MRS. M PPS-SIGNIFICANT CHANGE CAA DOCUMENTATION

CAA Summary Note: #1 Delirium
Date: 12/30/10
MDS items: #1 Delirium

Triggers: BIM score declined from 13-14 to 11

1. DELIRIUM: REVIEW of INDICATORS OF DELIRIUM		
Mark if Area Triggered	**Change in Vital Signs**	**Supporting Documentation: (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
x	Rectal temp above 100^0F or below 95^0F (38^0C/ 35^0C)	Has been running a low grade temperature every afternoon
x	Pulse rate <60 or >100 beats/ min	Irregular Grade III systolic murmur
	Respiratory rate >25 breaths/minute or < 16 breaths/minute	
	Hypotension or a significant decrease in blood pressure	
	Systolic b/p < 90mmHg OR	
	Decline of 20 mmHg or greater in systolic b/p from person's usual baseline OR	
	Decline of 10 mmHg or greater in diastolic b/p from person's usual baseline OR	
	Hypertension – systolic b/p above 160 mmHg OR a diastolic b/p above 95 mmHg.	
	Abnormal Laboratory Values	
	Electrolytes, such as sodium	
	Kidney function	
	Liver function	
	Blood sugar	
	Thyroid function	
	Arterial blood gases	
	Other	Anemic
	Pain	
	Pain Care Area triggered (review findings for relationship to delirium	Yes was triggered
x	Pain frequency, intensity, and characteristics (time of onset, duration, quality) indicate possible relationship to delirium	Defines pain as 7 out of 10. Has impacted ability to participate in therapy.
	Adverse effect of pain on function may be related to delirium	
	Diseases and Conditions	
	Circulatory/Heart: anemia, cardiac dysrhythmias, angina, MI, ASHD, CHF, pulmonary edema, CVA, TIA	History of CHF and a CVA. Irregular pulse and a systolic heart murmur, MI, ASHD

	Respiratory: asthma, emphysema, COPD, shortness of breath,	SOB if lies flat
	Infectious: Infections, wound infection other than foot or lower extremity, Isolation - active	Recent hospital stay with foley catheter that has now been removed
	Metabolic: diabetes, thyroid, hyponatremia	On thyroid replacement
	Gastrointestinal bleed	DX GI Bleed and Ulcer
	Renal disease, dialysis	
	Hospice Care	
	Cancer	
	Dehydration	
	Signs of Infection (from observation, clinical record	
	Fever	Daily afternoon elevated temperatures
	Cloudy or foul smelling urine	
	Congested lungs or cough	SOB if lies flat
	Dyspnea	
	Diarrhea	
	Abdominal pain	
	Purulent wound drainage	
	Erythema around an incision	
	Indicators of Dehydration	
	Dehydration care area triggered, indicating s/s of dehydration are present	No S/S but did have IV fluids in hospital for hydration after surgery
	Recent decrease in urine volume or more concentrated urine than usual	
	Recent decrease in eating habits – skipping meals or leaving food uneaten, weight loss	Decrease appetite with recent weight loss
	Nausea, vomiting, diarrhea or blood loss	History of GI Bleed. Recent blood transfusion post surgery.
	Receiving IV meds	
	Receiving diuretics or drugs that may cause electrolyte imbalance	Bumex daily
	Functional Status	
	Recent decline in ADL status	Requires more assist since hip fx
	Increased risk for falls	Fell causing fx hip
	Medications (that may contribute to delirium)	
	New med or dosage increase	
	Drugs w/anticholinergic properties (antipsychotics, antidepressants, antiparkinsonian, antihistamines)	Prozac was just increased but symptoms were noted before increase
	Opioids	
	Benzodiazepines, especially long acting	
	Analgesics, cardiac and GI meds, anti-inflammatory drugs	On both cardiac, GI meds, and analgesics
	Recent abrupt discontinuation, omission, or decrease in dose of a short/long acting benzodiazepine	
	Drug interactions	
	Resident taking more than one drug from a particular class of drugs	
	Possible drug toxicity, esp. if the person	

