

Washington's Electronic Assessment & Care Plan/ Management System

Tuesday October 5th, 1:00-2:30

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A presentation of Washington State's MIS and the importance to the single point of entry system and rebalancing WA's long term supports system; background on development, system integration; demonstration; advantages and disadvantages; lessons learned for ADRCs

Speaker Biography

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Handout

Care Assessor Manual

CARE Assessor Manual



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1 Background and Overview

1.0 Intent

This manual will provide guidelines for how to apply standards, clinical judgment and “best practices” for assessing, developing care plans, determining eligibility, and authorizing services for long-term care clients.

Development and coordination of service delivery to clients within the Aging and Disability Services Administration (ADSA) in Washington State is complex and challenging work. Services are provided to clients with a vast array of clinical issues, support systems, and functional abilities in residential facilities, in-home settings, and skilled facilities. Our work utilizes observational skills and assessment expertise in order to develop individualized service plans.

Throughout the world people are living longer; the population of persons over the age of 65 is rapidly growing both in numbers and as a proportion of the whole. In most developed countries the increase is particularly striking for those aged 80 and older. Also, due to advances in medicine, individuals with chronic care needs secondary to traumatic injuries, developmental disabilities, and genetic congenital conditions are living longer. Improving the ability of the health care delivery system to respond to the needs of all of these individuals in a fiscally responsible manner is one of the greatest challenges of our times (Morris et al). The CARE tool has been designed to be an automated, client centered assessment system that will be the basis for comprehensive care planning. The tool has been designed to be compatible with the congressionally mandated Resident Assessment Instrument (RAI) used in nursing homes in the United States and several countries abroad. (The RAI is also referred to as the Minimum Data Set or MDS). “Such compatibility will promote continuity of care through a “seamless” assessment system across multiple health care settings, and will promote a person centered evaluation in contrast to a site-specific assessment” (Morris et al).

Protocols have been developed which will provide guidelines and individualized care planning for clients who have problematic conditions. These problematic conditions are “triggered” by particular CARE items. At this time, the protocols consist of the following domains:

- Pressure ulcers
- Medication issues
- Referral to nursing services

The CARE tool assists assessors to gather definitive information on a client’s strengths and needs, which must be addressed in an individualized care plan. It also



aids staff to evaluate goal achievement and revise service plans accordingly by providing a tracking mechanism of changes in the client's status. As the process of problem identification is integrated with sound clinical interventions, the service plan becomes each client's unique path toward achieving or maintaining his or her highest practicable level of functioning.

The CARE tool helps assessors look at clients holistically. Persons generally enter the long term care system due to functional status problems caused by physical deterioration, developmental disabilities, cognitive impairment or decline, mental illness, the onset or exacerbation of an acute illness or condition, or other related factors. The individual's ability to manage independently has been limited to the extent that assistance with activities of daily living, skilled nursing, medical treatment and/or rehabilitation is needed for clients to maintain and/or restore function or to live at an optimum level from day to day. While we recognize that there are often unavoidable declines, particularly in the last stages of life, available resources and disciplines must be used to assist clients to achieve the highest level of functioning possible (Quality of Care) and maintain a sense of individuality (Quality of Life).

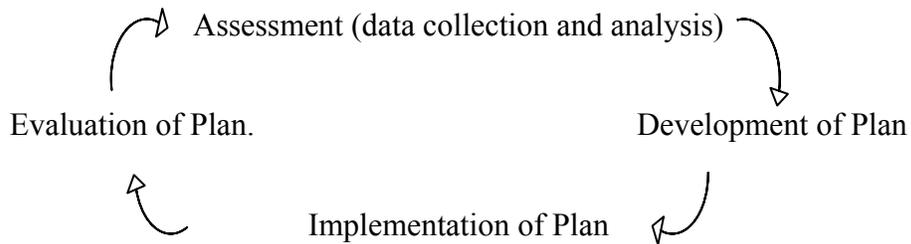
Assessors are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, planning, implementation and evaluation. The CARE tool simply provides a structured, standardized approach for applying a problem identification process in long term care settings.

Good problem identification models have 5 basic steps:

1. **Data Collection (objective; "what is").** Taking stock of observations and information (both limitations and strengths) of an individual in order to find out whom he/she is.
2. **Analysis (decision making).** –Answers the why question. Determining the severity, functional impact, and scope of a client's problems; Understanding the causes and relationships between a client's problems.
3. **Development of a plan.** Establishing a course of action that moves that individual client toward a specific goal, utilizing the individual's strengths and interdisciplinary expertise when necessary; crafting the "how" of client care.
4. **Implementation of the plan.** Putting that course of action (specific interventions on the service plan) into motion by caregivers knowledgeable about the care goals and approaches; carrying out the "how" and "when" of client care.
5. **Evaluation of the plan.** Critically reviewing service plan goals, interventions and implementation in terms of achieved client outcomes

and assessing the need to modify the service plan (i.e., change interventions) to adjust to changes in the client’s status, either improvement or decline.

This is how the problem identification process would look as a pathway.



1.1 Uses of the CARE Tool

The CARE tool is used for assessing, developing care plans, determining eligibility, and authorizing services for clients served by the Aging and Disability Services Administration.

1.1.0 Assessment

- CARE is designed to collect accurate, consistent data through a thorough assessment. CARE includes various types of assessments, each with different validations. The assessment types included within CARE are listed below. Each of these assessment types requires a face-to-face visit between the assessor and the person being assessed.
- **Initial:** Use for all new COPES, MPC and CHORE clients, as well as those who are re-entering the system. A minimum set of items must be completed, many of which are necessary to determine the client’s program eligibility and payment. Many non-mandatory items impact payment so it will be necessary to perform a thorough assessment to place your client in the appropriate payment category.
- **Annual:** Use for all COPES, MPC, and CHORE clients. Must occur no more than one year from the previous assessment. Each annual assessment will require the same mandatory fields as the Initial. Each screen will have a “Changes” box, and you will need to verify the accuracy of the items on each screen to determine if there have been any changes since the last



assessment. If there have been none, you will answer “No”. If there have been changes, you will select “Yes” and update the information on the screen. All items on each screen must be reviewed to see if the information is true for the new time period.

- **Significant Change:** A face-to-face interview is required whenever there is a significant change, for better or worse, in the client’s cognition, mood/behavior, ADL’s or medical condition. The Significant Change assessment type may be used in the office for other changes, such as a change in the availability of informal support. If the assessment is not performed in the client’s home, document reason in the Presenting Problem.
- **Brief:** HCS staff uses for clients who are discharging from a hospital to a nursing facility and meet the PASRR criteria OR have been admitted from the hospital to the nursing facility and require a level of care determination within 7 days of admission. The mandatory fields will be those required for a Brief assessment.
- **Respite:** AAA staff uses for clients receiving respite services.
- **Non Core:** AAA staff uses for clients receiving non-core services.

Here are some helpful hints for the data collection process:

- Assure that clients and their families are actively involved in the information sharing and decision-making processes.
- Gather information from as many sources as you reasonably can. How you gather the information includes observation, interview, review of medical record (if available), etc. You may need collateral contacts to validate information from the individual. Weigh what the client says, and what is observed about the client against other information obtained from other sources. When respondents give conflicting information, clarify and ultimately use your best professional judgment in weighing the information. Remember that for most items, you are looking back at the last seven days.
- Have a framework in mind before you begin the interview. Use whatever framework works for you, and let the individual’s needs guide you during the assessment process. For example, you might begin the process with obtaining demographic data. Then you might review current medications. This will be helpful in terms of the diagnosis and potential health problem sections. CARE allows you to move quickly and efficiently from one area to another.



- There are standardized screening tools within CARE in which you will ask direct questions of the individual (the depression screening, test for short term memory, etc.), **but, generally speaking, CARE is NOT a questionnaire.** You do not need to ask the individual or collateral contact each and every question in order to elicit accurate data. Much of the information can be obtained through open-ended questions. Examples may include:
 - “Other than high blood pressure, do you have any other problems with your heart or circulation?”
 - “Tell me about your eyesight”. Clarify information as needed.
 - “How is your health?”; “In the last week, have you had any medical problems or concerns?”
 - Have you had any concerns about your bladder or bowels in the last 2 weeks?”
 - “Tell me more about that, can you give me an example, tell me what you have in mind”.
 - “I’m interested in how you spend your days. Can you tell me how you spent yesterday, starting from the time you got up?”
 - “How often do you get assistance, what do they do for you, how many people help you, can you support your own weight?”
- Capture information that is based on **what actually happened during the observation period**, not what usually happens or what you think should have happened. Problems may be missed when the client’s actual status over the entire observation period is not considered.
- Take your time with your first couple of assessments, and carefully study the definitions. Always code to the CARE definitions when gathering information. For example, self-performance is evaluated with appliances if used. Also a client with a catheter who is “dry” is considered continent. The observation period timeframes must also be kept in mind, e.g. last 7 days, last 14 days.
- Communicate with collateral contacts. Communicating with collateral contacts should be done to supplement and/or verify information gathered from the clients. Whenever possible, the client will be the primary source of information for an assessment:



- Direct caregivers. Formal caregivers talk with and listen to the clients on a regular basis. They observe and assist the client's performance of ADLs and involvement in activities. They observe the client's physical, cognitive and psychosocial status frequently during the assessment period.
- Family. The client's family (or person closest to the client) can be a valuable source of information about the client's health history, history of strengths and problems in various functional areas, and customary routine. This information is particularly necessary when the client is cognitively impaired or has a great deal of difficulty communicating. Using this source obviously depends on the presence of family members, their willingness to participate, and the client's preferences. Assessors need to respect the cognitively intact client's right to privacy, and should have permission from the individual in order to ask questions of family members. In most instances, family will not be the sole source of information but will supplement information from other sources. The assessment process provides an excellent opportunity to develop trusting, working relationships with the client, family, and caregivers.
- Communication with relevant others (licensed professionals, etc.)

NOTE: All individuals have the right to privacy. The client must give consent before the assessor may gather information from anyone.

1.1.1 Authorization of Services

An SSPS interface within CARE will allow workers to input all authorizations for a client. Once a client has been assessed in CARE, all SSPS authorizations must be made through the SSPS interface in CARE. Before payment can be authorized, the assessment that generated the rate or number of hours must be in current status.

1.1.2 Payment System

CARE contains a formula that determines a set of hours or rate. It is based on the clients' functional, medical, and psych/social abilities. The allocation generated by CARE is the maximum that can be authorized to meet the client's needs without an approved ETR.



2 Service Episode Records

2.0 Intent

To document all contacts during the assessment, service plan, coordination and monitoring of care, and termination of services.

2.1 Process

Make all documentation entries within the CARE tool on the Service Episode Record (SER) screen. Anyone can access the SERs to enter a record. The primary case manager will have access to SERs for all of his/her clients, regardless of whether or not the case has been checked out.

Once assessments are completed (and moved to “current status”), the assessment is locked from editing. Minor changes in the client’s status should be noted in the SER in accordance with standards of clinical practice and documentation. Major changes in the client’s condition will require a new, significant change assessment.

2.2 Coding

It is important that documentation within the SER’s be written in an objective and clear manner. Once the SER entry is submitted or once the application is closed, the entry cannot be altered. However, workers may append to an existing SER entry.

Each SER contains the following:

2.2.0 Contact Code

The contact code is used to identify the type of contact. It is a required field within the CARE tool. The contact codes with CARE are as follows:

- TC (Telephone Contact): This code is to be used to document a telephone contact. The telephone contact may be with the client, client representative, collateral contact or paid service provider. Include fax and e-mails in this code.
- HV (Home Visit): This code is to be used to document a face-to-face visit with the client conducted in the place of residence.
- CC (Collateral Contact): This code is to be used to document a contact with a collateral. CC is to be used either when a collateral initiated the contact or when a member of the care team initiates the contact.
- 30 Day: This code is to be used to document when a 30-day visit occurred. In the event of a joint visit (HCS and AAA) that replaces the 30-day visit, this code should also be used.

- Clerical: This code would be used to document clerical functions such as authorization changes.
- Consult RN: This code is to be used by care team members to document nursing services referrals, coordination or consults. This code also includes any documented activity by the nursing services RN.
- FV (Facility Visit): Use this code to document a face-to-face visit with the client not conducted in the place of residence (nursing facility, hospital, etc.).
- File review: This code is to be used to document a file reviewed by a supervisor, program manager or other staff responsible for file monitoring and compliance activities.
- Intake: Date referral was received.
- NFCM: Nursing facility case management activity: This code is to be used to document any nursing facility case management activity.
- OV (Office visit): This code is to be used to document an office visit by a client and/or a provider who informally or formally provides services to a client.
- S/P approval: This code is to be used to document a client's verbal consent to the service plan. Client consent must be obtained prior to service authorization.
- Staffing: This code is to be used to document any case staffing activity.

2.2.1 Contact Date

The contact date is a required field within CARE. This is the date the contact took place. All contacts are to be documented as soon as possible following the date of contact.

2.2.2 SER Entry Field

The SER field is an open text field that allows for up to 7900 characters.

3 Transfers In/Out

3.0 Intent

This is the process by which an electronic client file is transferred from one agency to another agency.

3.1 Process:

This protocol is used to transfer any client file. Use these protocols when any file is transferred:

- From one HCS office to another;
- From one AAA/Aging Network office to another;
- Between HCS offices and AAA/Aging Network offices.
- DDD workers will use procedures established by the division.

Prior to transferring a case for ongoing case management in another office, staff should:

1. Complete the assessment and care plan. It is the responsibility of the transferring worker to ensure accuracy and thoroughness of the assessment.
2. Move the assessment into current status after reviewing the pending care plan with the client.
3. Have the client sign the current service summary or verbally agree to care plan (per MB 02-15)
4. Authorize services in CARE SSPS screens. Call the client and/or the authorized service providers to verify that all services have been authorized and have started. Use the phone call to notify the client of the imminent transfer and give the client contact information should they have questions/concerns prior to the receiving worker contacting them.
5. Change the SSPS worker ID to 00TC00 and complete the Financial/Social Services Communications Form (#14-084) to notify the Financial Worker of the case transfer.
6. Transfer the file electronically and send the paper file. If the case involves an Individual Provider authorization, the transfer materials will include IP contract information. Required items include (not applicable to DDD):
 - Copy of the WATCH background check results;
 - Copy of the IP's signed Central Background Unit check form;
 - Documentation that fingerprint card was sent to Central Background Unit, if applicable;
 - Signed IP contract with provider's Social Security Number;



- I-9 form with supporting documentation (copies of required identification or documentation that documents were seen);
- Documentation in the Service Episode Record that the provider has received the IP Handbook and that training and time slip requirements have been discussed with the provider;
- Documentation in the Service Episode Record that the client's service plan and description of the personal service definitions were reviewed with the IP; and
- Documentation that the IP has completed mandatory IP orientation. This is required only if the IP is working for his/her first DSHS client. When applicable, the SSPS provider file needs to be updated prior to the file transfer to indicate completion of orientation.

NOTE: All of the above should be completed within 30 days. There may, however, be valid reasons that a case is not transferred within 30 days. Document these reasons in the SER's.

The receiving office must:

1. Enter the transferred file into the barcode system, as required by policy.
2. Review/approve the paper file within 10 days.
3. Notify the sending office if major problems exist. The sending office will need to make necessary corrections within 10 days. There may be instances where another assessment will need to be completed in order to ensure an accurate and complete assessment.
4. Assign the case to a case manager/social worker once the file is approved. Change the worker ID on the 154/159 upon assignment of the case to an individual Social Worker/Case Manager.

Note: Unresolved differences between the HCS regions and AAA's should be referred to the Chief of the State Unit on Aging and Assistant Director of Home and Community Services Division or their designees for resolution.

In cases where the client has moved prior to an assessment being moved to current status, the originating office will transfer the entire case, regardless of whether the assessment is in pending status.



4 Client Demographics

4.0 Intent

To gather information about the client which is required for reports to the Legislature, federal government, and other entities.

4.1 Process

Keep demographic information current. All demographic data can be updated at anytime.

4.2 Coding

- SSN: This should be the actual Social Security Number for the client. If this number is taken from the Medicare card, it may be a spouse's number and not the client's. Even if the client is claiming benefits under a spouse's or other person's account, you still should put the actual SSN for the client in this field.
- ACES ID: Include the nine-digit number, leading with 0's. Make sure the number is the client's number and not the assistance unit number.
- Interpreter required?: HCS local offices will offer a certified/qualified interpreter at no cost and without significant delay to LEP clients at each contact with DSHS, even if clients bring their own interpreters. This pertains to ADSA/HCS staff only. AAA staff must offer a certified/qualified interpreter at no cost and without significant delay to LEP clients but may use client's interpreter. Record information about the interpreter on the Collateral Contact screen.

5 Overview

5.0 Intent

To document the reason for referral, obtain information about the referent, identify the team assigned to the client, record discharge information, and reasons why the case was closed or was not opened.



5.1 Process

5.1.0 Intake

The intake date is auto-filled based on the date that you added the client to the system. It will be used to track response times (See response timetable in Chapter 3 of the Long Term Care Manual and in the help screen).

5.1.1 Case Assignment

The assigned date is also auto-filled based on the date that a primary case manager is assigned to the client's team. A primary case manager and/or supervisor will need to be assigned before an assessment can be completed and whenever the case is transferred to a different office. The intake worker will automatically be assigned to the team so that she/he can update Client Details as needed.

5.1.2 Referral Information

Document the reason for the referral and record the name of the referent on the collateral contact screen. Ask the caller if she/he is an unpaid caregiver and whether they need caregiver services. If the answer is yes, refer them to the local I&A/AAA office to learn more about the Family Caregiver Support program

5.1.3 Discharge and Nursing Facility Case Management

HCS workers will use this screen to track clients on Nursing Facility Case Management (When making entries re NFCM clients, use the NFCM contact code on the SER screen).

Document discharge status and barriers to discharge when the client is in a hospital or nursing home setting. Refer to LTC Manual Chapter 3 for a discussion of Discharge planning and status.

5.1.4 Inactivation and Reactivation

Clients may be inactivated if they decline services, are denied services or they are screened out. These clients may be reactivated if another intake is performed.

5.1.5 Targeted Case Management

Follow guidelines in LTC Manual, Chapter 5, and select if the client meets the criteria for Targeted Case Management.

6 Addresses

6.0 Intent

To document the client's address, residence, or mailing address.



6.1 Process

Ask client for the complete address. If the client is residing in a residence or someone else's home, document that address and explain whether it is a mailing or temporary address. Include directions.

6.2 Coding

Click plus sign on the Address list to add a new address. To delete an address, click on the address and click the minus sign.

7 Collateral Contacts

7.0 Intent

To serve as the client's "phone book." List anyone who has contact with the client including informal supports, doctor, dentist, religious representatives, family, friends, etc. Once entered here, this list can be used throughout the assessment, where appropriate. If the client goes to a clinic or has visiting nurses, list under "organization."

7.1 Process

Contact Role Definitions:

- Backup caregiver: The person identified to assist the client in a situation in which lack of immediate care would pose a serious threat to the health and welfare of the client. This backup caregiver should be identified here and a plan should be outlined on the "Locomotion outside of room screen."
- Case Manager
- Dentist (This will pull to other screens.)
- Emergency contact: The person who should be contacted in case of an emergency, preferably not the client's caregiver or anyone in the client's household.
- Employer
- Facility staff
- Formal caregiver
- Home health
- Hospital: The client's preferred hospital.
- Hospital Staff



- Informal caregiver: This person may be a family member, a friend or neighbor (but not a paid provider). He/she does not have to live with the client, but may visit regularly, perform a specific service, or respond to the needs that the client may have. This person(s) is most helpful to the client, or is the person(s) the client most relies on.
- Informal decision maker
- Landlord
- Nurse
- Nurse Practitioner
- Other healthcare provider
- Pharmacy: All pharmacies that fill the client's prescriptions.
- (General) Power of Attorney, *Durable Power of Attorney Financial, *DPOA/Healthcare, *Guardian, Representative/Protective payee: Client's substitute decision maker. *(When the client has a legal substitute decision maker, the assessor must not accept or seek the person's decisions without a copy of the paperwork that confirms the legal relationship.) When the client has only an informal decision maker, this arrangement can only continue as long as the client is capable of telling this person what he/she wants. The assessor will need to confirm any decisions made by the informal decision maker with the client. See help screens for specific information on legal decision makers.
- Physician: Select for any practitioner that the client is seeing.
- Primary physician: The client's primary physician, or the physician who should be notified about changes in client's condition.
- Referent: Person who referred client for services.
- Representative/protective payee
- Respite Provider
- RSN case manager
- Teacher
- School
- Social worker
- Veterinarian

7.2 Coding:

Enter the last/family name of the collateral contact, followed by his/her first name. Enter the organization that this person may be affiliated with (if



applicable) in the next box. Then below you will enter more specific information such as address and telephone number(s).

8 Caregiver Status

8.0 Intent

To determine if a referral to the Family Caregiver Support Program (FCSP) is recommended. The Zarit Burden interview can also be used to determine the amount of stress experienced by a caregiver, whether that caregiver is unpaid or paid.

8.1 Process

8.1.0 Caregiver list

Select the name of the caregiver (list will pull from Contact screen). The intent is to use the interview with unpaid caregivers, however, if you want to use this screen for a paid caregiver who is not listed, just add their name to **Collateral Contacts**.

8.1.1 Caregiver detail

Indicate if caregiver lives with client. If they don't live with the client, indicate the distance they live from client. Include approximate length of time the caregiver has been caring for client.

8.1.2 Support Services

Indicate if the caregiver is receiving any support services; you may also enter the last date the service was provided.

8.1.3 Stress/Barriers

The Zarit Burden Interview can be used to determine the level of stress the caregiver is experiencing. NOTE: If the caregiver states that she/he is "Somewhat stressed" or "Very stressed", then the social worker/case manager should refer the caregiver to the Family Caregiver Support Program*. Use the Referral screen to locate the FCSP nearest to the caregiver and to record when referral was made. If the caregiver states that she/he is not stressed, but has a score of 24 or more on the Zarit Burden Interview, discuss the need for support services.

* **The Family Caregiver Support Program** provides services to unpaid caregivers. The caregiver may be caring for a family member or friend (18 years and older) with a disability. Grandparents and other older relatives raising children may also be eligible for this program. Services may include information and assistance, caregiver training, support groups, counseling, respite care and/or help in obtaining adaptive equipment. Most services are provided free of charge. Financial eligibility for services, such as respite care, is based on the care recipient's monthly income and is assessed on a sliding fee basis.

If a paid caregiver has a score of 24 or more refer to RCW 74.39A.095(8) and WAC 388-71-0546 to determine whether payment of that provider should be denied.

8.1.4 Barriers to continued care giving:

Select all that apply if the caregiver indicates that there are issues/obstacles that make them at risk of not being able to continue care giving.

9 Financial

9.0 Intent

Used to document financial eligibility.

9.1 Process:

Before services can be authorized, the assessor must verify the client's financial eligibility for Medicaid or State funded programs. For clients on Chore, Respite, COPES Fast Track, or the Medically Needy waiver, then all or part of the client's financial information must be provided. Consult "help screen" and the LTC Manual for program guidelines and details. For all other CORE clients, verify through ACES online, award letters, etc.

10 Employment

10.0 Intent

To gather information about the client's employment history and status.

10.1 Process

To complete information defined in each field.



11 Main Assessment

11.0 Intent

To document the presenting problem or reason for the re/assessment and sources of information.

11.1 Process

To gather accurate and timely information from the client and other contacts, file review, and from the client representative to begin assessment and care planning.

11.2 Coding

11.2.0 Presenting problem

State the reason for this assessment, documenting the client's or informant's perception of the problem. For reassessments, delete the old presenting problem and enter the current reason/circumstances for the reassessment.

11.2.1 Was client the primary source of information?

Indicate whether the client provided most of the information contained in the assessment.

11.2.2 If no, why?

Select the primary reason that the client was not the primary source of information contained in the assessment.

11.2.3 Other sources

Select the names of all who were a source of information for this assessment. This pulls from the names you have entered into the Collateral Contacts screen.

11.2.4 Assessment date

Enter the date the face-to-face assessment was performed. This is the end point of the assessment period and is essential to the concept of the last 7 days, 14 days etc. This is the date you are “looking back” from. Create date must be same as assessment date.

11.2.5 Next scheduled assessment

Enter the date of the next planned assessment.

11.2.6 Place of assessment

Indicate where the face-to-face assessment took place.



11.2.7 Creation Date

Date the assessment is created or copied. This date is auto-generated.

11.2.8 Name

Enter the name of the facility where assessment took place.

11.2.9 Living arrangements

Indicate whether the client and his/her paid provider (includes agency workers) live together or the client lives in a multi-client household. If the client and the paid provider live together, the status of assistance available for Housework, Meal Preparation, Wood Supply, and Essential Shopping must be “Met”. If Multi-client household is selected, then the user may choose between met and partially met. Unmet will not be available as a selection. If both living with a paid provider and multi-client household apply to a client’s situation, select “Lives with provider”.

11.2.10 Booklet received dates

Document when the client received booklets about Self-Directed Care and Advanced Directives.

12 Environment

12.0 Intent

To identify environmental conditions that are hazardous, especially when the client has a health, safety or functional status that places her or him at risk. One of the goals of ADSA programs is to maximize client independence. The concerns selected on this screen will pull to the **Environment** screen in the care plan. Features of the environment can represent hazards for mortality and injury, and risks for reduced functional performance. By noting significant and clearly hazardous conditions in each circumstance, it is likely that accidents, especially falls, will be diminished. The information also helps to identify potential environmental modifications that may make the client’s residence more accessible or adaptive equipment that can maximize independence.

This section addresses negative aspects or the:

- Condition of the home
- Location
- Accessibility
- Fire safety



12.1 Process

List any concerns observed during the assessment. If the client is eligible for COPES, Environmental Modification funds may be used for minor adaptations. See the Long Term Care manual for guidelines.

12.2 Coding

Select all that apply. To review the list of environmental concerns, select **Yes**. If none apply, select **No** and the screen will be disabled. The assessor should initially select YES to review the various elements with the client prior to making a determination.

Accessibility

- Access to home/rooms: Difficulty exiting or entering the home, unable to climb stairs.
- Barriers prevent access: Physical barriers in the house that prohibit client's access to areas of the home.
- Environmental modification (COPES waiver service): Select if the minor physical adaptation to the home:
 - Ensures health, welfare, and safety
 - Enables the client to function with greater independence
 - Has direct medical or remedial benefit to the client
 - Meets applicable state or local codes
- Home modification: Select if a modification is needed to accommodate the client's need (not a COPES waiver service).

Condition of home

- Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridor). Many clients have difficulty adapting to changes in lighting, are susceptible to glare, and generally require more lighting to see than may be available. Having light switches easily accessible and as few sudden changes as possible from light to dark areas may prevent serious accidents.
- Flooring/carpeting. Holes in floor, electric wires across the floors, scatter rugs. Scatter rugs should be avoided and especially worn and hazardous flooring coverings should be repaired or replaced. Discuss with the client the potential risks if any of these risks are present and available options to decrease the risk.



