

# ASSESSMENT PROCESSES FOR OLDER PEOPLE

*The New Zealand Guidelines Group has developed a best practice, evidence-based guideline providing recommendations for appropriate and effective processes for assessment of personal, social, functional and clinical needs in older people. This general summary provides an overview of the recommendations.*

## KEY MESSAGES

- Standardisation of assessment processes for older people across New Zealand is essential.
- Assessment of older people should be comprehensive and multidimensional.
- 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.
- 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.
- 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.

The Assessment Processes For Older People Guideline and summaries have been endorsed by:



The Royal Australian  
and New Zealand  
College of Psychiatrists  
- New Zealand Branch



Complete endorsement list available in full guideline.



**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:**

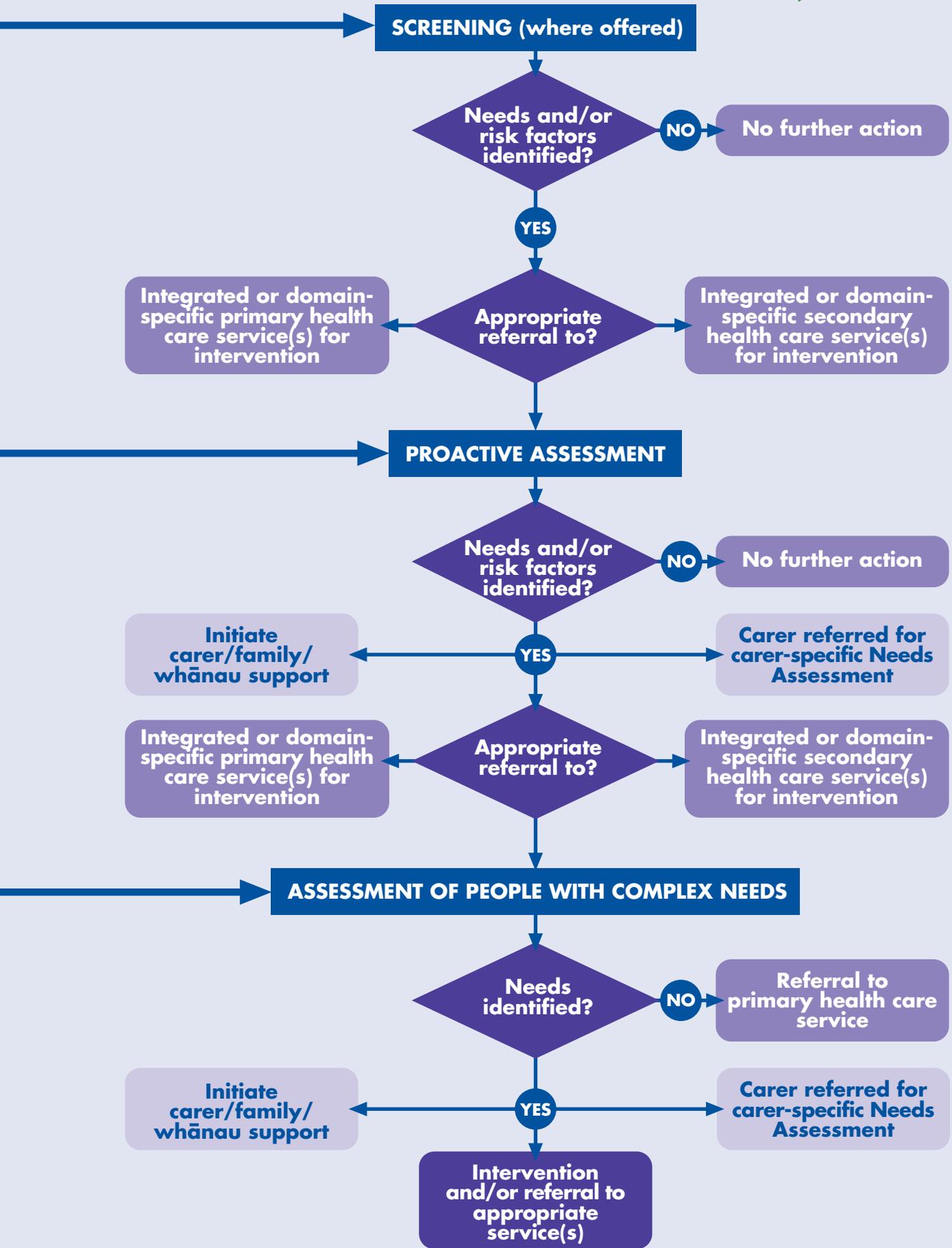
**People aged 65 years and over**  
**Māori aged 55 years and over**  
**Pacific people aged 55 years and over**  
**People with pre-existing disabilities aged 55 years and over**

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.

# OLDER PEOPLE ALGORITHM



# KEY RECOMMENDATIONS

## Screening

Screening would consist of questions 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.

