ABSTRACT

SOCIAL WORKERS’ PERCEPTIONS OF THEIR WORK IN NURSING HOMES

by Cris Wooddell

The purpose of this qualitative study is to explore social workers’ perceptions of their effectiveness in addressing the psychosocial needs of nursing home residents. Research questions involve the mission of nursing home social workers, ideal roles and actual work, and factors that influence their perceived effectiveness within a medical model of care. In-depth interviews were conducted with ten social workers at a range of facilities. They share a strong professional mission and find great satisfaction in their work with residents. Three important themes emerged from their stories: a focus on staff cooperation over conflict, an ongoing struggle between people and paperwork, and a discrepancy between their ideal roles and the daily realities of work. All informants expressed the desire for more time to personally attend to psychosocial issues; however, they believe that residents’ needs are being addressed in a variety of effective ways.
SOCIAL WORKERS’ PERCEPTIONS OF THEIR WORK IN NURSING HOMES

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Cris Wooddell

Miami University

Oxford, Ohio

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Advisor_____________________________

Dr. Christopher Wellin

Reader_____________________________

Dr. Lisa Groger

Reader_____________________________

Dr. Robert Applebaum
Table of Contents

Dedication and Acknowledgement iii

CHAPTER ONE: Introduction 1

Purpose of Research 2
Nursing Home Reform Act 3
Nursing Home Social Work 4

CHAPTER TWO: Literature Review 8

Social Work Standards and Roles 8
Social Services Staffing 11
Psychosocial Care in a Medical Model 14

CHAPTER THREE: Methodology 18

Informants 18
Data Collection and Analysis 19

CHAPTER FOUR: Themes of Nursing Home Social Work 22

Conflict and Cooperation 22
People and Paperwork 26
Ideal Roles and Daily Realities 31

CHAPTER FIVE: Implications for Practice 38

Job Satisfaction 38
Overcoming Time Constraints 41
Moving Toward a Social Model of Care 43

BIBLIOGRAPHY 47

APPENDICES

Appendix A Recruitment Letter 51
Appendix B Informed Consent 52
Appendix C Demographic Questionnaire 53
Appendix D Interview Questions 54
Dedication

I am dedicating this thesis to my best friend and husband, Michael, who has been my greatest supporter and encourager for over ten years. His constant enthusiasm for all of my endeavors has enabled me to delight even more in my work with older adults. He is always ready to listen to my stories and dreams, urging me forward despite my fears.

He tells me that I am a writer, and he reminds me that being a Gerontological Social Worker is special.

I am eternally grateful to Jesus for calling me into this field, which for me, is not just a job but a ministry.

Acknowledgment

I would like to thank my advisor, Dr. Chris Wellin, for his active involvement in the process of producing this thesis. He never failed to show genuine care and concern for my first work as a qualitative researcher, and his encouragement helped me to realize the importance of my project.

His seasoned skills and words of wisdom challenged me in my writing.
CHAPTER ONE

Introduction

How do social workers perceive their work on behalf of nursing home residents? How effective do they believe themselves to be in addressing the psychosocial needs of older adults living in an institutional environment? Initially conceptualized more like hospitals than homes, nursing facilities in the United States have traditionally operated within the acute-care, medical model that dominates the nation’s healthcare system (Atchley, 2000). Unfortunately for individuals living in nursing homes, who may have several chronic illnesses and functional impairments, this approach tends to neglect personally relevant needs that go beyond physical care (Strauss & Corbin, 1988).

Conceptualized as psychosocial well-being, or the interaction of emotional and social influences, these needs involve maintaining a sense of satisfaction and self-worth despite the many losses that accompany the transition from community to nursing home life (Vourlekis, Gelfand, & Greene, 1992). These intangible aspects of care are at least as important to the one receiving care as instrumental caregiving tasks, which occupy the vast majority of staff time (Shield, 1988). In her ethnographic nursing home research, Shield observed that talking with residents is tacitly given a lower priority than feeding, toileting, and bathing them. Ironically, in an environment where time and staff are both short, caring for the person may easily be neglected in favor of caring for the body.

Ideally, social work practice in nursing homes should seek to overcome an all-encompassing adherence to a medical model of care. Descriptions of what constitutes good care must be grounded in what is meaningful to care recipients (Bowers, Fibich, &
Social workers have a clear obligation to take the lead in promoting quality of life in nursing homes and encouraging all staff members to work toward this end. However, the distinctly different professional worldviews of social workers and nurses often lead to divisiveness about resident care needs (Shield, 1988). Shield’s ethnographic immersion into nursing home work revealed a strong dichotomy between the social work emphasis on quality of life and medical personnel’s strong allegiance to preservation of life.

**Purpose of Research**

To explore social workers’ perceptions of their effectiveness in addressing the psychosocial needs of nursing home residents, the following research questions were investigated:

- What is the mission of nursing home social workers?
- How do social workers’ ideal roles compare with their actual work?
- What factors influence social workers’ perceived effectiveness in attending to psychosocial issues?

In general, social work may be considered an “invisible trade” since social workers are usually unobserved in their interactions with clients, and the nature of their work cannot be fully understood or appreciated apart from being immersed in it (Pithouse, 1998, p. 4). However, social work practice in nursing homes is more visible than in community settings since interactions with residents are often observed by other staff, residents, and visitors. Hearing from social workers in their own words is the most effective way to give “outsiders” an in-depth look into their work. This study offers a
qualitative examination of social work practice in nursing homes by hearing the stories of those immersed in it.

**Nursing Home Reform Act**

Since the 1980s, the concept of quality has gained increasing attention in nursing home settings as a result of the exposure of rampant poor care, abuse, and neglect in many American nursing homes (Institute of Medicine, 1986; Vladeck, 1980). The Nursing Home Reform Act legislation, part of the Omnibus Budget Reconciliation Act (OBRA) of 1987, made quality of life a matter of federal policy (Vourlekis, Gelfand, et al., 1992). Outcome-oriented quality indicators were developed, which encompass mental status and behavioral issues, as well as functional and health status (Harrington & Carrillo, 2001). Government inspections of nursing homes became more comprehensive to include resident interviews and observation of caregiving in addition to medical record review.

On a practical level, quality of life is a desired outcome that is almost impossible to precisely define or measure. It involves psychosocial factors, which are much more difficult to measure than medical outcomes. Violations of regulations related to physical aspects of care are more easily identified by nursing home inspectors than those relating to social services. Technologically “soft” phenomena, those intangible aspects of life in a nursing home, are not easily subject to standardization and regulation for the simple fact that “it is almost impossible to ‘prove’ that aides are harsh with patients, that food is unnecesarily bland, or that the director of activities is condescending or indifferent” (Vladeck, 1980, p. 153).
According to federal regulations, nursing homes must ensure the provision of “medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident” and “to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs” (Centers for Medicare and Medicaid Services, tag F250). The Ohio Revised Code specifies 32 distinct resident rights bearing on quality of life in long-term care facilities, including the right to be treated with respect, dignity, and privacy; recognition of individuality; and the opportunity to make choices about issues affecting one’s medical treatment, care, and daily life (Ohio Department of Aging). Of course, these rights are of questionable practical value if they are not related in concrete ways to organizational practice. Ongoing observation of a reputable nursing home revealed to one researcher that “the reality of institutional living negates much of the well-intentioned bill of rights” (Farmer, 1996, p. 39).

**Nursing Home Social Work**

As a Licensed Social Worker with three years of nursing home experience, I offer the following description of nursing home social work practice. I worked at two facilities, one for-profit and one non-profit, before attending graduate school, and my roles and responsibilities were essentially the same at each. I intensely enjoyed advocating for residents and offering support in a variety of practical ways. As an integral member of the caregiving team, I intuitively understood that psychosocial well-being is interrelated with medical and physical aspects of care. Working toward an environment that enhances quality of life requires an interdisciplinary approach and a holistic view of the person. Contrary to the literature’s emphasis on sharp disciplinary boundaries and
opposing philosophies of care, I developed collaborative relationships with many other staff members, who consistently demonstrated their commitment to improving the quality of life for each resident under their care. Conflicts over resident rights required education and negotiation with the common goal of accommodating resident preferences to the greatest extent possible within an institutional environment.

My deliberate teamwork approach led to ongoing opportunities to serve residents in purely non-clinical ways. While a plethora of paperwork pressures often precluded face-to-face time addressing residents’ fears, worries, and concerns, I welcomed those moments to help at mealtimes or to take people to group activities. I also quickly discovered that actions as simple as assisting a lonely woman to make a phone call to her husband or arranging for a volunteer to spend time with a man, who has no outside support system, are vital to meeting their psychosocial needs. Unfortunately, a sense of blurred role boundaries made it difficult for me to redirect requests, and I occasionally spent a disproportionate amount of time on matters that seemed to be routed to social services by default (for example, searching for missing items and marking clothes with resident names).