- Bathroom and toilet room (e.g., non-operating toilet, leaking pipes, no rails, slippery bathtub, outside toilet)
- Kitchen: Dangerous stove, inoperative refrigerator, infestation by rats or bugs. Knobs for gas or electric stoves (and all other electrical appliances) should be easily operated and the “off” position clearly identified. Because clients with cognitive impairments are likely to be at special risk for leaving the stove on, for example, special attention should be directed to caregivers about these hazards if the client is cognitively impaired.
- Heating and cooling: Too hot in summer, too cold in winter, wood stove in a home with an asthmatic
- Clutter, filthy, animal and other feces, etc.

Fire safety

- Space heaters used, or any other fire hazards detected
- No smoke detectors: Many fire districts have programs that provide and install smoke detectors.
- Detectors don't work
- Fire hazards

Location

- Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street). Some clients are unable to perform IADLs because of hazards in the neighborhood, which may range from traffic patterns precluding the client from walking to the store with ease to a high prevalence of violent crime.
- Public transportation not close: Public transportation not available within walking distance
- Emergency services not close: Describe what the caregiver should do in case of fire, natural disaster, or medical emergency if emergency services cannot be accessed quickly. (There are emergency and evacuation caregiver instructions in the *Locomotion outside of room* screen.)
- Frequent power outages: If power outages are common in client's area, describe what caregivers should do in case of power outage. Does client have oxygen? Ventilator? Wood heat? Is local power company aware that client cannot survive without electricity? (Some will arrange a generator during outages). Who would be responsible for transporting client? Ask the client where flashlights and batteries are kept and how frequently she/he checks them.



13 Medical

13.0 Coding

13.0.0 How was medical information verified?

Information regarding the client's diagnosis and treatments should be confirmed with the client's healthcare provider whenever possible, especially when inconsistencies are noted. When this is done, note health care provider who confirmed the information.

13.0.1 Pertinent history

Diagnoses and conditions that are no longer current and affecting the service planning received by the client should be listed under the history section. It is not necessary to list information that is not pertinent to the client's current functional status.

14 Medications

14.0 Intent

To:

- Identify medications, supplements or other products that are prescribed/recommended and used by the client.
- Determine the client or caregiver's knowledge or awareness of medications/products/supplements. These products may be self prescribed or prescribed by an authorizing practitioner.
- Assist the assessor to further assess for physical or emotional problems the individual may have (e.g. as evidenced by use of PRN medications, prescriptions for psychoactive medications, or laxative misuse.) Research shows that individuals who use over 8-10 medications have a high probability of potential drug interactions; therefore it may be appropriate to consult with a nurse, practitioner, or pharmacist regarding potential interactions.

14.1 Process

Ask the client/caregiver if you may look at all of the client's medication bottles and packages to make a list of what medications he/she has been using in the last 7 days. Use the comments box to document medication, products and supplements that client has available to him/her but the client has not used in the last 7 days. If the client is in a facility, you will want to review the medication administration record as well as

discuss with the client. By involving the client with the documentation of medications, the assessor will be able to determine whether the client:

- Knows where medication is kept.
- Knows why the medications are taken.
- Knows how medications are to be administered
- Is able to see and read the labels.
- Understands label instructions.
- Is able to transfer, with or without assistance to obtain the medication.
- Is able to walk/locomote, with or without assistance to obtain the medication.

Other questions to keep in mind:

- Does client use more than one pharmacy?
- Is there more than one prescribing physician?
- Are medications being taken as prescribed?
- Do any medications need to be crushed or altered?
- Does the prescribing physician know about any herbal or home remedies the client is taking?
- Are the pills in appropriate containers (medbox or pharmacy container)? Or are being stored according to label directions?
- Are the prescriptions current, expired or out of date?

14.2 Coding

List all medications taken/used by the client in the last 7 days. This includes: Prescription, over-the-counter, herbal, or home remedies. Record the name of the medication from the container/ MAR and the dosage (i.e. number of milligrams-mg.; grams-gm.; drops-gtts.; ounces- oz.; cubic centimeters-cc's, etc.). A medication (drug) is any compound that changes the chemical activity within the human body. This information is in the dropdowns for Frequency and Route Codes:

| FREQUENCY CODES | ROUTE CODES |
|------------------------|--|
| QD (once a day) | Oral |
| BID (2X daily) | Subcutaneous |
| TID (3X daily) | Feeding Tube |
| QID (4X daily) | Topical (applied to skin or mucous membranes- ointments, creams, or drops) |
| 5 or more / 24 hrs. | Rectal/Vaginal |



| | |
|-----------------------|------------------|
| 2-3 times/week | Inhalant |
| QOD (every other day) | IV (intravenous) |
| 4-5 times/week | Other |
| HS (bedtime) | |
| Weekly | |
| Monthly | |
| PRN (as needed) | |
| Other | |

Additionally, if the individual receives a long acting injectable medication on a regular basis, e.g. Vitamin B12, Haldol, or Prolixin, code as “Monthly” and include in the medication list.

Select “Yes” from the Prescription dropdown list if the medication was prescribed or their primary care provider recommended they take an over the counter medication.

Ask the client and/or caregiver why each medication is taken. If the client and/or caregiver are not sure, then (with the client’s permission) consult the client’s healthcare provider, pharmacist. If the information is difficult to obtain or is not clear, then a referral to Nursing Services may be indicated. This is not a required field but without this information, the list of diagnoses may be incomplete.

15 Diagnosis

15.0 Intent

To document the presence of diseases/infections/conditions that relate to the client’s current functional status, cognitive status, mood or behavior status, treatments and therapies, or health status monitoring. In general, these are conditions that impact the current plan of care. *Do not include conditions that have been resolved or no longer affect the individual's functioning or care plan.*

15.1 Process

15.1.0 Diagnosis

To obtain diagnostic information on the client through interviews with client, caregivers, and collateral contacts. Validate the information obtained as needed with other appropriate collateral contacts. Home health nurses, the client’s health care provider(s), adult day services, or health care provider records may also supply information.

If for example the client states he/she has high blood pressure and is on a medication that reduces blood pressure, this could be a validation of the diagnosis of high blood pressure. If the client or collateral contacts cannot provide any information about the client’s diagnosis, consider a referral to nursing services or nurse oversight for a consultation or file review. (NOTE: These reasons would also be listed on the

Medication screen in answer to “Why taken?”). If the client, physician, or informal supports has no knowledge of the client’s diagnosis or the client has no healthcare provider, then select “Debility NOS”. The diagnosis may be updated at the next assessment. This option should be used only as a last resort.

1. Example: Mr. J had cancer 5 years ago. He has had no reoccurrence or no effect caused by the cancer on his current functioning, cognition, health status monitoring need, or treatments or therapies. Do **not** select Cancer because this is not currently impacting his functioning.
2. Example: Three years ago Mr. R had a stroke that left him with right-sided weakness. His gait is unsteady and he uses a quad cane for ambulation. Type in the first few letters of Stroke and then search. Select **Stroke** from the list.

15.2 Coding

15.2.0 Diagnosis

The following diagnoses are listed in the Generic Search. To search generic lists, you can select a chapter or type the first few letters in the Diagnosis name and click search. The advanced search contains the ICD-9 codes. An ICD-9 code is a billing code, used for Medicaid reimbursement, tied to a specific diagnosis or treatment.

Heart Diseases

- Angina (chest pain)** - Severe pain and a sensation of constriction about the heart. Pain may also spread to the left shoulder, arm, jaw, and back. The condition is caused by a relative deficiency of oxygen supply to the heart muscle.
- Arteriosclerotic heart disease (ASHD)** - Condition in which there is thickening, hardening, and loss of elasticity of the walls of arteries, which results in altered function of tissues and organs.
- Congestive heart failure (CHF)** - Inability of the heart to pump sufficient blood, characterized by water retention often resulting in edema, signs and symptoms of breathlessness, and confusion.
- Cardiac dysrhythmias (irregular heartbeat)** - Disorder of heart rate or heart rhythm.

Cerebrovascular Disease

- Stroke, Cerebrovascular Disease** - A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thrombosis (clot), infarcting, embolus (undissolved matter in a vessel).



Circulatory Diseases

- **Deep vein thrombosis** - The formation, development or existence of a blood clot in the deep venous system of the upper or lower extremities.
- **Hypertension (high blood pressure)** - A condition in which an individual has a higher blood pressure than that judged to be normal.
- **Hypotension (low blood pressure)** - Decrease of blood pressure below normal.
- **Peripheral vascular disease** - Vascular disease of the lower extremities that can be of venous (veins) and/or arterial origin.
- **Transient Ischemic Attack (TIA)** - A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

Neurological Diseases

- **Alzheimer's disease** - A form of progressive, chronic brain disease that can lead to confusion, memory loss, restlessness, perception problems, speech and gait disturbances, lack of orientation to time and place.

Mental Diseases

- **Anxiety disorder** - A category of psychiatric diagnosis that includes panic disorder, obsessive-compulsive disorder, generalized anxiety disorder, and other.
- **Personality disorders** - A large number of personality disorders are recognized. Some of these are paranoid, schizoid, histrionic, narcissistic, antisocial, borderline, avoidant behavior, dependent behavior, compulsive, and passive-aggressive personality disorders.
- **Post traumatic stress disorder (PTSD)** - The development of characteristic symptoms after a psychologically traumatic event that is generally outside the range of usual human experiences.

Psychoses

- **Autism** – A syndrome appearing in childhood with symptoms of self-absorption, inaccessibility, aloneness, inability to relate, highly repetitive play and rage reactions if interrupted, predilection for



rhythmical movements, and many language disturbances. An individual with this syndrome may be eligible for Developmental Disability services.

- Aphasia** - A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (e.g., speaking, writing), which is expressive aphasia, or understanding spoken or written language which is receptive aphasia.
- Bipolar disorder/manic depression** - Severe alterations in mood that are usually episodic and recurrent and fluctuate between depression and mania.
- Dementia other than Alzheimer's** - Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurological diseases other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.)
- Depression** - An emotional state in which there are extreme feelings of sadness, lack of worth or emptiness.
- Mental Retardation**- This is a condition that exist prior to age 18 resulting in significantly sub average general intellectual functioning and adaptive functioning as evidenced by a diagnosis of mental retardation documented by a licensed psychologist or certified school psychologist. These professionals would be expected to document this condition through the use of the Stanford-Binet (67 or less), Wechsler Intelligence Scale (69 or less) or Leiter International Performance Scale (69 or less) and show that this IQ score was not expected to improve with treatment, instruction, or skill acquisition. The assessor will want to learn if the individual has undergone this testing. The care providers or other individuals who know this person well may be aware if this testing has occurred. Check this box if testing has occurred and the results meet the above criteria. This can be a condition that would provide eligibility for Division of Developmental Disabilities services. Determine if the individual is currently receiving services by asking questions of the care provider or others who know this individual well. If this individual is not receiving services through the Division of Developmental Disabilities but could be eligible for such services, make a referral to the local DDD office. If you wish to have more information regarding eligibility for Division of Developmental Disabilities services review WAC 388-825-030.
- Schizophrenia** - A mental disorder in which the individual loses touch with reality, characterized by loss of contact with reality, hallucinations, delusions, abnormal thinking, and disrupted social functioning.



Endocrine

- **Diabetes** - A chronic disorder of carbohydrate metabolism, characterized by abnormal amounts of sugar in the blood and urine and resulting from inadequate production or utilization of insulin. Diabetes can be insulin-dependent diabetes mellitus (IDDM), also known as type I diabetes or non-insulin-dependent diabetes (NIDDM), also known as type II diabetes.
- **Gout** - Hereditary metabolic disease that is a form of acute arthritis and is marked by inflammation of the joints. Joints may be affected at any location, but gout usually begins in the knee or foot.
- **Hyperthyroidism** - A condition caused by excessive secretion of the thyroid glands, which increases the basal metabolic rate, causing an increased demand for food to support this metabolic activity.
- **Hypothyroidism** - A condition due to deficiency of the thyroid secretion, resulting in a slowing of body functions. Symptoms may be constipation, inability to tolerate cold and dry, scaly skin.
- **Obesity** - A diagnosis employed only when the individual is from 20% to 30 % over average weight for his or her age, sex and height, resulting in an increased amount of fat on the body.

Digestive Diseases

- **GERD (Gastroesophageal Reflux Disease)** – This is when digestive (gastric) juices from the stomach flow backwards (reflux) to the esophagus. The primary symptom is heartburn.
- **Ulcerative colitis** – Ulcerative colitis is a chronic, inflammatory ulcerative condition of the colon, with the most common symptom being bloody diarrhea.
- **Crohn's Disease** - Crohn's Disease is also characterized by chronic inflammation at various sites in the GI tract from the mouth to the anus and perianal area. The most common symptoms are chronic diarrhea associated with abdominal pain, fever, and weight loss.
- **Irritable Bowel Syndrome (IBS)** – This is a disturbance of intestinal function of unknown cause. The individual has intermittent symptoms of abdominal discomfort, including cramping and altered bowel activity. This syndrome does not produce fever or weight loss. Symptoms are often initiated or exacerbated by mental or social stress. It is the most frequent gastrointestinal disorder.
- **Gastrointestinal Ulcers** – Peptic gastrointestinal ulcers are an erosion of the lining of the gastrointestinal tract. The erosion is a



result of the action of digestive secretions, i.e. hydrochloric acid and pepsin. You may see a diagnosis of gastric ulcer (located in the stomach) or duodenal ulcer (located in the small intestine). These are both peptic ulcers; duodenal ulcers account for about 80% of them. Peptic ulcers can be acute or chronic. When there is pain, it is typically described as burning, gnawing, or aching, but it can also be described as soreness or empty feeling or even hunger. Generally, antacids or milk relieve the pain.

Infectious Diseases

- **Hepatitis**– Hepatitis is inflammation of the liver. It may be caused by a variety of agents, including viral infections, bacterial invasion, and physical or chemical agents. It is caused by viruses, bacteria, alcohol or drug abuse, some medicines, or serious harm to the liver. There are five kinds of hepatitis: hepatitis A, hepatitis B, hepatitis C, hepatitis D, and hepatitis E. Clinically, it is usually accompanied by systemic signs including fever, jaundice, and an enlarged liver. Other liver diseases, such as cirrhosis, should be chosen using the Advanced Search.
- **Polio, Post syndrome** - A variety of musculo-skeletal symptoms and muscular atrophy that create new difficulties with activities of daily living 25 to 30 years after the original attack of polio.
- **TB (Tuberculosis)** - An infectious disease caused by the tubercle bacillus, most commonly affects the respiratory system, but other parts of the body such as gastrointestinal and genitourinary tracts, bones, joints, nervous system, lymph nodes, and skin may become infected.

Musculoskeletal

- **Arthritis** - Inflammation of a joint, usually accompanied by pain, swelling, and frequently, changes in structure.
- **Fibromyalgia** – The fibromyalgia syndromes are a group of disorders characterized by achy pain and stiffness in soft tissues, including muscles, tendons (which attach muscles to bones), and ligaments (which attach bones to each other). The pain and stiffness (fibromyalgia) may occur throughout the body or may be restricted to certain locations.
- **Arthritis, Osteoarthritis** - A chronic disease involving the joints, especially those bearing weight. Characterized by joint pain, stiffness and impaired function.
- **Osteoporosis** - A disease of the bone, where normal bone density is lost, when the body is not able to regulate the mineral content of the



bone. It may cause pain, especially in the lower back, frequent broken bones, and loss of body height.

- **Fracture, Pathological** - Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process. The weakened bone may fracture only with a slight injury or no injury.
- **Arthritis, Rheumatoid** - A chronic systemic disease characterized by inflammatory changes in joints and related structures that result in crippling deformities, swelling, pain and stiffness.

Fracture

- **Fracture, hip** - Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatment, monitoring, etc. Hip fracture diagnoses also include femoral neck fracture, fractures of the trochanter, subcapital fractures.
- **Muscular dystrophy** - A group of genetic diseases characterized by progressive weakness and degeneration of the muscles responsible for movement.
- **Fracture, Unspecified**

Neurological

- **ALS** -Amyotrophic Lateral Sclerosis (also called Lou Gehrig's disease) - A syndrome marked by muscular weakness and atrophy (muscle wasting) with spasticity and hyperreflexia due to degeneration of motor neurons of the spinal cord and brain.
- **Cerebral palsy** - Paralysis related to developmental brain defects or birth trauma.
- **Hemiplegia** - Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor.
- **Impairment of the central nervous system** — A diagnosed impairment of the brain or spinal column, resulting in physical disabilities and the need for one to one assistance with ADLs. (This may not be a specific diagnosis that you will find listed in a facility record or medical chart. The intent of this item is to identify those individuals who are or may be eligible for Division of Developmental Disabilities services. Eligibility under DDD also has an IQ requirement.) There are neurological or other conditions closely related to mental retardation that require treatment similar to that required for individuals with mental retardation. Eligibility criteria



under these conditions are defined in WAC 388-825-030. If an individual may meet these criteria, make a referral to the local DDD office for an eligibility determination.

- **Multiple Sclerosis** – Chronic disease affecting the central nervous system with remission and relapses of weakness in coordination paresthesias (numbness, tingling), speech disturbances and visual disturbances.
- **Neuropathy** - Any non-inflammatory disorder of the nerves. May be caused by trauma, poor nutrition, alcoholism, diabetes, infection, etc. Signs may include changes in sensation, pain, or paralysis/muscle wasting.
- **Paraplegia**- Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.
- **Parkinson’s Disease** – A chronic nervous system disease characterized by a fine, slowly spreading tremor, muscular weakness and rigidity, and a peculiar gait. Onset may be abrupt; but is generally insidious. The first symptom is a fine tremor beginning in the hand or foot that may spread until it involves all extremities.
- **Quadriplegia** - Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs and usually the trunk. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.

Symptoms and Signs

- **Seizure disorder** - A sudden, violent uncontrollable contraction of a group of muscles. May occur in episodes. Includes epilepsy.
- **Sleep Apnea Temporary** - cessation of breathing while sleeping.

Injuries

- **Traumatic Brain Injury (TBI)** - Damage to the brain as a result of physical injury to the head.
- **Allergies (medications, food, environmental)** - Any hypersensitivity caused by exposure to a particular allergen. Includes agents (natural and artificial) to which the individual is susceptible for an allergic reaction, not only those to which he or she currently reacted to in the last 7 days. Hyper-sensitivity reactions include but are not limited to itchy eyes, runny nose, sneezing, contact dermatitis, etc.



Respiratory

- **Asthma** - A disease caused by increased responsiveness of the tracheobronchial tree to various stimuli resulting in constriction of the bronchial airways. Symptoms include coughing and wheezing.
- **Bronchitis, Chronic** – Is a condition associated with prolonged exposure to nonspecific bronchial irritants. The typical symptom is a chronic productive cough, which is a cough that brings up phlegm (or sputum), rather than a dry cough, which has no secretion. This condition is associated with cigarette smoking or can be due to exposure to allergens.
- **Emphysema** – A chronic lung diseases caused by the enlargement of the tiny air sacs of the lungs and the destruction of their walls. Clinically the individual may have breathlessness only during exertion, others may be breathless all the time.
- **Chronic Obstructive Pulmonary Disease (COPD)** - A persistent obstruction of the airways caused by emphysema or chronic bronchitis impairing the exchange of oxygen and carbon dioxide. The individual may have breathlessness at rest and on exertion, and may or may not produce sputum with coughing.
- **Pneumonia** - This is inflammation of the lungs, most commonly of bacterial or viral origin. Common symptoms are chills, high fever, pain in the chest, and a cough, which produces puss or often bloody mucus. Mortality is high unless treated with an appropriate antibiotic.

Eye Diseases

- **Cataracts** - A disease of the eye in which the lens loses its clearness. A gray-white film can often be seen in the lens behind the pupil of one or both eyes, resulting in reduced visual acuity.
- **Diabetic retinopathy** - Any disorder of the retina occurring in diabetics resulting in progressive loss of vision.
- **Glaucoma** - Disease to the eye, characterized by increased intraocular pressure. It can lead to irreversible damage to optic nerve and progressive loss of vision.
- **Macular degeneration** - Degeneration of the macular area of the retina of the eye and can lead to the loss of central vision.

Other

- **Amputation of upper limb**- Includes loss of any part of upper extremity (fingers to shoulder) from disease or trauma.



- **Amputation of lower limb-** Includes loss of any part of lower extremity (hip to toes) from disease or trauma.

Blood Diseases

- **Anemia** - Reduction in the number of red blood cells. Anemia is not a disease; it is a symptom of various diseases.

Malignant Neoplasm

- **Cancer** - Any type of malignant neoplasm that is currently present without specification of site (e.g., being treated, monitored, causing complications).
- **Explicit terminal prognosis** – The physician has documented in the facility chart or told the client or family/others that the client is terminally ill with no more than 6 months to live. This judgment should be substantiated with a well documented disease diagnosis and deteriorating clinical course.

Urinary Diseases

- **Renal failure** – Abnormal kidney function in which the kidneys are unable to adequately excrete toxic substances from the body. The failure may be acute or chronic, with a sudden or gradual decline in function.
- **UTI (Urinary tract infection)** - Infections of the urinary tract with microorganism. Include chronic and acute infection(s).

Skin Diseases

- **Decubitus ulcer** –Skin damage resulting from a lack of blood flow and from irritation to the skin over a bony prominence where the skin has been under pressure from a bed, wheelchair, cast, splint, or other hard object for a prolonged period of time.

15.2.1 Functional Limitations

Provide a snapshot of the client’s functional limitations and symptoms resulting from the selected diagnoses that impact care delivery and service planning.

- Cannot raise arms



- Contractures
- General weakness
- Left sided weakness
- Limited fine motor control
- Limited range of motion
- Non-weight bearing
- Partial weight bearing
- Poor balance
- Poor hand/eye coordination
- Right-sided weakness
- Tremors
- Unsteady gait
- Weak grip

15.2.2 Indicators

Select all choices that apply to the client in the last 7 days.

- Symptoms of Delirium: The indicator list includes **symptoms of delirium**, an acute confused state, which develops rapidly, usually in a few days or even hours. This must represent a **recent change in the client's normal functioning**:
 - Easily distracted
 - Altered perception
 - Disorganized speech
 - Lethargy
 - Mental function varies

Delirium is a serious problem, which can be treated. It can be caused by infections, reactions to medications, an electrolyte imbalance or by the stress of a physical illness. If client shows any of these signs, instruct the caregiver or others involved to make an immediate referral to a medical health professional.

- Breath sounds:** The client is wheezing or rattling or has moist (crackling) breathing sounds.
- Angina pectoris:** Severe pain and pressure felt in the chest or around the heart. Pain can typically radiate to the left shoulder and down the left arm.



- Dizziness/vertigo:** The client experiences sensations of unsteadiness when she/he is turning, or that the surrounding area is whirling around.
- Dry cough:** The client has a cough that does not produce sputum.
- Edema (swelling):** Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).
- Fever:** A fever is present when the client's temperature is 2.4 degrees fahrenheit greater than his/her baseline (normal) temperature.
- Headache:** Diffuse pain, acute or chronic, in different parts of the head. Can be dull or aching.
- History of recurrent infections:** Client has had a history, in the last 6 months, of recurrent infections (e.g., UTI).
- Nausea:** An unpleasant sensation before vomiting.
- Palpitations:** Throbbing pulsation or fluttering of heart.
- Productive cough:** Cough that produces sputum.
- Shortness of breath at rest:** Difficulty breathing (dyspnea) occurring at rest, or in response to illness or anxiety.
- Shortness of breath upon exertion:** Difficulty breathing (dyspnea) occurring with activity.
- Syncope(fainting):** Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery.
- Physical/mental function fluctuates:** Denotes the changing and variable nature of the client's condition.
- Vomiting:** Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic (of mental origin)
- None of these:** Select if none of these apply to the client.

Is client comatose? Select "Yes" if the client has a neurological diagnosis of coma or persistent vegetative state.

16 Medication Management

16.0 Intent

To identify the client's functional abilities for self-administration of medications, the need for any professional assistance, for caregiver education, for administration of

medication, assistance with medication administration or the delegation of medication administration.

16.1 Process

Select the level of medication assistance required by the client as determined by the assessment of the client's functional and cognitive ability.

16.2 Coding

16.2.0 Self-Administration of Medications

There exist four possible distinctions of an individual's functional and cognitive ability with respect to their medication management. Select the appropriate category. Code for the highest level of need even though an individual could, for example, be independent with oral medications taken four times daily, but need assistance with eye drops taken one time daily. In this example, select Assistance Required.

- Independent:** Client remembers to take medications as prescribed and manages own administration independently.
- Self directs:** Client with functional disability is capable and chooses to self-direct medication assistance or administration.
- Assistance required:** Relates to the assistance provided by a non-licensed provider to facilitate the client's self-administration of a prescribed, over the counter, or herbal medication, supplement or product. This includes reminding or coaching the client, handing the medication container to the client, opening the container, using an enabler to assist the client in getting the medication to their mouth, or placing the medication in the client's hand. This assistance does not include assistance with intravenous medications or injectable medications. The client must have awareness that they are taking medication and must be able to administer, apply or instill the medication, supplement or product.
- Must be administered:** Medication must be placed in the client's mouth, applied or instilled to the skin or mucous membrane. Administration must be performed by a licensed professional or be delegated by a Registered Nurse to a qualified caregiver (WAC 246-840). Administration may be done by a family member, unpaid caregiver, or through nurse delegation. Intravenous or injectable medication may never be delegated and must be administered by a licensed health care professional, family member, or unpaid caregiver.

16.2.1 Frequency

Indicate how often the client requires assistance:



- **Less than daily:** Client does not require assistance every day e.g., the client may need to have their syringes filled or their pillbox filled weekly but is independent with the administration.
- **Daily:** The client requires assistance every day with one or more medications.
- **2 to 6 days /week:** The client required assistance less than daily.
- **Weekly:** The client requires assistance with medications weekly. For example a client may have a weekly injection that requires administration, but is independent in oral medication administration.
- **Every two weeks:** The client requires assistance with assistance or administration of a medication scheduled every two weeks.
- **Monthly:** The client requires assistance or administration of a medication monthly. This may commonly occur for clients, who receive injectable hormone replacement therapy or vitamin B12 for pernicious anemia, monthly.

16.2.2 Status

Refer to Section 46.0.0 of the manual for details on how to assess for status.

16.2.3 Assistance available

Refer to section 46.0.2 of the manual for directions on how to assess for assistance available.

WAC 246-888 provides additional details of the definition of Medication Assistance in Community-Based Care Settings.

17 Treatments

17.0 Intent

To document any special treatments, programs, or therapies, that the individual has received in the last 14 days. It also assists in identifying those treatments, therapies, or programs that are presently needed so that appropriate plans may be developed and recorded for these services.

