# Social Worker PILOT PROJECT

## LONG-TERM CARE

*The Social Worker pilot project sets the stage for an infusion of best practices with its continuance.*

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**Acknowledgement – Province of Nova Scotia**

The Meadows, Villa Saint Joseph, Nakile, Bayside Home, Roseway Manor, Villa Acadienne and Tideview Terrace, wish to thank and acknowledge the Province of Nova Scotia's Department of Health & Wellness, now the Department of Seniors & Long-Term Care, for the investment in and support of this innovative pilot project, awarded in 2020. It has been a most successful pilot with many lessons learned and valuable information gathered on the meaningful impact of a Social Worker professional on site within long-term care. Thank you for your partnership and willingness to research and assess innovation and best practices in the long-term care sector.

# EXECUTIVE SUMMARY

Seven nursing homes in the counties of Digby, Shelburne and Yarmouth in southwestern Nova Scotia took part in a year long innovative pilot project which assessed and evaluated the value and impact of having a Social Worker as part of their care teams.

A professional Social Worker became a valuable resource within each long-term care facility, offering a holistic approach towards strengthening residents' ability to live their happiest and healthiest lives. The focus of the role was to support emotional and mental health needs of residents while also offering support and enhancing communications on the residents' individual care needs and overall well being, to residents directly, to their families or substitute decision makers as well as support and expertise to staff and management. The facilities worked very collaboratively and effectively together knowing the volume of residents in relation to the one resource plus the travel throughout a large geographical area would be challenging. Despite the expectation that these elements of the pilot project would be impacted by the scope of the geography and the number of residents in contrast to a dedicated Social Worker within each facility shared in closer proximity, the results proved meaningful and significant.

*The Social Worker pilot project sets the stage for an infusion of best practices with its continuance. It has built the foundation for a clear path of effective communications and conflict resolution for the residents/families which is a vital and necessary component in today's long-term care sector.*

The residents formally communicated that the Social Worker made substantial impact for residents making major life decisions and facing multiple challenges adjusting to life in long-term care through trustworthy, skilled support and care.

The organizational culture shifts quickly when residents and families can place their trust in a neutral third party, which is the Social Worker. The position becomes most impactful when leadership and staff involve the Social Worker and integrate their role at all levels to ensure the Social Worker is knowledgeable about shifts in practices and how this will affect the relationship with residents/families.

Staff also responded very favourably to the Social Worker position as did management and physicians. Staff valued the expertise given to residents citing the insight into complex cases, behavioural challenges, overall mental health well being and professional growth educational opportunities and self care for team members. The Social Worker provided vital navigation of critical services, was a necessary listening ear and a professional facilitator with a skilled ethical perspective for residents' self determination decision making.

The Social Worker position also built valuable partnerships with behaviour resource consultants as well as provincial mental health and addictions programs. This resulted in a more holistic and integrated perspective for care plans and reduced barriers to such services typically experienced by those living in long-term care.

The Social Worker also became an invaluable resource during the pandemic with increased isolation experienced by residents, increased staff burnout, workforce shortage and overload.

This pilot project also revealed a wealth of opportunities for a vital role for a Social Worker to enhance and grow mental health support. Resources such as a Social Worker's knowledge and proficiency are an important part of the path forward to transform long-term care standards in Nova Scotia. It is a natural fit to achieve progressive models of care such as the Eden philosophy with a resident directed approach and to further develop and address family dynamics support and staff resilience, overall health and safety, advanced care directives and behaviour management.

The Social Worker pilot project sets the stage for an infusion of best practices with its continuance. It has built the foundation for a clear path of effective communications and conflict resolution for the residents/families which is a vital and necessary component in today's long-term care sector.

# INTRODUCTION

A proposal to fund a full time Social Worker Pilot Project for a one year period in seven long-term care facilities in Yarmouth, Digby and Shelburne counties was submitted to the Province of Nova Scotia's Continuing Care Innovation Fund in 2020. This proposal, created by the administrators of The Meadows, Villa Saint Joseph, Nakile, Bayside Home, Roseway Manor, Villa Acadienne and Tideview Terrace, was accepted and following an official hiring process, a Social Worker began the term position on January 31, 2022, to serve all of the region's LTC facilities.

The primary goal was to provide professional Social Work expertise in a clinical setting that would strengthen the residents' abilities to live their happiest and healthiest lives and to provide a daily and accessible resource that would make mental health wellness in these organizations stronger and more effective.

*The Meadows, Villa Saint Joseph, Nakile, Bayside Home, Roseway Manor, Villa Acadienne and Tideview Terrace participated in the Social Worker Pilot Project which began on January 31, 2022.*

**Responsibilities were as follows:**

- As a member of a collaborative inter-professional team, coordinate care to achieve person-centered outcomes
- Provide transitional counselling and intervention services for residents and their families with follow-up as required
- Provide supportive counselling for residents and family in situations related to grief, loss of independence, declining health and end of life care
- Support staff and the organizations to develop skills and resources to enhance social functioning
- Advocate on behalf of the resident to ensure optimal level of care
- Keep accurate patient records
- Evaluate the effectiveness of counselling
- Provide links to external services in mental health

The project began with extensive meetings between the staff members from each facility and the Social Worker to explain and discuss the scope of practice. The majority of referrals were received in those first few visits from various staff members, including management. A referral form (see Appendix) was designed by the Social Worker to be distributed to staff members in all the facilities which gave staff an idea of what situations they could refer to social work and to help the Social Worker keep official record of referrals. A list of duties (see Appendix) that were within the Social Worker position's scope of practice for both resident and family support was also developed. This was also distributed to staff members in all the facilities to help orient staff further to what benefit a Social Worker provides within LTC. These documents were developed with guidance from the Canadian Association of Social Workers (CASW) document on Social Workers in LTC and an existing social work job description from a LTC facility in NS (see Appendix).

# SOCIAL WORKER PRACTICE AREA

The Social Workers duties within the area of **Resident Support** consisted of Counselling, Palliative Care Support, Grief Support, Personal Directives, Mediation, Financial Support, Transportation, Special Needs; Discharge Planning, Advocacy/Liaison and Planning, Teamwork, Meetings, Identifying other Resources, and Support Groups.

**Residents Support**

- **Counselling:** Individual counselling, emotional support and advocacy; addressing Mental Health concerns such as depression, anxiety, dealing with addictions; supporting adjustment to moving to LTC; supporting adjustment to illness and/or disability
- **Palliative Support:** Individual supportive counselling; providing education and support for end of life planning and legacy building
- **Grief Support:** Resource for residents struggling with death of some loved one
- **Personal Directives:** Provide general education to residents regarding advance care directives, SDM designation, and Power of Attorney questions; support residents in assigning a SDM and determining advanced directives using the personal directive form.
- **Mediation:** Provide mediation and conflict resolution between the resident and family, or between resident and team members.
- **Financial Support**
- **Transportation**
- **Special Needs:** Support not covered under usual resources
- **Be an Advocate to CPP/OAS, Public Trustee**
- **Discharge Planning:** Some residents may have an opportunity to return to community or transfer to another facility (LTC or DCS); Help connect residents with all relevant services before their discharge (e.g. home care, income support, housing, DCS); Be a liaison between these services, the resident, nursing home, and family.
- **Advocate / Liaison:** Act as an advocate / liaison to any community agencies residents use (e.g. mental health, CPP, public trustee); Work with mental health department to advocate for needs of residents as an ongoing project.
- **Teamwork:** Work with interdisciplinary team to coordinate needs, assess, and solve behavioural issues a resident may be experiencing, as well as support well-being for residents (e.g. behavior support consultant, supervisors/managers, OT, PT, Therapeutic Recreation, LPN, RN, CCA, LTCA)
- **Resources:** Connect residents with outside beneficial resources such as Mental Health Services, CNIB, Alzheimer's Society and more

- **Meetings, Support Groups & Educational Presentations:** Be involved in care plan meetings, behavior consultant meetings, and other relevant meetings regarding resident needs/ well-being; Consideration of support groups depending on interest, need, and COVID-19 regulations. Educational presentations for staff or resident educational presentations as required.

The Social Workers duties within the area of **Family Support** area consisted of Counselling, Advocacy, Palliative Support, Grief Support, Personal Directives, Meditation, Identifying Other Resources; Family and SDM Dynamics, Support Groups & Educational Presentations

**Family Support**

- **Counselling:** Individual counselling, emotional support, advocacy; Adjustment to having a family member move to LTC; Dementia support and education; Support families' understanding and managing of resident's mental health; helping with family dynamics
- **Palliative Support:** Provide support to SDM for end-of-life difficult decision making (e.g., stopping dialysis, questioning tube feeds)
- **Grief Support:** Short term support for a family member struggling with the death of a resident; Connections to outside resources, if long term support needed; Ambiguous loss support when their family member has dementia.
- **Personal Directives:** Provide general education to family members regarding advance care directives, SDM designation, and Power of Attorney questions
- **Mediation:** Provide mediation and conflict resolution between the resident and family, or between family and team members; Mediation for conflict between family members; Family/ SDM dynamics; Team needs assistance with figuring out who is SDM or mediating concerns with an SDM
- **Resources:** Connect family members with outside resources (e.g. Mental Health services, CNIB, Alzheimer's Society, VON, Caregivers NS)
- **Support Groups & Educational Presentation:** Education opportunities for families as required; consideration of support groups depending on interest, need, and COVID-19 regulations.


*Staff from Ville Acadienne*

**Staff Support**

Support was offered by the Social Worker to staff managing complex cases as well as providing education on self care to staff, alleviating added pressures during critical staff shortages and heavy work loads to provide emotional support for residents that would otherwise fall on staff's shoulders. Presentations were also given on ethics surrounding residents care and behaviour management as well as support for grief counselling roles.

