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Standardising assessment instruments and care planning in Ireland.

Eric Van Lente & Martin Power.

Abstract –

In recent decades there has been a move internationally toward increased standardisation of assessment and care planning for older people in residential care. In the Republic of Ireland, this trend is manifest within national standards governing care for older people that were introduced in mid-2009. This study was conducted approximately one year after the introduction of these national standards and sought to survey providers (n=106) around the standardised instruments in use for assessment and the processes that surrounded assessment and care planning in residential centres. It found that there were substantial variations in the use of standardised instruments between domains of care. Within some domains standardised instruments were common, while in other domains they were largely absent or external professional input was the preferred option. In contrast, assessment and care planning processes and practices displayed little variation and were almost exclusively the preserve of medical professionals.

There can be little doubt that the ageing of populations has become a matter of growing interest. Across many nations increased life expectancy coupled with diminishing birth rates have contrived to alter dependency ratios in a manner that poses significant challenges for care systems, especially long-term care (Bower *et al.*, 2009; European Commission, 2008; OECD, 2005; Tsoлова and Mortensen, 2006). Moreover, it is a set of circumstances that must be confronted against a backdrop of raised consumer expectations and diluted traditional family ties, which have contributed to a ratcheting upward of demand (European Commission, 2008; Guberman *et al.*, 2012; Kroger, 2003). At the same time, supply side factors offer cold comfort to decision makers charged with managing health and social care systems. Socio-cultural shifts for instance, have encouraged increased female engagement with education and labour markets, depleting supplies both of formal and informal carers, which many nations have relied upon in the past (European Commission, 2008; Fujisawa and Colombo, 2009; Kroger, 2003; Pavolini and Ranci, 2008; Simonazzi, 2009; Walsh and O'Shea, 2009).

While the particular configuration of these challenges is peculiar to each individual nation, a similarity in response is apparent. Many states have responded by introducing or updating regulations and standards governing residential care for older people, with particular attention devoted to assessment and care planning. In the

U.S.A., for instance, a Minimum Data Set – Resident Assessment Instrument (MDS-RAI) was introduced in 1990, as part of major reforms aimed at improving quality of care in nursing homes (Morris *et al.*, 1990). It is an approach that has been embraced by many other nations since that time. Sweden, Denmark, Norway, France, Germany, the U.K. and Japan have all moved toward increasingly standardised systems based upon MDS type instruments (Bernabei *et al.*, 2008). Designed to improve quality through facilitating problem identification, integration of care, organisational efficiencies, enhanced communication and inter-disciplinary working, standardisation has been hailed as establishing a ‘new philosophy and approach in the field of systematic geriatric care, laying the groundwork for evidence-based geriatric assessment and management’ (Bernabei *et al.*, 2008, p. 308).

In Ireland, this international pattern is reflected clearly in the Health Information Quality Authority’s (HIQA) National Quality Standards for Residential Care Settings for Older People, which were introduced in mid-2009 (Health Information and Quality Authority, 2009). There are 32 standards in total, with standard 10 expressly relating to assessment and requiring ‘a comprehensive assessment of the resident’s health, personal and social care needs, using a Minimum Data Set tool’ (HIQA, 2009, p. 17). Though the standards stop short of prescribing particular MDS instruments, they do require that such instruments possess the qualities of ‘validity’, ‘reliability’, ‘fitness for purpose’ and ‘international comparability’ (p. 70). In turn, standard 11 requires that ‘the

arrangements to meet each resident's assessed needs are set out in a care plan', which is formulated in conjunction with the resident or their representative (HIQA, 2009, p. 18).

In an Irish context, the introduction of these standards is a particularly significant development. As these standards form the scaffolding for a common regulatory framework, which was absent previously. It was not that there was no regulation, but rather that there was a bifurcated public/private split and different bodies were responsible for monitoring and inspection dependent upon provider type. In Ireland, a mixed economy of provision operates and though dominated by private providers, there are a substantial number of public providers, as well as a very limited number of voluntary providers, which mainly due to their small numbers were not included in this survey. As such, the introduction of a set of common standards both replaces previous fragmented arrangements and replicates the international trend toward standardising approaches to assessment and care planning.

This former feature is of particular import in an Irish context, as to-date there has been a lacuna in research on assessment and care planning in residential care for older people. Indeed, with the exception of Moore's (2010) work, which was contemporaneous with this study, these areas have received scant attention. Here, it appears reasonable to suggest that this can in part be attributed to the lack of a common framework that would have facilitated investigation.

This study, which was carried out in the autumn of 2010, sought to redress this situation by scoping the assessment instruments in use in residential centres for older people, by identifying the processes and practices that surround care planning and, by exploring the views that those responsible for care planning hold about it (this latter element is not reported here). In doing so, this study aimed to contribute to the growing literature on standardisation, establish a point for comparison and, in an Irish context, create a baseline for future studies.

Methods and survey development.

This study utilised an online/postal survey and the sample was comprised of 250 centres, approximately 42% of total provision (Department of Health, 2010). A random stratified sampling approach was adopted and centres were selected from the HIQA's website¹ based upon availability of contact details and so as to ensure comparable numbers of private and public providers. Directors of care, care managers or directors of nursing were the target group and in total 106 surveys were returned; 52 public and 54 private, for a response rate of 42.5%. This was a little under one fifth of total provision in terms of the number of centres, but almost one quarter of the total number of residents were captured by the survey, due to the large size of some public centres (Department of Health, 2010). Throughout this survey efforts were made to maximise

the response rate through follow up emails and phone calls. However, time constraints mean that it was not possible to follow up every centre with a phone call.

