

# PROACTIVE ASSESSMENT

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 summary covers the important issues for screening and assessment in primary health care, including social services.

'Proactive assessment' of older people is a preventive assessment for needs in multiple domains. Currently there is little consistency of assessment across New Zealand and little evidence on the effectiveness of current practice. A nationally consistent, standardised assessment process using standardised tools is essential to ensure equity of care and effective resource allocation.

## Why Assess?

Comprehensive, multidimensional assessment of older people improves outcomes in terms of the health and well-being of the older person and their carers, while a lack of adequate assessment results in avoidable health impairment and disability.

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.

## Who Should Be Assessed?

All people aged 65 years and over and older Māori, Pacific people and people with known disabilities aged 55 years and over should receive a proactive assessment, if they have not been assessed in the last six months:

- when they come into contact with primary health care or social services
- if the person has any risk factors
- if referred for further assessment by a screening process, or
- if referred by community workers, family/whānau or carer.

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



Complete endorsement list available in full guideline.

# KEY RECOMMENDATIONS

## Working Together

- To be effective, screening and assessment must operate on the principle of working together or concordance, where the older person being assessed, their family/whānau, their carers and all practitioners involved in their care and support are actively involved in the process.

## Proactive Assessment

- Processes and tools for screening older people for impairment and risk factors for developing future impairment should be adapted appropriately, piloted and evaluated to determine their effectiveness in the New Zealand setting before regional or national screening programmes are considered.
- Any screening and assessment must be performed, monitored and evaluated systematically.
- Strategies to improve uptake should be implemented alongside screening.
- Any screening and/or proactive assessment must be supported by appropriately planned, adequately resourced, further interventions for treatment/care to address any issues identified for the older person.
- The proactive assessment process should be used as an opportunity for health promotion, disease prevention, treatment, and care management.
- Proactive assessment of older people should be comprehensive and multidimensional.
- Regular follow-up should form part of the process of proactive assessment.

## Assessment of Carers

- Carers of older people, and older people who are carers, should be assessed for health, training and support needs. A carer-specific assessment should be integrated with any programme of assessment of older people.

## Assessment Tools

- A standardised, comprehensive, multidimensional screening and/or assessment tool with standard methods of collecting, reporting and comparing data should be used for screening and assessment. For a detailed comparative review of assessment tools, see the report *Assessment of Community Dwelling Older People in New Zealand: A Review of the Tools* at [www.nzgg.org.nz](http://www.nzgg.org.nz)

## Location of Assessment

- 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.
- Assessments for older Māori need to focus on the health and well-being of the person within the context of whānau well-being. The assessment should therefore be done in the person's own home.

## Assessor Skills and Support

- Assessors of older people must have specialist training in the assessment process, including training in consent issues, and need the following attributes:
  - good communication skills
  - ability to facilitate the older person's communication with other health practitioners
  - good interpersonal and relationship management skills
  - sensitivity to the older person's beliefs and attitudes
  - awareness of spiritual aspects of the person's care.
- Those carrying out assessment of older people should be part of (or have ready access to) a wider multidisciplinary team (MDT) to whom they can quickly refer and with whom they can consult.
- The 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.

## Assessing Māori

Where the older person chooses to be assessed using a Māori-specific approach:

- all decisions should be made collectively with the older person's whānau or hapū
- assessors of older Māori should be mature, well-known and respected within their community and should be fluent in te reo Māori me ona tikanga where the older person and/or their whānau prefers its use. If this is not possible, then the assessor should be supported by someone with these attributes
- whenever possible the person assessing older Māori should be of the same sex as the person being assessed.

## Assessing Pacific Peoples

- 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 where possible.
- 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.

## After Proactive Assessment of Older People

- Assessment must be supported by timely and effective interventions to address any issues identified.
- Where any needs are identified by the assessment process, a treatment/management plan must be developed with the older person.
- Regular follow-ups, where necessary, must be part of the process.

# 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