BEST PRACTICE
EVIDENCE-BASED
GUIDELINE

ASSESSMENT PROCESSES FOR OLDER PEOPLE

MINISTRY OF HEALTH
MANATŪ HAUORA

NEW ZEALAND GUIDELINES GROUP

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Best Practice Evidence-based Guideline

ASSESSMENT PROCESSES FOR OLDER PEOPLE

Moku anō enei ra
Mo te ra ka hekeheke
He rakau ka hinga
Ki te mano wai

(For me these days, for me the setting sun, for the tree that will be swept away in the floodwaters)

A plea for kindness and understanding in the days of old age

OCTOBER 2003

MINISTRY OF HEALTH
MANATŪ HAUORA

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The quote appearing on the title page is taken from *Māori Proverbs*[1]

STATEMENT OF INTENT

Evidence-based guidelines are produced to help health professionals and consumers make decisions about health care in specific clinical circumstances. Research has shown that if properly developed, communicated and implemented, guidelines can improve care. The advice on the assessment processes for people aged 65 years and over given in this guideline is based on epidemiological and other research evidence, supplemented where necessary by the consensus opinion of the expert development team based on their own experience.

While guidelines represent a statement of best practice based on the latest available evidence (at the time of publishing), they are not intended to replace the health professional's judgment in each individual case.

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PURPOSE

This guideline was commissioned as part of the Positive Ageing Strategy to develop an effective and integrated assessment pathway for the health and disability needs of New Zealand's older population. To date, assessment and provision for older peoples' physical and mental health needs and need for social support have been fragmented between various health and disability support services.

The purpose of the guideline is to provide evidence-based recommendations for appropriate and effective assessment processes to identify personal, social, functional and clinical needs in older people. That is, this is a guide to the processes required for effective assessment, and is not intended to address the specific details of assessments to be performed as part of these processes. 'Older people' generally refers to people aged 65 years and over, the age identified in the Health of Older People Strategy. In some cases, such as in the use of the term 'older Māori', the age is lower.

ABOUT THE GUIDELINE

FOREWORD

The New Zealand Guidelines Group Incorporated (NZGG) is a not-for-profit organisation established to promote effective health and disability services. Guidelines make a contribution to this aim by reviewing the latest national and international studies and interpreting these in a practical way for adoption in the New Zealand setting.

The Ministry of Health commissioned this guideline as part of implementing the New Zealand Positive Ageing Strategy[2] and the Health of Older People Strategy.[3] With the predicted dramatic growth in the proportion of the population aged 65 years and over and the Government's introduction of Primary Health Organisations (PHOs), evidence-based guidelines will be welcomed by health and disability service providers, funders, older people and their carers.

SCOPE

This guideline outlines the necessary elements of effective assessment processes for older people in New Zealand. It is intended to inform and guide funding agencies, such as the Ministry of Health, District Health Boards (DHBs) and ACC; service providers such as Primary Health Organisations (PHOs); community workers; practitioners from any discipline in primary or secondary health care; and older people and the people who care for them, including family/whānau and unpaid carers.

This guideline does not detail the specific measures used for assessments within domains and dimensions of health and well-being. It does not outline what domain-specific procedures (including assessments) should be completed following referral to a particular service, nor does it provide guidelines for interventions and follow-up. Domain or condition-specific evidence-based practice guidelines such as guidelines for Elder Abuse (under development); Hip Fracture and Falls Prevention; Support and Management of People with Dementia may be used to complement this guideline.

The guideline, while detailing the most effective processes around assessment of older people, is not intended to do more than inform development of service frameworks and does not extend to a detailed analysis of the most effective service configurations to support the recommended assessment processes. The section on implementation is similarly intended as a broad conceptual guide. This edition does not specifically address the needs of all minority populations within New Zealand and this may be considered in future reviews.

TREATY OF WAITANGI

The New Zealand Guidelines Group acknowledges the importance of the Treaty of Waitangi to New Zealand, and considers the Treaty principles of partnership, participation and protection as central to improving Māori health. As part of its commitment to the Treaty, the NZGG has explicitly involved Māori consumers and health professionals in all its work, including this guideline. The guideline contains a section giving a Māori perspective on assessment of older people, together with aspects of assessment particular to older Māori.

BACKGROUND TO THE GUIDELINE

The legislative and structural context for health policy and services changed with the launching of various government strategies setting the direction for future health services in 2001. The New Zealand Public Health and Disability Act 2000 set up 21 District Health Boards which are both funders and providers of services.

The 35 health-related strategies – including the New Zealand Health Strategy,[4] the New Zealand Disability Strategy,[5] He Korowai Oranga,[6] the New Zealand Primary Health Care Strategy,[4] and the New Zealand Health of Older People Strategy,[3] in conjunction with the New Zealand Positive Ageing Strategy[2] all have implications for assessment processes for older people. For example, the New Zealand Positive Ageing Strategy, Health Portfolio, has a commitment to *'…ensure the availability of multidisciplinary, comprehensive geriatric needs assessment as part of integrated delivery of health care for older people' (p 20).*

In 2001 Cabinet made a decision to separate funding and planning for disability support services for people aged 65 years and over from that for younger people with disabilities. This decision resulted from a growing belief that older people would be better served by having an integrated continuum of care available within the health system, recognising that their disability support needs are closely associated with changes in health status and thus differ from those of people who acquire their disability early in life and have relatively stable health.

Demographics

Most people aged 65 years and over are fit and healthy most of the time. A minority are frail and vulnerable and require high levels of care and either short-term or longer-term disability support. This is usually during the last few years of their lives, or may be temporary and acute, or as a result of chronic illness or disability present for many years.[4]

The proportion of older people (aged 65 years and over) in the New Zealand population is predicted to increase from 12% in 2001 to 26% by 2051. By 2051, there will be approximately 1.18 million people aged 65 years and over (26% of the total population), 708,000 (15%) aged 75 years and over, and 292,000 (5.3%) aged 85 years and over. At the 2001 Census, there were 400 people aged 100 years and over. In 2051, there are projected to be over 12,000 people aged 100 years and over. By about 2021 there will be more people over the age of 65 years than under the age of 15 years. The biggest increase in older people will be amongst people aged 85 years and over, due to increased longevity and the post World War II baby boom generation reaching this age group from about 2035.[7]

It is predicted that the older population will become more heterogeneous, with increasing diversity of culture, social attitudes and sexual orientation.[7] Increasing proportions of Māori, Pacific and Asian peoples will reach age 65 years and over, as a result of increasing life expectancy and larger birth cohorts reaching older age, and of changing patterns of migration.[7]

Life expectancy is increasing and, since the mid-1980s, has been increasing more for males than for females. Women can nevertheless still expect to live longer than men, with remaining life expectancy in the general population at age 65 currently 19.5 years for women and 16.1 years for men. Life expectancy at age 65 for Māori (15.0 years for women and 12.6 years for men) and Pacific peoples (16.6 years for women and 13.4 years for men) is lower than for the general population. This is due to higher mortality rates at younger ages, particularly for cardiovascular conditions and cancer. Life expectancy for Māori and Pacific peoples is, however, increasing.[7]

Older people are significant users of both health and disability support services. Around 39% of health and disability expenditure for the financial year 2001/02 was for the 12% of the population aged 65 years and over.[7]

At the primary health care level, general practice (GP) services are used predominantly by the very young (0 to 4 years) and older people. People aged 85 years and over visit a GP service around 9 times per year compared to 3 to 4 visits for people aged 45 to 64 years. Laboratory service use increases with increasing age and pharmaceutical services are used predominantly by older people, with the number of prescriptions per capita rising rapidly from age 45–64 years onwards.[7] Older people also use hospital services more than people aged less than 65 years. Public hospital admissions for older people have been increasing over the last 10 years, for the last four years at a rate of 4.3% per year. Over this period the rate of increase has been at least 1% higher than for people aged less than 65 years. Furthermore, there has been a 2.1% average annual increase in preventable hospitalisations for people aged 65–74 years since 1996/97.[7] Older people are lower users of ACC funded services, however. In 2000/01 only 3.9% of the $1,110 million ACC spent for treatment, rehabilitation and support following an accident was for people aged 65 years and over.

The likelihood of having a disability increases with age, so that for those aged 75 years and over, the proportion of people with a disability is 69% for women and 64% for men. The severity of disability also increases significantly with age. Around 36% of all people aged 75 years and over have a moderate disability (requiring some assistance or special equipment, but not daily assistance) and 18% have a severe disability (requiring daily assistance).

The majority (74%) of people aged 65–74 years live at home without any assistance. However, the proportion of people needing assistance increases with age, as does the need for residential care. Around half the population aged 85 years and over live at home with assistance, and 27% live in residential care. While the proportion of people aged 65 years and over in residential care at any single point in time is relatively low (around 5%), the New Zealand Ministry of Health has estimated from overseas data that 25–30% of people who reach the age of 65 years can expect to spend some time in long-term care before they die.[7]

Polypharmacy is also a significant problem in older people. The World Health Organization estimates that 20% of admissions to geriatric wards are associated with medication effects. A study of older people in New Zealand found pharmaceuticals used when contraindicated, inappropriately high doses used, under-use of medications for the prevention of osteoporosis, and inappropriate choices of medications for diabetes. In many older people, combinations of several psychoactive medications were being used. Older people are especially prone to the effects of drugs acting on the central nervous system, and the effects may worsen cognitive function and increase the risk of falls and fractures. Moreover, drug-induced delirium is not uncommon.[8](~)

Aim of Assessments

The aim of an assessment is to identify all needs for care and support of the person being assessed. This includes those needs already being adequately met by services, family or whānau, or other sources, as well as unmet needs for which a package of care is required.

Development of an Evidence-based Guideline for Assessment Processes

Timely access to health and disability support services is a critical issue for both the person wanting access and for the funder of services. The person wanting access and their family/whānau are concerned about their health and support needs being met. For the funder, there is a responsibility under the New Zealand Public Health and Disability Act 2000 to facilitate access to *'. . . appropriate, effective, and timely health services…and disability support services'*.[9] There is also a requirement for that access to be equitable, as from 1 January 2002, the government is no longer exempt from the requirements of the Human Rights Act.

To ensure that future assessment practices are appropriate, effective, timely and equitable, the Ministry of Health commissioned the development of best-practice, evidence-based guidelines for assessment processes.

These guidelines will have a significant role in the implementation of the Health of Older People Strategy. They will ensure that the New Zealand health system assists people aged 65 years and over to participate to their fullest ability in family, whānau and community life, and in decisions about their health and well-being, by supporting them with effective, co-ordinated and responsive health and disability support programmes.

Gaps Between Current Practice and Evidence-based Practice

How big is the gap between current and optimum care?

The 2000 report from the National Health Committee, *Health Care of Older People*,[10] and the consultations on the New Zealand Positive Ageing Strategy[2] and the New Zealand Disability Strategy[5] identified that there is an unacceptably large gap between current and best practice. This is evident in rising rates of preventable hospital admissions, discharges from hospital without support services in place, and preventable placements in residential care.

In New Zealand, support services for older people assessed as having a disability which will last longer than six months are currently accessed from a Needs Assessment and Service Co-ordination (NASC) agency. The current approaches of NASC agencies to assessment are based on professional opinion regarding good practice. Assessment processes across different regions appear variable, and there has been no systematic evaluation or comparison of effectiveness. Several projects and programmes for improving assessment have been started but not evaluated, and many have since ceased without reporting data on their level of success.[11](~) Consequently, there is a high level of uncertainty about what assessment should comprise, and what skills are needed to perform successful and effective assessments.

The ageing population world-wide has led to international interest in developing effective assessment processes. Many different approaches to the assessment of needs in older people are in use. The evidence for various approaches and their applicability to New Zealand requires critical evaluation before recommendations can be made for any particular model.

GAPS

Current Practice	Guideline-identified Best Practice
No nation-wide systematic screening or assessment of the health and support needs of people aged 65 years or over	Nationally equitable systematic assessment of the health and support needs of older people
National standards for assessment of support needs, but no evaluation of the effectiveness of assessment processes	Nationally comparable monitoring and evaluation data generated for assessment processes and outcomes
No standards and no systematic approach for ensuring assessment processes are adequately integrated	Nationally consistent, equitable integration of assessment processes National reporting protocols to enable regional comparison and trends over time
Substantial variation in assessment processes for older people with health and disability needs	Standardisation and comparability of assessment processes for older people with health and disability needs
Considerable delays between identification of the need for assessment and the person receiving that assessment; and also between receiving the assessment and identified needs being addressed	Prompt and timely integrated assessments followed by prompt and timely interventions
No clear definition of training competencies required by assessors carrying out the assessments	Training requirements of assessors defined and linked to the tool used. Specific national training programmes established
No standardised assessment tool, and therefore no consistent collection of data to enable comparison or evaluation	Use of internationally validated and reliable screening and assessment tools, adapted for the New Zealand environment, supported by a database of nationally and internationally comparable data
No evidence in New Zealand on the specific needs of carers, or how to assess for such needs	Carer needs assessed using a standardised tool with a supporting database which is internationally comparable. This allows analysis of the needs of carers, the refinement of assessment of these needs, and the consequent development of more effective support services
Limited knowledge of differences in the needs of members of particular cultural or other groups, such as Māori, Pacific peoples or people with longer-term disabilities; and of how to assess for such needs	Appropriately adapted, standardised, and evaluated assessment and reporting tools and processes, with supporting details of specific training and attributes required by assessors for these populations
Assessment for Māori and Pacific peoples is focused on the individual being assessed, and may not take account of the need to assess within the family/whānau or hapū context	Assessment of all older people includes contextual issues such as family/whānau and social networks. Assessment of Māori and Pacific peoples includes assessment of their family/whānau

Current Practice	Guideline-identified Best Practice
People with disability before the age of 65 years have special needs as they age that are not consistently assessed and addressed	Older people with pre-existing disabilities receive specialist assessment from assessors with expertise in both ageing and disability
Ageing parents of people with long-term disabilities have special needs as they age that are not consistently assessed and addressed	Ageing parents of people with long-term disabilities receive specialist assessment from assessors with expertise in both ageing and disability

Could the recommended changes be implemented?

Effective, integrated assessment processes are an important element of the 'continuum of care' approach to service planning, funding and provision that underpin the *Health of Older People Strategy*.[3] Objective 3.2 of the strategy specifies the development of an implementation plan by the Ministry of Health in collaboration with DHBs, together with the incorporation of these guidelines into the Nationwide Service Framework.

This guideline will inform the Specialist Services Review currently being undertaken by the Ministry of Health to develop a sound practice framework for specialist services for older people. These services include geriatric and psychogeriatric assessment, treatment, rehabilitation and clinical advisory/liaison functions provided by members of an interdisciplinary team in a variety of settings. The framework will set out the elements of service design and delivery that specialist services for older people will need to provide in order to meet the objectives of the *Health of Older People Strategy* and will contribute to the development of an integrated continuum of care for older people. The framework will also clarify how specialist services for older people need to interface with physical health, specialist mental health treatment, and support and disability support services for older people. The Specialist Services Review project will also develop the following:

- for the Ministry of Health and DHBs – a service coverage statement to be included in the Crown Funding Agreement, service specification(s) for the Nationwide Service Framework, and performance reporting requirements
- for ACC – service descriptions and reporting requirements that are integrated as far as possible between the health sector and ACC.

The specialist services covered in the framework will be accessed through an assessment of needs, and it is this process of assessment that is covered within these guidelines.

GUIDELINE DEVELOPMENT PROCESS

The Assessment Processes Guideline Development Team first met in December 2001 to identify the main topics to be covered in the guideline. The group met again in June 2002 to undertake training in the grading and assessment of evidence and to review the topic areas.

The principles underlying the guideline development were that the assessment process should:

- be client-centred, in terms of
  - the involvement of the older person in the process
  - the outcome for the older person
  - the inclusion of the older person's carer/family/whānau
  - the empowerment of both the older person and their carer/family/whānau
- be clinically safe
- allow for assessment of reversibility through treatment and/or rehabilitation of functional limitation
- enable national consistency in assessment practices and outcomes
- reduce bureaucracy and boundaries within and between funders and government agencies to a minimum, ensuring better integration and co-ordination between all sectors – health, disability, transport, education, housing, etc – so that barriers to older people receiving needed support and care are reduced
- reduce the number of times older people have to repeat their story
- lead to the provision of timely, appropriate and effective support.

Specific topics to be covered by the guideline were:

- population screening of older people
- assessment of older people with 'few needs'
- assessment of older people with many or complex needs, including those with progressive disorders
- special considerations in assessment of older people from populations of Māori, Pacific peoples and people with pre-existing disabilities.

For each topic, the following questions were to be addressed:

- Does the assessment process produce benefit and/or harm?
- Is the assessment process cost-effective?
- How should older people be assessed?
  - Should a standardised tool be used and if so, which?
  - Who would administer the assessment – what training and skills are required?
  - When should the assessment be performed – what should trigger an assessment?
  - Where should the assessment be performed?
  - What should be done following the assessment?

A systematic search was made for published guidelines on assessment processes for older people. The UK Royal College of General Practitioners' Occasional Paper: *An Evidence-based Approach to Assessing Older People in Primary Care* (February 2002)[12](+) was evaluated using the AGREE assessment tool before being selected as a 'seed' guideline.

The Guideline Development Team then identified questions and strategies for a systematic literature search and formulated inclusion criteria for studies. The literature search included both quantitative and qualitative studies as appropriate. A systematic critical appraisal of the selected literature published from 1980 to 2003 was undertaken by the Dunedin Medical School, University of Otago, and by the member(s) of the working subgroups responsible for drafting particular sections of the guideline. Attempts were also made to identify and include significant unpublished work and conference abstracts. Recommendations were based on the highest quality studies available. Where there was a lack of evidence from high quality studies, then recommendations were based on the best available evidence or expert opinion. Further details of the search strategy are available online at www.nzgg.org.nz

GUIDELINE DEVELOPMENT TEAM

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Competing Interests

All members of the team stated that they had vested interests in the guideline's subject matter through their professional roles and their own families, but none had any competing interests to report.

CONSULTATION

An early draft of this guideline was widely distributed to 300 organisations including consumer groups, primary health care organisations, service and provider organisations, expert reviewers, clinicians and other health care professionals for comment as part of the consultation and peer review process. Hui were held in Auckland, Northland, Wellington and Christchurch.

