Submission on Assessment processes for older people (2003) (NZGG guidelines)

April 2011

Submission to:

Stephanie Dixon
Corporate Services Manager
New Zealand Guidelines Group
Level 10,
40 Mercer Street,
PO Box 10 665,
The Terrace,
Wellington
E: SDixon@nzgg.org.nz

Submission prepared by Sylvia Meijer NP, (Elder Person Network Facilitator), on behalf of -

The College of Nurses, Aotearoa (NZ) Inc:
P.O. Box 1258
Palmerston North 4440
Email: admin@nurse.org.nz
Phone: +64 6 358 6000
Contact: Jenny Carryer, Executive Director

Nurse Practitioners New Zealand
PO Box 1258
Palmerston North 4440
Contact: Michal Boyd - Chairperson
Email: npnz@nurse.org.nz

This submission was prepared on behalf of the College of Nurses, Aotearoa (NZ) Inc and Nurse Practitioners New Zealand.
The College is a professional body of New Zealand nurses from all regions and specialties. It provides a voice for the nursing profession and professional commentary on issues which affect nurses, and also the health of the whole community. Its aim is to support excellence in clinical practice, research and education and to work with consumers to influence health policy. The College is committed to the Treaty of Waitangi and the improvement of Maori health. This commitment is reflected in the bicultural structure of the organisation

Assessment processes for older people (2003) (NZGG guidelines)

Thank you for the opportunity to comment on the assessment processes for older people. Comments and suggestions from members of the College of Nurses Aotearoa (NZ), were collated over a period of 2 weeks. Following are general comments and comments on the provided template.
Comments from College Members:
In general most agreed with the guidelines and objectives and are pleased with the guidelines. However, there seems to be specific foci missing.

Firstly, specific recommendations for Aged Residential Care are missing such as GP/NP cover and the utility of standardised assessment processes, multi-disciplinary team implementation and medication reviews.

We also have evidence in New Zealand about the benefit of DHB geriatrician and gerontology nurse specialist/NP proactive integration programmes into Residential Aged Care that should be included in the recommendations. Although there is little empirical evidence, the 'culture change' movement, such as the Eden Alternative would also be an important recommendation for these guidelines.

Secondly, there is little discussion about the primary care role in older people's health and the integration of services.
On behalf of the College of Nurses Aotearoa (NZ)

Sylvia Meijer, Elder Person Network Facilitator
Nurse Practitioner Older Adult

Recommendations and Evidence Grade:	**Remains Reflective of Current Evidence? Yes/No/ Comments?**
DOMAINS AND DIMENSIONS	
Screening, proactive assessment, and assessment of older people with complex needs should assess for risk factors, physical health and function; mental health; social circumstances; social support, including family/whänau; and the presence, role and potential needs of carers. (A)	
Carers of older people should be assessed for health, training and support needs. (B)	Carer's health should also be taken into consideration as there are often co-dependent relationships and if the carer takes ill, the daily care for the older person falls down.
Assessment of older people with pre-existing intellectual or other disabilities must detect impairment in those domains and dimensions in which they have been shown to be at particular risk in addition to those domains assessed in people without pre-existing disabilities. (B)	

Any screening and assessment should include assessment for abuse of the older person and/or their carer. (GOOD PRACTICE POINT)	This includes all forms of abuse.
SCREENING FOR IMPAIRMENT AND RISK FACTORS FOR DEVELOPING FUTURE IMPAIRMENT	
Screening of older people for impairment and risk factors for developing future impairment should be piloted to determine its effectiveness in the New Zealand setting. (C)	There has been development of a screening tool (BRIGHT tool) for Primary care and emergency dept. in New Zealand by Prof Ngaire Kerse and Dr Michal Boyd NP .(Kerse et al. Age & Ageing 2008; Boyd et al, J. Academic Emergency Med. 2008). Professor Kerse is currently testing its utility in a large RCT in New Zealand.
Any screening tool used in New Zealand should be adapted appropriately, piloted and evaluated before regional or national screening programmes are considered. (C)	The interRAI Contact Assessment is being used in NZ, but there has been no systematic evaluation of its effectiveness in the NZ setting.
To achieve the greatest benefits in terms of improved health and well-being, screening for impairment and risk factors for developing future impairment for older people should involve all members of the defined population (eg, all people aged 75 years and over). (A)	
Any screening must be performed, monitored and evaluated systematically. (A)	
Any screening must be supported by appropriately planned, adequately resourced, further interventions for treatment/care for older people identified by the screening as in need. (A)	Resources should not be fragmented.
Any screening should address those areas of need of most importance to older people. (B)	
To be effective, screening should cover both domains of potential impairment and risk factors for health or functional impairment. (A)	Particularly relevant to functional decline as this affects the day-to-day activities and coping abilities.
PROACTIVE ASSESSMENT: EARLY INTERVENTION	
Proactive assessment of older people should be comprehensive and multidimensional. (A)	The InterRai assessment should be incorporated into this somehow. The InterRai assessment tool is used for the over 65 years cohort and is used by a few NASCs around the country. It is MOH intention to further role this tool out.
An older person should receive a proactive assessment if the person has any risk factors; is referred after screening, is referred by community workers, family/whänau or	As the GP practice is mostly the main contact/provider, it is essential that all referrals and changes to treatment and medication are passed on to the GP practice. This may reduce

