

THE SINGLE ASSESSMENT PROCESS

ASSESSMENT TOOLS AND SCALES

26 SEPTEMBER 2002

This guidance has been updated as follows :

- It is emphasised that localities are not obliged to choose an off-the-shelf assessment tool, developed for national use, as they develop their approach to overview assessment. Home-grown approaches, that either rely solely on professional judgement and competence or locally developed assessment tools that support professional judgement, are acceptable as long as the guidance issued on 28 January 2002 is followed.
- The criteria for choosing a tool for overview or comprehensive assessment have been modified.
- It is emphasised that the Department does not endorse particular assessment scales. Rather localities may wish to explore the local usefulness of those scales mentioned in this guidance.

Localities should note that Ministers have approved the establishment of an accreditation process for off-the-shelf assessment tools that are developed for national use. The accreditation process will not apply to home-grown approaches that are not for use in other localities.

A worked example of the single assessment summary is available on the single assessment process web-site. All approaches to assessment should be capable of generating the information included in this worked example, so that assessment information may be consistently collected, stored and shared.

Introduction

1. The National Service Framework for Older People was published in March 2001, and detailed guidance on the single assessment process was published in January 2002 (HSC 2002/001; LAC (2002)1). The January 2002 guidance advised local NHS bodies and councils with social services responsibilities that they might wish to use assessment tools and scales in supporting professional judgement and good practice during assessment.
2. This Tools and Scales guidance provides advice on assessment tools and scales, that localities may wish to explore and adopt in their approach to single assessment. The Department emphasises that localities are not obliged to adopt an off-the-shelf assessment tool as they develop their approach to overview assessment. Other approaches that rely on professional judgement and competence or home-grown assessment tools are acceptable, as long as the guidance issued of January 2002 is followed.

Definitions

3. For the purposes of this guidance, an **assessment tool** is defined as a collection of scales, questions and other information, to provide a rounded picture of an individual's needs and related circumstances. In the context of the single assessment process, an assessment tool for overview or comprehensive assessment should cover all the domains and sub-domains of the single assessment process. (See Annex E of the January 2002 guidance.)
4. An **assessment scale** is a means of identifying, and possibly gauging the extent of, a specific health or care condition such as ability for personal care, mobility, tissue viability, depression, and cognitive impairment. In the context of the single assessment process, scales may be used individually or collectively at all stages of assessment, and at case finding.
5. Scales should be valid, reliable and culturally sensitive. A scale is :
 - ❑ **Valid**, if it accurately assesses what it is claimed to assess.
 - ❑ **Reliable**, if when different assessors use it they arrive at similar answers for people with similar needs. It can also refer to the same assessor achieving the same results over time for a particular individual when needs have not changed.
 - ❑ **Culturally sensitive**, if it does not unfairly discriminate against people either from minority ethnic communities or those whose preferred language is not English.

Background to single assessment

6. The single assessment process applies to health and social services, and should be implemented from June 2002. It recognises that many older people have health and social care needs, and that agencies need to work together so that

assessment and subsequent care planning are person-centred, effective and co-ordinated. In particular, implementation will ensure that :

- The scale and depth of assessment is kept in proportion to older people's needs.
 - Agencies do not duplicate each other's assessments.
 - Professionals contribute to assessments in the most effective way.
7. The January 2002 guidance recognised that older people are the most important participants in the single assessment process. As such they should be enabled to make a full contribution to all stages of the process. Assessments should not only focus on the needs presented by older people, but on the strengths and abilities that older people may bring to bear on resolving their needs. Local approaches to assessment, including the choice of assessment tools and scales, should reflect these issues.
8. Four types of assessment were identified :
- Contact assessment
 - Overview assessment
 - Specialist assessment
 - Comprehensive assessment.
9. The January 2002 guidance emphasised that these types should not be perceived as a sequence, to be followed by rote in each and every case. In practice, in many cases professionals will be able to reach decisions early on about the type(s) of assessment that would be most useful to follow. It was stressed that not every contact with a professional should lead to a contact assessment as defined in the guidance. For example, where individual older people present treatable and simple health problems to their GP, and it is obvious that there are no wider problems, there will be no need to enter into the single assessment process. In fact to do so would not only be inappropriate but also potentially intrusive.
10. In addition, the January 2002 guidance said that localities may wish to undertake case finding exercises. This will be useful where, for example, there is evidence that older people who might benefit from an assessment of their needs, and perhaps the provision of services, are not coming forward, or being referred, for help.

National consistency

11. The January 2002 guidance did not identify or recommend the use of particular tools for overview or comprehensive assessment. Rather, national consistency in assessment is to be achieved through localities following the 12 steps of implementation, comparing their progress with the criteria in Annex C of the guidance. Localities were also asked to ensure that their overall approach to assessment is capable of generating the information for the single summary record described in Annex I.