Comment was received from many individuals, including consumers, health care professionals and academics; and from the following groups and organisations:

- ACC
- Age Concern
- Arthritis New Zealand
- Canterbury DHB, Planning and Funding Division
- Clinical Services, Ministry of Health
- Coast Health Care
- DHB Funders and Planners groups
- Faculty of Psychiatry of Old Age, RANZCP
- First Health
- Health of Older People Clinical Leaders' Group
- Horowhenua Masonic Village
- Hospice New Zealand
- IHC
- Māori Health Directorate, Ministry of Health
- Massey University
- Nelson Marlborough DHB
- New Zealand Association of Gerontology
- New Zealand Geriatric Society
- New Zealand Society of Physiotherapists
- Older Person's Nursing Network, College of Nurses Aotearoa (NZ) Inc
- Post-Polio Support Society NZ Inc
- Princess Margaret Hospital
- Progressive Health Inc
- RNZCGP
- Supportlinks
- Tawa Mana Greypower
- Timaru Hospital and Community Services
- Waikato DHB
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PILOTING

The guideline has been tested for practicality with representatives of all stakeholders, and the feedback from these groups has informed the content. Evaluated piloting of the assessment processes is suggested as a first stage of implementation of these guidelines.

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- **Judith Davey** for an overview of the literature on assessment of people aged 65 years and over
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- **Wi Keelan** for reviewing the Māori Summary.

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This guideline was funded by the Ministry of Health and independently developed by the New Zealand Guidelines Group Inc.

EVIDENCE AND RECOMMENDATION GRADING SYSTEM

The Assessment Processes For Older People Guideline Development Team agreed to rank the evidence according to the NZGG grading system. More information on this grading system can be found at www.nzgg.org.nz

The NZGG grading system is a two-tier grading system with the following steps:

Step 1: Study appraisal

The piece of research that is being evaluated is critically appraised using the appropriate GATE FRAME checklist.[13](+) In the case of qualitative research, the CASP appraisal framework[14] is applied. Using these checklists, the validity, magnitude/precision of effect and applicability of the study are determined. The summary levels of evidence for each aspect are assigned as follows:

NZGG LEVELS OF EVIDENCE	
+	assigned when all or most of the criteria are met
~	assigned when some of the criteria are met and where unmet criteria are not likely to affect the validity, magnitude or applicability of the results markedly
x	assigned when few or none of the criteria are met

Levels of evidence are identified in the text. Where a series of references are cited in support of a particular point, the highest level of evidence only is indicated.

Step 2: Weighing the evidence

Evidence tables are constructed for each question. The Guideline Development Team considers the body of evidence contained in the evidence tables and makes joint decisions on the issues of quality, quantity, consistency, applicability and clinical impact of the entire body of evidence. A summary evidence statement is then entered onto the form.

Step 3: Developing recommendations

Recommendations are formed from the summary evidence statement with regard to the issues of validity, quantity, consistency, applicability and clinical impact (including benefits and harms) of the whole body of evidence. The recommendations are graded according to the following table:

NZGG GRADES OF RECOMMENDATIONS	
The recommendation is supported by good evidence	A
The recommendation is supported by fair evidence	B
The recommendation is supported by expert opinion only	C
No recommendation can be made because the evidence is insufficient ie, evidence is lacking, of poor quality or conflicting and the balance of benefits and harms cannot be determined	I

Where the group made a recommendation based on their own professional and/or clinical practice for which there was no other evidence, it is expressed as a 'good practice point':

Recommended practice based on the professional experience of the Guideline Development Team	✓

The whole group carefully reviewed the summary of conclusions and recommendations and any disagreements were resolved by consensus. The guideline was collated and drafted by the NZGG project manager in consultation with the Guideline Development Team Chair, the Ministry of Health project manager and the team sub-groups, then reviewed by the whole team, at which point comments from peer-review and public consultation were considered and addressed.

SUMMARY

KEY MESSAGES

- Standardisation of assessment processes across New Zealand is essential.
- Assessment of older people should be comprehensive and multidimensional as this leads to provision of services to improve health and well-being of the older person and their carers.
- Screening of the asymptomatic general population aged 75 years and over has been shown overseas to produce the greatest improvement in health and well-being.
- An older person should receive a proactive assessment if they have any risk factors; are referred following screening; are referred by community workers, family/whānau or carer; or are in contact with health or social services.
- All older people with complex needs should be offered a multidimensional, comprehensive assessment when they come into contact with health care or social services, or when an assessment is requested by carers, family/whānau or professionals involved in their care and support.
- Following assessment, the assessor should work with the older person to develop a treatment/management plan.
- Assessing and supporting carers' needs result in improved outcomes for both the carer and the care recipient, including reduction in abuse of older people.
- Older Māori, Pacific people and some people with known disabilities have a lower life expectancy than the general population and should be eligible for screening and assessment at age 55 years.
- Assessment must be followed by timely and effective interventions and regular follow-up.
- A standardised assessment tool and standard methods of collecting, reporting and comparing data should be used.
- Tools for screening and assessment should be complementary parts of an integrated system.
- Any screening or assessment programme for older people should assess for need in the areas of life that consumers consider most important: personal care, social participation, control over daily life, food and safety, risk factors and areas of greatest potential impairment.
- To be effective assessors must receive specialist training, be part of a multidisciplinary team, and have a good awareness of older peoples' issues.
- Assessors of older Māori should be fluent in te reo Māori me ona tikanga where the older person and/or their whānau prefers its use, and should be known and respected in their community.
- Assessors of older Pacific people should be from the same ethnic background and speak the same language as the person being assessed wherever possible.

ASSESSMENT PROCESSES FOR

People living in the community aged 70 years and over
Māori and Pacific people aged 55 years and over
People with pre-existing disabilities aged 55 years and over

Assessment of people with potential needs:

People aged 65 years and over
Māori aged 55 years and over
Pacific people aged 55 years and over
People with pre-existing disabilities aged 55 years and over

- If referred from a primary health care service
- If a risk factor is identified
- If referred by self/carers/whānau/community workers

Assessment of people with known needs:

People aged 65 years and over
Māori aged 55 years and over
Pacific people aged 55 years and over
People with pre-existing disabilities aged 55 years and over

- If referred from a primary health care service
- If in secondary care
- If referred by self/carers/whānau/community workers

Domain: a broad area of health and/or well-being such as 'mental health' or 'physical functioning'.
Integrated service: a single entry service providing interventions and support in multiple domains.

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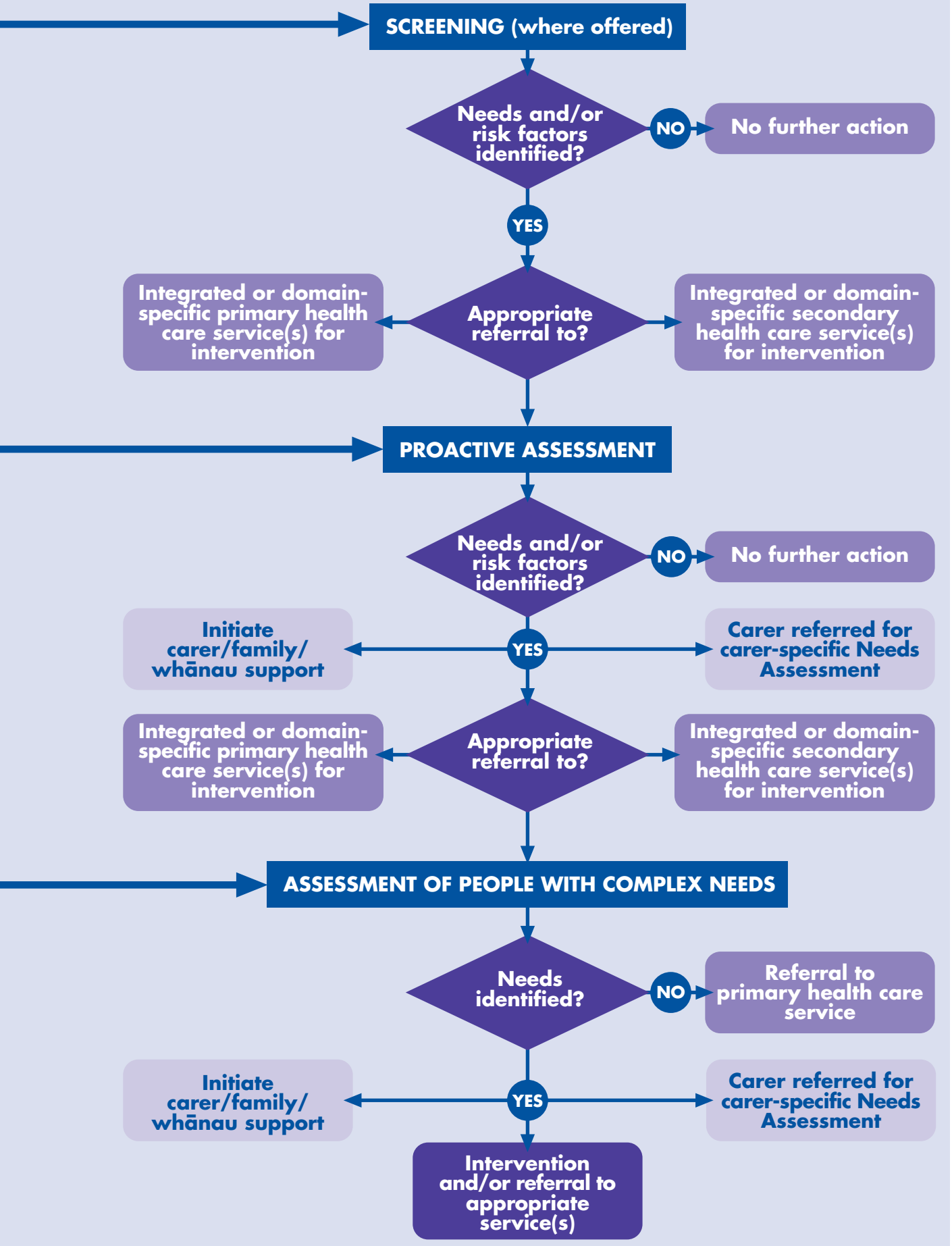
NEW ZEALAND GUIDELINES GROUP

OLDER PEOPLE ALGORITHM



CONSENT, CONFIDENTIALITY AND RISK MANAGEMENT

OVERVIEW

- Informed consent must be sought at the outset of the assessment process.
- Legislation covering informed consent must be observed.
- When assessing Māori, whānau should be involved in the consent process.
- For Pacific peoples, consent is seen as a dynamic relationship rather than a one-off event.
- Assessors need to be aware of the particular issues and protocols concerning consent from people with intellectual disabilities and/or cognitive impairment, or from people with communication difficulties.
- Information gathered in an assessment is subject to the Privacy Act 1993 and information systems should comply with the Act.
- Awareness of and proactive management of risks and barriers will maximise effectiveness of an assessment programme.

CONSENT

The process of assessing the needs of an older person requires informed consent from the person being assessed. The process may involve completion of an interview, questionnaire, performance of tests and other procedures likely to be part of a comprehensive assessment.

Informed consent is itself a process requiring effective communication between all concerned; provision of all necessary information about options, risks and benefits to the consumer; and the consumer's freely given and competent consent.[15] It is imperative that the person performing the assessment obtains permission at the outset for the process. The person being assessed should be informed about the nature and purpose of the assessment, the approximate duration of the assessment, how the information obtained from the assessment will be used, and what may result from the assessment.

The legislation governing informed consent is covered by the Code of Health and Disability Services Consumers' Rights[16], and more information can be obtained on the Code and its application from the Health and Disability Commissioner's website at www.hdc.org.nz

Māori

When assessing older Māori people the person's whānau is integral to the assessment process, providing the person wishes their whānau to be involved, see Chapter 12, *Assessment Processes for Older People: A Māori Perspective*. It is important that members of the whānau are proactively involved in the consent process, and that they collectively consent to the assessment. It is also important that the process of consent is carried out in a manner consistent with the needs of the older person and their whānau.[17]

Pacific Peoples

Within Pacific communities in New Zealand consent is understood to be a dynamic process rather than a single event, with consent needing to be revisited periodically during the assessment process, see Chapter 13, *Assessment Processes for Older People: A Pacific Peoples' Perspective*. Asking for consent requires skill and tact from the assessor.

Older People with Intellectual and/or Other Disabilities

The older person with a disability will usually be able to give informed consent to an assessment process. It is essential that the assessor should have expertise and training in both the type of disability and in issues for older people, and that the issue of consent is handled appropriately.

Right 7, and particularly 7(4) of the Code of Health and Disability Services Consumers' Rights[16] covers informed consent of people who may have diminished competence. Where the older person is not competent to give consent, there may be someone who has been appointed by the Family Court as that person's Welfare Guardian, or someone who holds Enduring Power of Attorney (EPA) (for the person's care and welfare) on that person's behalf. Either of those persons can give informed consent on behalf of the older person. Age Concern have produced information about EPA[18], and further details of its use and implications can be obtained from the Age Concern website at www.ageconcern.org.nz

CONFIDENTIALITY

The information obtained during the assessment of an older person is protected by the legislation on confidentiality of health information.[19] When consent is withheld, it may be because the person has misgivings about the confidentiality of the information gathered. Reassurance about the confidentiality of information when explaining the assessment process may avoid consent being withheld.

The Health Information Privacy Code

The Health Information Privacy Code[20] requires that health information is collected, recorded and accessed under tightly controlled conditions to protect the confidentiality of the individual's information. Assessment processes and any supporting database of information are subject to the Code. It is desirable that any authorities contracting the development of such a database complete a Privacy Impact Assessment prior to development. It is essential that any database designers and managers are familiar with and comply with the requirements of the Code. Further details of the Privacy Code and its relevance to assessment processes and tools may be obtained from the Privacy Commissioner's website at www.privacy.org.nz

RISK MANAGEMENT

Any factor which potentially could undermine the effectiveness or integrity of assessments and consequent interventions constitutes a risk to a programme of assessment for older people. If consumers, carers or health and support workers lose confidence in the programme, the integrity and effectiveness of the assessment will be challenged. Identification and proactive management of such factors will minimise risks to the programme and thus protect the effectiveness of assessment in terms of improved outcomes and cost.

Service Integration

Poorly integrated services are in themselves a risk. For example, the areas of polypharmacy, discharge planning, and effective carer support all demonstrate the benefits of an integrated information and service system.[21](+) An effective, comprehensive assessment process thus requires a supporting system to provide timely and responsible flow of information between sectors. In establishing this intersectoral system, it is important that potential gaps in information and barriers to information flow are adequately addressed. It is important to maintain the older person's right to privacy and confidentiality while achieving the level of information-sharing necessary for a well-integrated service delivery continuum (refer to The Health Information Privacy Code above).

Follow-up: Ensuring Interventions are Initiated

The evidence shows that a comprehensive assessment process alone is insufficient to improve outcomes.[21,22](+) The benefits of a comprehensive assessment for older people are dependent upon the assessment being followed by interventions to address the issues identified by the assessment;[21-28](+) and therefore the benefits are dependent upon funders and services providing such interventions.

Several authors have emphasised that assessment should be limited to those conditions likely to benefit from effective interventions.[27,29-31](+) Assessment will inevitably raise expectations in the older person of treatment and/or help for problems identified by the assessment. If there is no follow-up intervention or case-management provided, those expectations will not be met. It has been argued, therefore, that it is unethical practice to perform assessments unsupported by appropriate interventions.[12,21,32,33](+) However, assessment can provide valuable information for people with a particular medical condition, in terms of their own life planning and decisions, even if there is no treatment for that condition. Furthermore, under the Code of Health and Disability Services Consumers' Rights, Right 4,[16] it is a requirement that people in New Zealand are provided with services appropriate to their needs.

Not all problems identified by an assessment will be amenable to treatment. It is important not to generate unrealistic expectations, nor to over-treat.[12,34,35](+) Clinicians may also be frustrated if no treatment is offered following assessment, and this frustration would be a risk to the assessment programme as it could make clinicians lose confidence in the programme. It is essential that appropriate interventions are made available without significant delay following assessment. Funders of services should therefore use the data provided by assessments for planning resource allocation.

Intersectoral Links

With an intersectoral assessment and referral process, it is important that all participants in the process have a clear understanding of their roles and responsibilities. At each step of the process, it is important that each person involved knows whose responsibility it is to initiate and follow-up referrals and interventions, and that there are systematic checks and reminders in the process to make it as fail-safe as possible. The Code of Health and Disability Services Consumers' Rights requires co-operation and continuity between service providers.[16]

Implementation of Recommendations

Non-implementation of assessment recommendations by the older person, their carer or their health or support care workers is a barrier to effectiveness, and thereby a risk to any programme of comprehensive assessment of older people.[23,27,29,36](+) Such non-adherence may occur for a number of reasons. Any implementation of a comprehensive assessment should be supported by strategies to increase implementation of the recommendations, preferably taking an approach of proactively seeking concordance between those participating in the assessment process, see Chapter 10, *Working Together*.

Bias

The effectiveness of an assessment programme is reduced by variability in the assessments. Variability can be minimised by use of standardised tools. However, lack of validity, sensitivity or reliability in any tools used could also be a risk to an assessment programme, as the tools would be ineffective in detecting needs. Standardised tools that have good validity, sensitivity and inter-rater reliability should be used.[35,37-40](+)

Disempowerment

If an assessment programme is to be successful, it must be accepted and supported by the community. The person being assessed should feel empowered to make choices that enable them to lead as satisfying a life as possible; and that opportunities exist for them to participate and contribute to family/whānau, who in turn feel empowered by the process and outcomes.[21,35,41](+)

KEY - *Grades indicate the strength of the supporting evidence not the importance of the recommendations - see page xvi for details*

A Recommendation is supported by good evidence
B Recommendation is supported by fair evidence
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2

DOMAINS AND DIMENSIONS

OVERVIEW

- Any consumer-focused programme of screening or assessment of older people should use a tool able to assess for need in those areas of life that consumers consider most important. This includes personal care, social participation, control over daily life, food and safety.
- A *domain* is a broad area of health and well-being. A *dimension* is a subset of a domain. Any assessment tool used should be able to assess for needs in the domains and dimensions indicated.

RECOMMENDATIONS: DOMAINS AND DIMENSIONS OF ASSESSMENT	
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/whānau; and the presence, role and potential needs of carers.	A
Carers of older people should be assessed for health, training and support needs.	B
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.	✓

A *domain*, as used in this guideline, is a broad area of health and well-being such as 'mental health' or 'physical functioning'. A *dimension* is a subset of a domain, such as 'depression' or 'dementia' in the case of mental health, or such as 'mobility' or 'continence' in the case of physical functioning.

