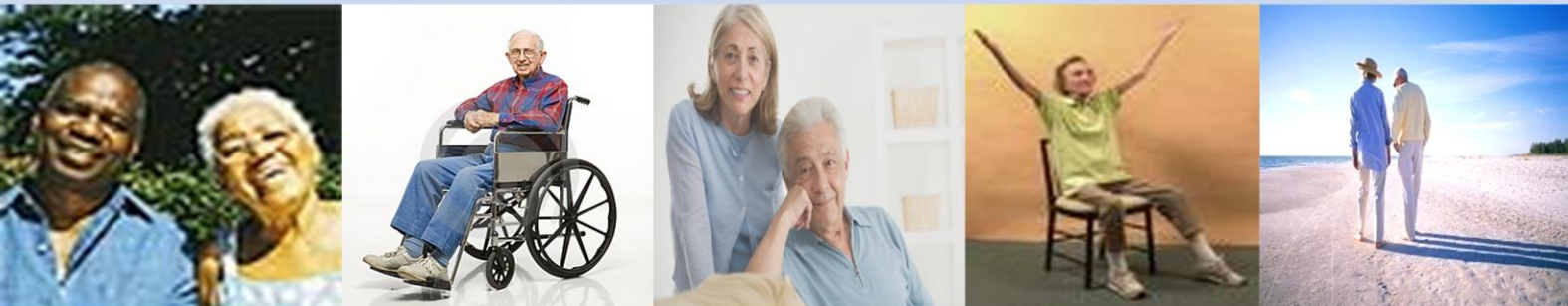




The Northern Ireland Single Assessment Tool (NISAT)

Procedural Guidance

January 2011 (Version 3)



Health and
Social Care

In line with our Communicating Information Well Policy, the Health and Social Care Board is committed to making information as accessible and equitable as possible and to promoting positive and meaningful dialogue with local people.

Alternative Formats

In an effort to make information as accessible as possible, the Northern Ireland Single Assessment Tool (NISAT) Procedural Guidance Version 3 January 2011 has been produced. The Report may also be made available in alternative formats.

For an alternative format, please contact:

Social Care and Children's Directorate
Health and Social Care Board (Northern Office)
County Hall
182 Galgorm Road
BALLYMENA
BT42 1QB

Tel: 028 2531 1216

PREFACE

I take great pleasure in being able to commend this latest version of the Procedural Guidance to underpin the on-going implementation of the Northern Ireland Assessment Tool (NISAT). The Health and Social Care Board (The Board) accepted responsibility for this role from DHSSPS in August 2009 and is fully committed to the concept of a tool which optimises inter-disciplinary co-operation and improves the experience for patients and clients by minimising replication of assessment and promoting more consistent practice.

A great deal of effort was devoted to the production of the initial version of the NISAT but practical application of it within services for older people has highlighted the need to tailor it to new operational realities such as the vigorous promotion of integrated team structures across the region. The NISAT must continue to respond to such changes in a timely fashion and the latest version of the tool is proof of this commitment.

We are also cognisant of the need to consider the further application of the NISAT within other Programmes of Care and confident that this guidance will be capable of being applied in those areas of activity if required. The Project Team, however, remains open to selective, necessary fine tuning as requested.

I hope that this guidance succeeds in its aim of providing clear guidance to front line professionals, standardising and improving assessment practice and, ultimately ensuring that patients and clients receive services which are responsive to and appropriate for their needs.



F McAndrew

Director of Social Care and Children

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THE NORTHERN IRELAND SINGLE
ASSESSMENT TOOL
(NISAT)

**PART 1: KEY CONSIDERATIONS AND
PROCESSES**

KEY CONSIDERATIONS IN RELATION TO THE NISAT

GOOD PRACTICE IN ASSESSMENT USING A PERSON-CENTRED APPROACH

Adopting a person-centred approach is a fundamental requirement when using the NISAT.

“The promotion of autonomy and personal growth in older people is a reflection of the person-centredness of the assessment process. A person-centred process encapsulates the desires and goals of the individual as expressed by the individual. Only through a deep knowledge of the person can one begin to promote personal growth and freedom.”

Slater P and McCormack B (2005)

- ✓ Consider the older person holistically in the context of their past life and present situation, their preferences, values and future wishes.
- ✓ Respect diversity in relation to language, race, culture, religion, gender and age.
- ✓ Approach assessment without preconceptions or assumptions in relation to the older person's needs or wishes.
- ✓ Recognise and capture the older person's skills and abilities and consider help and support that will encourage independence and self-care throughout the assessment process.
- ✓ Create a relationship based on respect, empathy and trust between assessor, the older person and those involved in their care.
- ✓ Ensure honesty, realism and openness is integral throughout all stages of the assessment process.
- ✓ Avoid addressing needs in terms of ability or inability to provide a service.
- ✓ Approach assessment as a partnership between the older person and others involved in their care by including them at each stage of assessment, planning, monitoring and review.
- ✓ Ensure maximum participation in the assessment process, regardless of capacity.
- ✓ Recognise and support the individual through major life transitions involving loss.
- ✓ Incorporate the different perspectives of those involved in the assessment and negotiate and conciliate between people who have different perceptions, values, attitudes, expectations, wants and needs.
- ✓ Approach assessment as a process of interconnected activities occurring over a period of time, not a single event.

- ✓ Ensure good practice in preparation, discussion, collaboration with others involved in the older person's care and monitoring and review of service delivery.
- ✓ Consider the most advantageous environment for assessment to maximise participation and ensure privacy.

REHABILITATION AND RE-ENABLEMENT

Rehabilitation can be defined as “the process of helping a person achieve the highest level of function, independence and quality of life possible”. Re-enablement extends beyond this definition and includes “helping people to adapt to changes in their life circumstances. It is a shared activity between the affected person, other people close to them, the multi-professional team and recognises the older person as experts on themselves and their own needs.”

(Royal College of Nursing, 2000)

Throughout assessment you should identify opportunities for Rehabilitation and Re-enablement.

Remember that:

- To apply the philosophy of rehabilitation and re-enablement you will need to use a person-centred approach (See above);
- All people, regardless of age should have access to services;
- Options should be selected in partnership with the individual; and
- Success of re-enablement should be judged from the perspective of the older person.

PALLIATIVE AND END OF LIFE CARE

Palliative care is defined as “the active, holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is to achieve the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.”

(World Health Organisation, 2002)

More latterly the importance of “early identification and impeccable assessment” has been added to this definition.

(Sepulveda et al, 2002)

Whilst assessing the older person's requirement of health and social care services, it is important to determine if and when the individual requires palliative and end of life care. This enables the development of advance care plans based upon the person's choices, for example, their preferred place of care, taking care of financial and family affairs and anticipating physical adaptations required to maximise quality of life.

End of life care is an integral part of palliative care and helps all those with advanced progressive and incurable conditions to live as well as possible until they die. End of life has been defined as the period of time during which an individual's condition deteriorates to the point where death is expected (DHSSPS, 2009).

When completing the assessment you should recognise that:

- ✓ This point will be different for each individual and will often depend on an assessment of their condition by health and social care professionals, carer and/or the patient themselves;
- ✓ Identifying the point at which illness becomes advanced or reaches the end of life phase allows planning best care for people in order to meet their needs and those of their families and carers throughout the last phase of life and into bereavement; and
- ✓ As with palliative care, end of life care also includes physical care, management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

HUMAN RIGHTS

You should consider the Human Rights of the older person throughout the assessment process. Those of particular relevance to health and social care are:

Article 2:	Right to life;
Article 3:	Right not to be subjected to inhuman or degrading treatment;
Article 5:	Right not to be arbitrarily deprived of liberty (and security);
Article 6:	Right to a fair hearing;
Article 8:	Right to respect for private and family life (including life without interference, to form friendships and relationships, enjoy sexuality and also covers sharing of information);
Article 9:	Freedom of thought, conscience and religion;
Article 10:	Freedom of expression (the right to share information and hold and express opinions and ideas);
Article 12:	Right to marry and found a family; and
Article 14:	Prohibition of discrimination.

(The Human Rights Act, 1998)

ADVOCACY

“Advocacy seeks to support individuals to express and have their views heard. It aims to redress the imbalance of power between the individual and professional. It is concerned with empowerment, autonomy and self-determination, the safeguarding of citizenship rights and the inclusion of otherwise marginalised groups.”

(The Bamford Review “Living Fuller Lives” 2007)

When carrying out your role as advocate:

- ✓ Use different approaches, such as engaging with others involved in the older person’s care to ascertain previous views or decisions where the older person has difficulty engaging in the assessment process;
- ✓ Identify legal arrangements;
- ✓ Be alert to the need for and source independent advocacy services, where necessary. All staff should also be aware of the free advocacy services offered by the Patient and Client Council and the voluntary sector and how to access them;
- ✓ Adhere to professional codes of conduct; (See also **Appendix 5 “Contact Details for Professional Regulatory Bodies”**)
- ✓ Ensure you highlight the older person’s views throughout the decision-making process with others involved in their care; and
- ✓ Ensure the older person’s voice is heard.

Note: When considering advocacy, consent and vulnerability issues in relation to the older person and who should interpret on his/her behalf, remember that:

- Family members may not necessarily communicate the true wishes and feelings of the older person;
- The older person may be reluctant to disclose information through a relative or acquaintance, e.g. if feeling under threat;
- The person(s) “helping” to translate on behalf of the older person must concentrate on the views and wishes of the older person and not their perspective of what is “best” for the person; and
- Children or young people should not have the burden of communicating potentially intimate details of that older person’s life.

DIRECT PAYMENTS

Within the NISAT Core component (“Work, Finance and Leisure” p13) assessors are prompted to ask about receipt of Direct Payments. Choosing Direct Payments enhances choice and supports independence.

“Direct Payments are cash payments given to persons in lieu of services that would otherwise have been arranged for them by HSS Trusts, so that they may arrange the provision of their own services. Direct Payments allow greater flexibility for service users, allowing them to make arrangements with providers of their own choice and at times convenient to them.”

(DHSSPS 2005)

Be aware of legislation and Trust guidelines in relation to Direct Payments

During the assessment process discuss the option of Direct Payments with the assessed person and/or carer. Sufficient information and time should be given in order for the assessed person to consider the suitability of these payments to meet their individual need and support required to manage them.

