

Monitoring: The Contact/ Activity Log and the Interim or Quarterly Client Review

Once the service plan is in place, the social worker's job is focused on seeing that the planned activities are carried out (process monitoring) and are moving the client and family toward meeting their goals as they were designed to do (outcome monitoring). During this phase, you usually have two ongoing record-keeping tasks. First, you track some events, situations, and activities while you are dealing with them, in order to stay informed about what is happening in the case. Second, you periodically document the significant events for your own use with the client and family, and for use by your supervisor and colleagues. In accordance with these two needs, we introduce two tools in this chapter—a simple Contact/Activity Log for recording ongoing notes, and an Interim or Quarterly Client Review tool for information that is especially significant and needs to be recorded in a more formal way and kept.

The Social Work behind the Record

A Model for Excellence describes monitoring as “a mechanism for maintaining accountability and for providing necessary technical assistance”

(p. 89). In the course of describing this mechanism, it makes the following major points:

- There are two types of monitoring: those relevant to process and those relevant to outcome.
- Process monitoring is the action you take to make sure that the activities in the service plan are occurring according to plan, in a timely fashion, and at an acceptable level of quality.
- Outcome monitoring is the action you take to assess whether the activities planned (and correctly carried out) are helping the client and family to reach their goals.
- Throughout the period of process and outcome monitoring, you work with the client and family to make adjustments to improve the quality of service activities and to modify or replace activities to “correct the course” toward the goals of the client and family.
- As a social worker, you make adjustments directly, or through consultation with colleagues, when problems are found in DSS activities or services.
- You use counseling and technical assistance to make adjustments in services or activities being provided by informal providers or other agencies.

The Contact/Activity Log

Why Is a Contact/Activity Log Important?

Most day-to-day monitoring focuses on activities and their effect on the service plan and/or goals. You notice and record the steps in getting a service, the quality of services obtained, any problems that arise, the feelings of the client and

family about them, and any changes they make in their lives. However, in the course of working with any given client and family toward meeting their goals, many tasks, concerns, and incidents arise that require your short-term attention and action.

Say, for example, that you tell a client you will pick up his insulin this month, because his usual arrangement for getting it is no longer working, or suppose that there is a conflict between a client’s in-home aide and one of his family members. You want to record the day-to-day details, both as a reminder to yourself and as information for a colleague if you were unexpectedly unable to come to work. However, only a summary of events and activities needs to be recorded as part of the Interim or Quarterly Client Review after the issue is resolved.

Take, for example, the case of a conflict between a family member and an in-home aide. The Interim or Quarterly Client Review in the case record might need a summarizing notation such as: “Mr. Bennett’s daughter, Sarah Sullivan, complained to SW that Ms. Lloyd, in-home aide, was doing nothing but watching soap operas during her visits. Met with both individually to review the in-home aide services plan. Mrs. Sullivan agreed to check whether the listed tasks were being done for two weeks following her complaint and to call if she still believed Ms. Lloyd was neglecting her written duties. There have been no additional complaints.” Some may prefer a briefer form such as “Conflict between client’s aide and daughter over aide’s job performance. Resolved by reviewing in-home aide service plan with both parties.”

Although either of these notes is an adequate summary for the client’s record, the same social worker would probably have made a longer series of notes in the course of this conflict. These notes, recorded on the Contact/Activity Log, might include the following:

2/15 tc from Sarah Sullivan—argument with father’s (John E. Bennett) in-home aide. Accused aide of doing

“nothing but watching soap operas.” Won’t meet with Ms. Lloyd and SW together—office appt. Tues. 2/19 at 12:15 noon. (Works near office.) Told her I would be talking to the aide.

2/15 tc from Bonita Lloyd, in-home aide. Mrs. Sullivan asked her to remove stains from carpet—told her carpet cleaning not her job. Told her of appt. with Mrs. Sullivan. Asked to talk with her when I came to bring Mr. B. his new quad cane.

2/18 hv to Mr. Bennett. Trying to walk more, glad to get new cane. Mr. B. does not want to get involved in disagreement, but willing for me to talk to daughter and aide. Talked to Ms. Lloyd. Reviewed in-home aide agreement. Supported refusal to clean carpet, but talked about ways to say “no” without being confrontational.

