Exploring Registered Health Professionals' Assessment of Older Adults in Care Facilities

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Abstract

Older adults in care facilities are increasingly frail, with a number of co-existing conditions and complex health care needs. Before entry into a care facility, and while they are residing in a care facility, older adults are assessed by health professionals from different disciplines. The aim of this research is to gain insight into registered health professionals'[1] understanding of assessment of older adults in care facilities and how these assessments are utilised by Registered Nurses to create a plan for care. Assessment is an integral part of clinical practice for health professionals. Health professionals assess older adults to plan and deliver care, to instruct others about the care to be provided to the older adult, and to meet contract and audit requirements. For this pilot project, fourteen health professionals who perform assessments of older adults in care facilities participated in this research. Participants were approached via their place of employment. Data were gathered through semi-structured interviews and analysed by Thematic Content Analysis.

The following theme was clearly identified in this research:

- Fragmentation of the assessment and care planning process,

with sub-themes related to

- human resource issues
- the focus on physical aspects by contracted health professionals
- the single-discipline approach to care planning
- the lack of formal information sharing

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Registered health professionals: For this research, the term 'Registered health professionals' includes Dietitians, Diversional Therapists, General Practitioners, Occupational Therapists, Pharmacists, Physiotherapists, Registered Nurses and Social Workers, who are employed or contracted by a care facility.

- the lack of a unified understanding of multidisciplinary team dynamics
- the positive approach of staff who choose to work in Aged Care

The overriding theme of fragmentation in assessment and care planning is a concern for the care delivery to older adults and is a barrier to providing a continuum of care. Recommendations for further research include:

- the use of the care plans by qualified and nonqualified staff
- the functioning of multidisciplinary teams in Aged Care
- the relationship between education and practice in Aged Care
- the relationship between clinical assessment as part of health professionals' practice and assessment for audit and contractual purposes.

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Chapter One

Introduction

This thesis is an explorative, descriptive study designed to gain insight into registered health professionals' understanding of assessment of older adults[1] in care facilities[2] and how these assessments are utilised by Registered Nurses to create a plan for care. The research is conducted as a pilot study, since little New Zealand information on this topic appears to be available.

The 'New Zealand Ageing In Place Strategy' (Ministry of Health, 2003), aims to support Older Adults wishing to stay in their own homes, by providing support with daily living and personal cares. In New Zealand, approximately 5% of Older Adults have multiple health concerns and require long-term care in care facilities, (New Zealand Guidelines Group, 2003). This increases to
27 % for adults over 85 years old, (New Zealand Guideline Group, 2003). For over a decade, there has been a trend towards increasingly complex care requirements by older adults in care facilities. The New Zealand Guidelines Group (2003) identified older people with complex needs as those who have multiple needs in a broad category of functional health and well-being, or those with needs of great severity. Mezey, Lavizzo-Mourey, Brunswick and Taylor (1992) noted in their research that, on average, residents in care facilities have 12 medical conditions and associated social and well-being concerns. The trend towards multiple diagnoses and complexity of care needs was also noted by Luk and Woo, (2000). In 2002 Bernstein-Lewis confirmed the need of older adults for care in

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[1] *Older adults* are persons 65 years of age or older, (New Zealand Guidelines Group, 2003). In national and international literature, older adults are also referred to as 'older people', the 'elderly' or 'aged'. In this thesis, these terms are used interchangeably.

[2] A *care facility* is a place of residence for older people with health care needs and/or disabilities, who require a level of assistance and monitoring with their daily living that is not suitably available in a home situation.

care facilities that were able to accommodate those people with multiple and complex health problems.

Skilled and experienced assessors and care planners are required to assist older adults with multiple diagnoses and complex care needs to find suitable accommodation and to achieve well-being. Older adults requiring care in New Zealand care facilities are subjected to a number of assessments which take place before entry into a care facility, on admission to a facility and as part of ongoing health assessments. Assessments identifying specific daily care needs are the basis of the 'Care Plan'[3] that is adapted to the individual person's needs, and are the link between the required level of care and a District Health Board (DHB) subsidy.

Prior to the 1990 health care restructuring, New Zealand public hospitals provided long-term care for frail older people. Specialised care facilities are now taking on this role, (Eliopoulos, 1997; Kane & Kane, 2000; Ministry of Health, 1995). Care facilities are operated by private corporate, (for-profit), and by Religious and Welfare, (non-profit) organisations. Before entry into a care facility, older adults are assessed for their level of care need. Older people who are privately paying residents do not require a needs assessment for subsidy purposes, however, a number of care facilities require a needs assessment to ensure the resident is placed at an appropriate care level (Jacobs, 2003).

[3] A *care plan* is a written plan that provides direction for each patient's care, including the goals for the patient and what actions are required to meet those goals. The plan ensures that nursing care is consistent with the patient's needs and progress toward self-care, (New Zealand Guidelines Group (2003).

Assessment before entry into a facility is completed by a Needs Assessment Support Co-ordination (NASC) assessor. NASC agencies are contracted by the DHB to identify support services for older people who have a disability that will last for more than 6 months. The NASC assessment is to determine the level of care that is required. It also determines the amount of the government subsidy that is being made available. NASC assessors are drawn from a variety of health professionals. The variation in health professionals' backgrounds may lead to variations in the outcome of the assessment, as identified by the NZ Guidelines Group (2003). The NASC assessment provides the baseline information that guides further assessments and care planning in a care facility.

Care facilities vary greatly in size. While care facilities are obliged by contract to subscribe to a multidisciplinary team approach, the size and makeup of the teams vary considerably. The health professionals carrying out assessments may be from a number of different disciplines. Each discipline has a somewhat different focus. Health professionals in care facilities are either contracted to, or employed by, the facility to be part of a multidisciplinary team. In large organisations the team usually includes; dietitians, diversional therapists, general practitioners, occupational therapists, pharmacists, physiotherapists, registered nurses and social workers. Smaller organisations employ or contract fewer allied health professionals.

The registered nurse is one of the health professionals who perform assessments and is also the professional responsible for creating and maintaining a care plan. The registered nurse compiles this care plan from the nursing assessments and the assessments and instructions for intervention as recommended by other health professionals. This details the person-specific care instructions to be used by care

assistants[4] to provide personal care. The care assistants delivering most of the personal care to a resident have varying skill levels. Most care assistants receive only on-the-job training. Some care assistants are enrolled nurses. Others are student nurses or people who have in the past undertaken some health professional training. Care assistants work under the direction and supervision of a registered nurse.

Assessment is the basis of professional practice and planning care. It is therefore an essential step in the process of assisting older people to achieve well-being. Assessment and care planning are components of the clinical decision-making cycle of assessment, planning, intervention and evaluation, (Bernstein-Lewis, 2002). Assessments of older adults by registered health professionals are carried out for different purposes and may be carried out in a variety of ways.

Assessment is a fundamental component of a health professional's practice and enables a health professional to

- Plan and personally deliver care to older adults
- Instruct others about the care they are required to deliver to older adults
- Meet financial, contractual and audit requirements.

Although all assessments may influence an older adult's well-being, the focus of this research is on the understanding of health professionals' assessment and the creation of care plans for older adults in care facilities[5]. The data to achieve this were gathered by interviewing 14 health professionals who perform assessments of older adults in care facilities, including registered nurses who are responsible for

[4] Unlicensed care staff are also referred to as *caregivers* or *health care assistants*. Care assistants' skill and education levels vary greatly.
[5] Care facilities may also provide care to people other than those defined as 'older adults'.

the creation and maintenance of the care plan. Participants were approached via their place of employment. Data were gathered through semi-structured interviews and analysed using Thematic Content Analysis.

The data indicated that a number of processes that relate to assessment and care planning are disjointed and fragmented, suggesting that this was caused by differences in understanding of working in teams, with disparities in knowledge about the focus of different health professionals' disciplines. A gap between education and practice also appeared to add to the fragmentation.

The data identified the overriding theme as:

- The fragmentation of assessment and care planning processes,

with sub-themes related to:

- human resource issues
- the focus on physical aspects by contracted health professionals
- the single-discipline approach to care planning
- the lack of formal information sharing
- the lack of a unified understanding of multidisciplinary team dynamics
- the positive approach of staff who choose to work in Aged Care

Background to this research

The motivation for this research originated from the researcher's professional concern and personal interest in issues related to care for older adults. As a health professional working in community and hospital settings with older adults, the researcher observed that over a number of years older adults admitted to care facilities had increasingly frail health, with the majority of these older adults having multiple diagnoses and complex health care concerns. The age at admission was high, increasing the likelihood of failing health and increasing care requirements. This suggested to the researcher that future assessments would need to be precise and detailed in order to link the outcome of the assessments to an appropriate plan for care.

In addition to these observations, the researcher gained the impression that health professionals do not always assess older adults in a consistent manner. Although health professionals in care facilities work in multidisciplinary teams, it was observed that the assessments by various health professionals appeared to happen parallel to other assessments, rather than contributing to a single plan of care. It appeared to the researcher that a number of health professionals performed assessments of older adults in a seemingly isolated manner. Discussions with colleagues hinted that there was an awareness of the need to better link assessments to a plan of care. The researcher's colleagues suggested that assessments were primarily performed to comply with professional and contractual obligations. For registered nurses these obligations included the creation and maintenance of the care plan. The decision-making process linking assessment to care planning was not always obvious or unambiguous. In the researcher's experience, the care plan appeared to be considered solely the domain of the registered nurse. The researcher also observed that the link between the

assessments performed by all the health professionals and the actual care plan was not evident. The care plan was largely dependent on the interpretation of the assessment results by the registered nurse.

The care plan detailing the specific care requirements for an older adult is an important document. It is designed for use by staff in the provision of appropriate and consistent care to residents in care facilities. Health professionals may be either employed or contracted by the care facility, or agency staff. Residents in care facilities have the majority of their personal cares provided by unlicensed care assistants. When a number of different staff members provide care in a team approach, there is the possibility that each team member has a slightly different approach to aspects of care. This may be based on their own experience and interpretation of care needs. To ensure appropriate intervention and consistency in care delivery, the care plan, - which is based on the health professionals' assessment-, should be a person-specific guide to the consistent delivery of care, 24 hours a day, 7 days a week.

The care plan is also used for contractual and audit purposes. Since October 2004, care facilities have received subsidies from their local District Health Boards (DHB). Previously, these subsidies were distributed by the Ministry of Health, (MoH). Unless the older adult is a private paying client[6], care facilities receive a subsidy related to the level of care they provide. Care facilities may be contracted by the DHB to provide hospital, rest home or dementia level care, and/or respite and day care. The higher the care requirement, the greater subsidy a facility receives for the resident.

[6] Private paying clients do not receive a subsidy. Subsidies are asset tested. The limit to qualify to receive a subsidy will be increased mid-2005.

In order to maintain a contract to provide certain levels of care, a care facility has to demonstrate its compliance with the contract, based on the DHB, Ministry of Health (MoH) and Health and Disability Sector Standards (HDSS). These audits are called *certification*. Regular audits related to contractual obligations are compulsory. These audits are contracted out to Designated Auditing Agencies (DAA). An example of a DAA is Quality Health New Zealand. Some facilities add to these requirements by independently enrolling with a DAA and adhering to further Best Practice Standards. The audits from these agencies are considered to be professional feedback as well as an indicator of good practice. These audits are voluntary. Both the compulsory and the voluntary audits make reference to assessment and care planning as part of a *Service Continuum*. The guidelines for assessments of older adults, provided by the funding and auditing agencies, can be subject to different interpretations and relate mainly to legal requirements for timely assessment and funding (Ministry of Health, 1995; Quality Health New Zealand, 1997,).

Mapping of the Assessments

In the preliminary stages of defining and re-defining the research, flowcharts were used to help the researcher identify and map the complex assessment paths associated with the care of older adults in care facilities. During this process, it was noted that the health professionals who conducted assessments of older adults in care facilities were all members of a multidisciplinary team. Members of these teams met in person, or kept in touch through forms or resident notes. The assessment forms were mostly assembled from a number of assessment tools, and tailored to the individual care facility. The forms also related to lists and task sheets. The information written on these forms was then used to create a care

plan. Although the composition of the teams varied, health professionals who would conduct assessments in care facilities could generally be divided into 3 groups: the general practitioners, the allied health professionals and the registered nurses. These groups formed the core of the multidisciplinary team. Further team members could be added, for example, a client's family, students, care staff or other health professionals such as a physiotherapist or occupational therapist.

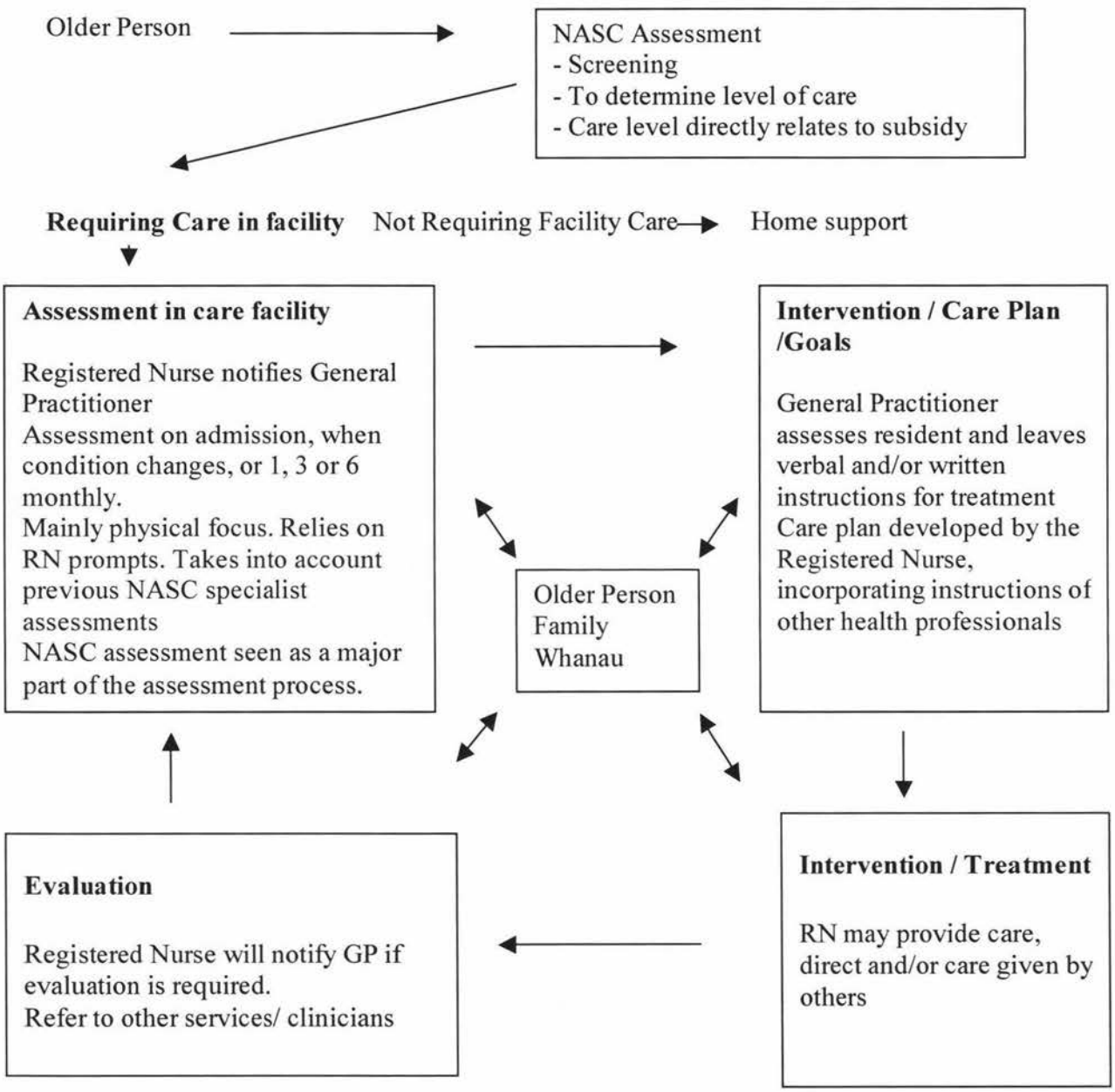
During this research, the following flowcharts were developed. They outline assessment by the General Practitioners (GP), the Allied Health Professionals (AHP), the Registered Nurses (RN) as well as assessments specifically required for contractual purposes. The timing of these assessments is clearly linked to contractual requirements and fits a fixed timeframe. Assessment also comes into force when a resident's condition changes. Regular assessment takes place on admission, 3-monthly for hospital level residents and 6-monthly for rest home level residents. Residents who are not in a stable condition, are required to have more frequent evaluative assessments. Other assessments evaluate a resident's condition, when this appears to have changed and the resident requires a different level of care or additional subsidy. These assessments generally take place as part of a multidisciplinary assessment. However, not all team members are always part of the process, and although the older adult is the focus of the assessment, the actual multidisciplinary team approach to assessment does not necessarily incorporate the older adult as part of the team. Assessment findings and instructions for intervention were mostly left in the person's file. This might be integrated into the daily notes or be on separate pages. It is the registered nurse's responsibility to collect and collate these assessment findings and create a care plan.

Assessment and the General Practitioner

(Figure 1, map on next page).

General practitioners are contracted to facilities to provide medical care as required. Most general practitioners hold a weekly clinic, and are available on call, and/or can be contacted if a resident's condition changes. The evaluative assessment by the general practitioner is usually one of the first assessments. The majority of older adults admitted to care facilities are on medication, similarly, when a person's condition changes s/he also often requires medication. It is the general practitioner who generates a prescription for medication when this is required. The exception is when an older adult is admitted via another health care facility; in that case a prescription accompanies him/her. When an assessment is required, the general practitioner appears to be prompted by a registered nurse to take action. These assessments have a predominantly physical focus and are problem oriented. The general practitioner leaves instructions for intervention to be incorporated into the care plan. These instructions are usually written in the client notes and verbally conveyed to the registered nurse or the care staff, who in turn convey this information to the registered nurse. The registered nurse may also prompt the general practitioner when additional assessments are required and for evaluation of the intervention. The general practitioner also performs a clinical assessment as a routine part of his/her clinical decision-making process.

Figure 1 **Assessment and the General Practitioner**

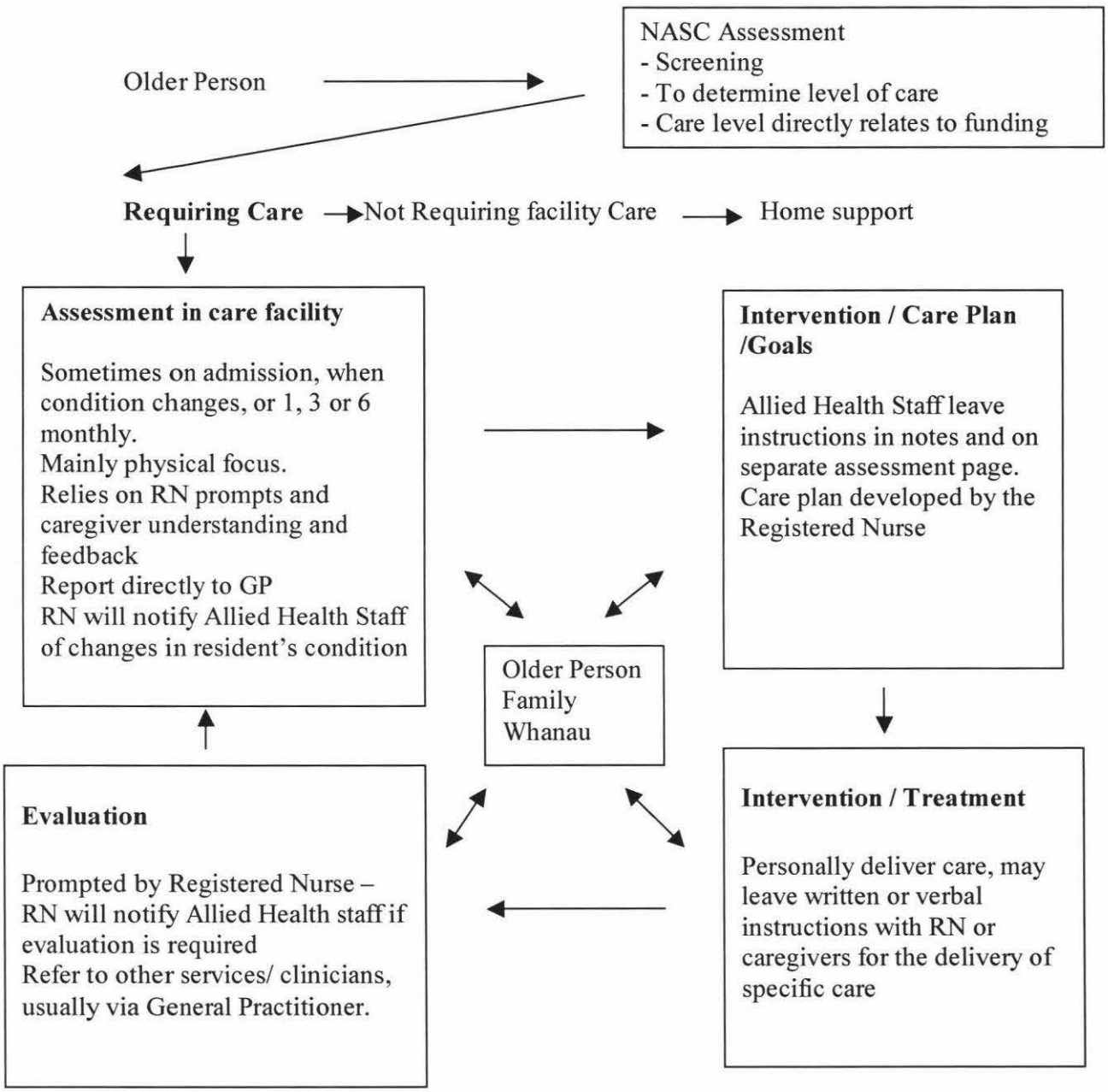


Assessment and the Allied Health Professional

(Figure 2, map on next page).