The survey had four discreet sections. The first sought basic information about the centre, such as number of residents (Figure 1) and dependency levels (Figure 2). The second section (section A) surveyed the assessment instruments in use. The third section (section B) gathered data on the processes surrounding care planning at centres. The fourth and final section, which is not reported here, explored respondents' perspectives in relation to the benefits, obstacles and drawbacks they associated with care planning.

The survey was based upon the domains of care noted in the HIQA's national standards. In developing the survey an exploratory internet search for relevant tools was conducted. In addition, 25 randomly chosen HIQA inspection reports were subjected to summary content analysis and prior to piloting, advice was sought from a local provider and an academic with expertise in care planning. It is worthy of note that piloting of the survey revealed that the term 'care plan' was often understood in a variety of ways. For some a 'care plan' was a folder that contained all relevant material, whereas for others a 'care plan' was a single document associated with a specific domain or intervention. Thus, a resident would commonly have multiple 'care plans'. In other cases, 'care plan' meant a computerised version of either of the above. It would appear that such variation may not be an isolated phenomenon, as inconsistency in the

meanings attached to concepts and terminology has been observed amongst nursing home survey respondents (Tyler *et al.*, 2011). Indeed, even terms such as 'direct-care staff', which have been assumed to have a 'shared' meaning that is 'well understood' by practitioners and researchers alike, can be subject to a range of interpretations (Tyler *et al.*, 2011, p. 209).

Section A of the survey was concerned with the assessment of domains of need and the instruments used for assessment. Within the national standards, 14 domains of need are noted and these can be divided into two subcategories. The first subcategory (A1) contained 11 domains (see Table 1), which are commonly associated with standardised instruments, for instance, the domain of 'dependency, mobility and activities of daily living' and the Barthel index. The second subcategory (A2) was concerned with residents' personal information and preferences and, included: A – identification and background information; B - activities and interests; C – special treatments, therapies or treatment programmes (Table 3).

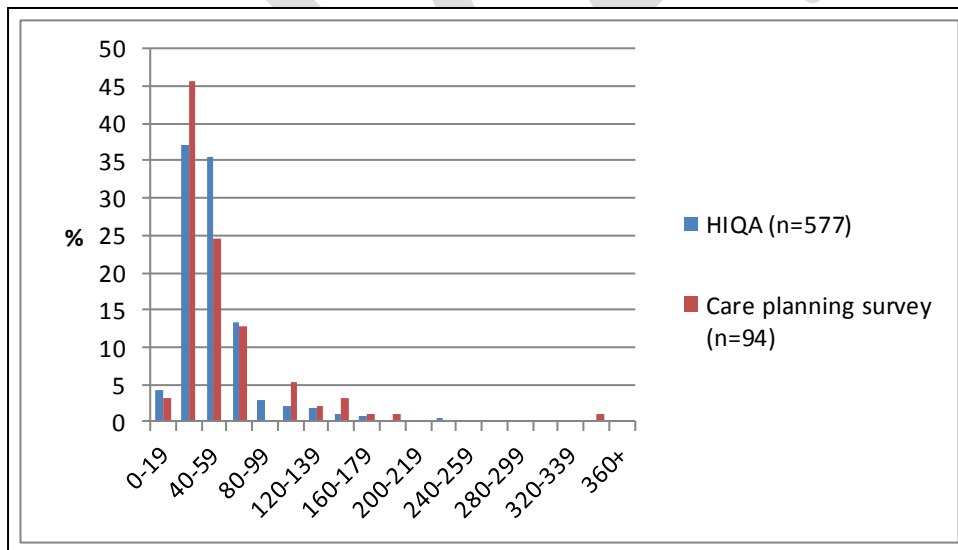
A tick box format was used for both subcategories and respondents were presented with a list of instruments associated for that domain. An 'other' option was also included to allow for instances where a standardised instrument was not in use. In the case of domain H – 'visual limitations and abilities', no standardised instrument was located during development of the survey and 'please describe' replaced the tick box format.

Ethical Considerations.

Ethical approval was granted by the Research Ethics Committee of National University of Ireland, Galway. Potential respondents were contacted initially by email or phone and were provided with information about the study, including contact details, so that any queries or concerns could be addressed. Those who chose to participate were provided with the option of completing the survey in hardcopy or online (surveymonkey) and receipt of a completed survey was considered to satisfy informed consent.

Results.

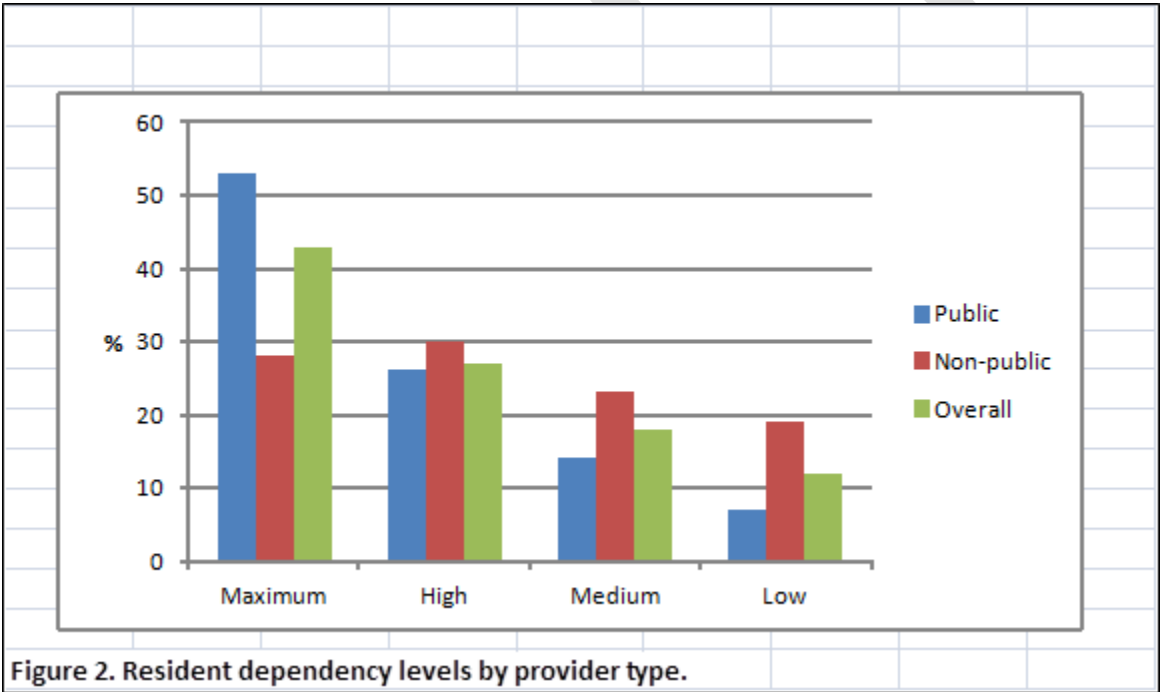
Figure 1.



