Assessment of Older People's Health and Social Care Needs and Preferences

Conference Proceedings

National Council on Ageing and Older People
An Chomhairle Náisiúnta um Aosú agus Daoine Aosta

Proceedings of the National Conference on the Assessment of Older People's Health and Social Care Needs and Preferences

Patricia Conboy (Editor)

National Council on Ageing and Older People

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Foreword

As Chairperson of the National Council on Ageing and Older People, it gives me great pleasure to present the Proceedings from the Conference on the Assessment of Older People's Health and Social Care Needs and Preferences.

The Conference took place on May 30th, 2002 in the Royal Marine Hotel, Dun Laoigaire. It attracted over 250 delegates from across the statutory, voluntary and private sectors and the interest that was expressed in the Conference was indicative of the growing recognition of the importance of establishing a more co-ordinated way of conducting health and social care assessments for older people. The Conference provided the opportunity to both discuss the necessity for a standardised approach to conducting assessments and to explore the merits of establishing a national framework for the multi-disciplinary assessment of older people's health and social care needs and preferences.

I would like to express my appreciation to the Chairs of each of the four Sessions and to the speakers for presenting such excellent papers. I would also like to thank the Conference participants for their contribution.

On behalf of the National Council on Ageing and Older People, I would like to thank the editor, Ms Patricia Conboy, for her commitment and dedication in preparing the Conference Proceedings. I would also like to thank Mr Bob Carroll, the Council's Director and Ms Sinead Quill, Research Officer for their commitment in the planning of this Conference. A very special thanks is due to Ms Michelle Rogers and the administrative staff of the Council who co-ordinated the planning and organisation of the event. Finally, thanks to Ms Deirdre Fitzpatrick who prepared the Proceedings for publication and to Sandwell Third Age Arts for providing the image used on the cover of the report.

Michael Loftus

Dr Michael Loftus
Chairperson NCAOP

Introduction to Conference Proceedings

Introduction to Conference Proceedings

The Structure of the Report

The structure of this report reflects the format of the National Conference on the Assessment of Older People's Health and Social Care Needs and Preferences. It begins with a welcome and introduction to the conference from the Chairperson of the National Council on Ageing and Older People, Dr Michael Loftus. The conference presentations follow.

The conference programme incorporated four sessions. A series of speakers presented papers at three of these sessions, with discussion time scheduled at the end of each one. The final session was a panel discussion, with brief contributions from three speakers, intended to trigger an exchange of views with conference participants. Outline details of the four sessions are set out below.

The Opening Session included presentations on:

- the policy context for the assessment of older people's health and social care needs
- old age screening and assessment in the community, incorporating Public Health Nurse and General Practitioner perspectives
- a project promoting an integrated hospital and community-based approach to assessment and provision of home supports to a targeted group of older people.

The second session, Specialist and Comprehensive Assessments, included presentations on :

- physiotherapy needs assessment
- psychiatric needs assessment in older people
- comprehensive geriatric assessment

Due to a late change in the schedule of presentations, a paper on the assessment of competence to drive was not delivered at the conference, but is included as an appendix to this report.

The third session, Current Initiatives, included presentations on:

- the development of standardised approaches to the assessment of older people's needs and preferences, with perspectives from the Southern Health Board and the North Eastern Health Board
- the single assessment process in the UK.

The final session focused on a theme, The Way Forward and raised questions as follows:

- a national framework for multi-disciplinary assessment?
- are there other priorities?

Conference Presentations

Opening Session

Considering the policy context, **Eamon O' Shea** said that good policy has been developed in respect of older people over the past fifteen years, but the issue is that the policy has not been implemented. He proposed that the approach to funding the long-stay care of older people should be underpinned, not by available funding and resources such as buildings and Nursing Homes, but by the care requirements of older people. These would best be determined by broad-based assessment of the older person's needs, incorporating the range of social and economic factors that impact on his/her capacity to continue living in the community. He clarified a distinction between the dependency of an older person and their situation of dependency as a consequence of social and economic factors. He went on to advocate a national approach to conduct in conducting dependency assessment for publicly-funded long-stay care on the basis that it would reduce inequity and he also recommended systemic changes, including the introduction of community subvention, to enable older people of low and medium dependency to continue living in the community.

Public Health Nurse (PHN) Perspectives on old age screening and assessment in the community were presented by **Margaret Daly**, Geraldine Tabb and Marion Duffy. Margaret Daly characterised assessment as a process rather than an event and she described how the patient-centred philosophy of PHN's influences their approach to assessment. She located the approach to assessment in the Southern Health Board within the framework of its strategy for the development of services for older people in Cork and Kerry, 'Ageing with Confidence'.

Geraldine Tabb's presentation concerned the piloting of the Winchester Disability Rating Scale (WDRS) as an approach to old age screening and assessment in the Waterford Community Care area of the South Eastern Health Board region. Among the reasons why this approach was developed were the requirement to develop anticipatory care and an 'at risk' register for older people in the community and the fact that the commonly used Barthel Index was insufficient on its own to measure the needs of older people. One of the outcomes of the project was the development of packages of care for 583 maximum dependency older people living in the community during the year 2001.

Marion Duffy described the approach to assessment developed in the Western Health Board. This incorporates a contact and overview assessment and four specialist assessments, one of which involves the application of a locally-developed functional and social assessment screening tool. The health board's intention was to develop a tool that was brief, easy to use, involved no extra cost and was pertinent for use in home/community settings by PHNs. Limitations of the tool included its failure to both highlight persons suffering physical and emotional abuse due to family distress and disharmony and to identify those suffering from depression. The benefits of the screening programme included the early identification of potential or actual problems and earlier referral and follow-up of problems.

Speaking from a GP perspective, **Dr. Sheelagh Prosser** shared the findings of a European working group for the standardised assessment of elderly people in the community called STEP. She identified the group's emphasis on the concept of proactive assessment as an important contribution to overall understanding of assessment. STEP has designed a standardised assessment tool for use in the

community which combines both health and social profiling. This tool has now been taken to each of the STEP member countries for evaluation. Caveats to be aware of in promoting the screening of older people were also identified. These related to the need to ensure that follow-up procedures and services are in place and available to older people in a timely way.

Adrian Charles and **Celine Deane** made a joint presentation about Home First, a collaborative project to provide home care for older people. With the support of the Eastern Regional Health Authority, Home First has been piloted by the Northern Area Health Board and Beaumont Hospital since 2000. Both speakers explained that the project seeks to develop comprehensive packages of care and support that will enable older people to continue living at home. Home First clients receive a geriatric assessment from a geriatrician, a psycho-social assessment from the Care Organiser (who is a member of the project team and acts as the client's advocate throughout the process) and multi-disciplinary assessment of clinical need as appropriate.

Second Session: Specialist and Comprehensive Assessments

The process of physiotherapy needs assessment was described by **Emma Stokes**. She explained that physiotherapists focus on identifying client needs at four levels, namely body functions, body structures, activity in terms of the execution of a task and participation in terms of involvement in a life situation. The physiotherapy assessment involves an objective examination of the person at the four levels identified, combined with the use of information from the client, colleagues and family members and carers as appropriate. Intervention treatment is then defined in terms of individualised short-term and long-term goals for the person, which take account of their own needs and preferences.

Psychiatric assessment focuses, **Dr Ruth Loane** explained, on the diagnosis of mental illness and on risk assessment. She said that mental illness in older people can be divided into two main categories, functional illness and organic illness. As a consultant in old age psychiatry, her caseload is divided into two main groups, with 50 percent of patients suffering from dementia with associated behavioural problems and 50 percent suffering from functional illness, mainly depression. The standard psychiatric assessment is carried out by one of the medical members of the multi-disciplinary team with further assessment by other members as required. The emphasis is on domiciliary assessment because it gives a more accurate assessment of an individual's cognitive function, an opportunity to assess the home circumstances of the patient and time to interview the carer. A history is taken from the patient in an individual interview, collateral history is gathered from relevant sources and a mental state examination is conducted. A medical examination can be carried out, if necessary. Based on the resulting formulation of the patient's situation, an individualised management plan is developed.

Prof Desmond O'Neill said that the goal of comprehensive geriatric assessment is individualised assessment leading to the individualised treatment of older people. Since disability increases with age, it is crucial that the older person's disease is recognised and treated appropriately, so that he or she is enabled to participate in and contribute to society. One of the main concerns about screening and the assessment of older people's needs is that it does not always result in appropriate referral and follow-up action. He said that ageism permeates society and this affects healthcare professionals and structures also. The fact that older people don't receive appropriate cancer treatment in some cases is one example of ageism in practice. The value of screening tools was highlighted, but it was

also emphasised that screening tools and policies alone will not meet the needs of older people. They are subsidiary to appropriate training, appropriate philosophy incorporated into everyday practice and the availability of adequate services to meet the needs of older people.

Third Session: Current Initiatives

In her presentation, **Ber Power** outlined the work undertaken in the Kerry Community Care area of the Southern Health Board in the development of a standardised approach to the assessment of older people's needs and preferences. The approach to assessment is developing within the framework provided by the board's 'Ageing with Care' strategy and comprises a system of procedures which form a continuum from initial assessment through to specialist assessment and assessment by age care evaluation team.

The North Eastern Health Board has, **Antoinette Doocey** said, developed a five-year strategy for the delivery of health and social services to older people, 'Healthy Ageing - A Secure Future'. This strategy is providing the framework for the development of instruments to assess older people's needs and preferences. The health board's view is that in the absence of such a framework, assessment will be carried out on a piecemeal basis. Having examined other models, it has identified the UK single assessment approach as one to which it can refer in developing its own process. A commitment to ongoing change management is seen by the NEHB as central to the successful development of a standardised approach to assessment.

The single assessment process in the UK was described by **Dr. Chris Dunstan**. Ideally, its key attributes are that the process is person-centred and standardised, duplication is avoided, clients are assessed to the correct level with triggers to further assessment as required, and the process is outcome-centred. The approach comprises a number of components. The client's basic data are collated and available to all professionals who need them. There is then a contact assessment on the basis of which a decision is made about the client's needs. If these include an overview, specialist or comprehensive assessment, the client is referred to whichever is appropriate. The implications for professionals of the single assessment process were also outlined. These include:

- understanding the person-centred values underpinning the process
- knowledge about the different types of assessment
- structuring information for sharing with other professionals
- acceptance of the need for culture change, supported by training.

One of the elements of culture change specified in this presentation is the need for professionals to aim for joint ownership of information to meet the needs of clients. Individualised concerns about ownership of parts of the information and the processes that comprise an overall assessment approach are barriers to effective joint working between all concerned.

Final Session: Panel Discussion

Three speakers made brief inputs to trigger an exchange of views with conference participants on the theme of the final session, 'The Way Forward'.

Dr Finbarr Corkery highlighted the need to maintain a balance between the work of generalists and specialists in the health system. He was opposed to the development of a centralised assessment framework, believing that the need is to achieve coherence at the local level, but to maintain the kind of flexibility that is responsive to local needs. He proposed the development of a mechanism to share information about the range of practice in assessment that had been presented at the conference.

Jimmy Duggan also advocated the establishment of a central point for the dissemination of information about assessment. Posing the question, 'what is it we want to move on to ?', he suggested that there was a need to develop a national approach to assessment and that the National Council might have a role in facilitating this development. He noted the concerns expressed at the conference that assessments may lead to raised expectations in circumstances where there are gaps and shortcomings in the system. His view was that assessments yield necessary information about existing levels of need, both met and unmet, in the older population. This information could support the case for increased resource allocation for older people.

Mary McDermott recommended the routine screening of older people who are well. She emphasised the need for the health services to be able to respond to needs identified through the screening and assessment of older people. She said that a common assessment process for admission of older people to residential care is needed. In terms of the way forward on assessment, she expressed the view that a process is needed to help people clarify where they want to go and how they want to get there. She felt that the establishment of a national steering committee could be the way to approach this process.

Chairperson's Welcome and Introduction

Chairperson's Welcome and Introduction

Dr Michael Loftus, Chairperson, National Council on Ageing and Older People

It is my great pleasure to join in the Cead Mile Failte to each and everyone of you to this, the National Conference on the Assessment of Older People's Health and Social Care Needs and Preferences. Your presence in such numbers here this morning is proof, if proof were needed, of the commitment of health and social care professionals to older people and to good practice in their provision of health and social services.

Older people are a heterogeneous group with diverse needs. They often suffer from multiple inter-related medical, social, functional and environmental problems requiring the assistance of a number of health and social care providers. Current health and social needs assessments are carried out using a number of different assessment instruments in a wide range of service settings, depending on the service that is being accessed by the older person. Due to the diversity of an older person's needs and preferences and the variety of professionals conducting assessments and the range of settings in which assessments take place, it can often be difficult to correlate the various elements of the assessment. This in turn makes it difficult to devise and deliver a plan of action to meet the needs and preferences of an older person in a person-centred and holistic way.

Right from the outset, I would like to state that we in the National Council on Ageing and Older People do not pretend to know any more than others about the complexity of assessing older people's health needs, much less how assessments should be conducted and co-ordinated. The Council has organised the conference out of a conviction that it is important to provide a forum at national level for all professionals engaged in assessing frail, ill or disabled older people's needs and in planning a co-ordinated service for them on the basis of the needs identified. It is therefore hoped that this conference will provide an opportunity for an exchange of views on, and experiences of, old age screening and assessment practices.

While the Council is by no means expert in the field of old age assessment, some of its recent reports have highlighted the necessity for a better system of identifying older people's needs and preferences to ensure that services are delivered to a high standard and on an equitable basis. The Council report, *A Framework for Quality in Long-Term Residential Care for Older People in Ireland*, highlighted the necessity of identifying the needs of older people entering long-term care through a comprehensive assessment procedure in order to guarantee a high standard of care. This report concluded that it was important that a multi-disciplinary team should be involved in a thorough evaluation of the health and social status of older people entering residential care.

In relation to acute and community care, the HeSSOP study of 2001 recommended that a framework for the multi-disciplinary assessment of older people be developed at a national level in order to ensure fairer access to services, based on clear and universal guidelines of eligibility. The report, Care and Case Management for Older People, published in 2001, documented an unease expressed by

health and social care providers, both about the multiplicity of assessment tools for older people that were currently being used and the manner in which assessments were carried out separately across disciplines. On the basis of these findings, the Council recommended that the development of a standardised generic assessment tool be made a priority.

There is growing evidence for the need to establish a more co-ordinated way of conducting health and social care assessments for older people. It is hoped that the Conference today will provide an opportunity to both discuss the necessity for a standardised approach to conducting old age Assessments and to explore the merits of establishing a national framework for the multi-disciplinary assessment of older people's health and social care needs and preferences. Finally, it is hoped that the Conference today will identify priorities for the further development and improvement of old age assessment policies and practices in the context of promoting equality of access to health and social care services for older people.

The National Health Strategy has proposed that the principles of equity and person-centredness will be central to developing policies to ensure equitable access to services based on need. The development of timely, accurate and appropriate assessments of the needs and preferences of older people will ensure that they are directed to the services that are most appropriate to their needs. It will also ensure that, in the words of the Health Strategy, the right care will be given in the right place and at the right time.

The Conference today is intended as the first word rather than the last and as an impetus for further discussion and debate about the complex issues surrounding old age assessments. I believe that this Conference is timely and the huge interest that has been expressed in it is indicative of the mood for change that is currently manifest throughout the health and social care system. There is a great desire to place the consumer at the heart of service planning and provision. Service planning and provision begins with assessment. If we get this process right, the concepts of health and social gain will move closer to becoming a reality for the older people who need to access health and social services.

Thank you very much.

Opening Session

Chair: **Dr John Gibbon**, Retired Consultant Physician in Geriatric Medicine and member of the National Council on Ageing and Older People

Assessment of Older People's Health and Social Care Needs : The Policy Context

Dr Eamon O'Shea, Economist, National University of Ireland, Galway

Introduction

This paper considers the policy context within which approaches to the assessment of older people's health and social care needs and preferences are being explored at the Conference today. Broadly, good policy has been developed over the past fifteen years with respect to older people, but the issue is that stated policy objectives have not been implemented. There is agreement that, by and large, older people want to live at home, that they should be able to do so and that the range of community care options to support that choice needs to be extended. Implementing policy and reallocating resources so that older people are enabled to live at home is, in my view, a priority for the next three to five years.

Principles for Funding Long-Stay Care

A number of basic principles should underpin the approach to funding the long-stay care of older people.

Funding

Funding should not determine care requirements; rather care requirements should determine funding. For example the availability of buildings and nursing homes should not determine the flow of funding in that direction. What is needed is broad-based assessments which, instead of focusing primarily on the physical dependency or mental state of an older person, consider the whole range of social and economic factors that have an impact on the decision of an older person, in a state of dependency, to continue living at home.

Dependency and Situation of Dependency

It is also critical to make a distinction between the terms 'dependency' and 'situation of dependency'. For example, we talk about 'social dependency' when, more accurately, we should think in terms of factors creating social dependency. Social factors are a cause of dependency and 'social dependency' is not itself a measure, though there is sometimes confusion about this in our approaches to assessment.

Bias Towards Home Care Solutions

There should be a built-in bias towards home care solutions while retaining a capacity for financing care in institutional settings.

The Need for Equity

The access of older people to appropriate care should be on the basis of need and should not be impeded by an inability to pay or by geography. However, the reality is that where older people live does determine the process surrounding them, in terms of the availability of services, the allocation to care, the measurement of dependency and the assessment of need. This is creating inequity and is a situation that needs to be redressed in terms of the implementation of stated policy objectives.

Aspects of the Current Environment

There are a number of known aspects of the current environment which need to be addressed. These include the following :

- in terms of resource allocation, demand is skewed in the direction of the option of residential care
- demands on the exchequer from the Nursing Homes Subvention Scheme have made significant calls on the available public resources for older people and have skewed resource allocation in the direction of residential care
- there is an absence of an in-built bias in support of community care
- there is little by way of innovation and ingenuity towards of community care
- family care is viewed as a free resource.

Taken together, these aspects point to the need to think about the overall care process and about the development of community and social care approaches in a more eclectic and holistic way than we have been doing. We need broad-based assessment of older people's health and social care needs and preferences to help us to do this.

The assessment process should focus on the real needs of older people, recognising that dependency is just one part of the process. With regard to dependency, there are a number of factors to be considered, as outlined below.

Common Understandings

There is a need for the establishment of a common dependency assessment for all types of publicly-funded long-stay care, or at a minimum, some discussion of the assessment and dependency measures and tools currently in use. Within and across health boards, there is variation in the measures and tools in use and, where there is such wide variation, inequity is inevitable.

There is a need for national guidelines for the measurement of dependency or, again at a minimum, some broad agreement as to what is being measured when the dependency of older people, including their physical and mental dependency, is assessed. This is a need which could be addressed within three to six months.

People with Low or Medium Dependency

Older people with low or medium dependency ought to be cared for in an expanded community care system rather than in long-stay care, unless they themselves choose otherwise. However, the most recently published statistics on people in long-stay care show that one in three of those are of low or medium dependency. People working with the Nursing Home Subvention Scheme will also know about 'dependency creep' through which older people are assigned to higher levels of dependency simply to take advantage of higher levels of subvention. If we are changing the behaviour of those assessing dependency because of funding mechanisms, this is an irrational way of allocating older people to care, of measuring dependency and of funding long-stay care and it needs to stop.

In the context of changing the structure of the system to enable people of low and medium dependency to be cared for within community care settings, we need also to identify and address the economic and social determinants of dependency.

An Integrated Approach

For high dependency older people, there should be a guarantee that all possible community care strategies will be explored before a decision on admission to residential care is taken. This requires an expansion of the community care system, but does not imply the creation of a dichotomy between community and institutional long-stay systems.

We need one subvention payment for dependency instead of the three-tiered payment mechanism currently in use, because only seriously dependent people should now be in care.

Public hospital beds should be reserved for those in need of intensive nursing care, with significant public investment in, and development of, both rehabilitation and step-down facilities for older people. In other words, what is needed is an integrated care system for long-stay care, predicated on the view that community care is a viable option.

Subventions for Community Care

The policy context must include community-based measures of support. Subventions for community care might not be the best term but, whatever the term, there needs to be an equalising of opportunity for people living in community care. The following points are relevant:

- a subvention for nursing home care should never be granted unless it is clear that the older person concerned cannot be looked after at home. Pilot studies examining community care subvention systems are needed in all health board areas and in urban and rural areas. These studies could be conducted over the next six to twelve months

- in terms of funding, the costs of community care subvention could be met as a percentage of the residential care rate. In other words, it would be marginal funding and, with an investment of €100,000,000, a lot of progress could be made in terms of developing viable community care options

- community-based subvention should be targeted at people on the boundary of in-patient care

- community based living ought to be facilitated by needs assessment rather than dependency assessment

- packages of care, funded by a new community care subvention scheme, should be negotiated between the relevant health board personnel (optimally through a designated Care Manager) and older people and their families. This would form part of the pilot study process referred to above

- new services should be put in place and all of these should be made more flexible to support care in the evenings, at night and at weekends

- in thinking about dependency, we need to distinguish between older dependent people and older people in situation of dependency. If we both made the distinction and then, in our policy implementation process, acted on that distinction, I think we would have made real progress.

Conclusion

In conclusion, we need to conduct assessments of older people's needs and preferences that take into account their income, family care, social networks, access to health and social services, housing and transport. Each of these factors impacts on the quality of life and well-being of the older person. For example, if housing is the issue that is creating a situation of dependency for an older person, then housing is the problem that must be solved. The solution is an integrated approach on the part of the health board and local authority, not sending the older person concerned to a nursing home.