Assessments by the allied health professional are an ongoing part of his/her clinical practice. They may also be prompted by the registered nurse, or the general practitioner. These assessments also have a predominantly physical focus and are problem oriented. The allied health professionals most commonly employed or contracted by care facilities are physiotherapists (PT), occupational therapists (OT), diversional therapists (DT) and dietitians. Physiotherapist and occupational therapists have a functional and restorative focus. Allied health professionals leave instructions for intervention, so that these can be incorporated into the care plan. At times, the allied health professional will report directly to the general practitioner. Allied health professionals' instructions are usually written in the residents' notes and verbally conveyed to the registered nurse or the care staff by that person. The majority of allied health professionals are contracted part time, with some being contracted to provide services for only a few hours per week.

Figure 2 **Assessment and the Allied Health Professional**



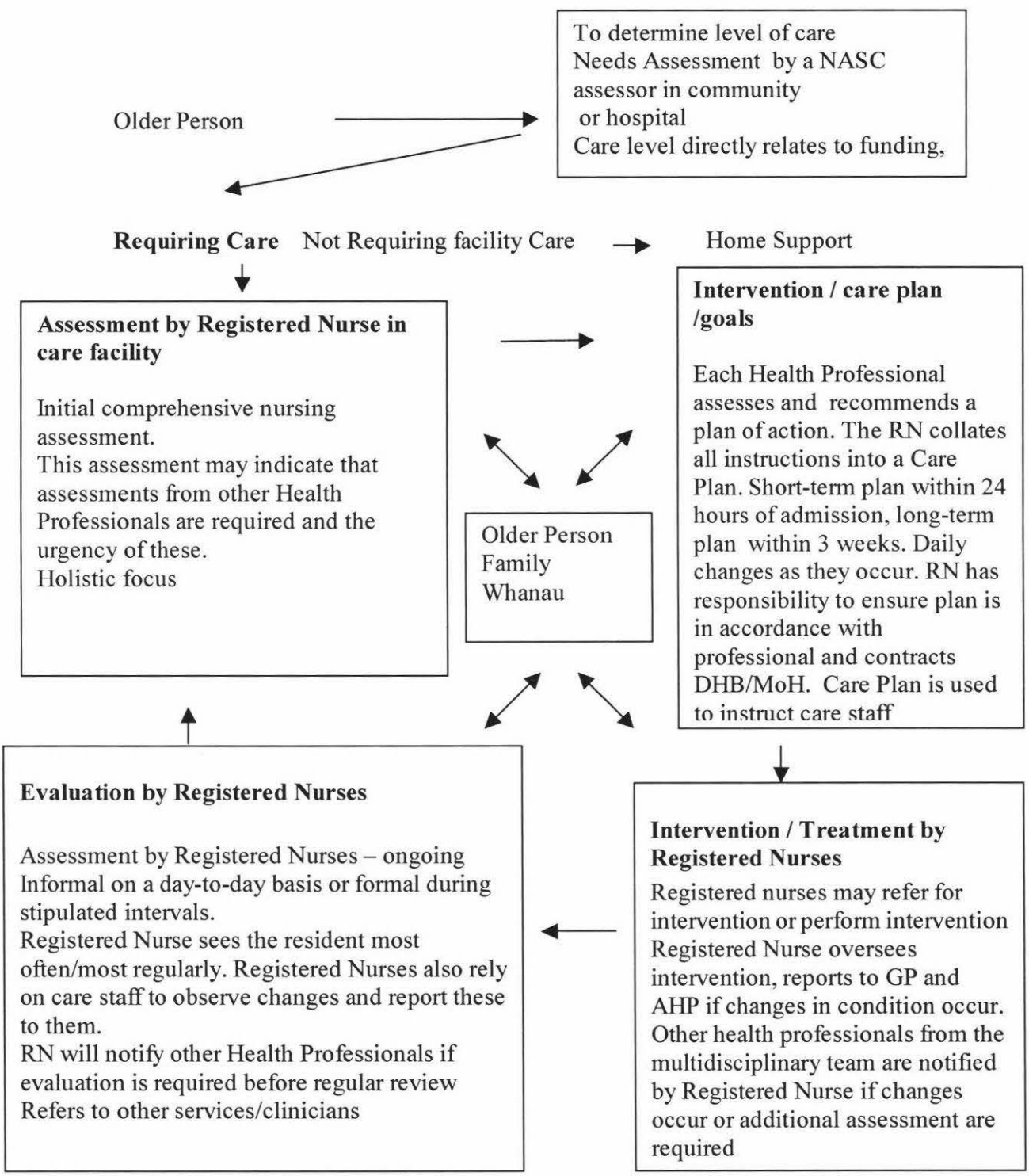
Assessment, Care Planning and the Registered Nurses

(Figure 3, map on next page).

Registered nurses are in an exceptional position. They are the health professionals who take on a dual role in a care facility. A care facility is required by contract to have a registered nurse on duty. Registered nurse coverage may be provided by full-time or part-time nurses. The registered nurses have the general oversight of a care facility. They assess older adults as part of their clinical practice and create and co-ordinate the care plan. They are the health professionals who have generally the most contact with the older adults and their families. Registered nurses use the assessment information from their own assessment as part of their clinical practice. The nurses' own assessment and the assessment and intervention suggestions of other health professionals are used by registered nurses to plan care. A registered nurse creates the care plan, and is usually the first contact for family members, alerts other health professionals when changes in condition occur, co-ordinates the care plan and co-ordinates the care delivery by care assistants. The nursing assessment is often the preliminary to further assessments by other health professionals, as well as providing the baseline observations for other health professionals.

The care plan provides the care assistants with instructions for person-specific care. Care assistants provide basic personal care and have the most frequent contact with the resident. Any changes in a resident's condition needs to be passed on to the registered nurse. Care assistants need to be aware of baseline information so that variations from the norm can be detected and reported to the registered nurse.

Figure 3 **Assessment, Care Planning and Registered Nurses**



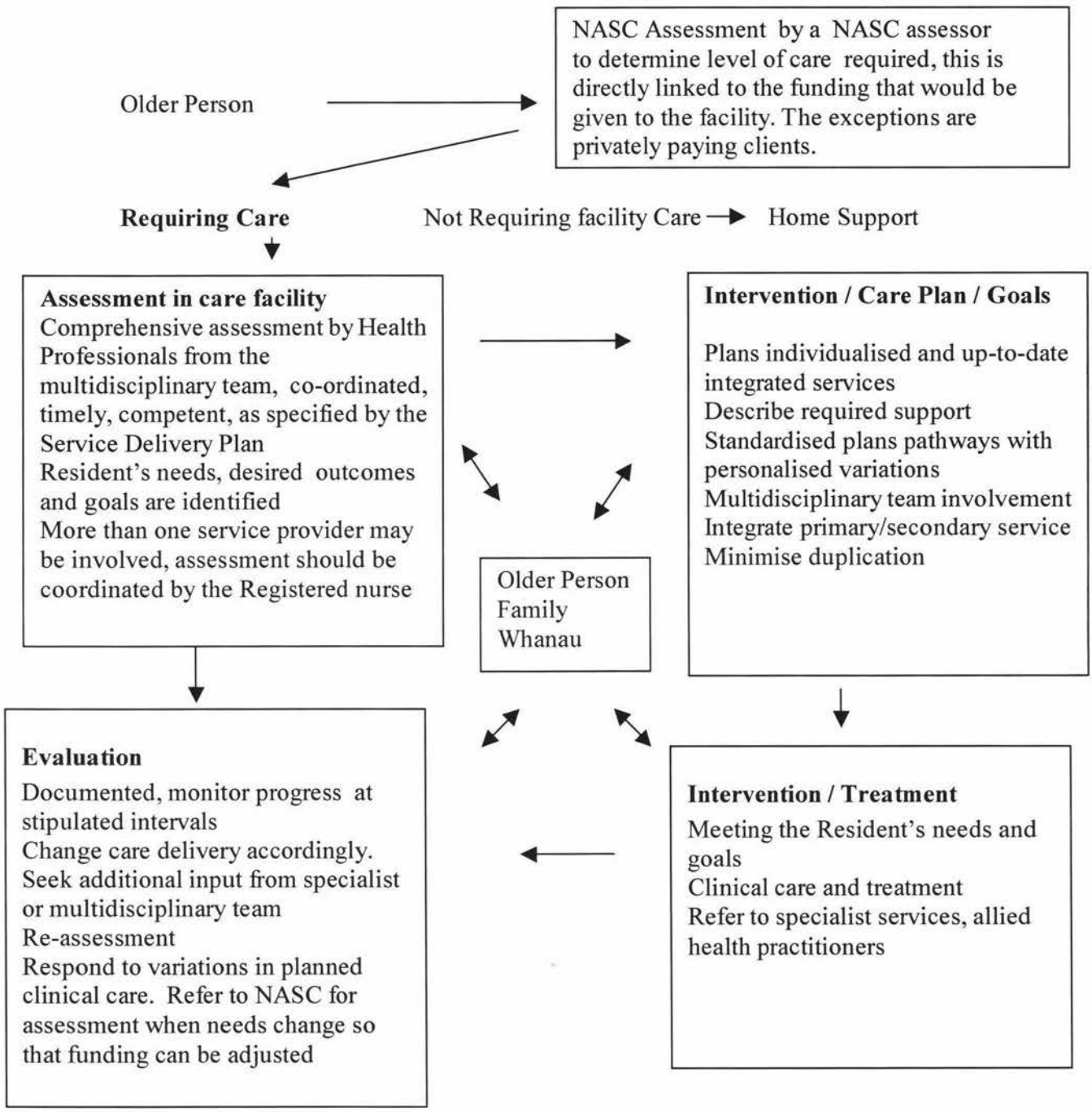
Assessment for Contractual Requirements

(Figure 1, map on next page).

In order to receive a DHB contract and subsidy for residents, a care facility has to comply with a contract. Assessment and care planning are specified in the contract as requiring a multidisciplinary team approach. Assessments by multidisciplinary teams may occur in any setting and usually are done in sequence, rather than all professionals attending simultaneously. The timing of multidisciplinary team meetings depends on the urgency of the assessment and the availability of the health professional. It is not unusual for these meetings to takes place without the resident present. A multidisciplinary team would usually meet and discuss the findings on a regular basis, but not all team members are always present at all meetings. The registered nurse writes and adjusts the care plan, based on suggestions for intervention from the different health professionals.

Standardised contracts are used, mostly based on the Health and Disability guidelines. The contracts are to provide a certain service, detailed in the *Service Delivery Plan*. The service delivery plan specifies the health care service to be provided in general terms. The care plan specifies the service to be provided for one specific resident. Compliance with the contract is checked by audits, performed by independent auditing agencies. Care facilities and health professionals have a vested interest in ensuring compliance with the contracts, as non-compliance could result in revoking of the contract and subsequent repercussions for residents, stakeholders and health professionals.

Figure 4 **Assessment for Contractual Requirements**



This mapping assisted the researcher to consider assessment and care planning from different viewpoints. It became noticeable that some areas of assessment and care planning appeared to show degrees of fragmentation between the required and actual assessment and care planning. For the researcher, this was an indication that further exploration would be appropriate. Preliminary enquiry into the literature related to health professionals' assessment of older adults showed an abundance of assessment literature, however a large section of this related to international standardised assessments and assessments of specific body systems, (e.g. cardiac assessments). Trends in the literature indicated an increased interest in assessment in the 1980s and again around 1998. This was linked to an increased awareness of person centred care and professional responsibilities. Only a modest amount of literature on assessment of older adults in care facilities was available. Although professional decision-making was apparent in literature related to all health professionals, assessment directly related to care planning was mostly evident in nursing literature.

To reiterate, a combination of the researcher's professional interest and observations, discussions with colleagues, the diverse applications of assessments and care planning, the mapping of the actual assessment and care planning process, and the scarcity of research related to assessments in New Zealand care facilities, was the incentive for the researcher to commence this research.

Chapter Two

The Literature and background information

This chapter addresses information about health professionals' assessment of older adults residing in care facilities and the utilisation of these assessment findings to create a plan for care. Assessments are performed in order to plan and deliver care, provide specific instructions for others who care for older adults, and to ensure compliance with contractual and audit requirements. Assessment is viewed as an ongoing process that may take place in a wide variety of settings. Assessments of older adults are influenced by extensive factors. To set the scene, in this chapter reference is made to these factors influencing assessments and care planning in the wider context. However, the main focus of the literature review is on those assessments specific to older adults in New Zealand care facilities.

The literature was reviewed, utilising the guidelines of LoBiondo-Wood and Haber(1998). Resources included the Massey University and MidCentral Health libraries, Internet resources, (MSN, Synergy Journal Channel) and computerized data-bases (CINAHL, Medline, Web of Science, Psychlit, Lippincott, Statistics New Zealand, and Ministry of Health). The main search terms included: health professionals, assessment, care planning, older adults, aged, elderly, care, care-needs, care facilities, rest homes, long-term care, care plan, care planning, decision making, clinical decision making, multidisciplinary assessment and health professionals' assessments. Excluded were articles related to people younger than 65 years of age. For the purpose of this research, specific assessments, (e.g. coronary care assessment and lung function tests,) were excluded, as these assessments are not generally performed in care facilities.

Explanation of terms

A multitude of terms and phrases is used in the general literature and professional sphere. At times the context makes clear to the reader which meaning is intended. To avoid misunderstanding, a list of terms was compiled to provide clarity and consistency to the research.

Registered health professionals

- *Registered health professionals*: are health professionals who are required to have a practising certificate in order to use a particular title and to practise their profession, or who at the time of commencement of the research, were registered by a National Professional Body or in the process of applying for practice certification as per Statutory Regulation (for example social workers and diversional therapists). For this study, the term *registered health professionals* includes dietitians, diversional therapists (DT), general practitioners (GP), occupational therapists (OT), pharmacists, physiotherapists (PT), registered nurses (RN) and social workers (SW), who are employed or contracted by a care facility. Registered health professionals other than general practitioners or registered nurses are also referred to as *allied health professionals* or *allied health staff.*

- A *Dietitian* provides guidelines on nutrition. This can be on a personal or facility basis. Nutritional advice is related to age and nutritional requirements, (New Zealand Dietetic Association. Inc., 2002). In care facilities, dietitians assess personal nutritional requirements, provide overall nutritional and menu advice and give guidance regarding diets and

food consistency to the kitchen staff. Dietitians tend to have their own practice and are contracted by facilities.

- A *Diversional Therapist* facilitates purposeful recreational and leisure activities designed to increase the intellectual, spiritual and emotional well-being of older people in supportive environments. (New Zealand Society of Diversional Therapists Inc.,2002). In care facilities, Diversional Therapists provide a person-centred recreational and leisure programme which is incorporated in the residents' care plan. Diversional Therapists are employed by facilities. Before standardised qualifications were available for staff working in this sphere, DTs were known as *Recreation Officers* or *Recreation Assistants*.

- A *General Practitioner* is a licensed medical practitioner, working in a community practice. A GP service usually provides primary care for people of all ages. (Royal New Zealand College of General Practitioners, 2003). General Practitioners' involvement in care facilities relates to resident assessment and treatment at regular intervals and when a resident's condition deteriorates or changes. Most are employed by a community practice and contracted by a care facility.

- An *Occupational Therapist* (OT) is registered by the Occupational Therapy Board. OTs enable people with impairment or dysfunction to participate and become independent in activities required for self-care, leisure and play, (New Zealand Association of Occupational Therapists, 2002). In care facilities, the Occupational Therapist assists with providing guidelines for daily living activities. They assist a person in obtaining maximal independence by adjusting environment and personal equipment. Usually,

Occupational Therapists are contracted by facilities, although larger facilities may employ an OT. The OT works closely with the DT and oversees and assists the Diversional therapy programme.

- A *Pharmacist* is a registered practitioner responsible for providing and reviewing medication, (New Zealand Health Care Pharmacists' Association, 2002). In care facilities, the pharmacist may be part of a multidisciplinary team. Pharmacists provide resident medication reviews, dispensing, carries out assessment of medication interaction for residents and provides staff education. It is usual for pharmacists to be contracted to a care facility.

- A *Physiotherapist* (PT) is registered by the New Zealand Physiotherapy Board (2002), and is responsible for developing and restoring physical function to the body. In care facilities, a physiotherapist may be invited to assess mobility and muscle strength of a resident as well as providing manual handling education for staff. Physiotherapists may be employed or contracted by a care facility.

- A *Registered Nurse* (RN) is registered by the Nursing Council of New Zealand, under the Nurses Act 1977 and the Nurses Regulation 1986, (Nursing Council of New Zealand, 2001) In care facilities, Registered Nurses are employed to deliver nursing care, and assess residents' needs, plan and implement plans of care. Registered nurses manage the care required for a residents, as well as providing guidance and supervision to care assistants. Registered Nurses liase with residents, families and other health professionals. In care facilities, registered nurses have contact with residents more often than do other registered health professionals.

- A *Social Worker* (SW) assesses people on their eligibility for support services and advises on what support services are available. (Aotearoa NZ Association of Social Workers, 2003). In care facilities, social workers advise specifically in regard to the financial and disability services, counselling and communication services that are available. Most often, social workers conduct their work from a public hospital or community centre. Social workers are seldom located in care facilities, however, some larger care providers in NZ employ social workers.

- *Enrolled Nurses* (E/N) are on the Nursing Council roll, working under the supervision of Registered Nurses. For the purposes of this research however, Enrolled Nurses were not included as a separate category of staff. In part this was because a number of Enrolled Nurses are now employed as care assistants.

- Unlicensed care staff - also referred to as *care assistants, caregivers*, or *health care assistants*-, are employed by a care facility and work under the supervision and direction of a Registered Nurse. In care facilities, caregivers assist older people with personal cares and perform general household duties. They are the care staff most likely to have the greatest and most personal contact with the resident.

Terms other than those specific to health professionals that are used in this research include:

Care facility

- A *care facility* is a place of residence for older people with health care needs and / or disabilities who require a level of assistance and monitoring

with their daily living that is not suitably available in a home situation. Care facilities are private organisations that may have a corporate, religious and welfare, or personal business affiliation. The Ministry of Health requires that licence holder of a facility is a Registered Nurse. The contractual responsibilities related to care facilities were transferred from the Ministry of Health to the District Health Boards in October 2004. Licensed care facilities may have unlicensed (private) and licensed beds allocated. In New Zealand, there are 34,969 licensed hospital, rest home and dementia care beds, in a total of 830 premises, (MoH 2003, personal communication). A care facility may offer an older person an unlicensed bed if the person is a private paying customer. A care facility may be licensed for a number of beds at Rest home level care, Continuing care / Hospital level care, Dementia level care, Respite Care, Day care or any combination of these. The various levels of care relate to the level of reimbursement, as is detailed in individual contracts. The higher the assessed needs level of the resident, the higher the reimbursement. Residential Care New Zealand, the Private Hospitals Organization and the Rest Home and Residential Villages Association are nationally recognised umbrella organisations to which care facilities may belong. These organisations promote their members' collective views and concerns, and inform care facilities about issues in the health and disability sector as well as workforce and Ministry of Health issues. In the literature, care facilities may be referred to as *nursing homes, care homes, long-term care*, and *rest homes*.

A Care Plan is defined as:

- A *care plan*[7], also called a *plan of care* or *life style plan*, is defined by Bernstein Lewis, (p. 381, 2002) as; "Statements that specify the anticipated goals and the expected outcomes, predicted levels of optimal improvement, specific intervention to be used and proposed duration and frequency of the interventions that are required to reach the goals and outcomes". In the New Zealand context, the Care Plan has a similar meaning according to Quality Health New Zealand, (1998).

A Multidisciplinary team is defined as

- A *multidisciplinary team* is identified by the New Zealand Guidelines Group (2003, p. 71) as: "Teams comprising of members from different disciplines, covering areas of expertise from different and usually separate disciplines".

Residents, Patients, Clients and Consumers

- Both the participants and the reviewed literature appear to give similar meaning to the term 'resident', 'patient', 'client' and 'consumer', using these terms interchangeably. The main differentiation, as understood by the researcher, was that 'resident' is used to designate someone who lives in a care facility permanently, that is it is his/her home. A resident may have

[7] For the purpose of this research, *Care Plan* refers to a plan developed and maintained by the Registered Nurse to comply with contractual requirements and to specify individual instructions to deliver care.

one or more disabilities, illness or chronic disease, and require assistance with daily living for this on an ongoing basis. The term 'patient', indicates that there is a more acute illness process happening. This term appears to be more medical/illness focused. The terms 'client' and 'consumer' are seen in more recent literature and are more often used in literature related to health care management rather than specific clinical literature. In this research, all terms are used in order to link the findings to the original source.

Older Adults

- *Older Adult*: a person 65 years of age or older. The professional literature also refers to 'older people' 'older adults', 'elderly' and 'the aged'. The Ministry of Health guidelines for assessment refer to 'Older People', (New Zealand Guidelines Group, 2003).

Evidence-based practice

- *Evidence-based practice* originates in medicine and implies an orientation towards Randomised Controlled Trials. That is, making decisions on the best available evidence (Bishop & Scott, 2001).

Best Practice

- *Best Practice*, a term emerging in recent years, refers to clinical practices that result in the best possible outcome for the client. The notion of Best Practice derives from the wider health care community. Best Practice is

based on an understanding of a common source of information that is available, for example, research, personal experience, benchmarking and expert opinion. It is a way to respond to clinical questions, to give value to care practices and guide consistent care, (Schilling, 2003).

Older Adults and changing need for care

Worldwide the elderly population is increasing. In New Zealand, 6.9 % of Older Adults require long-term care, (Statistics New Zealand, 2004). The demographic profile of the District Health Board (DHB) in which this research took place has the 9th oldest population (13.39 %), of all New Zealand DHBs, (MidCentralHealth, 2004). The average age for people entering care facilities is 82 for women and 75 for men, (Statistics New Zealand, 2004, Ministry of Health, 2002). The increasingly ageing population poses challenges for social and health care settings and this affects assessment and care planning for older adults.

