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# Design of *ISD-1*: an instrument for social diagnosis in care homes for older persons*

# Diseño del *IDIS.1*: un instrumento para el diagnóstico social en residencias para personas mayores

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**ABSTRACT**

This article describes the design process and main features of an instrument developed for use in the specialist area of intervention in care homes for older persons. The essential aim of *ISD-1* (instrument for social diagnosis) is to permit the correct formulation of social diagnoses and to standardise and define the professional language used by social workers. Its content has been organised into 4 dimensions of social diagnosis, divided into 15 sub-dimensions containing 83 diagnostic categories. This work was performed in Spain, in the 24 care homes of the Madrid Social Care Agency of the Community of Madrid, involving the participation of the 40 social workers practising in these centres. *ISD-1* is an easily understood and used tool, of potential use for social workers practising in care homes for older persons and capable of being adapted for use in other institutional environments, as well as being capable of adaptation and translation for its application in other countries.

**RESUMEN**

Este artículo describe el proceso de diseño y las principales características de un instrumento para el diagnóstico social (*IDIS.1:* Instrumento para el diagnóstico social), desarrollado para su uso en el ámbito especializado de intervención de las residencias para personas mayores. La finalidad fundamental del *IDIS.1* es facilitar la correcta formulación del diagnóstico social y unificar y definir el lenguaje profesional empleado por los trabajadores sociales. Su contenido se ha organizado en torno a cuatro dimensiones de diagnóstico social, divididas en 15 subdimensiones, que agrupan 83 categorías diagnósticas. Este trabajo se ha realizado en las 24 residencias de la Agencia Madrileña de Atención Social de la Comunidad de Madrid, contando con la participación de los 40 trabajadores sociales en ejercicio en estos centros. El *IDIS.1* es una herramienta fácil de entender y utilizar, potencialmente útil para trabajadores sociales en ejercicio en residencias para personas mayores, y susceptible de ser adaptada para su uso en otros entornos institucionales de atención a personas mayores, o personas en otro tipo de situación de dependencia, así como de ser adaptado y traducido para su aplicación en otros países.

**KEYWORDS**
Social diagnosis; instrument; professional language; care homes; older persons

**PALABRAS CLAVE**
Diagnóstico social; instrumento; lenguaje profesional; residencias; personas mayores



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## Introduction

This article describes the design process and main features of an instrument for the formulation of social diagnosis in the specialist area of intervention in long-stay care homes for older persons. The instrument is named *ISD-1* (instrument for social diagnosis). *ISD-1* reflects the important of social diagnosis, which has been one of the key concepts in social work since Richmond (1917a) popularised it and emphasised its methodological significance. Social diagnosis has a dual methodological function: it is the final synthesis of the process of researching a specific social situation, and must be expressly formulated by the social worker as a ground for their intervention (Cury & Arias, 2016; Greenwood, 1955; Hamilton, 1923, 1946, 1948; Karls & Wandrei, 2008; Perlman, 1957; Richmond, 1917a, 1917b; Selby, 1958; Turner, 1968, 1996, 2002; Woods & Hollis, 1964).

The concept of 'social diagnosis' has been the object of controversy and concern in social work, sometimes being seen as insufficiently developed (Hamilton, 1946; Karls & Wandrei, 2008; Perlman, 1962; Richmond, 1917a; Turner, 1968, 1996, 2002; Woods & Hollis, 1964). However, throughout the evolution of the discipline there has always been a need for knowledge regarding the nature of social situations subject to intervention to be as broad and accurate as possible.

The choice of the specific research area is related to the process of an ageing global population, which influences the care-related needs of the very elderly. This ageing process is currently highly noticeable across all developed countries, with Europe the most aged continent. Within this demographic phenomenon, it is particularly striking that the population segment aged 80 years and above is one of those experiencing the highest growth rate (United Nations, 2015). It is specifically from this age (80 years) that experts are beginning to set the current threshold for old age, directly related with the start of a loss of independence in caring for oneself and carrying out the basic activities of daily life (European Commission, 2014). In many cases, the care-related needs of the very elderly may be met through the network of socio-healthcare services that allow older persons to remain in their homes. Nonetheless, the current demographic situation and future projections continue to place great importance on care homes. At the least, this type of centre must offer long-term care involving complex socio-healthcare aid, permanently or for an extended period of time (European Commission, 2014; US Dept of Health and Human Services, 2013).

In the institutional context of care homes, social diagnosis must contemplate the particular features of the social situation in which the older persons find themselves. The process of adapting to community life and to the institutional environment is one of the most delicate elements in the life of older persons at the centre and requires a careful assessment to ensure that the resident's well-being is affected as little as possible (Phillips & Waterson, 2002; Ray et al., 2015). Of particular impact in this process is the possibility of the older persons actively participating in institutional decision-making and in the care home activities (Gaugler, 2005; Goffman, 1961; Port, Barret, Gurland, Pérez, & Riti, 2011).