Some tasks must be completed according to a strictly regulated schedule. The Minimum Data Set (MDS) is a standardized assessment tool mandated by the reform legislation. All Medicare and Medicaid-certified nursing facilities must gather information on each resident and submit it electronically to the Centers for Medicare and Medicaid Services at least quarterly. The MDS provides the basis for facility reimbursement, the inspection process, and resident care planning (Kane, Kane, & Ladd, 1998). Social workers are typically responsible for assessing mood, behavior,
psychosocial well-being, and cognition. Ideally, they would interview residents, family members, and staff, in addition to reviewing the medical chart, and then capture the information on the quantitative MDS form. Unfortunately, deadlines and time constraints may make this process less intensive than it should be.

Resident Assessment Protocols (RAPs) provide the framework for an interdisciplinary and comprehensive evaluation of the individual by honing in on problem areas triggered by the MDS. Then, individualized care plans are written and updated periodically to reflect resident-specific needs, objectives, and interventions. Care conferences are held quarterly for the purpose of involving residents and their families in this process, and social workers write progress notes as an official record of adjustment issues and social services provided.

In addition to scheduled tasks, new challenges arise almost daily that require the attention of social workers. They are depended upon to intervene in problematic roommate situations, deal with resident and family concerns, discuss advance directives, offer emotional support during the final days of life, and spend time with individuals who are distressed. Other responsibilities include discharge planning, assisting with admissions, training staff on resident rights, facilitating resident council meetings, arranging transportation to appointments, making referrals to ancillary services, and maintaining contact with families.

Many social work responsibilities require direct contact with residents and families. I worked on a unit of 60 residents at both facilities, and each individual had his or her own important needs and requests at any given time. I was intensely aware of the potential to neglect those psychosocial issues in the course of working to
complete all of the paperwork on time. As I reflect on my professional experiences in light of my research findings, I realize how common this situation is to many dedicated and conscientious nursing home social workers, regardless of caseload size.
CHAPTER TWO

Literature Review

Social Work Standards and Roles

Older adults living in a nursing home are dealing with a number of significant losses. Not only are they experiencing health problems and impaired physical or cognitive functioning, but the loss of independence, home, and familiar surroundings, as well as changes in daily routine and family relationships, may overwhelm their coping abilities. Social workers represent the most equipped nursing home workers to assess the impact of these changes and to provide psychosocial care (O'Neill & Rosen, 1998). However, according to the National Association of Social Workers (NASW), most nursing home residents are not receiving adequate psychosocial services due to poor enforcement of regulations and unclear social work practice domains (O'Neill & Rosen).

The NASW (1981) gives a comprehensive description of the responsibilities of those working in a nursing home setting:

The functions of the social work program should include, but not be limited to, direct services to individuals, families, and significant others; health education for residents and families; advocacy; discharge planning; community liaison and services; participation in policy and program planning; quality assurance; development of a therapeutic environment in the facility; and consultation to other members of the long-term care team. The social work program is directed toward providing services designed to identify and meet the social and emotional needs of each resident; to assist each resident and family to adjust to the effects of the illness or disability, treatment, and stay in the facility; and to assure adequate discharge planning and the appropriate use of community social and health resources. (p. 5)

Almost a decade prior to implementation of the Nursing Home Reform Act in 1990 (Vourlekis, Gelfand, et al., 1992), the NASW (1981) developed ten detailed standards for social work services within the context of long-term care. These
standards, which encompass facility policy, social work personnel, and direct services, may be viewed as a guide to operationalizing the reform legislation in social work practice. Enhancing quality of life is the overarching goal to which each NASW objective points. Services should focus on the social and emotional impact of illness, advocacy, quality assurance, and working toward a therapeutic environment.

The core values of the social work profession challenge social workers in nursing homes to maximize the environmental resources and relationships available to residents through the beliefs that all individuals:

- must be given access to resources in difficult situations and opportunities to reach their full potential;
- are unique, worthy, and deserve to maintain their dignity and individuality;
- have the right to freedom, independence, and self-determination (Hepworth & Larsen, 1993).

This value system reaches even into the nursing home setting, where institutional forces often work against ensuring the dignity and individuality of those living inside. Applying these values within the constraints of this environment requires diligence, creativity, teamwork, compassion, advocacy, and a strong sense that those who live there are deserving of respect despite their level of physical or cognitive impairment. A qualitative study on social workers' perceptions of their roles in promoting autonomy, choice, and decision-making found that the informants do “strongly identify with an advocacy role” (Reinardy, 1999, p. 59).

Value conflicts between social workers and organizational goals often become an impediment to maintaining a true advocacy role on behalf of residents, an issue that
arises in the context of cost containment (Dane & Simon, 1991). Social workers must balance their multiple roles as advocates for residents and employees of organizations operating under fiscal constraints (Reinardy, 1999). Effective advocacy requires good judgment and a careful approach to avoid alienating other staff (Hancock, 1987). It is important to note that administrators and social workers share many of the same goals for resident and family satisfaction (Hancock, 1987; Vourlekis, Gelfand, et al., 1992).

Andrew Pithouse (1998) offers this insightful portrayal of social work practice in general:

Work is the learned skill of juggling competing demands and responding to unwelcome emergencies. Work also includes the lulls between urgent demands and the discretionary use that can then be made of time. Social work is not a monotonous series of identical activities but essentially the varied practice of workers who largely regulate their own daily efforts. (p.68)

This is an accurate description of work in the nursing home setting, where the range of social work activity is not easily delineated. Unlike their counterparts in typical community settings, social workers in nursing homes are actually working in their clients’ “home”, which facilitates their ongoing involvement in resident concerns.

Nursing home social workers often perform concrete tasks requiring little clinical skill (Dane & Simon, 1991). Silverstone and Burack-Weiss (1983) stress that social workers must carefully screen the competing demands upon their time to determine what can more reasonably be carried out by the resident, family, or another staff member. Role overload and inadequate utilization of expertise are outcomes of poorly defined expectations for social work practice in nursing homes (Vourlekis, Greene, Gelfand, & Zlotnik, 1992). It may be more appropriate for social workers to oversee a procedure for handling non-clinical concerns, which certainly impact psychosocial well-
being, without taking on the responsibility to personally attend to residents’ needs in these areas (Vourlekis, Gelfand, et al., 1992). They would then have more time to devote to critical issues that may otherwise be poorly addressed, such as adjusting to the nursing home or dealing with terminal illness (Gleason-Wynn & Mindel, 1999).

Silverstone and Burack-Weiss (1983) propose the “auxiliary function model” as the framework for social work practice in nursing homes (p. 11, 31). This model calls for the coordination of a network of helpers for meeting residents’ needs and wishes. The social worker may assume the auxiliary function to a greater or lesser extent with each resident, depending on the level of involvement the individual has with others, who may be family, friends, volunteers, or staff members. A vital characteristic of this model is that of supportive relationship, in which emotional bonding is considered just as important as addressing instrumental needs. According to Silverstone and Burack-Weiss, social workers should seek to enlarge the auxiliary network and restrict their own direct interventions to complicated situations not easily handled by others.

**Social Services Staffing**

Pithouse (1998) states that social work practice is derived less from formal theory than from “common sense theory” resulting from the everyday, practical experiences learned on the job (p. 126). This has certainly been the case for social workers in the field of aging. Prior to the Nursing Home Reform Act, Toseland and Newman (1982) reviewed studies on staffing patterns of social services departments and found no consistency in professional training and experience, which often led to poor quality in the provision of social services.
Federal and state of Ohio nursing home regulations indicate that facilities with over 120 beds must have a qualified, full-time social worker on staff (Centers for Medicare and Medicaid Services; Ohio Department of Health). Social workers are considered to be qualified if they have at least a bachelor’s degree in social work or a related field and one year of supervised experience in health care working directly with clients; licensure is not a requirement. Facilities with up to 120 beds may use their own discretion in how they will provide social services to their residents. Some facilities use consultants on a limited basis, “social services designees” with no degree or training, activities staff, nursing assistants, or licensed practical nurses to comply with regulations regarding social services (O’Neill & Rosen, 1998).

According to Vourlekis, Gelfand, et al. (1992), “Professionalization of the social service role in nursing homes has been a prominent political issue” (p. 114). Even prior to the Nursing Home Reform Act, the NASW (1981) called for “a sufficient number of appropriately trained and experienced” social workers, including a qualified social services director (p. 7). The NASW (1981, 1993) recommends that nursing homes employ Licensed Social Workers with a bachelor’s or master’s degree in social work. The organization registered a formal complaint with the Department of Health and Human Services Office of Inspector General concerning the practice of hiring social services designees to provide psychosocial services, which does not fulfill the intent of the Nursing Home Reform Act (O’Neill, 2001). The main point of their argument is that no other professions allow untrained designees to perform their services. Specialized education and training is necessary to provide medically-related social services, which include assessing and planning psychosocial interventions for residents with dementia,
behavioral symptoms, mental illness, depression, anxiety, pain, grief, interpersonal problems, legal or financial issues, loss of function and independence, and inability to cope (Centers for Medicare and Medicaid Services, tag F250).