To effectively assess older adults and plan care, it is helpful to have an understanding of the influences of ageing in general as well as specific aspects that may impact on the ageing process. Ageing can be explained by biological and psychological theories. Biological theories explain why the physical changes of ageing occur. Psychological theories explain why older adults have different responses to the ageing process. This is reflected in the disengagement theories, explaining an ageing person's desire to separate from the mainstream of society. Life-course theories trace personalities and personal adjustments throughout life. Social theories explain ageing as influenced by social factors and the impact of society on older people, (Anderson, 2003). People age at a different rate and

chronological age is not always a reflection of the physiological age (Wold, 2004). Organ systems age at different rates. For example, someone with heart failure may be physically impaired but function at a high cognitive level. Theories of ageing motivate health professionals' clinical practice. Those whose focus is predominantly physical tend to use biological theories as a framework rather than those that subscribe to one of the other ageing theories. The framework underpinning a professional practice is most often the framework that guides the assessment of people.

Older adults, although generally healthier than in previous generations, do experience acute and life threatening conditions. Older people have diverse health care needs as functional decline in old age is likely to occur (Hebert, 1997). Often this decline is the result of an existing chronic condition or a chronic condition which developed after an acute episode. Eighty percent of older people live with chronic conditions such as arthritis, hypertension, diabetes, and vision and hearing disorders, (Wold, 2004). One of the characteristics which distinguishes this age group from others is the unique concerns of older adults, specifically their multiple losses, financial needs, and age related idiosyncratic responses to medication (Ebersole and Hess, 1998 ; Eliopoulos, 1997 ; Jarvis, 2000). Because of this, older adults are at risk of developing frail health. Those who suffer the combined effects of old age and chronic disease are likely to be particularly vulnerable and frail. Frail implies: "very limited reserves and potentially rapid decline into dysfunction and dependency" (Rockwood, Silvius, & Fox, 1998, p. 247). Although intervention in continence, mobility, and dementia concerns at an earlier stage, could prevent residential care admissions. Weatherall, Slow and Wiltshire (2004) noted that most older people who are assessed as having these problems are destined to go into residential care.

Historically, long-term care and care in facilities have been linked to an institutionalised approach and many of the concerns of health professionals and consumers have been related to lack of knowledge and awareness and stereotypical approaches to residential care (Challis, Carpenter, & Traske, 1996). Flicker (2000) raises questions about the adequacy of health care throughout the residential care industry, identifying the changes this industry has had in the last 15 years. The acuity of residents is much higher and the availability of skilled staff has not increased at the same rate. Flicker (2000) mentions that the majority of disabilities suffered by people in residential care relate to chronic degenerative conditions. The pressure of caring for people with increasingly complex needs may put a health system under stress. In recent years, changes in the development of health services in New Zealand have brought about awareness and a shift to increasing personalised care, both in the community and in care facilities. These changes include legislation relating to privacy issues, the rights and responsibilities of health care consumers, the change in focus from central to regional health authorities, increased accountability by health providers and professionals and an increased customer focus.

Howe (1999), describes Australia's reforms in the aged care sector following the new operating standards. End of life care has become a major function of nursing home care, as more people with chronic conditions are admitted. Howe also found that closer integration of care for frail older people with acute care facilities and social support services is proving beneficial. Between 1981 and 1991, New Zealand embarked on a restructuring of public services, (Joseph & Chalmers, 1996). Public hospitals exited from long-term care and private facilities increased over this period. The New Zealand Residential Care sector has changed significantly since 1993 (Clarke, 2001) when resthome residents tended to be active, and aged 65-70. A decade later, residents are older and have a higher

severity and complexity of disease. The level of institutionalisation of older people increased in this decade (Clarke, 2001; Joseph & Chalmers, 1996). The "Health of Older People Strategy", (Ministry of Health, 2002), was developed to set guidelines for health and disability support services for older people. This strategy promotes wellness, quality of life, as an integrated continuum of care and culturally appropriate community-based person-centred care. 'Ageing in Place' is the philosophy guiding this strategy. For some older people this could be in their own home, for others, it might be elsewhere. In New Zealand, long-term care provides many levels of health care and activities for older adults (Grubbs & Blasband, 2005). Residents with high needs, previously cared for in hospitals providing long-term care are increasingly cared for in care facilities, (Bonita, Broad, Thomson, Baskett, & Richmond, 1989; Clarke, 2001; Nay, 1989). To facilitate the transition to long-term care, close attention needs to be paid to on assessment and coordination between multidisciplinary teams. (Cotter, Meyer, & Roberts, 1998). This may prevent the increasing problem of older people requiring acute care and frequent re-admission to hospital after placement in nursing homes, (Nazarko, 1996).

Re-admission to hospital is a very real risk for residents in long-term care. Residents in long-term care may have acute episodes, and exacerbation of chronic illnesses, as well as a need for rehabilitation care, dementia care and palliative care. Residents in care facilities have multiple and complex needs, with a number of chronic conditions, disabilities and associated social concerns, (Luk & Woo 2000, Mezey, Lavizzo-Mourey, Brunswick, & Taylor, 1992). These researchers made the important point that no standard assessment in care facilities deals with these complex situations. Chronic disabilities of residents in long-term care are usually heart-disease, osteoporosis, arthritis, cancer, cognitive changes, and bowel and bladder concerns, (Eliopoulos, 1997; Jarvis, 2000; Mulhearn, 1989; Redfern,

1991; Wold, 2004) Given the complex needs of people entering long-term care facilities, the necessity for intervention based on astute assessment becomes apparent.

A high level of staffing is not always an indication that an adequate comprehensive assessment is provided, (Lavizzo-Mourey, Mezey, & Taylor, 1991). However, short-term and long-term residents have different assessment needs. Short-term residents appear to have more frequent assessments. Older adults in institutions may not be able to make decisions about daily activities. Life in long-term care can become regimented around the routine of the institution. In the process, a depersonalisation may take place, (Bernstein-Lewis, 2002). Practitioners, especially those on contract, generally have to adhere to legal and organisational frameworks and time constraints. Older people may structure their life through domestic and social routines, with different perspectives on time. The elderly may see assessment and intervention as leading to a loss of independence and privacy as they view it (Anderson, 2003; Kaufman, 1999).

A lack of communication and information sharing among providers can result in a gap in the continuum of care. In the late 1980s, financial and political interest in patient outcomes led nurses to investigate the fundamental aspects of the nursing process and best practice. Johnson, Maas, and Moorhead (2000), refer to this as the 'Era of assessment and accountability'. In 2003, the New Zealand Guidelines Group launched the *Assessment processes for older people* guidelines. These guidelines identified disparities between current practice and best practice. Kane and Kane (1981, 2000) believe assessment is the means to reach a diagnosis, prognosis and formulate a plan. In contrast, Luk and Woo (2000), emphasise the need for a more holistic approach. This is in line with the view that actions and treatment in long-term care may be less aggressive.

Assessment definitions

Assessment is the foundation of long-term care (Kane & Kane, 2000). The purpose of assessment determines its scope and focus. "Assessment intended as an evaluative tool would focus on the areas being treated or those that should have been treated.", (Kane & Kane, 2000, p. 671). Assessment is an opportunity to learn more about the person, his/her situation, experiences, desires and perspectives. Assessment is the foundation of care (Webster, 2004). Multidimensional assessment of older people is promoted in many health care strategies all over the world (Anderson, 2003; Fletcher, 1998; New Zealand Guidelines Group, 2003). Possible benefits of good assessment processes include reduced hospital admissions and better preventative healthcare. The term *assessment* is at times used as an alternative to the term *screening*, to describe a mixture of needs assessment and case finding. Assessment is designed to uncover problems and identify the various potential problem areas, (Kane & Kane, 2000). Assessment may be defined as; " Critical analysis and evaluation or judgment of the status and quality of a particular condition, situation, or other subject, gathering of information, and making a clinical judgment." (Miller & Brackman, 1982, p.117). The New Zealand Guidelines Groups', (2003, p. 69) definition in essence is the same: " A process to detect and identify needs for treatment, support or other intervention", Assessment is the first step to critically develop a plan of care, (Anderson, 2003; Becknell & Smith, 1975; Jarvis, 2000; Haas & Hackbarth, 1995; Hogstel, 1992; Mezey, Rauckhorst & Stokes, 1980) and determine precise intervention (Burke & Laramie, 2004, Redfern 1991). Kane and Kane (2000) assert that the discipline of the assessor is the greatest defining factor in what is assessed "Assessment, in medicine and nursing, an evaluation or appraisal of a condition or process of making such an evaluation, including the patient's subjective report of the symptoms and the examiner's objective findings of data

obtained through laboratory tests, physical examination and medical history.", (Wold, 2004, p. 304).

A comprehensive geriatric assessment is the evaluation of the medical, functional psychosocial and environmental problems of elderly patients, (Gold & Bergman, 2000). These researchers found that admission assessment was not integrated in a systematic fashion. They attributed this to the use of traditional educational nursing models which refer to body systems, without understanding the effects on a person's overall condition, (Bernstein-Lewis, 2002; Ebersole & Hess, 1994). Bernstein-Lewis (2002) and Ebersole and Hess (1994) also point out that assessment is the cornerstone of gerontological nursing. Assessment skills are required to plan and further evaluate functioning. A good assessment will identify those clients who require more detailed assessment by health professionals from specific disciplines.

Consumers viewed loss of independence as more critical than did professionals. Professionals are more concerned about loss of an ability to carry out basic daily cares. If consumers and professionals hold different views on what is more important, to find the best treatment course can become difficult. To overcome this it is suggested that the client, if able, determines his or her own set of factors to be assessed against, what is important to him/her (Kane, Rockwood, Finch, & Philp, 1997). Good assessment takes into account the perception, problems and beliefs of older people. Past and current health practices need to be taken into account, as these may be predictors for future health practice (Wold, 2004). The needs as identified by the older person and as identified by the health professionals should be clearly linked.

Assessment is not a linear process. (Foote & Stanners, 2002) suggest that there are four stages to assessment and that assessment can start at any of these stages. They identify the stages as (1) contact assessment, (2) overview assessment, (3) in-depth assessment, (4) comprehensive old-age assessment. Reed and Bond (1991) suggest that nursing assessment in long-term care tends to be focused on medical diagnosis and cure. Ford and McCormack (1999) note that care for older people in long term care is always in danger of being broken down into tasks and becoming fragmented. To further complicate matters, assessment takes place on different levels, for instance formal, informal, for pain or to assess risk. Su and Ferraro (1997) contend that social relations are an important factor influencing health beyond effects due to functional health. Social integration has a positive effect on health. The evaluation of health does not appear in a vacuum, it is influenced by social setting. This ensures a person-centred assessment.

The purpose of assessment is " to identify where help is needed and to lay foundations for working with the older person." (Age Concern, 1992, p. 12).
Allowing older people to talk makes an assessment an intervention helping the older person to think through a situation (Richards 2000). Knowing the patient is a core attribute of gerontological assessment and care, (Clarke, Hanson, & Ross, 2003). It provides a platform to caring in partnership. It enhances the personhood and person-centred approach to care.

Reed and Watson (1994) noted that assessment in long-term care units is ad hoc, and purposeless and is usually descriptive comments made by colleagues. Assessment on the units were seen as irrelevant as patients were assessed by the Assessment, Treatment and Rehabilitation (ATR) units in hospital. Different terminology in assessment is used by health professionals. In the same year,

Caldock (1994) suggested that assessment is a 'piecemeal effort', an unsatisfactory approach. Nurses gate-keep by tailoring the information they provide to doctors. In long term care, use of the medical model can cause problems, devaluing long-term care work. Long-term care needs a nurturing environment with minimal medical influence and ideology. (Reed & Watson, 1994).

Only a few years later, the viewpoint is changing. Assessment is being seen as a way of maximising independence. Continuing care professionals need to recognise ageing as part of a developmental process. Care should promote functional abilities and enhance a sense of fulfilment. Care should focus on what life means for the older person. Nurses use their skills, experience and knowledge to create relationships that allow them to identify significant issues for the older person. (Jacques & Ryan, 1997). In 2002, Bernstein-Lewis stressed the importance of differentiating between disease-related changes and natural age-related changes, emphasising that cognitive processes are the basis of functional performance.

Needs Assessment for entry into Care

Most Western countries have initiated policies and assessment guidelines to ensure that only those older people with the greatest need have access to residential care. Specialist clinical assessment may identify people at risk of requiring nursing home care, (Challis, Clarkson, 2004). Rothera, Jones, Harwood, Avery and Waite (2003) researched comparison assessment findings prior to admission, on the dependency status of older adults in rest homes. Pre-placement assessment was essential, but required support by admission assessments. It was also noted that it is essential that residents have monitoring on an ongoing basis. Wilkinson's (1992) view of accurate assessment before entry into a facility and prior to

suggesting a higher level of care, - when this is of social and financial benefit -, is still relevant. Unfortunately, when patients are assessed before placement, - as suggested by Hutchinson (1998),-, sharing of information across agencies may become troublesome. Vernon, Ross and Gould (2000) relate this to the fact that different health professionals may not use common terms and may have different communication systems. In New Zealand, there is recognition of the need to have specific New Zealand research into assessment, (Milligan & Neville, 2003). To counteract the inconsistencies in assessing older people's needs, the National Advisory Committee on Core Health (1994) initiated steps towards a standardised assessment, the Needs Assessment Support Coordination (NASC). In the Central region this is named the 'Supportlinks Needs Assessment Facilitation' (SNAF). Assessor qualifications are not specified, assessors may be from different disciplines, and 'professional judgment' can have a variety of interpretations. This problem is also identified by the New Zealand Guidelines Group (2003). To determine the level of care that is required, a person is assessed in the community, on entering a care facility or while living in a facility, and when changes to his/her condition occur, requiring a different level of care. The assessment is linked to funding. However, assessors from different disciplines are seen to be effective once the assessors have received training in the process (Richards, 2000). For older adults and their families, the assessment process may appear to be very complex. (Nolan & Caldock, 1996; Webster, 2004). Older people and their families may not always be aware of how to access services. There is no indication in the literature that nurses in care facilities utilise NASC assessments for care planning, or to what extent nurses have undertaken education to gain knowledge in contemporary assessment practices.

The Ministry of Health and, since 1st October 2004 the District Health Boards, set assessment criteria for residential care in New Zealand. An assessment is required within 24 hours of admission, with a complete Care Plan within three weeks of admission. For reasons of accountability and for creating audit trails, assessment and care planning are to be documented. This documentation is designed to assist continuity of care. Documentation in care facilities tends to mean that each health professional documents his/her part, while the responsibility of the general oversight and management of the residents' notes rests with the registered nurse.

Components of assessment

"The usefulness of an assessment is determined by the actions it can direct." (Kane & Kane, 2000, p. 675). Assessment is not an end in itself. Assessment is used for evaluation which should lead to a conclusion. Components of assessments now generally include: medical history, physical examination, current presence or absence of disease, nutrition, preventative health practices, medication, pain, presence of abuse or neglect, nutritional assessment, attention to culture and ethnic background, religion, alcohol consumption, actual intake, weight, hearing, digital rectal examination, oral examination, musculo-skeletal, examination, and blood pressure always in both thelying and standing position to determine the presence of orthostatic hypertension, a leading cause of frequent falls, (Burke & Laramie, 2004). Health assessment for older people may also include an assessment of mobility, dexterity, vision, hearing, nutrition, continence and depression: vision is

particularly important, as this directly affects functional status on all levels (Henrickson, 2000).

Additional suggestions for functions to assess include the ability to dress self, balance, gait assessment, shoulder function, range of movements, cognitive function (Fleming, Evans, Weber, & Chutka, 1995), and vital signs (Cavendish, 1999). Assessment involves collecting information about patients' problems, observations, listening, an ongoing process. Observations may, however, be very casual when care assistants are asked to recall events, without specific prior warning that they needed to pay attention to certain tasks.

The venue of assessment can not always be chosen by the person being assessed. A frail older person may not have the choice. Collecting basic information can be done anywhere, but as the assessment progresses a more specific environment may be necessary, (Foote & Stanners, 2002). Price (1987) and Anderson (2003) both indicate that an assessment may consist of formal and informal elements, baseline observations, history and clinical measurements. The time and place of assessment have a direct bearing on the outcome. The manner of the assessor can also influence the outcome.

The components of the well known Roper Assessment Model (Roper, Logan, & Tierney, 1981) include Activities of Daily Living (ADL), lifespan history, dependency/independency continuum individuality. The model demonstrates that all aspects of life are reliant on each other. The authors noted that 'The whole model is more than simply the sum of its parts" (Roper, Logan, & Tierney, 1996, P. 10). This suggests that the care plan should be an expression of this philosophy.

Kane and Kane, (2000) argue that the domains assessed in nursing care homes that can be assessed at an individual and at an facility level include: autonomy, privacy, dignity, meaningful social interaction, meaningful activity, individuality, enjoyment, safety and security, spiritual well-being, and comfort.

Bernstein-Lewis (2002) argues that physicians pay greater attention to diagnosis, medication and physical attributes and nurses pay attention to skin, and level of understanding of the client. Nurses and social workers are also more attuned to assessing the potential for self-neglect. This author states that *"Assessment is: the measure or quantification of a variable or the placement of a value on something. Assessment should not be confused with examination or evaluation."* (Bernstein-Lewis, 2002, p. 379), separating *functional assessment* from *assessment.* "*Functional assessment* is: "*The measurement or quantification of those activities identified by an individual as essential to support physical, social, and psychological well-being and to create a personal sense of meaningful living.*" (Bernstein-Lewis, 2002, p. 380). This adds a new dimension to the generally accepted concept of assessment, but is congruent with a contractual framework.

Functional abilities and disabilities may be influenced by economic constraints. These, for example, may determine if a person has been able to afford heating or not and therefore economic constraints may have adversely affected his or her health. Although financial resources of the older person will not affect the care received in a facility, it is important to know this as part of the life history. Functional decline happens to 12 % of people over 75 years old; unfortunately, geriatric teams are often able to put interventions in place only after the functional decline has happened. The effectiveness of such interventions is often limited (Hebert, 1997).

Functional assessment

As populations age and chronic disease becomes a more dominant form of illness, measurement of loss of functional abilities becomes more important in assessment in regard to quality of life and cost-effective care, (Kane, Rockwood, Finch, & Philp, 1997). Functional abilities related to self-care are usually referred to as 'Activities of Daily living' (ADL). ADL generally involve: mobility with or without aid, transferring, getting in and out of bed/chair. Gait and mobility become important because these may indicate potential for falls, bathing/hygiene, shower /bath/ assisted or independent, continence, sphincter control, bowel pattern, getting to toilet, dressing, selecting clothing, getting dressed, nutrition, and ability to feed oneself. Another facet is the time taken to complete a task. If a person is independent in feeding himself/herself, but it takes 2-3 hours, it may become a burden rather than an independent task, (Kane & Kane, 2000). Functional abilities are a large component targeted in the assessment. Environmental assessment is closely related to functional ability, and should be taken into consideration when assessing and planning a person's care (Burke & Laramie, 2004).

Depression is an oftenoccurring diagnosis that may negatively influence functional ability (Burrows et al., 1995). The authors found that nurses observe symptoms of depression in long-term care residents, but often symptoms are not treated. Nurses also confuse signs of dementia with mood symptoms. Families were more likely to acknowledge symptoms of depression than were patients. The study supports the information given by family caregivers. Signs and symptoms of depression may not be evident when a doctor visits. As depression is one of the most common illnesses in the elderly, it may present with non-specific physical complaints or be

disguised by physical complaints (or co-exist) like sleep disturbances, weight loss fatigue (Burke & Laramie, 2004). Particularly frail elderly are at risk of developing major depression and associated functional decline (Katz, Parmelee, & Streim, 1995). Treatable depression, overlooked on examination, may hinder the treatment of physical illnesses and functional repair (Goldberg & Chavin, 1997). Asking people if they feel sad may help to determine depression. If answered positively, additional screening may be instigated (Burke & Laramie, 2004).

Cognitive assessment

Bernstein-Lewis, (2002 p.15), further differentiates cognitive assessment: "*Cognition* refers to *awareness by perception, reasoning, judgment, intuition, memory and knowledge*". An accurate assessment of cognitive abilities is essential to the good care of older people, according to Fleming, Evans, Weber, & Chutka, (1995). Before dismissing answers from cognitively impaired clients, every effort should be made to determine whether this information is in some way reliable (Kane & Kane, 2000). Social resources, family, neighbours, friends, church, support social and social functioning all influence overall functional capacity. This is particularly important for older people who rely on others to maintain independence. Family is a resource for information, (Burke & Laramie, 2004). The ability of an older person to remain independent has an intense influence on the perceived quality of life and the cost related to care. Carefully identifying the abilities using appropriate assessment tools can increase the efficiency of the assessment, according to Fleming, Evans, Weber, & Chutka (1995).

Comprehensive Geriatric Assessment (CGA)

British geriatrician, Marjory Warren, created the first geriatric assessment units in the 1930s. Problem-focussed assessment may be ineffective in assessing the multiple and complex needs of older people, (Burke & Laramie, 2004). A systematic structural approach to measuring the physical, mental and social functioning of older people in order to identify needs and plan care, is essential, (Hansebo, Kihlgren, Ljunggren, & Winblad, 1998). A Comprehensive Geriatric Assessment can exist as a continuum, a series of assessments, and may occur in various settings. Part of the CGA is the Minimum Data Set (MSD), an assessment tool suitable for many settings which is completed mostly by nursing staff. The CGA is cost effective, but there does not appear to be an agreed approach to its implementation in primary care, (Philp, et al., 2001). Geriatric assessment in primary care is feasible, economical and would benefit the patient and practitioner. Comprehensive Geriatric Assessments are not widely used, although there is evidence of the usefulness of these (Kane & Kane, 2000). Comprehensive Geriatric Assessments are generally labour and time intensive and therefore not always practical in a busy setting, (Henrickson, 2000). Philp et al. (2001) promote this form of assessment and note that the key to successful implementation is the support of the nursing staff.

The average time a first assessment takes is 2.7 hours, a follow-up assessment would be 10-15 minutes, (Burke & Laramie, 2004). The CGA is multi-facetted and the information obtained can be used to maintain and improve an older person's health. It also indicates a need for referral to other health professionals.

Understanding of the pathophysiology of frailty is a challenge. TheCGA is the most appropriate manner to detect this, allowing identification of medical, functional and psychosocial needs of older people, (Rockwood, Silvius, & Fox, 1998). All assessments take time, however in real terms, the CGA is a more rapid accurate method of assessment according to these authors.

