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Caring about care planning:

A survey of assessment and care planning tools, processes and perspectives from residential settings for older people in the Republic of Ireland.

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2012



Contents

Acknowledgements.....	3
Introduction	4
Methods.....	7
Questionnaire/tool development.....	8
Results.....	10
Background information.....	10
Section A1	10
Section A2	19
Section B	20
Section C	23
Discussion.....	25
Limitations	25
Overview of results	27
Advantages and disadvantages of flexibility.....	27
Dominant tools	28
Possible reasons for variability in domains –national & international	29
Domains with low use of standardised tools.....	30
Dominance of medical professionals	32
Role of care plans in promoting personalised care	37
Technology in care planning.....	38
Recommendations	40
Further research.....	42
Bibliography	44
Appendix A – Copy of care planning survey	52
Appendix B – Standardised assessment tools with citations.....	60
Appendix C – Care plan templates.....	67
Appendix D – Useful website links.....	69

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Martin and Eric

Introduction

Throughout the developed world the ageing of populations has become a matter of increasing attention both for policy-makers and practitioners. Indeed, as far back as the late 1990s, the Organisation for Economic Co-operation and Development (OECD) advised that for many nations population ageing was a key policy priority, not least because of its 'implications for pensions, health care and long-term care' (OECD, 1998, p. 15). Though changing population demographics may appear to be the most clearly quantifiable aspect of such concerns, they represent only one side of the coin. For example, within many nations increased female participation in education and labour markets in conjunction with socio-cultural changes have contributed to a reduction in the supply of carers, a dilution of family ties and an increase in single person households. As a consequence, the availability both of formal and informal carers has diminished at the same time as the demands on care systems have risen (European Commission, 2008; Pavolini & Ranci, 2008; OECD, 2005; Kroger, 2003).

In Ireland, the particular configuration of these challenges differs somewhat from many of Ireland's European neighbours. On the one hand, it is anticipated that over the next three decades the percentage of older people in the Irish population will double, rising from 11.4 percent to 22 percent. In addition, similar socio-cultural changes such as increased female participation in education and labour markets have been observed (Timonen & McMenamin, 2002; Department of Health and Children, 2008; Kavangh, 2007). As if to compound matters further, in recent years increased emigration has again emerged as a common feature of Irish life (McGreevey, 2009; Houston, 2009). On the other hand, any shift in the old age dependency ratio, which has been relatively static over previous decades, is likely to be dampened by the current 'baby boom' (Department of Health and Children, 2008). Indeed, preliminary data from the most recent census in Ireland (2011) suggests that in the period 2006-2011, there were almost three times as many births as deaths; the 'highest natural increase' for any inter-censal period (CSO, 2011, p. 10).

If these competing trends are likely, over time, to shape the Irish response to the challenge of population ageing in a manner that differs from other nations, it is nonetheless clear that the Irish response thus far has been informed by developments that have emerged elsewhere. For example, in July 2009, Ireland's Health Information Quality Authority introduced *National Quality Standards for*

Residential Care Settings for Older People, a move similar to developments in the U.K. where national standards were introduced in 2001 (Department of Health, 2001). If such developments reflect a tint of policy transfer, its hue becomes deeper within the standards themselves, especially in relation to standards 10 and 11, which cover assessment and care planning respectively. Here, the standards require that a Minimum Data Set Tool (MDS), possessing qualities of 'reliability', 'validity', 'fitness for purpose' and 'international comparability' be used (HIQA, 2009, p. 70). While MDS type instruments have now become popular in many nations, it was in the U.S.A. that they manifested most forcefully.

In the U.S.A., in the late 1980s, an MDS- Resident Assessment Instrument (MDS-RAI) was developed in the wake of significant reforms aimed at improving quality in nursing home care and was signed into regulations in 1990 (Morris et al., 1990). Though the mandatory component has not been popularly embraced, MDS instruments have been introduced in a variety of care settings for older people, including home care, community care and long-term care and, in an increasing number of countries, such as, Japan, Sweden, the Netherlands, Denmark, Norway, France, Germany and the U.K. (Bernabei, Landi, Onder, Liperoti & Gambassi, 2008).

In the U.K., where the focus in previous years has been on developing an inclusive and robust Single Assessment Process (SAP) for older people, a number of MDS type tools have been developed and tested. The culmination of these efforts emerged in 2004 when the SAP was introduced to 'promote a multi-disciplinary model of service deliver' (Challis, Abenbster, Clarkson, Hughes & Sutcliffe, 2010, p. 1115). However, as those such as Stosz and Carpenter have noted, adoption of an American style MDS-RAI 'has been sparse' in the U.K. (Stosz & Carpenter, 2008, p. 6).

Notwithstanding such national variations it is clear that the emergence and adoption of MDS instruments has created an increasing focus on standardised approaches to services for older people, especially in relation to assessment and care planning. It is a set of circumstances that reflects both past and present influences. Care plans and planning, for example, have a long tradition within the arena of healthcare and have been an integral element of nursing for decades. This longevity is no doubt a reflection on their multiplicity of uses, since care plans can contribute to safety, continuity and quality of care, as well as intra and inter-disciplinary working and, the fulfilment of regulatory requirements. In short, care plans facilitate information flow both horizontally and vertically. More importantly, they are tools for

encouraging a holistic and client-centric approach that is facilitated by client input into care plans. As one care manager remarked, 'we are now getting people telling us about things that would solve their problems that perhaps we hadn't thought of' (in Seddon et al., 2008, p. 11).

The benefits of care documentation, however, are not confined to the frontline delivery of care. At an organisational level, for instance, aggregate data from care documentation can enhance strategic and operational planning, resource management, efficiency and cost effectiveness (Foster, Harris, Jackson & Glendinning, 2008; Lee, Bott, Gajewski & Taunton, 2009). In a similar fashion, cumulative data at a regional or national level can be drawn upon by funders, commissioners, regulators and policy-makers to inform decision making in relation to resource targeting, service gaps, quality improvement, workforce planning or policy development. At an international level the increasing introduction of standardised instruments presents opportunities for cross-national comparison and the mining of data sets on a scale that was hitherto unavailable. It is a set of developments that those such as Bernabei, Landi, Onder, Liperoti & Gambassi (2008) have characterised as establishing a 'new philosophy and approach in the field of systematic geriatric care, laying a groundwork for evidence-based geriatric assessment and management (p. 308). Thus, whether patient, professional, provider or policy-maker, care documentation has a contribution to make.

Against the backdrop of standardisation it is possible to characterise it into two broad categories; Standardisation with a capital 'S', which is exemplified by developments in the U.S.A. and standardisation with a small 's', which reflects a voluntary embracing of standardisation with a less prescriptive approach to tool usage and, which typifies the approach adopted in most nations.

While developments in Ireland would sit more comfortably in the standardisation with a small 's' category, the introduction of national standards is a significant development that cannot be understated. In large part this is because within Ireland's mixed economy of public, private and voluntary provision, the move toward standardisation altered a previously bifurcated system of public/non-public regulation. As such, the introduction of national standards represents a substantial change to previous arrangements. Indeed, it could be argued that the standards are as pivotal a change to services for older people in Ireland as the emergence of the *Care of the Aged* report in 1968, which encouraged a move from institutionalised care

to community care, or the shift toward market provision of nursing home services that emerged in the 1980s. More importantly in relation to this study, the introduction of the standards presented a unique opportunity, since the standards both provide a lens through which to examine an evolving regulatory process and a device for scrutinising that process. Indeed, it is worthy of note that with few exceptions (see Moore, 2010), little research on this topic has taken place in Ireland to date and it would seem reasonable to contend that this is precisely because of the absence of a framework of national standards.

Keen to exploit this opportunity, this study, conducted in the summer of 2010 one year after the introduction of the standards, focused on standards 10 and 11 - assessment and care planning. It explored three inter-related areas (A) tools - coverage of assessment domains (as outlined by the minimum data set specifications) and use of specialist tools (B) processes – professional contribution; responsibilities for care planning and training around care planning (C) perspectives – respondent's views around benefits, obstacles and barriers to care planning. As such, it will be of interest to service providers, practitioners and regulators, as it represents a timely examination of an evolving regulatory process, a baseline for further studies and, informs understanding of an area that has been largely conspicuous by its absence from Irish research.

Methods

A sample of 250 long-stay residential centres was selected from the Health Information Quality Authority (HIQA) website. A stratified random sample approach was utilised, so as to include similar numbers of private and public providers. Centres for which contact details were readily available were prioritised and contact was made either by phone or email. Dependent upon preference, participants were provided either with a link to the questionnaire online (surveymonkey) or were forwarded the questionnaire in hardcopy. A total of 106 responses (42.5%) to the survey were returned (53 public and 53 private providers responded). Participants were also asked to forward a blank copy of their care plan documentation for later analysis (not reported here - the term 'care plan documentation' was used, because in a pilot study, it was found that the term 'care plan' could refer to: a) a single document, b) a folder including all documents relating to care of an individual resident, c) a plan related to a specific aspect of a

resident's care (i.e. each resident may have many care plans, d) a computerised version of any of the above).

Questionnaire/tool development

The questionnaire was comprised of four sections (Appendix A). The first dealt with basic data about the centre (total number of residents and dependency levels). The second (Section A) explored types of assessment tools in use at that centre. The third (Section B) examined care planning related processes. The final section (Section C) investigated respondents' perspectives on the benefits, drawbacks and obstacles to care planning.

Section A of the survey included questions on tools and assessments in relation to domains of need, as described in Appendix A of the HIQA residential care standards minimum data set tool guidance note. Many of these domains are associated with specific standardised tools, for example, skin condition is often assessed by the Waterlow Pressure Ulcer Risk Assessment (Appendix B). In contrast, other domains are more focused on eliciting information, for instance, activities and interests and, therefore, standardised tools may not be appropriate or available. In response to this variance two subsections (A1 and A2) were created within section A of the questionnaire. The first provided respondents with a standard set of response options for each of 11 domains:

- a - Dependency, Mobility and Activities of Daily Living
- b- Skin Condition
- c- Continence and Elimination
- d - Nutritional/Oral Health
- e - Health conditions and risk factors for illness, accident and functional decline
- f - Current Medication use
- g - Dental/Oral Status
- h - Visual Limitations and Abilities
- i - Cognitive ability/patterns and organisation of self-care activities
- j - Communication, hearing and understanding
- k - Mood and behaviour patterns / Psycho-social well-being, adjustment and relationships).

In addition, there was an 'other' option to allow for recording of the use of a tool(s) not listed in the standard set of responses or where a tool had been developed/devised in-house/modified (Appendix C provides information in relation

to care plan templates in use/developed in Ireland. Appendix D includes national and international websites in relation to care of older people). Categories were then derived to categorise the open-ended 'other' responses. Below are descriptions of the categorisation protocol and description of the categories used.

- 1) *Standardised tool – not listed above*: This group includes standardised tools (i.e. 'evidence-based' tools) not mentioned in the original list of questionnaire response options.
- 2) *Standardised tool – modified/adapted*: Occasionally residential homes use 'modified' or 'adapted' versions of standardised tools. They may have made these modifications to the tool in house or may have adopted the modified tool from elsewhere.
- 3) *Devised in-house*: Sometimes residential homes devise their own tool from scratch. These tools tend not to be validated / evidence-based.
- 4) *Electronic*: One 'other' response was often simply 'electronic tool' or 'computerised tool', which left the actual name of the tool unspecified.
- 5) *Insufficiently specified*: It was common for homes to provide a tool name that could not be identified as a standardised tool, nor placed in any of the other categories above.
- 6) *Guidelines led rather than a specific tool or form*: Although (unstructured) care guidelines or protocols were not the focus of this survey, respondents sometimes mentioned these in their response.
- 7) *Based on Pharmacy notes or GP referral/ Optician visit of referral / Dentist visit or referral / Referral to / visit by Medical / Healthcare specialist*: Some needs corresponding to some domains-of-care are more naturally met by professionals external to the nursing home, such as GPs/ dentists etc. Residents may be referred to these specialists or specialists may visit the residential centre.
- 8) *Observation / resident presentation*: Nursing staff sometimes use observation of a resident, as an alternative to tools, to assess the resident's needs.

The categories used varied from question to question.

Section A2 focused on whether a specific form or section of a form was used to assess/ record information in relation to a - Identification and Background Information/ b - Activities and Interests/ c - Special treatments, therapies or treatment programmes, e.g. speech & language.

Section B of the questionnaire was comprised of ten questions, which sought information in relation to processes and practices surrounding assessment and care planning. In most cases, respondents were provided with a list of set options to select from.

Section C was comprised of three open-ended questions around advantages, drawbacks and obstacles to care plans and planning. The responses to these questions were analysed with a variation of a conventional content analysis approach (Hsieh & Shannon, 2005). This involved both authors individually examining and categorising the responses. Subsequent to this, the authors jointly reviewed their categories, negotiating a reduced list of categories and re-categorising all responses into this list.