Assessment of need should be carried out in the same way and depth whether the older person chooses to receive services or Direct Payments.

FUEL POVERTY

Consideration of potential fuel poverty and repercussions of this on the person’s environment and therefore their health and social well-being is a main consideration during assessment.

Fuel poverty is defined as:

“A household is in fuel poverty if, in order to maintain an acceptable level of temperature throughout the home, the occupants would have to spend more than 10% of their income on all household fuel use”

(DSDNI 2004)

Be aware of legislation, strategies and Trust guidelines in relation to Fuel Poverty.

The World Health Organisation defines a satisfactory heating regime as 21°C in the living room and 18°C in other areas, although householders with specific needs may require different levels of heating.

Identify potential contributory factors when assessing the older person, such as evidence of cold and/or damp, energy costs and concerns they may have in relation to their living arrangements.

Work in partnership with the older person, their carer and appropriate services when planning action to address fuel poverty.

KEY PROCESSES IN RELATION TO THE NISAT

CONSENT

(See also *“Practitioner Manual”* - Section A, Page 26)

Consent is an integral to the assessment process. A NISAT Consent Form is provided to be used in conjunction with the Tool. The older person is asked to consent:

- a) **To share his/her information with others involved in his/her care;**
- b) **To information being obtained from others in relation to their health and social care needs; and**
- c) **To be referred for further assessment where appropriate.**

Restrictions in relation to information sharing are also captured on this form.

The principles of Consent are listed below:

- ✓ It is assumed that a person has capacity to consent unless the contrary is shown.
- ✓ All practicable steps are taken to help a person make a decision and consent is reviewed as an on-going process and is as inclusive as possible.
- ✓ The consent is a “freely given informed indication of the individual’s wishes”.
- ✓ The older person understands the purposes for which information will be used.
- ✓ The older person is aware of how and potentially with whom the information will be shared.
- ✓ The older person is aware of his/her right to restrict parts or all of the information given and the impact, if any, this may have on the delivery of safe and effective care and/or services.
- ✓ Where a person lacks capacity to consent, act in the best interests of that person and consider if action resulting from the decision-making process could be achieved in a less restrictive way. Involve those who may know the older person and could give opinion on former wishes and decisions made by them.
- ✓ The purpose for which confidential information is used can be justified, if required to do so.
- ✓ Information is shared only when necessary and on a “need to know basis”.
- ✓ The minimum information required is used.

- ✓ Be clear with the older person and/or carer that there may be particular circumstances in which confidentiality has to be broken and information shared, for example, someone at risk of harm, public safety is at risk or a crime has been committed.

VULNERABLE ADULT AND POTENTIAL ABUSE ISSUES

A vulnerable adult is defined as “a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.”

(“Safeguarding Vulnerable Adults”, the Regional Adult Protection Policy and Procedural Guidance (September 2006))

Throughout the NISAT you are prompted to consider situations where the older person could be seen as a ‘vulnerable adult’, or could be potentially subject to abuse. The investigation of abuse of a ‘vulnerable adult’ is regarded as a specialist assessment and, therefore where concerns about possible abuse are raised referral should be made to the appropriate Designated Officer within the Trust as soon as possible. Assessment of the individual’s wider health and social care needs will have to be progressed in tandem with any investigation into abuse.

You should consider:

- ✓ Conditions and circumstances that may make the older person “vulnerable”. For example:
 - Poverty
 - Environment
 - Social or emotional isolation
 - Deteriorating physical or mental health
 - Reduced ability to make decisions or choices
 - Exploitation or poor family dynamics.
 - A carer overwhelmed with caring responsibilities
- ✓ Information given by the older person or others involved in their care.

Note: Remember the older person’s right to self-determination in relation to the action you take.

- ✓ Your professional observations and judgment.
- ✓ Departmental and Trust guidelines and protocols in relation to safeguarding vulnerable adults.

- ✓ Investigation where potential abuse is triggered. Areas highlighted in the NISAT include; physical, psychological, financial, sexual, neglect, age, institutional, racial, religious, stranger, domestic, familial and verbal abuse.
- ✓ Potential for abuse of others due to the behaviour of the older person.

COLLABORATIVE WORKING

Recent policy and modernisation agendas all advocate collaborative and partnership working. Collaborations across health and social care boundaries have been defined as:

“a way of working with others on a joint project where there is a shared interest in positive outcomes.”

(Sullivan and Sketcher, 2002)

The gathering and sharing of information using the NISAT relies on interagency and inter-professional collaboration if it is to be effective in planning care and reducing duplication. This requires:

- Trust in each other’s ability to assess effectively;
- Understanding of and respect for the roles and responsibilities of other professionals; and
- A belief in the need to keep the older person at the centre of assessment and planning of his/her care.

ASSESSING RISKS TO INDEPENDENT LIVING

At any stage of the assessment process, risks to the older person's ability to remain independent may become apparent. Risk is a concept which often has negative connotations in health and social care. However, to attempt to avoid risk altogether constrains the choices people can make and reduces empowerment.

"Services must be delivered in a way that appropriately manages risk for service users, carers, the public and visitors... It is acknowledged, however, that in some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking can be considered to be a positive action. Health and social care staff need to work in partnership with service users and carers to explore choices and agree on how risk can be managed and minimised for the benefit of individual service users, carers, families and communities."

**(Quality Standards for Health and Social Care, DHSSPS, (2006),
Theme 2 - Safe and Effective Care)**

When using the NISAT you should:

- ✓ Approach assessment of risk in the above context;
- ✓ Support decision-making, autonomy and choice by:
 - Using a person-centred approach;
 - Capturing the older person's perspective on the risks to his/her independent living and that of others involved in his/her care, including your own;
 - Facilitating discussion where the views and perspectives of all are considered; and
 - Outlining consequences if risks are not addressed and record the level of risk accepted by the older person and others involved in care;
- ✓ Relate risk to the person's ability to remain independent. Consider this in four areas:
 - Autonomy and choice;
 - Health and safety;
 - Ability to manage daily routines; and
 - Involvement in family and community life.

See also ***"Practitioner Manual" - Section A, Page 25.***

CARER'S SUPPORT AND NEEDS ASSESSMENT

See also "*Practitioner Manual*" – Section A, Page 27.

The Act places a requirement on Trusts to inform carers of their right to a carer's assessment and gives Trusts the power to supply services directly to carers to help the carer in their caring role. This change includes a statutory right to a carer's assessment which allows for an assessment to be carried out even where the person cared for has refused an assessment or the provision of personal social services.

**(Carers and Direct Payments Act (NI) 2002
Carer's Assessment & Information Guidance)**

Informal carers play a vital role in the care of the older person. The NISAT provides a **Carer's Support and Needs Assessment** as an additional component to be used to:

- Enrich information gathered in relation to the older person;
- Facilitate an independent assessment for the carer in his/her own right;
- Recognise the role of the carer, his/her contribution to the life of the older person and the impact this has on his/her daily life; and
- Identify the support required by the carer in order to sustain his/her caring role.

In relation to the use of the NISAT, assessors should:

- Be aware of criteria, policy and guidance in relation to Carer's Assessment;
- Where carers are identified, routinely offer an independent assessment of their needs; record reason for carer's refusal of the offer of assessment and provide contact details to facilitate access where the carer changes his/her mind
- Consider financial options that could be provided directly to support the caring role, including Direct Payments and benefit maximisation;
- Apply the principles of person-centred assessment when completing this component of the NISAT with the carer;
- Seek the carer's views at all stages of assessment of the older person where his/her contribution will assist holistic assessment;
- Be alert to the possibility that a carer may need access to services in his/her own right; and

- Be alert to the presence of a young carer.

Note: It is important to ensure that children and young people do not assume caring roles that will disrupt their education or adversely impact on their development, health or well-being. Where a young carer is identified refer to Trust guidelines in respect to action that is required.

THE NORTHERN IRELAND SINGLE ASSESSMENT TOOL (NISAT)

PART 2: THE PRACTITIONER MANUAL

SECTION A: The NISAT, Completion and Associated Roles

SECTION B: The Process Guidance

SECTION A: The NISAT, Completion and Associated Roles

WHAT IS THE NISAT?

- The Northern Ireland Single Assessment Tool (NISAT) is designed to capture information required for holistic, person-centred assessment of the older person.
- It is structured in component parts and using domains which will be completed according to the level of health and social care needs experienced by the older person, from non-complex to complex.
- The NISAT will support and guide you through an assessment with a clear person-centred focus and give you a structure to record information you have gathered. As a result you will be able to identify what support, treatment or care that older person may need and where necessary trigger to Specialist Assessment.

Note: Single Assessment is not an assessment carried out as a single event; it is an assessment unique to the older person using a standardised approach and recorded on a single record. Information accumulates as the assessment process progresses and is dependent on contributions from all those involved in the older person's care. Effective sharing of this information and good practice in assessment will be essential when using the NISAT.

WHAT ARE THE BENEFITS OF USING THE NISAT?

- You will be using a well researched tool, based on literature, policy and good practice. During its development contributions were made by practitioners from different professional backgrounds and grade, senior Trust managers, representatives from voluntary organisations such as Help the Aged and Carers NI, older people and their carers. Throughout implementation the NISAT has had further refinement to ensure compatibility with an Information and communication technologies (I.C.T.) solution and due to feedback from practitioners following a period of use in practice.
- The NISAT focuses on the older person's abilities and strengths, rather than disabilities. This will enable you to highlight opportunities for rehabilitation, re-enablement or support available to maintain his/her current way of life. Where this is not possible, you will be able to identify the most appropriate care available to meet his/her needs.
- The NISAT will help you focus on the older person as the 'expert' on his/her own life. You will see the older person in the context of his/her past life and current situation. It will help you capture his/her views on his/her health and social care needs and how these should be met.

