



## **Assessment prior to institutional care: time to move past the Support Needs Assessment Form (SNAF)**

John Campbell

‘When I use a word’ Humpty Dumpty said in rather a scornful tone, ‘it means just what I choose it to mean—neither more nor less’  
(*Lewis Carroll, Through the Looking Glass*).

Assessment is certainly a word that means different things to different people. In the assessment of elderly people prior to institutional care there would be advantage to patients and the health system if all the purposes of assessment could be met in a single process and assessment came to mean more, not less.

To clinical staff, medical, nursing, social, and rehabilitation, assessment means the full evaluation of an elderly person with disability to determine what is causing the problems and what can be done to improve the situation.

There are good reasons for doing this at the time the person considers moving to institutional care. The person obviously has problems of sufficient severity that she is proposing giving up her independent lifestyle. Indeed, it is a major social change, and professional advice at this time is a service that a health system should provide.

Although much of the professional advice will come from the person’s general practitioner, many of the conditions which affect elderly people are chronic and slowly progressive. They creep up on both patient and practitioner alike. A fresh look might well identify alternative approaches to long-standing difficulties. And there is good evidence that assessment prior to a proposed rest home admission affects the decision. Of 158 elderly people living at home who were assessed in Christchurch prior to rest home or hospital admission, 76 were able to continue in their own homes and 67 were still there 6 months later.<sup>1</sup> This is consistent with overseas findings on the value of clinical assessment prior to moving from home .

Assessment includes more than the evaluation of the elderly person alone. Family carers will often have provided support and their views and wellbeing need careful consideration. Final advice to the patient and family commonly requires a careful evaluation of conflicting desires and open and frank discussion of the options. The health professional has a responsibility to ensure all parties understand the compromises that will have to be made in coming to a decision.

To those responsible for funding institutional care, assessment means ensuring that the people in most need receive the financial support available. Institutional care is expensive, and all developed countries are concerned about the rising costs of providing continuing care for an ageing population. Assessment to ensure that the public expenditure is warranted is an entirely justifiable activity in a health service which must balance competing demands. The Support Needs Assessment Form (SNAF) was an instrument designed 10 or more years ago primarily to meet this assessment objective.

One of the long-standing problems with developments in the New Zealand health system is that we fail to budget for evaluation at the time of planning and introduction. This has been so for SNAF. Despite the many hours that have gone into completing innumerable SNAFs, we do not know whether the process is meeting clearly stated objectives. As Weatherall, Slow, and Wiltshire point out very clearly in the introduction to their paper *Risk factors for entry into residential care after a support needs assessment* (N Z Med J. 2004;117(1202). URL: <http://www.nzma.org.nz/journal/117-1202/1075>) in this issue of the *Journal*, theirs is the first published review of the effectiveness of the SNAF since its introduction.

The study by Weatherall, Slow, and Wiltshire reports on 2060 SNAF assessments. One-third of people assessed required residential care and the predictors of this need were increasing age, incontinence, mobility problems, and dementia. Unfortunately, the SNAF is such a limited instrument that other possible predictors of residential care admission are not measured. The importance of the predictors that were identified is that their impact can be modified. This is also the situation with other conditions not recorded on the SNAF.

Urinary incontinence in frail, elderly people living in the community is common and associated with potentially reversible conditions.<sup>2</sup> These conditions can be identified by a more comprehensive, clinically focused assessment instrument.<sup>3</sup>

Mobility problems result in falls, which are known to be an independent risk factor for admission to institutional care.<sup>4</sup> Studies, both overseas<sup>5</sup> and in New Zealand,<sup>6</sup> have demonstrated very clearly that around one-third of falls experienced by elderly people can be prevented.

Although people with dementia are likely to require high levels of family and social support, a recent United Kingdom study has shown that they are less likely to use general practice and hospital consultant services than those with preserved cognitive function.<sup>7</sup> People with dementia often have co-morbidities which, if unrecognised and untreated, may contribute to the need for residential home care.