Results

Background information

The average number of residents per residential care centre was 54; ranging from 9 to 345. The levels of dependency of residents are displayed in table 1.

Table 1 Levels of dependency

	Maximum %	High %	Medium %	Low %
Public	54	27	15	6
Non-Public	25	28	22	16
Overall	43	28	18	10

Section A1

This section was comprised of sets of response options for each of 11 domains (a-k). In addition, 'other' was provided for recording of the use of a tool(s) not listed in the standard set of responses or where a tool had been developed/devised in-house/modified.

Tables 2a to 7a summarise the responses to the standard response options. Tables 2b to 7b provide summaries of the responses to the 'other' response option.

Table 2a Assessment Tools used to assess a resident in domains a-b

a. Dependency, Mobility and Activities of Daily Living		b. Skin Condition	
Survey Response option	% endorsing each response (n=104)	Survey Response option	% endorsing each response (n=104)
Barthel Activities of Daily Living	93	Waterlow Pressure Ulcer Risk Assessment	67
Katz Activities of Daily Living	2	Braden Scale for predicting Pressure Sore Risk	34
Lawton Instrumental Activities of Daily Living	1	Norton Pressure Sore Risk Assessment	7
Cheltenham Score	1	Nursing Homes Ireland Wound Assessment Form (National Pressure Ulcer Advisory Panel)	24
The Hendrich II Fall Risk Assessment	3	'Other' responses	12
Nursing Homes Ireland Manual Handling Chart	27	Did not respond	2
Nursing Homes Ireland Restraint Assessment Form	25		
Nursing Homes Ireland Dependency Levels Form	17		
Other responses	38		
Did not respond	2		

Table 2b Percentage Breakdown of 'Other' Assessment Tools used to assess a resident in domains a-b

a. Dependency, Mobility and Activities of Daily Living		b. Skin Condition	
Breakdown of 'Other'	% (n = 73 tools)	Breakdown of 'Other'	% (n = 13 tools)
Standardised tool (not listed above):	32	Standardised (not listed above)	15
Frase	11	Stirling	15
Roper, Logan & Tierney	11		
MMSE	4		
HSE Handling and Moving Assessment	3		
HSE Manual Handling Chart	3		
Standardised tool modified/adapted	7	Standardised tool modified/adapted	15
Insufficiently specified	49	Insufficiently specified	62
Devised in-house	7	Devised in-house	8
Electronic	5	Electronic	0
TOTAL	100	TOTAL	100

Table 3a Assessment Tools used to assess a resident in domains c-d

c. Continence and Elimination		d. Nutritional / Oral Health	
Survey Response option	% endorsing each response (n=102)	Survey Response option	% endorsing each response (n=101)
Urogenital Distress Inventory Short Form (Udi-6)	1	Malnutrition Universal Screening Tool (MUST)	78
Incontinence Impact Questionnaire-Short Form (Iiq-7)	6	Mini Nutritional Assessment (MNA)	20
Cleveland Clinic Incontinence Score	2	'Other' responses	0
Assessment form for Urinary Incontinence (Nursing Homes Ireland)	36	Did not respond	5
Fecal Incontinence Severity Index	2		
'Other' responses	39		
Did not respond	4		

Table 3b Percentage Breakdown of 'Other' Assessment Tools used to assess a resident in domains c-d

c. Continence and Elimination		d. Nutritional / Oral Health	
Breakdown of 'Other'	% (n = 42 tools)	Breakdown of 'Other'	% (n = 7 tools)
Standardised (not listed above)	31	Standardised (not listed above)	0
(HSE) Continence Promotion Dept./Unit Assessment	12		
HSE Continence Assessment	9		
HSE Baseline Continence Assessment Tool	5		
HSE bladder and bowel dysfunction form	5		
Standardised tool modified/adapted	7	Standardised tool modified/adapted	0
Insufficiently specified	48	Insufficiently specified	57
Devised in-house	12	Devised in-house	43
Electronic	2	Electronic	0
TOTAL	100	TOTAL	100

Table 4a Assessment Tools used to assess a resident in domains e-f

e. Health conditions and risk factors for illness, accident and functional decline		f. Current Medication Use	
Survey Response option	% endorsing each response (n=90)	Survey Response option	% endorsing each response (n=70)
The Hospital Admission Risk Profile (HARP)	4	Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, Part I	2
Pain: Numeric Rating Scale (NRS)	28	Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, Part II	4
Pain: Verbal Descriptor Scale (VDS)	13	Nursing Homes Ireland Medical Notes Form	39
Abbey Pain Scale	34	'Other' responses	31
Pain Assessment & Advanced Dementia (PAINAD)	8	Did not respond	34
'Other' responses	21		
Did not respond	15		

Table 4b Percentage Breakdown of 'Other' Assessment Tools used to assess a resident in domains e-f

e. Health conditions and risk factors for illness, accident and functional decline		f. Current Medication Use	
Breakdown of 'Other'	% (n = 24 tools)	Breakdown of 'Other'	% (n = 29 tools)
<i>Standardised (not listed above)</i>	25	<i>Standardised (not listed above)</i>	0
<i>Brief Pain Inventory</i>	17		
<i>Nursing Homes Ireland Residents Comprehensive Assessment Form</i>	8		
<i>Standardised tool modified/adapted</i>	4	<i>Standardised tool modified/adapted</i>	0
<i>Insufficiently specified</i>	59	<i>Insufficiently specified</i>	39
<i>Devised in-house</i>	4	<i>Devised in-house</i>	10
		<i>Guidelines led rather than a specific tool or form</i>	34
		<i>Based on Pharmacy notes or GP referral</i>	17
<i>Electronic</i>	8	<i>Electronic</i>	0
TOTAL	100	TOTAL	100

Table 5a Assessment Tools used to assess a resident in domains g-h

g. Dental / Oral Status		h. Visual Limitations and Abilities	
Survey Response option	% endorsing each response (n=43)	Survey Response option	% endorsing each response (n=31)
Kayser-Jones Brief Oral Health Status Examination (BOHSE)	8	'Other' responses	29
'Other' responses	41		
		Did not respond	71
Did not respond	59		

Table 5b Percentage Breakdown of 'Other' Assessment Tools used to assess a resident in domains g-h

g. Dental / Oral Status		h. Visual Limitations and Abilities	
Breakdown of 'Other'	% (n = 32 tools)	Breakdown of 'Other'	% (n = 31 tools)
<i>Standardised tool (not listed above):</i>	0	<i>Standardised (not listed above)</i>	0
<i>Standardised tool modified/adapted</i>	22	<i>Standardised tool modified/adapted</i>	0
<i>Insufficiently specified</i>	29	<i>Insufficiently specified</i>	20
<i>Devised in-house</i>	9	<i>Devised in-house</i>	6
<i>Guidelines led rather than a specific tool or form</i>	9	<i>Electronic</i>	0
<i>Electronic</i>	9	<i>Optician visit or referral</i>	61
<i>Dentist visit or referral</i>	22	<i>Observation / resident Presentation</i>	13
TOTAL	100	TOTAL	100

Table 6a Assessment Tools used to assess a resident in domains i-j

i. Cognitive ability/patterns and organisation of self-care activities		j. Communication, hearing and understanding	
Survey Response option	% endorsing each response (n=103)	Survey Response option	% endorsing each response (n=39)
Mini mental state examination (MMSE)	82	Brief Hearing Loss Screener	10
Mini-Cog	1	'Other' responses	29
Confusion Assessment Method (CAM)	3		
Abbreviated Mental Test Score	26		
Addenbrooke's Cognitive Examination	0		
Montreal Cognitive Assessment	0		
The Clinical Dementia Rating Scale	0		
AD8 Dementia Screening Interview	0		
Informant Questionnaire on Cognitive Decline in the Elderly	0		
Delirium Observation Screening Scale	0		
Other's responses	8		
Did not respond	3	Did not respond	63

Table 6b Percentage Breakdown of 'Other' Assessment Tools used to assess a resident in domains i-j

i. Cognitive ability/patterns and organisation of self-care activities		j. Communication, hearing and understanding	
Breakdown of 'Other'	% (n = 11 tools)	Breakdown of 'Other'	% (n = 25 tools)
<i>Standardised tool (not listed above):</i>	18	<i>Standardised (not listed above)</i>	8
MMSE	18	Y – Resident Comprehensive Assessment Form	8
<i>Standardised tool modified/adapted</i>	0	<i>Standardised tool modified/adapted</i>	0
<i>Insufficiently specified</i>	46	<i>Insufficiently specified</i>	16
<i>Devised in-house</i>	0	<i>Devised in-house</i>	28
<i>Electronic</i>	9	<i>Electronic</i>	4
<i>Referral to Medical/Healthcare specialist</i>	27	<i>Referral to Medical/Healthcare specialist</i>	44
TOTAL	100	TOTAL	100

Table 7a Assessment Tools used to assess a resident in domain k

k. Mood and behaviour patterns / Psycho-social well-being, adjustment and relationships	
Survey Response option	% endorsing each response (n=71)
Geriatric Depression Scale	52
The Impact of Event Scale - Revised (IES-R) (PTSD)	1
The Pittsburgh Sleep Quality Index (PSQI)	0
Cohen Mansfield Agitation Inventory	10
'Other' responses	17
Did not respond	33

Table 7b Percentage Breakdown of 'Other' Assessment Tools used to assess a resident in domain k

k. Mood and behaviour patterns / Psycho-social well-being, adjustment and relationships	
Breakdown of 'Other'	% (n =19 tools)
<i>Standardised tool (not listed above):</i>	16
<i>Y -A.B.C. functional analysis tool / record chart</i>	16
<i>Standardised tool modified/adapted</i>	0
<i>Insufficiently specified</i>	57
<i>Devised in-house</i>	11
<i>Electronic</i>	5
<i>Referral to/visit by Medical/Healthcare specialist</i>	11
TOTAL	100

a - In the 'Dependency, Mobility and Activities of Daily Living' domain of care (Table 2a) some 93% of residential centres endorsed the Barthel activities of daily living scale, while one quarter (27%) used the Nursing Homes Ireland Manual Handling Chart. Of the 73 'other' tools reported in this domain (Table 2b), 11% of the tools were the Falls-risk assessment FRASE tool and 11% used the Roper, Logan Tierney tool/model of care.

b - In the 'Skin Condition' domain of care (Table 2a) some two thirds (67%) of residential centres endorsed the Waterlow pressure ulcer risk assessment, while one third (34%) used the Braden scale for predicting pressure sore risk.

c - In the 'Continence and Elimination' domain of care (Table 3a) over a third (36%) of residential centres endorsed the Assessment form for Urinary Incontinence (Nursing Homes Ireland). Of the 42 'other' tools reported in this domain (Table 3b), 12% were the HSE Continence Promotion Dept./ Unit Assessment).

d - In the 'Nutritional/Oral health' domain of care (Table 3a) three quarters (78%) of residential centres endorsed the Malnutrition Universal Screening tool (MUST). There were no 'other' responses.

e - In the 'Health conditions and risk factors for illness, accident and functional decline' domain of care (Table 4a) the Abbey Pain Scale was endorsed by around one third (34%) of respondents. While just over a quarter (28%) used the Pain: Numeric Rating Scale (NRS) and one fifth (21%) endorsed the 'other' option.

f - Current medication use (Table 4a) was recorded on specific forms, for example, 'Nursing Homes Ireland Medical Notes Form' (39%) rather than by standardised instruments (6% - Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (part I -2%, part II -4%). In addition, there were a large proportion of 'other' responses (31%) and non-responses (34%).

g - The domain of Dental/oral status (Table 5a) contained only one standardised instrument: The Kayser-Jones Brief Oral Health status examination, which was used by only 8% of the responding homes.

h - Optician visits or referrals featured strongly in the 'other' category of the domain 'visual limitations and abilities' (61%) (Table 5b). However, the 'other' category was

endorsed by less than one third of respondents (29%), with most (71%) respondents not providing a response.

i - The domain of 'cognitive ability/patterns and organisation of self-care activities' (Table 6a) was dominated by the use of the Mini Mental State Examination (82%), with the 'Abbreviated Mental Test Score' comprising most of the remaining responses (26%).

j - In the domain 'communication, hearing and understanding', non-responses dominated (63%) (Table 6a), with the category 'other' accounting for 29% of the overall responses and the 'Brief Hearing Loss Screener' only making up 10% of responses.

k - The domain of 'Mood and behaviour patterns / Psycho-social well-being, adjustment and relationships' was almost evenly split between the 'Geriatric Depression Scale' (52%) and a range of responses – 'did not respond' (33%), 'other' responses (17%), 'Cohen Mansfield Agitation Inventory' (10%) and, 'The Impact of Event Scale – Revised (IES-R) (PTSD) (1%).

Section A2

Respondents were asked how they recorded information in relation to residents across three domains: identification and background; activities and interests; and, any special treatments or therapies. Table 8 shows the results.