A parallel issue in the nursing arena involving inadequate staffing of registered nurses has received a great deal of attention as financial pressures faced by facilities have grown, and paraprofessional nursing assistants provide the bulk of hands-on care (Harrington, 2000). The current climate of cost containment directly impacts the amount of time available for licensed social services or nursing staff to attend to the psychosocial needs of residents (Peterson, 1986; Reinardy, 1999).

The Institute of Medicine (2001) found that staffing levels have increased to a small degree over recent years but are inconsistent among facilities. Many nursing homes do have appropriate staffing patterns resulting in high-quality care. Unfortunately, substandard care continues to be a reality in some places despite reforms, and these problems are directly related to inadequate staffing levels. The Institute of Medicine also reported that quality of life outcomes have improved somewhat but not as significantly as the reduction in the use of physical and chemical restraints. This may be attributable to poor enforcement of some regulatory standards. Even worse, the new regulations have not led to an overall improvement in nursing home quality of care (Harrington, 2000).

Several researchers have documented the lack of gerontological training of most nursing home social workers (Greene, Vourleakis, Gelfand, & Lewis, 1992; Quam & Whitford, 1992). Despite regulatory changes emphasizing psychosocial care, the NASW charges that nursing homes continue to hire unqualified social services staff
(O’Neill, 2001; O’Neill & Rosen, 1998). Tirrito (1996) recommends that federal policy should require gerontological training for these workers, in the form of college degrees or continuing education seminars, due to their poor knowledge of mental health and behavioral issues. In addition to a lack of qualifications and shortage of social services staff, the United States Department of Health and Human Services (1996) found that even qualified social workers struggle to give adequate attention to the psychosocial needs of residents because of paperwork demands and unclear role expectations.

Nursing homes receiving government funding must be held more accountable for meeting residents’ needs through the availability of qualified, professional staff (Harrington et al., 2001). Social workers are facing increasing accountability for the provision of quality services, and a set of clinical indicators for psychosocial services in nursing homes was developed in the early 1990s (NASW, 1993; Vourlekis, Bakke-Friedland, & Zlotnik, 1995). According to Vourlekis et al., these outcome measures offer a reliable rationale for hiring qualified social workers despite limited budgets.

**Psychosocial Care in a Medical Model**

Nevertheless, psychosocial care is not the full responsibility of any one discipline (Dane & Simon, 1991; Vourlekis et al., 1995). Care plans relating to psychosocial issues will only be effective to the extent that they are consistently carried out by workers involved in the daily care of residents. A national survey utilizing both quantitative and qualitative data found that a poor understanding of the social work role and lack of support by other staff were indicated to be the leading causes of ineffective social services (Greene et al., 1992). Specific barriers to providing adequate psychosocial care are role overload; poor communication and territoriality among staff;
lack of follow-through on care plans; priority given to admissions, marketing, and paperwork; and a strong medical model influence.

The medical model of institutional care is reflected in a national study on nursing home staffing levels, in which physical care amounted to 3.4 hours per resident per day, while social services accounted for only 6 minutes per resident per day (O’Neill & Rosen, 1998). These statistics translate into an average of one full-time social services employee for every 80 nursing home residents. A study on job satisfaction among nursing home social workers recommends policy changes to lower the ratio of residents to social workers in order to decrease stress and increase job satisfaction (Gleason-Wynn & Mindel, 1999). However, there is no simple formula for an ideal ratio of social workers to residents. As in the nursing profession, empirical evidence is lacking on the amount of time necessary to provide high quality care (Harrington et al., 2001).

A large quantitative study of 13,770 nursing homes across the United States is one of the few studies in the field that include staff other than nurses and nursing assistants (Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000). Although the relationship between deficiencies and staff hours is quite complex, the data seem to support the hypothesis that fewer staff hours, including social workers, are associated with a higher number of deficiencies, including quality of life issues. However, isolating the effects of social work is difficult, if not impossible, within a multidisciplinary care environment.

A nursing home ethnographer delivers an indictment of the strong allegiance to a medicalized model of caregiving (Henderson, 1995):

It was in the psychosocial care domain that there was the greatest staff blindness to what quality of life in long term care should and could be. The product of this
organizational culture was that patients with chronic, incurable disease lived their remaining days in a system based on acute care hospital models. Psychosocial care was a footnote grudgingly delivered in muted forms. (p. 38-39)

Henderson notes that despite the Nursing Home Reform Act’s greater emphasis on quality of life issues, inspections of nursing homes continue to be driven by the medical model. This is evidenced by an unbalanced emphasis by inspectors on physical aspects of care in contrast to psychosocial care and activities. A great chasm exists between federal mandates and actual delivery of psychosocial services to people living in nursing homes (O’Neill & Rosen, 1998).

In their study of organizational factors impinging on social workers, Kruzich and Powell (1995) found daily routines to be one area of low social work influence, which may be attributable to the dominance of the medical model in structuring residents’ lives. A study by the University of Denver Institute of Gerontology also noted inflexible care routines to be at odds with social work efforts to uphold residents’ personal decision-making (Cox & Parsons, 1994).

The marginal status of social workers in nursing homes, where they constitute a small minority of the staff, is an inherent challenge to effectively fulfilling their advocacy role (Dane & Simon, 1991). A continual struggle exists between the ideal scope of social work services and the daily realities of working in an institutional setting (Vourlekis, Greene, et al., 1992). The following example illustrates a typical situation in which social workers struggle to maintain their focus on psychosocial issues:

Staff members, even social workers, may become so accustomed to admitting new residents that the admitting procedure becomes automatic. Consideration of feelings of the patient may be overlooked due to the pressures involved in completing the paperwork and attending to the mechanical details of admission. (Hancock, 1987, p. 167)
Regulatory changes focusing attention on psychosocial well-being have left social workers at risk for role strain as they seek to adequately address these needs, as well as a range of other responsibilities, “under severe time constraints” (Vourlekis, Greene, et al., p. 45).
CHAPTER THREE

Methodology

Informants

Opportunistic sampling for the purpose of maximizing range and eliciting rich data from “conceptually important cases” drove my selection of informants (Weiss, 1995, p. 31). The qualitative nature of this inquiry necessitated a small number of interviews in order to effectively manage an abundance of data. In the words of Lofland and Lofland (1995), “The researcher legitimately sacrifices breadth for depth” (p. 89). McCracken (1988) states that eight informants are sufficient for many studies, but it is also important to reach the “saturation point”, where no new information is forthcoming (Schutt, 2001, p. 289).

Following approval from the Institutional Review Board for Human Subjects Research, I mailed twenty-eight recruitment letters (Appendix A) to carefully selected facilities that vary in size, for-profit/non-profit status, and secular/church-affiliated ownership. Ten social workers at ten different nursing homes, which reflect these organizational differences, were willing to participate in this study. My informants work at five for-profit, secular facilities, ranging from 82 to 258 beds, and five non-profit facilities, ranging from 85 to 174 beds. Three of the non-profits are church-affiliated, one is secular, and one is a county nursing home. Caseload size ranges from 60 to 148, with about 100 residents being the most common scenario. Most of the larger facilities employ more than one social worker, and several utilize social services assistants.
I recruited Licensed Social Workers with at least one year of full-time nursing home work. Five informants have worked at the same facility between ten and 23 years; the other five have only been working for several years. Six are directors of social services (a title that implies a management-level position), four have a social worker or social services job title, and one is a social services designee. Eight are Licensed Social Workers, one is a Licensed Independent Social Worker, and one plans to seek licensure after completing schooling. Two have a master’s degree in social work, three have a bachelor’s degree in social work, and one is currently working on a bachelor’s degree in social work. The others have bachelor’s degrees in sociology, psychology, and religious studies. Only one informant mentioned gerontology as a substantial part of her coursework. To protect confidentiality, pseudonyms are used for the social workers and nursing homes throughout this report, and no other information is provided that would reveal their true identities.

Data Collection and Analysis

My challenge was to pose questions that would generate sufficient data without leading the informants to answer in a specific way based on my own biases and expectations. I was also concerned that social workers would be more likely to sacrifice honesty for acceptability if they felt that they were being judged by a knowledgeable and experienced colleague. I chose to focus on my status as a gerontology graduate student but also disclosed my professional background by signing the recruitment letter with the LSW suffix. Several informants inquired about my social work experience, and I responded honestly but briefly. Most of the informants appeared to be at ease during the interview and shared openly about their work.
The interviews began with informants reading and signing the informed consent (Appendix B). I utilized a short demographic questionnaire to collect information on informant and facility characteristics (Appendix C). Each interview took place in a private office at the nursing home and lasted between 25 to 60 minutes, depending on the talkativeness and time constraints of the social worker. Eight of the ten informants gave consent to audiotape the interviews, and I transcribed each tape within several hours of the interview. Capturing the conversation on tape reduces the distraction of taking notes and allows the interviewer to pay full attention to what the informant is expressing, thereby remaining alert to potential probes and the need for clarification (Lofland & Lofland, 1995; McCracken, 1988; Schutt, 2001). The two interviews that I was not permitted to tape provided corroboration of the data but contributed no direct quotes to this paper due to the limitations of my notes and memory.