Accreditation of assessment tools

12. Similarly, this Tools and Scales guidance does not recommend particular tools for single assessment. There are two reasons for this. First, developers of assessment tools for national or local use are currently reviewing their tools to ensure that they comply with the single assessment process guidance. Second, useful approaches to assessment, including the generation of forms and procedures for rounded assessments of older people's needs, have been developed in some localities. (See the section on "Good practice localities" below.) Asking these localities to replace their good local initiatives with a nationally prescribed assessment tool would damage local achievements and ownership. Moreover, as long as they follow the January 2002 guidance, localities can develop acceptable approaches to overview assessment using home-grown approaches that emphasise the part played by professional judgement and competence, which may or may not involve the use of a locally-developed tool.
13. Instead, and in support of the Annex C criteria of the January 2002 guidance, this guidance offers criteria that localities should refer to when choosing or developing tools (see below). To further help localities that wish to explore the use of assessment tools developed for general use or by good practice localities, the Department of Health is setting in train a process to accredit assessment tools for overview assessment. This process begins in 2002, and it is anticipated that some tools will be accredited in either 2002 or 2003. It is emphasised that the accreditation process will only apply to off-the-shelf assessment tools developed for national use. Home-grown approaches to overview assessment will be monitored through local progress reports and in other ways. Details and results of the accreditation process will be posted on a dedicated web-site.
14. The single assessment process should be fully implemented by April 2004, in accordance with the criteria set out in Annex C of the January 2002 guidance. If by April 2004, localities have not achieved full compliance and one of the reasons is difficulty with overview assessment, the Department of Health will ask those localities to address their difficulties promptly. It will be suggested to them that unless local solutions can be agreed, they should use one of the assessment tools that will have been accredited by then. Authorities in difficulty should be compliant with the Annex C criteria by April 2005.

Assessment tools for overview and comprehensive assessment

15. When developing their approaches to overview and comprehensive assessment, localities may wish to explore the assessment tools listed below. Contact details are given for further information. Brief descriptions of each tool are also provided. These descriptions have been provided by the developers of each tool. **They do not necessarily represent the views of the Department of Health.**
16. Localities should bear in mind that none of the tools listed below currently meets the criteria for overview assessment given in the January 2002 guidance

and in this guidance. (Developers are, however, aware of the progress that needs to be made.) If localities wish to use one the listed tools for overview assessment, they will have to add to it or modify it possibly in consultation with the developers.

TOOLS FOR OVERVIEW ASSESSMENT

Camberwell Assessment for the Needs of the Elderly (CANE)

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The CANE is a comprehensive multi-agency needs assessment tool for older people. It defines which needs are not met and can be used to identify services and interventions required in a variety of settings including primary care, mental health services, and care homes. The CANE can be used by qualified and competent health and social care professionals; as an initial assessment, as part of CPA (until CPA is replaced by the single assessment process, when implemented), as an outcome measure, for evaluation of services, and for research. It has 24 areas of need covering psychological, physical, and social functioning and two areas for carers' needs. The CANE can also identify needs for more detailed assessments in specific areas. It includes ratings for staff, user and carer views of needs. The older person can therefore have their own views of their needs rated separately and can express their level of satisfaction with services received. The CANE is intended to model good clinical practice and the ratings are based upon expert professional assessment. The CANE has very good validity and reliability and a detailed manual is available. It has been used widely in the UK and internationally.

Tools for Overview Assessment (continued)

EASY-Care 2002 –2005

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Guidelines that accompany EASY-Care advise that it is a tool for integrating assessment of an older person's physical, mental and social well-being. As well as assessing individuals' needs, data from EASY-Care can be used to measure population needs and outcomes. The EASY-Care guidelines emphasise that older people should play a full part in the assessment and consent to the information that is collected and shared about them.

EASY-Care is designed for use by any front-line health or social care professionals : at initial and subsequent contact with an older person with needs; as a foundation for specialist assessment; following a change in functioning; as part of a screening programme; or as part of a survey. EASY-Care provides prompts for where further assessment and action is required.

EASY-Care is continually being updated to meet the requirements of the single assessment process for contact and overview assessment. An accompanying training programme has been developed to support organisational and professional development in assessing the needs of older people. The core items in EDASY-Care have been extensively validated and are used in 18 countries world-wide. An on-going programme of validation is taking place for the added items to comply with the single assessment process and for cross-cultural validation for older people from minority ethnic groups. Updates will be posted on the EASY-Care website.

Tools for Overview Assessment (continued)

Functional Assessment of the Care Environment (FACE)

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FACE – The Core Assessment and Outcomes Package for Older People :

- Supports contact, overview and comprehensive assessment
- Ensures accurate holistic assessment of health and social needs
- Engages service users and their carers
- Supports risk assessment and risk management
- Measures health, social and risk outcomes
- Provides information for benchmarking of both individuals and populations.

FACE includes a contact and overview assessment and four specialist assessments that collectively provide a comprehensive, multi-faceted and holistic assessment in the areas of physical well-being, activities of daily living, psychological well-being, social well-being and risk.