Our policy framework and culture also have an impact on the quality of life and well-being of older people. We have the policy right, but we have not, as I've already said, been able to implement it. The consequence has been that many older people have not been able to end their lives in places where they would have chosen to.

You cannot look at policy implementation and the allocation of resources outside the prevailing

culture within which there is a significant degree of ageism. As a society we have to move beyond economic determinism to consider philosophical, social and ethical dimensions of human existence. More public and philosophical discussion is needed about the role of older people in society and about notions of kinship, solidarity and the relationship between older people and their families. Intergenerational solidarity at the levels of the family and the state is the key to achieving full citizenship for all elderly people. That solidarity cannot be taken for granted and must be continually renewed through dialogue and discussion among all of the social partners, including older people themselves.

Pathways to Care – Old Age Screening and Assessment in the Community: Public Health Nurse Perspectives on Practices and Procedures

Margaret Daly, Director of Public Health Nursing, Southern Health Board

Introduction

The aim of this paper is to present a Public Health Nurse perspective on old age screening and assessment in the community

The Philosophy of Public Health Nursing

The philosophy that PHNs work from combines a patient-centred approach with the goal of empowering people in self-care. This flows from their training which is based on meeting the biological, psychological, developmental and social needs of patients. For good health people must have their physiological needs met, have a positive self-concept, fulfil social roles and be able to strike a balance in relationships with others[1]. The PHN assesses needs bearing all of these factors in mind and she does this for individuals, communities and populations.

The Process of Assessment

Assessment is a process rather than an event. In assessing a patient, the PHN looks at the individual's health-illness continuum, taking into account his or her hereditary disposition, lifestyle, risk factors in the lifestyle as well as activities promoting health, such as diet and exercise in that life style and environmental factors such as housing and transport.

From that assessment, a nursing diagnosis is made combining both subjective and objective data. The subjective data comes from the patient's own view of the situation and the objective data comes from the examination by the PHN and others. This leads to the development of a care plan which is implemented and evaluated in collaboration with other members of the multi-disciplinary health care team.

1. Clark, M.J. (1999), 3rd edition, Nursing in the Community, Appleton and Lange: Stamford, Connecticut.

Assessment Levels and Tools

Any assessment we do can be conducted at three levels: the basic level which looks at functional activities and personal care, the instrumental or intermediate level which is concerned with tasks of moderate complexity, such as shopping, doing the laundry, self medications, the advanced activities of daily living, for example, the occupational or recreational activities of the older person.

In the Southern Health Board, the assessment tools that we are using include the Barthel Index, the Abbreviated Mental Test (AMT) and the Mini Mental Test Exam (MMSE). Each has its strengths and limitations. The Barthel Index looks at functional activities only and does not cover social activities. The AMT looks at orientation and gives a global measure of mental health. The MMSE attempts to measure cognitive and behavioural tasks, but is open to misinterpretation. For example, a well-educated older person can cover up some cognitive difficulties and score a false positive. Equally, a poorly-educated older person can score a false negative.

Ageing with Confidence

'Ageing with Confidence' is the strategy which expresses our vision for the development of services for older people in Cork and Kerry. It provides a framework for service development and implementation, has informed our planning process and incorporates an agreed assessment approach. What we are working towards, within the direction provided by 'Ageing with Confidence', is an assessment process that is:

- continuous
- inclusive of both carers and patients
- patient-centred
- enabled by the sharing of information from other professionals and agencies
- supported by reflective practice on the part of the professionals involved
- has links between assessment outcomes and evaluation.

Conclusion

I would like to leave you with a comment from Muir Grey who suggested that, in the health care sector:

- the 1970s had been about doing things cheaper
- the 1980s about doing things better
- the 1990s about doing the right things
- the twenty-first century would be about doing the right things right[2].

2. Grey, M. (1997), Evidence Based Health Care, Sage: London.

Pathways to Care – Old Age Screening and Assessment in the Community : Using the Winchester Disability Rating Scale (WDRS)

Geraldine Tabb, Director of Public Health Nursing, South Eastern Health Board

Introduction

This paper concerns the piloting of the Winchester Disability Rating Scale (WDRS) as an approach to old age screening and assessment in the community in the Waterford Community Care area of the South Eastern Health Board region.

Rationale for the Pilot Project

There were a number of reasons why we, as Public Health Nurses, decided to pilot the Winchester Disability Rating Scale in our work with older people. These were:

- the requirement to plan services
- the need to plan and develop our anticipatory care of older people as opposed to crisis intervention
- the requirement to develop suitable 'packages of care' for older people
- the need to develop an 'at risk' register for older people in the community
- the fact that the commonly-used Barthel scale was insufficient on its own to measure the needs of older people
- the lack of standardised reliable instruments for use in our screening and needs assessment processes with older people.

The Winchester Disability Rating Scale

The Winchester Disability Rating Scale is a fifteen item instrument designed to measure an individual's ability to perform the activities of daily living (ADL).
It includes sub-scales which measure :

- activities of daily living (ADL)
- social care
- mental health

- general health
- vision and hearing

For each sub-scale, the WDRS has five response options, compared to the Barthel which has just three response options. This means that the data gathered is more specific and useful to the PHN.

Implementation of the Project

The project commenced in November 1999 and was completed in February 2000. During this time, all clients aged 75 years and over, with medical cards, were visited and assessed using the WDRS. They numbered 3,871 clients in all. Those with scores of 33 or more were identified as being at risk and nursing care plans were put in place. The project was subsequently audited using a set of questions put to participating PHNs and recommendations arising from the audit were implemented. Community RGNs and home care assistants were employed in January 2001 and have continued to work on the project to date.

Intermediate Outcomes

The intermediate outcomes of the project were as follows :

- a total of 3,871 medical card holders were visited and assessed
- of those, 6.4 per cent (274) were found to have a WDRS score of 33 or more. Females outnumbered males by two to one
- the most common risk factors were a medical condition combined with living alone
- we found that WDRS was useful as a measure of disability
- it identified actual as opposed to potential problems
- in an audit of care plans, we found thirty-one nursing problems
- one of the issues arising was the non-availability of services; specifically home helps and home care assistants in the numbers required. As a result of identifying this as an issue, we were given funding to provide these services, thus developing the skill mix team in our area
- the project represents value for money: 583 maximum dependency patients were provided with a package of care and maintained at home in 2001; of 989 discharges from Waterford Regional Hospital for the same period, 512 patients were provided with a package of care following assessment by the area PHN; the total cost of the service for 2001 was £31,525.

Conclusion

Through the WDRS pilot project, we have operationalised an 'at risk' register for older people in our Community Care area. This register is updated monthly by PHNs and helps us to identify older people who will need packages of care.

Information from the 'at risk' register is currently being shared with the Accident and Emergency Department of Waterford Regional Hospital on a pilot basis. A directory of PHN's, with their contact details, has been supplied to each ward at Waterford Regional Hospital to facilitate early discharge planning.

There are now data available to assist anticipatory service planning, and packages of care providing home support, have been developed for patients, as outlined earlier.

Pathways to Care: Old Age Screening and Assessment in the Community: The Approach of Public Health Nurses in the Western Health Board

Marion Duffy, Public Health Nurse, Western Health Board

Introduction

This paper provides an overview of the assessment of older people carried out by PHN's in the Western Health Board area. Specifically, it describes a functional and social assessment screening tool developed for the assessment of older people in our area.

The comprehensive assessment of older people is a structured approach to measuring their physical, mental and social functioning in order to identify needs and plan care. The process of assessment with an older person is an opportunity to learn more about the individual, his/her current situation, experiences and desires for the future. It is also an opportunity to build a relationship with the individual, to offer a professional view on problems and to plan with the individual, family and carers, if appropriate, what treatment, supports and services could best meet needs. The older person should be at the centre of assessment and should feel empowered by the process.

The Assessment of Older People's Needs in the WHB

The WHB Approach to Assessment

The approach to assessment developed in the Western Health Board area includes a contact and overview assessment and four specialist assessments that provide a holistic view of an older person's needs. These assessments are in the areas of:

- twelve activities of daily living
- application of a functional and social assessment screening tool
- pressure risk assessment, using the Norton Score
- continence assessment.

Background to the Development of the Assessment Tool

In terms of older people, PHN's concentrate on providing a service to older people aged 75 years and over. The service includes provision of a surveillance programme, screening programme, monitoring of the elderly at risk and treatment and care service. PHN's by tradition maintain a register of persons at risk, but the criteria for inclusion have not yet been standardised at regional or national level. The PHN department in the WHB, conscious of the need to standardise criteria for identifying older people at risk, set about developing a procedure for functional assessment screening of the elderly by PHN's which would be consistent throughout the health board area. A Regional Working Group, comprising PHNs, DPHNs and a Consultant Geriatrician was established to work on the project.

Development of the Tool

Four criteria were observed in developing the Functional and Social Assessment Tool. It needed to:

- be brief
- be easy to carry out
- involve no extra cost
- be pertinent for use in home/community settings by PHNs.

The first goal in developing the tool was to identify unappreciated functional disabilities that should be systematically reviewed for older people. After the list was formulated, suitable procedures to evaluate the disabilities were devised. A pilot study was carried out in 1993 and the screening programme introduced in 1994, following education of all PHNs in the region on the use and interpretation of the findings.

The WHB Functional and Social Assessment Tool

The WHB tool was divided into functional assessment and social assessment. Many of the functional problems of older people are relatively minor, but can have a significant effect on the quality of life. Screening has an important part to play in helping people to realise that their problems are not part of a normal ageing process and that solutions can be found. Functional assessment is of the older person's vision, hearing, continence, mental status, vulnerability to falls and mobility. Social assessment is of the older people's social support (for example who they would call in an emergency); their social risk (for example, whether they are in need of support services); their economic situation; their housing and house-keeping ability.

Limitations of the WHB Tool

PHNS in the WHB found that the functional and social assessment tool was easy to use. However, they have also identified some limitations. These are as follows:

- it did not necessarily identify people at risk
- the carer's opinion was not taken into account
- it did not highlight persons suffering physical and emotional abuse due to family stress and disharmony

- older people suffering depression were not identified
- it did not take account of the cost impact on subsequent service utilisation.

Reflections on the Screening of Older People

Potential Risks of Screening Older People

Screening is not without its risks and nurses should consider the following issues carefully when undertaking a screening programme with older people:

- the sensitivity of highlighting problems not previously realised by the older person
- expectations may be raised and solutions to their problems may not be found
- there is a risk of intrusion of privacy, though this can be overcome by giving adequate explanation of the purpose of the assessment
- it is important to remember that the person being assessed may be a carer.

Benefits of Screening Older People

A screening programme for older people has benefits. These are :

- the early identification of potential or actual problems
- earlier referral and follow-up of problems
- contribution to appropriate care planning
- opportunity for primary prevention/health education
- opportunity to give information about services and entitlements.

Some Reflections on the Assessment Process

While the comprehensive assessment process described uses a combination of tools in supporting professional judgement, it recognises that many older people have health and social care needs and that professionals need to work together so that assessment and subsequent care planning is person-centred, effective and co-ordinated.

Since the well-being of older people is often dependent on the effectiveness and health of family members, the assessment process should extend to include family carers. In our approach, the dependency levels are not measured by tools such as the Barthel Index and it could be argued that this makes it difficult to assess improvement in a person's functional or social ability. However, if nurses are to be effective in their role, they need to adopt a holistic framework. This includes seeing the experiences of older people as the older people themselves see them. It also means not reducing and compartmentalising people into quantifiable or measurable indices. Independent living is more dependent on the older person's own perspective and on psychological, environmental and social factors than on functional ability.

Finally, there is little point in screening persons unless services and treatments are available, acceptable and can influence the course and progress of a disease. A high detection rate can swamp existing facilities, causing frustration and distress to all concerned.

Conclusion

Our screening programme for older people has been successful in as much as it has identified a number of undiagnosed problems, in particular vision and hearing problems. In order to fully assess the screening programme, it would be necessary to carry out a clinical audit of outcomes of referrals of older people in the WHB. A review of the screening programme has been recommended in the WHB, 'Services for Older People – A Strategy for Health and Well-Being 2001-2006'.

Pathways to Care - Old Age Screening and Assessment in the Community : A General Practitioner Perspective

Dr Sheelagh Prosser, General Practitioner, Bruckless, Co. Donegal

Introduction

As a General Practitioner with a special interest in old age screening and assessment in the community, I would like to bring both that perspective and a focus on an evidence-based approach to assessment to you today.

Standardised Assessment of Elderly People (STEP)

In March of 2002, we saw the publication of the report of the STEP group which is a European working group for the Standardised Assessment of Elderly People in the community in Primary Care in Europe. One of the outcomes of the group's work is the recent report, *Royal College of General Practitioners*, OCC. Paper No. 82. It is an important report because it will add to our knowledge base for models for the assessment of elderly people in primary care.

Reactive Assessments

At present, there is a focus on reactive assessments in Ireland. These occur:

- when there is an actual or potential breakdown of independent living
- on admission into a residential or other long-term care facility
- on discharge from hospital
- when there is a crisis in the community, whether medical or social.

The most common example of reactive assessment we hear about is the comprehensive geriatric assessment, often conducted by a multi-disciplinary team in a hospital Geriatric Department.

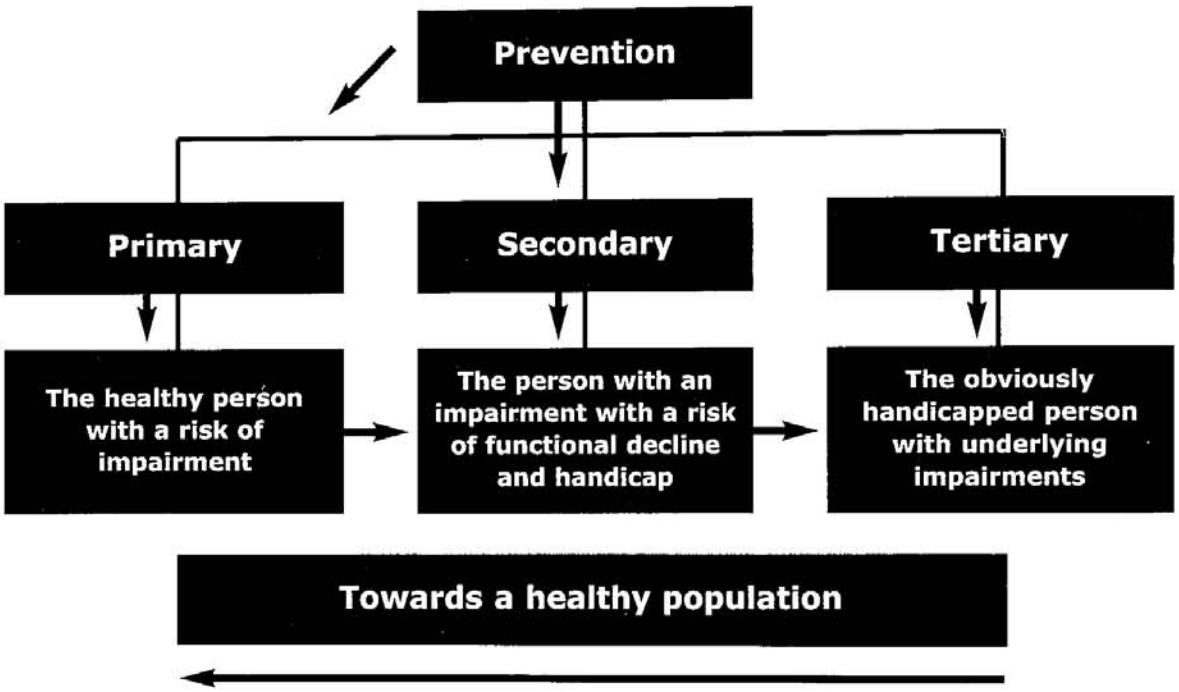
Proactive Assessment

The great contribution of the STEP group was to try and bring the concept of a proactive assessment to our understanding of what we should do in the community. The overall aim of the group was to

improve the quality of life of older people and to preserve their autonomy in the community. In order to do this, it had three objectives.

The first of these objectives was to design a standardised assessment tool for use in the community which would combine health and social profiling since economic status and social status are the best predictors of health in older age. It will be important to integrate into assessment tools the concepts of primary, secondary and tertiary prevention as illustrated in Figure 1. For example primary prevention applies to the person who needs to go into an influenza programme, secondary prevention to the person with hypertension who needs to be adequately treated to prevent stroke, so that such persons don't get the diseases which bring them to hospital, take them into the category of dependency and the ensuing need for comprehensive geriatric assessment.

Figure 1: Proactive Assessment



The STEP group had a secondary objective of reviewing the quality of scientific evidence for screening and therapy of selected disease groups, for example cardiovascular disease and mental health disease. It has looked at the evidence base for using symptom questions for screening in primary care. It has also coined an approach which is unique in that they have defined a preventive primary care impact factor. This incorporates the screening and prevention of diseases not known to the assessor, with expert and improved management of existing disease, which is an important development. It also ranks the importance, in preventive terms, of diseases such as high blood pressure and this is a significant contribution to good preventive care for older people.

Standardised Proactive Assessment Instrument

A two-part standardised proactive assessment instrument has been designed by the STEP group and this has been taken to each of the European member countries for evaluation. Part I of the assessment involves a thirty-point questionnaire which may be self-administered by the patient, though if an assessor is present with the patient, he/she can gain great insight into the patient. If there are certain areas of positive response in Part 1, a trained assessor then conducts a follow-up, thirty-point assessment with the patient. In Part 2 of the assessment, the emphasis is on administration by a trained assessor, since it includes clinical questions which would have medico-legal consequences if not followed up properly.

Screening Older People: Caveats

There are two caveats to be aware of in promoting the screening of older people. The STEP group is anxious that older people should not go into a screening programme unless follow-up procedures and services are in place and likely to be available to them in a timely way. Otherwise expectations are raised that cannot be met and this is ethically questionable. It is also extremely frustrating for workers in services to identify conditions and find that they cannot do anything about them[3].

Conclusion

There are important overview issues and questions to be considered as we become involved in a process which may lead to a national assessment framework for older people in the community. We need to adhere to WHO/Wilson's 1968 principles and practices for screening disease which state that:

- screening must deal with common and important health problems
- it must deal with significant unreported illness
- intervention must be of benefit
- suitable tests must be available, with high degrees of sensitivity and specificity so that tests yielding high numbers of false positives or false negatives are disregarded
- side-effects must be low and procedures should not distress patients more than they benefit them
- treatment/therapy must be available
- the procedure must be acceptable to patients and not be carried out if it is not
- it must be cost effective and costs in this exercise must be looked at broadly so that the cost implications of primary prevention, of reducing the possibilities of patients arriving in hospitals, for example, are fully considered.

3. Dr Prosser's own research background has been with the National Care of the Elderly Study, implemented by the Irish College of General Practitioners, following the 1991 Year of the Elderly. This research was conducted across 26 counties, involved 350 GPs and 2,617 patients and studied the prevalence of mobility, hearing, vision and incontinence problems in older people in the community. The results of the four studies were presented in her paper, as were the referral patterns to hospitals and community services. The detailed research findings have been published in the British Journal of General Practice, the European Journal of General Practice and the Irish Medical Journal. See Natin D. Prosser, S. Maguire N. Boland K. 'Screening for visual problems in elderly patients in general practice'. Eur J Gen Pract 2000; 6:10-14; Maguire N, Prosser S, Boland R, McDonnell A, Screening for hearing loss in general practice using a questionnaire and the Whisper Test, Eur, J. Gen Pract 1998; 4 : 18-21; Dobbs, F, Prosser, S, Maguire, N.. 'Mobility Screening in the elderly and resulting referral'. Irish Med Journal 1999 vol 92:1; and Prosser, S. Dobbs, F. 'Case-finding Incontinence in the over 75s' BJGP 1997, 47, 498-500.

Finally, my view is that we need a national model for the assessment of older people's health needs. I don't favour the development of models within individual health boards since this leads to the duplication of scarce resources. We have seen here that there is great expertise within each health board area and I would be in favour of selecting and combining from that experience and expertise to produce the best thinking in this area.

Assessment of the Health and Social Care Needs of Older People: The Northern Area Health Board/Beaumont Hospital Home First Experience

Adrian Charles, General Manager, Community Services, Northern Area Health Board
Celine Deane, Head Social Worker, Beaumont Hospital, Dublin

Introduction

This paper concerns Home First, a collaborative project to provide home care for older people. With the support of the Eastern Regional Health Authority, Home First has been piloted on a partnership basis by the Northern Area Health Board, Community Services 8, one of three management units in the ERHA, and Beaumont Hospital since 2000. The Home First project seeks to develop comprehensive packages of care that will provide the increased level and availability of home support to enable older people to continue living at home. The Authority has provided €630,000 to fund the initiative and the first patient was discharged from hospital to Home First in March 2001.

The Philosophy of Home First

The philosophy underpinning Home First is people-centredness. The crux of patient-centred care is informed and shared decision-making. The success of patient-centred care depends on achieving a satisfactory blend of professional, managerial and person-centred perspectives. At present, in the planning and delivery of services, the main influence determining the assessment of need and the resources necessary to provide for these needs is the professional and managerial perspective.

