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Assessing older people with complex care needs using EASY-Care, a pre-defined assessment tool

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Abstract
The aim of this paper is to explore the practicability of EASY-Care, a structured tool designed to assess older people with complex care needs. Assessors undertook assessments of 119 older people living in a care home setting or awaiting discharge from hospital. Older people who had been assessed also completed questionnaires to evaluate use of the tool. Assessors took part in semi-structured focus groups or interviews. The results suggested that EASY-Care was considered in general to be useful in exploring needs and acceptable to both assessors and older people. Assessors thought it was person-centred in that open-ended questions allowed people to describe their circumstances in their own words. Some assessors were less comfortable with the open-ended questioning approach and felt it made collecting information difficult and was likely to cause confusion. On the whole, use of the tool was considered to facilitate rapport. Nevertheless, some questions provoked anxiety and assessors needed to use their professional judgement to identify non-verbal cues of anxiety in order to achieve a person-centred assessment. Professional training and skills were essential to identify non-verbal cues of distress and to moderate potentially difficult situations where older people became upset during assessment.

Key words: Assessment tools, older people, professional judgement, nurses

Introduction

Policy reforms require a greater degree of standardisation in assessment procedures for older people (DoH, 2002; WAG, 2002). To facilitate the move towards greater consistency, NHS Trusts and local authority social services departments are required to choose off-the-shelf assessment tools that have been developed by independent organisations, or to develop shared tools informed by assessment domains specified under the single assessment process (SAP) (unified assessment process [UAP] in Wales). In Wales, UAP differs from SAP in that it is led by local authority social services departments and it was developed by the Social Services Inspectorate in the Welsh Assembly Government. UAP embraces the whole process of care management including case finding, assessment, care planning review and shared summary record keeping. Systematic assessment together with long-term care management is associated with improved outcomes for older people (Stuck *et al.*, 1993). The needs of older people may be more fully understood when using structured

assessment instruments (Lowles & Philp, 2001; Boyle, 2004).

National Service Frameworks for Older People (DoH, 2001; WAG, 2006) state that assessment should cover the complexity of older people's cognitive, physical and social needs in order to trigger timely health and social care support. Models of assessment should therefore be appropriate for the particular client group and flexible enough to identify the diversity of situations a person may encounter. The single and unified assessment processes (DoH, 2002; WAG, 2002) set out prescriptive frameworks for the assessment of older people. The Royal Commission on Long Term Care (Sutherland, 1999) recommended the adoption of the same standardised assessment tool by all local authorities in England and Wales. Similarly, the Report of a Joint Working Party of the Royal College of Physicians recommended the use of a single agreed assessment tool to inform commissioning and care planning (RCP, 1992). The Department of Health and Welsh Assembly however did not support these recommendations.

The use of assessment tools provides guidance to practitioners in the *structured* gathering of information. Assessment tools complement and inform practitioners' assessment skills and professional judgement. However, there are risks attached to over-dependence on forms and for assessment practice to be dominated by a procedural, questioning model of assessment. Care management is enhanced when older people express their needs and aspirations in their own words and Barker (2003, p.62) suggests that 'all people are storytellers'. From such stories practitioners piece together a comprehensive picture of the individual. Assessment should be person-centred and support rather than replace professional judgement (DoH, 2002; Cutcliffe & Barker, 2004). The 'exchange model' of assessment emphasises the importance of partnership between the assessed person and the assessor and of negotiating a shared understanding of priorities and needs (Smale *et al.,* 2000).

Understanding the perceptions of the professionals who undertake assessment is vital if care is to become more focussed upon the older person's needs and wishes. Person-centred care is defined by Innes *et al.,* (2006) as care that prioritises the needs and views of individuals, promotes independence and offers flexible, multidisciplinary support. Social work and nursing assessment practice emphasises the importance of independence and quality of life when establishing needs and thus is a person-centred activity (Ford & McCormack, 2000; Themessl-Huber *et al.,* 2007). Different professionals should be involved in holistic assessment of older people with complex care needs (Nolan & Caldock, 1996). However, health expertise has been missing from the assessment process (Challis *et al.,* 2004) and some elements of nursing practice have been neglected in assessment processes (Heath *et al.,* 1996). Lymbery (2005, p.95) reported that a nurse's contribution to the assessment process 'strengthened the credibility of the assessment recommendation'. Lymbery also noted duplication in assessment procedures where nurses' and social workers' assessments confirmed each other's recommendations. In brief, nurses are in a strong position to comment on the value of assessment tools designed to collect data on a range of health and social care needs.