Centre capacity.

On average centres catered for 54 residents. The occupancy capacity of centres ranged from as few as 9 residents to as many as 345 residents. The percentage spread of centres by occupancy capacity, both for this survey and for HIQA registered public and non-public centres at that time, is detailed in Figure 1. Large centres and centres that catered for between 20-39 residents were over-represented in this study, whereas medium sized centres were somewhat under-represented.

Figure 2.



Resident dependency levels by provider type.

The dependency levels of residents by provider type are noted in Figure 2. The spread of dependency levels was much more even amongst private providers. In contrast, a little over half of all residents in public centres were ‘maximum’ dependency, with decreasing percentages as the levels moved toward ‘low’ dependency.

Section A of the questionnaire focused on the 14 domains of need noted in the national standards and was divided into two subsections – A1 and A2.

Section A1 – domains of need and standardised instruments.

Table 1 details the extent of usage of *standardised instruments across the 11 domains of care (A – K).

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TABLE 1.

Table 1. Extent of usage of *standardised instruments across the 11 domains of care (A – K).

Domain	Public % (n=52)	Non-public % (n=54)	Total % (n=106)
A - Dependency, mobility and activities of daily living (n=104)	98	96	97
B - Skin condition (n=104)	94	100	97
C - Continence and elimination (n=102)	89	85	87
D - Nutritional/Oral health (n=101)	92	94	93
E - Health conditions and risk factors for illness, accident and functional decline (n=90)	85	69	76
F - Current medication use (n=70)	10	69	40
G - Dental/oral status (n=43)	6	9	8
H - Visual limitations and abilities (n=31)	0	0	0
I - Cognitive ability/patterns and organisation of self-care activities (n=103)	96	96	96
J - Communication, hearing and understanding (n=39)	6	19	12
K - Mood and behaviour patterns, psychosocial well-being and relationships (n=71)	42	67	55

*Standardised instruments included those listed as a response option in the questionnaire, as well as instruments that were not listed, but which were noted more than once by respondents.

Within domain H no standardised instruments were noted. In contrast, within domains A, B, D and I standardised instruments enjoyed near universal usage.

Table 2. Coverage of number of domains of need broken down by centre type.*

TABLE 2.

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Number of domains covered by at least one standardised instrument*	Public % (n=52)	Non-public % (n=54)	Total %
0	2	0	1
1	0	0	0
2	0	0	0
3	2	2	2
4	0	2	1
5	19	13	16
6	36	19	26
7	31	15	23
8	8	40	25
9	0	7	4
10	2	2	2
11	0	0	0

* Standardised instruments included those listed as a response option in the questionnaire, as well as instruments that were not listed, but which were noted more than once by respondents.

No centre employed standardised instruments in all 11 domains of care and 1% of centres noted no standardised instrument for any of the 11 domains. The majority of centres (74%) covered between 6 and 8 domains.

Section A2 - recording of information in relation to 'Identification and background', 'Activities and interests' and any 'Special treatments or therapies'.

Table 3. Recording of residents' information.

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Survey response	Identification and background information (n=101) % endorsing each response	Activities and interests (n=101) % endorsing each response	Special treatments, therapies or treatment programmes (n=98) % endorsing each response
A specific form	47	46	53
A general background form	20	21	18
The Nursing Homes Ireland 'Core Resident Details' form	21	19	10
The Nursing Homes Ireland 'Resident Comprehensive Assessment' form	25	20	15
'Other' responses	24	28	23
Did not respond	5	5	8

** Respondents may have selected more than one option and therefore percentages may add up to more than 100%.

Specific forms were the norm for recording information, though standardised instruments such as 'A key to me' were used rarely.

Section B.

Section B – processes, practices and responsibilities in relation to assessment and care planning.

Figures 3 through 7 provide a breakdown of responses in relation to selected questions.

FIGURE 3.