	is dehydrated or has renal insufficiency. Check serum drug levels	
	Associated or Progressive Signs and Symptoms	
	Sleep disturbances (up & awake at noc, asleep during day)	Altered levels of consciousness
	Agitation & inappropriate movements (unsafe climbing out of bed or chair, pulling out tubes)	
	Hypoactivity (low or lack of motor activity, lethargy or sluggish responses)	Sluggish
	Perceptual disturbances such as hallucinations and delusions	
	Other Considerations	
	Psychosocial: - Recent change in mood: sad or anxious, crying, social withdrawal - Recent change in social situation (isolation, recent loss of family or friend	Fell less than a week ago resulting in a hip fracture which resulted in the hospital stay. Returning now as more depressed DX Depression. Prozac recently increased.
	Physical or environmental factors: - Hearing or vision impairment, may have an impact on ability to process information like directions, reminders, environmental clues - Lack of frequent reorientation, reassurance, reminders to help make sense of things - Recent change in environment (room change, new admission, return from hosp) - Interference w/resident's ability to get enough sleep (light, noise, frequent disruptions) - Noisy or chaotic environment (calling out, loud music, constant commotion, frequent caregiver changes)	Return from hospital. Is having difficulty processing new information at this time. Dx macular degeneration, Hard of Hearing
Input from resident and/or family or representative regarding the care area. Questions/comments/concerns Preferences/suggestions		Family has noted a decline since returning from hospital

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem • Causes and contributing factors • Risk factors related to the care area	Care Plan? Yes No	Document reason(s) care plan will or will not be developed.
Problem: Mrs. M's BIM score has decreased from previous assessment. Causes: Low grade fever, multiple medical diagnoses including CHF, CVA, hypothyroid, and anemia. Recent hospitalization with surgery. Risk factors: Increase confusion may interfere with	Yes	Care plan to be developed to monitor current level of cognition for further decline. Will incorporate interventions to minimize further loss of cognition

providing care, and put Mrs. M at risk for further injury such as another fall, skin breakdown, weight loss, etc.		
Referral to another discipline is warranted - to whom and why?		Speech to see for compensatory techniques

CAA Summary Note: #2 Cognitive Loss/Dementia
Date: 12/30/10
MDS items: BIM score less than 13 C0500 and inattention and altered level of consciousness C01300

Analysis: Mrs. M does show signs of delirium, see Delirium CAA 12/30/10. She does have a history of a CVA with new onset of changes in behavior in inattention and altered levels of consciousness. Her PHQ-9 also shows an increase in depression from her previous assessment. Medically she does have a thyroid disorder, ASHD, Hx of MI and GI Bleed/Ulcer, CHF, SOB with activity and inability to lie flat, and depression. Pain control has also been an issue since readmission but better participation noted in therapy over the last several days. Due to her recent surgery she does require more assistance with her ADL's. In the last week she has also had several environmental changes between the hospital and the nursing home which may also impact her cognition. Speech therapy to see. Will care plan to minimize further decline and to possibly improve her cognitive ability with continuity of care and pain management.

Decision to proceed with care plan - **YES**

CAA Summary Note: #3 Visual Function; #4 Communication
Date: 12/30/10
MDS items: Vision Impaired: B1000 Hearing, B0200 and Ability to understand others: B0800

Mrs. M triggered for these CAA areas due to sensory deficits, resulting in highly impaired vision and hearing. There have been no changes in either area since the original admission. See Visual Function and Communication CAA note dated 1/21/10.

Decision to proceed with care plan - **YES**

CAA Summary Note: #5 ADLs; #11 Falls
Date: 12/30/10
MDS items: #5 ADL's **-** Requires assistance with ADLs G0110 and has a decline in cognition C0500; #11 Falls - Has balance problems G0300

See PT eval 12/21/10 and OT eval 12/21/10
Vision/Communication CAA 12/30/10 and Urinary incontinence CAA dated 12/30/10

Mrs. M triggered for the above CAAs due to her need for limited to extensive assistance with ADLs and a recent fall resulting in a fracture. PT and OT have addressed recommendations for Mrs. M's ADL status. In addition to a recent history of falls, Mrs. M is at fall risk due to possible medication side effects, urinary incontinence; weakness requiring limited to extensive staff assist at times because of fatigue, and sensory

deficits. Medications that contribute to fall risk include Prozac, Bumex, Calan, NTG (PRN) and Digoxin. Pharmacy review to be done per facility protocols to determine further recommendations at this time. Urinary incontinence is related to urgency secondary to diuretics and is likely to be exacerbated by recent catheter insertion.