The Contact / Overview assessment is designed for use by all front line practitioners. The specialist assessments are for use by qualified professionals and may be used in conjunction with other overview tools as well as FACE. The tools are completed as part of a joint process with the older person which includes review of valued aspects of the person's daily life as well as concerns and difficulties. Needs are identified and care planned collaboratively using FACE care documentation.

Tools for Overview Assessment (continued)

Minimum Data Set for Home Care (MDS Home Care)

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The MDS Home Care provides the health or social care assessor with the minimum information required for developing an appropriate care plan for an older person seeking treatment or support. The tool comprises a screener and a fuller version, which provide evidence-based guidance for further assessment at contact, overview and comprehensive assessment. The MDS Home Care can be applied by a competent, but not necessarily qualified, professional. It includes triggers to indicate when a qualified professional should be involved.

The MDS Home Care also provides managers and policy makers with valid and reliable data for monitoring outcomes, quality of care and resource-use case-mix including the RNCC for people admitted to care homes which provide nursing care. In considering the assessment the assessor discusses with the older person not only their abilities and needs, but also asks about the older person's priorities and preferences and things that are important to them.

TOOLS FOR COMPREHENSIVE ASSESSMENT – IN THE COMMUNITY

Camberwell Assessment for the Needs of the Elderly (CANE)

As above

Functional Assessment of the Care Environment (FACE)

As above

Minimum Data Set for Home Care (MDS Home Care)

As above

Sheffield “Rainbow Assessment”

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The Rainbow Assessment is primarily a comprehensive screening and assessment tool, intended for use by qualified nurses, occupational therapists, physiotherapists and speech and language therapists at the point of entry to rehabilitation services, either within primary or secondary care settings. The assessment comprises two sections : a screening section and more detailed assessments of particular needs and issues. The screening section provides an indication of when detailed assessment is required.

Although developed for use within a rehabilitation setting, the Rainbow Assessment may be used for assessing older people’s needs generally. The screening section may be used during overview assessment. Although designed for use by qualified health care professionals, agencies may feel that other competent and experienced professionals are able to use the tool.

TOOLS FOR COMPREHENSIVE ASSESSMENT – IN CARE HOMES

Minimum Data Set – Resident Assessment Instrument

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The MDS/RAI provides systematic assessment of key domains of need for older people in care homes and guides staff towards appropriate courses of action to plan individual care. It is for use in residential and nursing homes as a comprehensive assessment at admission and review. The MDS/RAI is designed for use by nurses and experienced home staff under supervision, with advice being obtained where necessary from outside specialists. It provides information to monitor outcomes, quality of care and resource utilisation. This approach to assessment and care planning is designed to enable the older person to discuss with staff their needs, difficulties and abilities and to express their preferences and priorities about their care.

Tools for Comprehensive Assessment – in Care Homes (continued)

The Royal College of Nursing Assessment Tool for Nursing Older People

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The RCN assessment tool has been designed to be used as part of the overall assessment of a resident in a nursing or care home. The framework promotes the concept of holistic care, independent living and full involvement of the older person in assessments of their needs, wants and aspirations. Nurses working in the community and in hospitals have made use of this tool to assess an older person's need for nursing care.

Use of the tool supports professional judgement and provides evidence for that judgement. It generates data that can be used :

- to formulate a care plan, identify how and by whom needs should be met; and
- identify the exact nature of any registered nursing input required and predict the number of registered nurse hours required on an individual and group basis, thereby assisting in workforce planning.

The RCN tool generates an holistic nursing assessment which can also be used to inform the RNCC process.

Criteria for choosing a tool for assessment

17. Tools that may be used for either overview and comprehensive assessment must be consistent with the January 2002 guidance, and Annex C in particular.
18. In summary, the criteria localities should work to in ensuring appropriate tools are used or adapted are given in italics below. Localities, and national tool developers, should note that these criteria will be used during the accreditation process for off-the-shelf assessment tools developed for national use. When considering off-the-shelf assessment tools localities should explore as full a range of tools as possible in support of both good procurement and good professional practice.
 - ❑ *The contribution older people make to their assessment should be made explicit by the tool.*
 - ❑ *Older people's views, wishes, strengths & abilities should be to the fore throughout assessment. How this is to be achieved should be made explicit by the tool.*
 - ❑ *The tool should cover the impact of older people's environments, relationships and other external factors on their needs.*
 - ❑ *The tool should be structured and used in such a way that it supports professional judgement. The tool should not replace professional judgement.*
 - ❑ *Scales that form part of the tool should be valid, reliable, and culturally sensitive, and should not unfairly discriminate against people on the grounds of their age, gender, race, disability and other factors.*
 - ❑ *Tools should use national standard data-sets as they become available.*
 - ❑ *The tool should help professionals to link different parts of the assessment and evaluate risks. It should suggest further assessment where appropriate.*
 - ❑ *All the domains and sub-domains of the single assessment process should be adequately covered by the tool.*
 - ❑ *The tool should be suitable for use by health and social care professionals. It should be made clear if particular competence or qualifications are required to administer the tool.*
 - ❑ *Manuals or guidance that accompany the tool should give clear instructions on how the tool should be used, by whom and when.*
 - ❑ *The tool should be capable of working on several types of software, at least.*