17.1 Coding

17.1.0 Treatment

Code regardless of where the client received the treatment (hospital, ADH, etc.).
Code for whether received in last 14 days.

- **Application of dressings** - with or without topical medications: Includes dressings moistened with saline (salt) or other solutions, transparent dressings, or other absorbent dressings used to manage wounds with large amounts of drainage. Simple dressing changes may be delegated.
- **Application of medications/ointments (skin conditions only)** - (other than to feet)-Includes ointments or medications used to treat a skin condition (e.g. cortisone, antifungal preparations antibiotic ointments etc). This includes over the counter items that have been **prescribed or recommended** by their health care provider. This definition does NOT include ointments used to treat non-skin conditions (e.g. nitropaste for chest pain or estrogen patches for replacement therapy). Simple application of medications or ointments may be delegated.
- **Blood glucose monitoring**- this is a test that can detect and monitor elevated blood glucose levels in clients with diabetes. Usually this test is done on a regular basis per the doctor's order. The fingerstick etc, and the other tasks in blood glucose monitoring can be delegated in Adult Family Home and Boarding Homes.
- **Bowel program**- Includes interventions such as digital stimulation, OTC/Rx suppositories.
- **Chemotherapy**- Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatments.
- **Continuous Positive Airway Pressure (CPAP or BiPAP)**- An airway treatment via a mask that creates a slight positive pressure during inhalation to increase the amount of air breathed in, decrease the work of breathing, and keep the throat from collapsing during sleep. This treatment is commonly used for adults with sleep apnea (the stopping of breathing during sleep).
- **Dialysis**- A technique used to remove toxins & wastes from the blood when the kidneys fail. There are 2 types- Peritoneal dialysis uses the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) to remove the waste materials. A special dialysis fluid is put into the peritoneum through a surgically implanted tube on the abdomen. The fluid is held in place for a period of time, and then drained out of the body thus removing the wastes. This process can be performed manually or with the help of a machine.



Hemodialysis occurs by circulating all of the individual's blood directly through a dialysis machine that has special filters to remove the wastes. A special large tube called a shunt is permanently implanted (typically) into the individual's arm. Another removable tube connects the individual from their shunt to the dialysis machine to allow the filtering of the blood with the dialysis fluid.

- **Enemas/Irrigation:** Any type of enema or bowel irrigation, including ostomy irrigations.
- **Gastostomy/Peg care:** Cleaning around tube site; changing, cleaning, and filling bags.
- **Indwelling catheter care** Care of catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision. The care includes daily cleansing of the site, flushing and cleaning of lines.
- **Injections-** a syringe with a needle is used to administer medications under the skin or into a muscle.
- **Intake/output- (I & O)** The measurement and evaluation of food and fluid taken into and emitted from the body in a 24-hour period. Substances emitted from the body may include such things as fecal material, vomit, urine etc. Monitoring specifically ordered fluid limits, fluid intake goals, or measurement of output is common.
- **Intermittent catheter** - A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. This task may be delegated.
- **Intravenous (IV) medications** - Includes any drug given directly into a vein from a syringe or diluted in a volume of fluid that drips in over a period of time. The IV access may be from a peripheral vein (e.g. in the arm) or through a tube or port permanently implanted into a large central vein of the body. Epidural, intrathecal and baclofen pumps that deliver medications may also be recorded here. **DO NOT** include IV fluids for hydration as this is covered in the nutrition section. This also **does not include** a saline or heparin flush to keep a heparin lock open.
- **Management of IV Lines** - This includes monitoring of the entry site for signs and symptoms of infection, cleansing of the site and applying a sterile dressing for central lines. Central line care may not be nurse delegated, as this is as sterile procedure.
- **Monitoring of acute medical condition by a licensed nurse** - Includes observation by a licensed nurse for ANY acute physical or psychiatric illness.

- **Nebulizer-** A machine that produces a fine spray or mist through which medications may be administered into the nose, mouth, and lungs. Nebulized medications are a common medical treatment for individuals with asthma or chronic obstructive pulmonary (lung) disease (COPD).
- **Ostomy care -** Cleansing of any opening onto the abdomen (stoma) that diverts contents of the bowel (fecal material) or bladder (urine). This includes cleansing of the skin around the stoma, or reapplication of the bag as needed.
- **Oxygen therapy-** Includes continuous or intermittent oxygen via mask, cannula (tube), etc.
- **Radiation -** Includes radiation therapy or having a radiation implant.
- **Routine lab work:** Examples would be protimes and digoxin level checks.
- **Skilled nursing (waiver):** Skilled nursing service (COPES in-home waiver service) is authorized when the service is (a) provided by a registered nurse, or a licensed practical nurse (who is under the supervision of a RN), (b) is beyond the amount, duration, or scope of Medicaid-reimbursed home health services.
- **Suctioning -** The act of drawing or sucking out liquids through a tube- Oral (by mouth), Nasal (by nose), Pharyngeal (to the back of the throat), Tracheal (windpipe).
- **Tracheostomy care -** Includes cleansing of a tracheostomy (a surgical opening of the trachea / windpipe to provide for an adequate airway for breathing) and tracheostomy tube.
- **Transfusion -** Includes transfusions of blood or any blood products (e.g. platelets).
- **Tube feedings-** The administration of nourishment & fluids via a tube such as a gastrostomy / PEG tube (inserted directly into the stomach through the abdomen) or nasogastric tube (tube inserted through the nose, down the throat & into the stomach).
- **Ulcer care:** Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.
- **Ventilator or respirator-** A mechanical device that assists an individual to breath when they are unable to do so on their own. Individual being weaned from mechanical ventilation by a machine-means that attempts are being made to gradually remove the individual from the machine so that they may return to breathing on their own. Does not include CPAP or BiPAP. Do not select ventilator if client received it in the last 14 days, solely in conjunction with a surgical procedure.



- **Vital Signs (temperature, pulse, respiration, blood pressure, and weights)** - This is the monitoring of these issues to report to the primary health care provider or the home health nurse any change that would be indicative of an unstable health condition that would require further evaluation and or treatment.
- **Wound / skin care-** Measures used to treat open skin areas or post-operative incisions to promote healing.
- **Other-** This could include monitoring that lab work ordered by the primary health care provider is completed as scheduled.

Programs

- **Adult Day Care-** Provides supervised programs of less than 24 hours per day where frail and disabled adults can participate in social, educational, and recreational activities. A Registered Nurse and Social Worker must also provide consultation regarding the individual's participation in the program and assessment of the client's overall well being and need for additional services. The program offers a rest to caregivers, by providing a safe alternative to home care.
- **Adult Day Health-** A structured program that provides licensed rehabilitative and skilled nursing services, in an environment that also offers social work services and socialization for frail and disabled adults. Each participant has a specialized service plan designed to individualize and assess for response to his or her program. The service plan is developed with the participation of the client to address particular needs.
- **Alcohol / drug treatment program-** A comprehensive interdisciplinary program where interventions are designed specifically for the treatment of alcohol or drug addictions.
- **Alzheimer's / dementia special care unit-** Any special section of a facility where staffing patterns and individual care interventions are designed specifically for cognitively impaired clients who may or may not have a specific diagnosis of Alzheimer's disease.
- **Behavior evaluation program** - A program of ongoing comprehensive, multidisciplinary evaluation of behavioral symptoms. The purpose of such a program is to attempt to understand the "meaning" behind the individual's behavioral symptoms in relation to the individual's health and functional status, and social and physical environment. The ultimate goal of the evaluation and management program is to develop and implement a plan of care that serves to reduce the distressing symptoms. In order to check this box, we would expect there to be documentation in the individual's facility chart of this evaluation occurring and a plan being implemented. In the in home setting this is confirmed through the case managers involvement

in a multidisciplinary team meeting and care planning effort with other professionals in the community to address the specific behavior symptoms. This would be documented in the Service Episode Record and the client's service plan.

- Cardiac rehabilitation-** A multi-dimensional, medically supervised program designed for clients who suffer cardiac disease (e.g. heart attack, chest pain/angina, or following heart vessel bypass surgery, etc.). The program (typically outpatient) teaches clients methods to modify their risk factors (diet, smoking, etc.), provides for an increase of the individual's functional capacity through exercise (develops endurance, strength, flexibility), and instills confidence for the individual to resume normal life activities.
- Community Integration** – Emphasizes development of personal relationships within the individual's local community.
- Employment support**
- Hospice Care-** A multi-disciplinary program for terminally ill clients where services are necessary for palliation (comfort measures) and management of terminal illness and related conditions. This program may or may not be covered by Medicare hospice benefits.
- Modify environment for behavior** - Adaptation of the environment (milieu) focused on the individual's mood/ behavior/ cognitive pattern. Examples include placing a banner labeled "wet paint" across a closet door to keep an individual from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for an individual who frequently stops wandering to rummage. The latter diverts the client from rummaging through belongings in others rooms along the way.
- Mental health therapy/program** - Clinical services provided by a licensed mental health specialist including individual psychotherapy, group therapy, or a regimen of medications. **DO NOT** check this item for routine visits by a social worker or case manager.
- Respite Care-** A program for providing relief for families or other unpaid caregivers of people with disabilities. Both in-home and out-of-home care is available and is provided on an hourly and daily basis, including 24-hour care for several consecutive days. Respite care workers provide supervision, companionship, and personal care services.
- Sheltered workshop**

Skilled Therapy



- **Occupational Therapy**- Defined therapy program designed to gain/regain skills that will assist an individual to reach a higher level of function regarding direct personal care and household activities (e.g. bathing, dressing, cooking, eating, etc.). OT services focus on small muscle, fine motor activities, as well as adaptive devices. These services are provided by an occupational therapist (OT) or by a certified occupational therapy assistant (COTA) under the direction of an occupational therapist.
- **Physical Therapy** - The treatment of disorders with physical agents and methods, to assist in rehabilitating clients and restoring normal functioning following an illness or injury. PT services focus on large muscle groups, strengthening, endurance building, and adaptive equipment to improve mobility. These services are provided by a physical therapist or by a licensed physical therapy assistant (PTA) under the direction of a physical therapist.
- **Respiratory therapy** - Included are coughing, deep breathing, heated nebulizers, or aerosol treatments that are provided by a licensed Respiratory Therapist or qualified professional nurse. In addition the nurse must have received specific training on the administration of respiratory treatments and procedures.
- **Speech Therapy** - The treatment of defects and disorders of the voice, of spoken and written communication and swallowing deficits. These services are provided by a licensed speech language pathologist.

Rehabilitation/ Restorative Care

Definition of Range of motion: The extent or limit to which a part of the body can be moved around a joint (or a fixed point); the totality of movement a joint is capable of doing. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body.

- **Passive Range of Motion** - The individual is unable to move the joint and needs a caregiver to perform maintenance movements to each joint ONLY to the extent the joint is able to move. (NOTE: Caregivers may NOT stretch the joint- . A formal program needs to be first established by a qualified nurse or therapist.
- **Active Range of Motion** - Exercises performed by an individual to maintain their joint function to its optimal range (may be with cueing or reminders by caregivers). A formal, active Range of Motion program needs to be first established by a qualified nurse or therapist.
- **Splint or brace assistance**- Assistance can be of 2 types:



- Verbal and physical guidance are provided to teach the individual how to apply, manipulate, and care for a brace or splint, or
- A scheduled program of applying and removing a splint or brace to assess the individual's skin and circulation under the device and reposition the limb in correct alignment.

Rehab/Restorative Training

Training and self care skill practice activities are part of a rehabilitative or restorative program established by a qualified therapist or nurse BUT provided by a caregiver that promotes the individual's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning and preventing any decline of function. In order for these activities to be selected, there must be: measurable objectives and interventions on the SP, caregivers must be trained in techniques that promote client involvement, programs must be periodically reevaluated by a nurse and time spent on each program must be at least 15 minutes a day.

- **Amputation / prosthesis care** - Activities used to improve or maintain the individual's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g. leg stump or eye socket).
- **Bed mobility** - Activities used to improve the individual's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.
- **Client training/waiver**
- **Communication** - Activities used to improve or maintain the individual's performance in using newly acquired functional communication skills or assisting the individual in using residual communication skills and adaptive devices.
- **Dressing or grooming** - Activities used to improve or maintain the individual's performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.
- **Eating or swallowing** - Activities used to improve or maintain the individual's performance in feeding oneself's food and fluids, or activities used to improve or maintain the individual's ability to ingest nutrition and hydration by mouth.



- **Instrumental Activities of Daily Living** - Activities used to improve or maintain the individual’s self –performance in Meal Preparation, Ordinary Housework, Managing Finances, Telephone use, Essential Shopping, Transportation and Wood Supply.
- **Medication Self-Administration** - Activities used to improve or maintain the individual’s ability to manage and or administer their own medication (s).
- **Transfer** - Activities used to improve or maintain the individual’s self-performance in moving between surfaces or planes either with or without assistive devices (e.g. move from bed to chair, etc.).
- **Walking** - Activities used to improve or maintain the individual’s performance in walking, with or without assistive devices.

17.1.1 Received/Needs

The assessor will identify all treatments, programs or therapies received by the individual by selecting the drop down “**Received**”. If the treatment, program or therapy is to be continued, revised, or referred for evaluation, also select the drop down “**Need**”.

17.1.2 Frequency/Provider

This is done so that the care plan will specifically indicate how the individual’s ongoing care needs will be met.

- **Client** - This refers to the individual we are assessing. A client may be able to perform a treatment himself or herself.
- **Family/informal supports** - Informal supports can be neighbors or friends.
- **IP/Agency** -These are individual providers or individuals hired by the home care agencies to provide the personal care services ADSA pays for through CHORE, COPEs or Medicaid Personal Care
- **Self-Directed Care (IP only) *** - An individual client who has a functional impairment can direct their IP to perform a skilled task that they would normally be able to perform themselves if they did not have a functional impairment that prohibited them from doing so.
- **Home Health Agency** - This is a Medicare/Medicaid certified agency that provides skilled nursing observation and treatment and skilled OT, PT, Speech and Respiratory therapy to clients in their own home, AFH or Boarding Homes.

* Self-directed care tasks will be documented on the Treatment screen; include the name of the health care provider that is working with the client as well as a description of the task being self-directed, including whom, what, and when.



- Hospice** - An inter-disciplinary program of palliative care and supportive services that addresses the physical, spiritual, and social, and economic needs of terminally ill patients and their families. This care can be provided through a Home Health Agency, Hospice Agency, or a hospice center.
- Outpatient rehabilitation** - This is a structured program where an individual will receive skilled nursing and other skilled therapies at a hospital, clinic or other outpatient setting.
- Mental Health** - This is therapy given by an licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker or case manager.
- Clinic/practitioner's office** - When a procedure or a treatment is performed in a clinic or office by the primary care provider or a member of their staff who is licensed or certified to perform the specific treatment or procedure
- Private duty nursing** - This is a specific program that is authorized by the Community Nurse Consultants that work for Home and Community Programs. Specific skilled nursing interventions need to occur for a continuous 4-hour period in order for a client to be considered for this option. Only choose this option when you know that a client is receiving Private Duty Nursing services to meet a specific treatment need.
- Nurse Delegation** - In Adult Family Homes and in Boarding Homes with an Assisted Living contract a RN can delegate specific skilled tasks to a certified or registered Nursing Assistant (At the present time only the following tasks can be delegated if the unlicensed staff is being paid to provide care: Oral and topical medications and ointments; nose, ear, eye drops, and ointments; Dressing changes and catheterization using a clean technique; Suppositories, enemas, ostomy care; blood glucose monitoring and Gastrostomy feedings in established and healed condition.
- Facility Nurse** - This is the boarding home staff person who is a Registered nurse (RN) or the Adult Family Home provider who is a registered nurse or include here the instance where an Adult Family home has **hired** a RN to provide a skilled task for a specific client. (Do not include home health staff in this category)
- AFH/Boarding home staff** - This is the unlicensed staff providing care in an AFH or a Boarding home setting. This can be a certified or registered Nursing Assistant.
- ADH/ADC**
- Other (specify in comments)**



18 Pain

18.0 Intent

To assess and document the client's pain including factors such as the site and intensity of pain, the frequency of the pain, any associated treatments and the impact of the pain on the individual's functional or cognitive abilities.

Definition: "An unpleasant sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage" (International Association for the Study of Pain, 1979). For our purpose, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement.

"Whatever the experiencing person says it is and exists whenever he/she says it does" (McCaffery, 1972)

18.1 Process

Ask the individual if he or she has experienced any pain in the last 7 days. If so, take their word for it- pain is a subjective experience. (If the individual is unable to verbally express whether pain exists, you will base your assessment on observations of the individual's behavior, reports from the caregivers, and as needed, consultation with the primary care practitioner. Refer to the "tips" at the end of this section for further information when assessing pain for clients with cognitive impairments). Ask the individual or appropriate caregivers, if the individual is unable to verbalize, specific questions related to particular physical location, intensity and duration of the pain as well as specific treatments for the pain

Pain should be considered when clients are not performing at their optimal level or are not doing what they usually do. Consider how the pain impacts their daily functioning and code under Impact. If the individual is experiencing new or acute pain in the last 7 days, immediate evaluation by a practitioner or primary care provider may be necessary to identify & treat the underlying cause. Pain in the last 7 days could also be of a chronic nature- the assessor needs to ascertain that the highest possible level of relief or intervention is being provided for the individual.

18.2 Coding

Ask the individual to describe the pain in terms of *frequency and intensity*. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level or pain. Individuals having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. We never want

to miss an opportunity to relieve pain. Code for the presence or absence of pain, regardless of pain management efforts. Select yes from the drop down “**Pain Identified**” if the client is experiencing pain. Select from the Pain list, the Pain Site and Score. Consider how the pain impacts their daily functioning and code under Impact.

18.2.0 Frequency

Select from the drop down “**Frequency with which the client complains of pain:**” to determine from the individual or caregiver how often the client is experiencing pain.

18.2.1 Intensity

You will code the intensity of the pain using a 1-10 scale with 1 being the least intensive and a 10 being the most intensive.

Tips for assessment of pain in cognitively impaired older adults:

Assessment of pain in cognitively impaired older adults requires familiarity with the individual. Ask the clients’ families or caregivers for cues that indicate expressions of pain.

Please assess for the following, which are associated with expressions of pain in cognitively impaired older adults:

- Back pain:** Localized or generalized pain in any part of the neck or back.
- Bone pain:** Commonly occurs in cancer that has spread to other parts of the body (metastasis). Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.
- Feet**
- Stomach pain:** The client complains or shows evidence of pain or discomfort in the left quadrant of the abdomen.
- Chest pain while doing usual activities:** The client experiences any type of pain in the chest area, which may be described as burning, stabbing, vague discomfort, etc. “Usual activities” are those that the client engages in normally. For example, the client’s usual activities may be limited to minor participation in dressing and grooming, short walks from chair to bathroom.
- Soft tissue pain:** Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, and wound pain.
- Incision pain:** The client complains or shows evidence of pain at the site or a recent surgical incision.



- **Hip pain:** Pain localized to the hip area. May occur at rest or with physical movement.
- **Overall:** Includes diffuse pain throughout the body. Examples include general “aches and pains”, etc.
- **Headache:** The client regularly complains or shows evidence (clutching or rubbing the head) or a headache.
- **Joint pain (other than hip pain):** The client complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.
- **Other:** Include either localized or diffused pain of any other part of the body. Examples include general “aches and pains”, etc.

18.2.2 Amy’s Guide*

18.2.2.0 Verbal Expressions

- Crying when touched
- Hollering
- Volume of voice increasing or becoming shrill
- Becoming very quiet
- Yelling or shouting
- Swearing, calling names
- Talking without making sense
- Grunting

18.2.2.1 Behavioral Expressions

- Jumping when you touch a particular spot
- Increased confusion
- Pointing with hand to a particular spot
- Persistently wearing an item (e.g., slippers, hat)
- Not wanting to eat

* This guide is for assessment of pain in cognitively impaired older adults or in those clients who temporarily have altered mental status or who do not communicate clearly. It is dedicated to Amy McAuley, clinical Nurse Specialist, Gerontology, Vancouver Hospital and Health Sciences Centre, Vancouver, British Columbia, Canada, who was one of the original researchers and who died on October 11, 1996.



- Forcing self back in chair or bed
- Rocking, shaking, or experiencing tremors
- Feeling grumpy
- Becoming limp
- Acting withdrawn
- Becoming agitated, increasing movement, feeling anxious or restless
- Having a temper tantrum, throwing things
- Pushing away or grabbing at you
- Acting like a child or baby
- Experiencing decreased concentration (e.g., “not fully there”), forgetting easily
- Having difficulty settling down or experiencing sleep disruption
- Hanging their heads, acting withdrawn or depressed, or having no expression
- Seeking beds or increased sleeping

18.2.2.2 Facial Expressions

- Facial grimacing (e.g., wincing, having a painful look)
- Closing their eyes
- Wincing with touch
- Having a worried expression

18.2.2.3 Physical Expressions

- Becoming cold
- Becoming pale
- Becoming clammy
- Having a red or swollen body part
- Changing of color
- Increasing vital signs (e.g., blood pressure, pulse, respirations) (acute pain only)



18.3 Pain Management

Ask the client or caregiver what methods are used to relieve the pain. Pain may be relieved by medications, relaxation techniques, rest, activity, distraction, massage, heat, and others. Try to determine pain management approaches or if additional professional consultation is warranted. Document discussion about a referral with client in the comment box if client suffers from pain daily scored at 4 or more and Pain Management is anything other than "Treated, full control".

19 Indicators/Hospital

19.0 Intent

To:

- Help identify stability of client's health related to factors such as weight loss or gain, self-rating of health, and frequency of hospitalization or emergency room care. Significant unintended declines in weight can indicate failure to thrive, a symptom of a potentially serious medical problem, or poor nutritional intake due to physical, cognitive and social/economic factors. Weight loss or gain secondary to appetite or swallowing may indicate a need to refer to nursing services.
- Assess the current plan.
- Help identify a need for referral to nursing services, or other health care providers.

19.1 Coding

19.1.0 Weight Change

Weight loss in percentages (e.g., 5% or more in last 30 days, or 10% or more in last 180 days). Code whether the weight change is intended or not. Ask the individual or appropriate collateral contacts about weight changes over the last 30 and 180 days.

Measurement: If actual weight records are available, they should be used. The following is a formula that can be used to calculate the percentage of change: number of pounds of weight change divided by the usual weight.

In the absence of actual weight records, a subjective estimate of weight change from the individual or caregiver can be used. Identifying a particular time approximately 6 months previous (such as "compared to last New Year's") may help visualize this previous point in time. You may be able to help the individual answer the question by asking "How much weight do you think you have lost?" and mentally compare this with the reported or your estimated current weight of the individual. You can

also ask, “Have you lost a lot of weight? Do you feel much thinner or weaker?” or “Your clothes seem very loose on you, were you much heavier six months ago?” “Do your clothes fit the same as they did 8 months ago? Are they looser, tighter or the same?” These possible questions begin to elicit useful information from the individual.

19.1.1 Health

Ask the individual: How is your health? Would you say it is?

- Excellent
- Good
- Fair
- Poor
- Unable to respond

This question is an excellent indicator of an individual’s health status. An individual’s perspective of their health can be a very good predictor of what their health status will be.

19.1.2 Hospital

- In the last six months:** Number of times admitted to the hospital with an overnight stay. (Include overnight admits to evaluation and treatment centers). Select the appropriate number (0 to 10) from the drop down list.
- Number of times visited the emergency room without an overnight stay:** Include managed care or HMO facilities/clinics that function as emergency rooms. For example: Include as an emergency room visit, a visit to an HMO facility or clinic in lieu of the ER for chest pain. Do not include as an emergency room visit, a visit to an HMO facility or clinic for an ear infection or mild flu. Select any number 0 to 10 from the drop down list. **NOTE:** If the individual went to the hospital or the emergency room more than 10 times, select the 10 and note it in the comment box.

19.1.3 Doctor Information

- Enter the date of the client’s last doctor visit.
- Select the doctor’s name. This pulls from the Collateral Contact Screen.



20 Foot

20.0 Intent

The assessor is looking to identify any potential or actual problems that affect foot strength, balance, or comfort that in turn may impact the individual's functional abilities that has occurred in the last 7 days. The pain assessment may also reveal problems with the feet.

20.1 Coding

Select all that apply from the two tables, foot problem(s) and foot care needs.

20.1.0 Foot Problems

The client may have one or more foot problems. These are listed separately:

- Corns
- Calluses
- Bunions
- Hammer toes
- Overlapping toes
- Fungus
- Infection of the foot – Includes infections of the foot or toes, toe nails (e.g. cellulitis, purulent drainage, etc.).
- Open lesions of the foot – Includes open lesions of the foot or toes. Includes cuts, ulcers, and fissures.

Each of these may have a different status:

- Healing:** Problem is improving either with or without treatment.
- Non-healing:** Problem not improving or worsening either with or without treatment.
- Deteriorating:** Problem is worsening either with or without treatment.

20.1.1 Foot Care

Identify foot care needs and the status of those needs.

- Diabetic foot care**
- Nails trimmed during the last 90 days**
- Application ointment/lotions:** Non prescription
- Foot soaks**

- Dry bandage change**
- Inserts**
- Pads**
- Protective booties**
- Special shoes**
- Toe separators**
- None of these**

For each item selected, the assessor will identify whether the client

- Received the treatment in the last 7 days, or
- Needs the treatment if the item is to be continued, revised, or referred for evaluation, or
- Received and Needs the foot care treatment, if both of the above apply or
- Need Met, if the foot care will be provided by the client or other non-ADSA paid resource (informal caregiver, healthcare provider, etc.).

21 Skin

21.0 Intent

To:

- Determine the condition of the individual's skin and to identify any types of skin breakdown including pressure ulcers.
- Document any skin treatments for active conditions as well as any protective or preventative skin or foot care treatments the individual has received in the last 7 days.
- Consider if general skin and foot care needs to continue, be revised or referred for evaluation.

Rationale: The skin is the largest organ of the body and the body's first line of defense. The health of the skin reflects the general health of the individual. Skin can be damaged by mechanical forces (pressure, trauma, or surgery), chemical irritants, poor blood supply to an area (disease processes), allergic reactions, heat, or other causes.



21.1 Process

General questions to pose to the individual / caregiver to identify potential skin problems:

- “Do you / caregiver have any concerns or problems with or about your skin or your feet that you would like to tell me about?” (If yes)- “How are you addressing it? Have you spoken with your health care provider about your concerns? Is the problem being addressed by your physician? Are you satisfied with the current plan to address your concerns? Or does the current skin care plan address your concerns?”
- To caregiver- “When you are assisting (the individual) with bathing / dressing, what have you noticed about the skin? Have there been any changes in the skin condition over the last 7 days?”
- In addition, the pictures of the stages of skin breakdown over pressure points can be a valuable tool to use with the client and their formal/informal caregivers to help in identifying potential skin issues.