2/19 ov with Mrs. Sullivan. Reviewed in-home aide services plan and nature of aide services. Gave her a copy of plan—told her to call if she felt that any of the scheduled aide duties were not being performed. Suggested one-time “deep cleaning” of her father’s house through local house cleaning service. Note: Call Ms. Lloyd and Mrs. Sullivan later in month.

2/27 Called Ms. Lloyd. No more conflicts with Mrs. Sullivan. Few contacts cool but not antagonistic.

2/28 Called Mrs. Sullivan. Reports no problems with aide services.

This example shows how the Contact/Activity Log and Interim or Quarterly Client Review are complimentary.

Using the Contact/Activity Log

The Contact/Activity Log is a simple, straightforward tool on which you can record phone calls, visits, and other activities you undertake with and on behalf of the client and family. It is

used between the creation of the initial service plan and the first quarterly review, and between successive quarterly reviews.

In most agencies, workers have kept day-to-day notes on service implementation and monitoring in their “case notes,” “narrative,” or “dictation.” These notes have usually gone into the client’s record permanently. The difficulty with relying on these notes later is that they do not usually distinguish between events that were significant over the long-term course of work with the client and those which were only important during the day-to-day management of the case. This is why we recommend that you transfer significant events to the Interim or Quarterly Client Review. If this is done, the day-to-day notes do not have to be presented in any particular format or produced in any special way, and they can probably be thrown away at the end of the quarter unless needed for court or auditing purposes. You will want to consult with your supervisor about the proper policies and procedures to follow to remain consistent with auditing expectations. It may be possible, for example, to record all vital dates of contact on the Interim or Quarterly Client Review. Regardless of policy considerations, you may want to keep notes longer when you first start using this system, until you feel comfortable that you are adequately summarizing the quarter’s significant events and will not need to refer to them again.

Unlike other tools presented in this guide, we are not recommending that you use the Contact/Activity Log instead of any other tool you might have. Workers do not have to be uniform in the tool they use to record notes about the day-to-day management of a case. The tool is primarily for your use. A pad of notepaper or a computer word-processing file will serve the same purpose. The only consideration for how you keep these notes is that they be accessible to your supervisor or a colleague so that someone knows where to look to be brought up to date on your case quickly. Some workers who are currently

using this format clip the current log to the inside front cover of the client’s record so all their information is together.

The notes on the Contact/Activity Log can be handwritten with strike-throughs or erasures as long as your colleagues can read them when necessary. This also means that the writing style and level of detail you keep is largely a matter of personal style and need. Because these notes do not have to be formal in either content or production, you should be able to write them on the spot in a few minutes and not get behind.

The example on page 88 shows the first two weeks of notes following the creation of the service plan for Mrs. Johnson and her family. It does not show all of the notes that would be made during the first quarter, but it does illustrate some of the activities associated with implementing and monitoring that plan. It shows that, even in writing up the notes, the main focus is on what changes have taken place relevant to the goals of the client and family.

Although most social workers today, with good reason, avoid the “and then I said . . . , and then she said . . .” style of notes, sometimes a notation of how the client or family member said something or how they responded to a suggestion helps convey their emotional response—fears, beliefs, hopes, and preferences—more clearly than a lot of analytical language. An example of this is found in the entry for the home visit on 2/20/95. At that time Mrs. Johnson reported that her sister said “nobody from this side of town” goes to the senior center.

The social worker looks into this possibility and finds that this correctly reflects a real skew in the senior center’s clientele. She further learns that Mrs. Johnson’s minister does not know anyone who attends the center. At this point, the social worker and Mrs. Johnson decide that this may not be a good activity to meet her goal of feeling more positive. For another client, going to the senior center with friends and working to help expand the diversity of its clientele might be a fulfilling activity.