Examples of standardised CGA are:
Camberwell Assessment of Need in the Elderly, (CANE). This is a comprehensive assessment tool, looking from various perspectives, from that of the person, the carer and the health professionals. It is a single assessment process, used in over 15 European countries. It creates a holistic assessment, and a standardised approach leading directly to intervention and care planning (Orrell & Hancock, 2004).

The Resident Assessment Instrument (RAI) was developed to improve individual care planning in nursing homes. The RAI consists of 3 components, the minimum data set, the triggers and the assessment protocol. To gain an impression of those issues affecting older people, Mezey, Lavizzo-Mourey, Brunswick, and Taylor (1992), collated a nursing home assessment list. The focus of this list is mainly on functional abilities. In this list, social, psychosocial, cultural and spiritual needs are minimally discussed as part of a person's total well-being. However, these assessments cannot be seen separately from each other, they overlap and influence each other. Owing to political, economic and social circumstances, there is a likelihood that a different list of priorities may emerge in another country or culture. The authors questioned 76 leading American health professionals who work with older people, and prioritised the list in the following order:

- medication,
- incontinence,
- vital signs,
- mental status,
- vision test,
- bowel function,
- family support,
- musculoskeletal function,
- nutrition and
- dental evaluation.

Experts agree that the RAI is congruent with the most important assessment components in nursing home admission assessments. Staff in nursing homes appear to view the RAI as a positive approach to assessment. Assessing elderly with cognitive decline requires special skills; these patients are often less able to communicate concerns. RAI assist in specifically pinpointing those areas that are not always well communicated by the person being assessed.

In the United States of America, implementation of the RAI has been associated with significant improvement in care. It provides a comprehensive summary across major functional domains and standardised definitions. It systematically links assessment to care planning, (Hawes, Morris, Phillips, Fries, Murphy, & Mor, 1997). The RAI is a practical instrument to improve care. It appears to have the most positive effect on frail residents, (Achterberg, Campen, Pot, Kerkstra, & Ribbe, 1999), particularly in regard to dehydration and pressure ulcers, the decline in hospital admissions and reduction in exacerbation of chronic disease, by early detection.

Assessment Tools

Assessment tools facilitate the assessment of various aspects of functioning. Tools are a fairly standardised and objective means to gather and communicate findings. Tools are often used as an important first step in gathering information. Using tools can save time, and improve accuracy and screening to detect problems that may otherwise go unnoticed (Anderson, 2003). Many tools are widely known and accepted and are usually tailored to assess specific domains. For instance, there are tools to assess ADL, cognitive function, pain, and balance, however, not all are suitable for long-term care. In long-term care, assessment tools' usual domains include: health status, physical functioning, cognition, social functioning, family care-giving and financial eligibility status (Kane & Kane, 2000). The holistic nature of caring for older adults in facilities is missed by many assessment tools (Anderson, 2003). Not all domains are assessed in one single tool (Burke & Laramie, 2004), and multiple tools may be required to achieve a total assessment of an older adult.

Tools are important for the collection of data, but too much reliance on tools can oversimplify the situation and shift attention away from the patient, (Burke & Laramie, 2004). Tools need to be meaningful and identify personal and nursing care, needs (McCormack, 2003). It is also important to have a working knowledge of the tools and their application to protect reliability, (Burke & Laramie, 2004).

Assessment tools guide decision making, but they are only as good and effective as their users. Continuous education is essential, yet often, education does not include the basic interview technique or the assessment skills that are required to administer the tool (Kane & Kane, 2000).

Assessment tools include the Folstein Mini Mental State Examination (MMSE), the KATZ index and the Bartel Index. The latter two are functional ADL tools. The Folstein Mini Mental State examination (MMSE) is the most appropriate and extensive tool to determine cognitive impairment (Burke & Laramie, 2004). Superficial and genial conversation may not reveal underlying cognitive problems. A 10-minute MMSE assessment can determine orientation, registration, attention, calculation recall and language. A score of 25/30 or above is considered to reflect minimal cognitive impairment. A person with dementia would have a score of 15/30 or below.

Education, language barriers and physical disabilities may affect the outcome. Another cognitive tool is the clock test, where the person draws a clock with face and numbers. This tool assesses executive functioning. The KATZ Index is a functional assessment, (Burke & Laramie, 2004). It assesses what a person is doing at the time, not what the person's full capabilities would be. This is particularly important to determine the potential for rehabilitative aspects in the care. The Bartel Index is widely used in New Zealand, a 100-point scoring indicates full abilities in all aspects. Loss of abilities signify functional decline. The assessor also needs to determine if an inability to perform a task is a functional decline or a social norm. (e.g. inability to do up shoes, because someone else always laced up his or her shoes). Utilising standardised assessments tools may, however, be counter-`productive, as assessment tools designed for one purpose may not identify other issues (McCormack & Slater, 2002).

Assessment, contractual obligation and funding

Spending on health care for older adults comprises of one-third of the New Zealand government health care expenditure. To curtail expenditure, rationing of health care may be required. In the last decade, assessment in long-term care has moved from being a recommended activity to being a mandated activity (Kane & Kane, 2000). Studies indicate that it is more cost effective to prevent problems, act in a preventative manner and provide good health promotion (Wold, 2004). The emphasis on assessment came about because of the increasing cost of care, (Jacques & Ryan, 1997). In New Zealand it is an assessor decides who should receive funding. Health professionals are in a powerful position, because they held the purse strings and decide about access and resource use, (Kaufman, 1999), are now in a less favourable position. Needs-based assessment for payment causes tension between agency-centred and patient-centred objectives. Older people who want health services and the practitioners who work in health care can have potentially conflicting perspectives (Richards, 2000). Assessment for payment, with a quite arbitrary threshold, may affect the residents adversely. "The decision making process in long term care affects the resident for the rest of their life. Such decisions are often made under adverse circumstances", (Kane & Kane, 2000 p. 659,). Today, long-term care relies on assessment as the basis for determining eligibility for payment as well as planning of care. Mandated assessments are introduced in nursing homes. "The common feature of such assessment is attention to physical functioning, but other domains are also relevant." (Kane & Kane, 2000 p. 659). As assessment has a time and financial cost, careful planning of assessment time is necessary, to avoid needlessly repeating part or the whole of the assessment, (Foote & Stanners, 2002).

Residential care in New Zealand is historically underfunded, (Residential Care New Zealand, 2004). In 2005, it is evident that the landscape for residential care in New Zealand is changing. Religious and welfare groups are exiting care, and corporate businesses are buying up care facilities. NASC is overdue for a review, with long waiting times for assessment and assessment not independent of funding, (Clarke, 2001).

Funding is closely associated to staffing levels. Higher staffing levels generally ensure more appropriate care (Kane & Kane, 2000). New Zealand Staffing Regulation in Aged Care relates to minimum staffing levels (Jacobs, 2003). Prior to 1 October 2004 residential care providers had to comply with the minimum staffing levels as set by the Hospital Regulation 1993 and Old People's Home Regulation 1987. As from October 2004, providers who have attained certification under the HDSS Act do not need to meet these staffing standards, they need to meet the service standards. The old regulation did not differentiate between staff: nurses or cooks were all staff. The new regulation stipulates that staff must meet certain education requirements. In Britain, nursing homes explored the use of a standardised assessment in care facilities, the Resident Assessment Instrument (RAI), and linked this to staffing, (Carpenter, Perry, Challis, & Hope, 2002). The time spent by the registered nurses with residents with complex conditions was more than time spent with others, thus requiring more reimbursement. The more unstable and unpredictable the residents' needs, the more complex the care requirements are. Allocation of nursing time should be based solely on professional judgement, according to these researchers.

The types of assessments used in New Zealand care facilities appear to be varied. There are 830 licensed care facilities in New Zealand at the time of data gathering, (Ministry of Health, 2002). One of the agencies accrediting health care facilities is Quality Health New Zealand. This organisation's New Zealand Health Care Standards, (Quality Health New Zealand, 1997), advises that the older persons' needs are assessed in accordance with contemporary nursing practice. The assessments should be conducted by an appropriate health professional according to Quality Health New Zealand. Residential Care New Zealand (RCNZ) is a national organisation representing residential care facilities, and offering collective support and guidance with issues related to care facilities. RCNZ (2004) asserts that an assessment needs to be completed within 24 hours of admission, and reviewed three monthly or more frequently. RCNZ, (1998), determines that assessment includes personal data, home situation, activities, next-of-kin, medical history, medication, and allergies. Both guidelines leave room for interpretation regarding the assessor and the context of the assessment. Poniatowski (1999) recommends nursing assessment within 24 hours and medical assessment within 30 days of admission to rest-homes.

The multidisciplinary team approach

A team approach requires processes to enable the team to work successfully together. These processes include creating a sense of belonging and commitment to the group, a sense of progress and accomplishment and clarification of each member's role and contribution, (Burke & Laramie, 2004).

"The recognition of the complex medical, social, and mental health problems and resulting functional disabilities of many frail older persons has led to the development of a multidimensional, interdisciplinary approach to the evaluation of this problem", (Burke & Laramie, 2004, p. 1). Multidimensional assessments, by a

multidisciplinary team have been advocated as most appropriate to determine the ability of older people (Opie, 2000). Dellasega, Salerno, Lacko and Wasser (2001), demonstrated that targeted assessment and intervention positively affects patients' outcomes, by identifying at risk elderly early. However, Fletcher (1998) noted that the cost effectiveness of multi dimensional assessment is not clearly evident. Fletcher suggests that assessment of older people should be on the basis of their needs, as these will not be identified with routine assessments, because interventions are at times described in such general terms that it is not clear what is suggested. Good long-term care requires assessment across multiple domains of functioning. This requires co-ordination across sectors and across health professionals, (Webster, 2004). Webster also indicated that health professionals from different disciplines use different terms, and different philosophies of care. Using the *medical model approach*, would mean that an intervention should yield a positive functional result. For frail older people this may mean simply slowing the rate of decline (Kane & Kane, 2000). Although assessment is the first step of an ongoing process, like all other aspects of care delivery it overlaps, and collaboration between services is important. (Feely, 1994; Opie, 2000). There is a belief that assessment will enhance and protect professionals' practice (Kane & Kane, 2000). However, in Long-term-care (LTC), assessment without actions to address the findings does not protect a professionals' integrity nor does it benefit the resident. Sometimes actions may involve further observation. "Fragmentation within LTC is reflected in the multiple assessments uses. To the extent that different professions emphasize different aspects of care, the assessments used by each will vary." (Kane & Kane, 2000, p. 660). In 1996, Nolan and Caldock noted that there is no clear consensus what good practice is for assessment. In 2005 there is no reason to think that this situation has changed. The nature and mechanism of assessment have to be clearly understood by all involved in order to be effective. For an assessment to be effective, a collaborative and coordinated approach

between agencies and professionals is a prerequisite. At an interprofessional level, difficulties appear to exist. This is due to lack of common values, culture and agendas.

The consequence of good assessment and intervention among older people, and regular assessments and visits by the same person, was seen as positive by the older person. In the community and in long-term care facilities, the focus should be on early recognition and prevention. Effective multidisciplinary practice improves health outcome (Burke & Laramie, 2004). Chronic conditions must be continuously assessed for their impact. Of concern is the weak link between primary care and specialist geriatric services. The lack of coordination can result in gaps or overlapping, (Gold & Bergman, 2000). Generally, professionals are uncomfortable designing and adhering to rules created to ensure inter-rater reliability of data collection for assessment. The different language used by each group further complicates matters (Kane & Kane, 2000).

Although assessment is a multidisciplinary activity, not every discipline needs to be represented with each assessment, as this is a cumbersome and expensive approach. A way has to be found to allow input from many without direct participation. Data collection could be delegated as a task to only a few professionals. Care could be planned by interdisciplinary negotiation (Kane & Kane, 2000). Health professionals' valuable time and effort are used in the replication of assessments, resulting in less time being available for others who need an assessment (Foote & Stanners, 2002). Assessments are often performed by inappropriately skilled staff. The Single Assessment Process (SAP) was introduced in Britain in April 2004 to ensure that older people's care needs are assessed thoroughly and accurately, without duplication of assessments. Nurses, and others, using the Single Assessment Process need to have skills and

knowledge updates. They need to understand the needs in the wider context of the older person's life. (Department of Health, 2001). Professionals should not duplicate each other's assessments. Webster (2004) advises that person-centred care requires practitioners to work in a different way, with greater flexibility because it is an ongoing activity. The model or framework underpinning assessment should reflect the need of the person and the values of the team. Formal models should be used by health professionals with little experience; more experienced practitioners will develop their own assessment methods without adhering to a rigid framework. Comprehensive Geriatric Assessment combined with long-term care management are effective to improve functional ability in older people, according to Stuck, Wieland, Adams and Rubenstein (1993). This first meta-analysis of Comprehensive Geriatric Assessments is a useful document, but as with all meta-analyses, it is only as good as its component parts.

Data for most assessments tools are obtained from the care assistants working most closely with the client. The data arre designed to best represent care assistants' observation. This is reported to a nurse who compiles the information. This approach relies heavily on observed behaviour. Staff however, may not care for the same resident, resulting in inconsistency in data collection. Clients' communications may be seen as being less important than the care assistants' observations, (Kane & Kane, 2000).

Because medication is an important component of care in aged care facilities and residents often have a multitude of medications, the pharmacist is an important contributor to positive patient outcome, (Wong, Vogenberg, Gilbert & Dupee, 1996). In collaboration with other Health Professionals they can assist in reducing polypharamacy and provide continuity between providers and community settings. However, pharmacists attend the multidisciplinary team meetings in care facilities.

The influence of the medical model on care practice, (Reed & Watson, 1994) is seen by some to be restrictive. The medical model can influence the way nurses organise and evaluate their work with residents. The focus of the medical model is often perceived as narrow and focussed with patients seen only in terms of their diagnosis. Such a focus can lead to the fragmentation of care.

Analysing assessment results and care planning is another part of the total care process. Analysing assessment results can be done by a team, or a single person. Decision making by a single person may be biased because of previous experiences. Multidisciplinary team decisions may have a more holistic approach, but can be cumbersome and slow, (Foote & Stanners, 2002). An agreed framework with clear boundaries would make decision making easier.

The cause of complaints, as given by the Ombudsman and Health and Disability Commissioner, usually refer to poor communication, poor documentation and failure to involve the practitioner in the initial investigation (Lowson, 2004). This author found that records are not updated, assessments are not signed and evaluations are rarely recorded. In most cases, specialists write in medical records rather than in the nursing notes. Poor documentation and communication were often linked to inadequate explanation to family members about the deterioration of the resident. Barriers to communication include the lack of a common language. "The same terms need to describe the same observations" (Kane & Kane, 2000, p. 681). It becomes clear that information must be understandable.

In care facilities, nurses are often the gatekeepers of information. As Hoban (2004, p. 24) notes, "Nurses are poised to take a more flexible and central role in future health care". Nurses, as case managers or coordinators of services in these settings, are well positioned to take a leadership role in the design and implementation of

interventions. They are the key component of efficient coordinated services. Nurses are often the primary contact, and play a leadership role throughout the assessment. Nurses generally coordinate the assessment process (Aminzadeh, Amos, Byszweski, & Dalziel, 2002) . If nurses are to play a large role in the assessment and co-ordination processes, it is clear that this needs to be supported by relevant programmes of education.

Assessment and care planning

As the world population of older adults is growing, and the needs of this diverse population group become increasingly wide-ranging, it seems only fitting to explore the way health professionals and residents work together to determine a plan for care. Discrepancies have been previously noted in areas of assessor qualification, consistency in the application of the content of assessment, and the relation of assessment to the actual care planning, (NZGG, 2003). Care assistants need to be familiar with the specific baseline assessment data for those residents they are looking after. Deviations from the baseline data need to be recognised and immediately brought to the attention of the registered nurse. Documentation needs to be relevant and up to date.

The New Zealand Nurses' Organisation (1996), survey highlighted that many care settings work with a small core of experienced nursing staff and a large number of inexperienced care staff. To work effectively towards a common goal, it is essential that the nature, purpose and mechanisms of assessment are clearly understood and communicated to all levels of staff.

Health care decisions are associated with uncertainties. "Ultimately, all treatment decisions in long-term care settings are operationalised through nursing. Timely and accurate assessment of patient needs, efficient communication with physicians, and the translation of physicians' orders into treatment at the bedside are all very much dependent on nursing availability and acumen.", (Katz, Mezey, & Kapp, 2004, p. 135). Judgments and decision making are intricately linked. Intuition and expertise are seen by some to be important factors in clinical decision making, others argue that intuition has no part in clinical decision making. Health staff may emphasise the importance of a comprehensive assessment, and act differently when writing Care Plans, (Thomas, Wearing, & Bennett, 1991). Time constraints are frequently mentioned as a reason for poorly developed care plans.

Good care planning requires discussion, judgment and decision making. This leads to the best possible outcome (Dowding & Thompson, 2004). Population demographics point towards a growing need for health professionals knowledgeable and skilled in care for older adults. Katz, Mezey, and Kapp, (2004) indicate that a shortage in skilled staff will result in poor care. People's individual values affect functioning. Values develop and are influenced over the course of a lifetime. They are what give a person his/her meaning in life. The care provider needs to understand the individual's values in order to develop a plan for care, (Burke & Laramie, 2004). Olenek, Skowronski, and Schmaltz (2003) found that the cornerstone of the nursing process is assessment. Due to the scarcity of nurses to work in long-term care, the information collected by the registered nurse was often not integrated in a systematic fashion. Another pitfall in care planning is the need by some nurses to define an outcome related specifically to a nursing diagnosis, when in effect describing symptomatic treatment. For instance, a nursing diagnosis may identify a need for education in wound care. This relates

assessment to specific service teaming 2 steps into one process (Kane & Kane, 2000).

Assessment is seen by some as the first part of the nursing process, the basis for a care plan. Patients will have assessments by various professionals. "It is important that nurses recognise their skills in carrying out patient assessments, as decisions about care packages and the need for further assessments by other services will be made on the basis of such assessments.", (Feely, 1994, p. 318). In a clinical setting, assessment should lead to a care plan or an adjustment to a care plan. The next step would be addressing potential helpful actions to cope with anticipated problems. (Kane & Kane, 2000). An identified problem can not be directly translated into remedial action. The problem needs to be defined in such a manner that the widest possible options can be used in response, (Kane & Kane, 2000). Care planning involves making choices, hence the need to include the client in this. (Kane & Kane,2000). This directly assumes that the client's values and preferences are assessed. The outcome of the assessment is not the same as the process. To establish a plan of care timely monitoring of intervention is necessary. Holistic health care encompasses the whole person, the physical, psychosocial, spiritual components of a person. (Bernstein-Lewis, 2002). Berkhout, Boumans, Van Breukelen, Abu-Saad and Nijhuis (2004) researched resident-orientated care models and how nurses made use of the nursing process and how care was implemented. The results indicated that a task-orientated division of work occurs in nursing homes. The use of the nursing process was found difficult by nurses. Nursing care plans were not up to date and were incomplete. Care as planned was not the same as the care that was given to the resident. Priority was given to basic care. Delegation and coordination of tasks wer not always achieved.

While all health professionals make decisions about the type of care that is required for a person, nurses refer to this decision making process as the "Nursing Process". This suggests that identifying needs is linked to setting or selecting goals. Interest in the Nursing Process started in the 1980s. The Nursing Process is usually described as being made up of four phases: assessment, planning, implementation and evaluation, (Mezey, Rauckhorst, & Stokes, 1980). The nursing process offers a framework for decision making, (Reed & Bond, 1991). Traditionally, the nursing process guided the assessment and intervention phase, not specifying the cognitive processes required in clinical decision making. The nursing process requires the nurse to make decisions about care, it is not a simple technical tool. The nursing process requires decision-making skills. In practical terms, assessment in this context is to clarify the condition and the circumstances surrounding it, as well as clarifying the knowledge and skill that are required to make a decision. Long-term care nurses rely on nursing process-orientated decision making. The nursing process offers nurses a framework for decision making, Ford (1997) explains that in long-term care however, using assessment will not necessarily ensure that nurses in long-term care work within a nursing framework, or recognise their work as being within a nursing framework. The nursing process, when used for problem solving, assists the novice nurse to develop a style of thinking that leads to judgment (Field, 1987). In contrast, the proficient nurse views situations as a whole and decisions are based on the nurse's perception of the situation, and experience (Grobe, Drew & Fonteyn, 1991).

Decision making varies according to setting (Hamers, Abu-Saad, & Halfens, 1994; Lauri & Salantera, 1998). The nursing process is described as problem solving, which is a deductive process, not the same process that is in place when providing care (Taylor, 2001). Roper, Logan and Tierney (1981) believe that nurses always

used this system, however, nurses were - and are - not always aware that they do. Often, to the new nurse, the rationale for the decisions for care is not apparent. The nursing process, while specific to nursing, is in essence the same decision-making process as that used by doctors and allied health professionals. However, the literature on decision-making by these groups is minimal.

Bowers, Lauring and Jacobson (2001) explored the conditions of work for nurses in long-term care and how this influences the residents. Nurses describe the tasks they are meant to achieve within a set timeframe. The main source of dissatisfaction is time restraint. Not enough time to spend with the resident. The short timeframes limit the ability nurses to utilise time creatively. They cope with time restraint by redefining responsibilities, prioritising and adhering to a routine. Also combining tasks and changing the sequence of tasks appear to be coping mechanisms. Adequate time is seen by nurses as the time required to do a task - this includes all tasks they must do - and tasks they should do. Providing higher staffing levels would ensure nurses could spend more time with residents and care would improve. Bowers, Lauring, and Jacobson (2001) contend that if policies related to staffing do not incorporate additional time with residents, the expectations for quality care should be revised.

In 2005, salary levels have become an important and contentious issue as a result of increased salaries for registered nurses working in the public sector and low pay for nurses in other sectors, as well as low pay for care assistants. This, together with the requirement for more education, is likely to have an increasingly adverse effect on the staffing levels and skill mix in care facilities.