- You will be able to capture the older person's goals and aspirations for the future. By working with him/her to plan the care and support he/she needs to achieve these, you will be promoting independence, autonomy and choice for that person.
- You will be able to record the perspective of others involved in the older person's care, including your own, to create a holistic picture of the older person.
- The information you gather will support your decision-making so that you can make appropriate referrals, and provide evidence of unmet need where services or other provisions are needed.
- The NISAT can be used to assess all levels of health and social care needs for those requiring short, intermediate or long-term care and can be used in many settings.
- By using the NISAT you will avoid the need to duplicate information. This will reduce the overall time currently spent on assessment and reduce the need for older people to repeat the same information many times to different practitioners.
- The NISAT will support good practice in assessment and collaborative working. You will be able to share information with others more easily and contribute to assessment in a more effective way as all health and social care staff will be familiar with the same assessment framework and process.
- Where you identify unmet need, this can be recorded to inform future service planning and collate statistics.

HOW DOES THE NISAT WORK?

- Each component is completed to build up information as the assessment process progresses.
- The number of components completed depends on the complexity of the older person's health and social care needs.
- Completed components are then shared with others involved in the older person's care to avoid duplication of information and to inform further assessment.
- Assessment can stop at any stage if enough information has been gathered to address the older person's needs.
- If needs change the information can be reviewed, additions made and, where necessary, more in-depth assessment may be triggered.

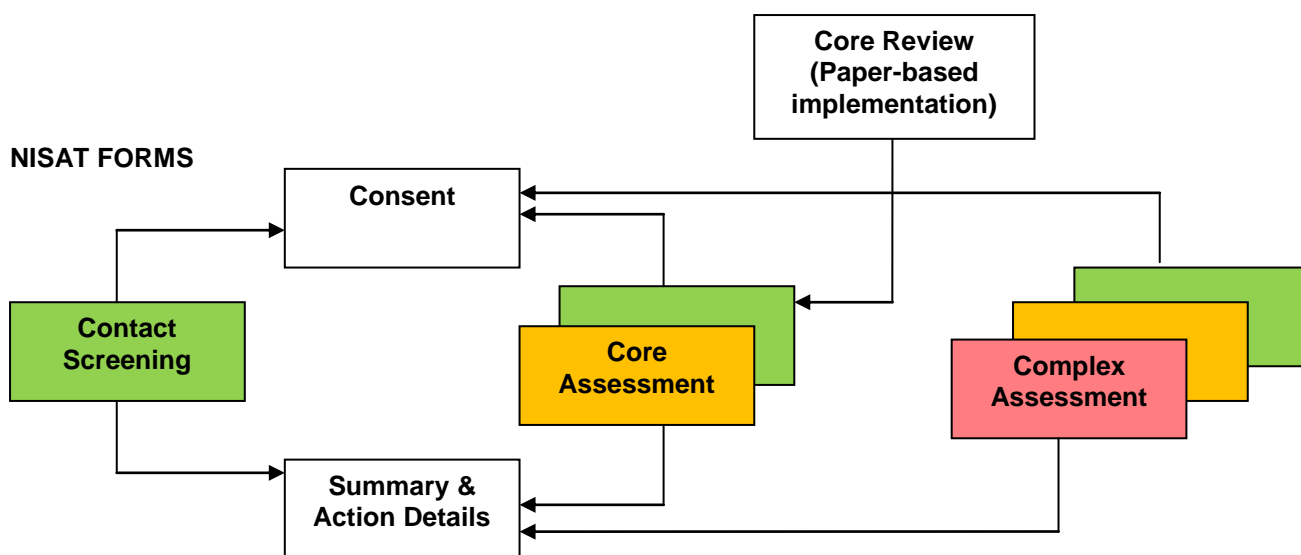
WHAT DOES THE NISAT LOOK LIKE?

The NISAT has been designed in components to be used to gather information at a level appropriate to the assessed person's health and social care needs. It has three primary components:

- **The Contact Screening.**
- **The Core Assessment.**
- **The Complex Assessment.**

Essential forms for use in association with these three primary components are:

- **Summary and Action Details.**
- **Consent.**
- **Core Review** (paper-based implementation).



There are also three additional components which can be used in conjunction with the above:

- **A Specialist Assessment Summary.**
- **A GP and Medical Practitioner Report.**
- **A Carer's Support and Needs Assessment.**

WHAT ARE THE AIMS OF EACH COMPONENT?

Contact Screening

AIMS

- Capture referral, allocation and initial assessment information.
- Identify key people important to the older person, including past and present professionals involved in their care and services, if any, received.
- Alert the assessor to the presence of wider health and social care needs that may require further assessment.
- Record potential carer's need, request and offer for Carer's Assessment.
- Enable 'one-off' interventions to be captured.
- Trigger appropriate onward referral for further assessment.

Core Assessment

AIMS

- Capture information on all aspects of the older person's life.
- Capture details of the older person's life history.
- Capture the older person's perspective on present health and social care needs and future goals and wishes.
- Capture professionals' views and those of the main carer and others involved in the older person's care.
- Capture the strengths and abilities of the older person and opportunities for rehabilitation.
- Identify key areas of need that require referral for specialist assessment or action.
- Identify needs and risks to independent living at an early stage so that preventative measures can be considered.
- Trigger appropriate onward referral for further assessment.
- Inform Complex Assessment.

Complex Assessment

AIMS

- Collate and summarise evidence gathered through all levels of assessment to support an application for funded care.
- Gather the older person's and carer's views, expectations and concerns regarding their ability to remain at home.
- Identify the older person's ability to participate in their care.
- Identify the carer's ability to participate in the older person's care or continue to carry out their caring role. This assessment should incorporate information gathered through the Carer's Support and Needs Assessment.
- Identify, where the need for transitional living and permanent placement is identified, the rationale, choices available and views of the older person and carer regarding change of domicile.
- Maximisation of benefits to support home living or identifying financial status relating to transitional living and permanent placement.
- Outline measures taken to address disagreement, concerns and issues raised during discussions.
- Trigger appropriate onward referral for further assessment.

Summary
and Action
Details

AIMS

- Capture risk including description, type, identified by and consequences if risks are not addressed.
- Identify the older person's / carer's understanding and acceptance of risk.
- Capture needs including category, level of severity, identified by, care aim and outcome.
- Collate an overall consequence and level of understanding and acceptance of risk and/or need.
- Outline action type, details and responsibilities to ensure action taken and when as a result of assessment.
- Identify agreement, disagreement, concerns and issues in relation to proposed actions and action taken to resolve these.
- Outline unmet need and action taken to address this.

Consent

AIMS

- Confirm the older person's consent to share information with those involved in their care and obtain information from others.
- Identify the older person's understanding in relation to the purpose of sharing information and their right to withdraw consent.
- Outline restricted information and to whom restriction applies.

Review

AIMS

- Capture existence of a Core Assessment and date of any previous reviews.
- Capture reason for review.
- Capture the older person's awareness of and ability to participate in their review.
- Identify the component(s) to be reviewed and details of change.
- Capture the views of carers and others.
- Record the assessor analysis and summary.

The Specialist
Assessment
Summary

AIMS

- Outline a summary of the specialist assessment carried out, treatment given and progress made.
- Outline recommendations in relation to future health and social care needs.
- Identify where onward referral has been made.

GP and Medical
Practitioner
Report

AIMS

- Outline the older person's medical history, medication, current clinics attended or on-going investigations.
- Outline key considerations for onward referral to other specialists from the GP.
- Identify potential for rehabilitation/re-enablement.
- Identify concerns in relation to the carer and their ability to cope with their caring role.
- Outline actions taken and referrals made.

Note: Individuals undergoing Complex Assessment should be considered for referral to a medical practitioner with expertise in assessment of older people e.g. a geriatrician or GP with specialist interest.

Carer's Support
and Needs
Assessment

AIMS

- Provide support to the carer in relation to their caring role.
- Gather personal details about the carer, the care they provide for the older person and how their caring role affects their daily life.
- Gather the carer's views on their desire to continue in their caring role and support they may need to do so.
- Gather information to inform assessment of the older person.

WHAT IS EACH COMPONENT, WHEN IS IT COMPLETED AND BY WHOM?

A description of the components and when they are completed is outlined in **Table 1** below.

TABLE 1: COMPLETION OF THE NISAT'S COMPONENT PARTS

COMPONENT	DESCRIPTOR	WHEN
CONTACT SCREENING	The Contact Screening incorporates referral, screening, allocation and initial assessment information.	<p>“Referral, Referral Screening and Allocation” When required as a source of referral information. Where Trust referral systems exist it may not be necessary to complete the referral, screening and allocation sections.</p> <p>“Contact Screening and Initial Assessment” On first contact between the older person and health and social services where a referral has been received and accepted regardless of priority.</p> <p>For short-term interventions.</p>
CORE ASSESSMENT	The Core Assessment gives a holistic overview of an assessed person’s health and social care needs. This may be sufficient to identify and describe assessed needs. If not, it should trigger a Specialist (in-depth) Assessment or Complex Assessment where appropriate.	<p>When presenting needs are identified at Contact Screening that require further assessment.</p> <p>Where there is multi-professional involvement.</p>
COMPLEX ASSESSMENT	The Complex Assessment collates findings from current assessments in order to evidence need for support services or change of domicile. This is informed by information captured on all other components of NISAT	<p>Where the level of support or treatment is likely to be intensive over a short or long period of time.</p> <p>Where care requires co-ordination due to the intensity, complexity and amount of health and social services input required.</p> <p>Where a change of domicile is being considered.</p>

COMPONENT	DESCRIPTOR	WHEN
ASSESSMENT SUMMARY AND ACTION DETAILS	The Assessment Summary and Action Details records the identified multi-disciplinary risks, needs and action associated with the current assessment.	<p>This should be recorded at the end of the assessment process regardless of the number of components completed.</p> <p>There should only be one “Assessment Summary and Action Details” completed based on the most up-to-date assessment. This may be updated as necessary as needs change and additional activities are planned</p>
CONSENT	Records consent of the older person to share and/or obtain information. It also outlines information to be restricted.	<p>The NISAT consent should be used at each level of assessment.</p> <p>It is completed on initial contact with the older person and reviewed and updated as necessary on subsequent assessment.</p>
CORE REVIEW (Paper-based implementation)	<p>This form relates to review of assessment information captured on the Core Assessment.</p> <p>It captures changes which will not significantly impact the information contained within the Core Assessment.</p>	Minimal assessment details change, however, completion of a new Core Assessment will not be required.
SPECIALIST ASSESSMENT SUMMARY	<p>This captures a summary of Specialist Assessment(s) carried out, treatment or therapy given and a summary of progress.</p> <p>Recommendations in relation to the older person’s risks and health and social care needs are also requested.</p>	<p>The Specialist Assessment Summary should be completed where a request has been made for specialist input to the assessment process and returned to the referrer.</p> <p>A copy of a full Specialist Assessment may not be required where this form is completed.</p>

COMPONENT	DESCRIPTOR	WHEN
GP AND MEDICAL PRACTITIONER REPORT	This captures aspects in relation to the older person's physical health, key considerations for onward referral, concerns in relation to the carer and recommendations for future care.	The GP and Medical Practitioner Report should be sought when input is required at Core or Complex level of assessment.
CARER'S SUPPORT AND NEEDS ASSESSMENT	<p>This assessment captures a holistic assessment of the level of care given by the carer, aspects of their life affected by their caring role and their views and future wishes.</p> <p>It also records contingency plans, facilitates referral, identification of unmet need and action planning to support the carer</p>	<p>Where a carer requests or is offered and accepts individual assessment.</p> <p>Where prompts within the cared for person's assessment indicates a potential need for a comprehensive Carer's Support and Needs Assessment.</p> <p>Where information is required to complete the cared for person's assessment.</p>

HOW DO I COMPLETE THE NISAT?