The design of a social diagnosis instrument in this field of intervention must also take into account the fundamental role played by the family as the main social support network for older persons, which extends beyond instrumental assistance and represents a determining factor for older persons' quality of life and preservation of identity (Bowers, 1988; Kelley, Swanson, Maas, & Tripp-Reimer, 1999; Port et al., 2005; Rowles & High, 1996). The involvement and participation of family members in institutional care has been associated with higher levels of social and psychological well-being in older persons and with increased satisfaction with residential life (Anderson, Lyons, & West, 2001; Cutchin, Owen, & Chang, 2003; Gaugler, 2005; Mitchell & Kemp, 2000). In this regard, the assessment of the relationship between the family and healthcare professionals is particularly significant. This relationship must encourage a continued bond between family members and residents and enable the family to carry out the fundamental role of providing older persons with social and emotional support (Cory, Sabir, Zimmerman, Suitor, & Pillemer, 2007; Duncan & Morgan, 1994; Hertzberg & Ekman, 2000; Herztberg, Ekman, & Axelsson, 2001; Port et al., 2005). Numerous studies also emphasise the importance of social support from the entire network of significant

persons who, together with the family, represent an important factor in people's well-being and health, particularly for older persons (Brown & Walter, 2014; Chappell & Funk, 2011; Colleen et al., 2015; Drageset, Kirkevold, & Espehaug, 2011; Kim & Kawachi, 2006; Rash, 2007; Van der Wel, 2007).

Additionally, *ISD-1* includes a social diagnosis dimension relating to the individual situation of older persons. The legal and financial situations of residents are taken into account, as well as key biographical background, emotional state, behaviour and social skills. These variables have a huge influence on general coping, successful social relations and adaptation to community life in older persons (Golant, 2015; Skodol, 2010; Wild, Wiles, & Allen, 2013).

Care home life also involves certain aspects of older people's situations that are resolved by the management of the institution itself, including hygiene, housing, food and healthcare. For this reason, *ISD-1* treats personal, relational and communal aspects as fundamental, recognising the importance of the family and of social support networks and the active participation of older persons and their families in community life. The content of *ISD-1* also encompasses the diagnosis of strengths and potential difficulties presented in older persons' situations.

Many neighbouring countries use the nursing home 'Resident Assessment Instrument' (RAI), developed in the United States by Fries and Cooney (1985), as the main system for gathering information and assessing the situation of older persons in care homes (Kane & Kane, 2000). However, social work has not had a specific and sufficiently tested instrument to formulate social diagnosis in this area of intervention. It is also worth highlighting that in 2007 the Madrid Social Care Agency of the Community of Madrid (*Agencia Madrileña de Atención Social*; hereinafter *MSCA*) implemented the 'Clinical protocols in care homes for older persons' as an IT system for assessment of the situation of older persons. The technical characteristics of these protocols have been particularly important in the design of *ISD-1*, since social diagnosis is a mandatory field in the IT application, which includes a section exclusively focused on formulating the social diagnosis. All care homes have a multidisciplinary team of clinical professionals, and the ratio of social workers per centre is 1 for every 200 residents. These professionals offer on-going social care for older persons and their families from the time of admission to the centre until the final day of their stay. They are obliged to formulate an initial social diagnosis one month after each new admission and to duly update this diagnosis whenever changes in the older person's social situation so require. For all this reason, it was considered apt to design an instrument such as *ISD-1* that would cover the need for an appropriate social diagnosis tool to be used in care homes for older persons.



## Research objectives and phases

The general objective of this study was to design a specific social diagnosis instrument for use in care homes for older persons. Three specific objectives were established to be carried out in three separate research phases (see Table 1).

**Table 1.** Specific research objectives and phases.

| Specific objectives | Research phases |
|---|---|
| (1) To understand the main situations subject to social diagnosis in care homes and the features of the formulation of such diagnosis | Phase 1: Selection and analysis of a representative sample of social diagnoses |
| (2) To understand the opinions of social workers with expertise in caring for older persons with regard to suitable structure and content for the design of a social diagnosis instrument in the context of care home interventions | Phase 2: Group analysis in order to design the instrument |
| (3) Determine, define and classify all the necessary diagnostic categories to correctly design the instrument for the formulation of social diagnoses in care homes for older persons | Phase 3: Thematic-categorical analysis in order to design the instrument |
| (4) Analyse validity of the instrument for the formulation of social diagnoses in care homes for older persons | Phase 4: Evaluation of the content of *ISD-1* by non-Madrid Social Care Agency judges<br>Phase 5: Application of *ISD-1* in Madrid social Care Agency care homes<br>Phase 6: Surveys to evaluate content and usefulness of *ISD-1* |

