ASSESSMENT FOR RESIDENTIAL CARE FOR OLD PEOPLE IN THE NORTH OF SCOTLAND

ROB MACKAY AND JOYCE LISHMAN

INTRODUCTION

The origins of this study lie in the recognition of apparent differences between assessments for residential care by field and residential workers for the same elderly people in a large voluntary organisation in the north of Scotland. There was concern that residential workers appeared to be more negative than fieldworkers in their assessment of old people’s suitability for residential care.

However, while opinions about the assessment of old people were rife, factual information was limited. The following questions emerged about the assessment of old people for residential care:

1. Were there, in fact, any differences between field and residential workers in their assessment of the same client for care?

2. How accurate were fieldworkers’ assessments in predicting the outcome of residential care?

3. If there were discrepancies between field and residential workers’ assessments, what underlay them? Possible explanations might be:

(a) that fieldworkers, because of anxiety about an old person deemed ‘at risk’, and the consequent need for residential care, might appear optimistic in their assessments of an old person’s functioning;
(b) that residential workers assessments, carried out after the old person had entered care, reflect a real decline in the old person;
(i) naturally over time;
(ii) associated with the transition of admission to care.

RELEVANT LITERATURE

The issue of assessment can only be addressed tangentially from the research-based relevant literature which focuses mainly on:

1. factors influencing admission to care;

2. differences between old people admitted to care and those remaining in the community;

3. the effects of the transition on old people coming into care.

What factors appear to influence applications to residential care?

An important reason for applying for care, according to the NISW (1988) report Residential Care for Elderly People: Using Research to Improve Practice, is being 'at risk' mentally or physically, but this anxiety tends to be felt more by carers than by old people themselves. Other major factors are stress on the carers (since applicants are likely to be living alone and receiving help from friends, relatives or neighbours) and disability and/or homelessness.

Other contextual pressures can result in admission to residential care and may override the preferred needs and wishes of the elderly person. These include hospitalisation, the inability of key people to
continue caring, and the lack of domiciliary or social support, all of which contribute to an old person being deemed ‘at risk’ and to professionals acting to remove the person into residential care.

Such pressures can lead to admissions being carried out as a crisis and to a situation where, as NISW (1988) reports, many people are admitted to residential homes in ‘a state of physical or emotional ill-health when their potential for rehabilitation is low.

The NISW report (1988) also suggests that insufficient assessment may sometimes be a factor in admission to care. Emergency admissions to care are common in some geographical areas, medical illnesses are minimised, and full medical, functional and social assessments are rare. Social workers may see the applicant only once or twice and not see the carer at all. Thus specific difficulties and the wishes of the key parties may not be identified, and problems which could be dealt with may be missed.

It is possible that the combination of contextual pressures, the anxiety of significant others that an old person is ‘at risk’ and the threat of removal of support by key carers may lead to the weighting of an assessment by a fieldworker in ways which might enhance the applicant’s suitability for care, and consequently for a residential worker to assess the old person more negatively than the original limited crisis assessment implied or acknowledged.

Negative assessments by residential workers might equally reflect a deterioration in the old person following admission to care. One strand of relevant literature examines the characteristics of old people who enter residential care versus those who remain in the community. If the elderly people who enter residential care are considerably more vulnerable and incapacitated than those who remain at home it may be that the discrepancy between assessments by field and residential workers represents a predictable downswing over time in an elderly person’s capabilities which, in itself, is a reason for admission to care.

The evidence that residents in local authority homes are more incapacitated that those who remain in the community is mixed. For example, Bebbington and Tong (1986) found at least five times as many severely disabled old people outside institutions as in. However, Sinclair et al. (1988) found that those entering residential homes were older, more disabled and more cognitively impaired, and more likely to live alone than those who remained in the community. This research has implications for the prevention of entry to residential care, e.g., targeting services to old people who are mildly cognitively impaired. While it supports the possibility that those who enter care may be more vulnerable than those remaining in the community it is not conclusive, particularly in view of Booth’s (1987) and Bebbington’s (1986) findings to the contrary.

Alternatively a deterioration might result from admission to care. Some research evidence suggests the process of care might in itself induce dependency and deterioration, with residents suffering ‘apathy, helplessness, withdrawal, and deterioration’ (Bebbington and Tong, 1986).