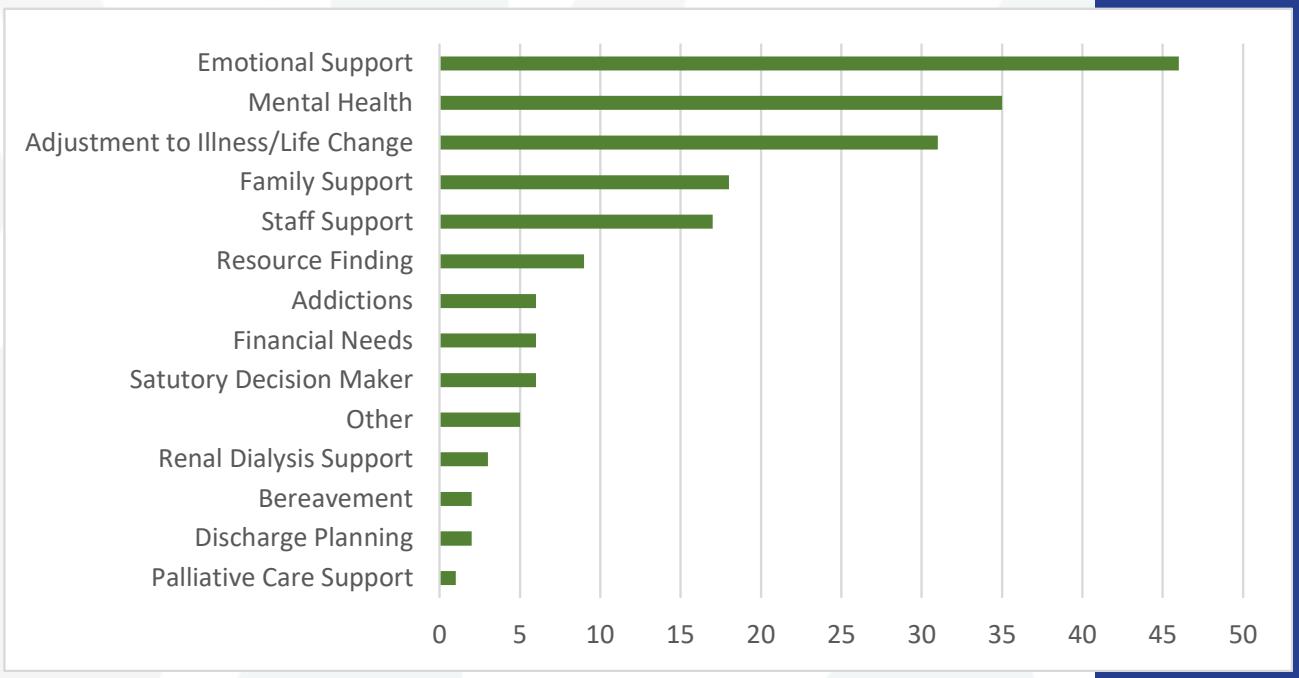
# PROJECT STATISTICS

The project statistics entail the Social Worker duties carried out at each facility, the reasons for referrals, the sources of referrals, as well as the facility source. Also included were depression and anxiety screens and information on the facilities demographics/population and orientation and models of care stats. Other frequent services needed were support for families and statutory decision makers, finances, advocacy and support for staff. Stats are also included on depression and anxiety screens.

Referrals for mental health and emotional support came from all seven facilities. Adjustments to illnesses and life changes referrals also came from every single facility involved in the project. Referrals came from many sources such as the administrators, nursing team, directors of care, physician, managers, business manager, hospital Social Worker, business manager, behaviour resource consultant, therapeutic recreation lead, families and even the residents themselves. Reasons for discontinuance of Social Worker services were usually because the resident passed away but sometimes were due to referral to physicians for more care, discharge of the resident or services no longer needed. There were also a number of behaviour support meetings held regarding topics such as self-care, mental health wellness understanding dementia and mental health issues, and addictions.

**Reason for Referral**

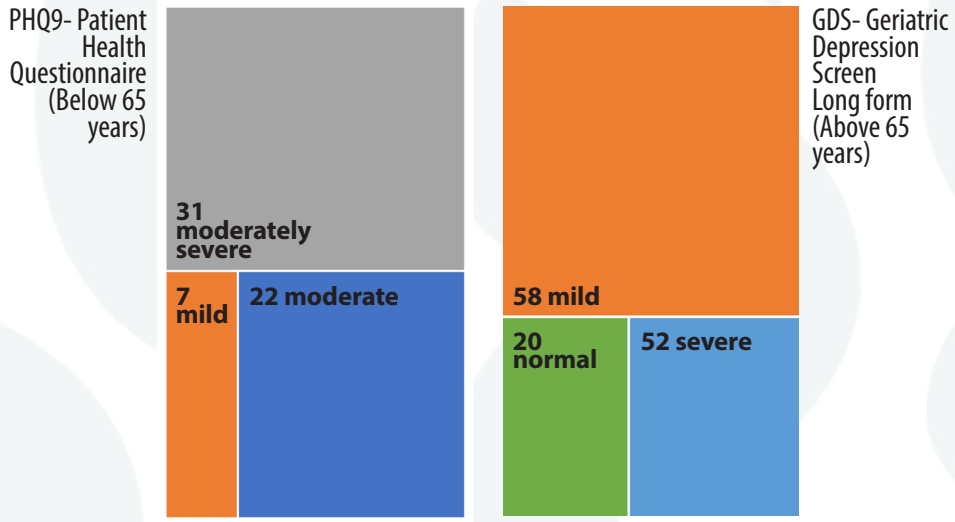
Reasons for referrals were broad in scope and were as varied as the residents and staff themselves. The majority of referrals addressed topics of emotional support, mental health support needs, mental health wellness, illness and life change. Examples of other referral reasons included financial support, family support, bereavement, behavioural management and more. For this report, all reasons for referrals were included (see chart below).



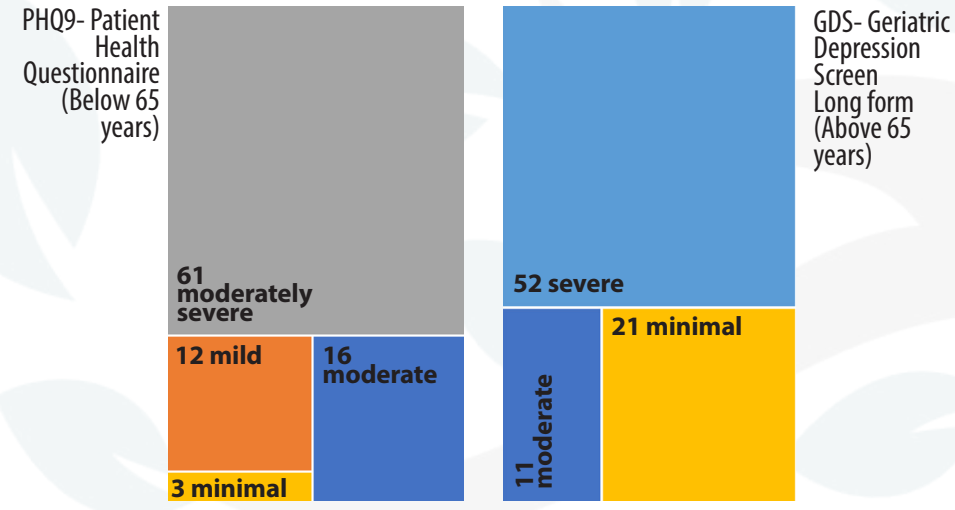
**Depression and Anxiety Screens**

The Social Worker attempted to have depression and anxiety screens on all residents who received emotional support. Those with well known mental health issues, or with cognitive impairment/challenges, did not complete screening. Below is a summary of the screening. The data collected showed that those above 65 years in age had low depression and anxiety scores and the under 65 years population had mixed scores. There was not enough data to determine if depression and anxiety issues were concerning. There would need to be more data collected to have a more accurate picture and assessment.

## Depression Screens:



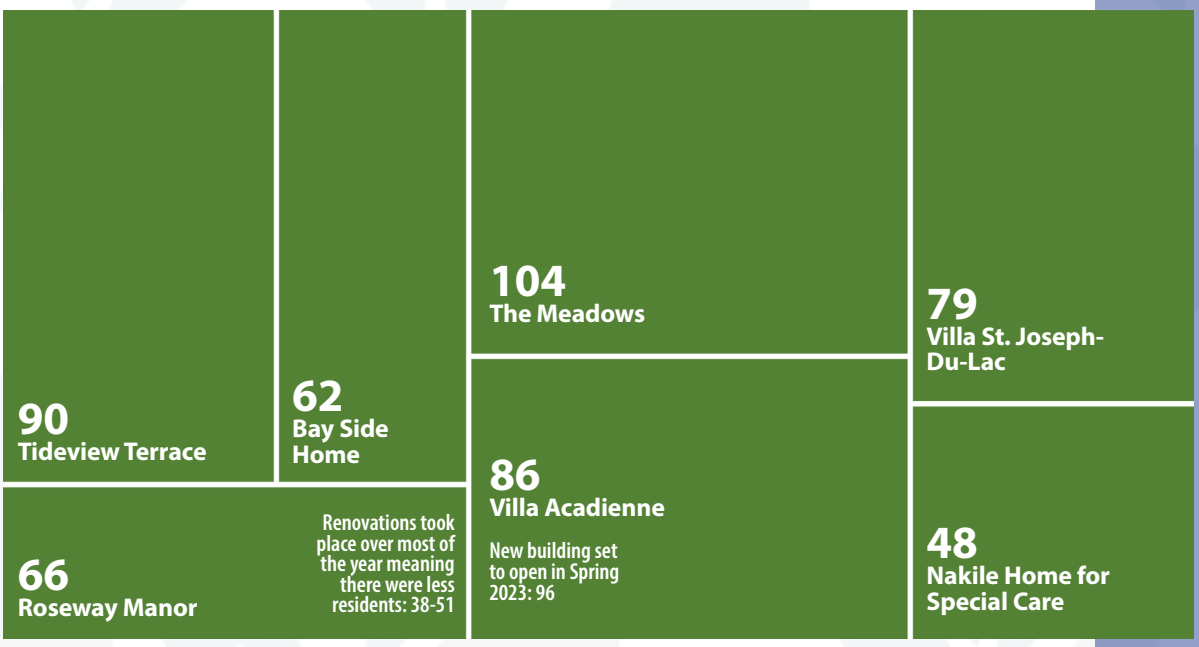

## Anxiety Screens:



**Long-term care Facilities Populations**
The Canadian Association of Social Workers recommend facility staffing levels to be one full time equivalent (FTE) clinically assigned Social Worker for every 60-70 residents. This would usually translate into a case load of 35-45 people.