The extent to which each dimension of each domain is assessed will vary according to the level of assessment, from screening to assessment of older people with complex needs. All screening and assessment programmes must include those domains that older people themselves consider to be most important.[42](+)

In addition, the assessment should cover the domains and dimensions known to be potentially those in which people will become impaired, and in which impairment can be detected at an early stage. This will allow interventions to be initiated proactively, maximising the effectiveness of the assessment.

Therefore, assessment of older people at any level must be sensitive to all the domains and dimensions listed in Table 1.[43](**x**) Those dimensions for which there is strong evidential support at the different levels of assessment are indicated.

Table 1: Domains and Dimensions of Assessment

Domains	Dimensions	Screening and proactive assessment	Assessment of people with complex needs	Assessment of people with disabilities	Carers
Physical health and functioning		☑	☑	☑	☑
	aged 75 years or older **R**	**E**	**E**		
	medical conditions			**E**	
	chronic illness		**E**		
	co-morbidities (ie, suffering multiple disorders or illnesses) **R**	**E**	**E**		
	cardiac conditions		**E**		
	gastrointestinal conditions		**E**		
	pulmonary conditions		**E**		
	cerebrovascular conditions		**E**		
	continence		**E**		
	is recently discharged from hospital **R**	**E**	**E**		
	has presented at an emergency department **R**	**E**	**E**		
	has had a change in health status with impact on capacity for independent living **R**	**E**	**E**		
	has poor self-perceived health **R**	**E**	**E**		
	gait		**E**		
	mobility			**E**	
	low physical activity	**E**	**E**		
	ADLs and IADLs		**E**		**E**
	is at the lower extreme of functional impairment	**E**	**E**		
	dental/oral health	**E**	**E**		
	sexual functioning	**E**	**E**	**E**	
	food/nutrition !		**E**	**E**	
	has a high or low body mass index **R**	**E**	**E**	**E**	
	impairment in sight or hearing	**E**	**E**	**E**	
Safety !		☑	☑	☑	☑
	control over daily life !	**E**	**E**		
	abuse (by another person)	**E**	**E**	**E**	**E**
	emergency planning				**E**
Polypharmacy (taking three or more prescription or non-prescription medications) **R**		☑	☑	☑	

		☑	☑	☑	☑
Mental health					
	emotional well-being	E			
	depression **R**	E	E	E	
	cognitive impairment/functioning **R**	E	E		
	anxiety		E	E	
	other mental illness		E	E	
	dementia		E		
	substance abuse		E		
	alcohol, tobacco and/or substance use	E	E	E	
	iatrogenic mental illness due to polypharmacy		E	E	
Personal care !		☑	☑	☑	
	domestic abilities			E	
Social functioning and context !		☑	☑	☑	☑
	family/whānau support/contact		E	E	E
	socially isolated (not necessarily living alone) **R**	E	E		
	living alone **R**	E	E		
	divorced/separated **R**	E	E		
	never married **R**	E	E		
	single or widowed **R**	E	E		
	recently bereaved **R**	E	E		
	no children **R**	E	E		
	has poor or limited economic resources* **R**	E	E		
	financial status and management		E	E	E
	housing	E	E	E	E
	future planning				E
	language and communication	E	E	E	E
	relationships with services				E
	transportation				E
	information needs				E
	equipment needs				E
	co-ordination of services				E
The presence and roles of carers		☑	☑	☑	
	carer showing signs of stress, or a change of carer **R**	E	E		
	carer requests an assessment for the older person **R**	E	E		
	respite needs				E
	relationship with care receiver				E
	emotional support for care receiver				E

Key for Table 1

R denotes risk factors

! denotes areas of most importance to older people

☑ recommended

E denotes strong evidential support

*In New Zealand, for example, where the person's sole source of income is New Zealand Superannuation.[43,44](x)

SCREENING AND PROACTIVE ASSESSMENT

To be effective, screening and proactive assessment should assess domains of potential impairment[45-49](+), for factors identified by the evidence as risk factors for health or functional impairment:[8,38,45,50-54](+), for alcohol, tobacco and/or substance use[43](x) and for abuse of the person by another.[55](~)

See Table 1 for a detailed list of domains and dimensions to be assessed when screening and assessing older people.

OLDER PEOPLE WITH COMPLEX NEEDS

The research literature indicates that a complex needs assessment should assess for:

- risk factors[7,12,21,25-29,45,47,48,56-72](+)
- physical health/functioning[12,21,24-26,28-30,45,47,48,52,53,58,61,62,73,75-87](+)
- mental health[21,23-25,27,29-31,40,45,52,57,58,61,69,73,75,78-81,84,88-105](+)
- the presence and roles of carers, especially informal carers[23,34,62,74,106-118](+)
- social functioning[23,24,45,47,48,49,52,56,64,74,79,80,83,85,119-130](+)
- abuse[55](~)
- alcohol, tobacco and/or substance use.[43](x)

See Table 1 for a detailed list of domains and dimensions to be assessed when assessing older people with complex needs.

OLDER PEOPLE WITH PRE-EXISTING DISABILITIES

Any screening or assessment for people with disabilities must have the ability to detect risk and or 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.[70,106,131-136](+)

See Table 1 for a detailed list of domains and dimensions to be assessed when assessing older people with pre-existing disabilities.

CARERS

People who are carers have particular needs, both in their own right, as well as in terms of providing effective care for an older person, that should be addressed by any assessment process. The evidence shows the areas listed as those in which carers most frequently have needs for intervention.[137](+)

See Table 1 for a detailed list of domains and dimensions to be included in a carer-specific needs assessment.

SCREENING FOR IMPAIRMENT AND RISK FACTORS FOR DEVELOPING FUTURE IMPAIRMENT

OVERVIEW

- Overseas evidence has shown that:
  - screening of older people is an effective way of identifying people with previously unrecognised impairment and/or risk factors for developing future impairment
  - screening of asymptomatic members of a defined population group produces greater overall improvement in health and well-being than screening only targeted subgroups
  - screening tools must accurately assess the areas of need that have been found to be of most importance to older people, risk factors for developing health or functional impairment, and domains of potential impairment
  - quality monitoring of screening is important to reduce the risk of harm to screened individuals and ensure the best possible outcomes from screening
  - follow-up from screening including further assessment and/or interventions must be provided soon after the screening process.
- There is no valid screening tool known to be wholly effective in the New Zealand setting.
- There is currently no New Zealand data from which to determine cost-effectiveness of screening.
- Currently there is insufficient evidence directly applicable to New Zealand to support a national population screening programme.

RECOMMENDATIONS: SCREENING	
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
Any screening tool used in New Zealand should be adapted appropriately, piloted and evaluated before regional or national screening programmes are considered.	C
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
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

The New Zealand National Health Committee[138] defines screening as:

> A health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by, a disease or its complications, are asked a question or offered a test to identify those individuals who are more likely to be helped than harmed by further tests or treatments to reduce the risk of disease or its complications.

In the context of this guideline, the screening would be to identify asymptomatic need, or symptomatic need previously unidentified, or risk factors known to be linked with increased need for health care and social services. The complexity of health and social support needs in later life require multidimensional assessments at an early stage, the earlier the better, in order to maximise benefit.[45](+)

However, there are currently no New Zealand data quantifying the benefits or harms of population screening of asymptomatic older people for risk factors and needs, nor adequate local data to suggest that an organised national population screening programme would be beneficial. If practitioners are to offer screening to older people on a regional level, they should ensure that there is a process for auditing the screening to ensure it is both safe and effective, and to monitor outcomes. Anyone offered the screening should be fully informed of the potential individual benefits and harms of screening.

SCREENING APPROACHES

Overseas literature on screening of older people to detect the needs of older people describes a two-stage process. The first stage involves systematically or opportunistically screening the asymptomatic population at the primary health care level to identify any existing disabilities or other unmet needs. If any issues are identified in the screening, this is followed by a second stage consisting of a multidimensional comprehensive assessment.[45,50,51](+) The potential for overlooking reversible situations supports the integration of early intervention and multidisciplinary professional contributions.[45,73,139-141](+)

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✓ Good Practice Point

A second approach described in the overseas literature is to screen for risk factors for present or future functional disability, followed by a two-stage case-finding/assessment process, repeated periodically.[46,142](+) One suggested possibility is screening of general practice-held medical records for people with known risk factors for the development of later disability and/or health impairments then targeting those people with such risk factors.[50](~) However, this approach would raise considerable privacy concerns. In addition, it would not reach people who do not go to their doctor or for whom there are only very limited health records.

OUTCOMES OF SCREENING OLDER PEOPLE FOR RISK FACTORS AND POTENTIAL IMPAIRMENT

International evidence has shown screening of older people to be an effective way of identifying people with risk factors and/or developing needs.[32,119,120,143](+) An Australian review of comprehensive geriatric screening and targeted assessments performed in the UK, USA, Canada, Denmark and the Netherlands between 1979 and 1999, found that screening of the asymptomatic general population resulted in the greatest improvement in outcomes in terms of overall health and well-being compared with projects which targeted specific groups.[45](+)

This finding is supported by other trials and systematic reviews of trials of screening asymptomatic populations in the UK, US, Netherlands, Canada and Denmark, with the numbers of people involved varying between a few hundred to more than 30,000.[47,88,119-121,144-146](+) For example, a trial in the US screening 1126 community-dwelling people aged 65 years and over for nutritional risk found 57% of those screened (and a greater proportion of those living rurally) had inadequate nutrition. They were consequently at greater risk of increased mortality, morbidity and reduced health outcomes, which could be avoided through detection and appropriate intervention.[120](+)

Another US study screening 6205 people aged 65 years and over for risk factors found that previously unidentified risk factors were detected in 52.1% of the screened participants, of whom two thirds received referral to appropriate services.[142](+) Similarly, a US randomised controlled trial with 414 asymptomatic people aged 75 years and over, found that annual screening, plus quarterly home visits (and interventions for needs identified), delayed the onset of disability, reduced the number of days of dependency and improved quality of life over the three years studied.[89](~)

Even those studies reporting little or no benefit from screening do not provide substantial evidence against comprehensive screening of older people. For example, a trialled screening of 1121 older people in the Netherlands for four specific disorders (impairment in hearing, vision, continence, and mobility), reported the benefits gained were too small to support screening. However, the screening was for a very limited group of disorders and it is possible that people with these disorders may have already sought early help. In all, 19% of the screened participants who agreed to remedial interventions showed improvement.[144](+) Many such studies of screening in the US and UK report that the participants' mental health improved, use of services reduced, or the rate of functional decline was reduced.[51,56,57](+) One group of authors point out that *'…programs targeted to exclude [people not already known to be impaired] may miss the opportunity to alter functional decline in well-functioning older people….. intervention successfully modified risk factors for disability before irreversible disability developed.'*[89](~)

However, although overseas evidence demonstrates effectiveness of screening older people, there is no New Zealand evidence specifically about screening older people in this country, and none of the screening tools currently used internationally are directly applicable to New Zealand without modification for the local conditions and population.[147](~)

SCREENING PROCESSES FOR OLDER PEOPLE IN NEW ZEALAND

Screening

There is a lack of local evidence about screening of older people in New Zealand on which to base a recommendation for national screening programmes. The evidence from screening overseas is sufficiently compelling that screening of older people in New Zealand should be systematically trialled at a local level.[43](x) However, screening will inevitably initially generate additional demand for services, and some attempt should be made to model, from results of pilot studies, the impact of this additional demand on services and resources. Once modelled, proactive measures, such as resource reallocation and effective scheduling, may be taken to minimise the negative impact.

No evidence was found of single-domain screening being more effective than multidimensional screening. Where multidimensional screening was used, any need for single-domain intervention was addressed through a more in-depth assessment triggered by a combination of multidimensional risk factors and/or existing impairment found by the screening. Therefore, where screening is offered, it should be multidimensional.

When to Screen

People show increasing levels of impairment as they age. For the general population in New Zealand, screening should be of people aged 70 years and over, as this is the age at which levels and severity of disability, and avoidable hospital admissions, are known to increase.[7] For Māori, Pacific peoples and people with pre-existing disabilities, comparable increase in levels and severity of disability are found earlier, at age 55, and any screening offered should therefore be commenced at 55 years.[74](+) Where offered, screening should be repeated annually.[43](x)

What to Screen for

Domains and dimensions of screening are addressed elsewhere in more detail but in summary, the evidence shows that to achieve most benefit from screening, a multidimensional screening should address:

- areas of need shown to be of most importance to older people
- factors identified by the evidence as risk factors for health or functional impairment
- domains of potential impairment.[8,38,42,45,50-54](+)

Screening Tools

Screening tools are discussed in detail elsewhere. There are no screening tools which have been rigorously trialled and evaluated for use in a New Zealand setting. Therefore any screening tool used for screening older people in New Zealand should be adapted appropriately, piloted and evaluated before regional or national screening programmes be considered.[43](x)

If the tool chosen requires someone to administer it, then to be effective, the screening staff must receive specific training in the screening process.[35,37,39,40,45,148](+) The evidence does not indicate that screening staff should be from any particular discipline. For more information on the attributes needed in an assessor, see Chapter 9, *Assessor Skills and Support*.

National Population Screening Programmes

The New Zealand National Health Committee has established a set of criteria for establishment of any national screening programme.[138] These criteria should be considered in relation to regional screening programmes for older people.

The suitability of the health problems of older people for screening, and the ability to detect and effectively treat problems at an early stage, are well documented.[7,25,45,48,51,58-60,75,90,122,140,149,150-154](+) However, the availability of validated and safe screening tools is currently a problem and potentially suitable tools need to be adapted, tested and evaluated within the New Zealand setting. The acceptability of the screening process would need to be established within the New Zealand population before any large-scale or national programme commenced.

The National Health Committee differentiates screening programmes from opportunistic screening, saying that in *'…screening programmes, all activities along the screening pathway are planned, co-ordinated, monitored and evaluated.'* Quality monitoring of screening is important to reduce the risk of harm to screened individuals and ensure the best possible outcomes from screening.[138] As there is a lack of New Zealand evidence about the effectiveness of both screening and needs assessment processes in older people,[11](~) it is particularly important that any screening should be performed, monitored and evaluated systematically to provide a source of reliable, comparable data.

Uptake of Screening

There are various forms of administration of screening tools for older people. Self-administered questionnaires, telephone interviews, home visits, dedicated community centres/older people screening centres, and clinics have all been used. The method of administration needs to be effective in terms of maximising uptake, and cost-effectiveness.[138]

Strategies that improve uptake of screening include:[155](+)

- invitation appointments, letters and telephone calls
- telephone counselling
- removal of financial barriers (eg, provision of transport and/or postage).

Strategies that are sometimes effective in improving uptake include:[155](+)

- educational home visits
- opportunistic screening
- multicomponent community interventions
- reminders for non-attenders
- invitation follow-up prompts.

Educational materials or sessions, and face-to-face counselling appear not very effective, while incentives or rewards appear completely ineffective in improving uptake of screening.[155](+) In order to maximise the uptake of any screening programme, therefore, older people should receive a letter or telephone call explaining and inviting them to complete the screening, and any costs involved should be disbursed.

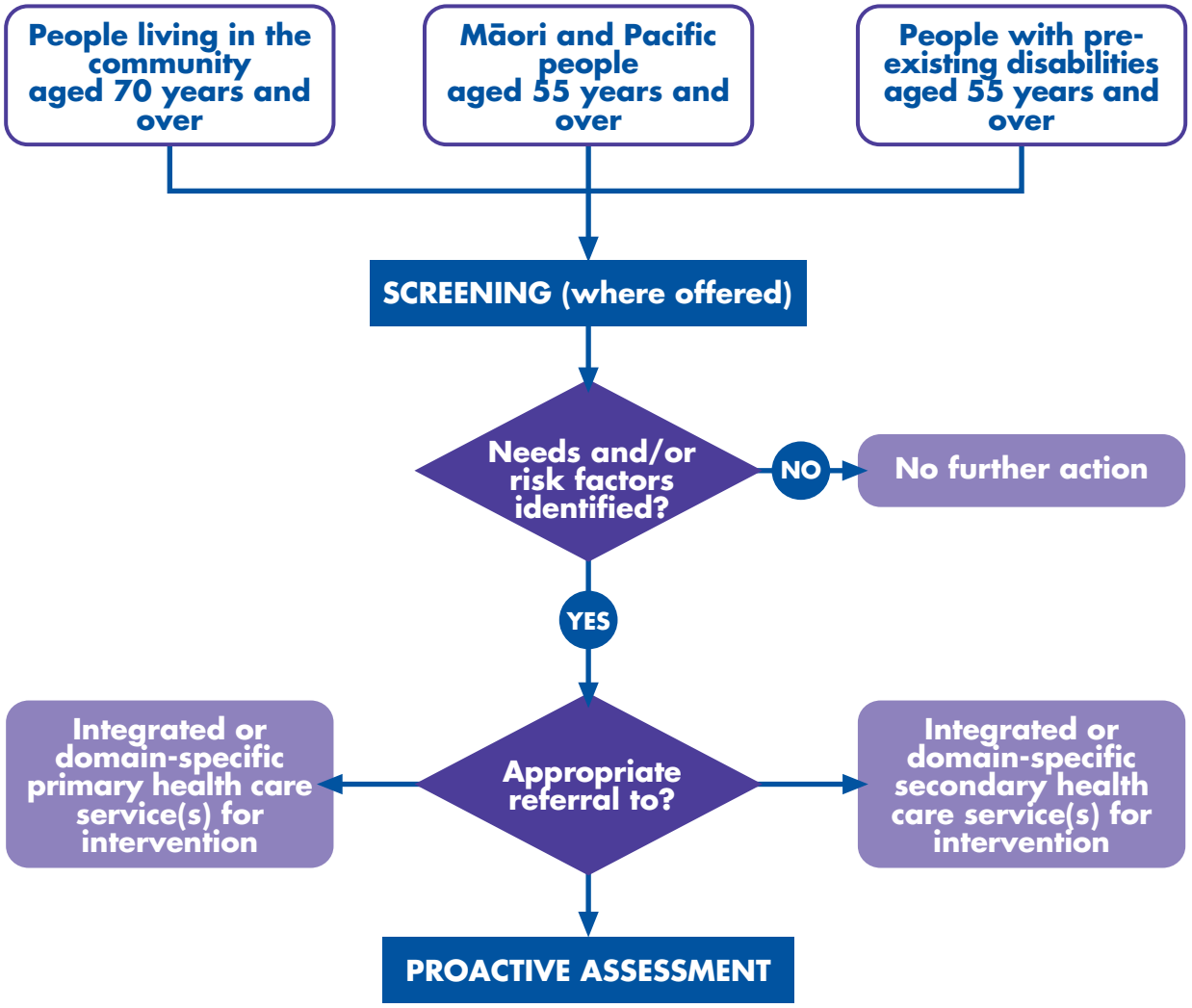
After Screening of Older People

Any process of assessing for needs, including screening, is concerned with the identification of needs in the person being assessed. Any subsequent benefit in health and well-being depends upon the interventions initiated to address the findings of the assessment process. It is implicit in, and essential to the success of any screening, that any issues identified will, where possible, be addressed. Too

great a delay between the screening and assessment and any follow-up causes distress to the older people being assessed. Follow-up from screening including further assessment and/or interventions must be provided soon after the screening process.[43] **(x)**

Furthermore, it is unethical to screen older people without following up any identified issues.[91] The National Health Committee states that *'… Once the invitation to be screened is issued, there is an ethical obligation to ensure that the screening programme can deliver the potential benefits.'*[138] It is therefore important that any screening offered is supported by resourcing to address identified issues. This resourcing should be established before the commencement of screening.[43,138] **(x)** Results of pilot studies should be carefully evaluated to predict pressures on services and resources likely to result from screening.