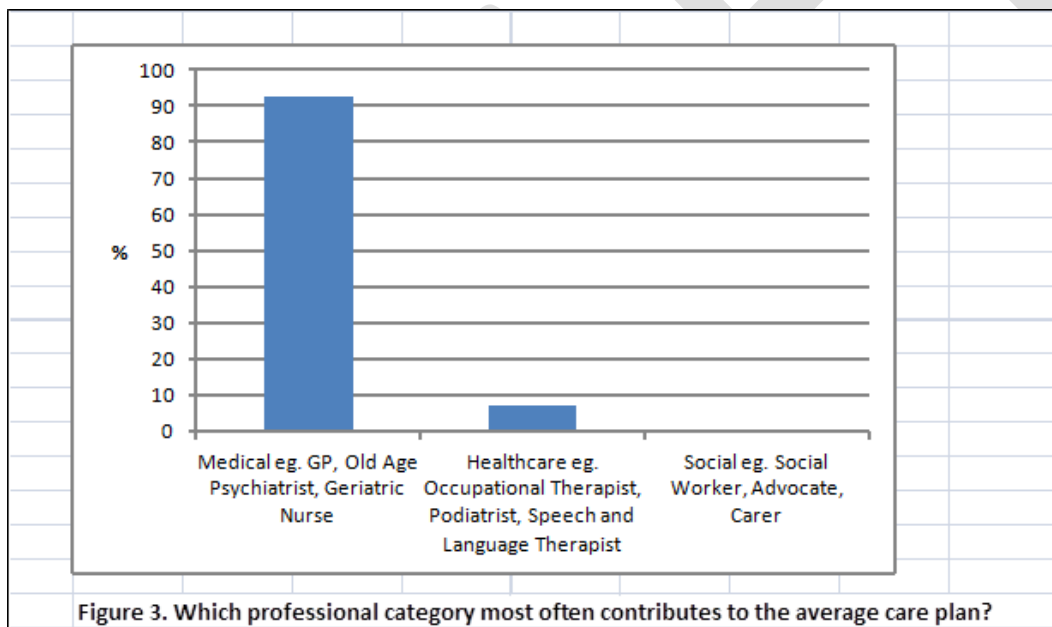


FIGURE 4.

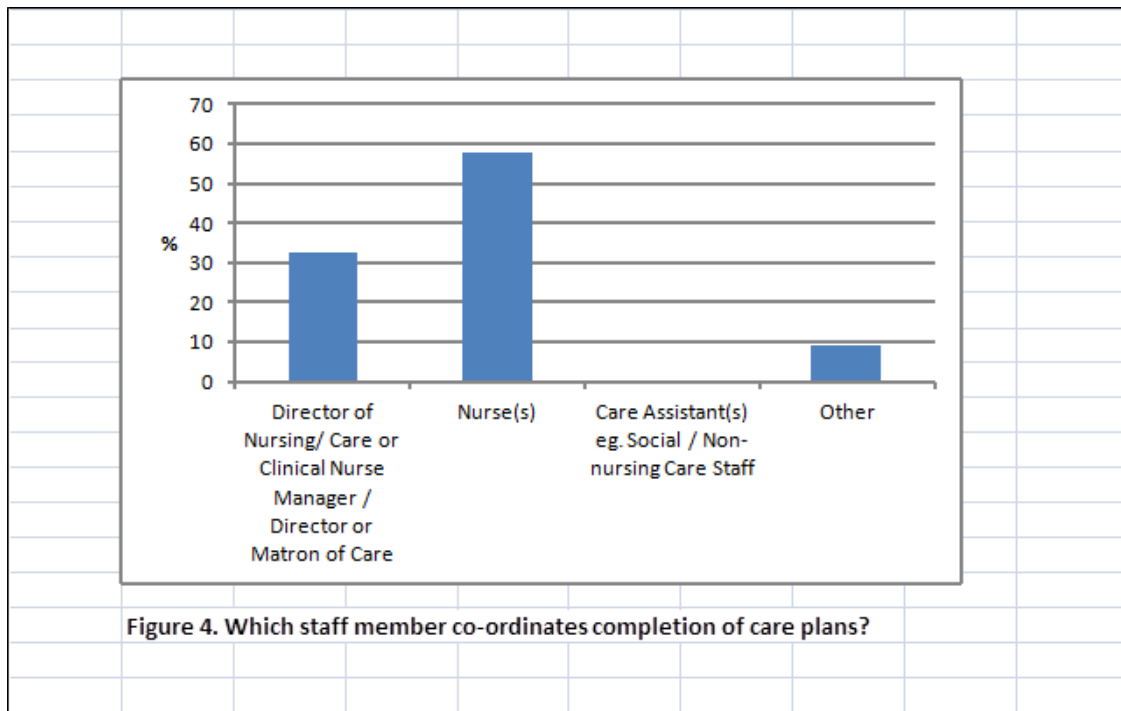


FIGURE 5.