For the purpose of this project, one Social Worker covered seven nursing homes for a total of 535 residents. This large number for one Social Worker to attend to, in addition to the time taken up to move from home to home make it very difficult to balance the needs of all residents and staff in the collective of all seven homes.

The demographics of the residents served was primarily in the 65 years plus population group but there were 22 referrals from a younger population of under 65 years old. When providing emotional support, the Social Worker also focused on residents without significant cognitive impairment disabilities as information could be retained and give continuity and consistency from session to session. There was also a distinct cultural element with a significant number of residents being of Acadian descent who spoke Acadian French, although several cultures were represented.




**Indirect Care  Statistics - Orientation and Models of Care Stats**
As detailed below, and of note, was the significant amount of time spent by the Social Worker driving to the various LTC facilities: approximately 211 hours. This was necessary due to the geographical distance among the facilities. There was also significant time spent on professional education, (approximately 106 hours) to increase the Social Worker's ability to understand the operations, models of care and culture within each facility and in turn to better support the residents and staff. There was also necessary time spent on writing reports and organizing schedules (approximately 173 hours).

| ACTIVITY | HOURS |
|---|---|
| Orientation to the LTC Facilities | 22.75 |
| Driving Time | 211 |
| Education Time | 106.25 |
| Program Development | 173.35 |
| Seniors Mental Health Project | 6.25 |
| LTC Social Work Group Meetings | 13.3 |


The Meadows

**The Resident Care Coordinator had this to say about the case:**

*"The Social Worker has been working very closely with a resident and his family to assist the resident to return to community living. She has advocated and facilitated meetings with the family, facility staff and outside resources (OT, housing, etc.) to ensure the outside supports are in place and the transition is both smooth and safe for the resident. This has taken a lot of work. It is something that may not have happened without her lead involvement."*

# EXAMPLES OF RESIDENT RELATED WORK

Residents throughout the seven facilities communicated that they greatly valued and appreciated the opportunity to have emotional support provided by a Social Worker, someone dedicated to listening to their concerns and needs, which in turn helped them cope more positively and sooner with life in long-term care. This was the focus area where the Social Worker spent the majority of her time. Staff advised that they felt residents needed an outside ear who could listen to their issues and offer a nonbiased perspective. They confirmed that the Social Worker role filled in gaps for mental health support.

**The following gives some specific examples:**

- At one LTC facility the Social Worker was able to work with a resident as well as his family, and staff to facilitate a successful discharge from the home to community assisted living.
- The Social Worker worked with another individual on discharge planning. Lack of housing in the community, was a significant barrier. The Social Worker was able to work with the team on care planning which resulted in establishing reasonable objectives in place for the resident to work towards her goal of eventually moving out. A plan is now in place for when the resources will become available.
- The Social Worker was able to work with a resident's friends and family to successfully apply for the resident's financial public trustee application. This included meeting with the residents' friend who had been helping with their finances, multiple phone calls, and the actual physical application that was written and sent to public trustee.
- The Social Worker was able to meet with four family groups to help support them in grief, loss, and self-care resources. These families were caregivers for the residents and were struggling with figuring out how to continue to offer support as well as move on with their lives.
- Support was also provided for Statutory Decision Maker concerns. The physicians were having difficulty contacting and receiving directions from the SDM on one case. The Social Worker was able to investigate the legal avenue from public trustee and help write a letter to the SDM to advise of expectations. The physician felt that it was essential to have the support of a Social Worker on this complex case. In another case the Social Worker was able to meet with a resident and identify who they wanted their SDM to be, as well as navigating the actual legal documents to assist management.
- The Social Worker was also able to participate in an innovative process where a targeted admission for a complex case was completed. These meetings were organized by the Continuing Care Access and Flow Manager. All relevant allied health workers from the hospital and LTC participated. This process was useful and helped give everyone more information to be better equipped to prepare for a successful admission.

*Windsor Elms*

# COMPARISON OF LTC SOCIAL WORKER ROLES IN NOVA SCOTIA

According to the Canadian Association of Social Workers, the primary mandate of Social Workers within long-term care is to advocate on behalf of residents and their families. Their focus is on the social and emotional impact of physical and mental impairment, preservation and enhancement of physical and social functioning and the promotion of physical and mental health towards an optimal quality of life. Emphasis is on building upon existing strengths, enhancing adaptations and modifying risks that interfere with optimal quality of life.

Information was collected from 13 LTC facilities throughout Nova Scotia to gain information on the scope and breath of this role within their organizations. This data is not exhaustive and there are likely more facilities with the Social Worker position. Some of these workers did not provide descriptions of their role or specify whether they were in a full time or a part time role. Our Social Worker took part in a meeting with many of these Social Workers and from this discussion it was determined that most roles were similar across the province.

The following represents the scope of responsibilities and variances in duties outlined by the 13 long-term care facilities with Social Worker positions that were interviewed:

- Facilitates Admissions Process including facility tours. (e.g., completes and sends paperwork, communicates with residents and/or family, orientates residents, declares vacancies and coordinates transfers, completes lease signing with resident or power of attorney when necessary.)
- First Person of Contact for residents and families- resources for identifying SDM process
- Financial & Legal Issues Support for Residents; including applying for Public Trustee if needed
- Resource for Advanced Care Planning
- Serves as a Resource for Residents and their Families, advocating with internal and community contacts; Resident need for new devices/ other resources
- Resource for Interdisciplinary Team
- Communications with Residents on social and emotional concerns
- Provides Conflict Resolution
- Addresses Resident Adjustment difficulties and navigating back to Independent Living
- Organize and hosts Family Council and Resident Council Meetings
- Provides Counselling to Residents in individual and group sessions; provides one to one support to resident and/or families
- Oversees Resident Behaviourial Challenges and take spart in external consultations
- Provides one to one support to resident and/or families (e.g., discharge information, providing transitional counseling)
- Collaborates with other Professionals to evaluate patients' mental health, medical or physical condition and to assess clients' needs
- Participates in Care Conferencing, sometimes in the Chair role
- Facilitates the completion of documents in accordance with the Personal Directives Act

- Primarily Work with Families
- Working Primarily with Younger Residents
- Legal Issues – such as applying for legal aid and other issues, such as navigating divorce
- Attends Doctor's Rounds

There were many similarities among the focus of the Social Worker role but also some differences. The roles focused on admissions work, financial assistance for residents, and advanced care directives/ SDMs. There was a counselling component, but the Social Workers advised that this was a limited part of their position. Many of the Social Workers participated in and facilitated resident and staff meetings and care conferences. They played a large role in working with the Behaviour Resource Consultant.

The Resident and Family Services Coordinator at three Shannex facilities was unique in that it was filled by an RN and the role focuses on supporting families through the admission process and working with the Behaviour Consultant and staff on residents that benefit from this support.

These LTC Social Workers explained that this role is not specifically funded for LTC in Nova Scotia so the homes they work for used their existing budgets to fund social work positions. All the Social Workers have witnessed benefit to their programs and from their professional lens, strongly support and believe that all nursing homes should have the ability to have a Social Worker on staff.

*Villa Saint Joseph*

# FEEDBACK FROM STAFF AND RESIDENT EXPERIENCE SURVEYS

*Staff appreciated that the Social Worker provided mental health/ emotional support for residents, giving residents expanded time to discuss and cope with being in LTC.*

**Team Members**

The Social Worker collected feedback from staff members who held many different positions within the participating LTC facilities. Twenty-five responses were received in total. This information has been collected in a chart that is shared in the appendix.

All feedback for the position was very supportive as staff in the different LTC facilities confirmed they valued having the Social Worker as part of their team. Staff appreciated that the Social Worker provided mental health/emotional support for residents, giving residents expanded time to discuss and cope with being in LTC; discharge planning for residents, education and support for staff, financial support for residents, support and direction with residents with complex challenges, family/caregiver support, resource information, resource and advocacy to the physician for resident concerns and bringing to the care teams, an unique viewpoint not currently present in these nursing homes to help with ethical issues. They also appreciated that the Social Worker attended behaviour support meetings with the Behavior Resource Consultant and was able to provide unique insight to staff from a new and insightful perspective, attended care plan meetings, and helped with complicated SDM issues.

Many of the staff felt that two to three visits a month for each facility was not enough. Reasons presented were that this was not adequate time at each facility to get a good feel for the bigger picture of what was going on for residents and within the facility, that residents needed visits more often for effective mental health support, and that it was difficult to keep up continuity of discussions and care plans. It was noted that if the Social Worker visited more often, this would have facilitated being involved in more timely discussions as the issues arose, rather than delayed input and feedback. It was also noted that the pilot project was not long enough to fulfill its full potential. The reasons given were that many resident issues could not be effectively dealt with in that short a time. It also took time for the staff to get to know what a Social Worker could do, and many felt they were only starting to fully understand the position just as the project was being completed. Many felt that a Social Worker should be present in all the LTC facilities permanently as they found the role invaluable and indicated they will miss the support when it is over.

The Social Worker received feedback from three physicians who also felt the social work role was vital and appreciated the ability to discuss complicated cases, as well as support on various issues. One physician advised that "the perspectives of a non-medical (MD/Nursing) health care provider" were really appreciated, making comments such as, "Many residents are often complex and their needs are only partly medical."