Contact/Activity Log		
		Client <u>Mary F. Johnson</u>
		Case # <u>95-10019</u>
		Id # <u>18937485368</u>
Date	Contact or Activity	Results of Contact/Activity
2/9/95	<i>Bob Griffith, Services for the Blind</i>	<i>Will send voucher for eye exam to Mrs. J. by mail.</i>
2/9/95	<i>tc to Louise Sullivan, Kudzu Hospice</i>	<i>Briefed me re: grief support. Will send brochures on bereavement support group—also widows' support group run by the Kudzu All-Faith Council. I will take them to Mrs. J. and answer questions.</i>
2/10/95	<i>tc from Mrs. J.</i>	<i>Eye appointment with Dr. Elkins set for 3/10/95. She has new heating pad and a lightweight flashlight/lantern to use on the stairs. Says that son will get new stove knobs next weekend. Stove knobs still marked with electrical tape—seems to help.</i>
2/10/95	<i>Cecilia Rossi, Transportation Worker</i>	<i>Will arrange transportation for Mrs. J. to eye exam</i>
2/17/95	<i>tc from Barbara Jenkins, Council on Aging</i>	<i>Today Mrs. J. scheduled to visit senior center, but waved van on. Will call Barbara to reschedule after hv to Mrs. J.</i>
2/20/95	<i>Home visit to Mrs. J.</i>	<i>Introduced Mrs. J. to in-home aide, Mrs. Gooch. Reviewed aide's schedule and activities. Gave Mrs. J. brochures. She said her son would read them to her as reading is getting too hard for her because of her vision. I asked her about not going to the senior center. She said she had called her sister, Dot (one of her weekly social calls) to try to make up for their past falling out. In the course of their conversation Dot told her that nobody from their side of town went to that center. Told her I would find out more about the center before our counseling visit next week.</i>
		<i>Discussed with Mrs. J. several possible physicians and gave her phone number to call for an appointment. She said she felt comfortable doing this herself.</i>
2/20/95	<i>tc to Mr. Johnson (son)</i>	<i>Reported Mrs. J. has not left the stove on this week. All other safety hazards fixed except permanent stair lighting. Reports his mother in better spirits than he has seen her for some time. Also reports Rev.</i>
2/20/95	<i>tc to Rev. Abernathy</i>	<i>Abernathy (Mrs. J's minister) happy to get church more involved. I asked whether any of his congregation goes to Sr. Ctr. He says he doesn't know any. He said he had spoken to her son and intended to ask Mrs. J. if she would like Tues. prayer circle to meet at her house next week.</i>

Other Day-to-Day Documentation

The notes in the Contact/Activity Log are not the social worker's only documentation for the activities shown in the example. For instance, she updated the face sheet to show the names and phone numbers of the aide, the ophthalmologist, and Mrs. Johnson's minister. She also updated the service plan as activities were completed. For example, on 2/9, after arranging for the eye-exam voucher, the social worker recorded that date in the "Activity Completed" column.

After Mrs. Johnson's call on 2/10, she recorded that date for what had already been done to correct hazards in her home. This included getting a new heating pad and arranging for temporary lighting for the stairs. Because rugs were still not secure and the stove knob had not yet been replaced, it was not possible to mark the entire activity as completed. In the example, the social worker struck through and dated the parts of activities as they were completed, but you may prefer to record this information only in your log.

During this same call, Mrs. Johnson reported that she had made an appointment with the ophthalmologist. This activity under goal 2C is then identified as accomplished. The social worker also used the service plan to record the decision for Mrs. Johnson not to visit the senior center (noting that this planned activity was withdrawn as of 2/14). Later, when Mrs. Johnson learned that she needed her cataracts removed, the social worker worked with Mrs. Johnson and family in adding new activities to the service plan, including transportation and additional aide services on a short-term basis. These updates are included on the sample at the end of this chapter, which shows how the service plan for Mrs. Johnson looked after the first quarterly review.

The Interim or Quarterly Client Review

Why Is the Interim or Quarterly Client Review Important?

You'll remember that *A Model for Excellence* describes two types of monitoring: process and outcome. You can document much of your process monitoring using the log and the service plan; however, the quarterly review is your tool for systematically recording outcomes. As such, it documents both an *event* (the quarterly visit with the client) and the essential changes in the client's and family's circumstances over the *review period*. This is the time for checking the progress of your client/family/social worker team. Are the activities meeting the goals? Does your team need to plan different activities? Does the team need to set new goals to address remaining problems? What has to happen to maintain the progress your team has made? This tool is designed to be used at least quarterly. However, when drastic changes occur in the client's life, you may want to perform this review, or even a full reassessment, at that time.

Using the Interim or Quarterly Client Review Tool

The Interim or Quarterly Client Review tool has three sections—orientation to the review, which gives you space to document your sources of information; a review of functional domains, which may include important process elements; and the progress on goals, which is very outcome-oriented. Let's look at each part separately.

