Complete Summary

GUIDELINE TITLE

Assessment processes for older people.

BIBLIOGRAPHIC SOURCE(S)

New Zealand Guidelines Group (NZGG). Assessment processes for older people. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 Oct. 82 p. [211 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

General health

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Geriatrics

Internal Medicine
Psychiatry

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Emergency Medical Technicians/Paramedics
Health Care Providers
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide evidence-based recommendations for appropriate and effective assessment processes to identify personal, social, functional and clinical needs in older people

TARGET POPULATION

- People in New Zealand aged 65 years and over, and Maori, Pacific people, and people with preexisting disabilities aged 55 and over
- People in New Zealand of any age who are carers of older people and older carers, who may have needs due both to their age and to their carer role

INTERVENTIONS AND PRACTICES CONSIDERED

1. Screen for:
    - potential impairment
    - risk factors
    - physical health and function
    - mental health and intellectual disabilities
    - social circumstances
    - social support, including family/whanau
    - the presence, role and potential needs, and potential abuse of the older person and/or their carer
2. Appropriate management of patient consent, confidentiality, and risk
3. Assessment Tools
    - *Screening and Proactive Assessment*
        - Minimum Data Set-Home care (MDS-HC) Overview and Overview+
        - EASY-Care
    - *Comprehensive Assessment*
        - MDS-HC Comprehensive Assessment with additional modules
4. Specialized assessments for Maori and Pacific peoples
    - Holistic model such as Te Whare Tapa Wha
    - Culturally and language appropriate
5. Specialized staff training and use of multidisciplinary teams
6. Appropriate follow-up and continuity of care

MAJOR OUTCOMES CONSIDERED

Key questions guiding the literature search:

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

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

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

The Guideline Development Team then identified questions and strategies for a systematic literature search and formulated inclusion criteria for studies. The literature search included both quantitative and qualitative studies as appropriate. A systematic critical appraisal of the selected literature published from 1980 to 2003 was undertaken by the Dunedin Medical School, University of Otago, and by the member(s) of the working subgroups responsible for drafting particular sections of the guideline. Attempts were also made to identify and include significant unpublished work and conference abstracts.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The Assessment Processes For Older People Guideline Development Team agreed to rank the evidence according to the New Zealand Guidelines Group (NZGG) grading system.

Levels of Evidence

+

Assigned when all or most of the criteria are met

~

Assigned when some of the criteria are met and where unmet criteria are not likely to affect the validity, magnitude, or applicability of the results markedly

x

Assigned when few or none of the criteria are met

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Study Appraisal

The piece of research that is being evaluated is critically appraised using the appropriate GATE FRAME checklist. In the case of qualitative research, the CASP appraisal framework is applied. Using these checklists, the validity, magnitude/precision of effect and applicability of the study are determined.

Weighing the Evidence

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

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Assessment Processes Guideline Development Team first met in December 2001 to identify the main topics to be covered in the guideline. The group met

again in June 2002 to undertake training in the grading and assessment of evidence and to review the topic areas.

Recommendations are formed from the summary evidence statement with regard to the issues of validity, quantity, consistency, applicability, and clinical impact (including benefits and harms) of the whole body of evidence. Where the group made a recommendation based on their own professional and/or clinical practice for which there was no other evidence, it is expressed as a "good practice point." The whole group carefully reviewed the summary of conclusions and recommendations, and any disagreements were resolved by consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Levels of Recommendations

A

The recommendation is supported by good evidence.

B

The recommendation is supported by fair evidence.

C

The recommendation is supported by expert opinion only.

I

No recommendation can be made because the evidence is insufficient (i.e., evidence is lacking, of poor quality, or conflicting) and the balance of benefits and harms cannot be determined.

Good Practice Point

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

COST ANALYSIS

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

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

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

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

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Piloting

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

Peer Review

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

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the Levels of Evidence (**+, ~, x**) and Grades of Recommendation (**A - C, I, and Good Practice Points [GPP]**) are given at the end of the Major Recommendations field.

Domains and Dimensions of Assessment

A: Screening, proactive assessment, and assessment of older people with complex needs should assess for risk factors, physical health and function; mental health; social circumstances; social support, including family/whanau; and the presence, role, and potential needs of carers.

B: Carers of older people should be assessed for health, training, and support needs.

B: Assessment of older people with pre-existing intellectual or other disabilities must detect impairment in those domains and dimensions in which they have been shown to be at particular risk in addition to those domains assessed in people without pre-existing disabilities.

GPP: Any screening and assessment should include assessment for abuse of the older person and/or their carer.