A physician also advised that having the Social Worker offer "*support for staff in this challenging time of staff shortage and the challenge of trying to meet families' expectations,*" was helpful. She appreciated a new perspective and *"having someone to discuss difficult ethical issues with as the Social Worker is someone with an objective view of various situations."* Another physician said they appreciated the Social Worker working with a "*resident who really should be living in a different setting, to explore options and consider supports for a transition to a different living arrangement.*" She believes and commented that *"social work is an absolutely necessary position in long-term care."*

**Residents**

Near the end of the project, the Social Worker collected feedback from 12 residents. These tended to be the residents the Social Worker saw over the length of the project, long term for emotional support. In the survey conducted, residents either strongly agreed or agreed that the innovative pilot with the new Social Worker position was a positive experience and that a valuable resource was provided. Comment was made that the program should be continued and that it made a great difference in the lives of many residents.

The role of the Social Worker and services provided were greatly valued by the residents surveyed and were often described as vital. These roles included listening to residents' concerns in confidence and with respect, while offering good, neutral advice; helping with financial concerns, addressing mental health concerns, supporting residents to have confidence and giving relevant and timely information needed to make better informed decisions, providing access to support and resources to adjust to significant life changes and issues, providing a perspective that addresses ethics and facilitating ethical decision making with professional experience and expertise, reduced isolation and identifying and offering resources that support the strengthening of mental health wellness.

Gaps identified included need for services to continue; need for position to be available at each facility and not to bf shared among multiple facilities; discontinuation was felt to be a loss; some indicated they were falling  between the cracks before this position was established;

The general theme was residents were thankful for someone who spent designated time listening to them and offering feedback. Four people out of the 12 respondents felt that the Social Worker should have visited them more often for emotional support. However, most residents felt the caseload the Social Worker covered was too large and expressed concern that the Social Worker had too many demands to spend enough time with them.

One resident commented many times, *"Don't let us fall through the cracks!"* Having support for mental health needs was new and important to these residents. Many came to rely on it and knowing they were losing it was very hard for them emotionally and a loss. It is important to these residents that the pilot project results be taken seriously, and a Social Worker role be considered for permanent funding.

The residents communicated that the Social Worker made a substantial impact establishing trust, confidence, support for residents making major life decisions and facing great challenges. She became a most trusted navigator of critical services and necessary listening ear.

*Bayside Home*

# UNANTICIPATED OUTCOMES OF THE PROJECT

For the duration of the Social Worker Innovation Pilot most of the LTC facilities participating were in a staffing crisis and in the midst of the COVID-19 pandemic. Naturally this was very challenging, impacting collaborations, communications, and interactions. But more importantly, it also clearly revealed the advantages the addition of a Social Worker could bring, especially in today's environment. The Social Worker could take on some of the duties currently assigned to others, in particular the already overworked managers. In one of the feedback forms from a director of care it was stated that at first it was hard to visualize the social work role as they felt *"the list of possible tasks the Social Worker would take on appeared to be things that typically fell on their desk."* However, after the opportunity to work with the Social Worker it was realized that these tasks were effectively placed in her capable hands and they were able to invest much more time and specific knowledge into many of these topic. The director of care also stated, *"Having the Social Worker be available to manage those complex cases was so helpful to my role."*

While other staff didn't have time to sit with residents or the ability to provide professional emotional support for long periods of time, the Social Worker could do this. The Social Worker was also able to provide education on self-care to staff to help them with their own coping methods. During a time when there is a lack of front-line staff in LTC an allied health role such as social work is of real benefit as the job is so broad and allows the person to support residents, staff, families and even management.

The Social Worker provided presentations to staff at a few of the LTC facilities on Self-Care and Mental Wellness after it was identified that staff were struggling with their own coping after working through so many challenges throughout the pandemic. The Social Worker also did presentations with the Behaviour Resource Consultant at some of the LTC facilities on Understanding Dementia and Mental Health Behaviours and another presentation on Addictions. These presentations were designed and given after it was identified by management and other staff that there was some education lacking for staff in these areas. These presentations fit well in the "wheelhouse" of a Social Worker, offering the staff and the Behaviour Support Consultant a valuable but different ethical perspective, which focused on the self-determination of individual residents.

*But importantly, it also clearly revealed the advantages the addition of a Social Worker could bring, especially in today's environment.*

*The Behaviour Resource Consultant also found it beneficial to have a Social Worker support the organization of meetings as well as offer perspective on the social and environmental factors that other staff could easily miss. It was appreciated the Social Workers provided a holistic view on all cases and the ability to bring in outside resources for complex cases.*

# PARTNERSHIPS

Several important partnerships were established that strengthened the Social Worker's role and capacity to serve residents, families, and staff. Of special note was collaboration with a Nova Scotia Health's Behaviour Resource Consultant and the Mental Health and Addictions Program. The partnership with the seven facilities predates this project, yet the project did support its continued growth and demonstrated that sharing of services and collaboration between facilities is possible.

**Behaviour Resource Consultant**

The Social Worker was able to develop a partnership with the Behaviour Resource Consultant, who works with all the LTC facilities in Yarmouth, Digby, and Shelburne counties, as well as with the local hospitals and the community. In this partnership the Social Worker worked with collaboratively to take part in the regular Behaviour Support Meetings held monthly at the LTC facilities. These meetings provided the opportunity for staff members to discuss resident behavioural issues cases. In turn, it also gave a setting where the Social Worker had opportunity contribute additional and appropriate information. Because the Social Worker was in the LTC facilities more frequently than the Behaviour Support Worker, they were able to follow up on recommendations made during meetings and provide updates to the Behaviour Consultant on how residents and staff were coping. On several occasions, residents who were struggling to cope with mental health wellness would also be discussed with the outcome being the Social Worker was given new referrals.

The Social Worker found having a colleague in the area who understood the dynamics and culture at the LTC facilities valuable. It facilitated collaboration but also gave the chance to debrief and brainstorm. Due to the Social Worker role being a brand new one in this region, having someone with inside knowledge and understanding of the systems resulted in greater efficiency. Without this resource, there would have been extra time spent trying to learn those things independently.

The Social Worker and Behaviour Resource Consultant worked well together to create two education sessions that were delivered collaboratively to two LTC facilities. These sessions were established based on requests from management and staff at the facilities who found staff were struggling in certain areas. The two sessions were: *"Understanding Dementia and Mental Health Behaviours"* and *"Addictions."*

The Behaviour Resource Consultant also found it beneficial to have a Social Worker support the organization of meetings as well as offer perspective on the social and environmental factors that other staff could easily miss. It was appreciated the Social Workers provided a holistic view on all cases and the ability to bring in outside resources for complex cases.

**Nova Scotia Health - Mental Health and Addictions Program**

When the pilot program began, the Social Worker reached out to the Mental Health manager for the counties of Yarmouth, Digby, and Shelburne. They had been consulted when the LTC facilities initially applied for funding for a Social Worker and consultation meetings were organized to start planning for a Seniors Mental Health Team. This was something identified as very useful but that has been lacking in this area for years. The LTC Social Worker Pilot Project added incentive for Mental Health to actively initiate this venture. Unfortunately, roadblocks came up over the process, so this has not moved along as anticipated or desired.

The Mental Health manager also asked for a consultation team to be developed for the LTC Social Worker throughout the project. The team met weekly and gradually tapered off, based on need. The clinical team lead (psychologist) for the area and one of the community mental health nurses comprised the team. This was a regular opportunity for the Social Worker to inquire about residents' mental health needs and the team offered resources and information based on their training and experience. This was invaluable to the Social Worker as their work background was not in the area of being a therapist.

This partnership revealed the significant barriers that exist for LTC residents in accessing mental health services.

**See the section Barriers where this topic is explored further.*

# BARRIERS TO SERVICE DELIVERY

### Time Limitations

The first significant barrier encountered throughout the pilot was time limitations. Due to the vast geographical area being covered throughout the three counties, the Social Worker was only able to get to each LTC facility two-three times per month. This was problematic because during each new visit, the Social Worker needed to spend  time catching up on what happened while they were absent. This steered the Social Worker to spend the most time on emotional support concerns as this was something that could be supported biweekly. However, it became more difficult to support, for example, discharge planning, SDM concerns, or family support, as each require timely follow up. In those cases, the Social Worker would follow up by email or phone but obviously this did not have the same timeliness or efficiency. The Social Worker relied on support of colleagues at the LTC facilities to do some of the "on the ground" work when they were absent.

Covering seven LTC facilities over three counties meant the Social Worker was traveling often (approximately 211 hours over the course of the year). This negatively impacted the time that could have been spent with residents or on other work. Had all of the LTC facilities involved had electronic charting available this would have added to efficiency and effectiveness in collecting useful information and files. If the Social Worker could have accessed notes and information through mobile means, it would have been easier for them to remain updated and to keep the team updated and informed on those more complicated cases. For example, discharge planning, SDM concerns, or family support.

### COVID-19 and Other Respiratory Illnesses

Living in LTC can be isolating in general but this isolation can be exacerbated by restrictions imposed in response to respiratory illness breakouts. Many LTC residents were familiar with lockdowns when there were influenza outbreaks in the past but these do not often last long. COVID-19 has brought about an increase and severity to outbreaks that impacted resident mental health. Throughout the course of this position all the LTC facilities the Social Worker visited struggled with COVID-19 and other respiratory illness outbreaks. Due to the wide range of homes visited by the Social Worker and the amount of vulnerable people, the Social Worker did not visit with residents who were experiencing symptoms. Unfortunately, this is when resident level of loneliness was most likely at its highest, due to being isolated in their rooms during pandemic cases and outbreaks. Because of the pandemic situation and adherence to public health directives, residents were not able to be seen on every visit to the facility, impacting the Social Worker's time spent with them. The pandemic circumstances had a significant impact on the achievement of several goals and intended procedures.

### Communication

The pandemic also had an impact on communication. The Social Worker needed to speak regularly with managers to keep updated on various concerns or to organize education sessions. Especially in times of outbreak, the follow up was limited. Managers tended to be very busy filling in other roles as needed during the critical nature of the pandemic to LTC. Serious staff shortages also naturally impacted the flow of communication.