‘There seems little doubt that a loss of expectation of independent action and a removal of the need for self help can cause rapid deterioration both physically and mentally in relatively old people’
However if this hypothesis, that residential care itself is responsible for a deterioration in function, is valid, homes which promote small group living and resident independence and responsibility should have residents who deteriorate less than residents who are in traditional institutions which induce dependency.

Booth and Phillips (1987) found the evidence for this mixed: on the one hand group homes were better at preventing deterioration and supporting independent residents: on the other they were less likely to stimulate improved functioning in residents or to meet the needs of only moderately independent residents.

The evidence that particular kinds of residential care induce deterioration, and consequently more negative assessments of residents by residential workers is not therefore straightforward.

A final area of relevant research (NISW, 1988) also focuses on the process of transition to care and suggests that there is evidence that ‘the residents most able to come to terms with admission were those who had exercised some degree of control or choice in entering residential care’ (Sinclair et al., 1988). Control (choice of move) and predictability (knowing where one was going) appeared to be positive factors in successful admission to care.

This would suggest that one factor predictive of more positive outcome for residents (and probably, consequently, of a more favourable assessment by the residential worker) is detailed planning and agreement over admission. In summary, several factors may be relevant to the questions surrounding assessment.

1. optimism or pressure on the part of field social workers; 2. the transition to residential care leading to deterioration; 3. the kind of residential care which may lead to deterioration;

4. pre-existing vulnerability of residents and therefore rapid decline in their capabilities following admission;

5. lack of residents’ control over admission or any predictability about admission, also associated with deterioration following assessment.

THE STUDY

Aims The study sought to examine assessment procedures by field and residential workers in more detail and to examine the progress or deterioration of old people over the period in which they entered care.

The major aims were:

1. to compare assessments by field and residential workers;

2. to examine residents’ progress or deterioration after admission and compare this with fieldworkers’ pre-admission assessments;

3. to provide baselines for residential staff to assess functional
abilities of residents;

4. to assess improvement and deterioration in functional abilities of residents, and to identify implications for the work of residential staff involved;

5. to gather information about key factors, pre-admission, which might be predictive of outcomes of residential care.

Design

The methods of data collection had to be relevant and meaningful to staff and be easily used in the normal course of work. Considerable time was spent discussing the development of assessment questionnaires with staff to ensure that the information sought was relevant to their concerns and that the assessment procedures could continue to be used even when the study period ended.

Two kinds of assessment were used: a structured questionnaire and a functional assessment.

The structured questionnaire

At the point of each admission to care field social workers were asked to complete a structured questionnaire which examined:

1. reasons for the application to care;
2. the client's attitude to residential care;
3. the client's expectations of care;
4. preceding illnesses or bereavements;
5. whether the admission was planned or an emergency;
6. the number of moves the client had made in the preceding year.

The field social workers were also asked about their own expectations of the admission.

An equivalent questionnaire was then completed two months after admission by the field social worker and six months after admission by the residential worker. This examined:

1. the resident's current attitude to residential care;
2. the resident's current expectations of residential care;
3. illnesses or bereavements since admission;
4. the resident's relationships with staff and other residents.

The residential workers were also asked about their expectations of the outcome for the old person of moving into residential care. Data from this questionnaire could be used:

1. to compare field and residential workers' assessments and ascertain whether one was generally more optimistic than the other,
2. to compare pre and post-admission assessments by the same fieldworker;
3. to try to identify key factors affecting the outcome of care.

The functional assessment questionnaire

This was designed to make much more detailed assessments of residents' functioning and improvement or deterioration. It examined, for example, mobility including walking and getting out of a chair or
bed, falling, climbing stairs, incontinence, dressing, feeding and sleeping. Each resident was assessed in this way at four stages:

1. date of application by field social worker;
2. date of admission by field social worker;
3. date of review (two months post admission) by residential worker;
4. date of evaluation (six months post admission) by residential worker.

Data from this questionnaire could be used:

1. to compare field and residential workers’ assessments;
2. to examine residents’ progress or deterioration after admission and compare this with fieldworkers’ pre-admission assessments;
3. to provide baselines for residential staff to assess functional abilities of residents;
4. to assess improvement and deterioration in functional abilities of residents.

In particular this information could help residential staff test out how much their concerns about residents’ deterioration and frailty were valid and examine the implications of these findings for their own work.

