

SINGLE ASSESSMENT PROCESS FOR OLDER PEOPLE

ASSESSMENT SCALES

Introduction

1. This guidance provides advice on assessment scales that localities may wish to use in the assessment of older people's needs and circumstances under the single assessment process (SAP) for older people. (Principal SAP guidance was issued in January 2002 under cover of HSC 2002/001; LAC(2002)1. It is available on the SAP website.)
2. An **assessment scale** is a means of identifying, and possibly gauging the extent of, a specific health or care condition such as ability for personal care, mobility, tissue viability, depression, and cognitive impairment. In the context of SAP, assessment scales may be used individually or collectively at all stages of assessment, and at case finding.
3. Advice on scales is given below for many of the sub-domains of the single assessment process. Where it is not possible to give advice for particular sub-domains, the Department will continue to explore possibilities and encourage research to fill the gaps. In the interim, localities may wish to use other scales, as long as they bear in mind the points listed below for choosing and using scales.

Choosing and using scales

4. It is important that localities and professionals bear the following points in mind when choosing and using assessment scales in individual cases.
 - It is neither obligatory nor necessary to use scales in all cases.
 - Scales should be valid, reliable, and culturally sensitive and should not unfairly discriminate against people on grounds of age, gender, race, disability and other factors. A scale is :
 - **Valid**, if it accurately assesses what it is claimed to assess.
 - **Reliable**, if when different assessors use it they arrive at similar answers for people with similar needs. It can also refer to the same assessor achieving the same results over time for a particular individual when needs have not changed.

- **Culturally sensitive**, if it does not unfairly discriminate against people either from minority ethnic communities or those whose preferred language is not English.
 - Agencies must not revise scales without prior knowledge of the impact of the changes on the usefulness of the scale.
 - Agencies should bear in mind that some scales have been developed for research purposes and may not perform well when used in practice for individual cases.
 - Professionals should remember that scales support, and do not replace, judgement.
 - The order and balance of scales in any assessment interview should be carefully considered. Difficult questions at the beginning of an assessment interview may not be received, or answered, well by older people.
 - Competent and/or qualified professionals should apply and interpret scales.
 - A literal and narrow interpretation of scales should be avoided. For example, focusing on specific items of a scale - such as the Barthel Index - can lead to a reductionist approach whereby a person's problems are seen and treated in isolation rather than holistically.
 - Some scales include scoring systems that can give an indication of the severity of problems. It is particularly poor practice for such scores to be used either as major determinants of individual's needs or to allocate services to people.
 - At contact or overview assessment, it is helpful if scales are kept as short as possible, as long as they are valid, reliable and culturally sensitive. For example, the 4-item Geriatric Depression Scale may be used instead of the 15- or 30-item versions of this scale.
- activities of daily living.

Scales localities may consider

5. It is the Department of Health's view that the following scales - or elements from them - may be used to explore the domains and sub-domains of the single assessment process. However, the Department does not endorse of these scales. Within each category, the scales are given in date order, with most recent last.
 - **Users perspective of their needs and priorities**
 - Life Satisfaction Index (Neugarten et al, 1961)
 - Schedule for the Evaluation of Individual Quality of Life (full or shortened form) (O'Boyle and McGee, 1992)
 - Sections on "Personal Fulfilment" and "Spiritual Fulfilment" from the RCN "Assessment Tool for nursing older people" (Royal College of Nursing, 1997).
 - Mayers' Lifestyle Questionnaire (Mayers, 1998)
 - Life Goals Questionnaire and Goal Planning Record (Wade, 1999)
 - The Quality of Life in Later Life (QuiLL) Assessment (Evans et al, forthcoming)

- **Nutrition**
 - Subjective Global Assessment (Detsky et al, 1987)
 - Mini-nutritional assessment (Guigozy et al, 1997)
 - Screening tool for adults at risk of malnutrition (Malnutrition Advisory Group, 2000)

- **Activities, and instrumental activities, of daily living**
 - The Index of Activities of Daily Living (Katz et al, 1963)
 - Barthel Self-Care Index (Mahoney and Barthel, 1965; and Shah et al, 1989 for a revised version) with the OARS Multidimensional Functional Assessment Questionnaire (Fillenbaum, 1988)
 - Functional Independence Measure (Keith et al, 1987)
 - Community Dependency Index (Eakin, 1993)
 - Canadian Occupational Performance Measure (2nd edition) (Law et al, 1994)

- **Pain**
 - McGill Pain Questionnaire (Melzack, 1975)
 - Oswestry Low Back Pain Disability Questionnaire (revised version) (Fairbank et al, 1986)
 - Brief Pain Inventory (BPI) (Cleeland, 1991)
 - Palliative Outcome Scale (Hearn and Higginson, 1999)