Table 8 Recording tools/methods used to record residents' information in three domains

	a Identification and background information	b Activities and Interests	c Special treatments, therapies or treatment programmes, e.g. speech & language
Survey Response	% endorsing each response (n=101)	% endorsing each response (n=101)	% endorsing each response (n=98)
A specific form	47	46	53
A general background information 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
	<i>% of tools (n = 22 tools)</i>	<i>% of tools (n = 29 tools)</i>	<i>% of tools (n = 14 tools)</i>
'Other' Breakdown:			
<i>Standardised (not listed above):</i>	0	20	14
<i>- A Key to me</i>		10	
<i>- Meaningful Activities Assessment (Pal) Checklist</i>		10	
<i>- The Nursing Home Ireland THERAPIES form</i>			14
<i>Standardised tool modified/adapted</i>	0	3	0
<i>Insufficiently specified</i>	59	29	0
<i>Devised in-house</i>	14	24	7
<i>Electronic</i>	27	24	43
<i>Referral to Medical/Healthcare specialist</i>			36
TOTAL	100	100	100

In the case of the identification and background domain of care (Table 8) about half (47%) of residential centres used a specific form, and a quarter (25%) used the Nursing Homes Ireland Resident Comprehensive Assessment form. In the case of the activities and interests domain of care (Table 8) about one half (46%) of

residential centres used a specific form, and a fifth (21%) used a general background form. Of those who used 'other' tools (29) – 10% used the 'a key to me' tool and 10% used the Meaningful activities (PAL) checklist. In the case of the special treatments, therapies or treatment programmes domain of care (Table 8) just over one half (53%) of residential centres used a specific form, and just under a fifth (18%) used a general background form. Of those who used 'other' tools (14) – 14% used the Nursing Homes Ireland 'Therapies' form.

Section B

While section A of the questionnaire was primarily concerned with tools in use for assessment and care planning, section B sought to gather information surrounding processes and practices. This section was included to collect information around professional input, scheduling intervals, care-plan associated training and type of system (paper/electronic) in use, so as to inform understanding of routines that are associated with care planning and the context within which it takes place. Tables 9 to 18b detail the questions and responses given.

Table 9 Which professional category most often contributes to the average care plan?

	%
	(n = 98)
Medical e.g. GP, Old Age Psychiatrist, Geriatric Nurse ...	93
Healthcare e.g. Occupational Therapist, Podiatrist, Speech and Language Therapist ...	7
Social e.g. Social Worker, Advocate, Carer ...	0
Total	100

An overwhelming majority of respondents (93%) indicated that medical professionals contributed most often to the average care plan. While other healthcare professionals contributed substantially less often and professionals from within the social category were never the ones to contribute most often.

Respondents were asked two questions about processing care plans - which staff member co-ordinates i) completion of care plans (Table 10) and ii) co-ordinates adding progress notes to care plans (Table 11). In both cases it was nurses that were primarily responsible for these tasks (58% and 81% respectively). In contrast, care assistants were rarely involved in either task.

Table 10 Which staff member co-ordinates completion of care plans?

	%
	(n = 92)
Director of Nursing / Care or Clinical Nurse Manager / Director or Matron of Care	33
Nurse(s)	58
Care Assistant(s) e.g. Social / Non-Nursing Care Staff	0
Other	9
Total	100

Table 11 Which staff member co-ordinates adding progress notes to care plans?

	%
	n = 101
Director of Nursing / Care or Clinical Nurse Manager / Director or Matron of Care	13
Nurse(s)	81
Care Assistant(s) e.g. Social / Non-Nursing Care Staff	1
Other	5
Total	100

As with professional contribution (Table 9 above), the responsibility for managing and maintaining care plans rested with medical professionals. Again, non-nursing care staff were rarely involved in either task.

Two very different approaches appear in relation to the timing of adding progress notes (Table 12), with a little over half (55%) of respondents indicating daily updating, while two fifths (41%) of respondents endorsed 'as required'.

Table 12 How often are progress notes added to care plans

	% (n = 99)
Daily	55
Weekly	2
Monthly	3
As required	41
Total	100

In line with the standards, care plans were revised on a regular basis (Table 13); most commonly quarterly (71%) or monthly (28%).

Table 13 How often are care plans revised

	%
	(n = 99)
Monthly	28
Quarterly (four times a year)	71
Biannually (twice a year)	0
Annually	1
Total	100

Care plans were always made available to residents or their representatives by about half of residential centres (51%) (Table 14). The other half of centres made them available less often and sometimes never.

Table 14 Is a copy of the care plan made available to residents or their relatives/representatives

	% (n = 99)
Always	51
Usually	20
Sometimes	12
Rarely	10
Never	7
Total	100

In about nine tenths of residential centres (87%), at least one staff members had received specific training in completing care plans (Table 15). Internal/In house training (65%) was just under twice as frequent as external training (36%).

Table 15 Have any staff members received specific training in completing care plans?

	%* (n = 99)
Internal/In-house	65
External	36
No staff members have received specific training	13

* Respondents may have ticked more than one category. The percentage of staff that received specific training both in-house and externally was 21%.

Of those who listed training courses (n=67), more than half (58%) had attended two or more training courses (Table 16). The top six most popular training courses for each staff category are list below (Table 17).

Table 16 Please list the training courses – number of training courses listed

	%
None	37
1	26
2	16
3	6
4	3
5	4
6	8
Total	100

Table 17 Top six training course for each staff category by percentage

	Director of Nursing	Nurse(s)	Care assistant(s)
	%	%	%
Behaviour that challenges			5
Care plan related	22	23	7
Dementia related	4	3	7
Documentation (general)	5	5	
FETAC course			8
Fire fighting			5
Gerontology related	3		
Manual Handling	4	3	8
Medication management/Nutrition		3	
Saturn/Cato Electronic System	3	3	

Three quarters of respondents (77%) said their care plans were paper-based (Table 18). The remainder had either electronic care plans or both formats.

Table 18 Are your care plans

	% of those who responded (n =100)
Paper-based	77
Electronic/computerised	14
A mixture of both	9
Total	100

Epiccare was the most popular care planning package with almost half (47%) using it, while 13% had devised their own care plan software (Table 18b).

Table 18b Details on specific care planning software package used

Computer system	% (n=15 systems)
Epiccare	47
Saturn	33
Abylss	7
Devised in- house	13
Total	100

Section C

In contrast to the structured approach of the preceding sections, section C posed three open-ended questions – drawbacks, obstacles and benefits of care plans and planning. This section was included to gain an insight into the manner in which care plans and planning were perceived by respondents. Due to the open-ended nature of the responses, it was possible for an individual response to be placed in more than one category. Consequently the count of responses / percentages exceeds the number of respondents in each case (all percentages have been rounded upward). The breakdowns of responses are detailed in tables 19, 20 and 21.

Table 19 What do you see as the drawbacks of care plans?

(Number of respondents: 89)

Category	Number of responses	% of responses (n= 129)
Time general *	34	26
Time away from care	13	10
Time initial (the time it takes to set-up the care plan initially)	8	6
Paper (storage, durability and management)	8	6
Quality (legibility/accuracy/completeness/consistency)	18	14
Bureaucratic burden (repetitive/boring)	19	15
Appreciation/know how of staff	9	7
No drawbacks	11	7
Lack of person-centeredness	5	4
Other (does not fit to given categories)	4	3

Time is the most frequent response at (n=34), however, when the two other time related categories (time away from care and time initial) are added, this sums to (n=55) which is 42% of all responses for this question. Lack of person-centredness (n=5) was the least popular categorised response.

Table 20 What do you see as obstacles to completing care plans?

(Number of respondents: 88)

Category	Number of responses	% of responses (n=133)
Time	52	35
Lack of appreciation (by in) and know-how by staff	22	17
Co-ordination (availability of information to/from residents/ MDTs/relatives)	19	14
Accuracy (language ability/legibility/consistency/completeness)	5	4
Paper work too exhaustive	5	4
Updating/changes	4	3
Interruptions	5	4
Lack of resources (money/staff)	14	10
None	1	1
Other	6	5

As with 'drawbacks', time was again indicated by respondents to be a primary obstacle to the completing of care plans, so much so that it was noted almost as many times (52), as the combined total of the next three most common responses (55).

Table 21 What do you see as the benefits of care plans?

(Number of respondents: 90)

Category	Number of responses	% of responses (n=154)
Helps define measurable outcomes	6	4
Continuity of care (intra-inter-professional working)	47	31
Promotes person-centeredness	41	27
Improves quality (quality must have been specifically mentioned)	9	6
Promotes a structured approach to the care process	18	12
Improves organisational efficiency (through accessibility or planning)	6	4
Promotes family involvement	8	5
Helps to meet regulatory/legal requirements	15	6
Other	4	3

Respondents most frequently noted 'continuity of care' (n=47) as the primary benefit of care plans with 'promotes person centredness' (n=41) a close second.

Discussion

Limitations

Before engaging in discussion of the results, it is appropriate that consideration be given to potential limitations and confounding factors that may have impacted on this study. One such area for consideration was the use of a stratified random sample. This approach was taken both for expediency and in an effort to ensure that both private and public facilities were adequately covered. However, it should be borne in mind that the perfect 50/50 public private split that ultimately emerged here is not reflective of the portion of public/private providers in Ireland. Rather the proportions are closer to one third public and two thirds private, with a small number of voluntary providers (which were not included).

Though the response rate (42.5%) was encouraging and lends confidence to the findings, the self-selecting nature of the respondents should not be ignored. Moreover, it is entirely possible that the respondents that did answer may have done so precisely because they had recently engaged in updating their assessment and care planning tools, documents or processes. Indeed, there can be little doubt that the introduction of the standards will have encouraged revisions and alterations to documentation or processes. As a consequence, it is likely that these developments

were ongoing at the time of this study and it is possible that many respondents replied specifically because they were engaged in such ongoing developments. As such, while this study may represent a timely snapshot, it may ultimately be no more than a snapshot, as change is likely to be continuing feature of this area for some time. Certainly, the apparent fondness for modification of standardised tools and/or the devising of tools in-house would appear to lend weight to this view.

The facility to complete the survey either electronically or on paper must also be considered. Few people would deny that it is extremely easy to mistakenly select a non-desired response with online forms. Moreover, there appears to be some incongruence between the high level of surveys completed online and the near absence of the use of computers for care planning. In addition, there are an array of terms and phrases surrounding care planning in use, which may have resulted in misinterpretation of exactly what was being asked. For example, as noted in the methods section, the pilot study revealed that for some a 'care plan' is a single document dealing with a discreet aspect of care. In contrast, for others a 'care plan' refers to a folder or file that is a repository for a collection of documents related to an individual's care.

In general, structured closed-ended surveys present a number of limitations, not least the absence of space to expand on responses. In relation to this survey, there are other factors that should also be considered. In designing the survey, account was taken of the time constraints that directors of nursing can face. Indeed, in many instances this was vividly illustrated by respondents' extremely brief retorts to the open ended 'obstacles' and 'barriers' sections, which on more than one occasion contained only a single word (sometimes repeated) – time. Conscious of this backdrop and in an effort to balance convenience for respondents with gathering sufficient data, this survey was designed in a largely 'tick box' format, with a category 'other' provided for responses that did not comfortably match one of the 'tick box' selections. In light of the proclivity of adaption, modification and in house development of tools, this approach was ultimately revealed as possible not the most prudent. Certainly, there are domains where the 'other' category attracted a significant number of responses, which often ranged widely and, which therefore presented difficulties in coding and categorising the data. If such imprecision can be seen as a limitation, it is nonetheless revealing, since it reinforces the finding that there is frequently a localised approach to assessment and care planning in long-stay settings in Ireland.

In spite of these limitations, the reasonable response rate and the inclusion of data from both public and private providers does generate grounds for confidence in the findings. Moreover, given the novelty of the introduction of the HIQA standards this study provides a baseline for further studies and contributes to the rather limited current research base.

Overview of results

This study sought to gain an insight into assessment and care planning in residential centres for older people in Ireland through the exploration of three related areas; tools, processes and perspectives. In each of these areas identifiable patterns emerged. For instance, in relation to tools (Section A), there is clearly significant variation in the use of standardised tools across domains. Moreover, while specific instruments are common in some domains, professional judgement is more prominent in others. In addition, there appears to be a penchant for in-house modification and/or development of tools. In the area of processes (Section B), it is apparent that assessment and care planning are almost exclusively the preserve of medical professionals and that documentation is predominately paper based. The views of those responsible for managing care documentation (Section C) also demonstrate extensive agreement; care plans are perceived as positively contributing to quality of care, but are also viewed as incurring substantial burdens, especially in relation to time.

While it is clear that each of the areas has identifiable patterns, it is also clear that the areas of processes (B) and perspectives (C) are rather more homogenous than that of tools (A). In part, this may be attributed to the standards themselves, as although there is a requirement to utilise an MDS instrument and some guidance is provided within Appendix A of the national standards, there is no requirement to use a particular MDS instrument or specific tools. As such, the standards represent a framework to work within rather than an explicit set of prescribed instructions.