As stated earlier, the conceptual questions framing data collection for this study are: What is the mission of nursing home social workers? How do social workers’ ideal roles compare with their actual work? What factors influence social workers’ perceived effectiveness in attending to psychosocial issues? I gathered detailed, reflective statements from experienced professionals to explore the relevance, meaning, and implications of these issues for their daily practice.

I devised a framework of fifteen open-ended questions to guide the interviews (Appendix D). I followed up on informants’ responses with impromptu questions in pursuit of additional details and examples. I questioned informants about their mission, the range of needs they address, the satisfactions and frustrations of their job, relationships with residents and staff, and prioritization of responsibilities. Their
responses offer great insights into the struggles and satisfactions of nursing home social work practice.

A preliminary analysis of interview data informed subsequent interviews as relevant new questions arose (Lofland & Lofland, 1995). In a process similar to that suggested by McCracken (1988), I manually coded transcript data to identify emerging topical themes as they relate to my research questions, and then I utilized a computer word processing program to categorize and link these themes together. This system allowed me to easily view all informants’ responses together on each specific topic.

Analysis in qualitative research involves an inductive, grounded theory approach, in which important categories and concepts are developed out of the data rather than prior to data collection (Glaser & Strauss, 1968; McCracken, 1988; Schutt, 2001). Examination of the interview transcripts began with particular details about each informant’s work experiences and progressed to the level of shared generalities. My goal was to uncover “patterns of inter-theme consistency and contradiction” (McCracken, p. 42). The emergence of conceptual categories is important for understanding the ideals and realities of nursing home social work, as well as the extent to which my data are supportive of the existing literature and my own experiences.
CHAPTER FOUR
Themes of Nursing Home Social Work

Three interrelated themes form the foundation of my informants' nursing home work: conflict and cooperation among staff, time spent on people and paperwork, and ideal roles versus daily realities of work. I will examine each of these themes in detail to illustrate their interconnectedness within social work practice. I am intrigued but not surprised that all of my informants share many of the same sentiments and struggles, and I strongly identify my own professional experience with each of the themes. The social workers, who graciously allowed me to interrupt their busy schedules, appeared to enjoy the opportunity to share the meaning of their work with an interested listener.

Conflict and Cooperation

Conflict between social workers and their work environment can be examined on both a micro and a macro level. Claire at Forest Pines weaves together elements of both as she discusses philosophy of care:

I know sometimes the different disciplines have different missions maybe. Where I may be looking at more of a resident rights and self-determination for that resident, maybe a nursing staff member or the physician is more, now we have to look at how this is going to affect the person’s medical situation or safety issues. Sometimes if I’m looking at resident rights, we have to kind of talk things out because the other disciplines may have other ideas, but I think the facility’s philosophy is pretty close to what my philosophy is as a social worker. Of course, then there are financial issues, and the facility and the administration have to look at budget, budget, budget, whereas I’m not always that concerned about the budget, so that may be a real big difference there. But I think the overall philosophy, we’re working toward Eden, and we’re working on really focusing on resident choice, individuality, and we’re going to be building a new building with resident choice in mind and households, and community and relationships. And we’re going to try to go to more of a social model and get away from the medical model, and that’s my philosophy, and that’s where our administrator is heading, which is really good. But sometimes maybe nursing or dietary, some of the different departments may have different ideas. We’re going to let the resident
get up at ten in the morning and fix them breakfast when they get up, but wait a minute, breakfast is at 7:00, those kinds of things.

Claire insightfully recognizes that conflicts reinforcing the medical model of care may exist at the discipline level, the facility level, and the regulatory level. She seems hopeful and excited about the movement of Forest Pines toward a new approach to nursing home care. She alludes to the Eden Alternative, a philosophy involving a paradigm shift away from the traditional view of the nursing home as a place for the dying to the deliberate creation of a life-affirming environment (Thomas, 1996). The key to a successful Eden program is the willing investment of all staff members into this nontraditional model of nursing home care, in which residents are active and involved participants in the life of the home.

Reflecting on his beginning years of nursing home work, Mike at Mountain View describes how he was socialized into a conflictual relationship with nursing staff:

It used to be when I first came in, and I had sort of been told this, that nursing and social work were often at odds with each other, and we can be, there are disagreements, there are some maybe natural conflicts. But what I’ve found is social work in a long-term care environment in particular because you’re working with so many other disciplines that really outnumber you, and they’re very powerful disciplines, particularly nursing in long-term care, but what I have found is that the better relationships that you have with those team members, those other disciplines, the more that you can get accomplished. And, really, nurses want many of the same things that social workers want. They want the residents here to be happy. I have seen this over and over again with many, many nurses.

After several years of working alongside nurses and developing cooperative relationships with them, Mike realized that the opposition he had been taught to expect was not evident in his own experience:

I think the common thought was, nursing is only interested in dispensing the medications and getting the treatments done and we’re done, and we’ve done what we’ve come to do, we’ve met their needs, which is only a tiny part of the whole. And that’s not true. I used to believe that, but I found that really it was a
lie. As I came to get to know these people, these nurses, and that is the largest counterpart I work with, I found that really they were after the same things I was after, and sometimes they had much better insights. Sometimes I had better insights, but working separately, we were never going to accomplish very much. But working together, that doesn’t mean you have to compromise what you believe. It means that now we have a relationship in which you can say what you believe, and they know they’re going to be heard as well as them listening to you, and it works much better. I think a lot more is being accomplished now, and they are our eyes and ears in many places, whereas I can only be in one place at a time. And so what has happened as a result of a greater relationship of working together is they’re telling me things I would never know without them. If they think a person’s depressed, they’ll say, you know, I think this person is having a tough time. And this isn’t just once in a blue moon; this is regularly.

The philosophy of nurses is not contrary to that of social workers, but both professionals have a common mission in mind as they care for residents: their well-being or quality of life. Teamwork is obviously a more effective approach to addressing residents’ psychosocial needs than territoriality. Still, disagreements do occur among staff due to differences in work roles. The medical model’s elevation of physical safety dictates the priorities of nursing staff, whereas social workers tend to approach situations from a resident rights paradigm. Hope at Garden View gives a classic example concerning a resident who wanted to smoke:

The nursing staff, of course, feels that it’s not good for him, which it isn’t, and there have been other concerns too. This time what had happened was he had just gotten through smoking a cigarette, and he came back in. Well, actually, staff has to assist him, but he sat up out of the wheelchair and fell, and they felt that that might have had something to do with the cigarette. So, basically, what happened was they had talked to his sister and told her, if you write a letter stating you don’t want him to smoke anymore and the reasons why we can’t have him smoking, and that’s not truly the case, because he is a person who’s making his decision to smoke. Well, I talked to the administrator, and I had the note in hand, and I had talked to the sister, and she said, well, the nurses told me that I needed to write this because it’s not good for him, and so we met, myself, the director of nursing and the administrator, and we decided it’s a resident rights issue, and if he wants to smoke, then that’s his right.
In this case, the social worker acted as the resident’s advocate by upholding his right to make his own decision about smoking. Conflict with nursing staff is almost inevitable in situations like this due to the notion that since people enter nursing homes for health and safety reasons, we cannot allow them to make questionable or risky choices. Of course, the overprotection of residents is rooted in a regulatory system that holds facilities liable for accidents and conditions resulting from the behavior of individuals with poor judgment.

Sophia at Springs Care Center expresses her own concerns with safety issues and implies that responsible social work involves working toward a safer environment for all residents:

This whole safety issue is a real significant hardship in this industry right now because residents in every nursing home in the country fall. Residents come to your nursing home because they fall. The serious, serious ramifications for your facility being cited for falls are significant. Your facility can be closed because residents are falling in your facility. So it is not a real cut and dry issue. Probably a lot of our work is really involved in supporting the restorative programs, getting equipment that’s useful and helpful, getting wheelchairs to better meet residents’ needs.

Sophia’s exaggerated fear of the facility being closed because residents are falling implies a sense of helplessness to avert punitive actions despite the best attempts by the facility to keep residents safe. Social workers are not free agents as they seek to advocate for residents; they are also employees of organizations operating under strong regulatory forces. It is only by choosing to work together for the common good of the residents and the facility itself that a collection of individuals, who are trained in diverse disciplines, emerges as an effective interdisciplinary team. Renee at Comforts of Home describes how cooperation often wins out over conflict:
We have an interdisciplinary care team, which I’m just one small part of, and sometimes I have to rock the boat. But usually we work very well together, and I have to say that everybody on that team, that their focus is basically the same as mine, the maximum function that person can do, as active as they can be, and sure, if you’re a nurse and you’re looking at this, and you’re saying, but that’s counteractive to their medical care, then somebody else has to step in and say, well so what, they’re 94 years old, let them enjoy whatever, you know, and we do work well together, so I see our mission as a team is the same, and we see it fulfilled every day.

