Objectives

- Explain the process of investigation, assessment, and critical thinking during the CAA analysis
- Discuss the steps involved in individualizing care plans that are meaningful and realistic for residents
- Describe an effective means to evaluate and audit care plans for residents

Resident Assessment Instrument

- **Goal:** Highest practicable level of functioning
  - Assesses each resident’s functional capacity, needs, and strengths to develop clinically relevant interventions
  - Results are used to develop, review, and revise the resident’s comprehensive care plan
  - Understand the causes and contributing factors of identified problems
  - Develop resident-specific care plan based on identified problems, needs, and strengths

RAI Terminology

- **Minimum Data Set (MDS)** – A screening tool that provides information about a residents’ clinical and functional status
  - *Not a complete assessment*
- **Care Area Triggers (CATs)** – MDS Items and responses that identify potential issues that need additional assessment and review.
Care Area Assessments (CAAs) – More in-depth assessment to identify contributing factors/risk factors to the possible problem as well as other areas the possible problem could affect.

A CAA must be completed for each care area that is identified as a possible problem, or triggered, as a result of the MDS assessment.

A care plan may or may not be warranted.

CAA Review Process, Step 1

Identify Triggered Care Area(s) & Triggers

Most software does this step for you.

Working the CAAs: 4 Steps

1. Identify the triggered Care Area(s) and triggers
2. Analyze the Care Area(s)
3. Decide if/what care planning
4. Document the process

When to Complete CAAs

- Are only required for MDS 3.0 comprehensive assessments
  - Admission assessment
  - Annual assessment
  - Significant change in status assessment
  - Significant correction of a prior comprehensive assessment

- May also be used any time the facility wishes to provide a more focused review of any area not triggered.

Care Area Assessments (CAAs)

1. Delirium
2. Cognition loss/dementia
3. Visual Function
4. Communication
5. ADL Function/Rehabilitation Potential
6. Urinary Incontinence/Catheter
7. Psychosocial Well-Being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcer
17. Psychotropic Drug Use
18. Physical Restraints
19. Pain
20. Return to Community Referral
CAAs Assist the IDT to:

- Identify causes and risk factors contributing to the triggered care area
- Identify and address associated causes and effects
- Determine whether and how multiple triggered conditions are related
- Identify a need to obtain additional medical, functional, psychosocial, financial, or other information

CAT: Care Area Trigger

- An MDS response indicating clinical factors exist that may or may not represent a condition that should be care planned
- Usually a sign, symptom, or other indicator of a possible problem, need, or strength.

*Triggers flag conditions that warrant further investigation*

CAT Logic: Visual Function

**Visual Function CAT Logic Table**

**Triggerring Conditions (any of the following):**
- 1. Cataracts, glaucoma, or macular degeneration on the current assessment as indicated by:
  \[ I6500 = 1 \]
- 2. Vision item has a value of 1 through 4 indicating vision problems on the current assessment as indicated by:
  \[ B1000 >= 1 \text{ AND } B1000 <= 4 \]

CAT Logic: Delirium

**Delirium CAT Logic Table**

**Triggerring Conditions (any of the following):**
- Worsening mental status is indicated by the BIMS summary score having a non-missing value of 00 to 15 on both the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) and the prior assessment, and the summary score on the current non-admission assessment being less than the prior assessment as indicated by:
  \[(A0310A = 03, \text{ OR } 04) \text{ AND } ((C0500 >= 0) \text{ AND } (C0500 <= 15)) \text{ AND } ((V0100D >= 0) \text{ AND } (V0100D <= 15)) \text{ AND } (C0500 < V0100D)\]
- Acute mental status change is indicated on the current comprehensive assessment as follows: \[ C1600 = 1 \]
• Some CAAs require only **one item**
  – Example: Pressure Ulcers
  – If the person is not independent in bed mobility

• Other CAAs require **two items**
  – Example: ADL Functional/Rehabilitation Potential
    – If the person is not independent in 2 or more ADLs – Bed Mobility, Transfer, Walk in room, Walk in corridor, Locomotion on unit, Locomotion off unit, Dressing, Eating, Toilet use, Personal hygiene, Bathing

• A few CAAs require **three or more items**
  – Example: Activities
    • Section F Interview of Preferences for Customary Routine and Activities

• Some CAAs use a **comparison** between the current assessment and the previous assessment (V0100E)
  – Example: Delirium
    • BIMS Summary Score
  – Example: Mood
    • PHQ-9 or PHQ-90V Total Severity Score

**Care Area Triggers (CATs)**

**CAA Review Process, Step 2**

**Analyze the Care Area(s)**

**Root Cause Analysis: Delirium**

**Delirium CAA**

**CAA Specific Resources**

• Virtually all MDS software includes a version of the tools in Appendix C of the RAI Manual

• There is a checklist of indicators that guides the assessment for the particular care area
  – This is often auto-populated by the answers on the MDS
  – However, the MDS doesn’t have all the answers!

