

# PLANNING THE CLIENT ASSESSMENT PROTOCOLS (CAPS)

## SOME SAMPLE APPROACHES

*The following are sample approaches that can be used in planning CAPs. Most are taken from the RAI-Home Care (RAI-HC) Assessment Manual. Support Coordinators should refer to this manual when preparing the POC and planning for triggered CAPs.*

### 1. Adherence

- Impaired Cognition (Refer to Cognitive CAP) – provide reminders or obtain physician delegation for administration as applicable for the client.
- Provide assistance to client with functional limitations as needed (e.g. hold cup or straw, consult with physician for crushable meds, etc.).
- If psycho-social distress is involved and client does not have resources to pay for medications, assist with applying for aide with pharmaceuticals to provide.
- Medications at a reduced cost refer to St. Vincent DePaul, etc.
- If the client has experienced sensory loss, provide assistance as needed by securing physician.

### 2. Alcohol Abuse

- Advise client of possible adverse reactions with medications such as reduced alertness, confusion, dementia-like symptoms, impaired judgment.
- Counsel client that buying alcohol but going without prescribed medications is detrimental to their health and such poor decisions is detrimental to their health and welfare.
- Report all falls and/or injury associated with alcohol use.
- Refer to counseling for AA group.
- If the client in denial that alcohol abuse problem exists a signed declaration of being informed of risks may be necessary.

### 3. Behavior

- Request physician to address health conditions that contribute to behavioral problems.
- If the client is not able to communicate their need, staff should be in tune to body language and facial expressions to be able to detect discomfort (Refer to Communication CAP).
- Environmental factors will be assessed to determine the association of lighting, room arrangements, etc. on behavior pattern.
- Psychosocial factors regarding family dynamics will be monitored (refer to Brittle Supports CAP).
- Safety precautions will be put into place for the client who wanders (Moves without rational purpose, seemingly oblivious to needs or safety) (e.g. monitor, alarm, etc.).
- Family will assure the client who wanders will have coverage for gaps in time when paid supports are not present.
- Clients will be gently redirected when exhibiting verbally abusive behavioral symptoms (e.g., threatens or screams at others) , physically abusive behavioral symptoms (e.g., hits, shoves, scratches) or Socially Inappropriate/Disruptive Behavioral symptoms (e.g., makes disruptive sounds, noises, screams) (Refer to Cognitive CAP).

- Encouragement will be provided to clients who resist taking medications/injections, ADL assistance, eating, or changes in position (related to cognitive issues, and not due to right to refuse care).

#### **4. Bowel Management**

- Report to home care professional the participant who experiences pain or discomfort in rectal area, diarrhea, constipation or fecal impaction.
- Encourage diet with roughage.
- Drink plenty of liquids.
- Stool softeners as prescribed by physician.

#### **5. Brittle Support**

- Report warning signs that are present to supervisor of agency.
- Encourage client to participate in IADLs to the extent capable.
- Provide family and natural care takers with resources to receive emotional support.
- Encourage participant/family to utilize respite services, ADHC services, and other resources available for their recoupment of strength and energy.

#### **6. Cardio/Respiratory**

- Report to home care professional client complaints of Irregular pulse, cough, sputum production, wheezing , chest pain , dizziness, light-headedness, blackout spells, swelling of ankles and legs, palpitations.
- Encourage client to avoid over exertion to reduce incidence of shortness of breath.
- Request home care professional to check client's blood pressure when symptoms above are reported.
- Encourage client to quit smoking.

#### **7. Cognition**

- Provide opportunities for client to reminiscence, work word puzzles, watch TV game shows which prompt recognition, etc.
- Allow the client the opportunity to make simple, every day decisions such as which clothing to wear, what to drink at mealtime, etc.
- Encourage and assist the client to participate in tasks that involve simple 2-3 step procedures:
  - No problems with Daily Decision Making
  - Problems with Daily Decision Making
- When faced with new tasks or situations gently guide the client in making sound decisions that could affect health and welfare.
- Reminding or cue the client even with familiar routine tasks when needed.
- Provide emotional support and referral sources to family members to learn coping skills for dealing with a cognitively impaired loved one.

