Emerging tensions in the use of assessment tools in home and community care

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Abstract

Access to community care services for older people and younger people with disabilities is based on the assessed needs of individuals seeking assistance to remain at home in the community. This paper reviews literature related to use of assessment tools in community care in the context of findings from a Victorian study that focussed upon initial needs assessment processes in home and community care. The trend toward more formalised (and potentially standardised) assessment tools in community care assessment may give rise to unintended tensions that potentially undermine the critical thinking and flexibility required to assess need across diverse populations. Training and professional development for community care assessment, where the focus is on critical thinking, rather than on the use of assessment tools alone is suggested.

Keywords: assessment tools, community care, training

Introduction

Home and Community Care (HACC) services, for frail older people and people with disabilities, include home care (such as cleaning or shopping), home maintenance, personal care, social support, day activities/day care, other forms of respite, delivered meals and community transport. HACC is a funding program of the Commonwealth and State governments. Access to HACC services is based on the assessed needs of individuals seeking to remain at home within their community. HACC assessors are required to meet certain standards of practice in areas such as developing cooperative relationships with other providers, collecting basic client data on a common referral form, assessing certain domains, involving the client and carers in the process, and developing care plans. The assessment process in HACC is usually clients' first point of contact with services and a critical stage in clients' engagement with the broader service system.

Reforms to community care systems in Australia have often focused on the use of assessment documents and processes. Ostensibly this has been to minimise duplicate assessment of clients shared by more than one agency (so that some questions only need to be asked once), and to improve systems of client data collection (Brian Elton and Associates & Department of Human Services and Health 1995; Caban 1993; Helling 2002). The Client Information and Referral Record (CIARR), a simple, common information and services record completed at the time of assessment, has been replaced (in Victoria) by the Service Coordination Tool Templates (SCTT), and all HACC providers, have been required to use these documents since 2002. Some non-HACC providers are also mandated by DHS to use SCTT such as

Psychiatric Disability Rehabilitation & Support Services (PDRSS). The SCTT has the same aims as the CIARR: to help improve service coordination and client referral, and reduce duplication and multiple assessments of the same person by different agencies, but is much more detailed in scope and depth of assessment domains. This essentially signifies a move towards more systematised assessment processes and documentation across a range of service providers, a trend that is set to continue as a requirement for HACC services (Howe & Warren 2005).

Staff employed in assessment roles have diverse backgrounds such as social and welfare work, nursing, health, and disability studies (Howe 2000: 100; Prideaux, Clark, Goonan and McCormack 2004). The need for flexibility in assessment that complements rather than competes with more formalised or standardised assessment tools is implicated in the various perspectives each staff member may contribute.

Method

A research study was conducted in Victoria with the aim of developing a greater understanding of the assessment workforce in HACC in order to develop better approaches to their professional preparation and support (Lindeman 2006). The study used qualitative methods: in-depth interviews were conducted with twelve key informants (including funding body representatives, trainers, consultants, and peak body representatives) and with twelve individuals employed in assessment roles in HACC. The current paper integrates findings from this study relating to implementation of assessment documentation with a discussion of literature focused on this area. De-identified direct quotes from research participants are included for this discussion.

Assessment tools in community care

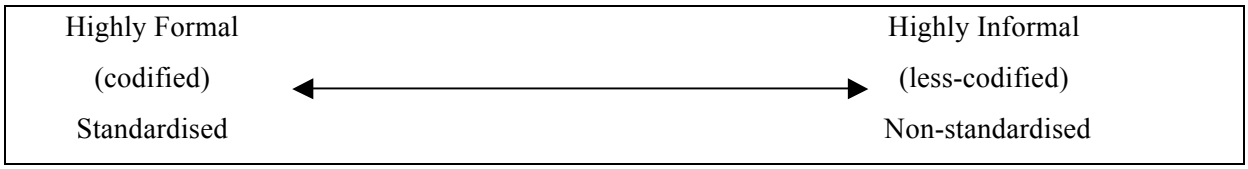
Assessment documents can be represented along a continuum of 'highly formal' to 'highly *in*formal', as represented in diagram 1. At the highly formal end of the continuum are the standardised tools that are norm referenced and which have been subjected to extensive field testing and statistical analysis. These standardised tools are said to rate highly in terms of reliability (they produce the same results regardless of who is administering the tool) and validity (they measure what they are supposed to measure). Examples of standardised tools include those that test for dementia, such as the Mini Mental State Examination (Folstein, cited in Hodges 2007), or for functional capacity for activities of daily living, such as the InterRAI suite of assessment tools (Lincoln Centre for Ageing and Community Care Research, 2004) (www.interrai-au.org/suite.htm) (InterRAI website accessed 31st March 2009). Standardised assessment tools are commonly used in health (The Royal College of Physicians of London & The British Geriatrics Society 1992) and allied health professions such as occupational therapy (Cramer & Bartholomew 2000; Eakin & Baird 1995; Vertesi, Darzins, Lowe, McEvoy, and Edwards 2000) and less frequently in social work (Ivry 1992). It is assumed that professionals are competent to administer standardised tools due to their professional training. In general, medical/health professions tend to favour standardised assessment tools, and social welfare professionals tend to favour non-standardised assessment tools (intuition and judgement-based approaches). The use of standardised assessment tools