## Method

### Study area and participants

The chosen study area was the 24 care homes of the *MSCA*. The entire group of 40 social workers practising in these centres participated and we had access to sufficiently broad information to enable us to obtain the knowledge we required regarding the domain of content that the instrument must cover: 'social diagnosis in care homes for older adults'. The population of social workers presented a profile with a clear majority of women (99.02%), with an average age of 46 years ($s_x$: 6.95), average professional practice experience of 21 years ($s_x$: 6.95), and an average of 15 years spent working in the care of older persons in residential environments ($s_x$: 7.86). All these professionals were social workers and nine of them also had other related university qualifications. Therefore, the population of social workers participating in this study had extensive experience in caring for institutionalised older persons as well as appropriate and sufficient academic training.



### Phase 1. Selection and analysis of a representative sample of social diagnoses

The units of analysis for the selection of the sample were all the social diagnoses made by the 40 social workers in the *MSCA* over the course of 1 year ($N = 4561$ social diagnoses). The sample selection was conducted by stratified random sampling with proportional allocation based on the 'care home size' variable, as the number of places in the 24 care homes studied varied significantly. Approximately 44 residents lived in the smallest homes, with around 100 in the medium-sized homes and between 200 and 500 residents in those with the largest capacity. The confidence level chosen for the sample selection was 95.5% (2 sigmas) and a sampling error of 4% was calculated for overall percentage data. The resulting sample size for the total of 4561 social diagnoses made during the year amounted to 516.

All the social diagnoses that comprise the sample were collected in order to obtain precise knowledge of the social diagnosis situation in the field of care for older adults resident in long-stay *MSCA* centres. After the sample of 516 cases had been completely reviewed, the first level of classification of the sample was carried out for each care home, identifying all the possible social diagnosis categories. This first level of analysis permitted the identification of 7086 categories in the social diagnosis sample. The high number of identified categories corresponds to the enormous disparity in formulation of social diagnoses, based on each professional's style. As the social workers did not have any system for organising their social diagnoses, a single social situation would receive different labels without this entailing any difference in the concept being described. Therefore, once all the identified categories had been recorded, there was a standardisation of the terminology used by the different social workers in each case. This classification was carried out based on an analysis of the main social and healthcare diagnosis instruments and the results of a previous study conducted by the authors concerning social diagnosis in an *MSCA* care home (Cury, 2009). The classification permitted an analysis of the frequency with which the social diagnoses that make up the study sample appeared, in order to identify the situations that are most representative of residents' social situation. Also recorded were those social diagnoses that were statistically less represented in the sample, so as to accurately reflect the range of social situations diagnosed in the care homes.

### Phase 2. Group analysis in order to design the instrument

Three focused group interviews were conducted for the group analysis, with the participation of a group of nine social workers from the *MSCA*, selected on the basis of interest, availability and ability to participate in this research phase. The size of this group is based on its suitability for the type of debate and reflection-focused group work carried out in this procedure, as well as on the need to ensure continuity in the composition of the group of nine social workers over the course

**Table 2.** Classification of the social diagnosis sample.

| Dimensions, sub-dimensions and percentages | | | |
|---|---|---|---|
| **Individual situation: 86.77%** | | **Social situation: 9.25%** | |
| Socio-demographic data | 40.40% | Relationship with other residents | 31% |
| State of health | 12.21% | Relationship with staff | 9.98% |
| Data relating to institutionalisation | 11.92% | Participation in activities | 22.86% |
| Family cohabitation background prior to admission | 9.03% | Acceptance by other residents | 0.19% |
| Legal situation | 2.37% | Adaptation to the care home | 26.93% |
| Financial situation | 2.71% | Integration into the care home | 15.50% |
| Working or educational background | 1.74% | Social skills | 0–96% |
| Psychosocial profile of resident | 3.49% | Behaviour associated with religion | 0.96% |
| Bereavement | 2.9% | Leaving the care home | 10.27% |
| | | Sociability | 0.19% |
| | | Social contact outside the centre | 0.58% |
| | | Respecting the rules of the centre | 3.68% |
| | | Social support in the care home | 1.74% |
| | | Behavioural problems | 0.38% |
| **Family situation: 35.73%** | | **Institutional situation: 1.89%** | |
| Number of children | 40.31% | Relationship between family and care home | 5.03% |
| Social and family support network | 76.35% | User satisfaction with care home | 0.38% |
| Relationship with social and family support network | 56.58% | Request to change care homes | 0.58% |
| Social and family uprooting | 2.51% | Type of room | 2.32% |
| Family problems | 2.90% | Relevance of resource | 1.16% |

of the three focused group interviews. Social workers in care homes assume a significant workload in the centres, and the decision was therefore taken to build a group of professionals with a sufficient level of availability to handle the task entrusted to them. At the same time, these professionals had excellent qualifications as experts in caring for older persons in institutional environments. The main aim of this technique is to focus the interviewees' attention on the experience under study (Merton, 1987; Merton, Fiske, & Kendall, 1956).

