

Carers' Assessments

Carers Assessment is still a matter of hit or miss across the divisions, across organisations and across Wales.

370,000 people in Wales are carers, giving unpaid support to loved ones who are older, disabled or seriously ill. A third are older people and 24,000 are over the age of 75. But Sarah Rochira told the assembly's health committee just 6,200 people were given an assessment and only 1,200 were offered support last year.

Older People's Commissioner Wales

The SSWBA has removed the eligibility criteria of 'regular and substantial' and introduced the notions of holism, joint assessments and proportionate assessments. Whilst the idea of joint assessment is a new concept it can also speed the process and serve the organisation as opposed to the service user and their carer. Practitioners will be doing combined assessments because the law allows them to and effectively the process ticks the box for carer and cared for. However, there is a risk (unsubstantiated as yet) that the assessment process will fall back to the situation where the cared for person's needs are prominent and the carer's secondary, with the carer not being offered a thorough assessment whilst their contribution is expected and assumed.

This paper justifies the logic of separate assessment as a basic principle of best practice that doesn't allow for misconceptions or shortcutting the process and offers solid reasoning why carers' assessment must follow comprehensive service user assessment and **come before any care planning can take place**. It is targeted at the assessment of adults and their carers as there is no legislative responsibility for one adult to care for another whereas disabled children remain the responsibility of their parents until adulthood – a fundamental difference.

1. Assessing service users

Assessment is the process of gathering facts and information about an individual's capacity to function, their strengths and their weaknesses. However, custom and practice seems to have diluted the process which has become an examination of what we need to do to keep the person at home with their family and as independent from services as possible to reduce the burden of cost (it is acknowledged that many people don't have family or carers). This has effectively reduced the carer's role to one that is expected, assumed and rarely officially recognised as a partner provider.

Blind assessment has been a concept for many years and featured in the guidance to the Unified Assessment Process in the early 2000's. Essentially

this is about assessing the cared for person in isolation. Isolation from their family and carer(s) determines that a person's total needs are assessed without any consideration of the contribution of their informal support.

Roper, Logan and Tierney developed a model of nursing based on holistic assessment of the individual and their ability to self-care. This paper proposes that a similar approach is fostered across social care teams where service users have their total functioning capacity assessed and their deficits identified.

2. Areas for assessment

Roper's model looks at the following:

- maintaining a safe environment
- communication
- breathing
- eating and drinking
- elimination
- washing and dressing
- controlling temperature
- mobilization
- working and playing
- sleeping
- sexuality
- death

These are termed: Activities of Daily Living and according to the model, there are five factors that influence the activities of living. The incorporation of these factors makes it a holistic model. If they aren't considered, the resulting assessment is incomplete and flawed. The factors are used to determine the individual patient's relative independence in regards to the activities of daily living.

They are: biological, psychological, sociocultural, environmental, and politicoeconomic. The biological factor addresses the impact of the overall health, of current injury and illness, and the scope of the patient's anatomy and physiology. The psychological factor addresses the impact of emotion, cognition, spiritual beliefs, and the ability to understand. According to Roper, this is about "knowing, thinking, hoping, feeling and believing."

The sociocultural factor is the impact of society and culture as experienced by the individual patient. This includes expectations and values based on class and status, and culture within the sociocultural factor relates to the beliefs, expectations, and values held by the individual patient for him or herself, as well as by others pertaining to independence in and ability to carry out the activities of daily living.

The environmental factor in Roper's theory of nursing makes it a "green" model. The theory takes into consideration the impact of the environment on the activities of daily living, but also examines the impact of the activities of daily living on the environment. The politicoeconomic factor is the impact of the government, politics, and economy on the activities of daily living. This factor addresses issues such as funding, government policies and programs, war or conflict, availability to benefits, political reforms, interest rates, and availability of public and private funding, among others. Significant others (Carers) must be invited to contribute to the process as they have expertise, experience and knowledge of the cared for person.

Underpinning practice with a model such as Roper's will shape practice and help guide practitioners through a comprehensive process that will stand scrutiny. In addition the model will serve as a framework for understanding what is important to individuals – a key element of the SSWBA.

When the service user has been carer blind assessed and their strengths and deficits understood, this proposal suggests that the family and carers are invited to declare how much of the person's deficits they are prepared to meet, for example;

Eating and Drinking:

Mr Jones has had a stroke. His cognition is fine but has suffered left side paralysis. His assessment showed that he cannot fend for himself. He cannot mobilise to get to the shops, cannot, therefore, buy provisions and cannot prepare food and drinks. Internet connectivity is poor so on-line shopping is not available and neither Mr or Mrs Jones are IT literate. The assessment has shown that Mr Jones is totally dependent in this 'activity of daily living'.

During her separate carer's assessment Mrs Jones has declared that she has always shopped and prepared his meals – his only contribution being that he would drive her to the shops and carry the bags – they live rurally at least five miles from any shops and Mrs Jones doesn't drive. Public transport is non-existent. Mrs Jones states that she is more than willing to continue with everything she has done for her husband but fears she won't be able to get to the shops and carry everything. Their daughter, also present, says that she is willing to drive her mum and help with the shopping every week and that her brother will also help out. Mrs Jones is relieved and says that as long as she is fit and well she will happily continue to ensure Mr Jones has adequate food and drink.

Mrs Jones must be offered to sign this care plan as the person who has agreed to deliver.

The care plan describes how this deficit will be addressed and who will be responsible for delivery – in this case Mrs Jones and her children. As the main provider of this service delivery Mrs Jones must be offered opportunity to sign the care plan and be involved at every review that follows. This practice promotes

inclusion and recognition of the carer and their contribution. In turn, the carer feels integral and recognised and retains a degree of control (e.g. ability to declare issues during reviews).

Extrapolating this example across each Activity of Daily Living ensures that the individual requiring care and support benefits from a comprehensive and inclusive assessment that is followed by an assessment of their carer's ability, capacity and willingness to contribute. The carer is offered opportunity to declare the amount of support they can offer, taking into account their own circumstances, e.g. work, education, leisure, other caring commitments, their own health and well-being and their aspirations. When the carer's circumstances are fully understood they are offered opportunity to state exactly how much they are prepared or not prepared to contribute (including breaks from caring) and this is recorded on the care plan as stated above. The care plan can then be fulfilled with commissioned support to address the AoDL where a deficit remains and is deemed essential.

What is beneficial about this model is the fact that it can be applied to all adult service user assessments and offers a framework that once embedded in practice will become a statute that practitioners can model practice on. It will eradicate the poor practice of assumptions and expectations and elevate carers as partners in the provision of care whilst themselves being assessed and allowed to state how much and how often they contribute. Partnerships between statutory agencies, commissioned providers and carers will form the basis of community care where everyone understands their role and commitment.

Key questions to identify levels of risk to the sustainability of the caring role (these are not exhaustive) may include:

- how long has the carer been caring?
- how much help does the carer get?
- how often does the carer get a full night's sleep?
- how much physical impact does the caring role have?
- how much emotional impact does the caring role have?
- does the carer understand the nature of the cared for person's condition?
- how much time does the carer have when they feel 'off duty'?
- how appropriate is the role for someone of the carer's age or in that particular relationship to the cared for person?
- how appropriate is the role for someone of the carer's culture, religion, gender?
- how many other roles (parent, employee, carer for someone

else) impact on the carer?

- how does the caring role impact on the carer's other relationships and community networks?
- how sustainable does the carer's role appear?
- does the cared for person want the carer to continue in this role?
- how far does the carer gain any sense of satisfaction/reward from caring?