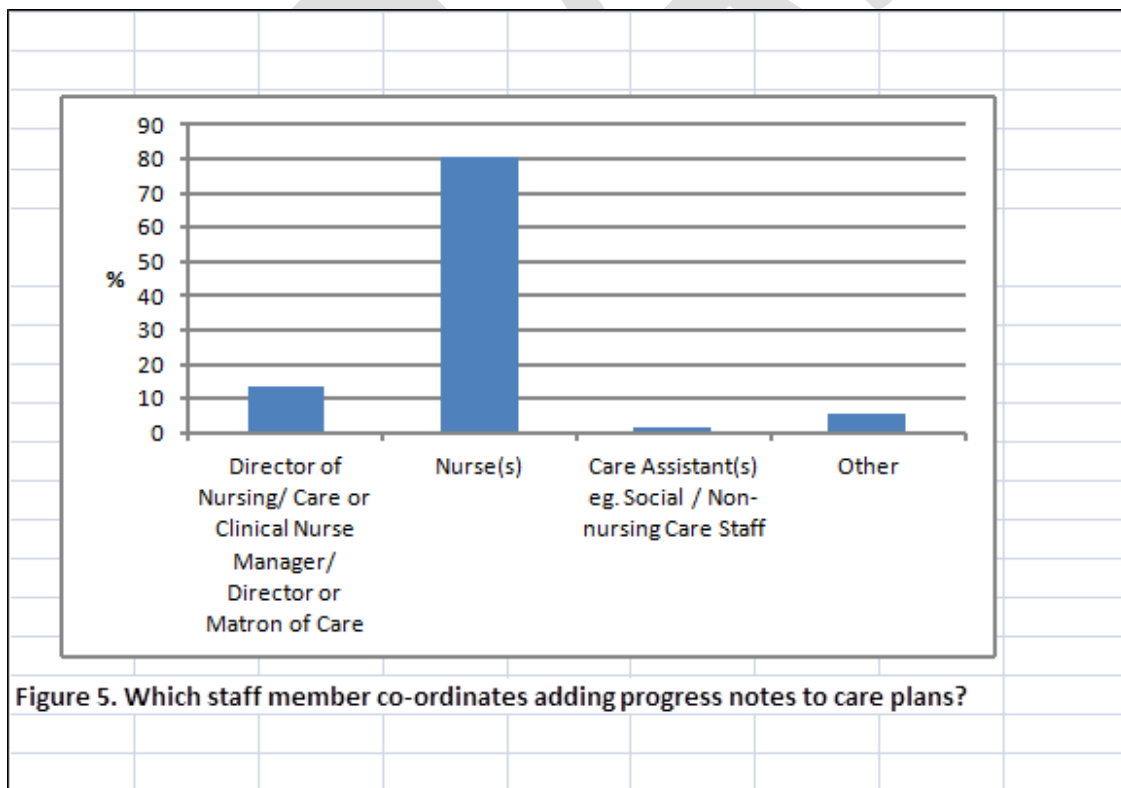


FIGURE 6.

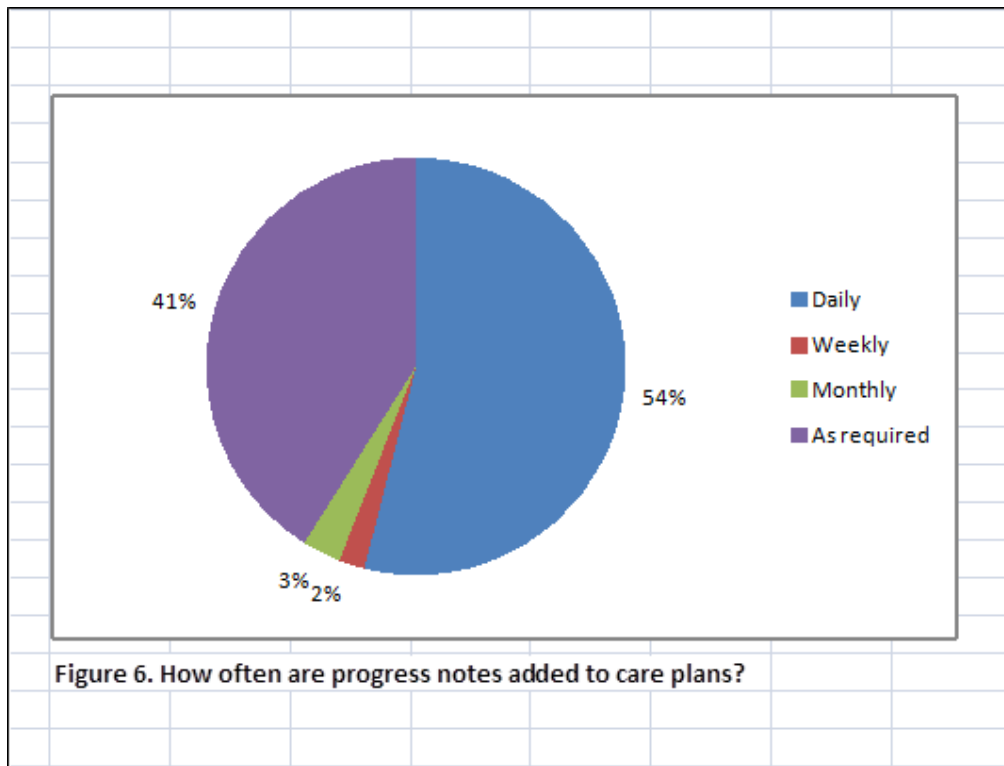
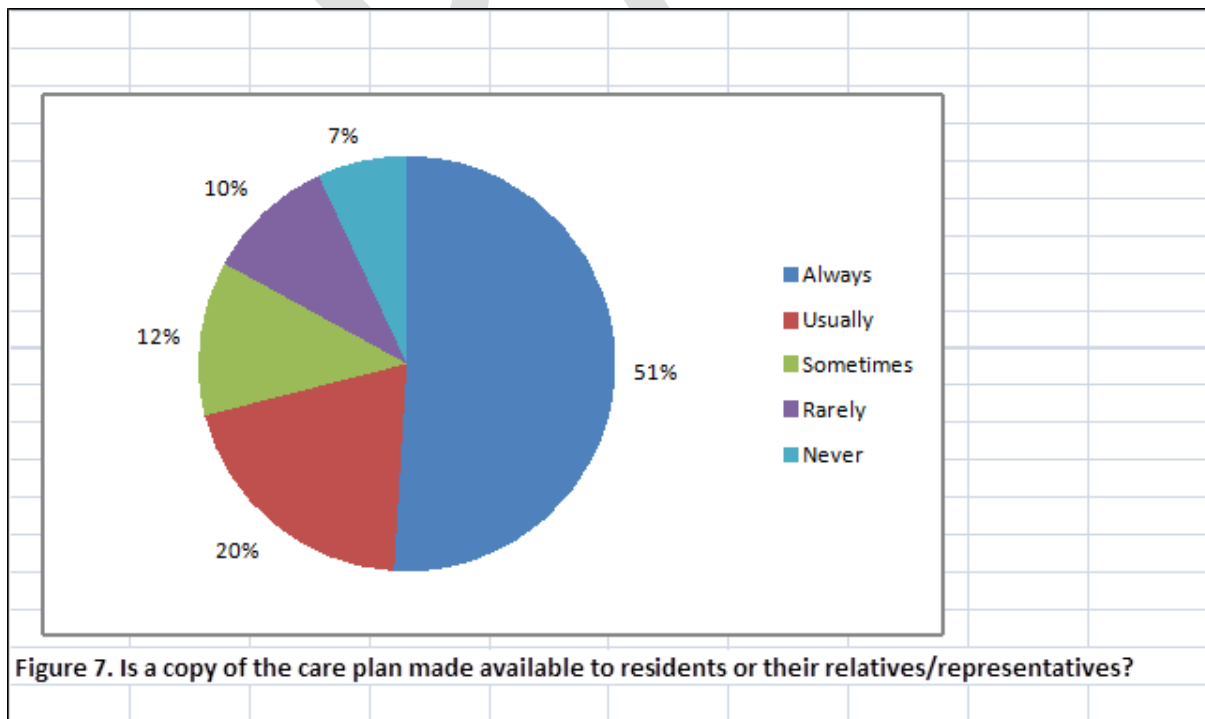