NISAT will support you to carry out good practice in assessment using a person-centred approach. The guidelines below will remind you of the important elements of good practice outlined in Part 1 which should be applied when using NISAT. Further details on the process of using the NISAT is outlined in “**Section B: The Process Guidance**”.

PRIOR TO ASSESSMENT

- ✓ Attend training and familiarise yourself with training materials provided. If you are unfamiliar or uncertain in relation to the completion of NISAT, liaise with a competent practitioner.
- ✓ Understand the background and ethos of NISAT.
- ✓ Know health and social care policies and guidelines within your area.
- ✓ Become familiar with the structure and contents of NISAT.
- ✓ Approach assessment as a partnership between the older person and others involved in his/her care, based on respect, empathy and trust.
- ✓ Approach assessment without preconceived ideas or assumptions about the needs of the older person, or how problems may affect his/her quality of life.
- ✓ Identify and arrange the most appropriate time and setting for assessment to maximise participation and ensure privacy.
- ✓ Give an outline of the benefits of single assessment to the older person. This should include the aim to improve information-sharing and to reduce the need for the older person to repeat information about their health and social care needs to practitioners.
- ✓ Give an indication of the process of assessment including how information is to be shared, how information has been gathered prior to assessment, those who have been, or are to be, involved in the assessment and the method(s) to be used, i.e. telephone, face-to-face contact, discussion with others.
- ✓ Remember that this is an assessment unique to the older person and should result in creative, individualised action planning.

DURING ASSESSMENT

- ✓ Keep the older person central to the assessment process. (See also **NISAT Guidance, Part 1, Page 1, “Good Practice in Assessment”**)
- ✓ Respect diversity in relation to language, race, culture, religion, political opinion, gender and age.
- ✓ Consider the older person holistically in the context of his/her past life and present situation, his/her preferences, values and future wishes.
- ✓ Recognise and support the individual through major life changes and transitions involving loss.
- ✓ Only complete the component(s) of NISAT appropriate to your role and level of competence.
- ✓ As a professionally trained member of staff you may be responsible for the completion of all or parts of the NISAT.
- ✓ Use the questions and prompts included in the NISAT to guide you through the assessment, aid discussion with the older person and structure information you record.
- ✓ NISAT uses a combination of questions with potential for ‘tick-box’ and ‘free-text’ answers. Where a question has ‘yes’ or ‘no’ options and where ‘no’ is answered, provide an explanation, where sought, and move to the next question. Where a number of options are available, one or more box may be ticked and further details given.
- ✓ Cross-reference or refer to information already gathered if appropriate.
- ✓ Keep the assessment appropriate and proportionate to need. In order to do this:
 - Be aware of the contents of NISAT.
 - Identify the domains that are most relevant to the assessed person.
 - Prioritise these to initiate assessment.
 - Complete additional domains if issues or needs become apparent as the assessment progresses.
- ✓ Each component uses person-centred, positive terminology to encourage maximum participation of the assessed person in his/her assessment. Use this when speaking to the older person and avoid using professional jargon.
- ✓ Recording of the older person’s views may be in their own words.
- ✓ Ensure that NISAT does not become a barrier between you and the older person. Information can be filled in after assessment and will be compiled on an on-going basis.
- ✓ Within the Core component your professional observation can be captured within each domain in the ‘**Assessor’s Perspective**’ text box if required. This should be used as an ‘aide memoire’ for each specific domain. A detailed summary is captured at the end of the assessment.

- ✓ Where a carer or family member is contributing to the assessment, their information may be captured in the **'Views of Carers and Others'** section at the end of the assessment.
- ✓ The capture of the older person's and/or the carer's perspective is not optional and is essential throughout the assessment process to maintain a person-centred focus.

Note: Initial completion of the Core Assessment domains should be carried out by one assessor to ensure consistency and manageability.

AFTER ASSESSMENT

- ✓ Consider the information given. Where there are gaps; either contact the older person or others involved in his/her care for clarification.
- ✓ Complete the **'Assessor Analysis and Summary'** section to record your views at the end of each component. In this section within the Core and Complex Assessment consider the assessed person's ability to remain independent in terms of 'Autonomy and Choice', 'Health and Safety', 'Ability to manage Daily Routines' and 'Involvement in Family and Community Life'. A full explanation of these headings is given in **Table 2**.
- ✓ **'Views of Others'** relates to information given by anyone else involved in the older person's care. These may be obtained from other practitioners, family members or formal carers.
- ✓ Record the assessment process used on completion of the assessment. This includes the method of assessment used, sources of information, contributors to assessment and location where this has taken place.
- ✓ Discuss the findings of assessment with the older person, carer and others involved in their care. Suggest referrals to be made and/or potential action to be taken.
- ✓ Inform the older person and carer that where onward referral is triggered from NISAT, acceptance criteria may apply for that profession or service and where possible advise what these are.
- ✓ Consider action which will support the older person's goals, abilities and strengths and maintain or improve his/her current health and well-being status, such as rehabilitation.
- ✓ Complete the **"Assessment Summary and Action Details"** component of the NISAT (See also **"Practitioner Manual"** - Section A, Page 33).
- ✓ Be open and honest regarding services or support that can be provided within your area.
- ✓ Promote independence by encouraging the older person to take action. They may wish to do this where possible, e.g. to contact his/her GP or self-refer to services.

- ✓ Offer a copy of the assessment and subsequent action plan to the older person.
- ✓ If you are unfamiliar or uncertain of action to be taken as a result of assessment seek advice from other professionals, agencies, or ask your line manager.

TABLE 2: EXPLANATIONS OF FACTORS OF INDEPENDENT LIVING

Autonomy and Choice:

This refers to the control a person has over their immediate situation and the extent to which they are able to make and act on informed choices.

Health and Safety:

This considers issues of risk to the health of the individual. It includes mental health, emotional well-being and physical health, in relation to maintenance of current health status and prevention of deterioration. Safety has two aspects, a) the safety of a person from harm, which could be caused by him/herself, others or his/her environment and b) the safety of others, including family members, from harm caused by the person.

Ability to Manage Daily Routines:

The ability of a person to look after his/her own personal care, domestic needs and other daily routines.

Involvement in Family and Community Life:

This refers to a person's ability to be involved in family life, social networks and activities within their community. It also includes recognition of individual's social roles and responsibilities, including caring for others. The ability of the individual to work, carry out training, education or pastimes, if desired, is also considered.

(DOH 2003, "Fair Access to Care")

WHEN AND HOW DO I REFER FOR A MORE IN-DEPTH ASSESSMENT?

NISAT is a uniquely holistic tool, capturing information on all aspects of a person's life, and therefore, you must use a combination of **practitioner judgment, experience, knowledge of services in your area and collaborative working** in order to make appropriate and timely referral for further assessment if indicated.

- ✓ As a result of Contact Screening, Core or Complex Assessment where you determine there is a need for specialist input refer to the appropriate professional(s). If required request completion and return of the '**Specialist Assessment Summary**'.
- ✓ Where a need for input from a GP or Medical Practitioner is required request completion and return of the '**GP and Medical Practitioner Report**'.

- ✓ Current referral processes for Specialist Assessments within your Trust may still apply.
- ✓ It is not necessary for the specialist to return an in-depth completed Specialist Assessment.
- ✓ Attach any other completed NISAT components on a 'need to know' basis or alert the practitioner to the existence of a completed NISAT.

WHAT IF THE PERSON CANNOT PARTICIPATE FULLY IN THEIR ASSESSMENT?

- ✓ Ensure maximum participation in the assessment process according to individual capacity.
- ✓ Complete the '**Assessed Person's Awareness**' section at the beginning of each component of the NISAT. This will give an indication of the person's level of awareness of, and ability to participate in, their assessment. Where there is partial or no ability to participate in the assessment the reason should be outlined.
- ✓ Where the person is not able to participate in the assessment and information contained therein is still required, you should complete all appropriate components of NISAT, considering all available information, views you have gathered from others and the exercise of professional judgement. It is important to identify whose perspective the information gathered reflects. In any domain where a rating scale is used the rating should not be completed. In this case the assessor may enter brief comments in the '**Details**' box.

WHAT IS THE CONSENT PROCESS IN RELATION TO THE NISAT?

- ✓ On initial assessment at **Contact Screening** explain the consent process, potential sources of information and those with whom you may share information.
- ✓ Gain the older person's consent using a participatory approach to:
 - a) Share information with professionals and their carer(s);
 - b) Obtain information from others; and
 - c) For further assessment.
- ✓ Use the **NISAT Consent** form provided.
- ✓ Record information to be restricted and from whom as stipulated by the older person.
- ✓ Consent may be verbal or written. If no consent is given outline the reason for this.
- ✓ Consent should be reviewed with the older person at each stage of the assessment process and updated as required.

- ✓ Where consent cannot be given, consult with others involved in the care of the older person and act at all times in their best interests.
- ✓ Refer to Trust policies and guidelines and be aware of the legal frameworks governing consent.
- ✓ Adhere to any restrictions the older person has made in relation to information sharing unless to do so would put him/her at risk of harm or a crime is suspected.