Table 2,[1] represented the main instrument analysed in the three group meetings that were held. Three scripts were also designed,[2] incorporating the thematic keys that were addressed in each one of the interviews. The content of the social diagnosis classification and the suitability of the main social diagnosis dimensions, sub-dimensions and categories that should be contemplated in the design of *ISD-1* were analysed in this manner, as well as all the other relevant aspects for the proper design of the instrument.

### *Phase 3. Thematic-categorical analysis in order to design the instrument*

*ISD-1* was designed via the identification of categories that were described and defined on the basis of their characteristic features and their classification into classes, types or dimensions. A category-based classification system was selected for the design of *ISD-1* due to its alignment with the general aim of this work since it facilitates communication among professionals, is in line with the requirements of a clinical institutional organisation, and constitutes an easy-to-use system for daily practice (American Psychiatric Association, 2013). Below we set out the specific objectives that guided this phase of the design of *ISD-1* and the units of analysis used in this procedure:

### *Specific objectives*

- Identification of the main areas of social diagnosis in this field of intervention.
- Identification and classification of all necessary social diagnosis categories to determine the social situation of older persons in care homes.
- Definition of each social diagnosis category in order to establish the fundamental concept of each category.

- Establishing of social diagnosis criteria to offer a precise definition of categories that require such criteria due to their complexity.
- Assignment of a precise title to each social diagnosis category.
- Assignment of alpha-numeric code to each category for purposes of identification.

### *Units of analysis*

- The results of the analysis of the literature specialising in social diagnosis and care for older persons in residential environments.
- The main systems and instruments for social and healthcare diagnosis.
- The results obtained from the analysis and classification of the sample of 516 social diagnoses.
- The results obtained from the group analysis relating to the suitable structure and content for the design of the instrument enabling social diagnoses in care homes for older persons.

The overall analysis of all these results enabled us to attain a high degree of knowledge with respect to the social situation of older persons in care homes and, in turn, regarding the suitable characteristics for the organisation of a social diagnosis classification system in this specialist area of intervention.



## Results

### *Results of the analysis and classification of the sample of 516 social diagnoses*

The results of analysis of the diagnosis sample showed the existence of a methodological problem in the formulation of the social diagnoses. A considerable degree of disparity was observed in the language used by social workers to formulate the same or equivalent concepts. The social diagnoses were fairly frequently drafted using colloquial and narrative language that did not clearly define the social situation subject to diagnosis. However, there was a sufficient degree of consistency with respect to the dimensions and criteria used by these social workers in formulating the social diagnoses. This permitted classification of the content of the studied sample. It was possible to encompass all the identified social diagnosis categories within 4 diagnostic dimensions relating to the 'individual', 'family', 'social' and 'institutional' situation of the residential older persons, such dimensions in turn being divided into 33 sub-dimensions. Table 2 shows this classification and the frequency of appearance of all the social diagnosis dimensions and sub-dimensions identified in the sample, as well as the percentage that they represent in comparison with the overall total.

The analysis of the content of this classification showed that the most represented dimension in the social diagnosis sample was that relating to the 'individual situation' of older persons, with a percentage of 86.77%. This frequency fell to 35.73% for 'family situation', to a far lower percentage for 'social situation' (9.25%) and to a residual frequency of occurrence for 'institutional situation' (1.89%). In the individual dimension of the social diagnoses analysed, it is noteworthy that only the sub-dimension relating to 'socio-demographic data' showed a high frequency (40.40%), while the percentages for all the other sub-dimensions were below 15%. The values fell significantly for the frequency of occurrence of 'psychosocial profile of resident', 'financial situation', 'legal situation' and 'working or educational background'. Though these sub-dimensions refer to personal characteristics of the residents, they have a strong impact on the social situation of older persons and represent particularly important variables in correctly formulating social diagnoses.

In the 'family' dimension of the social diagnosis, the high frequency of formulation of social diagnoses relating to the 'social and family support network' (76.35%) and to the resident's 'relationship with social and family support network' (56.58%) are of note. The low percentages of social diagnoses referring to the 'social' and 'institutional' situations of older persons (9.25% and 1.92%, respectively)

represented a notable finding as they specifically concerned variables which assessment and diagnosis are the particular competences of the social worker and which have a strong impact on the social well-being of older persons in this type of institutional environment.

