"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

Care Area Assessments

Overview and Practical Application

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AMERICAN NURSES CREDENTIALING CENTER

APPROVAL STATEMENT DISCLOSURE

- This nursing continuing professional development activity was approved by Broad River Rehab, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This course has been approved for 1.5 contact hours.

CONFLICT OF INTEREST DISCLOSURE

- Broad River Rehab is not charging for this educational offering and has no financial or other conflicts of interest regarding this program.

SUCCESSFUL COMPLETION REQUIREMENTS

- **Live, in-person**
  - In order to obtain nursing contact hours, you must attend the entire activity, participate in case study analysis, and complete the evaluation.
- **Live, virtual**
  - In order to obtain nursing contact hours, you must participate in the entire program, participate in audience polling and/or Q&A and complete the evaluation.
- **Web-Based/On-Demand**
  - In order to obtain nursing contact hours, you must view the entire program, and complete the evaluation.

DISCLOSURE OF THE EXPIRATION DATE FOR AWARDING CONTACT HOURS FOR ENDURING PROGRAMS

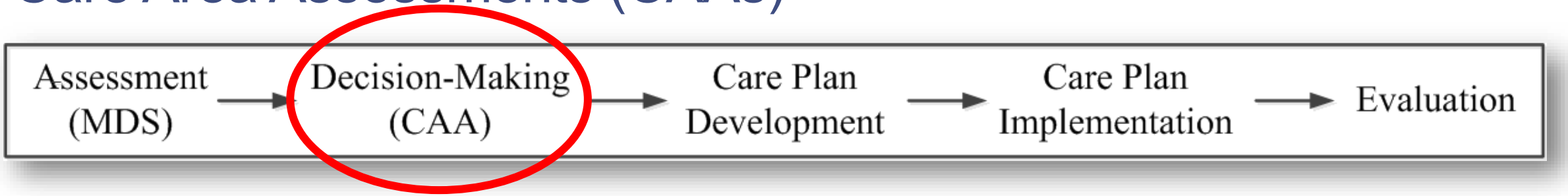
- Contact hours for this program will not be awarded after October 15, 2022

Agenda

Care Area Assessments

- RAI Components
- MDS as the starting point
- The CAA process framework
- What does the CAA process involve?
- Critical Thinking
- CAA Documentation
- Therapy Involvement a practical application
- Q&A

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



- **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 483.21(b) 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.

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

- **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 of the MDS related to nutritional status (Section K).

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

- When it is completed, the MDS provides a foundation for a more thorough assessment and the development of an individualized care plan.
- The information in the MDS constitutes the core of the required CMS-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern.
- The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further **assess these triggered areas of concern** in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors **related to the triggered care area under assessment**.
- **These conclusions** then provide the basis for developing an individualized care plan for each resident.

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

- **The CAA process framework.**
  - The CAA process provides a framework for **guiding the review of triggered areas**, and **clarification of a resident's functional status and related causes of impairments**.
  - It also provides **a basis for additional assessment of potential issues, including related risk factors**.
  - The assessment of the causes and contributing factors **gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care**.

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

- **When implemented properly, the CAA process should help staff:**
  - Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function;
  - Identify areas of concern that may warrant interventions;
  - Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences for interventions; and
  - Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management.

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

- **What Does the CAA Process Involve?**
  - Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(d)). The CAA process refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS.
  - The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning.
  - Interventions must be individualized and based on applying effective problem solving and decision-making approaches to all of the information available for each resident.

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

- Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident.
- **Each triggered item must be assessed** further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan.
- The significance and causes of any given trigger may vary for different residents or in different situations for the same resident.
- Different CATs may have common causes, or various items associated with several CATs may be connected.