In this climate, older people seek a new vision of care established on the principles of respect, dignity and choice. This vision of ageing highlights the need for a holistic approach and an acceptance of the importance of home and community care. This vision introduces a new perspective which moves the planning and delivery of care from a service-driven approach to a needs-led programme of care. This shift is significant as the service offered then places the person who uses the service at the centre of the process.

The ERHA in its own ten-year 'Action Plan for Services for Older Persons' affirms the principles of care recommended in *The Years Ahead: Shaping a Healthier Future and Quality and Fairness* (1994).

These principles, which have influenced the development of Home First, are:

- to maintain older people in dignity and independence at home in accordance with the wishes of older people as expressed in many research studies
- to restore to independence at home those older people who become ill or dependent
- to encourage and support the care of older people in their own community by family, neighbours and voluntary bodies in every way possible
- to provide a high quality of hospital and residential care for older people when they can no longer be maintained in dignity and independence at home.

Principles of the Assessment Process

The assessment process is the cornerstone of the Home First project. A comprehensive assessment process cannot pre suppose the service outcome in the initial service response. The response, most often in the form of a Care Plan, can only be considered when the strengths and needs of each client are identified. In this process the client contributes as an equal participant in the process, regardless of his or her dependency level. The assessment must pay particular attention to the needs of family carers for support and access to respite and the impact of caring on their physical and emotional well-being.

The principles that underline the care team's approach to assessment are as follows:

- responding flexibly and sensitively to the needs of each individual and their carers
- treating older people and their carers with dignity and respect
- exploring a range of options for care in order to widen the choice for older people
- focusing on enabling older people to go on living at home for as long as is practical
- intervening only when necessary
- encouraging and equipping older people and their carers to play an active part in the assessment of their needs and the shaping of their care arrangements
- having a multi-disciplinary framework.

Objectives of Home First Project

The objectives of Home First are to put the principles described above into a workable framework:

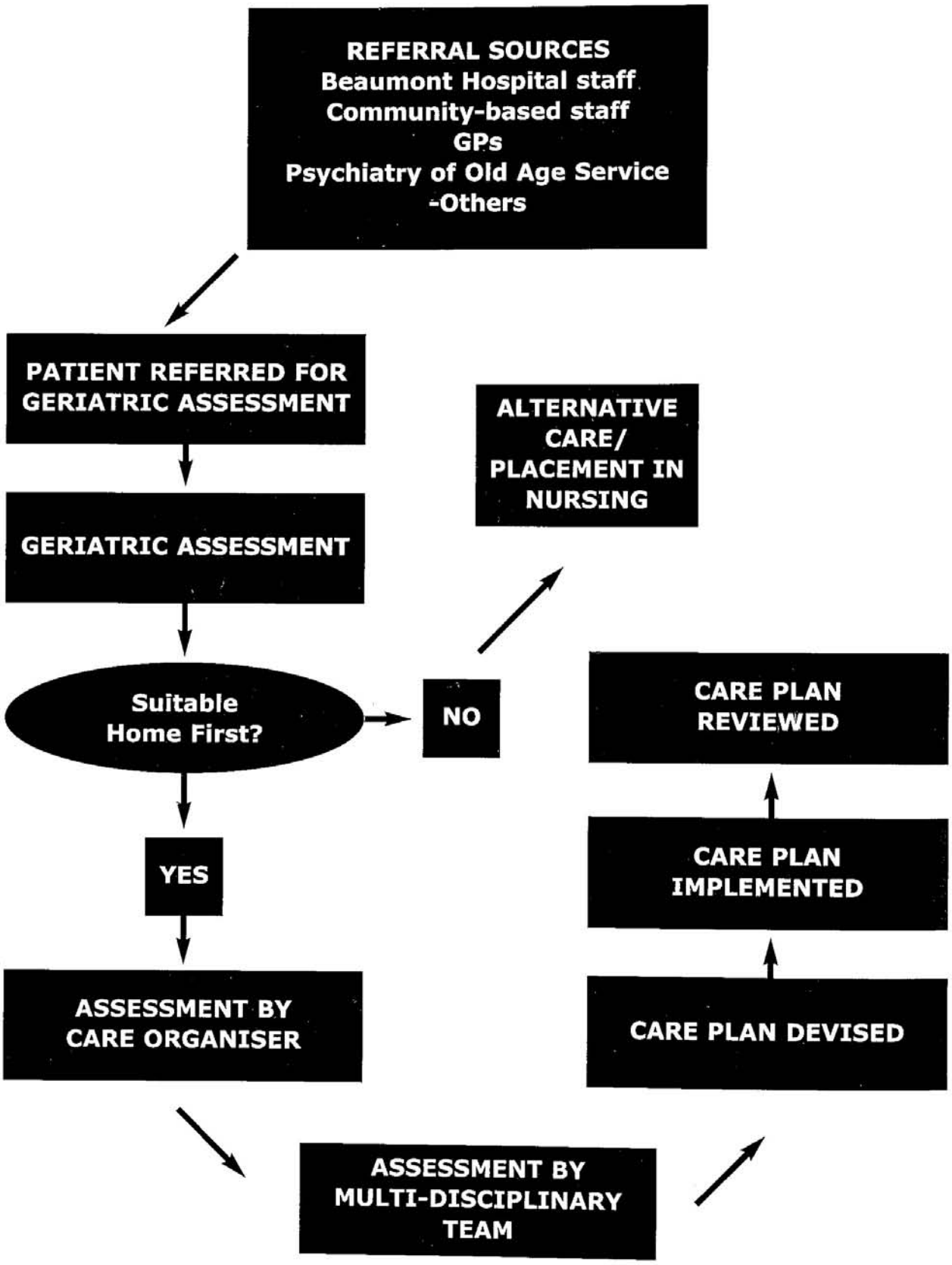
- to enable the older person to return home following discharge from hospital
- to modify levels of home-based services to enable older people remain at home where this is their choice
- to develop a seamless and integrated partnership between the primary care team, other agencies and the acute hospital to ensure the delivery of quality care for older people
- to develop a consultation process and evaluation of services by all concerned, ensuring that older people contribute to decision-making in a more equal and meaningful way
- to develop quality assurance systems in all care settings.

The Assessment Process

The assessment process in Home First, which is illustrated in Figure 2, incorporates a number of key elements. These are:

- collection of baseline information including psycho-social and functional assessments, along with standardised assessments such as Barthel, Easycare, Mini Mental Test Score and mobility/disability assessment
- multi-disciplinary assessment of clinical need as appropriate, with user involvement. (A basic assumption of many standardised measurement tools is the idea of improvement as an outcome measure. However, for many clients in Home First, maintenance of their current level of function and prevention of deterioration are valid goals. This area of assessment remains an ongoing challenge to the team
- discharge planning, including the production of a care plan, and the collection of qualitative information
- monitoring patient progress and identifying barriers that may impede choice
- matching patient experience to realistic expectations
- ongoing assessment by the team to reflect changing needs and to allow adaptations to the care plan as needed
- mechanism for direct referral for reassessment to the fortnightly Home First clinic in Beaumont Hospital.

Figure 2 Assessment Flow Chart



How Home First is Structured

The members of the Home First team are:

- the Care Organiser
- the Assistant Director of Public Health Nursing
- the Domiciliary Care Manager
- the Social Worker
- the Senior Occupational Therapist
- the Senior Physiotherapist
- Registered General Nurses
- home support workers.

Role of the Care Organiser

The role of the Care Organiser, as the initial contact for the patient and his or her carers with the project, has been very significant. The Care Organiser helps the older people with the assessment of their needs by ensuring that the appropriate package of care is drawn up, monitored and reviewed regularly.

The Care Organiser is the principal advocate who maintains a supportive caring relationship with the older person and acts as a broker between the different service providers.

He or she also ensures that the nature of need presented is matched to the appropriate professional or community service.

Some Reflections on the Role of the Care Organiser

While there are many similarities between the role of Care Organiser and the Care Management model practised in the UK and Northern Ireland, there are fundamental differences that have been key to the success of the Home First project to date. We have found that the Care Organiser plays an important role in:

- empowering the older person in the care process
- ensuring that the assessment is needs-led
- negotiating with service providers
- working all the time as advocate for the patient, without the restrictions of having to manage a budget
- acting as a link between hospital and community.

While the Care Organiser maintains ongoing contact with clients, no single practitioner or type of practitioner, individual provider or group can meet the total needs of a client or owns the total services system.

Some Issues

Some issues have been raised for us within the project in relation to the Care Organiser role. Dependency can build up between the client and the Care Organiser or a particular care team member. Family dynamics, related to social issues within the family, can emerge that are outside the role of the Care Organiser and that impact on the implementation of the client's Care Plan. The communication and networking dimensions of the role of Care Organiser can be very time-consuming. We under estimated the time needed for these functions at the outset and the amount of time that the Care Organiser would have to give to each client.

The Client Care Plan

The aim of the Care Plan is to detail the action to be taken in each case to meet the needs and objectives identified in the assessment. The Care Plan should identify:

- the assessed need
- overall objectives of the plan
- specific objectives of each service input/outcomes to be achieved
- when services are to be provided
- unmet needs
- monitoring and reviewing arrangements. The means of measuring the outcome will include the ability of the older person to remain at home, reduced hospitalisation and quality of life for older people and carers.

Current Status of Home First Clients

Thirty-nine clients have been involved in the Home First Project. Of those, eighteen are at home, five are awaiting discharge home, three are in nursing homes, two are awaiting assessment, two are currently hospital in-patients and nine have died.

Key Service Requirements

The service requirements that are necessary to optimise the value of Home First for clients are as follows:

- comprehensive home packages of care which can provide home support around the clock, seven days a week
- flexible working hours
- staff with transport to keep in touch with older people
- support for family and informal carers
- flexible respite
- the involvement of the General Practitioner
- services tailored to each individual's needs with personal preferences and choice to be taken into account
- involvement of all agencies and professionals from community services and Beaumont Hospital in the assessment procedure, as appropriate.

The Future of Home First

An independent evaluator was appointed at the outset of the project. Pending examination of the evaluation report, Home First Phase 2 will develop comprehensive packages of care in order to provide the increased level and availability of home support to enable older persons to continue living at home. The Northern Area Health Board has started a Home Subvention Scheme in limited form and criteria are currently being fine-tuned. It is planned that Home First will be integrated with the range of community services offered to older people in Community Area 8 and this will happen within the context of the National Primary Care Strategy.

Discussion Points Following the Opening Session

Introduction

In the time for discussion following the Opening Session of the Conference, the main points raised related to:

- the management of 'at risk' registers of older people
- supports needed to enable older people to continue living in their own homes and communities for as long as possible
- the sharing of information within and between different sectors of the health system
- aspects of the implementation and evaluation of Home First.

The 'At Risk' Register

It was clarified that older people on the 'at risk' register in the Waterford Community Care area are not reassessed monthly. Individuals are removed from the register in the event of death, a move to long-term care or a review of their Care Plans which indicates a relevant change in their circumstances.

The point was also made that there are increasing numbers of older people on 'at risk' registers with an attendant increase in expectations and the requirement for adequate resources to meet both needs and expectations.

Maintaining Older People in the Community

Issues arising if older people are to be maintained in the community, were highlighted. It was pointed out that there is a need for:

- the development of packages of care to enable older people to remain at home
- out of hours and weekend coverage by support services
- the availability of staff with a mix of skills, including specialised gerontological training
- community subvention funding.

Sharing of Information

The point was made that, within the health system, there is innovation and good practice in many areas of work, but people are not sharing information and telling each other enough about what works and what doesn't work. The idea of an information 'clearing house', using web technology, was mooted. The view was expressed that costs would not be high and such an initiative could be established quickly.

Home First

Aspects of the management and discharge of Home First clients were discussed. Clients are admitted to the programme, required levels of care and support are reviewed and, if they become more independent at home, they will move – as Home First goes into its second phase – from Home First to the care of the regular community services. It is anticipated that Home First will become an integral element of the range of services in the area in which it has been piloted. Each element of cost of the home care services is being examined as part of the project evaluation process and the indications to date have been that the costs compare favourably with those of maintaining individuals in nursing homes.

The evaluation of the Home First project was discussed. One participant asked if the evaluator was appropriately trained, was matching Home First clients with clients in a control group and weighting their respective dependency levels to ensure a valid study. In response, it was stated that the evaluator had prior experience of health service evaluation and that the Home First evaluation was an observational, and not a control-matched, case-matched study.

There was an emphasis on clarifying the purpose of the Home First project which was, and is, intended to provide an additional level and enhanced quality of care for selected older people in the community. Though some administrators in the Eastern Regional Health Authority may have spoken about the initiative as offering an alternative to nursing home care, it was stated that this is not the case and was never the intention of the Home First project.

Second Session – Specialist and Comprehensive Assessments

Chair: **Donal Devitt**, Director, Mental Health and Services for Older People, Department of Health and Children

Physiotherapy Needs Assessment

Emma Stokes, Lecturer, School of Physiotherapy, Trinity College, Dublin

Introduction

In talking about physiotherapy needs assessment, I will discuss a description of physiotherapy and consider physiotherapy assessment and measurement in the context of the International Classification of Functioning, Disability and Health (ICF). These models can inform our practice model in working with clients who come to the Physiotherapy Department and that takes us through the process of assessment, of identifying a client's needs and developing an intervention to meet those needs. I will also discuss briefly standardised outcome measurement.

Description of Physiotherapy

At a General Meeting of the World Confederation of Physical Therapy (WCPT) in Japan in 1999, a description of physiotherapy was agreed as follows :

Physiotherapy is providing services to people ... to maintain and restore maximum movement and functional ability throughout the lifespan. Physiotherapy is concerned with identifying and maximising movement potential within the spheres of promotion, prevention, treatment and rehabilitation. The physiotherapists' distinctive view of the body and its movement, needs and potential is central to determining a diagnosis and intervention strategy.

International Classification of Functioning, Disability and Health (ICF)

The International Classification of Functioning, Disability and Health is a classification of health and health-related domains. The domains focus on the individual and society and comprise two basic lists: firstly, body structures and body functions and secondly. activities and participation.

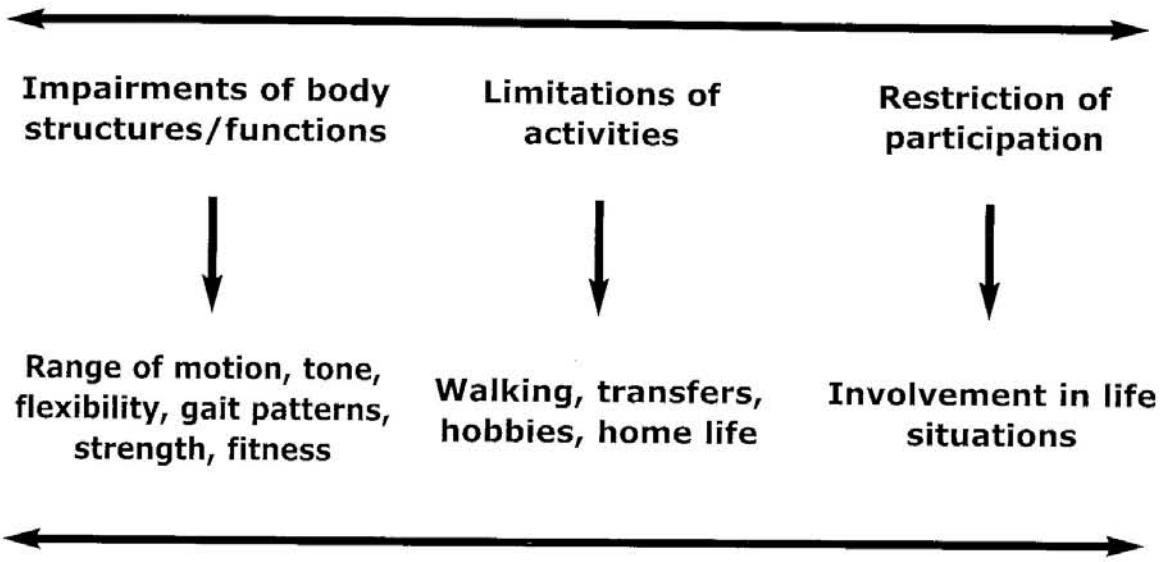
The following definitions are useful to describe the components that physiotherapists focus on in identifying client needs. Body functions are the physiological functions of the body systems:

- body structures encompass the anatomical parts of the body, for example, limbs and their components
- activities relate to the execution of a task or action by an individual
- participation is the involvement in a life situation.

Process of Physiotherapy Needs Assessment

In terms of physiotherapy needs assessment, a physiotherapist uses information from the client about his or her specific problem or limitation, supplemented by information from other colleagues and family members or carers, as appropriate. There is also an objective examination of the person at the level of body structures/functions and activity (see Figure 3). The physiotherapist establishes a link between the reported limitations and the potential structures causing them and arrives at a physiotherapy diagnosis. For example, a person with a stroke may present with impairments in muscle tone, control of voluntary movement and balance reactions (functions) as a result of a CVA (structure). This may prevent the person from walking or moving an arm and he or she may no longer be able to participate in social networks or work (activities and participation).

Figure 3: Physiotherapy Needs Assessment



Standardised Assessments and Measurements

The way we, as professionals, look at assessment and measurement is shaped by our own disciplines. In the context of physiotherapy, when we talk about measurement, we mean the application of standard scales to variables giving a numerical scale. The numerical scores may be combined for each variable to give an overall score. This might be something like the Barthel Index or the Elderly Mobility Scale. This then is measurement. Assessment is the process of understanding that measurement in a specific context and it is a very individualised process.

Needs and Preferences

One of the aims of the Conference is to consider the needs and preferences of older people. In the context of physiotherapy, one of the important things we try and get patients to do is to look at self-assessment to define what it is they are able to do in terms of time and mobility and how they feel after performing one of their routine tasks.

There are self-reported assessment scales available. The Physical Activity Scale for Older People (PASE) is one example. The difficulty is that we are still not 100 per cent sure how self-reported assessments match actual assessments by professionals.

Overall, treatment intervention in physiotherapy is always defined in terms of short-term and long-term individualised goals for the person and this inevitably takes account of their own needs and preferences.

Physiotherapy Outcome Measures

In physiotherapy, how do we measure outcomes, perhaps across a series of different activities, departments and patients? In a survey in 1997 (Stokes and O'Neill, 1999), we looked at the national use of outcome measurements in physiotherapy. We found that the use of standardised outcome measures was beginning to emerge. There was greater use of mobility scales than, for example, balance and stability scales. At the same time, the use of in-house generated, ad hoc scales which differ between hospitals was still quite common. The increasing use of standardised scales by physiotherapists is preferable since it allows us to measure change over time. There is also a need for further work to consider the need for pathology–specific scales in physiotherapy.

In many places in Ireland, physiotherapists who work with older people use the same standardised outcome measures. The process that leads to identification of the individual's needs and preferences is grounded in a process of physiotherapy clinical reasoning. The frameworks of the WCPT global description of physiotherapy and the ICF present models may help in the explanation of this process and activity. Individual reports of improvement/change and the development of patient-driven short-term and long-term goals further inform the practice of physiotherapy.

Psychiatric Needs Assessment in Older People

Dr Ruth Loane, Consultant in Old Age Psychiatry,
Mid-Western Health Board

Introduction

The topic I have been asked to address is psychiatric needs assessment. In this paper I am going to look at the aim of psychiatric assessment, the diagnoses that we see, the prevalence of different conditions, the treatment options that are available and the advice that we are asked to give. I will then look at the standard assessment that we carry out, the kind of rating scales that are available and needs assessment tools.

Aspects of Psychiatric Assessment

Aim of Psychiatric Assessment

The primary aim of psychiatric assessment is the diagnosis of mental illness. Secondly, risk assessment is part of the overall assessment process. We assess risk in terms of the risk of suicide, bearing in mind that there is an increased incidence of suicidal behaviour in the older population and particularly amongst older men. We also look at risk in terms of risk from emotional and physical abuse and the individual's level of functioning, for example, how well he/she is managing at home, whether there is wandering or other risk factors and so on. The next step is to coin a management plan for the individual.

Often on referral, we are asked to look at an individual's capacity to make decisions. For example, this might relate to:

- testamentory capacity i.e. the older person's capacity to make a will; financial capacity, the person's capacity to manage their money affairs, their pension and house
- functional capacity, how the individual is managing at home
- capacity to make decisions, for example, about going for surgery.

Diagnosis of Psychiatric Illness

Mental illness in older people can be divided into two main categories, functional illness and organic illness. The functional illnesses can be broadly divided into depression, anxiety, paranoid states, bipolar affective disorder and schizophrenia. Of these, the most commonly seen in older people is depressive illness. The symptoms experienced by an individual suffering from depression may include low mood, loss of enjoyment, poor memory and concentration, tiredness, unexplained pain, feelings of guilt, suicidal thoughts or impulses or actions of deliberate self-harm and, at the most severe end of the spectrum, delusions.

The organic illnesses can be divided into two categories, dementia and acute confusional states. The most common causes of dementia are Alzheimer's dementia, Vascular dementia and Lewy body dementia. With dementia, it is important to diagnose the type of dementia because there are different treatments and advice available for the individuals concerned. Factors seen in people suffering from dementia include memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character.

Acute confusional states are caused by an underlying medical condition or, perhaps, by medication and require full medical investigation.