  **Critical thinking is the key component of the process**
CMS does not endorse the use of any particular resource(s)

- ... including those in Appendix C!
- "Must be current, evidence-based or expert-endorsed research and clinical practice guidelines/resources"
- "The facility should be able to identify the resources they use upon request"

What’s the Point?

"The CAA is not just to gather the data but also to synthesize the information and determine: Is this important? Is it not important? Is this a problem? Is this not a problem? That analysis is never something that a computer can do for you."

Judy Wilhide Brandt, RN, RAC-NT, C-NE

Want to Write Better CAAs? (1 of 2)

- Know your resident
  - Fe Right or Left Hip?
- Go interdisciplinary
  - Average of 12 CAAs at 15 – 20 minutes each
- Don’t “silo”
  - A CAA is only going to be successful if it is written by a person who has consulted with the entire team, who has done a thorough review of the resident, and who is in a position to critically analyze all of the data that they have learned.

Want to Write Better CAAs? (2 of 2)

- Involve the Physician/NP
  - With the multi-factorial frail elderly, the IDT needs to get input from everyone, including the resident and the physician, so they can have an actual, authentic care plan.
  - Once the IDT members have completed the comprehensive assessment, they sit down with the physician/NP and go over each of the triggered CAAs with that prescriber to get their input in working the CAAs.
- Use Appendix C
  - It’s the current standard of practice
  - Most software incorporates it
  - You don’t have to explain it to the surveyors
- Know the purpose
  - How does this CAA affect the resident’s quality of life?

Case Study: Mrs. M

- Delirium CAA
- And
- Multiple CAA Summaries
• V0200B(1) and (2)
  - Date that the RN coordinating the CAA process certifies that the CAAs have been completed.
  - The CAA review must be completed no later than the 14th day of admission (admission date + 13 calendar days) for an Admission assessment and within 14 days of the Assessment Reference Date (A2300) for an Annual assessment, Significant Change in Status Assessment, or a Significant Correction to Prior Comprehensive Assessment.
  - This date is considered the date of completion for the RAI.

Discuss the steps involved in individualizing care plans that are meaningful and realistic for residents

The Care Plan Process

- Define the “problem”
- Identify goals and objectives of care
- Select interventions
- Implement plan of care
- Monitor progress towards goals
- Revise as needed

The “Problem” Statement

- Actual, potential, and possible problems, as well as strengths
- Based on the critical analysis of the IDT assessments, including the CAAs.
- Defines the issues specific to the individual’s problem to facilitate effective goal setting and the development of appropriate interventions.
- Defines significant risk factors
- Identifies actual or potential complications related to the problem.
The "Problem" Statement: Combos

- For example, if impaired ADL function, mood state, falls, and altered nutritional status are all determined to be caused by an infection and medication-related adverse consequences, it may be appropriate to have a single care plan that addresses these issues in relation to the common causes.

- For example, if impaired vision and communication function as well as mood and behavior symptoms are all related to the DX of Alzheimer’s Disease with profound cognitive deficits, it may be appropriate to have a single care plan that addresses these issues in relation to the common causes.

The "Problem" Statement

- Statement focus should be formulated based on root-cause analysis of data
- Should contain enough information to facilitate the development of interventions related to the specific problem and identified risk factors
- Example: For a resident with multiple falls, the problem statements below would result in different interventions:
  - Falls R/T attempts to get out of bed at night
  - Falls R/T attempts to self toilet after meals.

The "Problem" Statement

- Wording and Format is not mandated
- Resident, responsible parties, and all clinical staff should be able to understand
- Regardless of the wording, the problem must contain enough information to ensure that interventions selected are related to the true problem

The "Problem" Statement: Types

- Disease Related
  - "Problem" statement is a medical diagnosis combined with s/s exhibited by the resident:
    - CHF AEB SOB with exertion and pedal edema
    - FX right femur with pain, swelling, healing surgical incision
- Functional
  - Resident is unable to dress, groom, bathe self R/T CVA
  - Vision deficit R/T glaucoma

Nursing Diagnosis

- Alteration in self care R/T CVA
- Alteration in comfort R/T hip fx and surgery
- MDS or CAA Related
  - Section C, BIM's: Memory Deficit
- “I” Care Plan
  - I miss going out for Sunday brunch with my family. I don't go because I'm embarrassed I'll have an accident and not get to the bathroom in time. I worry about wet clothing and odor.