Assessment scales

19. This guidance advises on assessment scales that professionals may use to identify and gauge the extent of specific health and social care conditions. Advice on scales is given for many of the sub-domains of the single assessment process. Where it is not possible to give advice for particular sub-domains, the Department will continue to explore possibilities and encourage research to fill the gaps. In the interim, localities may wish to use other scales,

as long as they bear in mind the points listed below for choosing and using scales.

Choosing and using scales

20. It is important that localities and professionals bear the following points in mind when choosing and using scales in individual cases
- ❑ It is neither obligatory nor necessary to use scales in all cases.
 - ❑ Scales should be valid, reliable, and culturally sensitive and should not unfairly discriminate against people on grounds of age, gender, race, disability and other factors.
 - ❑ Agencies must not revise scales without prior knowledge of the impact of the changes on the usefulness of the scale.
 - ❑ Agencies should bear in mind that some scales have been developed for research purposes and may not perform well when used in practice for individual cases.
 - ❑ Professionals should remember that scales support, and do not replace, judgement.
 - ❑ The order and balance of scales in any assessment interview should be carefully considered. Difficult questions at the beginning of an assessment interview may not be received, or answered, well by older people.
 - ❑ Competent and / or qualified professionals should apply and interpret scales. Some scales include thought-provoking and challenging questions. For example, the Philadelphia Geriatric Centre Moral Scale asks “Do you sometimes feel that life isn’t worth living”. Those applying such scales should be confident and competent to both ask the questions sensitively and deal with any adverse response.
 - ❑ A literal and narrow interpretation of scales should be avoided. For example, focusing on specific items of a scale - such as the Barthel Index - can lead to a reductionist approach whereby a person's problems are seen and treated in isolation rather than holistically. To take a simple example from the Barthel Index : the fact that someone may have difficulty in dressing themselves may be associated with a range of physical, emotional or other factors, and the appropriate immediate and / or longer-term solution may not be to offer assistance with dressing.
 - ❑ Some scales include scoring systems that can give an indication of the severity of problems. It is particularly poor practice for such scores to be used either as major determinants of individual’s needs or to allocate services to people.
 - ❑ At contact or overview assessment, it is helpful if scales are kept as short as possible, as long as they are valid, reliable and culturally sensitive. For example, the 4-item Geriatric Depression Scale may be used instead of the 15- or 30-item versions of this scale. (See EASY-Care 2002-2005.) Items from the Barthel Index can be selected to give a useful indication of problems with activities of daily living and instrumental activities of daily living. (See the MDS – Home Care Screener).

Scales localities may consider

21. It is the Department of Health's view that the following scales - or elements from them - may be used to explore the domains and sub-domains of the single assessment process. However, the Department does not endorse of these scales. Within each category, the scales are given in date order, with most recent last.
- ❑ ***Users perspective of their needs and priorities***
 - Life Satisfaction Index (Neugarten et al, 1961)
 - Schedule for the Evaluation of Individual Quality of Life (full or shortened form) (O'Boyle and McGee, 1992)
 - Sections on "Personal Fulfilment" and "Spiritual Fulfilment" from the RCN "*Assessment Tool for nursing older people*" (Royal College of Nursing, 1997).
 - Mayers' Lifestyle Questionnaire (Mayers, 1998)
 - Life Goals Questionnaire and Goal Planning Record (Wade, 1999)
 - The Quality of Life in Later Life (QuiLL) Assessment (Evans et al, forthcoming)
 - ❑ ***Nutrition***
 - Subjective Global Assessment (Detsky et al, 1987)
 - Mini-nutritional assessment (Guigozy et al, 1997)
 - Screening tool for adults at risk of malnutrition (Malnutrition Advisory Group, 2000)
 - ❑ ***Activities, and instrumental activities, of daily living***
 - The Index of Activities of Daily Living (Katz et al, 1963)
 - Barthel Self-Care Index (Mahoney and Barthel, 1965; and Shah et al, 1989 for a revised version) with the OARS Multidimensional Functional Assessment Questionnaire (Fillenbaum, 1988)
 - Functional Independence Measure (Keith et al, 1987)
 - Community Dependency Index (Eakin, 1993)
 - Canadian Occupational Performance Measure (2nd edition) (Law et al, 1994)
 - ❑ ***Pain***
 - McGill Pain Questionnaire (Melzack, 1975)
 - Oswestry Low Back Pain Disability Questionnaire (revised version) (Fairbank et al, 1986)
 - Brief Pain Inventory (BPI) (Cleeland, 1991)
 - Palliative Outcome Scale (Hearn and Higginson, 1999)
 - ❑ ***Oral health***
 - Oral health assessment (Annex 2, British Society for Disability and Oral Health, revised 2000)
 - ❑ ***Tissue viability***
 - Waterlow Pressure Sore Assessment (Waterlow, 1996)