Prevalence of Diagnoses

As a consultant in old age psychiatry, my caseload is divided into two. Fifty percent of patients have dementia with associated behavioural or psychiatric problems. The other 50 percent have functional illnesses, mainly depression. The prevalence of the various diagnoses that we see is shown here (see Table 1). The rates are per 10,000 of the population and there is broad similarity between the Irish and international data.

Table 1: Prevalence of Diagnoses

Diagnosis	**Irish data**	**International data**
Dementia	550 – 790	520 – 1000
Depression	1301 – 2280	910 – 2200
Schizophrenia	0 – 40	10 – 30
Neuroses	110 – 1480	60 – 1790
Alcohol dependence	No data	20

As we know, dementia occurs in approximately 5 percent of those aged 65 years and over and 20 percent of those over 80. Depression in the community-dwelling elderly is somewhere in the region of 10–15 per cent, but when it comes those in institutional care, it can rise to as much as 40 percent. There is a huge hidden morbidity of depression which is not often recognised.

Standard Assessment

The standard psychiatric assessment is carried out by one of the medical members of the multi-disciplinary team, with further assessment by other members of the team as required. This might include input from some or all of nursing, psychology, social work and occupational therapy members of the team. The emphasis is on domiciliary assessment because it gives a more accurate assessment of the individual's cognitive function, an opportunity to assess the home circumstances and time to interview the carer. Collateral history is gathered from relevant sources, including the carer, the family, the GP, ward staff if applicable, and home help.

A history is taken from the patient in an individual interview. There we look at the patient's perception of the problem, its history, duration, mode of onset and precipitating factors. We look at past psychiatric history, relevant medical history, medication and alcohol use. The patient's social situation and supports are explored, as is his or her personal history.

A mental state examination is conducted. This is a standard assessment used with younger people also. With older people we assess particular areas, including appearance, behaviour, speech, hearing/sight loss, mood, thought (for example, the presence or absence of delusions) and perception (e.g. visual or auditory hallucinations).

For cognitive assessment, various tools can be used. One of the most common is the Mini Mental State Examination. This looks at orientation, language, memory and praxia. In addition, a tool for assessing dependency such as the CAPE can be a useful adjunct to the assessment.

Formulation

Having completed the assessment, we come to the formulation. This incorporates a diagnosis, a view of the severity of the condition and its prognosis. We look at precipitating or perpetuating factors, relevant medical factors, social supports and the level of functioning of the individual in the community or nursing home and how the individual might be helped in these areas. Medical investigations can be done if needed, for example, physical examination, dementia screening, urinalysis, ECG, CXR or CT scan. The management plan is then put together.

Management Plan

In developing a management plan for the individual, we look at the following:

- supports that are available, in terms of the individual's social supports, day care and the support that members of the multi-disciplinary team, such as the psychologist or community psychiatric nurse can offer to patients in the community
- liaison with local statutory or voluntary agencies that might be necessary or beneficial
- the treatments that might be suitable, for example, medication or Electro-Convulsive Therapy, or psychological treatment such as Cognitive Behavioural Therapy
- advice/education that can be given
- day hospital admission
- or full time hospital admission, if necessary.

Questions about Rating Scales

In looking at the rating scales that may be used in old age psychiatry, there are questions to ask. The first is why are we using the rating scale? The second is what is the purpose of it?
Is it for population screening, assessing the severity of problems, aiding diagnosis, or monitoring change if medication has been instituted? In terms of assessing the severity of problems and monitoring change, nothing can surpass the clinical interview with the individual and talking to his or her carer. Nonetheless, rating scales can be useful for other reasons, for example, to research an area of illness or disease or to have a clear measurement of change.

Rating Scales for Depression and Dementia

There are many scales available for depression and dementia. For example, the Geriatric Depression Scale or the BASDEC can be used to screen for Depression. The Hamilton rating scale can be used to assess the severity of depression. The Mini Mental Score Exam (MMSE) can be used to screen for dementia behavioural and psychological symptoms can be assessed using the Behave-AD scale and the activities of daily living can be assessed using the Bristol/ADFACS scales.

Camberwell Assessment of Need for the Elderly

The Camberwell Assessment of Need for the Elderly is a tool that is used for assessing the needs of elderly people with mental illness, be it in the community or in institutional care. It is used in interviews with the older people, their carers and a staff member, if relevant. It is a valuable tool to use in assessing needs that are met, partially met or unmet in that, from the clinical point of view, service needs can be quantified and, from the planning point of view, you can determine what services need to be planned for an area.

The tool addresses a broad range of areas which include accommodation, food, household skills, self-care, daytime activities, physical health, psychotic symptoms, information and psychological distress, safety, support, behaviour, memory and finances.

The Camberwell Assessment of Need for the Elderly tool is recommended for use in the single assessment process in the National Service Framework for the Elderly in the UK. It certainly would be a good tool to use in assessing the met and unmet health and social care needs of the older population here also. There are a range of outcome tools which could be used to assess effectiveness of service provision e.g. HONOS, FACE.

Comprehensive Geriatric Assessment

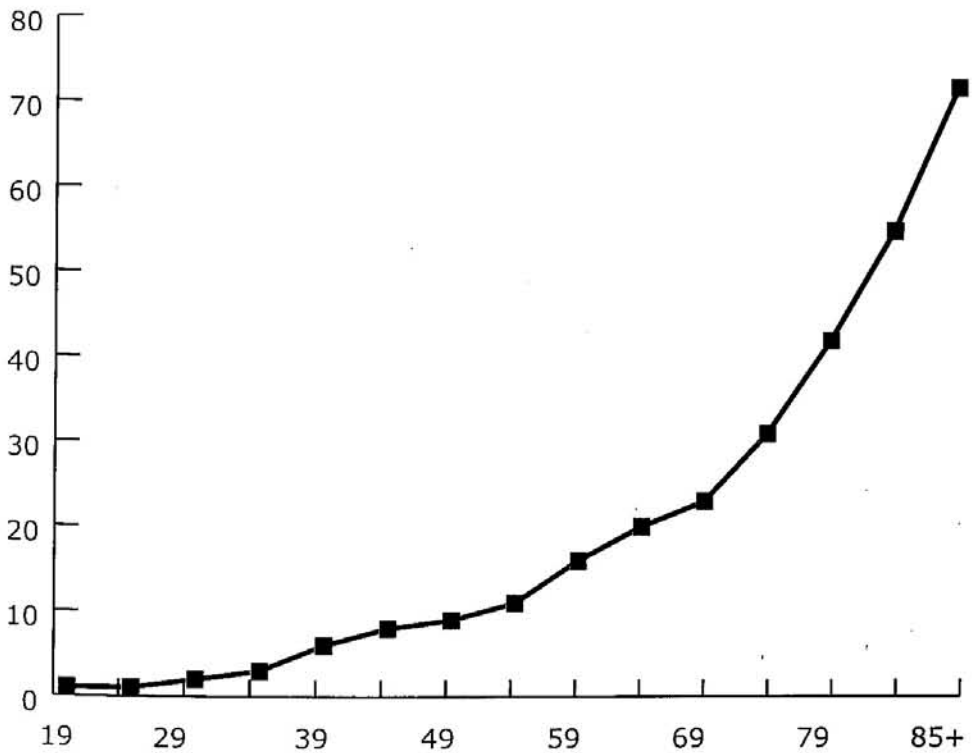
Professor Desmond O'Neill, Consultant in Geriatric Medicine, Adelaide and Meath Hospital and Centre for Medical Gerontology, Trinity College, Dublin

Introduction

One of the main concerns about the assessment of older people's needs is that it does not always result in appropriate referral and follow-up action. We know that disability increases with age (see Figure 4) and we need to deal with the disabilities of age so that older people will be able to participate in and contribute to society. All disability is due to disease and we need to recognise the older person's disease, intervene in a holistic fashion and treat every component of the disease.

Ageing brings extra qualities to people's lives, as shown by the late paintings of Jack Yeats, Renoir and Titian or the mature compositions of Verdi, Janacek and Haydn. However, if we don't deal adequately with the disabilities associated with age-related disease, older people cannot express the positive side of ageing in this way. This view is at the core of my talk today about Comprehensive Geriatric Assessment.

Figure 4: Disability Increases with Age



If a mammogram were positive, the person concerned would get a full assessment and full treatment. The problem with finding functional loss on screening older people has been that health care staff may have detected the disability, but often give substandard or prosthetic care, rather than care guided by a thorough diagnostic process: 'let's give her a Zimmer frame', instead of saying 'let's assess fully and treat properly'.

The King's Fund has reported on the assessment process in the UK and highlighted two problems from which Irish healthcare practitioners can learn[5]. In the first instance, it found that too few health care staff were involved in assessment; as a result of ingrained prejudice to provide a social response only to health and social care problems in later life. This is important because it is still too distressingly common in Ireland to hear nonsensical phrases such as 'too much emphasis on the biomedical model' when speaking of the care of older people. As it is clear that older people more often than not do not receive adequate medical assessment and treatment for their medical conditions (see below), it is important that the professionals in the field do not retreat behind slogans when faced with service deficiencies. In fact, what may be meant by such slogans is that older people do not have adequate access to appropriately trained medical care with up-to-date philosophies of care and adequate multi-disciplinary teams.

The second finding was that there was no clear linkage between the identification of problems and the formulation of solutions. This is at the very core of Comprehensive Geriatric Assessment, which lays emphasis on thorough and detailed multi-disciplinary assessment by adequately trained personnel. It has been shown to be vastly superior to generic assessment by generic health and social services care[6] in both in-patient[7] and out-patient settings[8]. The greatest challenges in Ireland relate to a) suitable numbers of adequately trained staff, b) facilitation of their ability to work together in full, true multi-disciplinary teams, and c) recognition by primary care providers of when they have reached the limits of their competence in this area and when they should refer on for a more specialist assessment.

Lastly, the fund found that the process was not centred on the person's own goals and insights. In my experience, health care workers often discount the older person's own assessment of their health status if the person rates it as better than objective healthcare measures. This represents a relative lack of awareness of a well-known gerontological fact. At the core of our assessment processes must be a respect for the older person's own perception of his or her health status, even if this may seem sub-optimal by objective standards. It is an essential part of the dignity of the process.

We have got to be careful that the Irish aren't themselves ageist. The greatest risk is that we find a problem but fail to treat it properly. This is something we have got to tackle and be open about. If, for example, a 40 year old woman presented to the Accident and Emergency with incontinence, immobility and confusion, would we put it down to middle age, with insertion of a catheter, provision of a wheelchair and admission to a nursing home. Yet we all know that it is common for many over-80s to have this type of treatment.

5. Stevenson, J., Comprehensive Assessment of Older People, King's Fund, London, 1999.
6. Ehrlick A.R, Comprehensive Geriatric Assessment , J.Amer Geriatric Soc 2002, 50, 966.
7. Nikolaus T., Specht-Leible N , Bach M , Oster P , Schlierf G. A randomized trial of comprehensive geriatric assessment and home intervention in the care of hospitalized patients , Age and Ageing, 1999 Oct 28 (6): 543-50.

Ageism

Ageism is the quadruple whammy. Old people themselves can be ageist. They absorb ageist attitudes towards disability in later life and say 'What do you expect ? I'm 71'. Their advocacy organisations may be so obsessed with promoting positive ageing that they cannot adequaltely incorporate appropriate attitudes to frail ageing. Society and families are similarly ageist. Finally, it is well established that our healthcare professionals and health structures are ageist. The underdeveloped state of popular advocacy on ageing issues may explain the relatively low level of outcry at deficits in community care and long-term care, as well as the indifference to some of the overt ageism in the health care system. These include a breast cancer screening programme (www.nbsp.ie) that has an upper cut-off age of 65 (despite protestations from geriatricians) and clear evidence of less aggressive treatment for older people with many forms of cancer[9] true of health care professionals and health structures.

Screening Tools

The Value of Screening Tools

Screening tools are of value for a number of reasons:

- they are educational
- they raise awareness, for example, with pressure sore risk assessments, it doesn't matter which tool is used because its real role in the ward is to make everybody think about pressure sore risk and develop a philosophy of care
- they are good support for advocacy. It is advantageous when pressing for appropriate resources to be able to quantify unmet need. For example, the nurse manager of an elderly care ward can make a much better case for resources if he/she is able to say, for example, that sixteen out of thirty on the ward scored critical on pressure sore risk assessment
- they are systematic. As older people may not present spontaneously with their agerelated disease and disability and some care settings are insensitive to their need, use of a screening tool can break down some of these barriers to detection
- they enable comparison, internationally and with other community or institutional settings. It is critical to use published tools for this reason, rather than to invent new ones. For cognition, use the Mini Mental test or the Abbreviated Mental Test should be used. For functional assessment, the Barthel Index is widely accepted. For screening in primary care, EASYCARE is rapidly becoming a European standard. It has high patient and practitioner acceptability and is cost effective. Key beneficial features are the assessment of mental health and sources of support goal setting generation of a disability score and high patient satisfaction from contact with nursing staff[10]

8. Keeler E B , Robalino, D A , Frank J C , Hirsch S H , Maly R C , Reuben D C , Cost-effectiveness of outpatient geriatric assessment with an intervention to increase adherence Med. Care. 1999 Dec; 37(12): 1199-206.

9. National Cancer Registry of Ireland. Cancer in Ireland, 1994-1998 : Incidehce, Mortality, Treatment and Survival. Cork: National Cancer Registry of Ireland, 2002. www. ncri.ie

10. Philp, I., Newton, P., McKee, K., Dixon, S., Rowse, G., Bath P., 'Geriatric assessment in primary care: formulating best practice'. Br. J. Community Nursing. 2001 Jun; 6(6): 290-5.

What Screening Tools are Not

Screening tools are not a replacement for appropriate training, appropriate philosophy or adequate service provision. A cogent example of this is provided by a survey of companies' health and safety policies. Those companies with a very good accident record have almost no paperwork on health and safety policies because they have incorporated the philosophy, underpinning health and safety policies into their practices. In health care, we want to get to the point where we have incorporated the philosophy underlying screening and assessment into everyday practice.

Limits of Tools and Policies

There is a danger in relying on tools and policies alone to solve problems. In the USA, there was concern that the quality of care in nursing homes was inadequate. Rather than responding with specialist medical and nursing care and appropriate levels of therapy for patients, the authorities introduced the Minimum Data Set (MDS-RAI). Subsequently, there has been, for example, no change in pressure sore prevalence[11]. Tools and policies are subsidiary to getting appropriate training, philosophy and services in place.

Geriatric Medicine

Principles

What is at the core of geriatric medicine ? We assess and then prioritise, because very often there's a range of illnesses to respond to. We treat treatable disease, minimise medication, rehabilitate and, having done all of these things, we then, and only then, introduce compensatory techniques.

The goal then of the Comprehensive Geriatric Assessment is individualised assessment leading to individualised treatment of older people.

Skills

There are specific skills needs for staff working in geriatric medicine. Some groups will hopefully get postgraduate training in the area because they have to work with patients who have multiple illnesses and attenuated presentations. There are very well defined knowledge bases for functional loss such as falls. We need dedicated team work, diagnostic facilities and therapeutic facilities.

11. Coleman, E.A., Martau, J.M., Lin, M.K., Kramer, A.M.. 'Pressure Ulcer Prevalence in Long-Term Nursing Home Residents Since the Implementation of OBRA'87'. J Amer Geriatr Soc 2002, 728 -32.

The Team

The multi-disciplinary team comprises specialist medical, nursing, physiotherapy, occupational therapy, speech and language, clinical nutrition, social work and clinical psychology staff. Unfortunately, the term 'multi-disciplinary' team is much abused and very many involved with the care of older people in Ireland do not have access to a full multi-disciplinary team. What they have is an oligo-disciplinary team (oligo = few) with perhaps two, three or four of the disciplines. Look at the make-up of the multi-disciplinary team and tell me whether you are in a multi-disciplinary or an oligo-disciplinary team. A part of the mission of any aspiring multi-disciplinary team is the struggle to ensure that all the relevant disciplines are incorporated into the team.

Full Team in the Community?

Comprehensive Geriatric Assessment at the moment mainly occurs in the hospital or day hospital setting. However, it would be possible to have a full team in the community. The Australians have already done it. We need recognition and validation of the complement of the full multi-disciplinary team, to recognise that specialist skills are required and that secondary care approaches may be more appropriate in the treatment of certain conditions. For example, studies by David Challis from Manchester have shown that secondary care approaches to the treatment of conditions such as dementia are better than primary care approaches[12]. Trying to do Comprehensive Geriatric Assessment without the full team complement is like a breast cancer service planned without radiotherapy.

Nursing Home Assessment

Purpose of Nursing Home Assessment

Nursing home assessment is a hot topic and we need to be really clear as health and social care professionals where we stand on this. Why are we doing nursing home assessment? Is it to help health boards determine financial support? Is it to consider whether other care options might be more appropriate? Or is it, as it ideally should be, to plan care.and support in the nursing home?

Of 140 patients referred to our services as needing long-term care, forty were routed to home with treatment and support. This represents a major issue. In the ERHA, it is policy that all those referred should have a comprehensive assessment by the geriatrician or old age psychiatrist with their team unfortunately, this is not yet the case for all other health boards.

12. Challis, D., Von Abendorff, R., Brown, P., Chesterman, J., Hughes, J., 'Care management, dementia care and good specialist mental health services : an evaluation'. Int. J Geriatr Psychiatry. 2002 Apr; 17(4): 315-25.

Older People in Extended Care

We must plan for the appropriate, multi-disciplinary care of older people in extended care. If somebody is going to a nursing home, it is very important to say that they will, for example, need physiotherapy twice a week or ongoing occupational therapy or review on a regular basis. If we think that somebody's needs are not going to be met, we need to act as advocates and let the CEO of our health board know about the likely failure to meet ongoing therapy and care needs in institutional care.

If we do assess a patient and find that it is appropriate for her to go to a nursing home, but that she needs ongoing care, whom do we advise about the details of that care ? At the moment, there is no requirement for medical officers with specialist knowledge of older people's needs in nursing homes. There is no requirement that nursing and other staff should have specialist training in gerontological care and no requirement for a therapy complement. These are all changes we must push for.

Financial Aspects

The nursing home financial regulations are unjust and unethical. Irish geriatricians have formally expressed this view to the Department of Health and Children[13] and it is probable that the civil servants are unhappy with the regulations as well. The Nursing Home Act was enlightened for its time, but the politicians drew back when it came to addressing the financial regulations and they left it to the civil servants. The main issue here is that it is not our business to be means-testing our patients. If we think that the financial regulations are unethical, then it is important to advocate on behalf of patients through our professional bodies.

Conclusion

Finally, we are all professionals and need to act as professionals. We should not accept fudge or fluffy language, (i.e., multi-disciplinary teams which are oligo-disciplinary, unhelpful slogans like 'too much emphasis on the biomedical model'). If we do, we send out the message that our academic credentials are not as good as they should be. That applies to evaluations in particular. We need real evaluation which are solidly based in good health services methodology rather than the consumer preference studies which have often posed as evaluation up to now. Such evaluations will give us a valid view of whether or not our therapeutic interventions have been effective. There should be zero tolerance for inadequate teams. We need a balance between both specialist and generalist approaches in our work. Lastly, we must keep the older person's own preferences at the core of our work.

13. O'Neill, D., Gibbon, J., Mulpeter, K. on behalf of the Irish Society of Physicians in Geriatric Medicine. 'Responding to care needs in long term care: a position paper by the Irish Society of Physicians in Geriatric Medicine', Ir Med J, 2001, 94, 72.

In summary, we can state that:

1. Comprehensive Geriatric Assessment has demonstrated usefulness in improving the health status of frail, older patients. Therefore, elements of CGA should be incorporated into the acute and long-term care provided to these elderly individuals.

   Not all older persons who might benefit From Comprehensive Geriatric Assessment will receive the specialized services of the geriatric assessment unit. Therefore, practising physicians should be encouraged to utilise the expertise of other disciplines that deal with the functional integrity of these patients through the application of CGA. Physicians' professional organisations could appropriately take a leadership role in the dissemination of this assessment methodology.

2. Research clarifying principles, procedures and applications of CGA should be a priority for all public and private health care funding agencies.

   Research could define more accurately:
   - which elements of the assessment process contribute most to the achieved results
   - which patients benefit most from assessment
   - whether there are better assessment instruments for measuring levels and changes in functional status at the extremes (highest and lowest levels) of ability
   - what modifications to current comprehensive geriatric assessment would maintain efficacy, yet reduce the time and effort involved in CGA.

3. Comprehensive Geriatric Assessment should be an integral part of the curriculum for all medical training programmes.

   Routine CGA examines, at the very least, a patient's mobility, continence, mental status, nutrition, medications and personal, family and community resources. It involves all disciplines responsible for providing care, as well as the patient and family, in developing an appropriate Care Plan. Comprehensive Geriatric Assessment is an effective tool for teaching the integration of the biological, psychological, social and environmental aspects of health care, while recognising the geriatrician's special area of expertise.

Discussion Points Following the Second Session

Introduction

In the time for discussion following the second session of the Conference, the main points raised related to:

- the segregation of older people in society and the health services
- travel insurance for people aged 75 years and over
- focus on treating the underlying disease
- depression in the older population
- the use of the word 'dementia'.

Segregation of Older People

A participant expressed the view that services, including health services, should not be developed in a way that leads to the segregation of older people within the community. A geriatrician in response noted that in 1908 the same argument was used against the development of specialist paediatric services for children. Noting the wider recognition that the general services deal badly with older people's health issues, he strongly advocated specific services for older people.