ALGORITHM: SCREENING FOR IMPAIRMENT AND RISK FACTORS FOR DEVELOPING FUTURE IMPAIRMENT



Domain: a broad area of health and/or well-being such as 'mental health' or 'physical functioning'
Integrated service: a single entry service providing interventions and support in multiple domains

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4

PROACTIVE ASSESSMENT: EARLY INTERVENTION

OVERVIEW

- There is little evidence on the effectiveness of current assessment practice in New Zealand.
- Currently there is no consistency of assessment across New Zealand.
- A proactive assessment would aim to detect problems at an early stage to allow for early interventions and reduce irreversible disability.
- In the long term, multidimensional assessment of older people improves health and well-being in the older person and their carers.
- Assessment must be followed by timely interventions.

RECOMMENDATIONS: PROACTIVE ASSESSMENT	
Proactive assessment of older people should be comprehensive and multidimensional.	A
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/whānau or carer; or is in contact with health or social services.	B
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
Regular follow-up should form part of the process of proactive assessment of older people.	A
The proactive assessment process should be used as an opportunity for health promotion, disease prevention, treatment, and care management.	✓

The difference between screening and proactive assessment, is that in the case of proactive assessment, the person being assessed has presented to primary health care services. For the purposes of this guideline, the Guideline Development Team

has defined *proactive assessment* of older people as a preventive assessment that tests for unmet needs in different domains (including physical and mental health, functional performance and social functioning). A proactive assessment would have the aim of detecting problems at an early stage in order to initiate interventions designed to improve health, reduce disability and functional decline, improve social participation and improve the older person's quality of life.

While standardised tools are frequently used overseas, assessment (NASC) practice in New Zealand over the last ten years has favoured a narrative approach with single domain standardised assessment tools widely used as local and international benchmarks to inform the assessments. This approach, with its lack of standardisation and formal evaluation, has limited the development of a research base, and consequently there is no evidence about the effectiveness of assessment processes in New Zealand.[11](~) The evidence shows that the New Zealand approach to assessing people 'with few needs' as it is often termed, without considering reversibility, has generally not worked well for the older person concerned.[11,43](~)

There is an extensive body of international literature showing that in the long term, comprehensive, multidimensional assessment of older people improves outcomes in terms of health and well-being in the older person and their carers.[22,23,29,30,45, 52,57,58, 61-65, 75-79, 88, 89, 92,123,144,156-158](+) No evidence was found to support single-domain assessment. The evidence is that a lack of adequate assessment results in avoidable poor health and disability.[7,12,25,45,48,60,66,67,73,78,80,89,93,139,140,159,160,161](+) Therefore, older people with few needs should be offered a multidimensional assessment.

WHEN TO PERFORM A PROACTIVE ASSESSMENT

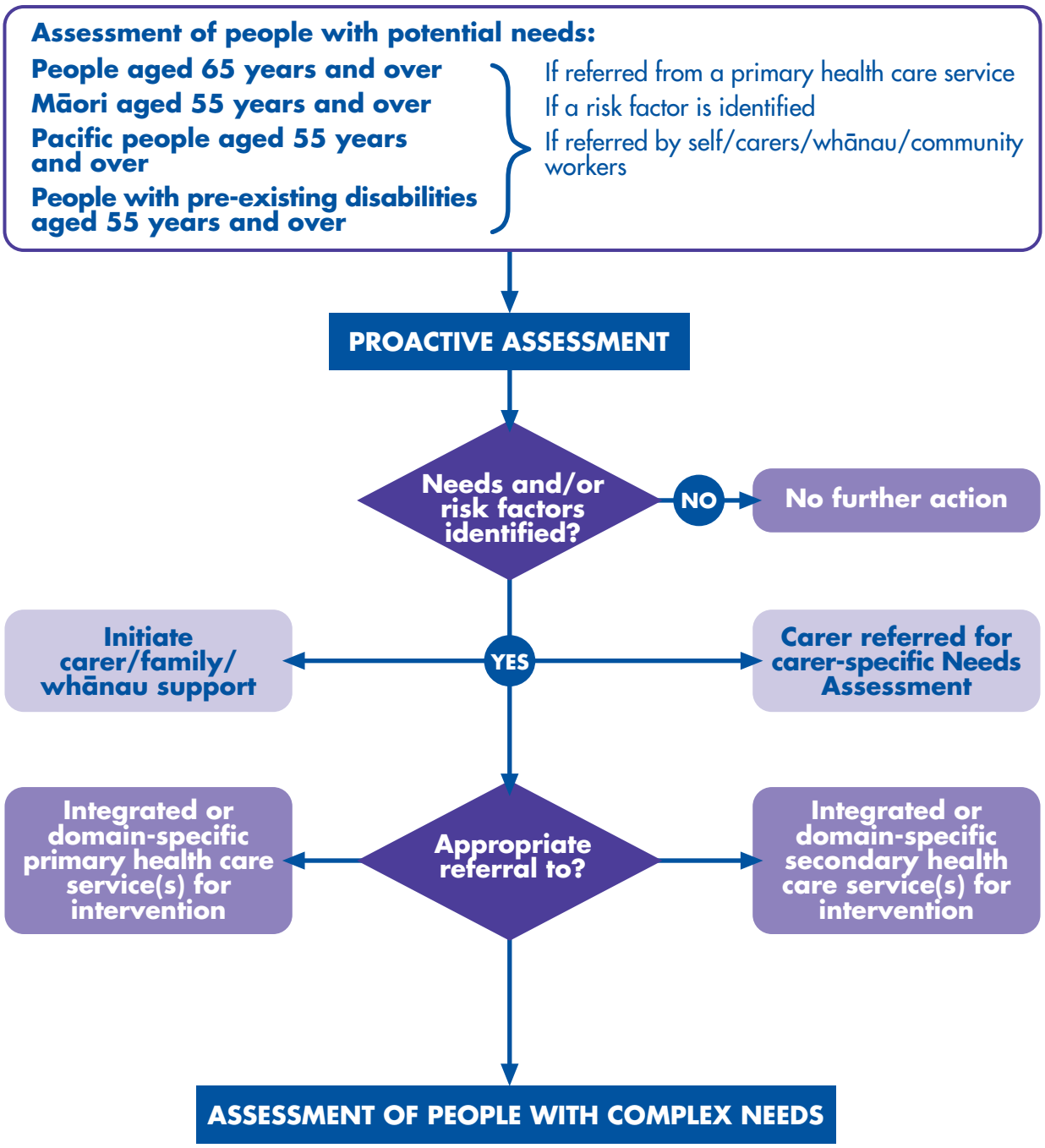
The complexity of health and social-support needs in later life requires multidimensional assessments at an early stage, the earlier the better in order to maximise benefit.[45](+) When an older person comes to the attention of primary health care or social services, it is an opportunity for a proactive assessment if the person has not received one in the last six months. Social presentations, such as caregiver request, or relating to a change in living circumstances, are also significant.[51](x) Identification of risk factors through screening (where used) would also trigger an assessment.

Maximum benefit from the proactive assessment process will be gained if it is used as an opportunity for health promotion, disease prevention, treatment and care management.[43](x)

AFTER PROACTIVE ASSESSMENT OF OLDER PEOPLE

The evidence shows that an assessment with inadequate follow-up can lead to negative outcomes, so it is essential that regular follow-up is part of the overall process.[12,21,22,28,31,91,151](+) It is also important that the assessment is supported by effective interventions to address any issues identified.[12,21,32,91](+)

ALGORITHM: PROACTIVE ASSESSMENT



Domain: a broad area of health and/or well-being such as 'mental health' or 'physical functioning'
Integrated service: a single entry service providing interventions and support in multiple domains

KEY - *Grades indicate the strength of the supporting evidence not the importance of the recommendations - see page xvi for details*

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ASSESSMENT OF OLDER PEOPLE WITH COMPLEX OR MANY NEEDS

OVERVIEW

- 'Complex needs' is the term used to describe those needs of people with multiple health, functional and/or social problems, of vulnerable health, or at risk of functional decline and/or hospital admission.
- Older people with complex needs are known to be at risk.
- All older people with complex needs should receive a comprehensive, multidimensional assessment when they come into contact with health care or social services, or when an assessment is requested by carers, family or professionals involved in their care and support.
- Following assessment, a treatment plan should be developed by the older person and the assessor.
- Regular follow-up contact is necessary to maintain the benefit of assessments and avoid negative outcomes.

RECOMMENDATIONS: ASSESSMENT OF COMPLEX 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.	✓

Despite the considerable body of research literature on assessment of older people with complex needs, there is no standardisation of the terms used. For example, published research uses a variety of terms for assessment of people with complex needs, most usually 'comprehensive geriatric assessment'. However, comprehensive geriatric assessment is also used to mean an assessment that is comprehensive in

the level of detail, or one that is comprehensive in its scope (the different domains and dimensions covered).

Similarly, there is no standardisation of what is meant by 'complex' need. Definitions vary, from older people reaching a certain age;[47](+) those with a number of risk factors for decline of function or in health;[28,31,162](+) those with risk factors likely to exacerbate disability;[25](~) through to those at high risk of functional decline;[68](~) and to those who have specific existing (known) conditions,[24, 69,73,164](+) sometimes including polypharmacy,[24,163](+) chronic medical conditions,[24](+) or chronic functional impairment[81](+) as a requirement. A few studies have assessed complex needs only within an emergency department[28,82](+) or in those admitted to hospital,[24,61,69](+) while others have only assessed people who were eligible for home-care services[56,165](+) or who were in or about to enter residential care.[58,61,79,166-170](+)

However, it is generally agreed that 'complex' needs are those resulting from multiple, usually interrelated, problems[30,94](+) over several different physical, mental and social dimensions of health and well-being,[30,68,156](~) where the person is showing signs of functional decline[30,69,81,94](+) or frailty (that is, in a vulnerable state of health).[27,29,94,163](+) For the purposes of this chapter, therefore, complex needs is used to describe the needs of people with multiple health, functional and/or social problems, who are of vulnerable health, or at risk of functional decline and/or hospital admission. 'Comprehensive assessment' is used to mean an in-depth, multidimensional assessment of people with complex needs.

ASSESSMENT OF OLDER PEOPLE WITH COMPLEX NEEDS

People with complex needs are known to be at risk,[25,38,45,46,48,51,58,119,139,140](+) and therefore to require assessment. There was no evidence found to support the use of single-domain assessments rather than a comprehensive, multidimensional assessment for older people with complex needs. There is strong evidence that all people with complex needs should receive a comprehensive, multidimensional assessment supported by any treatment or interventions indicated by the assessment. Benefits of this type of assessment for people with complex needs have been shown to include:

- improved diagnostic accuracy[24,27,28,30,53,95,156](+)
- improved effectiveness of care[21,24,26,28,30,69,79,139,166,171](+)
- improved functionality or reduced functional decline[22-24,26,29-31,53,61,64,69,77,92, 95,96,169,172](+)
- prolonged survival[23,30,45,53,73,95,172](+)
- prolonged maintenance of independence[23,28-30,165,169](+)
- improved quality of life[24,30,45,53,61,79,95,96,164](+)
- improved mental health[24,53,61,69,95,171](+)
- improved client satisfaction[30,31,53,158](+)
- improved primary physician satisfaction[24,29,31](+)
- reduction in burden for carers and improved carer satisfaction[31](+)
- decreased use of hospital and/or residential care[21,23,26-28,30,53,61,64,92,95,169,173](+)
- decreased or no increase in cost of care.[24,29,31,174](+)

When to Perform a Comprehensive Assessment

Older people should receive a comprehensive assessment:

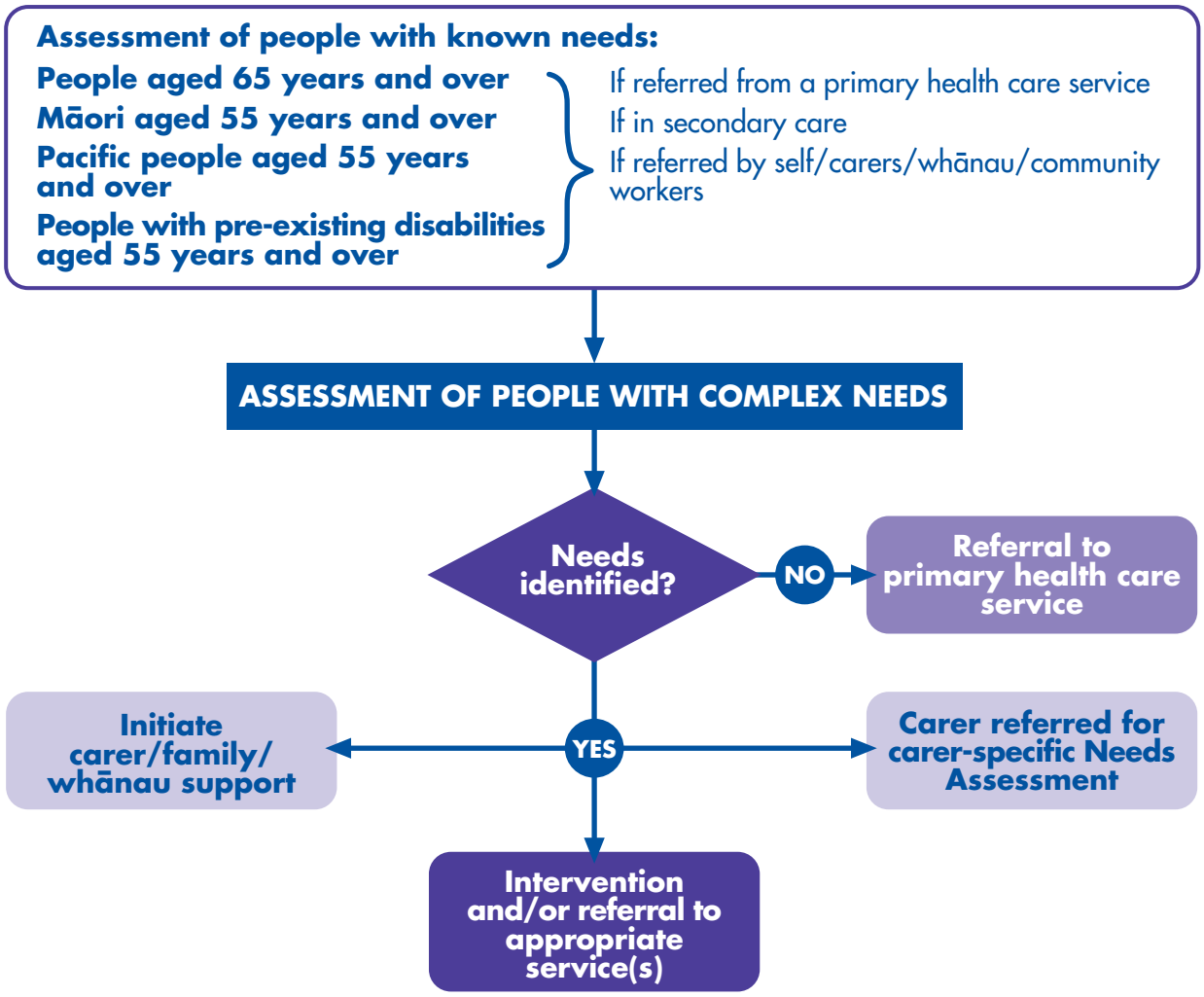
- when a comprehensive assessment is triggered by a proactive assessment[43](**x**)
- prior to discharge when they have presented at an emergency department[11,28](**+**)
- when they are referred to or receiving secondary health care services, including acute care[21,26,27,47,61,62,64,69,70,81,82,131,141,153,157,168,175-178](**+**)
- when they are referred for comprehensive assessment by primary health care or social services[43](**x**)
- when they are referred by community workers, carers or family/whānau.[43](**x**)

After Comprehensive Assessment of Older People

The evidence is very clear that the comprehensive assessment process alone is insufficient to improve outcomes.[21,22](**+**) It is essential that the assessment is supported by interventions to address any issues identified.[22-29,163,166,179](**+**) The evidence also shows that a comprehensive assessment with inadequate follow-up can lead to negative outcomes, particularly in the three months following assessment.[21,22,28,151](**+**)

Following comprehensive assessment, an ongoing treatment, rehabilitation and care plan should be developed in consultation with the person. This should include a process to ensure adherence to the plan, both by the older person and by professionals involved in the care of the older person.[43](**x**)

ALGORITHM: ASSESSMENT OF PEOPLE WITH COMPLEX NEEDS



Domain: a broad area of health and/or well-being such as 'mental health' or 'physical functioning'
Integrated service: a single entry service providing interventions and support in multiple domains

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CARERS

OVERVIEW

- 'Carers' refers to all people caring for older people, including older people caring for others.
- Carers have particular needs resulting from their carer role, and supporting those needs results in improved outcomes for both the carer and the care recipient, including a reduction in abuse in caregiving situations.
- Carer needs assessment should be integrated with any programme of assessment of older people.

RECOMMENDATIONS: CARERS	
Carers of older people should be assessed for health, training and support needs.	B
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.	I
There is insufficient evidence to determine who should perform assessments of the needs of carers.	I
Assessment of the needs of carers should be linked with the assessment of older people.	✓

There are two groups of carers for whom this guideline is relevant: people of any age who are carers of older people, and older carers, who may have needs due both to their age and to their carer role.