Sample

The study was carried out from July 1986 to February 1988 and involved all clients who were admitted for permanent care to the voluntary organisation’s six residential homes. They were 25 women and 7 men. The age range at admission was 68-93, and the average age was 81.

Methodological problems

The analysis involves a number of methodological problems which must be acknowledged when the findings are being presented.

1. The sample was small (25 women, 7 men) so that cell sizes are often too small and there are problems about generalisation from these findings.
2. The data was not always complete.
3. Scoring for some items is unsophisticated.
4. There are problems of comparability. Different assessments over time might reflect difficulties in collecting information or different staff making observations and assessments rather than reliable changes in functioning.
5. Clients’ or relatives’ views were not sought or included.

Analysis

The data was analysed in the following ways:

1. reasons for admission to care;
2. residents’ expectations of care and attitudes to it;
3. the planning of the admission;
4. comparison of assessments by field and residential workers;
5. patterns of improvement and deterioration;
6. deterioration or improvement compared with previous illness or bereavement;
7. resident and worker expectations compared with outcome.
FINDINGS

Reasons for admission

The main reasons for seeking care were because clients 'could no longer manage on their own' and because 'they were isolated and lonely'.

Expectation of care

The new residents' expectations of care were of 'assisting self care' rather than providing 'hotel care' or 'nursing care', and this attitude was generally sustained over the first six months after admission.

Attitudes to care

The majority of residents were very positive initially and remained so although two became very negative by six months after admission.

Planning

Only one new admission was an emergency: 19 of the 32 admissions were thought by staff to have been 'carefully planned and carried out' (in contrast to the findings of the NISW report, 1988).

Comparison of assessments by field and residential workers

Comparing assessment of specific functions by field and residential workers, the two assessments were similar in the majority of cases. However, out of 43 instances where the two assessments differed (on the functional assessment questionnaire) it was more likely (in 31 instances compared with 12 instances) to be the field social worker who was more 'optimistic' e.g. continence: in two cases the field social worker scored '0' (full control) while the officer in charge scored '1' (occasional accident) and in one case the field social worker scored '1' (occasional accident) while the officer in charge scored '2' (regularly wet).

Other instances where the field social worker's assessment was more optimistic were for mobility, getting in and out of bed, use of the WC, dressing, feeding, sleeping, understanding, orientation and recognition, and appetite.

There was also an opposite trend, i.e. the residential worker's assessment about climbing stairs and a resident's ability to make social contacts was more optimistic.

Table 1
Reasons for admission

(more than one answer may be given)
Can no longer manage on own  26
Relatives can no longer cope/ conflicts with relatives  7
Inappropriately placed in hospital  8
Homeless  3
Isolated or lonely  13
Table 2
Residents’ expectations of care

<table>
<thead>
<tr>
<th></th>
<th>At admission</th>
<th>2 months later</th>
<th>6 months later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hotel care</td>
<td>6</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Assisted self care</td>
<td>25</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>Nursing care</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>(Missing data)</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 3
Residents’ attitudes to care

<table>
<thead>
<tr>
<th></th>
<th>At admission</th>
<th>2 months later</th>
<th>6 months later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very positive</td>
<td>20</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Accepting it</td>
<td>9</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Rather negative</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Very negative</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>(Missing data)</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Individual patterns
- Becoming more negative: 11
- Becoming more positive: 9
- ‘Very positive’ throughout: 10
- ‘Accepting it throughout’: 1
- Insufficient data: 2

Table 4
Patterns of deterioration or improvement

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deterioration</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varied patterns</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insufficient data</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5
When did it occur?

1. Deterioration:
   - Between referral and admission: 0
   - Admission and 2 months later: 3
   - 2-6 months: 3
   - Varied for different functions: 2

2. Improvement:
   - Between referral and admission: 1
   - Admission and 2 months later: 7
   - 2-6 months: 0
   - Varied for different functions: 5

Patterns of improvement or deterioration

Overall there were more significant patterns of improvement (13) than patterns of deterioration in terms of significant degrees of brain failure, depression, serious illness, physical decline, bereavement or marked behavioural change. The majority of patterns of improvement occurred between admission and two months later. Deterioration was
more likely to occur at any time.