Process Suggestions

- Arrange the problem and strength areas in the same order as the MDS Sections
  - Facilitates a holistic care plan model
  - Facilitates identifying the MDS area as a strength or deficit
  - Increases efficiency with MDS/Care Plan comparison
  - Decreases the risk of forgetting key areas of care
- Keep high profile areas as separate problems to facilitate evaluation and revision
  - Fall risk, Pressure ulcer risk, Pain
- Prioritize based upon resident choice
Goals Should Be ...

**SMART**

- Specific
- Measurable
- Achievable
- Realistic
- Timed

Goals

As identified in the RAI Manual, the goal should include: a subject, a verb, modifiers, and a time frame

<table>
<thead>
<tr>
<th>Subject</th>
<th>Verb</th>
<th>Modifiers</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident</td>
<td>Will walk</td>
<td>With physical assist of 1 and RW to and from all meals</td>
<td>Daily through next 90d</td>
</tr>
</tbody>
</table>

How Can These Be More Measurable?

- Resident will demonstrate decreased anxiety.
- Resident will gain less weight.
- Resident will be more independent with ADLs.

How Realistic/Reasonable Are These?

- Is it realistic for a resident who is steadily losing weight to gain 5 # in the next month?
- Is it realistic for a resident with Alzheimer's to improve expressive communication?
- Is it realistic for a resident with frequent falls not to fall in the next 90 days?

Time Limited

- Federal Regulations require goals to be no longer than quarterly
- Assessment data, resident condition, and specifics of the care area should determine how often to evaluate the goal
- It is not reasonable for all goals to be "next review", next 90 days
  - Medication change to improve a condition, mitigate symptoms
  - Fall problem intervention changes
  - Healing wounds

Types of Goals

- Improvement goals
- Maintenance goals
- Preventative goals
- Palliative goals
- Coping goals
Goals: Improvement

- **Improvement goals:**
  - Encourage a higher level of physical, social, or psychosocial functioning

Goals: Maintenance

- **Maintenance goals:**
  - Aimed at keeping the resident at his/her highest level of health and functioning and/or retard the rate of severity of deterioration

Goals: Preventative

- **Preventative goals:**
  - Directed at preventing complications from occurring

Improvement Goals

- Resident will progress to walking with limited assist of 1 within 30 days
- Resident will dress upper body independently within 30 days
- Resident will attain independent bed mobility within 2 weeks
- I will gain 2 pounds within 30 days
- Resident will demonstrate improved pain management AEB intensity of 5 or less daily within 1 week.
- Mary will improve activity participation by attending 2 groups per week within next 60 days.

Maintenance Goals

- Resident will maintain ability to wash/dry hands during AM/PM partials with set-up and cues through next review
- Resident will maintain ability to walk up to 50’ daily with extensive assist of 2 through next review.
- Resident will maintain ability to recognize self evidenced by appropriate response when addressed.
- Resident will maintain ability to feed self at all meals after set up through next review.

Preventative Goals

- Resident will not demonstrate fall related major injuries in next week.
- Resident will not develop new pressure ulcers within the next 30 days.
- Mary will not demonstrate S/S of significant GI distress with use of the ordered medication within the next 2 weeks.
**Goals: Palliative**

- **Palliative goals:**
  - Directed at making the resident more comfortable
  - May be part of a general condition plan of care or individual areas of care such as pain management, mood, nutrition.

**Goals: Coping**

- **Coping goals:**
  - Directed at helping a resident understand, accept/compensate for losses
  - Often used in a psychosocial, mood, or activity plan of care

**Interventions/Approaches**

- Instructions/directions to the IDT
  - Should include clear, focused action statements of direction regarding the resident's care:
    - **Action** - such as walk
    - **Amount, distance, quantity** such as to the dining room
    - **Method** - such as physical aid of 1 and RW
    - **Frequency** - such as to all meals
    - **Additional clarifying information or direction**, such as observe for SOB, or c/o left hip pain

**Palliative Goals**

- John’s quality of life will be maintained, as evidenced by:
- John’s symptoms will be controlled, as evidenced by:
- John’s pain will be managed
- John’s nausea will be managed as evidenced by:

**Coping Goals**

- Resident will verbally identify effective and ineffective coping patterns within 30 days.
- Resident will verbalize an increased sense of control as evidenced by _____ within 30 days.
- Resident will verbalize decreased negative feelings as evidenced by _____ within 30 days.
- Resident will demonstrate modifications to leisure lifestyle as evidenced by_____ within 30 days.