There is growing international evidence of the value of assessing the health, training and support needs of older carers or carers of older people. The evidence identifies health benefits to both carers in their own right and to those for whom they care. It is clear that people who are carers have particular needs that should be addressed by any assessment process, both in their own right, as well as in terms of providing effective care for the older person.[137] **(+)**

CARERS OF OLDER PEOPLE

Carers of older people are more often women and, in the case of spouse-carers, are often older themselves. Younger carers – sometimes known as the 'sandwich generation' – may be caring for both the older person and their own children,[132,180](~) often with a lack of needed support.[106](~) There is good evidence to support the need for carer assessments: assessments of carers (supported by interventions) have been shown to reduce carer burden and improve the carers' quality of life,[95,107,164](+)and to reduce stress and anxiety.[163](+) In one study, staff of a geriatric unit rated a carer-strain screening tool as the most useful component of a package of standardised assessments.[141](x)

Furthermore, assessment of carer needs can be useful in avoiding elder abuse.[181](~) The limited information available specifically about the needs of those who care for older people should be noted. Particular gaps in the research include differences in rural and urban caregiving, caregiving for older people with mental health problems, and the support needed by caregivers who are in other employment. It is also noteworthy that much of the evidence reviewed in the preparation of this guideline does not specifically consider the impact on carers of differential outcomes for the care recipient.

There is insufficient evidence to determine whether carer assessment is more effective when part of or connected with an assessment of the person being cared for, focusing on carer stress and burden, or whether an independent carer assessment would be more appropriate. There is, however, some evidence of the value of support, education, training and upskilling of carers.[108] Therefore, it is clear that carers of older people should be assessed for unmet health, training and support needs.

Carer assessments have been administered in differing ways: self-assessments,[82](~) assessment by a multidisciplinary team (MDT),[109,163,182](+) by social workers[34,95,183](+) and by nurses.[95,108,110,156](+) However, there is insufficient evidence to indicate who should perform the assessment for the best outcomes.

There is, however, some evidence supporting the use of a specifically-designed tool for the assessment of carer needs. This need has recently been addressed in Canada, leading to the development of assessment tools for carers.[137](+) A specifically designed tool of this sort should be used for the assessment of carer needs to ensure standardisation and collection of appropriate information.

CARERS OF PEOPLE WITH INTELLECTUAL DISABILITIES

Carers of older people with intellectual disabilities are usually older themselves, typically parents. In addition, there are older parents who are still caring for a younger adult with intellectual disabilities. It is also relevant to consider the needs of carers whose son/daughter may be in residential care, as 'non-home' carers still show high levels of commitment and involvement in that care, and anxieties about future care.[184](+)

Carers of people with intellectual disabilities are known to have specific issues. For example, fathers of intellectually disabled people have been identified as having less coping ability than mothers,[132] but all carers have high levels of unmet need.[106](~) It is important that a family-oriented approach is taken.[183](+) Therefore the needs of older carers of people with intellectual disabilities should be assessed.

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ASSESSMENT TOOLS

OVERVIEW

- An assessment tool (a collection of appropriate measures) is a key part of an assessment programme.
- There is currently no standardisation in the assessment of unmet needs of older people in New Zealand.
- Standardisation of assessment processes and the tools used is essential to ensure equity of service, allow for evaluation and inform planning for resource allocation.
- A standardised database for storing records and other information pertaining to assessment is essential to support the assessment process.
- Any tool used should be adaptable to the demands of different cultural populations, such as Māori and Pacific peoples.
- Any tool used should also be capable of assessing domains and dimensions of potential impairment, where impairment can be detected at an early stage, as well as the presence and roles of carers.
- None of the currently available tools completely fulfil the requirements of a tool for New Zealand; however, there are some that are close to meeting requirements and that provide a basis for further development.
- Existing tools require modification to meet the particular needs of New Zealand, but tool developers have indicated their willingness to participate in this process.

RECOMMENDATIONS: 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
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

RECOMMENDATIONS: ASSESSMENT TOOLS (CONTINUED)	
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.	✓
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.	✓

An 'assessment tool', defined as *a collection of scales, questions and other information, to provide a rounded picture of an individual's needs and related circumstances,*[178] is a fundamental part of the assessment process. However, currently there is no New Zealand-wide systematic screening or assessment of the needs of older people.[11](~)

STANDARDISATION

Standardisation of assessment processes, including the tools used, across New Zealand is essential to assure older people that their needs are being appropriately assessed, with the best available measures and techniques available for this purpose.

Comprehensive assessments that include the use of a standardised tool allow for comparability of data as well as time-trend analyses, regionally, nationally and internationally.[31,64,73,79,151,168](+) The lack of comparability and evidence about effectiveness and costs of assessment processes in New Zealand[11](~) is a hindrance to developing, maintaining and evaluating equitable services. The ability to evaluate and compare services is an essential requirement of providing effective, equitable services for older people within New Zealand.[4,7,25,74,138](+) Use of a standardised tool can also allow the funders of services supporting the assessment to predict service demands and allocate resources accordingly.[153,178,185](+) Therefore any screening or assessment should use standardised tools with valid, sensitive and reliable methods of collecting, reporting and comparing data. Before selection of any national tool, pilot studies using the tools within New Zealand should be conducted to determine costs, training needs and any modifications that may be required.

Evidence also supports developing a standardised, nationally and internationally comparable database/dataset for storing records and other information pertaining to assessment which will enhance the capacity for evidence-based best practice, provide a quality-monitoring potential through standardised monitoring of outcomes; and allow for detection (and therefore addressing) of regional inequities.[61,147](+) A standardised tool will enable the development of such a database,[43](x) while at the same time assuring older people that their needs are being assessed in a valid, reliable and sensitive manner.

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✓ Good Practice Point

Furthermore, the evidence shows that potentially treatable conditions may be missed or minimised in an interview-only assessment, and/or in self-report.[12,21,77,143](+) The use of appropriate standardised tools can protect against potential bias, if they have been tested for inter-rater reliability, and if critical risk factors can be identified.[35-37,40,64](+)

Effective use within New Zealand also requires that any tool used should be adaptable to the demands of different cultural populations, such as Māori and Pacific peoples. Similarly, it should also be able to identify the presence and roles of carers, and should include or be compatible with a specifically designed assessment of carer needs.

CRITERIA FOR ASSESSMENT TOOLS

A suitable assessment tool is thus a significant part of improving practice. The one chosen should meet the following criteria:[43,147](~)

- be capable of detecting risk factors and impaired health or function, see Table 1
- have good *validity* (ie, good at detecting what it is designed to measure)
- have good *sensitivity* (ie, it will detect most cases of need)
- have good *inter-rater reliability* (ie, it will obtain the same results regardless of who is using it)
- be *standardised* (ie, it should have been systematically tested to ensure consistency of performance)
- be adaptable to the demands of different cultural populations, particularly Māori and Pacific peoples
- have provision for comment/open-ended questions
- be supported by and feed data into a database, allowing for monitoring and evaluation
- be practical to administer
- include or be compatible with a specifically designed assessment of carer needs.

WHICH TOOL?

Following the literature review for the development of this guideline, it became apparent that a complementary systematic review of the many geriatric assessment tools available would be required to inform the development and support implementation of this guideline. The New Zealand Guidelines Group commissioned a comparative review and analysis of the leading assessment tools currently available internationally. This work remained independent of the guideline development process until the rest of the guideline was completed, to avoid the Guideline Development Team being influenced by its findings.

The resulting report[147](~) gives an introduction to the elements of an assessment tool, an overview of the concepts of reliability, validity and cultural sensitivity, and reviews various tools ranging from screening to comprehensive tools, with a focus on suitability and applicability for implementation within New Zealand. The tools were compared on the basis of these concepts, and issues regarding costs and implementation were discussed. The material in this section of the guideline is entirely based on the review, which can be accessed and freely downloaded at www.nzgg.org.nz

From this report, it is apparent that none of the reviewed tools meet exactly the requirements of an assessment tool as outlined above. However, the tools which most closely meet requirements are the UK version of the MDS-HC (Minimum Data Set for Home Care) for comprehensive assessment, combined with EASY-Care for screening and proactive assessments. The MDS-HC plus EASY-Care are modular, computer-based tools, and the developers are currently working on modules for specific

cultural groups. Furthermore, the developers have expressed their interest and willingness to work with interested parties to develop a tool for New Zealand that meets the criteria developed within this guideline.

Screening and Proactive Assessment

There are many tools that have been developed for screening purposes. The review was limited to those tools that had been developed systematically with good research support. Of the screening/proactive assessment tools reviewed, the two that most closely met the requirements identified by the guideline team were the MDS-HC Overview, Overview+ and EASY-Care.

EASY-Care provides the most thorough screening coverage of the assessment domains. However, it does not provide decision support, prioritise needs or offer solutions in the way of triggering particular interventions. An electronic version has been developed and is currently being piloted in the UK.

The *MDS-HC Overview* assessment is approximately one-third of the total comprehensive assessment, while the Overview+ is approximately two-thirds. The domain coverage is based on the domains developed for the UK Department of Health's Single Assessment Process (SAP). The MDS-HC Overview also provides decision support and prioritisation and is available in electronic format. It also has the advantage of feeding smoothly into the comprehensive assessment version.

Comprehensive Assessment

Of the four comprehensive assessment tools reviewed, the two that most closely meet the criteria stipulated in this guideline are the MDS-HC and the Core Assessment and Outcome Processes for Older People (FACE).

FACE is compiled from a collection of standard assessment measures, but has little published literature supporting its use. It has provision for inclusion of data from other tests – such as provision for entering the results of the Mini Mental State Exam (MMSE). However, the language it uses is quite complex, which could lead to misunderstanding, and it lacks decision support for responding to unmet needs.

MDS-HC has good coverage of the required domains, simpler language than FACE, and is well supported by software for decision support and prioritising needs. It also has modules which can assist with resource planning and funding decisions, and a version specifically for use in residential care situations; and quality monitoring. The MDS-HC has, in addition, the advantage of being part of an integrated assessment process which minimises repetition for the older person being assessed.

Carers

The only comprehensive, systematically developed, specific tools for assessing the needs of carers identified by the Guideline Development Team is the Caregiver Assessment Tool recently developed in Canada.[137,186]**(+)** The Guideline Development Team recommends that this tool be reviewed, adapted and trialled for use in New Zealand.[43]**(x)**

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LOCATION OF ASSESSMENT

OVERVIEW

- There is insufficient evidence directly comparing the effectiveness of screening and assessment of older people performed in different locations.
- Assessment in the home environment is the most effective. Assessment in other settings creates a barrier to access, particularly for non-urban-dwelling people and those with transport, mobility, and/or financial difficulties. Such barriers are a risk to the effectiveness of any assessment programme.
- When assessment is performed in a setting other than the person's home (such as when the person is in hospital care), a visit to the person's home must be included for assessment of housing and living circumstances.

RECOMMENDATIONS: 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
All complex needs assessments should include a home visit by a trained assessor.	A
Screening and assessment of older Māori should be done at the home of the older person and their whānau.	C
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.	✓

SCREENING AND PROACTIVE ASSESSMENT

Practical considerations factor into the location of the screening. Home visits have been shown to increase the uptake and thereby effectiveness of screening, as has the removal of financial barriers.[155](+) If the screening is taken to the older person's home, there are no financial barriers to participation. Many older people may have difficulties attending any other location, due to mobility, disability, transport or other barriers.[23,25,35,36,99,127,159,160,187-189](+) In New Zealand, there has been inadequate assessment of non-urban-dwelling older people.[43](x) In addition, some older people may find other settings intimidating and inhibiting.[47,77,83,89,120,124,153,175,190-192](+)

There is no evidence specifically comparing the effectiveness of screening or proactive assessment of older people by the location of the procedure. Several different locations have been used: older people have been screened in their homes by a postal questionnaire,[32,193](+) by telephone,[143](+) home visits;[153](+) or within primary health care facilities.[51](x) Similarly, there are a number of alternative venues for proactive assessment of older people. For example, assessments can be conducted in special clinics designated for the purpose; in a general practice,[12,24,47,50,69,95,121,144,145,156,194,195](+) an outpatient department or other community medical setting; or in the home of the person being assessed.[26,39,56,77,88,89,97,123,124,148,153,168,181](+) There is no evidence to indicate the relative effectiveness of any particular setting for these proactive assessments. One study showed that telephone contacts can be effective for rural-dwelling and other hard-to-reach people[191](~) although this would introduce a risk of abuse.

A proactive assessment includes assessment of the person's housing and general living circumstances, and this requires the assessor to visit the person's home. A rural network of assessors should be developed to allow for assessment of rural-dwelling people in their own homes.[43](x)

Screening and proactive assessment should therefore be located within the person's home to make the process easier for the older person, both physically and emotionally, and to provide opportunity for the assessor to assess the housing and living circumstances of the person in a more holistic and realistic manner.

ASSESSMENT OF COMPLEX NEEDS

In New Zealand, older people who have multiple or highly complex needs may be seen in different settings. People may be in a community setting with contact with a general practice, other health/support worker or carer(s); in an ED following admission for an accident or worsening of a particular condition; or in an acute care setting after being admitted for more serious health problems.

The evidence is limited on the most effective location for assessment. However, location of complex needs assessment will often be driven by circumstances. For people with complex needs presenting at an ED, it has been suggested that an initial assessment should be available within the ED.[28](+) It has also been suggested that assessment should be available wherever the person to be assessed is, whether that is in hospital or in the person's home.[22](+) For people with complex needs in hospital, either acute care or the ED, or in residential care, the assessment should be performed there.[22,28,61,67,82](+)

Assessment in Hospital Settings

In EDs, the episodic and acute nature of emergency care does not currently respond adequately to the complex and long-term care needs of older people experiencing multiple and often interrelated medical, functional and social problems. An alternative approach shown to have good outcomes for people with complex needs is one where screening and intervention protocols are used to ensure effective targeting of high-risk older people. In such an approach, a brief screening tool is used by ED

staff to identify older people at risk for decline in health and or functioning, who are then referred to an on-site specialist for complex needs assessment, discharge planning and follow-up intervention.[27](+) A recent study in Australia has shown the effectiveness of a nurse practitioner in geriatrics working in EDs to assess the needs of older attenders.[196](~)

However, the evidence shows that targeting only high-risk people by screening for risk factors reduces the overall level of benefit.[45](+) This is presumably because the screening tools have inadequate sensitivity to detect all of the high-risk people, missing many. Therefore maximum benefit of an assessment in EDs is gained by all older people attending the ED receiving a proactive assessment. If attendance at an ED is to trigger assessments for older people, a specialist trained assessor must be available in the ED or available at short notice.

In both cases, where a risk assessment or a comprehensive assessment is performed in an ED, the assessment should be initiated prior to the person's discharge.[43](x)

A complex needs assessment will require home visits as part of the assessment process,[27,31,190](+) as a home visit by a trained assessor has been demonstrated to improve the effectiveness of both outpatient and inpatient assessment. Therefore all complex needs assessments of older people should include a home visit by the trained assessor.

ASSESSMENT OF OLDER MĀORI

When assessing the needs of older Māori, the older person is to be considered in the context of their environment, both physical and social (that is, their physical circumstances and their whānau). The well-being of the whānau is considered to be as important as the individual well-being of the older person. The assessor will need to enlist the support of whānau, hapū and iwi resources in the assessment of the older person, and for any consequent interventions. The assessment, therefore, should be done at the person's home.[43](x)

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ASSESSOR SKILLS AND SUPPORT

OVERVIEW

- Assessors may be from any discipline within health care and social support, but must have specialist training in the assessment process, including training in consent issues.
- Assessors must be supported by a multidisciplinary team (MDT) whose expertise includes all aspects of health and social care and support.
- The attributes required for an assessor include good communication skills; sensitivity, awareness and understanding of older people's issues; and advocacy and facilitation skills.

RECOMMENDATIONS: ASSESSORS AND MULTIDISCIPLINARY TEAMS	
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 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

RECOMMENDATIONS: ASSESSORS (CONTINUED)	
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.	✓
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.	✓

Assessors from different disciplines have been shown to be effective at performing both proactive and comprehensive, multidimensional assessments of older people. The research includes the use of assessors such as nurses with qualifications in gerontological nursing, general practitioners and other physicians, therapists, social workers, research nurses and other health care professionals.[45,75,168](+) There is insufficient evidence to compare the effectiveness of assessment by people from different disciplines, but there is good evidence that whatever their discipline, to be effective, the assessors must receive specialist training in the assessment process.[23,26,28,29,35,37,39,40,45,53,58,62,77,79,81,82,101,125,144,148,168,169,197](+) In addition, assessors should have sufficient health/clinical knowledge to be able to recognise health problems, and should receive training in awareness of health-related organisations who can offer support (such as Arthritis New Zealand).[43](x)

Specialist assessors must also be part of or have quick access to a MDT (see below) to whom they can quickly refer the older person for more in-depth assessment or for help in any particular domain, and with whom they can consult.[8,21,22,24,26-28,30,31,53,54,69,73,89,96,101,158,164,168,190,197](+) This enables the assessor to build a multidisciplinary perspective and develop expertise beyond the domains of their own discipline.

It has been shown that where older people are dissatisfied with their interactions with health professionals, the effectiveness of those interactions can be improved by the older person receiving training and support in communication skills.[158,179,191,197](+) Assessors must have both the skills to ensure their own interactions with the person being assessed are effective, and to be able to facilitate the person's communication with other health care professionals.

Assessors will also need good interpersonal and relationship management skills. Sensitivity to the older person's beliefs and attitudes is an important attribute in the assessor, particularly in relation to spiritual aspects of the person's care.[49,83,125,198-200](+) Recognising and addressing the anxieties, issues and need for information of the person being assessed and their family/whānau is part of the process.[21,35](+) The person being assessed and their family/whānau should feel empowered by the process, and the risks of disempowerment must be addressed.

Any person involved in screening or assessment of older people should have received specific training in the process, including training to enhance their sensitivity, knowledge, and skills in dealing with older people and their issues,[158,179,191,197](+) and training on consent issues.