### *Results of the group analysis*

The results of the group analysis conducted with the group of 9 social workers confirmed the main findings obtained through the analysis and classification of the content of the sample of 516 social diagnoses. This group of social workers explained the need to contemplate both those social diagnosis dimensions and sub-dimensions represented in the studied sample (such as those relating to the family situation and the residents' support network) and those that appeared less frequently or even residually in the design of *ISD-1*. These social workers considered that *ISD-1* should contemplate aspects barely represented in the sample, such as residents' social and institutional situation, and individual aspects of older persons' situations, such as their biographical background, their legal and financial situation, their general emotional state, and the main characteristics of their behaviour, pursuant to the importance of these aspects for the social well-being of older persons.

### *Results of the thematic-categorical analysis for the design of* ISD-1

*ISD-1* is the main contribution of this study: this instrument identifies, defines and classifies all the necessary categories to consider the social situation of older persons in care homes. The content of *ISD-1* has been organised based on the 4 essential dimensions of social diagnosis that have been identified: 'individual', 'family', 'social' and 'institutional', divided into 15 sub-dimensions, which include 83 categories for the formulation of social diagnoses in care homes,[3] depending on the diagnostic group to which each category belongs (see Table 3).

All the social diagnosis categories, sub-dimensions and dimensions included in *ISD-1* are codified through an alpha-numeric system. The letters 'A', 'B', 'C' and 'D' have been used to denote each of the 4 dimensions, and have been assigned a number between 100 and 1400 according to the number of sub-dimensions classified in each one. The 83 social diagnosis categories of *ISD-1* consist of a 'label', with the name and definition of the category and a list of 544 diagnostic criteria have been designed to complete and specify such definition. Where considered necessary, we have established the minimum number of criteria to formulate a particular diagnosis, the necessary types of information sources and, in some cases, the time that must have passed from the appearance of certain signs or manifestations. Therefore, *ISD-1* classifies the different social situations according to a series of criteria that constitute the defining characteristics of each one; characteristics that provide the observable

**Table 3.** *ISD-1*. Classification of dimensions and sub-dimensions for the social diagnosis.

| Dimensions of social diagnosis | Sub-dimensions |
|---|---|
| A.100–600. Individual situation | A.100. Personal background |
| | A.200. Legal situation |
| | A.300. Financial situation |
| | A.400. Emotional state |
| | A.500. Behaviour |
| | A.600. Social skills |
| B.700–800: Social situation | B.700. Social relationships |
| | B.800. Participation |
| C.900. Family and personal friends situation | C.900–906. Family support network |
| | C.909. Personal friends network |
| D.1000–1400. Institutional situation | D.1000. Relationship with professional care |
| | D.1100. Relationship with centre rules |
| | D.1200. Relationship with room-mate |
| | D.1300. Family relationship with the centre |
| | D.1400. Adaptation to the centre |

cues/inferences that cluster as manifestations of a diagnosis (NANDA International, 2011). We described below the different types of category for the *ISD-1* social diagnosis:

1. Categories consisting of label, code and definition: only in those cases in which a descriptive paragraph has been deemed sufficiently clear and complete to act as a definition, with no specific criteria designed for the diagnosis, as shown in the examples categories: A.203. 'Admission due to social emergency' and category B.602. 'Limited social skills' (see Figures 1 and 2).
2. Categories including a list of diagnostic criteria:

2.1. Categories without a minimum number of criteria to establish the diagnosis: depending on the nature of particular categories, the definition itself or a single criterion may be sufficient to establish the diagnosis. In Figures 3 and 4, we see two examples of this type of category.

2.2. Categories requiring a minimum number of criteria and specific conditions to establish the diagnosis: due to the nature and/or complexity of many diagnostic categories, it has been necessary to identify a minimum number of criteria and conditions to be able to establish a particular diagnosis, as well as to distinguish a particular social situation from other similar ones, as shown in the two examples provided at Figures 5 and 6.

*ISD-1* also contemplates social diagnosis categories that are qualitatively different with respect to their duration. In this regard, it includes social situations which diagnosis will remain essentially unchanged over the course of the resident's stay, and situations that may change, worsen, improve or end in full remission. Moreover, *ISD-1* includes categories for the diagnosis of potential social difficulties and strengths of older persons, in order to provide the foundations for effective social intervention. In the case of older persons in care homes, their possible social needs are often related to the danger of social isolation within the centres, lack of a family support network, lack of independence in carrying out the activities of daily life and health problems deriving from the ageing process. For this reason, human factors and strengths are one of the main resources that the social worker must take into account for purposes of designing effective interventions.