**Interventions/Approaches**

- Care areas may have multiple causes and contributing factors and multiple items can have a common cause or related risk factors.
- Acceptable to cross reference related interventions from several care plan problems:
  - “See current hospice plan of care”
  - “See current therapy plan of care”
Interventions/Approaches

- Categories to consider
  - Observation, Monitoring, Assessment
  - Specific clinical approaches designed to achieve specific outcomes
  - Teaching activities (Resident or Family)
  - Resident preferences

Intervention Focus

- Facilitate Improvement
  - Skilled Physical Therapy as ordered, refer to TX plan for specifics
  - Pressure ulcer treatment as ordered, refer to TAR for specifics
- Prevent Avoidable Decline
  - Restorative Nursing Program to maintain:
    - Ensure at each meal
- Provide Palliative Care
  - Monitor pain q shift and administer analgesics as ordered, refer to MAR for specifics

Interventions Categories

- Observation, Monitoring, Assessment
  - Observe for SOB during walking
  - Monitor pain q shift (requires documentation)
  - Assess cognitive status quarterly and PRN
- Specific clinical approaches designed to achieve specific outcomes
  - Antipsychotic Med as ordered, refer to MAR
- Teaching activities (Resident or Family)
  - Independent colostomy management
  - Insulin administration

Interventions/Approaches

- Use approaches specific to the resident
- May use actual physician orders or refer to the physician orders
- Do not use unrealistic approaches such as:
  - Interventions that appear important but are not necessary to the resident
- Do not include an unrealistic number of approaches under one problem
  - Select only those you are going to use

A "Typical" Care Plan: Vision

When to Update/Revise the Care Plan?

- With a new problem
- With any deletions to the care plan
- With any change in condition
- When the interventions change
- When the goal changes
- With new MD orders not addressed

Key Points:

- Initial and date any changes (additions or deletions)
- Are additions included in appropriate problem or just on some available white space?
Effective Care Plans

- A central source of information
- Direction for resident centered or resident directed care
- Facilitate continuity of care
- Facilitate quality care
- Reimbursement impact
- Documentation for legal issues
- Implications for staffing needs
- A basis for evaluating team functioning

Ineffective Care Plans

- Incomplete or inaccurate assessments leading to incomplete or inaccurate data
- Failure to tailor the care plan to meet the individual needs of the resident
- Omission of significant resident needs or problems
- Lack of objective, time limited, measurable goals
- Being too vague or too complex to be implemented easily

Ineffective Care Plans

- Lack of periodic evaluation resulting in outdated information
- Inadequate time devoted to care plan development
- Lack of resources/training for accurate care
- Failure to clearly designate responsibilities the care plan should not force the caregiver to make a decision about care

Care Plan Overview

In a Nutshell

- What is the issue, concern, or strength (Problem)
- What is the result the resident, the family, and the IDT have agreed upon (Goal)
- What are you going to do to assist the resident to achieve the result (Interventions)

QAPI

Describe an effective means to evaluate and audit care plans for residents

Planned interventions in order to improve the quality of the care and services delivered to residents

A comprehensive, structured, and ongoing transformational approach used to assess and improve the quality of care and services
**Potential PIPs r/t Care Plans**

- Initial care plans
- “I” care plans
- Goal statements
- Acute care plans

---

**“I” Care Plans**

- What is the system?
  - Does it fit in with person-centered or person-directed initiatives or will this be a “culture change”?
  - “N 1 trails”
  - One staff person, one unit, one resident
- Process long term residents over one quarter
  - Start with the dementia unit
  - Start with “problems” identified primarily as psychosocial
- Start with short term resident discharge goals

---

**Initial Care Plans**

- What is the system?
- Conduct care plan audit along with existing audits at 24 hours and/or 72 hours
- Are these items included:
  - Risk factors: Skin, Falls/Safety, Pain
  - ADLs
  - Discharge Plans
  - Reasons for Medicare skilled coverage
    - Rehabilitation, Skilled Nursing, Observation and Assessment, Management of Complex Care, Teaching and Training