The fact that some older people themselves would prefer to be treated in a general medical, rather than a geriatric medical, ward was also acknowledged. The need for a dialogue with older people's organisations on the issue was recognised.

Treating the Underlying Disease

The focus, in all speakers' presentations, on identifying underlying disease in older people and treating that appropriately, was welcomed. It was pointed out that current research shows that, contrary to prevailing myths, older people benefit as much as younger people from chemotherapy and that treatments for cancer, blood pressure, osteoporosis and other conditions can make a great difference to quality of life in older age.

Travel Insurance for People aged 75 years and over

Difficulties experienced by people aged 75 years and over in obtaining travel insurance to go abroad, regardless of medical assessment, were raised. The view was expressed that the issue should be referred to the Equality Authority.

Depression in the Older Population

A concern was expressed about the current focus on dementia in older people at the expense of due recognition of the problem of depression. Since it is a treatable condition, the value of screening for depression was noted, as was the need to raise awareness of its incidence and prevalence.

The Use of the Term 'Dementia'

The use of the term 'dementia' was questioned on the basis that it stigmatises people suffering from that condition. Further academic thought was recommended to change a category which was viewed as serving no positive purpose.

Third Session – Current Initiatives

Chair: **Dr. Suzanne Cahill**, Director, Dementia Services Information and Development Centre, St James Hospital, Dublin

Developing a Standardised Approach to the Assessment of Older People's Needs and Preferences:

A Perspective from Kerry, the Southern Health Board Region

Ber Power, Continuing Care Placement Co-ordinator, St. Columbanus Home, Killarney, Kerry

Introduction

The aim of this paper is to provide an overview of the system of assessment procedures that we have in place in Kerry, which is a Community Care area of the Southern Health Board. Our system of assessment procedures form a continuum from initial assessment through to specialist assessment and assessment by our age care evaluation team.

Assessment within a Strategic Framework

'Ageing with Confidence'

Our approach to assessment has been developed as an integral part of our strategy for older people in both Cork and Kerry which is called 'Ageing with Confidence'. This strategy was developed after extensive consultation with all the relevant stakeholders and adopted by the Southern Health Board in 2000. One of the goals of the strategy is to enable older people, in accordance with their own preferred wishes, to live in their own homes for as long as possible. 'Ageing with Confidence' has four foundation stones which guide our assessment continuum. These are:

- keeping the older person well
- supporting the older person to remain at home
- acute care
- continuing care.

Need for Standardised Assessment

In developing the 'Ageing with Confidence' strategy, we recognised the need for a standardised approach to assessment. This was in order that we, as professionals, would speak the same language, share a common understanding and, as such, meet the needs of older people. In order to do this, we had to develop a tool which would be common to all our groups, be they in the acute hospital, community hospital or community setting. This has ensured that older people receive appropriate, effective and timely interventions to their health and social care needs, and again, I emphasise social care needs. It has also helped the co-ordination and integration of services and information between acute hospital and community settings.

Initial Assessment

Initial assessments are conducted by the General Practitioner or the Public Health Nurse. The advantage of this is that both are familiar faces to older people. They make use of the Barthel Index, the ten Point Mental Test Score and also assess home and social circumstances.

Such assessments are done only if a need is identified. We question the need to carry out assessments with older people when they are well.

Community Hospital Assessment

The next level of assessment is the community hospital assessment. Community hospitals in Kerry provide long-stay, respite and palliative care for older people. Community hospital assessments are carried out by a team comprising a medical officer, director of nursing, physiotherapist, PHN and continuing care placement co-ordinator. This team generally meets weekly or fortnightly in each community hospital to discuss patient care. Discharge plans are prepared for patients who are leaving the hospital, community supports are identified and 'at risk' older people are identified.

Specialist Assessment

Specialist assessment is carried out by the consultant in medicine for the elderly and a multi-disciplinary team in Tralee General Hospital. Older people who receive specialist assessment are those whose needs cannot be met in community hospitals or who have complications in terms of discharge and continuing care. The purpose of the specialist assessment is to provide an accurate diagnosis of the older people's problem; to arrange co-ordinated treatment from the specialist team which would then try to improve their functional capacity and to examine their rehabilitative potential. All of this is done in order to improve the autonomy of the older person and to reduce his or her dependency.

Older people are involved in the assessment process. It is not just professionals making a plan for older people. They have to be part of that plan themselves.

Age Care Evaluation Team

The next level of assessment is conducted by the age care evaluation team. Essentially, this team collates the assessments of the multi-disciplinary team. We also do further assessment with carers, so there is assessment of carer management, difficulties and satisfaction. The team will recommend care options that aim to meet the needs and preferences of the older persons and their carers. A package of care is developed and we then liaise with the GP, the PHN, statutory bodies such as the local authority, and voluntary bodies, for example, the Alzheimers Association (always with the consent of the older person) so as to ease the transition of the older person either to home or to long-stay care.

Reflections on the Assessment Model

Strengths of the Model

The strengths of our model of assessment are :

- the excellence of the inter-professional working
- the fact that key staff have embraced the vision of comprehensive, integrated care for older people
- the contribution of the Elder Care Group, comprising heads of disciplines, which was set up to support the implementation of the 'Ageing with Confidence' strategy in Kerry it identifies service deficits and problems; and aims to find solutions to those problems
- local multi-disciplinary teams which identify problems at their own level and feed information to the Elder Care Group.

Issues

Issues have arisen in our work as well. The key staff have embraced the vision which supports our approach to assessment, but there are others who are reluctant collaborators. There can be difficulties with the sharing of information, for example in relation to discharge notifications. We are piloting a new discharge system to address that issue as I speak.

Though we have a framework for a service, we have just one geriatrician and one specialist age care evaluation team, so we do need additional resources. There is a lack of appropriate resources, such as sheltered housing, in local areas. Another issue is the predominance of the biomedical model. Older people's needs are very complex and a combined bio-social-psychological model would be more appropriate to meet those needs.

Our social structure is changing. An increasing number of older people are living alone and more women are working outside the home. There is increasing cultural diversity in our society and we have to be able to respond to the needs of ethnic groups who have different approaches to ageing and death.

We also have to take on the challenge of inter-agency working. Older people's needs encompass social needs such as housing and transport. As a health board, we have to recognise those needs and act as a catalyst to bring the services together to meet older people's needs.

Conclusion

As health professionals, we are sometimes accused of being ageist in our attitudes. I would like to conclude with a poem which looks at ageing in a positive way.

Figure 5: Age

Age is an opportunity no less than youth itself,
though in another dress and as the evening twilight fades away,
the sky is filled with stars;
invisible by day.

(Longfellow, 1874, 'Marituri Salutamus')

A Perspective from the North Eastern Health Board

Antoinette Doocey, Director of Governance, Planning and Evaluation –Services for Older People, North Eastern Health Board[14]

Introduction

This presentation outlines the approach undertaken by the North Eastern Health Board in addressing the needs of older people in our region. We have developed a five-year strategy for the delivery of health and social services to older people - 'Healthy Ageing- A Secure Future'. This strategy provides the framework for the development of a wide range of services for older people and also an approach to the development of appropriate instruments for the assessment of older people's needs and preferences.

Framework for an Approach to Assessment

Our approach to assessment is underpinned by the vision and underlying values outlined in our strategy for older people. The NEHB's stated vision is: 'to promote and support the health and social well-being of each older person living in the North East'. Our values express a commitment to promoting the independence, empowerment and dignity of older people and of their right to participate in decision-making regarding available care options. The specific aims of the strategy are:

- to support older people in achieving and maximising health and social gain
- to support the choice of older people living in their own communities
- to ensure easy access to appropriate assessment, diagnosis and treatment for acute care interventions and timely discharge to the most appropriate setting
- to provide appropriate access to high quality continuing care for older people who are unable to be maintained in independence and dignity in their own homes.

The vision, values and aims of our strategy have emerged from an extensive consultative process with all of the stakeholders, including service users and carers residing in our region.

14. Now on secondment to the Primary Care Task Force, Department of Health and Children.

Four Pillars

The strategic framework of services outlined in the strategy is dependent on the four service pillars as follows:

1. Maintaining the health and well-being of older people.
2. Community supports.
3. Acute care.
4. Continuing care.

Assessment and a Continuum of Care

Assessment of older people's needs is necessary to ensure a continuum of care as envisaged in the four pillars above. We have decided to move towards the development of a single assessment approach in the first instance, rather than imposing a single assessment instrument.

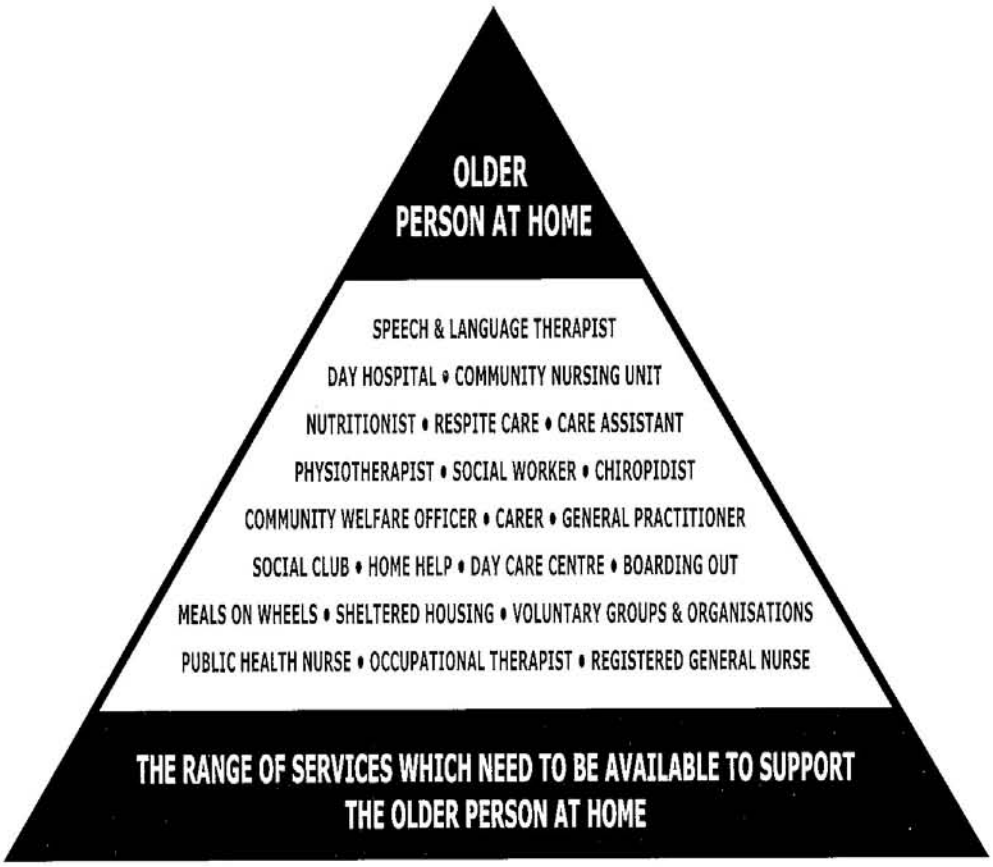
Having identified a range of assessment tools in use in our service areas, it became apparent that there is very little sharing of information and of evaluative outcomes. In moving towards a single assessment approach, we are working towards achieving a consensus on agreed criteria across different assessment processes, both within services and within different health professional groupings. The outcome of this process will influence the future direction of the development of an appropriate assessment framework.

The range of services required to support older people at home is illustrated in Figure 6. Looking at the number of services represented there, we are asking questions such as:

- How do we assess clients for these services?
- How do clients and carers access them?
- Is gate keeping required and who should the gatekeepers be?
- What are the systems necessary to enable a user to receive a continuum of care to meet their needs, following initial contact with the services?
- What do we need to do to ensure that all services appropriate to assessed need respond following one contact by the user as opposed to having to contact a range of services?

These questions emphasise the need for a common approach to assessment, particularly within the community setting.

Figure 6 : Service Requirements to Support Older People at Home



Acute Care

The strategic aim we have adopted in relation to our third pillar, acute care, is to ensure easy access to appropriate assessment, diagnosis and treatment for acute care interventions and timely discharge to the most appropriate setting. We are beginning the groundwork for the development of a Comprehensive Geriatric Assessment. We are in discussion with TCD in regard to undertaking a research project on discharge planning based on the five acute hospitals in the region. The outcome of this project will assist in the identification of common criteria and protocols which will support effective discharge planning to ensure appropriate discharge at the appropriate time to the appropriate setting.

Critical Success Factors

I wish to share with you some of the critical success factors identified for the successful implementation of our overall strategy for older people because this essentially provides a basic framework for a single approach to assessment. In the absence of such a framework, assessment will be carried out on a piecemeal basis. The critical success factors include:

- realignment of service delivery structures. Many of the problems currently experienced with assessment are due to the current structures and services framework. It is impossible to get patients across the systems that exist in many areas

- cross programme/multi-sectoral commitment to integrated care
- the development of quality information systems to underpin the integrated approach to service planning, delivery and evaluation. We have, for example, begun work on the development of a single database for older people in the NEHB which includes their functional status. It is envisaged that availability of such data will inform appropriate and effective planning of future service requirements.

Developing a Standard Assessment Process

Aims of the Process

In developing a standard assessment process, the NEHB has examined local, regional, national and international models and has identified the UK single assessment approach as an appropriate process model to which we can refer in developing our own approach. The aims of the UK model are to:

- raise standards to validate equity of access and accountability
- reduce duplication and inconsistency
- develop person-centred care as a standard
- support good practices and professional judgement
- promote effective and appropriate outcomes
- promote a standardised and efficient professional approach to assessment
- support service integration processes.

Implementation Process

In terms of the implementation process, the steps we are currently working on are as follows:

- agree the purpose and outcomes
- agree shared values
- agree terminology
- map care processes
- estimate target population
- agree stages of assessment
- relate diagnosis to assessment
- agree the assessment domains
- agree tools and scales
- agree joint working
- agree the single assessment summary
- develop inter- and multi-disciplinary education and professional development.

Assessment Domains

The assessment domains will cover the following:

- users' perspective
- clinical background
- disease prevention
- personal care and physical well-being
- senses
- mental health
- relationships and involvement
- safety
- immediate environment and resources.

Critical Issues

The critical issues that we have to address in developing an assessment approach are as follows:

- how do we define a need? For example, do we define needs in terms of ability or/and disability?
- is expectation synonymous with age? In other words, is it acceptable to have decreasing expectations of mobility for an 85 year old person than a 65 year old?
- how will we respond to people who need more or less personal attention? For example, are we saying that if you need a lot of personal care, you have a greater need than an older person living alone but able to get around and manage many of the activities of daily living but who is socially isolated and lonely.
- where resource deficits impact on the quality of life, how will we measure this?
- is our Intervention responsive and are needs met or unmet as a consequence of it?

Conclusion

Getting There

In the NEHB, we have a number of different assessment tools in use in various settings. We are currently evaluating those as a prelude to developing a standardised approach. We also need to identify and develop the concept of key worker with overall responsibility for ensuring the completion of assessment and the mobilisation of an appropriate service response. Central to the success of this approach is the development of appropriate and integrated care pathways, monitoring and evaluation criteria, referral and care protocols. Finally, our belief is that a commitment to ongoing change management must underpin the process of developing a standardised approach to assessment. In the absence of that commitment, the process will flounder.

National Service Frameworks

In conclusion, we would suggest that there is a need for a National Service Framework for Older People. This would provide a direction in the development of evidence-based quality services for older people which can demonstrate a high standard of accessible services, resulting in effective outcomes for our elder citizens and their families and carers.

The Single Assessment Process in the UK: Key Attributes and Implications for Older People and Professionals

Dr Chris Dunstan, General Practitioner and formerly Co Chair of National Assessment Working Group, UK

Introduction

The aim of this paper is to describe the Single Assessment Process in the UK. I became involved in assessment because, as a GP, I was becoming frustrated and that sense of frustration was fuelled by the experiences of colleagues and patients. The following comments are illustrative :

'When the Health Visitor came in after her day off, she told me she already knew all the information I spent yesterday afternoon collecting about that patient' ***(District Nurse)***
'I can't think why the A&E department sent that patient home. Why didn't they check the home circumstances first ?'
'It is difficult for us to get any nursing or medical input to assessments, so we often don't get the whole picture' ***(Care Manager)***
'Why do so many people keep asking me the same questions? Haven't they got anything better to do, or don't they talk to each other' ***(Patient)***

Developing a Single Assessment Process

The Local Level

As health and social care workers, we began to come together to clarify the kind of information we needed about patients and clients and to look at how information was collected and shared. We discovered that 80 percent of the information we needed, whether we were district nurses, health care visitors, doctors, was the same. Despite this, we were collecting the information independently and in different formats. This led to the development at local level of a common Single Assessment Process for 30,000 patients, using one computer in one health centre. We call it a Single Assessment Process, not because there is a single assessment event but because, from the point of view of the client, the aim is that it should be experienced as a single, seamless process.

Whole System Audit

Our work on assessment was given further stimulus by a whole system audit that we carried out. This was an audit to follow older people through the health and social care systems and to follow how decisions were made at key points as their care needs changed. One of the findings of the audit was that the views of users and carers about who had made the decisions, and about their own involvement in the decision-making process, were markedly different from those of the professionals involved. In other words, we were not doing as well as we thought we were in involving users and carers in assessment systems. Other findings showed a low level of joint working between the health and social care systems and that a lack of information at the point of decision-making in patient care was impeding good decision-making.

National Service Framework

Our local process was underway during the 1990s as the National Service Framework for Older People was published in the UK. A Single Assessment Process formed part of the National Service Framework and stated that the process should be based on the principle of person-centred care.

Key Dimensions of the Assessment Process

Person-Centred Assessment

Person-centred care is about involving the older people, respecting them, recognising their individuality and encouraging their autonomy. Applied to the assessment process this means that older people should be able to:

- receive information about assessment (in contrast with a situation where older people do not know how to get an assessment or do not even realise that they have been assessed)
- be involved in decision-making, remembering that we professionals think we are better at involving older people and their carers than we are in practice
- have their perspective as the starting point
- have a focus on their strengths and abilities as well as on their needs
- understand how, and in what circumstances, information about them will be shared; this is very important for the confidence of both patients and professionals who are naturally concerned about the security and confidentiality of what can be very sensitive, personal information
- know who to turn to if they wish to challenge decisions or if things go wrong.

Purpose of Assessment

When we are doing assessment we have to constantly remind ourselves as professionals what the purpose of the assessment is. Assessment is about diagnosis, prognosis, rehabilitation potential, and the development of the Care Plan and eligibility criteria. In England, eligibility criteria apply to funding of nursing home placements.

We recognise that diagnosis and prognosis are medical terms. In discussion, we could not find other terms that fitted quite as well, so I do ask you to excuse the medicalisation of the model in this particular case.

Key Attributes of the Single Assessment Process

Ideally, the key attributes of the Single Assessment Process are as follows:

- it is person-centred
- there is a standardised approach
- duplication, and thus the waste of time and resources are avoided
- clients are assessed to the correct level
- triggers to further assessment are recognised. For example, the right questions are asked to enable further assessment needs to be identified, if appropriate to the needs of that client
- it is outcome-centred.

Levels of Assessment

In terms of assessing clients to the correct level, it is very important that people do not go into the assessment process at one end and then go through all the way, as if on a conveyor belt, until they come out the other end, regardless of their assessment needs. Our experience has been that some people become involved in the assessment process and are over-assessed and others are not assessed at all because there is not enough time to do it. It is important to get the balance right.

We also found that professionals were not linking clients with services until a full assessment had been completed. They were afraid of making the wrong decisions and thought that awaiting the outcome of a complete assessment was good practice. In fact this is not ideal and we have tried to encourage professionals to identify a need, respond to it and continue with the assessment process as required.

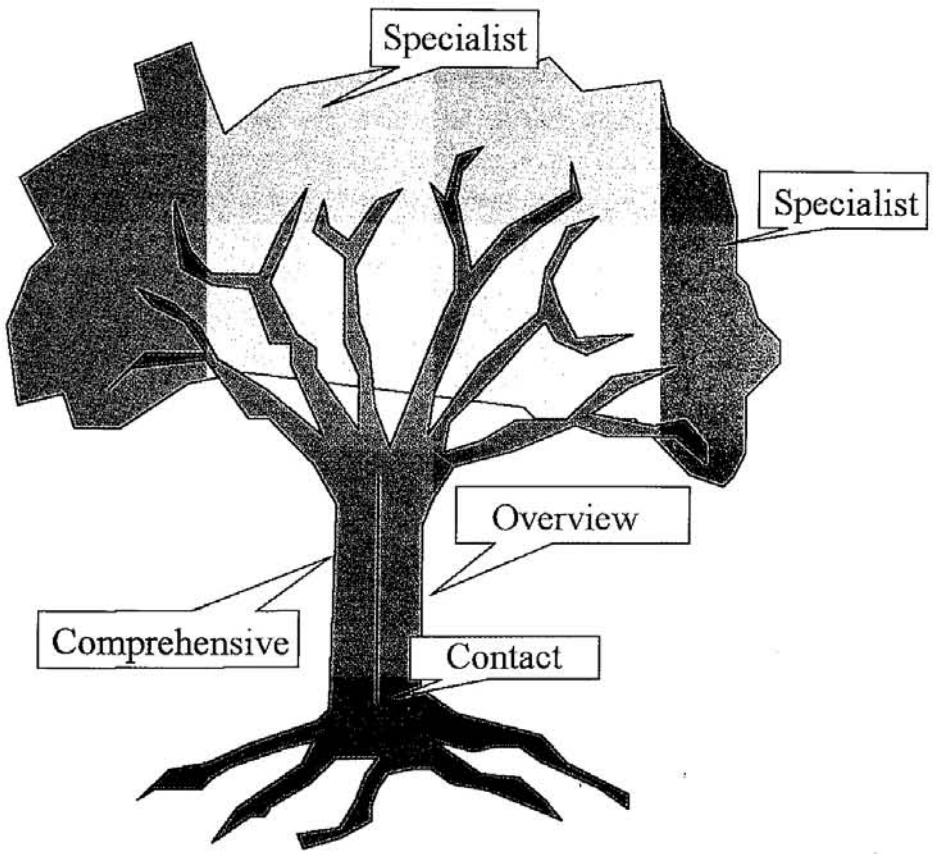
Components of the Single Assessment Process in the UK

The Single Assessment Process in the UK has the following components:

- basic data, i.e the client/patient's basic personal details, are collated and available to all professionals who need them
- there is a contact assessment. This is professionally-driven and is the point at which decisions about further assessment are made. Needs may be identified and met through the contact assessment with no further inquiries needed. On the other hand, it may be decided that there is need for an overview, specialist or comprehensive assessment
- an example of overview assessment is Easycare which covers all the domains of assessment in a way which identifies any areas needing further assessment
- a specialist assessment drills into particular areas of investigation and can be very focused
- a comprehensive assessment is necessary if a client has numerous and complex problems, covering a number of the domains of assessment. Comprehensive Geriatric Assessment is an example of this.