- **Oral health**
 - Oral health assessment (Annex 2, British Society for Disability and Oral Health, revised 2000)

- **Tissue viability**
 - Waterlow Pressure Sore Assessment (Waterlow, 1996)

- **Mobility and balance**
 - Performance Oriented Assessment of Mobility Problems in Elderly Patients (POAM) (Tinetti, 1986)
 - Balance Scale (Berg et al, 1992)

- **Falls**
 - Falls Efficacy Scale (Tinetti et al, 1990)
 - Falls Handicap Inventory (Rai et al, 1995)

- **Communication, visual and hearing disability**
 - 4 questions from the Lambeth Disability Screening Questionnaire (Peach et al, 1980)
 - Do you have difficulty ...
 - ... seeing newsprint even with glasses?
 - ... recognising people across the road even with glasses?
 - ... hearing a conversation even with a hearing aid?
 - ... in speaking?
 - Frenchay Aphasia Screening Test (Enderby et al, 1987)

- Assessment of Communication and Interaction Skills (ACIS) (Salamy et al, 1993)
- Sheffield Screening Test for Acquired Language Disorders (Syder et al, 1993)
- **Cognitive impairment / memory**
 - Mini-Mental State Examination (MMSE) (Folstein et al, 1975)
 - Short orientation-memory-concentration test of cognitive impairment (6 items) (Katzman et al, 1983)
 - Gujarati version of the MMSE (Lindesay et al, 1997)
- **General mental health**
 - General Health Questionnaire (12 or 28 items) (Goldberg, 1978)
- **Depression / anxiety / mood**
 - Philadelphia Geriatric Centre Morale Scale (Anglicised version, 17 items) (Davies and Challis, 1986) (See Lawton, 1975 for the original version.)
 - Geriatric Depression Scale (15 items - or the 4 item scale for overview assessment) (Yesavage et al, 1983; Yesavage, 1988)
 - BASDEC (Brief Assessment Schedule Depression Cards) (Adshead et al, 1992)
 - Hospital Anxiety Depression Scale (Zigmond and Snaith, 1994)
- **Relationships**
 - Significant Others Scale (Power et al, 1988)
 - Practitioner Assessment of Neighbourhood Type (Wenger, 1994)
- **Impact of caring on family carers**
 - Cost of caring index (Kosberg & Crail, 1986)
 - Relative stress scale (Zarit et al, 1998)
 - COPE Index (Nolan and Philp, 1999)
- **Housing**
 - Housing Options for Older People (HOOP) (Heywood et al, 1999)

Helpful publications

General references

6. In addition to considering the scales given above, agencies may wish to refer to three publications that have usefully reviewed a range of assessment scales of relevance to older people. The publications are :
 - The Research Unit of the Royal College of Physicians and the British Geriatrics Society (1992) "*Standardised assessment scales for elderly people*", Royal College of Physicians of London and the British Geriatrics Society

- ❑ McDowell I and Newall C (1996) *“Measuring health : a guide to rating scales and questionnaires”* (2nd edition), Oxford University Press
- ❑ Clarke C, Sealey-Lapes C and Kotsch L (2001) *“Outcome measures : information pack for occupational therapy”*, College of Occupational Therapists

Assessing dementia

7. The Department is aware that the accurate assessment of dementia can play a vital part in helping many older people and their families. The Department wishes to see agencies place great emphasis on this aspect when implementing the single assessment process. In this context, agencies may wish to refer to the Alzheimer’s Society, which provides a wide range of information and advice on all aspects of dementia care. Comprehensive guidance can be downloaded free of charge from the Society’s website at www.alzheimers.org.uk. The following publications may be of particular interest :
 - ❑ “Dementia : diagnosis and management in primary care (CD Rom format), August 2003
 - ❑ “The Mini-Mental State Examination (MMSE) – a guide for people with dementia and their carers”, Information sheet 436, June 2002
 - ❑ “Building on strengths : providing support, care planning and risk assessment for people with dementia”, 2003

8. With respect to dementia and minority ethnic older people, professionals should find the Lindesay et al (1997) and Patel et al (1998) publications cited below useful.