- **Mobility and balance**
 - Performance Oriented Assessment of Mobility Problems in Elderly Patients (POAM) (Tinetti, 1986)
 - Balance Scale (Berg et al, 1992)

- **Falls**
 - Falls Efficacy Scale (Tinetti et al, 1990)
 - Falls Handicap Inventory (Rai et al, 1995)

- **Communication, visual and hearing disability**
 - 4 questions from the Lambeth Disability Screening Questionnaire (Peach et al, 1980)
 - Do you have difficulty ...
 - ... seeing newsprint even with glasses?
 - ... recognising people across the road even with glasses?
 - ... hearing a conversation even with a hearing aid?
 - ... in speaking?
 - Frenchay Aphasia Screening Test (Enderby et al, 1987)
 - Assessment of Communication and Interaction Skills (ACIS) (Salamy et al, 1993)
 - Sheffield Screening Test for Acquired Language Disorders (Syder et al, 1993)

- **Cognitive impairment / memory**
 - Mini-Mental State Examination (MMSE) (Folstein et al, 1975)
 - Short orientation-memory-concentration test of cognitive impairment (6 items) (Katzman et al, 1983)
 - Gujarati version of the MMSE (Lindesay et al, 1997)

- **General mental health**
 - General Health Questionnaire (12 or 28 items) (Goldberg, 1978)

- **Depression / anxiety / mood**
 - Philadelphia Geriatric Centre Morale Scale (Anglicised version, 17 items) (Davies and Challis, 1986) (See Lawton, 1975 for the original version.)
 - Geriatric Depression Scale (15 items - or the 4 item scale for overview assessment) (Yesavage et al, 1983; Yesavage, 1988)
 - BASDEC (Brief Assessment Schedule Depression Cards) (Adshead et al, 1992)
 - Hospital Anxiety Depression Scale (Zigmond and Snaith, 1994)

- **Relationships**
 - Significant Others Scale (Power et al, 1988)
 - Practitioner Assessment of Neighbourhood Type (Wenger, 1994)

- ❑ ***Impact of caring on family carers***
 - Cost of caring index (Kosberg & Crail, 1986)
 - Relative stress scale (Zarit et al, 1998)
 - COPE Index (Nolan and Philp, 1999)
- ❑ ***Housing***
 - Housing Options for Older People (HOOP) (Heywood et al, 1999)

Helpful publications

General references

22. In addition to considering the scales given above, agencies may wish to refer to three publications that have usefully reviewed a range of assessment scales of relevance to older people. The publications are :
- ❑ The Research Unit of the Royal College of Physicians and the British Geriatrics Society (1992) “*Standardised assessment scales for elderly people*”, Royal College of Physicians of London and the British Geriatrics Society
 - ❑ McDowell I and Newall C (1996) “*Measuring health : a guide to rating scales and questionnaires*” (2nd edition), Oxford University Press
 - ❑ Clarke C, Sealey-Lapes C and Kotsch L (2001) “*Outcome measures : information pack for occupational therapy*”, College of Occupational Therapists

Assessing dementia

23. The Department is aware that the accurate assessment of dementia can play a vital part in helping many older people and their families. The Department wishes to see agencies place great emphasis on this when implementing the single assessment process. In this context , agencies are encouraged to refer to the publication “Dementia care planning” (Alzheimer’s Society, 2000). It contains an overview assessment tool that, while it has a focus on dementia, can be applied to other groups of older people. The publication also covers care planning and reviews.
24. The Alzheimer’s Society has also published a guide to the Mini-Mental State Examination for people with dementia and their carers (Alzheimer’s Society, 2001). Professionals may wish to familiarise themselves with this guide and share it with older people prior to carrying out the test.
25. With respect to dementia and minority ethnic older people, professionals should find the Lindesay et al (1997) and Patel et al (1998) publications cited below useful.

Assessing the needs of minority ethnic older people

26. Care should be taken when assessing the needs of an older person from a minority ethnic community. Agencies and professionals will need to ensure that information about services and the assessment process is given in appropriate ways. Assessment approaches and the use of tools or scales will need to be culturally sensitive. Professionals must be ready and competent to understand how old age, needs and race combine, in order to respond appropriately. The following publications can help professionals think through these matters :
- ❑ Commission for Racial Equality and partner organisations (1997) *“Race, culture and community care : an agenda for action”*, Chartered Institute of Housing Publications
 - ❑ Social Services Inspectorate (1998) *“They look after their own, don’t they?”*, Department of Health
 - ❑ Rawf S and Bahl V (eds) (1998) *“Assessing health needs of people from minority ethnic groups”*, Royal College of Physicians and Faculty of Public Health Medicine
 - ❑ Patel N et al (1998) *“Dementia and Minority Ethnic Older People : managing care in the UK, Denmark and France”*, Russell House Publishing
 - ❑ Butt J et al (1999) *“Respect – learning materials for social care staff working with black and minority ethnic older people”*, Race Equality Unit
 - ❑ Department of Health (2001) *“From lip service to real service – the report of the first phase of a project to assist councils with social services responsibilities to develop services for black older people”*, Department of Health