The assessor will utilize the following method(s) to verify what the individual’s actual skin condition was within the last 7 days:

1. Documentation of the skin condition from a facility chart/notes, or from facility discharge information/summary;
2. Reports of skin condition from professional (facility nurse, home health nurse, primary care provider);
3. Reports of skin condition from the individual, a credible family member or caregiver, and/or:
4. Review list of Highest-Risk Indicators for Skin Breakdown Over Pressure Points and skin observation protocol located in Appendix A of the manual. If the individual’s condition falls into any of the high risk categories for skin problems over pressure points, it is important for the assessor to determine that a facility nurse or other caregiver has looked at the client’s skin within the last seven days and can report to the assessor what the condition of the skin is.

21.1.0 Pressure Ulcers

Definition: A pressure ulcer is any skin lesion caused by pressure, friction or shearing, resulting in damage of underlying tissues. Other terms used to indicate this condition include bed sores and decubitus ulcers.

Coding: While a staging or classification system is typically used to describe the severity of the skin breakdown, the assessor will utilize the following definitions to describe the tissue damage:



IMPORTANT NOTE: The pressure points we are concerned with are: Heels and outer ankle; Back of head, Elbows, Rim of ears, Hips, Shoulder blades, Ischial Tuberosity – pelvic – “seat bone,” Inside of knees, or Sacrum and Coccyx (tailbone area).

- Skin is intact over all pressure points.**
- Any area of persistent skin redness** (without a break in the skin) that does not disappear when pressure is relieved. (**NOTE-** For clients with darkly pigmented skin, the assessor may note the following: when compared to adjacent skin or other parts of the body, there may be changes in skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The area may appear with persistent red, blue, or purple hues. In medical records, these changes would be called a Stage I.
- Partial loss of skin layers** that presents as an abrasion, blister, or shallow crater in the skin. In the medical records, these changes would be called a Stage II pressure ulcer.
- A full thickness of skin is lost**, exposing the underlying tissue, presents as a deep crater in the skin. In the documentation present in the medical record these changes would be called a Stage III pressure ulcer *OR* the underlying tissue is lost exposing muscle or bone. In medical records, these changes would be called a stage IV pressure ulcer.
- Unable to see ulcer due to scab (eschar) over ulcer.** When eschar or scabs are present, a pressure ulcer cannot be accurately staged or described until the eschar or scab is removed.

21.1.1 Skin Care (for any skin problem)

Document client’s skin care needs and status. Select all that apply to the client:

- Pressure relieving device(s) for chair or bed:** For the chair this includes gel, air, or other cushioning placed on a chair or wheelchair. For the bed this includes air fluidized mattress, low air-loss therapy beds, flotation, and water or bubble mattresses. Does not include egg crate cushions or mattresses.
- Turning/repositioning program-** Includes a continuous, consistent program for changing the individual’s position & realigning the body.
- Nutrition/hydration -** Dietary measures received by the individual for the purpose of preventing or treating specific skin conditions- e.g. wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing. Vitamins used to manage a potential or active skin problem should be coded here.



- Other preventative or protective skin care-** (other than to feet)- Includes application of creams or bath soaks to prevent dryness, scaling, application of protective elbow pads (e.g. down, sheepskin, padded, quilted). **When this option is selected, the comment box must be used to describe the skin care needed.**
- Dry bandage change -** Changing dry bandages or dressings when professional judgment is not required.
- Application of ointment/lotion -** Application of non-prescription ointments or lotions.

For each of the above selected, select "Received" if client received care in the last 7 days. Select "Needs" if care is to be continued, revised, or referred for evaluation. Select Received/Needs if client receives and still needs the care. Select "Need Met" if the skin care will be provided by the client or other non-ADSA paid resource (informal caregiver, healthcare provider, etc.).

21.1.2 Skin Problems (**not related to damage from pressure**)

Document the client's skin problems and status of those problems. Remember that skin problems documented in this section are NOT related to pressure points. Select all that apply to client:

- Abrasions, skin tears, or cuts**
- Bruises-** skin discolorations (blue/black), changing to greenish brown or yellow; localized areas of swelling and tenderness.
- Burns-**tissue injury (blisters, damage to tissue under skin) caused by exposure to heat, chemicals, electrical, or radioactive agents. (This category does not include first degree burns where there are only changes in the skin color).
- Open lesions-** (other than ulcers, rashes, cuts); include lesions, abscesses, or any other lesions that do not fall into the other categories. This open sore may develop because of an injury or due to other diseases such as syphilis.
- Rashes-** (due to any cause)-Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and have symptoms of itching, burning, or pain.
- Skin folds/perineal rash-** Rash that develops in skin folds and perineum related to moisture, heat, or skin to skin contact. There may be inflammation or eruption of the skin with a change in color, pain, drainage, or odor.
- Skin desensitized to pain/pressure-** The client is unable to perceive sensations of pain or pressure-may be the result of a spinal cord injury, stroke, peripheral vascular disease or neuropathies.



- **Surgical wounds-** Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. The does not include healed surgical sites or stomas.
- **Stasis ulcers-** An open lesion, usually of the ankle or lower third of the lower extremities, caused by decreased blood flow from blood pooling in the legs; also referred to as a venous ulcer. Include venous ulcers, in which the skin may appear reddish-brown, dry, but without any open areas.

Skin problem status: Select status for each problem.

- **Healing** - Skin problem is improving either with or without treatment.
- **Non-healing** - Skin problem is not improving either with or without treatment.
- **Deteriorating** - Skin problem is worsening either with or without treatment.

21.1.3 Ulcer (Related to pressure)

1. Determine whether client had a skin ulcer (related to pressure) that was cured/resolved in last year.
2. Record the total number of current pressure ulcers identified through the assessment.

22 Skin Observation

22.0 Intent

Used to note the locations of any abrasions, bruises, skin tears, burns, open lesions, rashes, ulcers, surgical wounds, and pressure or stasis ulcers. A space for a short description will appear on the right of the screen as the assessor indicates an area of concern on the figure. A longer description can be entered below the figure.

See Exhibit A for Skin Observation Protocol.

23 Vitals/Preventative

23.0 Intent

Assessors will complete those elements of the nursing assessment measured, observed or reported on assessment date. Note baseline data when indicated. Additional nursing specific and functional measures may be located within elements of CARE based on the referring critical indicators. Vital signs/nursing assessment data is measured when indicated and based on nursing judgment and experience.

Select all of the types of preventative care that pertain to this client. Clients needing additional preventative care may be referred to a health care practitioner for education and consultation.

- Date: Enter date that preventative care took place.
- Temperature: May be reported to or measured by the nurse.
- Blood sugar: History or recording of blood sugars reported to the nurse by the client or caregiver.
- Pulses: May be reported to or measured by the nurse.
- Blood pressure: May be reported to or measured by the nurse.
- Respiration rate: May be reported to or measured by the nurse.

24 Comments

24.0 Intent

Use this screen to indicate teaching/interventions for referred critical indicators and follow-up needed by nursing services and/or case manager.

25 Communication

Document client needs with telephone, vision, and speech/hearing within this folder.

26 Telephone

26.0 Intent

To assess how telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed.)

27 Vision

27.0 Intent

To evaluate the individual's ability to see close objects in adequate lighting, using the individual's customary visual appliances (glasses and magnifying glass), if used for close vision. To assess how vision impairment affects individual's activities of daily living.

27.1 Process

- Ask client, family and/or care provider if there has been any change in usual vision patterns in the last seven days. For example, is the individual still able to read newsprint, menus, greeting cards, etc?
- Ask the client about his or her visual abilities.
- Ask the client to look at regular-size print in a book or newspaper in adequate lighting, with visual appliances, if used.
- Be sensitive to the fact that some clients cannot read or are unable to read English. If a client cannot read, ask them to name items in small pictures.
- If the client is unable to communicate or follow your directions for testing vision, observe his/her eye movements to see if their eyes seem to follow movement and objects. This will help you in assessing whether the individual has any visual ability.

27.2 Coding

Definition: Adequate lighting is what is sufficient or comfortable for an individual with normal vision.

Select from the drop down “**Ability to See**” the choice that best describes the client’s current ability to see in adequate light and with glasses, if used.

- Adequate** - Sees fine detail, including regular print in newspapers/books.
- Impaired** - Sees large print, but not regular print in newspapers/books.
- Moderately impaired** - Limited vision, not able to see newspaper headlines, but can identify objects.
- Highly impaired** - Object identification in question, but eyes appear to follow objects (especially people walking by).
- Severely impaired** - No vision or sees only light, colors or shapes; eyes do not appear to follow objects. **Choose severely impaired if client is comatose.**

Many clients with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many of these clients appear to track or follow moving objects in their environment with their eyes. For clients who appear to do this, code, Highly Impaired.

Select Limitations that apply to client.



- Left peripheral problem** - Decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self).
- Right peripheral problem** - See above
- Sees rings around lights** - Sees rings or halos around lights.
- Sees flashes of light**
- Sees “curtains” over eyes**
- None of these** - Select if client is comatose or if none of the above apply.

Select from the **Equipment/Supplies** table any **Type** of equipment the client uses or needs to assist with vision. Also select the **Status** of that equipment and if the equipment is needed type in the **Supplier** where it can be obtained.

28 Speech/Hearing

28.0 Intent

To document how the client communicates and understands/hears language.

28.1 Process

Interact with the client. Consult with family.

28.2 Coding

28.2.0 Comprehension: By others, client is...

Document the individual’s ability to make self understood, to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, symbols, or a combination of these, including use of a communication board or keyboard. Interact with the individual. Observe and listen to the individual’s efforts to communicate. If possible, observe his or her interactions with family. *Comprehension by others* is to be assessed looking at how individuals closest to the client are able to understand him/her.

Check all modes of expression used by individual to make needs known. Making self understood expressing information content however able (By others, client is...)

- Understood** - The client expresses ideas clearly.

- Usually understood** - The client has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or requires some prompting to make self-understood.
- Sometimes understood** - The client has limited ability, but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).
- Rarely/never understood** - At best, understanding is limited to caregiver's interpretation of client specific sounds or body language (e.g., indicated presence of pain or need to toilet). **Choose this if client is comatose.**

28.2.1 By client, others are...

Determine the individual's ability to understand and comprehend information, whether communicated orally in his/her own language, by writing, in sign language, or Braille. How does the client process and understand language.

- Understands** - The client clearly comprehends the speaker's messages and demonstrates comprehension by words or actions/behaviors.
- Usually understands** - The client may miss some part or intent of the message but comprehends most of it. The client may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- Sometimes understands** - The client demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions. When caregivers rephrase or simplify the messages and/or gestures, the client's comprehension is enhanced.
- Rarely/never understands** - The client demonstrates very limited ability to understand communication or caregiver has difficulty determining whether the client comprehends messages, based on verbal and nonverbal responses. Or, the client can hear sounds but does not understand messages. **Choose Rarely/never understood if client is comatose.**

28.2.2 Progression rate

The client's ability to express or understand information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days.)

- No change
- Improved
- Deteriorated

28.2.3 Ability to Hear

Identify how the individual hears with the appliance.



- Hears adequately-normal talk** - Also hears TV and can use telephone.
- Minimal difficulty in noisy setting**
- Hears in special situations only** - Speaker has to adjust tonal quality and speak distinctly
- Highly impaired** - Absence of useful hearing (select if client is comatose).

28.2.4 Progression rate

The client's ability hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days.)

- No change
- Improved
- Deteriorated

EXAMPLE:

In the last week, Mrs. K. has been wearing hearing aids in both ears. With her hearing aids turned on she hears normal conversation, hears the television and is able to hear well on the telephone. Without her hearing aids, Mrs. K. has difficulty hearing normal conversation, hearing the television and what is being said on the telephone. Select "Hears adequately" **Ability to Hear** drop down.

28.2.5 Equipment/Supplies

Select from the **Equipment/Supplies** table any **Type** of equipment the client needs to assist with speech and hearing. Also select the **Status** of that equipment and if the equipment is needed type in the **Supplier** where it can be obtained. Select Specialized Medical Equipment if an assistive device will be obtained with COPES waiver services and describe in the comment box.

29 Pysch/Social

29.0 Intent

The Psychological/Social assessment section is to assess the various components that will assist the assessor and the individual to identify current functional abilities and indicators of potential or existing service needs that may be impacted by the



individual's mental status, memory, behavioral patterns, indicators of depression and/or suicide, sleep patterns, existing and potential relationships and interests and decision making abilities.

- How was Psych/Social verified?: Indicate sources for the information in this section. Use the comment box to describe any conflicting information.
- RSN enrolled?: Indicate whether client is enrolled in the Regional Support Network.
- RSN name: Enter the name of the RSN.
- RSN telephone: Enter the phone number of the RSN.
- MMSE: Score of last Mini-Mental Status Exam will be displayed here.
- Depression: Score of CES-D Depression Symptoms Index. (A score of six or more indicates possible depression).
- CPS: The Cognitive Performance Scale is made up of the following elements taken from this assessment:
 - Whether or not client is comatose or in a persistent vegetative state
 - Ability of client to feed her/himself
 - Ability of client to make her/himself understood?
 - Ability of the client to make daily decisions.
 - Short-term memory?

The CPS score for this assessment cannot be displayed until these elements have been completed.

30 MMSE

30.0 Intent

The Mini Mental Status Examination is a practical and recognized method for grading the cognitive state of clients for the CARE assessor. It estimates the severity of cognitive impairment at a given point in time. It can track changes in cognition, improved or worsened, over time and provides reliable, similar results when administered by different examiners. The Mini Mental Status Evaluation (MMSE) assesses six areas of cognitive functioning including orientation to time and place, attention/concentration, recall, language function, motor planning and perception.

Keep in mind that the MMSE is not a diagnostic tool. It's not a substitute for a neurological exam or formal mental status testing. It's not a test of personality, mood

or behavior function and it doesn't by itself determine competence. The intent is not to diagnose but to assist in determining if problems exist that may impact functioning, service delivery, client participation or the need for additional referrals or medical assessments.

The tool also relies heavily on verbal response and reading and writing skills, therefore clients that are impaired in these areas may perform poorly even if they are cognitively intact. The tool can be used with these individuals to establish a baseline to assess changes in cognitive performance over time.

30.1 Process

The assessor must first determine if the MMSE can be administered to the client using the guidelines below. After determining this, the assessor should explain to the client that he/she will be asked a set of questions. Some require verbal answers, and some will require written instructions. . Also explain that you will not respond to the client's answers during the questions. . Note any impairments that might affect the score in the Other Factor screen. If the client refuses to answer, score item with a "No" or "0" and proceed to the next item.

30.2 Coding

Can the MMSE be administered to the client? If **Yes**, then the proceed to the next tab. If **No**, the MMSE **screens** will be disabled.

***If no, why?** The MMSE may be skipped only if the client has one or more of the following; however, it is recommended that the MMSE be administered for those who are legally blind. Identify reason for adjusted score in comment box.

- Moderate to profound retardation: Client's IQ is below 55.
- Non-verbal: Client cannot communicate verbally.
- Severe delirium/dementia: Delirium is the temporary worsening in mental function. Severe delirium may include hallucinations, confused and/or violent behavior, and unconsciousness. Severe dementia is characterized by the progressive loss of all verbal and psychomotor abilities; the client eventually needs total assistance in all activities.
- Under 18: Client is under age of 18 at time of assessment.
- Legally blind: Client is not able to read large print.

NOTE: If the client cannot take the MMSE for one of the reasons listed above, ask the client's informal support or caregiver to verify the following two orientation questions.



- Is the client oriented to place? Does the client know where he/she lives? Address? State? City?
- Is the client oriented to time? Does the client know what day, month, and/or year it is? Does he/she know the season?

Orientation to time: Ask the client "What is today's date?" because this is a familiar question. If the client doesn't answer completely, begin asking the most general first: "What is the season?" "What is the year", "What month is this?", etc. Even if the client does not provide the information, continue to ask every question.

Orientation to place: Begin by asking "What is the name of the state in which you live?", continue with the other questions.

Registration: Tell the client that you are going to name three objects, which she/he will need to remember. To ensure reliability across interviews, all persons should use the same three objects. In a slow and clear voice state the objects. Ask the client to repeat the objects. Score one for each repeated correctly. Enter the numbers of trials that were given in the space provided.

Attention/Calculation

Spelling "world" backwards: This tests the client's ability to perform a mental function. Tell the client to spell the word "world" backwards. If the client does not know how to spell world, spell it once correctly. If the client's first impulse is to spell "world" the correct way, allow the client to do this once and then reiterate the instruction to spell "world" backwards. Encourage the client to take her/his time, but do not allow them to write it down. Score one point for each correct letter in the correct order and place. For example: "DLORW" is worth 3 points because the letters "D", "L", and "W", are in the right place. A spelling like "D" "R" "O" "L""W" would equal 2 points.

OR

Serial 7's: Ask the client to subtract 7 from 100 and keep subtracting seven from the answer from the previous subtraction until you tell them to stop. Have them do 5 subtractions and then tell them to stop. Score 1 point for each correct subtraction. Note that if a subtraction is wrong, then all subsequent subtractions, even if they are the correct interval, are also considered wrong.

Recall: This tests short-term recall of previously learned items. Ask the client if she/he can recall the 3 objects that you asked them to remember earlier. For each one recalled, score one. Skip recall if the client took 6 trials in the Registration item and client was still unable to remember the objects.

Naming: This item tests the client's ability to use words and to connect the appropriate word with its object. The client is asked to name 2 objects. In order to insure reliability across interviewers, the same objects should be used by all assessors. First show the client a pen and ask them "What is this?" Repeat with watch. Score 1



point for each correct answer to a total of 2 points. Scores can range from "0" to "2". If assessing a visually impaired client, choose 2 objects that are easily distinguishable by touch, which the pen and watch are. Place each object in their hand one at a time and ask them to name the object.

Repeat: This item tests the client's immediate recall ability, as well as their ability to use speech. Begin by telling the client "I am now going to tell you something, and I want you to repeat it after me". Then say "Repeat after me, 'No ifs, ands, or buts'".

Command (part 1): This item attempts to determine whether the client can process a simple series of verbal requests. Begin by saying "I am now going to put a piece of paper in front of you". Then say "Take the paper in your (non-dominant) hand, fold it in half, and put it on the floor (or table). Score 1 point for each request followed correctly.

Command (part 2): This tests the client's ability to follow a written command. On a piece of paper, written in sufficiently large letters so that the person being assessed can read it from a distance of a least 5 feet should be the following sentence: "Close your eyes". Keep the lettering face down, so that the client does not see the request until you hand it to them. Then say to the client, "I am now going to hand you this piece of paper. I would like you to do exactly as it says". Then hand them the paper so that the client clearly sees the sentence "Close your eyes". Score 1 point if the client closes her/his eyes. For visually impaired clients, skip this question and enter score of "0".

Write a sentence: This item test the ability of the client to communicate in writing. Again, using a blank piece of paper, hand the client the paper and then say "I would like you to write a sentence. Do you have any questions about what I would like you to do? If not, please write a sentence." Allow the client about 2 minutes to write a spontaneous sentence. The sentence must contain a subject and a verb and must make sense. Correct grammar and punctuation are not necessary. For example, "He done good" is a correct sentence. Score 1 point for correct sentence.

Copy design: This measures the client's capacity for integrating a visual cue and then reproducing it. On a piece of paper a figure showing 2 interlocking pentagons should be drawn. This demonstration should be large enough so that it is easily visible to the client. Hand the drawing to the client, along with an additional piece of paper. Say "This paper has a design on it. I would like you to look at that design and copy it onto the other piece of paper." All ten angles with two of them intersecting must be present to score 1 point. Tremor, that is the lines being straight, and rotation, that is the direction in which the copied design faces, do not figure into the score.

NOTE: For the visually impaired, every attempt should be made to have them complete all exercises, except those which require sight to complete, following the visual command "Close your eyes" and drawing the picture. For the hearing impaired, every item should be completed by that person. If necessary, instructions can be written or signed to the person. For persons both visually and hearing impaired, if an

interpreter is available and the applicant knows hand sign, then all the items except "Close your eyes" and the drawing should be completed. Whenever possible, and with the client's permission, share the results with the client's healthcare professional.

30.2.0 Other Factors

Indicate if any of the following factors affected the client's performance.

- Agnosia:** Loss or lessening of the ability to recognize familiar objects.
- Aphasia:** Loss or impairment of the power to use or comprehend words.
- ESL:** (English is a second language)
- Illiteracy:** Client cannot read or write.
- Learning disorder:** Client's trouble with math, reading, and/or writing significantly interferes with daily living.
- Motor skill disorder:** The client has problems with skill carried out by small muscle groups.

31 Memory

31.0 Intent

The memory screens will record the client's ability to remember recent and long past events as well as his/her orientation to person.

31.1 Coding

31.1.0 Response to Short Term Memory question:

Determine the client's functional ability to remember events that occurred recently. If the MMSE was administered and the client had difficulty with Registration and/or Recall, he/she may have a short-term memory problem. Follow up by asking the client to tell you about recent events that you may know or be able to verify, such as what he/she had for breakfast or when his/her daughter last visited. Recent memory will be evaluated by asking the client to tell you about events that you may know or be able to verify.

When evaluating an individual's memory it is good to begin with an introductory question, such as: (*Choose one*)

- Have you had any difficulty concentrating or remembering what you read or watch on television? Have you had any difficulty remembering telephone numbers or appointment times?

- Have you recently gotten lost or forgotten an important event? Have you forgotten something you were cooking?
- Have you had any difficulty recalling people's names? Where do you know them from?
- Have other people said to you that your memory is not as good as it was?
- Less direct:** Sometimes it helps to begin with an example such as "Many of my clients tell me that they have trouble with their memory. They have trouble remembering names, appointments, what they read or watched on television, etc. Does that ever happen to you?" It will open the door for more questions about memory. Many clients seem more willing to admit memory problems if they know that they are not the only ones with problems.

Note: For clients with limited communication skills, ask family members, caregivers or others who know the client well for examples that reflect whether the client's short-term memory is intact.

After completing the assessment for short term memory and talking with others who know this client well (when needed to confirm what this client may have told you) make a determination about this client's short term memory functioning in both these areas. Select either "recent memory is OK" or "recent memory problem".

31.1.1 Long-Term Memory

The Long Term Memory questions will assist in the determination of the client's functional capacity to remember long-past events. **Definition:** Long-term memory is memory that extends from 6 months ago up through the individual's lifetime.

Engage the client in conversation by saying, "I have always been fascinated by people's life journey – how they got to where they are now. Would you tell me about yours?" If this phrase is not typical of your presentation style adjust it, examples may include discussing a person's history, background information, etc. (Ask some of the following questions, if applicable, during the conversation.)

- Where did you grow up?
- Are you married?
- Have you ever lived with anyone for a long period of time?
- What is your spouse's/partner's name?
- What are the names/birthdays/ages of your children?
- What kind of work did you do? Was it in the home or out of the home?
- What was your first job?
- What job were you doing when you retired?



The questions above will help you gather information about this individual and his/her past. If you question the content of the information provided by the individual or if the client has limited communications skills, attempt to confirm details through contact with family members or others who know this individual well.

From the process described above, make a determination about this client's long-term memory. If this client's long-term memory is OK, select that item. If there is evidence that he/she cannot remember his/her life history in much detail this is indicative of long-term memory problems and select that item.

Select the types of assistance that work well for the client. Clients with short-term memory loss can have definite preferences regarding their surroundings, routine and care. Something that works for one client may agitate another. Ask someone who knows the client well about the client's preferences if the information cannot be gathered from the client.

31.1.2 Progression rate:

Indicate change (improved or decreased) since the last assessment. If the client is new, ask the client and someone who knows the client well to compare the client's memory to what it was a year ago.

- Is the client oriented to person?: Does the client know who she/he is? Earlier in the assessment you asked the client their name, possibly how to spell it. Did they know personal history, such as marriage, relationships, siblings or children?

32 Behavior

32.0 Intent

The intent of these items is to identify the symptom, frequency, and the alterability of the behavioral symptoms (in the last 7 days). Document behavioral symptoms that cause distress to the client or are distressing or disruptive to others with whom the client comes in contact. Focus on the client's action not the reason for the behavior. Included here are behaviors potentially harmful to the individual or disruptive to others. Be objective about documenting behavioral symptoms.

It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording any behavioral symptoms. The fact that others may have become used to the behavior and minimized the client's intent is not relevant. Does the client manifest the behavioral symptom or not — that is the test you should use in coding these items. Code for the "what is". The analysis of why the behavior occurred and the need for appropriate interventions will occur during the development of the service plan.

This section also documents behaviors that occurred within the last 5 years. Even though a behavior is not presently occurring, it is important that the formal caregivers be aware of this history.

Document if the client has had any mood or behavior symptoms in the last 5 years. If the client has not had any behaviors that have caused him/herself distress or disruption to everyday activity select NO and the screen will be disabled. If unsure, select YES to view the contents of the list with the client. View with significant collateral contacts if necessary.

32.1 Process

Talk to and observe the individual. Gather additional information from collateral contacts that know this individual well. Remember to take into account the entire 7 day period, 24 hours per day.

32.2 Coding

Coding targets specific behaviors, frequency of behavior and alterability of the current behavior.

32.2.0 Symptoms

Symptoms of Distress

- Crying, tearfulness** – many incidences of explained or unexplained crying that occurs throughout the assessment period. The assessment period is the last 7 days for this screen.
- Easily irritable/agitated-** Annoyed, impatient, perturbed, to the point that this requires caregiver intervention. The assessor is seeking to determine if any irritation or agitation is unreasonable and if the relationship between the caregiver and the client is balanced.
- Obsessive about health or body functions** – e.g. persistently seeks medical attention, obsessive concern with body functions. The assessor is seeking to determine extremes in behavior rather than regular concern over on-going health care or body function care that may be inadequately provided for.
- Repetitive anxious complaints or questions – non-health related -** For example, persistently seek attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues, etc. Individual may repetitively ask “ Where do I go, what do I do?” when will she be here or may cry out for help.
- Repetitive physical movement/pacing, hand wringing, fidgeting-** also includes restlessness, “picking” at body, clothing etc.



- **Unrealistic fears or suspicions** – expresses fear of being abandoned, left alone, being with others. There is no basis for this fear or belief. Additional symptoms to consider in this category are: the individual is unwilling to be left alone, may follow caregiver or other significant individual's of importance to them, unwilling to let these individual's out of their sight. This does not represent the concerns or fears a client may have about consistent service or replacement workers. Any fears or suspicions related by a client should be reviewed for potential referrals to protective services in the event they reflect a suspicion of caregiver abandonment, missing items, etc.