For the most part, social workers in this study describe their relationships with nurses and other staff members to be cooperative and built upon a foundation of mutual respect, communication, and teamwork. The interdisciplinary team functions most effectively when workers within each discipline recognize the challenges facing the other disciplines and refrain from pushing a narrowly defined agenda. Although social workers experience conflict with nursing staff from time to time, a more pervasive obstacle to consistently addressing residents’ psychosocial needs involves the government regulations guiding nursing home policy and procedures.

**People and Paperwork**

The medical model asserts its influence primarily through macro-level processes rather than through conflicts between disciplines within the setting. In his nursing home ethnography, Diamond (1992) refers to the “commodification of care”, in which reimbursement for care and the management of workers is based on the completion of certain tasks rather than on establishing relationships with residents. The same system of authority that is far removed from the daily life and care of residents also controls the time of social workers in a nursing home setting.

The regulatory system seeks to ensure accountability and quality through rules governing all aspects of nursing home life. Control is maintained through excessive
documentation requirements that are impersonal and disconnected from residents’ daily lives (Diamond, 1992). As a result, paperwork competes with people for the time of professionals, who experience great frustration as they strive to address the psychosocial needs of residents. As Mike at Mountain View explains:

You’re trying to always do between people and paper. The two “p’s” are sort of where you’re dealing, and the paper is important, I don’t mean to minimize its impact because it can be very important for the well-being of the people who are here. At the same time, I think there’s more emphasis on it than there really should be. But that’s the way government is able to run, and it can only see what it sees written down. And trying to marry the two [people and paperwork] is very difficult, and it’s becoming increasingly so. I’ve seen just over the several years I’ve been here that it’s only increasing. The federal and state regulations for paperwork and this kind of assessment, it only demands more and more time, and there’s only so much time in the day. Social worker burnout is very high. Our paperwork is becoming a harsh stark reality, and you can barely stand another set of papers but you must.

Allison at Eastside House brings the struggle between people and paperwork into sharper focus by sharing a poignant example of a dying resident. At these times, pressure to complete the paperwork seems completely incongruous with the immediate needs of the person:

Well, as far as the paperwork, because our part plays a major part in the payment issues, of course, for administration purposes we need to get that done in a timely manner, and there are deadlines. We’re locked out of the computer if things are not done in a timely manner, so that’s always one of the priorities. But the other one is if you have a person on one of the wings, and they’re not doing well, and they need that time and attention with you, and maybe the family has been called, maybe the family won’t make it here in time, then that’s the priority, to be back there with the resident when they need you the most.

The most frequently voiced frustration of my informants concerns the indirect impact that the never-ending paperwork has on the people they are there to serve. The lack of time to interact meaningfully with residents is the recurring theme underlying all of the discussion about paperwork. Social workers view time with residents as a scarce
and valued commodity, as evidenced by the following descriptions shared by two informants:

There’s a lot of paperwork involved. I wish there was more time to spend with the residents, just conversing. It just seems like that’s the kind of thing that is put last, and it shouldn’t be. I mean, not just going and seeing them when they have a need, but being able to stop in and chat with them about their family or their past.

I don’t get nearly as much time with the people, the residents themselves, as I would like to spend. Ninety-five percent of my job unfortunately is paperwork, and no matter how well you organize or plan or prioritize, you’re still lost in paperwork.

The concept of time impinges upon many aspects of resident life. Social workers may become experts at managing their own paperwork responsibilities, but they have no control over the bureaucratic systems paying the bills for residents that have run out of money due to the exorbitantly high costs of nursing home care (Diamond, 1992). John at Rolling Greens vents his frustration with a tedious paperwork process to secure something as basic as teeth:

Medicaid is very frustrating because I have to deal with pre-authorizations for dentures and stuff like that, to get people approved for the things they need, and sometimes it takes three or four months of paperwork. You send it out, the information, and it takes forever to get approved, and that’s very difficult. Paperwork is really a pain. You spend all of your day it seems writing; it gets tedious, but it has to be done.

The common nursing home maxim, “if it’s not charted, it didn’t happen” (Diamond, 1992, p. 131), ironically overlooks the fact that many aspects of quality care are never charted; in fact, the medical chart is silent on the actual story of each resident’s life in the nursing home. There are not enough hours in a workday for social workers to document every meaningful interaction. It follows that many of their direct contacts with residents are unrecognized as having occurred. After one social worker itemizes her long list of standardized paperwork requirements, describing them as
“constant”, she adds, “There’s documentation, don’t forget documentation, it’s very important, if it isn’t written down, you didn’t do it.” In distinguishing between the scheduled tasks and unstructured documentation, she perceptively recognizes that much of her work with residents is at risk for never having happened from the larger system’s perspective.

Several informants began their work prior to the Nursing Home Reform Act. Reflecting on the extent to which the new regulations have impacted their work over the years, they offer valuable insights into the contradictions inherent in attempting to legislate quality of life. From the perspective of Sophia at Medley Care Center, state surveyors continue to be process-oriented rather than outcome-based:

I’m a real strong proponent of OBRA. I think the goals are absolutely wonderful, and the issues of quality of life, they’ve really elevated the entire industry to a much better standard than it was thirteen years ago, ten years ago. But unfortunately, I was also taught or led to believe that when they were in homes that were excellent, and good care was being provided, and the outcomes were good, you had a real high level of resident and family satisfaction, the residents are clean and happy, with smiles on their faces, and contented expressions, and they speak highly of the care and service that they’re receiving, that basically then the survey team would have very little information or findings because it was going to be outcome-based, and that would be the summation of their review. And I’ve not found that to be true. I’ve found that if that’s the case, then they pursue other deeper things. They continue to just keep getting at things and keep looking at the paperwork process and such.

Adequately addressing psychosocial issues requires time, which is often spent immersed in paperwork rather than involved with people. Documentation that is intended to control quality care by maintaining an exhaustive written record of it is counterproductive to its purposes by diverting professionals from actually providing that care. Claire at Forest Pines acknowledges the surveyors’ interest in talking to residents
and families, but her remarks illustrate how paperwork requirements have continued to increase despite the regulatory changes designed to promote quality of life:

When I first came, we had state surveys, but they weren’t like what they are now. We didn’t have the MDS, all the involved RAPs, and I guess it’s a good thing to do good assessments and to write the RAPs and come up with good care plans, but it also takes a lot away from the resident because I spend so much time doing paperwork. We need surveys, it’s good to have them, and they do really look at resident rights; they come in and they talk to the residents and talk to the families.

Claire acknowledges the importance of the individualized documentation requirements and seems to struggle with the positive and negative aspects of the regulatory changes.

In the midst of a long description of job responsibilities, Renee at Comforts of Home also reveals her acceptance of the purpose for the standardized paperwork:

We also have to fill out a document called the MDS, minimum data set, and it is very, very detailed and comprehensive on that individual. If you would never meet that person and just read that whole MDS, you’d probably feel like you know that person. And that is how we get our reimbursement from Medicare and Medicaid, from the information on the MDS. So that’s kind of a primary focus; those have to be done in a timely manner.

But even when social workers understand its purpose, they struggle to manage the never-ending paperwork, which takes them away from direct contact with residents and is a great source of stress.

The comments of Sophia at Springs Care Center clearly illustrate why some would choose not to work in nursing homes:

I would never be a weak enough person to have that [the paperwork] run me out of the field, but unfortunately, I’ve seen a lot of really good people run out because they can’t stand it, and I think that’s real unfortunate. We have a lot of good people who could do a really great job but just don’t like the regulation atmosphere and the punitive aspects of some of the kind of work that we’re involved in. So, that is really frustrating and increasingly so.
Interacting with residents is inherently more meaningful than writing care plans about that interaction. The mission of social workers is impeded by the excessive documentation required to remain in compliance with government regulations. As a result, their ideal roles are restricted by the daily realities of working in a nursing home.

**Ideal Roles and Daily Realities**

The social workers in this study conceptualize their work using many similar words and ideas. The intricacies of improving quality of life, meeting psychosocial needs, and advocating for residents are expressed in a variety of meaningful ways. One informant aptly summed up her mission as “to help people keep their dignity, to help them get the respect and care that they deserve”. The following three descriptions are typical of the responses:

Generally, my personal mission is what I share with new staff, especially as to what the social work role is in long-term care, and that I perceive to be helping to meet the psychosocial needs of residents, which I usually then just give a little equation to making people as happy as we can. The psychosocial term is sometimes a bit of a mouthful for some persons, so I always explain it that way. And then I'm also involved in explaining the mission of the facility and the philosophy of the care and the kind of work that we attempt to do to meet the needs of our residents.

My personal mission is just to try to help the residents find as much satisfaction in their latter years of life as they can. I'm the resident rights advocate. If they don't want to get up at 7:30 in the morning and have breakfast, then they have the right to stay in bed, and it's kind of focusing more on them and what they want. So just to see that they have as good a quality of life as they can have in their latter years.

I guess basically what my primary purpose would be is just to better each person's life that comes through this facility. Now we have some that are here short-term, that are planning on going home, and I help them achieve that goal, and then the ones that we have long-term, I'm just trying to work to make things more comfortable for them.

A strong agreement about their professional purpose is evident among my informants.