is relatively uncommon in HACC (Howe & Warren 2005) but very common in Aged Care Assessment Teams in Australia (Lincoln Centre for Ageing and Community Care Research, 2004) which are staffed by medical and allied health (discipline-based) professionals.

Further along the continuum, are highly codified documents that assist workers to formulate judgements but which are not necessarily standardised. In community care, some falls risk assessment tools (Hill, Schwarz, Smith, Gilsenan and Bull 2001) are in this category, and the tool to assist workers judge need for personal alarms/personal alert systems (Mayhew-Rankcom, Lindeman, Hill and Smith 2001) also fits here. Further along still are more simple tools designed to assist assessors judge whether or not an issue requires monitoring, a special service response, or referral to a specialist assessor. The HACC nutrition risk assessment tool (Wood 1998) is an example of this which is designed for application by any HACC assessor.

At the opposite end of the continuum are assessment processes that are highly *informal or unstructured*. These may simply be lists of domains (or headings, such as "mobility") with free text space allowing for the assessor to record any information they feel is relevant.

Diagram 1: Continuum of levels of formality of assessment tools



Arguments that support the use of formal, or structured, instruments include that they reduce the risk of inconsistency between assessors and enhance the program's ability to collect reliable data. On the other hand, there are arguments that assessment tools are only as good as their users (Kane & Kane 2000). Seed & Kaye (1994) suggest that the assessor's attitude is more likely to influence the assessment process and outcome than the instrument itself. Woods and Baldwin (1998) note that while needs assessment processes that include predetermined lists are helpful to ensure that an adequate range of activities is considered for assessment, it cannot substitute for more open-ended techniques that are based upon the assessor using good professional judgement. They also note that while all clients share universal needs, most clients will also have specific needs, often relating to religious, ethnic and other cultural factors including specific aspects of their disabilities (Woods & Baldwin 1998). The implication is that formal/structured (standardised tools) are less likely to capture client diversity than less structured, open-ended, and fluid processes. Highly formalised documents (including standardised tools) are more likely to be 'score based' compared to less formal documents. Score based approaches give a numeric score to clients based on data collected from them which assists assessors to make comparative judgements and to assess relative need objectively (Seed & Kaye 1994).

An assessment in community care may include application of a number of 'tools' depending on the nature of the referral. There will also usually be a document (or it will be all inclusive) that records other client data important for the provision of services. Informal tools are more

often associated with application by non-professional staff, although these are the tools that rely most heavily on professional judgement of the assessor. A lack of integration of 'health' and 'social' domain groups in community care assessment tools has been reported (Stewart, Challis, Carpenter and Dickinson 1999), possibly reflecting an assumption that no one assessment worker can cover both (all) areas sufficiently.

Professional backgrounds of staff

Evidence from the United Kingdom suggests that differences in professional backgrounds of staff involved in client assessment presented difficulties when a common assessment form was introduced (Lewis, Bernstock and Bovell 1995; Vernon, Ross and Gould 2000). Essentially this was because the information required by the different professions was different, and because it was unclear whether one profession should accept another's assessment. Similar issues were experienced in Australia in relation to implementation of the CIARR for the HACC program (Brian Elton and Associates & Department of Human Services and Health 1995). The difficulty of designing a comprehensive tool to suit the diversity of the aged and community care workforce, despite the range of services having common clients and common objectives, is marked. The influence of the professional background of the assessor in community care is well recognised (Butler, Dickens, Humphries, Otis and Russell 1998; Kane & Kane 2000). A person with greater expertise in a particular domain is likely to explore that domain in greater detail than someone whose expertise lies elsewhere. The implication here is that the worker's professional background and training will shape the assessment process and the information that is collected and, in turn, the client outcome.