FIGURE 7.



It is clear that practices surrounding care planning are dominated by medical professionals, with such professionals contributing most often to (Figure 3), co-ordinating completion of (Figure 4) and co-ordinating addition of progress notes to (Figure 5), care plans. In contrast, two approaches to the addition of progress notes were indicated (Figure 6). On the one hand, were centres where progress notes were updated daily. On the other hand, were centres that adopted an 'as required' approach to adding progress notes. Furthermore, while the majority of centres 'always' or 'usually' (71%) made care plans available to residents or their relatives/representatives, almost one third (29%) only did so 'sometimes', 'rarely' or 'never' (Figure 7).

Discussion.

This study aimed to explore assessment and care planning in long-stay centres for older people in Ireland within the context of the introduction of national standards. It examined both assessment instruments in use for gauging residents' needs and the routines that surrounded care planning. At the very broadest level, it is clear that contrasting themes characterise these two areas. The area of assessment instruments is diverse, with substantial variation in coverage among domains. On the one hand, are domains associated with physical functioning where typically well-known standardised instruments are common. On the other hand, are domains where a variety of approaches are to be found. Here, some domains have a near absence of standardised instruments, while others displayed a range of approaches including, an assortment of

standardised instruments, few standardised instruments, external professional input and/or in-house adaption or modification of existing instruments.

In marked contrast, the processes and practices that surrounded care documentation were uniform and near homogeneous. Medical professionals, primarily nurses, contributed most often to care plans and were most frequently responsible for the completion, co-ordination and updating of such care documentation. This homogeneity was mirrored in the ascendancy of paper-based approaches, with 77% (n=100) of centres operating exclusively paper-based systems (14% electronic/computerised and 9% a mixture of both). In short, considerable diversity in relation to the use of standardised instruments was matched by a lack of diversity in roles, routines and responsibilities.

The finding that there is diversity in coverage amongst domains of need and that domains with an emphasis on physical functioning tend toward more comprehensive coverage is unlikely to surprise many. Certainly, research on care documentation has consistently noted these trends, no matter whether care is provided in a residential, home or community setting (Gallagher and Kennedy, 2003; Holtkamp, 2001; Lee, 2005; Moore, 2010; Stephenson, 1999; Stewart *et al.*, 1999; Thompson and Thompson, 2001; Voutilainen *et al.*, 2004). It is a set of circumstances no doubt reinforced by medical professional dominance over care documentation processes and practices.

Within this study further, if indirect, evidence for a penchant for the physical over the social can be seen when private and public providers are compared. For instance, results for domain 'E' suggested slightly less coverage in private centres. In contrast, domains 'J' and 'K' were less frequently addressed by standardised instruments in public centres. It is a situation that can be attributed to differences in resident dependency levels.

In a similar fashion, the findings in relation to domain F appear to be shaped substantially by provider type, though in a counterintuitive manner when considered against the backdrop of a concentration on the physical. For example, while standardised instruments were largely absent, specific forms were common in private centres (69%) but significantly less so in public centres (10%). In large part, this seemingly counterintuitive situation can be attributed to the previous fragmented regulatory system. As the umbrella organisation for private providers in Ireland, Nursing Homes Ireland, had produced a number of care related documents for use by its members, including a medical notes form. Indeed, in responding to this question (n=70) 39% of participants indicated use of the Nursing Home Ireland form, while only 6% of all respondents noted use of a standardised instrument – Beers criteria for inappropriate medication use in older adults. While the legacy of prior regulatory arrangements may help to explain this apparent anomaly, a limited engagement with standardised instruments and the low response rate to this question raise cause for

concern. For example, weak or inadequate record keeping has often been associated with covert administration of medicines (Haw and Stubbs, 2010a & 2010b; Kirkevoid and Engedal, 2005; Treloar *et al.*, 2000).

While such examples may suggest echoes of the earlier fragmented system of oversight, which are likely to diminish as the standards become embedded, within some domains there is a near absence of use of standardised instruments. For example, among domains 'G', 'J' and 'H', standardised instruments are largely conspicuous by their absence, regardless of the type of provider. Though responses within these domains sometimes noted within the 'other' response option a preference for external professional input, from GPs, opticians and dentists, a non-response was much more common (59% (G), 63% (J) and 71% (H) respectively).