The Single Assessment Process is not a linear one. Figure 7 attempts to provide an illustration of what the Single Assessment Process, integrating the components identified above, looks like.

Figure 7 : The Single Assessment Process Illustrated



From the contact assessment, an overview assessment or a comprehensive assessment can follow and either can result in further specialist assessments. The black line up the centre of the trunk illustrates that specialist assessments can follow straight from a contact assessment alone.

Contact Assessment

The contact assessment is the key to the Single Assessment Process. In conducting a contact assessment, there are seven issues to be considered. The GP would not have, for example, to conduct a formal contact assessment each time he/she meets a patient, but if the seven issues are borne in mind, it improves the decisions reached about the care that a patient needs. The issues are:

- the nature of the presenting problem
- the significance of the presenting problem for the older person
- the duration of the problem
- potential solutions identified by the older person
- other problems the older person is experiencing
- recent relevant life events
- the perceptions of family and carers

Implications for Professionals and Organisations

Implications for Professionals

The implementation of the Single Assessment Process has implications for professionals. They need to :

- understand the person-centred values underpinning the National Service Framework
- know about the types of assessment which have been described earlier
- understand the uses of tools and scales, recognising that these tend to be of most use in areas which are outside our own speciality and where we struggle to confirm a diagnosis
- know how to structure information for sharing with other professionals
- accept the need for culture change
- undergo training.

Culture Change and Training

The requirement for culture change goes from the top to the bottom of an organisation. It means that professionals have to understand roles and responsibilities, develop mutual trust and come to an understanding of shared objectives. There is a need to lose individual ownership of information and individual bits of the work and to aim for joint ownership of information to meet the needs of patients. We are all very concerned about our part of the information, our processes, our own bits of paper, what they look like and whether they have our logos on them. All of that gets in the way of effective joint working. We need to undergo training to enable us to arrive at joint ownership and responsibility for meeting the needs of patients. The training needs, in implementing a Single Assessment Process, are significant.

Structuring Information for Sharing

There are questions to ask when we are structuring information for sharing such as: How easy is it to share information if it is held by us or by others? What information is yet to be collected? Who needs to do this?

We also need to distinguish between information-gathering and assessment. Some of the basic information that is needed in the Single Assessment Process can be provided by the patient, for example using a patient questionnaire, or it can be gathered by an individual with clerical skills. However, as you move up the scale, you need skilled assessors to conduct clinical interviews and devise a Care Plan for the patient.

In structuring information, we need to:

- code for sharing, bearing in mind concerns about confidentiality and security
- ensure that information is accurate, current and complete
- ensure that all staff be involved in improving the quality of information and that again involves training
- if information is properly structured, one of the benefits is that we can audit what we are doing and it gives us a common basis for morbidity data and other uses.

Information Sets

What we have tried to do with the Single Assessment Process is not to define the multiplicity of tools that might be used, but to have a common starting point with contact assessment and a common ending point with the outputs of assessment which are the information sets. The information sets are as follows:

- basic personal data, standardised with common content and format if possible
- patient needs and health status, that is assessed needs, medication and linked diagnoses and other relevant medical conditions
- a summary of the Care Plan, with care aims linked to needs and services to be provided identified.

Conclusion

In conclusion, the benefits of the Single Assessment Process, as we have experienced them, can be summarised as follows:

- standard data content and format to aid information sharing in many clinical settings
- duplication avoided
- improved data quality
- improved inter-professional working
- better decision-making
- most important of all, improved patient care.

Discussion Points Following the Third Session

Introduction

During the discussion following the third session of the Conference, the issues raised were:

- dementia patients and assessment
- the auditing of an assessment process.

Dementia Patients and Assessment

A question was asked about the approach taken to the disclosure to patients of their diagnosis of dementia during an assessment process with reference to the approach in the UK. It was stated that every effort was made to involve people suffering from dementia as much as possible in the assessment process. Trying to reflect the views of people with dementia in Care Plans presents a particular challenge. Since people with dementia may not have a real understanding of their abilities, their life situation or what others can do for them, difficulties arise in getting their realistic input into a decision-making process.

Auditing an Assessment Process

The difficulties that might arise in carrying out an audit of assessment approaches in instances where standardised tools had not been used were explored. In reply it was stated that most assessment scales had been designed for intended usage in research on populations, rather than for individual assessment purposes. Audits of the benefits of the assessment process, should look at whether assessed needs have been met and whether, in reality, individual independence has been maintained or improved.

The Way Forward: A National Framework for Multi-Disciplinary Assessment?

Chair: Dr J.B. Walsh, Consultant Physician in Geriatric Medicine, St James Hospital, Dublin

This was a panel discussion with introductory contributions from three speakers who had been asked to make brief remarks to trigger an exchange of views with Conference participants. The key points from each contribution are outlined below.

Dr Finbarr Corkery, General Practitioner, The Medigroup, Cork

This has been an extraordinary meeting in terms of the presentation of information about assessment. My own reactions include the following:

- The role of generalists is to save us from the excesses of specialists. Excellent, tightly-focused work emanates from our specialist units, but I think we should evaluate specialist approaches in terms of what we want to achieve. We need the generalists to keep the balance in our approach to all aspects of health care, including assessment.

- Constitutionally, I am against centralised policy-making, except perhaps in establishing a very basic framework for fiscal policy. A national body to provide assessment tools could produce a tool that is unusable. It would be either too long and cumbersome to use in different situations or, if short, would be effectively meaningless. We need coherence at local level, but we also need to be flexible enough to be able to respond to different needs in different settings.

- It is evident that excellent work in assessment is being done across the country. However, in the days of instant communication, we have had to come in to a room here today to find out about it. The fact that this information is available to be shared by people who are anxious to disseminate it and that the rest of us don't have access to it is something that should be addressed immediately. I would suggest that the National Council (which is a serious and under valued player in terms of looking at questions of age and ageing) might consider developing and supporting a website which would allow people in their own time to have access to this information.

- The other thing that worries me a little bit is the terminology. Within the specialist context, we understand one another when we talk about assessment. If we go into the community, assessment implies means-testing. Furthermore, it is seen as means-testing for a person to be given something, as opposed to an assessment which assures individuals that they are getting the most appropriate service to meet their needs. People should be looking for this kind of assessment and they would if it were patient-friendly. The antithesis of this is the phonecall from the relative who says 'I was told I had to contact you to get a letter to send my relative to the geriatrician to be assessed for a grant'. That attitude to assessment won't help any of us.

- There is a danger that assessment tools would be used rigidly. All of us, doctors, nurses, social workers, have to guard against this when we are using them to get resources. I would be cautious about developing an assessment model based on ticking the boxes, adding up the score and saying 'Now that's the road you follow'. Not everything that is important can be measured.

- One of the issues is that people talk about 'the problem of the elderly'. If your picture is of an irrational person, emotionally labile, unable to look after him/herself, incontinent, needing to be fed, needing full or part-time care and with huge resource implications for the next fifteen to twenty years, well that is not an attractive picture. However it's also the picture I get when I look

at my newborn grandchildren. This is how they are going to be for the next twenty years. Nobody is worried about assessing them and there is no problem about saying that they deserve the best. That's one of the concepts I would like to leave you with.

- The other concepts, I've mentioned already: the value of assessment, we can all agree with. My concerns are centralised approaches and the type of assessment model and tools that we might develop.

Jimmy Duggan, Principal, Services for Older People, Department of Health and Children.

Arising from the presentations at today's high quality conference, a number of points struck me.

- The first is the fact that we are very poor at gathering information. When we then gather the information, we are very poor at sharing it. It is clear that a lot of work is being done in the area of assessment of older people's needs, but it is not being shared. Perhaps we need to look at how we can establish some central point for the dissemination of this information.

- The next point is a question: What exactly is it we want to move onto? At the moment, I'm chairing a Carers' Needs Group. I know from discussions there that the needs of carers and those they care for go hand in hand. One of the views in that group is that we should have a nationally agreed assessment system. Having heard what I heard today, I'm not sure that we need to do that either. However, I think there would be a value in a body, perhaps the National Council, taking the process onto a point where there is an agreed national approach to assessment that everybody buys into. We shouldn't reinvent the wheel. The work is already done to a great extent, but what is needed is to pull that work together.

- In his presentation on the Single Assessment Process in the UK, Dr Dunstan used a drawing of a tree to illustrate that approach. I was struck by the idea that people can be moved onto different levels of assessment to suit their needs. The implication of this is that all professionals, at every level, need to understand their role, what it is they are expected to do and what response they are expected to provide when needs are expressed. An agreed national approach would facilitate this kind of understanding.

- One of the issues identified at the Conference is the fact that the conduct of assessments will lead to raised expectations and, in circumstances where there are gaps and shortcomings in the system, this will create difficulties. For example, there have been references to multi-disciplinary teams that are not in effect multi-disciplinary teams. My own view is that in terms of making an argument for services for older people, we need to know what the level of need is out there, both met and unmet. In order to continue to press for increased resource allocation for older people, we need to know what progress is being achieved with the services that are in place and what level of unmet need exists. It seems to me that carrying out assessments will be a contribution to that.

Ms. Mary McDermott, Regional Director, Services for Older People, Western Health Board, Merlin Park Regional Hospital, Galway

At the end of our Conference on assessment, there are a number of points that I would like to make:

- Firstly, I would like to challenge the concept that a person is old at 65 years. Older people are living longer, healthier lives and I think we should be planning services for older people aged 75 years and over. As a general rule, I think we need to focus more on health promotion for older people. We also need to examine the idea of screening older people who are considered to be well and to carry out pilot studies to assist us in developing this idea.

- We have heard many examples of good practice in assessment of older people's needs today. Though the approaches to assessment described have developed in isolation from each other, they share many similarities and I find that reassuring in terms of the future direction of this work. However, assessment approaches will fail if we do not get our health systems and health delivery services right. We must be able to respond to the needs that are identified through assessment processes. Furthermore, we must enable older people to access the services that they need. The GP and the Practice Nurse each have key roles to play in facilitating this kind of access. Other challenges for us include the need to involve service users in the planning of assessment approaches and to look at how we can evaluate our approaches to find out whether they are improving the quality of life of older people.

- All older people who need it should have access to a geriatrician and his/her team of whatever type, and we need to develop a common approach to this part of the assessment process. In particular, we need to develop a common assessment process for admission to long-term residential care. At the moment, the processes for admission to public and private facilities differ greatly. There is also a need to include service users in our assessment processes.

- I want to include a comment about the 'at risk' register of older people which has been mentioned here today. I have difficulty with the concept of a book of names which, in my view, is what it amounts to. We do need data for planning purposes, but could achieve this if we installed effective IT systems. We have been talking about computerising our records in the health boards for many years now.

- What is the way forward from the point we're now at? My view is that we don't know what we need, but we do need a process to help us find out what we need. A National Steering Committee could be established to work on the agenda of a common assessment process. This Committee would look at what needs to happen and guide the future development of a common assessment process. In that context, a number of pilot projects could be undertaken, but we would need ring-fenced funding for those and appropriate follow-up services for clients.

Discussion Points from the Final Session

Introduction

In the time for discussion following the final session of the Conference, the points raised related to:

- the need to focus first on infrastructural deficits and inequalities.
- assessment, Care Plans and the ambulance service.

Focus on Infrastructural Variations and Inequalities

The view was expressed that the issue for people in the health services is not lack of clarity about future directions, but a reluctance on the part of the Irish people to pay for what is needed. It was pointed out that there is a plethora of strategies, goals and guidelines, none of which are being implemented. The immediate focus should be on addressing infrastructural variations within and between different counties. More beds and personnel are needed and when that deficit is addressed, perhaps people could begin to talk about a national assessment framework.

Assessment, Care Plans and Ambulance Services

Experiences of difficulties created for patients and staff when ambulance drivers refuse to cross boundary lines in the greater Dublin area were presented. This applies in the case of patients whose needs and preferences have been assessed, following which Care Plans are devised, involving a rota of visits to different family members. If, on a stay with one relative, the patient has an extension of a condition such as a stroke and needs to go to hospital by ambulance, patients are taken to the hospital on call in the relative's catchment area, which may not be the hospital where the patient has originally been assessed and treated and which holds all of the relevant records. Records are not shared between the hospitals and the outcome is that all of the completed needs assessments are invalidated.

Appendix A Biographies: Speakers and Session Chairs

Dr Suzanne Cahill

Dr. Suzanne Cahill is the Director of the Dementia Services Information and Development Centre based at St James Hospital and a Lecturer in Gerontology in Trinity College Dublin where she teaches an aged care policy course. She comes with a background in social work practice, teaching and research. She worked in Australia for many years prior to returning to Ireland in 1999. She wrote her PhD on the topic of aged care policy, dementia and family care-and has published widely in this area. Her current research interests include dementia and quality standards, women and social policy, family care-giving, assistive technologies and dementia and elder abuse.

Adrian Charles

Adrian Charles is the General Manager for Community Services Area 8, one of the three Area Management Units of the Northern Area Health Board. Area 8 serves a population currently estimated in excess of 220,000 people. Adrian has been in his current position for nearly four years. Prior to this, he held a senior management post in Community Care Head Quarters in the former Eastern Health Board at Dr Steeven's Hospital.

Dr. Finbarr Corkery

Dr Finbarr Corkery is a general practitioner with the Medigroup in Cork. He has a long-standing interest and expertise in the care of older people as Medical Director of St Patrick's, a 64-bed hospital in Cork providing extended care and respite care. Dr Corkery was a member of the National Council from 1990 to 1994.

Margaret Daly

Margaret Daly has a background in nursing and nurse management. She has qualifications and nursing experience from London and Edinburgh as well as Ireland and she has undertaken an MA at UCC in Cork. For the last twelve years, she has been Director of Public Health Nursing for the Southern Health Board and does part-time lecturing for the nursing department in UCC. She has contributed to many articles in nursing journals and is a member of committees nationally, regionally and locally, focusing on the areas of strategy and planning of public health nursing and community services.

Celine Deane

Celine Deane has practised as a social worker since 1986. Her clinical experience has been primarily in the medical setting. Currently she is Head of the Social Work Department in Beaumont Hospital, one of the largest acute general hospitals in the country.

Donal Devitt

Donal Devitt is the Assistant Secretary of the Department for Health and Children. He has responsibility for the areas of: Services for the Elderly, Palliative Care Services, Mental Health Services and Health Services for People with Disabilities, Travellers and Adult Homeless.

Marion Duffy

Marion Duffy, Public Health Nurse, works in Roscommon Community Services and has experience both in management and in clinical practice. Marion trained as a general nurse at Sligo General Hospital and completed her midwifery training at the National Maternity Hospital, Dublin. She holds a Diploma in Public Health Nursing from UCD, a BA Nursing (hons) from NUI, Galway and Diplomas in Microbiology, Child Psychology and Gerontology from the Royal College of Surgeons.

Jimmy Duggan

Jimmy Duggan is Principal, Services for Older People in the Department of Health and Children. As such he has particular responsibilities for overseeing the implementation of those parts of the health strategy relating to older people. He was recently a member of the Irish official delegation at the United Nations World Assembly on Ageing in Madrid.

Dr Chris Dunstan

Dr. Chris Dunstan has been a General Practitioner since 1978. He is a member of the Department of Health Older People's Task Force in the UK and Co-Chair of the National Assessment Working Group. He is also Chair of the West Surrey Electronic Record Development Project, part of the national electronic record development work, which has a health and social care record for older people as one focus of its work. He is a former member of the External Reference Group of the NSF for Older People. Dr Dunstan has worked on local strategies for mental health services for older people. He was a member of the project group which developed the whole system audit methodology to allow effective audit of his local health and social care system, and its refinement for roll out to other health/social care systems.

Antoinette Doocey

Antoinette Doocey MBA, BA Health Services Management, HDip, PHN, RM, RGN, has a nursing background and has acquired a wide range of experience in a number of clinical and service settings, including acute, continuing care, hospice and community.

She was a member of the Commission on Nursing and is currently a member of both the National Council for the Professional Development of Nursing and Midwifery and of An Bord Altranais. She has worked as a senior executive officer in the community services programme of the North Eastern Health Board. Antoinette has held the post of Director of Governance, Planning and Evaluation – Service for Older People in the NEHB for the last two years, during which she led and managed the development of a five-year strategy of services for older people, 'Healthy Ageing - A Secure Future'. She has recently been seconded to the Department of Health and Children as a member of the Primary Care Task Force with the remit of implementing the new primary care strategy, 'Primary Care – A New Direction'.

Dr John Gibbon

Dr John Gibbon is a graduate of Trinity College, Dublin. He worked as a Physician in Geriatric Medicine in Derry from 1974 to 1980. He then worked with the Southern Health Board, as Adviser in Geriatric Medicine to Waterford Community Care Area and from 1990 to 1999 as Physician in Geriatric Medicine. He retired in 1999. Dr Gibbon is a member of the National Council on Ageing and Older People.

Dr Ruth Loane

Dr. Ruth Loane is a graduate of Trinity College Dublin. She trained in psychiatry in both the Western and Eastern Health Boards. She undertook higher specialist training in Old Age Psychiatry and General Psychiatry on St. Mary's Higher Training Scheme in London. Dr Loane was appointed Consultant in Old Age Psychiatry in Limerick in 1998.

Dr Michael Loftus

Dr Loftus is a practising General Practitioner in Crossmollina, Co. Mayo, where he is also Chairman of the local Community Council. Well-known for his sporting involvement, he played on the great Mayo team of the 1950s and subsequently became President of the Gaelic Athletic Association.

He is Chairman (Dóthain), which means 'enough' – the organisation which highlights issues relating to the abuse of alcohol, and as Coroner for North Mayo, e is well acquainted with suffering cause to so many as a result of this serious problem in Irish society.

He has also a keen interest in issues affecting the health and well-being of older people and is particularly enthusiastic of health promotion in later life. He is currently Chairman of the National Council on Ageing and Older People, having being appointed by the Minister for Health and Children in December 1998.

Mary McDermott

Mary McDermott is Regional Director of Services for Older People in the Western Health Board which has just produced a five-year strategy for the promotion of the health of older people and the provision of health and social care services to them. She is currently a member of the National Council.

Professor Desmond O'Neill

Professor Desmond O'Neill completed his undergraduate studies at Trinity College Dublin, Marseilles and Hamburg and his postgraduate studies at Dublin, Bristol and Birmingham. He is currently Professor in Medical Gerontology at Trinity College Dublin and Consultant Geriatrician at the Adelaide and Meath Hospital, Dublin. He is the Irish representative of the Easycare consortium; Chair of the Council on Stroke, Irish Heart Foundation; Medical Director of the Alzheimer Society of Ireland; a member of the Committee for Safe Mobility for Older People, US Transportation Research Board; and a member of the OECD Expert Group on Safe Mobility for Older People. Professor O'Neill's research interests are the older driver, dementia and stroke.

Dr Eamon O'Shea

Dr. Eamon O'Shea studied economics at University College Dublin, the University of York and the University of Leicester. His research interests include health economics, the economics of ageing and the economics of the welfare state. His work in these areas has been published in several journals. He has also published a number of reports and policy documents in Ireland, mainly in the fields of ageing and disability. Dr O'Shea is the author of a number of studies prepared for and published by the National Council on Ageing and Older People, including more recently 'An Action Plan for Dementia' and 'The Cost of Care for People with Dementia and Related Cognitive Impairments'.

Ber Power

Ber Power has worked in the area of services for older people for the past nine years. In her current position as Continuing Care Placement Co-ordinator with the Southern Health Board, she is responsible for assessing older people's needs prior to discharge from community hospitals and, together with the age care evaluation team, is responsible for assessing their requirements prior to placement in continuing care. Before this she worked in community nursing services and is currently completing a degree in gerontological nursing.

Dr Sheelagh Prosser

Dr. Sheelagh Prosser is a GP working in Co Donegal. She is Primary Care Research Advisor to the North Western Health Board.

