THE NORTHWEST TERRITORIES
CONTINUING CARE
ASSESSMENT AND PLACEMENT PACKAGE
(CCAP)

Guide

TABLE OF CONTENTS

CCAP OVERVIEW - A FOUR STEP PROCESS

The Continuing Care Assessment Package (CCAP) is designed to provide a comprehensive needs assessment of the Continuing Care Client and to co-ordinate a plan to service those needs. The package includes assessment and placement components linked together with a service plan. Assessment and placement is performed in the following four-step process:

5. REVIEW THE CLIENT'S HISTORY - Using part one of the CCAP documents, collect the client's information, health history, and medication record as requested.

6. PERFORM A COMPREHENSIVE ASSESSMENT - Assess the client's level of functioning and independence in 26 areas identified. Assess informal care providers for 5 areas of care-giver burden.

7. SCREEN AND DOCUMENT THE ASSESSMENT INFORMATION - Assessment findings are categorized, and problem areas are isolated and documented. Active or unresolved problems are addressed. The Service Plan provides a summary of the assessment.

8. DEVELOP A PLACEMENT PLAN - Problems difficult to service within the client's existing environment are identified. Service resources are explored and service options are identified. Placement options are reviewed with involved individuals and preferences are identified. A Placement Plan is chosen and implemented.

The following pages provide a more detailed guideline of the four step CCAP process.

CONTINUING CARE ASSESSMENT PACKAGE

1. REVIEW THE CLIENT'S HISTORY

The first step involves the collection of baseline information about the client. Information can be collected from a variety of sources (e.g. medical records, care-givers, client interview). However, second-hand information should be verified with the client or primary care-giver. Complete the following CCAP forms:

a) Client Information

On side one, enter the requested demographic data, languages used, residency, source of referral, formal and informal contacts involved in the clients care. On side two, complete legal contacts and consents as applicable.

b) Health History - Medical/Surgical/Social History

List all current diagnoses and pertinent past medical diagnosis, and include comments regarding the onset and/or current status. List surgical procedures performed within the last 3 years and, if pertinent, prior surgical procedures. Using the cues provided, provide a brief social history.

c) Medication Record

Review all current medications including any regularly-used over-the-counter medication. Assess medication management for independence. Review the client's known allergies and sensitivities to medications. Discuss the type and severity of their reaction and treatments used. Identify the baseline measurements pertinent to the client''s medical/surgical conditions. Identify the client's normal range of measurement.

2. THE COMPREHENSIVE ASSESSMENT

a) Client Assessment

A comprehensive assessment includes twenty-eight areas or "domains" , which are assessed on the basis of functioning and/or level of independence. The domains are listed on the General Assessment.

Each domain is assessed for situations or conditions which are causing difficulty /problems for the client, along with the underlying reasons/causes for these problems. The clients needs are clearly identified and assessed for their management. The situation/condition is assessed for client risk.

A *short term client* is one that is admitted to the program for no greater than 90 days. Clients in the Home Care Program for a limited time i.e. for dressing change, will require only the client's history (a,b,c) to be completed. If the dressing change is extensive then the focal assessment should also be completed.

b) Informal Care-Provider Assessment

Persons providing significant informal care are identified and assessed for care-giver burden. The care-provider assessment includes the assessment of five aspects of burden. The focus of this assessment includes identification of :

Time related/dependency burden: speaks to the burden created due to the lack of time available for the care-provider to pursue personal needs. This type of burden includes the time required for the care provider to be gainfully employed.

Developmental burden: speaks of burden created when the role of care giving does not fit into the care provider's developmental expectations. Such an example would include the young husband 's care giving role for his wife.

Physical burden: describes the burden created by the physical demands of the care providing role. Examples would include the demands placed on the elderly spouse for providing care , or the lack of sleep care providers may experience when 24 hour care is required.

Social burden: recognizes the burden which can be created for the care provider to develop and maintain relationships within their peer group. Social burden would include isolation the care provider may experience with the care provider role , as well as , the affect the clients behaviour may have on the social relationships of the care provider.

Emotional burden: addresses the emotional reaction to the care giving role. Feelings such as frustration, anger, hopelessness or guilt may be a few of the feelings the care provider may experience.

The care-giver's support needs are identified and the management of these needs are assessed. Informal care-provider arrangements are assessed for risk for harm to the care provider. In turn, the client's risk for institutionalization is identified should the informal care-provider arrangement be unavailable to the client.

3. DOCUMENTING THE ASSESSMENT

a) General Assessment / Screening Tool

This tool functions to isolate the problem areas found during the comprehensive assessment and organizes this information. The Screening tool satisfies the minimal documentation required for areas in which "no problem" has been identified. Detailed documentation is required only when "problem" areas are identified.

To complete the General Assessment / Screening tool, the client's perception of their problems, needs and solution(s) are entered in the space provided at the top of the screening tool. Using the grid created on the tool , assessment finding of each domain are described as to whether a problem exists, whether the problem is currently being managed. Indicate whether documentation will occur as a narrative note or a focal assessment. "Managed" problems are documented on the Narrative Note form ,whereas active problems are addressed on the corresponding focal assessment form.