THE MULTIDISCIPLINARY TEAM

The MDT in most studies has been a geriatrician, a registered nurse with competency in gerontological nursing and a social worker. However, to ensure the best outcomes, a MDT should also include or have ready access to psychogeriatricians and clinical psychologists with expertise in mental health of older people, physiotherapists, social workers, speech-language therapists, audiologists, dieticians,

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neurologists, pharmacists and occupational therapists to whom they can quickly refer the client for more in-depth assessment or for help in any particular domain.[21,22,24,26-28,30,31,53,69,73,89,96,101,158,164,168,190,197](+) 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.

Furthermore, it is important that all members of the wider MDT have received appropriate training to enhance their sensitivity, knowledge, and skills in dealing with older people and their issues.[158,179,191,197](+)

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WORKING TOGETHER

OVERVIEW

- A major barrier to the effectiveness of programmes of assessment of older people is the incomplete implementation of the recommendations by health care professionals (both at the primary health care and specialist levels), and by the older people themselves.
- To be effective, an assessment programme must operate on the principle of working together or *concordance*, where the older person being assessed, their family/whānau, their carers and all professionals involved in their care and support are actively involved in the process.
- Strategies to promote concordance and implementation of recommendations should be part of any assessment programme.

RECOMMENDATIONS: 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

Reduced effectiveness of assessment can result from a failure to follow the resulting recommendations by either the person being assessed or any of the health care and social service professionals involved. The evidence shows that such non-adherence is a major barrier to effectiveness of assessment programmes.[15,19,21,30](+) A major review of factors underlying compliance or adherence to therapeutic

recommendations found that the main factor was a lack of understanding by the health care professional and the consumer about the difference in their priorities and beliefs about health care issues. Working together by discussion and acknowledgement of these differences allows for agreement or concordance on interventions, and consequently better adherence by all parties to agreed interventions.[201](+)

The model of compliance or adherence carries the assumption that people should merely carry out instructions received from a practitioner. *Concordance*, in contrast, is based on the idea that the work of the practitioner and the person receiving health or social care in the consultation is a negotiation between equals, and that the aim is a therapeutic alliance between them. The strength of this alliance lies in an assumption of respect for the person's concerns and aims, and the creation of equality in the relationship, so that both the practitioner and the person together can proceed on the basis of openness and not of misunderstanding, mistrust or concealment.[201](+)

People to be involved in the assessment include the older person, their carer(s), their family/whānau if appropriate and desired, their primary health care practitioner, and others where appropriate.

HEALTH AND SOCIAL SERVICE PROFESSIONALS

Overseas studies have found that one of the major barriers to the effectiveness of assessment of older people has been that the resulting recommendations have not been fully implemented by both primary and secondary physicians.[23,27,29,36](+) There is some indication that the use of some of the purpose-designed comprehensive geriatric assessment tools is perceived as undervaluing the expertise of specialists.[168](+) Possibly in consequence of this perception, some geriatricians are known not to accept or act upon the recommendations arising from the use of these tools.[27](+) Therefore it would be essential that any implementation of assessment tools be supported by a programme of education for specialists highlighting the accuracy and benefits of the use of these tools. The tool indicates the need for detailed specialist assessment when needed and thereby makes the most efficient use of specialist time and skills.

Another similar barrier found in overseas research to the effectiveness of a comprehensive assessment of people with complex needs has been GPs not following the resulting recommendations.[23,29,36](+)

It would therefore be essential that any implementation of assessment tools be supported by strategies to increase the implementation of recommendations by physicians. Working together to achieve agreement between all people involved at the outset should help improve adherence to the recommendations. Other strategies which may increase physician implementation of recommendations resulting from comprehensive assessment of older people include:[23,201](+)

- effective communication between geriatricians and primary health care practitioners (eg, telephone contact and personalised follow-up letters)
- provision of specific advice focused on the reason for the consultation
- limiting and prioritising the number of recommendations
- use of physician education strategies (such as provision to the physician of relevant published references, CME)
- empowerment interventions such as teaching people how to communicate effectively with their doctor.[158,179,191,197](+) For example, one study found there was an 11-fold increase in GPs following recommendations when the patient specifically requested the treatment
- adoption of the principle of concordance, where all involved have an active and equal role in the assessment process.

OLDER PEOPLE

One of the barriers to effective assessment of older people is that the older people themselves do not follow the recommendations.[23,29,36](+) An assessment should include consideration of the older person's likelihood of following recommendations.

Barriers to an older person being able or willing to implement recommended treatment and support interventions include:[36](~)

- poor health status, high symptom burden, illness
- lack of social support: poor caregiving, poor social environment, lack of family/whānau support, inadequate housing, little access to social groups, transport or shops
- health transitions, ie, changing health status, which may present the older person with more complex daily routines where the individual needs to learn new habits or regimes
- polypharmacy: three or more prescription or non-prescription medications
- a decline in cognitive function
- complex disease states
- ageism: where either older people are not targeted for health promotion activities because they are seen by health care professionals as being unwilling or unable to change their health behaviours, or older people themselves are too fearful to engage in exercise or other programmes because they see themselves as too old.

Predictors of the assessed person following the recommendations include:[36](~)

- social support: people offering information, reminding the person to take medications, ensuring prescriptions are filled, seeking care for side effects and caregiving
- education and monitoring provided in times of health transitions
- development, prior to discharge, of a post-discharge plan for someone who was hospitalised
- supportive caregiving and social environment, family/whānau support, adequate housing, access to social groups, transport and shops.

Strategies to support implementation of recommendations should be initiated. Such strategies include:[23](~)

- identifying the individual's barriers to implementing the recommendations and addressing them through problem-solving
- consultations of sufficient duration to allow the person to develop a rapport with the health care professional
- gaining an understanding of the person's goals and beliefs, and developing realistic treatment plans based on them
- multiple communication methods (ie, written material supported by oral explanation)
- writing treatment plans in plain language
- follow-up appointments
- involving family/whānau and carers.

Following a comprehensive assessment, a treatment plan should be developed in partnership with the older person. The aim of the process is to promote implementation of the plan by the older person, their carers, family and whānau and by professionals involved in their care. Active involvement is an essential step in achieving the aim of older people feeling empowered.

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OLDER PEOPLE WITH PRE-EXISTING DISABILITIES

OVERVIEW

- There is limited research available on the particular needs of people with pre-existing disabilities as they age other than for those people with intellectual disabilities.
- Historically, people with intellectual disabilities have a shorter life expectancy than the general population. Over the last 50 years, life expectancy has been increasing for this group, and there will be growing numbers of older people with intellectual disabilities in New Zealand in the future.
- Most older people with disabilities live within the community and have their health needs met through the primary health care system.
- Some needs of this group are not met adequately due to the lack of integration of supporting services.
- 'Diagnostic overshadowing' can be a barrier to effective assessment and care: the assumption in an aged care setting that problems are caused by the person's disability, or in a disability service setting that they are just a normal part of ageing.
- Polypharmacy (including the use of inappropriate psychotropic medication) is a particular issue for people with intellectual disabilities.

RECOMMENDATIONS: 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

OLDER PEOPLE WITH PRE-EXISTING DISABILITIES

In New Zealand, a person with a disability is defined by the Ministry of Health[202] as someone who has been assessed as having a physical, psychiatric, intellectual, sensory, or age related disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required.

For the purpose of this guideline, therefore, the following groups are included as people with pre-existing disabilities:

- people with physical disabilities (both congenital and acquired before 65 years of age)
- people with pre-existing visual or hearing impairments
- people with intellectual disabilities (existing from early childhood)
- people with pre-existing chronic mental illness
- people with pre-existing neurological impairment (such as traumatic brain injury or multiple sclerosis).

Research on older people frequently either excludes these special populations or fails to use appropriate recruitment strategies to ensure their inclusion. Consequently, other than for people with intellectual disabilities, there is a scarcity of evidence about the particular needs of these special populations as they grow older.

The majority of older people with disabilities live in their own home or in community-based services. Very few live in institutional care. Their health needs are therefore typically addressed through primary health care. It is a frequent experience that some of the issues of this group of people fail to be addressed as the supporting services (health care or disability) do not agree on which service should have responsibility for addressing that issue.[43](**x**) More integration of services could provide a route for addressing such needs.

People with disabilities also age, but their needs as part of the population of older people are often not adequately addressed.[25,59,60,98,133-135,149,203-205](**+**) General issues which should be noted are:

- they may have particular needs associated with their disabling condition
- their life histories and experiences may be very different from other people of their own age
- they may already be receiving significant levels of informal and formal support from family/whānau and disability support services.

The literature search for this guideline failed to find evidence of sufficient quality on particular issues for people with disabilities other than intellectual disabilities as they age, and therefore much of this section is based on evidence extrapolated from the research around intellectual disabilities. Further evidence was sourced too late for inclusion, and this section will be developed further in the next revision of the guideline.

Older People with Ongoing Mental Illness

Older people with ongoing mental illness have traditionally under-utilized primary health and dental care services, and may not be recognised as having a disability. Ongoing mental illness may be either episodic or enduring in nature, and older people with such illnesses have particular health issues that require attention in any multidimensional assessment process. These include issues such as physical frailty and co-morbid physical illness, both frequently experienced by older people with ongoing mental illness; and adverse effects of psychotropic medications, particularly those resulting from long-term use. There may also be issues resulting from different culturally-held beliefs and values about health and mental health, which require recognition and understanding in relationship to ageing and the process of assessment.

Older People with Intellectual Disabilities

Historically, people with intellectual disabilities have not lived long. Although their life expectancy is still shorter than that of the general population, it has been steadily increasing over the last 50 years. For example, more than half of IHC service users in the central region of New Zealand are currently aged over 55 years.[136](~) This trend of increasing longevity is expected to continue. As a result, the numbers of older people with intellectual disability will continue to increase over the next decades. Interest and research into this special population has developed significantly over the past 20 years.

Screening and Assessment of Older People with Pre-existing Disabilities

It is important that the extreme heterogeneity of the population with intellectual or other disabilities[135](~) is taken into account when designing any screening or assessment programme. Notwithstanding this diversity, people with disabilities of all ages are known to have undetected need which will benefit from multidimensional health assessment. For example, when 1311 service-users of the IHC were first screened in 1997 with a health screening tool, 72.6% required follow-up intervention.[136](~)

In addition, specific characteristics of some disorders and disabilities make it particularly important that active measures are taken to include all older people who have disabilities in screening and assessment programmes for the general, older population. It is known, for example, that people who have intellectual disabilities are less likely to make spontaneous complaints of pain, discomfort, or feeling unwell.[70](x)

Some conditions, also cause accelerated ageing, or have associated disorders. For example, in the case of Down's syndrome, there is a higher risk of Alzheimer's disease.[136](~) Furthermore, comprehensive medical histories are frequently lacking for many people with intellectual or other disabilities and it is clearly not sufficient to rely on the person's caregiver to refer to a health practitioner when help is needed. The complexity of health risks and support needs of people with pre-existing disabilities mean that the age at which they are eligible for the screening programme may need to be lowered.[4,136](~)

DOMAINS OF ASSESSMENT

The evidence shows that people with intellectual disabilities have high levels of undetected sensory impairment; poor dental health; communication difficulties; polypharmacy, including frequent multiple neuroleptic medications; lack of social relationships and support; and economic hardship.[134-136](~) It is also known that, at age 65, people with pre-existing disabilities are likely to have more than one pre-existing disability;[135](~) have a high rate of co-morbid medical conditions;[131,135](~) have a high incidence of psychiatric illness;[131,133](+) and are less likely to have family/whānau support in old age.[133](+) Furthermore, informal caregivers of people with disabilities often fail to plan for future out-of-home care for their relative.[106,132,134,135](~)

In 2001 the IHC commenced a programme of detailed, targeted screening of service users considered to be at risk, either because they had inherently vulnerable health, or because they were older. Of the people identified as being high risk, 38% were over 55 years and 15% were aged 65 years and over. For the 30% of high-risk service users in the South Island, 33% had minimal or no family/whānau contact, more than half needed help with basic self-care, more than half were visually impaired, a third had mobility problems and they used an average of 3.3 prescribed medications.[136](~)

It is therefore important that any multidimensional screening or assessment tool for use with people with intellectual or other disabilities has the ability to detect risk and or impairment in these particular areas.

Polypharmacy

Polypharmacy of people with disabilities is prevalent in New Zealand. Studies in New Zealand and overseas have shown similar trends: people with intellectual or other disabilities receive too many medications, for too long, with a poor diagnostic base inconsistent with evidence-based best practice, medications are prescribed inappropriately, and outdated or cheaper medications are given rather than those best practice would indicate. There is also evidence of specialist assistance and hospital admission being withheld, and of lack of co-operation from specialists when reviews are requested. Medication reviews have been shown to be effective when provided.[206](~)

Special Considerations in Assessment of Older People with Pre-existing Disabilities

When assessing older people with pre-existing disabilities, there is a risk of 'diagnostic overshadowing' – that is, assuming in an aged care setting that any problems identified are caused by the person's disability, or in a disability service setting assuming the problems are just a normal part of ageing.[133](+)

Also, there are some conditions that result in specific health issues – for example, in the case of schizophrenia, there is the associated risk of diabetes and tardive dyskinesia from the medications used. The need for specific expertise in both the disability and geriatric care[131,204](+) indicates that while older people with disabilities should receive multidimensional comprehensive assessments, it is important that assessors of people with disabilities are trained in the area of the disability, and that specialists with expertise in the disability are part of the MDT supporting the assessment.

Although older people with disabilities may need a special approach, it should not be assumed that the older person with a disability is incompetent to consent to the process. Any assessment process should be designed to ensure that the older person with a disability is involved in the assessment process.

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ASSESSMENT PROCESSES FOR OLDER PEOPLE: A MĀORI PERSPECTIVE

OVERVIEW

- Life expectancy, including independent life expectancy, is lower for Māori than for the general population.
- Levels of moderate and severe disability are higher in older Māori than in the general population.
- Social and cultural changes have led to a breakdown in the traditional structures for providing for older Māori.
- Disability may be underreported for Māori because of the tendency to measure disability by the ability to participate rather than the effect on personal health.
- The assessment process should be actively offered to older Māori, rather than relying on people in need making contact with services.
- Increasing the Māori trained workforce in all aspects of care, including assessment, is essential to improving the well-being of older Māori.
- Assessment services must be equally available to those older Māori who may choose not to access Māori-specific programmes.
- Assessors should have had training to enhance their sensitivity and awareness of culture-specific issues.

RECOMMENDATIONS: ASSESSMENT PROCESSES FOR OLDER MĀORI	
Assessment processes should be made available at age 55 years for older Māori.	A
An holistic model such as *Te Whare Tapa Wha* or a similar model should be used when assessing older Māori.	A
All decisions should be made collectively with the older person's whānau or hapū.	B
Assessors of older Māori should be fluent in te reo Māori me ona tikanga where the older person and/or their whānau prefers its use.	B

RECOMMENDATIONS: ASSESSMENT PROCESSES FOR OLDER MĀORI (CONTINUED)	
Assessment of older Māori people requires mature Māori assessors who are well-known and respected within their community.	B
Where a Māori assessor with the necessary skills is not available, a skilled assessor should be supported by someone who is fluent in te reo Māori me ona tikanga and who is well-known and respected within the community.	C
When assessing older Māori the assessor should be of the same sex as the person being assessed whenever possible.	B
Assessment services must be equally available to older Māori who do not have Māori-specific programmes available, or choose not to access them.	✓

MORTALITY, MORBIDITY AND DISABILITY IN MĀORI

Life expectancy for Māori, although increasing slightly, is lower than for the general population due to higher mortality rates at younger ages, particularly for cardiovascular conditions and cancer.[7] Life expectancy is increasing much more slowly for Māori than for the general population, with the result that the gap in life expectancy between Māori and the general population is widening – Māori women have a life expectancy of 71.0 years compared with non-Māori, non-Pacific women of 80.8 years (a gap of 9.8 years), and Māori men have a life expectancy of 65.8 years compared with non-Māori, non-Pacific men's life expectancy of 75.7 years (a gap of 9.9 years).[207](+) Shorter life expectancy for Māori is reflected in fewer years of independent life expectancy at age 65 years (7.4 years for Māori men compared to 9.9 for all men, and 7.5 years for Māori women compared to 11.9 for all women).[7]

The Māori population structure is not ageing in the same way as the wider population. Nonetheless, by 2051, 13% of the total Māori population will be aged 65 years and over, making up approximately 10% of older people. This represents more than a 500% increase in the number of Māori aged 65 years and over, with the largest proportions of older Māori in the 65–74 age group, and increasing numbers living to older ages.[7]

In the 65–74 age group the Māori mortality rate is 104% higher than that of other New Zealanders, with common causes of death being ischaemic heart disease, other cancers, and other causes including diabetes and immune disorders. In the 75–84 years and 85 years and over age groups, ischaemic heart disease is the leading cause of death, with other circulatory disorders, other cancers, respiratory diseases and 'other' causes increasing with age.[7]

There are significantly higher rates of both moderate and severe disability in Māori aged 45–64 than in the same age group in the total population (18% more with a moderate disability and almost 100% more with a severe disability). Māori aged 65 years and over also have a significantly higher rate of severe disability than in the total population (over 40% more).[7] However with earlier detection and management, many of these conditions would have less severe consequences in terms of both disability and mortality.

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CULTURAL AND SOCIAL CHANGES IMPACTING ON OLDER MĀORI

Traditionally, the mana (standing) of a tribe has been largely vested in the tribal elders. Implicit in this status of older Māori has been expectations of them and their 'kaumātua roles' within the tribe: to be the spiritual leaders, mediators in conflict, guardians of cultural integrity, and mentors to younger members of the whānau, hapū and iwi. The acceptance of these influential roles by people approaching retirement is a considerable, often arduous responsibility. In return, whānau and/or hapū have traditionally recognised a responsibility to look after the comfort and needs of their kaumātua.[208](x)

However, changes in traditional Māori social structure over recent decades have had significant impact on the status of older Māori. For example, the movement of many Māori from rural to urban living and financial pressures on whānau, can lead to the situation where women (including kuia) are often working full-time outside the home and are thereby not available to encourage in younger Māori the value of culturally traditional relationships with kaumātua and kuia. This has contributed in some instances to a breakdown of traditional Māori whānau structures.[181,208](~)

Similarly, there have been changes in personal expectations. For example, older Māori now tend to want quiet time for themselves, their 'own' lives (rather than the traditional roles). The increasing lack of involvement of Māori men in caring for their elders means that older Māori themselves have frequently had little or no experience of caring for the elderly in their own lives.[181,208](~)

Together with the loss of te reo Māori and a loss of identity such that kaumātua and kuia are frequently unable to pass on the tikanga (cultural values and beliefs) as they would have formerly, these changes have led to a loss of the traditional relationship with the elderly. All of these changes – social and economic – have led to a situation where the traditional whānau-based care of older Māori is no longer working well across the general Māori population.[181,208](~)

HEALTH PERCEPTION FOR MĀORI

Self-reporting of health impairment or deterioration in older Māori tends not to reflect the higher levels of disability. It has been suggested that this is because older Māori *'… measure good health not so much by the presence of illness as the capacity to participate.'*[208](x)

Traditionally, Māori have a more holistic view of health than the general population. The *Te Whare Tapa Wha* model is one model developed to represent this. It is used within Māori health, and consists of four dimensions: *Te taha wairua*, which reflects spiritual health, including the practice of tikanga Māori; *te taha hinengaro* which refers to the emotional and spiritual well-being of each individual, whānau or hapū member; *te taha whānau*, which supports the importance of whānau and the environment in which individuals and whānau live, including the cohesiveness of the whānau unit and the collective unity derived from membership within the whānau environment; *te taha tinana* which refers to physical aspects of health (including physical symptoms of ill health); all within the context of *te ao turoa* (the environment) and use of *te reo Māori* (the Māori language).[209](~) When these are in balance, there is a state of positive health and well-being.

