CAA's = Critical Thinking

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Critical Thinking Steps

- Recognition/Assessment
  - Gather essential information about the individual
- Problem definition
  - Define the individual's problems, risks, and issues

Critical Thinking Steps

- Diagnosis/Cause and effect analysis
  - Identify physical, functional, and psychosocial causes of risks, problems and other issues, and relate to one another and to their consequences

Critical Thinking Steps

- Identifying goals and objectives of care
  - Clarify purpose of providing care and of specific interventions, and the criteria that will be used to determine whether the objectives are being met

Critical Thinking Steps

- Selecting interventions/planning care
  - Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems and risks
- Monitoring of progress
  - Review individual's progress towards goals and modify approaches as needed

RAI Process

- RAI is not intended to provide diagnostic advice or how things relate
- Yields information on the resident's
  - Functional status
  - Strengths
  - Weaknesses
  - Preferences
- The IDT determines the connections and how things are related

CAA Process Framework

- Consider each resident as a whole with unique characteristics and strengths
- Identify areas of concern that may warrant interventions
- Develop interventions to help improve, stabilize or prevent decline
- Address the need and desire for other important considerations such as advanced care planning
  - RAI Manual Pg. 4-2

What is a CAA

- Triggered responses to items coded on the MDS specific to a resident possible problems, needs or strengths.
- Conditions that are common in nursing home residents
  - RAI Manual pg 4-2

CAA Process

- CMS does <u>not</u> mandate any specific tool for completing the triggered areas nor does it provide any guidance on how to understand or interpret the triggered areas.
- We are to use tools that are current and evidenced based resources to practice.
- "Critical thinking"
  - RAI Manual page 4-3

CAA Timing

- By statute: RAI must be completed within 14 days of admission as well as the CAAs.
- We must assess resident needs, plan care and implement interventions in a timely manner

Care Area Triggers

- Identify conditions that may require further evaluation because they:
  - May impact specific issues or conditions
  - Or the risk of issues
- Must be assessed further through the CAA process BUT it may or may not represent something that needs to be care planned

CATs to CAA's

- Care Area Triggers
  - to
- Care Area Assessment
- Purpose: to drive the development of an individualized care plan for the resident

Care Area Assessment (CAA)

- MDS is preliminary screening tool
- MDS does not constitute a comprehensive assessment
- CAAs provide for a more comprehensive assessment

CAA Goals

- Promote the highest practicable level of functioning for a resident through an assessment of triggered care areas from the MDS
- Determine if there is a problem and understand the causes / contributing factors
- Triggered care areas form a critical link between MDS and care planning decisions

Assessment (MDS)

↓

Decision Making (CAA)

↓

Care Plan Development

↓

Care Plan Implementation

↓

Evaluation

CAA 1

- Delirium: acute brain failure caused by medical conditions which presents with psych symptoms, acute confusion and fluctuates in levels of consciousness. It is not a part of normal aging and associated with high mortality and morbidity.

CAA 2

- Cognitive Loss/Dementia: prerequisites for an independent life include the ability to remember recent events and the ability to make safe decisions. Focus on decline or worsening cognitive abilities that threaten personal independence

CAA 3

- Visual Function: the aging process leads to a decline in visual acuity, such as a decreased ability to focus on close objects or to see small print reduced capacity to adjust to changes in light and dark and diminished ability to discriminate colors.

CAA 4

- Communication: many conditions can affect how a person expresses and comprehends information, the communication CAA focuses on the interplay between the person's communication status and his or her cognitive skills for everyday decision making.

CAA 5

- ADL Functional/Rehabilitation Potential: the assessment should be used to identify the resident's actual functional deficits and risk factors as well as to identify any possible contributing and or risk factors related to the functional issues/conditions.

CAA 6

- Urinary Incontinence and Indwelling Catheter: aging affects the urinary tract but incontinence is not a normal part of aging. Incontinence is risk factors for rashes, falls and social isolation. Catheters can increase the risk of life threatening infections

CAA 7

- Psychosocial Well Being: involvement in social relationships is a vital aspect of life. Decreases may affect psychological well being and have impact on mood, behavior and physical activity. May have a negative impact on the resident's life.

CAA 8

- Mood State: sadness and anxiety are normal as well as fluctuations. But extreme or overwhelming as to impair personal and psychosocial function is not normal. This is a screen and is not intended to definitively diagnose.

CAA 9

- Behavioral Symptoms: behavior varies widely and is often dysfunctional and problematic. The MDS only identifies certain behaviors but is not intended to determine the significance of behaviors including whether they are problematic and need an intervention.

CAA 10

- Activities: capabilities of residents vary, the purpose of the CAA is to identify strategies to help residents become more involved in relevant activities including those that have interested and stimulated them in the past and or new/modified ones.

CAA 11

- Falls: falls are a leading cause of morbidity and mortality among the elderly. Identify and address the underlying cases of the fall as well as identify any related possible causes and contributing factors. Develop an individualized care plan based directly on these conclusions.

CAA 12 and 13

- Nutritional Status: reflects the need for an in-depth analysis of residents with impaired nutrition and identify those who are at risk.
- Feeding Tubes: identify and address the resident status and underlying issues/ conditions that necessitated the use of the tube and related risk factors.