Screening

C: Screening of older people for impairment and risk factors for developing future impairment should be piloted to determine its effectiveness in the New Zealand setting.

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

A: To achieve the greatest benefits in terms of improved health and well-being, screening for impairment and risk factors for developing future impairment for older people should involve all members of the defined population (e.g., all people aged 75 years and over).

A: Any screening must be performed, monitored, and evaluated systematically.

A: Any screening must be supported by appropriately planned, adequately resourced, further interventions for treatment/care for older people identified by the screening as in need.

B: Any screening should address those areas of need of most importance to older people.

A: To be effective, screening should cover both domains of potential impairment and risk factors for health or functional impairment.

Proactive Assessment

A: Proactive assessment of older people should be comprehensive and multidimensional.

B: An older person should receive a proactive assessment if the person has any risk factors: is referred after screening; is referred by community workers, family/whanau or carer; or is in contact with health or social services.

A: Proactive assessment must be supported by timely, effective interventions to address any issues identified.

A: The assessment process should use standardised tools and standard methods of collecting, reporting, and comparing data.

A: Regular follow-up should form part of the process of proactive assessment of older people.

GPP: The proactive assessment process should be used as an opportunity for health promotion, disease prevention, treatment, and care management.

Assessment of Complex Needs

A: A comprehensive, multidimensional assessment should be available for older people with complex needs.

A: Assessment must be supported by resourcing for interventions to address the needs identified.

A: Assessment must be supported with regular follow-up.

GPP: Comprehensive assessment should inform and assist an ongoing treatment, rehabilitation, and care plan that includes strategies to encourage implementation of the treatment/care plan.

Carers

B: Carers of older people should be assessed for health, training, and support needs.

B: Older people who are carers of people with intellectual or other disabilities should be assessed for health and support needs.

B: A specifically designed tool for the assessment of carer needs should be used.

I: There is insufficient evidence to determine whether carer assessment is more effective when conducted independently or as part of an assessment of the older person receiving care.

I: There is insufficient evidence to determine who should perform assessments of the needs of carers.

GPP: Assessment of the needs of carers should be linked with the assessment of older people.

Assessment Tools

A: A standardised comprehensive, multidimensional assessment tool with standard methods of collecting, reporting, and comparing data should be used for screening and assessment of older people.

B: A specifically designed assessment of carer needs should be used when assessing carers.

B: Any tools used must be able to assess the domains and dimensions indicated.

A: *Screening and Proactive Assessment*: the Minimum Data Set for Home Care (MDS-HC) Overview and Overview+, and EASY-Care most closely meet guideline specifications.

A: *Comprehensive Assessment*: The MDS-HC comprehensive assessment with additional modules for those domains not currently addressed should be used for the comprehensive assessment of older people.

B: The needs of carers should be assessed using a purpose-designed tool after adaptation for use in New Zealand where necessary.

GPP: Any screening and proactive assessment tool selected should be modified in collaboration with the developers to meet the needs of older people in New Zealand.

GPP: Before selection of a national tool, pilot studies using the tools within New Zealand should be conducted to determine costs, training needs, and any modifications of the tools required.

Location of Assessment

A: Screening should usually be located within the older person´s home.

A: Proactive assessments of people should usually take place within the older person´s home, unless the older person is in an emergency department (ED). Attendance at an ED should trigger a comprehensive assessment prior to discharge.

A: Complex needs assessment of people within hospital settings or in residential care should be initiated in that setting.

A: All complex needs assessments should include a home visit by a trained assessor.

C: Screening and assessment of older Maori should be done at the home of the older person and their whanau.

B: A specialist trained assessor must be available in or on call for any ED.

GPP: A rural network of assessors should be developed for assessment of non-urban-dwelling older people.

Assessors and Multidisciplinary Teams

A: Assessors should have specialist training in the assessment process, including training in consent issues.

B: Assessors of older people need the following attributes:

- good communication skills
- ability to facilitate the older person´s communication with other health care professionals
- good interpersonal and relationship management skills
- sensitivity to the older person´s beliefs and attitudes
- awareness of spiritual aspects of the person´s care

A: Assessors of older people should be part of (or have ready access to) a wider multidisciplinary team (MDT) to whom they can quickly refer the older person for more in-depth assessment or for help in any particular domain.

B: The MDT should comprise registered nurses with competence in gerontological nursing, geriatricians, psychogeriatricians and clinical psychologists with expertise in mental health of older people, physiotherapists, social workers with competency in working with older people, speech-language therapists, audiologists, dieticians, neurologists, occupational therapists, and pharmacists.