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

- **CATs provide a "flag" for the IDT members**, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions.
- Further assessment of a triggered care area may identify causes, **risk factors**, and complications associated with the care area condition.
- The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable declines

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

Care Area Assessment (CAA) Key:

CAA 1 – Delirium

CAA 2 - Cognitive Loss/Dementia

CAA 3 - Visual Function

CAA 4 - Communication

CAA 5 - Activity of Daily Living (ADL) Functional / Rehabilitation Potential

CAA 6 - Urinary Incontinence and Indwelling Catheter

CAA 7 - Psychosocial Well-Being

CAA 8 - Mood State

CAA 9 - Behavioral Symptoms

CAA 10 - Activities

CAA 11 - Falls

CAA 12 - Nutritional Status

CAA 13 - Feeding Tubes

CAA 14 - Dehydration/Fluid Maintenance

CAA 15 - Dental Care

CAA 16 - Pressure Ulcer

CAA 17 - Psychotropic Medication Use

CAA 18 - Physical Restraints

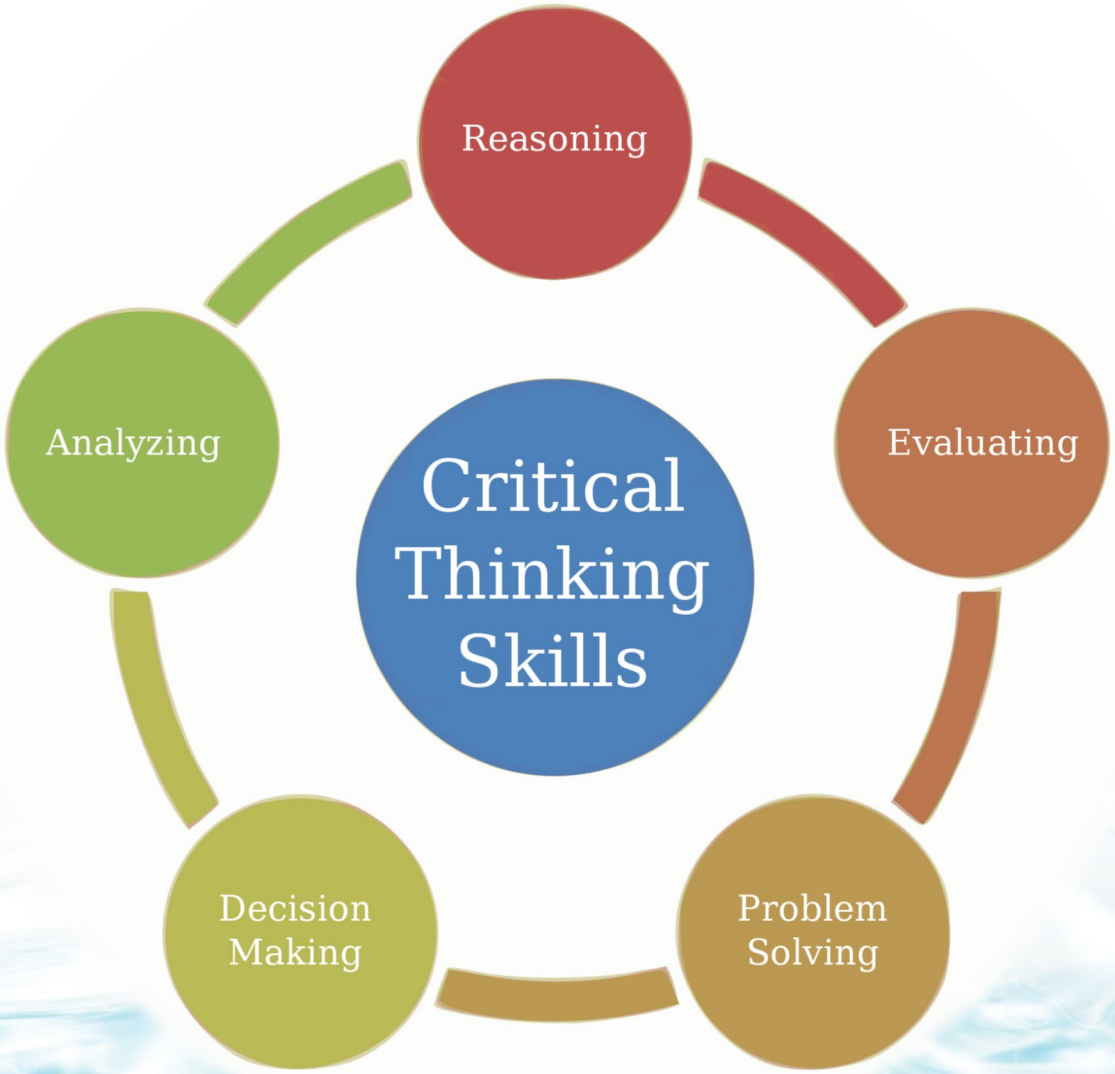
CAA 19 - Pain

CAA 20 - Return to Community Referral

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

- A risk factor increases the chances of having a negative outcome or complication.
  - For example, impaired bed mobility may increase the risk of getting a pressure ulcer/injury.
  - In this example, impaired bed mobility is the risk factor, ➡ unrelieved pressure is the effect of the compromised bed mobility, ➡ and the potential pressure ulcer is the complication. (Critical thinking in action)
- **Critical Thinking:** "…the objective analysis and evaluation of an issue in order to form a judgment." Oxford Languages

Critical Thinking



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

- There can also be a single cause of multiple triggers and impairments.
- For example, hypothyroidism is an example of a common, potentially reversible medical condition that can have diverse physical, functional, and psychosocial complications.
- Thus, if a resident has hypothyroidism, it is possible that the MDS might trigger any or several of the following CAAs depending on whether or not the hypothyroidism is controlled, there is an acute exacerbation, etc.:

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

- Delirium (#1),
- Cognitive Loss/Dementia (#2),
- Visual Function (#3),
- Communication (#4),
- ADL Functional/Rehabilitation (#5),
- Urinary Incontinence (#6), Psychosocial Well-Being (#7),
- Mood State (#8),
- Behavior Symptoms (#9),
- Activities (#10),
- Falls (#11),
- Nutritional Status (#12),
- Dehydration (#14),
- Psychotropic Medication Use (#17), and
- Pain (#19).

NOTE: Even if the MDS does not trigger a particular care area, the facility can use the CAA process and resources at any time to further assess the resident.

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

- Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome.
- Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with hypothyroidism or other complex or mixed causes of impaired behavior, cognition, and mood.