- Any screening of older people for impairment and risk factors for developing future impairment should be adapted appropriately, piloted and evaluated to determine its effectiveness in the New Zealand setting before regional or national screening programmes are considered.
- 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 70 years and over).
- To be effective, screening should cover both domains of potential impairment and risk factors for health or functional impairment.

## Proactive Assessment

A preventive assessment that tests for unmet needs in different domains (including physical and mental health, functional performance and social functioning).

- Proactive assessment of older people should be multidimensional.
- The assessment process should use standardised tools and standard methods of collecting, reporting and comparing data.
- The proactive assessment process should be used as an opportunity for health promotion, disease prevention, treatment, and care management.

## Assessment of Older People with Complex Needs

People with 'complex needs' have multiple health, functional and/or social problems, vulnerable health, or are at risk of functional decline and/or hospital admission.

- Assessment of older people should be comprehensive and multidimensional.
- Assessment must be supported by resourcing for interventions to address the needs identified.
- Assessment must be supported with regular follow-up.
- Comprehensive assessment should inform and assist an ongoing treatment, rehabilitation and care plan that includes strategies to encourage implementation of the plan.

## Carers' Needs

Carers include all people caring for older people and older people caring for others.

- Carers of older people should be assessed for health, training and support needs.
- Older people who are carers of people with intellectual or other disabilities should be assessed for health and support needs.
- Assessment of carers should be linked with the assessment of older people.

## When Should Older People be Assessed?

- Assessment should be made available at age 65 years and over for the general population and screening should take place when the older person reaches 70 years.
- For older Māori, Pacific people and people with pre-existing disabilities, screening and assessment should be made available at age 55 years.
- Proactive assessment should occur when risk factors are identified by screening, or when the older person comes to the attention of primary health care or social services, including through social presentations, such as caregiver or family/whānau request, or relating to a change in living circumstances, if not screened in the last six months.
- Attendance at an emergency department (ED) should trigger an assessment initiated prior to discharge.
- A comprehensive assessment should occur when triggered by a proactive assessment; or when an older person is referred to or receiving secondary health care services, including acute care; or when they are referred for comprehensive assessment by primary health care, social services, community workers, carers, or family/whānau.

## Where Should Assessment Take Place?

- Screening and proactive assessments of people should usually take place within the older person's home, unless the older person is in an ED.
- Assessment of older people within hospital settings (including EDs) or in residential care should be initiated in that setting, but if the person is to return home, all comprehensive assessments should include a home visit by a trained assessor.
- Screening and assessment of older Māori should usually take place at the home of the older person and their whānau.
- A rural network of assessors should be developed for assessment of non-urban-dwelling older people.

## Assessors

- Assessors should have specialist training in the assessment process, including training in consent issues.
- Assessors of older people need the following attributes:
  - good communication skills, including the ability to facilitate the older person's communication with other health 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.
- A specialist trained assessor for older people must be in or available at short notice for an ED.
- Assessors of people with intellectual or other disabilities must have specialist training in the area of disability.
- Assessment of older Māori people who prefer a Māori-specific approach requires mature Māori assessors who are well-known and respected in their community and fluent in te reo Māori me ona tikanga. Where a Māori assessor with these skills is not available, the assessor should be supported by someone with these attributes.
- Assessors of older Pacific people should be from the same ethnic background and able to speak the same language as the person to be assessed wherever possible.
- It should be publicised to Pacific peoples that assessors of older people have professional skills and status to encourage trust.

- Assessors of older people should be part of (or have ready access to) a wider multidisciplinary team with whom they can consult and to whom they can quickly refer the older person for more in-depth assessment or for help in any particular domain.
- Initial contact and assessment of older people with complex needs in a primary health care setting should be performed by a core assessment team.

## The Multidisciplinary Team

- The multidisciplinary team (MDT) should comprise: registered nurses, geriatricians, psychogeriatricians, clinical psychologists, physiotherapists, social workers, speech-language therapists, audiologists, dieticians, neurologists, occupational therapists, pharmacists and the older person's general practitioner where appropriate. MDTs supporting assessors of older Māori or Pacific people should include a Māori or Pacific health care professional. All members of the team should have competency (where appropriate) or experience in working with older people.

In addition, when the MDT is supporting the assessment of people with known disabilities, it should include specialists with expertise in the disability.

- The core team for primary health care initial contact and assessment of older people with complex needs should comprise a primary care physician, a nurse with gerontological training and experience, and a social worker with experience in working with older people.