GPP: The core MDT for initial contact and assessment of older people with complex needs in a primary health care setting should comprise a primary care physician, a nurse, and a social worker, all with training and/or experience in working with older people.

GPP: All staff involved in screening, assessment, and treatment of older people (including ED staff) should undergo training to enhance their sensitivity, knowledge and skills in dealing with older people and their issues.

Working Together

B: Implementation of a comprehensive assessment tool must be supported by a programme of education for specialists and other health care professionals.

A: Implementation of a comprehensive assessment tool must be supported by strategies to improve physician implementation of the recommended interventions.

B: An assessment of the older person´s likelihood of following the recommendations should be made, and strategies should be initiated to support implementation of the recommendations by both the older person and health care and social service professionals.

A: Comprehensive assessment should result in a treatment/management plan that includes a process to promote concordance and implementation of that plan by the older person and health care professionals.

Older People with Pre-Existing Disabilities

A: Older people with pre-existing disabilities should be eligible for any screening programme at 55 years.

A: Assessors of people with pre-existing intellectual or other disabilities must have specialist training in the area, in addition to specialist training in the assessment process and consent issues.

A: The MDT supporting the assessment of people with pre-existing disabilities should include specialists with expertise in the disability.

B: Any assessment process for people with disabilities should be designed to ensure that the older person with disability is involved in the assessment process.

Assessment Processes for Older Maori

A: Assessment processes should be made available at age 55 years for older Maori.

A: A holistic model such as *Te Whare Tapa Wha* or a similar model should be used when assessing older Maori.

B: All decisions should be made collectively with the older person´s whanau or hapu.

B: Assessors of older Maori should be fluent in te reo Maori me ona tikanga where the older person and/or their whanau prefers its use.

B: Assessment of older Maori people requires mature Maori assessors who are well-known and respected within their community.

C: Where a Maori assessor with the necessary skills is not available, a skilled assessor should be supported by someone who is fluent in te reo Maori me ona tikanga and who is well-known and respected within the community.

B: When assessing older Maori the assessor should be of the same sex as the person being assessed whenever possible.

GPP: Assessment services must be equally available to older Maori who do not have Maori-specific programmes available, or choose not to access them.

Pacific Peoples

B: Assessment processes should be initiated at age 55 years for older Pacific people.

B: Information relating to an assessment should be produced in Pacific languages as well as English, and produced in oral form (through videos and radio and as part of Pacific health promotion and health education forums) rather than relying on written formats.

C: Assessment programmes for older Pacific people should be actively offered rather than being made available and expecting the older people to initiate contact.

C: Assessors of older Pacific people should as far as possible be from the same ethnic background and able to speak the same language as the person to be assessed, or be supported by someone with these attributes.

C: It should be publicised to Pacific peoples that assessors of older people have professional skills and status to encourage acceptance by the older people and their families.

C: The MDT supporting the assessor of older Pacific people should include a Pacific health care professional.

B: Consent to the process of assessment needs to be revisited periodically during the assessment process because consent is understood to be a dynamic relationship rather than a single event.

Definitions:

Levels of Evidence

+

Assigned when all or most of the criteria are met

~

Assigned when some of the criteria are met and where unmet criteria are not likely to affect the validity, magnitude or applicability of the results markedly

x

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Grades of Recommendations

A

The recommendation is supported by good evidence.

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C

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No recommendation can be made because the evidence is insufficient (i.e., evidence is lacking, of poor quality, or conflicting) and the balance of benefits and harms cannot be determined.

Good Practice Point

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

CLINICAL ALGORITHM(S)

Algorithms are provided in the original guideline document and companions for:

- Assessment Processes for Older People.
- Screening for Impairment and Risk Factors for Developing Future Impairment
- Proactive Assessment
- Assessment of People with Complex Needs
- Carer Support and Assessment

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations were based on the highest quality studies available. Where there was a lack of evidence from high quality studies, then recommendations were based on the best available evidence or expert opinion.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Screening

- Screening of the asymptomatic general population aged 75 years and over has been shown overseas to produce the greatest improvement in health and well-being.
- Overseas evidence has shown that:
    - screening of older people is an effective way of identifying people with previously unrecognised impairment and/or risk factors for developing future impairment
    - screening of asymptomatic members of a defined population group produces greater overall improvement in health and well-being than screening only targeted subgroups

- Screening older people with preventive home visits has been found to be cost-effective overseas.