Emma Stokes

Emma Stokes is a lecturer at the School of Physiotherapy where she teaches a course entitled 'The Study of Ageing' to undergraduates over a three - year period. Prior to this she worked as a Senior Physiotherapist in the Department of Medicine for the Elderly at St James Hospital, Dublin. Her PhD research is in the area of outcome measurement for physiotherapists working with older people. She co-ordinates a physiotherapy research group called PROP. - Physiotherapy Research and Older People - a joint academic and clinical physiotherapy research group; and supervises research in stroke rehabilitation and the rehabilitation of older people.

Geraldine Tabb

Geraldine, Tabb, is a Senior Public Health Nurse in the Waterford Community Care Area of the South Eastern Health Board.

Dr. J. Bernard Walsh

Dr. J. Bernard Walsh is a Consultant Physician in Geriatric Medicine and Clinical Director of Medicine for the Elderly in St James Hospital. He is also a Senior Lecturer in Medicine for the Elderly in Trinity College, Dublin.

Appendix B: Safe Mobility for Older People

Safe Mobility for Older People[15]

Professor Desmond O'Neill, Department of Medical Gerontology, Trinity Centre for Health Sciences and Adelaide and Meath Hospital

Driving: A New Geriatric Giant?

Over the last fifty years geriatric medicine has promoted the concept that functional loss in older people is primarily a health issue. For a major loss of function, such as incontinence or immobility, we recognise the need for detection, investigation and treatment. The diagnostic/therapeutic/rehabilitation paradigm takes precedence over the prosthetic approach. Not only do we appreciate the benefits of an interdisciplinary assessment, but we are also accustomed to estimating risk and competence when making decisions about discharging frail older people back to their home environment.

These skills will provide the foundation for tackling a different set of challenges over the next fifty years. The second generation of geriatric giants may be earlier (or preclinical) diagnosis of functional loss, increasing understanding of the physiological mechanisms of geriatric syndromes (i.e. vasodepressor syncope) and attention to higher order functional impairment. One common higher order function is the ability to drive, and geriatricians have many of the skills necessary for enhancing safe mobility in older people. A small but growing literature on the older driver supports the concept that age-related disease may interfere with the ease and safety of using many modes of transportation. The data also suggest that there are many interventions that can ameliorate the impact of disease on driving ability.

Transportation is very important to older people. At the White House Conference on Ageing in 1971, transportation was ranked third in importance after income and health as priorities in later life [16]. Although environmental and other considerations may not favour increasing use of the motor car, we need to recognise that for many older people driving has become the main form of transportation. Older people do not consider that public transport is adequate or efficient, and it poses problems of security and convenience[17] . In the US public transport accounts for less than 3 percent of trips by older people[18] and its use by older people has been steadily declining in both Europe and the US.

As a result, there has been an exponential increase in the number of older drivers in the developed world. In the United Kingdom there has been an increase of 200 percent and 600 percent

15 Due to a late change in the programme for the Conference, Professor Desmond O'Neill presented a paper on Comprehensive Geriatric Assessment on the day. The topic he had originally been scheduled to address, the assessment of competence to drive, is discussed here.

16 Carp FM, Byerts T, Gertman J, Guillemard A, Lawton MP, Leeds M, et al. Transportation. *Gerontologist* 1980;12:11-16.

17 Rabbitt P, Carmichael A, Jones S, Holland C. *When and why older drivers give up driving*. Basingstoke: AA Foundation for Road Safety Research, 1996

18 Eberhard, J.,. 'Safe mobility for senior citizens'. *IATSS* 1996; 20 (1): 29-37.

respectively in the number of men and women drivers over the age of 65 between 1965 and 1985 [19]. Only 5.9 percent of drivers in the United States were over 60 in 1940: this had increased to 7.4 percent by 1952 and to 11.4 percent by 1960. This trend is expected to continue so that elderly drivers should comprise 28 percent of the driving population by the year 2000 and to reach 39 percent by 2050 [20]. Just over one third of the population aged over 80 in Ontario, Canada was driving a motor vehicle at least once a year in 1998 [21].

Driving is a skill of huge practical and psychological importance to many older people. Maintaining social contacts, getting to appointments, access to health care and shopping are among the primary functions of driving in older age groups: 77 percent of drivers over the age of 55 perceive driving as essential or very important[22]. The psychological importance has been referred to as the 'asphalt identikit' and continued driving by the elderly should be welcomed as sign of integration into society [23]. The cost of driving cessation is likely to be high: loneliness, lower life satisfaction and lower activity levels are linked with the loss of driving ability among elderly people [24].

Societal And Professional Prejudice

The significance of the ageing of the driving population is vigorously debated. It could be argued that the greatest risk to older people is societal and professional prejudice, a theme familiar to geriatricians and gerontologists. If driving and adequate transportation is so important, a physician should be deliberating on fitness to drive with a view to correcting any physical or functional deficits and enabling patients to be more comfortable, secure and safe in their driving. Several societal prejudices and processes militate against this positive approach to driving assessment. As the art/science of driving assessment is relatively young, those asked to test driving competence must appreciate these undercurrents which may impinge on a fair assessment.

The first is that the literature on health and driving is phrased predominantly in negative terms, emphasising the selection of those who should not drive rather than promoting the concept of enabling those who are affected by illness to drive through remediation. This is expressed in its most concrete form in the negative tone of fitness-to-drive regulations in most jurisdictions, despite evidence that various health care interventions can improve driving skills and ease in illnesses such as arthritis[25], stroke[26] and cataract[27]. Many older drivers cease driving for health reasons, and it is possible that remediation strategies have been insufficiently explored in a proportion of this group. In

19 Department of Transport. The older driver: measures for reducing the number of casualties among older people on our roads. London: Department of Transport, 1991.

20 National Center for Statistics and Analysis: 'National Highway Traffic Safety Administration'. *Traffic Safety Facts 1994: Older population*. Washington, DC: National Highway Traffic Safety Administration, 1995.

21 Chipman, M.L., Payne, J., McDonough, P,. 'To drive or not to drive: the influence of social factors on the decisions of elderly drivers'. *Accid Anal Prev* 1998; 30 (3):299-304.

22 AA Foundation for Road Safety Research. *Motoring and the older driver*. Basingstoke: AA Foundation for Road Safety Research, 1988.

23 Eisenhandler, S.A.,. 'The asphalt identikit: old age and the driver's license'. *Int J Aging Hum Dev* 1990;30 (1):1-14.

24 Marottoli, R.A., Mendes de Leon, C.F., Glass, T.A., Williams, C.S., Cooney, L.M. Jr., Berkman, L.F., et al. 'Driving cessation and increased depressive symptoms: prospective evidence from the New Haven EPESE. Established Populations for Epidemiologic Studies of the Elderly' *J Am Geriatr Soc* 1997;45 (2):202-6.

25 Jones, J.G., McCann,J., Lassere, M.N.,. 'Driving and arthritis'. *Br J Rheumatol* 1991;30: 361-4.

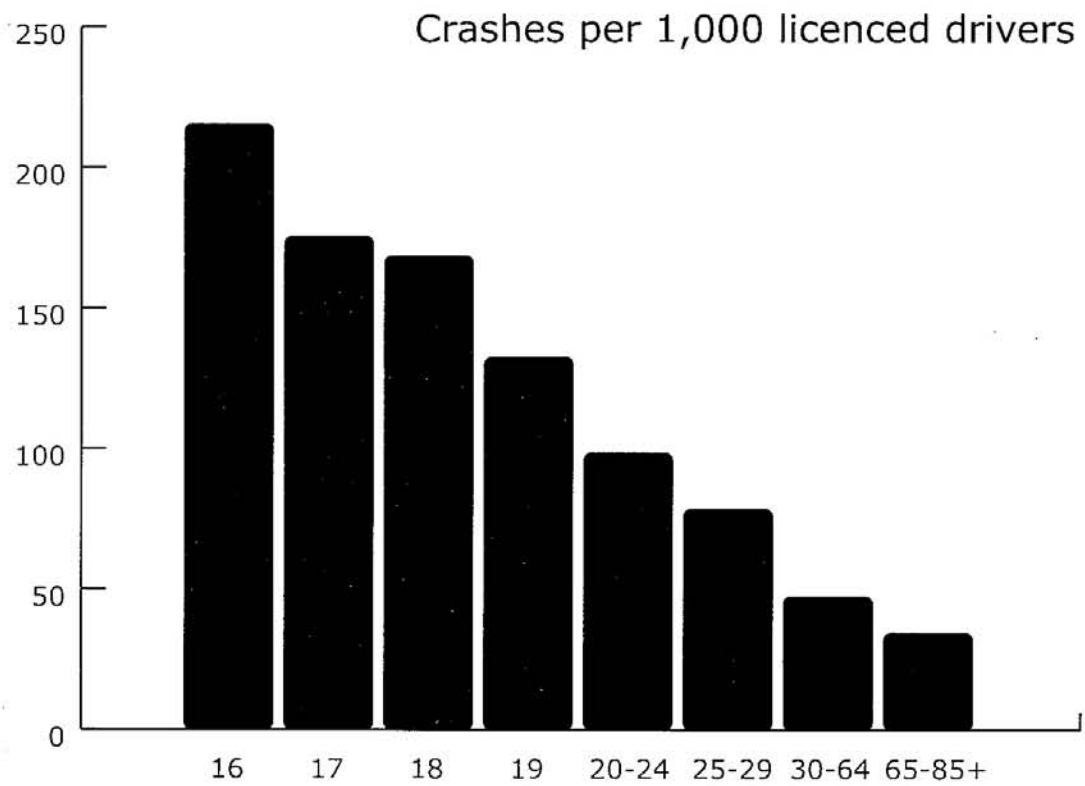
26 Van Zomeren, A.H., Brouwer, W.H., Minderhoud, J.M., 'Acquired brain damage and driving: a review'. *Arch Phys Med Rehabil* 1987; 68: 697-705.

27 Monestam E, Wachtmeister L. Impact of cataract surgery on car driving: a population based study in Sweden. *Br J Ophthalmol* 1997;81(1):16-22.

one study, one in four older drivers stopped driving over a six-year period[28]. Medical factors which predicted those who would not drive included neurological disease (Parkinson's disease or stroke) and cataract, but interestingly not cognitive impairment. In Florida, health factors accounted for about half of decisions to stop[29] and in Europe, medical and financial reasons were rated equally in importance by those who had stopped driving in later life [30].

The second is a prejudice that older drivers represent an increased risk to themselves and older drivers. Evans defends older drivers as a relatively safe group[31] and this is supported by crash rates per driver (Fig 8). Carr has shown healthy older drivers to perform better than younger controls[32]. An increase in the crash rate per miles driven in elderly populations in comparison to middle aged controls is often quoted by the media and those seeking research grants: it is of academic interest as long as older drivers drive a lower mileage than younger drivers.

Figure 8 : Annual Crash Involvement Per Capita Basis (NHTSA 1994)



28 Marottoli, R., Ostfeld, A., Merrill, S., Perlman, G.D., Foley, D., Cooney, L.. 'Driving cessation and changes in mileage driven among elderly individuals'. *J Gerontol* 1993;48: S255-60.

29 Campbell MK, Bush TL, Hale WE Mdical conditions associated with driving cessation in community- dwelling, ambulatory elders. *J Gerontol* 1993;48(4):S230-4.

30 Rabbitt, P., Carmichael, A., Jones, S., Holland, C.. *When and why older drivers give up* nriving. Basingstoke: AA Foundation for Road Safety Research, 1996.

31 Evans, L., 'Older driver involvement in fatal and severe traffic crashes'. *J Gerontol* 1988; 43 (6):S 186-93.

32 Carr, D,, Jackson, T.,W,, Madden, D.J, Cohen, H.J..'The effect of age on driving skills. *J Am Geriatr Soc* 1992;40(6):567-73.

The calculation of risk is highly complex: ironically, some of the protective measures undertaken by older people (low mileage and low speeds) may conspire to present a spuriously high risk per mile driven[33]. Also older people are more frail and crashes involving the elderly are also more likely to be fatal, by a factor of 3.5 in two-car accidents[34]. Janke has suggested a reasonable interpretation of these apparently contradictory findings[35]. A group's average crash rate per year may be considered as an indicator of the degree of risk posed to society by that group, whereas average accident rate per mile indicates the degree of risk posed to individual drivers in the group when they drive, as well as their passengers. The increased risk to individual drivers is most likely due to age-related illnesses, particularly neurodegenerative and vascular diseases[36,37,38]rather than to age per se.

Two opposing viewpoints have been taken on the likely impact of increasing numbers of older drivers on crash trends. The most alarmist viewpoint is that the number of elderly traffic fatalities will more than triple by the year 2030, based on current rates. If this expected increase occurs, the number of elderly traffic fatalities in 2030 would be 35 percent greater than the total number of alcohol-related traffic fatalities in 1995[39]. A more optimistic approach is a reiteration of Smeed's law, whereby increasing numbers of new drivers in a population display a diminishing number of accidents over time[40].

A third problem is that healthcare providers are placed in an awkward situation in several states in the US, provinces in Canada and a minority of countries in Europe. In these jurisdictions it is mandatory to report drivers with certain illnesses to driver licencing authorities[41,42]. In the absence of evidence-based guidelines and pathways of remediation after reporting, this process does not represent a health gain for our patients, and may even represent a loss of independence. That doctors have a difficulty with this type of legislation is typified by the effect of the introduction of compulsory reporting of drivers with dementia to the California Department of Motor Vehicles. In the years following the introduction of the legislation, there was no increase in the numbers reported. Although some of this under-reporting may stem from ignorance, it is also likely that doctors are unwilling to commit their patients to judgement by a system which is not evidence-based and seems pre-occupied with keeping patients off the road.

Enabling or Policing?

The medical literature on medical fitness to drive is relatively recent. It reflects societal bias and two major themes are obvious. These are i) a relative unawareness among doctors and the rehabilitation disciplines of the functional and medical importance of fitness to drive and ii) an over-emphasis on selecting those who should not drive rather than on enabling older drivers. Doctors are unaware of

33 Hakamies-Blomqvist, L., Wahlstrom, B., 'Why do older drivers give up driving?' *Accid Anal Prev* 1998;30(3):305-12.

34 Klamm, E.R.. 'Auto insurance: needs and problems of drivers 55 and ove'. In: Malfetti JL, editor. *Drivers 55+: needs and problems of older drivers: survey results and recommendations*. Falls Church, VA: AAA Foundation for Road Safety, 1985:87-95.

35 Janke, M.K., *Age-related disabilities that may impair driving and their assessment*. Sacramento: California Department of Motor Vehicles, 1994.

36 O'Neill,D. 'Physicians, elderly drivers, and dementia'. *Lancet* 1992;339 (8784):41-3.

39 Burkhardt. *XXX*, 1998.

40. Hakamies-Blomqvist L, Wahlstrom B. Why do older drivers give up driving? *Accid Anal Prev* 1998;30(3):305-12.

41, Millar, W.J., 'Accidents in Canada', 1988 and 1993. *Health Rep* 1995;7 (2):7-16

42 White, S., O'Neill, D., 'Health and relicencing policies for older drivers in the European Union'. *Gerontology* in press.

both driving habits of their patients when prescribing drugs which may affect driving[43] and of fitness to drive regulations[44,45,46]. Patients who attend glaucoma, syncope or dementia clinics are often not advised appropriately[47,48]. There may also be an element of ageism whereby doctors may assume that older patients do not drive: a review of dementia from the UK seemed to take this attitude[49], whereas US reviewers were aware of the high number of older drivers[50]. Finally, even in the rehabilitation environment, disabled drivers and stroke victims are not offered appropriate advice and rehabilitation about driving[51,52].

The emphasis on negative rather than enabling aspects of medical fitness to drive is disconcerting. A typical illness with potential for enabling is arthritis. Patients experience many difficulties in driving[53], despite evidence that appropriate intervention may improve driving ability and comfort[54]. Many patients do not return to driving after stroke[55], and rehabilitation and specialized driving re-education may return some of these to driving again[56]. Less than 5 percent of the papers in the author's database of over 1300 papers relating to older drivers have a significant focus on enabling or rehabilitation. This bias may influence the relationship between the physician and patient. Patients attend their physicians in the hope of remaining healthy and retaining maximum function, particularly in later life. Ideally, a physician should be considering whether or not patients are fit to drive with a view to correcting any physical or functional deficits and *enabling* the patient to be independent. The emphasis of many government manuals on fitness to drive, as well as much of the scientific literature, is on who should not drive, stressing the safety of other people preceding the right of the patient to drive: in effect, conferring a policing role on physicians. From a clinical and ethical viewpoint, this poses a dilemma, and a policing mentality may have a negative impact on attitudes to older drivers. It may also deter patients from attending their physicians if they fear that disclosure of illness may result in limitation of driving.

43 Cartwright, A., 'Medicine taking by people aged 65 or more'. *Br Med Bulletin* 1990;46 (1):63-76.

44 Miller, D.J., Morley, J., 'Attitudes and awareness of primary care physicians towards elderly drivers and driving policy'. *Gerontologist* 1991; 31 (special issue II):10.

45 O'Neill, D., Crosby, T., Shaw, A., Haigh, R., Hendra,T., 'Physician awareness of driving regulations for older drivers'. *Lancet* 1994; 344: 1366-7.

46 Strickberger, S.A., Cantillon, C., Friedman, R., 'When should patients with lethal ventricular tachyarrhythymias resume driving?' *Ann Intern Med* 1991;115: 560-3.

47 MacMahon, M., O'Neill, D., Kenny, R.A., 'Syncope: driving advice is frequently overlooked'. *Postgrad Med J* 1996;72 (851):561-3.

48 O'Neill, D., Neubauer, K., Boyle, M., Gerrard, J., Surmon, D., Wilcock, G.K., 'Dementia and driving'. *J R Soc Med* 1992; 85 (4):199-202.

49 Almeida, J., Fottrell, E., 'Management of the dementias'. *Rev Clin Gerontol* 1991;1: 267-82.

50 Winograd, C.H., Jarvik, L.F., 'Physician management of the demented patient'. *J Amer Geriat Soc* 1986; 34: 295-308.

51 Barnes, M.P., Hoyle. E.A., 'Driving assessment - a case of need'. *Clinical rehabilitation* 1995; 9: 115-20.

52 Fisk, G.D., Owsley, C., Pulley, L.V., 'Driving after stroke: driving exposure, advice, and evaluations'. *Arch Phys Med Rehabil* 1997; 78 (12): 1338-45.

53 Thevenon, A., Grimbert, P., Dudenko, P., Heuline, A., Delcambre, B., Polarthrite, 'Rhumatoïde et conduite automobile'. *Rev Rhum Mal Osteoartic* 1989; 56 (1):101-3.

54 Jones, J.G., McCann,J., Lassere, M.N.,. 'Driving and arthritis'. *Br J Rheumatol* 1991;30: 361-4.

55 Legh-Smith, J., Wade, D.T., Hewer, R.L., 'Driving after a stroke'. *J R Soc Med* 1986; 79 (4):200-3.

56 Van Zomeren, A.H., Brouwer, W.H., Minderhoud, J.M., 'Acquired brain damage and driving: a review'. *Arch Phys Med Rehabil* 1987; 68: 697-705.

There are almost no universally agreed guidelines for fitness to drive for any one illness, and there is an extraordinarilyy large range of existing guidelines among the states of both the United States[57] and the European Union[58]. For the academic, this represents an unrivalled opportunity to assess the validity or effectiveness of any guidelines by studying cross-national comparisons[59]. For the clinician, the issue is not so easy. While the geriatrician is aided in the assessment and rehabilitation of problems with balance and gait by an understanding of the underlying mechanisms, driving is a complex task, and there has been a marked lack of progress in developing a comprehensive model of driving behaviour. Michon has outlined some of the criteria for models of driving behaviour, and his emphasis on a hierarchy of strategic, tactical and operational factors is the most helpful theoretical concept for clinicians[60]. Strategic performance includes the planning of choice of route, time of day (avoiding rush hour), or even the decision not to drive and to take public transport. Tactical decisions are those aspects of the driving style which are characteristic of the driver and are consciously or unconsciously adopted for a great range of reasons, e.g., decisions on whether or not to overtake, go through amber lights or signalling in good time before turning. Operational performance is the response to specific traffic situations, such as speed control, braking and signalling.

Driving a car requires organisation of action at and between all three levels, but clinically, the strategic and tactical components are the most important elements of safe driving.

Five main types of model have been explored: psychometric, motivational, hierarchical controls, information processing and error theory. A preliminary emphasis on psychometric measures relating to accident-causing behaviour has been faulted for having been conducted without the benefit of a process model of driving, for focusing primarily on accident-causing behaviours and not on everyday driving, and on relying heavily on post hoc explanations[61]. For example, correlations have been shown between accident behaviour and some of these measures, particularly Useful Field Of View, a composite measure of preattentive processing, incorporating speed of visual information processing, ability to ignore distractors (selective attention) and ability to divide attention[62] Some of the problems with using such post hoc research measures are

- restricted range of criterion and/or predictor variables as can arise from the death of the worst drivers before they can be tested
- the potential effect of testing on drivers in a special category due to accident involvement
- the questionable assumption that skills or attributes measured by the individual variables do not change over time.

57 Retchin, S.M., Anapolle, J., 'An overview of the older driver'. *Clin Geriatr Med* 1993; 9 (2):279-96.

58 White, S., O'Neill, D., 'Health and relicencing policies for older drivers in the European Union'. *Gerontology* in press.