Other Symptoms

- **Delusions** – a fixed, false belief of any of the following types:
 - **Delusions of grandeur**- a false belief that one's own importance is greatly exaggerated;
 - **Paranoid/persecutory delusions**- a false belief of being attacked, harassed, cheated, persecuted, poisoned or conspired against.
 - **Somatic delusions**- the central theme of this type of delusion involves body functions or sensations. (E.g., the individual has a false belief related to the body such as believing that they have cancer despite exhaustive negative testing, or that they emit a foul odor from their skin or mouth, etc.)
 - **Jealous type delusions**- the central theme of this type of delusion is the individual's persistent belief that their spouse, partner or lover is unfaithful. This belief has no basis for truth and is arrived at without due cause.
- **Religious delusions**-persistent belief that he or she is God, Jesus Christ, other deities or a representative of a deity
- **Hallucinations** – Sensory experiences that can't be verified by anyone other than the person experiencing them. Hallucinations may occur in all senses.
 - Hearing (auditory hallucinations) voices that are familiar or unfamiliar that are perceived as distinct from the person's own thoughts. Derogatory or threatening voices are especially common, two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behavior. Auditory hallucinations are the most common.
 - Seeing (visual hallucinations). Seeing objects or people that no one else can see.



- Feeling (tactile hallucinations). Feeling strange sensations, odd feelings in the body or feeling that something is crawling on him/her.
- Tasting (gustatory hallucinations). Client feels that there is a strange taste in their mouth e.g., metal, electricity, poisons, etc.
- Smelling (olfactory hallucinations). Client thinks there is a strange odor that can not be accounted for, e.g., something burning, sewage, odd smells from their own body, dead spirits, etc.)
- Command hallucinations. These are hallucinations that direct the client to do something or act in a particular manner. It is a voice telling the individual to hurt or kill himself or herself or someone else or perform some other dramatic act. Command hallucinations are separated out from the others because of their severity and the potential lethality of the content of the hallucination.

There are incidences where “hallucinations” are considered to be within the range of normal experiences. For example, the religious experiences in certain cultural contexts or those that occur while falling asleep or waking up. Isolated experiences of hearing ones name called or experiences like hearing humming in one’s head are also not considered to be hallucinations.

Many items can be misrepresented as delusions when the complaint is the result of a medical change or condition. Examples include: metal tastes in an individual’s mouth, undiagnosed conditions that impact well being and allergic reactions to medications, food or chemicals that result in unusual skin sensations. Utilize nursing resources and other medical/health care resources if you have concerns that experiences related may be medically based.

- **Manic** – This is evidenced by a distinct period of time (at least a week) during which the individual has an abnormally and persistent elevated mood. This includes an inflated self-esteem, with an exaggerated opinion of him/herself, or an inflated belief about his/her ability, or arrogance. Additional associated behaviors are decreased need for sleep, excited, loud or nonstop talk, which can go on for hours. There may be excessive involvement in pleasurable activities with a high potential for significant consequences. Examples of these are buying sprees, without the money to pay for what is bought, reckless driving, increased sociability, calling friends or strangers at all hours of the day without regard to the intrusive, domineering, and demanding nature of these interactions. The individual may describe his/her thoughts as racing, as if he/she is watching two to three television programs simultaneously and he/she cannot articulate all that he/she is thinking. There may also be evidence of the individual



having a very difficult time concentrating on one topic and he/she moves abruptly from one topic to another. The individual may exhibit constant motion, may become theatrical, with dramatic mannerisms and singing.

- **Mood swings** – This is evidenced by labile affect, which is a rapid, abrupt shift in emotions. For example, the individual is observed to have periods of tearfulness alternating with laughter with or without a reason. This includes those clients who have a documented cyclical behavioral pattern of either depressed or manic states.

Verbally agitated/aggressive

- **Accuses others of stealing** – This behavioral symptom could be a type of paranoid thinking, a reality, or that a cognitively impaired individual misplaced an item and then accuses others of stealing.
- **Inappropriate verbal noises** – Disruptive sounds e.g. smacking lips, excessive noise, repetitive utterances, that cause distress to others. Some verbal noises may be the result of medications or side effects from past medications.
- **Resistive to care with words/gestures** – Resists taking medications, injections, ADL assistance, help with eating or treatments. The signs of resistance in this category are limited to words or gestures not physical actions. This category does not include instances where the individual has made an informed choice not to follow a course of care (e.g., individual has exercised the right to refuse treatment and reacts negatively as others try to reinstate treatment).
- **Uses foul language** – The individual uses swear words or other language during normal conversation that is offensive to those around him or her.
- **Verbally abusive** – threatens, screams, curses at caregivers, family or others.
- **Yelling/ screaming**– To utter a loud or piercing cry.

Physically agitated/aggressive

- **Assaultive** – There is a documented or confirmed incident where the individual was physically abusive/ combative, hit, shoved, scratched, punched, bit etc. These symptoms will occur at times other than during the provision of personal care. These symptoms will occur towards a caregiver, family member or others.



- Breaks, throws items** – Breaks and/or throws their own or other’s property.
- Combative during personal care** – Hits, shoves, scratches, bites, pinches, etc. caregivers when attempting to provide care.
- Hiding Items** - Conceals items from others. The items can be the individual’s property or that which belongs to others.
- Hoarding /collecting** – Storing up excessive amounts of food, medications, magazines, etc. which are well beyond one’s current needs. This item does not reflect the hobby an individual might have that involves collecting items such as stamps, records, coca cola items, etc.
- Intimidating/threatening** – Individual attempts to force or deter someone else using threatening gestures, threatening stance with no physical contact, shouting or screaming angrily, personal insults, curses directed at someone else, using foul language in anger, kicking the wall, throwing furniture, etc. This includes explicit threats of violence against others.
- Rummages through or takes belongings of others** –without appropriate consent. E.g. goes through someone else’s drawers, looks through or takes other’s mail.
- Seeks vulnerable sexual partners** – This includes any instance of deliberate sexual violence such as pedophilia, incest, rape of adult males/ females or sexual violence toward family members or others.
- Wandering** - individual moves about with no discernible, rational purpose. A wandering person may be oblivious to his/her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about their living area in search of food). Wandering may be by walking or wheelchair. Do not include pacing back and forth or elopement as wandering behavior). Elopement is an individual’s attempt to leave where they are living without the caregiver’s knowledge or a formal discharge. This includes the intent to leave the facility on either a permanent basis or an extended leave without anyone’s knowledge. This pertains to those clients who are alert and oriented with no evidence of memory loss, who are unhappy with where they are living or residing.

Select only one of the following 2 items if the individual’s behavior meets the definition of wandering.

- Wanders within the residence or facility or may wander in an enclosed area, but does not exit seek.
- Wanders inside and is exit seeking or gets outside or off the property.



Inappropriate or unsafe behavior

- **Disrobes in public** – Public disrobing targets dress behavior that is contrary to local community laws, norms and individual’s usual behavior. The individual is unaware that this is inappropriate. Examples of inappropriateness would include, undoing buttons on blouse so that breasts are exposed, taking off pants etc.
- **Eats non-edible substances/objects (Pica)** – This is the persistent eating of nonnutritive substances for a period of at least one month. There is no aversion to food. This behavior must be developmentally inappropriate and not part of a culturally sanctioned practice. The eating of nonnutritive substances is an associated feature of other mental disorders e.g., pervasive developmental disorder, mental retardation or brain disorder.
- **Fire setting behaviors** – Targets deliberate fire-setting behavior (individual has set fires or attempted to set fires in wastebaskets, on bed linens, drapes, etc.) This does not include the individual who is a careless smoker.
- **Inappropriate toileting/menses activity (specify)** – Includes smearing or throwing feces, urinating in inappropriate places, shredding sanitary napkins, smearing blood etc.
- **Injures self** – Includes both lethally motivated suicidal behavior (intentional, self-inflicted attempt to kill oneself), and behavior inflicting intentional self-injury without suicide intent (e.g., self-mutilation). This does include head banging, self-choking, poking self in eyes, cutting oneself. The following are not considered self-injurious behaviors for this item: non-intentional, accidental or unconscious self-destructive behaviors that may lead to injury or premature death (e.g., chronic substance abuse, hyper obesity, non-compliance of treatments for illness, risk taking behaviors).
- **Left home and gotten lost** – The individual got lost in familiar surrounding and was unaware of the need to ask for assistance. This may occur on a walk, when driving a car or in a public place where they are unable to find their way home.
- **Law breaking activities** – Or other problems that resulted in law enforcement involvement or place the individual at risk for law enforcement involvement (e.g., shoplifting, theft, trespassing, forgery, disturbing the peace, etc). It is not necessary when coding for this items that these be a criminal charge. However, if an individual has a history of criminal activity with a charge(s), document this here; or because of diminished capacity (the prosecutor is unwilling to charge) and they have engaged in activities that would put them at risk for criminal charges or police involvement document this here.



- Sexual acting out**– Sexual behavior that is contrary to usual social norms. For example, masturbating in public or in areas where others are present, inappropriate touching, etc. The individual does not intend to victimize others. This does include deliberate exhibitionism towards adult males/females or towards children in order to elicit reactions from others. The individual is aware that the behavior is inappropriate. (This does not include same sex relationships, unmarried relationships or an individual who masturbates in private.)
- Spitting** –spits inappropriately e.g. on the floor, or at others etc.
- Up at night when others are sleeping and requires intervention(s)** – Includes being awake and calling out, but not getting up; also includes being awake and out of bed, moving around the house when others are sleeping, and disturbing the milieu. The assessor should explore if the individual has lived/worked on an awake/sleep schedule that may have included sleeping during the day and being awake at night. Document in the comment section, if applicable.
- Unsafe cooking** – has left stove on, also includes evidence of burned pots/pans, burned food, fire in microwave, etc.
- Unsafe smoking**- Burns cigarettes down to fingertips, smoking in unauthorized areas, not using ashtrays or other containers, smoking when on oxygen, etc. This category includes instances where there was an actual, accidental fire.

32.2.1 Status

Select *Current* if behavior has occurred in the last 7 days. Select the appropriate frequency and alterability item.

Select *Past* if behavior occurred in the last 5 years. Document interventions that took place or reason why behavior no longer occurs. Past behaviors may no longer occur because effective interventions are in place to manage the behavior or eliminate the catalyst. For example, the individual rummaged through other’s belongings two weeks ago, but has not done it within the last 7 days. Select *Past* under Status In this instance the family has provided the individual with a bureau with which to rummage. Select “Past issue,” once an intervention is in place to manage this behavior.

Explore if past behaviors, that have not occurred in the last 7 days but may appear regularly, are cyclical in occurrence. If there is an appearance of cyclical behavior that impacts service delivery or client distress, the assessor should seek to plan contacts and additional supports for periods of cyclical exacerbations.

32.2.2 Frequency:

When coding frequency of a current behavior, make a selection from the Frequency drop down section. Document behavior symptom frequency in the last 7 days:

- Behavior of this type occurred on 1 to 3 days in the last seven days.



- Behavior of this type occurred on 4 to 6 days in the last seven days.
- Behavior of this type occurred daily.

32.2.3 Alterability

When coding for the alterability of a current behavior, make a selection from the Alterability drop down box. The intent is to describe whether any behavior symptom exhibited by the client was easily altered or represented significant challenges in managing the behavior.

Easily altered means that the client was easily distracted from persisting in a behavior or his/her behavior symptom was easily channeled into other activities. For example, an client who wanders into a noisy room and becomes very agitated and verbally abusive has easily altered behavior if he or she immediately stops the verbal abuse when a caregiver gently guides him or her to a quieter area or room.

Behavior symptoms that are not easily altered are those that occur with a degree of intensity that is not responsive to the caregiver's attempts to reduce the behavioral symptom through interventions, e.g. limit setting, diversion, adapting routines to the individual's needs, environmental modification, individualized activities, comfort measures and when appropriate, drug treatment.

32.2.4 Comment box

It is important to use the comment boxes to provide caregivers with instructions on methods to decrease or respond to current behaviors. Details on successful interventions need to be documented in the comment boxes. Include the intervention for all current behaviors and past behaviors addressed with current interventions.

33 Depression

33.0 Intent

To identify if the individual being assessed may have symptoms of depression. The assessor is not diagnosing depression but identifying elements that may highlight the need for a referral to a primary care provider or mental health professional for diagnosis and/or treatment.

Depression is very treatable. It is important that indicators of possible depression are identified so appropriate referrals and/or treatment can be recommended to the individual. Depression can impact an individual's functional ability, overall health and need for services.



5%, or 15 million Americans suffer from Depression at any given time. Three groups that deserve special attention when screening for depression are: teens, the elderly, people with chronic illness or developmentally disabled.

We have included a reliable and validated screening tool (the Iowa Version of the CES-D Depression Symptoms Index) to assist in the assessment process. Using this assessment tool will aid in determining if the client you are seeing may have depressive symptoms, and would benefit from further evaluation and treatment by their primary health care provider.

33.1 Process

33.1.0 Client

1. Begin this discussion by asking the individual one or more of following questions:
 - How do you feel about life in general?
 - How are your spirits generally?
 - Do you find yourself avoiding being with people? If yes, why is that?
2. Then ask the individual if you can ask him/her some specific questions about how they have been feeling during the last week? If the individual you are assessing can read, give them an index card with the following responses on it. Tell them to answer each question you ask them, using the following scale:
 - Hardly ever or never
 - Some of the time
 - Most of the time
3. If they cannot read, you will have to repeat the scale to them after each question is asked, so they can make their choice. Proceed by asking the following questions:
 - Did you feel like eating; was your appetite poor?
 - Did you feel depressed?
 - Did you feel like everything you did was an effort?
 - Was your sleep restless?
 - Did you feel happy?
 - Did you feel lonely?
 - Were people unfriendly?
 - Did you enjoy life?



- Did you feel sad?
- Did you feel that people disliked you?
- Did you feel like you couldn't "get going"?

A score of (6) or more indicates possible depression. Discuss with this individual that from their responses to the questions you just asked, it appears they may be suffering from depression. If needed, reassure him/her that Depression is a serious illness, not a moral weakness. Inform him/her that there are many medications that are very effective in treating depression. Ask the individual if they are interested in a referral for diagnosis and/or treatment. The referral may be to the individual's primary health care provider or a mental health professional. Discuss with the appropriate caregiver (family, AFH, boarding home, etc.) if necessary. Document discussion with client in comment box when score is 6 or more. Document referral on Referral screen in Care Plan.

If the client chooses to seek assistance for any problem identified then document on the Referral screen; include the date you referred the client and who is responsible to follow through. If the client or others are responsible, the case manager should contact the client within 30 days of the referral and document the outcome. If the client chooses not to be referred, document in the comment box. If the case is transferred during this period, the new case manager will follow-up.

33.1.1 Surrogate

Surrogate Report of Depression Symptoms: A surrogate report of Depressive Symptoms is to be used when a client has Alzheimer's disease* or other types of Dementia that has progressed to a point where the client cannot relate pertinent information. Clients with these conditions are not able to reliably respond to the questions themselves in the Iowa Version of the CES-D Depression Symptoms Index in item above. Research has shown that family (or other primary) caregivers are reliable informants in reporting depressive symptoms using this modified version of the Iowa CES-D Depression Symptoms Index.

As an introduction to this issue, ask the family (or primary) caregiver if they have observed the individual you are assessing as having persistent sadness or crying, a sleep impairment or a change in their appetite.

Then ask the caregiver if you can ask him/her some specific questions about how the individual they are caring for may have been feeling during the last week? Proceed by following the process below.

* 30% of individuals who have Alzheimer's disease also suffer with major depression. Many of these individuals have symptoms that cause significant distress and dysfunction to both the individual and the caregiver.



1. If the caregiver can read, give them the index card with the following responses on it. Telling them they are to answer each question you ask them, using the following scale:
 - Hardly ever or never
 - Some of the time
 - Most of the time
2. If they are unable to read, you will have to repeat the scale to them after each question is asked, so they can make their choice.

Client/Surrogate cannot answer: Select this category if the client is unable to respond and there is no surrogate who can accurately provide information regarding the client's behaviors that may point to depression.

Here is some additional information regarding depression and the elderly and its impact on clients with chronic health problems.

The National Institute of Mental Health (NIMH) commissioned the Harris survey. The survey showed that:

- Lack of energy, recurrent thoughts of death and difficulty concentrating were viewed by half of the medical providers polled as natural components of aging rather than symptoms of depression.
- Tragically, accordingly to data cited in a recent NIMH report, 70 % of elderly people who commit suicide visit their family doctors within a month of their death, and 39% have a medical encounter within one week of killing themselves, yet their depression remains undiagnosed and untreated.
- 25 % of elderly individuals experience periods of persistent sadness that lasts two weeks or longer and more than 20% report persistent thoughts of death and dying.
- 20% of clients in nursing home are depressed.
- More than ½ of the people polled, 75 years or older, believed that depression is a natural part of the aging process. Additionally, 93% of all adults polled said they believed depression is a normal side effect for those suffering from a medical condition. These individuals believed there was little that could be done to impact this. Depression is one of the most common and potentially dangerous complications of every chronic illness. It is particularly common in those with:
 - Recent heart attacks
 - Hospitalized cancer patients
 - Recent stroke survivors
 - People with multiple sclerosis



- Parkinson's Disease and
- Diabetes
- Depression caused by chronic illness often aggravates the illness, especially if the condition causes pain, fatigue or disruption in social life. Depression makes pain hurt more.
- Depression impairs the immune system, which can hurt the body's efforts to combat chronic illness.

34 Suicide

34.0 Intent

Many of the clients we assess are experiencing some very difficult problems and are struggling with many issues. It is important that we explore with them any thoughts they may be having or did have in the last 30 days regarding taking their life through suicide.

34.1 Process

Utilize one of these introductory questions to begin your initial inquiry with the client: (Ask one of these options as a question, not all of them together).

1. You have been telling me about many things you have been struggling with lately. Have you recently said to yourself or others things like:
 - Life is not worth living?
 - I can't take anymore of this.
 - Who needs this pain?
 - Soon it will all be over.
 - My situation is hopeless.
2. Then ask the client the following question: Have you thought of hurting yourself or taking your life in the last 30 days?
 - If the answer is No, the screen will be disabled. If the answer to any question on this screen is Yes, discuss a referral to a mental health professional or to the client's primary healthcare provider. Document the referral on the Referral screen or document the client's refusal (in comments or on the Referral screen).



- If the answer is Yes to the first question, then the next set of questions is enabled. If this client has a plan and has the means to carry it out, do not leave the client alone. Contact the local mental health professional, explain what the client has told you and that you are concerned for his/her safety. Document steps taken in comment box.

Note: The highest rate of completed suicide among all population groups is in older white men who become excessively depressed and drink heavily following the death of their spouse.

35 Sleep

35.0 Intent

The intent of the sleep pattern screen is to identify sleep patterns for care planning, care giving and potential care settings.

35.1 Process

Select Yes or No to the question: “Is the client satisfied with sleep quality?”

Definition: Sleep quality is defined as difficulty falling asleep, fewer or more hours of sleep than is usual for the individual, waking up too early and unable to fall back to sleep.

Strengths, Limitations, Preferences, Sleep patterns: The choices may be used to describe any problems or preferences that the client may have concerning **his/her** sleep habits. Select all the items that apply.

Is caregiver able to get 5 hours of sleep? Answer no if the caregiver is unable to get 5 hours of sleep in any 8-hour period during the day. If the client wakes up frequently during the night, but does not need the assistance of a caregiver answer “yes”.

36 Relationships/Interests

36.0 Intent

The intent of the Relationship/Interests screen is to document important relationships, conflicts and losses in an individual’s life. It will also assist you to identify a client’s

activity preferences. Both of these areas are important in care planning and in estimating how an individual may or may not adapt in various care giving settings or situations.

36.1 Coding:

36.1.0 Relationships

Document the client's relationships.

- Close relationships with family and/or friends? Select yes if the client sees or hears from family and/or friends on a regular basis.
- Openly expressed conflict and/or anger with family, partner, friends, roommate or caregiver? If the client expresses any conflict or anger with the caregiver, encourage the client to speak with the caregiver directly. If the client is uncomfortable speaking with the caregiver directly, ask how you can be of help to resolve the issue. The Zarit Burden Interview in the Caregiver Status screen can be used to determine if stress is a factor. If conflict with anyone creates potential for abuse and neglect, document on the Legal Issues screen.
- Had a recent loss of family and/or friend? Indicate if a friend or relative has recently died.
- Other losses. Select all that apply from the bucket. If a loss is expressed that is not in bucket, include it in the comment box.

36.1.1 Average time involved in activities

Determine the proportion of available time that a client was actually involved in activity pursuits as an indication of his or her overall activity pattern. This time refers to free time when the client was awake and was not involved in receiving nursing care, treatments, or engaged in ADL or IADL activities.

Include time spent pursuing independent activities such as reading or letter writing; social contacts such as visits and phone calls with family, other clients, staff and volunteers; recreational pursuits in a group, one-on-one or an individual basis and involvement in therapeutic recreation. Select the proportionate time that most closely fits. Consult with the individual, direct care staff, activity staff members, and family when necessary.

36.1.2 Interest/Activity and Status

Select all that apply. Indicate the status and the preferred time for each item, whether the interest is current, past, or if the client is not participating at this time but is interested in doing so. Discuss the screen questions with the individual to gain insight into the network and support system available to the client. Also explore various interests and the amount of time, a client may spend or want to spend in a particular activity. **Definition of activity:** Any activity other than ADLs that an individual pursues in order to enhance a sense of well-being. These include activities



that provide greater self-esteem, pleasure, comfort, education, creativity, and success or financial/emotional independence.

Scenario 1

Mrs. H. enjoys visiting with those around her. She is functionally but not cognitively impaired. She is a life long Democrat and enjoys watching CNN and discussing politics. Her son is a member of the Washington State Senate. She is placed at an AFH where all the residents have dementia. She becomes unhappy and depressed.

Scenario 2

Mrs. H. enjoys visiting with those around her. She is functionally but not cognitively impaired. She is a life long Democrat and enjoys watching CNN and discussing politics. Her son is a member of the Washington State Senate. She is placed at an AL facility where she enjoys visiting with other clients at meals and in her and their apartments. Mrs. H. is happy and enjoys her new home.

In either scenario, the assessor would check “talking/conversing, TV. The assessor can write Enjoys Politics in the comment box.

37 Decision Making

37.0 Intent

To document the client's ability and actual performance in making everyday decisions about tasks or activities of daily living.

37.1 Process

Rate how the client makes decisions regarding tasks of daily living. Here are things we want you to consider when making a determination about how clients actually make decisions about their daily life:

- Can this client appropriately choose what clothes he/she will wear?
- Does the client know when to get up?
- Does the client know when to eat?
- Can the client use a clock or a calendar?
- Can the client seek information appropriately?
- Is the client aware of his/her own strengths and limitations?



- Can the client use a telephone or television?
- Does the client realize he/she needs to use assistive devices?

In order to be able to evaluate this, it is important to determine how the client is presently making decisions about every day tasks or activities of daily living. Talk to the client first; it is also important to consult with caregivers, family, and other persons who know this client well or to review a facility record. When talking to the client or others, the inquiry should focus on whether the client is actively making decisions, and not whether there is a belief that the client might be capable of doing so.

37.2 Coding

37.2.0 Rate how the client makes decisions.

- Independent** - Decisions about the client's daily routine are consistent and organized; reflecting the client's lifestyle, choices, culture, and values.
- Difficulty in new situations (Modified independence)** –The client has an organized daily routine, was able to make decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations.
- Poor decisions/unaware of consequences (Moderately impaired)** - Decisions are poor **and** the client requires reminders, cues, and supervision in planning, organizing and correcting daily routines. Clarification: If client attempts to make decisions, although poorly, code moderately impaired.
- No/few decision or preferences re ADL's (Severely impaired)** - Decision making severely impaired, **never/rarely** makes decisions.

If the client "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, this item would be coded as "Severely Impaired". If the client attempts to make decisions, although poorly, code "Moderately impaired".

Example: If a client seems to have severe cognitive impairment and is non-verbal, but usually clamps his mouth shut when offered a bite of food, would the client be considered moderately or severely impaired?

Example: If a client does not generally make conversation or make his needs known, but replies "yes" when asked if he would like to take a nap, would the client be considered moderately or severely impaired?

These examples are similar in that the clients are **primarily non-verbal and do not make their needs known**, but they do make basic verbal or non-verbal responses to



simple gestures or questions regarding care routines (comfort). More information about how they function in their environment is needed to definitely answer the questions. From the limited information provided about these clients, one would gather that their communication is only focused on very particular circumstances, in which case it would be regarded as "rarely/never" in the relative number of decisions a person could make during the course of a week, and this would be coded at 'Severely Impaired'. The assessor should determine if the client would respond in a similar fashion to other requests made during the 7-day observation period. If such "decisions" are more frequent, the **clients may only be moderately impaired or better.**

Example: Your client has an IQ of 70, lives with his parents, and has worked through supported employment for the last 5 years. He has ridden the same bus since he started his job. Last week the schedule changed and he became so agitated that his mother had to drive him to work. Once he adjusted to the change, he was once again taking the bus by himself.

From the information in this brief description, this client appears to have difficulty making decisions in new settings (Modified Independence). He is able to ride the bus independently as long as he is picked up at the same place and time, but a change in schedule confuses him and he is no longer able to make the simple decisions necessary to get to work on his own. A routine must be re-established before he is once again independent.

37.2.1 Plan of Care Supervision

Client is always able to supervise paid care provider? Consider the client's ability to supervise their care. Consider whether the client can tell a provider how to meet the needs or whether he/she can notify someone when the needs are not being met.

If no, is there someone else who can supervise the paid care provider? Develop a plan to identify how this supervision and/or monitoring will occur. When no informal support can be identified to meet this need, other options for care planning may include case manager arranges for:

- A reliable informal caregiver may be able to identify when problems with care exist.
- Authorize more than one provider to provide care so that there is an "additional set of eyes" in the client's home.
- More frequent contact with the client.
- Periodic contact with other professionals.



Where possible, develop the service plan so that one provider is not relied upon to meet all of a client's needs. Consider authorization of home delivered meals, adult day care/health, combining agency and IP caregivers.

Name: Name of person who will supervise client's providers. Input the name onto the *Collateral Contacts* screen in order to pull the person who will be supervising the care.

38 Personal Elements

39 Goals

39.0 Intent

To document and track any goals the client may have.

39.1 Process

Ask the client if they have any goals. Examples may be “I’d like to have the strength to walk to my mailbox” or “I’d like to be able to get together with my friends more often.” A younger client may want to move to her/his own residence or get a GED or return to work.

40 Legal Issues

40.0 Intent

To document any legal matters concerning the client.

40.1 Process

Establish an understanding of the potential issues, (e.g. are advanced care directives in place? is divorce proceeding? is there a no contact or protection order?). It is important to document or see documentation relating to each issue. In addition, “who” is an important element to document in order to promote proper care planning or continued understanding of protections or restrictions, as appropriate.

Potential for Abuse or Neglect (click on ellipse button) to see multiple reasons for abuse and/or neglect potential. This is not an exhaustive list so you can type in comments as necessary. You are encouraged to review the matrix below for additional cues and responses.

NOTE: If no potential for abuse or neglect is identified, select “Nothing reported or observed”.