Advantages and disadvantages of flexibility

This approach has the advantage of providing structure, while at the same time retaining flexibility. In many ways, this reflects the consensus manner in which the standards were developed, but it is also an approach that is clearly cognisant of potential pit-falls that can accompany an overly rigid 'one size fits all' accent to

assessment and planning. Indeed, those such as Welford (2006) have been keen to caution against the notion that one size will fit all and have warned that simply taking a care plan from one site and imposing it at another is likely to result in failure, since it is probably that it will be 'unsuitable to the care environment, patient profile and services available' and, as a consequence, will 'sink like the Titanic' (Welford, 2006, p. 16). More importantly perhaps, it has been noted that mandatory imposition of resident assessment systems has tended to produce resistance and 'negative reactions', potentially resulting in compliance 'in name (on paper) only' (Bernabei, Murphy, Frijters, DuPaquir & Gardent, 1997, p. 35). Nonetheless, it may be that a desire to ensure flexibility and avoid the pitfalls of a 'one size fits all' approach has contributed to the substantial variation across domains observed in this study.

Dominant tools

Certainly, within some domains there were clear 'favourites'. For example, the Barthel index was near ubiquitous in the domain of dependency, mobility and activities of daily living. In contrast, within other domains there were, to borrow from racing parlance, favourites and 'also rans'. For instance, in the domain 'skin condition' the 'Waterlow pressure ulcer risk assessment' enjoyed significant usage and was the favoured tool, but there was also a crowded chasing pack of other instruments in use. In part, it is a situation that may be attributable to the emergence of a synonymous relationship between a particular tool and a domain. No discussion of activities of daily living for example, would be complete without reference to the Barthel index. As such, it may be that where there is little variation within a domain this may be due to a specific tool having reached the status of exemplar in the same way that certain brands have become household names.

The domain of 'nutritional/oral health' presents a further example of this dominance of particular tools. For instance, Green and Watson (2004) identified from a review of the literature twenty one tools 'designated for use with an older population' (Green & Watson, 2004, p. 477). Yet, within this study two tools, the Malnutrition Universal Screening Tool (78% endorsed this response) and the Mini Nutritional Assessment (20% endorsed this response), accounted for nearly all responses.

In marked contrast to such harmonised domains were domains such as 'visual limitations or abilities' or 'communication, hearing and understanding', where the use of standardised instruments was limited and, guidelines or professional

judgement were to the fore. This variability within and between assessment domains has been observed in previous and contemporary studies that have focused on care documentation for older people. For example, in the area of community care Stewart, Challis, Carpenter and Dickson (1999) noted 'enormous variability in the type and content of assessment tools used' (p. 14). In a similar vein, Stevenson (1999) concluded that though domains such as activities of daily living tended to be well documented and most forms collected information on 'cognitive patterns, mood state and social activity...very few collected this in any detail' (Stevenson, 1999, p. 10). A study in the Netherlands in the wake of the introduction of an MDS/RAI, which sought to explore whether this development had reduced gaps between perceived need and care, also concluded that 'perceived gaps were found most in the psychosocial area' (Holtkamp, Kerkstra, Ooms & van Campen, 2001). More recently, Moore's (2010) study of nursing documentation in public nursing homes in Ireland noted very similar findings, with considerable variations across the four HSE regions and least coverage observed in domains such as 'psychosocial, rehabilitation, general health, and end of life care needs' (Moore, 2010, p. 1). As such, variation both within and between domains would appear to be a common feature of assessment and care planning for older people.

Possible reasons for variability in domains –national & international

Though the non-prescriptive nature of the standards may be a contributing factor in the continuation of such variation, the antecedents to this set of circumstances can be firmly located in the evolution of care and care documentation. Throughout the last century care services were shaped by a medical model of care, which tended toward the privileging of the objective, often at the expense of more subjective influences, such as social activity and/or psychosocial factors (Thompson & Thompson, 2001; Gallagher & Kennedy, 2003; Lee, 2005). To compound matters, the architecture of nation states and the specialisation of labour frequently resulted in discreet departments or sections within departments, which served distinct sub-populations (Pavolini & Ranci, 2008; European Commission, 2008). Thus, there can be little surprise that 'traditionally, assessment tools have been developed by specific disciplines for specific patient or service user groups in specific settings' (Lambert, Thomas & Gardener, 2007, p. 351). Moreover, as those as Taylor (2005) have observed, 'tools are often updated on a regular basis' and can become rapidly obsolete (Taylor, 2005, p. 8). It is a situation that has often been compounded by practitioners reflecting their needs in care plans rather than the needs of the patient (McMahon, 1988).

If such factors have shaped the manner in which care documentation has evolved and have become general characteristics of the field, in Ireland there also appears to be a strong tendency to tweak existing tools and/or to devise new ones. Indeed, one striking feature of the responses in this study was that within almost every domain respondents' noted that there were modifications to existing instruments and/or instruments had been devised in house.

Domains with low use of standardised tools

At first glance such observations may appear to suggest that there is a requirement for the development of further standardised instruments for domains that may be poorly served at present. Certainly, the finding noted above that domains that tended to receive least coverage were those where guidelines or professional judgement were more prevalent would appear to lend weight to this view. This is not to suggest that tools should be developed as a substitute for professional judgement, but rather that tools and professional judgement should inform and support each other. Indeed, the standards specifically note this, suggesting that tools used 'should support rather than replace professional judgement' (HIQA, 2009, p. 63). Nonetheless, it is also important to keep in mind that for some domains an extensive array of tools is already in existence (Green & Watson, 2004). As such, variation may reflect local preferences, which have developed in the vacuum of the absence of national standards.

Yet, even in domains where standardised instruments are available their use was frequently patchy. For example, within the domain of dental/oral status nearly 60% of respondents did not respond and of those that did only 8% (n=43) indicated usage of an unmodified standardised screening tool, the Kayser-Jones Brief Oral Health Status Examination (BOHSE). The low number of responses and the limited use of a standardised instrument would appear to support the concern that oral health care for older adults in nursing homes is frequently 'inadequate' and that training and education are needed for nursing and care staff (Fitzpatrick, 2000, p. 1325; Jablonski, Munro, Grap, Elswick, 2005). The importance of oral health cannot be overlooked, for as those such as Jablonski, Swecker, Munro, Grap & Ligon (2009) have observed, there is increasing evidence of a relationship between poor oral health and systemic diseases. More importantly perhaps, where there are time and staffing pressures oral health care is often the first area to be omitted (Jablonski, Munro, Grap and Elswick,

2005). Against this backdrop, the low level of responses noted for this domain clearly raises concerns other than the apparent absence of standardised instruments.

Other domains where there were high numbers of non-responses include, (f) current medication use (n=34), (h) visual limitations and abilities (n=71), (j) communication, hearing and understanding (n=63) and, (k) mood and behaviour patterns/psychosocial well-being, adjustment and relationships (n=33). The latter mirrors plainly the common finding that psychosocial domains tend to be poorly covered in care documentation (Stewart, Challis, Carpenter and Dickson, 1999; Stevenson, 1999; Holtkamp, Kerkstra, Ooms & van Campen, 2001; Moore, 2010). However, in the other domains, reasons for the large number of non-responses are less clear.

In the case of the domains 'visual limitations and abilities' and 'communication, hearing and understanding' the large number of non-responses may suggest that this is an area that is not prioritised in assessment. Certainly, it has been observed that visual impairment is generally not 'routinely assessed' for older adults (Abdelhafiz & Austin, 2003, p. 26). Nonetheless, visual impairment is extremely common in nursing home residents (VanNewkirk, Weih, McCarthy, Stanislavsky, Keefe & Taylor, 2000; Abdelhafiz & Austin, 2003; Chou, Dana, Bougatsos, 2009). Indeed, Wang, Mitchell, Cumming and Smith (2003) found that visual impairment was both a marker for and a contributor to nursing home placement. More importantly, visual impairment has been strongly linked with falls and fractures (Lord & Dayhew, 2000; Abdelhafiz & Austin, 2003; Todd & Skelton, 2004). In a similar vein, the domain of 'communication, hearing and understanding' has also been associated with an absence of screening, a high prevalence among nursing home residents and a low level of detection (Brodie, 1986; Burnip & Erber, 1997). This may be particularly important in light of the growing body of evidence that links hearing impairment to negative moods and reduced social engagement (Brink & Stones, 2007).

However, it is important to note that even where such areas form an integral part of an MDS assessment, debate has emerged. For example, Swanson, McGwin, Elliott and Owsley (2009) have observed a lack of sensitivity in the visual assessment element of MDS 2.0 (U.S.A.), which can lead to individuals with a visual impairment being classified as having adequate vision. This has led to a questioning of the

‘validity’ of the MDS as a ‘mechanism for triggering comprehensive eye care for nursing home residents’ (Swanson, McGwin, Elliott & Owsley, 2009, p. 486).

The interrelated issues of variability in instrument usage, weak coverage of psychosocial domains and a proclivity for adaption are also reflected in the findings in relation to recording of ‘activities and interests’. Within this area a number of specific forms are employed, but standardised tools such as ‘a key to me’ or the ‘meaningful activities checklist’ are almost conspicuous by their absence. Again, it would seem plausible to suggest that such variations on a single theme can be related to a historical localised approach, which may be maintained by the inherent flexibility in the standards. This is not to suggest that the standards are responsible for the array of variations, but rather that the standards may serve to sustain this situation.

Dominance of medical professionals

While it may be appealing, not least for reasons of simplicity, to attribute these patterns solely to the manner in which instruments have been developed by specific disciplines for particular groups or flexibility in standards, it may be that less obvious factors also play a part. For instance, a Canadian study examining the strengths and learning needs of staff in nursing homes noted that as nursing home care is ‘often regarded as custodial, task-oriented and regimented, with little imagination required...nurses in the study found ways to improvise and create meaningful activities for older persons and learning for themselves’ (Cruttenden, 2006, p. 354). Thus, it may be that the observed fondness for modifying or developing tools may be a consequence of a complex combination of factors; some more obvious than others.

In contrast to the potential complexity of factors that may be contributing to the modification of tools, it is clear from this study that medical professionals dominate assessment and planning processes. For instance, in response to the question ‘which professional category most often contributes to the average care plan?’ respondents were largely unambiguous; medical professionals (93%) (healthcare professionals accounting for the remaining 7%). This ascendancy can be attributed to a number of factors including, the traditional ‘custodial’ nature of care for older people, dominance of the medical model throughout the last century and, the legal nature of care documentation.

In Ireland, the origins of health and social care services are rooted firmly in the 'workhouses', which provided institutional care for a variety of groups for many decades (O'Connor, 1995; Timonen & Doyle, 2008). While in the early 1900s recommendations aimed at developing more appropriate care facilities for older people emerged, these went largely unimplemented and care for older people remained almost exclusively institutionally based, custodial in nature and task orientated in delivery. Indeed, it was not until the late 1960s and the publishing of the *Care of the Aged* (1968) report, which recommended a shift from institutional to community based services, that Irish policy began to move away from institutionalised care (Timonen & Doyle, 2008). Nonetheless, a legacy of passive and routine dictated care has remained in many institutions (Gallagher & Kennedy, 2003; Murphy, O'Shea, Cooney, Shiel & Hodgins, 2006; Walsh & O'Shea, 2009; Timonen & O'Dwyer, 2009). To compound matters further, throughout this period, care for all groups was dominated by a medical model (Thompson & Thompson, 2001). While such historical factors may play less of a role today, there remains little doubt that professional cultures are imbued with traditions and beliefs, which shape assessment and care planning (Chevannes, 2002; Healy, Victor, Thomas & Sargent, 2002; Abendstern, Clarkson, Challis, Hughes & Sutcliffe, 2008). Indeed, those such as Brittis (2011) contend that care documentation not only tends toward concentrating on 'ailments afflicting' older individuals, but that it is shaped largely by the 'professional orientation of the staff caregiver' (Brittis, 2011, p. 24).

In Ireland, is a set of circumstances undoubtedly influenced by the relationship between care documentation and the law, since 'Legislation and guidelines governing nursing documentation clearly state that nursing documents are legal documents that can be requested as evidence in legal cases' (Moore, 2010, p. 5). Given that Ireland is one of the most litigious countries in Europe and that the 'level of medical litigation' in particular has encouraged the 'epithet "51st state of the [US] Union"', there can be little surprise that documentation is the near exclusive preserve of medical professionals (Cusack, 2000, p. 1431).

This dominance of medical professionals is further reflected in the responses to questions regarding co-ordination of care plans, specifically, 'which staff member co-ordinates completion of care plans?' and 'which staff member co-ordinates adding progress notes to care plans?' The responses to both questions indicated clearly that these activities were the preserve of directors of nursing or nurses. While there can be little surprise that any individual who was ultimately legally responsible for

documentation would be loath to abdicate responsibility to others, there can equally be little doubt that the dominance of one or two professional groupings presents challenges for multi-disciplinary and or inter-disciplinary working. Certainly, it could be argued that such dominance reflects intra rather than inter-disciplinary working.

