NHS

Hertfordshire

HERTFORDSHIRE SINGLE ASSESSMENT PROCESS

1. Single Assessment Process – Background Information

The single assessment process is a national initiative designed to improve health and social care services for older people. Older people[1] use health and social services more than any other group. However, these services have been criticised by older people themselves, by consumer groups and by government for not co-ordinating their approaches to assessment or to care planning and service delivery. Older people talk of repeatedly having to give similar information to different professionals, of spending wasted time answering questions not relevant to their particular problem, of care needs not being considered because the person assessing them is not from a particular professional background, of not being consulted about decisions affecting their care and of a general confusion about who is doing what and when.

The picture is, of course, not all bad. There are some excellent examples of good, collaborative, person-centred care in our communities. The problem is that good practice is not universal. The single assessment process is being implemented to change all of this. It will build on what is good within the current system and will change things that are not so good. Single assessment will mean that the older person has to give information about needs only once, regardless of the complexity of their needs. Care professionals will work more closely together in the best interests of the older person (as defined by the older person). The single assessment process aims to ensure that all care available for all older people is of a high standard and that the older person is at the centre of decisions being made about themselves.

In the National Service Framework for Older People it was recognised that despite the fact that older people are in frequent contact with health and social care services, physical, social and psychological problems can be missed and go unreported. This is because:

- Assessments are frequently duplicated with no standardised approach across health and social care.
- Information systems are fragmented leading to duplication of information held by various agencies.
- Failure to share information between agencies can result in failure to deliver the best possible packages of care.
- Care provided on the basis of assessment may not be well co-ordinated or follow the complex care pathway an older person might follow.
- Service and system failings undermine older people's confidence in

[1] In Hertfordshire, it has been agreed that this way of working should also apply to adults with a physical disability

other respects of care and their ability to remain independent.
- The needs of people from diverse cultural groups are often not properly addressed in the assessment process.

The single assessment process should ensure that resources are utilised to best effect, that assessment is appropriate to older people's needs, that agencies do not duplicate each other's assessments and that professionals contribute to assessments in the most effective way. Single assessment also provides information to support the determination of the Registered Nursing Contribution for residents in care homes that provide nursing care.

2. Stages of Assessment

Assessment is about collecting information about a person's needs, interpreting that information and making decisions about what support, treatment or care should be provided. All professionals are trained to undertake assessments although the way in which they approach assessment and the terminology they use may vary.

3. Types of Assessment

The single assessment process comprises four broad types of assessment:

- Contact assessment
- Overview assessment
- Specialist assessment
- Comprehensive assessment.

The four types of assessment are not progressive – it is not expected that people will move through the stages in an orderly fashion. The important thing is that all older people should receive good assessment matched to their individual circumstances. Some older people will benefit from a fuller assessment across a number of areas or domains and some may need more detailed assessment of one, or a few, specialist areas or domains. The single assessment process should be flexible enough to be sensitive to all circumstances. For the older person it will mean less duplication and less worry.

Properly targeted and timely assessment may reduce demands for services through assessing need more accurately and will ensure services remain appropriate to needs. All assessments should be carried out using reliable assessment tools, should be culturally sensitive and should be supported by a locally agreed framework.

The four types of assessment are described briefly below.

Contact Assessment
This type of assessment refers to the first contact between an older person and health or social services where significant needs are first described or suspected. It does not refer to every contact between, for example, a practice

nurse, GP, social care services and an older person. At contact assessment basic personal information is collected, the nature of the presenting problem is established and the potential presence of wider health and/or social needs is explored. Trained, but not necessarily professionally qualified, staff can undertake a contact assessment.

Overview Assessment

An overview assessment is a more rounded assessment and should cover all or some of the 9 domains (areas of need as set out in the Department of Health guidance). In some cases an older person may have already had a contact assessment but in others, it will become quickly apparent that the needs of the older person are such that an overview assessment is deemed necessary from the outset.