Cues for Possible Abandonment/Abuse/Neglect/Self-Neglect/Financial Exploitation

| Possible Cue | Response |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Client expresses, or there are signs, that he/she has been hurt or harmed recently. <input type="checkbox"/> Client expresses, or there are signs, that he/she has been restrained or isolated. <input type="checkbox"/> Client indicates he/she is forced to do unwanted things. <input type="checkbox"/> Client expresses or shows fear of someone in close contact. <input type="checkbox"/> Client indicates that someone calls him/her names and/or states that he/she is worthless. | <p><i>Explore situation with the client.</i> If you have reason to believe that abandonment, abuse, neglect, self-neglect, or financial exploitation occurred:</p> <p>If the client is in immediate danger, call 911</p> <p>If the client is in medical distress, call 911</p> <p>Immediately report suspected physical/sexual abuse/neglect/abandonment to APS/RCS</p> <p>Immediately report suspected physical/sexual abuse to law enforcement</p> <p>Employ case management activities to mitigate issues (e.g., change in services, referrals to other support services, etc.)</p> <p>Coordinate with the appropriate entity (APS/RCS/Law Enforcement or other involved entity) to provide needed services</p> |
| <ul style="list-style-type: none"> <input type="checkbox"/> Client’s belongings/financial documents are missing. | <p><i>Explore situation with the client.</i> If you have reason to believe that exploitation or financial exploitation occurred:</p> <p>Immediately report suspected abandonment/abuse/neglect/self-neglect/financial exploitation to APS/RCS</p> <p>Attempt to identify what belongings/financial documents</p> |

| Possible Cue | Response |
|--|--|
| | <p>are missing</p> <p>If client lives in a residential facility, explore situation with owner/provider, if appropriate</p> <p>Coordinate with the appropriate entity (APS/RCS/Law Enforcement or other entity), if involved, to provide needed services.</p> <p>Employ case management activities to mitigate issues (e.g., change in services, referrals to other support services, etc.)</p> |
| <p>□ Client's environment is filthy, inadequate, and may be hazardous.</p> | <p><i>Explore situation with the client.</i> If you have reason to believe that abandonment, neglect, or self-neglect, occurred:</p> <p>Explore client's capacity to make the decision to remain in surroundings and his/her health and safety</p> <p>Explore the need to provide case management activities to mitigate safety issues</p> <p>If the client lives in a residential facility, speak to the owner/provider/staff as to the living conditions and client's needs</p> <p>If client's judgment appears so impaired as to jeopardize his/her health and safety <i>AND</i> the client has a mental disorder, call the local County Designated Mental Health Professional office to request an investigation under the Involuntary Treatment Act</p> <p>If the client does not fit the criteria under the Involuntary Commitment Act <i>OR</i> the client lives in a residential facility and the living conditions are contrary to the client's health and safety, make an APS (community)/RCS (facility) report</p> |

41 Alcohol

41.0 Intent

For our purposes, during the assessment of this issue we will consider if a client is at risk of having an alcohol problem or is in fact a problem drinker. For individuals over the age of 65, the National Institute on Alcohol Abuse and Alcoholism offers the following recommendations for low risk drinking:

- No more than one drink per day
- Maximum of two drinks on any drinking occasion
- Somewhat lower limits for women

The National Institute set these limits to establish a safety zone for healthy older adults who drink. Their goal is to foster sensible drinking that avoids health risks, while allowing older adults to obtain the beneficial effects that may accrue from alcohol. These limits are set for healthy older adults, so the clients we are seeing usually have unstable medical problems and are taking many medications that may present a serious issue when alcohol is also consumed. Regular drinking of relatively small amounts of alcohol can worsen certain medical conditions such as diabetes and hypertension. Therefore, any client we are assessing who has significant health related problems and who is drinking alcohol in excess of the recommended amount above, is considered at risk for a problem or may already have an alcohol abuse problem.

Risk factors for alcohol abuse:

- Gender:** Older men are much more likely to have alcohol related problems than women. Men who drink have been found to be two to six times more likely to have medical problems than women who drink, although women who drink are more likely to develop cirrhosis of the liver.
- Loss of spouse:** Alcohol use/abuse is more prevalent among older adults who have been separated or divorced and among men who have been widowed. *The highest rate of completed suicide among all population groups is in older white men who become excessively depressed and drink heavily following the death of their spouse.*
- Other losses:** The loss of family or friends, physical functioning or income all has a significant impact on alcohol abuse or misuse.
- Substance abuse earlier in life:** Research suggests that a previous drinking problem is the strongest indicator of a problem later in life.
- Mental status:** Depression appears to precipitate increased drinking, particularly among women.

- **Family history:** If there is a history of alcohol abuse in the family, there is strong evidence that drinking behaviors are greatly influenced.

41.1 Process

Engage the client in a conversation about her/his patterns of alcohol use. This information may be sensitive to the client or create uneasy feeling in the assessor. Be sure to acknowledge these feelings. Be prepared that talking to a collateral contact may unleash this individual's simmering anger toward the client, which may be because of past and current alcohol related behavior.

41.2 Coding

Begin by asking:

- **Do you currently drink alcohol beverages like beer, wine, or liquor?** If the answer is **no**, the screen can be skipped. If the answer yes, ask the next question:
- **If yes, within the last year, has this drinking affected your job or family life and friendships or caused you a legal problem?** If Yes, the CAGE Questionnaire will be enabled. The CAGE is a simple set of questions to determine if the client might have an alcohol misuse or abuse problem.*

Comment box: Two or more “yes” answers are indicative of a problem. Document discussion of a referral to an alcohol counselor, treatment program, or healthcare provider in comment box.

42 Substance Abuse

42.0 Intent

To determine if the client has a problem with substance abuse. Many health care providers tend to overlook substance abuse and misuse in older adults because they mistake the symptoms for those of dementia or depression.

The use of sedatives, or other prescription drugs used to treat acute or chronic anxiety or insomnia (such as Lorazepam/Ativan) can have significant adverse effects when taken for extended periods of time. Some of these effects are sedation, decreased attention, **memory loss**, impairment in cognitive function, problems with

* Two or more **Yes** answers are considered indicative of an alcohol/ substance abuse problem. Discuss referral to an alcohol counselor, drug treatment counselor, or primary health care provider for follow-up.

coordination, increased falls, and more auto accidents.

Older adults are more likely to hide their substance abuse, and less likely to seek professional help. However, when an intervention is made, **they are more likely to complete treatment** and have outcomes that are as good if not better than the younger adult. Many relatives of older clients are ashamed of the problem and choose not to address it.

42.1 Process

Ask the following questions:

- Are you presently using any street or illegal drugs, misusing/abusing prescribed medications, glue, inhalants, etc?** If the answer is No, the screen will be disabled.
- If yes, within the last year, has this affected you job, family life, and friendships or caused you legal problems?** If yes, use the CAGE Questionnaire which is a simple set of questions to determine if the client might have an abuse problem.
- Comment box: Two or more “yes” answers are indicative of a problem. Document discussion of a referral to an alcohol counselor, treatment program, or healthcare provider in comment box.**

43 Tobacco

43.0 Intent

To identify the client’s pattern of use of smoking or chewing tobacco. Some things to consider regarding tobacco use:

- Smoking is the major preventable cause of premature death in America; smoking is responsible for one out of five deaths (according to statistics from 1996).
- The trend in tobacco user shows decline with age, however, the problem remains with over 4 million adults 60 or older smoking in the United States.
- Research also shows that current cigarette smoking is also associated with an increased risk of losing mobility in both men and women.
- Smoking is a major risk factor for at least 6 of the 14 leading causes of death among individuals over 60 years and older; these causes are:



- Heart disease
- Cerebrovascular disease
- Chronic obstructive pulmonary disease (COPD)
- Pneumonia/influenza
- Lung cancer and colorectal cancer

43.1 Process

Ask the client directly if she/he smokes or chews tobacco, how often does she/he smoke or chew and how much. Consult with caregivers or family members to gather additional information. Reassure the client she/he is not being judged but this is simply a further effort to find out more about her/him.

44 Activities of Daily Living (ADL)

44.0 Intent

Many clients that we serve are at risk of physical decline. Most also have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Due to these many, possibly adverse influences, a client's potential for maximum functionality is often greatly underestimated by family, caregivers, and the individual himself or herself. Thus, all are candidates for care that focuses on maintaining and expanding self-involvement in ADLs. Individualized service plans can be successfully developed only when the client's self-performance has been accurately assessed and the amount and type of support being provided to the client by others has been evaluated.

44.1 Process

An individual's ADL self-performance may vary from day to day, and even within a twenty-four hour period. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a caregiver he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the individual's ADL self-performance over the seven day period, 24 hours a day – i.e., not only how

the assessor sees the individual, but how the individual performs at other times (in the last 7 days) as well.

Therefore, it is important to gather information from multiple sources – i.e., interviews/discussion with the individual, caregivers, and family, and reviews of documentation, if any. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Bed Mobility with a caregiver, be sure to inquire specifically how the individual moves to and from a lying position, how the individual turns from side to side, and how the individual positions himself or herself while in bed. An individual can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The best way to gather this information is through open-ended questions of the client and caregivers about what assistance for each ADL has actually occurred in the last seven days.

44.2 Coding

44.2.0 ADL Self-Performance– Measures what the individual actually did (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

Bed Mobility – How the client moves to and from a lying position, turns side to side, and positions body while in bed, recliner or other type of furniture.

Transfer – How the client moves between surfaces – i.e., to/from bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath, toilet or car, which is covered under Toilet Use, Bathing, and Transportation.

Walk in Room, Hallway and rest of Immediate Living Environment – How client walks between locations in his/her room and immediate living environment. Immediate living environment is defined as areas adjacent to the client's room. In facilities such as an AL, EARC, ARC, or NF, this pertains to the hallway and close sitting areas. In homes and AFHs, this pertains to areas within the house.

Locomotion in room and immediate living environment - How client moves between locations in his/her room and immediate living environment; if in a wheelchair, code for how self-sufficient once in wheelchair.

Locomotion outside of immediate living environment to include outdoors– If the client is in an AL, EARC, ARC, or NF, this item pertains to more distant areas set aside for dining, activities, etc. This item also includes (for all settings) how the individual moves to and returns from a patio or porch, backyard, to the mailbox, to see the next door neighbor, etc.



Dressing – How the client puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis.

Eating – How the client eats and drinks, regardless of skill. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition or hyperalimentation).

Toilet Use – How the client uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.

Personal Hygiene – How the client maintains personal hygiene, including combing hair, brushing teeth, and applying makeup, and washing/drying face hands, menses care, and perineum.

Bathing – how the individual takes a full-body bath/shower, sponge bath, and transfers in/out of tub/shower.

Record the individual's self-care performance in activities of daily living (i.e., what individual actually did for himself or herself and/or how much verbal or physical help was required by caregiver (s) during the last seven days. **Self-performance** measures what the individual actually did (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale. Follow these guidelines.

1. In order to be able to promote the highest level of functioning among clients, you must **first identify what the client actually does for himself or herself**, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.)
2. The wording used in each **coding option is intended to reflect real-world situations, where slight variations are common**. Where variations occur, the coding ensures that the client is not assigned to an excessively independent or dependent category. For example, Independent, Supervision, Limited Assistance, and Extensive Assistance) permit one or two exceptions for the provision of heavier care. This is clinically useful and increases the likelihood that assessors will code ADL Self Performance items consistently and accurately.
3. To evaluate an individual's ADL Self-Performance, talk with the individual and the caregiver or review the clinical record if available, to ascertain what the individual does for himself or herself in each ADL activity as well as the type and level of caregiver assistance being provided. As previously noted, be alert to differences in



individual performance during the 24-hour period, and apply the ADL codes that capture these differences. For example, an individual may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the individual would be coded as needing (Limited Assistance) in Toilet Use.

4. For each ADL category, code the appropriate response for the individual's actual performance during the past seven days. In your evaluations, you will also need to consider the type of assistance known as "set-up help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the caregiver). **Set-up help is recorded under ADL Support Provided not in ADL self-performance.** But in evaluating the individual's ADL Self-Performance, include set-up help within the context (Independent) For example: If an individual grooms independently once grooming items are set up for him, code (Independent) in Personal Hygiene.
5. Use the following definitions for all ADLs except Bathing:
 - Independent** – No help or staff oversight – OR – Staff help/oversight provided only 1 or 2 times during the last seven days.
 - Supervision** – Oversight (monitoring, standby), encouragement, or cueing provided 3 or more times during last seven days – OR – Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last seven days.
 - Limited Assistance** – individual highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight bearing assistance on 3 or more occasions – OR – limited assistance (3 or more times) plus more help provided only 1 or 2 times during last seven days.
 - Extensive Assistance** – While the individual performed part of activity over last seven days, help of following type(s) was provided 3 or more times:
 - Weight-bearing support provided 3 or more times
 - Full caregiver performance of activity (3 or more times) during part (but not all) of last seven days
 - Total Dependence** – Full caregiver performance of the activity during entire seven-day period. Complete non-participation by the individual in all aspects of the ADL definition. **For example:** For an individual to be coded as totally dependent in Eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by caregiver), and never initiate any subtask of eating (e.g.,



picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

- **Activity did not occur during entire 7-day period because:**
 - **No provider available** - Client would have accepted assistance with task if a caregiver had been available.
 - **Client not able** - Client is not capable of task.
 - **Client declined** – Client refused assistance with task.

NOTE: Do not confuse a client who is totally dependent in an ADL activity – Total Dependence) with the activity itself not occurring. For example: Even a client who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A client who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as “Total”.

Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited Assistance, non weight-bearing supervision or physical assistance must increase from one or two times up to three or more times during the last seven days.

Keys to evaluating self-performance:

Always code for the highest level of activity that actually occurred three or more times in the last 7 days. Code self performance with use of assistive devices.

- Independent: No assistance OR any type of assistance that occurred only one or two times in the past 7 days. Remember that set-up is not coded under self-performance.
- Supervision: The highest level of assistance received 3 times was verbal or monitoring; physical contact did not happen 3 or more times.
- Limited: The highest level of assistance received 3 times involved physical contact; caregiver does not bear the client’s weight. Caregiver did not fully perform any subtask 3 or more times.
- Extensive: The highest level of assistance received 3 times was either weight bearing OR full caregiver performance of one or more (but not all) of the sub-tasks within an ADL definition.



- Total Dependence: No participation by the client in any part of the task during the entire 7-day period.
- Activity did not occur in the last 7 days.

6. ADL Self Performance Codes for Bathing ONLY:

- Independent – No help provided
- Supervision – Oversight help only
- Physical help limited to transfer only
- Physical help in part of bathing activity
- Total dependence
- Activity itself did not occur during entire 7 days

44.2.1 ADL Support Provided

Record the type and **highest** level of support the individual received in each ADL activity over the last seven days. **ADL Support Provided** measures the highest level of support provided by caregivers over the last seven days, even if that level of support only occurred once. This is a different scale, and is entirely separate from the ADL Self-Performance assessment.

1. For each ADL category, code the maximum amount of support the individual received over the last seven days irrespective of frequency. Be sure your evaluation considers 24 hours per day, including weekends.
2. Code independently of the individual's Self Performance evaluation. For example, an individual could have been Independent in ADL Self-Performance in Transfer but received a one-person physical assist one or two times during the seven-day period. Therefore, the ADL Self-Performance Coding for Transfer would be (Independent), and the ADL Support coding (One person physical assist).
3. Code using the following definitions:
 - No setup or physical help from caregivers**
 - Setup help only** – The individual is provided with materials or devices necessary to perform the activity of daily living independently. The type of help characterized by providing the individual with articles, devices or preparation necessary for greater individual self-performance in an activity. This can include giving or holding out an item that the individual takes from the caregiver.
 - One person physical assist**
 - Two plus persons physical assist**



- **ADL Activity did not occur** during the entire 7-days – When “did not occur” is entered for an ADL Support Provided category, “did not occur” should be entered for ADL Self-Performance in the same category.

4. Examples of Setup Help

- **Bed mobility** – handing the individual the bar on a trapeze.
- **For transfer** – giving the individual a transfer board or locking the wheels on a wheelchair for safe transfer.
- **Walking** – handing the individual a walker or cane.
- **Wheeling** – unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **Dressing** – retrieving clothes from closet and laying out on the individual’s bed, handing the individual a shirt.

- **Eating** – cutting meat and opening containers at meals; giving one food category at a time, bringing food to client (if client cannot eat unless food is brought to her/him).
- **Toilet use** – handing the individual a bedpan or placing articles necessary for changing ostomy appliance within reach.
- **Personal hygiene** – providing a washbasin and grooming articles.
- **Bathing** – placing bathing articles at tub side within the individual’s reach; handing the individual a towel upon completion of bath.

44.2.2 Guidelines for Assessing ADL Self-Performance and ADL Support

- Self Performance and Support Provided reflect actual level of involvement in self-care and the type and amount of support actually received during the last seven days. Code for the “what is”. The assessor uses various sources of information, including their own observations, client reports, caregiver reports, medical records, and collateral contacts, to determine actual performance in the last 7 days. For example: if the assessor views the client walking and transferring with no difficulty but the client reports needing weight bearing assistance, then the assessor would rely on their own observations, medical records, and other sources to determine what level of assistance was actually provided over the last 7 days.



- Do not record your assessment of the individual’s capacity for involvement in self-care – i.e., what you believe the individual might be able to do for himself or herself based on demonstrated skills or physical attributes. If the assessor believes that the client does not need all of the assistance provided, then document the reasons why. The assessor would then determine how the client could achieve their highest possible level of functioning through discussions with the client, caregiver, informal supports or health care provider. This may involve caregiver training, an OT/PT evaluation, or obtaining assistive devices. If the interventions outlined by the assessor are successful, a reassessment of the client’s self-performance would reflect a higher level of functioning.
- Do not record the type and level of assistance that the individual “should” be receiving according to the service plan. The type and level of assistance actually provided may be quite different from what is indicated in the plan. Record what is actually happening using the guidelines above.
- Engage, when possible, caregivers who have cared for the individual over the last seven days in discussions regarding the individual’s ADL functional performance. Remind caregivers that the focus is on the last seven days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.



Here is a typical conversation between the Assessor and a caregiver regarding an individual's Bed Mobility assessment:

Assessor: "Describe to me how Mrs. L positions herself in bed. By that I mean, once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side, and positioning herself?"

Caregiver: "She can lay down and sit up by herself, but I help her turn on her side."

Assessor: "She lays down and sits up without any verbal instructions or physical help?"

Caregiver: "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

Assessor: "How do you help her turn side to side?"

Caregiver: "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

Assessor: "Do you lift her by yourself or does someone help you?"

Caregiver: "I do it by myself."

Assessor: "How many days during the last week did you give this type of help?"

Caregiver: "Everyday."

Bed Mobility was similar over the twenty-four hour period, Mrs. L would receive an ADL Self-Performance Code of (Extensive Assistance) and an ADL Support Provided Code of (one person physical assist). Now review the first two exchanges in the conversation between the assessor and caregiver. If the assessor did not probe further, he or she would not have received enough information to make an accurate assessment of either the individual's skills or the caregiver's actual assistance, or whether the current plan of care was being implemented.



44.2.3 Exercise

The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the individual descriptions. Cover the answers, read and score the example, and then compare your answers with those provided.

| | | |
|--|--------------------------------|-----------------------|
| <p>Locomotion in room and immediate living environment: How client moves between locations in his/her room and immediate living environment. If in a wheelchair, code for how self-sufficient once in wheelchair. (If the client does not use a wheelchair, then score will be same as Walk in Room and it will not be necessary to re-record Strengths, Limitations, Preferences, or Caregiver Instructions on the Walk in Room screen).</p> | | |
| <p>Coding Examples: ADL Self-Performance and Support</p> | <p>Self Performance</p> | <p>Support</p> |
| <p>Individual ambulated slowly in the hallway of the assisted living facility pushing a wheelchair for support, stopping to rest every 15-20 feet. She has good safety awareness and has never fallen. Caregivers felt she was reliable enough to be on her own.</p> | <p>Independent</p> | <p>No setup</p> |
| <p>Individual walked independently within the AFH, socializing with others. Because she can become afraid at night, she received contact guard of one caregiver to walk her to the bathroom at least twice every night.</p> | <p>Limited</p> | <p>One person</p> |



| | | |
|---|--------------------------------|-----------------------|
| <p>Locomotion Outside Room If the client is in an AL, EARC, ARC, or NF, this item pertains to more distant areas set aside for dining, activities, etc. This item also includes (for all settings) how the individual moves to and returns from a patio or porch, backyard, to the mailbox, to see the next door neighbor, etc. Do not select “Did not occur/Client unable” unless the client is physically unable to leave the residence.</p> | | |
| <p>Coding Examples: ADL Self-Performance and Support</p> | <p>Self Performance</p> | <p>Support</p> |
| <p>Individual wheels herself to the main dining room of the assisted living facility for breakfast and lunch. However by the evening meal she is tired and a caregiver pushes her there and back.</p> | <p>Extensive</p> | <p>One person</p> |
| <p>An individual residing in an adult family home walks with a cane to the mailbox everyday at 2 pm. He received no set up or physical help in the last 7 days.</p> | <p>Independent</p> | <p>No setup</p> |



| | | |
|---|--------------------------------|-----------------------|
| <p>Walk In Room: How individual walks between locations in his/her room and immediate living environment. Immediate living environment is defined as areas adjacent to the individual's room. In facilities such as an AL, EARC, ARC, or NF, this pertains to the hallway and close sitting areas. In homes and AFHs, this pertains to areas within the house.</p> | | |
| <p>Coding Examples: ADL Self-Performance and Support</p> | <p>Self Performance</p> | <p>Support</p> |
| <p>Individual walked independently during the day and received non-weight bearing physical help of 1 person for getting to the bathroom room at night 3 times in the last week.</p> | <p>Limited</p> | <p>One person</p> |
| <p>Individual did not walk but wheeled self independently in own room.</p> | <p>Did not occur</p> | <p>Did not occur</p> |
| <p>A timid, fearful individual is usually physically independent in walking. During the last week she was very anxious and fearful of falling, and therefore received reassurance and encouragement from someone walking next to her while walking back to her room from meals in the dining room of the AFH.</p> | <p>Supervision</p> | <p>No setup</p> |
| <p>Individual walked twice daily 4-6 feet in the hallway outside his room of the AL facility. He received weight-bearing assistance of 1 person for each walk.</p> | <p>Extensive</p> | <p>One person</p> |



| | | |
|---|--------------------------------|-------------------------|
| <p>Bed Mobility How client moves to and from lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.</p> | | |
| <p>Coding Examples: ADL Self-Performance and Support</p> | <p>Self Performance</p> | <p>Support</p> |
| <p>Individual received supervision and verbal cueing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons.</p> | <p>Supervision</p> | <p>Two plus persons</p> |
| <p>Individual independently turned on his left side whenever he wanted. Because of left-sided weakness he received physical weight bearing help of 2 persons to turn to his right side or sit up in bed.</p> | <p>Extensive</p> | <p>Two plus persons</p> |

Bedfast or Chairfast all or most of the time (in Limitations): Determine if the individual has a physical health or mental condition that restricts the individual's functioning. For care planning purposes, this information is useful for identifying clients who are at risk of developing physical and functional problems associated with restricted mobility, as well as cognitive, mood, and behavior impairment related to social isolation. Select Chairfast if the client is wheelchair dependent when not in bed or recliner. Select Bedfast if client is confined primarily to bed or recliner. Both may be selected.



| <p>Transfers - How the individual moves between surfaces – i.e., to/from bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet or to/from car, which is covered under Toilet Use and Bathing.</p> | | |
|--|-------------------------|----------------|
| Coding Examples: ADL Self-Performance and Support | Self Performance | Support |
| Dan is able to move independently in and out of armchairs, but his caregiver provides weight bearing assistance each day to get him in and out of bed. | Extensive | One person |
| Once the caregiver correctly positioned the wheelchair in place and locked the wheels, the individual transferred independently to and from the bed. | Independent | Setup only |

| <p>Toilet Use - How the individual uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not limit assessment to bathroom use only. Elimination occurs in many settings and includes the above-mentioned activities. Toilet use focuses on whether or not elimination occurs, rather than the process.</p> | | |
|---|-------------------------|----------------|
| Coding Examples: ADL Self-Performance and Support | Self Performance | Support |
| In the toilet room individual is independent. As a safety measure, the caregiver stays just outside the door, checking with her periodically. | Supervision | No setup |



| | | |
|---|------------------|-------------------|
| <p>When awake, individual was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one caregiver several times each night after incontinence episodes.</p> | <p>Extensive</p> | <p>One person</p> |
|---|------------------|-------------------|

| | | |
|--|--------------------------------|-----------------------|
| <p>Eating - How the individual eats and drinks, regardless of skill. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition or hyperalimentation). NOTE: Bringing food to client is coded in Support Provided.</p> | | |
| <p>Coding Examples: ADL Self-Performance and Support</p> | <p>Self Performance</p> | <p>Support</p> |
| <p>Cognitively impaired individual ate independently when given one food item at a time and monitored to assure adequate intake of each item.</p> | <p>Supervision</p> | <p>Setup only</p> |
| <p>Individual fed self with caregiver monitoring at breakfast and lunch but tired later in day. She was fed totally by caregiver at supper meal.</p> | <p>Extensive</p> | <p>One Person</p> |

Eating Limitation Definitions:

- Mouth pain – Any pain or discomfort associated with any part of the mouth, regardless of cause. Clinical manifestations include favoring one side of the mouth while eating, refusing to eat, refusing food or fluids of certain temperatures (hot or cold) or textures, complaining of sores.
- Chewing Problem – Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., individual uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, or has temporomandibular joint (TMJ) or jaw pain, or a painful tooth).
- Current swallowing problem – Dysphagia (difficulty in swallowing). Clinical manifestations include frequent choking and coughing when



eating or drinking, holding food in mouth for prolonged periods of time or excessive drooling.

| <p>Bathing: How the individual takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. Bathing is the only ADL activity for which the ADL Self-Performance codes differ because of the frequency with which the bathing activity is carried out during a one-week period. Assuming that the average frequency of bathing during a seven-day period would be one or two baths, the coding for the other ADL Self-Performance items, which permits one or two exceptions of heavier care, would result in the inaccurate classification of almost all clients as “Independent” for Bathing.</p> <p>If a residential facility has a policy that all clients are supervised when bathing (i.e., they are never left alone while in the bathroom for a bath or shower, regardless of client capability), it is appropriate to code as “supervision”, even if the supervision is precautionary.</p> | | |
|---|-------------------------|-------------------|
| Examples: ADL Self-Performance and Support | Self Performance | Support* |
| <p>Individual received verbal cueing and encouragement to take twice-weekly showers. Once caregiver walked individual to bathroom, he bathed himself with periodic oversight.</p> | <p>Supervision</p> | <p>No setup</p> |
| <p>On Monday caregiver helped transfer client to tub and washed his legs. On Thursday, individual had physical help of one caregiver to get into tub but washed himself completely.</p> | <p>Physical help</p> | <p>One person</p> |

*For Support Provided, code for the maximum amount of support provided. These codes do not change for the bathing activity.



| <p>Dressing - How the individual puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis. Dressing includes putting on and changing pajamas, and housedresses.</p> | | |
|--|-------------------------|-----------------|
| Coding Examples: ADL Self-Performance and Support | Self Performance | Support |
| <p>Individual is totally independent in dressing herself except for her TED stockings. Caregiver applied the TED stockings each AM and removed them at bedtime.</p> | Extensive | One person |
| <p>A 325-pound individual received total care by two caregivers in dressing. He did not participate by putting arms through sleeves, lifting legs into shoes, etc.</p> | Total | Two plus person |

| <p>Personal Hygiene - How the individual maintains personal hygiene, including combing hair, brushing teeth, and applying makeup, and washing/drying face hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing. NOTE: If client's hair is shampooed in the sink (at home, a beauty or barber shop), then include as a Personal Hygiene subtask. If client's hair is shampooed during bath, include in Bathing.</p> | | |
|--|-------------------------|----------------|
| Coding Examples: ADL Self-Performance and Support | Self Performance | Support |
| <p>Individual shaves self with an electric razor, washes his face and hands, brushes his teeth, and combs his hair. Because he is losing his sight, caregiver stands-by to hand grooming articles to him, and return articles to their proper location.</p> | Supervision | Setup |
| <p>Individual required total daily help combing her long hair and arranging it in a bun. Otherwise she was independent in personal hygiene.</p> | Extensive | One person |



45 Instrumental Activities of Daily Living (IADL)

45.0 Intent

The intent of these items is to examine the areas of function that are most commonly associated with independent living.