WHAT ACTION DO I TAKE WHERE A CARER IS IDENTIFIED?

- ✓ If the older person has a carer who provides substantial or regular care, inform the carer of his/her right to an individual assessment and offer this to them. Record a reason, if an assessment is refused.
- ✓ Complete the 'Referral for Carer's Assessment' section that is provided at the end of each component. This needs to be completed at initial assessment, however, offers for a Carer's Assessment should be made throughout the assessment process and forms updated as required.
- ✓ Where the offer of assessment has been accepted at any stage ensure this is actioned.

Note: The NISAT 'Carer's Support and Needs Assessment' is now the regionally agreed tool for Carer's Assessment in all Adult Programmes of Care.

- ✓ If the older person is also a carer, consider the impact his/her present condition may have on his/her ability or willingness to continue in this role, either in the short or long-term.

**Note: a) Assessment of the health and social care needs of the person he/she cares for may be required; and
b) Completion of the NISAT Carer's Support and Needs Assessment will not be required as information on their caring role will be captured on their NISAT assessment.**

- ✓ If a family member/acquaintance is offered as an interpreter, consider the appropriateness of this and safeguards needed.
- ✓ Be alert to the possibility of 'young carers' undertaking caring responsibilities inappropriate to their age and activate Trust procedures accordingly.
- ✓ Adhere to all protocols, guidelines and policy in relation to Carer's Support and Needs Assessment.
- ✓ Ask the carer if they wish the cared for person to be present during their assessment.

WHAT ARE PROMPTS AND HOW DO I USE THEM?

Prompts can be found under many questions within all components of the NISAT. They are included to:

- Remind you of areas to address relating to a particular question.
- Enable you to give the older person suggestions of areas to consider when they answer questions.
- Help you with your assessment when addressing domains/components with which you are less familiar.
- Prompt you to consider referral for Specialist Assessment.

There are **two** types of prompts:

TYPE 1:

'**PLEASE SPECIFY**' prompts will have '**TICKS**' to denote areas that should always be covered, for example:

Domain 3 - Awareness and Decision Making	
Complete to reflect assessed person's perspective. Ensure all questions are considered	
Have you noticed changes in your memory and / or decision-making skills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify	
✓ When you /others first noticed this	
✓ Nature of the changes	
✓ Frequency of episodes	
✓ Other	

TYPE 2:

'**PLEASE CONSIDER**' prompts have **BULLET POINTS** to guide conversation in areas in which the assessor is less familiar, and will have an "**OTHER**" option, for example:

Domain 8 – Living Arrangements and Accommodation	
Have you any issues in relation to heating your accommodation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please consider	
• Cost of heating	
• Type / age of heating system	
• Regulation of heat	
• Adequate ventilation	
• Ability to light fire or operate the heating system	
• Other	

WHAT IS SPECIFIC TO NISAT'S PRIMARY COMPONENTS?

THE CONTACT SCREENING

The Contact Screening is divided into **four** elements:

Element 1:

Referral Information, including:

- Referral details.
- Access information and specific risk factors.
- A brief outline of current services and professionals involved.
- Communication needs, if any.
- Identification of a Key Worker.
- Actions taken on referral.
- Referral Screening and Allocation.

Note: Where Trust referral systems exist it may not be necessary to complete the above details.

Element 2

Contact Screening and Initial Assessment. On acceptance and allocation of the referral this section will be completed on first contact with the older person.

Element 3

Completion of the NISAT Consent (a mandatory element).

Element 4

Completion of the "**Assessment Summary and Action Details**", (where assessment is complete at Contact Screening).

THE CORE ASSESSMENT

The Core Assessment is the largest and most comprehensive component of the NISAT. There are **four** main areas of the older person's life to be considered:

- **His/her past life.**
- **His/her present life which is captured through ten domains.**
- **How any difficulties affect his/her quality of life.**
- **His/her future goals and wishes.**

The Domains

There are **three** central domains:

1. **Physical Health.**
2. **Mental Health and Emotional Well-being.**
3. **Awareness and Decision-making.**

Difficulties experienced within these domains may impact on other aspects of the older person's life captured in the remaining **seven** domains:

4. **Medicines Management.**
5. **Communication and Sensory Functioning.**
6. **Walking and Movement.**
7. **Personal Care and Daily Tasks.**
8. **Living Arrangements and Accommodation.**
9. **Relationships.**
10. **Work, Finance and Leisure.**

Note: All domains interrelate and **MUST** be considered as part of a holistic assessment. As outlined below, 'Assessment Triggers' can be used to prioritise domains to be explored initially. However, the need for assessment of further domains will become apparent through discussion with the older person, information gathered from other sources and by using your professional judgment.

WHAT ARE CORE ASSESSMENT TRIGGERS AND HOW DO I USE THEM?

Prior to completion of domains, complete the **Core Assessment Triggers**. (See also the **NISAT Core** component, Page 2)

The aims of these Triggers are to:

- Identify the domains which the older person considers to be of importance.
- Provide an initial picture of the older person's needs.
- Identify deterioration, if any, in the three central domains.
- Identify the level of awareness the assessed person has in relation to their physical and mental health, awareness and decision-making skills.
- Identify domains which cover aspects of the older person's life affected by conditions within the three central domains.

- A number of potential responses are outlined. Where the reply is 'Yes' or 'Don't Know' complete the corresponding domain. Where the reply is 'No' only complete the corresponding domain if needs become apparent during assessment or where there is a need for information to inform decision-making.

WHAT SCALES ARE USED IN THE CORE ASSESSMENT?

- Simple scales are used throughout the Core Assessment and are not to be confused with in-depth specialist scales. They are person-focused and used to gather how the older person rates his/her condition as opposed to the view of the assessor or significant other, e.g. carer.
- By capturing the older person's perspective you will not only ensure he/she participates in their assessment, but you will also have a clear picture of his/her perspective and level of awareness of the situation.

There are **two** types of scales.

TYPE 1: This scale is found in the 'Physical Health' and 'Mental Health and Emotional Well-being' domains as shown below.

Domain 1 - Physical Health

Where possible reflect the assessed person's perspective. Ensure all questions are considered

How do you view your physical health?

Good It varies Quite bad Very bad

TYPE 2: This scale is used for functional domains 4-7.

The scale indicates level of independence, where 1 is independent and 4 is totally dependent.

Domain 6 Walking and Movement

Complete to reflect assessed person's perspective. Ensure all questions are considered

How do you view your ability in relation to the following?

- Level 1 = I am able
- Level 2 = I am able with difficulty (e.g. pain, stiffness, other)
- Level 3 = I am able with assistance, equipment or aids
- Level 4 = I am not able (please give reason)

	Level	Details
Walking indoors	<input type="text"/>	<input type="text"/>
Walking outdoors	<input type="text"/>	<input type="text"/>
Getting up and down stairs / steps	<input type="text"/>	<input type="text"/>

- Only give further details if you consider this to be necessary.
- Only one level score should be entered.
- Remember to cross-reference to other domains/components so that information is not unnecessarily duplicated.
- When you have completed the relevant domains, ask the older person how any difficulties affect their quality of life, future goals and wishes. Record details on the free-text boxes provided. (See Page 14 of the **Core Assessment**)

THE COMPLEX ASSESSMENT

- Complex Assessment involves collation and interpretation of information gathered through Contact Screening, Core Assessment and where appropriate, Specialist Assessment Summaries, Carer's Support and Needs Assessment and input from GP and medical practitioners.
- Information recorded at this level of assessment will mainly be in free-text following conversation and discussion with the older person and others involved in his/her care.
- You will need to consider all sections of the Complex Assessment, however, complete only those appropriate to the older person.
- Collate information you have received and ascertain which referrals have been made at Core and are still pending.
- When completing the 'Evidence of Support' section prioritise information and cross-reference to completed components to avoid duplication of information wherever possible.

THE ASSESSMENT SUMMARY AND ACTION DETAILS

This form captures:

- Risk Identification including; a description and type of risk, who identified this, consequences if these are not addressed and an indication of the older person's/carer's understanding and acceptance of risk. (See **Table 2**, p25 "**Health and Safety**")
 - Need Identification including; a description, category and severity of need, who identified this, the care aim and outcome. (See **Appendix 6** for explanation of "**Care Aims**")
 - Action Details including; action type and details, date actioned, authorisation and responsibility.
-
- ✓ Identify risks and discuss the consequences if these are not addressed. Indicate if the older person and/or carer understands and accepts these risks. Under each heading record one option only.
 - ✓ Describe, categorise and indicate severity of need and the care aim. Under each heading record one option only.
 - ✓ Outline the cumulative overall consequences if risks and / or needs are not addressed and action taken to improve understanding if necessary.
 - ✓ Record any disagreements, issues or concerns expressed by the older person or others involved in his/her care. Negotiate, conciliate and record how resolution has been achieved and measures taken to address these.
 - ✓ Identify unmet need through completion of the NISAT, record and report this according to Trust policy and guidelines relating to unmet need.
 - ✓ Record where no further action is required or the case is closed.

Note: Details can be updated or added as required by any practitioner involved in the assessment process. (The Key Worker must be informed of all updates).

WHAT IS THE PRACTITIONER'S ROLE IN THE ASSESSMENT PROCESS?

Departmental guidance states that accountability and responsibility for assessment rests with professionally trained staff. (*Circular HSC (ECCU) 1/2010: Care Management, Provision of Services and Charging Guidance, DHSSPS, March 2010*). It is acknowledged that assistant grades have a contributory role in person-centred assessment, planning and review. However, their contribution requires critical evaluation, in-depth collaboration with professionally trained staff and authorisation, “sign-off”, by a professional involved in the older person’s care.