#### **8. Communication Disorder**

- If the client can fully communicate with no impairment or only minor impairment (e.g. slow speech) encourage client to take their time and not rush.
- If the client can fully communicate with use of assistive devices (e.g. communication board) assure the board is on hand when needed.
- If the client has expressive difficulty (forming words, combining sounds, producing speech) allow time for expression but don't allow frustration to build without assisting to finish thoughts.

- If the client depends on others to communicate needs , staff should anticipate needs.
- Provide opportunities to practice communication skills (physical environment limits the ability, social environment limits ability because of elder being excluded from conversation.
- If the client has problems understanding others (e.g. gets confused easily, does not process information well, etc.) speak slowly and watch client's body language and facial expression.

## **9. Dehydration**

- Assure the client has easy access to fluids unless fluid restricted.
- Be aware of medications the client receives which may cause loss of appetite, nausea, or diuresis.
- If client is on fluid restriction, keep a log of fluid intake.
- Report to home care professional the presence of vomiting and/or diarrhea.
- Thicken liquids for client who has difficulty swallowing.
- Encourage the client who is incapable of making decision to ingest fluids to drink.
- Use communication techniques that are effective for the client with communication problems for cueing to drink liquids.
- Assist the client with coordination problems to hold glass, straw or cup.

## **10. Depression and Anxiety**

- Report to home care professional symptoms associated with depression (loss of appetite, insomnia, decreased appetite or weight loss, feelings of guilt or worthlessness, fatigue, inability to concentrate, psychomotor agitation, loss of interest in activities, suicidal thoughts.
- Report to home care professional symptoms associated with anxiety (restless, fatigued, lack of concentration, irritable, muscle tension, sleep disturbance.
- Request physician to review client's drug regimen for medications that may produce symptoms of depression or anxiety.
- Refer to Cognitive CAP for approaches.

## **11. Elder Abuse**

- Refer to Cognitive CAP.
- Refer to ADL CAP.
- Refer to Brittle Supports CAP.
- Refer to EPS/APS when client is suspected of abuse/neglect/exploitation.
- Refer Caregiver with impaired psychological status (substance/alcohol abuse or MI) to counseling sources Provide information to caregivers of support groups such as Alzheimer's Association.

## **12. Environmental**

- Assist with finding resources to assist with cost of heating/cooling repairs.
- Replace burned out light bulbs in fixtures.
- Remove flooring/carpeting that may be a trip hazard.
- Secure railings and grab bars.
- Use carbon monoxide detectors when gas stoves or heat is used.
- Have fire extinguishers checked annually to assure fire prevention.
- Be sure hot water temperature is less than 130 degrees to prevent burns.
- Arrange furniture to prevent clutter and reduce risks of falls and injury.

- Assist with contacting resources for general home repairs.
- Provide client with neighborhood safety phone numbers.
- Client wears an emergency pendant.

### **13. Falls**

- Implement preventive approaches by arranging furniture so floors are not cluttered.
- Wear skid resistant foot wear.
- Change burned out bulbs in fixtures.
- Clean up spills immediately.
- Have frequently used items within easy reach.
- Remind client as needed to use assistive devices when ambulating.
- Place cognitively impaired client in a low bed with fall pad on floor. (NEVER use side rails to prevent falls.)

### **14. Health Promotion**

- Client will be encouraged to reduce smoking or consult with physician for smoking cessation aides.
- If client continues to smoke, recommend techniques to reduce the number of cigarettes smoked during the day such as not smoking in the house; chew gum or have hard candy on hand, etc.
- Conserve energy to reduce incidences of shortness of breath by performing tasks in segments.

### **15. Institutional Risk**

- Cognitive CAP
- Incontinence
- Falls
- ADLs
- IADLs
- Brittle Supports
- Behavior
- Depression/Anxiety
- Nutrition
- Dehydration
- Elder Abuse

### **16. Medication Management**

- Physician will be contacted to perform a total drug regimen review to avoid duplication, possible drug interactions, and side effects.
- Implement supportive and preventive measures to reduce the risk of injury for suspected symptoms of drug interactions or side effects.
- Report to physician conditions that exist which may be symptoms of adverse drug reactions (confusion, falls, depression, incontinence, constipation, restless, EPS syndrome, memory loss, dry mouth, nausea, dizziness, rashes/itching/bruising, diarrhea, tiredness).

### **17. Nutrition**

- Refer client to physician for disease and/or polypharmacy which may be contributing to poor nutritional status.
- Follow client's wishes for palliative care when at end of life phase of disease or illness.

- Refer to CAPS for ADL/IADL, Cognition, Oral Health, Brittle Supports and Bowel Management when there is a functional decline which affects nutritional status.
- Provide supportive measures for symptoms of Depression which may include depression/anxiety, social dysfunction, loneliness, isolation, bereavement, and alcohol abuse.
- Contact food banks and other resources when client is in need of food and lack of financial resources.
- Tube feeding
- Client will be monitored during meals to avoid choking (needs reminding to chew well, take small bites, etc.).
- Problems with teeth or gums that hampers eating (Refer to Oral Health CAP).
- Special diet or dietary restrictions (e.g., Diabetic Diet, No/Low Salt, No/Low Sugar, Low Fat/Cholesterol, Thickened Liquids to prevent choking) no nuts (allergy).

### **18. Oral Health**

- Assist client in receiving dental care when caries are present, experiencing oral pain, have fractured teeth, bleeding gums, dentures with poor fit, or in need of dentures.
- Assist client with oral hygiene as needed.
- instruct client to swish with warm salt water if gums bleed.
- Assist client in receiving services from a dental hygienist as needed.
- Enhance client's sense of taste or smell with use of aromatic fresheners.
- Refer to Nutrition CAP.

### **19. Pain**

- Respond to client's complaints of break-through pain after pain medication has been taken by providing therapeutic measures to reduce discomfort.
- Encourage the client take pain medication as prescribed.
- Physician will be contacted for medication review if pain increases.
- Therapeutic measures implemented:
  - Ice pack
  - Warm compress
  - Repositioning
  - Back Rub for relaxation

### **20. Palliative Care**

- Pain CAP triggered
- Nutrition CAP triggered
- Brittle Supports CAP triggered
- Medication CAP triggered
- Dehydration CAP triggered

### **21. Pressure Ulcers**

- Refer to the following CAPS:
  - ADLs
  - Bowel Management
  - Nutrition
  - Urinary Incontinence

- Relieve pressure over bony prominences by repositioning or boosting client at least every 2 hours.
- Avoid friction and shearing forces.
- Avoid maceration of skin from moisture by changing incontinent pads immediately upon soiling.
- Apply moisture barrier to skin.
- Identify risk factors that predispose client to development of pressure ulcers: (Peripheral vascular disease, edema, diabetes, impaired tactile perception, medications, impaired cognition, anemia, low body weight, smoking).
- Notify health care professional when persistent redness is present.

## 22. Preventative Health

- Did the participant receive the following procedures according to recommendations of CDC?
  - Influenza vaccination
  - Pneumonia vaccination
  - Colo-rectal screening
  - Mammogram (if female)
  - Prostate exam (if male)
  - Osteoporosis screening
  - Blood Pressure measurement
  - TB skin test

## 23. Psychotropic Drugs

- **Strategy #1:** Refer to CAPS:
  - Cognitive for confusion & delusions
  - Incontinence
  - Behavior ADLs for locomotion
  - Falls for unsteady gait & falls
- **Strategy #2:**
  - Provide primary clinician with information concerning all medications currently prescribed, over the counter medications being taken, and concerns of the participant and family.
  - Keeping the participant as safe as possible when medically unstable by implementing fall precautions.
  - Redirect client when exhibiting inappropriate behavior.
  - Related CAPS to refer.