Another factor was that this being a new role, there was no process in place for reporting. The Social Worker wrote notes in the medical charts and spoke with staff that were present for updates. As the position progressed, the Social Worker discovered there were other methods of communication between team members such communication books or other documents. These were not utilized to their potential as the Social Worker was not aware of them for most of the position. The Social Worker would have ideally had an established reporting system that included all team members and offered an opportunity to discuss and learn from each other. The reason this occurred could have been a misunderstanding of the Social Worker's role and not understanding that the component of teamwork is essential and inherent to success.

As stated in the time limitation section the Social Worker would have benefited from electronic charting to be able to communicate with the team and do more work on resident files when off site. The time limitations also impacted communication as it was difficult for the Social Worker to keep informed about cases and the changes day to day. Being spread across seven different sites meant that the Social Worker had to take time to learn who each team was and struggled to feel connected to the staff at the various sites as this was a large task, given the number of staff

involved in all facilities. The lack of strong communication procedures impacted the Social Worker's ability to have a big picture understanding of resident cases and the ability to plan interventions.

The management teams respected the Social Worker's expertise and did not micromanage. This was greatly appreciated. Social Workers work best in collaboration with others and bringing everyone's strengths to the case and a stronger commitment to this approach would naturally evolve should the position be established.

**Accessing Mental Health Services**

Traditionally, it has been difficult for residents to access mental health support in LTC facilities. One of the main responsibilities of the Social Worker was to develop a way to connect mental health support and resources to LTC residents. As explained in the partnership section, the Social Worker met with representatives from Mental Health and Addictions to consult about residents who needed extra support. During these conversations the Social Worker was able to discuss programming on a larger scale. Although the Seniors Mental Health Team (a team that will be developed by Mental Health and Addictions) will be established in the future, the services that would be offered do not align with what long-term care residents require for supports.

After completing assessments with residents and working with them for a length of time, it became clear that the traditional mental health and addictions services were not aligned to what LTC residents usually require. Mental Health services currently offered are the support offered by a therapist either in person at the Mental Health and Addictions clinic or virtually through Zoom or by phone.

The main issue is the concerns experienced by LTC residents are not what Mental Health and Addictions services typically offer. Mental Health and Addictions offer one-on-one therapy where clients are expected to work with a therapist on goals that will help them alleviate their mental health concerns. Clients need to meet criteria for services which include a moderate to several mental health condition/diagnosis. It requires homework and follow through on behalf of the client. Mental Health and Addictions also have a psychiatrist team that assists with diagnosed conditions that require medication support. As there is not a specific team that focuses on seniors they tend to focus on younger populations. A mental health team devoted to seniors' specific needs is something Mental Health and Addictions is looking to develop in future.

Many of the residents served during this project did not want to have to travel to appointments due to mobility or cost concerns. Many residents also prefer to meet face-to-face, as many are uncomfortable with technology and there is a better connection established when meeting in person. These are not surprising nor unreasonable concerns.

Another significant concern is that impact many LTC residents is that they often may not be able to engage in a goal-oriented model of therapy due to various cognitive issues. Therefore, they are unable to benefit from a traditional therapy process.

What residents are looking for and deserve is someone unbiased to discuss their day-to-day issues with and who can offer balanced, informed perspective and suggestions. This helps them with their coping skills, and through the many changes they experience moving into LTC as well as the challenges they continue to encounter. LTC residents would benefit greatly from on-going supportive counselling, which Mental Health and Addictions do not offer. This is what the Social Worker did while working in this role and it was deemed helpful by residents. Staff also commented that having someone to talk to who is outside of the day-to-day interactions really helped residents with their ability to cope.

A meaningful example is that many younger residents struggle with living in LTC due to feelings that they do not fit in with the other residents who are usually much older. There are significant generational differences. The Social Worker was able to meet with younger residents periodically and offer them the space to talk about their experiences. This helped them release these difficult emotions so that these emotions did not escalate and fuel behaviour reactions with staff.

Another good example is that residents struggled with their loss of independence and living in an environment where they feel they have lost most control in their lives. Again, the Social Worker was able to listen and help them release these difficult emotions. The Social Worker was also able to support the residents by helping them identify positive things in their life and work on changes to alleviate negativity.

*What residents are looking for is someone unbiased that they can discuss their day-to-day issues with who can offer balanced, informed perspective and suggestions. This can help them with their coping skills, and through all the changes they experience moving into LTC as well as the challenges they continue to encounter.*

# MISSED OPPORTUNITIES

**Group Sessions**

At the start of the project the Social Worker had intended to organize group sessions with residents and family members to assist them in various aspects of their mental health. Three groups were considered. One was that the Social Worker could meet with residents to provide regular sessions on guided imagery and deep breathing. Another idea was to have a group specific for the younger residents (or young at heart) in the nursing homes as an opportunity for them to talk about coping in a nursing home, managing transitions well, and other mental health concerns. The third idea was to meet with family members in a support group format to assist them in self-care as well as for grief and loss resources.

Although very worthwhile, unfortunately these ideas, did not come to fruition. As the Social Worker was starting to plan these groups, COVID-19 outbreaks happened at many of the LTC facilities. When outbreak restrictions are in effect residents from different units are not able to join together in common areas. It was understood that participants would be from all over the facilities in order to have a sufficient number of people, so the group planning was put on hold. When it was considered again the Social Worker had to acknowledge the lack of time left in the pilot project to be able to action these group meetings. The Social Worker relied on staff members (mainly managers) at the LTC facilities to identify people that needed support. Many needed extra support during COVID-19 outbreaks, which also affected the Social Worker decision to not go ahead with the group planning. The limited time spent at each LTC facility also impacted this decision as only being at the home two to three times a month altered the time available to plan these groups as well as run them. It was decided that the one-on-one time with residents and other meetings were top priorities. Group meetings would have proven valuable had there been more time and resources.

*It was decided that the one-on-one time with residents and other meetings were top priorities. Group meetings would have proven valuable had there been more time and resources.*

*The Meadows*

*Social Workers provide invaluable support to residents in LTC and their quality of life by "influencing the social determinants of health that are relevant to the resident*

# RECOMMENDATIONS

The following outlines constructive assessment of the innovation pilot and recommendations pertaining to important elements of the effectiveness of the Social Worker role within long-term care.

**Social Work in LTC**

The feedback for the pilot project was very positive and supports that this role continue and that funding can be secured. It is an investment in the transformation and path forward of long-term care in our province.

Social Workers provide invaluable support to residents in LTC and their quality of life by *"influencing the social determinants of health that are relevant to the resident by intervening with the resident, the family, other residents and staff within the facility, and also the broader community. Emphasis is on building on existing strengths, modifying risks and seeking solutions to issues that interfere with optimal quality of life."* (CASW, 2002). This mirrors many LTC facility vision statements and is a perfect fit into the Eden Alternative Philosophy that many LTC facilities in NS abide by or are heading towards. *"The Eden Alternative is a philosophy of care promoting a "quality of life" for our elders. It helps to bring about deep cultural change and supports values and behaviours which focus on person-centered care. The Eden Alternative helps organizations transform from an institutional model to a human habitat model of care where individuals can live a full life."* (EdenCan.com).

The Canadian Association of Social Workers (CASW) recommends that Social Workers in LTC be engaged in the following activities: "admission preparation, screening, assessment, counselling, practical assistance, identifying, locating and/or arranging resources, internal and external advocacy, education, group work, and discharge planning." All of these duties are things that the Social Worker did during this project and/or are being completed by other Social Workers working in LTC in NS. The seven facilities involved in the project strongly urge that in further versions of this role the above duties remain focal to the position.

**Yarmouth**
**231 Residents**
**Meadowns, Villa St. Joseph, Nakile**

**Digby**
**176 Residents (186 when the new Villa Acadienne opens)**
**Villa Acadienne, Tideview Terrace**

**Shelburne**
**164 Residents**
**Bay Side Home, Roseway Manor, Surf Lodge**

### Coverage Area and Caseload Numbers

The pilot project covered a very large geographical area which spanned 200km. The Social Worker lived in Yarmouth County, meaning that they were somewhat in the middle of the area. However, no matter where the location, hours would be spent traveling that could have been spent on other work items. Also having seven homes to cover meant the Social Worker had the potential clients of 535 clients. This did not include the large number of staff and family members who also benefit from the services. With a smaller caseload the Social Worker would have had more had more time to expand the duties she was able to participate in and fully flesh out what the role could do.

The Canadian Association of Social Workers (CASW) recommends the following regarding staffing levels: ***"a facility requires one full-time equivalent (FTE) clinically assigned Social Worker for every 60-70 residents. This person would usually have an active monthly caseload of 35-40 people."*** This is relevant when considering future staffing of a Social Worker in LTC.

It is recommended that there is funding for one Social Worker per LTC facility, based on the CASW ratio guideline.

Another thing to consider is the Residential Care Facilities (RCF) in the area and whether these should be included in the Social Worker's caseload. There are four in Yarmouth, Digby, and Shelburne counties holding a total of 63 residents. That would be eight residents in Yarmouth County, 14 in Shelburne County, and 41 in Digby County (where there are two RCF facilities). These residents would likely also benefit from social work support as they are dealing with a similar state of transition. RCF families and staff would also require support, similar to those in LTC.

### Social Work Duties

The position would be designed and adapted according to lessons learned from the pilot project. Due to the time constraints and other factors discussed above, the Social Worker focused on emotional support. However, with more time to focus on individual homes and more residents per home, the Social Worker could have done more group work, given more family support, and offered more in depth resident work on resources, discharge planning, or care planning. Please see the Missed Opportunities section for more examples of expanded duties the Social Worker could do. Below are more details of some options that could be included in a Social Worker caseload. To make the Social Work role reach its full success potential and maximum positive impact either caseloads would need to be reduced or duties streamlined. The LTC facility needs should be examined and the role streamlined for the greatest results.