Yet, both policy and research literature proclaim consistently the benefits of multi-disciplinary working. No matter whether it is healthcare in general or more specialist services, policy in Ireland is saturated with references to multi-disciplinary working. For example, *Planning for the Future* (Department of Health, 1984), *Quality and Fairness* (Department of Health and Children, 2003) and the *Report of the National Task Force on Medical Staffing* (Hanly, 2003) to name but a few, all assert that multi-disciplinary working should be a cornerstone of practice. In the case of research literature multi-disciplinary working could almost be described as a field in its own right, given the attention it has received. More importantly perhaps, within this study respondents' felt that 'continuity of care (intra-inter-disciplinary working)' was the number one benefit of care plans.

In spite of this perceived benefit, respondents' nonetheless also perceived gathering information from multi-disciplinary teams and relatives as the third greatest obstacle to care planning. Thus, there can be little doubt that multi-disciplinary working has a somewhat Janus faced quality, it that it is valued as a key element in the delivery of quality care, but in practice it can frequently fail to live up to this expectation. For those such as Jones (2006) it is often professional boundaries that contribute to this difficulty, as professionals frequently display a 'protectionist mentality' that causes them to be 'more concerned with protecting their image rather than committing to an outcome' (Jones, 2006, p. 26).

It is a phenomenon that can be attributed to each profession viewing and approaching an issue from its own professional perspective (Frost, Robinson & Anning, 2005) against a backdrop of blurred professional boundaries, which are frequently the result of disagreements both within and between professions around professional responsibilities and the limits of professional partitions (Bliss, Cowley & White, 2000; Booth & Hewison, 2002). In Ireland, debate and disagreement over professional boundaries is likely to be a feature of the health and social care landscape for some time to come, in part due to the introduction of the Health and Social Care Professionals Act (2005). This Act lead to the establishment of CORU, a

single agency charged with overseeing the registration and regulation of twelve health and social care professions. Against this backdrop, it is plausible to suggest that there will be an increasing rigid approach to demarcating professional boundaries. The traditional professions will no doubt seek to maintain claims over unique professional knowledge and expertise. While at the same time, emerging professions will seek to establish themselves by also laying claim to specialised knowledge and expertise and, there can be little doubt that some of these claims will overlap (O'Connor, 2006). It is a scenario that has already been observed in other nations. For example, in Canada, dispute arose between dentists and dental hygienists in the wake of 'changes to the regulation of health professions', which afforded dental hygienists the opportunity to pursue more vigorously their 'professional project aimed at expanding their status, scope of practice and independence' (Adams, 2004, p. 2241). In the arena of care for older people this situation may be exacerbated by increasing complex co-morbidities and care needs associated with population ageing, which are likely to provide fertile ground for nourishing medical dominance in care provision. Though far from the 'perfect storm', it would seem reasonable to anticipate that this combination of factors is likely to have negative consequences in relation to multidisciplinary working and/or the delivery of person-centred care. Both of which have been highlighted in the literature as key drivers of quality care (Dellefield, 2006; Suhonen, Valimaki & Leino-Kilpi, 2009; Johansson, Eklund & Gosman-Hedstrom, 2010).

If, in relation to the drawing of professional battle lines, only time will tell, in the present the backdrop of the supremacy of medico-legal influences may also be a contributing factor in the reluctance among some providers to make available copies of care plans to residents and/or their representatives. Within this study a divergence of approaches was obvious, with half of respondents (51%) indicating that care plans are 'always' provided. In contrast, other providers make care plans available to residents or their representatives, 'usually' (20%), 'sometimes' (12%), 'rarely' (10%) or 'never' (7%). On the one hand, such findings may suggest that the adoption of a person-centred approach that is inclusive of the resident remains an aspiration at present and that, care continues to be shaped largely by a custodial and task oriented culture within which residents are passive recipients of care. Certainly, the standards require that residents or their representative(s) are provided access to their care plan. On the other hand, that almost three quarters of centres 'always' or 'usually' make care plans available, does present grounds for optimism that a more person-centred approach is taking hold.

Nonetheless, such optimism may be tempered by the continued dominance of one profession or professional grouping, as this presents other concerns for the delivery of individualised care, particularly in relation to the role and input of direct care workers. It has long been noted that direct care staff are best placed to provide individualised care. Yet, it has also been highlighted that this staff group is excluded consistently from inputting into the care planning process (Dellefield, 2006; Kontos, Miller & Mitchell, 2009). It is a set of circumstances that would appear to be confirmed within this study by the finding that few care assistants have received 'care plan related' or 'documentation (general)' training. This reflects the general finding that training and education of non-nursing care staff for older people tends to be limited and vocational in nature (Power & Lavelle, 2011). More importantly perhaps, while Dellefield (2006) contends that the input of direct carers is crucial to the integration of care planning into the day to day running of nursing homes, those such as Kontos, Miller and Mitchell (2009) go further, arguing that participation of direct carers is the required catalyst 'to effectively shift care plans from being provider driven and problem based to person-centered and quality enhancing' (p. 360).

Certainly, there is evidence to suggest that not only can team working by all staff groupings enhance quality of care, but that MDS instruments and care plans can form the hub around which such team working takes place (Hansebo, Kihlgren, Ljunggren, & Winbald, 1998; Hansebo & Kihlgren, 2004; Kontos, Miller & Mitchell, 2009). For instance, a Swedish study conducted with carers of dementia patients examined the impact of ongoing learning for care staff in assessment, individualised care and care planning. It found that not only did the use of an MDS assessment instrument contribute to seeing a 'real person behind a dementia surface' but also that when this detailed assessment was used as the focus for inter-disciplinary discussion of care provision, it facilitated carers' 'personal and professional development', contributing to improvement in the quality of care (Hansebo & Kihlgren, 2004, p. 269). It is a view supported by those such as Funkesson, Anbacken and Ek (2007) who contend that knowledge of the client developed over time impacts upon the complexity of reasoning employed in the care of that client (Funkesson, Anbacken, Ek, 2007). As such, there appears to be a positive feedback loop between knowledge of the client and the thinking employed in caring for that client, which creates a win/win situation; enhanced quality of care for the client and improved personal and professional development for the carer. Win/win situations

of this type can also have broader ramifications. For instance, those such as Chou, Boldy and Lee (2003) have observed that in nursing homes staff satisfaction 'plays a crucial and central role in determining resident satisfaction' (p. 459).

In light of such findings, it seems plausible to suggest that staff views in the U.S.A., which have associated the MDS/RAI with improvement to the quality of care, may in many ways, reflect advancement that has been brought about by the mandated interdisciplinary approach that the MDS/RAI requires (Straker & Bailer, 2008). In other words, it may be that quality improvements have been shaped as much by more integrated working arrangements as other drivers. Of more import to this study, the finding that staff buy-in and know how is seen as the second greatest obstacle to care planning, may reflect the general absence of input from frontline workers.

Role of care plans in promoting personalised care

Against this backdrop, the responses within this study surrounding the addition of progress notes provide another window, though at present a rather opaque one, into the manner in which assessments and care plans can act as catalysts in improving quality of care. Among respondents in this study two contrasting approaches to the addition of progress notes emerged, with just over half (55%) of respondents indicating that progress notes were added 'daily' (a minimum required by the standards – see section 32.3), whereas, two fifths of respondents indicated that they added progress notes 'as required'. In many ways, this divergence of approaches illustrates a central theme of care documentation; care documentation as a driver of care or as a record of care. For instance, the addition of progress notes 'as required' may suggest a recording approach, where the addition of notes is activated by an event. In contrast, the daily addition of progress notes may suggest a more proactive approach, within which the care plan acts to facilitate constant reappraising. However, it is also possible that the reverse is true and more research would be required to provide a clearer picture. In spite of these muddied waters, such divergences draw attention to the manner in which assessment and care planning tools can serve as drivers of care from a task-orientated approach toward a person-centred approach. Certainly, it is important to note that respondents in this study perceived the second greatest benefit of care plans as the promotion of a 'person-centred' approach, whereas, 'helps to met regulatory/legal requirements' was viewed as the fourth most positive benefit (41 and 15 responses respectively). Thus, such findings may provide grounds for optimism that care documentation is encouraging a proactive person-centred approach that is replacing a passive

recording approach, which has previously been a characteristic of care for older people.

Technology in care-planning

While such findings may suggest that new practices are becoming an increasing feature of care for older people, few differences are apparent regarding the use of computers for care planning, as the overwhelming majority of respondents (77%) noted that their care plans were 'paper-based'. While a discussion of the advantages/disadvantages of paper-based or computer based systems is beyond the remit of this study, the preference for paper-based systems may be reflective of a broader societal 'digital divide'. Certainly, given that digital technologies are a very recent phenomenon, older people may be less familiar with these technologies and their use could, for example, act as a barrier to resident input into their care plan. At the same time, the ageing of the care workforce for older people has been noted as an emerging trend in many European nations and in Ireland, indirect indicators of this phenomenon are present (Tsolova and Mortensen, 2006). For instance, Walsh and O'Shea (2009) found that a high proportion of carers within the care workforce for older people were non-nationals, which would suggest that it is difficult to attract younger entrants into this field. Given such circumstances, the introduction of computer technologies could act as a hindrance rather than a help. Moreover, in light of a backdrop of high profile debacles surrounding the introduction of computerised systems in recent years, for instance the PPARS payroll system in the HSE or the move toward electronic voting, a general reticence toward computerisation would come as little surprise.

In many ways, such considerations bring this discussion full circle, since at first glance, the development of a 'Standardised' (capital S) computer assisted approach, such as that adopted in the U.S.A, may appear a straightforward solution to counteracting the variability in assessment and care planning observed in this study. Indeed, those such as Dellefield (2006) have noted that the literature increasingly emphasises the benefits of MDS frameworks supported by computerised systems. However, this would require substantial investment in the development, rollout and maintenance of such a system. Thus, on the one hand, the development and use of MDS resident assessment tools is seen as enhancing quality of care and efficiency (Hawes, Morris, Phillips, Fries, Murphy & Mor, 1997; Bernabei, Murphy, Frijters, DuPaquir & Gardent, 1997; Bernabei, Landi, Onder, Liperoti & Gambassi). On the other hand, major MDS tools generally have in excess of '350 data elements',

(Bernabei, Landi, Onder, Liperoti & Gambassi, 2008) and therefore implementation requires specialist training and skills. Indeed, in many U.S.A. nursing homes a full-time co-ordinator is employed to manage this process (Straker & Bailer, 2008).

In light of the current challenges Ireland is facing, especially in relation to the provision of long-term care, an overhaul of the entire system along the lines of the U.S.A. model, even if desired, is highly unlikely. Indeed, given that the recently introduced 'Fair Deal' system is in crisis, the future trajectory of long-term care provision is far from clear. Nonetheless, some certainties, such as population ageing and increasing complex co-morbidities, are apparent and, more importantly perhaps, crisis often provides fertile ground for nourishing opportunity. One such opportunity would appear to be the encouragement of increased participation of direct care workers in assessment and care planning, for as those such as O'Connor (2009) have noted, the introduction of standards 'represent a necessary – but not a sufficient – condition for change' (O' Connor, 2009, p. 38).

Recommendations

Prior to engaging in any discussion of recommendations, it is important to note that the national standards were, in the words of Dr Tracey Cooper, CEO of the HIQA, designed to provide a 'baseline for those with the responsibility for providing care to assess the quality of care planning, strategically develop appropriate and sustainable resources, and provide continuity and stability to the lives of those in their care' (Forward to National Quality Standards, 2009). As such, the standards represent a minimum that services should attain and are a critical first step toward creating gold standard services and, it is within this context that recommendations have been formulated.

It is obvious from this study that localised approaches to assessment dominate in many of the domains of care noted in the standards. If standardisation is to be encouraged, increased guidance in relation to the use of available instruments would no doubt be of benefit, especially in areas where there is significant variation. This should not be taken to suggest that particular instruments or tools should be prescribed, but rather that direction on tools appropriate for a domain could make a useful contribution. Moreover, such guidance may reduce the strong tendency to devise or modify tools in house. While devising or adapting tools may present benefits locally, such tools are by their very nature unique and untested and, are therefore largely of unknown effectiveness, as they lack reliability and validity. The dissemination of guidance that narrowed the variety of instruments used would also have the potential to contribute to creating, over time, a standardised structure and language around assessment. Given that there is indirect evidence that staff recruitment is a concern and that this is likely to result in high staff turnover, the creation of a more harmonised national approach could facilitate more seamless integration for newly enrolled staff. Indeed, in light of the pressures that the long-term care system currently faces, which are likely to result in the closure of some centres, a more harmonised system could contribute to easing any resulting transition of residents.