---

**Goal Statements**

- What is the system?
- Are they SMART?
- Process long term residents over one quarter
  - For short term residents
    - Conduct care plan audit along with existing audits at 24 hours and/or 72 hours
    - Attend care plan meeting
    - Get resident and family input ASAP

---

**Acute Care Plans**

- What is the system?
- Are they timely?
- Are they SMART?
- Incorporate as part of Risk Management or clinical follow up
  - Falls
  - Pressure Ulcers
  - Weight Loss
  - “www.com”

---

**The Weakest Link**

The weakest link in the process is implementing solutions that are centered on training & education, or asking clinicians to “be more careful.”
**WEAK Actions**

Weak actions enhance or enforce existing processes:

- Double checks
- Warnings/labels
- New policies / procedures / memoranda
- Training/education

Depend on staff to remember their training or what is written in the policy.

---

**WHY?**

These solutions *don’t impact the system*, & are based on two assumptions:

1. Lack of knowledge contributed to the event, and
2. If a person is educated or trained, the mistake won’t happen again.

---

**Human Error**

Solutions that rely on vigilance or memory are equally problematic because they create expectations for staff to remember more or be more careful.

This is not always realistic when staff are in stressful situations or when multi-tasking.

If the system doesn’t provide support, it is part of the problem.

---

**INTERMEDIATE Actions**

Somewhat dependent on staff remembering to do the right thing, but provide *tools* to help staff remember or to promote clear communication.

*Intermediate actions modify existing processes:*

- Decrease workload
- Software enhancements & modifications
- Checklists, cognitive aids, triggers, prompts
- Read back
- Enhanced documentation & communication

---

**STRONG Actions**

Do not depend on staff to remember to do the right thing.

May not totally eliminate the vulnerability but provide strong controls.

*Change or re-design the process - help detect so there is an opportunity to correct*

---

**Strong Actions = Hard Stops**

Won’t allow the process to continue unless something is corrected or signals intervention to prevent significant harm:

- EMR: Cannot save unless all fields are filled in
- Simplifying: Pre-printed check-off acute care plans
- Physical changes: Laptop computers or tablets; point of care charting
- Forcing functions: Care plan library is written in appropriate format
APPENDIX C

CARE AREA ASSESSMENT (CAA) RESOURCES
CAA Summary Note: #1 Delirium
Date: 12/30/10
MDS items: #1 Delirium

Triggers: BIM score declined from 13-14 to 11

<table>
<thead>
<tr>
<th>Mark if Area Triggered</th>
<th>Change in Vital Signs</th>
<th>Supporting Documentation: (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td>Rectal temp above 100°F or below 95°F (38°C / 35°C)</td>
<td>Has been running a low grade temperature every afternoon</td>
</tr>
<tr>
<td>x</td>
<td>Pulse rate &lt;60 or &gt;100 beats/ min</td>
<td>Irregular Grade III systolic murmur</td>
</tr>
<tr>
<td></td>
<td>Respiratory rate ≥25 breaths/minute or &lt; 16 breaths/minute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypotension or a significant decrease in blood pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Systolic b/p &lt; 90mmHg OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decline of 20 mmHg or greater in systolic b/p from person’s usual baseline OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decline of 10 mmHg or greater in diastolic b/p from person’s usual baseline OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypertension – systolic b/p above 160 mmHg OR a diastolic b/p above 95 mmHg.</td>
<td></td>
</tr>
</tbody>
</table>

**Abnormal Laboratory Values**

- Electrolytes, such as sodium
- Kidney function
- Liver function
- Blood sugar
- Thyroid function
- Arterial blood gases
- Other: Anemic

**Pain**

- Pain Care Area triggered (review findings for relationship to delirium)
  
- Yes was triggered

| x | Pain frequency, intensity, and characteristics (time of onset, duration, quality) indicate possible relationship to delirium |
|   | Defines pain as 7 out of 10. Has impacted ability to participate in therapy. |

**Diseases and Conditions**

- Circulatory/Heart: anemia, cardiac dysrhythmias, angina, MI, ASHD, CHF, pulmonary edema, CVA, TIA
  