Evaluating assessment information

27. As a means of evaluating information from an assessment, and charting progress over time, professionals may wish to refer to the Health of the Nation Outcome Scales for Older Adults (HoNOS 65+) (Royal College of Psychiatrists, 1998).
28. Although devised in the 1970s, professionals may find the measurement of “interval need” a very useful way of evaluating assessment information and planning services in individual cases. It places people in four categories of interval need, which gives a good indication of when help is required. The highest level is critical interval need for people with significant needs that arise daily but at any time of the day or night. The next level is short interval need, which means help is required each day but at regular and predictable times. Planning care for people with critical interval needs poses challenges different from those with short interval needs. (See Isaacs and Neville, 1976)

Case finding

29. Where agencies wish to identify older people who may have health and social care needs, but who have yet to be referred to them, or may not be referred until problems have significantly worsened, they may wish to become involved in case finding.
30. Localities may wish to explore two approaches to case finding using postal questionnaires. They are :

Taylor and Ford's adaptation of the Barber Postal Questionnaire (Taylor et al, 1983; and Barber et al, 1976)

Do you worry about your health? *Yes / No*
Are you housebound? *Yes / No*
Do you depend on help from others? *Yes / No*
Do you have poor hearing? *Yes / No*

Risk is indicated by any "yes" answer.

Sherbrooke Postal Questionnaire (Hebert et al, 1996)

Do you live alone? *Yes / No*
Do you take more than 3 medications daily? *Yes / No*
Do you regularly use a walking aid / wheelchair? *Yes / No*
Do you see well? *Yes / No*
Do you hear well? *Yes / No*
Do you have memory problems? *Yes / No*

Risk answers are in italics. "At risk" = more than 1 risk answer. No response is a risk factor.

Contact assessment

31. In the January 2002 guidance, the Department recommended that at contact assessment professionals complete their consultations or discussions having covered seven key issues.
 1. The nature of the presenting need.
 2. The significance of the need for the older person.
 3. The length of time the need has been experienced.
 4. Potential solutions identified by the older person.
 5. Other needs experienced by the older person.
 6. Recent life events of changes relevant to the older person.
 7. The perception of family members and carers.
32. At contact assessment, where appropriate, professionals can gain insights into an individual's level of independence and potential needs through the use of some simple devices. For example, the **Self-reliance Screening Algorithm**

(unpublished, based on work based at the Hebrew Rehabilitation Center of the Aged, Boston, USA) can prove useful. This easy-to-administer tool is based on consideration of seven areas that relate to an older person's independence. A simple scoring system enables the professional to determine the extent of self-reliance.

1. Cognitive skills for daily decision-making
2. Hours of physical activity in the last 3 days
3. Meals preparation
4. Ordinary housework
5. Transportation
6. Person hygiene
7. Bathing

People are determined to be :

Self reliant when they are independent in daily decision making (item 1) AND at least three of the stamina (item 2) and ADL and IADL items (items 3 to 7) in the algorithm.

Not self-reliant when they are either not independent in daily decision making (item 1) OR independent in two or fewer of the stamina (item 2) and ADL and IADL items (items 3 to 7)

More details of the scoring are included in the MDS - Home Care Screener.
Note : ADL is an abbreviation for “activities of daily living”; IADL is an abbreviation for “instrumental activities of daily living”.

33. While the adapted **Barber Postal Questionnaire** and the **Sherbrooke Postal Questionnaire** have been developed for case finding purposes, questions from them can usefully be woven into a contact assessment discussion.
34. While questions from the three devices given above can be useful, they should not be asked by rote. They should be asked appropriately, and will often arise naturally as the older person talks about their needs and circumstances.

Good practice localities

35. While the Department of Health's guidance on single assessment reflects the Government's policy for person-centred care and more effective care services for older people, the content of the guidance draws to a great extent on the good practice between health and social care professionals to be found in many localities.
36. The arrangements for joint working and their approach to joint assessment from three of these localities – Cambridgeshire, Leeds and West Byfleet – are given below. Further information can be obtained by contacting the named individuals.

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Cambridgeshire Social Services Department and Health Authority in collaboration with housing agencies, voluntary organisations and local older people, have developed a Common Assessment Tool (CAT) for assessing the needs of older people. Work on CAT began in earnest in April 2000 when agencies in Cambridgeshire collaboratively explored a range of assessment tools focusing on older people and discovered the original 'EASY-Care' model of assessment. This version of assessment was piloted adopting an "action learning approach" testing its functionality across different professional groups in different PCT areas with full cross-agency ownership.