### Admissions

Throughout the position the Social Worker was aware that new admissions were often challenging for management and staff. A Social Worker could assist with connecting relevant professionals from the hospital or community and families with LTC staff to allow for much more effective transitions. Admissions organization was an administrative duty at all the LTC facilities of the project. There were examples of cases the Social Worker identified whereby if she had an opportunity to bring the teams together then there would have been more successful admissions. In these cases, there appeared to be missing information in the reports that were sent to the LTC facilities. If the Social Worker had an opportunity to work on these cases, the LTC facilities could have been better prepared.

A Social Worker in a role focused on admissions could also assist with discharges. Right now, there is no one designated in the LTC facilities in this area to assist with this important duty. Although discharge from LTC is rare, it can and does happen and without someone with the skills and knowledge of the needs of residents for

the transition, it is difficult to get that completed. The Social Worker skill set is well versed in investigating resources and discovering what is needed for individual residents on this journey.

### Family Dynamics

Many of the complex family dynamics are also taken care of by managers or directors of care. This is something a Social Worker would be very successful in handling and would be an efficient alignment of skills, resources and time management.

### Advanced Care Directives

A Social Worker could also assist in advanced care directives. The Social Worker saw many examples where resident advanced care plans needed attention. It is preferred that residents come to LTC with advanced care directives all planned out but in reality, this is often not the case. Management and RN staff often do not have time within their caseloads to address these matters until a situation comes up when it is absolutely necessary. Social Workers come with a set of skills that could manage these difficult conversations with residents and families and support them to be well prepared to choose appropriate statutory decision makers when the time comes. The Social Worker could also direct them in their questions about financial management of their affairs (e.g. how to get a POA). These are all duties well suited to a Social Worker's expertise, education, and experience.

### Care Planning and Behaviour Management

Care planning and behaviour management is something that many of the LTC facilities are struggling with due to staff shortages and the steady increase of complex cases. A Social Worker could work with the Behaviour Consultant to assist in organizing behaviour support meetings, making assessments and analysis as well as and following up on the plans made in the meeting. The Social Worker would also be effective in helping with the creation of care plans.


*Villa Acadienne*

# CONCLUSION

Despite the challenges associated with working through a pandemic and this valuable resource being stretched across seven facilities in a large geographical area, the social work role was very well received in the LTC facilities. The Social Worker's impact and broad scope of contributions were appreciated by residents and families and many staff have commented that it will be a huge loss to no longer have the role available.

Knowing this role was temporary was a significant factor in being able to delve deep into what the role could do to fully maximize its potential. Some duties that could have been taken over by the Social Worker if the role had been permanent were kept by the individual doing the role for consistency sake. That meant the Social Worker role was limited to entirely new duties. The Social Worker also felt that there was a large learning curve in developing a new role. It took time to see what worked for each LTC facility and what could be done within the restrictions of the project.

As the project drew to a close the Social Worker had to step back on some duties in order to ensure there were no loose ends at the end of the project. All of these factors were difficult and made it feel like the project just scratched the surface to prove the scope of what a Social Worker could really do in LTC.

As the Social Worker progressed to the end of this project many staff and residents commented on how fast the year had gone by. Many staff members had not previously worked with a Social Worker and, therefore, were not aware of the scope and impact of the role prior to the project. They commented that it took them months to fully appreciate and understand what a Social Worker could do and to utilize the role properly but as the role became settled and the growing pains were addressed, it proved to be both effective and impactful.

*Many staff members commented that it took them months to fully appreciate and understand what a Social Worker could do and to utilize the role properly but as the role became settled and the growing pains addressed, it provide to be both effective and impactful.*

# APPENDIX

1 -- REFERRAL FORM
2 -- LONG-TERM CARE SOCIAL WORKER DUTIES CHART
3 -- PROJECT STATISTICS
4 -- REASON FOR REFERRAL CHART
5 -- DEPRESSION AND ANXIETY SCREENING STATISTICS
6 -- FEEDBACK FROM RESIDENTS CHART

## APPENDIX 1 -- REFERRAL FORM

**SOCIAL WORK REFERRAL PILOT PROGRAM: JAN. 2022 - JAN. 2023**

Send referrals to Samantha Mason

samantha.mason@nshealth.ca

Questions: 902-247-4617

| Location | Unit & Room Number |
|---|---|
| ☐ The Meadows | |
| ☐ Villa Saint-Joseph du Lac | |
| ☐ Nakile Home for Special Care | |
| ☐ Villa Acadienne | |
| ☐ Tideview Terrace | |
| ☐ Bay Side Home | |
| ☐ Roseway Manor | |

**Resident Name:**_____ **Relevant Family Members & Contact:**

**DOB:** _____ _____

**Brief Medical History/ Relevant Diagnoses:** _____

_____

_____

**Reason for Referral:**

☐ Mental Health ☐ Adjustment to Illness/Life Change ☐ Addictions ☐ Emotional Support
☐ Financial Issue ☐ Palliative Support ☐ Family Support ☐ Bereavement ☐ Staff Support
☐ Discharge Planning ☐ Dementia Support ☐ Family/SDM Dynamics ☐ Resources Needed
☐ Other: _____

**Specific Details of the Referral:** _____

_____

_____

_____

_____

_____

_____

**Person making referral:** _____

**Date:** _____

Is resident or family aware of the social work referral?

☐ Yes ☐ No

## APPENDIX 2 -- LONG-TERM CARE Social Worker DUTIES

| Resident support | Family Support |
|---|---|
| Individual counselling, emotional support, advocacy<br>-Mental Health concerns (e.g. depression, anxiety, dealing with addiction)<br>-Adjustment to moving to LTC<br>-Adjustment to illness/ disability | Individual counselling, emotional support, advocacy<br>-Adjustment to having a family member move to LTC.<br>-Dementia support and education<br>-Support families' understanding and managing of resident's mental health<br>-Family dynamics |
| Resources<br>-Connect residents with outside resources (e.g. mental health services, CNIB, Alzheimer's Society) | Resources<br>-Connect family members with outside resources (e.g. mental health services, CNIB, Alzheimer's Society, VON, Caregivers NS) |
| Palliative support<br>-Individual supportive counselling<br>-Provide education/ support for end-of-life planning<br>-Legacy building | Palliative support<br>-Grief and loss<br>-Provide support to SDM for end-of-life difficult decision making (e.g. stopping dialysis, questioning tube feeds) |
| Grief support<br>-Resident struggling with death of someone | Grief support<br>-Short term support for a family member struggling with the death of a resident. Will connect them to outside resources, if long term support needed.<br>-Ambiguous loss support when their family member has dementia. |
| Personal Directives<br>-Provide general education to residents regarding advance care directives, SDM designation, and Power of Attorney questions.<br>-Support residents in assigning a SDM and determining advanced directives using the personal directive form. | Personal Directives<br>-Provide general education to family members regarding advance care directives, SDM designation, and Power of Attorney questions. |
| Mediation<br>-Provide mediation and conflict resolution between the resident and family, or between resident and team members. | Mediation<br>-Provide mediation and conflict resolution between the resident and family, or between family and team members. |

| | |
|---|---|
| Financial Support<br>-Transportation<br>-Special needs not covered under usual resources<br>-Be an advocate to CPP/OAS, public trustee | Family/ SDM dynamics<br>-Team needs assistance with figuring out who is SDM or mediating concerns with an SDM<br>-Mediation for conflict between family members. |
| Discharge Planning<br>-Some residents may have an opportunity to return to community or transfer to another facility (LTC or DCS).<br>-Help connect residents with all relevant services before their discharge (e.g. home care, income support, housing, DCS)<br>-Be a liaison between these services, the resident, nursing home, and family. | |
| Advocate / Liaison<br>-Act as an advocate / liaison to any community agencies residents use (e.g. mental health, CPP, public trustee)<br>-Work with mental health department to advocate for needs of residents as an ongoing project. | |
| Teamwork<br>-Work with interdisciplinary team to coordinate needs, assess, and solve behavioural issues a resident may be experiencing, as well as support well-being for residents (e.g. behavior support consultant, supervisors/managers, OT, PT, Recreation, LPN, RN, CCA, LTCA) | |
| Meetings<br>-Be involved in care plan meetings, behavior consultant meetings, and other relevant meetings regarding resident needs/ well-being. | |
| Support Groups<br>-Will consider support groups depending on interest, need, and Covid regulations. | Support Groups<br>-Will consider support groups depending on interest, need, and Covid regulations. |
| Educational Presentations<br>-Will consider staff, resident, or family educational presentations if there is interest/ need on any topics above. | Educational Presentations<br>-Will consider staff, resident, or family educational presentations if there is interest/ need on any topics above. |

