NASC
Needs Assessment and Service Coordination

Treve Swan
Who are we?

A team of 5 experienced Nurses

- **1 full time manager**: Penny, RN
  Vets all referrals and distributes to appropriate assessor. Attends to CORE NASC business, managers budget, works with older persons portfolio manager.

- **3 Registered Nurses**:
  - Kate – Full time, community assessments, hospital assessments and under 65’s with chronic medical conditions.
  - Beth – 0.7 community assessments, hospital assessments
  - Patsy – 0.6 community assessments, hospital assessments

- **1 Enrolled Nurse**
  Treve Swan – Full time, community assessments, hospital assessments and East Coast assessments.
Who are we?

• For a Enrolled Nurse to work in NASC you must be accomplished level on PDRP. There is a policy within TDH that identifies this.

• All assessors have their own case load, this helps with continuity of care, and because we are a smaller DHB it is more manageable.

• Also we have Leanne – full time administrator; she is worth her weight in gold.
About NASC

• Older persons (HOP) - Over 65s
• Palliative
• Under 65 with chronic conditions
• Access to non clinical supports
• Community support
• Day programmes
• Rest home care
Who do we engage with?

- Close links - Primary care, Aged care, inpatient wards
- Clinical nurse specialist falls prevention
- Nurse practitioner intern
- Allied Health (social work, OT, Physio)
- Mental Health for Older Persons
- NGO providers (Alzheimer's, Life Unlimited, Arohaina) - aged residential care, CCS, NPH
NASC relationships

Person, whanau, community

Whāia te Haurora i Roto i te Kotahitanga  A Healthier Tairāwhiti by Working Together
Where do we sit within the DHB?

• Part of the Planning and Funding team, situated in Gisborne CBD.

• Clinical service.
Who do we work with (for)?

• People over 65
• Maori over 55 years
• Under 65 years with chronic medical conditions
• People who need palliative care
• People who use Mental health services for older persons
• Their whanau
Our people our services

• 12% over 65 Maori
• 40% NASC clients are Maori
• In the past 5 years....
• 13% increase in rest home/ hospital level beds
• 31% increase in occupancy
• 20% increase in people receiving home supports
• 53% increase in dementia beds
• 58% increase in occupancy
Area we cover

• From Hicks Bay to Nuhaka and Matawai
• Approx 1000 Health of older people requiring our services, this is steadily increasing
• 5 rest homes in Gisborne
• 11 beds at Te Puia Hospital
• About 86% occupancy in ARRC
Whāia te Hauora i Roto i te Kotahitanga  A Healthier Tairāwhiti by Working Together
What do we do

• **Needs Assessment**

• **interRAI**: web based electronic comprehensive geriatric assessment tool.

• Formal training is required to use this programme, complete 10 AIS test every year to maintain competences, set by the MOH.

• Always involve whanau, MDT/support person if and when possible.
Service Coordination

• Coordinate packages of care. Identify needs by the interRAI assessment outcome scores, triggers. (this is an evidence based tool) Also use other supporting documentation from nursing staff notes in the hospital community and assessments from MDT, specialists.
Things to consider

• Patient rights
• Enduring power of attorney
• “Acopia”
• “Medically stable”
• Dementia Vs delirium
• Hospital level aged care
• RESPECT
Ageing in Place

• MOH commitment to support the elderly to remain in their homes for as long as possible.

• Ensure safe care that promotes optimum quality of life.

• Need to qualify as needing 24-hour care.
Hospital Clients

- NASC assess for residential care only.
- Need reports from Occupational Therapy and Physiotherapy.
- Client MUST consent.

- Clients are not discharged to resthome respite. (this is designed for the caregivers)
- People who live alone are not eligible for respite.
Implications

- Significant life changing event. (must remember)
- Need to be able to make choices.
- Unethical to view client as a nuisance and want to ‘get them out’.
- Clients with dementia can’t sign legal documents.

- Major issues if they don’t consent.
Rest Homes

• All have the same contract to provide various levels of care.
• It is not like an acute ward.
• Staffing levels are much lower.
• May be one Registered Nurse for 90 residents after hours.
Post-discharge short term care

• 6 weeks.

• Managed by District Nurses.

• They refer to NASC if need long-term home-based support.
Days as needs assessor / coordinator for patients / clients on the East Coast

• **When:** 2 days a month.
• **Areas covered:** Tolaga Bay, Tokomaru Bay, Te Puia Springs (Ngati Porou Hauora), Tikitiki, Ruatoria, Te Araroa.
• **Referrals**
• **Process of Assessment**
• **The interRAI Assessment**
• **Co-ordinating Assessment**
• **Why I enjoy my role**
Process of assessment

Part II: Item-by-Item Guide to the interRAI Home Care (HC) Assessment Form

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Care Plan considerations:

- Have I gathered all relevant information from the person, family and care givers?
- What additional information do I need to assist in developing the Care Plan?
- Am I respecting the person’s beliefs, values, needs, preferences and strengths?
- Am I recognizing and putting aside my own assumptions?
- Is my rationale clear for my clinical decisions?