Finally, *ISD-1* is an open social diagnosis system and its content does not assume that the possible situations of older persons will be entirely homogeneous with respect to the diagnosis, or that the criteria established exclude the presence of others not listed in the classification. The proper use of the instrument in no way prevents social workers from considering the formulation of other social diagnoses not covered in the current version of *ISD-1*. The tool requires professional expertise



**Category A.203. Admission due to social emergency.**

**Definition:**

Admission due to social emergency occurs when the situation of the older person in their habitual environment presents deficits in physical and/or psychological wellbeing that require urgent admission, within 24 hours, to a care home for older adults, without the existence of a court order

Note: Spanish Civil Procedural Act, art.763.

**Figure 1.** Category A.203. Example of *ISD-1*'s categories consisting of label, code and definition.

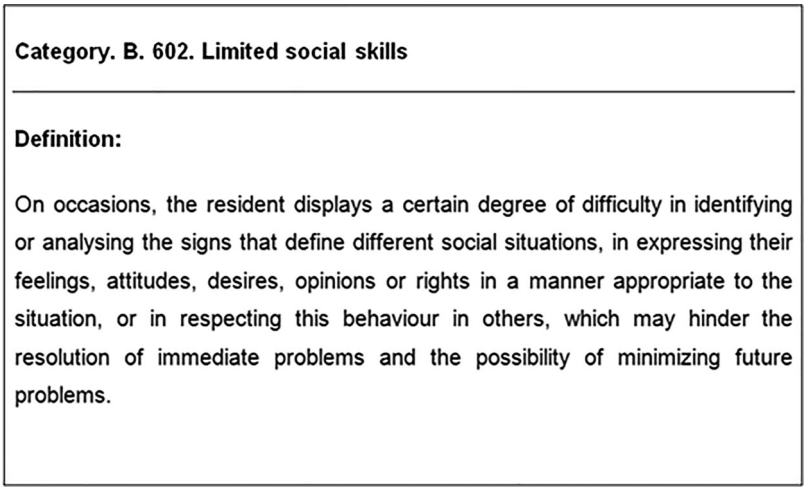


**Figure 2.** Category B.602. Example of *ISD-1*'s categories consisting of label, code and definition.

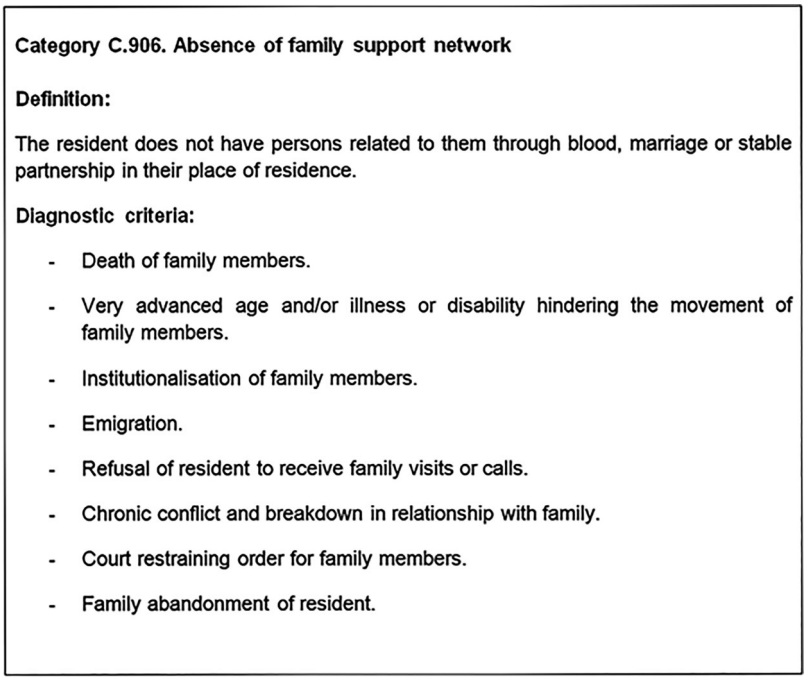


**Figure 3.** Category C.906. Example of *ISD-1*'s categories without a minimum number of criteria to establish the diagnosis.

and appropriate management by social workers who are experienced in the care of residential older persons, and remains subject to modifications that its daily use may reveal to be necessary, as well as to the results of future studies to validate its content.

## Discussion and conclusions

Designing instruments to formulate a diagnosis is always a significant disciplinary challenge in both the healthcare and the social contexts, bearing in mind that the effectiveness of any intervention depends on the suitability and precision of such diagnosis.