The mission of these nursing home social workers is clearly rooted in the language of
the Nursing Home Reform Act and is consistent with the mission described by the NASW (1993):

Social work services in long-term care are provided directly to nursing home residents and their families to promote their social and psychological well-being. In addition, as part of the multidisciplinary team, the social worker is responsible for fostering climate, policy, and routines that enhance quality of life; that respect the culture, religion, and ethnicity of the resident; and that emphasize helping residents retain individuality, independence, and choice. (p. 4)

Given their ideal roles and the reality of paperwork that diverts their attention from residents, what is it that social workers hope to accomplish by spending more time with residents? Many of my informants share ideas about what this time would include. John at Rolling Greens explains it this way:

Ideally, I would be able to spend way more time with my residents, actually sit down, talk, how are you, how’s the family, how are the kids, get a good feel for their emotional well-being. Realistically, a lot of times I have to base what I go on by those 30 seconds in the hall or depend on the nursing staff for their documentation. A lot of the stuff that happens I don’t get to see firsthand, so there’s a big margin of, I don’t want to say error, but guessing, in the care that I provide because I have 85 residents, and that total is climbing everyday, and one of me, so I can’t be everywhere all the time. That’s probably the biggest thing that I see, the actual one to one time. Definitely need more help, it gets very overwhelming, very overwhelming.

A lack of time to simply talk to residents about how they are doing is an example of the great chasm that exists between ideal roles and actual work. Social workers cannot realistically establish relationships with residents if their knowledge of them is based primarily on brief encounters in the hallway or secondhand reports.

Renee at Comforts of Home reveals her minimal involvement with many of the residents and strives for a very modest goal of regular visits:

With all of the demands, and I’m the only person in this department, I would love to be able to do one to one visits with each person. At least on the nursing floors, if I could see each person maybe every two weeks, and I just can’t do that.
Over time, social workers do get to know many individuals living at the nursing home long-term. Cindy at Valley View expresses her desire to use her clinical skills, implying that she has managed to establish deeper relationships with residents:

> It should be that I should be able to have one to one counseling sessions with my residents and not rely on outside counseling sources to come in and do the counseling because I know the residents better than they do, and I feel that I really don’t give the residents the benefit of me knowing them and being able to help them through some of their problems. I just can’t do it; I wish I could but I can’t.

The United States Department of Health and Human Services (1996) study on mental health services in nursing homes found a lack of time to be a major obstacle to the provision of counseling services by facility staff. According to one administrator, “Mental health services could be provided in house by most facilities if the social worker were not so burdened by paperwork. The social worker doesn’t have time, and psychological services are not in the Medicaid rate” (p. 14). Medicaid does cover psychological services billed directly by providers rather than as part of the facility’s per diem reimbursement rate.

Nursing homes commonly contract with clinical psychologists to provide counseling services to residents with severe adjustment problems, depression, or behavioral issues. Social workers are responsible for making referrals and should maintain ongoing dialogue with counselors about treatment progress so that interventions remain relevant and responsive to current issues. Sophia discusses how she takes an active role in collaborating with the mental health providers who visit Springs Care Center:

> There are some residents we’re seeing increasingly in the field, who have some real long-standing, serious, and significant mental health issues, and in those areas, I feel I have an opportunity to learn a great deal from the higher levels in
psychosocial support, for example psychiatrists and the psychologist service that we use. And they are usually very generous with their education and information on how I can be more effective in dealing with a particular resident or a particular client. But the kind of clientele that I was originally trained and educated to treat are probably 86 or 87, who are declining physically, who have some emotional and psychosocial response to their placement, situational depression, concerns about their health, working through new diagnoses, as well as even the residents with dementia. I feel that I'm really pretty effective in terms of common sense and helping them to adjust to this placement. And like I said, I have a good wealth of resources. If I have a need of higher information and education, I can refer them directly for use of those services, and I can also just bounce ideas off of those professionals to help them help me.

Cindy at Valley View recognizes that other staff members also have a role in meeting residents’ psychosocial needs. She expresses appreciation for their involvement as she discusses the extent to which these needs are being addressed:

I think they are; I don’t think they’re not being addressed. I think they’re not being addressed by me. Like I said, I have a lot of staff here that are very caring, like my activities director, she should’ve been a social worker. I mean, she’s just very good, very involved, knows these residents inside and out, and she will sit and talk to them. My assistant DON [director of nursing] will sit and talk, and they’re very involved people. I have a good supportive staff here.

Another informant believes that residents often just “need some basic reassurance in their lives; they just need someone to hear them, to listen to them”, and he credits nurses, activity coordinators, and housekeepers with being “listening people”.

Competition for social workers’ time exists even beyond the paperwork. The nature of the work environment continually stretches social work resources to the limit. Mike at Mountain View blames government regulations for establishing an inadequate minimum standard for social services staffing. He discusses his limitations in accomplishing all of his responsibilities in light of time restraints:

You can’t do the best job that could be done without all the resources that you want, and we’re talking about people resource here. A lot more could be accomplished with two or three social workers easily. I think the state law is for every 120 residents you need a licensed [sic] social worker, and that’s not a very
good ratio. Realistically, if you are one of the 120 people, and you've got one person split up between the 120, I don't think you'd want a nurse with that ratio, you wouldn't want the kitchen worker to have one person sitting there. I think social workers are really behind in that sense, and so I think our laws are way behind in how many people we need to do this job. Now I have a helper, who's not a social worker, who does some task work, the errand kind of thing, scheduling kind of thing, which gives me some more hours, but even at that, here in this setting, if you had three social workers, you wouldn't have too many, personally.

Mike is aware that nursing homes with over 120 beds are only required to employ one qualified (not necessarily licensed) social worker, and he laments the inconsistency between the great need for social services and the resources available to effectively meet those needs. Working at a facility with a current census of almost 120 residents, he illustrates the difficulty of spreading his services equitably among a large number of people.

Multiple demands upon their time lead social workers to develop personal conceptions about what is most important at any given moment and what can wait until later. Allison at Eastside House expresses her frustration with being interrupted during her interactions with residents:

I may forget to tell them [workers answering the phone] that I'm going back into a resident’s room for awhile, and as sure as I get back there, then they'll start paging, so I'll have to be interrupted, and sometimes I'll just stay back there because if the resident is telling me something that's very serious, then I will just miss the phone calls. But then a lot of times when you're working on care plans or something and a [staff] person needs you, they'll call you back [to the unit]; somebody needs a bath and they're refusing to take one. A lot of it is just interruptions, and you can't seem to get the flow because of the constant interruptions.

Also viewed as an interruption to her ideal roles and responsibilities, Claire at Forest Pines clearly states what she considers to be a poor use of her time:

One of the things that just over the last maybe three or four years that's been an additional responsibility for all the department heads is helping in the dining
room. So two nights a week, I have to pour drinks, pass trays, and I find that to be kind of frustrating because, you know, I didn’t go to school to pour drinks. But everyone’s doing it, the administrator, the director of nursing, MDS people, everybody does it, but I find it frustrating when I’m assigned jobs that I don’t feel are really social work jobs.

While her position is understandable, it is at odds with the perspectives of other social workers, who do find value in even the mundane tasks that bring them into contact with residents. One informant stated that she does not mind assisting with practical matters because these times help in establishing rapport. From her experience, therapeutic benefits can be gained apart from formal counseling sessions. She also noted that if she wanted to do counseling full-time, she would be working at a mental health agency.

Sophia at Springs Care Center would probably attribute this difference in perspective to the fact that social work roles are often not clearly defined:

A lot of things that people don’t know where else to put became social work issues, specifically, things like beauty shop, barber shop, dentist, vision, audiology, shopping, setting up appointment times for people to participate in those things, working on contracts with those professionals, and all of the ramifications of that. Those can be very time intensive projects, and part of me thinks that a really good clerical person who really stays on top of things, a medical secretary kind of position, can do excellent work with those, and it really wouldn’t require my expertise. However, in many facilities it’s hard to change that, and so we do get a lot of that, and that can be frustrating at times, but it’s not the end of the world.

Sophia seems to be resigned to the discrepancy between her ideal roles and the daily realities of her work, recognizing that these aspects of the job do not require specialized social work training. Claire at Forest Pines relies on an assistant to do practical tasks, but paperwork continues to divert her attention from residents:

I am lucky in that I have my assistant, but before, I really hated dental stuff. If someone’s dentures were broken, then it was my responsibility, if someone needed to see the dentist, I thought, now isn’t that a nursing issue, why is that my
responsibility, so that kind of thing. Missing items fall under social work, and that takes a lot of time, running around; my assistant helps me with that, trying to find things that are missing. I don’t know who else would do it, but I don’t really like having to do that, it’s kind of a waste of time. My assistant calls the phone company and sets up newspaper service, which is nice because I don’t have to do that anymore. I guess really over the last two years with the assistant, I’ve managed to be able to do more social work stuff, but I have a lot more MDSs, RAPs. I have more paperwork to do, so I didn’t really come out ahead. It’s not like, well, now I can use this time when I’m not calling the phone company and taking the dentures to the dentist to do one to one visits, spend time with the residents. No, now I’m using that time just to keep up with the care plans, all the PPS [prospective payment system] stuff.

