Section 5

Institutional Risk CAP

Problem

The Institutional Risk CAP identifies persons who have an increased risk of entering a long-term care facility in the coming months. They typically have deficits in physical functioning, memory, decision making, and health. This CAP describes steps to be taken to lessen the likelihood of entering such a facility.

Most persons identified for this CAP will remain in the community, receiving informal support mainly from family members and modest supplemental support by formal agencies. However, as the person's problems increase in complexity, so too does the likelihood of entering a long-term care facility.

Institutional placement is most likely to occur following a long process of decline. Functional decline typically begins with minor decrements in performing instrumental ADLs (for example, cleaning the home or shopping for groceries). Sensing that something is amiss, family and close friends step forward to help compensate for this new loss. This level of assistance may remain the same for a long period of time, as functional decline is often a remarkably slow process. With time, a person may experience additional problems in day-to-day decision making and memory, and eventually develop dependency in one or more basic ADLs. As the person and others note the loss, informal help increases. The first ADL tasks to require assistance are usually personal hygiene and dressing. The onset of behavioral problems may further complicate the situation.

Although the person and family are usually able to adapt and adjust levels of assistance according to changes in capacity, the person's needs may eventually exceed the capacity of the informal network to provide appropriate support. At this point, the person or key family members believe that entry into a long-term care facility may be in the person's best interests. This may happen after a hospitalization for an acute problem or the flare-up of a recurrent chronic condition. The precipitating event may be a fall, a fracture, pneumonia, or other reason for a prolonged period of inactivity or bed rest. Regardless of the underlying cause, with functional independence further compromised, the person, family, and discharge personnel may consider a long-term care facility admission. However, for many of these persons, institutional admission will often be avoided with appropriate interventions and community supports.

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Overall Goal of Care

- Avoid premature admission to a long-term care facility by supporting family efforts and providing community intervention programs.

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Institutional Risk CAP Trigger

This CAP trigger identifies persons with impaired functioning who are at high risk of institutional placement in the coming months.

TRIGGERED

This group includes persons who have four or more of following conditions:

- Any stay in a long-term care facility in the past 5 years
- Short-term memory problems
- Any deficit in cognitive skills for daily decision making
- Alzheimer's disease
- Any limitation in making oneself understood
- Any limitation in understanding others
- Any of the following behavioral problems (at any frequency): wandering, verbally abusive, physically abusive, socially inappropriate behavior, inappropriate public sexual behavior, or resists care
- Receiving any help in transfer (or did not occur)
- Receiving any help in locomotion (or did not occur)
- Receiving any help in personal hygiene (or did not occur)
- Decline in ADLs in the prior 90 days
- Wheeled by others (indoors)
- Does not go out of the house
- One or more falls in the last 90 days
- Occasional, frequent, or daily urinary incontinence

This triggered group includes 40% of persons receiving home care and 1% of older adults living independently in the community. About 80% of persons newly admitted for long-stay care in long-term care facilities will meet this trigger condition. For triggered persons in home care, about 20% will enter a long-term care facility within a year — twice the rate of those not triggered. For triggered older adults living independently in the community, about 30% will enter a long-term care facility within 1 year — about four times the rate of those not triggered.

NOT TRIGGERED

All other persons. This group accounts for about 60% of persons receiving home care and 88% of older adults living independently in the community.

Institutional Risk CAP Guidelines

Identifying persons and families who appear ready to make the decision to consider a long-term care facility admission. The following approach may be used to redirect premature decisions to enter a long-term care facility.

- For a person in hospital, assess premorbid levels of function and changes in status following the precipitating event. Consider whether there is a reasonable expectation of partial or full recovery. For the vast majority of persons, declines in functional status will be of recent onset and, in the absence of a massive cognitive loss, there is substantial

potential for the person to improve and not need institutionalization. For those who were dependent prior to the precipitating event, determine the level of assistance that family or other caregivers were providing on a routine basis.

- If there has been a fall, review the Falls CAP.
- If delirium is present, review the Delirium CAP.
- If the person is depressed, review the Mood CAP.
- If there has been a decline in ADLs, review the ADL CAP.
- If family is distressed and seems not able to continue the informal caregiving, review the Informal Support CAP.

- For a person in the community who has not had a recent hospital admission:
  - Assess whether decline is related to any of the following:
    - Decisions by the family to do more for the person than may be necessary (for example, a family member, concerned for the person's safety, may have begun to do things for the person without being asked, or the family member does not have the patience to wait when the person performs an activity slowly).
    - Recent changes in medications may cause the person to slow down.
  - Do not forget to highlight the person's residual strengths. For example, consider his or her capacity to make decisions, ability to walk, positive outlook, love of grandchildren, financial resources, and determination to stay in the community.
  - Ask about any rehabilitation intervention to address previous declines. [See ADL CAP.]