## APPENDIX 3 -- PROJECT STATS

| *Jan 31, 2022- January 27, 2023* | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Meadows | Villa St. Joseph-Du-Lac | Nakile Home For Special Care | Villa Acadienne | Tideview Terrace | Bay Side Home | Roseway Manor |
| **Referrals:** | 12 | 12 | 12 | 10 | 19 | 9 | 12 |
| **Reason for Referral:** | ·Mental Health<br>·Emotional Support<br>·Addictions<br>·Discharge Planning<br>·Adjustment to illness/life change<br>·Financial needs<br>·Statutory Decision Maker (SDM) concerns<br>·Staff Support<br>·Behaviours | ·Mental health<br>·Emotional Support<br>·Adjustment to illness/life change<br>·Resource finding<br>·Family Support<br>·Staff Support<br>·Renal Dialysis Support<br>·Behaviours | ·Mental Health<br>·Emotional Support<br>·Adjustment to illness/life change<br>·Resource finding<br>·Staff Support<br>·Family Support<br>·Bereavement<br>·Behaviours | ·Mental Health<br>·Emotional Support<br>·Addictions<br>·Adjustment to illness/life change<br>·Family Support<br>·Financial needs<br>·Statutory Decision Maker (SDM) concerns<br>·Staff Support | ·Mental Health<br>·Emotional Support<br>·Addictions<br>·Adjustment to illness/life change<br>·Resource finding<br>·Family Support<br>·Palliative care support<br>·Financial needs<br>·Statutory Decision Maker (SDM) concerns<br>·Staff Support<br>·Renal Dialysis support<br>·Advocacy<br>·Family request | ·Mental Health<br>·Emotional Support<br>·Addictions<br>·Adjustment to illness/life change<br>·Resource finding<br>·Family Support<br>·Financial needs<br>·Statutory Decision Maker (SDM) concerns<br>·Staff Support | ·Mental Health<br>·Emotional Support<br>·Discharge Planning<br>·Adjustment to illness/life change<br>·Resource finding<br>·Family Support<br>·Staff Support |
| **Referral Source:** | ·Administrator<br>·LPN Team Leads<br>·Physician<br>·Resident<br>·Behaviour Resource Consultant | ·Recreation<br>·Director of Care<br>·Physician<br>·Resident<br>·Behaviour Resource Consultant<br>·Occupational Therapist | ·RN<br>·LPN<br>·Recreation<br>·Resident Care Coordinator<br>·Director of Care | ·RN Clinical Lead<br>·LPN<br>·Behaviour Resource Consultant | ·Neighbourhood Manager<br>·LPN<br>·CCA<br>·Family<br>·Resident Care Coordinator<br>·Physician | ·Director of Care<br>·Community Care Coordinator<br>·Business Manager | ·Recreation<br>·Director of Care<br>·RN<br>·Hospital Social Worker<br>·Family |
| **Discharges:** | 6 | 7 | 6 | 7 | 14 | 6 | 5 |
| **Reason for Discharge:** | ·Passed away<br>·Referred to Physician for more appropriate care<br>·Social Worker no longer needed/ relevant | ·Passed away<br>·Referred to Physician for more appropriate care<br>·Social Worker no longer needed/ relevant<br>·Referred to Behaviour Resource Consultant | ·Passed away<br>·Referred to Physician for more appropriate care<br>·Social Worker no longer needed/ relevant | ·Social Worker no longer needed/ relevant | ·Passed Away<br>·Social Worker no longer needed/ relevant | ·Social Worker no longer needed/ relevant | ·Referred to Physician for more appropriate care<br>·Social Worker no longer needed/ relevant<br>·Discharged from LTC |
| **Minutes Spent working on resident files and presentations:** | 7275 | 5243 | 7687 | 3632 | 7962 | 5192 | 6988 |
| **Days Attended Home:** | 25 | 21 | 25 | 18 | 27 | 23 | 23 |
| **Behavior Support Meetings:** | 2 | 4 | 5 | 5 | 5 | 6 | 5 |
| **Education Sessions** | 1- Self-care and Mental Wellness<br>2- Understanding Mental Health Behaviours | 0 | 2- Self-care and Mental Wellness | 2- Understanding Dementia and Mental Health Behaviours | 1- Self-care and Mental Wellness<br>2- Understanding Dementia and Mental Health Behaviours<br>2- Addictions | 0 | 1- Understanding Dementia and Mental Health Behaviours |

## APPENDIX 4 -- REASON FOR REFERRAL

| | January 31- January 27, 2022 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Reason for Referral | | | | LTC Facility | | | | |
| | The Meadows | Villa St. Joseph-Du-Lac | Nakile Home For Special Care | Villa Acadianne | Tideview Terrace | Bay Side Home | Roseway Manor | Totals |
| Mental Health | 3 | 4 | 4 | 2 | 9 | 4 | 9 | 35 |
| Emotional Support | 6 | 7 | 5 | 2 | 12 | 5 | 9 | 46 |
| Addictions | 1 | | | 1 | 3 | 1 | | 6 |
| Discharge Planning | 2 | | | | | | 1 | 3 |
| Adjustment to Illness/ Life Change | 5 | 2 | 4 | 2 | 8 | 4 | 6 | 31 |
| Resource Finding | | 1 | 1 | | 3 | 2 | 2 | 9 |
| Family Support | | 6 | 3 | 1 | 2 | 2 | 4 | 18 |
| Palliative Care Support | | | | | 1 | | | 1 |
| Financial needs | 1 | | | 2 | 1 | 1 | 1 | 6 |
| Statutory Decision Maker (SDM) concerns | 2 | | | 1 | 1 | 1 | 1 | 6 |
| Staff Support | 2 | 2 | 1 | 3 | 7 | 1 | 1 | 17 |
| Renal Dialysis Support | | 2 | | | 1 | | | 3 |
| Bereavement | | | 2 | | | | | 2 |
| Other | Behaviours | Behaviours | Behaviours | | Family Request Advocacy | | | 5 |

## APPENDIX 5 -- DEPRESSION AND ANXIETY SCREENING STATS

| Depression Screens | Scoring Scale | Scores |
|---|---|---|
| PHQ9- Patient Health Questionnaire<br>(Below 65 years) | 0-4 is none/minimal<br>5-9 is mild<br>10-14 is moderate<br>15-19 is moderately severe<br>20-27 is severe | 11- moderate<br>7- mild<br>16- moderately severe<br>15- moderately severe<br>12- moderate |
| GDS- Geriatric Depression Screen- Long form<br>(Above 65 years) | 0-9 is normal<br>10-19 is mild depressives<br>20-30 is severe depressives | 1- normal<br>13- mild<br>14- mild<br>5- normal<br>3- normal<br>27- severe<br>4- normal<br>7- normal<br>14- mild<br>16- mild |

| Anxiety Screens | Scoring Scale | Scores |
|---|---|---|
| BECK Anxiety Inventory- Long form<br>(Below 65 years) | 0–7 is minimal anxiety<br>8–15 is mild anxiety<br>16–25 is moderate anxiety<br>26–63 is severe anxiety | 16- moderate<br>24- severe<br>12- mild<br>37- severe<br>3- minimal |
| GAS- Geriatric Anxiety Screen- 10 items<br>(Above 65 years) | 1-6 is minimal<br>7-9 is mild<br>10-11 is moderate<br>12-30 is severe | 4- minimal<br>2- minimal<br>2- minimal<br>3- minimal<br>20- severe<br>2- minimal<br>20- severe<br>4- minimal<br>4- minimal<br>11- moderate<br>12- severe |

## APPENDIX 6 -- COMPARISON OF LTC SOCIAL WORKER ROLES IN NOVA SCOTIA

| Nursing Homes | Position | What role includes |
|---|---|---|
| Evergreen Home for Special Care (NH)<br>Kentville, NS<br><br>No. of Beds - 118<br>Respite Beds - 1<br><br>The Senior Centre: 97 permanent residents and 1 respite bed.<br><br>The Children Centre: 18 permanent residents and 3 respite beds. | One Full time Social Worker for the Seniors Center at Evergreen.<br><br>One Part time Social Worker with the Children's Centre at Evergreen. | |
| Northwoodcare Incorporated (NH and RCF)<br>Halifax, NS<br><br>No. of Nursing Home Beds – 445<br>Nursing Home Respite Beds - 0<br><br>No. of RCF Beds – 40<br>RCF Respite Beds - 0 | | Facilitates admissions process (e.g., completes and sends paperwork, communicates with residents and/or family, orientates residents, declares vacancies and coordinates transfers, completes lease signing with resident or power of attorney when necessary.)<br><br>Counsels clients and patients in individual and group sessions. Provides one to one support to resident and/or families (e.g., discharge information, providing transitional counseling) |

| Nursing Homes | Position | What role includes |
|---|---|---|
| | | Responds to needs for resources for residents and interdisciplinary team.<br><br>Participates in care conferencing. May be required to chair or participate in care conferences and/or resident and family councils.<br><br>Collaborates with other professionals to evaluate patients' mental health, medical or physical condition and to assess clients' needs.<br><br>Provides conflict resolution.<br><br>Facilitates the completion of documents in accordance with the Personal Directives Act.<br><br>Serves as a resource for residents and their families advocating with internal and community contacts. |
| Northwood Bedford Incorporated – Christina & Hedley G. Ivany Place (NH and RCF)<br>Bedford, NS<br><br>No. of Nursing Home Beds – 130<br>Nursing Home Respite Beds - 0<br>No. of RCF Beds – 26<br>RCF Respite Beds - 0 | | |

| Nursing Homes | Position | What role includes |
|---|---|---|
| Ivy Meadows Continuing Care Centre (NH) Owner: Rosecrest Communities Beaverbank, NS<br><br>No. of Beds – 38<br>Respite Beds - 0<br><br>Northwood to take over in 2023 | One Social Worker from Northwood helps with admissions only | Admissions work only. |
| Parkstone Enhanced Care Limited (NH) Owner: Shannex Halifax, NS<br><br>No. of Beds – 193<br>Respite Beds – 1 | One Social Worker | First person of contact for residents and families.<br><br>Work with families primarily.<br><br>When work with residents they tend to be younger.<br><br>Organize and attend family council and resident council meetings |
| Arborstone Enhanced Care (NH) Owner: Shannex Halifax, NS<br><br>No. of Beds – 190<br>Respite Beds – 0 | One Social Worker works with younger adults<br><br>One Social Worker works with the seniors. | |

| Nursing Homes | Position | What role includes |
|---|---|---|
| Maplestone Enhanced Care (NH) Owner: Shannex<br>Halifax, NS<br><br>No. of Beds – 87<br>Respite Beds – 0 | Part Time Social Worker | Main focus of job is admissions: review admission applications, meet with families to complete paperwork, provide emotional support.<br><br>Work on issues with resident's finances, including applying for Public Trustee if needed.<br><br>Host Family and resident council meetings monthly. Work with family members. Do facility tours.<br><br>Weekly care conferences.Apply for 1:1 attendants.<br><br>Take part in any external consultations (behavioural, mental health).<br><br>Attend doctor's rounds.<br><br>Meet with residents to discuss any social/emotional/financial concerns. |