- History of CHF and a CVA. Irregular pulse and a systolic heart murmur, MI, ASHD
<table>
<thead>
<tr>
<th>Sign of Infection (from observation, clinical record)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
</tr>
<tr>
<td>Cloudy or foul smelling urine</td>
</tr>
<tr>
<td>Congested lungs or cough</td>
</tr>
<tr>
<td>Dyspnea</td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Purulent wound drainage</td>
</tr>
<tr>
<td>Erythema around an incision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators of Dehydration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dehydration care area triggered, indicating s/s of dehydration are present</td>
</tr>
<tr>
<td>Recent decrease in urine volume or more concentrated urine than usual</td>
</tr>
<tr>
<td>Recent decrease in eating habits – skipping meals or leaving food uneaten, weight loss</td>
</tr>
<tr>
<td>Nausea, vomiting, diarrhea or blood loss</td>
</tr>
<tr>
<td>Receiving IV meds</td>
</tr>
<tr>
<td>Receiving diuretics or drugs that may cause electrolyte imbalance</td>
</tr>
<tr>
<td>Bumex daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functional Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent decline in ADL status</td>
</tr>
<tr>
<td>Increased risk for falls</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications (that may contribute to delirium)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New med or dosage increase</td>
</tr>
<tr>
<td>Drugs w/anticholinergic properties (antipsychotics, antidepressants, antiparkinsonian, antihistamines)</td>
</tr>
<tr>
<td>Opioids</td>
</tr>
<tr>
<td>Benzodiazepines, especially long acting</td>
</tr>
<tr>
<td>Analgesics, cardiac and GI meds, anti-inflammatory drugs</td>
</tr>
<tr>
<td>Recent abrupt discontinuation, omission, or decrease in dose of a short/long acting benzodiazepine</td>
</tr>
<tr>
<td>Drug interactions</td>
</tr>
<tr>
<td>Resident taking more than one drug from a particular class of drugs</td>
</tr>
<tr>
<td>Possible drug toxicity, esp. If the person</td>
</tr>
</tbody>
</table>

Respiratory: asthma, emphysema, COPD, shortness of breath
Infectious: infections, wound infection other than foot or lower extremity, isolation - active
Metabolic: diabetes, thyroid, hyponatremia
Gastrointestinal bleed
Renal disease, dialysis
Hospice Care
Cancer
Dehydration

SOB if lies flat
Recent hospital stay with foley catheter that has now been removed
On thyroid replacement
DX GI Bleed and Ulcer
<table>
<thead>
<tr>
<th><strong>Associated or Progressive Signs and Symptoms</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep disturbances (up &amp; awake at noc, asleep during day)</td>
<td>Altered levels of consciousness</td>
</tr>
<tr>
<td>Agitation &amp; inappropriate movements (unsafe climbing out of bed or chair, pulling out tubes)</td>
<td></td>
</tr>
<tr>
<td>Hypoactivity (low or lack of motor activity, lethargy or sluggish responses)</td>
<td>Sluggish</td>
</tr>
<tr>
<td>Perceptual disturbances such as hallucinations and delusions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other Considerations</strong></th>
<th></th>
</tr>
</thead>
</table>
| Psychosocial:  
- Recent change in mood: sad or anxious, crying, social withdrawal  
- Recent change in social situation (isolation, recent loss of family or friend) | Fell less than a week ago resulting in a hip fracture which resulted in the hospital stay. Returning now as more depressed. DX Depression. Prozac recently increased. |
| Physical or environmental factors:  
- Hearing or vision impairment, may have an impact on ability to process information like directions, reminders, environmental clues  
- Lack of frequent reorientation, reassurance, reminders to help make sense of things  
- Recent change in environment (room change, new admission, return from hosp)  
- Interference w/resident's ability to get enough sleep (light, noise, frequent disruptions)  
- Noisy or chaotic environment (calling out, loud music, constant commotion, frequent caregiver changes) | Return from hospital. Is having difficulty processing new information at this time.  
Dx macular degeneration, Hard of Hearing |

**Input from resident and/or family or representative regarding the care area.**

**Questions/comments/concerns**

**Preferences/suggestions**

**Analysis of Findings**

Review indicators and supporting documentation, and draw conclusions.

Document:
- Description of the problem
- Causes and contributing factors
- Risk factors related to the care area

**Problem:** Mrs. M's BIM score has decreased from previous assessment.

**Causes:** Low grade fever, multiple medical diagnoses including CHF, CVA, hypothyroid, and anemia. Recent hospitalization with surgery.