CAA 14

- Dehydration/Fluid Maintenance: identify whether the resident is dehydrated or at risk for dehydration as well as to identify any related possible causes and contributing and or risk factors. Care plan then to prevent dehydration, maintain or restore fluid and electrolyte balance and address the underlying causes.

CAA 15

- Dental Care: identify oral/dental issues and or conditions and to identify any related possible causes and or contributing risk factors.

CAA 16

- Pressure Ulcers: draw conclusions about the status of a resident's pressure ulcer and to identify and related causes /contributing factors. Care plan to prevent or to heal or close it.

CAA 17

Psychotropic Medication Use: draw conclusions about the appropriateness of the residents medication in consultation with physician and the consultant pharmacist and to identify an adverse consequences as well as related possible causes and or contributing risk factors.

CAA 18

- Physical restraints: consider the effect of the device on the resident and not the purpose of the device. Should identify the specific reasons for and the appropriateness of the use of the restraint and any adverse consequences caused by or risks related to restraint use.

CAA 19

- Pain: identify characteristics and possible causes, contributing faces and risk factors related to the pain Care plan focus should be to alleviate symptoms and to the extent possible address the underlying condition that causes the pain.

CAA 20

- Return to the Community referral: assess the resident's situation begin care planning discharge plans and other follow up measures.

Triggering a CAA

- Care Area Triggers (CAT)
  - Alerts assessor to problem/needs/strength
  - Directs assessor to conduct assessment activities
  - Is a specific MDS item(s) and response(s)

Triggering a CAA

- All triggering care areas are available on the current MDS 3.0 item set except for
  - Delirium
  - Mood State
- These 2 compare scores from a previous assessment (CAM and PHQ9)
- MDS items target (trigger) care areas for additional assessment and review

Types of CATs

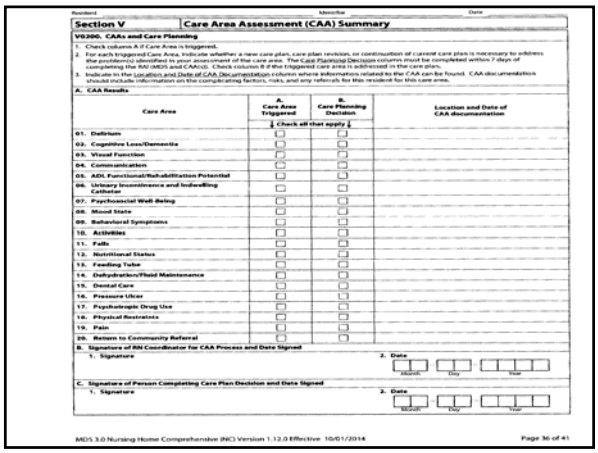
- Potential Problems
- Broad Screening Triggers
- Prevention of Problems
- Rehabilitation Potential

CAA(s) and Care Planning

- IDT decides whether or not to create a care plan for each of the triggered care areas
- Chapter 4 of MDS manual provides detailed instructions on the CAA process and care planning

CAA and Care Planning Documentation

- Section V of the MDS is the road map to direct a person to where the documentation is regarding the triggered CAA
- May occur anywhere in medical record
  - RAI Manual Page 4-7



Section V | Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

1. Check columns 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 (Check all that apply)	B. Care Planning Decision (Check all that apply)	Location and Date of CAA documentation
01. Delirium			
02. Cognitive Loss/Dementia			
03. Visual Function			
04. Communication			
05. ADL Functional/Rehabilitation Potential			
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			

B. Signature of RN Coordinator for CAA Process and Date Signed
1. Signature 2. Date (Month / Day / Year)

C. Signature of Person Completing Care Plan Decision and Date Signed
1. Signature 2. Date (Month / Day / Year)

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CAA and Care Planning Documentation Criteria

- **P** Nature of issue or condition, what exactly is the issue/problem and why is it a problem
- **C** Causes, contributing factors complications affecting or caused by the CAA
- **R** Risk Factors
  - RAI Manual 4-6

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CAA and Care Planning Documentation Criteria

- Resources used – Facilities may have written policies/protocols/standards of practice
- Appendix C – Sample of web based resources

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RAI Limitations

- 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
  - RAI manual pg 4-8

CAA Tips and Clarifications

- It is NOT necessary to always review and document findings on subsequent assessments the way performed on the initial assessment… but you must validate that the status has not changed as compared to the initial assessment RAI 4-12

CAA Tips and Clarifications

- Upon admission an initial plan of care needs to be implemented
- Annual and SCSA the care plan can be updated with the new information and does not have to be rewritten
  - RAI Manual 4-16

CAA Tips and Clarification

- The RAI will not identify every conceivable problem
  - Ex: "chewing problem" = no CAA but do we need to care plan depends on the resident

Using the CAA Resources

- 1. Identify the Triggered CAA
- 2. Analysis of Triggered CAA: in depth, resident specific assessment of the triggered condition
- 3 and 4. Decision Making and CAA documentation
  - RAI Manual pg 4-15

Appendix C

- Review of Indicators for each of the 20 CAAs
- Checklist format with a summary of the findings

Example 1

- **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 providing care, and put Mrs. M at risk for further injury such as another fall, skin breakdown, weight loss, etc.

Example 2

- 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 dairy with the previous admission diary.

Example 2

- 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**