- **For example**, it is necessary to assess a resident's orientation and recall in order to complete portions of the MDS that relate to cognitive patterns (Section C) and to obtain a resident's weight and identify his or her food intake in order to complete MDS items related to nutritional status (Section K). A positive finding in Section C may trigger one or several CAAs, including Delirium (#1), Cognitive Loss/Dementia (#2), and ADL Functional/Rehabilitation Potential (#5).

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

- Additional evaluation is then required to:
  - identify whether the resident has delirium, dementia, or both;
  - how current symptoms and patterns compare to their usual or previous baseline,
  - whether potentially reversible causes are present,
  - what else might be needed to identify underlying causes (including medical diagnoses and history), and
  - what symptomatic and cause-specific interventions are appropriate for the resident.

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

- If the Nutritional Status (#12) CAA also triggered, due to weight loss and the resident is found to have delirium, then it is possible that both findings could have a common cause (e.g., an infection or medication side effects), that delirium resulted in impaired nutritional status, or that impaired nutritional status led to delirium, or still other possibilities.
- Thus, identifying the sequence of events is essential to understanding causes and choosing appropriate interventions.

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

- The RAI is not intended to provide diagnostic advice, nor is it intended to specify which triggered areas may be related to one another or and how those problems relate to underlying causes.
- It is up to the IDT, including the resident's physician, to determine these connections and underlying causes as they assess the triggered care areas and any other areas pertinent to the individual resident.
- **Not all triggers** identify deficits or problems.
- Some triggers indicate areas of resident strengths and can suggest possible approaches to improve a resident's functioning or minimize decline.
  - **For example**, MDS item responses indicate the "resident believes he or she is capable of increased independence in at least some ADLs" (Item G0900A) may focus the assessment and care plan on functional areas most important to the resident or on the area with the greatest potential for improvement

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

- In addition to identifying causes and risk factors that contribute to the resident's care area issues or conditions, the CAA process may help the IDT:
  - 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 about a resident's condition that may be obtained from sources such as the resident, the resident's family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests;

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

- Identify whether and how a triggered condition actually affects the resident's function and quality of life, or whether the resident is at particular risk of developing the conditions;
- Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions;
- Determine whether a resident could potentially benefit from rehabilitative interventions;
- Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment.