This type of assessment is likely to be undertaken by District Nurse, social worker or occupational therapist in consultation with the service user and their carers. Assessors should seek confirmation from users about the current level of support being received from carers, health services, social services, housing and other services. Assessment information needs to be updated or revised over time as needs change.

The assessment may identify the need for more specialist assessments - (see below). In some instances a full multi-disciplinary comprehensive assessment may be needed, particularly if long-term care is a possibility (see below).

Specialist Assessment

Specialist assessment offers a way of exploring specific needs and may be identified as being required from either a contact or overview assessment. As a result of specialist assessment professionals should have sufficient information to confirm the presence and extent of a health or social care need. Appropriate professionally qualified individuals should carry out specialist assessments.

Comprehensive Assessment

In some instances it will be obvious that that the needs and circumstances of the older person are such that a comprehensive assessment involving specialist assessment of all or most of the 9 domains of single assessment are required. A comprehensive assessment will always be required where an older person needs prolonged and/or intensive support including permanent admission to a care home, or substantial packages of care at home.

Comprehensive assessment will involve a range of professionals with different expertise. The information gathered for the comprehensive assessment will provide the detail needed to determine the banding for an RNCC determination where older people require care in a nursing home.

4. The 9 Domains

The 9 Domains (or areas of need) to be considered in an overview assessment are outlined below:

User's perspective
□ Problems and issues in the user's own words
□ User's expectations and motivation

Clinical background
□ History of medical problems
□ History of falls
□ Medication use

Disease prevention
□ History of blood pressure monitoring
□ Nutrition
□ Vaccination history
□ Drinking and smoking history
□ Exercise patter
□ History of cervical and breast screening

Personal care and physical well-being
□ Personal hygiene, including washing, bathing, toileting and grooming
□ Dressing
□ Pain
□ Oral health
□ Foot-care
□ Tissue viability
□ Mobility
□ Continence
□ Sleeping patterns

Senses
□ Sight
□ Hearing
□ Communication

Mental health
□ Cognition including dementia
□ Mental health including depression

Relationships
□ Social contacts, relationships and involvement
□ Caring arrangements

Safety
□ Abuse or neglect
□ Other aspects of personal safety
□ Public safety

Immediate environment and resources

- Care of the home
- Accommodation
- Finances
- Access to local facilities and services.

5. Assessment Summary and Care Plan

The purposes of the assessment summary and care plan are to analyse the assessment information and identify the support that the older person needs. Local agencies are required under the Single Assessment Process to work to an agreed assessment summary for the collection of information on older people who are assessed, whether or not they go on to receive a service and the summary is shared between agencies where appropriate. The three components of the single assessment summary are:

- Basic personal information.
- Health and social care needs.
- A summary of the care plan.

Agencies must agree on how the information identified for their single assessment summaries is to be collected, stored and shared, with due regard for the Data Protection Act of 1998, Caldicott requirements, informed consent and other similar related legislation.

Following an assessment consideration should be given to what help to provide and how care should be managed. All care should be managed appropriately and effectively. However, when assessment highlights the need for intensive and/or complex care co-ordination, a dedicated care co-ordinator should be allocated to the older person. The care co-ordinator should be the most appropriate professional, given the older person's needs.

Following assessment older people will receive an individual care plan that clearly describes the objectives and outcomes of providing help as well as details of that help and who to contact in an emergency or if needs change. Care plans should be responsive to – but not prejudiced against – the age, living circumstances, geographic location, disabilities, gender, culture, faith, personal relationships and lifestyle choices of clients/patients. Care plans should build on the strengths of individuals and the part they can play in addressing their own needs. Care plans should be agreed with the older person who will hold a copy of his or her own care plan.

Refer to Guidance Notes for Health And social Care Staff - ACS 685 (available on Connect and Herts website for Single Assessment www.hertsdirect.org/singleassess)