Assessing the needs of minority ethnic older people

9. Care should be taken when assessing the needs of an older person from a minority ethnic community. Agencies and professionals will need to ensure that information about services and the assessment process is given in appropriate ways. Assessment approaches and the use of tools or scales will need to be culturally sensitive. Professionals must be ready and competent to understand how old age, needs and race combine, in order to respond appropriately. The following publications can help professionals think through these matters :
 - ❑ Commission for Racial Equality and partner organisations (1997) *“Race, culture and community care : an agenda for action”*, Chartered Institute of Housing Publications
 - ❑ Social Services Inspectorate (1998) *“They look after their own, don’t they?”*, Department of Health
 - ❑ Rawf S and Bahl V (eds) (1998) *“Assessing health needs of people from minority ethnic groups”*, Royal College of Physicians and Faculty of Public Health Medicine

- ❑ Patel N et al (1998) *“Dementia and Minority Ethnic Older People : managing care in the UK, Denmark and France”*, Russell House Publishing
- ❑ Butt J et al (1999) *“Respect – learning materials for social care staff working with black and minority ethnic older people”*, Race Equality Unit
- ❑ Department of Health (2001) *“From lip service to real service – the report of the first phase of a project to assist councils with social services responsibilities to develop services for black older people”*, Department of Health
- ❑ Department of Health (2002) *“Developing services for minority ethnic older people – the Audit Tool”*, Department of Health

Case finding

10. Where agencies wish to identify older people who may have health and social care needs, but who have yet to be referred to them, or may not be referred until problems have significantly worsened, they may wish to become involved in case finding.
11. Localities may wish to explore two approaches to case finding using postal questionnaires. They are :

Taylor and Ford's adaptation of the Barber Postal Questionnaire (Taylor et al, 1983; and Barber et al, 1976)

Do you worry about your health? Yes / No
 Are you housebound? Yes / No
 Do you depend on help from others? Yes / No
 Do you have poor hearing? Yes / No

Risk is indicated by any "yes" answer.

Sherbrooke Postal Questionnaire (Hebert et al, 1996)

Do you live alone? Yes / No
 Do you take more than 3 medications daily? Yes / No
 Do you regularly use a walking aid / wheelchair? Yes / No
 Do you see well? Yes / No
 Do you hear well? Yes / No
 Do you have memory problems? Yes / No

Risk answers are in italics. "At risk" = more than 1 risk answer.
 No response is a risk factor.

Contact assessment

12. In the January 2002 guidance, the Department recommended that at contact assessment professionals complete their consultations or discussions having covered seven key issues.
 1. The nature of the presenting need.
 2. The significance of the need for the older person.
 3. The length of time the need has been experienced.
 4. Potential solutions identified by the older person.
 5. Other needs experienced by the older person.
 6. Recent life events or changes relevant to the older person.
 7. The perception of family members and carers.

13. At contact assessment, where appropriate, professionals can gain insights into an individual's level of independence and potential needs through the use of some simple devices. For example, the **Self-reliance Screening Algorithm** (unpublished, based on work based at the Hebrew Rehabilitation Center of the Aged, Boston, USA) can prove useful. This easy-to-administer tool is based on consideration of seven areas that relate to an older person's independence. A simple scoring system enables the professional to determine the extent of self-reliance.
 1. Cognitive skills for daily decision-making
 2. Hours of physical activity in the last 3 days
 3. Meals preparation
 4. Ordinary housework
 5. Transportation
 6. Person hygiene
 7. Bathing

People are determined to be :

Self reliant when they are independent in daily decision making (item 1) AND at least three of the stamina (item 2) and ADL and IADL items (items 3 to 7) in the algorithm.

Not self-reliant when they are either not independent in daily decision making (item 1) OR independent in two or fewer of the stamina (item 2) and ADL and IADL items (items 3 to 7)

More details of the scoring are included in the MDS - Home Care Screener. Note : ADL is an abbreviation for "activities of daily living"; IADL is an abbreviation for "instrumental activities of daily living".

14. While the adapted **Barber Postal Questionnaire** and the **Sherbrooke Postal Questionnaire** have been developed for case finding purposes, questions from them can usefully be woven into a contact assessment discussion.

15. While questions from the three devices given above can be useful, they should not be asked by rote. They should be asked appropriately, and will often arise naturally as the older person talks about their needs and circumstances.

Good practice illustrations

16. The three illustrations below demonstrate different aspects of good practice, where the use of different types of assessment and different scales is involved. They focus on :
 - **Contact and subsequent assessments in a GP practice and beyond. See Box A.** This illustration shows how a GP and practice nurse reach decisions based on a contact assessment, followed by an overview assessment coupled with the application of a scale to confirm the strong possibility of mental health problems.
 - **Specialist assessments in the case of African-Caribbean patient for whom a return home following hospital treatment and intermediate care is being considered. See Box B.** This illustration highlights the need for professionals to be aware of how old age, race and language and needs interact, and not to jump to conclusions about the relationship between older people and their carers.
 - **Joint and non-judgemental working in the case of challenging behaviour arising from dementia. See Box C.** This illustration emphasises that informed professional judgement will be at a premium in cases involving older people with dementia. Approaches to assessment, including the use of scales, will be unhelpful if they label behaviour as aggressive or challenging, without attempting to understand the reasons for it and thinking through appropriate ways of dealing with it.