These absences would point to omission from assessment, which raises a number of issues. For example, the weight of evidence linking poor oral health with systemic disease and diminished quality of life increases to grow (Jablonski *et al.*, 2009; Takeyoshi *et al.*, 2002; Tsakos *et al.*, 2011). More importantly perhaps, older people in residential care frequently have poor oral health and oral healthcare is often not prioritised (Jablonski *et al.*, 2005; Jablonski *et al.*, 2009; Jablonski *et al.*, 2011; Miegel and Wachtel, 2009; Worden *et al.*, 2008). It is a situation that has been attributed to a myriad of organisational and attitudinal barriers, such as low prioritisation by care managers, time and equipment constraints, anxiety over being bitten, staff group disagreements

over roles and responsibilities and, as confirmed here, an absence from assessment (Jablonski *et al.*, 2005; Miegel and Wachtel, 2009). In such circumstances, negative spirals are likely to emerge, since if issues are not identified at assessment, then external professional input is likely to be reactive and *ad hoc* in nature at best. At the same time, the failure to integrate oral health into assessment can only serve both to nurture a view that oral healthcare is an 'unpleasant' task and continue to contribute to its low prioritisation (Forsell *et al.*, 2010; Miegel and Wachtel, 2009; McNally *et al.*, 2012; Reed *et al.*, 2006).

If an ambivalence toward oral healthcare can in part be ascribed to distaste for its invasive aspects or anxiety over being bitten, such factors do not appear applicable to the other domains where an absence of standardised instruments has been noted in this study. Yet, these domains exhibit many of the same features associated with the provision of oral care. For example, visual impairment has been identified both as a marker for, and a contributing factor in, placement into long-term care (Wang *et al.*, 2003). As a consequence, it is known to be common amongst long-term care residents, nonetheless, as with oral healthcare it is not assessed routinely (Abdehafiz and Austin, 2003; Chou *et al.*, 2009). Moreover, as with poor oral healthcare, visual impairment has been linked with negative impacts, such as accidents, falls and fractures (Lord and Dayhew, 2001; Todd and Skelton, 2004). In a similar fashion, impairments in communication, hearing and understanding have been associated with a high

frequency of incidence, against a backdrop of low levels of routine screening and detection (Wallhagen and Pettigill, 2008; Wallhagen, 2009).

The establishment of requirements to fully assess such domains is therefore to be welcomed, not least because an absence from assessment can adversely impact psychosocial aspects of care. For example, impairments in hearing have been associated with negative moods and diminished social engagement (Brink and Stones, 2007). In such circumstances, it would be all too easy for staff or other residents to misinterpret such behaviours and to label the individual as 'difficult'. In turn, undermining the development of relationships and opportunities for social interaction, which are the lifeblood of quality individualised care (Brittis, 2011; Brownie and Nancarrow, 2012; Clarke *et al.*, 2003; Suhonen *et al.*, 2009; Ward *et al.*, 2008). Moreover, limited engagement provides fertile ground for a task-orientated rather than a person-centred approach to flourish (Brownie and Nancarrow, 2012; McCormack *et al.*, 2010; Suhonen *et al.*, 2009).

If the standards are likely over time to encourage an addressing of the gaps in assessment observed in this study, in the short term, the standards may actually exacerbate this situation. The standards require the use of standardised instruments for assessment and detail the features that these instruments should possess. However, they do not go as far as indicating or identifying appropriate instruments. As such, the standards provide a framework only. Thus, there is considerable room for ambiguity, ambivalence and confusion.

It is a situation compounded by a range of factors related to care documentation more generally. Indeed, care documentation can be characterised as a crowded arena, where change is an ongoing feature. For example, some twenty one instruments have been identified as having been developed specifically for use with older populations in relation to nutritional/oral health (Green and Watson, 2004). At the same time, instruments are updated frequently, which can lead to rapid obsolescence (Taylor, 2005). A lack of appreciation of the importance of assessment has also been noted (Daskein, 2009). In part, such tensions in care documentation can be attributed to the development of instruments 'by specific disciplines for specific patient or service user groups in specific settings' (Lambert *et al.*, 2007, p. 351). With such a range of factors that can muddy the waters and in the absence of clear guidance, it is not difficult to appreciate how providers and staff may be paralysed by choice.

In addition, such complicating influences may be a factor in the finding within this study that in-house modification or adaption of standardised instruments is not uncommon. For example, within 13% of centres standardised instruments had been customised. The domains within which instruments were modified were G (7 modifications of standardised tools), A (5 modifications), C (3 modifications), B (2 modifications) and E (1 modification).

If at first glance a legislative mandated system may seem to present as a straightforward solution to such complications, it is an approach far from free of its

own challenges. It has been observed for example, that the introduction of rigid mandatory assessment systems can result in resistance and a clinging to the familiar (Bernabei *et al.*, 1997). Thus, it is not surprising that most nations have shied away from embracing such systems (Bernabei *et al.*, 2008; Stosz and Carpenter, 2009). A situation replicated in Ireland.