Another informant commented that the last facility where she had worked went so far as to appoint her as laundry supervisor in addition to her full-time social worker status. As a result, she feels that her psychosocial work on behalf of residents was disregarded, and it was impossible for her to effectively fulfill her professional mission.

Despite strong conceptions of their ideal roles, social workers recognize their limitations in addressing psychosocial needs, and they resourcefully rely on other staff to offer support to residents during the course of their own responsibilities. The “common sense theory” guiding social workers (Pithouse, 1998, p. 126) may also apply to housekeepers, activity coordinators, nursing assistants, nurses, and others, who are willing to take the time to actively listen to residents. Despite facing a range of responsibilities that do not always conform to their ideal roles, my informants express a genuine commitment to improving the quality of life for nursing home residents.
CHAPTER FIVE

Implications for Practice

The themes of nursing home social work are consistent in this study regardless of facility characteristics. Interestingly, these themes are also applicable to all of the social workers, regardless of specific job title, length of time in the field, or educational background. Each informant spent a major portion of the interview talking about time constraints, frustrations with paperwork, and desire for more interaction with residents. Although some degree of interdisciplinary conflict may be inherent in the nursing home setting, all informants focus on the cooperation that exists among the staff in promoting quality of life. My research findings suggest that a strong sense of mission, a teamwork approach, and time management skills are highly relevant to addressing psychosocial needs.

Job Satisfaction

Despite all of their frustrations with the paperwork aspects of their jobs, the social workers in this study express a high level of satisfaction with their chosen career. Many have held their positions for many years, and none expressed a desire to leave the field. Interspersed throughout their accounts of government regulations, time constraints, and paperwork overload are stories of meaningful encounters with residents. Whether it is a long overdue time of conversing about their past histories or just exchanging a quick greeting in the hallway, social workers are energized by these contacts.

The rewarding aspects of practicing social work in a nursing home setting range from assisting in the adjustment process, to arranging a seamless discharge back to the community, to offering emotional support to residents and their families during the final
days of life. However hectic their schedules may be on a given day, social workers are committed to making time for those services most directly impacting residents’ quality of life. Interruptions of this sort are welcomed and responded to with genuine care and concern.

It should not be assumed that meaningful interactions preclude difficult conversations and conflicts. The social workers in this study believe that the heart of their work involves enhancing quality of life, regardless of residents’ physical and cognitive conditions. They understand that their efforts will not necessarily lead to positive measurable outcomes, and not every resident and family will express gratefulness for their assistance. Sometimes their interventions are unrecognized, unappreciated, or unwelcome, although informants rarely alluded to these situations. However, fulfilling their mission successfully is not entirely dependent on observable results because social services are not “a discrete and measurable service that can be uniformly ‘dispensed’” (Pithouse, 1998; Rojiani, 1994, p. 140). Sitting at the bedside of an unconscious, dying individual with no family, so that she does not have to die alone, is just as integral to providing high quality social services as coordinating a discharge home.

Hearing from social workers in their own words conveys the sense that they are not only doing a job but fulfilling a ministry or answering a calling. I asked my informants about the most satisfying and rewarding aspects of their work, and the following are some of their responses:

Maybe knowing you have made a difference in somebody’s life that day, whether it be to help solve a problem with roommates, or maybe a family situation. A person may be upset with their family because they feel like they’re responsible for their being here, and you finally kind of have a breakthrough to where they
accept that visit or they talk to them pleasantly on the phone, something like that. Or I guess the most rewarding is to walk in somebody’s room and hear them say I’m so glad you’re here.

Helping them, giving them that continuity, that comfort level, providing that stability, I guess you’d say, because a lot of these older people don’t have families, they don’t have anybody that really has an interest in them, and when they finally get to the point where they have that trust, and they look at you and you can just tell, and it’s a good feeling, so building trust with these people.

Consistency, results, there’s a whole lot of failure in this job, but if you keep trying, people see that you really care, and that you’re really working toward helping them, and that’s the good stuff. But like I said, social work is not the job for the weak at heart really because you go home exhausted mentally, crying, everything else, but you have that one little moment where they smile at you, you know, it’s good, it makes it all better. It’s the most interesting job I’ve ever done in my life.

We’re dealing with a lot of people who are disoriented, have some real struggles there, and if you can just make them feel better for five minutes, you’ve accomplished a great thing. And I’ve learned to sometimes accept those limitations, that’s it’s ok, that if you can win five minutes, make five minutes better, you’ve done something. I think it’s the one on one resident contact that is the better part.

When you send somebody home, somebody finally leaves. Because I work in long-term care, you don’t see it much, actually getting someone back out in the community and productive. That’s real big, it doesn’t happen much, and long-term care is changing, so it’s not just your typical grandma coming to the nursing home. Now you have a lot of mental illness, polysubstance abuse, a lot of stuff like that, so the fight is harder to get them reacclimated to the community.

The fact that I know I help people in crisis situations. I do a lot of discharge planning, that takes a lot of my time, and we have 28 subacute beds here. So I help people in crisis situations where they have no idea what to do, new placement, and when I go home, I feel that I’ve helped people with that situation that they would’ve not known how to handle. I also help people with hospice and end of life decisions, and that does make me feel like I’ve played an important role and made somebody’s life easier.

Whenever we have worked with or we’ve had a resident here for quite some time, and you get to know them, and you know that the body’s deteriorating, there isn’t any hope for further improvement, they’re not going to get better, but you provide them with as much quality as you can and a peaceful death. It brings sadness, but it brings satisfaction that you know you have kept that person as comfortable as possible, as active as possible. You’ve provided for their needs.
And so, when they pass from this life into the next, you know it was a comfortable thing, and their families are satisfied with the care they've received.

A strong dedication to long-term care motivated one informant to participate in this research project. She believes an unfortunate perception may exist among social work students that nursing home work should be avoided. She welcomed the opportunity to express her enjoyment of working in a nursing home and to encourage others to consider this field. Rojiani (1994) asserts that “by virtue of the time, effort, and expense they have invested, professionals are emotionally committed to their professional identities, no less so than the long-term care patient is invested in maintaining her preferred identity” (p. 147).

Without exception, the residents are the reason the social workers in this study have chosen to remain at the nursing homes. Taking time to involve themselves in the resident’s world represents a reordering of priorities for social workers, many of whom are at risk of burnout. The sense of satisfaction that comes with meaningful interactions supplies energy for returning to the tasks. The ones who discover this phenomenon are those who are able to overcome their frustrations with time constraints and remain in the profession for many years.

**Overcoming Time Constraints**

A constant tension exists between informants’ ideal roles and the daily realities of their work. The proliferation of paperwork threatens to keep social workers too busy to consistently attend to residents’ psychosocial needs in a meaningful way. Rojiani (1994) attributes this to the “complexity of fit between institutional structures and human needs” (p.145). Diamond (1992) notes the slow pace of many people living in nursing
homes and the dilemma this poses for caregivers, who are pressed for time in completing their tasks.

In their ethnographic research at an Alzheimer’s care facility, Wellin and Jaffe (2002) distinguish between two incongruent conceptions of time. “Clock time”, legitimized by the medical model of care, holds paid caregivers to a rigid task schedule and competes with “story time”, the flexible use of time that encourages relationships and reminiscence (p. 1). Clock time often makes it impossible for nursing assistants to respond to residents’ requests for company and conversation (Diamond, 1992). An early nursing home ethnography, “Living and Dying at Murray Manor”, illustrates the hustle and bustle of administrative staff, who greet residents in a perfunctory but polite manner as they walk quickly through the hallways carrying papers (Gubrium, 1975).

Although the relational nature of social work implies the use of story time, nursing home social workers are working within a medicalized system of care, in which accomplishing tasks requires the most efficient use of clock time. My informants clearly articulated their belief that appropriately addressing psychosocial needs in a genuinely caring manner requires unhurried time. As Rojiani (1994) so relevantly states, “people’s unique needs, fears, beliefs, and resources can only be ascertained by spending time with them. Allowing information to be revealed, as trust and familiarity increase, means taking time to learn personal history” (p.140). Rapport-building and active listening cannot be accomplished without deliberately investing time for this purpose.

So how do social workers reconcile the constant tension between clock time and story time? While they acknowledge that more effort is often spent developing interventions than actually implementing them, psychosocial work proceeds, albeit not
always as planned. More often than not, it is the unplanned and uncharted interactions with residents that serve to develop relationships, assist in adjustment, and bring a degree of comfort to those who have lost so much. Whether they realize it or not, social workers often abide by the well-known words of Mother Teresa, who stated, “We can do no great things, only small things with great love”. Taking the time to listen to a resident’s cherished memories, wheeling someone outside for a breath of fresh air, or noticing family photographs are the sorts of small actions that can make a great difference in an individual’s day.