Box A

USING A SCALE WITHIN GENERAL PRACTICE

A family doctor suspects that the older person she is seeing may be suffering from depression. This is the third consultation in the last month, and on this occasion there are signs of tearfulness and agitation. The doctor addresses this by asking about the person's relationships and social contacts, sleeping patterns and diet. All of these matters are symptomatic of depression. Having done this the doctor is further convinced there are problems for this person.

At this stage, the practice nurse is asked to carry out an overview assessment, and – with the person's consent – administers the 15-item Geriatric Depression Scale (GDS). The older person scores highly while the overview assessment reveals no other significant problems apart from growing social isolation following the death of her husband two years ago and the admission of a close friend to residential care six months ago. This leaves the doctor in no doubt that the person is severely depressed.

The high score prompts the doctor to make a referral to the local community mental health team for older people.

Had the older person not responded to the symptom-related questions, she would not have administered the GDS. If the GDS was applied and showed a low score, the doctor might not have referred the person to the CMHT, but suggested another option appropriate to the person's situation.

Box B

UNDERSTANDING OLD AGE, NEEDS AND RACE

An old woman, born in St Lucia who moved to the Midlands in 1962 to join her husband, is referred to the Community Rehabilitation Team following a stroke. She is currently in an intermediate care bed in a local nursing home, but a return home is planned. The stroke has restricted her mobility and speech and, before she can go home, these problems need to be addressed. She lives alone, but indicates that her family provides considerable support. Her husband died 25 years ago.

A registered nurse, occupational therapist, physiotherapist, speech and language therapist and social worker are all involved in various aspects of her care. At a first assessment visit to her home, the old woman has a minor fall, and this seems to greatly affect her confidence. Her daughter, who attends the visit, seems unduly critical of her mother. Back at the nursing home, she tells her daughter that perhaps she should stay in the home. The team get together to compare notes and share assessment information, including biographical details.

At this meeting, it transpires that the patois spoken by the old woman has continued to be a strong feature of her speech. It could account, to some extent, for her speech being seen as a “problem”. A multi-lingual co-worker is called in, and he reports that he is able to understand her whereas others can hardly follow. The social worker also reports that there is considerable tension within the family, and the old woman’s portrait of a supportive family may not be borne out in reality. The team feels that this may be one of the reasons for the daughter’s strong reaction to her mother moving back home, and why the old woman now wishes to stay in the nursing home on a permanent basis.

As a result of these insights, and the help of the multi-lingual worker in ensuring key messages are shared effectively between the old woman and the team, she is eventually returned home. The team puts her in touch with a local day centre that has a good reputation for multi-cultural awareness. This provides much needed social support. The team also contacts a local befriending services run by African – Caribbean older people for African-Caribbean older people. This seems to give the old woman a new lease of life. At the same time, the therapists continue to visit to help her improve her mobility. The social worker works with the family to see if bridges can be built between them and the old woman, and to explore any needs the daughter has in her own right.

Box C

EFFECTIVE AND NON-JUDGEMENTAL JOINT WORKING

A 82 year old man is referred to the local social services office as his behaviour has grown erratic in the past six months, and his wife and son report verbal and minor physical attacks on them. The man is reported as increasingly forgetful, and was found wandering by a neighbour in the local park after midnight two nights before.

After the collection of basic personal information by a receptionist, the man and his wife see an approved social worker. After some preliminary questions, suspecting that the reported behaviour may be symptomatic of dementia, the care manager administers the Mini-Mental State Examination. The result is a low score. Prompted by this, the care manager undertakes an overview assessment, where further potential problems are identified, particularly with regard to the man's safety in the home and problems of eating and drinking.

The care manager contacts the GP surgery where the man is registered. The practice nurse reports that the man was last seen seven months about apparently unrelated problems. The care manager and practice nurse agree that given the nature of the man's problems, a referral to the Community Mental Health Team (CMHT) for Older People should be made. The care manager discusses this with the man and his wife, and having secured their agreement, a referral is made accompanied by a summary of the overview assessment including relevant medical information from the GP's surgery.

A Community Psychiatric Nurse (CPN) co-ordinates further assessment activity on behalf of the CMHT. On the advice of an old age psychiatrist, she and her team colleagues are able to confirm that the man is in the early stages of dementia. The CPN helps the wife to understand that the perceived aggression in this case, while upsetting to her, is one of the few ways in which he can communicate his thoughts and distress to her. The wife is helped to see the aggression as communication, and she is advised on how to reduce or avoid the potentially harmful aspects of it. They advise her what to should the aggression become more pronounced.

The team provides the man with support at home, including advice on diet and food intake. The CPN refers the wife to the Alzheimer's Society for further advice. The care manager and the practice nurse are informed, and the common information base, shared by local agencies, is updated to reflect the results of the assessment and the care plan. The CPN maintains her role of care co-ordinator, at least until the first review of the man's needs in three month's time.

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