Perhaps the most positive finding was the extent to which improving patterns were recorded in relation to marked physical decline. Out of 22 cases where marked physical decline featured, 11 had improving patterns and only 5 deteriorating patterns. However in terms of brain failure and serious illness residents were more likely to deteriorate than improve. Similarly depressed residents were more likely to deteriorate (13 deteriorated and 3 improved).

In terms of functional abilities there were overall 57 instances of deteriorating patterns, 38 instances of improved patterns and in 64 cases patterns were static. The balance of improvement or deterioration varied for different functions. Overall the pattern improved for coping with falling, climbing stairs, the use of the WC and with stiff joints and feet. There tended to be deteriorating patterns of incontinence, dressing without assistance, feeding without assistance, sleeping, expression, understanding and co-operation.

Table 6
Individual patterns of deterioration or improvement

<table>
<thead>
<tr>
<th>Of residents with:</th>
<th>deteriorating</th>
<th>patterns</th>
<th>improving</th>
<th>patterns</th>
<th>Static</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marked brain failure</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>13</td>
<td>3</td>
<td>8</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious illness</td>
<td>10</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marked physical decline</td>
<td>5</td>
<td>11</td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bereavement</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marked behavioural change</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>26</td>
<td>16</td>
<td>11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7
Changes in functional abilities (Omitted)

Expectations and outcomes

Staff were asked to state their 'hopes, expectations and intentions' of residential care at admission. Their aims were often multiple, for example, to reduce worries of relatives; to provide company; to halt decline in terms of orientation of time and place.

For analysis, however, each case was allocated to one exclusive category based on the main distinguishing feature of aims at admission. These categories were as follows:

1. cases where the main aim was orientated towards easing the burden of a relation;
2. cases where the emphasis was on relief to the client;
3. cases emphasising the promotion of stimulation and/or B. independence for the client;
4. cases emphasising the development of social contacts for the client;
5. non-specific aims.

Staff were also asked to state 'outcome' at two months and at six months. An attempt was made to compare aims and outcome but this was difficult for two main reasons. Outcome was not always clear, e.g. functional abilities might deteriorate (negative outcome) while
morale improved (positive outcome). Numbers were so small that it was impossible to show any significant association between aims and outcomes.

However a descriptive analysis of aims/expectations, grouped under the headings described earlier, was attempted. Examples of three main aims/expectations are included here:

A. Relief of a burden for the resident: in six cases the main emphasis was on relieving the burdens of self-care for the client, e.g.
   - to relieve her of managing at home;
   - to provide regular food and care;
   - to give a higher standard of care than can be offered in the community.

   In one case, however, the relief was to the client in caring for her sister.

   Relief was often combined with other more positive benefits that residential care could provide, e.g.

   - to help resident not to be afraid of being ill; to provide increased social contact.

   In some cases the aim was to continue and develop the client's existing interests, e.g.

   - to be free to continue with his own interests;
   - to continue with her outside interests;
   - to continue with her intellectual interests.

   Almost all the outcomes in this group were positive, e.g. a new lease of life;

   - she is enjoying life again;
   - she can enjoy life again now that she does not have domestic tasks;
   - he pursues his own interests without having to worry about getting back to his wife (who was also now in residential care); enjoys a higher quality of life; can keep her outside interests. In two of the cases it was regarded as a positive outcome that the client had made a good adjustment to residential care and had accepted that this was necessary. Negative outcomes for this group were mentioned in terms of physical health (in two cases) and in one case it was mentioned that a lady (for whom a number of positive outcomes were listed) 'has become slower in attending to her daily needs'.

To promote stimulation and/or independence: stimulation and/or independence was stressed in the intentions for eight residents, e.g.

- to help her be as independent as possible for as long as possible; to help him to see residential care as an extension of the hospital system (more independence in caring for himself); to re-establish some independence; stimulation to encourage him to become more independent (linked with preventing depression caused by bereavement); to help him accept shared living (as distinct from being dependent on his sister at home); to receive the care, stimulation and company she seeks. Two of these eight residents died within the first four months and no comments were given in a third case. Positive outcomes were recorded in four out of the following five cases, e.g. benefited from atmosphere and stimulation; had more
security and peace of mind; standard of life improved. In three cases benefits to other members of the fan-lily were noted (although these were not listed in initial aims). There were no specific outcomes, however, to suggest in concrete terms what additional or sustained independence meant in practical ways of living. Indeed a positive outcome for one resident within this group was that she was 'happier and relaxed because she no longer has the responsibility for looking after her flat'. How then, it may be asked, is her independence promoted? The one resident in this group for whom there was a negative outcome, paradoxically, had the only specific benefit mentioned as a result of encouraging independence, namely that he 'looks more alert'. This was at two months, but at six months it was recorded that 'he had no positive outlook for the future about life in general'.