THE KEY WORKER ROLE

A vital component of an effective assessment process is the ability to share and co-ordinate information by all those involved. Therefore, the need for a ‘Key Worker’ at all levels of assessment has been identified as essential. In principle, adults who receive regular input from health and social care should have access to a practitioner who will act as their Key Worker. Their role is to:

- Promote the importance of a person-centred approach when using the NISAT.
- Maintain and promote a consistent, person-centred relationship with the person receiving care.
- Ensure an explanation of the purpose and process of single assessment is given to the older person and their carer(s).
- Ensure the older person and their carer(s) is aware of their role and contact details.
- Inform co-workers of their key worker role and the existence and location of a completed NISAT.
- Act as a focus for communication and co-ordination for different professionals involved in the assessment and intervention process.
- Offer advice and support including sign-posting to other services/agencies if required.
- Allocate completion of the NISAT to an appropriate practitioner.
- Ensure assessments and subsequent outcomes have been fully communicated and disagreements resolved.
- Ensure a carer’s assessment has been offered, carried out and reviewed as necessary.
- Identify the need for assessment review based on information received.
- Close cases, collate information and adhere to policies and guidelines in relation to record keeping.

THE KEY WORKER

The Key Worker will:

- Be a health and social care professional.
- Have major involvement in the older person's care.
- Be in regular contact with the older person during the assessment process.

In particular:

- Where the older person's needs are predominantly health care related, a nurse may be the most appropriate Key Worker.
- Where social care needs are foremost, a social worker should provide this role.
- Where mobility and access needs are a primary consideration an allied health professional should provide this role.

Note:

- Where case/care management applies, the case/care manager should be the Key Worker.
- Where specific risks are identified at Contact Screening, e.g. Vulnerable Adult issues, the most appropriate professional **should become Key Worker**.

CHANGE OF THE KEY WORKER

As the older person moves through the health and social care system, the professional best placed to be the Key Worker may change depending on the assessed needs. There should only be one Key Worker identified at any one time.

Note: If the Key Worker changes, it is the responsibility of the preceding Key Worker to:

- Explain the reason for this change to the older person and, where possible, effect an introduction.
- Provide contact details of the new Key Worker to the older person.
- Provide the new Key Worker with up to date assessment information and documentation.
- Update all records.
- Inform all other health and social care practitioners of the change and date this takes effect

STOPPING THE KEY WORKER ROLE

The Key Worker role should not stop whilst the older person is in receipt of services. The Key Worker's role would stop whenever:

- No further assessment or monitoring is required.
- No further services are provided.

THE ROLE OF OTHERS WITHIN THE ASSESSMENT PROCESS

All health and social care staff involved in the older person's care have a responsibility to:

- Collaborate to ensure an up-to-date, single shared record is available for the older person and colleagues.
- Be aware of their roles and responsibilities, and those of others, in the assessment process.
- Be aware of the contents of the most up-to-date NISAT prior to any further assessment of the older person.
- Where there has been change in the older person's condition or views, the NISAT should be reviewed, updated as necessary and the key worker notified.
- Contribute to the multi-disciplinary completion of the "**Assessment Summary and Action Details**" form.
- Where there is disagreement in relation to the content and/or outcome of the assessment between practitioners a discussion should take place, the nature of the disagreement and method of resolution recorded and the NISAT reviewed and updated as appropriate.

SECTION B: The Process Guidance

This section outlines the Regionally agreed process for use of the NISAT in practice. Processes will vary between services and settings and therefore the information contained within this guidance is to provide an overview that can then be applied to your area of practice. However the principles outlined herein must be applied. Generic Process Maps are outlined in Appendices 1-4.

THE NISAT PROCESS (per episode of care)

An “episode of care” refers to the older person’s journey from the point of first involvement with the person until the case is closed, regardless of the number of practitioners involved or complexity of need.

REFERRAL SCREENING AND ALLOCATION

On acceptance and allocation of a referral the response by the service or team may be either:

- a) Uni-professional or;
- b) Multi-professional (**i.e. requiring input from more than one professionals**)

This decision on the potential level of assessment required is based on the presenting needs and complexities of the individual.

CONTACT SCREENING AND INITIAL ASSESSMENT

a) Uni-professional response

Note: You will become the “Key Worker” for this person.

- Complete the ‘Contact Screening and Initial Assessment’ on contact with the older person.
- Where the intervention is short-term complete the ‘Assessment Summary and Action Details’. In this situation, your role as Key Worker will stop when you have no further input to the case. This case may be closed, or you may feel onward referral is appropriate.
- Where it is evident that further assessment is required at Contact Screening the assessment will be escalated straight to Core. A brief explanation of your movement to Core should be recorded in the ‘Assessor Analysis and Summary’ section of the Contact Screening. In this instance the “Assessment Summary and Action Details” will be completed following Core Assessment.

b) Multi-professional response

- Agree which assessor will become the Key Worker on allocation of the case.
- Complete all appropriate components of the NISAT.

Note: As two or more professionals will be involved in this scenario, it is likely that the person will require a Core Assessment.

PROGRESS TO CORE ASSESSMENT

- Progress to Core Assessment is based on professional judgement considering:
 - The complexity of the person's need.
 - The need for multi-disciplinary involvement.

PROGRESS TO COMPLEX ASSESSMENT

- Where the person requires short or long-term intensive input from services, support to remain at home, or a potential change in domicile, the Complex Assessment should be completed.
- Completion of this level of assessment is reliant on information gathered in the other NISAT components, the views of the person and carer and others involved in their care.
- Negotiation may be necessary at this point to identify the most suitable person to continue with the Key Worker role.
- The Key Worker will be responsible for the co-ordination of information required for complex assessment.

REVIEWING INFORMATION CAPTURED ON THE NISAT AND REASSESSMENT

Reviewing information captured on the NISAT may result in reassessment by adding to the completed existing NISAT, or revising the assessment completely. A “**Core Review**” form is available to capture minimal changes within domains or other sections of this component. This is relevant to paper-based implementation.

The decision in relation to the level of reassessment required is based on:

- Professional judgement in relation to the amount of information that will require amendment as a result of the person's changing needs.
- The outcome of Specialist, Medical Practitioner's or Carer's Assessments.
- The changing views, goals or future wishes of the person or others involved in their care.
- Trust guidelines and targets for review of assessment.

There may be service-specific agreed timings for review of the NISAT information, e.g. on acceptance to or discharge from a service; however, reassessment should be undertaken as appropriate.

Where services provided can no longer safely maintain a person in their own home and they are on the threshold of institutional care, a referral to care management should be considered.

THE NORTHERN IRELAND SINGLE ASSESSMENT TOOL (NISAT)

APPENDICES

- Appendix 1. PROCESS MAP 1 - CONTACT SCREENING**

- Appendix 2. PROCESS MAP 2 - CORE ASSESSMENT**

- Appendix 3. PROCESS MAP 3 - COMPLEX ASSESSMENT**

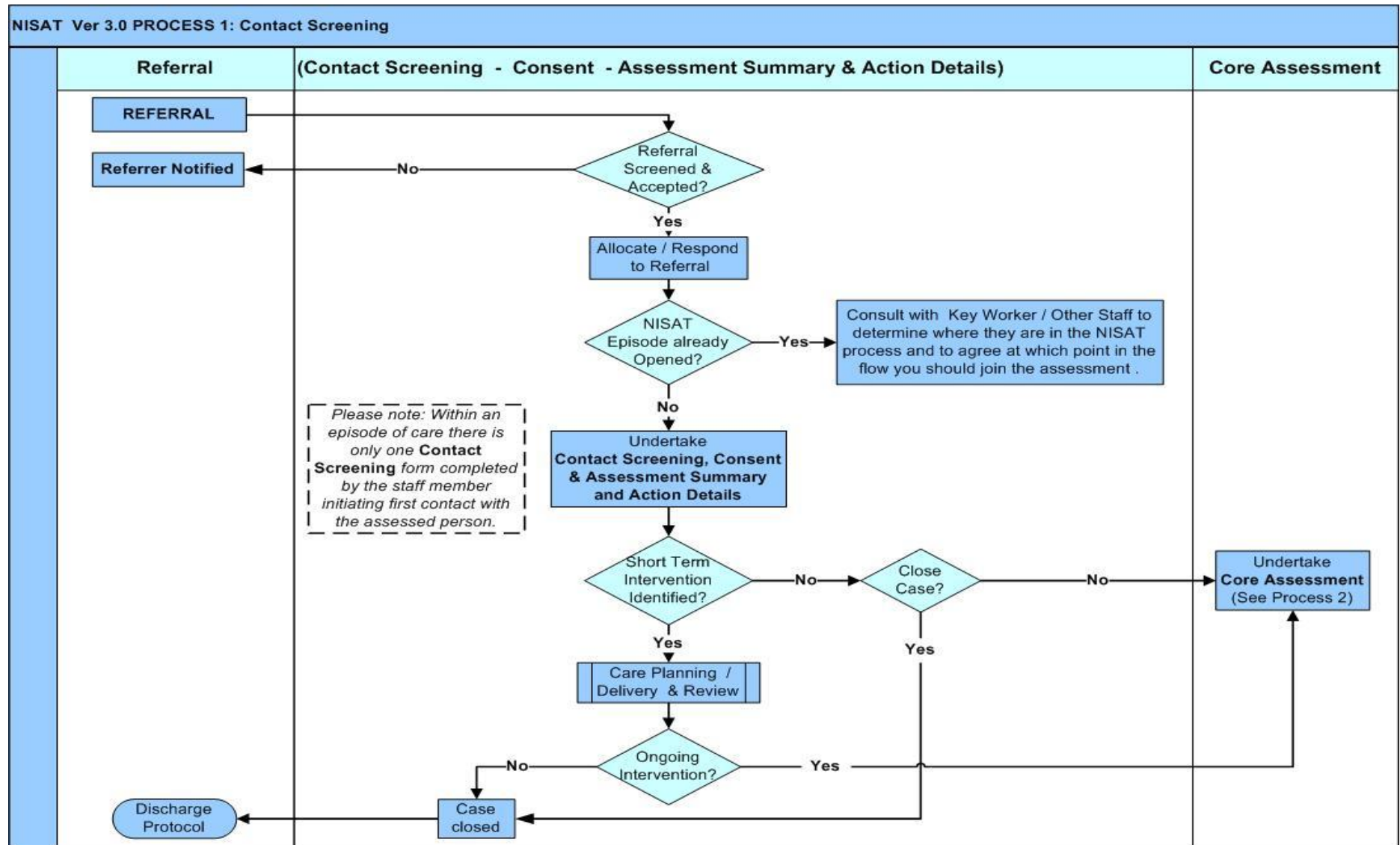
- Appendix 4. PROCESS MAP 4 - OVERALL PROCESS**