| Nursing Homes | Position | What role includes |
|---|---|---|
| Ocean View Manor (NH)<br>Eastern Passage, NS<br><br>No. of Beds – 171<br>Respite Beds - 0 | One Social Worker | Admissions/discharges/transfers- work with Continuing Care to facilitate all admissions to the building. Meet with all new admission families to do paperwork and discuss everything about admission / LTC and answer questions / offer support etc.<br><br>Resident care conferences: Monthly care meetings where SW make the schedule each month and also facilitate all the meetings with residents and families present.<br><br>Resident banking. Help residents who want to withdraw cash from their resident trust account.<br><br>Building tours to anyone in the general public.<br><br>Family council meeting. Staff support / facilitator. 4 meetings/year with family members / NOK.<br><br>Resident council. Staff support / facilitator. 1x/month.<br><br>Responsive behaviour meetings. 1x/month with Seniors Mental Health, Challenging Behaviour Resource Consultant and staff to discuss any identified residents who are exhibiting responsive behaviours that we need some assistance with managing. Facilitate and organize meeting.<br><br>Committees and groups (ethics, resident care, palliative care). |

| Nursing Homes | Position | What role includes |
|---|---|---|
| Cedarstone Enhanced Care (NH) Owner: Shannex<br>Truro, NS<br><br>No. of Beds – 126<br>Respite Beds - 0 | One Social Worker | |
| Musquodoboit Valley Home for Special Care / Braeside Home for Special Care (NH) Middle Musquodoboit, NS<br><br>No. of Beds – 29<br>Respite Beds – 0 | One Social Worker ½ day once per week | Identifying Statutory Decision Maker (SDM) and Power of Attorney (POA) when needed<br><br>Resident Financial issues<br><br>Advance Care Planning discussions/making personal directives<br><br>Navigating residents who want to transfer or move back into independent living/ Discharge Planning<br><br>Resident adjustment difficulties<br><br>Resident need for new devices/ other resources<br><br>Applying for legal aid and other legal issues, such as navigating divorce. |
| Harbourview Lodge Continuing Care Centre (NH and RCF) Sheet Harbour, NS<br><br>No. of Nursing Home Beds – 28<br>Nursing Home Respite Beds - 0<br><br>No. of RCF Beds - 4<br>RCF Respite Beds - 0 | One Social Worker ½ day once per week | Identifying Statutory Decision Maker (SDM) and Power of Attorney (POA) when needed<br><br>Resident Financial issues<br><br>Advance Care Planning discussions/making personal directives<br><br>Navigating residents who want to transfer or move back into independent living/ Discharge Planning |

| Nursing Homes | Position | What role includes |
|---|---|---|
| | | Resident adjustment difficulties<br>Resident need for new devices/ other resources<br><br>Applying for legal aid and other legal issues, such as navigating divorce. |
| Harbourstone Enhanced Care (NH) Owner: Shannex<br>Sydney, NS<br><br>No. of Beds – 272<br>Respite Beds - 0 | Two Social Workers | |
| Blomidon Court Continuing Care Residence (NH) Owner: Shannex Greenwich, NS<br><br>No. of Beds – 50<br>Respite Beds - 0<br><br>Orchard Court Continuing Care Residence (NH) Owner: Shannex<br>Kentville, NS<br><br>No. of Beds – 62<br>Respite Beds - 0<br><br>Ryan Hall (NH and RCF) Owner: Shannex Bridgewater, NS<br><br>No. of Nursing Home Beds - 50<br>Nursing Home Respite Beds - 0<br><br>No. of RCF Beds – 15<br>RCF Respite Beds - 0 | One Full Time Resident and Family Services Coordinator- RN role | Coordinating the admissions within the three sites, as well as helping residents and their families with concerns along the way. All families have been directed to call The Resident and Family Services Coordinator, where they would previously contact the site managers. Position is a year old.<br><br>Oversee behavioural challenges at our sites as well by working closely with nursing staff, physicians, and behavioural consultants in each region. This may require a PIECES assessment, care plan review, resource planning or over-cost fund requests.<br><br>Attend weekly responsive behaviours meetings to review any incidents at each site. Meet 1x month with behavior resource consultant to discuss resident behaviour concerns. Complete the referrals when required as well.<br><br>Assist with finances. |

| Nursing Homes | Position | What role includes |
|---|---|---|
| | | Similar role to Social Worker roles listed above. Difference is that this role works more closely with the nursing team.<br><br>Coordinator feels a Social Worker would be beneficial to help provide families with counselling for grief as they often cannot access counselling due to their financial situation. |

# APPENDIX 6 -- FEEDBACK FROM RESIDENTS

| When are you completing this form | Having a social worker meet with me periodically was good for my mental health | The number of times the social worker could visit with me was sufficient. | Was your experience with the social worker role positive? | Do you have any examples to provide of what the social worker did for you that you really appreciated? | What will you miss about the social work role when the pilot project is over? | Are there gaps in what the social worker provided? What do you feel was missing? What could have been done better? | What do you feel is the most important thing the social worker provided and why? | Any other comments |
|---|---|---|---|---|---|---|---|---|
| 11/8/2022 | Neutral | Agree | Strongly agree | Helped me a lot with letting me talk about what was on my mind. | Really will miss having the help to find me a place out of where I live now. | Nothing. Everything has been fine. | Lending me a ear was also very helpful because I feel no one else would give me advice and listen like her. | I would like to have my social worker back to be there for me and others. |
| 11/8/2022 | Agree | Agree | Strongly agree | Being able to visit and talk to someone other than staff as confidentiality was respected. | We need more. She needs to stay to help by listening to me. | I think we should have one social worker just for our nursing home. Take for a walk around the building. | It brightens my day to have an outside person to discuss life issues and respect confidentiality. | Nursing home needs social work for people like me (people with mental illness) really need the support. I look forward to her visits. Don't let us fall through the cracks! |
| 11/24/2022 | Strongly Agree | Disagree | Strongly agree | Offered to assist exploring "self-managed care" community options as available for the younger crowd. | Sincere neutrality as an active listener serving a notable gap in services prior to the pilot. | In house access to this integral continuum of care. More Visits. | | Highly recommend this vital service. |
| 12/6/2022 | | Agree | Agree | Someone to talk to who made sense. | | | | |
| 12/6/2022 | Strongly Agree | Agree | Agree | I had confidence that I could tell the social worker things I couldn't tell others. I keep a lot to myself and it is hard to trust people but I trusted the social worker right away. I could tell she was okay to talk to about these things. I could ask her anything and get an honest answer. | I will have nobody that I have confidence in like the social worker. She helps me when I have a lot on my mind and won't have someone to talk to about my thoughts and worries. | No | Listening | It helped to have a person that understands what my concerns are. It is so hard to have a project start, get used to someone, and then have the project end and no longer have that support. |
| 12/6/2022 | Neutral | Agree | Agree | Good listener. | | No | Listening. | Wish I felt better when social worker visited so I could engage in the process better. |
| 12/12/2022 | Strongly Agree | Agree | Strongly agree | She listened to me and was able to offer perspective on my situation. Her approach offered me reassurance that I could tell her anything without judgement. She has a unique way of guiding people to a different way of thinking. I would think about things after she would leave and then more ideas would come helping me explore my situation. | Conversation. I really enjoyed having someone to engage in intellectual conversation with and someone to speak to about whatever is going on in my life. It gave me a different perspective and helped me to stop worrying about what had been bothering me by being able to talk about it. | No | Listening. She was always friendly and open and had a good sense of humour, which was inviting and helped me to feel more able to discuss what I had been thinking about. | Twice a month visits were fine for me but might not be for everyone else. |
| 12/12/2022 | Strongly Agree | Agree | Strongly agree | She listened to me. She gave me feedback, which was needed. | The sharing and someone I can talk to about anything, knowing it will be kept confidential. | No | An ear to listen. | I wish she could be here longer in this role. |
| 12/13/2022 | Strongly Agree | Disagree | Strongly agree | Helping me with calling the bank and CRA. | Having company and talking to someone closer to my age. | She could have wheeled me around the building or outside. I would have liked to be taken to the store or to get food. | Social contact. I don't get many visitors and feel like there isn't much to break up my days. Most days are the same. | No |
| 12/23/2022 | Strongly Agree | Disagree | Agree | Talked to me a lot about my lifestyle and helped me cope. | I always looked forward to her visits. | No | Talking to me about how I was feeling. | I wish she could have visited me more than twice a month. |
| 1/9/2023 | Strongly Agree | Strongly agree | Strongly agree | She helped me move on without my husband who has a life limiting illness. She helped me believe in myself. | Having someone to talk to as I always felt better after speaking with the social worker. She had many ideas for things to try to help me build up a life again away from husband. | No | Listening and not making me feel small for asking for help. | This would be good support for everyone. Please keep this program going.<br><br>This was a report from a family member. |
| 1/10/2023 | Strongly Agree | Disagree | Strongly agree | Patience is your greatest virtue. Kindness is your asset. Your devotion is amazing. | I will miss you as a person. I will miss somebody to be able to tell about what is going on in my life. It is very hard to see you go. | No. | Good advice. Follow up on previous concerns I brought up. You would ask if it was resolved. You do your job right. | No |

# RESOURCES

**Relevant documents used to help support this Pilot Project and written Final Report:**

- Social Work in Long-Term Care- Canadian Association of Social Workers (CASW), 2002
- Northwood LTC Social Worker Job Description, 2017
- Braeside and Harbourview LTC Social Worker Job Description, 2020
- Report: Results from the Exploring The Value and Need of Social Work in Nursing Homes Survey- New Brunswick, 2018
- Provincial Practice Profiles: BSW and MSW Social Workers in Healthcare- Model of Care Initiative in Nova Scotia (MOCINS), 2012
- Position Statement for the Mental Health Care in Long-Term Care During Covid-19 by Canadian Academy of Geriatric Psychiatry (cagp) and the Canadian Coalition for Seniors' Mental Health, 2022

# A SPECIAL THANK YOU

On behalf of the seven nursing homes that participated in this innovative pilot project, we would like to recognize and thank Samantha Mason for her work on both the project and this report. She is an impressive Social Worker; knowledgeable, approachable, caring, and compassionate. Ms. Mason is a leader in the industry, a self-starter, and a trail blazer in bringing Social Work services to our long-term sector. Her contributions were most valuable and provided meaningful impact towards the improved health and well-being of both our residents and staff.

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