While such issues draw attention to the tensions that can surround assessment and care planning, they also highlight the importance of recognising the manner in which organisational and professional structures and cultures can shape care and its documentation. Certainly, this study revealed considerable homogeneity in the routines and processes of care planning. Care documentation was nearly always the exclusive preserve of nurses, while other health care professionals inputted rarely and direct care staff almost never. It is a scenario that can be related to an overarching medico-legal paradigm of care in Ireland (Cusack, 2000; Fullen *et al.*, 2008; Moore, 2010). Nonetheless, if it is accepted that care documentation tends toward concentrating on 'aliments' and is shaped largely by the 'professional orientation of the staff caregiver' (Brittis, 2011, p. 24). It is likely that this situation will be exacerbated in the future, as growing numbers of older residents with increasingly complex co-morbidities are likely to facilitate the crystallisation of medical professional dominance (Gair and Hartery, 2001; Gallagher and Kennedy, 2003; Heath, 2010).

More importantly perhaps, given the homogeneity in practices and processes it could be argued that intra-disciplinary rather than multi-disciplinary working is to the fore. In light of the contribution that multi-disciplinary working can make to enhancing quality of care, the absence of input from direct carers appears, at best, an opportunity missed (Brittis, 2011; Davies *et al.*, 2011; Dellefield, 2006; Kontos *et al.*, 2010; Perry *et al.*, 2003; Suhonen *et al.*, 2009; Wild *et al.*, 2010). Indeed, in light of the finding that some domains are rarely assessed, input from direct carers could at the very least provide the opportunity for issues, such as poor oral health or visual impairment, to be identified and referrals made. Thus, there can be little surprise that it has been argued that what is needed to 'shift care plans from being provider driven and problem based to person-centered and quality enhancing' is direct carer input (Kontos *et al.*, 2010, p. 360). Certainly, it has been observed that care documentation can form a fulcrum for multi-disciplinary working, leading to improved quality of care (Hansebo, 2004; Perry *et al.*, 2003; Stalker and Bailer, 2008). In the U.S.A. for instance, staff associated the MDS/RAI with quality improvements and noted that it was a process facilitated by a required multi-disciplinary approach, which created a 'true collaboration, with equally shared input' (Stalker and Bailer, 2008, p. 42).

Against such a backdrop, the introduction of national standards represents an important first step to improving quality, through facilitating evidence-based practice, multi-disciplinary working and person-centredness. Certainly, the finding that almost

three quarters of centres make care plans available 'always' or 'usually' is encouraging and suggests a growing recognition of the importance of user involvement and a focus on individualised care (Figure 7). Nonetheless, in isolation the standards are likely to be insufficient to alter deeply embedded organisational hierarchies and cultures. Indeed, many nurses working in residential care settings for older people in Ireland recognise that it is nurses who often 'can be set in the ways they have always done things and resistant to change' (Heath, 2010, p. 47).

Thus, what will be needed are champions and strong leadership. In particular, those charged with co-ordinating assessments and care planning will need to be supported to negotiate successfully the myriad of challenges that reform will incur, since 'changing vision and practice takes time before benefits can be realised and initially could lower staff morale, produce resistance and harden the subscription to traditional values' (Wild *et al.*, 2010, p. 16).

At the same time, while the standards arguably represent the most significant alteration to residential care provision for older people in Ireland, they cannot be divorced from the context of an embedded and potent medico-legal paradigm. Against this backdrop, it will be important to ensure that a mere compliance 'in name (on paper) only' approach does not emerge (Bernabei *et al.*, 1997, p. 35). Thus, it will be vital not only to evaluate the impact of the standards, especially their influence on practice, but also for policy-makers and regulators to remain cognisant of the influence of this

broader framework and the manner in which it can constrain the delivery of quality care. With such considerations in mind, a number of areas for further research are presented (see Research considerations).

Limitations of this study.

This study was confined to the Republic of Ireland and therefore the generalisation of findings to other nations is unlikely to be straightforward. The response rate (42.5%), though not untypical for studies of this type, must also be viewed as a limitation. More importantly perhaps, consideration must be given to the self-selecting nature of participants. As this study was conducted approximately one year after the introduction of the national standards, it may have attracted participants who were, or who had recently been engaged in, developing their care documentation in line with the standards. As such, this survey may be more reflective of centres in the vanguard of change. In addition, this study did not include voluntary providers and though their numbers are extremely small, this nevertheless, remains a limitation.

Conclusion.

The introduction of national standards governing care provision for older people in residential settings in Ireland provided the backdrop to this study. These national standards require that standardised instruments are used for assessment and that care planning is based upon such assessment. This replicates the international trend toward increasing standardisation in assessment and good practice in care planning. The

findings of this study reflect general patterns in the literature; variation among domains in relation to the usage of standardised instruments, with standardised instruments used regularly for physical domains but less so in psychosocial domains; domains associated largely with professional judgement rather than standardised instruments; and, medical professional dominance of assessment and care planning processes. In light of these findings, recommendations include increased guidance from regulators in relation to appropriate instruments for assessment and the encouragement of input from direct carers, who remain an untapped resource.

Practice considerations

- Guidance for providers is needed around the selection of appropriate assessment instruments, so as to ensure all areas are assessed fully and appropriately and to mitigate in-house modification of instruments.
- Assessment should be exploited as an opportunity to facilitate a proactive approach to external professional input.
- Increased input from direct carers is required to encourage inter-disciplinary working and counteract the current largely medical intra-disciplinary culture.
- Support for champions and leaders is needed to promote a more person-centred rather than problem focused approach.

Research considerations

- Evaluation of the contribution of the standards to quality improvements.
- Assessment of the extent to which the standards can be used to enhance multidisciplinary working.
- Appraisal of how the standards are contributing to an appropriate balance between assessment instruments and external professional input.
- Appraisal of the manner in which the broader medico-legal framework can help or hinder the provision of quality care.

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¹ Providers are obliged to register with the Health Information Quality Authority (HIQA) and the HIQA's website provides a wealth of information, including details of provider type, occupancy capacity, named 'person in charge', location and copies of inspection reports.