- Appendix 5. CONTACT DETAILS FOR PROFESSIONAL
REGULATORY BODIES**

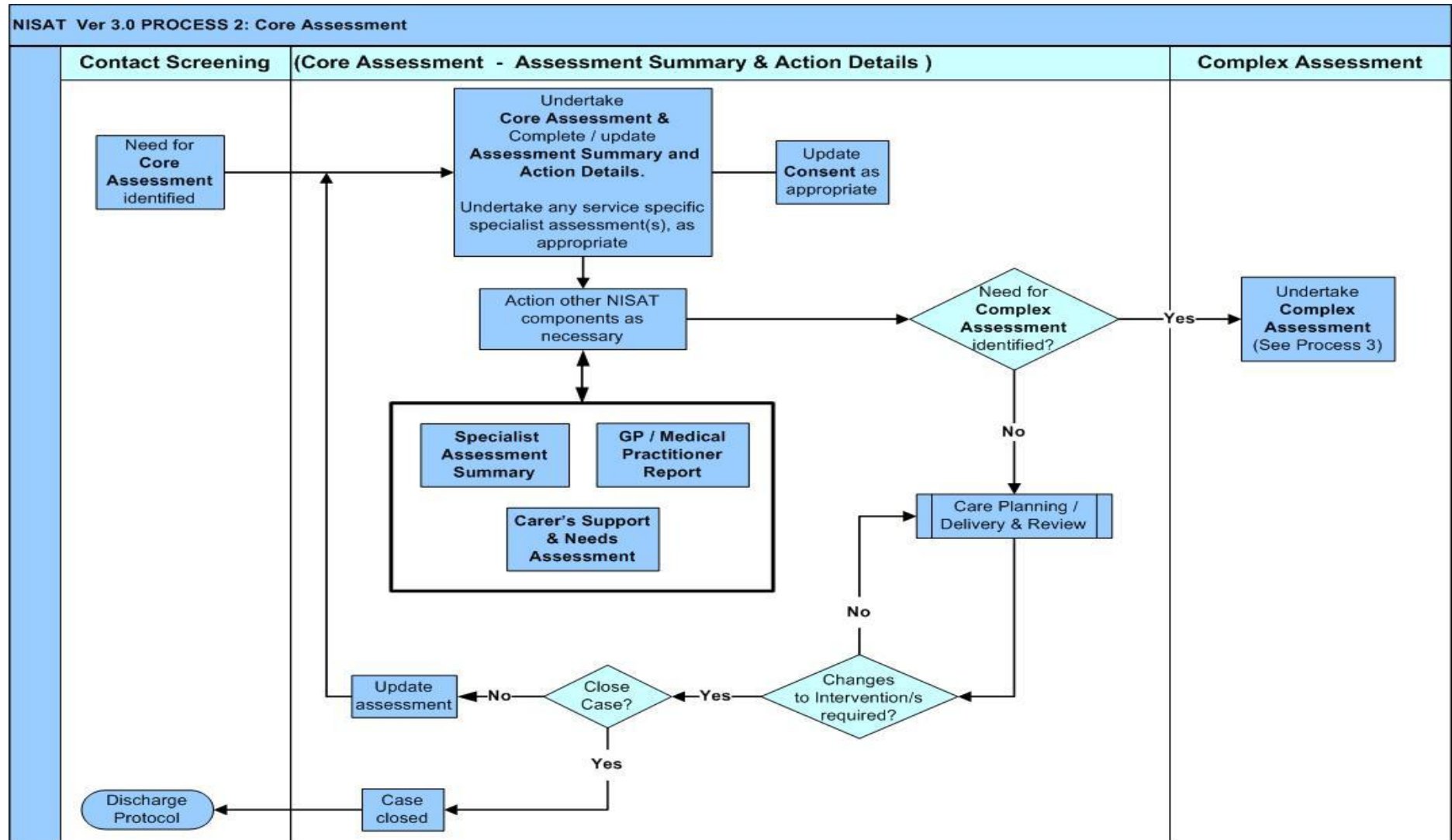
- Appendix 6. EXPLANATION OF CARE AIMS**

- Appendix 7. REFERENCES, FURTHER INFORMATION AND
REPORTS RELATING TO SINGLE ASSESSMENT**

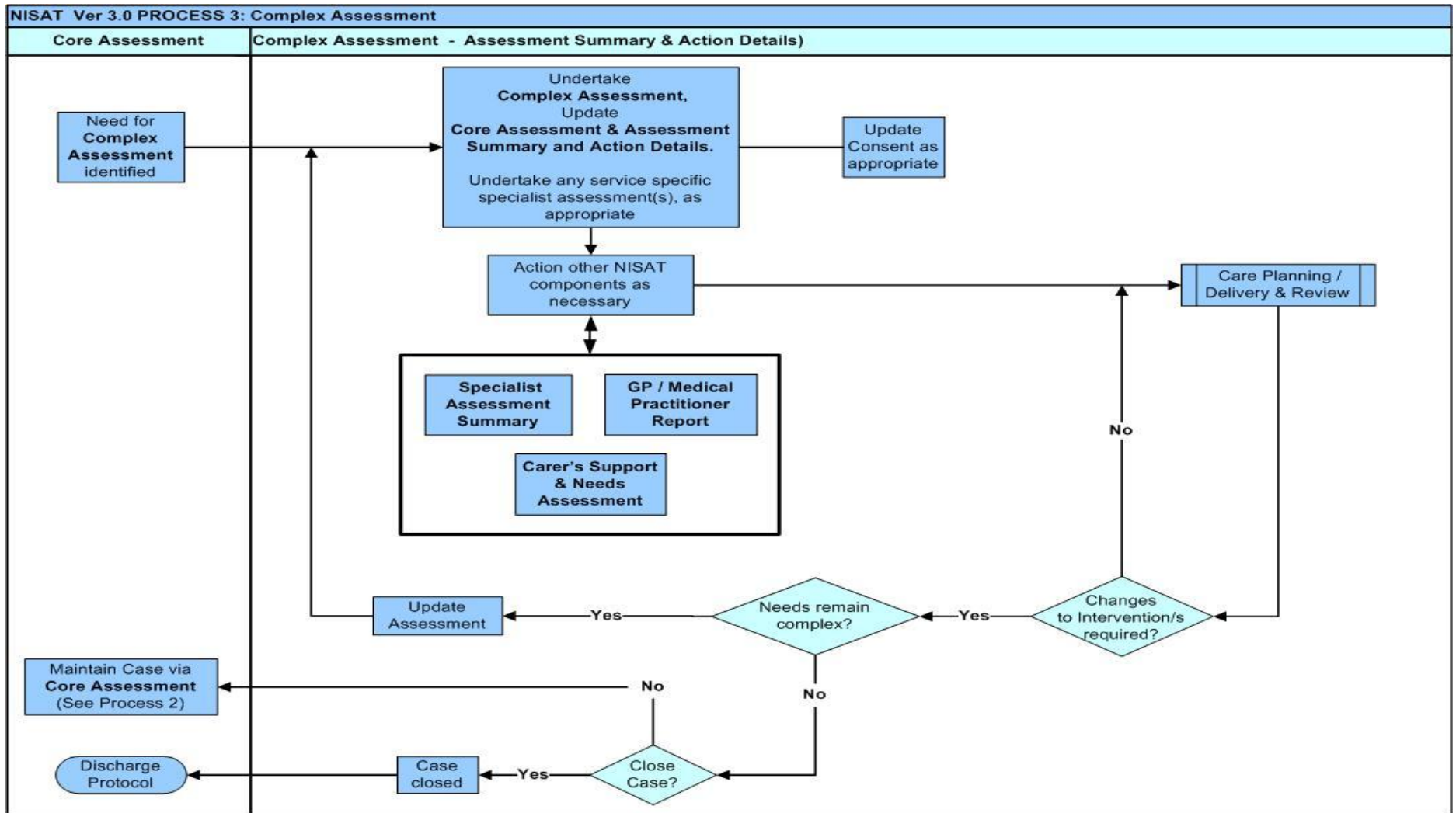
Appendix 1: Process Map - Contact Screening



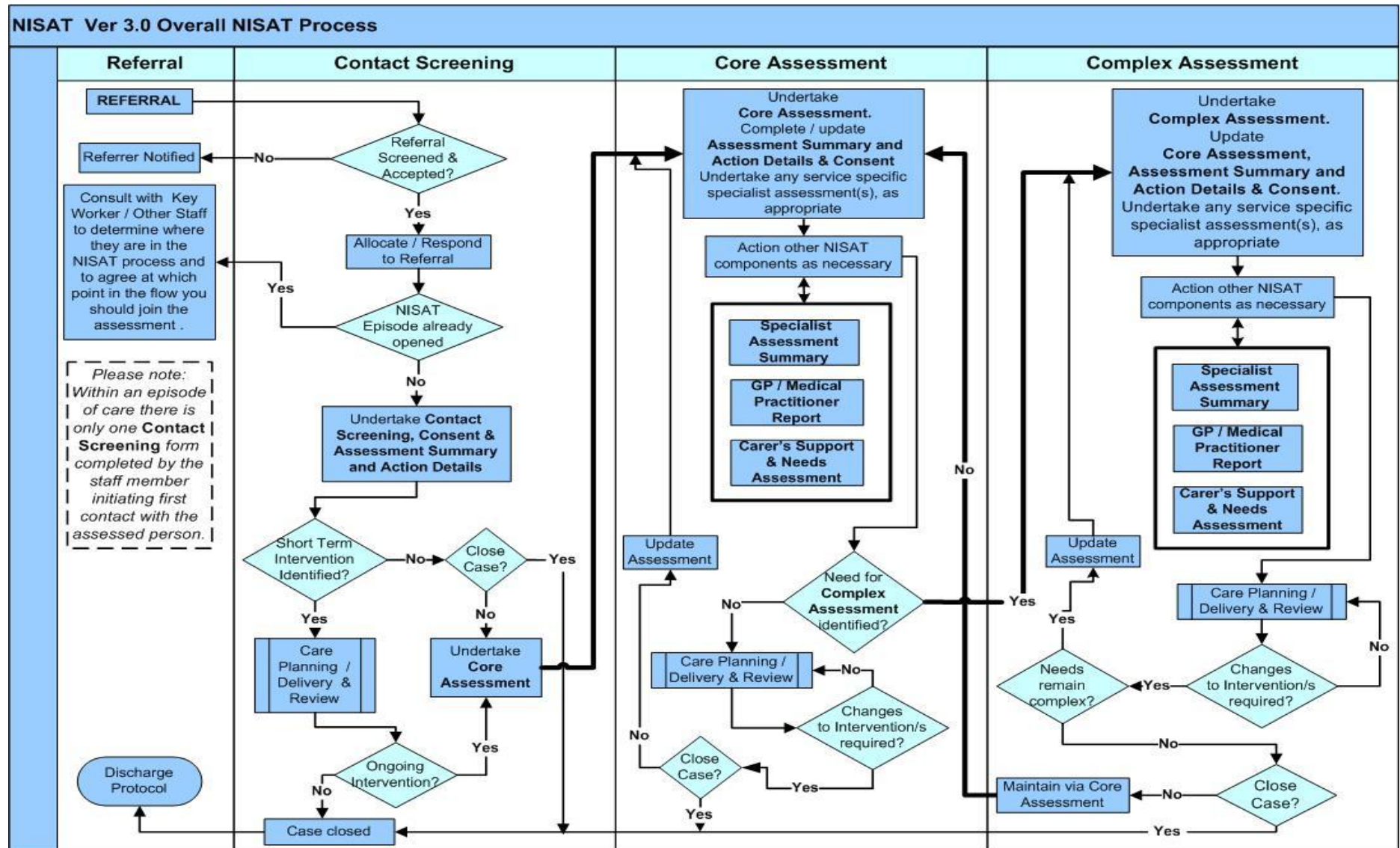
Appendix 2: Process Map – Core Assessment