45.1 Process

The individual is questioned directly (if possible) about his or her performance of normal activities around the home or in the community in the last 30 days. You may also talk to family members if they are available and facility staff. You should also use your own observations as you are gathering information.

45.2 Coding

45.2.0 Self Performance

Code for level of self-performance in the last 30 days.

- Independent** - No help, set up or supervision
- Set up help/arrangements only** - On some occasions the client did their own set up/arrangement; at other times the client received help from another person.
- Limited assistance** - On some occasions the client did not need any assistance but at other times in the last 30 days the client required some assistance.
- Extensive assistance** - the client is involved in the activity but required cueing/supervision or partial assistance at ALL times.
- Total dependence** - The activity occurred but with full performance by others.
- Activity did not occur**

45.2.1 Difficulty Code

This box will document how difficult it is (or would be) for the client to do the activity on her/his own. For those involved in activities ask: How difficult was it (or would it be) for individual to do activity on their own. This may be a judgment call by the assessor for the individual may never have done this activity (e.g., never cooked a meal or never managed finances him/herself).

- No difficulty**

- **Some difficulty:** The client needs some help, is very slow or fatigues easily.
- **Great difficulty:** little or no involvement in the activity is possible by the client.

45.2.2 IADL Tasks

- **Meal Preparation** - How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils. NOTE: This task may not be authorized only to plan meals or clean up after meals. Client must need assistance with actual meal preparation. **Sub-Tasks** include meal planning (if combined with actual meal preparation), preparing ingredients for cooking, re-heating meals, operating kitchen appliances, throwing out spoiled food, and cleaning up after a meal in combination with meal preparation. **Set-up** includes cueing or reminding to prepare meals/snacks, taking items from shelves, opening cans/bottles and packaged foods, and assembling ingredients for cooking.
- **Transportation** - How client travels by vehicle to a healthcare provider in the local area to obtain diagnosis or treatment and includes driving vehicle or traveling as a passenger. **Sub-Tasks** include driving to/from appointment, accompanying client if provider is not driving (does not include need for translation), using public transportation, transferring in/out of car. **Set-up** includes cueing or reminding client about medical appointment, making appointment, making arrangements for transportation, and placing assistive device into/out of vehicle. **Does client live more than 45 minutes from essential services?** Select this if the client lives more than 45 minutes from essential shopping location(s). If the client lives within 45 minutes of essential shopping services, but more than 45 minutes from doctor's appointments, do not check the box.
- **Essential Shopping** - How shopping (including transportation) is performed for food and household items (e.g., selecting items, managing money). Shopping is limited to brief, occasional trips in the local area to shop for food, medical necessities, and household items required specifically for the client's health, maintenance, or well-being. **Sub-Tasks** include providing transportation to/from store, selecting items, placing items in cart, pushing cart or carrying basket, transporting purchased items from store to vehicle to home, putting items away, and assisting with car transfers. **Set-up** includes cueing or reminding to purchase food, prescriptions, household items; making a list of needed items; making transportation arrangements to/from store; placing assistive device into or out of vehicle.
- **Wood Supply** - How wood is supplied (e.g. splitting, stacking, or carrying wood) when you use wood as the sole source of fuel for heating and/or cooking. **Sub-Tasks** include splitting wood/kindling,

stacking wood, and carrying wood inside. **Set-up** includes cueing or reminding to order wood supply, cueing or reminding to split/stack wood, and arranging for resupply of wood. Yes/no question whether wood is the only source of heat for this individual. If yes fill out the screen to document how client is able to get necessary wood supply for heat.

Housework- How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry). These are tasks required to maintain the client in a safe and healthy environment. Assistance with ordinary housework is limited to those areas of the home which are used by the client. It does not include yard work or cleaning up after other household members or guests. **Sub-Tasks** include cleaning kitchen and appliances, cleaning bathroom and other rooms used by client, vacuuming, dusting, taking out garbage, changing linens, and laundry. **Set-up** includes cueing or reminding client to do housework, set-up of laundry supplies, bringing laundry to client to be folded, and setting up cleaning supplies. **Does client use off site laundry?:** Select ‘yes’ from the drop down list if the client’s laundry facilities are not in the client’s residence and the paid provider must stay with the laundry while it is being washed and dried. Do not select “Yes” if client lives with provider.

- Finances** - How bills are paid, checkbook is balanced, and household expenses are managed. ADISA cannot pay for any assistance with managing finances. **Sub-Tasks** include balancing the checkbook, paying bills, budgeting expenses, using an ATM machine, and completing financial paperwork. Examples of **Set-up** include organizing bills/bank statements and cueing or reminding to pay bills.
- Pet Care-** Formal supports **cannot** be paid to provide pet care; use this screen to identify who will care for client's pets and to identify any problems concerning the pet(s).

Shopping Example:

Mrs. Q does not do her shopping. Her daughter visits every Sunday, gets the list from her mother, and does the shopping. Mrs. Q, while appreciating her daughter, feels she would have no difficulty doing the shopping on her own.

Because of lack of skills and experience in performing some activities, some clients may not perform an activity, but would be capable of doing so with the proper training. Therefore, it is important to identify the distinction between physical capability and non-performance for reasons not related to health problems. For example some males may never have learned to cook and some females may never have handled financial matters. For some activities, the individual may perform the

activity independently at times, but receive or require assistance at other times. First determine whether the individual performed the activity.

Transportation Examples:

When scoring for Transportation, it does not depend upon the client's ability to drive, but on the need for assistance. For example, code:

- Independent**, if a client drove without assistance OR if client did not drive, but used other modes of transportation independently.
- Limited**, if the client sometimes traveled without assistance.
- Extensive**, if the client needed someone to accompany him/her to assist with driving, ambulation or transfers, etc.
- Total**, only if the client did not participate at all in the task. In other words, the client was not involved in planning the trip and required a total assist with transfer, total assist with ambulation, driving, etc.
- NOTE:** If client needs to be accompanied to appointment due to Extensive or Total need in Locomotion outside of room and Transfer, Status may be coded as Unmet if transportation is provided by non-ADSA paid resource.

46 ADL/IADL

46.0.0

46.0.1 'Status

To document the anticipated or expected degree of unmet need. Assessing status means you need to look at how the client's need is going to be met looking forward, rather than looking at what has actually happened in the past. Ask the client and/or informant if there is an unpaid caregiver who is meeting this need. If there is, then the need is met. **Status indicates future availability of non-ADSA paid support; however, do not include assistance that occurs less than weekly.**

- Met:** Non-ADSA paid resources will meet this need. This may not reflect what has occurred in the past 7 days but will reflect anticipated support from a non-ADSA paid provider.
- Partially met:** Non-ADSA paid resources will provide some assistance with task. The client will have paid and unpaid providers meeting this need. If partially met is chosen, then the assessor will need to identify assistance available (below).
- Unmet:** Non-ADSA paid resources are not available to assist with task.
- Declines:** Client does not want assistance with task.

Non-ADSA Paid resources are any resources available to fully or partially meet the client's need for assistance with a particular task that is not paid for through ADSA. Examples of non-ADSA paid resources include: family members, church groups, adult day health, home delivered meals (not paid for by COPEs), neighbors, home health, congregate meal site, etc.

NOTE: If the client uses Paratransit and requires an escort to assist with transfers, locomotion outside of room, and/or cognitive needs, Unmet may be selected.

46.0.2 Assistance Available

Indicate amount of informal support for this task.

- Less than $\frac{1}{4}$ of the time:** Non-ADSA paid resources can assist up to $\frac{1}{4}$ of the time.
- $\frac{1}{4}$ - $\frac{1}{2}$ of the time:** Non-ADSA paid resources can assist from $\frac{1}{4}$ to $\frac{1}{2}$ of the time.
- Over $\frac{1}{2}$ - $\frac{3}{4}$ of the time:** Non-ADSA paid resources can assist $\frac{1}{2}$ up to $\frac{3}{4}$ of the time.
- Over $\frac{3}{4}$ of the time:** Non-ADSA paid resources can assist more than $\frac{3}{4}$ of the time but not all of the time.

The chart below is available on the help screen of CARE. The chart can assist the assessor in determining the correct percentage of assistance available. To use the chart, the assessor asks the client and/or collateral contacts about the average number of times each particular task happens during the day or week and the number of those times that non-ADSA paid resources are meeting the client's needs. Where the two intersect is the percentage of the time that needs to be used to determine the appropriate level of assistance available. If the task happens more frequently than 20, both numbers can be divided by 2 to determine the percentage.



NUMBER OF TIMES TASK IS MET INFORMALLY

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| 1 | 100% | | | | | | | | | | | | | | | | | | | |
| 2 | 50% | 100% | | | | | | | | | | | | | | | | | | |
| 3 | 33% | 67% | 100% | | | | | | | | | | | | | | | | | |
| 4 | 25% | 50% | 75% | 100% | | | | | | | | | | | | | | | | |
| 5 | 20% | 40% | 60% | 80% | 100% | | | | | | | | | | | | | | | |
| 6 | 17% | 33% | 50% | 67% | 83% | 100% | | | | | | | | | | | | | | |
| 7 | 14% | 29% | 43% | 57% | 71% | 86% | 100% | | | | | | | | | | | | | |
| 8 | 13% | 25% | 38% | 50% | 63% | 75% | 88% | 100% | | | | | | | | | | | | |
| 9 | 11% | 22% | 33% | 44% | 56% | 67% | 78% | 89% | 100% | | | | | | | | | | | |
| 10 | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% | | | | | | | | | | |
| 11 | 9% | 18% | 27% | 36% | 45% | 55% | 64% | 73% | 82% | 91% | 100% | | | | | | | | | |
| 12 | 8% | 17% | 25% | 33% | 42% | 50% | 58% | 67% | 75% | 83% | 92% | 100% | | | | | | | | |
| 13 | 8% | 15% | 23% | 31% | 38% | 46% | 54% | 62% | 69% | 77% | 85% | 92% | 100% | | | | | | | |
| 14 | 7% | 14% | 21% | 29% | 36% | 43% | 50% | 57% | 64% | 71% | 79% | 86% | 93% | 100% | | | | | | |
| 15 | 7% | 13% | 20% | 27% | 33% | 40% | 47% | 53% | 60% | 67% | 73% | 80% | 87% | 93% | 100% | | | | | |
| 16 | 6% | 13% | 19% | 25% | 31% | 38% | 44% | 50% | 56% | 63% | 69% | 75% | 81% | 88% | 94% | 100% | | | | |
| 17 | 6% | 12% | 18% | 24% | 29% | 35% | 41% | 47% | 53% | 59% | 65% | 71% | 76% | 82% | 88% | 94% | 100% | | | |
| 18 | 6% | 11% | 17% | 22% | 28% | 33% | 39% | 44% | 50% | 56% | 61% | 67% | 72% | 78% | 83% | 89% | 94% | 100% | | |
| 19 | 5% | 11% | 16% | 21% | 26% | 32% | 37% | 42% | 47% | 53% | 58% | 63% | 68% | 74% | 79% | 84% | 89% | 95% | 100% | |
| 20 | 5% | 10% | 15% | 20% | 25% | 30% | 35% | 40% | 45% | 50% | 55% | 60% | 65% | 70% | 75% | 80% | 85% | 90% | 95% | 100% |

46.1 Equipment

Select from list the items that the client has and items that would maximize the client’s independence. Indicate the status for each item. Use text field to identify supplier if known. If client needs an item not on the list, select "Other" and describe in Comments. If Specialized Medical Equipment is selected, describe in Comments (it will pull to assigned needs bucket). If client is eligible for PERS, select the unit and/or installation here; they will pull to assigned needs bucket.

46.2 Comment boxes

Comment boxes: If the strengths, limitations, or preference lists do not adequately describe the client's needs, then the comment box must used to provide a clear description of the client's needs. For each identified need, adequate caregiver instructions must be provided. Use the comment box to add those that are not listed or to personalize those selected.

Note: An explanation of the coding is NOT required unless the information on this screen is inconsistent with other information in the assessment.

Emergency plan should include:



- **An evacuation plan:** In CARE, select standard language on the Locomotion Outside of Room screen under Caregiver instructions, using the comment box to add client specific information if necessary.
- **Back-up plan of care:** If lack of immediate care would pose a serious threat to the health and welfare of the client, a backup caregiver may be identified on the Collateral Contact screen. Standard backup plans are listed on the Locomotion Outside of Room screen, under Caregiver Instructions (use the comment box to add client specific information).

47 Falls

47.0 Intent

To document history of falls within the last 30 days and within 31-180 days and history of hip fracture or other fracture with in the last 180 days due to falls. There are also items to determine the individual's risk of future falls or injuries. Falls are a common cause of morbidity and mortality in this population. Clients who have sustained at least one fall or a near fall are at risk of future falls. Serious injury results from 6 to 10 percent of falls, with hip fractures accounting for approximately one half of all serious injuries.

47.1 Process

Indicate when and where the fall occurred as well as the consequence of each fall. If client has fallen more than 6 times in the last 6 months, use the table for the 6 falls with the most serious consequences and use the comment box to indicate how often client has been falling.

47.2 Coding

If the client has not fallen within the last 6 months (180 days), then answer No and proceed to the next screen. If the answer is Yes, then indicate where the client fell, when they fell, and the consequences of each fall. Repeat for each fall in the last 6 months. If the client cannot remember details about falling, then ask the caregiver or other sources. If the site cannot be verified, then select Unknown from the list. If the client cannot remember when she fell, then record her estimation.

48 Toileting

48.0 Intent

Refers to control of the urinary bladder or the bowels **in the last 14 days**. These items describe the individual's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances like an indwelling catheter. You are documenting the frequency with which the individual is wet and dry during the 14-day assessment period, which considers the entire 24 hours each day.

48.1 Process

Here are some things to consider and questions to ask when beginning the assessment of an individual's bowel and bladder control:

Many clients may hesitate to admit they have a problem. Many clients with poor bowel or bladder control may be struggling to maintain control and will try to hide their problems out of embarrassment or fear of retribution. Others may not report problems because they mistakenly believe that incontinence is a natural part of aging and nothing can be done to reverse the problem. Hold your conversation in private with the individual. Validate continence patterns reported by the individual by talking to family members, or caregivers who know the individual well. **Remember to consider continence patterns over the last 14-day period, 24 hours a day including weekends. Research has shown that 14 days are the minimum time period necessary to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel continence and bladder continence are evaluated over 14 days.**

Determination of whether or not to code incontinence is not a matter of volume. It is a matter of skin wetness and irritation, and the associated risk for skin breakdown.* Coding incontinence is a matter of acknowledging and recording a client's incontinence problem on the assessment, and ensuring that the plan derived from the assessment addresses the problem. If the client's skin gets wet with urine, or if whatever is next to the skin (i.e. pad, brief, underwear) gets wet, it should be counted as an episode of incontinence—even if it's just a small volume of urine, for example, due to stress incontinence. Any episode of incontinence requires intervention not just in terms of immediate incontinence care, but also in terms of dealing with the underlying problem whenever possible, and instituting a re-training, toileting or

* According to Dr. Courtney Lyder, Ph.D., a nationally recognized incontinence and pressure ulcer expert from Yale University School of Nursing, "Urinary incontinence is a major risk factor for pressure ulcer development. Hence excessive moisture (from stool and/or urofecal incontinence) can cause the skin to become macerated with less pressure needed to develop a Stage II pressure ulcer. In the presence of moisture, less pressure may be required to develop an ulcer."

incontinence care plan. In addition, since incontinence is a problem that many clients are sensitive about, intervention involves maintaining dignity and lifestyle.

Do not ask “Are you incontinent” because many people do not know what *incontinence* means. Some questions to consider asking are:

- Do you ever leak urine (wet your clothes) when you don’t want to?
- Do you ever leak urine (wet your clothes) when you sneeze, laugh, pick up something heavy, or move quickly?
- Do you ever leak urine (wet your clothes) on the way to the bathroom?

When getting information from caregivers, start to narrow your questions to focus on either end of the continence scale, then work your way to the middle. For example using the urinary continence scale, if the client is always dry, code continent. If the client is always wet and has no control, code incontinent. Incontinence occurs only once a week or less, code usually continent. The difference between the codes occasionally and frequently incontinent is that for frequently, the client is incontinent at least daily or multiple times a day.

48.2 Coding

A five-point coding scale is used to describe continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bladder and bowel. The reason for these differences is that there are more episodes of urination per day and week, whereas bowel movements typically occur less often.

- Continent** – Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, appliances, etc.
- Usually Continent** – Bladder, incontinent episodes occur once a week or less; Bowel incontinent episodes occur less than once a week.
- Occasionally Incontinent** – Bladder incontinent episodes occur two or more times a week but not daily; Bowel incontinent episodes occur once a week.
- Frequently Incontinent** – Bladder incontinent episodes tend to occur daily, but some control is present (e.g. during the day time); Bowel incontinent episodes occur two to three times per week.
- Incontinent** – Has inadequate control. Bladder incontinent episodes occur multiple times daily; Bowel incontinent is all (or almost all) of the time.

Select one response to describe the level of bladder continence and one response to describe the level of bowel continence for the client over the last 14 days. Code for the actual continence pattern.



| EXAMPLES OF BLADDER CONTROL CODING | |
|--|---|
| *SELECT ONE | |
| Mr. Q. was taken to the toilet after every meal, before bed, and once during the night. He was never found wet. | Continent |
| Mr. R. had an indwelling catheter in place during the entire 14-day assessment period. He was never found wet and is considered continent. | Continent |
| Although she is generally continent of urine, every once in a while (about once in 2 weeks) Mrs. T. doesn't make it to the bathroom to urinate in time after receiving her daily diuretic pill. | Usually Continent |
| Mrs. A has less than daily episodes of urinary incontinence, particularly late in the day when she is tired. | Occasionally Incontinent |
| Mr. S is comatose. He wears an external (condom) catheter to protect his skin from contact with urine. This catheter has been difficult for caregivers to manage as it keeps slipping off. They have tried several different brands without success. During the last 14 days, Mr. S has been found wet at least twice daily on the day shift | Frequently Incontinent |
| Mrs. U is terminally ill with end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress, and is turned and repositioned hourly for comfort. She is not toileted and is incontinent of urine for all episodes. | Incontinent, multiple daily episodes |

Additional Information:

There are primarily 4 different types of urinary incontinence. This information is being made available to help you realize that depending on the diagnosis made by the health care provider, different methods may be used to manage the incontinence based on the type or combination of types of incontinence an individual may be experiencing.

1. **Stress Incontinence**, this is the involuntary leaking of urine during physical exertion. This can occur during exercise, coughing, sneezing, laughing or other body movements that put pressure on the bladder. This occurs most often in women of all ages. An individual should see their health care provider for treatment because Pelvic Muscle (Kegel)



Exercises, Medications or other bladder retraining programs and incontinence supplies may be used to manage this issue.

2. **Urge Incontinence** refers to the sudden desire to void and the inability of the bladder to hold urine long enough for an individual to reach a toilet. It is often associated with conditions such as stroke, senile dementia, Parkinson's disease, and multiple sclerosis, but it can also occur in otherwise normal elderly persons. An individual should see their health care provider for treatment because medications, bladder retraining programs, regular toileting plans, the use of incontinence supplies or specific surgical procedures may be used to manage this issue.
3. **Overflow Incontinence**, this is the involuntary leaking of urine associated with an over distended bladder. This means that the bladder is retaining urine that then overflows. This condition is characterized by a constant loss of small amounts of urine either periodically or continuously in the presence of a distended bladder. This is observed in clients with an obstructing prostate gland or the loss of normal contraction of the bladder in some people with diabetes or other disease processes which impact bladder function. An individual should see their health care provider for treatment. Surgical procedures can positively impact this condition as well as intermittent catheterizations, the use of incontinence supplies, and sometimes indwelling urethral or supra-pubic catheter drainage.
4. **Functional Incontinence** is observed in clients with normal bladder function. This becomes a problem for those clients who have an inability to comprehend the need to void or communicate the sense of urgency or imminence of voiding. Functional incontinence is typically seen in clients with severe dementia, a closed head injury or in some instances a stroke. Many people with normal urine control may have difficulty reaching a toilet in time because of arthritis or other crippling disorders. For an individual who is not able to reach a toilet in time to avoid wetting, every effort should be made to develop a plan to assist this individual in managing this issue more effectively. Some care planning options may be using a bedside commode or urinal, a scheduled toileting plan, a bladder retraining program or external condom catheter and incontinence supplies.

Examples of Bowel Control Coding

***CHECK ONE**



| | |
|---|---------------------------------|
| <p>Mr. S. has a colostomy and there has not been any leakage of stool onto his skin in the last 14 days.</p> | <p>Continent</p> |
| <p>Mrs. F. had some diarrhea this past week and had “an accident”. This was an unusual event for her; she was fine the week before.</p> | <p>Usually Continent</p> |

Appliances and Programs Used in Last 14 Days, select all that apply:

- Any scheduled toileting plan—An individualized plan whereby caregivers at scheduled times each day either take the individual to the toilet room, or give the individual a urinal, or remind the individual to go to the toilet. This includes habit training and or prompted voiding based on specific cues given by that individual. This item also includes bladder retraining programs. These are programs where the individual is taught to consciously delay urinating (voiding) or resist the urgency to void. Clients are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.
- Did not use toilet room, bedside commode, urinal or bed pan – Individual never used any of these items during the last 14 days.
- External (condom) catheter—A urinary collection appliance worn over the penis.
- Pads/briefs used—Any type of absorbent, disposable or reusable undergarment or item, whether worn by the individual (e.g. adult brief or diaper) or placed on the bed or chair for protection for incontinence. Does not include the routine use of pads on beds when an individual is never or rarely incontinent.

Progression Rate: For both bladder and bowel, compare status of 90 days ago (or since last assessment if less than 90 days). Has there been no change, improvement, or deterioration?

Bowel Pattern: In the last 14 days, select all that apply: Constipation, diarrhea, regular, fecal impaction, or none of these.

Individual Management: Individual’s management of bowel and bladder supplies or appliances (pads, briefs, ostomy, catheter) in last 14 days. * Select one

- Individual doesn’t need or use supplies or appliances.
- Individual uses supplies or appliances independently.
- Individual uses supplies or appliances and is dry and clean with such, requires assistance with the supplies or appliances.



- Individual uses supplies or appliances, has leakage onto skin with such, necessitating cleansing/assistance.
- Individual does not use supplies or appliances, and has leakage onto the skin.

Please remember that you are to complete each item of this section so as to thoroughly assess an individual's pattern of bowel and bladder control, the use of appliances or programs used to assist and manage the incontinence, and the individual's ability to manage the use of incontinence supplies or appliances. Remember to consider this information and include it in your care planning.

49 Nutritional/Oral

49.0 Intent

To record any specific oral or nutritional problems, conditions and risk factors present in the last 7 days that affects or could affect the individual's health or functional status.

49.1 Process

Ask the individual about difficulties in these areas. Consult with caregivers, family if necessary.

49.2 Coding

Nutritional Problems: Select all that apply. If none apply, select None of these.

- Anorexia nervosa** - is the unyielding pursuit of thinness. An individual refuses to maintain normal body weight and generally weighs 85% or less than what is generally accepted for her/his height and age. In addition, anorexia nervosa often includes depression, irritability, withdrawal, and peculiar behaviors such as compulsive rituals, strange eating habits, and division of foods into "good/safe" and "bad/dangerous" categories.
- Appetite change** – this includes an increase or decrease in appetite.
- Binge eating disorder** - is a disorder that includes eating frequently and repeatedly often secretly and with little enjoyment of the food. The individual is often ashamed and feels very guilty about this behavior.
- Bulimia nervosa** - is a disorder that includes dieting, bingeing and purging. An individual suffering from Bulimia nervosa often feels out

of control while eating and may vomit, misuse laxatives, excessively exercise or fast to get rid of calories.

- Complains about the taste of many foods** – The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based – e.g., someone used to eating spicy foods may find facility or home delivered meals bland.
- Insufficient fluid intake/last 3 days**; did NOT consume all/almost all liquids provided during the last three (3) days - Liquids can include water, juices, coffee, gelatins, and soups.
- Leaves 25% or more of food uneaten at most meals** - Eats less than 75% of food (even when substitutes are offered) at least 2 out of 3 meals a day.
- Overeating** - Overeating not followed by purging and resulting in continued weight gain.
- Regular or repetitive complaints of hunger** – On most days (at least 2 out of 3), individual asks for more food or repetitively complains of feeling hungry (even after eating a meal). The assessor would also question the general serving amounts provided.
- Oral/Dental Problems** - Select any that apply. Select none of these if the client has none of the problems in the list.

Special Diet/Nutritional Approaches: Review the treatment/therapies help screens for additional information on nutritional approaches, as appropriate or necessary to meet any of the nutritional needs that have been identified in this screen. Select all that apply. If no conditions apply, select None of these.

- ADA** - Client follows or prefers to follow the American Diabetic Association dietary guidelines.
- Calorie Restriction** - Client is on a weight loss program that includes a limit on the number of calories eaten each day.
- Dietary Supplement between meals** - Any type of dietary supplement that is preplanned and provided between scheduled meals for the health of the individual. Do not include routine snacks.
- Fluid Restriction** - Client is participating in a diet plan that restricts the amount of fluid intake.
- Low Sodium** - Client is participating in a diet plan that restricts the amount of sodium in their diet.
- Mechanically altered diet** - A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, and ground meat. Diets for clients who can only take liquids that have been thickened to prevent choking are also included in this definition.



