized in all aspects of elder services provision and will reflect the unique personhood of elders and honor them for the contribution that they have made through the lives that they have lived.