C. Maintain or develop social contacts: aims for five residents came into this category, e.g. to maintain contacts in the community through a friend; to become involved in leisure activities; company to ease his depression; to overcome his loneliness with the support available in a residential setting; greater support and security - to begin to blossom with the company and to take on a more active role; to provide understanding and support to meet the challenge of living in the community (a resident who had spent forty years in a mental hospital).

Some positive outcomes were recorded for each of these residents, e.g. self esteem improved greatly; developing ability to make personal decisions; developed friendship with one resident; happy, contented resident, attends social activities; has joined in outings and organised activities. For two residents, however, the positive outcomes noted bore no relation to the original aim. For one lady the aim was to provide greater support so that she could begin to blossom in company the only recorded outcome was that she had the 'security of knowing she is being looked after'. Another specific aim was that a very elderly man should 'overcome his loneliness'. After six months the outcome noted that 'he was happy and managed well with his affairs'. It was also noted, somewhat enigmatically that 'he has found the reality (of residential care) a little different from his expectations'. For one resident the aim of providing company to 'ease depression' did not apparently succeed. After six months although the resident had benefited from 'regular meals and supervision of medication' she was 'reluctant to enter social activities in spite of encouragement' and she had made no friends with the other residents. (This lady was aged over ninety and had had six moves between hospital and residential care over a three month period before being admitted to this home).

DISCUSSIONS AND CONCLUSIONS

Three questions may usefully be addressed here:

1. How far was it possible to meet the original aims of the study?
2. What are the principal conclusions?
3. What value was the study for the staff and institutions involved?

How far was it possible to meet the original aims of this study? It was possible to compare residential and field social workers
assessments, although these took place at different times. It was possible to provide a baseline for the assessment and monitoring of functional abilities of residents. It was also possible to assess improvement and deterioration in residents.

What was not possible was to identify key factors (e.g. intentions, expectations, or previous illnesses or bereavements) predictive of outcome for residential care for residents. This was partly because outcomes tended to be mixed but mainly because the sample was too small to permit this kind of analysis.

What were the principal findings? Contrary to prediction, assessments by field and residential workers were in general similar, although in those instances where the two assessments differed it was more likely to be the field worker who was more optimistic. This occurred in assessment of continence, mobility, dressing, feeding and orientation. Thus while residential workers' suspicions that field workers were overly optimistic (if not dishonest) in their pre-admission assessments were not confirmed, it would appear that field workers were less realistic than residential workers about residents' 'functional abilities'.

The findings suggest that the majority of residents in the sample had a positive attitude to entering a home and realistic expectations, that arrangements were well planned, or reasonably well planned and that staff had, on the whole, clear expectations which were more often than not fulfilled. All of this adds up to a positive view of residential care emphasising, for example, caring, choice, continuity, opportunity for change and common values, in contrast to a view of care as the last resort or a place where the elderly are dumped by relatives.

The study shows that specific physical or mental functions can deteriorate but that this deterioration can be separated from the realisation of social goals such as a sense of independence, making friends and freedom from previous burdens.

A further significant finding to emerge from the functional assessment questionnaires was the extent to which residents needed practical help from staff in getting about, going to the toilet, getting dressed, feeding and some other self-management tasks.

How useful was this study for the staff involved? The functional assessment form proved useful not only for the study but as a tool to identify individual patterns of progress or deterioration and is to be retained for operational use. Staff have recognised the need for joint assessment by fieldwork and residential staff in the applicant's own home as well as the residential setting. Staff are to receive additional training on the assessment of old people suffering from senile dementia. The final comment should be from the staff. They felt the study had helped them examine and reflect on their own practice in ways which were likely to maintain and improve resident care.

