NASC

Needs Assessment and Service Coordination

Treve Swan

Whāia te Hauora i Roto i te Kotahitanga A Healthier Tairāwhiti by Working Together

Hauora Tairāwhiti

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 continunity of care, and because we are a smaller DHB it is more managable.

- 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

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)?

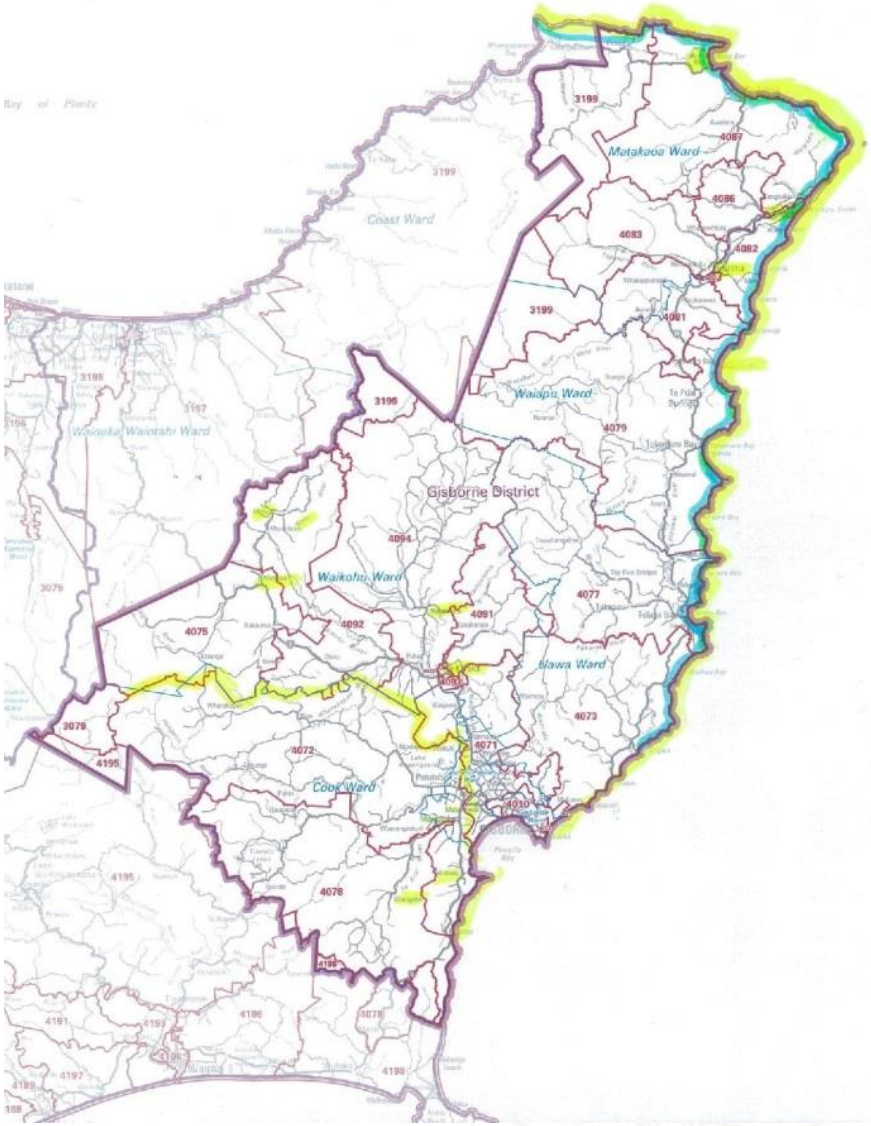
- People over 65
- Maori over 55 years
- Under 65 years with chronic medical conditions
- People who need palliative care
- People who use Mental health services for older persons
- Their whanau

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



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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 whanāu, 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.

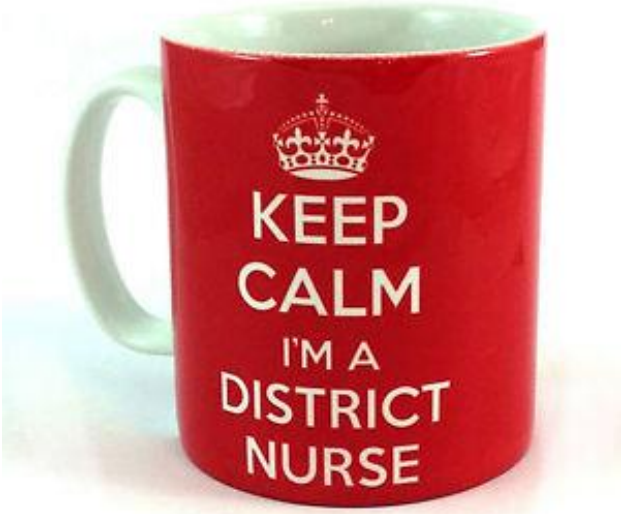
- Major issues if they don’t consent.

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.