Appendix 3: Process Map – Complex Assessment



Appendix 4: Process Map – Overall NISAT Process



Appendix 5: Contact Details for Professional Regulatory Bodies

General Chiropractic Council

44 Wicklow Street
London
WC1X 9HL
Tel: (020) 7713 5155
Website: www.gcc-uk.org

General Dental Council

37 Wimpole Street
London
W1G 8DQ
Tel: (020) 7887 3800
Website: www.gdc-uk.org

General Medical Council

Regent's Place
350 Euston Road
London
NW1 3JN
Tel: 0845 357 0022
Website: www.gmc-uk.org

General Optical Council

41 Harley Street
London
W1G 8DJ
Tel: (020) 7580 3898
Website: www.optical.org

General Osteopathic Council

176 Tower Bridge Road
London
SE1 3LU
Tel: (020) 7357 6655
Website: www.osteopathy.org.uk

Health Professions Council

Park House
184 Kennington Park Road
London
SE11 4BU
FREEPHONE: 0800 328 4218
Tel: (020) 7840 9814
Website: www.hpc-uk.org

Northern Ireland Social Care Council

7th Floor, Millennium House
19-25 Great Victoria Street
Belfast
BT2 7AQ
Tel: (028) 9041 7633
Website: www.niscc.info/

Nursing and Midwifery Council

23 Portland Place
London
W1B 1PZ
Tel: (028) 7462 5800/5801
Website: www.nmc-uk.org

Pharmaceutical Society of Northern Ireland

73 University Street
Belfast
BT7 1HL
Tel: (028) 9032 6927
Website: www.psni.org.uk

Appendix 6: Explanation of Care Aims

HIGH LEVEL CARE AIMS

These Care Aims have been designed as a set of multi-disciplinary descriptions for use across all community services. They have been produced by the NHS Management Executive.

The Care Aim describes the overall aim or purpose of a period of care. It does not refer to specific care planning goals or to individual patient/client contacts but to the main reason why care is being delivered. For example, physiotherapists rehabilitating a stroke patient or a district nurse healing a wound will both assess the progress of their clients at each contact. The overall aim of service delivery however is Rehabilitation and Curative Care respectively.

For some clients a single Care Aim will be allocated to a period of care and remain unchanged. For example, preventative health education, promotion and screening services will generally be recorded as Anticipatory Care. Patients suffering from ill health however may have changing Care Aims. For example, the patient with cancer may move from a Curative to a Palliative Aim

Only one Care Aim can be recorded for a specific problem at any one time and with the exception of particularly complex and multi-disciplinary care, it will be unusual for an individual to have more than one Care Aim active with a professional practitioner at any one time.

PURPOSE

The purpose of the Care Aim is to provide a means of describing community services in terms of the individual or group receiving services. This is particularly important within community services where, unlike acute care, cure and discharge will not be possible for large groups such as the elderly, disabled and chronically ill. The aim of care is also important in describing the differing intensity of resource input to individuals with similar diagnoses but differing levels of disability, prognosis and carer support.

CARE AIMS

A Anticipatory Care

Care given to promote health, prevent disease and minimise the risk of ill health through early detection activities.

This type of care includes general health promotion, specific prevention, for example, immunisation, and early detection activities such as screening. It is recognised that health promotion is an integral part of care delivery. This Care Aim therefore only applies when Anticipatory Care is the primary purpose of client contact.

B Curative Care

Care given to address problems or conditions where that main aim is to restore an older person to his/her normal level of health and/or ability to resolve a specific problem.

This type of care is frequently focused upon short-term interventions and medically prescribed treatment and is therefore geared to carrying out this treatment, measuring its progress and encouraging the clients co-operation with the plan of care. The overall aim of this type of care will be to achieve resolution of the problem and discharge.

C Enabling

Care given to exploit an individual's potential for self-care when due to disabilities, their ultimate level of functioning is unknown.

Care is aimed at developing potential to a state in which the individual and/or carer/family can obtain self-care and autonomy. The content of this Care Aim may include a care plan, which considers the learning needs, ability and aptitude of the individual and their family. Progress should be monitored and measured. Continuity of care is important.

D Assessment

The assessment of, and planning for, the needs of individuals where the aim of care is not known or where the sole purpose of care delivery is to carry out an assessment.

Care should take account of the older person, his/her carers and the home environment. This Care Aim would be applicable to new referrals where the individuals condition is unknown, first visits to individuals and families new to the caseload and for existing patients/clients where there is a significant change in their condition which requires a full reassessment of their care delivery. This Care Aim may take one or more older person's contacts to complete. It is recognised that assessment is an on-going part of day to day clinical care activity. The Assessment Aim should not be recorded for the on-going assessment of care such as observation of wounds or general progress, or for assessment such as child health surveillance which take place as part of the day to day process of care delivery within an overall Care Aim.

E Maintenance

Care aimed at maintaining stability within the family and maintaining an existing level of health/functioning when further improvement is unlikely.

This Care Aim will be distinguished by stable care plans and long term routine interventions aimed at maintaining stability and preventing deterioration. Care plan aims and goals should indicate how deterioration is to be identified as this may indicate a need to change Care Aims.

F Rehabilitation

Care given to improve the existing level of self-care when, although a potential for improvement exists, the final level of improvement is uncertain.

Key features of this type of care are enabling the client to adapt to the situation or health problem through realistic and achievable goals, which encourage him/her to aim for the highest possible level of health or resolution. Key actions include guidance on modifying and adapting the home environment and liaison with, or referral to, or other care agencies. Continuity of care is improvement.

G Supportive

Care required to sustain the patient's and carer's ability to cope with a sudden or slowly deteriorating condition or situation within the family

Care will be aimed at arresting the deterioration so that a revised care plan and Care Aim can be identified which aims to resolve the problem wherever possible. Monitoring and evaluation activities should focus upon measuring any further deterioration in the situation. Continuity of care is important. For services other than those with degenerative conditions and the seriously ill, supportive periods of care will tend to be short-term with immediate action taken to resolve the crisis.

H Palliative and Bereavement

Care given to those whose death is not too far distant and where the aim of care is now palliative.

Care will aim to enable the individual to die in the place of their and their family's choice. The focus of this type of care is prevention or relief of pain and other distressing symptoms together with physical, psychological and social support. This Care Aim relates to the nature of care being delivered and does not require practitioners to anticipate or adhere to any specific time constraints. The participation of other agencies is important and continuity of care should have the highest priority. This Care Aim includes immediate bereavement support. Where long term support to the family is required, care should be re-categorised.

Appendix 7: References, Further Information and Reports Relating to Single Assessment

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social services" London: DOH

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World Health Organisation (2001) "**International Classification of Functional Disability and Health (ICF)**" World Health Organisation, Geneva

FURTHER INFORMATION

General information on **Care Standards** can be accessed at:

<http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards/sqsd-standards-care-standards.htm>

Gold Standards Framework Clinical Prognostic Indicators can be accessed through:

http://www.goldstandardsframework.nhs.uk/Resources/Gold%20Standards%20Framework/PIG_Paper_Final_revised_v5_Sept08.pdf

Guidance in relation to best practice in relation to **Consent for Examination, Treatment or Care** can be accessed through:

http://www.dhsspsni.gov.uk/index/phealth/professional/professional_good_practice_guidelines/public_health/consent.htm

Guidance in relation to the **Protection and Use of Patient and Client Information** can be accessed at: http://www.dhsspsni.gov.uk/the_protection_and_use_of_patient_and_client_information_.pdf

Guidance on "**Good Management, Good Records**" can be accessed through:

<http://www.dhsspsni.gov.uk/dhs-goodmanagement.pdf>

Guidance on Abuse of **Vulnerable Adults** can be accessed at

http://www.dhsspsni.gov.uk/ssi/guidance_on_abuse_of_vulnerable_adults.pdf

Information about **carers' issues**, including Carer's Assessment can be accessed through:

<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/ec-carers.htm>

Information and Guidance about **Direct Payments** can be accessed through:

<http://www.dhsspsni.gov.uk/index/hss/ec-community-care/directpayments-about.htm>

"Safeguarding Vulnerable Adults", the Regional Adult Protection Policy and Procedural Guidance (2006) can be accessed at:

http://www.dhsspsni.gov.uk/ssi/safeguarding_vulnerable_adults.pdf

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<http://www.opsi.gov.uk/acts/acts1998/19980042.htm>

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http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf

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