In 1997, public health strategies identified as being needed to improve the health of kaumātua included improved national/local co-ordination and integration of health services, effective health promotion and disease prevention programmes, establishing and/or strengthening intersectoral links between government, community and professional organisations, and between health, disability support and welfare.[74](+) The comprehensive, multidimensional assessment approach both meets these needs for integration, standardising and evaluation, and accords well with traditional models, as it addresses spiritual and social aspects of life in addition to mental and physical health. Mason Durie also identified the need for *'….local research to form an evidence base for resolving health service issues…*

that are particular to New Zealand . . .'.[74](+) The proposed assessment processes will, through the data collection and ongoing programme evaluation, provide a readily comparable database of evidence from which refinements to services and to the assessment process itself will be developed.

SPECIFIC ISSUES TO BE CONSIDERED IN ASSESSMENT TOOLS AND PROCESSES FOR OLDER MĀORI

When assessing the needs of older Māori, it is important to remember that the older person is not to be considered in isolation, but in the context of their environment both physical and social (that is, their physical circumstances and their whānau). Not all Māori are the same, and it is important to ascertain whether the person wishes to be assessed using a Māori culture-specific approach or not.

Under a Māori culture-specific approach, the well-being of the whānau is considered to be as important as the individual well-being of the older person. The assessor will need to enlist the support of whānau, hapū and iwi resources in the assessment of, and for any consequent interventions for the older person. All decisions should be made collectively with the older person's whānau, not by the assessor without consultation. In urban settings, it may be necessary to help to create or re-establish connections with other Māori to enable whānau support for the older person.

It is also important that assessment services are equally available to those older Māori who choose not to access Māori-specific programmes. Some specific areas of impaired health or functioning, such as incontinence, may have considerable stigma for older Māori and it is important that assessors should be aware of this and handle the subjects sensitively.[74](+)

Does the age at which Māori should be assessed differ from that of the general population?

There are significantly higher rates of both disability and ill health in Māori aged 45–64 years than in the same age group in the total population, and Māori have fewer years of independent life expectancy at age 65 years than other New Zealanders.[7] There is no specific evidence about the assessment of needs at different ages for Māori. However, it can be inferred from the disability statistics that in order to take the same proactive detection of need in Māori as in the non-Māori population, a younger age in Māori should be equated with age 65 years in the non-Māori population, and thus that assessment processes should be initiated proportionately earlier. This is consistent with the *He Matariki* definition of the older Māori age range as over 55 years. This was fully endorsed by hui participants in 1995, and this definition was adopted for the report *The Health and Well-being of Older People and Kaumātua*.[199](+)

Assessors

Assessment of older Māori should be performed by Māori assessors who are well-known and respected within their community, and preferably are older themselves. Personal (face-to-face) visits are necessary, and the assessor should be fluent in *te reo Māori* where the older person and/or their whānau prefers its use. Assessment of older Māori will be more effective when the assessor is the same sex as the older person being assessed.[181](~)

However, as long ago as 1995, increasing the trained Māori workforce to provide care within the community for older Māori was identified as a priority.[74](+) Unless sufficient numbers of assessors can be trained, it is likely that assessments will be performed by people who do not have all the desirable attributes. In this case, a skilled and qualified assessor should be supported by someone who is fluent

in te reo Māori me ona tikanga and is well-known and respected within the community in which they are completing assessments.[43](**x**)

Process of Assessment of Older Māori

Many Māori have difficulty in asking for services. Traditionally, it was usual for help to be offered when needed, and to ask for something was considered ill-mannered. Any assessment process for older Māori must take this into account: reliance on Māori people seeking help is likely to be less effective than a more proactive approach. The assessment process will therefore need to be actively offered to the older people, rather than relying on people in need making contact with services themselves. It will also take more than one contact. There should be an initial contact of introduction with the older person and their immediate whānau. Following this, consultation with whānau should take place. The opportunity for meeting with the older person individually should be offered to provide an opportunity for disclosure of anything they prefer not to discuss in front of their whānau. The use of *Te Whare Tapa Wha* or other similar holistic Māori models are recommended.[83,209](**~**)

KEY - *Grades indicate the strength of the supporting evidence not the importance of the recommendations - see page xvi for details*

A Recommendation is supported by good evidence
B Recommendation is supported by fair evidence
C Recommendation is supported by expert opinion only
I No recommendation can be made because the evidence is insufficient
✓ Good Practice Point

13

ASSESSMENT PROCESSES FOR OLDER PEOPLE: A PACIFIC PEOPLES' PERSPECTIVE

OVERVIEW

- The number of Pacific people aged 65 years and older in New Zealand is expected to increase by about 860% by 2051.
- Pacific peoples in New Zealand aged 65 years and over have higher mortality and morbidity than the general population and their rate of severe disability is almost twice that of the general population.
- Traditionally, in Pacific cultures, people in need of care through illness, disability or age have been cared for within the extended family structure.
- Language and other communication difficulties are significant problems for Pacific peoples in New Zealand.
- Being very reserved is a notable characteristic and the families of the older person may not be comfortable saying a particular service does not suit them. It is essential that the assessor develop a good rapport with the older person being assessed and their family.
- Consent of the person being assessed needs to be revisited periodically during the assessment process.

RECOMMENDATIONS: PACIFIC PEOPLES	
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

RECOMMENDATIONS: PACIFIC PEOPLES (CONTINUED)	
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

Pacific peoples in New Zealand include many different ethnic groups, including people originating from Samoa, the Cook Islands, Tokelau, Tonga, Fiji, Papua New Guinea, Tuvalu, Tahiti, Vanuatu, the Solomon Islands, Kiribati, Niue, and those born in New Zealand or from multiple ethnicities.[188] **(+)** This section therefore provides only a broad overview of issues concerning Pacific peoples in common, rather than any detailed cultural explanations.

The 2001 Census showed that a total of 83,282 Pacific people living in New Zealand were born in the Pacific Islands versus 133,791 New Zealand-born Pacific people. The 2001 Census also showed that only 1.6% of those aged 65 years and over were of Pacific ethnicity compared with 6.2% of the general population. These lower numbers of older Pacific people reflect higher mortality at younger ages, return migration for some older Pacific people, and a recent predominance of younger Pacific immigrants coming to New Zealand.[7]

However, the number of Pacific people aged 65 years and over is expected to increase by around 860%, from 7,800 in 2001 to 65,800 in 2051. Pacific peoples are projected to increase as a proportion of people aged 65 years and over (from 1.6% in 2001, to 4.4% by 2051) and increasing numbers are expected to be living to 85 years and over. There will be considerable regional differences in population, so that by 2021, for example, it is projected that the proportion of people aged 65 years and over who are Pacific peoples will be 8.5% in Counties-Manukau, 6.5% in Auckland, and 4.9% in the Capital and Coast DHB area.[7]

MORTALITY, MORBIDITY AND DISABILITY IN PACIFIC PEOPLES

Pacific people in New Zealand aged 65 years and over have higher mortality and morbidity than the general population, and their rate of severe disability is almost twice that of the general population. At birth, life expectancy for Pacific peoples is 70 years for males and 76 years for females. This is slightly higher than for Māori, but still lower than the New Zealand average, and the same pattern is repeated at age 65 years. The mortality rate for Pacific peoples aged 65 years and over is 77% higher than for European and other groups of the same age; the three main causes of death in Pacific peoples aged 65 years and over being ischaemic heart disease, other cancers, and 'other' causes (principally endocrine disorders including diabetes). Furthermore, although Pacific peoples

aged 65 years and over have a lower rate of moderate disability than that of the total population (14% compared to 27%), severe disability is significantly higher amongst older Pacific peoples (28% compared with 12% in the total population).[7]

However, as with older Māori, many of these conditions would have less severe consequences in terms of both disability and mortality, if processes were in place to enable earlier detection and management. Although there is no specific evidence about the assessment of needs at different ages for Pacific peoples, it can be inferred from the disability statistics that in order to take the same proactive detection of need as in the general population, as with Māori, a younger age in Pacific peoples should be equated with age 65 in the general population, and that assessment processes should be initiated proportionately earlier. This is consistent with the adoption of age 55 years for the report *The Health and Well-being of Older People and Kaumātua*.[74](+)

CULTURAL ISSUES IMPACTING ON ASSESSMENT OF OLDER PACIFIC PEOPLES

There are a number of cultural issues that will impact on the assessment of older Pacific people. Traditionally, in the various Pacific cultures, people in need of care through illness, disability or age have been cared for by their family and within the extended family structure, which includes family, friends and local community contexts. Caring for people is seen as the responsibility of the family, as only family, it is felt, will provide care with the necessary kindness. This has been a barrier to obtaining services outside the family.[210](x) The family should therefore be central to the care of their older relatives and health care and social service professionals should work collaboratively with the family.

Health perception in Pacific peoples

As with Māori, self-reporting of health impairment or deterioration in older Pacific people tends not to reflect the higher levels of disability and illness. There is a high degree of stigma attached to disability in Pacific cultures, so that the presence of disability is shaming for the family, and carries with it a fear of 'gossip' about the family of the disabled person.[210](x) There is no specific evidence that this sense of shame attached to disability extends to age-related disabilities in older people who have had no pre-existing disability. Furthermore, these ideas are altering with education within the younger generation in New Zealand. Nonetheless, it is necessary to bear in mind the traditional and religious beliefs and stigma about illness and disability and to be sensitive to the potential for giving offence.[210](x)

Communication

Traditionally, Pacific cultures (including Māori) are more sociocentric (that is, their orientation is towards the social group) than mainstream New Zealand, which tends towards being more individualistic (where orientation is towards the individual).[211](x) One result of this is that, for Pacific peoples in New Zealand, lacking the family and community structures of their island homes, asking for help (which can extend to seeking out services) may be seen as rude.[210](x) In order for any assessment process to be effective, therefore, the service will need to be offered to the older people, rather than expecting them to initiate contact and ask for it.

Communication is a significant problem with Pacific peoples in New Zealand for whom English is a second language. Many people, when consulted, describe the considerable disadvantages to not being able to communicate clearly and confidently, and the consequent reluctance to consult outside their own small communities. Reserve and diffidence, often described as 'shyness', resulting from this difficulty in communicating, together with the cultural reluctance to attract attention to one's self,

exacerbates the problem so that it becomes a significant barrier to accessing care and services.[210](x) Furthermore, information on health and disability services in New Zealand tends to be disseminated within services by means of written material. This is not culturally appropriate for the Pacific peoples with their oral tradition, and requires too high a proficiency in written English.[210](x) Information relating to an assessment should be produced in Pacific languages as well as English, and produced in oral form (through videos and radio) rather than relying on written formats.[199,210](+) Access points for communicating information include churches, health promotion and education programmes, mobile services, PHOs and Pacific service providers.

ASSESSORS

Assessors of older Pacific peoples will ideally need to be from the same ethnic background, and able to speak the same language in order to maximise the effectiveness of the assessment. This will have to be managed carefully, as many people may fear their privacy will be compromised if someone from the same community is allocated. This fear may be allayed and trust established if the person is known to have the necessary 'professional' skills and status.[210](x) Acceptance of assessors will be increased through use of existing Pacific community structures such as church ministers and other community leaders and institutions.[210](x)

It is important, however, that the assessor does not assume the needs of the older person being assessed. Being very private or reserved is a notable characteristic of many Pacific peoples, and the families of the older person may not have the confidence or assertiveness to say a particular service does not suit them. It is important that any assessor is aware of this tendency and establishes a rapport and trust with the family, enabling them to ask questions in such a way that the family can respond frankly.[210](x)

The Fono a Matua, Pacific Elder Peoples workshop, held in Wellington in 2003, made strong recommendations for Pacific health care professionals to be included at all stages of the assessment and care pathway. The MDT supporting the assessor, see Chapter 9, *Assessor Skills and Support*, should include Pacific health care professionals.

CONSENT

Within Pacific communities in New Zealand, asking for and giving consent is understood to be a dynamic, mutual trust relationship rather than a single event. Therefore the consent of the person being assessed needs to be revisited periodically during the assessment process. Also, asking directly for consent can be considered offensive, and the assessor will need to handle this issue with skill. Consent is given more to the person (and their trustworthiness) than the process, and therefore it is essential that the assessor establishes and maintains a relationship of trust and integrity with the person being assessed.[210](x)

14

SERVICE DELIVERY: SUPPORTING THE PROCESS

OVERVIEW

- This guideline does not provide a service framework, but gives a broad indication of necessary elements of service to support effective assessment.
- Necessary elements include:
  - service configuration to support features of assessment
  - the ability to work intersectorally
  - co-operation between different regional service providers
  - appropriate training for those involved in the assessment process
  - a link between needs assessment and service co-ordination
  - links to existing standards.

The scope of this guideline is limited to describing effective processes for assessment of older people in New Zealand, and does not extend to a detailed analysis of the most effective service configurations to support those processes. However, the recommendations for the processes dictate certain necessary elements of the supporting services. These include:

1. Service configuration

   This should support:

   - formation of MDTs to support and inform the assessments and assessors
   - in-home assessments, including the in-home assessment of non-urban-dwelling people
   - follow-up
   - case management
   - monitoring and evaluation.

2. The ability to work intersectorally

   A systematic review of comprehensive assessment of older people undertaken by the Kings Fund in the UK identified ideas and techniques for promoting interagency collaboration.[62](+) These include:

   - ensuring that the need for, and purpose of, the partnership is widely understood and accepted across the different agencies
   - identification of and planning to overcome cultural, structural and resource obstacles to effective co-operation

- agreement on clear agenda and framework for working partnership from all organisations involved, that will align 'grass roots' and top level activities and take account of planning and performance management processes
- finding new ways to engage the different communities who are intended to benefit from the changes.

3. Co-operation between different regional service providers

   To ensure consistency of service and smooth transitions for people who move between regions.

4. Training

   Any service must allow for and require appropriate training and skills for all those involved in assessment, treatment and follow-up of older people.

5. A close and bi-directional link between needs assessment and service co-ordination
6. Linking to existing standards

   Any service should link to existing standards relevant to the process of assessment of older people.

IMPLEMENTATION

OVERVIEW

- An implementation plan for assessment processes is being developed jointly by the Ministry of Health, ACC and DHBs independently of this guideline.
- Summary guidelines will be produced for particular users.
- Implementation will require:
  - close liaison and co-operation between the Ministry of Health, ACC, DHBs and PHOs
  - review of service specifications
  - understanding of the needs of Māori
  - participation of Pacific peoples.
- The tools review published with this guideline will inform the choice of and development of a national assessment tool.
- Members of the Guideline Development Team are willing to liaise with tool developers and training organisations.
- Implementation of the tool and supporting database will probably require collaboration by DHBs.
- DHBs have suggested the formation of a central steering committee to guide the development and ongoing performance of assessment processes, and provide support for smaller DHBs.
- A staged approach to implementation of guideline recommendations has been suggested by the DHBs.

Implementation of the recommendations for practice and service delivery in this guideline is going to be a challenging process. The implementation plan for assessment processes is being developed between the Ministry of Health, ACC and the DHBs independently of this guideline. The outline given here therefore covers only some of the broader points that have come from the research literature and consultation with DHBs.

Implementation of the recommendations will require:

- close liaison and co-operation between the Ministry of Health, ACC, DHBs and PHOs
- active involvement of consumers and carers in the development of regional assessment services
- review of service specifications for Needs Assessment and Service Co-ordination, along with specialist services for older people and home-based community support services
- development of close liaison and continuity of service between services for people with disabilities under the age of 55 years and those for older people with disabilities
- appropriate training to understand the needs of Māori so programmes are delivered in a culturally appropriate manner. Development of assessment programmes, information resources and education for kaumātua (particularly for rural-dwelling Māori) and whānau[74](+)
- participation of Pacific peoples in the development of assessment programmes for Pacific peoples. Consultation, co-ordination, delivery and monitoring of assessment programmes should be done in partnership with organisations (eg, churches) and Pacific radio/television. Pacific language interpreters with detailed knowledge of health/well-being issues for older Pacific people should work alongside health care professionals, both in mainstream services and community-based initiatives. Visual (eg, videos) and verbal media will have greater effect than printed material as an education resource.[74](+)

SUMMARY GUIDELINES

Summaries of the guideline will be produced, focusing on the issues of particular sections or for particular audiences. These will include summaries on:

- screening and proactive assessment
- comprehensive assessment
- consumers and carers (with large-print versions available for the visually impaired)
- Māori: written in Māori, and presented through hui.

IMPLEMENTING ASSESSMENT TOOLS

An independent comparative review and analysis of the leading assessment tools currently available internationally has already been completed as part of the guideline development process. The resulting report reviews various tools ranging from screening tools to comprehensive tools with a focus on applicability for implementation within New Zealand.[147](~) These tools while comprehensive do not meet the legislative requirements of ACC to separate the effects of injury from medical needs. ACC has agreed to work with the Ministry of Health and DHBs to determine whether any modifications can be made to these tools to provide an integrated tool. Guideline Development Team members are willing to liaise with developers of those tools most closely matching the criteria identified in this guideline to promote development of a tool that meets all the criteria.

Implementation of the tool and supporting database is likely to be most efficient and cost-effective if DHBs collaborate. Support for organisations adopting the appropriate tool, together with establishing the necessary underlying databases, will be provided by the Ministry of Health.