Multiple Triggered Item Assessments (Section C)

Section C	Cognitive Patterns $$ CATs

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK $$ CATs

Enter Code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem CAA: 2**

C0800. Long-term Memory OK CATs

Enter Code ☐

Seems or appears to recall long past

0. **Memory OK**
1. **Memory problem CAA: 2**

C0900. Memory/Recall Ability

Check all that the resident was normally able to recall

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **D. That he or she is in a nursing home/hospital swing bed**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making $$ CATs

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable **CAA: 5**
1. **Modified independence** - some difficulty in new situations only **CAA: 2, 5**
2. **Moderately impaired** - decisions poor; cues/supervision required **CAA: 2, 5**
3. **Severely impaired** - never/rarely made decisions **CAA: 2**

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Emerald/PDPM Crimson/CATs (*) – Single Item Trigger Royal/QMs (*Italics = Associated Exclusions*, Underline = Associated Covariates) (*) – Single Item Trigger

Gold ★/5-Star Violet/QRP (*Italics = Associated Exclusions*, Underline = Associated Covariates (1)=performance , (2)= goals)

Multiple Triggered Item Assessments (Section C)

CAT Specifications: 2 Cognitive Loss/Dementia			
Triggering Conditions	**MDS 3.0 Item**	**Description**	**Response Values**
1. BIMS summary score is less than 13 as indicated by:	• C0500	BIMS resident interview: summary score	= 00 - 12
2. BIMS summary score has a missing value of 99 or Dash (–) or Blank and there is a problem with short-term memory as indicated by:	• C0500 • C0700	BIMS resident interview: summary score Staff assessment mental status: short-term memory	= 99, OR dash (-) OR Blank AND = 1
3. BIMS summary score has a missing value of 99 or Dash (–) or Blank and there is a problem with long-term memory as indicated by:	• C0500 • C0800	BIMS resident interview: summary score Staff assessment mental status: long-term memory	= 99 OR dash (-) OR Blank AND = 1
4. BIMS summary score has missing value of 99 or Dash (–) or Blank and at least some difficulty making decisions regarding tasks of daily life as indicated by:	• C0500 • C1000	BIMS resident interview: summary score Cognitive skills for daily decision Making	= 99, OR dash (-) OR Blank AND = 1 - 3
5. BIMS, staff assessment or clinical record suggests presence of inattention, disorganized thinking or altered level of consciousness as indicated by:	• C1310B • C1310C • C1310D	inattention Signs of delirium: disorganized thinking Signs of delirium: altered level of consciousness	= 1 OR 2 OR = 1 OR 2 OR = 1 OR 2 OR
6. Presence of any behavioral symptom (verbal, physical or other) as indicated by:	• E0200A • E0200B • E0200C	Physical behavioral symptoms directed toward others Verbal behavioral symptoms directed toward others Other behavioral symptoms not directed toward others	= 1 - 3 OR = 1 - 3 OR = 1 - 3
7. Rejection of care occurred at least 1 day in the past 7 days as indicated by:	• E0800	Rejection of care: presence and frequency	= 1 - 3
8. Wandering occurred at least 1 day in the past 7 days as indicated by:	• E0900	Wandering: presence and frequency	= 1 - 3

Multiple Triggered Item Assessments (Section C)

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©) CATs

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change CATs

Enter Code ☐ **Is there evidence of an acute change in mental status** from the resident's baseline?

0. **No**
1. **Yes CAA: 1**

↓ **Enter Codes in Boxes**

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? **CAA: 1, *2**

☐ **C. Disorganized Thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? **CAA: 1, *2**

☐ **D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria? **CAA: 1, *2**

- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.