It is also apparent from this study that there are domains in which tools are either largely absent or professional judgement exclusively (or near exclusively) is to the fore. Examples of such domains would include the domains of 'visual limitations and abilities' and 'communication, hearing and understanding'. Here, the use of standardised tools or screening by healthcare professionals may form a crucial element of assessment by assisting in early detection. Certainly, the general findings

that these are domains in which it is known that there is a generally high incidence among nursing home residents, compounded by low detection rates, presents a cause for concern. Indeed, given growing bodies of evidence surrounding visual impairment and falls, oral health and systemic disease and/or hearing impairment and social withdrawal, there is a compelling case for the adoption of a precautionary rather than reaction approach, which would enhance early detection and trigger a timely response (Fitzpatrick, 2000; Lord & Dayhew, 2000; Abdelhafiz & Austin, 2003; Todd & Skelton, 2004; Jablonski, Munro, Grap, Elswick, 2005; Brink & Stones, 2007).

The greater involvement of both residents and direct care workers in assessment and care planning activities would also be of benefit. The finding that almost three quarters of centres 'always' or 'usually' provide copies of documentation for residents or their representative does provide grounds for optimism that resident involvement is becoming an increasing feature of care provision. Nonetheless, it appears that this could be improved for a significant minority.

In a similar vein, the dominance of one or two professional groupings in assessment and care planning would suggest a challenge to well integrated inter-professional working. The encouragement of greater participation by direct care workers that exploits their intimate knowledge and understanding of residents would therefore be of benefit (Dellefield, 2006; Kontos, Miller & Mitchell, 2009; Suhonen, Valimaki & Leino-Kilpi, 2009; Johansson, Eklund & Gosman-Hedstrom, 2010).

Indeed, it is plausible to suggest that if it is accepted that standards, inspection and monitoring act to improve quality of care in a top-down fashion by pulling standards of care upward, the greater integration of direct care workers into assessment and care planning could act to as an equivalent bottom-up driver that works to push standards upward. This is not to underestimate the challenges that interdisciplinary working can create. For instance, concern has been expressed that '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, Szczepura & Nelson, 2010, p. 16). In order to mitigate against this it is imperative that there is leadership at all levels and that those charged with co-ordinating assessment and care planning are provided with the 'mandate and time available for performing this task' (Jansson, Pilhamar, & Forsberg, 2011, p. 8).

Further research

As is frequently the case with exploratory studies, more questions are often generated than answered. This study is no exception. It is appropriate therefore to provide some discussion of areas where future research may usefully be directed toward.

At a broad level the introduction of the national standards represents a significant development in the care of older people in Ireland and provides an opportunity to examine a regulatory process as it unfolds. Against this backdrop, it is likely that examination of this process will be appealing to two broad categories of researchers. Political scientists/policy analysts will no doubt be intrigued by the manner in which examination of this process can inform understanding of regulatory bodies and systems and, the extent to which national and international socio-political contexts shape regulatory approaches. In a similar fashion, researchers of a more applied persuasion will no doubt be interested in the impact of the standards on quality of care, the extent to which the standards can contribute to individualised care and the manner in which the standards shape the delivery of care, especially as residential care for older people confronts the challenge of increasingly complex care needs.

As importantly perhaps, the national standards for older people inform and serve as a template for future standards for other vulnerable groups, such as individuals with disabilities or children. Thus, in addition to many of the areas outlined above, there is likely to be an increasing focus on comparative studies.

If this brief discussion draws attention to potential areas for future research at a broad level, a number of areas of more immediate interest are suggested by this study. It is apparent from this study for example, that variability within and between assessment domains is a common feature of care provision for older people. Investigation of the factors that contribute to this situation may therefore provide insight into this phenomenon. This could be carried out in conjunction with research that focuses on whether the standards are influencing the trajectory of this phenomenon and, if so, to what extent.

The proclivity observed in this study for in-house creation and/or modification of instruments would also appear to be an area worthy of further investigation, potentially shedding light on the drives of this trend and, more importantly, its consequences. Here again, the manner in which the standards may shape or constrain this situation would be of interest. Recognition of the dearth of tool usage in particular domains, such as 'visual limitations and abilities' and 'hearing,

communication and understanding', also presents opportunities for research. Not least in relation to informing understanding of the factors that militate against the adoption of standardised instruments in these domains.

One key area, which emerged implicitly rather than explicitly in this study, is care documentation as a driver of care or as a record of care. Certainly, the finding that the addition of progress notes was either scheduled (daily (55%), weekly (2%), monthly (3%) or 'as required' (41%)) draws attention to divergent approaches. Given that care documentation can contribute to the fulfilment of a wide range of requirements, further investigation of where there may be areas of conflict between requirements and the manner in which care planners negotiate such disagreements is no doubt warranted.

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- Wang, J., Mitchell, P., Cumming, R. & Smith, W. (2003). Visual impairment and nursing home placement in older Australians: The Blue Mountains Eye Study. *Ophthalmic Epidemiology*, 10(1), 3-13.

Welford, C. (2006). Care planning in long-stay care of the older person. *Irish and Scottish Nurse* (December 2006), 16-17.

Wild, D., Szczepura, A., & Nelson, S. (2010). *Residential care home workforce development: The rhetoric and the reality of meeting older residents' future care needs*. Joseph Rowntree Foundation. U.K.

Appendix A – Copy of care planning survey

Care Planning Survey - Print version (8 pages)	
Basic Information	
What is your name?	<input type="text"/>
Your email address?	<input type="text"/>
What is the name of your long-stay setting/nursing home?	<input type="text"/>
Current number of residents?	<input type="text"/>
Dependency levels of your current residents? [PLEASE GIVE NUMBER OF RESIDENTS AT EACH LEVEL]	
Maximum	<input type="text"/>
High	<input type="text"/>
Medium	<input type="text"/>
Low	<input type="text"/>
1 When assessing a resident which of the following assessment tools do you use for each area? If you use another tool or have developed/devised a tool, please describe it under 'Other' [TICK ALL THAT APPLY]	
a. Dependency, Mobility and Activities of Daily Living	
<input type="checkbox"/>	Barthel Activities of Daily Living
<input type="checkbox"/>	Katz Activities of Daily Living
<input type="checkbox"/>	Lawton Instrumental Activities of Daily Living
<input type="checkbox"/>	Cheltenham Scire
<input type="checkbox"/>	Canard Falls Risk Assessment Scale
<input type="checkbox"/>	The Hendrich II Fall Risk Assessment
<input type="checkbox"/>	Nursing Homes Ireland Manual Handling Chart
<input type="checkbox"/>	Nursing Homes Ireland Restraint Assessment Form
<input type="checkbox"/>	Nursing Homes Ireland Dependency Levels Form
<input type="checkbox"/>	Other [PLEASE DESCRIBE]
<input type="text"/>	

Care Planning Survey - Print version (8 pages)

b. Skin Condition

- ☐ Waterlow Pressure Ulcer Risk Assessment
- ☐ Braden Scale for predicting Pressure Sore Risk
- ☐ Norton Pressure Sore Risk Assessment
- ☐ Nursing Homes Ireland Wound Assessment Form (National Pressure Ulcer Advisory Panel)
- ☐ Other [PLEASE DESCRIBE]
-

c. Continence and Elimination

- ☐ Urogenital Distress Inventory Short Form (Udi-6)
- ☐ Incontinence Impact Questionnaire-Short Form (Iiq-7)
- ☐ Cleveland Clinic Incontinence Score
- ☐ Assessment form for Urinary Incontinence (Nursing Homes Ireland)
- ☐ Bristol Stool Scale
- ☐ Fecal Incontinence Severity Index
- ☐ Other [PLEASE DESCRIBE]
-

d. Nutritional/Oral Health

- ☐ Malnutrition Universal Screening Tool (MUST)
- ☐ Mini Nutritional Assessment (MNA)
- ☐ Other [PLEASE DESCRIBE]
-

Care Planning Survey - Print version (8 pages)

e. Health conditions and risk factors for illness, accident and functional decline

- ☐ The Hospital Admission Risk Profile (HARP)
- ☐ Pain: Numeric Rating Scale (NRS)
- ☐ Pain: Verbal Descriptor Scale (VDS)
- ☐ Abbey Pain Scale
- ☐ Faces Pain Scale-Revised (FPS-R)
- ☐ Pain Assessment & Advanced Dementia (PAINAD)
- ☐ Other [PLEASE DESCRIBE]

f. Current Medication Use

- ☐ Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, Part I
- ☐ Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, Part II
- ☐ Nursing Homes Ireland Medical Notes Form
- ☐ Other [PLEASE DESCRIBE]

g. Dental/Oral Status

- ☐ Kayser-Jones Brief Oral Health Status Examination (BOHSE)
- ☐ Other [PLEASE DESCRIBE]

h. Visual Limitations and Abilities [PLEASE DESCRIBE]

Care Planning Survey - Print version (8 pages)

i. Cognitive ability/patterns and organisation of self-care activities

- ☐ Mini mental state examination (MMSE)
- ☐ Mini-Cog
- ☐ Confusion Assessment Method (CAM)
- ☐ Abbreviated Mental Test Score
- ☐ Addenbrooke's Cognitive Examination
- ☐ Montreal Cognitive Assessment
- ☐ The Clinical Dementia Rating Scale
- ☐ AD8 Dementia Screening Interview
- ☐ Informant Questionnaire on Cognitive Decline in the Elderly
- ☐ Delirium Observation Screening Scale
- ☐ Other [PLEASE DESCRIBE]

j. Communication, hearing and understanding

- ☐ Brief Hearing Loss Screener

Other [PLEASE DESCRIBE]

k. Mood and behavior patterns / Psycho-social well-being, adjustment and relationships

- ☐ Geriatric Depression Scale
- ☐ The Impact of Event Scale - Revised (IES-R) (PTSD)
- ☐ The Pittsburgh Sleep Quality Index (PSQI)
- ☐ The Epworth Sleepiness Scale (ESS)
- ☐ Cohen Mansfield Agitation Inventory
- ☐ Other [PLEASE DESCRIBE]

Care Planning Survey - Print version (8 pages)

2 When assessing a resident how do you record information in the following areas?
[TICK ALL THAT APPLY]

a. Identification and Background Information

We record this information with:

- ☐ a specific form
- ☐ a general background information form
- ☐ the Nursing Homes Ireland 'Core Resident Details' form
- ☐ the Nursing Homes Ireland Resident Comprehensive Assessment Form
- ☐ Other [PLEASE DESCRIBE]

b. Activities and Interests

We record this information with:

- ☐ a specific form
- ☐ a general background information form
- ☐ the Nursing Homes Ireland 'Core Resident Details' form
- ☐ the Nursing Homes Ireland Resident Comprehensive Assessment Form
- ☐ Other [PLEASE DESCRIBE]

c. Special treatments, therapies or treatment programmes, e.g. speech & language

We record this information with:

- ☐ a specific form
- ☐ a general background information form
- ☐ the Nursing Homes Ireland 'Core Resident Details' form
- ☐ the Nursing Homes Ireland Resident Comprehensive Assessment Form
- ☐ Other [PLEASE DESCRIBE]

Care Planning Survey - Print version (8 pages)

3 Which professional category most often contributes to the average care plan?
[TICK ONE ONLY]

- ☐ Medical e.g. GP, Old Age Psychiatrist, Geriatric Nurse ...
- ☐ Healthcare e.g. Occupational Therapist, Podiatrist, Speech and Language Therapist ...
- ☐ Social e.g. Social Worker, Advocate, Carer ...

4 Which staff member co-ordinates completion of care plans? [TICK ONE ONLY]

- ☐ Director of Nursing / Care or Clinical Nurse Manager / Director or Matron of Care
- ☐ Nurse(s)
- ☐ Care Assistant(s) e.g. Social / Non-Nursing Care Staff
- ☐ Other [PLEASE DESCRIBE]

5 How often are care plans revised [TICK ONE ONLY]

- ☐ Monthly
- ☐ Quarterly (four times a year)
- ☐ Biannually (twice a year)
- ☐ Annually

6 Which staff member co-ordinates adding progress notes to care plans? [TICK ONE ONLY]

- ☐ Director of Nursing / Care or Clinical Nurse Manager / Director or Matron of Care
- ☐ Nurse(s)
- ☐ Care Assistant(s) e.g. Social / Non-Nursing Care Staff
- ☐ Other [PLEASE DESCRIBE]

7 How often are progress notes added to care plans [TICK ONE ONLY]

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ As required

Care Planning Survey - Print version (8 pages)

8 Is a copy of the care plan made available to residents or their relatives/representatives [TICK ONE ONLY]

- ☐ Always
☐ Usually
☐ Sometimes
☐ Rarely
☐ Never

9 Have any staff members received specific training in completing care plans?

- ☐ Internal/in-house
☐ External
☐ No staff members have received specific training

10a Please list the training courses

1st Training Course	
2nd Training Course	
3rd Training Course	
4th Training Course	
5th Training Course	
6th Training Course	

10b Please select the categories of staff that took the above training courses [TICK ALL THAT APPLY]

	Director of Nursing / Care or Clinical Nurse Manager / Matron or Director of Care	Nurse(s)	Care Assistant(s)
1st Training Course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2nd Training Course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3rd Training Course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4th Training Course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5th Training Course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6th Training Course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11 Are your care plans: [TICK ONE ONLY]

- ☐ Paper-based
☐ Electronic/computerised
☐ A mixture of both

[IF YOU USE A SPECIFIC CARE PLANNING SOFTWARE PACKAGE, PLEASE GIVE DETAILS]

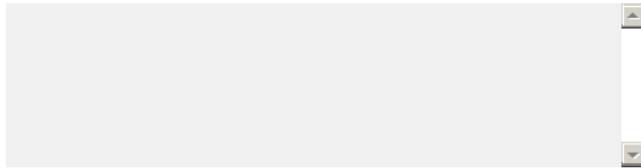
--

Care Planning Survey - Print version (8 pages)

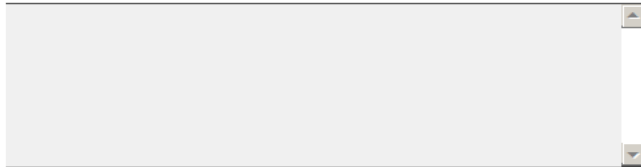
12 What do you see as the benefits of care plans?