- **Planned weight change program** - The client is receiving a program of which the documented purpose and goal are to facilitate weight gain or loss. For example, double portions, high calorie supplements; reduced calories, etc.

Tube Feedings – Total calories the client received through parenteral or tube feedings in the last 7 days and the average fluid intake per day by IV or tube in the last 7 days. Document how the individual obtains nourishment, both caloric intake and fluid intake if he/she receives nourishment through parental or tube feedings. These 2 questions only apply to those clients that require tube or parental feeding. If the client being assessed does not require this skip these two questions.

Code greater than 50% if the client took in no food or fluid by mouth in the last 7 days. To calculate the percentage of total calories by tube feeding divide the calories received by tube by the total calories.

Ask the client or caregiver, as applicable, if the average fluid intake per day by IV or tube in the last 7 days was greater than 2 cups (500cc). This is the actual fluid received, not the amount ordered. Select the amount.

- 1 ounce = 30 cc
- 8 ounces = 240cc
- 1 pint = 500 cc
- 1 quart = 1000 cc

50 Functional Status

50.0 Intent

To monitor the client’s overall progress over time. Document changes in overall self-sufficiency as compared to status of 90 days ago (or since last assessment if less than 90 days).

50.1 Coding

Improved, deteriorated, no change.

In a typical week, during the last 30 days, indicate the number of days the client usually went out of the house or building in which client lives (no matter for how short a time period): Select one.

Improvement potential in IADL's/ADL's: Select all that apply. Select None of these if none in the list apply to the client.

Task segmentation for ADL's? for IADL's? Task segmentation provides the client with directions or cueing (verbal and/or physical) for performing each separate step in an ADL activity.

Does not easily adjust to change in routine? Does the client become agitated or confused when the daily routine is changed?
Care Plan

51 Care Plan

51.0 Intent

To display the results of the eligibility and payment methodology algorithms, based on the assessor's assessment data. The level of care for residential settings and the hours for in-home care generated by CARE will determine the maximum payment to meet the client's care plan needs. These levels will be shown on the Care Plan screen.

Clinical Categories/Level of Care is determined by: The rate and level methodology is determined by a computer algorithm that evaluates the information entered into the CARE tool using the following four criteria:

1. Cognitive performance;
2. Clinical complexity;
3. Mood/behaviors; and
4. Activities of daily living (ADL).

Cognitive performance is determined by using the cognitive performance scale (CPS) and assigning a score. The score assigns ranges from zero to six with six being very severely impaired. Examples of the data elements that determine the score are as follows:

- Short term memory
- Self-performance in eating
- Ability to make self understood
- Ability to make decisions regarding ADLs
- Comatose or in a persistent vegetative state



Clinical complexity is determined by those client characteristics that take more or less care time. Examples of the data elements that determine clinical complexity are as follows:

- Diagnoses, in combination with an ADL score
- Skin problems receiving treatment
- Skilled nursing needs
- Mood/behaviors** is determined by those symptoms that take more or less care time.

ADL score is based upon the amount of assistance the client receives to perform the ADLs.

51.1 Process

Client is eligible for: The eligibility algorithm indicates that client is **functionally** eligible for the programs in this list. Select the appropriate program. If COPEs is a choice but the client is receiving SSI (or has SSI level of income), and waiver services (PERS, HDM, etc.) are not authorized, then choose MPC.

Living situation, Recommended: Indicate the recommended setting if the current plan will not meet all of the client's needs.

Living situation, Planned: Indicate the setting chosen by the client or her/his representative.

- Residential Care Settings:** There are six payment levels within CARE for care provided in community based settings including Adult Family Homes, Assisted Living, ARC's and EARC's. The payment levels are determined by the clinical category groups as described above. The CARE tool will generate a level of care for the client. That level of care is the maximum payment that can be paid for services in any community based residential setting.
- In Home:** There are fourteen payment levels within CARE for care provided in in-home settings. The payment levels are determined by the clinical category groups as described above. There are then adjustments made to the base hours of the clinical category based on the factors described below. The hours generated by the CARE tool are the maximum number of hours that can be paid for services prior to accounting for client choice, program limits, cost effectiveness and client health and safety. Authorizations that exceed the maximum number of hours generated by the CARE tool require an approved Exception to Rule (ETR).

The in-home algorithm includes adjustments to the maximum hours of each clinical category based on the following data elements:



1. Status boxes in ADL and IADL screens. Status measures the assistance available to meet the client's needs. Assistance available is defined as:
 - Met;
 - Unmet;
 - Partially met.
 - Home and community programs (HCP) services may not replace other available resources the department identified when completing CARE. The hours will be adjusted to account for tasks that are either fully or partially met by other available resources. These resources may be unpaid or paid for by other state or community sources.
2. Environment as indicated on three IADL screens, such as whether the client:
 - Has laundry facilities out of home; and/or
 - Uses wood as sole source of heat and/or;
 - Lives greater than 45 minutes from essential services.
3. Living arrangement. The department will adjust payments to a personal care provider for household tasks (e.g., essential shopping, meal preparation, housekeeping, and wood supply) if:
 - There is more than one client living in the same household; or
 - The client and paid provider live in the same household;
 - **Classification:** This will display the grouping that this client falls into based upon Clinical complexity, Cognition, Behavior, and ADL score. An explanation of the different groupings is in the help screen. NOTE: A higher number does not necessarily mean that the client will have more hours and clients with the same grouping may have different hours because of a difference in their informal supports.

Daily rate: This is the daily rate determined by algorithm and choice of facility

Maximum in-home hours: The maximum number of hours that may be authorized for this client. When authorizing under the MPC or CHORE program, these hours may be "spent" on Individual Provider or contracted Home Care Agency hours. When authorizing under the



COPES program, these hours may be “spent” on Individual Provider hours or contracted Home Care Agency hours and Adult Day Care, Home Health Aide, or Home Delivered Meals (one meal=.5 hour).

In MPC and CHORE, the case manager and client will work together to develop a care plan authorizing personal care services within the hour allocation generated by the CARE tool. Factors that must be considered in care planning include cost effectiveness of the care plan, client health and safety and established program limits.

In COPES, the case manager and client will work together to develop a care plan authorizing as appropriate, personal care services, home delivered meals and adult day care within the hour allocation generated by the CARE tool. Factors that must be considered in care planning include eligibility for waiver services, cost effectiveness of the care plan, client health and safety and established program limits. The hours generated by the in-home algorithm are the maximum number of hours that can be authorized for any combination of personal care services, home delivered meals, adult day care and home health aide. Use the hours generated by CARE as follows, deduct:

- One hour for each hour of personal care services authorized
- One half-hour for each unit (meal) of home delivered meals authorized
- One half hour for each hour of adult day care authorized
- One hour for each unit (visit) of home health aide authorized

If the client needs services provided by COPES waiver services not listed above, these authorizations can be done outside of the maximum hours generated by the CARE tool. These services include:

- Environmental modifications
- Personal response system (PERS)
- Skilled nursing;
- Specialized medical equipment
- Training
- Transportation services

Does client have a need for NSA: (Necessary supplemental accommodation plan) Describe accommodation plan if the client has a special need (mental, neurological, physical or sensory impairment) that prevents her/him from getting program benefits in the same way that an unimpaired person would get them. E.g., Who will handle the application and eligibility process if client is not able? Should staff only communicate in writing because client has a hearing impairment? NSA description: Refer to Chapter 4 in the Long Term Care Manual for guidelines. NSA plans may include translation of materials if requested by the client.



52 Nursing Referral

52.0 Intent

If certain data elements or combination of data elements were selected in CARE, they will trigger a critical indicator, which means the assessor needs to determine whether or not a referral to nursing services is warranted. Referrals to Nursing Services are made according to the requirements of Chapter 24 of the Long Term Care Program Manual, as well as the local referral process in each HCS or AAA office.

52.1 Coding

Critical indicators: These are indicators that were triggered by the client's assessment through the selection of certain data elements. Click on a line to read the list of the data elements and values selected in the assessment that triggered this Indicator (there may be more than one indicator). Potential Critical Indicators include the following:

- Unstable/potentially unstable diagnosis
- Caregiver training required
- Medication regimen affecting plan of care
- Nutritional status affecting plan of care
- Immobility risks affecting plan of care
- Past or present skin breakdown
- Skin Observation Protocol

Note: If Skin Observation Protocol appears in this list, the client has been identified as having a high risk for skin breakdown related to pressure. Follow the procedures outlined in Chapter 24 of the Long Term Care Program Manual when a Nursing Services referral and the Protocols for Skin Observation for other actions required by the case manager. If the client appears to be at imminent risk related to skin breakdown over pressure points, refer to the protocol for suggested actions and consult with your supervisor. **Documentation in assessment is required if protocol is triggered. If client refuses observation, note on the Service Summary.**

Refer: Indicate whether a referral to Nursing Services was made for each Critical Indicator. Nursing services should not be referred if the client is already receiving nursing care or health related care. (This should be addressed in **Treatments**).

Reason: Select all that apply, indicating why a referral was made or why it was not required.

Date of referral: You must enter the date referral was made.

Skin Observation Protocol:

If Skin Observation Protocol is listed on the nursing referral screen the assessor must refer to the Skin Observation Protocols contained in Appendix A of the Assessor's Manual.

PREVENTION PLAN FOR SKIN BREAKDOWN OVER PRESSURE POINTS

Caregiver instructions will automatically print in assessment details if the skin protocol is triggered and the client falls into any of the following categories:

For Clients Who are Primarily Bedfast**Do's:**

- Look at the client's skin at least once a day for changes in color or temperature (warmth or coolness), rashes, sores, odor or pain. Pay special attention to the pressure points.
- Assist the client to change position at least every 2 hours
- Use pillows or other cushioning to:
 - Keep bony pressure points from direct contact with the bed
 - Raise the heels off the bed.
 - Keep the knees and ankles from directly touching one another.
- When the client is lying on their side, avoid placing them directly on the hipbone.
- Raise the head of the bed only as much as necessary for comfort and only as long as necessary for eating, grooming, toileting, etc. Raising the foot of the bed at the same time helps keep the client from sliding down to the bottom of the bed.
- Lift; don't drag clients unable to assist during transfers or positioning.
- Use special pressure reducing equipment when available.

Don'ts:

- Do not use donut-type devices purchased at the drug store. These cause more pressure rather than reducing pressure.

Report to the appropriate person when:

- The client you are caring for develops changes in their skin, develops swelling, or if you are unsure of how to provide care,
- If you notice that the heels turn hard and black or purple and soft, contact the case manager and health care professional immediately.

For Clients Who Are Primarily Chairfast

Do's:

- Look at the client's skin at least once a day for changes in color or temperature (warmth or coolness), rashes, sores, odor or pain. Pay special attention to the pressure points.
- Assist to change position at least every hour if unable to shift their own weight.
- Ask or help the client to shift their weight in the chair every 15 minutes for 15 seconds.
- Use cushions, pillows or other pressure reducing devices to protect pressure points from hard surfaces.
- Position the client in the chair for good posture.

Don'ts:

- Do not use donut type cushions in a chair. These cause more pressure rather than reducing the pressure.
- Report to the appropriate person:
- The client you are caring for has skin changes, develops swelling, or you are unsure of what to do.

Preventing Problems With The Skin**Do's:**

- Look at the skin at least once a day for changes in color or temperature (warmth or coolness), rashes, sores, odor or pain. Pay special attention to the pressure points.
- Use mild soap (avoid soaps labeled "antibacterial" or "antimicrobial"). Use warm (not hot) water. Rinse and dry well (pat, don't rub).
- Lubricate dry skin with moisturizing creams or ointments (such as Eucerin or Aquaphor).
- Use cushion or towel on shower chair.
- Protect bare skin during transfers.

Don'ts:

- Do not rub the skin over the bony pressure points

Report to the appropriate person:

- The client gets worse in their ability to shift weight, turn, transfer, etc.
- You feel that you could more safely and easily transfer the client with special equipment, call the Case Manager.
- There are problems or changes.



Management of Bowel and Bladder Supplies

Do's:

- Follow the toileting schedule on the service plan
- If the client is unable to control their urine or stool, use incontinence products of the client's choice and assist with changing the product as soon as it is wet or soiled.
- Gently cleanse or bathe as soon as the client needs it to keep their skin clean, and free from urine and stool.
- Use a water proof cream or protective barrier to protect the skin from wetness.

Don'ts:

- Use blue pads, they hold the moisture on the skin.

Report to the appropriate person when:

- You are not sure what incontinent products or barrier creams to use, contact the case manager for a referral to nursing services.

Eating Problems:

Do's:

- Follow the service plan for instruction on any special diet needs, or food preferences.
- If the client has lost weight, or has a change in their eating habits, ask the client about the reason for the changes.
- Offer small, frequent meals to the client if their appetite is poor. If their diet allows, encourage the client to eat foods high in protein (milk, eggs, meat, cheese, etc.)
- Contact the appropriate person when the client has a major change involving weight gain or loss, appetite changes, or new/worsening swelling.



53.0 Intent

To assign a provider to each need identified in the assessment. Met needs will be assigned to an unpaid caregiver (taken from the collateral contact screen). Partially met needs will be assigned both an unpaid and paid caregiver, and unmet needs will be assigned to paid caregivers. Identify a schedule for each provider.

53.1 Coding

1. Select the provider type that will meet each need.
 - Paid provider:** Enter the provider number or the provider's name and city and click on Search. Highlight the provider's name in the provider list and click on OK. The name will appear in the Provider list on the **Support** screen.
 - Resource:** Select county and/or type of resource. Resources will appear below in the Resource list; click on Details for more information. Highlight selection and click OK to add to provider list on **Support** screen.
 - Contacts:** Select the name of person or organization that will meet need. Click OK to add name to provider list on **Support** screen.
2. Select the needs to be assigned to each provider. ADLs and IADLs will be labeled with the following:
 - U:** The need is unmet and at least one paid provider will need to be assigned.
 - P:** The need is partially met and at least one paid and one unpaid (Resource or Contact) will need to be assigned.
 - M:** The need is met by a Resource or Contact (not paid by ADSA).
3. Provider's schedule: A provider schedule must be entered for each paid and unpaid provider. Time of day is not required unless client has multiple providers and coverage is not clear.



54 Environment Plan

54.0 Intent

Use this screen to identify who will address environment concerns. Also include the date when the concern(s) will be addressed. After a concern has been addressed, document in the comment box.

55 Equipment

55.0 Intent

Use this screen to identify how equipment identified in the assessment as needed and wanted will be addressed. Indicate who is responsible and date when equipment should or will be acquired. After equipment has been acquired, document in the comment box.

56 Referrals

56.0 Intent

To search for appropriate resources to address needs identified in the assessment and to document the referral.

56.1 Process

Does client refuse non-mandatory case management services? Describe which service client refuses in comment box.

Mandatory case management services:

- Reassessment or reauthorization of services when eligible
- Review of service plan with the individual provider
- Verification that services are being provided in accordance with the plan of care

Examples of non-mandatory case management services:

- Client advocacy
- Technical assistance

- Consultation with others
- Assistance with IP or self-directed care issues
- Networking
- Family support
- Crisis intervention



57 Appendix A: Skin Observation Protocols

| TOPIC | PAGE |
|---|------|
| ASSUMPTIONS | b |
| OBSERVATION NOT REQUIRED | c |
| 1) Client does not meet highest risk indicators | c |
| 2) Client has skin problem over pressure points present and care is being done by a non-professional. | c |
| 3) Client reports that they have a pressure ulcer and <ul style="list-style-type: none"> ○ There is an appropriate treatment plan in place and ○ Client’s skin has been seen by the health care professional responsible for treatment within the last 7 days | c |
| 4) Client is cognitively intact and <ul style="list-style-type: none"> ○ Meets the highest risk indicators ○ Declines skin observation and ○ CM doesn’t know if there is a problem | c |
| OBSERVATION REQUIRED | d |
| Client meets the highest risk indicators | d |
| THE SKIN OBSERVATION MAY BE DELAYED IF: | d |
| 1) The situation is unsafe... | d |
| 2) Unable to visualize skin because..... | d |
| 3) Client is cognitively intact and <ul style="list-style-type: none"> ○ Declines observation of skin over pressure points and ○ There is evidence of negative skin outcome... | e |
| 4) Client is cognitively impaired and refuses once | e |
| 5) Client is cognitively impaired and consistently refuses | e |
| 6) Client meets highest risk indicators but observation not completed due to culture or gender | f |
| HIGHEST RISK INDICATORS OF SKIN BREAKDOWN OVER PRESSURE POINTS | g |



Assumptions: The protocols are based on the following assumptions.

1. It is our responsibility to assess the client's care needs which include health care issues. Addressing identified issues in the client's service plan is integral to a comprehensive plan of care. The definition below is offered here because it incorporates many of the functions of caregivers in support of clients. It is not intended to be a definition of case management.
 - Health Insurance Portability and Accountability Act (HIPAA) definition of health care: "Health care" means care, services or supplies related to the health of an individual, including, but not limited to: preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affect the structure or function of the body; and sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription."
2. Skin observations do not need to be done for every client. It is estimated that the protocols will apply to 7-10% of the caseload, those clients whose assessments are positive for the highest risk indicators. The number of clients who require direct observation will be reduced further by those clients who already have an appropriate plan in place.
3. HCS Nurses and AAA Nurses will perform assessment functions, including skin observation.
4. Assessing the skin has always been an expectation of case managers as part of a comprehensive assessment, but we largely relied on self-reporting and protocols were not in place.
5. There are many indicators that place a person at risk for skin breakdown over pressure points. Out of these the indicators that place a person at highest risk will trigger the protocols for skin observation.
6. Case Managers are expected to gather indicator information, identify, document and make appropriate referrals according to protocols.
7. It is expected that there will be a reasonable effort to schedule the home visit when there will be a third party present. However, if the assessment triggers the skin observation protocol, the HCS Nurse or AAA Nursing Services is expected to complete the observation if the protocol indicates the need.
8. HCS Social Workers and Aging Network Case Managers will not continue authorization of services and payment, but will attempt to offer alternatives, when services cannot be delivered according to the plan of care or services are not being adequately delivered due to caregiver issues or client choice.
9. It is recognized that even with a good service plan in place, the potential for a negative outcome exists. The protocol provides policy direction for definition of case management practice related to skin observation over pressure points.
10. Nursing services will be used by HCS/DDD Social Workers and AAA/ Case Managers according to the AAA Nursing Services Plan.



11. Training is an important component in decreasing the risk of skin breakdown over pressure points for our clients. This includes training for caregivers and case managers as well as educational materials for clients and their families.

Skin Observation Protocols

Observation Not Required

- 1) Client does not meet highest risk indicators
 - (a) **Document** all activities
- 2) Client has skin problem over pressure points and a non-professional is doing care.
 - i) When possible, on the same day, the HCS/AAA Nurse will:
 - (a) **Review** the treatment being done with the caregiver and the client.
 - (b) **Document** what is being done and who authorized treatment.
 - (c) **Verify** by asking the caregiver that he/she is checking all pressure points.
 - (d) **Distribute** educational materials about pressure points to caregiver and client (pictures or text).
 - (e) **Revise** service plan as needed.
 - (f) **Document** all activities
- 3) Client reports that they have a pressure ulcer
 - i) HCS/DDD Social Worker/Nurse or the AAA Case Manager or Nurse **verifies**:
 - (a) There is a treatment plan in place
 - (b) Client's skin has been seen by the Health Care Professional (HCP) responsible for treatment according to timeframes recommended in the treatment plan or within the last 7 days.
 - ii) HCS/DDD Social Worker/Nurse or the AAA Case Manager or Nurse **communicates** with the HCP, as soon as possible, but not to exceed 5 working days, to:
 - (a) **Verify** that all pressure points are being checked and discuss response to treatment.
 - (b) **Request** to be notified when client is discharged from care for pressure ulcers. At that time, the HCS/DDD Social Worker/Nurse or the AAA Case Manager consults with nursing services.
 - (c) **Document** all activities.
- 4) Client is cognitively intact and:
 - o Meets the highest risk indicators and
 - o Declines observation of skin over pressure points and
 - o HCS/DDD Social Worker/Nurse or the AAA Case Manager does not know if there is a problem
 - iii) **Probe** for reasons client doesn't want skin observed
 - iv) **Suggest** appropriate alternatives (such as asking if the client has checked their pressure points themselves or if the caregiver is reliable, have they checked)
 - v) **Document** and
 - vi) **Refer** to HCS/AAA nurse or nursing services for follow up or
 - vii) **Contact** client's primary care provider as soon as possible, discuss skin concerns and document or **Advise** the client of skin care issues, educate and document and **Do not complete** skin observation, ask the client to sign a refusal form,
 - viii) **Document** and discuss with supervisor.

Observation required

Client meets highest risk indicators:

Client will be referred to HCS/AAA Nurse to complete the observation.

Steps to complete the observation

- i) Arrange to have a third party present if you know in advance that there is a likelihood that you will need to observe the client's skin. Involve the client in determining who this third party should be when possible.
- ii) Explain what is involved in the skin observation to the client and ask permission.
- iii) Tell the client where the pressure points are
- iv) Look at the back of the head, both ears, shoulder blades, elbows, insides of the knees, "seat" bones, tailbone area, hips, sides of ankles and both heels.
- v) Help or have the caregiver help if the client needs to undress partially. Be sure that there is privacy for the client and the client remains covered except for the area being observed.
- vi) Observe for specific conditions - skin intact, persistent redness, abrasion, blister, shallow crater, deep crater, etc. as directed on the CA using section 13a-d as a guide.
- vii) If no skin problem is observed, document and revise service plan to include a prevention plan.
- viii) If a skin problem is observed:
 - (1) Determine if there are any health professionals involved with treatment of the client's skin problem or if any health professionals are aware of the problem.
 - (2) Contact any health professionals involved with treatment of the client's skin problem, within 2 working days, or
 - (3) Contact family rep if no health professionals involved or client is refusing treatment or HCP is not treating.
 - (4) Document all steps taken in the service episode record or progress note.

The skin observation may be delayed if the client meets the highest risk indicators and:

- 1) The situation is unsafe and the personal safety of the HCS CNC or AAA Nurse may be at risk because of threatening animals, sexually inappropriate behavior or threatening behaviors.
Or
- 2) Unable to observe skin because of soiling or unhygienic conditions and no caregiver present to assist or the client's physical condition makes it physically very difficult to observe skin (immobile, needs transfer or positioning assistance, client is in pain) or client refuses to allow observation, has an unreliable provider and won't let anyone else in, and /or refuses services related to skin integrity over pressure points.
 - i) Anticipate these barriers as much as possible and make arrangements prior to the visit to have a caregiver, assistant, or family member present to help client.



- ii) **Discuss** other resources and approaches with supervisor within one working day and follow usual CM response times. Utilize collateral contacts for information and assistance.
 - iii) **Reschedule** observation within 2 working days.
 - iv) **Follow** usual CM timeframes per LTC Manual
 - v) **Refer** to APS if abuse, neglect or self neglect is suspected
 - vi) **Document** all of your activities including any arrangement you have made, discussions you have had or referrals you have made.
- 3) Client is cognitively intact
- o Declines skin observation over pressure points and
 - o There is evidence of negative skin outcome (foul odor, staining on clothing over pressure points or other visible sign).
 - i) **Call 911**, if emergency,
 - ii) **Identify** someone else to observe- for instance- the caregiver, a family member or person that client feels comfortable with-
 - iii) **Refer to** home health nurse or primary care provider within 2 working days.
 - iv) **Verify** and document that observation was done.
 - v) **Collect** collateral info re: skin problems over pressure points from health care providers, caregiver, family or other involved parties.
 - vi) **Educate** caregiver by going over section of the service plan that describes skin care over pressure points. - 5 working days.
 - vii) **Refer** to APS or CRU as appropriate if negative skin outcome is believed to be the result of abuse or neglect, make referral same day as visit
 - viii) **Refer immediately** to Nurse or Nursing Services for visit as soon as possible, if HCS/DDD Social Worker or AAA Case Manager is not a nurse.
 - ix) **Explore** other appropriate services such as residential placement, different caregiver, community clinic, other community-based resources (discuss with supervisor).
 - x) **Discuss** with all involved parties' and come to consensus about concrete criteria about when or whether to terminate services.
 - xi) **Document** all activities
 - xii) **Incorporate** recommendations of "Challenging Clients Workgroup" as appropriate. Client may be kept open to CM services, may use a PERS unit and may be referred to CDMHP or the "A" team. Activities such as daily welfare checks by CM, family or other community members such as police, EMTs, mail carriers or other identified gatekeepers.
- 4) Client is cognitively impaired and,
- o Meets the highest risk indicators and
 - o Declines skin observation once or mildly objects to the observation
 - i) **Request** permission a second time using good interview and assessment techniques,
 - ii) **Be sure** that the client understands as much as possible what you are requesting.
 - iii) **Document** all activities
- 5) Client is cognitively impaired and
- o Meets highest risk indicators,
 - o Consistently refuses, and
 - o Skin condition over pressure points is unknown.
 - o Has an unreliable provider and won't let anyone else in, and /or

- Refuses services related to skin integrity over pressure points.
 - i) **Immediately refer** for guardianship with AAG involvement.
 - ii) **Refer** to and consult with other services
 - (a) Offer alternative services or;
 - (b) Offer a different provider or;
 - (c) Residential placement or;
 - (d) Change in way services are delivered and;
 - iii) **Probe** to understand basis of refusal and
 - iv) **Refer** to APS if there are allegations of abuse, neglect or self-neglect.
 - v) **Will incorporate** recommendations of "Challenging Client's" Workgroup
 - vi) **Refer** to 911, ER or possible IDT, or MHPs, if appropriate.
 - vii) **Document** all activities
- 6) Client meets highest risk indicators but observation not completed due to culture or gender
 - i) **Consult** with supervisor as soon as possible to find a reasonable solution. A reasonable solution is defined as timely, respecting of personal and professional boundaries, and has an end result that someone observes client's skin and documents what was done for client or
 - ii) **Document** all activities.

Highest Risk Indicators for Skin Breakdown over Pressure Points

Stand Alone Items

- Current Pressure Ulcer
- Quadriplegia
- Paraplegia
- Total Dependence in Bed Mobility
- Comatose or Persistent Vegetative State
- History of pressure ulcer within one year

Combination of Elements

1. Bedfast and/or chairfast, and cognition problems.
2. Bedfast and/or chairfast, and incontinent of bladder or bowel.
3. Hemiplegia, and cognition problems, and incontinent of bladder or bowel.
4. Bedfast and /or chairfast, and Insulin Dependent Diabetes Mellitus (IDDM)

Bladder incontinence is defined as multiple daily episodes of the individual being wet, even with the use of appliances or programs used to manage this.

Bowel incontinence is defined as inadequate control all or almost all of the time, even with the use of appliances or programs to manage this.

Note: Cognitive impairment is defined by a score of 3 or higher on the Cognitive Performance Scale.