Multiple Triggered Item Assessments (Section C)

CAT Specifications: 1 Delirium			
Triggering Conditions	**MDS 3.0 Item**	**Description**	**Response Values**
1. Symptoms of delirium are indicated by the presence of an acute mental status change and/or the presence of inattention, disorganized thinking or altered mental status on the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) as indicated by:	(a) • C1310A	Acute Onset Mental Status Change	= 01 AND
	• C1310B	Inattention	= 01 OR 02 AND EITHER
	• C1310C C1310D	Disorganized Thinking Altered Level of Consciousness	= 01 OR 02 OR = 01 OR 02
	(b) • C1310B C1310C C1310D	Inattention Disorganized Thinking Altered Level of Consciousness	= 02 OR = 02 OR = 02 AND
	• C1310B	Inattention	= 01 OR 02 AND EITHER
	• C1310C C1310D	Disorganized Thinking Altered Level of Consciousness	= 01 OR 02 OR = 01 OR 02

Multiple Triggered Item Assessments (Section C)

A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture CAA: 5, *16, *N015.03* ★, *N028.02* ★, **N028.02* ★	☐	☐
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet) CAA: 5, *N037.03* ★, *N015.03* ★, *N028.02* ★, **N028.02* ★	☐	☐
C. **Walk in room** - how resident walks between locations in his/her room CAA: 5	☐	☐
D. **Walk in corridor** - how resident walks in corridor on unit CAA: 5, *N037.03* ★	☐	☐
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair CAA: 5, *N035.03* ★, *N037.03* ★	☐	☐
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair CAA: 5	☐	☐
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses CAA: 5	☐	☐
H. **Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration) CAA: 5, *N028.02* ★, **N028.02* ★	☐	☐
I. **Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag CAA: 5, *6, *N028.02* ★, **N028.02* ★	☐	☐
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers) CAA: 5	☐	☐

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Gold ★/5-Star Violet/QRP (*Italics = Associated Exclusions*, Underline = Associated Covariates (1)=performance , (2)= goals)

Multiple Triggered Item Assessments (Section C)

CAT Specifications: 5 ADL Functional/Rehabilitation Potential

Triggering Conditions	MDS 3.0 Item	Description	Response Values
1. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for bed mobility was needed as indicated by:	• C1000 • C0500 • G0110A1	Cognitive skills for daily decision making BIMS Summary score ADL: bed mobility : self-performance	= 0 - 2 OR = 5 – 15 AND = 1 - 4
2. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for transfer between surfaces (excluding to/from bath/toilets) was needed as indicated by:	• C1000 • C0500 • G0110B1	Cognitive skills for daily decision making BIMS Summary score ADL: transfer: self-performance	= 0 - 2 OR = 5 – 15 AND = 1 - 4
3. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in his/her room was needed as indicated by:	• C1000 • C0500 • G0110C1	Cognitive skills for daily decision making BIMS Summary score ADL: walk in room: self-performance	= 0 - 2 OR = 5 – 15 AND = 1 - 4
4. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in corridor was needed as indicated by:	• C1000 • C0500 • G0110D1	Cognitive skills for daily decision making BIMS Summary score ADL: Walk in corridor: self-performance	= 0 - 2 OR = 5 – 15 AND = 1 - 4

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

An Interdisciplinary process

- Per the OBRA statute, the resident's assessment must be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals.
- It is common practice for facilities to assign specific MDS items or portion(s) of items (and subsequently CAAs associated with those items) to those of various disciplines (e.g., the dietitian completes the Nutritional Status and Feeding Tube CAAs, if triggered).
- It is the facility's responsibility to obtain the input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice.
  - For example, a physician may need to get a more detailed history or perform a physical examination in order to establish or confirm a diagnosis and/or related complications.

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

- The State Operations Manual (SOM) defines the IDT as, "…interdisciplinary team, that includes but is not limited to:"
- The attending physician.
- A registered nurse with responsibility for the resident.
- A nurse aide with responsibility for the resident.
- A member of food and nutrition services staff.
- To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
- Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

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

CAA Documentation

- CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident.
- The CAA documentation should:
  - indicate the basis for these decisions,
  - why the finding(s) require(s) an intervention, and
  - the rationale(s) for selecting specific interventions.
- Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan.