Worth (1998) refers to research studies that conclude that assessment is seen to be rooted in the professional identity of the assessor; the assessment style and language is profession-specific and is therefore limited in scope. The differences between the value frameworks of nursing and social work professions and the resulting differences in practice are cited. In contrast, Hughes (1995) reports not only differences in the scope and content of assessments performed by different professional categories (social workers, occupational therapists, and home care co-ordinators), but often wide variation between people within the *same* professional category. Similarly, Dill (1993) points out that precisely because of the uniqueness of each assessor (in relation to personal characteristics and approach) as well as each individual who is assessed, needs assessment will vary from case to case regardless of the degree of standardisation of the assessment instruments used (Dill, 1993). Assessments have been shown to be a selective and interpretive process, either a structured exploration of key needs of service users according to key topic areas with the assessment framework, or they can be more conversational with services users and informed by the assessment framework (Foster, Harris, Jackson, Morgan and Glendinning 2006). Whilst the sector tends to be preoccupied with the influence of individual professions in community care assessment, this suggests that the professional background of the assessor only tells part of the story and that a range of other factors may come into play to influence an individual's approach to assessment. A greater understanding of these other factors would enable initiatives, such as joint training/learning programs which focus on common 'frameworks for thinking', to be developed more strategically. Even within respective disciplines, there is considerable

diversity in the professional training/disciplinary approach of the worker as well as personal characteristics of the workers themselves (Lindeman 2009).

Current Practice and Emerging Tensions in Application of Assessment Tools

Some of the critical tensions that are pervasive in community care become clear on consideration of assessment documentation in needs assessment. According to Dill (1993)

> "the technical superiority of the bureaucratic form derived largely from its ability to rationalise decision-making, replacing personalistic, affective criteria with universalistic, objective means and measures" (Dill 1993: 456).

As such, assessment documents that are designed to enable predictability, fairness of decision-making and efficiency fit within a positivist frame. Practitioners are required to uncover essentialised patterns and determine whether they contribute to or hinder functioning (Iversen, Gergen and Fairbanks 2005). Professionals often tend to make extensive use of formal documentation to both assist in their judgements and to justify their decisions. Yet, while professional (discipline-based) practitioners are encouraged to use formal assessment tools, they are also encouraged to evaluate them from the perspective of the tools' ability to take into account "each person's unique needs and abilities, as well as the environmental and social factors that may be affecting the clients' performance" (Pollock 1993: 298). This seems to be at the heart of a tension between the need for service providers to manage the volume of clients presenting for services and to be responsive to the diversity of clients and contexts. The place of clients' stories, the narrative that should provide the context for assessment judgements, can become secondary through over prescriptive use of some assessment tools with predetermined frameworks (Dill 1993; Tanner 2001). Tanner (2003) states that a focus on health and medical concerns may even obscure the significance of clients' social situations as the medical model serves to objectify or depersonalise clients' stories.

In the Victorian study, that included interviews with assessors, participant 'Jennifer', who worked with Indigenous clients, made a similar observation. She described existing assessment documentation as being too skewed towards health and medical information perhaps at the exclusion of other potentially useful information. She felt such questions were often unnecessary as her clients (Indigenous people) found them to be intrusive and served to obstruct the assessment process. The professional relationship between the client and the assessor was the most crucial aspect, rather than the tool itself:

> "…I don't think assessment is one form, one visit. It needs to be an ongoing process where you are learning more about the person and developing a relationship as you go along" (Jennifer).