IMPLEMENTING ASSESSMENT SKILLS

Members of the Guideline Development Team will liaise, in an advisory capacity, with local and overseas training provider organisations to develop appropriate training programmes to ensure assessors are equipped with appropriate knowledge and skills.

STAGED IMPLEMENTATION

There are a number of tasks necessary for the implementation of this guideline. It was suggested during the consultation on the guideline that implementation should be staged to make it more achievable.

Staged tasks involved in implementing this guideline are likely to include:

- database development
- selection, modification, piloting and evaluation of assessment tools and processes
- some reconfiguration of services
- training of assessment staff
- development of MDTs
- clarification of roles.

During the consultation phase of the guideline development, it was also suggested that some of these tasks may be more effective if done centrally. This would require development of collaborative liaison between DHBs, such as the formation of a central steering committee. A central committee of this nature could provide:

- centralised guidance
- liaison with the Ministry of Health
- support for consistency of approach at a regional level
- a cost-effective solution to tool implementation and database development
- supervision for cross-DHB membership of MDTs by specialist health care practitioners
- ongoing consumer input both nationally and locally.

ORGANISATIONAL BARRIERS

There are a number of existing barriers to the implementation of the recommendations in this guideline, particularly resource allocation, and implementation will require considerable restructuring of the supporting services to address the barriers. However, the guideline has been developed in response to a recognition that the current service provision is not adequately meeting the needs of older people in New Zealand, and the enthusiasm with which the recommendations have been received during the open consultation process indicates the willingness of those involved to develop effective assessment services.

16

COSTS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

OVERVIEW

- There is no New Zealand data from which to calculate the costs of an assessment programme.
- Pilot projects to determine an expenditure guide for New Zealand will ensure that assessment programmes are cost-effective.
- Reductions in health service usage will be reflected in reduced costs.
- Screening older people with preventive home visits has been found to be cost-effective overseas.

An overseas study reported by Boult et al[32](+) has stated that comprehensive assessment of older people is most cost-effective when used for people who are at high risk of functional decline and/or heavy users of health care services. Consistent with this finding, a review of the effectiveness and cost-effectiveness of Britain's programme of health checks for people aged 75 years and over recommended a two-step process: an initial brief assessment for everyone, and then a further comprehensive assessment for those found to be at risk.[47](+) However, to date there is insufficient evidence to support such an approach in New Zealand and no New Zealand data from which to calculate the costs of an assessment programme.

Reductions in length of hospital stays, improved function in ADLs, reduced use of services, and reduction in unnecessary prescribing and improved treatment of iatrogenic disease will be reflected in reduced costs,[45,47,56,64,144,150](+) but equally, the cost of the programme has to be offset against this reduction. The evidence from screening and assessment programmes overseas is that, providing the programme costs are managed well, there will be net savings in expenditure. One study in 1999[89](~) estimated a cost of US$6,000 for each disability-free year of life gained, but suggested similar interventions could be made more cost-effective.

For example, a systematic review and analysis found that screening older people with preventive home visits, while requiring an average initial investment of US$433 per person in the first year, produced net average savings of US$1,403 per person per annum by the third year.[148](+) Stuck et al[153](+) in their 2002 systematic review, found that screening older people with preventive home visits was cost-effective for programmes with expenditures of below £1,000 (US$1,500) per participant.

Determining the equivalent expenditure guide for New Zealand will ensure that programmes are cost-effective. In order to determine the costs, it will be necessary to obtain data from pilot programmes run within New Zealand. Set-up costs will include the purchase of the tools (if applicable), development of a database, recruiting, training and equipping staff.

KEY - *Grades indicate the strength of the supporting evidence not the importance of the recommendations - see page xvi for details*

A Recommendation is supported by good evidence
B Recommendation is supported by fair evidence
C Recommendation is supported by expert opinion only
I No recommendation can be made because the evidence is insufficient
✓ Good Practice Point

AUDIT, PERFORMANCE INDICATORS, EVALUATION AND CLIENT SATISFACTION

OVERVIEW

- Service providers have a responsibility for the collection of data relevant to different perspectives.
- The information gathered in programme evaluation should reflect the values of the assessment processes and meet the needs of all the stakeholders.
- Audit evidence is comprised of statements of fact or other information, which are relevant to the audit criteria and verifiable.
- Client satisfaction should be linked with outcome evaluation. A client's satisfaction with a service may bear no relationship to the health care professional's concept of a quality service.
- The Guideline Development Team urges the development of national standards of competencies for professionals involved in assessment and care of older people.

GOOD PRACTICE POINTS	
The ultimate aim of audit should be to improve the quality of care.	✓
Audit of programme performance indicators is necessary to monitor service provision and quality of care. Audit should take place every six months.	✓
Collection and audit of ethnicity data is recommended to monitor services for equitable access and delivery of programmes.	✓
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.	✓
Consumers' views should be sought to assist the development of a quality service.	✓

QUALITY

Audit, evaluation and feedback are integral aspects of quality improvement, with the ultimate aim to improve the quality of care.

Quality refers not only to clinical effectiveness but also to other factors such as equity and respect for autonomy. As well as seeking to improve care by bringing about direct changes in clinical practice, audit can produce beneficial changes through indirect effects on professional education and team development.

A client's satisfaction with a service may bear no relationship to the health care professional's concept of a quality service. This emphasises the importance of coupling client satisfaction with outcome evaluation. The consumers, service providers, purchasers and funders of assessment processes for people aged 65 years and over all have a particular interest in the quality of the assessment. This puts a responsibility on service providers for the collection of data relevant to the different perspectives. Often different levels of data will be required for different purposes and this chapter describes:

- the minimum data required for programme evaluation that a service provider should collect (obtained routinely and by client satisfaction questionnaire)
- additional data for periodic audit (by internal or external agencies)
- suggested performance indicators that a provider could report against or that could be included in service specifications.

Programme Evaluation

Programme evaluation is a way of monitoring and improving the quality of care. The information gathered should reflect the values of the assessment processes and meet the needs of all the stakeholders, including people aged 65 years and over. Analysed information should be used to improve performance in identified areas and celebrate the success of others. When deciding which outcomes to measure it is important to measure those that are important to the people being assessed, their carers, as well as the service. It is important to remember when auditing outcome data and comparing results with a similar time period problems may arise because of case mix.

Audit is a systematic, independent and documented process for obtaining evidence and evaluating it objectively to determine the extent to which the audit criteria are fulfilled. Audit evidence is comprised of statements of fact or other information, which are relevant to the audit criteria and verifiable. Audit evidence can be qualitative or quantitative. There are no randomised controlled trials of the efficacy of audit and whether it is a good use of resources. There are many observational studies, both quantitative and qualitative that have sought to evaluate audit.

Audit is a strategy that assists in the enhancement of the quality of a service. Audit is not an endpoint but a precursor to aid improvement. Audit can evaluate whether:

- changes in practice are actually happening
- those changes in practice are actually effective.

Client Satisfaction and Consumer Input to the Programme

Clients are increasingly involved in the evaluation of their care. There are no universally accepted means for measuring client satisfaction. Measures of satisfaction have been developed primarily so that clients could furnish health care providers with feedback on the services provided to them.

If using satisfaction surveys it is important to be aware of the percentage of:

- people given a client satisfaction survey
- clients completing a satisfaction survey
- spouses/partners given a satisfaction survey
- spouses/partners completing a satisfaction survey
- 'dropouts' contacted and asked for feedback.

Performance Indicators

Some measurable outcomes which would be able to demonstrate a change in the gap between current practice and optimal practice have been identified as:

- the number of people accessing assessment processes, with an analysis of ethnic and socio-economic differences
- waiting times for assessment
- waiting times for service intervention
- acute admissions while waiting for an assessment
- re-admission rates after discharge from acute care
- the number of people discharged without a support package in place
- changes (increase or decrease) in the numbers of community support packages
- changes (increase or decrease) in the rate of residential care admissions.

STANDARDS

The research and consultation stages of the development of this guideline have revealed that there is a need for the development of national standards for competencies for assessors and all those professionals involved in the assessment and care of older people. Although it is outside the scope of this guideline to make recommendations about what those standards should be, the Guideline Development Team urges the development of such standards.

GAPS IN THE RESEARCH

During the development of this guideline, the systematic literature search was unable to identify a body of research in the following areas sufficient to answer the questions. This may have been because there was little or no published evidence addressing the specific questions being asked, or because the evidence that was identified was of insufficient quality upon which to base recommendations. In most cases, there was very little New Zealand-based research, although there are several studies currently underway which should provide more information.

Specifically, the team found there was:

- a need to develop some standard terminology to describe and define frequently used terms in the area of assessment of older people. Terms covering the types of assessments and the groups of people (with levels of complexity of needs) were misleadingly variable
- no systematic evaluation or comparison of effectiveness of assessment programmes in New Zealand
- insufficient evidence about the potential harms to older people in the process of assessment for needs (which may include under- or over-assessment, lack of follow-up, waiting times, misrepresentation of needs, or other unknown harms)
- a need for research on the relative effectiveness of targeted screening and population screening
- a need for more research (as opposed to opinion pieces) on what older people themselves want from an assessment programme, and whether being guided by such consumer preferences increases the effectiveness of the assessment
- not enough research to be able to identify who are the most effective people to do multidimensional assessments – that is, what specific qualifications, training and/or skill-set the assessor should have, whether they should be from a particular discipline, and if so, which etc
- not enough research directly comparing the relative effectiveness of different locations, settings and timings for assessment
- a need for systematic research on the particular needs of older Māori, Pacific peoples, and other groups of older people in New Zealand
- a need for quantitative research on the particular needs from assessment as they age, of people with pre-existing disabilities, both congenital and those acquired earlier in life
- a need for more clarity about whether assessment of carers is most effective when linked with assessment of the care recipient, or if there are other triggers for carer assessment that would be more effective
- a need for testing of the applicability of screening and assessment tools to the New Zealand setting
- a need to develop or modify screening and assessment tools for the New Zealand setting
- no screening and/or assessment tool that exactly matched the identified criteria
- limited information about the validity, inter-rater reliability, acceptability, specificity and sensitivity of screening and assessment tools
- insufficient information about whether an assessment should be a single process from screening to the more in-depth assessment, or discrete assessments along the continuum of care
- a need for research exploring the reasons for the apparent reluctance of health care professionals in overseas studies to follow the recommendations of a multidimensional assessment, and to consider the extent to which this could be an issue in New Zealand

- not enough information to reliably determine the cost in New Zealand of multidimensional assessment processes of the type outlined in this guideline, or the timescales over which costs could reasonably expect to be recouped.

Although somewhat beyond the scope of this guideline, when looking at recommendations for implementation, the guideline development process also revealed that there is:

- no research specifically looking at the impact of the structure of the New Zealand health care system on the needs of older people in New Zealand
- a lack of information about how the different sectors involved in providing for the needs of older people in New Zealand, such as health care and social services, could effectively create an intersectoral collaboration; and what modifications to existing services would be necessary.

GLOSSARY

Definition

This is the way that this term is used in this guideline. Usage and/or meaning may vary in other contexts.

A T and R: Assessment, treatment and rehabilitation services for older people provided by hospitals.

ADL: Activities of Daily Living.

Assessment [of Needs]: A process to detect and identify needs for treatment, support or other intervention.

Assessor: Person who performs an assessment.

cf **Rater**

Asymptomatic: Literally, showing no symptoms. Within the context of this guideline, however, someone is said to be asymptomatic if they have not sought or been referred for help or treatment for the problem.

Care workers: Health and/or support workers paid to provide care.

cf **Carers**

Caregivers: Providers of care. Most often used to denote informal carers, but occasionally the literature will refer to paid care workers as caregivers.

Carers: Informal/unpaid providers of care, often family members.

cf **Care workers**

CGA; Comprehensive Geriatric Assessment: *Comprehensive Geriatric Assessment (CGA)* is used in the literature with two different meanings:

1. a broad-spectrum assessment, and
2. a more in-depth specialist assessment.

cf **Comprehensive assessment**

CME: Continuing Medical Education. Structured educational programmes for health practitioners.

Community-dwelling: People who are living, relatively independently, in the community (ie, not in residential care or in hospital).

Comparable data: Data that is collected and stored in a format that allows for comparison with similar data from a different source.

Complex needs: Multiple needs or potential needs in more than one domain, or fewer needs in fewer dimensions but of greater severity.

Comprehensive assessment: Multidimensional, in-depth assessment (ie, covering many dimensions of mental and physical health, functional and social well-being).

cf **CGA**

cf **Multidimensional**

Concordance: A new approach developed around the prescribing and taking of medicines. It is an agreement reached between a person and a health care professional that fully respects the beliefs and wishes of the person in determining whether, when and how medicines are to be taken.

Consumer: A consumer of health or disability services; and, for the purposes of rights under the *Code of Health and Disability Services Consumers' Rights*, any person entitled to give consent on behalf of that consumer.

DHB: District Health Board.

Dimension: A subcategory within a domain of function. For example, 'mood' and 'dementia' are dimensions within the domain of 'mental health'; 'hearing' and 'nutrition' are dimensions within the physical health domain; 'social contact' and 'financial status' are dimensions within the 'social functioning' domain.

cf **Domain**

Disability: Incapacity caused by congenital state, injury or condition expected to last six months or more. A disability may or may not cause need for assistance.

Mild disability: not requiring assistance

Moderate disability: requiring assistance or special equipment, but not daily

Severe disability: requiring at least daily assistance.

Discipline: An area of professional competence such as social work or nursing.

Domain: A broad category of functional health and well-being, such as mental health, physical health and functioning, social and environmental.

cf **Dimension**

Evaluation: A systematic and objective assessment of the relevance, effectiveness and impact of activities in light of their objectives.

Frail: In a vulnerable state of health.

Functional decline: The loss (gradual or otherwise) of elements of normal physical function.

Health: The World Health Organisation defines health as a complete state of physical, mental and social well-being (ie, not just the absence of disease). Māori definitions of health include physical, spiritual, mental and family health along with cultural elements such as land, environment, language and extended family.

Health information: Any information about a person's health or the impact of other factors on their health and well-being. The confidentiality of all health information is protected under the Privacy Act.

Hospitalisation: A term used to indicate the amount of disease and conditions in the community. Includes inpatients who leave hospital to return home or transfer to another hospital, or those who die in hospital.

Hui: A traditional Māori forum for discussion of an issue.

IADL: Instrumental Activities of Daily Living; a measure used to assess functioning.

Iatrogenic: Illness caused by medical treatment.

IHC: IHC New Zealand Inc. A not-for-profit organization providing services to intellectually disabled people in New Zealand.

Independent life expectancy: The average number of years lived without being dependent on care from others if current sex-specific and age-specific mortality and morbidity rates continue to apply.

Informal carers: Unpaid providers of care, often family members.

cf **Carers**

Informed consent: A process requiring effective communication between all concerned; provision of all necessary information about options, risks and benefits to the consumer; and the consumer's freely given and competent consent.

Integrated service(s): Where all the services of different sectors providing assessment and/or interventions arising from the assessment have an efficient and effective flow of information, and the 'gaps' between services are proactively addressed to provide smooth service delivery to the older person.

Inter-rater reliability: The degree of stability that exists when a measurement is repeatedly made by different observers.

Intersectoral: Involving different sectors of society, such as health, disability, community organisations, housing and social services, working in collaboration.

Intervention: Introduction of or change in treatment or management of a person or their health condition aimed at improving outcomes.

Kaumatua: Wise and experienced older members of a whānau.

Kuia: Wise and experienced older female members of a whānau.

Life expectancy: The average lifetime in years if current sex-specific and age-specific mortality rates continue to apply.

MDT: Multidisciplinary team.

Measures: Questionnaires or scales.

Medication Review: A structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste.

Monitored: Observed or measured regularly.

Morbidity: Illness or impairment of health or function.

Mortality: Death.

Multidimensional: Covering many dimensions of mental and physical health, functional and social well-being across several usually separate disciplines within health, disability and social care.

cf **Comprehensive assessment**

cf **Multidisciplinary**

Multidisciplinary: Covering areas of expertise from different and usually separate disciplines, such as mental and physical health, occupational therapy, gerontology, social work, dietetics etc.

Multidisciplinary teams: (see also *Multidisciplinary*) Teams comprising members from different disciplines.

NASC: Needs Assessment and Service Co-ordination.

Need: For the purpose of this guideline, 'need' is need for care, support or intervention in one or more areas of health, social or disability support.

Older people: Generally, people aged 65 years and older. This may vary for certain populations who have lower disability-free remaining life expectancy at age 65.

Opportunistic screening: Population screening where the members of the population are only screened when they meet a certain criteria – for example when they present to a primary health care service.

cf **Targeted screening**

Polypharmacy: The administration of multiple medications, either prescribed or non-prescription, particularly where psychoactive medications are involved.

Practitioner: A health, disability, social or community services worker.

Preventable hospitalisations: Cases of people being hospitalised for an illness or disorder which, if it had been detected early, could have been treated effectively so that it would not have been necessary to be admitted to hospital.

Primary health care: Primary-level health, disability, social and community services care provided by a range of health workers including physicians, nurses, auxiliaries and community workers.

Privacy Impact Assessment: A systematic analysis of a proposed process to determine the impact on privacy issues. More details are available from the Office of the Privacy Commissioner.

Rater: The person completing a measure. Sometimes used in the literature and by some assessment tools interchangeably with 'assessor'.

cf **Assessor**

Rehabilitation: Any of a wide range of measures and/or activities designed to provide and/or restore functions, or compensate for loss or absence of a function or for functional limitation, not necessarily involving medical care.

Reversibility: The potential to reverse impairment of health or function (rather than to adapt to the impairment).

Risk factor: An aspect of personal behaviour, an inherited characteristic, or an environmental factor that is associated with an increased likelihood of that person developing a particular condition.

Screening: A systematic test applied to a whole population. Testing may be for a particular condition, or for risk factors for one or more conditions.

Services: Health services, or disability services, or both; including health care procedures.

Secondary health care: Public hospitals, hospital-based services and specialist services.

Special populations: Populations who differ from the general population in particular attributes, requiring an adapted approach.

Targeted screening: Screening that is targeted at particular subsets of the general population, such as people with particular risk factors.

Tools: A collection of scales, questions and other information, to provide a rounded picture of a person's needs and related circumstances.

Unmet need: A need for support or intervention that is known but has not been (adequately) addressed.

Whānau: Extended family: relationships that descend from a common ancestor.

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