Names of informal care providers are entered under the final domain titled "informal care-giving" and problems are described as they relate to the caregiver.
The assessor's initials, signature, and date are entered a the bottom of the General Assessment.

b) Narrative Notes

"Managed" problems can be documented in brief detail in narrative format. Information should include a description of the situation/condition, the related causative factors, and the current management of care needs.

c) Focal Assessments

A specialized focal assessment form has been developed for each domain, and is used to document active problems and their management. Each focal assessment is formatted in the following problem solving approach:

- Assessment Detail
  Provide a narrative description of the current situation/condition. Where applicable, cues, tables and/or body charts are also provided to simplify documentation. In the right-hand column, identify the relative duration and prognosis (if known) of the problem.

- Related To
  Identify the underlying reasons/causative factors for the situation/condition. Enter the dates and specialty of formal assessments in the right-hand column. If causative factors are unknown, consider the need for referral.

- Planning
  Identify the client's needs including the type and frequency of intervention required. These needs should reflect the identified underlying causes. If formal recommendation (s) have been made, indicate the specialty and date in the right-hand column. If recommendations for care are required, consider the need for a referral.

- Current Management
  List all the current formal and /or informal care provided in the management of the identified problem. Include the type and frequency of care provided. Identify equipment and therapies being used in the right- hand column.

- Summary
  Using the cue boxes provided, summarize the status of this problem, indicating if the problem is managed, requires a referral for management or if a service problem may exist. Identify risks associated with the situation/condition and qualify this as low or high.

It is not necessary to do a focal assessment on every domain just what is appropriate for the client.

d) Service Plan

The Service Plan is located on the final page of the General Assessment/Screening tool and provides a summarized overview of the clients problems (needs) and servicing. The service plan provides a point of co-ordinate service planning and, when needed, a link to the Placement Plan.

Problems which are identified on the General Assessment /Screening tool are numbered and entered in the service plan. Risks which have been identified are entered beside the corresponding problem. "High Risk" factors are highlighted on the service plan. Formal services are entered along with the frequency of service provided. As problems are managed, the date is entered onto the service plan. If management of a problem is pending a referral, wait for the results of the referral before indicating the problem to be "managed" or "service problem".

The indication of a "High Risk" factor or a "Service Problem" on the service plan will initiate the development of a Placement Plan, the second component of the CCAP.

4. DEVELOPMENT OF THE PLACEMENT PLAN

The need for development of a Placement Plan is warranted when the needs of the client are becoming difficult to service within their existing environment, or when to do so creates a high risk for injury. The Placement Plan is a two sided CCAP form which documents a problems solving approach to "Placement Problems". This approach is outlined in the following steps:

a) Identify Service Problems

Service problems and high risk factors highlighted on the service plan are carried over onto the Placement Plan under the section titled "Service Planning". Following this, the problems are considered together.

b) Exploring Resources

The assessor works from a broad knowledge base of available services to identify where services are available to meet the total service needs. Consideration of services available within the client's community, region, and territory is explored and documented in the Service Planning section.

If services are not available in the least restrictive environment such as the client's home or the client's community, consider what services would be required to do so. i.e. evening home care service, alarm service, day support program, etc. This information can be used to create a database for future service development.

The final area of resource exploration includes considering alternative ideas that may have presented during the problem-solving process. Innovative ideas presented by family members, allied professionals can be noted as potential and effective ways of meeting the clients needs in the least restrictive manner.

Alternative ideas that have been presented can now be more formally considered with the issue of feasibility identified more clearly.

c) Creating Service Options

Service options are identified after reviewing the available resources. Document each option available to the client, remembering that the current situation, even if less than desirable, may very well be an option, and possibly preference, for the client. Each option is given a number for reference.

d) Choosing a Placement Plan

Persons who are directly involved with the clients care are identified on the placement plan. The service options are presented to each person, and their preference is documented.

Once all preferences are identified, consideration and consultation regarding these preferences will help identify the most desirable Plan. Highest consideration is given to the clients preference and when the chosen Plan differs, rationale is documented in the space provided. Interim planning, if required, is identified in the space provided.

e) Implementing the Placement Plan

Using the space provided on the placement plan, identify the major actions required to implement the placement plan. eg. applications, referrals, calls. Enter the date as each actio is completed, and follow with comments regarding the outcome of the action.

CONTINUING CARE ASSESSMENT DOCUMENTS

The Continuing Care Assessment Package contains the following documents:

Part One - Client Information
Part One - Health History
Part One - Medication Record

Part Two - General Assessment / Screening Tool
Part Two - Narrative Notes
Part Two - Focal Assessments:

Vision	Household Activities
Hearing	Home Living arrangements
Nutrition	Mental Status
Elimination	Communication: Speech
Circulation	Communication: Receptive Understanding
Respiration	Psychological Status
Skin Tissue Integrity	Safety - Self
Physical Function	Safety - Others
Mobility	Vulnerability
Activities of Daily Living	Social Interaction
Medication Management	Sexuality
Allergy Management	Lifestyle/Recreation
Pain Management	Spirituality
Sleep/Comfort	Informal Care giving

INCLUDED IN THIS PACKAGE

	X	MASTER COPY (one copy of all CCAP forms)
	X	CCAP GUIDELINES
	X	Client Information
	X	Health History (Medical/ Surgical/Social History)
	X	Medication Record
	X	General Assessment / Screening Tool
	X	Narrative Notes
	X	Each of 28 Focal Assessments (Includes Informal Caregiver Assessment)
	X	Placement Plan
	X	Supplemental - Medical/Surgical History
	X	Supplemental - Medication Record
	X	Supplemental - Social History

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