SMART goals:
- Specific
- Measurable
- Achievable
- Relevant
- Time-bound

New Zealand Comprehensive Clinical Assessment – Home Care Assessor Workbook
October, 2016
## Outcome Measures

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical activity promotion</td>
<td>To increase levels of exercise and physical activity - person does &lt;2 hrs activity/day; moves and goes up/down stairs without help; increased independence possible.</td>
</tr>
<tr>
<td>Instrumental Activities of Daily Living</td>
<td>To improve IADL self-performance and capacity – decline in IADL function; increased independence possible.</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td>To improve ADL performance or prevent avoidable functional decline – receive some ADL help; potential to improve self-performance.</td>
</tr>
<tr>
<td>Home Environment Optimization</td>
<td>To improve safety of environment – Problems with lighting, flooring, bathroom, toilet, kitchen, heating, disrepair, squallor and indicators of frailty.</td>
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<tr>
<td>Institutional Risk</td>
<td>To avoid premature admission to LTCF - Identifies persons with impaired functioning who are at high risk of institutional placement.</td>
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<tr>
<td>Physical Restraints</td>
<td>This CAP applies to persons in LTCF and post-acute care settings.</td>
</tr>
<tr>
<td>Cognitive / Mental Health</td>
<td></td>
</tr>
<tr>
<td>Cognitive Loss</td>
<td>To maintain independence, prevent and monitor cognitive decline - Identifies persons with CPS of 0.1,2 and associated clinical risk factors.</td>
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<tr>
<td>Delirium</td>
<td>To identify persons with acute symptoms of delirium – acute change in mental status and behaviour appears different from usual functioning.</td>
</tr>
<tr>
<td></td>
<td>Communication</td>
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<td>-------------------------------------------------------------------------------</td>
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<td>Mood</td>
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<td>11</td>
<td>Behaviour</td>
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<td>12</td>
<td>Abusive Relationship</td>
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<td><strong>SOCIAL LIFE</strong></td>
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<td>13</td>
<td>Activities</td>
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<td>Social Relationships</td>
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<td>16</td>
<td>Falls</td>
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<tr>
<td>17</td>
<td>Pain</td>
</tr>
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</table>

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| 18 | Pressure Ulcer | To prevent, identify and treat pressure ulcers - Has or is at risk of developing a pressure ulcer. | L1G1;G2g;H1;H2;L2;L3;N2k |
| 19 | Cardiorespiratory conditions | To assess and manage cardiorespiratory conditions - Symptoms of chest pain, shortness of breath, irregular pulse, dizziness and test results – BP, respiratory rate, heart rate, oxygen saturation. | J3e;J3c;J4 |
| 20 | Undernutrition | To address and manage undernutrition - based on a person’s BMI score. | BMI & J7c |
| 21 | Dehydration | To identify and treat underlying causes of dehydration – insufficient fluid intake; and diarrhoea, vomiting, weight loss, delirium, fever, dizziness, syncope, constipation. | K2c;K2b;C3a;C3b;C3c;C4;J3c;J3b;J3m;J3n;J3e;K2a |
| 22 | Feeding tube | To identify persons with a feeding tube and manage – has feeding tube and some residual cognitive abilities/absence of cognitive abilities. | K3;C1 |
| 23 | Prevention | To prevent illness and disability- BP, Colonoscopy, dental exam, hearing exam, flu vac, mammogram, pneumovax. | N4c;N1f;N1h;N1g;N1a;N1c;N1e;N1d;N1b |
| 24 | Appropriate Medications | To identify and promote appropriate medication management - 9+ medications and 2 of the following - chest pain, dizziness, oedema, shortness of breath, poor health, recent deterioration. | Number of medications & J3c;J3e;J3u;J4;J8;R2 |
| 25 | Tobacco and alcohol use | To identify strategies to help people cease smoking/ cut back on excessive drinking – daily smoker; alcohol intake, pressure to cut back. | J9a; J9b |
| 26 | Urinary continence | To facilitate improvement and prevent decline in bladder function – reoccurring episodes of incontinence, minimal cognitive abilities, locomotion impaired; possibility of improvement. | C1;H1;G2e;G6;I1a;I1r;J3m;H2;H1;N2l |
| 27 | Bowel Continence | To facilitate improvement and prevent decline in bowel function – risk of decline and improvement and bowel continence. | H3;C1;C3a;C3b;C3c;C4;G2i;G2j;H1; H3 : R2 |

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East Coast
Questions?