A large, empty rectangular text area with a light gray background, intended for handwritten responses. It has small upward and downward arrow icons on the right side.

13 What do you see as the drawbacks of care plans?

A large, empty rectangular text area with a light gray background, intended for handwritten responses. It has small upward and downward arrow icons on the right side.

14 What do you see as the obstacles to completing care plans?

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15 Any other comments?

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Please remember to email a blank copy of your care plan documentation to:
careplansurvey@gmail.com, or post to:

Dr. Martin Power
Care Planning Survey
Health Promotion Research Centre
16 Distillery Road
National University of Ireland, Galway
Ireland

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Appendix B – Standardised assessment tools with citations

Domain with Tools	Reference	Link General	Link to scale
a Assessment Tools used to assess a resident in domains a-b			
Barthel Activities of Daily Living	Mahoney FI, Barthel DW, Functional evaluation: the Barthel Index. Md State Med J. 1965 Feb;14:61-5.	http://www.medicaleducation.co.uk/resources/Barthel.pdf	http://en.wikipedia.org/wiki/Barthel_scale
Katz Activities of Daily Living	Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. The Gerontologist, 10(1), 20-30.	http://www.annalsoflongtermcare.com/article/6412	http://son.uth.tmc.edu/coa/FDGN_1/RESOURCES/ADLandIADL.pdf
Lawton Instrumental Activities of Daily Living	Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. The Gerontologist, 9(3), 179-186.	http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=781867	http://consultgeriatricn.org/uploads/File/trythis/try_this_23.pdf
Cheltenham Score	n/a	n/a	n/a
The Hendrich II Fall Risk Assessment	Hendrich, A.L. Bender, P.S. & Nyhuis, A. (2003). Validation of the Hendrich II Fall Risk Model: A Large Concurrent CASE/Control Study of Hospitalized Patients. Applied Nursing Research, 16(1), 9-21.	http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=751426	http://consultgeriatricn.org/uploads/File/trythis/try_this_8.pdf
NHI* Manual Handling Chart	n/a	n/a	n/a
NHI* Restraint Assessment Form	n/a	n/a	n/a
NHI* Dependency Levels Form	n/a	n/a	n/a
Frase	Cannard, G. (1996) <i>Falling trend</i> . Nursing Times 92: 2, 36-38.	http://www.google.ie/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CDYQFjAB&url=http%3A%2F%2Fwww.nihs.ie%2Fpdf%2FACF6734.doc&ei=iKR0T7jNNMTQhAfTxM2IBQ&usg=AFQjCNGOrQmHMrdHO1rB3YelOf-u3fb3ig&sig2=nawAeXo5s2dl7LIYlWuRnUw	http://www.calderdale.nhs.uk/fileadmin/files/Local_Services/Slips_Trips_and_Falls_-_15.7_-_CHFT.pdf
Roper, Logan & Tierney	Roper N., Logan W.W. & Tierney A.J. (2000). <i>The Roper-Logan-Tierney Model of Sciences</i> . ISBN 0443063737. Nursing: Based on Activities of Living. Edinburgh: Elsevier Health. ISBN 0443063737.	http://en.wikipedia.org/wiki/Roper%E2%80%93Logan%E2%80%93Tierney_model_of_nursing	

MMSE	Folstein MF, Folstein SE, McHugh PR (1975). "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician". <i>Journal of psychiatric research</i> 12 (3): 189–98.	http://en.wikipedia.org/wiki/Mini%20mental_state_examination	http://www.patients.co.uk/doctor/Mini-Mental-State-Examination-(MMSE).htm
HSE Handling and Moving Assessment	n/a	n/a	http://www.hse.gov.uk/healthservices/moving-handling.htm#a7
HSE Manual Handling Chart	n/a	n/a	http://www.hse.gov.uk/pubns/indg383.pdf
b Skin Condition			
Waterlow Pressure Ulcer Risk Assessment	Waterlow, J. (2005) Pressure Ulcer Prevention Manual. Taunton: Waterlow.	http://www.nursingtimes.net/nursing-practice/clinical-specialisms/wound-care/best-practice-pressure-ulcer-risk-assessment-and-grading/201852.article	http://www.judy-waterlow.co.uk/the-waterlow-score-card.htm
Braden Scale for predicting Pressure Sore Risk	http://www.bradenscale.com/bibliography.htm	http://www.nursingcenter.com/productions/article.asp?tid=751548	http://www.bradenscale.com/images/bradenscale.pdf
Norton Pressure Sore Risk Assessment	Goldstone LA, Goldstone J (1982) The Norton Score: an early warning of pressure ulcers? <i>Journal of Advanced Nursing</i> 7(5): 419 – 426	http://www.woundsinternational.com/pdf/content_79.pdf	http://www.rdx1.com/wrc/pdf/w0513_norton_pressure_sore_risk_assessment_scale_scoring_system.pdf
NHI* Wound Assessment Form	n/a	n/a	n/a
Stirling	Reid K, Morrison M (1994) Towards a consensus: classification of pressure ulcers. <i>J Wound Care</i> 3(3): 157–60.	http://www.woundsinternational.com/pdf/content_79.pdf	http://www.scireproject.com/outcome-measures/stirlings-pressure-ulcer-severity-scale
c Continence and Elimination			
Urogenital Distress Inventory Short Form	Uebersax, J.S., Wyman, J.F., Shumaker, S.A., McClish, D.K., Fantl, J.A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory.		http://consultgeriatri.org/uploads/File/trythis/try_this_11_2.pdf

(Udi-6)	Neurology and Urodynamics, 14(2), 131-139.		
Incontinence Impact Questionnaire-Short Form (Iiq-7)	Uebersax, J.S., Wyman, J.F., Shumaker, S.A., McClish, D.K., Fantl, J.A., & the Continence Program for Women Research Group. (1995). Short forms to assess life quality and symptom distress for urinary incontinence in women: the Incontinence Impact Questionnaire and the Urogenital Distress Inventory. <i>Neurology and Urodynamics</i> , 14(2), 131-139.	http://consultgeriatri.org/uploads/File/trythis/try_this_11_2.pdf	
Cleveland Clinic Incontinence Score	Jorge JMN, Wexner SD. Etiology and management of fecal incontinence. <i>Dis Colon Rectum</i> 1993; 36: 77-97.	http://en.wikipedia.org/wiki/Fecal_incontinence	http://www.uhs.nhs.uk/Media/SUHTInternet/Services/Pelvicfloor/Pelvicfloorpatientquestionnaires.pdf
Assessment form for Urinary Incontinence (Nursing Homes Ireland)		n/a	n/a
Fecal Incontinence Severity Index	Rockwood TH, Church JM, Fleshman JW, Kane RL, Mavrantonis C, Thorson AG, Wexner SD, Bliss D, Lowry AC (1999). "Patient and surgeon ranking of the severity of symptoms associated with fecal incontinence: the fecal incontinence severity index". <i>Dis. Colon Rectum</i> 42 (12): 1525-32	http://eprints.usq.edu.au/5790/3/Fallon_Westaway_Moloney_2008_AV.pdf	
(HSE) Continence Promotion Dept./Unit Assessment		http://www.hse.ie/eng/services/Find_a_Service/Older_People_Services/Tips_for_Healthy_Living/Continence_promotion.html	
HSE Continence Assessment		http://www.hse.ie/eng/services/Publications/services/Older/dmlmds.pdf	
HSE Baseline Continence Assessment Tool		http://www.hse.ie/eng/services/Publications/services/Older/dmlmds.pdf	
d Nutrition / Oral health			
Malnutrition Universal Screening Tool (MUST)	Elia M (2003) Screening for Malnutrition: A Multidisciplinary Responsibility. Development and Use of the Malnutrition Universal Screening Tool ('MUST') for Adults. Redditch: BAPEN.	http://www.bapen.org.uk/must_tool.html	http://www.bapen.org.uk/pdfs/must/must_full.pdf
Mini Nutritional Assessment (MNA)	Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). <i>J. Gerontol</i> 2001; 56A: M366-377.	http://www.mna-elderly.com/	http://www.mna-elderly.com/forms/MNA_english.pdf

e Health conditions and risk factors for illness, accident and functional decline			
The Hospital Admission Risk Profile (HARP)	Sager, M.A., Rudberg, M.A., Jalaluddin, M., Franke, T., Inouye, S.K., Landefeld, C.S., Siebens, H., & Winograd, C.H. (1996). Hospital admission risk profile (HARP): Identifying older patients at risk for functional decline following acute medical illness and hospitalization. <i>JAGS</i> , 44(3), 251-257.	http://www.nursingcenter.com/prod/ev/ce_article.asp?tid=807373	http://consultgerirn.org/uploads/File/trythis/try_this_24.pdf
Pain: Numeric Rating Scale (NRS)	McCaffery, M., & Beebe, A. (1993). Pain: Clinical Manual for Nursing Practice. Baltimore: V.V. Mosby Company.	http://consultgerirn.org/uploads/File/trythis/try_this_7.pdf	http://painconsortium.nih.gov/pain_scales/NumericRatingScale.pdf
Pain: Verbal Descriptor Scale (VDS)	Jacox, A., Carr, D.B., Payne, R., et al. (March 1994). Management of Cancer Pain. Clinical Practice Guideline No. 9. AHCPR Publication No. 94-0592. Rockville, MD: Agency for Health Care Policy and Research, U.S. Department of Health and Human Services.	http://consultgerirn.org/uploads/File/trythis/try_this_7.pdf	http://consultgerirn.org/uploads/File/trythis/try_this_7.pdf
Abbey Pain Scale	Abbey, J., Piller, N., De Bellis, A., Esterman, A., Parker, D., Giles, L. and Lowcay, B. The Abbey Pain Scale: A one minute indicator for people with end stage dementia. <i>International Journal of Palliative Nursing</i> ; 2004; 10(1): 6-13.	http://www.bgs.org.uk/Publications/Clinical%20Guidelines/pain%20concise%20guidelines%20WEB.pdf	http://www.apso.org.au/owner/files/pirac4.pdf
Pain Assessment & Advanced Dementia (PAINAD)	Warden, V., Hurley, A.C., & Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) Scale. <i>Journal of the American Medical Directors Association</i> , 4(1), 9-15.	http://www.geriatricpain.org/Content/Assessment/Impaired/Pages/PAINADToolInstructions.aspx	http://consultgerirn.org/uploads/File/trythis/try_this_d2.pdf
Brief Pain Inventory	Cleeland CS, Ryan KM (March 1994). "Pain assessment: global use of the Brief Pain Inventory". <i>Ann. Acad. Med. Singap.</i> 23 (2): 129-38.	http://en.wikipedia.org/wiki/Brief_Pain_Inventory	http://medicine.iupui.edu/RHEU/Physicians/bpisf.pdf
NHI* Residents Comprehensive Assessment Form	n/a	n/a	n/a
f Current medication use			
Beers Criteria for Potentially Inappropriate Medication Use in Older Adults,	Fick, D.M., Cooper, J.W., Wade, W.E., Waller, J.L., Maclean, J.R., & Beers, M.H. (2003). Updating the Beers Criteria for potentially inappropriate medication use in older adults: Results of a US consensus panel of experts. <i>Archives of Internal Medicine</i> , 163(22), 2716-2724.	http://consultgerirn.org/uploads/File/trythis/try_this_16_1.pdf	