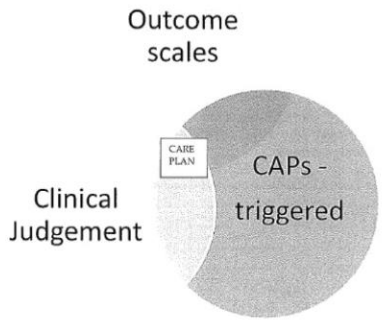
Days as needs assessor / coordinator for patients / clients on the East Coast

- **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 7**

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 recognising and putting aside my own assumptions?
- Is my rationale clear for my clinical decisions?
- SMART goals:
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Time

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OUTCOME MEASURES

ADL Self Performance Hierarchy
Body Mass Index (BMI
Cognitive Performance Scale
Communication Scale
Depression Rating Scale
Pain Scale
CHESS- Change in Health and Signs & Symptoms
Aggressive Behaviour Scale
Pressure Ulcer Risk Scale
ADL – Short Form
ADL Long Form
IADL- Performance
IADL - Capacity
IADL Capacity Hierarchy scale
Functional Hierarchy scale
Deaf/Blind severity index
MAPLe - Method of Assigning Priority Levels

Number	CAP	Major issues that trigger this CAP	Major MDS items that trigger/ are considered for this CAP
	FUNCTIONAL PERFORMANCE		
1	Physical activities promotion	*To increase levels of exercise and physical activity* - person does <2 hrs activity/day; moves and goes up/down stairs without help; increased independence possible.	G4a; G1fa;G2f ;G5a & b
2	Instrumental Activities of Daily Living	*To improve IADL self-performance and capacity* – decline in IADL function; increased independence possible.	CPS & ADL Hierarchy scales G8a&b; G5; G1ab; G1bb; G1gb; G1hb
3	Activities of Daily Living	*To improve ADL performance or prevent avoidable functional decline* – receive some ADL help; potential to improve self performance.	CPS & ADL Hierarchy scales J11; C4a;C4c; C5; C2; G5; I1a;I1r; J1; J7b; N4ea;N2a; R2
4	Home Environment Optimization	*To improve safety of environment* – Problems with lighting, flooring, bathroom, toilet, kitchen, heating, disrepair, squalor and indicators of frailty.	DRS<3 Q1a;Q1b;Q1c;Q1e;J3g;J3h;J3f;G1fb;G4a;J3d;J7a;J8
5	Institutional Risk	*To avoid premature admission to LTCF* - Identifies persons with impaired functioning who are at high risk of institutional placement.	B4a;C1; D1; D2;G2b;G2f;G2g;G3a;G4b;G6;H1;I1c;J1
LTCF 6	Physical Restraints	*This CAP applies to persons in LTCF and post-acute care settings.*	
	COGNITION / MENTAL HEALTH		
7	Cognitive Loss	*To maintain independence, prevent and monitor cognitive decline* - Identifies persons with CPS of 0,1,2 and associated clinical risk factors.	CPS;C3a;C3b;C3c;C4;C5;D1;D2;E1e;E1h;E3a;E3c;I1c;I1d;J7c;R2
8	Delirium	*To identify persons with active symptoms of delirium* – acute change in mental status and behaviour appears different from usual functioning.	C3a;C3b;C3c;C4

9	Communication	*To improve communication ability and to prevent avoidable communication decline* – Moderate-severe communication issues in understanding/expression.	C1;D1;D2
10	Mood	*To identify, treat, monitor mood issues* - negative statements, persistent anger, expressions of unrealistic fears, repetitive health complaints, repetitive anxious complaints, sad, crying, tearfulness. DRS score medium to high risk.	DRS score 1<
11	Behaviour	*To prevent, manage behavioural problems* - Wandering, verbally abusing others, physically abusing others, socially inappropriate, disruptive behaviour, inappropriate disrobing or public sexual behaviour, resisting care.	E3a;E3b;E3c;E3d;E3f;E3e
12	Abusive Relationship	*To identify potential abuse/neglect situations* - fearful of family member, caregiver, close acquaintance, unusually poor hygiene, unkempt appearance, neglected, abused, mistreated—plus "stressors".	F1e;F1f;J3t;E1i;E1j;F2;K2a;K2c;J7a;J8;M3;A13c;F1d; P2b & BMI
	SOCIAL LIFE		
LTCF 13	Activities		
14	Informal Support	*To identify where a person needs help* - not independent with meals/housework/shopping/transport and alone for long periods or lives alone and no primary informal helper present.	G1ab;G1bb;G1gb;G1hb;F4;P1a1;A13a
15	Social Relationships	*To identify reduced social relationships and facilitate engagement* - feels lonely, cognition adequate able to understand others.	CPS & D2;F2/F3/F4
	CLINICAL ISSUES		
16	Falls	*To identify and change any underlying risk factors for falls* - report of multiple falls/report of a single fall.	J1
17	Pain	*To identify and treat underlying reasons for pain* - High risk trigger - severe, horrible or excruciating pain; medium risk trigger - daily mild/moderate pain.	J6a;J6b

18	Pressure Ulcer	*To prevent, identify and treat pressure ulcers* – Has or is at risk of developing a pressure ulcer.	L1G2i;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	Dehyrdration	*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;J3l;J3m;J3n;J3r;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 vax, 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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Questions?

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