Decision making by Health professionals

Clinical practice involves ongoing decision making. Health professionals decide what information to collect and how to utilise this. Judgment and decision making are defined in many ways; clinical decision making (Field, 1987; Lucker, & Kenrick, 1992), clinical judgment, (Benner, & Tanner, 1987, Clinical Inference (Hammond, 1964), Clinical reasoning, (Grobe, Drew, & Fonteyn, 1991), and diagnostic reasoning, (Carnevali, Mitchell, Woods, & Tanner, 1984). Dowie (1993) makes the distinction between *judgment* as *the assessment of alternatives* and *decision* as *choosing between alternatives.* Globally, there is pressure on health professionals to account for the decisions they make. Mulhall and Le May (1999) indicate that policies are leading to an evidence-based health care culture with a need for greater transparency in the decision making. When making choices, people draw on a variety of sources of information. Thompson (1999) refers to this as experience or stored knowledge or facts. However, people can be selective in the information they supply, often supplying what they think is needed. Old knowledge can be replaced with new knowledge. Information needs to be fit for the purpose. Policies and professional imperatives can guide and hamper nurses in their decision making.

Nurses in advanced practice have integrated medical diagnosis reasoning to compensate. (Frauman & Sakelly, 1999) Thompson, Melia and Boyd (1995) point out that this also includes the use of relevant rules and principles to come to a conclusion. By clearly defining the concern, a course of action can involve the following stages, according to these researchers;

- consideration of knowledge of specific procedures
- retrospective examination of past experiences

- anticipation of likely consequences of alternatives
- choice of resources available
- formulate a plan /contingency

Thompson (1999) suggests that theories of judgment making can be divided into normative, descriptive and prescriptive. *Normative theory presumes that the person making the decision is rational and logical,* Normative theory is concerned with the outcome of the decision rather than how the decision came about. *Descriptive theories describe how people make their decision. Prescriptive theories attempt to improve on previous decisions, examining the process of decision-making.*

The role of Registered Nurses in planning care

Historically, nursing actions were directed by medical practitioners. Nursing job descriptions generally specified that nurses were to act on instructions of medical personnel only (Murphy, 1976, Shetland, 1976). Old textbooks viewed assessment as a medical domain, (Altschul, 1969; Roper, 1967). More recently, the medical perspective is seen to be more concerned with pathology and treatment, while nursing is more concerned with a person's response to illness and well-being, (Leddy & Pepper, 1998). Over time, the boundaries of both disciplines have moved and blurred, as a multidisciplinary and interdisciplinary approach to patient care was advocated.

In the late 1980s, financial and political interest in patient outcome led nurses to investigate more fully the fundamental aspects of care planning. Johnson, Maas, and Moorhead, (2000), refer to this as the 'Era of assessment and accountability'.

Literature reviewed suggests an abundance of interest in assessment during 1960-1970, and again a renewed interest in the early 1990s. However, the New Zealand literature pertained more to guidelines than to research. Although international research is essential to the health professional's knowledge base, international research seldom reflects the unique New Zealand conditions, or allows for ethnic and cultural variations. Caution is therefore required when applying international findings to a New Zealand setting, (Davidson & Tolich, 1999).

Care Planning

In the literature, *care plans* are also referred to as *lifestyle plans* and *pathways*. Nurses are the largest group of health professionals who perform assessments and care for older people in care facilities. Nurses perform the majority of initial assessment and notify other health professionals if additional assessments are required. The need for appropriate education for nurses in long-term care is apparent. The Nursing Council of New Zealand (2000) surveyed nurses about their educational qualifications using self-reported data. It found that 18.2 % of the nurses with a practicing certificate hold a Bachelor's Degree and 10-20 % of nurses in elderly care held Bachelor's Degrees. This is similar to nurses in emergency departments and palliative care. Four percent of nurses in care facilities hold degrees in non-nursing fields.

Assessment, Care planning and Education

According to Byles (2000) assessments are being undertaken in an idiosyncratic and ineffective fashion. Health professionals hold stereotypical views of older people and not all who care for older people are skilled and educated in assessment (Burke & Laramie, 2004). Anecdotal evidence indicates that older people's dignity is often undermined in the care environment (Lothian & Philp, 2001). Ensuring a person's dignity is maintained is an integral part of assessment and care planning. Education and the exposure of negative attitudes can help to preserve older people's dignity by assisting in the provision of additional information to the client and his/her family, (Lothian & Philp, 2001). A person-centred assessment is not something that happens in isolation - it needs to be part of a philosophy of care. Care managers in long-term care recognise the need to have good assessment skills, because the health status of residents has become increasingly fragile, (Anderson, Skillen, & Knight, 2001). A highly skilled workforce is essential (Webster, 2004). The absence of standard assessment criteria and tools make assessment an indistinctive activity (Byles, 2000). To assist and guide the care, a sharing of knowledge and skills benefits all health professionals, (Burke & Laramie, 2004). Katz, Mezey, and Kapp (2004) promote a collaborative approach to assessment education, with sharing of knowledge to achieve appropriate outcomes. With the present move towards increasing restorative care, there may be a need for additional training for care assistants, (Grubbs & Blasband, 2005). Foote and Stanners (2002) report on 20 randomised controlled trials of health assessment for older people and point to an improved health outcome once assessors received appropriate education. These researchers note that education should include the selection and use of assessment tools and ways of communicating with older people and colleagues. Assessors must be trained and there must be an agreement to follow instruction to ensure reliability

(Kane & Kane, 2000). An understanding of the interdependence between health professionals is critical to providing comprehensive quality care.

Tutors question career choices involving long-term care, (Reed & Watson, 1994). Research in the United Kingdom indicates that nurses in care homes are faced by professional isolation, (Taylor, 2001). Health professionals still do not appear to have a large component of care for older people in their curriculum. Nurses have the impression that physical assessment is a complete 'head-to-toe' assessment, rather than a focused assessment. Comprehensive courses would increase nurses' confidence in conducting assessments and enhance the quality of care (Nazarko, 1996). Nazarko also mentioned the lack of money in Aged Care in general and that marked for education in particular. Anderson, Skillen and Knight (2001) suggest that education and assessment skills could be enhanced with computers.

Health Practitioner Competency Assurance Act
(HPCA ACT 2003)

For this research the term ''Registered Health Professionals' indicates a group of health professionals who perform assessments of older adults in care facilities. There is a large number of health professionals who would be involved in care for older people in general, however, this term is used in this thesis to identify the group of health professionals that would typically do assessments in care facilities and would be part of the core team that is the multidisciplinary team. While the researcher was collecting data for this research, the Health Practitioner Competency Assurance Act (2003) came into effect in September 2004. The purpose of this Act is to protect the health and safety of the public and to ensure that health practitioners are competent to practise. The Act aims to provide a

consistent framework for all health professionals to work in. When the HPCA Act (2003) came into force, some aspects of professional registration, monitoring and control of health professionals' competencies and actions changed. The Act replaced all previous regulations of separate professional bodies and combined these into one Act.

The Act defines: '*health practitioner*: as *a person who is, or is deemed to be, registered with an authority as a practitioner of a particular health profession*' (Statutes NZ 2004). The term *health professional'*, used in this research equates to *health practitioners* in the Act. The Act requires practitioners to comply with and work within the set competencies for the profession. The practitioner is required to apply for an annual practising certificate and demonstrate competencies by participating in educational professional updates and be employed for a minimum number of hours in a setting that is directly or indirectly affecting client care. The Act provides channels to address practitioners' misconduct via the Health Practitioners Disciplinary Tribunal.

Although the processes around accountability changed, the competencies related to health professionals' assessment of older adults in care facilities did not change because of this Act.

Chapter Three

The Research Design

The design of the research is detailed and the context of the research topic illustrated. The rationale for using a qualitative design and Thematic Content Analysis is explained. This is followed by a description of the proposed manner in which this research was to be conducted. For a variety of reasons, the planned and actual processes differ and those components of the actual research that differ from the design as set out at the beginning of the research are identified.

The context of this research

The context of this research is the existing knowledge about assessment and care planning related to older adults in care facilities in New Zealand. Although assessments and care planning are frequently referred to as parts of professional practice, there is evidence, as seen in the previous chapter, that assessment and care planning can occur at varying levels, vary in intensity, can be brief or lengthy, and undertaken for different reasons. Assessment can be formal, informal, contain baseline observations, history and functional tests. The formal assessments usually relate to those assessments that are required for contractual purposes or when significant changes in condition occur. The informal assessments are usually remarks or observations that flag that there is a need to do a further (formal) assessment. The knowledge about assessment and care planning is closely linked to knowledge of health professionals' practice, older adults, care facilities and other aspects of health care systems and processes that influence assessment.

Therefore, the knowledge base required for a good assessment and care planning is rather complex and extensive. Assessment and care planning are not isolated processes. Assessments and care planning processes, related to a population in New Zealand care facilities, may have a resemblance to those in care facilities in other countries, however, the cultural and New Zealand-specific health care practices provide a unique framework. As previously observed and indicated in Figures 1-4, assessment and care planning in the Aged Care sector constitute a complex and challenging topic.

In order to gain insight into assessment and care planning related to older adults in care facilities, an exploratory and descriptive study appeared to the researcher to be the most appropriate action to find out what health professionals' understanding of assessment is and how registered nurses use the assessment findings to plan care. Exploring and describing an issue of interest using a qualitative approach is a useful way to determine what is happening and why this is happening in a particular way. This approach may also help to explain how a series of seemingly unrelated topics influence and affect each other. Exploratory research aims to discover whether the topic under investigation is worthy of further research and/or indicates a need for further research.

Descriptive research describes a phenomenon in detail (Davidson & Tolich, 1999). Descriptive research is a qualitative method and a basic form of inquiry. Description is largely unembellished and can answer questions of special relevance to practitioners, (Sandelowski, 1998). Descriptive research identifies the nature of the topic and connection with associated topics. This is suited to health professionals, as it enables them to discover or classify information, (Chin & Kramer, 1991). Minichiello, Sullivan, Greenwood and Axford, (1999, p. 4) explain that "Through descriptive research, health care professionals are able to describe what exists in practice,...".

By exploring and describing the relationship between the various elements, processes and systems connections and links may become evident and be clarified. This framework orients the research into practice and provides the rationale for the interview questions to further explore health professionals' assessment of older adults in care facilities.

Qualitative Research

In choosing a design for this research, the advantages and disadvantages of a quantitative approach as well as those of a qualitative approach were considered. A quantitative approach would reveal actions and would enable the researcher to list tasks. However, it may not necessarily clarify the interactions and links influencing these actions. Another hesitation about using a quantitative approach was that participants would not have the opportunity to elaborate on those issues that they consider important and on which they could provide valuable insight. The important factors influencing the final choice of design were:

- The time available to complete the study
- The subject area, which does not easily lend itself to a quantitative design
- The likely unwillingness of people to contribute quantitative and potentially market-sensitive data at a time when financially related matters are of great concern to care facilities

Usually conducted in a natural setting and using descriptive data, (LoBiondo-Wood & Haber, 1998), qualitative research is primarily concerned with discovery and description and allows the researcher to view the data in a social context. Qualitative research assists in exploring topics more indepth, and can address broadly stated questions. The focus of qualitative research is on exploring topics that are not extensively researched or bewildering in nature.

Qualitative research also offers an opportunity to inquire into professional issues of concern, (Davidson & Tolich, 1999). It acknowledges multiple realities, from the view of the participant. Investigating topics that assume multiple realities or those that are complex or insufficiently understood most appropriately accomplished through qualitative research, (Kuckelman-Cobb & Forbes, 2002).

Kuckelman-Cobb and Forbes (2002) offer a useful outline of the five fundamental steps in qualitative research. These five steps are identified by the researchers as:

- creating written text from interviews,
- identifying units,
- reducing data through coding,
- clustering codes into patterns (themes),
- providing interpretation of the relationship that compose the descriptive or explanatory framework.

Other authors offer similar steps. Boyatzis, (1998) for instance, suggests these steps:

- sense themes through reading data,
- recognize a theme consistently,
- develop a code for the theme,
- interpret the information,

It was decided that a qualitative method, based on semi-structured interviews and thematic Content Analysis, was well suited to research. It was felt that this approach would best would allow participants to elaborate and give their own explanations

Content Analysis and Thematic Content Analysis

The field of qualitative data analysis consists of many approaches. Content analysis is one of the qualitative approaches generally found in disciplines of communication, political and social sciences, psychology and anthropology. Content analysis is a method to analyse verbal and written communication and a broadly used technique to identify issues and patterns. In the 18th century, in Scandinavian countries, quantitative content analysis was used when words in religious sermons and hymns were counted by authorities to determine heresy. This was followed by a less dramatic use of the technique to prove or disprove bias in media representation, (Rosengren, 1981). The precise development of content analysis has taken different paths and patterns in different parts of the world, however, an overall, parallel pattern is noticeable. Content analysis emerged as an analytical research method in the 1940s, where it was applied to war propaganda (Krippendorff, 1980). Content analysis was applied to propaganda material in World War 1 (Berelson, 1952). Berelson made a distinction between qualitative and quantitative content analysis, indicating that there was a history of qualitative content analysis. This technique was later refined and used in market research. Around the 1960s, continental European influence became evident, with a revived interest in Marxism and a wave of new ideas and social freedom that was

previously not acceptable. In this climate, qualitative content analysis came to be seen as a more liberal approach than the stricter, quantitative analysis. The distinction in qualitative content analysis is that this uses the data as the source for a code (theme), as opposed to quantitative content analysis, where a representation of the number of occurrences are identified.

Qualitative content analysis is distinct in both approach and interpretation, (Morgan, 1993). A key element is the use of a code to designate data segments, (Morgan 1993). Researchers using qualitative data analysis are more likely to use the data themselves as the source of the code according to this author. The 'why and how' of the pattern becomes more evident in qualitative analysis. Morgan (1993) states that qualitative content analysis facilitates answering the questions and allowing further explanation about why differences occur. It also allows a blend of social activities to be viewed from a personal perspective, according to Rosengren (1981). Content analysis seeks to understand data not as a collection of events but as symbolic representations. (Krippendorf, 1980). It is capable of: "accepting relatively unstructured symbolic communications as data.", (Krippendorff, 1980, p. 33). The aim in using qualitative content analysis is to gain an understanding of the context in which the data occurs (Morgan, 1993). Content analysis has also long been recognised as a relevant strategy to conduct practice oriented nursing research, (Cole, 1988; Davidson & Tolich, 1999). Cole recommends content analysis for research in clinical settings, and suggests that the intent in using practice-orientated research is to discover, expand the knowledge base. Content analysis can be used to explore ambiguous concepts and can be used also to clarify "..vague concepts that are prevalent in using practice so that everyone who subsequently uses the term will be speaking of the same thing."(Walker & Avant, (1995, p. 38).

Advantages of qualitative content analysis are the opportunities to look at meaning rather than at a number of occurrences. The disadvantage of quantitative content analysis is that it cannot be generalised and that the quality of the findings is directly related to the skill of the researcher, (Minichiello, Sullivan, Greenwood, & Axford, 1999). A novice researcher is more likely to overlook significant findings.

Content analysis is one of the fastest growing research techniques. It allows the researcher to make decisions about the scope and complexity. This method is particularly suited to compare data gained from participants from different disciplines (Davidson & Tolich, 1999). Hence the suitability to analyse interviews in this study by this method. By grouping passages and remarks of the interview transcripts, themes would emerge.

The term *Thematic Content Analysis* initially occurred in text related to Thematic Apperception Tests, and in Burnard (1991). This is also described as Thematic analysis. Stone, (cited in Roberts, 1997), describes how, in the last three decades, thematic analysis has evolved in the social sciences, noting that text analysis applications have shifted from testing theories to more grounded objectives. Burnard's technique is often cited in the literature. Searches in CINAHL and Medline databases do not have references to thematic content analysis before 1991. This implies that thematic analysis and thematic content analysis are linked. There is no standardised definition for the term *Theme* in the literature, (DeSantis, & Ugarriza, 2000). These researchers found the concept of 'theme' was a critical component of the interpretation of qualitative data, particularly in relation to the development of nursing research, where consistency of terms can assist in the riguor of the research. Denzin and Lincoln (1994, p. 6), refer to thematic analysis as " a beneficial bridge between researchers and varying orientations and fields".

Boyatsiz (1998) explains that thematic analysis is a way of 'seeing', sometimes seeing what does not instantly appear to others. Thematic analysis as defined by Boyatsiz describes four stages. Boyatsiz (1998, p. 4), illustrates 'theme' as "a pattern found in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon". The stages described are:

- sensing the themes
- recognizing codable moments
- recognizing and reliability coding the theme consistently
- developing codes
- interpreting the information in the context of a framework or theory.

A code should have the following five elements according to Boyatsiz: a name or label, a definition or characteristic description of the theme, an indicator on how to flag the theme, and a description of exclusions from the theme, (Boyatsiz, 1998, p. 31).

The definition that is least restrictive and best describes the term *theme* is : "A recurrent regularity emerging from analysis of qualitative data", (Polit & Hungler, 1997, p. 470). DeSantis and Ugarrizza (2000), explain that themes unify and are woven throughout data. Aronson (1994) promotes a practical version of thematic content analysis and details this simply as patterns that emerge. Themes are identified by bringing together components and fragments of ideas. Theme statements develop to support the story line. For a researcher using thematic content analysis, the first step is to collect data by interview. Then to identify data and patterns and catalogue these patterns into groups, giving a comprehensive picture of a collective experience.

Reliability of the data from this research would best be assured by repeating the coding and achieving the same results. Neuendorf (2002) cautions that certain messages are socially and historically situated, and repeated sampling may not be possible. The validity would be ensured by the questions, where the answers to the questions would reveal data related to health professionals assessment. To explore and describe health professionals assessments, grouping text by exact phrase was not appropriate, as different disciplines of Health Professionals have their own jargon. " Distinct interpretation of the same term stems from differences in disciplinary assumptions, divergent approaches within each discipline, and the evolution of these interpretations over time" (Lowenberg, 1993, p. 67). Lowenberg suggests that nursing is increasingly incorporated into other disciplines, hence the need to be aware of terminology and underlying assumptions when analysing data. For this research, the meaning of the phrase would be looked at. For example, a physiotherapist may use the terms *subjective and objective assessment* while a nurse may use the term *total assessment*. Probing questions could identify if the initial meaning of the assessment was similar or different. Other obstacles to the accurate analysis of data are also the education and ideology of the researcher, as specific knowledge may bias the coding.

In this research, transcripts were analysed using the steps as described by Miles and Huberman (1994) and Aronson (1994) by marking text and key phrases and affixing a code to the text. Data were handled multiple times to become familiar with the transcripts and sense connections and patterns. Reflections and remarks were noted in the margin of the transcripts. The transcripts were then to be sorted to identify patterns and relationships between patterns. These patterns were grouped in themes and the connections and relation between the themes further explored and described, exploring commonalities and differences. Themes

emerging consistently in the data were elaborated on and explored in relation to existing knowledge identified by the literature. Thus the level of congruency between existing knowledge as derived from the literature, and the practice of health professionals' assessment and care planning of older adults was recognised. Concerns with utilising thematic content analysis were the inexperience of the researcher as well as the researcher's familiarity with the assessment process. Coder bias is likely to occur as the aspects that are researched are part of the daily employment tasks of the researcher. The risk of bias was reduced by frequent contact with the supervisor and repeated analysis of the data at different time intervals. Coder bias in this research was identified as an issue because the researcher's employment closely relates to the subject being explored. This was negated by the researcher's time-out. This was deliberate time away from employment, to ensure that assessment practice and research were not blurred. This exploratory descriptive study took place in the Central Region of New Zealand. This research commenced in April 2002, following receipt of the Ethics Committee's approval.

Obtaining Ethics Committee approval

A proposal for research was submitted to the Manawatu/Whanganui Ethics Committee and the Massey University Human Ethics Committee on the 15th of April 2002 and 16th of April 2002 respectively. The Massey University Ethics Committee was to be the primary committee for this research.

Minor amendments were suggested by both the Ethics Committees. These amendments included an additional phone number of the Ethics Committee in the information sheet, a tick box on the consent form for offering transcripts to participants, and the addition of the Ethics Committee's contact number on the consent form. The amendments were processed and re-submitted to the

Committees. The Manawatu/Whanganui Ethics Committee granted approval to proceed on 14th of May 2002 and Massey University Human Ethics Committee on 17th of May 2002. It was anticipated that this research would be completed in 14 months. Unfortunately, because of unanticipated work and family commitments of the researcher, the research was delayed.

The design

The manner chosen to explore health Professionals' assessment of older adults was as follows. Health professionals from different disciplines would be interviewed using semi-structured interviews. The transcripts from these interviews would be analysed to identify themes.

For this research, only registered health professionals were considered as possible participants. The inclusion criteria were identified as being registered health professionals who assess older adults in care facilities. Participants would be employees of, or contracted to, a care facility. A convenience sample was chosen because of time constraints and geographical proximity. The researcher anticipated recruiting at least two participants from each of the following health disciplines: Dietitians, Diversional Therapists, General Practitioners, Occupational Therapists, Pharmacists, Physiotherapists, Registered Nurses and Social Workers as well as a minimum of four registered nurse participants to explore the utilisation of assessments for care planning. Research participant numbers were set in the range of 12-20 participants. Registered nurses work different duties, (shift work). Registered nurses also have more direct contact with older adults in care facilities and they are responsible for assessment and the care planning. For these reasons, there was a greater number of registered nurse participants in this research. All

these health professionals were required to have a practicing certificate in order to use a particular title and practise their profession, or be registered by a national professional body and in the process of applying for practice certification as per Statutory Regulation, (for example Social Workers and Diversional Therapists).

The exclusion criteria then became: health professionals without a New Zealand registration and /or not employed or contracted by a care facility.

Health professionals who were not included in this research, but who are captured under the Health Practitioner Competency Assurance Act (2003) Act and might be involved in care for older people are optometrists and podiatrists. Deteriorating vision is a component of functional decline for older people as is an increased incidence of falls. From that perspective, both health professionals should have been included in this research. With the benefit of hindsight, this was an oversight on the researcher's part. At the time of commencing this research, only the health professionals most commonly involved in care facilities were identified as potential participants.