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

- Relevant documentation for each triggered CAA describes:
  - Causes and contributing factors;
  - The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem;
  - Complications affecting or caused by the care area for this resident;
  - Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning;
  - Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident;
  - The need for additional evaluation by the attending physician and other health professionals, as appropriate;
  - The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
  - Completion of Section V

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

- Written documentation of the CAA findings and decision-making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM) (*page 201 under guidance for F636, Resident Assessment).*
- Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision-making documentation can be found in the resident's record.
- Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan.

CAA Documentation

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	Check all that apply		
01. Delirium	☑	☑	See Delirium CAA Documentation
02. Cognitive Loss/Dementia	☑	☑	See Cognitive Loss/Dementia CAA Documentation
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☑	☑	See ADL Rehab Potential CAA Documentation
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

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

Using the CAA Resources (Appendix C)

- **Step 1: Identification of Triggered CAAs.**
  - After completing the MDS, identify triggered care areas.
  - Many facilities will use automated systems to trigger CAAs. The resulting set of triggered CAAs generated by the software program should be matched against the trigger definitions to make sure that triggered CAAs have been correctly identified.
- **Step 2: Analysis of Triggered CAAs.**
  - Review a triggered CAA by doing an in-depth, resident- specific assessment of the triggered condition in terms of the potential need for care plan interventions.
  - While reviewing the CAA, consider what MDS items caused the CAA to be triggered.
  - <u>This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition but are not necessarily captured in MDS data</u>.
  - Review of CAAs helps staff to decide if care plan intervention is necessary, and what types of intervention may be appropriate.

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

- Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident's representative to identify areas of concern that:
  - Warrant intervention;
  - Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions;
  - Can help to minimize the onset or progression of impairments and disabilities; and
  - Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

CAA Documentation

See Handout: ADLs - Functional Status/Rehabilitation Potential Review of Indicators

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

Limitations of the RAI-related instruments.

- The RAI provides tools related to assessment including substantial detail for completing the MDS, how CATs are triggered, and a framework for the CAA process. However, the process of completing the MDS and related portions of the RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.
- Neither the MDS nor the remainder of the RAI includes all of the steps, relevant factors, analyses, or conclusions needed for clinical problem solving and decision making for the care of nursing home residents.
- By themselves, neither the MDS nor the CAA process provide sufficient information to determine if the findings from the MDS are problematic or merely incidental, or if there are multiple causes of a single trigger or multiple triggers related to one or several causes.

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

- Although a detailed history is often essential to correctly identify and address causes of symptoms, the RAI was not designed to capture a history (chronology) of a resident's symptoms and impairments. Thus, <u>it can potentially be misleading or problematic to care plan individual MDS findings or CAAs without any additional thought or investigation because;</u>
  - The MDS may not trigger every relevant issue
  - Not all triggers are clinically significant
  - The MDS is not a diagnostic tool or treatment selection guide
  - The MDS does not identify causation or history of problems
- Although facilities have the latitude to choose approaches to the CAA process, compliance with various OBRA requirements can be enhanced by using additional relevant clinical problem solving and decision-making processes to analyze and address MDS findings and CAAs. (See additional handout)

CAT Specifications: 4 Communication			
Triggering Conditions	**MDS 3.0 Item**	**Description**	**Response Values**
1. Hearing item has a value of 1 through 3 indicating hearing problems on the current assessment as indicated by:	• B0200	Hearing	= 1 - 3
2. Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants as indicated by:	• B0700	Makes self understood	= 1 - 3
3. Impaired ability to understand others through verbal content as indicated by:	• B0800	Ability to understand others	= 1 - 3

Communication Assessment Guide

The information gleaned from the assessment should be used to evaluate the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication.

The assessment should also help to identify any related possible contributing and/or risk factors.

The next step is to develop an individualized care plan based directly on these conclusions.