All of my informants perceive themselves to be effective in addressing psychosocial needs at least part of the time. They have come to terms with the fact that no matter how urgent the paperwork seems to be, people are always more important. These social workers set aside the documentation to respond to residents’ requests for support, and they are conscious of the fact that many residents are unable to actively seek them out.

**Moving Toward a Social Model of Care**

In “Shaping a New Health Care System: The Explosion of Chronic Illness as a Catalyst for Change”, Strauss and Corbin (1988) describe a social model of care in the context of home care services. Chronic care is inherently different from acute care; slowing deterioration and relieving symptoms, rather than curing illness or restoring functioning, are the primary considerations. They argue that the home should be the center of care, with the medical arena providing support as needed. They emphasize the work of patients in managing their conditions, their daily lives, and their personal biographies to lessen the traumatic impact of their circumstances. Central to this
perspective is the premise that quality of life must be the focus of both clinical and non-clinical care.

The social model of care discussed by Strauss and Corbin (1988) is also relevant to the nursing home setting, in which residents’ psychosocial well-being is inseparable from medical or physical needs. In the words of Vourlekis, Gelfand, et al. (1992), “psychosocial care is intertwined with medical care but distinct from it” (p. 113). The Nursing Home Reform Act attempts to integrate these dimensions of care, although the process is far from complete. One social worker mentions that in the fourteen years she has worked at the nursing home, surveyors have rarely talked to her. Another notes the changing emphasis on different care issues from year to year. Quality of life issues may be the focus during one inspection, but “then they’ll shift over to dietary . . . the thermometer goes in the food, and it’s not exactly right, or they use the wrong size spoon, it just shifts”. Despite an inconsistent inspection process, the intent of the Nursing Home Reform Act is worthy and relevant in that it seeks to bring a medicalized system into greater balance by emphasizing psychosocial well-being.

Social workers are in a pivotal position to influence the implementation of the provisions of the reform legislation despite the profusion of paperwork. They represent a vital subspecialty of the profession as the projected aging of the population places a greater demand on long-term care services than ever before (Institute of Medicine, 2001). Although short-term placements for rehabilitation have become commonplace over recent years, a significant number of residents will remain at the facility for the rest of their lives (Atchley, 2000). Social workers are charged with helping them adjust to the nursing home environment regardless of their anticipated length of stay. Initiating
high quality social services at the time of admission is vital to making a very difficult transition a little easier. Recognizing that the first few weeks or months of placement are generally a time of crisis for new residents, one social worker admits, “It’s a destination no one ever wants to find themselves in”.

The ethnographic studies of Gubrium (1975), Shield (1988), and Diamond (1992) were conducted prior to the reforms that legitimized psychosocial issues in nursing home care. The irreconcilable goals of nursing and social services staff as described by Shield seem to have come closer together, at least as experienced by my informants and me in our nursing home work. Gubrium and Diamond’s valid criticisms of the irrelevancy of paperwork to residents’ lives are not echoed by my informants in the same tone. Although these social workers lament the time-consuming amount of documentation they must complete, they seem to accept its purpose. They actively attempt to balance their attention to people and paperwork by creatively blending their ideal roles and the daily realities of their work.

If social workers are to effectively address the psychosocial needs of residents, they must first establish their professional identity within the nursing home environment. The roles of social workers would be more clearly defined and strengthened by utilizing the guidelines developed by NASW (1981, 1993) as the framework for nursing home practice. The publication entitled “NASW Clinical Indicators for Social Work and Psychosocial Services in Nursing Homes” (1993) delineates empirical measures of social work intervention within these foundational areas of practice: timely and comprehensive psychosocial assessment, resident and family involvement in care planning, successful problem-resolution, and facilitation of resident preferences in
everyday life. Consistently giving top priority to these aspects of work would ensure a high degree of direct contact with residents. Excessive paperwork will continue to be a reality, but the core of social work practice always involves people. Social workers add a crucial component to the work of the interdisciplinary team as they promote and model those intangible aspects of care that make nursing homes a little more “homelike”.
Bibliography


Appendix A: Recruitment Letter

December 6, 2002

Are you a full-time, Licensed Social Worker with at least one year of experience working in the nursing home? If so, would you please consider participating in an interview about your work experiences?

I am a graduate student in the Master of Gerontological Studies Program at Miami University. For my thesis, I will explore the roles of nursing home social workers. My goal is to interview ten social workers at a variety of nursing homes. The interviews will be completely confidential. Only pseudonyms will be used in the thesis, and no identifying information will be included that would link responses to specific individuals or facilities. I would prefer to audiotape the interviews for ease of data collection; however, you do have the option to refuse to be taped.

If you are interested in participating in this study, please contact me by e-mail (wooddech@muohio.edu) or by phone (513-607-9272). For more information, you may also contact Dr. Chris Wellin, my faculty advisor for this project, by e-mail (wellincr@muohio.edu) or by phone (513-529-1592).

Please share this letter with your supervisor so that I may interview you at your workplace, or I would be happy to meet you at a neutral location. Due to my practical need to accomplish the interviews within a certain timeframe, I will follow-up with a phone call in a week if I haven’t yet heard from you. Thank you in advance for your willingness to share your experiences and insights.

Sincerely,

Cris Wooddell, LSW
Appendix B: Informed Consent

Dear ______________________________,

This research project will offer an in-depth examination of social work practice in nursing homes by inviting social workers to share the realities of their work experiences. I am interested in how the mission and ideal roles of social workers relate to actual daily practice in nursing homes. A gap exists in the professional literature dealing with nursing home quality. Studies have generally focused on nursing staff and medical/functional outcomes. My goal is to contribute a meaningful examination of how social workers perceive their own work with nursing home residents.

The interview will be conducted in a private office at your place of employment with your supervisor’s approval or a neutral location of your choice. I expect the interview to last up to an hour. I will audiotape it for ease of data collection; however, you do have the option to refuse to be taped.

Your participation is completely voluntary, and you may discontinue the interview at any time or refuse to answer specific questions at your discretion. I will be happy to give you more information, or you may contact Dr. Chris Wellin, my faculty advisor for this project. He can be reached at the Department of Sociology and Gerontology at Miami University by phone (513-529-1592) or by e-mail (wellincr@muohio.edu). You may also contact the Office for the Advancement of Scholarship and Teaching by phone (513-529-3734) or by e-mail (humansubjects@muohio.edu) for questions about your rights as informants in this research.

Risks to informants are expected to be minimal. You may be uncomfortable with sharing personal insights about your work experience. You may worry about repercussions from your employer if you voice any negative or unpopular viewpoints, or you may feel as if you are not being loyal to the facility if you express difficulties about your job. However, please let me reassure you that the interview will be completely confidential. Only pseudonyms will be used in the thesis, and no identifying information will be included that would link responses to specific individuals or facilities. My faculty advisors and I will be the only ones with access to the audiotapes and interview transcripts.

I strongly believe that you will benefit from the opportunity to discuss your work roles. Social workers continually assist others with problem-solving and psychosocial issues to the possible neglect of their own emotional well-being, which often leads to burn-out. The opportunity to confidentially express your feelings and frustrations about your job will offer a supportive outlet for relieving stress and a needed time of self-reflection. With the long-term goal of publication of this study, substance will be given to the intangible world of social work in nursing homes. Your perspectives will offer valuable direction for improving the psychosocial well-being of the large and growing population of nursing home residents.

Please sign below to indicate your full voluntary and informed consent to participate in this research. Thank you for your willingness to share your experiences and insights.

Signature                                                     Date                   Initial for consent to audiotape
Appendix C: Demographic Questionnaire

About the Informant

Job title: __________________________________________________________

Education/training/credentials: _______________________________________

Number of hours worked per week: ____________________________________

Length of time employed at this facility: ________________________________

Length of time as a social worker: _____________________________________

Number of other nursing homes where you have worked: _________________

Future plans/career goals: ____________________________________________

About the Nursing Home

Number of beds: ____________________________________________________

For-profit or non-profit: _____________________________________________

Church-based or secular: _____________________________________________

Chain-operated or single facility: _____________________________________

Other levels of care offered: _________________________________________

Number of residents on your unit(s): _________________________________

Number of social workers in the department: ____________________________
                                                    (Part-time)
                                                   (Full-time)

Education/training/credentials of other social workers if known: ________

Appendix D: Interview Questions

1) What are your roles and responsibilities as a nursing home social worker?

2) How do you prioritize your time?

3) What resident needs and concerns do you assist with regularly?

4) How effective do you perceive yourself to be in addressing these needs and concerns? What are some obstacles?

5) What is your mission as a nursing home social worker?

6) How does your mission compare with the facility’s mission?

7) How do your ideas about what social work in a nursing home should be compare with your actual work?

8) How involved are you in residents’ daily lives?

9) What are your relationships like with other staff members?

10) How does your philosophy toward care compare with that of other disciplines?

11) How do you think residents view you as compared with other staff members?

12) To what extent are resident rights a part of your job?

13) How much authority do you have to impact facility policy and procedures?

14) What are the most satisfying and rewarding aspects of your work?

15) What are the most frustrating and difficult aspects of your work?