Professionals highlighted gaps that required attention, the need for assessment to promote prevention, the need for triggers to specialist services, and multi-agency training to ensure a joint approach to assessment and information sharing, through IT wherever possible. Local older people highlighted their frustrations around professionals' concerns about "confidentiality" and the barriers to the sharing of case information – as they have few problems with these issues.

As a result the recent major focus in developing CAT has been on IT and cultures. Agencies have now developed an electronic version of CAT that is about to be piloted. The learning from this experience will steer local agencies and stakeholders towards the continuing development of an integrated county-wide approach to assessment, in line with the single assessment process guidance, that will enable us to establish a shared person-centred approach.

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In 2000, Leeds City Council, with Leeds Community Health Trust, Leeds Acute Hospital Trust and the five Leeds Primary Care Trusts (PCTs) established “Joint Care Management Teams” (JCMTs). This followed work with older people and their carers to reconfigure assessment and care management arrangements. The JCMTs are jointly accountable within both the City Council and PCT structures, and there is one team per PCT.

The JCMTs comprise a manager and professionals drawn from nursing, social work and occupational therapy. The JCMTs offer short-term direct care management for older people with complex and intermediate care needs. Care is purchased by care managers from a budget drawn from both health and social services sources. The JCMTs are supported by dedicated administrative support staff, and work from 8.00 am to 8.00 pm, seven days a week. The JCMTs use standard assessment documentation recorded onto the existing social services client record and management system.

Members of the JCMTs act as care managers using their own disciplinary expertise, but will liaise with colleagues from different professional backgrounds whenever necessary. There is evidence that this collegiate approach broadens professional perspectives, reduces delays in transfers of care, and promotes positive outcomes. In addition, the introduction of the JCMTs is seen as a key developmental opportunity in the construction of a “whole systems” approach to care management for older people. The learning opportunities that have been presented have led to one of the JCMTs acting as a demonstrator site for the Electronic Record Development and Implementation Programme (ERDIP), piloting joint consent and confidentiality protocols. This work has both informed the development of the single assessment process and the procurement of the accompanying Electronic Social Care Record system.

Recently the JCMTs have been augmented by skilled unqualified professionals to support the care managers. Their introduction has significantly increased their workload capacity of the teams. The next significant development will be the addition of lead nurses to the JCMTs to take responsibility for the evaluation and reviews of people’s entitlement to NHS registered nursing care.

West Byfleet

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In the early 1990s the West Byfleet Total Purchasing Pilot - covering a population of 30,000 and involving GPs, practice nurses, district nurses, health visitors, and care managers - put together the common elements of assessments currently being used by community health and social care professionals to form a basic assessment. The work was informed by the RCGP occasional paper 59, and good practice elsewhere. The assessment comprised a screening level, with triggers for both deeper assessment of particular areas and referral on to specialist assessment. Data were entered direct onto a hand-held PC.

It became clear that training and cultural change are as important as the assessment used. Professionals have to understand and respect each other's roles and responsibilities. They must be prepared to lose individual ownership of processes and information, and replace it with joint ownership of the responsibility to meet the needs of service users / patients.

Agencies are now taking a county-wide approach to single assessment, and planning to use EASY-Care when it has evolved. Convergence will be achieved by PCT-based working groups feeding into county-wide system and project groups.

Sharing information effectively is vital to the single assessment process. Local agencies are using the ERDIP (EHR) project to progress IT-based information sharing using web-browser technology.

Good practice illustrations

37. This guidance emphasises that tools and scales, and the four assessment types, should be used appropriately in support of professional judgement. The assessment types are not a sequence to be followed mechanistically in each and every case.
38. The three illustrations below demonstrate different aspects of good practice, where the use of different types of assessment and different scales is involved. They focus on :
- ❑ **Contact and subsequent assessments in a GP practice and beyond. See Box A.** This illustration shows how a GP and practice nurse reach decisions based on a contact assessment, followed by an overview assessment coupled with the application of a scale to confirm the strong possibility of mental health problems.
 - ❑ **Specialist assessments in the case of African-Caribbean patient for whom a return home following hospital treatment and intermediate care is being considered. See Box B.** This illustration highlights the need for professionals to be aware of how old age, race and language and needs interact, and not to jump to conclusions about the relationship between older people and their carers.
 - ❑ **Joint and non-judgemental working in the case of challenging behaviour arising from dementia. See Box C.** This illustration emphasises that informed professional judgement will be at a premium in cases involving older people with dementia. Approaches to assessment, including the use of scales, will be unhelpful if they label behaviour as aggressive or challenging, without attempting to understand the reasons for it and thinking through appropriate ways of dealing with it.

Box A

USING A SCALE WITHIN GENERAL PRACTICE

A family doctor suspects that the older person she is seeing may be suffering from depression. This is the third consultation in the last month, and on this occasion there are signs of tearfulness and agitation. The doctor addresses this by asking about the person's relationships and social contacts, sleeping patterns and diet. All of these matters are symptomatic of depression. Having done this the doctor is further convinced there are problems for this person.