The focus of the care plan should be to address any underlying issues/conditions and causes, as well as verbal and nonverbal strategies, in order to help the resident improve quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident can strive to expand their nonverbal communication skills, for example, touch, facial expressions, eye contact, hand movements, tone of voice, and posture

Communication CAA & Rehab

Speech Language Pathology Referrals may be indicated for:

- Changes and/or maintenance needs for expressive/receptive language
- Aural Rehab assessment and treatment to support individuals with hearing loss in areas of conductive and/or sensorineural loss.

CAT Specifications: 3 Visual Function			
Triggering Conditions	**MDS 3.0 Item**	**Description**	**Response Values**
9. Vision item has a value of 1 through 4 indicating vision problems on the current assessment as indicated by:	• B1000	Vision	= 1 - 4
10. Cataracts, glaucoma, or macular degeneration on the current assessment as indicated by:	• I6500	Cataracts, glaucoma, or macular degeneration	= checked

Visual Assessment Guide

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's declining visual acuity, identifying residents who have treatable conditions that place them at risk of permanent blindness (e.g., glaucoma, diabetes, retinal hemorrhage) and those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances, as well as to determine any possibly related contributing and/or risk factors.

The next step is to develop an individualized care plan based directly on these conclusions.

The focus of the care plan should be to prevent decline when possible and to enhance vision to the extent possible when reversal of visual impairment is not possible, as well as to address any underlying clinical issues and/or conditions identified through the CAA or subsequent assessment process. This might include treating infections and glaucoma or providing appropriate glasses or other visual appliances to improve visual acuity, quality of life, and safety.

Falls CAA & Rehab

Occupational Therapy Referrals may be indicated for:

- Increasing success with visual field changes following a neurological event such as a stroke which results in neglect
- Promoting ability to participate in ADLs by increasing accuracy of visual field.

CAT Specifications: 11 Falls

Triggering Conditions	MDS 3.0 Item	Description	Response Values
1. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last month prior to admission as indicated by	• A0310A • J1700A	Type of assessment: OBRA Admission Fall history: fall during month before entry	= 01 AND = 01
2. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last 2 to 6 months prior to admission as indicated by:	• A0310A • J1700B	Type of assessment: OBRA Admission Fall history: fall 2 to 6 months before entry	= 01 AND = 01
3. Wandering occurs as indicated by a value of 1 through 3 as follows	• E0900	Wandering: presence and frequency	= 1 - 3
4. Balance problems during transition indicated by a value of 1 or 2 for any item as follows:	• G0300A • G0300B • G0300C • G0300D • G0300E	Balance: moving from seated to standing position Balance: walking (with assistive device if used) Balance: turning around while walking Balance: moving on and off toilet Balance: surface-to-surface transfer	1 OR 2 OR 1 OR 2 OR 1 OR 2 OR 1 OR 2 OR 1 OR 2
5. Resident has fallen at least one time since admission or the prior assessment as indicated by:	• J1800	Falls since admit/prior assessment: any falls	= 1
6. Resident received antianxiety medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:	• N0410B	Medications: antianxiety	= 1 - 7
7. Resident received antidepressant medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:	• N0410C	Medications: antidepressant	= 1 - 7
8. Trunk restraint used in bed as indicated by a value of 1 or 2 as follows:	• P0100B	Restraints used in bed: trunk restraint	=1 OR 2
9. Trunk restraint used in chair or out of bed as indicated by a value of 1 or 2 as follows:	• P0100E	Restraints in chair/out of bed: trunk restraint	= 1 OR 2

Falls Assessment Guide

- The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and contributing and/or risk factors.
- The next step is to develop an individualized care plan based directly on these conclusions.
- The focus of the care plan should be to address the underlying cause(s) of the resident's fall(s), as well as the factors that place him or her at risk for falling

Falls CAA & Rehab

Physical Therapy Referrals may be indicated for:

- Changes in balance before they become a fall!
- Promoting ability to ambulate across multiple surfaces.
- Restraint reduction

QUESTIONS?

Find Out More

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Broad River Rehab Reflections are the third Thursday of each month. In October we will discuss item by item Changes to MDS 3.0v1.18.11