Part I			
Beers Criteria for Potentially Inappropriate Medication			
Use in Older Adults, Part II	Fick, D.M., Cooper, J.W., Wade, W.E., Waller, J.L., Maclean, J.R., & Beers, M.H. (2003). Updating the Beers Criteria for potentially inappropriate medication use in older adults: Results of a US consensus panel of experts. Archives of Internal Medicine, 163(22), 2716-2724.		http://consultgeri rn.org/uploads/File/trythis/try_this_16_2.pdf
NHI* Medical Notes			
Form	n/a	n/a	n/a
g Dental/Or al Status			
Kayser-Jones Brief Oral Health Status Examination (BOHSE)			
Status Examination (BOHSE)	Kayser-Jones, J., Bird, W.F., Paul, S.M., Long, L., & Schell, E.S. (1995). An instrument to assess the oral health status of nursing home residents. The Gerontologist, 35(6), 814-824.		http://consultgeri rn.org/uploads/File/trythis/try_this_18.pdf
h Visual Limitations			
i Cognitive ability/patterns and organisation of self-care activities			
Mini mental state examination (MMSE)	Folstein MF, Folstein SE, McHugh PR (1975). "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician". <i>Journal of psychiatric research</i> 12 (3): 189-98.	http://en.wikipedia.org/wiki/Mini%E2%80%933mental_state_examination	http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/geriatrics/education/Documents/MMSE.pdf
Mini-Cog	Borson, S., Scanlan, J., Brush, M., Vitallano, P., & Dokmak, A. (2000). The Mini-Cog: A cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. <i>International Journal of Geriatric Psychiatry</i> , 15(11), 1021-1027.	http://www.hospitalmedicine.org/geriatricsresource/toolbox/mini_cog.htm	http://consultgeri rn.org/uploads/File/trythis/try_this_3.pdf
Confusion Assessment Method (CAM)	Inouye, S., van Dyck, C., Alessi, C., Balkin, S., Siegel, A. & Horwitz, R. (1990). Clarifying confusion: The confusion assessment method. <i>Annals of Internal Medicine</i> , 113(12), 941-948.		http://consultgeri rn.org/uploads/File/trythis/try_this_13.pdf
Abbreviated Mental Test Score	Hodgkinson HM (1972) Evaluation of a mental test score for assessment of mental impairment in the elderly. <i>Age and Ageing</i> 1, 233-8.	http://www.patient.co.uk/doctor/Abbreviated-Mental-Test-(AMT).htm	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2560932/pdf/occpage

		r00113-0035.pdf
Addenbrooke's Cognitive Examination	Mioshi E, Dawson K, Mitchell J, Arnold R, Hodges JR (2006), The Addenbrooke's Cognitive Examination Revised (ACE-R): a brief cognitive test battery for dementia screening, <i>International Journal of Geriatric Psychiatry</i> 21(11):1078-1085.	http://www.stvincents.ie/dynamic/File/Addenbrookes_A_SVUH_MedEl_tool.pdf
Montreal Cognitive Assessment	Michael Lerch et al. Could the Montreal Cognitive Assessment (MoCA) be the new "gold standard" in cognitive evaluation in geriatric patients: a clinical comparison. The Journal of the Alzheimer's Association, Vol. 6, Issue 4, Supplement page S494, July 2010	http://www.stvincents.ie/dynamic/File/Montreal%20cog%20assess_SVUH_MedEl_tool.pdf
The Clinical Dementia Rating Scale	Morris, J.C. (1993) The Clinical Dementia Rating (CDR): current version and scoring rules. <i>Neurology</i> , 43, 2412-4.	http://rgp.toronto.on.ca/dmcourse/toolkit/app5.htm
AD8 Dementia Screening Interview	Galvan, J.E. et al. (2005). The AD8, a brief informant interview to detect dementia. <i>Neurology</i> 2005;65:559-564.	Adapted: http://alzheimer.wustl.edu/About_Us/PDFs/AD8form2005.pdf
Informant Questionnaire on Cognitive Decline in the Elderly	Jorm, A. F. (1994). A short form of the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE): Development and cross-validation. <i>Psychological Medicine</i> , 24, 145-153.	http://en.wikipedia.org/wiki/Informant_Questionnaire_on_Cognitive_Decline_in_the_Elderly http://ageing.anu.edu.au/Iqcode/
Delirium Observation Screening Scale	Schuurmans, M. J., L. M. Shortridge-Bagget, et al. (2003). "The Delirium Observation Screening Scale: a screening instrument for delirium." <i>Research & Theory for Nursing Practices</i> 17: 31 – 50	http://www.primarycareforms.com/delirium%20observation%20score.pdf
j		
Communication, hearing and understanding		
Brief Hearing Loss Screener	Reuben, D.B., Walsh, K., Moore, A.A., Damesyn, M., & Greendale, G.A. (1998). Hearing loss in community-dwelling older persons: National prevalence data and identification using simple questions. <i>JAGS</i> , 46(8), 1008-1011.	http://consultgerirn.org/uploads/File/trythis/try_this_12.pdf
k Mood and behaviour patterns / Psycho-social well-being, adjustment and relationships		
Geriatric Depression Scale	Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M.B., & Leirer, V.O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. <i>Journal of Psychiatric Research</i> , 17, 37-49.	http://consultgerirn.org/uploads/File/trythis/try_this_4.pdf http://en.wikipedia.org/wiki/Geriatric_Depression_Scale
The Impact	Weiss, D.S., & Marmar, C.R. (1997). The Impact of Event Scale-Revised. In J.P.	http://consultgerirn.org

of Event Scale-Revised (IES-R)(PTSD)	Wilson, & T.M. Keane (Eds.), <i>Assessing Psychological Trauma and PTSD: A Practitioner's Handbook</i> (pp. 399-411). New York: Guilford Press.	rn.org/uploads/File/trythis/try_this_19.pdf
The Pittsburgh Sleep Quality Index (PSQI)	Buyse, D.J., Reynolds III, C.F., Monk, T.H., Berman, S.R., & Kupfer, D.J. (1989). The Pittsburgh Sleep Quality Index: A new instrument for psychiatric practice and research. <i>Journal of Psychiatric Research</i> , 28(2), 193-213.	http://consultgeri rn.org/uploads/File/trythis/try_this_6_1.pdf
Cohen Mansfield Agitation Inventory	Cohen-Mansfield, J., & Billig, N. (1986). Agitated behaviors in the elderly I. A conceptual review. <i>Journal of the American Geriatrics Society</i> , 34, 711-721.	http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/cohen-mansfield.aspx
Y-A.B.C. functional analysis tool / record chart		http://wanderingnetwork.co.uk/Cohen%20Mansfield%20Agitation%20Inventory.pdf http://abama.webs.com/abcsofabam.htm http://behaviorgu y.com/Documents/abc_chart.pdf

1 Identification and Background information, Activities and Interests, Special treatments etc.

NHI* core residents details' form	n/a	n/a	n/a
NHI* 'resident comprehensive assessment form'	n/a	n/a	n/a
(Activities and interests only) A key to me			Section K: http://www.hse.ie/eng/services/Publications/services/Older/dmlmds.pdf
(Activities and interests only) Meaningful Activities Assessment		Pool J. (2008) <i>The Pool Activity Level (PAL) Instrument for Occupational Profiling: A Practical Resource for Carers of People with Cognitive Impairment</i> (3rd ed). Jessica Kingsley Publishers, United Kingdom.	Section M: http://www.hse.ie/eng/services/Publications/services/Older/dmlmds.pdf
(Special treatments only) NHI* Therapies form	n/a	n/a	n/a

* NHI – Nursing homes Ireland

Appendix C – Care plan templates

	1) Dublin Mid-Leinster (DML) MDS for Older Persons Care	2) Patient Assessment and Nursing Care Plan	3) Assessment and Care planning Integrated Resident Record and Policy Documentation Set
1. Full name of care plan (template):	DML Minimum Data Set and Resident Care Record. Resident Assessment Instruments (RAIs), Resident Assessment Protocols (RAPs) & Personalised Care Planning. DML Services for Older Persons & The NMPD, September 2010	Patient Assessment and Nursing Care Plan	Assessment and Care planning Integrated Resident Record and Policy Documentation Set
2. Name of care plan development group/team:	DML Documentation Sub Group	Community Hospitals Nursing Documentation Project	Steering Group on Assessment and Care Planning Tool
3. Leader of group/team:	Linda McDermott-Scales (Chairperson)	Christine Grandon – Project Coordinator, Nursing and Midwifery Planning and Development Unit, Cork. Finola Finn and Una Cronin – Documentation Facilitators	Caroline Connelly Practice Development Facilitator, Nursing Homes Ireland
4. Sponsoring body/organisation (if applicable):	HSE DML Services for Older Persons & the NMPD, Palmerstown, Dublin 20	Southern Health Board	Nursing Homes Ireland
5. Date development work began:	September 2008	March 2002	2006
6. Duration of development work:	2 years	Eighteen Months	One year
7. Initial release date:	November 2010	December 2003	2008
8. Last updated/amended:	September 2010	Individual sites may have amended area of document to suit requirements	Currently being reviewed and updated
9. Estimate of number of residential care settings who currently use substantial components of this care plan template.	18 +	Twenty six. Community Hospitals and residential care settings throughout Cork and Kerry – (predominately HSE South Cork/Kerry)	Three hundred and thirty four private and voluntary nursing homes who are members of NHI have access to the document
10. Information on settings that currently use substantial components of this care plan template (to the authors' knowledge)	The documentation is mainly used in the DML HSE region. Centres include private, public & voluntary designated centres for Older Persons.		Care plan made available to all private and voluntary nursing homes throughout Ireland who are members of NHI

11. Brief description of care plan template:	The aim of the care planning process is to develop a tailor made, single plan of personalised care that is owned by the resident, but can be accessed by those providing direct care or by other relevant people as agreed by the resident. Therefore, the Care Plan Template can be used by all members of the multi-disciplinary team.	Assessment and plan of care is based on Roper Logan Tierney Activities of Living template.	Based on Roper Logan and Tierney activities of daily living incorporating the draft standards of HIQA. Contains problem identification sheets, and a number of assessment tools.
12. Special characteristics / features or especially innovative components of care plan template:	The DML MDS is composed of Resident Assessment Instruments (RAIs), which are supported by Resident Assessment Protocols (RAPs). These structured and standardised assessment tools are integrated into a Resident Care Record. The Resident Assessment Instruments provides prompts denoted by the symbol I which prompt nurses for the need of further in-depth assessment in certain areas i.e. by using the Resident Assessment Protocols (RAPs). Prompts are further provided on the RAIs for onward MDT referral, and for care planning. The RAPs while focusing on the requirements of a comprehensive MDT assessment further give direction on personalised care planning and outline protocols for the expected standards of evidenced based care. Flow charts are included with detail care pathways and sample care plans are provided to assist nurses in documenting care. The DML MDS documentation process also includes quality monitoring audit mechanisms.	Coding system in communication and flow chart to highlight any change in patient's condition; triggering the commencement of appropriate documentation to reflect current situation i.e. problem identification page	0
13. Pages (if applicable):	The MDS Manual contains 325 pages.		
14. Is this care plan template free of charge?	Yes	Yes	Only available to NHI members
15. Conditions of use:	No conditions to use applied	Mention source of care plan template components somewhere in the care plan	As above, only available to NHI members to use as a template
16. Contact info:			
Name:	Linda McDermott-Scales	Christine Grandon	Nursing Homes Ireland
Address:	DML Services for Older Persons, 3rd Floor Stewarts Hospital, Palmerstown, D. 20	Nursing and Midwifery Planning and Development Unit, Cork	Unit A5 Centrepont Business Park, Oak Road, Dublin 12
Phone:	01 6201730	021-4927466	01 429 2570
Email address:	linda.mcdermotscales@hse.ie	christine.grandon@hse.ie	info@nhi.ie
17. Internet link to document:	http://www.hse.ie/eng/services/Publications/services/Older/dmlmlds.pdf		

Appendix D – Useful website links

The following websites may be helpful. Beside each is a description taken from the webpage or the relevant 'about' page:

http://www.hiqa.ie/functions_shss_standards_residential_care.asp National Quality Standards for Residential Care Settings for Older People in Ireland

http://www.hiqa.ie/functions_ssi_inspect_rep_older_people.asp Hiqa inspection reports of residential services for older people.

http://hartfordign.org/Resources/Try_This_Series/ A publication of the Hartford Institute for Geriatric Nursing, the *Try This* Series is a set of assessment tools where each issue focuses on a topic specific to the older adult population. The goal of the Try This:® Best Practices in Nursing Care to Older Adults series of assessment tools is to provide knowledge of best practices in the care of older adults that is: easily accessible, easily understood, easily implemented, and to encourage the use of these best practices by all direct care nurses

<http://hartfordign.org/> Since its inception in 1996, the mission of the Hartford Institute has been to shape the quality of nursing care to older adults by assuring geriatric competency of America's nurses. The Hartford Institute, developed with core funding from The John A. Hartford Foundation, is recognized as unique in academic nursing in its focus on disseminating best practices to nursing students, faculty, practicing nurses, and policy makers.

<http://consultgerirn.org/> ConsultGeriRN.org is the evidence-based geriatric clinical nursing website of The Hartford Institute for Geriatric Nursing, at New York University's College of Nursing. ConsultGeriRN.org, an online resource for nurses in clinical and educational settings, is endorsed by the National Gerontological Nursing Association (NGNA), the American Association for Long Term Care Nursing (AALTCN), The National Association Directors of Nursing Administration in Long Term Care (NADONA), and others.

<http://www.pogoe.org/about/> POGOe's mission is to promote geriatric education through the provision and encouragement of free exchange of teaching and assessment materials that support the fields of geriatrics and gerontology.