## Assessment Tools

See the supporting document: *Assessment of Community Dwelling Older People in New Zealand: A Review of the Tools*, available at [www.nzgg.org.nz](http://www.nzgg.org.nz)

- 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.
- Any tools used must be able to assess the domains and dimensions identified as significant (see back page).
- The needs of carers should be assessed using a purpose-designed tool after adaptation for use in New Zealand where necessary.
- 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.
- Any screening and/or assessment tool selected should be modified in collaboration with the developers to meet the needs of older people in New Zealand.
- MDS-HC Overview and Overview+, and EASY-Care most closely meet guideline specifications for a screening and proactive assessment tool for older people.
- The MDS-HC comprehensive assessment with additional modules for those domains not currently addressed should be used for the comprehensive assessment of older people.
- Implementation of a comprehensive assessment tool must be supported by a programme of education for specialists and other health care professionals and strategies to improve physician implementation of the recommended interventions.

## After Assessment

- Any screening and/or assessment must be performed, monitored and evaluated systematically.
- Any screening and/or assessment must be supported by appropriately planned, adequately resourced, timely further interventions for treatment/care for older people identified as in need by the screening or assessment.
- Regular follow-up of older people identified should form part of the process of assessment.

## Special Considerations

- Any assessment process for older people should be designed to ensure that the older person is involved in the assessment process, including people with intellectual or other disabilities.
- 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.
- 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.
- When assessing older Māori who prefer a Māori-specific approach:
  - *Te Whare Tapa Wha* or a similar holistic model should be used
  - all decisions should be made collectively with the older person's whānau or hapū
  - the assessor should be of the same sex as the person being assessed whenever possible.
- Assessment programmes for older Māori and older Pacific peoples should be actively offered rather than being made available and expecting the older people to initiate contact.
- For Pacific peoples, information relating to an assessment should be produced in Pacific languages as well as English, and produced in oral form (through videos, radio and as part of Pacific health promotion and health education forums) rather than relying on written formats.
- For Pacific peoples, 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.

### Guideline Development Process

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. The guideline was funded by the Ministry of Health and independently developed by the New Zealand Guidelines Group. A multidisciplinary group of professionals and representatives of consumer organisations and other appropriate organisations was convened as the guideline development team. Members of the guideline development team included: Sally Keeling, Anne Bray, Keith Carey-Smith, Keita Dawson, Crawford Duncan, Paulette Finlay, Margaret Guthrie (CNZM), Beatrice Hale, Stephen Jacobs, Sandie Kirkman, Mairi Lauchland, Daphne Marshall, Julie Martin, Dennis Paget (MNZM), Karen Palmer, Maree Pierce, Lauren Prosser, Hēmi Ririnui-Horne, Margaret Sanders, Tim Slow, Denise Udy and Rowena Cave. Details of the team's backgrounds and the institutions they are representing are available in the full document.

A systematic critical review of relevant published and unpublished research and conference abstracts between 1980 and May 2003 was performed. Recommendations have been based on the highest level of evidence available, and informed by the professional expertise of the team, together with the need to maintain a consumer focus. Details of the grading system can be found at [www.nzgg.org.nz](http://www.nzgg.org.nz)

An early draft of this guideline was widely distributed to over 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.

The guideline is supported by a review of assessment tools, commissioned by the NZGG, and available at [www.nzgg.org.nz](http://www.nzgg.org.nz). It is intended that the guideline be reviewed in 2006.

# DOMAINS OF ASSESSMENT

## Areas of need of most importance to older people

- personal care
- social participation
- control over daily life
- food
- safety

## Domains and dimensions

These are areas in which impairment can be detected at an early stage.

### Physical health and functioning

**key dimensions:** chronic illness, continence, nutrition, gait, mobility, cardiac conditions, gastrointestinal conditions, pulmonary conditions, cerebrovascular conditions, co-morbidities, ADLs and IADLs (including self-care and domestic abilities), iatrogenic disease (specifically due to polypharmacy), sexual functioning, speech and language impairment, dental/oral health, vision and hearing

### Mental health and functioning

**key dimensions:** anxiety, depression, other mental illness, cognitive functioning, dementia, substance abuse, iatrogenic disease due to polypharmacy, emotional well-being

### Social functioning

**key dimensions:** financial status and management, housing, family/whānau support/contact, social networks, social activities and support

### Presence and roles of carers, especially informal carers

#### Risk factors

- aged 75 years or older
- socially isolated and/or living alone
- divorced/separated, never married, single or widowed
- recently bereaved
- has no children
- has poor or limited economic resources
- recently discharged from hospital
- presenting at an emergency department
- recent change in health status with an impact on capacity for independent living
- has multiple disorders or illness
- cognitively impaired
- depressed
- poor self-perceived health
- high or low body mass index
- at the lower extreme of functional impairment
- low physical activity
- taking 3 or more prescription/non-prescription medications
- impairment in sight or hearing
- carer showing signs of stress/change of carer
- carer requests an assessment for the older person

#### Also consider:

- alcohol, tobacco and/or substance use
- abuse of the person by another