Orientation to the Review

The tool begins with an orientation to the review, which includes space to record identifying data, sources of information, and major changes in the

life of the client or family. After filling out the identifying information, you can describe how the review was performed, using a pair of checklists that ask where the review was conducted and who contributed information during the review period.

In the first checklist you indicate where your review with the client and family was conducted (e.g., client's home, hospital, nursing home/domiciliary care). The social worker in the example has checked client's home and telephone because her review included information gathered from a visit in the client's home as well as information from other sources contacted by telephone at the time of the review and throughout the preceding quarter.

Using the second checklist, the social worker notes her sources for information on the tool. Her source during the visit was the client; but she also lists the son (other family), the ophthalmologist, the in-home aide, and the home health nurse, because all of them have given her information reflected on this tool. This social worker has not included contacts who gave her less vital information such as her contact at the Council on Aging and Mrs. Johnson's minister. This is a judgment call, and not all social workers will make exactly the same decisions about whom to identify using the checklist.

After describing how the review was conducted, you are then given space to record any major changes or events since the last review that have "substantial" impact on the life of the client and family or their need for services. You might record here a change of environment, such as placement in a facility or moving into a new home; a serious health problem such as a stroke, heart attack, or automobile accident; or a change in financial status, such as selling a piece of land or cashing a life insurance policy.

In the example, the social worker has recorded Mrs. Johnson's cataract surgery as an event that had a substantial impact because it affected Mrs. Johnson's functioning in several domains and influenced several of her goals.

The social worker also uses the space to give a brief statement of how the surgery affected her. For other clients whose vision had not deteriorated as much as Mrs. Johnson's, or whose vision was not so central to the positive changes they hoped to achieve (their Checklist for Change), information about the surgery might have been recorded instead under the physical health domain in the next section of the tool. If there are such changes as a new address or difference in family composition, you will also want to update the Face Sheet.

Review of the Functional Domains

This second section of the tool is a sort of mini-reassessment, structured in terms of the six functional domains. It is a place to note changes in any or all of them. Using what you have learned over the quarter and from your review, you can use the space provided in the second section to summarize any important findings and impressions that may help when you next think about the goals and what changes in the service plan might be necessary. This may include new problems, worsening conditions, improvements, and new resources as well as accomplishments. In addition to space for each functional domain, you also have room to summarize any other significant events, contacts, or activities that occurred since the last review. You probably will want to note the date for each important happening you mention. An alternative to recording this information is to attach and highlight relevant sections of your Contact/Activity Log.

The example at the end of the chapter shows how a review of the functional domains could help Mrs. Johnson's social worker in several ways. It documents improvements in Mrs. Johnson's social functioning and environment that support conclusions about her goals being met. It identifies a newly diagnosed health problem (high blood pressure), and two types of medication Mrs. Johnson had not been taking previously. Perhaps most importantly, it shows the changes in her ADLs and IADLs—more

activities that she attempts, but worse arthritis—and the emotional impact of seeing that she cannot keep her house as clean as she wants. This sets the stage for new goals that can probably be met by the same in-home aide. It also indicates that Mrs. Johnson’s economic situation has changed with her need to purchase the medication, the cost of which is not covered by Medicare. The client/family/social worker team tackle this with an addition to the service plan. The social worker in our example cross-referenced this by writing “(see service plan).”

The final space in the functional domain portion of the tool is for summarizing other events in the quarter that did not fit well within a domain. In some counties, a list of the dates of contacts (from your log) with a brief summary of overall events will constitute adequate documentation of daily activities for monitoring purposes. However, if your county asks you to attach your contact log to the quarterly, it is unnecessary to duplicate information here. Still, you may want to use this space to put a “red flag” on any event with particularly urgent consequences for the client and family.

Goals

The tool concludes with a section to record progress notes on goals. The section is set up first to identify each goal with the number from the service plan or by recording some brief notation to remind you of it. You may want to do both. You do not need to write the full goal. In the example, below and on the following page, the social worker has simply written “stove” by goal 1A, which is sufficient to remind her that the goal was “stove turned off consistently while not being used for one month.” Notice that she lists goals for the same item for change separately where the progress and disposition are unrelated (e.g., for goals 1A and 1B). In other instances, where disposition is the same, and the progress notes are related, she combines goals (e.g., for goals 2A and 2B, medical care).

For each goal or set of goals, there is a place to note progress or setbacks and then to check whether the client/family/social worker team has met the goal and can stop working on it, will continue as is since the goal is being met, is still working toward it, needs to try a new strategy, or should revise the goal.