Higher value tends to be placed on clinical expertise over other areas of expertise in the sector. Mykyta and English (2002) criticise the trend of "de-medicalisation" of assessment on

the basis that assessment, particularly basic assessment for home and community care, has been "de-professionalised by the introduction of protocols and screening instruments that can be administered by clerical rather than clinical workers" (Mykyta & English 2002: 84). The evidence from the Victorian study negates this conceptualisation; such a polarisation is not evident from the professional identities of assessment workers. They are, in fact, a highly diverse group with health and social care backgrounds represented, and no participant in the study was without some sort of formal qualification (Lindeman 2009). Further, evidence suggests that basic (initial) assessments in community care are undertaken holistically in HACC services:

> "… how is the family relating to each other? Who's letting who have a word? What's the physical environment like? Have these people struggled all their lives and are real battlers? Are these people that perhaps in the past have had very comfortable existences and now are struggling and don't know how to deal with that circumstance? Is this a household that is absolutely falling down around their ears, that's perhaps a health risk, dangerous? Are there things like electrical cords everywhere? Are we in a real mess here, are we at the point where we need an industrial clean? You know, all of those things give you alarm bells as to how this person is coping or where they're at in their life now. Whether it is through health issues, whether it be mental issues, whether it be through just having absolutely no repertoire of the experience to understand, 'I'm old now and this is what's happening to me'. You know, all of that, so just listening and observing everything. There are cues everywhere and you've got to be on red alert for taking in and looking for information everywhere and then I guess drawing on your experience … whether it be professional or personal or whatever and putting it into some sort of context" (Heather).

However, HACC assessors *are* faced with the program requirements for more formalised documentation and standardised approaches to assessment that can present challenges to holistic practice. Some participants held the view that the funding body placed too many demands on the sector for assessment "paperwork", reporting, accountability, and minimum service standards without providing adequate funding and other support to assist services with these tasks nor to meet the growing demand for their services in the community. This is a view commonly encountered when a practice innovation involves the use of assessment tools (Guberman, Keefe, Fancey and Barylak 2007).

Client-centred assessment necessarily requires the assessor to obtain 'biographical information' in order to arrive at an understanding of the client's world view (Worth 1998). Without allowing the client to tell their own story, their account could become objectified and depersonalised through the assessment process so that their goals and values are hidden (Richards, 2000). Attention to narrative is therefore crucial. As well as eliciting information about the client that will help needs identification and care planning, allowing clients to tell their stories helps to reduce the power imbalance between clients and practitioners as the assessor engages with the client instead of "expecting them to fit into bureaucratic and professional agendas and ways of thinking" (Richards 2000: 47). Some commentators view

the language of 'assessment' itself as unhelpful as it is a "social construction that privileges the professional and disempowers the client" (Iversen et al. 2005: 695). Participant Jennifer made a similar observation, pointing out that terms such as 'assessment' and 'need' may have unintended connotations, or even be meaningless, for many Indigenous people with whom she works.

According to Dill (1993), clients' stories are not amenable to interpretation within the framework of many formal assessment instruments used by highly trained professionals. In some instances it is not possible to easily 'fit' the client's story into a standardised assessment instrument, thereby leaving the client's perspective open to misinterpretation and for assumptions to be made based on normative data (Dill 1993). Similarly, Chevannes (2002) reports that diverse voices of older people are little considered in defining needs, and professionals exercise control over how clients are categorised. The findings of the Victorian study indicate less constraint felt by assessment workers in implementation of assessment tools in current use. Participants were very aware that clients' stories were critical to establishing the nature of client need and, although the SCTT is not a standardised assessment instrument, assessors were aware of the potentially negative consequences of using the assessment document too prescriptively. As the following quote indicates, the assessment tool is not the primary focus of the assessment process:

> "Apart from the full assessment [SCTT], in your own head you're listening to just how they talk about their family, like when you're asking them 'who is your next of kin, do you have family locally', generally just the way they talk about them, you can tell whether they actually help or not and then whether you can then speak to the family to rely on getting a bit of help from them. Also, looking around the house, just to see the conditions - is it safe, what sort of condition is it in? Things like that. Safety aspects like steps, rails and things like that - they may say their walking is fine but they may take a couple of minutes to answer the door and you can hear the frame shuffle up the hallway, but they'll say 'oh no I walk really well, I walk to the shop every day'. But then you get in the house and there might be steps into every room, and yeah they may walk fine, but it is an issue because they've got to lift the frame up or lower it down. So you look at all that, and it's just being open to anything, like you just don't know what to expect when you get into some houses" (Ivan).

Assessors were very aware of the primacy of client stories and dialogues and described instances of negotiation and collaboration with clients. For example:

> "Working with the carers you do the 'gate assessment'. That is where as they are walking you to the gate they tell you that the client is telling lies, or it is really like this. We used to joke about this being the 'gate assessment'. You sit with the client in the assessment, and the carer is sitting there shaking their head or rolling their eyes. So you talk to them as you walk to the gate. But then as an assessor how do you use that information? It might mean another phone call or a second assessment if necessary" (Anna).