**Risk factors:** Increase confusion may interfere with

**Care Plan Considerations**

<table>
<thead>
<tr>
<th>Care Plan?</th>
<th>Document reason(s) care plan will or will not be developed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Care plan to be developed to monitor current level of cognition for further decline. Will incorporate interventions to minimize further loss of cognition</td>
</tr>
<tr>
<td>No</td>
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</table>
Cognitive Loss/Dementia

Date: 12/30/10
MDS items: BIM score less than 13 C0500 and inattention and altered level of consciousness C01300

Analysis: Mrs. M does show signs of delirium, see Delirium CAA 12/30/10. She does have a history of a CVA with new onset of changes in behavior in inattention and altered levels of consciousness. Her PHQ-9 also shows an increase in depression from her previous assessment. Medically she does have a thyroid disorder, ASHD, Hx of MI and GI Bleed/Ulcer, CHF, SOB with activity and inability to lie flat, and depression. Pain control has also been an issue since readmission but better participation noted in therapy over the last several days. Due to her recent surgery she does require more assistance with her ADL’s. In the last week she has also had several environmental changes between the hospital and the nursing home which may also impact her cognition. Speech therapy to see. Will care plan to minimize further decline and to possibly improve her cognitive ability with continuity of care and pain management.

Decision to proceed with care plan - YES

Visual Function; Communication

Date: 12/30/10
MDS items: Vision Impaired: B1000 Hearing, B0200 and Ability to understand others: B0800

Mrs. M triggered for these CAA areas due to sensory deficits, resulting in highly impaired vision and hearing. There have been no changes in either area since the original admission. See Visual Function and Communication CAA note dated 1/21/10.

Decision to proceed with care plan - YES

ADLs; Falls

Date: 12/30/10
MDS items: #5 ADL’s - Requires assistance with ADLs G0110 and has a decline in cognition C0500; #11 Falls - Has balance problems G0300

See PT eval 12/21/10 and OT eval 12/21/10
Vision/Communication CAA 12/30/10 and Urinary incontinence CAA dated 12/30/10

Mrs. M triggered for the above CAAs due to her need for limited to extensive assistance with ADLs and a recent fall resulting in a fracture. PT and OT have addressed recommendations for Mrs. M’s ADL status. In addition to a recent history of falls, Mrs. M is at fall risk due to possible medication side effects, urinary incontinence; weakness requiring limited to extensive staff assist at times because of fatigue, and sensory
deficits. Medications that contribute to fall risk include Prozac, Bumex, Calan, NTG (PRN) and Digoxin. Pharmacy review to be done per facility protocols to determine further recommendations at this time. Urinary incontinence is related to urgency secondary to diuretics and is likely to be exacerbated by recent catheter insertion.

Decision to proceed with care plan - **YES**, to alert staff to multiple risks for falls, and assistance with ADL's

**CAA Summary Note:** #6 Urinary Incontinence  
**Date:** 12/30/10  
**MDS items:** Incontinence and requires assistance with toileting H0300

Mrs. M triggered for this CAA due to urinary incontinence that has been a problem for her since prior to her admission at home and has continued since her original admission. A bladder diary was done with the first admission and has been repeated during days 3-6 of this stay (See Nursing Note 12/26/10). During the hospitalization a catheter had been inserted but has since been removed on 12/21/10. Since the removal Mrs. M has been incontinent several times a week, which is similar to her voiding pattern prior to hospitalization. This was confirmed by comparing the current diary with the previous admission diary. Mrs. M is unable to ambulate to the BR w/ walker due to fatigue. She requires weight bearing assistance of one person to transfer on/off the commode. She is able to call for assistance, but due to urgency can only hold her urine for about 5 minutes. Urgency is greater in the morning after Bumex administration. Delirium was also a possible incontinence factor as well as her increased need for assistance in toileting.

Decision to proceed with care plan – **YES**

**CAA Summary Note:** #10 Activities  
**Date:** 12/30/10  
**MDS Items:** Little interest or pleasure in doing thingsD0200 A

Mrs. M triggered for Activities due to the observation of little interest or pleasure in doing things. She has been a resident here for over a year. Prior to this most recent hospitalization she was an active participant in activities inside the home and occasionally went out with her daughter. She enjoyed small group activities but also enjoyed her time working on crossword puzzles. Currently due to pain, therapy attendance she has been too tired to participate in many activities. There are no other barriers such as environmental or staffing at this time. Review also the Cognitive loss, Delirium and Mood state CAAs 12/30/10.