Assessment and Support

- In the long-term, multidimensional assessment of older people improves health and well-being in the older person and their carers.
- Assessing and supporting carers´ needs result in improved outcomes for both the carer and the care recipient, including reduction in abuse of older people.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- While the guidelines represent a statement of best practice based on the latest available evidence (at the time of publishing), they are not intended to replace the health professional´s judgment in each individual case.
- This guideline does not detail the specific measures used for assessments within domains and dimensions of health and well-being. It does not outline what domain-specific procedures (including assessments) should be completed following referral to a particular service, nor does it provide guidelines for interventions and follow-up.
- The guideline, while detailing the most effective processes around assessment of older people, is not intended to do more than inform development of service frameworks and does not extend to a detailed analysis of the most effective service configurations to support the recommended assessment processes. The section on implementation is similarly intended as a broad conceptual guide. This edition does not specifically address the needs of all minority populations within New Zealand and this may be considered in future reviews.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation

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

Implementation of the recommendations will require:

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

Summary Guidelines

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

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

Implementing Assessment Tools

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

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

Implementing Assessment Skills

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

Staged Implementation

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

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

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

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

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

Organisational Barriers

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

Audit, Performance Indicators, Evaluation and Client Satisfaction

Good Practice Points:

- The ultimate aim of audit should be to improve the quality of care.
- Audit of programme performance indicators is necessary to monitor service provision and quality of care. Audit should take place every six months.
- Collection and audit of ethnicity data is recommended to monitor services for equitable access and delivery of programmes.
- All assessment processes for people aged 65 years and over should monitor and evaluate data relevant to their locality, the population served, and the stakeholders of the service.
- Consumers´ views should be sought to assist the development of a quality service.

Quality

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

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

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

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

Programme Evaluation

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

Audit is a systematic, independent, and documented process for obtaining evidence and evaluating it objectively to determine the extent to which the audit criteria are fulfilled. Audit evidence is comprised of statements of fact or other information, which are relevant to the audit criteria and verifiable. Audit evidence

can be qualitative or quantitative. There are no randomised controlled trials of the efficacy of audit and whether it is a good use of resources. There are many observational studies, both quantitative and qualitative that have sought to evaluate audit.

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

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

Client Satisfaction and Consumer Input to the Programme

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

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

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

Performance Indicators

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

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

Standards

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

IMPLEMENTATION TOOLS

Clinical Algorithm

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Oct

GUIDELINE DEVELOPER(S)

New Zealand Guidelines Group - Private Nonprofit Organization

SOURCE(S) OF FUNDING

New Zealand Guidelines Group (NZGG)

GUIDELINE COMMITTEE

Guideline Development Team

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

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

ENDORSER(S)

Age Concern New Zealand, Inc. - Medical Specialty Society
Arthritis New Zealand - Medical Specialty Society
Australasian College for Emergency Medicine - Medical Specialty Society
Cardiac Society of Australia and New Zealand - Disease Specific Society
Carersnetnz - Professional Association
College of Nurses Aotearoa NZ - Academic Institution
Grey Power-New Zealand Federation Inc. - Professional Association
Mental Health Commission (NZ) - Disease Specific Society
New Zealand Home and Health Association, Inc. - Professional Association
Pharmacy Guild of New Zealand, Inc. - Private For Profit Organization
Royal Australasian College of Physicians - Professional Association
Royal Australian and New Zealand College of Psychiatrists - Professional Association
Royal New Zealand College of General Practitioners - Medical Specialty Society
Women's Health Action - Medical Specialty Society

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

Print copies: Available from the New Zealand Guidelines Group Inc., Level 10, 40 Mercer Street, PO Box 10 665, The Terrace, Wellington, New Zealand; Tel: 64 4 471 4180; Fax: 64 4 471 4185; e-mail: info@nzgg.org.nz

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- New Zealand Guidelines Group (NZGG). General summary. Assessment processes for older people. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 Oct. 8 p. Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG). Proactive assessment: guideline summary. Assessment processes for older people. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 Oct. 4 p. Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG). Assessment of older people with complex needs: specialist services: guideline summary. Assessment processes for older people. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 Oct. 4 p. Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG). Assessment of older people with pre-existing disabilities: guideline summary. Assessment processes for older people. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 Oct. 2 p. Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG). Domains and dimensions of assessment: guideline summary. Assessment processes for older people. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 Oct. 2 p. Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG). Screening and assessment tools: guideline summary. Assessment processes for older people. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 Oct. 2 p. Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
- New Zealand Guidelines Group (NZGG) Carer support and assessment: guideline summary. Assessment processes for older people. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2003 Oct. 2 p. Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.
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- Davey JA. NZ Guidelines Group: needs assessment for the over 65s. Overview of the literature to inform the guidelines development team. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2002 Jul. 12 p. Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

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PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on June 17, 2004. The information was verified by the guideline developer on July 19, 2004.

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