According to a key informant employed in a policy role, the assessment documents are not designed to encourage a 'form-driven' process, but rather, to enable individual assessors and organisations some flexibility while meeting certain minimum standards:

> "Obviously there are certain standards and the need for flexibility. That's why the … tools have been developed as templates rather than 'mandatory forms' that have to be used in a certain way… It creates a mindset and a framework rather than dictating that this is the one and only way that it can be done" (State government employee).

However, the trends towards more formalised documentation may have unintended consequences for practice. In a study of implementation of a standardised assessment tool in community care in Canada (Bay Consulting Group & Workflow Integrity Network 2004), assessment/case management staff were found to be experiencing "pathology of drift", meaning that increasing administrative functions (a by-product of the current environment of community care and associated trend towards more formalised, standard documentation) were reducing the 'flow' of their work. This was found to create a less than ideal environment for the "critical thinking" required in dealing with complex clients and "messy situations" which tend to be common in community care (personal email communication with K., Parent, 29 March 2005). Similar findings from Victoria, where some assessors felt that assessment "paperwork" had become "burdensome", indicate that greater attention needs to be focused on the realities of practice resulting from changing (increasing) documentation requirements. Any move towards the introduction of more formalised or standardised tools in initial needs assessment in home and community care should be considered in the light of research evidence.

Implications for Practice and Professional Development

Standardisation is often equated with equity and therefore 'fairness' in regard to allocation of services and resources. However, practitioners need to be able to reflect upon and consider the unique and diverse needs of clients in order to provide safe and equitable care. Standardisation can, without adequate flexibility and encouragement of critical thinking, lead to a 'one size fits all' mentality that inherently discriminates against sectors of the community. Training in the use of assessment tools to avoid over-prescriptive application is recommended (Guberman et al. 2007; Kane & Kane 2000). The emerging tensions for assessors in managing both the increasing demands on services through practices such as prioritisation, as well as responding to the diversity of client's individual stories in assessment, should be acknowledged in professional development programs.

In preparing workers for needs assessments that are based on standardised or highly formalised tools, the role of critical thinking and critical reflection should be prominent. The adoption of frameworks for service delivery to diverse populations such as cultural safety and cultural competence has prompted a shift in thinking around what it means to provide equitable care. In regards to cultural safety specifically, there has been a major philosophical

shift from the provision of care *regardless* of cultural background, to care that is *regardful* of the unique needs of individuals and groups (Ramsden 2002). This philosophy in particular has reflection on the practitioner's own cultural influences and power, as well as the need to engage in dialogue with the client as key tenets. The value of this conceptualization of culture is that it has broadened the definition from ethnicity only to include culture as relevant to age, gender, socioeconomic status, religion, sexual orientation and so on.

Further, the use of common 'frameworks for thinking' in professional development programs and practice such as the International Classification of Functioning, Disability and Health (ICF), developed by the World Health Organisation, also holds the promise of encouraging critical reflection and consideration of the uniqueness of individual clients when applied along with standardised assessment tools. Used as a conceptual framework, the ICF provides a model for assessing the interaction between different components of a person's life, provides a common language and framework for multidisciplinary and lay workers and carers, and provides an integrative framework for training (Allan, Campbell, Guptill, Stephenson and Campbell 2006; Lindeman & Newman 2006).

Conclusion

Standardised assessment tools, based on normative assumptions and used inflexibly, can have difficulty capturing diversity. At this stage in HACC, assessors report flexible approaches in their use of common documentation, and clients' stories are at the heart of the assessment interaction. However, current practice may be challenged as assessment documentation becomes even more formalised (and potentially standardised), along with the associated trend towards professionalisation of the workforce, and the need to manage ever increasing demand for services. Deeper understanding of the practice and professionalism of these workers is therefore required, and a greater focus on developing appropriate training and professional development opportunities is suggested. Rather than focusing on the physical design and content of assessment documents such training should be focused on developing critical thinking and reflection skills to assist assessors use such tools in their holistic practice with diverse clients and in diverse settings. Frameworks for practice and professional development such as 'cultural safety' and the 'ICF' can assist multidisciplinary practitioners to develop the necessary critical thinking and reflective skills to ensure that their practice remains responsive to the unique needs of individuals.

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