Decision to proceed with care plan – **YES**

**CAA Summary Note:** #12 Nutritional Status; #14 Dehydration/Fluid Maintenance  
**Date:** 12/30/10  
**MDS items:** #12 Nutritional Status - Therapeutic diet K0500; #14 Dehydration/Fluid Maintenance - Taking diuretic: N0400

See current dietary note dated 12/22/10. No change essentially since original admission; see CAA note dated 1/19/10 for Nutritional Status and Dehydration/Fluid Maintenance

MU MDS and Quality Research Team, Sinclair School of Nursing, University of Missouri (revised 03/11)
Decision to proceed with care plan - **YES**

**CAA Summary Note:** #8 Mood state; #17 Psychotropic Drugs  
**Date:** 12/30/10  
**MDS Items:** #8 Mood state - Would be better off dead D0200 and increase in PHQ 9 from last assessment to current assessment D0300; #17 Psychotropic Drugs - Antidepressant N0400

Mrs. M was readmitted back to the facility after a fall resulting in hip fracture requiring surgery and a 3 day hospitalization. Mrs. M has a history of depression secondary to CVA and has taken Prozac since 1997. Upon readmission she showed signs of delirium, decline in ADL’s with diagnosis of cardiac disease, and post CVA. She is on cardiac and pain medications. She is on thyroid replacement. Will contact Dr. G for a thyroid level as no levels have been drawn in over a year. Dr. G is aware of her wish to die but denied that she had a plan to follow through with those thoughts. She has been on Prozac but it has recently been increased.

Decision to proceed with care plan - **YES**

**CAA Summary Note:** #16 Pressure Ulcers M0300  
**Date:** 12/30/10  
**MDS Items:** Currently has 2 pressure ulcers

Mrs. M triggered for pressure ulcers due to an intact blister on her left heel that developed during her hospital stay as well as a nonblanchable area on her coccyx. Risk factors include: decreased mobility, friction and shear from sliding in bed, stress incontinence, delirium. She is on an antidepressant but this is a long standing medication and it has been increased recently. She has diagnosis of delirium, post CVA, depression, and edema. She also has the following conditions: recent weight loss, SOB if lies flat, and a recent decline in ADL’s. Other factors include recently readmitted, and head of bed elevated for ease in breathing. Will care plan to ensure pressure is reduced to that area and that no further problems develop.

Decision to proceed with care plan - **YES**

**CAA Summary Note:** #19 Pain  
**Date:** 12/30/10  
**MDS Items:** Pain has limited day to day activities J0500

Diseases: Circulatory, pressure ulcers, post stroke, hip fracture  
Characteristics of pain: Left hip, intermittent with an increase with movement, and decrease with rest. Pain described as throbbing  
Frequency: Hurts worst with ambulation and lessens after sitting  
Pain effect on function: Does not disturb sleep, but appetite has decreased; more depressed compared to previous admission and impacts ability to complete ADL’s  
Associated signs and symptoms: delirium  
Other considerations: Decrease in mobility due to recent surgery

MU MDS and Quality Research Team, Sinclair School of Nursing, University of Missouri (revised 03/11)  
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Decision to proceed with care plan - YES
CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING

4.1 Background and Rationale

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) mandated that nursing facilities provide necessary care and services to help each resident attain or maintain the highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident’s clinical condition demonstrates that the decline was unavoidable.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident’s functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident’s status and needs, are to be used to develop, review, and revise each resident’s comprehensive plan of care.

This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

4.2 Overview of the Resident Assessment Instrument (RAI) and Care Area Assessments (CAAs)

As discussed in Chapter 1, the updated Resident Assessment Instrument (RAI) consists of three basic components: 1) the Minimum Data Set (MDS) Version 3.0, 2) the Care Area Assessment (CAA) process, and 3) the RAI Utilization Guidelines. The RAI-related processes help staff identify key information about residents as a basis for identifying resident-specific issues and objectives. In accordance with 42 CFR 483.20(k) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident’s exercise of rights including the right to refuse treatment.

The MDS is a starting point. The Minimum Data Set (MDS) is a standardized instrument used to assess nursing home residents. It is a collection of basic physical (e.g., medical conditions, mood, and vision), functional (e.g., activities of daily living, behavior), and psychosocial (e.g., preferences, goals, and interests) information about residents. For example, assessing a resident’s orientation and recall helps staff complete portions of the MDS that relate to cognition (Section C), and weighing a resident and identifying his or her food intake helps staff complete portions
## Care Area Assessment (CAA) Summary

### Care Planning

Care Area is triggered.

Care Area, Indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary in your assessment of the care area. The **Care Planning Decision** column must be completed within 48 hours (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.

The **Location and Date of CAA Documentation** column where information related to the CAA can be found. CAA documentation may include information on the complicating factors, risks, and any referrals for this resident for this care area.

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<th>Care Area</th>
<th>A. Care Area Triggered</th>
<th>B. Care Planning Decision</th>
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