

ASSESSMENT OF OLDER PEOPLE WITH COMPLEX NEEDS

SPECIALIST SERVICES

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 specialist services.

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

Older people with complex needs should receive a comprehensive, multidimensional assessment when they come into contact with health or social services, or when an assessment is requested by carers, family, health or social service professionals involved in their care and support.

All older people attending an emergency department must receive an assessment by a specialist trained assessor.

Why Assess?

Benefits of a multidimensional assessment for older people with complex needs include:

- improved diagnostic accuracy
- improved effectiveness of care
- improved functionality or reduced functional decline
- prolonged survival
- prolonged maintenance of independence
- improved quality of life
- improved mental health
- improved client satisfaction
- improved primary physician satisfaction
- reduction in burden for carers and improved carer satisfaction
- decreased use of hospital and/or residential care
- decreased or no increase in cost of care.

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



Complete endorsement list available in full guideline.

KEY RECOMMENDATIONS

Assessing Older People with Complex Needs

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

Who to Assess?

- All people aged 65 years and older and Māori, Pacific people and people with pre-existing disabilities aged 55 years and older should receive an assessment:
 - when a comprehensive assessment is triggered by a proactive assessment
 - prior to discharge when they have presented at an emergency department (ED)
 - when referred to or receiving secondary health care services, including acute care
 - when referred for comprehensive assessment by primary health care or social services, community workers, carers, or family/whānau.

How to Assess?

- 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 with complex needs. 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

Where to Assess?

- Assessment of older people within hospital settings or in residential care should be initiated in that setting, but if the person is to return home all assessments should include a home visit by a trained assessor.
- A specialist trained assessor must be available in an ED or available at short notice.
- 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.

Assessing 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.

Working Together

- Comprehensive assessment should include a process to promote agreement between practitioners and the older person and their family/whānau. It should result in a treatment plan that includes measures to promote implementation of that plan by the older person and health care and social service professionals.

Assessor Skills and Support

- Assessors 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 care and social service 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.
- 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

- Assessment processes should be made available at age 55 years.
- 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

- Assessment processes should be initiated at age 55 years.
- Assessors of older Pacific people should, where possible, be from the same ethnic background and able to speak the same language as the person to be assessed or supported by a person with these attributes.
- 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 Assessment

- An ongoing treatment, rehabilitation and care plan should be developed in consultation with the older person.
- It is essential that the assessment is supported by interventions to address any issues identified.
- To avoid negative outcomes, regular follow-up is essential.

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