At this stage, the practice nurse is asked to carry out an overview assessment, and – with the person's consent – administers the 15-item Geriatric Depression Scale (GDS). The older person scores highly while the overview assessment reveals no other significant problems apart from growing social isolation following the death of her husband two years ago and the admission of a close friend to residential care six months ago. This leaves the doctor in no doubt that the person is severely depressed.

The high score prompts the doctor to make a referral to the local community mental health team for older people.

Had the older person not responded to the symptom-related questions, she would not have administered the GDS. If the GDS was applied and showed a low score, the doctor might not have referred the person to the CMHT, but suggested another option appropriate to the person's situation.

Box B

UNDERSTANDING OLD AGE, NEEDS AND RACE

An old woman, born in St Lucia who moved to the Midlands in 1962 to join her husband, is referred to the Community Rehabilitation Team following a stroke. She is currently in an intermediate care bed in a local nursing home, but a return home is planned. The stroke has restricted her mobility and speech and, before she can go home, these problems need to be addressed. She lives alone, but indicates that her family provides considerable support. Her husband died 25 years ago.

A registered nurse, occupational therapist, physiotherapist, speech and language therapist and social worker are all involved in various aspects of her care. At a first assessment visit to her home, the old woman has a minor fall, and this seems to greatly affect her confidence. Her daughter, who attends the visit, seems unduly critical of her mother. Back at the nursing home, she tells her daughter that perhaps she should stay in the home. The team get together to compare notes and share assessment information, including biographical details.

At this meeting, it transpires that the patois spoken by the old woman has continued to be a strong feature of her speech. It could account, to some extent, for her speech being seen as a “problem”. A multi-lingual co-worker is called in, and he reports that he is able to understand her whereas others can hardly follow. The social worker also reports that there is considerable tension within the family, and the old woman’s portrait of a supportive family may not be borne out in reality. The team feels that this may be one of the reasons for the daughter’s strong reaction to her mother moving back home, and why the old woman now wishes to stay in the nursing home on a permanent basis.

As a result of these insights, and the help of the multi-lingual worker in ensuring key messages are shared effectively between the old woman and the team, she is eventually returned home. The team puts her in touch with a local day centre that has a good reputation for multi-cultural awareness. This provides much needed social support. The team also contacts a local befriending services run by African –Caribbean older people for African-Caribbean older people. This seems to give the old woman a new lease of life. At the same time, the therapists continue to visit to help her improve her mobility. The social worker works with the family to see if bridges can be built between them and the old woman, and to explore any needs the daughter has in her own right.

Box C

EFFECTIVE AND NON-JUDGEMENTAL JOINT WORKING

A 82 year old man is referred to the local social services office as his behaviour has grown erratic in the past six months, and his wife and son report verbal and minor physical attacks on them. The man is reported as increasingly forgetful, and was found wandering by a neighbour in the local park after midnight two nights before.

After the collection of basic personal information by a receptionist, the man and his wife see an approved social worker. After some preliminary questions, suspecting that the reported behaviour may be symptomatic of dementia, the care manager administers the Mini-Mental State Examination. The result is a low score. Prompted by this, the care manager undertakes an overview assessment, where further potential problems are identified, particularly with regard to the man's safety in the home and problems of eating and drinking.

The care manager contacts the GP surgery where the man is registered. The practice nurse reports that the man was last seen seven months about apparently unrelated problems. The care manager and practice nurse agree that given the nature of the man's problems, a referral to the Community Mental Health Team (CMHT) for Older People should be made. The care manager discusses this with the man and his wife, and having secured their agreement, a referral is made accompanied by a summary of the overview assessment including relevant medical information from the GP's surgery.

A Community Psychiatric Nurse (CPN) co-ordinates further assessment activity on behalf of the CMHT. On the advice of an old age psychiatrist, she and her team colleagues are able to confirm that the man is in the early stages of dementia. The CPN helps the wife to understand that the perceived aggression in this case, while upsetting to her, is one of the few ways in which he can communicate his thoughts and distress to her. The wife is helped to see the aggression as communication, and she is advised on how to reduce or avoid the potentially harmful aspects of it. They advise her what to should the aggression become more pronounced.

The team provides the man with support at home, including advice on diet and food intake. The CPN refers the wife to the Alzheimer's Society for further advice. The care manager and the practice nurse are informed, and the common information base, shared by local agencies, is updated to reflect the results of the assessment and the care plan. The CPN maintains her role of care co-ordinator, at least until the first review of the man's needs in three month's time.

Updates

39. This guidance is intended to be relevant to contemporary practice. As such it will be updated as and when necessary.
40. Older people, agencies, organisations and professionals working in the field of health and social care are invited to comment on this guidance, and / or submit good practice examples, by writing to or emailing :

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