carer; or is in contact with health or social services. (B)	fragmentation.
Proactive assessment must be supported by timely, effective interventions to address any issues identified. (A)	
The assessment process should use standardised tools and standard methods of collecting, reporting and comparing data. (A)	Some situations may not be acceptable to use the tools as directed by the DHB. The tools however need to be evidenced based.
Regular follow-up should form part of the process of proactive assessment of older people. (A)	Processes to ensure all providers and specifically the GP practice are aware of follow up and treatment. This to reduce fragmentation.
The proactive assessment process should be used as an opportunity for health promotion, disease prevention, treatment, and care management. (GOOD PRACTICE POINT)	Health promotion could take place on all levels, not just in health care but as part of social services and general information via Age Concern and other interest groups.
ASSESSMENT OF OLDER PEOPLE WITH COMPLEX OR MANY NEEDS	
A comprehensive, multidimensional assessment should be available for older people with complex needs. (A)	
Assessment must be supported by resourcing for interventions to address the needs identified. (A)	
Assessment must be supported with regular follow-up. (A)	
Comprehensive assessment should inform and assist an ongoing treatment, rehabilitation and care plan that includes strategies to encourage implementation of the treatment/care plan. (GOOD PRACTICE POINT)	
CARERS	
Carers of older people should be assessed for health, training and support needs. (B)	Carer assessment needs to be completed before any crisis occurs so that long term planning /Advanced care planning can take place. The national Advanced Care Planning Group is currently completing work on this and the guidelines could benefit from into this.
Older people who are carers of people with intellectual or other disabilities should be assessed for health and support needs. (B)	`
A specifically designed tool for the assessment of carer needs should be used. (B)	
There is insufficient evidence to determine whether carer assessment is more effective when conducted independently or as part of an assessment of the older person receiving	

care. (Insufficient evidence)	
There is insufficient evidence to determine who should perform assessments of the needs of carers. (Insufficient evidence)	
Assessment of the needs of carers should be linked with the assessment of older people. (GOOD PRACTICE POINT)	
ASSESSMENT TOOLS	
A standardised comprehensive, multidimensional assessment tool with standard methods of collecting, reporting and comparing data should be used for screening and assessment of older people. (A)	The NZGG could seek feedback from providers such as Age Care providers to ensure they also align their policies and procedures with these guidelines.
A specifically designed assessment of carer needs should be used when assessing carers. (B)	
Any tools used must be able to assess the domains and dimensions indicated. (B)	
Screening and Proactive Assessment: the MDS-HC Overview and Overview+, and EASY-Care most closely meet guideline specifications. (A)	
Comprehensive Assessment: The MDS-HC comprehensive assessment with additional modules for those domains not currently addressed should be used for the comprehensive assessment of older people. (A)	
The needs of carers should be assessed using a purpose-designed tool after adaptation for use in New Zealand where necessary. (B)	
Any screening and proactive assessment tool selected should be modified in collaboration with the developers to meet the needs of older people in New Zealand. (GOOD PRACTICE POINT)	
Before selection of a national tool, pilot studies using the tools within New Zealand should be conducted to determine costs, training needs and any modifications of the tools required. (GOOD PRACTICE POINT)	
LOCATION OF ASSESSMENT	
Screening should usually be located within the older person's home. (A)	
Proactive assessments of people should usually take place within the older person's home, unless the older person is in an emergency department (ED).	

Attendance at an ED should trigger a comprehensive assessment prior to discharge. (A)	
Complex needs assessment of people within hospital settings or in residential care should be initiated in that setting. (A)	The InterRAI MDS LTC will be implemented in Residential Aged Care in New Zealand in the near future.
All complex needs assessments should include a home visit by a trained assessor. (A)	
Screening and assessment of older Mäori should be done at the home of the older person and their whänau. (C)	This would include Pacifica People as they often have the same health profile as seen in the Maori population.
A specialist trained assessor must be available in or on call for any ED. (B)	
A rural network of assessors should be developed for assessment of non-urban-dwelling older people. (GOOD PRACTICE POINT)	To reduce fragmentation, a rural assessment could be completed by another health professional, such as a Nurse Practitioner or District Nurse using the selected tool
ASSESSOR SKILLS AND SUPPORT	
Assessors should have specialist training in the assessment process, including training in consent issues. (A)	
Assessors of older people need the following attributes: • good communication skills • ability to facilitate the older person's communication with other health care professionals • good interpersonal and relationship management skills • sensitivity to the older person's beliefs and attitudes • awareness of spiritual aspects of the person's care. (B)	Assessors should have: • Excellent clinical assessment skills • Have knowledge of the referral systems and health providers in the district.
Assessors of older people should be part of (or have ready access to) a wider MDT to whom they can quickly refer the older person for more in-depth assessment or for help in any particular domain. (A)	
The MDT should comprise registered nurses with competence in gerontological nursing, geriatricians, psychogeriatricians and clinical psychologists with expertise in mental health of older people, physiotherapists, social workers with competency in working with older people, speech-language therapists, audiologists, dieticians, neurologists, occupational therapists and pharmacists. (B)	

The core MDT for initial contact and assessment of older people with complex needs in a primary health care setting should comprise a primary care physician, a nurse and a social worker, all with training and/or experience in working with older people. (GOOD PRACTICE POINT)	
All staff involved in screening, assessment and treatment of older people (including ED staff) should undergo training to enhance their sensitivity, knowledge and skills in dealing with older people and their issues. (GOOD PRACTICE POINT)	
WORKING TOGETHER	
Implementation of a comprehensive assessment tool must be supported by a programme of education for specialists and other health care professionals. (B)	
Implementation of a comprehensive assessment tool must be supported by strategies to improve physician implementation of the recommended interventions. (A)	
An assessment of the older person's likelihood of following the recommendations should be made, and strategies should be initiated to support implementation of the recommendations by both the older person and health care and social service professionals. (B)	
Comprehensive assessment should result in a treatment/management plan that includes a process to promote concordance and implementation of that plan by the older person and health care professionals. (A)	
OLDER PEOPLE WITH PRE-EXISTING DISABILITIES	
Older people with pre-existing disabilities should be eligible for any screening programme at 55 years. (A)	
Assessors of people with pre-existing intellectual or other disabilities must have specialist training in the area, in addition to specialist training in the assessment process and consent issues. (A)	
The MDT supporting the assessment of people with pre-existing disabilities should include specialists with expertise in the disability. (A)	

Any assessment process for people with disabilities should be designed to ensure that the older person with disability is involved in the assessment process. (B)	
ASSESSMENT PROCESSES FOR OLDER PEOPLE: A MÄORI PERSPECTIVE	
Assessment processes should be made available at age 55 years for older Mäori. (A)	Older people who affiliate with Maori should be asked if they want a Maori assessor, as in practice not all Maori would like this.
An holistic model such as Te Whare Tapa Wha or a similar model should be used when assessing older Mäori. (A)	A comprehensive /holistic/multidimensional assessment will take all aspects of Te Whare Tapa Wha into consideration.
All decisions should be made collectively with the older person's whänau or hapü. (B)	
Assessors of older Mäori should be fluent in te reo Mäori me ona tikanga where the older person and/or their whänau prefers its use. (B)	
Assessment of older Mäori people requires mature Mäori assessors who are well-known and respected within their community. (B)	
Where a Mäori assessor with the necessary skills is not available, a skilled assessor should be supported by someone who is fluent in te reo Mäori me ona tikanga and who is well-known and respected within the community. (C)	
When assessing older Mäori the assessor should be of the same sex as the person being assessed whenever possible. (B)	
Assessment services must be equally available to older Mäori who do not have Mäori-specific programmes available, or choose not to access them. (GOOD PRACTICE POINT)	
ASSESSMENT PROCESSES FOR OLDER PEOPLE: A PACIFIC PEOPLES' PERSPECTIVE	
Assessment processes should be initiated at age 55 years for older Pacific people. (B)	
Information relating to an assessment should be produced in Pacific languages as well as English, and produced in oral form (through videos and radio and as part of Pacific health promotion and health education forums) rather than relying on written formats. (B)	
Assessment programmes for older Pacific people should be actively offered rather than	

being made available and expecting the older people to initiate contact. (C)	
Assessors of older Pacific people should as far as possible be from the same ethnic background and able to speak the same language as the person to be assessed, or be supported by someone with these attributes. (C)	
It should be publicised to Pacific peoples that assessors of older people have professional skills and status to encourage acceptance by the older people and their families. (C)	
The MDT supporting the assessor of older Pacific people should include a Pacific health care professional. (C)	
Consent to the process of assessment needs to be revisited periodically during the assessment process because consent is understood to be a dynamic relationship rather than a single event. (B)	
EVALUATION AND CLIENT SATISFACTION	
The ultimate aim of audit should be to improve the quality of care. (GOOD PRACTICE POINT)	
Audit of programme performance indicators is necessary to monitor service provision and quality of care. Audit should take place every six months. (GOOD PRACTICE POINT)	Audits should look at the patient journey and not just aspects of the journey. How parts of the health care /patient journey are linked is what improves quality , when taking parts out of this it is not necessarily seen in context.
Collection and audit of ethnicity data is recommended to monitor services for equitable access and delivery of programmes. (GOOD PRACTICE POINT)	
All assessment processes for people aged 65 years and over should monitor and evaluate data relevant to their locality, the population served and the stakeholders of the service. (GOOD PRACTICE POINT)	
Consumers' views should be sought to assist the development of a quality service. (GOOD PRACTICE POINT)	