The importance of assessment in residential care

To ‘assess’, as defined in the Cambridge Dictionary (Cambridge University Press, 2003), is ‘to judge or decide the amount, value, quality or importance of; to evaluate’. With accurate assessment, interventions can be planned, goals established and appropriate referrals made to other service providers.

The Care Standards Act 2000 defined assessment as the collection and interpretation of data. By adopting simple and basic principles of assessment, a care home can improve understanding of methods to promote an individual’s social and health-care development.

Good understanding of residents’ needs, when shared by all significant staff, ensures that effective coordinated care is provided to meet individual needs. A clear assessment procedure within a residential care environment is therefore essential.

Start of assessment

The majority of individuals moving into a residential or nursing home environment will have a community care assessment. This can involve health- and social-care staff and a care plan should be in existence and form the basis of the home’s own assessment.

Although care homes should base their own assessment of the individual upon the care plan, it is important that internal systems and procedures are in place to translate the care plan into actual daily living. Assessment of residents by care staff occurs from first contact, perhaps by admission meetings or discussions with residents or their families. Assessment within the care home setting is open to inter-observer error and bias.

Julie Swann, an independent occupational therapist, outlines the assessment of residents and how this relates to planning practical activities in a care setting.

Continuous assessment

No single assessment document captures needs forever, as they change and develop over time. Assessment is not a ‘one-off’ event, but part of a continuum that quantifies changes in a resident’s function.

We carry out informal assessment on a day-to-day basis, sometimes purely by observation. For example, when encountering a new situation or person, we quickly form judgments – often in an automatic and subconscious way. We have ‘gut-feelings’ about people and situations and observe appearance (clothing, posture, physique, facial expression and movement patterns), attitude and communication skills (words, tone, speed, non-verbal signals and body language).

We rely on many forms of perception to place facts and feelings into a framework to make decisions believed to be correct at the time. However, first impressions are not always the most reliable and a more systematic framework helps to minimize bias.

Formal assessment is structured. Assessment is open to inter-observer error and standardized testing helps reduce this through the following ways:

- Through validity, i.e. it measures what it says it measures
- By providing scoring systems with normative data on the population – results can be compared across age and gender, for example.

Department of Health guidelines

The National Service Framework for Older People (Department of Health, 2001) introduced the idea of a single assessment process (SAP) to avoid duplication of assessments and to ensure that older people receive appropriate, effective and timely responses to their health- and social-care needs, with professional resources used effectively.

The Department of Health’s (2002a) guidelines on suitable assessment criteria, although aimed at local NHS bodies and councils, contains useful material that care homes may find valuable. This document provides an overview of tests on specific areas, for example:

- Activities of daily living
- Mobility and balance
- Cognitive impairment and memory.

The National Minimum Care Standards for Care Homes for Older People (Department of Health, 2002b) introduced several standards that directly relate to practical activities with residential care. Standards 12–15 of this Act deal with the social contact and activities of service users. There is an expectation on homes to provide a varied and flexible routine of daily living and activities (standard 12).

Assessment within the care home setting

Care staff should identify and meet the unique and separate needs of individual residents. Most residents have the capacity for self-determination and staff should recognize the positive skills inherent with each individual. Much attention needs to be paid to the strengths and capacities of individuals to undertake tasks for them-
selves, as well as focusing on individual problems and difficulties.

Assessment holistically considers both strengths and development areas within a social and physical context. Assessment processes need to recognize physical or mental frailty, yet see the individual in broader dimensions. Individuals are not defined by their physical or mental frailty. It is inappropriate to refer to someone as 'the person with a stroke in room 22' or 'the person with Alzheimer’s in room 13'. We are all complex beings that live and function within a social setting.

It is possible to use a number of different assessment tools that can be of value to comply with the care standards regulations. The Department of Health’s (2004) guidelines provide advice on specific assessment scales that can be used in the assessment of older people’s needs and circumstances under the SAP. Inspectors look for evidence that care homes meet the assessed needs of service users and that changing needs continue to be met. Formal recording of assessment is therefore vital.

**A resident’s profile**

Care staff can use a resident’s profile to record assessment and preferences to help in the planning of appropriate practical activities. Essential information on previous lifestyle, medical problems, medication, communication skills, physical abilities, functional abilities and interests are noted. The family network, as well as any friends, neighbours, other residents or relatives who have regular contact with the individual, should be considered.

Completing a resident’s profile focuses on the abilities of a resident and methods that you can use to improve his or her quality of life. This alone can be motivating. By assessing a resident’s level of function and abilities, we identify strengths and problem areas. Additionally, a baseline of function is established to compare function over a period of time, to assess improvement or deterioration in abilities.

The information within your existing in-house assessments may provide sufficient detail, particularly if there is a section on recreational activities, hobbies or leisure – so ‘why re-invent the wheel’? Alternatively, you may find one of the many commercially available tests useful or wish to compile your own. Whatever form of assessment and intervention is selected, records should be kept. This is useful for sharing with other members of staff who may not be on duty at that particular time, and demonstrates positive intervention.

**Outcomes of assessment using a resident’s profile**

A resident’s profile can identify desirable outcomes to enhance lifestyle, improve function and abilities perhaps to achieve a greater degree of independence. Assessment may uncover areas of difficulty that need addressing and areas of ability that can be enhanced.

Problem areas can cause difficulties with activities of daily living and recreation that small assistive devices can address. For example:

- Resident A previously enjoyed bingo but his vision has deteriorated – large print bingo cards are available or can be made and an eyesight test arranged.
- Resident B has loss of arm function in one side (hemiparesis) – some adapted cutlery and crockery facilitate eating.

Care staff may discover a common interest or a common problem area that can be concentrated on within a programme of activities, perhaps on a small group basis. Assessment may identify that referral is needed to outside agencies, such as the continence advisor, physiotherapist or occupational therapist.

Although with the normal processes of ageing the body will slow down, it is...
important to maximize the remaining functions and maintain a reasonable quality of life. To enable residents to participate in leisure activities of their choice, therefore, is an important goal but it is also important to remember that residents may not want any active intervention and are quite content with their level of abilities and lifestyle. Not all residents wish to join in with group activities but may need individual help to continue to their interests while in residential care.

A regular review
Assessment is a continuous process, subject to adaptation and amendment. It is important that progress is reviewed regularly against set targets. This should include the residents and their carers. The review should be formally recorded with new targets established based upon clear and defined outcomes.

Conclusion
Assessment is not only a formal requirement, but a desirable activity in its own right. The outcome of assessment will be an improvement to the overall well-being of the residents within the home.

All care staff working within residential care should share the values and principles of maximizing independence, respecting individuals and maximizing self-determination. Within these principles, residents should be centre-stage and this equally applies to the assessment process. Individuals need to be actively involved from the first day of admission and encouraged to have ownership of their care plan, which staff work consistently and collectively towards achieving.

**KEY POINTS**

- Duplication of assessment will be avoided by reading information already obtained.
- Assessment should support but not replace judgment.
- Assessment should help, and not be time-consuming.
- Assessment should measure what it purports to measure.
- Assessment and provision of help is continuous.
- Regular formal reviews are needed, rather than assessment being a ‘one-off’.

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**Sources of Assessment Tests**

- Goyt Side Road
- Chesterfield
- Derbyshire S40 2PH
- Tel: 0845 230 2777
- Available from: www.winslow-cat.com/cgi-bin/winslow.storefront

- The Chiswick Centre
- 414 Chiswick High Road
- London W4 5TF
- Tel: 020 8996 8444
- Available from: www.nfer-nelson.co.uk

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