Center4PT Services

SOCIAL SERVICES PROGRESS NOTE

EPISODE: 01/09/15 - 03/09/15
02/20/15 9:00 AM - 10:00 AM 60 MIN

Phone: 626-683-9959
Fax: 626-683-9969

NAME: Doe, Jane
DOB: 06/01/1900

Homebound Status

- ☑ residual weakness
- ☑ assistive device
- ☑ assistance of another person
- ☑ fall risk

leaves home with taxing effort, leaves for med appointments only

Mental and Emotional Status

- ☑ depressed
- ☑ feelings of hopelessness
- ☑ anxious
- ☑ unmotivated
- ☑ denial of problems
- ☑ frustrated

Cognitive Status

- ☑ memory deficit
- ☑ impaired problem solving
- ☑ Oriented to Person
- ☑ Oriented to Place
- ☑ Oriented to Reason for treatment

Pain	Pain Interferes	Pain Intensity (0-10)	Patient Satisfied w/Pain Control
		4	yes

Additional Observations

According to the patient's daughter (Paula) the entire family as agreed to place their mother into an nursing home; at this time no one in the family is able to take care of the patient. The family appears to be overwhelmed. Patient appears depressed (flat affect), Patient was abused emotionally by her husband (Per Paula); husband is deceased.

Medical Social Services Interventions Performed

	Intervention	Intervention Details
1	Assess emotional factors	MSW began probing patient to assess emotional stability and coping mechanism in place to cope with emotional issues; patient appeared depressed with a flat affet; patient's daughter verbalized that patient has periods of extreme anxiety where she can not be calmed. Pateint does not have functional coping skills in place.
2	Assess for depression	Flat affect with patient appearing to be depressed; noted medication for bipolar disorder.
3	Assess for memory loss	Patient demonstrated poor remote memory; unable to state 3/3 random items or the date today; unable to state who is the current US president, but was able to recall the names of her children. Patient tends to perseverate on returning back to New York.
4	Develop plan & education regarding Advance Directives	Explained to the patient/PCG (Paula) what Advance Directives are and that a POA might be a good options for them at this time. Patient specifically requested her son, David to be the POA. MSW will be mailing the patient/PCG a copy of a POA in Spanish.
5	Develop plan & education regarding Durable Power	MSW will coordinate with PCG (Paula) on

	of Attorney	developing a POA; if patient goes to a SNF, MSW will coordinate with the Social Services departement at the SNF to see about developong a POA.
6	Assist with Placement: SNF	MSW provided patient/PCG with a list of 6 SNFs (with PCG to call MSW to see which location best fits their needs prior to contacting SNF).
7	Recommend Referral to: Skilled Nursing	Pending on the patient's family final location of a SNF. They basically are requesting a location that is clean and that provides a good service for their mother along with Spanish speaking staff and residents.

Progress toward Medical Social Services Goals

	Goal	Goal Progress
1	Patient's psychological/emotional needs affecting patient's physical status will be addressed within MSW Initial Evaluation visit.	Explained to patient/PCG various coping mechanisms to deal with physcological/emotional needs; for the PCG explained coping mechanisms for caregiver stress due to Paula explaining that it was "too much" for her and for her husband.
2	Patient will receive necessary assistance with being placed in a nursing home within 1 week.	MSW will contact SNF once the patient's family decides which specific area and ECF they would want.
3	Patient will verbalize understanding of Advance Directives within MSW Initial Evaluation visit.	Advacnce Directives were discussed and explained.
4	Patient will verbalize understanding of Durable Power of Attorney for Health Care (DPAHC) within MSW Initial Evaluation visit.	POA was discussed for financial and health care needs.

Medical Social Services Goals Achieved

1. Patient's psychological/emotional needs affecting patient's physical status will be addressed within MSW Initial Evaluation visit.
2. Patient will verbalize understanding of Advance Directives within MSW Initial Evaluation visit.
3. Patient will verbalize understanding of Durable Power of Attorney for Health Care (DPAHC) within MSW Initial Evaluation visit.

Instructions

☑ patient
☑ caregiver

Explained to the patient/PCG the role of MSW in the home along with the current goals to help them. A list of SNF was given to the patient/PCG. Patient has no social services in place (e.g. IHSS, ACCESS, MOW) and they would prefer not to have any community resources initiated. Explained to the patient/PCG that once she was admitted to a SNF, that after two months, she would become a long term care candidate and that her income would be sent to the SNF to offset her care at the SNF.

Supervision

Coordination

☑ MD
☑ RN/LPN

Agency

Discharge Planning

☑ discussed expected date of D/C
☑ discussed continued care needs
☑ discussed additional resources need
☑ discussed assessed progress
☑ notified case manager
☑ discharge instructions given to patient/caregiver

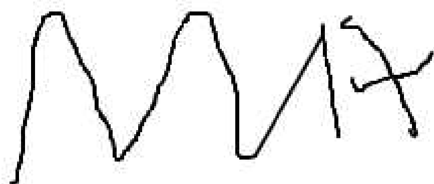
Plan for Next Visit

☑ N/A

Place of Service

☑ Patient's home/residence

SIGNATURES:
COMPLETED AND ELECTRONICALLY SIGNED BY MARY SMITH, MSW



PATIENT'S SIGNATURE: