LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Clinical Assessment Protocols (CAPs) Summary Instructions

<table>
<tr><td>CAP Triggered</td><td><u>Identifying CAPs</u>- Indicate X, O, A, or N on the line next to the CAPs that triggered, CAPs that are important to the participant and he/she wishes to address, as well as CAPs that are concerns to the assessor and/or family (e.g., if there is a concern about the environment).
Example:

_X_ ADL ___ Elder Abuse _N_ Environmental Assessment _X_ IADL ___ Institutional Risk

X = CAP triggered and will be care planned on the issue category page.
O = CAP triggered and will be moved to a different issue category page.
A = CAP triggered but the participant does not want to plan for the issue.
N = CAP did NOT trigger, but will be care planned for.</td></tr>
<tr><td>Related CAPs:</td><td>Type in the name of the CAP(s) from another issue category that was indicated above with an ‘O’ and will be care planned with a related CAP. Address the goals and interventions for the related CAPs on the same CAP Summary page instead of having the same information repeated on multiple pages.</td></tr>
<tr><td>CAPs Goals:</td><td>Identify the name of the CAP(s) in bold that the goal is addressing for both short term and long term goals. There must be a short or long term, for each addressed CAP. It is acceptable to have a short and long term goal for a CAP.

<u>Short term goals</u> – can be resolved within 3 months.

Note: It is acceptable to include the intervention (i.e., who, what, when, where) within the short term goal section or in the intervention section.

Example: Environmental- Son will repair steps at front door.

<u>Long term goals</u> – address ongoing issues for the plan of care year that cannot be resolved in 3 months or less.

When creating long term goals, the assessor may include triggering language such as “prevent”, “monitor”, and/or “improve” but goals are not limited to these terms. Avoid using only the triggering language (Incorrect: Falls - Prevent Decline; Correct: Falls – Reduce fall risk)

Example: Pressure Ulcers/Bowel Management – Maintain skin integrity.</td></tr>
<tr><td>Interventions:</td><td>There must be an intervention(s) for every goal.

<u>How to begin writing interventions:</u>
1. Review the CAP objective, <u>AND</u>
2. Review each item that caused the CAP to trigger.

Assessor will need to use professional judgment to determine if the intervention needs to be written for each item that triggered a particular CAP OR the overall objective only.

<u>Item specific Example:</u>
Cardio-Respiratory CAP: The Cardio-Respiratory CAP was triggered for Mrs. Sedan because she experienced shortness of breath. The goal and intervention would specifically address shortness of breath.

<u>Objective Example:</u>
Psychotropic Drug CAP: The Psychotropic Drug CAP triggered for Mrs. Cadillac because she currently takes an antidepressant and has potential side effects present. The objective of this CAP is to identify those taking psychotropic medications that may be causing possible or problematic side effects. The assessor should consider the the items that triggered the CAP may be possible negative side effects of the medication and write an intervention suggesting medication review by physician and monitoring of side effects instead of addressing the individual side effects that may have triggered this CAP.</td></tr>
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	<u>Additional information to include in Intervention Section</u>: • Interventions that address any chronic problems and reoccurring trends discovered by reviewing last year's critical incident reports (CIRs) and all support coordination documentation (SCD). Address the working approaches in the appropriate CAP/goal/intervention. <u>*Example:*</u> In the past year, a participant had several falls. The CIR fall assessment and analysis shows that implementing staff to assist in transferring, having hand rails installed in the bathroom and wearing gripper socks at night. The assessor would address the **Fall** CAP by incorporating the interventions that are working for the participant. • Information indicating how medications are administered and who administers medications should be included in the appropriate CAP. <u>*Example*</u>: **IADL:** Mr. Truck's Home Health nurse will fill pill box weekly and Mr.Truck will self- administer medications. • Information indicating the management of health-related tasks (e.g. catheterization, tube feeding, tracheotomy suctioning, etc.) should be included. <u>*Example:*</u> **Urinary Incontinence**: Mr. Car's daughter Honda has been trained and manages the catheter. • ADL/IADL tasks should include concise person specific/person centered information that details the participant's requests and allows for flexibility and the varying nature of a participant's condition. <u>*Example*</u>: **ADL**: Mr. Car's family will assist with bathing, dressing, and toileting when available. Mr. Car prefers to take a shower before breakfast every day except Saturdays. On Saturdays, his son Ford assist him with taking a tub bath. • Assess and include non-waiver/informal resources that are needed and identify them within the appropriate CAP section, if applicable. • **"A - Participant does not want to address":** Assessor(s) will need to evaluate the risk to health and welfare of the participant and address the risk accordingly. If the assessor determines that the concern would not be a risk to health and welfare no further documentation in the CAP is needed. If the assessor determines that the health and welfare is at risk the CAP can be marked "A" but must be care planned for. <u>*Example*</u>: Ms. Corvette does not want to plan for falls; however, she has an unsteady gait and history of falls. The assessor will complete a goal and intervention for falls to address the health and welfare. (e.g., Family will encourage Ms. Corvette to use her walker when ambulating to avoid falls.)
Interventions for family and informal supports:	Interventions will address activities performed by unpaid individuals and needs to include who, what, when and where. Person Centered Planning (PCP) concepts must be incorporated when appropriate. CAPs that identify risks (actual or potential) and CAPs important to the individual should include specific information in the interventions to decrease the risks for the individual.
Interventions needed for formal services:	Formal intervetions will address activities performed by paid individuals and agencies. The interventions will include the same content as the informal interventions instructions above. Interventions that are specific to formal supports should be addressed in the appropriate section. Interventions that are addressed exactly the same for both formal and informal supports **<u>do not</u>** have to be repeated. The assessor can refer to the Family/Informal supports section by including a general statement, such as, "Staff will assist as described above when family is unavailable." **Note:** When using a general statement, assesors must make sure that the informal interventions do not include non-delegable tasks (e.g., Administration of oxygen).