Cultural considerations

This researcher acknowledges that traditionally, older adults of Maori descent are not often cared for in care facilities, and statistically there are fewer registered health professionals with Iwi affiliations, (Statistics New Zealand, 2003). At present there are few Maori in care facilities. To act in accordance with the Principles of the Treaty of Waitangi, the significance of this research for the health of Maori as well as that of non-Maori was considered. This study would have meaning for both Maori and non-Maori. It is anticipated that as the older

population of Maori increases, the information generated by this research will assist in the development and implementation of assessments and care planning more appropriate to both Maori and non-Maori. This research may assist in gaining insight into participants' understanding of assessment and care planning and relating this to assessments of older people from another culture.

Approaching participants

All participants were to be approached via their place of employment. The initial contact was to be via the manager of a facility, as he or she was responsible for the day-to-day management of a facility. The manager is also the person who formally gives permission to pass on information to employees and contracted personnel. Managers in the Central North Island, excluding the area where the researcher is employed, were contacted. Managers of both rural and urban care facilities were sent a letter asking if they would agree to distribute an information envelope containing the Information Sheet, Consent Form, Reply Slip and self-addressed stamped envelope to registered health professionals with their fortnightly time sheets. Managers were also to be asked if they could forward the information envelope to the practice address of employees who were on contract and did not complete a fortnightly time sheet. Postage for this was supplied. The study was designed so the researcher would not be aware of who participated and who declined to participate in the research.

A reply slip and self-addressed stamped envelope were provided with the initial letter to the manager. On the reply slip, the managers were asked to indicate if s/he agreed or did not agree to distribute the information envelopes to his/her staff. Managers indicating agreement were contacted by phone to arrange a time to hand over the envelopes. This was also to be an opportunity for the managers to discuss

the process of distribution and query any concerns s/he may have. These managers would then be asked if they would agree to the interviews taking place in the facility, if this was the choice of the participant.

Participation was to be entirely voluntary. Health professionals agreeing to participate were to be asked to return the Reply Slip and Consent Form to the researcher. Contact details for Advocacy Network Services, (ADNET) and Ethics Committees/ Supervisor/Researcher were provided in the Information Sheet. The researcher then planned to contact the potential participant to arrange an interview time and place convenient for both the participant and the researcher. The cultural needs of the participant were addressed when an appointment was made. For instance, the participant was able to choose the place for the interview and arrangements could be made for the participant to have support people present. Other cultural aspects were taken into account, generally related to code of conduct for communication and courtesy

Data were to be gathered by semi-structured interviews which would be audio-taped with the participants' consent and transcribed. Interview tapes were offered to the participants. If declined, the tapes were to be kept in a secure place for 10 years. Taped interviews were transcribed and stored separately from each other. Prior to commencement of the interviews, participants would have an opportunity to ask questions about the research. Written consent was to be obtained before every interview. At the beginning of each interview, the validity of the consent was to be checked and the researcher explained that the participant could discontinue the interview at any time. It was to be arranged that if participants indicated distress during the interview, the interview would be discontinued and

further participation would be at the discretion of the participant. There were no anticipated benefits or risks to the participants. Interviews were to be concluded with the researcher's thanking the participants for their willingness to contribute to the research.

Sharing research results

Preliminary findings were presented at a Research Symposium of the New Zealand Institute for Research on Ageing, (NZiRA), on October 2003. This was a symposium for emerging researchers. The preliminary findings were also presented at New Zealand Gerontology Association conference in April 2004. Information has also shared with colleagues and with fellow-students at research and study days. A summary of the research will be submitted to *Residential Care New Zealand*, the New Zealand Nurses Organisation and/or the College of Nurses Aotearoa (NZ). The final results will be disseminated by publications or conference proceedings as opportunities arise.

Funding

Scholarship applications were forwarded to Massey Graduate Fund and MidCentral Health, and both grants were approved. The MidCentral Health grant will be redeemable on completion of the research. Costs for this research were covered by the researcher, who was partly reimbursed by the previously mentioned scholarships.

Interview questions

Qualitative studies usually employ structured or semi-structured interviews, organised around areas of particular interest. Semi-structured interviews may have a combination of open-ended and closed questions, (Minichiello, Sullivan, Greenwood, & Axford, 1999). Because interviews by inexperienced researchers at the beginning of the research are likely to be more unstructured, with the skill of structuring developing as the researcher becomes more skilled, (May, cited in Morse, 1991), it was decided to use a semi-structured interview format. This had the additional advantage of ensuring consistency while interviewing a range of health professionals, and ensuring that all questions were covered in the time available. The disadvantage of using a semi-structured format is that it reduces the range of information obtainable.

The primary purpose of the semi-structured interview questions (Appendix 5), was to gain data that could be transcribed. The questions were customised so that the answers relate to the various reasons, processes and systems for which health professionals assess older adults and how this translates into a care plan. A follow up question was used when the answer was not entirely clear or could be construed in more than one way.

Example of the Interview questions

Exploring registered health professionals' assessment of older adults in care facilities.

Check if consent is understood and if consent to recording still applies. Ask if there are any questions or queries.

1. I understand that you are a health professional associated with a care facility, and in that capacity, are part of a multidisciplinary team. It is not unusual for health professionals to gain expertise through varied work experiences and education. In a few sentences, could you describe your work experience and professional education?

2. One of the characteristics of a multidisciplinary approach is that team members bring their own professional outlooks and thoughts to the team.

   -How would describe your specific contribution to the assessment process?

   -How is your focus different from those of other health professionals in the team?

3. I would like to discuss the assessment process a little further, particularly when your expertise is required to assess a resident.

   -How and when do you become involved in an assessment?

   -Could you describe what you include in an assessment of an older adult?

4. Older adults reside in care facilities because they require care and support with their daily living activities. Your assessment is an important factor in their care and support.

   -How do you inform others of your assessment findings?

   -How do you think you influence a resident's plan for care?

5. An older adult who is under the care of a multidisciplinary team may have more than one assessment. Different members of the team complete these assessments.

   -What do you consider are the strengths and weaknesses of such an assessment approach?

6. Multidisciplinary teams may at times have other health professionals who join the team. An orientation day could be one way of introducing new staff members. If you were asked to contribute to an orientation day and your topic would be 'assessment'.

   -How would you define the assessment process in the context of older adults in care facilities?

The questions proved to provide a range of unexpected information. They yielded information about registered health professionals' understanding of assessment and care planning in relation to:

- planning and delivering care to an older adult,
- providing instructions to others about the care they are required to deliver to the older adult,
- contractual and audit requirements.

Following constitute the rationale for the questions:

- Question one was designed to encourage the participant to feel at ease and provide an opportunity for him/her to express his/her feelings about his/her career and profession. The question yielded useful biographical

information. The question helped to explore the possible links between experience, education and health professionals' assessment. The literature indicates that there is a clear link between the level of education and the quality of assessments and care planning, (Kane & Kane, 2000). There is also the general perception that health professionals in aged care do not have the same high level of education as other health professionals.

- Question two explores health professionals' contribution to the assessment process from a multidisciplinary team perspective. The literature suggests that a multidisciplinary approach to assessment is beneficial, however, health professionals in multidisciplinary teams do not always have a common language or an understanding of other professionals' knowledge base (Foote & Stanners, 2002).

- Question three asks the participant to elaborate on the assessment process at greater depth, exploring how the participant becomes involved in the assessment process. What health professionals include in the actual assessment was explored in this question. The literature shows evidence of those domains in which it is important for older adults to be assessed and what to include to make an assessment appropriate (Jarvis, 2000; NZ Guidelines Group, 2003). The timing of assessment yields information about the practical knowledge related to the contractual and audit requirements.

- Question four inquires how others were informed about the assessment findings and how the health professional influenced the plan for care. The literature suggests that there is duplication in documentation and that the actual care plan does not always directly relate to the findings (Kane &

Kane, 2000). This question yields data about information sharing and utilising assessment outcomes to plan care.

- Question five relates to the multidisciplinary team approach, looking at the perceived strength and weaknesses of a multidisciplinary team approach to assessment. Multidisciplinary assessments are the hallmark of contractual and best practice guidelines. The literature indicates that assessment by multidisciplinary teams can be beneficial for the older person, but can also be cumbersome and lengthy (NZ Guidelines Group, 2003).

- Question six asked the participants to explain and define the assessment process for other health professional joining their team. Exploring the context of older adults residing in a care facility provided insight into the understanding of health professionals' assessment and how this may differ when related to older people who reside in facilities. The literature illustrates that older people in care facilities have a multitude of health concerns, are often frail and not always encouraged to participate in their care decisions, (Kane & Kane, 2000). This question yields responses of how assessments in facilities would be approached.

Actual process of research

Because of the size of the population of New Zealand health professionals working in care facilities, and those with an interest in care for older adults, tend to have a close professional network. These health professionals often meet or hear about each other at conferences, workshops and through professional networks. Involvement in national and international professional activities is part of professional and personal development. The knowledge base and networks within the New Zealand health care setting are of such a nature that few degrees of separation exist. The researcher acknowledges that it is difficult in this sphere to be completely anonymous. Although participants' confidentiality was paramount, anonymity may at times have been inadvertently compromised by participants or managers. Confidentiality, however, was always maintained by the researcher.

In the period between May 2002 and July 2002, a total of 13 managers of care facilities were approached. Of these, only 2 managers agreed to distribute envelopes. These managers were helpful and had a positive approach towards research. They were also aware that they would have no knowledge of which staff member would participate, unless the staff member chose to disclose this information to the manager. There was an initial return of 8 participants. To obtain additional participants, another 13 managers were approached between July and November 2002. This time, 5 managers agreed to distribute envelopes, resulting in another 6 participants. This made a total for 14 participants. Participants agreeing to be interviewed for this research project included two physiotherapists, a dietitian, a general practitioner, and ten registered nurses. All participants were associated with care facilities. Four participants had their own practices and were contracted to care facilities, the other participants were employed by the facility.

Some managers assumed a gatekeeper's position. On one occasion the researcher had an uncomfortable reception, and on enquiry found that one manager had decided not to distribute the envelopes. One other manager notified staff in a newsletter of the intention of approaching participants before the researcher was able to hand out the Information Sheets. In one instance the researcher discovered on arriving for the initial appointment, that the manager wanted staff to be interviewed as a group. As the researcher did not identify this as the agreed process, this opportunity was declined. One manager had the view that only the registered nurses are health professionals. Two managers did express surprise about the complexity of the research process and/or the researcher's inability to tailor the process to the manager's personal views. Some managers omitted to forward envelopes to doctors, nurses and physiotherapist, deciding that they were too busy to participate. One manager had a different understanding of the research and indicated that the sole registered nurse in charge was not available, but did not indicate why the information was not forwarded to other health professionals. One manager indicated that the registered nurse was solely in charge and that the care facility actually does not work with other health professionals. Managers from rural facilities appear to have been less keen to approach staff. Time constraint was frequently mentioned as a reason for this.

All managers who agreed to participation by their staff in the research agreed to have interviews at their facility. In instances where the participant preferred to be interviewed at the facility, arrangements were made with the contact person of the facility. Once participants returned the consent form to the researcher, they were contacted to set a date and time for an interview. Interviews were planned to be one hour in length, and conducted outside working hours.

The actual progression of the study proved to be an unexpected but interesting process that placed a number of unanticipated constraints on the research. Of particular concern were the imbalance between the number of general practitioners, allied health professionals and registered nurses and the lack of allied health professionals from other disciplines. Time pressure proved to be considerably more than originally anticipated because of unexpected work and personal commitments. At one stage, consideration was given to abandoning the study, but it was felt that because this is an exploratory pilot study, it was worthwhile to continue with the research.

Chapter Four

Findings and Participants' responses

Following are the clusters of responses that indicated how themes evolved. The themes directly relate to assessment for the planning and delivery of care, the instructions based on the assessment that are required to deliver the care and the assessments required to comply with contractual and audit requirements.

Transcribing the interviews

After each interview, brief field notes were made to record ideas and views. During the return travel, the researcher replayed the interview on a cassette. Answers to a single question were combined in a single list. The transcripts were read and re-read until themes and subthemes emerged.

Interview findings

In this chapter the findings from the transcribed interviews are addressed. Excerpts from the transcripts are used to illustrate significant remarks. Significant quotations are mentioned and shown in square brackets [ ]. The letters identifying the quotations are systematically chosen by linking numbers to letters. These are not the participant's initials. The themes evolving from the responses will be identified at the completion of each section and further explored in the Discussion chapter. Some participants chose not to reply directly to the questions asked, but made general statements or comments. These supplementary comments are reported on in a section after question six.

Fourteen participants were interviewed in the period between June and November 2002. All interviews were audio-taped. The average duration of the interviews was 43 minutes with the shortest interview being 20 minutes and the longest interview 58 minutes. (The shortest interview was brief because of the unexpected work commitments of the participant. An offer from the researcher, to cancel or re-schedule the interview was declined.) Nine interviews took place in facilities, one at the participant's home, and three at the participant's practice address. One participant opted to be interviewed at a public library. Two participants did not attend their initial appointments and alternative arrangements were made for another interview time. Two participants had prepared for the interview by means of reading articles related to assessment. Evidence of this, in the form of articles and books was present during the interview. Three interviews were interrupted - by the intercom systems - the CEO, and maintenance personnel respectively.

Question One

Answers to this question confirmed that all participants were associated with a care facility and participants were asked to elaborate on work experience and professional qualifications. This question was designed to provide biographical data, which could provide information on how the participants' experience is related to assessment and care planning and if the participants' education influences their understanding of assessment and care planning.

Ten participants were employed by a care facility, 4 participants were contracted by the care facility. Participants were employed full-time or part-time at care facilities. Contracted participants appear to have flexible arrangements as to their actual attendance at the care facility;

[That is an elderly care facility in ..... I visit every day. OI]

[I just go one day a week. RO]

[From once a month to once a week. Rest homes are really only wanting to employ me for minimal hours. HA]

[I am not here on a daily basis. OU]

13 Participants reported themselves as being part of a multidisciplinary team. The remaining participant saw herself as being in sole charge

All participants referred to experience as length of time worked in health care. This varied from 4 decades to nine months. Experience could be in any health care setting, not necessarily in Aged Care facilities. The time worked in Aged Care facilities varied from seven years to three months. Areas where participants had previously worked included[8] Medical and Allied Health practices, District Nursing, Education/Tutoring, ICU, Midwifery, Surgical, Orthopaedic and Medical public hospital wards, Continuing Care Units, A & E, Oncology, and casual and agency work. In a number of these situations, the participants came in contact with older people.

These are broad areas in which participants gained skills in and some participants related this wide variety to their current work, indicating transferable skills for assessment;

[Because of the work I was doing...A&E.. assessment was something I was really interested in. SV]

[I have a wide range in experience I draw on. OU]

[8] Areas of employment are mentioned in general terms and are clustered, to avoid identification of the participants.

[My knowledge as E/N was invaluable. EU]

Three participants had the perception that working in care facilities is easier than working in hospitals;

[I found it easier to go back in here, not a lot has changed. OA]
[I think I decided to work in care facilities because I have been out of the main stream public sector so long. EL]
[It is straightforward here, compared to hospitals. SV]

Working in hospitals was seen by two participants to be more attractive;

[I thought it would be really cool to work in hospitals. HO]
[I would like to go back to hospital. IH]

A yearning to work in other areas was at times evident;

[I would like to go back to midwifery. OA]

Ten participants said they purposely chose to work in care facilities because they enjoyed working with older people;

[It is my field of interest, you get to look after these people for a long time. AE]
[I am lucky, I enjoy what I do. EU]
[People who need caring, I have that feeling in my heart. FI]

One participant also mentioned that s/he felt s/he was a role-model to encourage others to work with older people;

> [I hope that, by my example, students may develop an interest in giving good care to elderly people. EL]

There was no consistent relation seen between experience, education and the senior position held;

> [I applied for the RN position and got the charge nurse job, yes, it is my first job since being an RN, ...a new grad really. HO]

Participants could change employment positions in care facilities, seemingly without specific education or experience for the position;

> [I did my training years ago, nursed in private and public, in ICU, A&E, and moved to education in Aged Care nine months ago. SV]

All participants referred to their education. They reported that they felt they were generally well educated; Professional qualifications of participants included: Enrolled Nurse bridged to Registered Nurse, Comprehensive Nurse, Diploma of Nursing, Bachelor of Nursing, Midwifery Diploma, Physiotherapy Diploma, Bachelor of Medicine, Diploma in Dietetics.

One participant mentioned that attendance at conferences was an excellent form of education and networking;

> [It is good to network at conference, you learn a lot. UN]

Only a small number of participants had completed specific Aged Care-related courses, for example a gerontology course and a dementia course[9]. Although it can be assumed that health professionals' initial education would have elements of assessment, none of the participants had attended an assessment course specific to the assessment of older people.

Knowledge in care for older adults was frequently self-taught;

> [I didn't do any specific geriatric or elderly service specific training...it is mostly self-taught, from working as a (---).RO]
> [Regarding older people in facilities, self-based study. HA]

One participant identified limits in his/her own knowledge and sought additional knowledge through colleagues and the library;

> [..looking for guidance from people with experience...having support people, literature, ...I know my limitations. HA]

Registered nurse participants who had previously been enrolled nurses felt they had good nursing skills when employed as enrolled nurses. This was an incentive to bridge to become a registered nurse;

> [...as E/N, I was responsible for the day-to-day running of the unit. EU]
> [Polytech nurses were just coming out, and I had to educate them, they didn't know a lot of things. They got all the glory, I did all the work, I might as well do the course, HO]

[9] Some information has been altered slightly to protect participants' anonymity.

[I applied for a hospital position but was not accepted, I was an enrolled new grad, not the same as the young new grads. HO]

Registered nurse participants educated in hospital-based programmes related to this with a certain fondness and pride;

[Traditional, old-fashioned education, we had some excellent role models. EL]

[I did general nursing, good old school. OA]

Nurse participants educated by non hospital-based programmes did not relate to their educational institution in the same way. There is also the perception that new graduate nurses are not educated in assessment skills;

[Some nurses are experienced and others are inexperienced...that is a developing trend which is quite a concern for us.. the older experienced nurse is getting few and far between... new grads coming out, can't get a job in hospitals and choose to work in rest homes...when they come out of Tech, they are not good at assessment because they never really learned it...that is a worry. RO]

One registered nurse worked with new graduate nurses to improve their knowledge of assessment:

[They are learning about assessment. I have found that working from top to toe is a way to get them to look at all aspects. SV]

Addressing the skill mix in care facilities was considered a challenge. Participants related skill mix to education, communication and funding issues. Working with care assistants was considered a challenge by most participants. Two participants mentioned the differences in levels of training for care assistants and that the care planning required adjustment to ensure understanding of care;

> [with care givers, you notice they haven't had training.. you have to plan your care accordingly. AH].
> [Some others, like caregivers, might not understand. UE]

The wages for care assistants were mentioned as a reason for attracting staff that may not be suitably qualified or experienced;

> [They are lousy paid, we do not have the number of people, they can't hire them, they are not around, there is very few qualified staff. OU]
> [Care assistants work for low wages, SV]

Two participants noted that Aged Care was not seen by funding authorities in the same light as other types of health care;

> [We are the Cinderella of all the health services, SV]

There is an indication that care is linked to education and attracting qualified staff;

> [...residents' acuity levels have increased and attracting good qualified staff is a huge issue. Politicians could increase the funding to increase the knowledge base of people working in elder care. SV]

All participants were associated with care facilities. Those participants who appear to have the most contact with residents and would consequently do the initial and ongoing assessments are the registered nurses, who are employed by a care facility. The allied health staff is contracted by a care facility and assesses residents as consultants.

Relating the participants' responses to assessment and care planning, all the subthemes have elements of fragmentation. Although health professionals saw themselves as well educated and experienced, this is in a broader sense rather than Aged Care specific. Because the experiences and education come from such a diverse background, it can be expected that each health professional has his/her own interpretation of assessments. The likelihood of differences in the understanding in assessments is further linked to the lack of formal education of assessment of older adults. Aged Care is seen as a less attractive discipline to work in, this is reflected in the wages and the fact that qualified staff are not readily available. It appears that health professionals are employed in positions without Aged Care specific education.

The main points that arise from the answers to question one are;

- Differences in attendance for assessment by employed staff and contracted staff.
- Health Professionals in Aged Care see themselves as being educated.
- Health Professionals in Aged Care generally have broad work experiences.
- No specific Age Care related assessment courses were attended.
- The skill mix of staff hinders consistency of assessment.
- Qualified staff are difficult to attract.

The underlying subtheme that emerges is that there are significant human resource issues in the Aged Care sector.

Question Two

Question two explores health professionals' specific contribution to the multidisciplinary team assessment process and explores how this is different from those of other members of the multidisciplinary team.

Two participants felt their specific contribution was the length of service:

> [The length of experience that I've had and building upon experience after experience. SV]
> [The fact that I have done this for many years. EL]

Life experience in a broader sense was mentioned by two participants as a contributing factor:

> [Life experience does contribute. H.O]
> [.. it's the years of life experience. SV]

Two participants indicated that their contribution was related to their specific discipline;

> [My role is the medical supervision or medical overview of the person's health. RO]

[Basically because I think, as a nurse, I have more understanding of the behaviour of the resident. UE]

One nurse participants noted that her contribution was a co-ordinating role;

[I try to bring all the facets of care to the meeting about that particular resident that they are talking about. UN]

One participant had a very specific understanding of his/her role;

[It is a legal requirement that I put a system in place, my task is educating the staff. OU].

Frustration with the focus of other team members also emerged;

[Some others might not understand. UE].
[For nurses I know having a social worker included in the team can be quite difficult...Nurses feel social workers don't have the link. SV].
[Nursing staff do a wonderful job, but they have their personal ideas in certain situations, so you have to be aware. HA].
[What they need, from my point of view, is not always acted upon. OA].
[In my experience, they don't see the point, they don't have the experience. OU].