59 Hakamies-Blomqvist, L., Johansson, K., Lundberg, C. 'Medical screening of older drivers as a traffic safety measure - a comparative Finnish-Swedish Evaluation study'. *J Amer Geriatr Soc* 1996; 44: 650-3.

60 Michon, J.A. 'A critical review of driver behaviour models: what do we know, what should we do?' In: Evans, L., Schwing, R.C., editors. *Human Behaviour and Traffic Safety*. New York: Plenum, 1985:487-525.

61 Ranney, T.A. 'Models of driving behaviour: a review of their evolution'. *Accid. Anal. and Prev.* 1994;26 (6): 733-750.

62 Owsley, C., Ball, K., Sloane, M.E., Roenker, D.L., Bruni, J.R. 'Visual/cognitive correlates of vehicle accidents in older drivers'. *Psychol Aging* 1991; 6 (3):403-15.

Motivational models which distinguish between drivers' performance limits and on-road driving offer more promise For example, a pioneering Swedish study showed that when drivers are asked to remember road signs, the accuracy ranged from 17-78 percent, depending on the subjective importance of the sign, i.e. the amount of risk involved in ignoring the sign[63]. Early models emphasise transient situation specific factors and assume risk to be a primary motivating factor.

Second generation motivational models have incorporated a hierarchical control structure which has given emphasis to motives other than risk, i.e. pleasure in driving, traffic risks, driving time and expense[64]. They also allow for concurrent activity at operational, manoeuvring and strategic levels and portray the driver as an active decision-maker rather than as a passive responder implicit in early information-processing models. The driver's allocation of attention depends on the immediate driving situation and the driver's motives which include the level of risk and other motives relating to the purpose of the trip. The main research interest is in identifying factors that influence the driver's allocation of attention among the tasks of the different control levels.

Table 2 : Matrix Incorporating the Hierarchical and Knowledge/Rule Skill Models

	Strategic	**Tactical/Manoeuvring**	**Operational/Control**
Knowledge	Navigating in unfamiliar area	Controlling skid	Novice on first lesson
Rule	Choice between familiar routes	Passing other vehicles	Driving unfamiliar vehicle
Skill	Route used for daily commute	Negotiating familiar intersection	Vehicle handling on curves

Much routine driving is done automatically, and automaticity, which represents fast effortless cognitive processing and can occur at all three levels of control. This contrasts with control processing which demands attention and resources. Automaticity can develop as a response to several types of stimuli and underlies much experienced driving behaviour until knowledge-based problem solving is required. A combined model of a control hierarchy and an automaticity/controlled processing scheme is illustrated in Table 2.

Assessment

While the art/science of risk assessment is at such an underdeveloped state, it is better to live with uncertainty and apply a considered individualised clinical approach than to prematurely adopt guidelines with apparent face validity. This is not so different from the diagnosis of dementia, where there is no single fail-safe battery of tests: rather we work with a range of assessments, familiarise ourselves with their limitations and make a clinical diagnosis.

63 Johansson, G., Backlund, F. 'Drivers and road signs'. *Ergonomics, 1970* 1970; 13 (6):749-759.

64 Rothengatter, T., de Bruin,R. 'Risk and the absence of pleasure: a motivational approach to modelling road user behaviour'. *Ergonomics* 1988; 31: 599-607.

Risk assessment in older drivers is affected not only by our understanding of models of driving behaviour and empirical studies of disease and crash risk, but also by clinical attributes common to the assessment of function in older patients. Inter-individual variability is extremely important and necessitates a case by case approach. Factors relating to age-related diseases include not only a different spectrum of illness to younger people, but also the presence of multiple illnesses. In any one patient, is it the arthritis, the dementia, the visual acuity or even the multiple medications which is affecting driving? Within the rubric of one illness there may be multiple facets. For example, there is an increased risk of crashes with Parkinson's disease[65, 66]. The illness may involve problems of motor function, depression and impaired cognitive function. Rather than stating Parkinson's disease is dangerous for driving, it is vital to take a phenomenological approach. The depression and the motor function must be treated and cognitive function assessed and managed before any decisions are made about fitness to drive.

Any broader assessment of group risk due to illness will require careful scrutiny of the relevant literature. The source of information is critical to decision-making. Did it come from a specialised clinic or from the community? Was it a large study? What level of risk is implied for our patients? A study on diabetes, epilepsy and risk of crashes is a useful illustration of this[67]. Epilepsy and diabetes are both illnesses that have been very clearly defined in many fitness-to-drive manuals, often with stringent licence restrictions and/or punitive insurance loadings. This large-scale community study demonstrated that the increased risks were in fact quite small. It is probably no coincidence that the United Kingdom Driver and Vehicle Licencing Authority has subsequently relaxed the restrictions on both diabetes and epilepsy[68]. If a more selected group is studied, for example people over 65 in a health maintenance organisation, the relative risk for diabetes and crashes may be higher[69]. As in any application of the medical literature, the physician has to relate the sample population to his own practice.

The Insurance Corporation of British Columbia's gives a wider driving population-based perspective of risk of driving and dementia[70], but many studies of driving and illness have originated from specialised clinics in cardiology, dementia or syncope. Studies of dementia and driving which are taken retrospectively from dementia clinics tend to show a high risk, whereas those which are quasi-prospective and which look at the early stages of dementia show a less pronounced pattern of risk. In the first two years of dementia the risk approximates to that of the general population[71]. This is an important finding because many physicians assume that dementia is an absolute contra - indication to driving. In a UK study of dementia deterioration in driving skills was a phenomenon of the early stage in 10% of the patients studied[72]. A higher than expected number of tangles and plaques have

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65 Dubinsky, R.M., Gray, C., Husted, D., Busenbark, K., Vetere-Overfield, B., Wiltfong, D. et al. 'Driving in Parkinson's disease'. *Neurology* 1991; 41 (4):517-20.

66 Lings, S., Dupont, E. 'Driving with Parkinson's disease. A controlled laboratory investigation'. *Acta Neurol Scand* 1992;86 (1):33-9.

67 Hansotia, P., Broste, S.K. 'The effect of epilepsy or diabetes mellitus on the risk of automobile accidents' *N Engl J Med* 1991;324 (1):22-6.

68 Medical Advisory Branch D. 'At a glance guide to the current medical standards of fitness to drive'. 1994 (November).

69 Koepsell, T.D., Wolf, M.E., McCloskey, L., Buchner, D.M., Louie, D., Wagner, E.H., et al. 'Medical conditions and motor vehicle collision injuries in older adults'. *J Amer Geriatr Soc* 1994;42: 695-700.

70 Cooper, P.J., Tallman, K., Tuokko, H., Lynn Beattie, B. 'Vehicle crash involvement and cognitive deficit in older drivers'. *Journal of Safety Research* 1993; 24(1):9-17.

71 Drachman, D.A., Swearer, J.M. 'Driving and Alzheimer's disease: the risk of crashes' [published erratum appears in Neurology 1994 Jan;44(1):4]. *Neurology* 1993;43(12):2448-56.

72 O'Neill, D., Neubauer, K., Boyle, M., Gerrard, J., Surmon, D., Wilcock, G.K., 'Dementia and driving'. *J R Soc Med* 1992; 85 (4):199-202.

been found in the brains of drivers who crash[73], but subsequent assessment of the families did not reveal significant premorbid deterioration in the subjects' general function[74]. The most carefully controlled study of crashes and dementia showed no increase in crash rates for drivers with dementia[75]. Likely causes for this counter-intuitive finding include a lower annual mileage and restriction of driving by the patient, family and physicians

The effect of drugs on driving has also assumed greater importance[76]. This is a complex area, with many difficult methodological considerations, not least of which is the question of whether it is the disease or the medication that impairs the driver. From the existing literature, several key points emerge when considering the prescription of psychoactive medications. Does the patient really need the medication? If benzodiazepines are required, long-acting agents should be avoided[77]: if unavoidable, they would tip the scales towards driving cessation during the course of the prescription. The choice of an antidepressant in an older driver should be directed away from tricyclic[78]. Neuroleptic medication (and the underlying illness) would be a negative influence on driving ability. Physicians need to be vigilant about over– the –counter medications (particularly those containing antihistamines) and newer drugs with uncommon but important side effects which may affect driving, such as changes in neurological status due to ciprofloxacin[79].

Assessment Strategy

The schedule for the assessment of the older driver is akin to that of geriatric assessment of older people, a process which is marked by the following qualities: medical and functional assessment, detection and prioritisation of diseases, interdisciplinary assessment and remediation (Table 3). Functional assessments, such as a comprehensive test of visual processing, a falls history and a review of current medications may be of greater relevance than specific medical conditions in the identification of older at-risk drivers[80]. Early specialist referral may prove beneficial for the primary care physician who does not have access to an interdisciplinary team.

73 O'Neill,D. 'Physicians, elderly drivers, and dementia'. *Lancet* 1992;339 (8784):41-3

74 O'Neill, D., editor. 'Follow-up of Alzheimer's disease and apolipoprotein E E4 allele in older drivers who died in automobile accidents'. *The Older Driver, Health and Mobility*; 1999; Dublin. ARHC Press.

75 Trobe, J.D., Waller, P.F., Cook-Flannagan, C.A., Teshima, S.M., Bieliauskas, L.A.. 'Crashes and violations among drivers with Alzheimer disease'. *Arch Neurol* 1996;53 (5):411-6.

76 O'Neill, D. 'Benzodiazepines and driver safety ' *Lancet* 1998;352 (9137):1324-5.

77 Hemmelgarn, B., Suissa, S., Huang, A., Boivin, J.F., Pinard, G. 'Benzodiazepine use and the risk of motor vehicle crash in the elderly' *Jama* 1997; 278 (1):27-31.

78 Ray, W.A., Thapa, P.B., Shorr, R.I. 'Medications and the older driver'. *Clin Geriatr Med* 1993;9 (2):413-38

79 Gray, K.J., Allen, K.D., Ridgway, E.J. 'Impairment of driving by ciprofloxacin'. *Br Med J* 1994; 309: 542.

80 Sims, R.V., Owsley, C., Allman,R.M., Ball, K., Smoot, T.M. 'A preliminary assessment of the medical and functional factors associated with vehicle crashes by older. *J Am Geriatr Soc* 1998; 46 (5):556-61.

Table 3: Process of clinical driving assessment

1.	**History:** • patient, family/informant • driving history • medications
2.	**Examination:** • functional status • vision • mental status testing
3.	**Diagnostic formulation and prioritisation.**
4.	**Remediation.**
5.	**In-depth cognitive/perceptual testing.**
6.	**On-road assessment.**
7.	**Overall evaluation of hazard:** • strategic • tactical • operational
8.	**Advice to patient/carer:** • driving • insurance • licencing authority
10.	**If driving too hazardous, consider alternative mobility strategies.**

A cascade system for interdisciplinary assessment is probably the most cost-effective way to approach the patient (Table 4). For example, if the physician detects visual acuity below the standard for the jurisdiction, referral to an ophthalmologist and maximal remediation of vision should occur before returning to the assessment cascade. Similarly, should a patient in the European Union have a homonymous hemianopia (one of the few absolute medical contra-indications to driving), then referral to the social worker for developing strategies for alternative transportation is the next step in the cascade.

Table 4: Cascade Assessment Pathway

Decision-Making

The high rate of accuracy of test batteries in dementia depends on the care that clinicians take in developing a liaison and familiarity with local occupational therapists and neuropsychologists, so that results can be taken in context, not only of the patients but also of the training and quirks of the assessors. It is likely that the same approach is critical to good assessment practice in driving competency.

To most clinicians, it is relatively easy to detect those patients who represent a low risk and those who represent a high risk for driving. It is those in between who represent the greatest challenge. If we consider dementia as a paradigm for age-related illnesses which may affect driving, we can glean some interesting information from various components of the assessment and treatment processes outlined above.

Most published assessment papers include a common core[81, 82, 83]. One of the most important final common pathways of concern in driving is obviously cortical function, whether impaired due to syncope, cognitive function, inattention or neglect, personality change, or obvious motor problems. Cognitive and visual parameters appear to carry the highest risk of compromising driving ability[84], and it is possible that decrements reported for cardiovascular disease may in fact relate to occult or undetected cognitive impairment.

Another important area of evaluation is the utility and validity of the informant report. At present many of us rely quite strongly on an informant's report of driving skills. Evaluation of a semi-standardised informant's report would be very useful in appropriate referral for more specialised testing.

81 Reuben, D.B. 'Assessment of older drivers'. *Clin Geriatr Med* 1993;9 (2):449-59.

82 Carr, D., Schmader, K., Bergman, C., Simon, T.C., Jackson, T.W., Haviland, S., et al. 'A multidisciplinary approach in the evaluation of demented drivers referred to geriatric assessment centers'. *J Am Geriatr Soc* 1991;39 (11):1132-6

83 O'Neill, D. 'Illness and elderly drivers'. *J Ir Coll Phys Surg* 1993:14-16.

84 Owsley, C., Ball, K., Sloane, M.E., Roenker, D.L., Bruni, J.R. 'Visual/cognitive correlates of vehicle accidents in older drivers'. *Psychol Aging* 1991; 6 (3):403-15

A wide range of tests has been described in relatively small groups of older drivers in community settings and clinics: some have also been correlated with sophisticated simulators and on-road tests. A comprehensive summary has been published in 1999[85]. It is useful to divide these into first-level, ie primary care or community screening tools, second level functional screening and finally on-road tests of driving competence. Some tests will be common to the first and second tiers

Simple screening tests which may be helpful include Road Traffic Identification tests[86]. These overcome difficulties with literacy and language differences. At a more clinical level, virtually all cognitive screening tests have a correlation with compromised driving ability. The Short Blessed Test was less sensitive than Trials A or B in predicting crashes in a study based at the time of driving licence renewal[87]. The Mini-Mental State Examination has the benefit of an (almost) consensus statement that scores less than 10 imply immediate cessation of driving, scores of less than17 require urgent assessment and scores of more than 17 mean that decisions should be based on the functional level of the patient[88].

At the secondary assessment level, tests which have been found to be helpful are the Trials A and B, tests of visual and auditory attention, and Digit Symbol Subscale of the WAIS[89]. A number of specific test batteries have been formulated, none of which is sufficiently widely assessed to be relevant for clinical practice[90].

Simulators have not yet gained widespread acceptance for driver testing. Inexpensive simulators are as yet little more than psychometric tests in fancy dress. High quality simulators will play a valuable role in providing performance parameters against which clinical and functional assessments can be measured. For example, a pioneering study by Rizzo has confirmed the correlation of the Trails test with driving performance[91]. In the near future, the exponential increases in microprocessor power and decreases in their cost may lead to a more general development of the simulator as an assessment tool.

Several standardised on-road tests have been formulated in recent years [92,93], and will help to provide a common language for specialist driving assessors. The Forum of Driving Centres, representing the thirteen specialist driving centres in Britain and Ireland, has already run educational programmes for its members concentrating on the older driver.

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85 Staplin, L.S., Lococo, K.H., Stewart, J., Decina, L.E. *Safe mobility for older people notebook*. Washington DC: National Highway Traffic Safety Administration, 1999

86 Carr, D.B., La Barge, E., Dunnigan, K., Storandt, M. 'Differentiating drivers with dementia of the Alzheimer type from healthy older persons with a Traffic Sign Naming test'. *J Gerontol A Biol Sci Med Sci* 1998;53(2):M135-9.

87 Stutts, J.C., Stewartm J.R., Martell, C. 'Cognitive test performance and crash risk in an older driver population'. *Accid Anal Prev* 1998;30 (3):337-46

88 Lundberg, C., Johansson, K., Ball, K., Bjerre, B., Blomqvist, C., Braekhus, A., et al. *Dementia and driving - an attempt at consensus*. 1996

89 Staplin, L.S., Lococo, K.H., Stewart, J., Decina, L.E. *Safe mobility for older people notebook*. Washington DC: National Highway Traffic Safety Administration, 1999

90 Staplin, L.S., Lococo, K.H., Stewart, J., Decina, L.E. *Safe mobility for older people notebook*. Washington DC: National Highway Traffic Safety Administration, 1999

91 Rizzo, M., Reinach, M., McGehee, D., Dawson, J. 'Simulated car crashes and crash predictors in drivers with alzheimer disease'. *Archives of Neurology* 1997; 54 (May):545-551.

92 Hunt, L.A., Murphy, C.F., Carr, D., Duchek, J.M., Buckles, V., Morris, J.C. 'Reliability of the Washington University Road Test. A performance-based assessment for drivers with dementia of the Alzheimer type'. *Arch Neurol* 1997;54 (6):707-12.

93 Dobbs, A.R., Heller, R.B., Schopflocher, D. 'A comparative approach to identify unsafe older drivers'. *Accid Anal Prev* 1998;30(3):363-70.

Screening

Screening for medical illness relevant to driving is difficult due to the complex nature of the driving task and underlying societal prejudices. Some European countries have attempted screening by demanding a doctor's certificate at regular intervals after a certain age. A comparison of accident rates between Sweden (where there is no medical control) and Finland (requiring regular medical recertification after age 70) showed no reduction in motor crash fatalities and an increase in pedestrian and cycle fatalities among the over 70s in Finland. This may be as a result of stopping older people driving unnecessarily and forcing them into the much higher risk group of pedestrians and cyclists[94]. A more enlightened approach is under assessment in the State of Maryland, where the screening process is directed towards a rehabilitation outcome. Those who screen as 'at risk' on a simple test battery at the time of licence renewal are offered an assessment by the Geriatric Evaluation System of Maryland State. Preliminary results are awaited with anticipation!

Intervention

Access to the full interdisciplinary team, a good working relationship with a specialist driving assessment centre, and the availability of car adaptation services are important factors in offering an appropriate service. If a patient with dementia is judged to be capable of driving, the driver and carer should be advised against driving alone, to return for review in three to six months, or sooner should the co-pilot notice any deterioration in driving skills. This form of restriction makes sense for two reasons. Drivers with medical conditions and restricted driving licences have been shown to have fewer crashes than those similarly affected but with no restrictions[95], and drivers with dementia who drive accompanied are also more crash-free[96].

When Driving is No Longer Possible

When driving cessation is indicated, it is important to explore alternatives with the patient. A sympathetic social work intervention may be helpful, and can work though the various options available to the patient. Public transport, even if free, is often irrelevant to older, compromised adults. Family members may be able to provide some driving input. The ideal situation is to provide a system of paratransit: affordable, tailored individual transportation. Various models have been developed (an excellent example is the service in Portland, Maine), but the funding remains problematic[97].

Refusal to stop driving occurs in a minority of cases. In the Republic of Ireland, only a District Court (and not, as is often supposed, the Driver Licencing Section of the newly founded Department of Transport) can remove a licence. Approaches to the Garda Síochána may be needed in such cases. As

94 Hakamies-Blomqvist, L., Johansson, K., Lundberg, C. 'Medical screening of older drivers as a traffic safety measure - a comparative Finnish-Swedish Evaluation study'. *J Amer Geriatr Soc* 1996; 44: 650-3.

95 Transportation Research Board. *Evaluating drivers licensed with medical conditions in Utah*. 1992-1996. 1999; Washington DC.

96 Bédard, M., Molloy, M., Lever, J. 'Should demented patients drive alone?' *Journal of American Geriatric Society* 1996; 44 (September, 1996):S9.

97 Freund, K. 'The politics of older driver legislatio'n. *Gerontologist* 1991; 31 (special issue II):162.

these are often (but not invariably) drivers with dementia, it is interesting to note some changes in the literature. Early reviews on the subject suggested that subterfuge and working around the patient was the only strategy. An interesting case report has suggested a possible alternative involving exploring the patient's feelings and fears about giving up driving[98]. The intervention was designed with the patient as collaborator and by dealing with the events at an emotional rather than at an intellectual level. The patient was able to grieve about the disease and in particular about the loss of his car. This in turn enabled him to redirect his attention to other meaningful activities that did not involve driving. Although this approach may be hampered by the deficits of dementia, it reflects a more widespread trend towards sharing the diagnosis of dementia with the patient.

98 Bahro, M., Silber, E., Box, P., Sunderland,T. 'Giving up driving in Alzheimer's disease - an intergrative therapeutic approach'. *International Journal of Geriatric Psychiatry* 1995;10: 871-874.

Terms of Reference and Membership

Terms of Reference

The National Council on Ageing and Older People was established on 19 March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:

1. To advise the Minster for Health on all aspects of ageing and the welfare of older people,either at its own initiative or at the request of the Minister and in particular on:

   (a) measures to promote the health of older people;

   (b) measures to promote the social inclusion of older people;

   (c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;

   (d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;

   (e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;

   (f) meeting the needs of the most vulnerable older people;

   (g) means of encouraging positive attitudes to life after 65 years and the process of ageing;

   (h) means of encouraging greater participation by older people;

   (i) whatever action,based on research,is required to plan and develop services for older people.

2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:

   (a) undertaking research on the lifestyle and the needs of older people in Ireland;

   (b) identifying and promoting models of good practice in the care of older people and service delivery to them;

(c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health,well-being and autonomy of older people;

(d) liaising with statutory,voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.

3. To promote the health,welfare and autonomy of older people.

4. To promote a better understanding of ageing and older people in Ireland.

5. To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other Ministers,at their request,on aspects of ageing and the welfare of older people which are within the functions of the Council.

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