**Category. D.1401. Good adaptation to and integration within the centre**

**Definition:** The resident has satisfactorily adapted to the centre and integrated into community life.

**Diagnostic criteria:**

- Voluntary admission.
- Involuntary admission or admission due to social emergency, but subsequent understanding and acceptance of the residential situation.
- Good social skills.
- Positive social relationships.
- Active acceptance of professional care.
- Cordial and collaborative relationship with roommate.
- Active participation in community activities.
- Good overall mood.
- Positive identification with status, standard of living and functions of their role prior to admission.
- Acceptance of cohabitation rules.
- Integration and active relationship of collaboration between resident's family and centre.

**Figure 4.** Category D.1401. Example of *ISD-1*'s categories without a minimum number of criteria to establish the diagnosis.

**Category A.111. Record of abuse of third parties**

**Definition:**

Older person who has been involved in situations of physical or psychological abuse of others; and therefore, has engaged in any intentional activity that has caused physical harm or illness or who has intentionally eroded another person's self-worth.

**Diagnostic criteria:** At least one of the criteria to establish the diagnosis must be satisfied, and will be established when recorded in a socio-healthcare report and/or a court judgment or has been directly observed or verbally reported by the resident and/or their family members.

- Court sentence regarding a physical abuse offence.
- Court sentence regarding a psychological abuse offence.
- Situation of temporary detention for criminal abuse.
- Court-ordered loss of custody of children for abuse.
- Loss of parental authority for abuse.
- Court restraining order relating to abuse of third parties.
- Social and/or healthcare reports recording situations of abuse.
- Physical or psychological abuse causing a serious situation of conflict between family members and resident.

**Figure 5.** Category A.111. Example of *ISD-1*'s categories requiring a minimum number of criteria and specific conditions to establish the diagnosis.

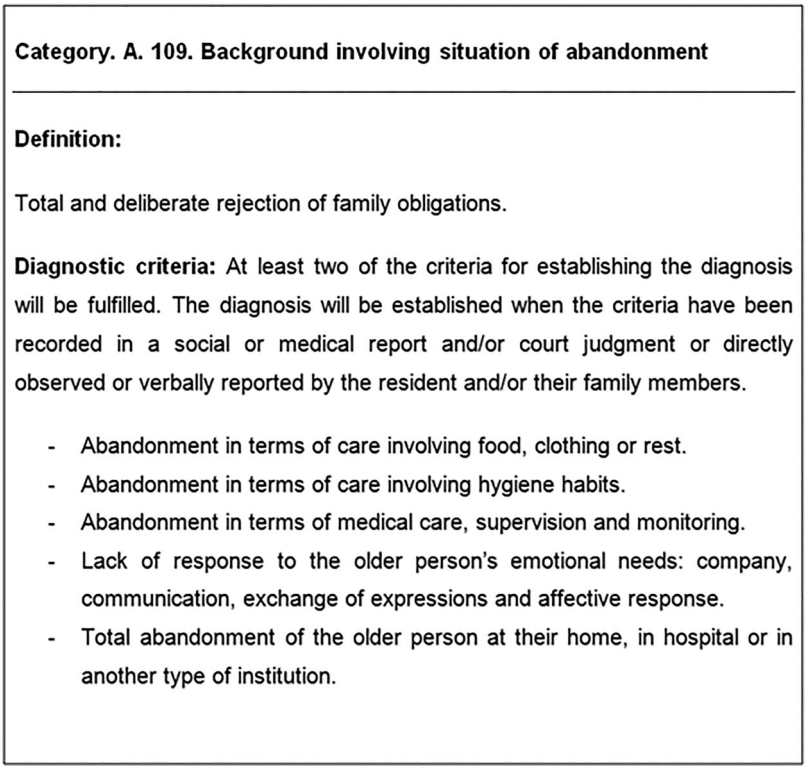


**Figure 6.** Category A.109. Example of *ISD-1*'s categories requiring a minimum number of criteria and specific conditions to establish the diagnosis.



In this sense, it should be noted that the breadth and complexity of the domain of content represented by social diagnosis constituted the fundamental aspects to be contemplated in designing *ISD-1*. In this regard, we consider that one of the main strengths of *ISD-1* is the method used in its design. The entire population of the 40 social workers in the *MSCA* care homes participated in the first phase of this study, and contributed the corresponding sample of social diagnoses requested from each of the care homes. We were hence able to analyse the content of a statistically representative sample of all the diagnoses made in the centres over the course of a one-year period. The results of the analysis and the classification of the sample content enhanced this study with knowledge of the variables that social workers contemplated when formulating social diagnoses in care homes. The content of this sample also allowed us to understand the terminology used to formulate the social diagnoses and to identify the difficulties that could affect the formulation process.

The main difficulty we discovered in the analysis and classification of the sample content was that each social situation (or its features) would be differently defined, according to the style and language used by the social worker in question. Moreover, the style and language used in formulating diagnoses were frequently anecdotal, narrative and even colloquial, which coincides with the concern expressed in the literature regarding the limited and belated development of social diagnosis and the need to establish a common body of social work knowledge and professional terminology.