Two allied health participants indicated they have a consistent physical focus in their assessment:

[A physical, I establish a diagnosis RO]

[So really it is the physical aspect that we take. OI]

Five nurse participants clearly expressed their perception that they have a more holistic focus;

[I have more understanding of the behaviour of the resident. EU]
[Look at the whole person. SV]
[Looking at the whole person, we look at the bigger picture. AH]
[A full assessment has become a nursing thing rather than a doctor thing. Doctors are diagnosis driven, nurses look at everything. AO]
[Nurses dabble a bit in everything, we are more comprehensive. HO]

However, while the holistic approach is emphasised by some nurse participants, there may be an initial focus on physical assessment;

[My focus is very much holistic. I try a blood pressure first, try to change position, try to get a response. AE]

Three nurse participants indicated that their focus was different because they work intuitively when assessing residents;

[I follow my gut feeling. UE]
[I always go with my gut instinct, I mostly have been right. HO]
[A lot of time nursing staff don't realise they are doing it (assessment) in daily practice...I think it is a skill you learn by watching, listening, life experience. EL].

Allied health participants did not say that assessment has an intuitive aspect. Availability determined some of the work undertaken by registered nurses;

> [We do the day-to-day things, other members of the team don't have that. HO]

Some participants tailored their focus to a medical diagnosis;

> [According to the diagnosis as seen by the doctor. FI]
> [The doctor does an assessment, that indicates the care. IH]

One nurse participant mentioned that they benefit from contact with medical staff, almost as if to aspire to that model;

> [I enjoy having the pharmacist...to hear the discussion between the pharmacist and the doctor. EL]

Night care is an important focus for the registered nursing staff;

> [At night I have to assess the building and staff as well. AE]
> [Assessment focus at night is different, you don't see them up. The basis is the same, you all want a full assessment. HO]
> [We pick up on the subtle things other people might not see. AE]

Time constraint was perceived as infringing on the daily work schedule of the staff. Time constraints were mentioned in relation to care and support staff. The team approach seems to suffer from time constraints;

[The one that I come across is "we don't have time", it happens quite a lot that you can not see certain people because they are not ready, that is lack of staff. OU]
[Sometimes it can just take time. HA]

One allied health professional directly mentioned care as a focus;

[So from my viewpoint, I am interested at achieving the best care for the patient, I am not so focused on the cost, but I would be influenced by management, if they would be concerned about the cost. RO]

Registered health professionals seem to view assessment only from their particular discipline. Nurse participants noted that they bring all aspects of care together, while allied health staff are specific about having initially a physical focus. Nurses have the perception that they have a holistic focus, with a broader perspective than other health professionals. Participants gave the impression that there was a lack of understanding of how teams operate and what the specific focus of other disciplines is.

The main points that arise from the answers to question two are ;

- There are two distinct viewpoints: that of the registered nurses and that of the allied health professionals.
- Allied health professionals have a physical focus.
- Registered nurses see themselves as having a holistic and intuitive focus.
- Experience is related to time served

The underlying subthemes that emerge are ;

- The focus of contracted employees is on the physical aspects.
- The focus is on one's own discipline and the contribution is discipline specific.

Question Three

This question explores Health Professionals' involvement in assessment.

The timing of a Health Professional's involvement in assessment is varied;

> [I go one day a week, and we troubleshoot anything. RO].
> [Multidisciplinary meeting at 11 a.m. HO].
> [When a staff member has an inkling that something is not right. SV].
> [……..on admission, and three-monthly. EL].
> […..there is a schedule, no one falls through the gaps. EL]

Assessment was seen as being instigated by verbal request, notes, diaries or by phone/fax.;

> [We have a referral system. HA]
> [They leave a note on my desk. OI]
> [We have a task list to tell you. FI]
> [If a caregiver came to me and said. AE]

[Often on the telephone or fax. EL]

Three participants viewed assessments from health professionals outside the care facility as useful;

[When they come in with a hospital assessment, that is so helpful. R.O]
[The NASC assessment is a good guide to what is wrong, they know what they are doing. EL]
[Well, if a patient was sent from public hospital, I have received the whole assessment, care, summary, and I would follow from what they say. FI]

The admission and 3-monthly assessments were guided by forms, either with open spaces or tick boxes for prompts;

[I have my favourite tool, literally starting at the head and going right to the toes. SV]
[I check the assessment forms from the multidisciplinary team. RO]
[It is an assessment package, it is like a head to toe check. AE]
[We check on the form if all is covered. OI]
[The resident is assessed on admission and we go through the process of all the forms. AE].

Three participants note that assessment is ongoing, requiring time;

[Not something you can do in five minutes. IH]
[You always do assessment, it is ongoing. UN]
[Assessment is ongoing. SV]

Participants were also assessing residents at other times, and are alerted to do an assessment in different ways;

> [The RN would go back and re-assess if warranted. AH]
> [At night, you look for different things. HO]
> [You observe when you walk behind them. EL]

Assessment was often seen as information gathered from others;

> [The caregivers will tell you. AE]
> [I will ask the nurses. RO]
> [The caregivers can give you good information. OU]
> [I would listen to the nursing staff. AH]
> [Care assistants are very good at passing on things, you pass that knowledge on too, HO]

The content of assessment often related to the main diagnosis. Some participants indicated that they did assessments rather instinctively as well as at predetermined intervals. For instance, assessment was when they looked at a resident and, in passing, noticed that 'something was different'. However, assessment was generally seen as a formal structure, as a 3-monthly multidisciplinary assessment.

Assessment after an event, (e.g. stroke) in some cases was determined by verbal or written referrals, not by a physical examination of the resident;

> [According to diagnosis as seen by the doctor. FI]
> [Personal details, history, mental assessment, we find out the likes and dislikes. AH]

[All aspects, mental, social state, medical review, not in any specific order, maybe alphabetical. EL]

Participants included the following into their assessment;

Blood pressure, general condition, personal details, date of birth, abilities for hygiene care, sleep patterns, appetite, bowel and bladder function, ears and eyes.

[B/P, pulse, temp. SV]
[All the vital signs. EL]
[Blood pressure and pulse. AE]

Five nurse participants noted that observation is related to an assessment;

[Our eyes, noses, you observe, use your senses. UE]
[You look and listen, observe. OU]
[Sometimes it is obvious, because I think nurses are very observant...identify quickly that they are having difficulties with this. HO]
[Observe urine samples, pain and so on. IH]
[What you see may not be correct, you need to investigate. EL]

On the other hand, three participants mentioned that assessment was systematic;

[We do a head to toe assessment, we do it systematic, so things don't get missed. HO]
[From head to toe. EU]
[You need an objective, a subjective and then analyse and plan. OI]

Assessment tools are mentioned as guides. Only three specific assessment tools were mentioned, these related to falls, pressure area and mental state;

> [The examination is directed towards the symptoms. RO]

Some assessment tools are tailor made;

> [The fact that there is no specific tool which will work for everybody, you have to alter your thinking, your way of assessing for every individual. SV]
> [I made that, with a bit of help from different forms, how efficient is that? UN]

> [A package with 16 categories, everything is there. AE]

Two participants mentioned assessment as the gathering of information from a variety of sources;

> [I do an investigation, look at notes, biochemical indicators. HA]
> [I go through the files, it doesn't stop with the person. SV]

Not having information available was not seen by one participant as a barrier to providing safe care;

> [If we don't have the information, if we don't know the answer, we go for the safety option, resident safety. EL]

Two allied health professionals include other staff members in their assessment, at times relying on their observations;

> [I would listen to the client, listen to the nursing staff, I build up a rapport, making sure the person and the team are involved. HA]
> [I will ask the nurse. OI]

Assessments from teams in other health care facilities are generally considered an advantage. It is unclear how residents' own goals, wishes or choices in relation to assessment are considered. Although nurses differentiate that they see the complete picture, particular interest is focused on medical diagnosis.

The main points to arise from the answers to question three are;

- Involvement in assessment is via a number of channels.
- Assessment may be linked to the time frames stipulated in the contract.
- Assessment is systematic for allied health professionals and to some extent for registered nurse participants.
- Assessment may be based on information provided by nonclinical staff or care assistants
- Assessment tools are not consistently used.

The subthemes that emerge are ;

- Assessment is initiated by a variety of channels and events.
- There is not a single approach to doing an assessment.

Question Four

This question links to the planning of care, enquiring how health professionals inform others about their findings and how they influence the plan for care.

Two participants emphasise the role assessment has in the planning of care;

> [Assessment covers a huge amount, and that is what we base our care on. SV]
> [Assessment is the basis, after the care planning you need an evaluation. FI]

Information is shared in writing and verbally. Information can be commands, instructions or explanations to a variety of people;

> [We share information, verbally and written, the doctor knows what the nursing problems are, the caregiver knows what the medical problems are. EL]
> [..usually phoning and writing in the notes as well.. RO]
> [You write this big spiel in their progress notes. EA]
> [Personally would go to the charge nurse to make her aware. I tell the one who is...who is the person who is there all the time. SV
> [I tell the one who is...who is the person who is there all the time. OU]
> [Yes it is the full thing, in their notes, the care plan, and the diary that's in the wings and I tell the RN. HO]

Two allied health participants noted that not all Aged Care facilities have the same systems for informing others;

> [Different homes, different situations, you have to know the facility, to know who is responsible for what, then you communicate, talk, write. HA]
> [It is different in each place, I go to the staff nurse. OI]

Nurse participants note that allied health professionals have their own system of informing others. This does not include the ongoing care plan or progress notes;

> [Anyone could write on here, but you never can get a doctor to write, they write in the doctor's, the physiotherapy notes, they don't. UN]
> [The OT writes on green paper. AE]
> [The allied staff has blue notes. FI]

Obtaining information is at times viewed as cumbersome;

> [Hopefully they come with a referral. AE]
> [Not all information is with them. EU]
> [We have to wait for the faxes. SV]
> [It takes a long time before the papers have gone past everyone. EL]
> [They are not always here on the admission day, so you wait. FI]

Others attempt to make the information user friendly, recognising the skill mixed and abilities of others that take part in the care of the resident;

[I usually get a telephone call, or written in the diary. I make sure that information is available and put it into a format so that they can find and use it. HA]

[I communicate verbally a lot. RO]

[Because we have so many caregivers as such, documentation must be kept very simple. SV]

One participant deliberately withheld information to avoid hierarchal discipline issues;

[I find that the night duty nurse doesn't get listened to. You better not say too much of what you are doing. I am responsible for my duty. OA]

Participants indicated that the care plan is based on assessment; registered nurses influence the plan because they write the plan;

[That comes together through us, we write the plan, sometimes we refer to bits of it. At times I get the physio to write, but usually we do it, all information gets channelled through us. AE]

[We write it all. FI]

[We are there all the time, we make the plan. OU]

[If they (GP, physiotherapist) are involved and write a report, I translate it into here. UN]

[We write in the Care Plan, report it verbally, and in the communication book. FI]

Nurse participants translated the instruction of others into a care plan that is less cumbersome to read;

[I translate what they write. EL]

[I know they are a pain, all the paperwork. Some of the language is not user friendly, I have corrected that, I removed all the 'Latinish terms'. EU]

[We have to write it simple, change the words to make it understandable. SV]

Nurse participants tailor the care plan for use by the care assistants;

[...with care givers, you notice they haven't had training.. you have to plan your care accordingly. AH]

[Care givers may not understand, you have to be clear in the plan. SV]

Frustration is also evident and the significance of care instructions is not always shared;

[Sometimes I just say 'Just do as I say", they don't have the background and therefore can not understand why I say what I say. OU]

[It will all be in the Care Plan. ...If they bother to read it. AE]

All participants were aware of the legal aspects of maintaining documentation;

[Get all legal documentation done. The assessment would be photocopied for each department. EU]

[You have to write. RO]

[The legal aspect, make sure you write it all. EU.]

In many instances, documentation was in a variety of places;

[Write in the notes. HO]

[You have to go through the diaries and notes make sure it has happened. AE]

[Residents' notes are at the meeting, we leave messages in the book. EL]

[We have special forms for care. FI]

[In the communication book and hand-over sheet. UN]

[It goes in their care management record. AH.]

[A communication book down here, all is in there. OI]

Duplication is mentioned by 2 participants;

[There is lots of doubling up, it's quite a lot of writing... it is quite a bit of a burden actually. RO]

[We write it in many places, handover sheet, notes, communication book, all information is passed on. SV]

Participants informed others through the assessment forms, verbally, by phone, writing in a diary, progress notes, handover notes in different sections of the resident folder, photocopies, in care plans, by photocopy, phone, verbal, on forms, use specific sheets and on an alert board. Participants also indicated that they influenced the care plan by looking at information from all sources and providing information to all. Allied health professionals tend to talk to nurses and give nurses very specific care instructions. Some participants indicated that there was a concern about influencing the care plan, as their notes were usually in the back of the residents' notes and the care plan was often very general. Registered nurses tend to be confident that they influence the plan, as they set up the care plan. Registered nurses are also conscious that there is an expectation that the caregivers

read the plan, and therefore they need to leave the instructions clear, precise and will often talk to the caregivers.

The main points that emerge from answers to this question are;

- Only registered nurses see themselves as responsible for the Care Plan.
- Registered nurses are gatekeepers of information.
- Allied health professionals prefer to use their own assessment section.
- Information sharing is ad hoc, whether verbal or written.
- Documentation related to the assessment is kept in a number of places.
- Registered nurses tailor the language of the care plan to the needs of care assistants.

The subthemes emerging are;

- There is a single discipline approach to planning care.
- There are no formal processes for sharing information.

Question Five

Older adults in care facilities are assessed by health professionals from a multidisciplinary team. This question enquires how health professionals consider the strengths and weaknesses of such an assessment approach.

The majority of participants viewed the multidisciplinary approach to assessment of an older adult, as a strength. Particularly, sharing knowledge was mentioned as an important strength. The team meetings are seen as an educational opportunity;

> [I respect all the other assessments made by anyone in the team. AE]
> [It depends on how you utilise team members. SV]
> [Good strengths, because the different areas look at different things. IH]
> [I think it is a really good approach, because you get, I mean, many heads are better than one. AE]
> [I can't really see any weak point, you always learn. OU]
> [I am used to working in teams, I really enjoy it, to interact with others, you look at the client and the staff. OI]

Two allied health professionals viewed teams in a wider context, and viewed the interaction of others with clients as an integral part ;

> [I work with two teams, support and nursing, the support services are answerable to the budget people, a different group from the clinical people. Sometimes the request from the clinical staff is beyond what is practical and feasible for the support staff. HA]

[It is good to get different people's opinion, but it varies according to their own levels of knowledge and skill and experience. I work in more than one team. RO]

Most participants noted that strengths of the multidisciplinary approach included that more people's see different things, ensuring less likelihood of older people falling through the gaps ;

[Good strengths, it is good to get other people's opinion. RO]
[Many heads are better than one. AE]
[I don't think there are any weaknesses. IH]
[This is a way of preventing them falling through the gaps. UN]

Two participants indicated that the strength of this assessment approach depends on the knowledge of the team members;

[It varies according to their own levels of knowledge. RO]
[Each person will have their skilled area that they will assess. EL]

Four participants noted that the dynamics of a multidisciplinary team also varied, with different composition of the team ;

[GP, Team leader, OT, Physio, Pharmacist, Charge nurse, Family members, anyone else who wants to be involved. HO]
[Student, CEO, kitchen staff, anyone really, EL]
[All who are interested, cook, nurses, doctors, everyone. UN]
[That depends on who is available, usually we make sure the doctor and the nurse is there. OA]

Resources were linked to the multidisciplinary team meetings, indicating that this could be very costly;

> [I would be led by the cost...for the facility. RO]
> [We can only have the meeting once a month, it costs too much to have everyone in all the time. EL]
> [Care facilities can not afford to have contracted for more than once a month. HA]

Multidisciplinary reviews were not necessarily face-to-face meeting. It could be that a form was distributed where everyone could contribute, this was later discussed with the GP, the registered nurse and some others;

> [The form goes to everyone to fill out. EL]
> [Once the forms are back, and everyone has written their part, I collect it all and we look at it. UN]
> [Sometimes I just meet with the nurse. RO]
> [I always let the nurse know, I don't necessarily see the others. HA]

One participant noted that at times the residents were unaware that they were assessed, and this appeared to be an advantage;

> [The team works really well, the residents are not even aware they are assessed, EL]

There appear to be layers of teams, the core team consists of the nurse, GP, physiotherapist and sometimes family. Additional health professionals are called upon when required by this group ;

> [If the person is having a problem, I call in a psycho-geriatrician, that is one step above me. RO]
> [Any other professional services are invited when necessary. UE]
> [The residents visit the doctor every three months, not all health professionals come I and assess. UN]

Three participants mentioned that, at times, other teams enter the equation ;

> [Most patients have gone through the public system, are assessed by the geriatric assessment unit, that is a great help. RO]
> [If they were in hospital you get a nursing and a medical referral about what is normal for this person. EA]
> [The assessments team from the hospital comes in and assesses. FI]

The presence of administrative management personnel in relation to assessment was mentioned by three participants ;

> [If the students are there, they attend the meeting, sometimes the CEO, or just observers. I can't really see any weak points. EL]
> [Some of these meetings are fantastic, a wonderful way of learning. HA]
> [I will discuss this with management at the meeting. RO]

Similar assessments and overlapping of assessments were acknowledged by three participants - but not deemed a concern - and at times overlap was viewed as very positive ;

> [Absolutely, there is overlap, but that is OK as long as we come to the same conclusion. OU].
> [Sure overlap is valuable, we see things different, we can't get enough information. EU]
> [Some times we overlap, that's OK. RO]

One participant noted weaknesses in terms of disadvantages for the resident, but not to the extent that a different approach was considered;

> [You get all facets of knowledge, GP knowledge. A disadvantage is that a resident is bombarded with a lot of people at once, asking all the same type of questions. I wouldn't like to see that stopped just for that reason. HA]

Three participants suggested that the number of assessments could be daunting for the resident ;

> [There is a lot to go through, they get tired. UN]
> [If it is too much, we stop. OA]
> [They get tired, may not get you the right answers. SV]

Some participants mentioned going back to the resident as part of collecting information, but did not identify multiple questions as a disadvantage for the resident. It was felt that residents' frustration was reduced by pacing the assessment;

[You might have to wait a little, because they are agitated. AE]

[Residents may feel overawed, and say 'No more questions', I go back and might see the person another time. HA]

The multidisciplinary team approach to assessment was seen as positive. The team was an opportunity to exchange ideas and gain more than one perspective. Participants acknowledged that the resident could find the assessment approach too tiresome. Allied health professionals noted a cost factor to this approach.

The main points that are evident from these answers are ;

- Health professionals appear to gain professional confidence from working in teams.
- The composition of the team is varied.
- There is no mention of common terms of reference.
- Allied health professionals view teams in relation to cost.
- Overlap in assessment exists.

The subthemes emerging from this question are related to ;

- No uniform understanding of a multidisciplinary approach to assessment.
- Duplication of assessment has time and cost implications.

Question Six

This question asks the participants to explain assessment of older adults who reside in care facilities. The replies provide insight into how health professionals consider assessments in care facilities. The replies to this question were rather unexpected, as all participants responded to this question differently.

The following are excerpts from participants' replies to what they understand to be the essence of assessment of older adults in care facilities;

> [the difficulty of assessment in the older person is the inability to communicate. SV]

One participant acknowledged the routine task-orientated practices in care facilities ;

> [The mere fact that most organisations have relatively set regimes about cleaners, food, they are all things we need to consider in assessment EL]

One participant focussed on care planning before assessment ;

> [The initial care plan first, AE]

One participant had fixed ideas about residents' co-operation ;

> [In elderly care facilities you may have to do everything yourself, I expect they will not participate. OU]

One participant explained that assessment forms were the guide to information ;

> [The form, it holds a lot of information, current and past. HO]

Assessment was mentioned as an ongoing process by one participant ;

> [Very important, it is an ongoing tool. EU]

The legal aspect of assessment was mentioned ;

> [I would explain the whole assessment, go through the forms, everything is covered, the RN does the assessment, by law. UN]

One participant indicated a systematic approach, guided by tools ;

> [The assessment of surroundings, and head to toe assessment. EU].

Communication was seen as a basis for assessment by another participant ;

> [Talk to people, communicate, OI]

The actual written information was regarded as important by another participant ;

> [I think that going through the notes and showing the needs, falls assessment, going through the paperwork. OA]

A holistic approach was reiterated by one participant ;

[Look at the resident as a whole person. AH]

Assessments from other facilities were considered important ;

[If I had received an assessment from the hospital, I would follow that. FI]

Participants' responses indicated that they did not have a similar understanding of the aspects of assessment of older people in care facilities. There was no congruence in the participants' responses, every person interviewed had a different approach to assessment. This could be because the question was poorly worded, or because health professionals do have different views. The results, however, are congruent with the emerging central theme of fragmentation.

Assessment as the basis for care planning

Assessment as the basis for care planning is required to be accurate in order to deliver appropriate care. Health professionals understand assessment of older adults as a process with many components. A large number of these components are ad hoc, disjointed and not clearly linked or supported by systems that could create continuity for appropriate care. Aged Care-specific assessment education is not readily available. The care planning is based on these assessments performed by health professionals who have no congruent understanding of a multidisciplinary team approach. The differences in focus from the multidisciplinary team health professionals add to the difficulty of creating a coherent plan for care. Fragmentation of processes, systems and practices is

evident from the responses of the participants. All aspects of assessment appear to take place in good faith, however, information sharing, content and care planning are ad hoc. This ad hoc approach is supported by the lack of education regarding assessment for older adults. The multidisciplinary team approach to assessment and care planning appears to be a process that occurs in a parallel fashion. Allied health professionals have different views on assessment from these of registered nurses. Allied health professionals appear to be more aware of the financial implications. Registered nurses felt that they do assessments more from a holistic point of view. Care planning is tailored by the registered nurses. All health professionals rely on their own experience to do assessments and each appears to understand assessment from his/her own discipline's focus.

Supplementary Comments

Supplementary information was not directed at answering a specific question. These remarks were volunteered by the participants and considered by them to relate to the research or be beneficial for the research. Some participant made comments personal to his/her experience.