Decision to proceed with care plan - **YES**, to alert staff to multiple risks for falls, and assistance with ADL's

CAA Summary Note: #6 Urinary Incontinence
Date: 12/30/10
MDS items: Incontinence and requires assistance with toileting H0300

Mrs. M triggered for this CAA due to urinary incontinence that has been a problem for her since prior to her admission at home and has continued since her original admission. A bladder diary was done with the first admission and has been repeated during days 3-6 of this stay (See Nursing Note 12/26/10). During the hospitalization a catheter had been inserted but has since been removed on 12/21/10. Since the removal Mrs. M has been incontinent several times a week, which is similar to her voiding pattern prior to hospitalization. This was confirmed by comparing the current dairy with the previous admission diary. Mrs. M is unable to ambulate to the BR w/ walker due to fatigue. She requires weight bearing assistance of one person to transfer on/off the commode. She is able to call for assistance, but due to urgency can only hold her urine for about 5 minutes. Urgency is greater in the morning after Bumex administration. Delirium was also a possible incontinence factor as well as her increased need for assistance in toileting.

Decision to proceed with care plan – **YES**

CAA Summary Note: #10 Activities
Date: 12/30/10
MDS Items: Little interest or pleasure in doing thingsD0200 A

Mrs. M triggered for Activities due to the observation of little interest or pleasure in doing things. She has been a resident her for over a year. Prior to this most recent hospitalization she was an active participant in activities inside the home and occasionally went out with her daughter. She enjoyed small group activities but also enjoyed her time working on crossword puzzles. Currently due to pain, therapy attendance she has been too tired to participate in many activities. There are no other barriers such as environmental or staffing at this time. Review also the Cognitive loss, Delirium and Mood state CAAs 12/30/10.

Decision to proceed with care plan – **YES**

CAA Summary Note: #12 Nutritional Status; #14 Dehydration/Fluid Maintenance
Date: 12/30/10
MDS items: #12 Nutritional Status **-** Therapeutic diet K0500; #14 Dehydration/Fluid Maintenance - Taking diuretic: N0400

See current dietary note dated 12/22/10. No change essentially since original admission; see CAA note dated 1/19/10 for Nutritional Status and Dehydration/Fluid Maintenance

Decision to proceed with care plan **- YES**

CAA Summary Note: #8 Mood state; #17 Psychotropic Drugs
Date: 12/30/10
MDS items: #8 Mood state - Would be better off dead D0200 and increase in PHQ 9 from last assessment to current assessment D0300; #17 Psychotropic Drugs **-** Antidepressant N0400

Mrs. M was readmitted back to the facility after a fall resulting in hip fracture requiring surgery and a 3 day hospitalization. Mrs. M has a history of depression secondary to CVA and has taken Prozac since 1997. Upon readmission she showed signs of delirium, decline in ADL's with diagnosis of cardiac disease, and post CVA. She is on cardiac and pain medications. She is on thyroid replacement. Will contact Dr. G for a thyroid level as no levels have been drawn in over a year. Dr. G is aware of her wish to die but denied that she had a plan to follow through with those thoughts. She has been on Prozac but it has recently been increased..

Decision to proceed with care plan - **YES**

CAA Summary Note: #16 Pressure Ulcers M0300
Date: 12/30/10
MDS items: Currently has 2 pressure ulcers

Mrs. M. triggered for pressure ulcers due to an intact blister on her left heel that developed during her hospital stay as well as a nonblanchable area on her coccyx. Risk factors include: decreased mobility, friction and shear from sliding in bed, stress incontinence, delirium. She is on an antidepressant but this is a long standing medication and it has been increased recently. She has diagnosis of delirium, post CVA, depression, and edema. She also has the following conditions: recent weight loss, SOB if lies flat, and a recent decline in ADL's. Other factors include recently readmitted, and head of bed elevated for ease in breathing. Will care plan to ensure pressure is reduced to that area and that no further problems develop.

Decision to proceed with care plan - **YES**

CAA Summary Note: #19 Pain
Date: 12/30/10
MDS Items: Pain has limited day to day activities J0500

Diseases: Circulatory, pressure ulcers, post stroke, hip fracture
Characteristics of pain: Left hip, intermittent with an increase with movement, and decrease with rest. Pain described as throbbing
Frequency: Hurts worst with ambulation and lessens after sitting
Pain effect on function: Does not disturb sleep, but appetite has decreased; more depressed compared to previous admission and impacts ability to complete ADL's
Associated signs and symptoms: delirium
Other considerations: Decrease in mobility due to recent surgery

Decision to proceed with care plan - **YES**