You can use the space labeled “Progress” to note the current state of the client and family in relation to the goal—how a goal was met, what part of the goal remains unmet, what factors interfered with meeting it, why it needs to be revised, or to identify some other approach to meeting it. In short, these notes support the disposition checklist. Most of these possibilities are demonstrated in the case example.

Three of the six goals listed on the example are marked “goal met/discontinue,” and the other three have very straightforward explanations. The goals of getting a physical exam and a mechanism for regular care (2A and 2B) are explained by a notation naming her new general practitioner. Similarly, the goal of identifying and correcting her vision problem (2C) was met by cataract surgery.

The note for goal 1A gives a little more detail because there had been some ambiguity about the reason for Mrs. Johnson leaving the stove on. Because the problem appears to have been remedied by correcting her vision, the client/family/social worker team feel free to discontinue the goal. If, on the other hand, Mrs. Johnson had met her goal by using memory training and behavior modification techniques, they might have decided to “continue working on the goal” or “revise the goal” to reinforce this behavior for a longer time and make sure a permanent change had been achieved. Goal 1B, fixing or removing hazards from the home, was finally met by the end of the quarter. Mrs. Johnson’s son did tuck down her throw rugs and replaced the knob on the stove.

Three of the goals required more work, or at least some ongoing review. On the goals related

to Mrs. Johnson's outlook on life (4A and 4C), the planned activities were carried out and there was some indication that she was benefiting from them, but more time was needed to achieve the goals. Goal 4B, increasing Mrs. Johnson's social contacts, is revised so that it becomes a goal to be maintained instead of a goal to be achieved. Both Mrs. Johnson and the social worker know that reaching out to people is a new habit that must be practiced before it becomes second nature.

Goals 3A and 3B, involving Mrs. Johnson's ability to bathe and wash her hair, must be revised to reflect changes in ADLs. Notice how the social worker uses the relevant domain in the previous section of the tool to record additional notes about changes to this goal.

You can use the disposition "other" for cases where the checklist items don't fit. One example where this disposition might be used is when a client wishes to stop working toward a goal that has not yet been met. However, this label could be used for any unusual dispositions.

Because there are more goals than space on the Interim or Quarterly Review tool, the social worker copied the back of the tool, recorded some identifying information about Mrs. Johnson, and continued recording goals, progress, and disposition. You could do this if you need more space, or you could use a blank sheet of paper. She also signed this last page when she completed the review.

The final step in the review process, other than signing the tool, is updating the service plan based on what is known about any significant functional changes and the progress on goals. A revised plan for Mrs. Johnson, for example, might reflect a goal and strategy to address the increased concern about her finances. Depending on the extent of the changes made to the service plan, the social worker may mark them on the existing tool, dating and initialing changes, or she may choose to start with a fresh page, copying over remaining goals and adding new or modified ones. The social worker in our sample case decided to mark them on the existing tool,

adding an additional page. Her revisions are shown on the last pages of this chapter.

Frequently Asked Questions

Question: What if there are significant things in my contact log that my colleagues and supervisor should know about, but they don't seem to fit anywhere on the Interim or Quarterly Client Review?

Answer: You are right that it is important to include this information on the quarterly review. If it is a major event you may want to record it in the opening section (events with substantial impact). Otherwise, if it does not fit well under any of the six functional domains or in the progress notes, you can use the additional space provided at the end of section two of the tool for summarizing any other significant events, contacts, or activities. Attach log sheets or additional notes if necessary. Remember that the tool is intended to work well for you and your clients and their families.

Question: How often do I need to update the face sheet and the service plan?

Answer: Updating documents is a little like keeping the house straightened up. You can take an extra minute to put things away as you use them, or you can take a few hours putting everything away when things have accumulated. It is your choice, but there are some rewards for doing it on the spot. This should just mean jotting the new address or phone number on the face sheet as you learn it, or writing a date on the service plan as you learn that an activity has been completed, or that a goal has been met.

At least once a quarter (preferably at the time of the quarterly review when you need to update the service plan with new goals and activities), you will take a

look at these documents and see if they are still readable or if you need to fill out a new copy of the tool. (Many social workers prefer to start a new service plan tool after the annual reassessment.)