Problem solving through other triggered CAPs. For a person considered at high risk of entering a long-term care facility, the goal is to identify those conditions that can be addressed in the community. For someone triggered on this CAP, consider his or her underlying risk of going into a long-term care facility as part of your review of other triggered CAPs. Some of the major CAP problem areas that may be triggered include

- ADL decline
- Falls
- Cognitive decline
- Delirium
- Communication decline
- Urinary incontinence
- Behavior problems

The primary task is to ensure that institutional risk status is highlighted, in the above areas, in the plan of care. Knowing that a person is at risk of admission to a long-term care facility should help ensure that identified problems are addressed.

Watch for subsequent loss in any of the areas identified in this CAP trigger: ADLs, memory, decision making, communication, falls, behavior, or bladder function.

- Identify the new problem or worsening status as soon as possible.
- Seek to identify changes in health status or care patterns that might explain what has happened to the person — a new disease or medication, or a failure to comply with a prescribed course of care.
- Consider strategies and education for self-management or family education about managing chronic conditions.

Role of family. Most persons will have reasonable family networks that naturally step forward to provide support.

- If family members are providing support today, they are likely to continue to perform in this way in the near term at least. As new needs arise, family members often surprise themselves as they step forward to help their loved one. Nonetheless, it is helpful to provide education to the family and person on self-management strategies, lifestyle changes, and coping strategies, as well as information on expected course of recovery or decline over time.
- At the same time, in the rare instance when the person has a poor informal support system, he or she can be expected to receive significantly less help from family and friends. If true today, this will be true tomorrow. Such informal support systems seldom self-correct. In these instances, you should be prepared to arrange for increased levels of formal care.
- Many key informal helpers will lack information both on what types of changes to expect for the person being helped and on how they can best respond over time. Programs of individual and group counseling, as well as the dissemination of information (either on a real-time, hot-line basis or through brochures on key facts), may be helpful.
- Recognize that the person may suggest going to a long-term care facility or assisted living so as “not to be a burden” on family and loved ones. Often it is an incorrect perception by the person that assistance cannot be continued, especially with additional support of formal care services. Discuss these perceptions with the person and his or her informal caregivers.
- Periodically planned respite care, including in-home or day care for a few hours at a time, or institutional respite care for days or weeks, may enable informal caregivers to sustain a support role for longer periods of time.

Temporary services for urgent problems. When families are severely distressed by the person’s new problems, refer them to a social worker or other appropriate professional to identify available formal support resources and housing. Respite care or increases of formal services may be important in keeping the family involved in the care of the person. In other instances, the person may require another housing setting on a temporary basis. This can be due to the absence of a caregiver because of illness or job considerations, or because the person’s current residence will no longer be available. In such cases, attention should be directed to why such placements are

necessary and to helping informal caregivers set sensible expectations about their responsibilities, duties, and preferences once the person returns home.

Specialized assisted living housing alternatives. To the extent that such resources are available in a community, specialized housing options can be considered. Assisted living housing (independent apartments with barrier-free features and access to supportive services) can have a significant effect on reducing the need for institutionalization. For impaired persons, including those with some cognitive loss and mild to moderate functional problems, assisted living options can be arranged where a partnership of formal and informal services help support the person.

Preventive measures that reduce the risk of events that increase disability. There is increasing evidence that lifestyle measures and medical interventions may reduce the subsequent risk of cardiovascular events or the morbidity arising from them, falls, and further functional decline. Actions that prevent such morbidity also often can reduce the likelihood of needing institutionalization.

Additional Resources

Barusha AJ, Pandav R, Shen C, Dodge HH, Ganguli M. 2004. Predictors of nursing facility admission: A 12-year epidemiological study in the United States. *JAGS* 52: 434–39.

Laukkanen P, Leskinen E, Kauppinen M, Sakari-Rantala R, Heikkinen E. 2000. Health and functional capacity as predictors of community dwelling among elderly people. *Journal of Clinical Epidemiology* 53:257–65.

Payette H, Coulombe C, Boutier V, Gray-Donald K. 2000. Nutrition risk factors for institutionalization in a free-living functionally dependent elderly population. *Journal of Clinical Epidemiology* 53: 579–87.

Soto ME, Andrieu S, Gillette-Guyonnet S, Cantet C, Nourhasheni F, Vellas B. 2006. Risk factors for functional decline and institutionalisation among community-dwelling older adults with mild to severe Alzheimer's disease: One year of follow-up. *Age and Ageing* 35(3): 308–10.

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