## 24. Reduction of Formal Services

- There is a potential for greater independence.
- Living conditions have changed. Assistance will be provided to enable client to cope with new surroundings.
- Client continues to require assistance in order to maintain current functional ability (see ADL and IADL Sections).

## 25. Skin and Foot Conditions

- Notify health care professional of a newly identified or change of appearance in a firm round/oval lesion present with border of papules.
- Provide good hygiene to prevent itching, dry, scaly skin.

- If client has complaints of foot pain examine their shoes to be sure they fit properly and are in good repair; report continued complaints to health care professional.
- Report Inflammatory conditions to health care professional.

## **26. Social Function**

- Provide Solitary Activities
- Provide activities with Groups/Clubs
- Provide Religious Activities
- Encourage Visiting with friends and family
- Watching Television (Programs of choice)

## **27. Urinary Incontinence and Indwelling Catheter**

- Wear pads or briefs to protect clothing against poor bladder control with sneezing or coughing.
- Remind client with poor cognition of the need to void or where to find toilet.
- Assist client who is unable to be mobile to reach toileting facilities.
- Report to physician symptoms of urinary tract infection (fever, confusion, burning at urethra, etc.).
- Depression (Refer to Depression CAP)
- Implement a prompted toileting program.
- Notify physician of other serious conditions identified.

## **28. Visual Function**

- Annual vision exam will be scheduled.
- Assure physician has reviewed medications that might cause visual difficulties (see CAP Medication Management).
- Report presence of redness of eyes, eye drainage, or complaints of eye pain to health care professional.
- Explore the need for adaptive devices to improve independence (e.g. talking scale, eye drop guide, syringe loader, pill organizer).
- Identify diseases present which might affect vision such as Diabetes.
- Provide adequate lighting.
- Encourage Adherence.

## **29. ADL**

- **Strategy 1:**
  - Request physician to address health complications that affect the client's ADLs performance.
  - Request physician approval for in-home physical/occupational/speech therapy when acute problem stabilizes.
  - Provide emotional support during recuperative period as needed.
  - Provide assistance with ADLs according to the needs of the MDS-HC assessment.
- **Strategy 2:**
  - Be supportive of client's efforts to attain greater self-sufficiency.
  - Encourage self-sufficiency to the extent of physical limitations without compromising physical or emotional state.
  - Adhere to prescribed therapy regimen.
  - Provide assistance with ADLs according to the needs of the MDS-HC assessment.

- **Strategy 3:**
  - Provide ADL assistance according to the needs of the MDS-HC assessment.
  - Allow the client to participate to the extent possible.
  - Employ safety measures to avoid the risk of injury during the performance of ADLs.

### 30. IADL

- **Strategy 1:**
  - Consult with physician concerning mental and health conditions which affect the client's ability to perform IADL tasks.
  - Provide assistance as needed in performance of IADL tasks.
  - Encourage client participation to the extent possible without inducing anxiety or exertion.
- **Strategy 2:**
  - Assist client as needed in performance of IADLs.
  - Break tasks down into simple subtasks to allow client to participate to the extent possible.
- **Strategy 3:**
  - Assist client as needed in performance of IADLs.
  - Break tasks down into simple subtasks to allow client to participate to the extent possible.
  - Enter phone number for client when making calls.
  - Perform grocery shopping for client according to client needs.
  - Perform meal preparation according to client needs.
  - Perform housework according to client needs.
  - Medication management according to client needs.
  - Perform financial management according to client needs (i.e. balance checkbook, file receipts, etc.).