Key Points

- There are two types of monitoring: process and outcome.
- Although there is overlap between the activities, process monitoring is generally documented on the Contact/Activity Log, while outcome monitoring is documented on the Interim or Quarterly Client Review.
- Information learned in the course of monitoring will often require updating the face sheet and the service plan.
- The style of entries in the contact/activity log and the tool on which they are written are at the discretion of the individual social worker. Of course, you want to be sure that they are readable by your supervisor and colleagues.
- The content of the contact/activity log focuses on the functional impact of events on the client and family—how activities and events affect the planned services and attainment of the goals for the client and family.
- An excellent quarterly review provides all information the client/family/social worker team needs to revise and add new goals, and to plan continued and additional activities to meet them.

Interim or Quarterly Client Review

Client Mary F. Johnson Date 5/5/95

Case # 95-10019 ID # 18937485368

Review was conducted
(check more than one, if applicable)

- in client's home
- at DSS
- by telephone
- in client's relatives' home
- hospital
- nursing home/domiciliary care
- adult day care center
- other (explain)

Information was obtained during the review period from: (check all that apply)

- client
- primary caregiver
- guardian
- other family Son
- friends
- aide or other paid assistant
- facility staff
- other professionals Dr. Elkins, ophthalmologist
- other Dana Gifford, RN (home health)

Have there been any changes/events since the last review which have a SUBSTANTIAL impact on the client's family's life or need for services? If yes, summarize briefly.

Cataract surgery—vision restored. Physical recovery very good. Some increased signs of depression—may be related to increased awareness that she is unable to keep her house as she wants it.

Update face sheet to reflect any changes such as address, phone, or household composition.

Review of the functional domains

Please include in your summary new problems, worsening conditions, improvements, and new resources or accomplishments. (Include information that documents the continuing need for services.)

Social Better rapport w/sister. Son & wife heartened by client's progress—have been more willing to be helpful. Client is reestablishing friendships at church—some members visit her and take her to church activities. Also making friends in widows' support group.

Environment (home and neighborhood) Though Mrs. J. isn't entirely happy w/housekeeping, house is cleaner and safety hazards have been fixed.

Mental/Emotional Health At first very happy after surgery, but now more aware of problems housekeeping, so sad and frustrated. "I see all the things I want to fix up, but I just can't do it like I used to." Likes widows' support group, finds it helpful to talk to "people who know what I been through."

Physical Health New meds for high blood pressure, diagnosed by new M.D., who also suggested change in diet. Mrs. J. not so happy about learning to cook differently. Also meds for arthritis pain mgmt. No ins./Medicare coverage for cost of meds., which puts her at least \$20 over current budget.

ADLs and IADLs Mrs. J. is doing more housework and self-care since surgery, but arthritis is worse.

Economic Mrs. J. and family concerned about cost of two extra medications.

Summarize below any other significant events, contacts, or activities during the quarter (include dates) or attach relevant sections of your log notes.

Plan for sr. ctr. visit withdrawn from service plan because Mrs. J. felt that the people who go there wouldn't share many of her interests and background.

Progress on goals

Goal # &/or description <u>1A, stove</u>	Progress <u>Eyesight seems to have been cause. Mrs. J. now turning off stove consistently. Son no longer worried about this.</u>	Disposition <input checked="" type="checkbox"/> goal met/discontinue <input type="checkbox"/> goal being met, ongoing <input type="checkbox"/> continue working toward goal <input type="checkbox"/> try new strategy <input type="checkbox"/> revise goal <input type="checkbox"/> Other:
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Goal # &/or description <u>1B, hazards</u>	Progress <u>Hazards fixed, permanent light in stairs.</u>	Disposition <input checked="" type="checkbox"/> goal met/discontinue <input type="checkbox"/> goal being met, ongoing <input type="checkbox"/> continue working toward goal <input type="checkbox"/> try new strategy <input type="checkbox"/> revise goal <input type="checkbox"/> Other:
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Goal # &/or description <u>2A&B medical care</u>	Progress <u>Dr. May Shepard is Mrs. J.'s new M.D. high bp diagnosed, new meds. and diet. New Rx for arthritis, not as helpful as hoped. Prescriptions make financial problems, though.</u>	Disposition <input type="checkbox"/> goal met/discontinue <input type="checkbox"/> goal being met, ongoing <input type="checkbox"/> continue working toward goal <input type="checkbox"/> try new strategy <input type="checkbox"/> revise goal <input checked="" type="checkbox"/> Other: <u>See service plan updates about finances</u>
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Goal # &/or description <u>2 C, vision</u>	Progress <u>Successful cataract surgery.</u>	Disposition <input checked="" type="checkbox"/> goal met/discontinue <input type="checkbox"/> goal being met, ongoing <input type="checkbox"/> continue working toward goal <input type="checkbox"/> try new strategy <input type="checkbox"/> revise goal <input type="checkbox"/> Other:
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See additional goals.