One participant voiced a political view and was keen to improve staff knowledge ;

> [Elder care is clearly not considered as important by our politicians, or they would be providing more funding to increase the knowledge base of people working in elder care. SV]

Two participants made comments regarding being admitted to care facilities;

> [Older people come to rest homes and private rest hospital facilities after having fallen ill and gone through the public hospital system, they are frailer now. RO]
> [They are much sicker now than years ago, luckily we can help. HA]

One participant was positive about her long-standing career ;

> [I have enjoyed all my nursing...I don't think there are any years in my nursing that I haven't enjoyed working. EL]

One allied health participant recommended a more innovative approach promoting individualised care ;

> [I think we can always be innovative in rest homes and I don't think that we do that enough, we can do things differently, we can individualise and ensure that people have what they need. HA]

One participant expressed a great affiliation with Older Adults in Care facilities ;

> [You give more of yourself in a facility. The rest home setting is their home and it is really important that you never forget that. OI].

Another participant acknowledged the challenges, but remained positive about finding solutions:

[Care in a facility, with skill mix of staff, I find it difficult sometimes dealing with that aspect of how to deliver care, we have to keep improving this. AH]

The participants did not have similar views or supplementary comments. Participant appeared to use the opportunity offered by the interviewer to mention those aspects of assessment, care and older adults that they felt passionate about. It was inspiring to note that despite participants' being aware of the challenges that impact on the aged care sector, they remain passionate about working with older people and want to work towards providing better care for them.

Chapter Five

Discussion

The overriding theme that emerges from this explorative research is fragmentation. Given that this was also mentioned in the international literature discussed in the literature chapter, this was not an unexpected finding.

Although health professionals in this study had broad work experience and felt they were well educated, this education was not always Aged Care specific. Only a few participants had only aged care-related education. Knowledge and information about older adults was often self-taught, indicating a willingness by some health professionals to ensure that they have up-to-date knowledge. The risk in this is, however, that the appropriateness and suitability of this self-education can not be guaranteed. It cannot be assumed that all health professionals have skills to ensure that the knowledge they seek is evidenced based or best practice. Assessment education, possibly part of most participants' initial professional education, was not evident in the participants' answers. None of the participants had completed a paper devoted solely to assessment. The researcher was unable to determine if this was because of a lack of availability of assessment papers or lack of opportunities to undertake a paper because of work commitments. Although Webster (2004) noted that a highly skilled workforce in aged care was essential, tutors confirmed the general perception that aged care is not a positive career choice, (Reed & Watson, 1994). Anderson, Skillen, and Knight (2001) also noted that continuing care is not part of mainstream nursing education. The use of assessment tools did also not appear to be part of these participants' education. Research on educational

needs of long term care staff (Birnie, 2003) indicated that nurses in care homes are faced with professional isolation. Study days in settings other than the workplace can reduce this isolation. Another concern regarding education and aged care is that nursing care facilities are increasingly being used to assist nursing students to meet their placement needs. The availability of further specific aged care education, linked to easily accessible education and supportive employment practices, may assist in health professionals gaining appropriate education for assessment and care planning of older adults. Researchers also identified a gap in assessment education for aged care health professionals (Kane & Kane, 2000).

Education and employment were not always congruent. It was noted that staff with minimal experience were sometimes employed in senior positions. This may be owing to the lack of availability of staff, or link to the less than positive feedback given by tutors previously mentioned by Reed and Watson (1994). Qualified staff, already difficult to attract are likely to prefer the more lucrative public sector following significant wage increases in that area. Funding for aged care is an ongoing and contentious issue. Funding to attract qualified staff as well as funding for staff to undertake education programmes, or have release time to attend education sessions, all comes from the total funds that are available for care. Because aged care is managed by a combination of business, religious and welfare organisations, it is likely that the organizations have slight differences in focus and education preferences and employment practices. Although aged care facilities are generally seen under the umbrella of aged care, the strategic focus and mission of the care facilities may be vastly different. It is therefore unreasonable to expect that health professionals in aged care would have equal access to education. Education improves the quality of assessment and care planning. Unless joint efforts are made by educators, employers and health professionals to work on

improving the links between assessment and care planning, practices may not improve.

The Health Practitioners Competency Assurance Act (2003) puts the onus of education on the health professional. It could be contended that health professionals in Aged Care are disadvantaged because Aged Care funding is insufficient, staff are not available, and education is generally not specifically tailored to this sector's needs.

Registered nurses and allied health professionals undertaking assessments in aged care facilities seemed to form two distinct groups. Allied health professionals who were contracted by the facility attended residents for assessment at the health professionals' convenience. Their attendance was fitted to the health professionals' daily schedule. Contracted health professionals were usually alerted by the registered nurses, when they were required to attend a resident for an assessment. Allied health professionals related their assessment to actual findings rather than to intuition. Allied health professionals assessed residents independently and generally noted the findings in separate parts of the residents' notes. Allied health professionals were time conscious and aware of time restraints and costs.

The registered nurses, who had the most contact with the residents were the gatekeepers and co-ordinators of care planning, and care delivery and team processes.

The composition of the multidisciplinary team is ad hoc and there is no mention of common terms of reference or mention of education in how to work in teams. The composition or membership of the multidisciplinary team may vary per facility, depending on availability of the health professionals. At times, administrative or management personnel were part of the multidisciplinary team. There appear to be

layers of teams, the core team consisting of the registered nurses and general practitioner. Similar assessments and overlapping of assessments were acknowledged, but not deemed a concern with the overlap at times being viewed as very positive. Only two participants suggested that the number of assessments could be daunting for the resident. Physiotherapists, family and additional health professionals are called upon to contribute to the team.

The majority of participants viewed a multidisciplinary approach to assessment of an older adult as a strength. Team meetings were seen as educational opportunities. During the team meetings, the sharing of knowledge and expertise was seen as most important. It was interesting to note members' enthusiasm for the face-to-face exchange of information. This contrasts with their unwillingness to use the residents' notes as a means of exchanging information with other health professionals. Whether this preference is the result of time pressure, especially for those contracted staff members with limited time available, or a personal preference for oral communication is not clear. Not surprisingly, there were frustrations about the failure to pass on information and ensure adherence to a plan of care.

Frustration with the focus of other team members also emerged. Nurses had the perception that they assess the resident from a broader perspective than do other health professionals, a more holistic approach. Some nurse participants indicated that they work intuitively, non-nurse participants did not make this distinction. Nurse participants explain their focus in terms of facilitating the process to alert other health professionals to assess a resident. The significance of care instructions is not always shared. An understanding of issues affecting older adults living in care facilities is not always evident. Older adults in care facilities were mainly referred to as being very frail, with poor cognition. Although it was recognised

that assessment is ongoing, the content and the timing of assessment fluctuate. The content of the assessment may vary according to the discipline of the health professional or the circumstances of the assessment. Assessment was often seen as information gathered from others. When physical examination was mentioned, it most often included basic vital signs. The health professionals' assessment skills were elaborated on in terms of observation. Of interest is the participants' focus on assessment as part of audit and contractual requirements. Assessment as an integral part of clinical practice was not seen by participants to be relevant to the discussion. Possibly this separates assessment into two clear categories. One's own clinical practice and assessment to meet audit and contractual requirements.

Non-nurse health professionals viewed teams in a wider context, and viewed the interaction of health professionals with clients as an integral part of working in a multidisciplinary team approach. However, some felt the team approach seemed to add to the time constraints. Possibly because multidisciplinary teams are mandated in aged care, no-one discussed the possibility of moving to an interdisciplinary or transdisciplinary approach. Assessment tools are mentioned as a guide only, a list to work through. Information is shared in writing and verbally. Information can be commands, instructions or explanations. Few participants mentioned going back to the resident as part of collecting information. Obtaining information was at times viewed as cumbersome. Participants indicated that the care plan is based on assessment. Nurses write the care plan and adjust the language to ease the use of the care plan by others.

Overall, assessment and care planning are fragmented. There appear to be a number of isolated processes that are not co-ordinated by the registered nurse. The variations in disciplines doing the assessments and the different focus of assessment is not conducive to a coherent approach. All health professionals

involved in assessment have slightly different education, experience, and background. This could be beneficial to the older person, as all aspects of health may be assessed by staff who have a different focus. However, to create a care plan, somehow these differences need to be incorporated into one set of instructions for care that are understandable for the users of the care plan, as well as truly reflecting the assessment and intervention suggestions of all health professionals involved. This may be achieved by ensuring that all members of the multidisciplinary team subscribe to the same terms of reference and that all members of the team are aware of and can accurately interpret, the meaning of assessment findings as presented by health professionals from other disciplines.

Assessment provides the framework for planning care. When assessment becomes a series of fragmented processes, the planning of care is likely to be fragmented as well. If assessment for an individual clinical practice is seen as a personal matter, with information shared at team meetings, it is not surprising that documentation of these assessments is fragmented.

Assessment is fragmented, in part owing to the fact that health professionals attend to assessments as part of a parallel process. These health professionals have no common ground, or common understanding of a multidisciplinary team approach. The support systems, (documentation and communication systems) are all fragmented, and there is no common agreement as to which systems or processes to use. The fragmented parts of information, may or may not, be collated by the registered nurse and re-worded into a care plan that is suitable for the care assistants to use to provide daily care. The process of doing an assessment and moving the findings into a care plan has a multitude of ad hoc, fragmented processes, so that it is nearly impossible to create a coherent care plan out of the fragmented parts of information that becomes available.

Conclusion

The aim of this research was to gain insight into registered health professionals' understanding of assessment of older adults in care facilities and how the assessments are utilised by registered nurses to create a plan for care. Older adults in New Zealand are being encouraged to "Age in Place". However, a number of older adults have multiple chronic conditions and health concerns that are not able to be cared for at home. Older adults are entering care facilities at an older age and are subsequently more frail and require specific skilled care. Older adults are assessed before entry into a care facility. This NASC assessment is linked to funding. Assessments of older adults take place for a number of reasons. Assessment is the basis for care planning and part of a health professional's clinical practice. Because of the increasingly frail condition of older adults entering care facilities, it is important to ensure that the care is specific and appropriate. Appropriate care can be given only if the assessment is accurate and comprehensive.

Data for this research were gained by interviewing 14 health professionals from disciplines that would usually make up the multidisciplinary team in a care facility. The researcher was unable to attract health professionals who were diversional therapists, social workers or occupational therapists. Data may have had a different outcome if these disciplines had been represented. Data were analysed using thematic content analysis. The overriding theme that emerged was fragmentation of processes and systems related to assessment and care planning, for older adults in care facilities in new Zealand.

The subthemes which emerged were:

- human resource issues in aged care,
- the focus on physical aspects by contracted health professionals,
- the single discipline approach to care planning,
- the lack of formal information sharing,
- no unified understanding of multidisciplinary team dynamics,
- the positive approach of staff who choose to work in aged care.

All health professionals were focussed on doing a good assessment, but as each had a different education, different understanding of working in teams, and a focus influenced by a different discipline, it was found to be difficult to combine these together in a coherent fashion to ensure that the care planning was appropriate. Registered nurses appear to have a different role from those of other health professionals. They gate-keep the information and translate other health professionals' findings into a care plan that becomes the guideline for care for yet another group (the care assistants) who mainly look after residents in care facilities.

This research was a great experience and opportunity to learn. Some aspects of the research are debatable and with the knowledge of hindsight, could have been completed differently. In particular, the questions could have been structured differently to collect more information about the actual care planning. The title of the research was rather cumbersome. Perhaps a further narrowing of the topic would have been more appropriate, especially in view of the inexperience of the researcher. A single health professional's view may have provided more in-depth information. However, information about assessment and care planning in New

Zealand care facilities is not abundantly available, and it is felt that this exploratory research may be an instigator of further research by others.

Relating the findings of the research to the aim, it suggested that New Zealand health professionals understand assessment as a fragmented process. This is owing to a wide range of causes, not in the least because there is confusion about the aim of assessment. These findings are congruent with the international literature. The manner in which registered nurses compile a care plan is also fragmented. Care planning is often dislocated from the assessments, yet registered nurses have the major input in the care plan. They decide what information from others in put into the plan and how it is to be utilised.

Care planning for older people in care facilities needs to be appropriate to ensure adequate care for the multiple conditions that are a feature of modern aged care. If the assessment and care planning process are not congruent and comprehensive, it could be argued that the care provided to older adults in care facilities is inadequate.

Recommendations for further research include ;

- the utilization of care plans by qualified and nonqualified staff,
- the functioning of multidisciplinary teams in aged care,
- the relationship between education and practice in aged care,
- the relationship between clinical assessment as an integral part of a clinician's practice and assessment for audit and contractual purposes.

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Date

Sylvia Roeters
[redacted]

Dear

My name is Sylvia Roeters. I am a Registered Nurse and a student in the School of Health Sciences at Massey University. For many years I have been involved in care for older adults, both in private and public care settings, in a variety of managerial, clinical and educational roles. Experiences in those years have fostered my interest in the care for older adults. As part of a thesis for my Masters Degree (Mphil) through Massey University, I am conducting a study, titled:

"Exploring Registered Health Professionals' assessment of older adults in care facilities"

With this study, I hope to gain insight in Registered Health Professionals' understanding of assessment of older adults and how the assessments are utilized by Registered Nurses to create a plan for care. I would like to ask your permission to approach the Registered Health Professionals* from different disciplines who are in your employment or contracted by you, and extend an invitation to them to participate in this study. Data for this study is gathered through interviews. The interviews will be approximately I hour in length and will take place outside working hours. If you are agreeable, some interviews may take place at the care facility, unless the participant prefers another venue. Interviews will be conducted under strictly confidential conditions and neither the care facility, nor the individual staff member will be referred to in any of the documents.

This study is supervised by Ms Charmaine Hamilton, Senior Lecturer and Health Programme Coordinator, School of Health Sciences, Massey University. My supervisor can be contacted at the Massey Campus, Palmerston North, phone 06-3505799.

This research has been reviewed and approved by the Manawatu/Wanganui Ethics Committee, Ethics Register 10/02. This research has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/32. If you have any concerns about the conduct of this research, please contact Professor Sylvia Rumball, Chair Massey University Regional Human Ethics Committee: Palmerston North, telephone 06-3505249, email S.V.Rumball@massey.ac.nz
If you have any queries or concerns about your rights as a participant, you may wish to contact: ADNET, Advocacy Network Services, (Independent Health and Disability Advocacy)P.O.Box 782, Wanganui, Ph. 06-3480074.

As mentioned previously, I would like to ask your permission to approach Registered Health Professionals in your employment and invite them to participate in this study. I will arrange the necessary forms for you to give to the Registered Health Professionals. If you agree to this, could you please sign and return the reply form in the envelope provided. Once I receive your letter of agreement, I will contact you regarding the distribution of the information sheets and consent forms. If you require additional information please contact me.

Yours Sincerely

Sylvia Roeters

* Footnote:

Registered Health Professionals are Health Professionals who are required to have a practicing certificate in order to use a particular title and practice their profession, or those who are registered by a National Professional Body and are in the process of applying for practice certification as per Statutory Regulation (for example Social Workers and Diversional Therapists). For this study, the term Registered Health Professionals may include Registered Nurses, Pharmacists, GPs, Occupational Therapists, Physiotherapists, Diversional Therapists, Dieticians and Social Workers, who are employed by a care facility.

Appendix 2, Reply slip Manager

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Sylvia Roeters
[redacted]

I have read the letter of introduction related to the study titled:

"Exploring Registered Health Professionals' assessment of older adults in care facilities"

- **I do agree** (Delete as appropriate)
- **I do not agree** (Delete as appropriate)

that Registered Health Professionals employed by

---

may be invited through this facility to participate in this study.

Signature: **Date:**

This research has been reviewed and approved by the Manawatu/Wanganui Ethics Committee, Ethics Register 10/02. This research has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/32. If you have any concerns about the conduct of this research, please contact Professor Sylvia Rumball, Chair Massey University Regional Human Ethics Committee: Palmerston North, telephone 06-3505249, email S.V.Rumball@massey.ac.nzIf you have any queries or concerns about your rights as a participant, you may wish to contact: ADNET, Advocacy Network Services, (Independent Health and Disability Advocacy)P.O.Box 782, Wanganui, Ph. 06-3480074

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INFORMATION SHEET

"Exploring Registered Health Professionals' assessment of older adults in care facilities"

My name is Sylvia Roeters. I am a Registered Nurse and a student in the School of Health Sciences at Massey University. For many years I have been involved in care for older adults, both in private and public care settings, in a variety of managerial, clinical and educational roles. Experiences in those years have fostered my interest in the care for older adults. To complete my Masters Degree, I am conducting a study to gain insight in what Registered Health Professionals* from different disciplines understand assessments to be and how Registered Nurses use the outcome of assessments to create a coherent plan for care.

I would like to extend an invitation to Registered Health Professionals to participate in this study. If you are willing to participate, you are asked to complete and return the consent form in the envelope provided. Please reply within two weeks if you agree to participate. When I receive your consent form, I will contact you to arrange a time for a face to face audio-taped interview of approximately one hour. This interview will be arranged at a time and place convenient for both of us and will be outside working hours. Managers of care facilities will be asked for permission to conduct some interviews at the care facility. The information from the interviews will be transcribed by the Researcher or a Transcriber, who will sign a confidentiality form. Audio-tapes and transcripts are offered to the Participant. All data will be securely stored.

If you would consider participating in this research, you have the right:

- To decline to participate
- To refuse to answer any particular questions;
- To withdraw from the study before transcription of the interview (one week after interview);
- To ask any further questions about the study at any time during participation;
- To provide information on the understanding that your name will not be used unless you give permission to the researcher;
- To be given access to a summary of the findings of the study when it is concluded.

The researcher will take all possible steps to ensure anonymity, and will treat all information as confidential. There is however the possibility that the discipline and therefore the identity of the Registered Health Professional may be obvious. However, the researcher guarantees that the thesis document or summary would not name a particular person or care facility. All data will be securely stored. On completion of the thesis, participants are offered a summary, which will be mailed to the address supplied at the time of the interview. Participants may wish to inform the researcher if they change address. A summary is also submitted for publication to professional journals and Residential Care New Zealand.

- This research is supervised by Ms Charmaine Hamilton, Senior Lecturer and Co-ordinator Health Programme, School of Health Sciences, Massey University. My supervisor can be contacted at the Massey University Campus Palmerston North, telephone 06-3505799, Ext 2542.
- This research has been reviewed and approved by the Manawatu/Wanganui Ethics Committee, Ethics Register 10/02. This research has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/32. If you have any concerns about the conduct of this research, please contact Professor Sylvia Rumball, Chair Massey University Regional Human Ethics Committee: Palmerston North, telephone 06-3505249, email S.V.Rumball@massey.ac.nz

If you have any queries or concerns about your rights as a participant, you may wish to contact: ADNET, Advocacy Network Services, (Independent Health and Disability Advocacy)P.O.Box 782, Wanganui, Ph. 06-3480074.

Researchers contact details : Sylvia Roeters, [redacted], [redacted]
Ph [redacted](After hours) Ph. 06-3688144 Ext 222 E-mail [redacted]

* Footnote
Registered Health Professionals are Health Professionals who are required to have a practicing certificate in order to use a particular title and practice their profession, or those who are registered by a National Professional Body and are in the process of applying for practice certification as per Statutory Regulation (for example Social Workers and Diversional Therapists). For this study, the term Registered Health Professionals may include Registered Nurses, Pharmacists, GPs, Occupational Therapists, Physiotherapists, Diversional Therapists, Dieticians and Social Workers, who are employed by a care facility.

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CONSENT FORM

"Exploring Registered Health Professionals' assessment of older adults in care facilities:"

I have read the information sheet for participants in this study. I have had the opportunity to ask questions and have these answered to my satisfaction. I may contact the researcher to answer any other questions I may have at any time.

I understand that I have the right to withdraw participation from the interview, and to decline to answer any particular question. I understand that my participation is confidential and that no material which could identify me personally will be used in any report of the study. For this study, the interview is audio taped. At any time, I can ask for a copy of my tape, and/or ask the tape to be turned off during the interview. The interview will take approximately 1 hour. I have had approximately two weeks time to consider whether to participate and I know where to contact the researcher if I need further information.

I hereby consent to take part in this study under the conditions as explained in the information sheet.

- I agree to have my interview audio-taped. (Delete as appropriate)
- I do not agree to have my interview audio-taped. (Delete as appropriate)
- I do / do not request a copy of the transcript (Delete as appropriate)

Participant signature; .....

Participant Name; .....(Please Print)

Participants Contact Phone Number .....Date.....

Researcher details; Sylvia Roeters, [redacted] email: [redacted]z

This research has been reviewed and approved by the Manawatu/Wanganui Ethics Committee, Ethics Register 10/02. This research has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/32. If you have any concerns about the conduct of this research, please contact Professor Sylvia Rumball, Chair Massey University Regional Human Ethics Committee: Palmerston North, telephone 06-3505249, email S.V.Rumball@massey.ac.nz
If you have any queries or concerns about your rights as a participant, you may wish to contact: ADNET, Advocacy Network Services, (Independent Health and Disability Advocacy)P.O.Box 782, Wanganui, Ph. 06-3480074.

Example of the Interview questions

Exploring registered health professionals' assessment of older adults in care facilities.

heck if consent is understood and if consent to recording still applies. Ask if there are any questions or ere are any questions or queries.

1. I understand that you are a health professional associated with a care facility, and in that capacity, are part of a multidisciplinary team. It is not unusual for health professionals to gain expertise through varied work experiences and education. In a few sentences, could you describe your work experience and professional education?

2. One of the characteristics of a multidisciplinary approach is that team members bring their own professional outlooks and thoughts to the team.

   -How would describe your specific contribution to the assessment process?

   -How is your focus different from those of other health professionals in the team?

3. I would like to discuss the assessment process a little further, particularly when your expertise is required to assess a resident.

   -How and when do you become involved in an assessment?

   -Could you describe what you include in an assessment of an older adult?

4. Older adults reside in care facilities because they require care and support with their daily living activities. Your assessment is an important factor in their care and support.

   -How do you inform others of your assessment findings?

   -How do you think you influence a resident's plan for care?

5. An older adult who is under the care of a multidisciplinary team may have more than one assessment. Different members of the team complete these assessments.

   -What do you consider are the strengths and weaknesses of such an assessment approach?

6. Multidisciplinary teams may at times have other health professionals who join the team. An orientation day could be one way of introducing new staff members. If you were asked to contribute to an orientation day and your topic would be 'assessment'.

-How would you define the assessment process in the context of older adults in care facilities?

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