Assessment prior to residential care admission has three main objectives:

- Ensuring that treatable conditions are identified,
- Ensuring that the elderly person and family have all the necessary information to make an informed decision, and
- Ensuring that public money is spent where it is most needed.

Can we meet all these objectives with a single assessment instrument? There has been considerable work done on developing such an instrument and the Minimum Data Set – Resident Assessment Instrument (MDS – RAI) was first used in the United States in 1991. A home care version was developed and tested in the mid-1990s.<sup>3</sup>

These instruments have two important components. They gather a comprehensive database of information, which is important to have available on a person moving to care. This information can be used subsequently to measure change in a person's clinical situation and improve care.<sup>8</sup>

The instrument also contains clinical triggers so that the person assessing is alerted to areas which need further clinical exploration. There has been international interest in

and use of these assessments. The RAI has proved reliable when used in a variety of countries.

In New Zealand we require an instrument that provides both clinical and economic assessment and that enables international comparisons. Such instruments are available and need to be considered and adapted for New Zealand use. Furthermore, they should be used as part of the assessment of an elderly person prior to the provision of publicly funded continuing care. The assessment instrument is, though, simply a screen indicating the possible need for more detailed professional evaluation. This assessment must be 'comprehensive and multidimensional'.<sup>9</sup>

It is critical, therefore, that the assessment process is closely linked with the District Health Board Assessment, Treatment and Rehabilitation service and with primary care.

The SNAF is not adequate as an assessment instrument. It has well and truly had its day. We need to move on and bring our assessment processes up to international standard.

**Author information:** A John Campbell, Professor of Geriatric Medicine and Dean, Faculty of Medicine, University of Otago, Dunedin

**Correspondence:** Professor A John Campbell, Faculty of Medicine, University of Otago, PO Box 913, Dunedin. Fax: (03) 479 5459; email: [john.campbell@stonebow.otago.ac.nz](mailto:john.campbell@stonebow.otago.ac.nz)

#### References:

1. Wilkinson T J, Sainsbury R. Elderly people referred for institutional care – is prior assessment necessary? *N Z Med J.* 1992;105:451–2.
2. Landi F, Cesari M, Russo A, et al. Potentially reversible risk factors and urinary incontinence in frail older people living in community. *Age Ageing.* 2003;32:194–9.
3. Morris JN, Fries BE, Steel K, et al. Comprehensive clinical assessment in community setting – Applicability of the MDS-HC. *J Am Geriatr Soc.* 1997;45:1017–24.
4. Tinetti ME, Williams CS. Falls, injuries due to falls, and the risk of admission to a nursing home. *N Engl J Med.* 1997;337:1279–84
5. Tinetti ME, Baker DI, McAvay G, et al. A multifactorial intervention to reduce the risk of falling among elderly people living in the community. *N Engl J Med.* 1994;331:821–7.
6. Robertson MC, Campbell AJ, Gardner MM, Devlin N. Preventing injuries in elderly people by preventing falls: a meta-analysis of individual level data. *J Am Geriatr Soc.* 2002;50:905–11.
7. Nelson T, Livingston G, Knapp M, et al. Slicing the health service cake: the Islington study. *Age Ageing* 2002; 31;445–50.
8. Hawes C, Mor V, Phillips CD, et al. The OBRA-87 Nursing Home Regulations and implementation of the Resident Assessment Instrument: Effects on process quality. *J Am Geriatr Soc.* 1997;45:977–85.
9. New Zealand Guidelines Group. Assessment processes for older people. Wellington: NZGG; 2003. Available online. URL: [http://www.nzgg.org.nz/guidelines/dsp\\_guideline\\_popup.cfm?&guidelineID=30](http://www.nzgg.org.nz/guidelines/dsp_guideline_popup.cfm?&guidelineID=30) Accessed September 2004.