Update service plan as needed.

Social worker's signature _____

Mary F. Johnson

18937485368

Q Rev. 5/5/95

~~Economic~~

~~Summarize below any other significant events, contacts, or activities during the quarter (include dates) or attach relevant sections of your log notes.~~

Progress on goals

Goal # &/or description

3A&B,
personal care

Progress Aide services meeting goals. Continues
to need some help with self-care.

Disposition

- goal met/discontinue
- goal being met, ongoing
- continue working toward goal
- try new strategy
- revise goal
- Other: _____

Goal # &/or description

4A, talk about
husband w/out
crying

Progress Six counseling visits. Through
reminiscence about good and bad times, she has
come to terms w/loss (doesn't always tear up).
Thinks about what she wants to do now for
herself. Enjoys widows' group, will continue
with them. Meetings w/SW as needed.

Disposition

- goal met/discontinue
- goal being met, ongoing
- continue working toward goal
- try new strategy
- revise goal
- Other: _____

Goal # &/or description

4C, better
outlook

Progress Self-rating from 7 good days first month
to 15 this last month. GDS from 12 to 9,
but she says she is sad that she can't
physically do everything she would like.

Disposition

- goal met/discontinue
- goal being met, ongoing
- continue working toward goal
- try new strategy
- revise goal
- Other: _____

Goal # &/or description

4C social
contacts

Progress She is pleased with progress,
though says sometimes when she is hurting she
just doesn't want to talk to anyone. Weekly
contact w/church members and widows group,
makes her phone call, son says wife is pleased,
relationship better with sister.

Disposition

- goal met/discontinue
- goal being met, ongoing
- continue working toward goal
- try new strategy
- revise goal
- Other: _____

Update service plan as needed.

See new goal on service plan.

Social worker's signature Virginia White

Client: Mary Foster Johnson

Adult and Family Service Plan

Case # 95-10019

ID # 18937485368

Initial Update Quarterly Reassessment

(Use additional sheets as necessary.)

Date initiated 2/6/95

Checklist for Change (Problem/Need)	Goal	Target Date	Activities/Services	Person/Agency Responsible	Activity Done	Goal Met
<p>1. Mrs. J. is not safe at home: stove is not turned off; problems with heating pad, stove knob missing, dark stairs, slippery rugs</p>	1A. The stove will be consistently off when not in use for 1 month	3/6/95	<p>a. Mark stove's off position with tape.....</p> <p>b. Mrs. J. will turn off stove ..</p> <p>c. Mr. J. will monitor stove to reassure himself.....</p>	<p>SW, Mr. J.</p> <p>Mrs. J</p> <p>Mr. J</p>	<p>2/6</p> <p>tc w/son</p> <p>2/20,</p> <p>3/20, o.k</p>	5/5
	Identified hazards in Mrs. J. home will be fixed or removed within 6 weeks.	3/22	<p>a. Rugs tacked down securely, new heating pad purchased, stove knob replaced, temporary lighting for stairs</p> <p>b. Find source of help for permanent lighting on stairs (COA, church, Boy Scouts?).....</p>	<p>J. Family</p> <p>J. Family & SW</p>	<p>2/10, partial remaining items fixed, 3/10, per tc w/Mrs. J.</p>	5/5
<p>2. Mrs. J. lacks current medical care: her arthritis, her cloudy vision, her forgetfulness have not been evaluated recently</p>	2A. Mrs. J. will have a physical exam within 6 weeks.	3/22/95	<p>a. Identify new physician, make appointment, and have physical</p>	<p>Mrs. J</p>	<p>2/15, per tc; appt. 2/28</p>	5/5
	2B. Mrs. J. will have a plan for routine preventive medical care					
	2C. Mrs. J. and family will know causes of cloudy vision within the quarter and whether/what treatment is possible			<p>a. Get voucher for eye exam from Services for Blind</p> <p>b. Make appt. w/eye doctor, have eyes checked</p> <p>c. Arrange transportation to appointments</p>	<p>SW</p> <p>Mrs. J</p> <p>SW or J. Family</p>	<p>2/9</p> <p>2/10</p> <p>2/10</p>

This page and the next show what might have happened to the original service plan over the first quarter. Colored ink for the changes would make them more obvious. The third page shows updated items for change and new goals.