What relevance may these findings from a small scale local project have for the assessment of need and provision of care for old people more generally? Assessment of old people's 'functional abilities' and needs occurs in a variety of settings (in the community, in day care, in residential care and in hospital) and is made by a range of professionals including field social workers, residential social workers...
workers, district nurses, hospital based nurses, geriatricians, occupational therapists and physiotherapists.

With the introduction of the NHS and Community Care Act 1990 (HMSO, 1990) these professionals will continue, in the role of care manager, to assess the needs and requirements of old people. 'Care management and assessment constitute the core business of arranging care which underpins all other elements of 'community care' (SSI/SWSG, 1991).

In this study although the assessments made by field and residential social workers were generally similar the two professional groups did differ in their assessments of old people's functional abilities. Consideration of potential reasons for this difference may illuminate other potential areas of difference in assessment between professionals from different disciplines.

The context within which an assessment is made affects the demands upon the old person and the capacities shown to meet them, e.g. the capacity to cope with finances and paying bills is necessary for an old person living at home but relatively inessential for an old person in residential care. In residential care a person's ability to cope with social relationships with staff and residents is highlighted, but may be less significant for an old person living at home.

The background, training and role of the worker making an assessment may also influence what is focused on and what judgements are made. For example a field social worker is likely to focus on understanding the old person in the context of family social and community relationships. A residential worker may be more likely to be concerned with meeting the old person's immediate needs and assessment of these inevitably will focus on functional abilities as well as emotional and social needs.

If we begin to see assessment as involving an interaction of the assessed person, and his/her functional abilities, emotional and social needs and family and social relationships, the different contexts within which the person lives, and the different backgrounds, training and roles of professionals involved in the assessments we may question the validity of an individual expert professional judgement. More usefully we can consider the concept of shared systems of assessment reflecting the judgements of different relevant professionals but also of the user and carer.

The advice issued by the Department of Health and the Scottish Office (SSI/SWSG, 1991) on 'Care Management and Assessment' reflects a view of assessment as user-led, wholistic, shared and potentially multi-disciplinary. The following sections seem particularly relevant:

1.1.9 Care management makes the needs and wishes of users and carers central to the caring process. This needs led approach aims to tailor services to individual requirements.

1.2.1 The aim in the future is that assessment procedures will be combined into an integrated process bringing together contributions from all relevant care agencies, so that the needs of the individual are considered as a whole.

3.6 The practitioner (care manager) has to decide whether subject to the consent of the individual there are needs which should be
referred to other people or other care agencies for assessment.

3.14 There may be advantages to some part of the assessment being undertaken in settings external to the home, for example, day and residential care settings so that staff have longer contact with the individual.

A full assessment, therefore, will involve the user's and carers' views and preferences, and a potential range of professional assessments based on the user functioning in a range of contexts. Achieving such a user-led, wholistic, multi-disciplinary assessment is not unproblematic.

First we have to listen to users and carers. Significantly the design of this study did not include their views. A real commitment to a user-led approach to assessment involves a fundamental change in professionals' views of assessment: no longer can the professional assume an expert stance and power base that he/she knows what is best for the client.

Second genuine wholistic assessments involve a multi-disciplinary approach: each profession has to abandon any temptation to promote their particular perspective as the only or best one, or to see themselves as the profession able to encompass all perspectives. We have to recognise the limitations discussed earlier of our professional background, training and role and the context in which we assess a client or user. In recognising our own professional limitations we also have to acknowledge and value the knowledge and skills of other professions. In this study the residential workers were more suited at assessing functional abilities because of their focus, training and skills and because of the context in which they assessed residents.

CCETSW (1991) identifies some relevant skills competencies required for multi-disciplinary work, including:

'Understand the different perspectives of other professionals, including skills, values and knowledge each may offer.

Be aware of potential conflicts which may arise from differences.

Be clear and assertive from own professional perspective.

Be committed and able to make maximum use of other professionals'.

None of these exhortations are easy to practise: we can all become limited by our own particular focus and context. Confidence in one's own abilities, recognition of one's limitations, and opportunities for communication about roles and boundaries and for direct joint work and assessment can all help members of different professions to build respect and trust for each others' judgements and a commitment to the client or user.

References


CCETSW (1991) Assessment, Care Management and Inspection in Community Care: Towards a Practice Curriculum. CCETSW.


SSI/SWSG (1991) Care Management and Assessment: Practitioners Guide. HMSO.