The results of the group analysis of the sample content of social diagnoses confirmed the existence of a methodological problem in the formulation of social diagnoses in care homes, as well as the need to carry out a process of organising diagnosis-related knowledge, the importance of which has been referred to in social work since its beginnings (Greenwood, 1955; Hamilton, 1923,

1946, 1948; Karls & Wandrei, 2008; Pelton, 1910; Perlman, 1957, 1962; Richmond, 1897, 1917a, 1917b, 1922; Selby, 1958; Turner, 1968, 1996, 2002; Woods & Hollis, 1964).

In this regard, the work of reflection and analysis performed in the three focused group interviews with the social workers contributed a significant degree of knowledge for purposes of the subsequent design of *ISD-1*. The results obtained from the group analysis carried out with the participating social workers coincide with the specialist literature concerning the main aspects to be contemplated in correctly formulated social diagnoses in the specialist field of intervention with older persons in care homes. These are the aspects that justify the design of a specific instrument for such purpose: the process of adapting to community life (Phillips & Waterson, 2002; Ray et al., 2015); the advanced age of the persons living in the centres; the older persons actively participating in institutional decision-making and in the care home activities (Gaugler, 2005; Goffman, 1961; Port et al., 2011) and the influence of family and social relationships on the well-being of older persons (Brown & Walter, 2014; Camfield, Chouury, & Devine, 2009; Keating, Otfinoski, Wenger, Fast, & Derksen, 2003; Sims-Gould & Martin-Matthews, 2007; White, 2010).

The results of this group analysis also coincide with the analysed literature concerning the need to consider both the social difficulties and strengths of persons in the diagnosis in order to provide a basis for an effective social intervention (Early & Glenmayer, 2000; Hamilton, 1948; Khistardt, 1994; Perlman, 1957; Rapp, 1998; Richmond, 1930; Salebeey, 1996, 2013; Weick, Rapp, Sullivan, & Kisthardt, 1989; Wenger Clemons, 2014; Woods & Hollis, 1964).

The design of *ISD-1* was carried out on the basis of all these results. The structure of *ISD-1* is that of a categorical diagnostic system. This classification system is in line with the majority of diagnostic systems in the medical, nursing and social fields. Moreover, the main diagnostic instruments in the medical, nursing and social work fields cited in this work make use of the system established in *ISD-1* to define the different diagnostic categories. This involves a descriptive paragraph and the design of specific indicators, temporal criteria and/or defining the type of sources to consult in formulating a diagnosis, depending on the nature or complexity of the different situations that are classified (American Psychiatric Association, 2013; Karls & Wandrei, 2008; NANDA International, 2011; World Health Organization, 2008, 2010; World Organization of Family Doctors, 2005).

*ISD-1* identifies, defines, codifies and classifies all the relevant categories to formulate social diagnoses, and its content *ISD-1* is adjusted to the specific characteristics of the situation of older persons in long-stay care homes and to the main recommendations of experts in this context.

We have therefore achieved the general objective of our research, having produced a new social diagnosis instrument that permits the proper formulation of social diagnoses in the specialist area of intervention in care homes for older persons. This potential use of *ISD-1* also implies that its future application in care homes may involve the possibility of reviewing and improving and/or broadening its content, and the continuation of this line of research.

We may nonetheless recall that this potential use of *ISD-1* is conditional, because the content of the instrument effectively covers the entire conceptual range of social diagnosis in care homes. Since *ISD-1* constitutes the first version of this instrument, the possible under-representation of the construct or the presence of factors that are irrelevant to it represent the main potential weaknesses of *ISD-1*. This aspect has been taken into account in this study, and two procedures were performed to analyse the content and usefulness of *ISD-1* once the definitive design of *ISD-1* had been completed, with the participation of 2 independent groups of experts: 1 group of 10 social workers from outside *MSCA*, experts in the care of older persons in institutional environments, and a group made up of the 31 *MSCA* social workers who did not participate in the focused group interviews. For reasons of length, the methodological design of the *ISD-1* validity study and its results and conclusions will be presented in a separate work. Depending on the results of the validity study carried out as part of this research and/or the future results of its use in the care homes of the Community of Madrid or in other institutional settings, *ISD-1* may be the object of future research and new versions of the instrument could be developed.

## Notes

1. We reproduce Table 2, 'Classification of the social diagnosis sample' in the Results section.
2. The three scripts used to conduct the focused group interviews are attached to this work as 'Supplemental online material' (http://goo.gl/cN2vUu).
3. The index of the 83 categories of *ISD-1* is attached to this work as 'Supplemental online material' (https://goo.gl/tiDuyz).

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