Checklist for Change (Problem/Need)	Goal	Target Date	Activities/Services	Person/Agency Responsible	Activity Done	Goal Met
3. Mrs. J. cannot bathe and wash hair as often as she wishes	3A. Mrs. J.'s hair will be washed twice a week (ongoing) 3B. Mrs. J. will have a bath at least every other day (ongoing)	2/24	a. 1 hour of in-home aide services 2x/week (see in-home service agreement) (short-term assistance)	DSS, SW	2/17	
			b. Check pain control, rehab possibilities with new physician (see item 2).....	Mrs. J.	2/28	
4. Mrs. J. is sad about her life and shows some signs of depression on the GDS	4A. Mrs. J. will be able to talk about her husband and his death without always crying or having the feeling that life will never be good again.	5/8/95	a. Counseling visit 2x/month for 3 months to talk about grief issues	SW	meetings PRN after 5/5	
			b. Read literature about bereavement group and consider joining.....	SW to get this, Mrs. J. will read	2/17	
	4B. Mrs. J. will talk to someone other than her son and his family at least twice a week	5/8	a. Talk to minister re: home visits, transportation to church	son, family	2/20	
			b. Phone one friend or relative (besides family) each week	Mrs. J.	5/5 ongoing	
4C. Mrs. J. will feel more positive about her life, as measured by her own daily rating and the Geriatric Depression Scale	5/8	c. Trial visit to senior center w/van pick-up	Council on Aging SW will arrange	withdrawn, 2/20		
		a. Mrs. J. will mark her calendar to indicate days when she feels better. GDS at next review.	Mrs. J., SW	5/5 ongoing		
<div style="border: 1px solid black; border-radius: 50%; padding: 10px; display: inline-block; margin-bottom: 10px;"> <i>Deferred Items</i> <i>Mrs. J.'s shaky finances</i> </div>						
<u>Virginia White</u> Social Worker <u>2/6/95</u> Date		<u>Mary F. Johnson</u> Client <u>2/6/95</u> Date		<u>Robert Johnson</u> Other (optional) <u>2/6/95</u> Date		

Client: Mary Foster Johnson

Adult and Family Service Plan

Case # 95-10019

ID # 18937485368

Initial Update Quarterly Reassessment

(Use additional sheets as necessary.)

Date initiated 3/15/95

Checklist for Change (Problem/Need)	Goal	Target Date	Activities/Services	Person/Agency Responsible	Activity Done	Goal Met
<p><u>Update</u> 3/15/93 2. Cloudy vision, continued</p>	<p>2C. know cause of cloudy vision, and treat if possible</p>	<p>4/30/95</p>	<p>a. Transportation to and from 2 outpatient surgeries..... b. Stay overnight w/Mrs. J. after each surgery c. Postsurgical home visits d. Temporary increase in in-home aide hours (see in-home aide plan)</p>	<p>church members dau.-in-law, grand-daughter Kudzu Home Health DSS/Mrs. Gooch</p>	<p>4/1 & 4/19/95 4/1 & 4/19 4/23 4/1 to 4/23/95</p>	<p>4/23</p>
<p><u>Update</u> 4/7/95 4. Outlook on life</p>	<p>4 A & B. Manageable grief about husband/more contact with others</p>	<p>8/6/95</p>	<p>a. Widows' support group</p>	<p>Kudzu All-Faith Council</p>	<p>begun 4/9/95; ongoing</p>	
<p><u>Update</u> 5/5/95 5. Mrs. J.'s monthly expenses exceed her income by \$20.00 because of new medications</p>	<p>5. Before the end of the year, Mrs. J. will have enough income to meet her regular expenses</p>	<p>12/30/95</p>	<p>a. Meet w/son and financial planner at Kudzu Women's Center b. Contact representative of SHIIP program through Sr. Ctr.</p>	<p>SW to provide phone nos. for both; Mrs. J. will call</p>	<p>5/9/95</p>	