This paper now reports the key findings of a study designed to explore the

practicability of assessment tools used to assess older people with complex care needs. We focus on EASY-Care (Sheffield University, 2002) because it is a structured assessment tool developed for use by social workers and nurses for overview assessments of older people's needs (see Lambert *et al.*, [2005] for the full report).

Methods

The aim of the study was to assess the practicability of EASY-Care in terms of ease of use, acceptability and usefulness from the perspectives of the older people who were assessed and the nurses who assessed them. The study combined quantitative and qualitative methods to assess tools for use in three settings: nursing homes, residential care and hospitals. Care homes and NHS Trusts in south-west Wales were invited to join the project. Named contacts in participating hospitals or care homes identified older people who met the study's inclusion criteria which were: participants should be over 65 years old; able to give informed consent; were in hospital but no longer required consultant-led care or were in a care home and resident for less than 12 months. Older people were recruited to the study by the project manager. The requirements of statistical testing of assessment data provided for a minimum target number of 30 participants in each setting.

Following an assessment of their needs using assessment tools, older people completed structured Client Evaluation Questionnaires. The questionnaires were adapted from Philp *et al.,* (2001) and covered ease of use (complexity and length), usefulness in exploring circumstances and acceptability. Semi-structured qualitative focus groups and telephone interviews with the nurses who undertook assessments, together with questionnaire data provided an insight into the complexity of achieving a person-centred assessment when using structured pre-defined tools.

EASY-Care is used internationally and was chosen for the study because it was listed by the Department of Health in 2002 for use under SAP. EASY-Care provides assessors with a pre-defined list of closed and open-ended questions in modular format. Assessment domains cover contact information; service user's perspective of current needs; clinical background including vision, hearing, communication, depression; activities of daily living, personal care and continence; memory and cognitive functioning; safety and support and health behaviours in relation to tobacco and alcohol consumption, exercise and screening. EASY-Care has been tested for practicability and validity for contact and overview assessments in primary care (Philp, 2000; Sheffield University, 2002). The version used in this study was issued in 2002 and the latest version issued in 2004 has been accredited for use under SAP by the Department of Health.

Assessments of older people using EASY-Care were undertaken by a total of 12 nurse assessors. The assessors were registered nurses with prior experience of undertaking structured assessments with older people in hospital and community settings. Six assessors were recruited at the start of the project and a further six joined the project later to increase research capacity and to replace four assessors who left. They received standardised training in the study's methodology and in the use of the tools. They did not undertake assessments in their workplaces so prior knowledge of participants did not inform the assessment process. Assessors undertook a minimum of five

assessments and maximum of sixteen each.

Assessors were invited to join two semi-structured two hour focus groups (FG-1 and FG-2). FG-1 was held four months after data collection began and FG-2 14 months later when data collection ended. The six assessors who participated in FG-1 were a homogenous group who had common interests in patient care and had not met before (Morgan, 1997). Four assessors participated in FG-2, two of whom had been members of FG-1. Participant numbers in FG-2 were lower than the suggested minimum of six people (Morgan, 1997), this did not appear to affect the depth and breadth of discussion. Focus groups provided an opportunity for discussion between participants on topics of which they had personal knowledge and experience (Morgan & Spanish, 1984; Kitzinger, 1994). The interaction between participants also provided further insights into the value of assessment tools (Powell & Single, 1996). The lead researcher and project manager facilitated both focus groups using semi-structured topic guides. The FG-1 topic guide was designed to explore participants' observations on the practicability of the tools including ease of use, usefulness and acceptability. FG-1 data were analysed to inform the development of the FG-2 schedule. FG-2 sought to identify new observations on the use of assessment tools together with further clarification of the main themes generated in FG-1 (Hoppe *et al*., 1995; Race *et al*., 1994). Four semi-structured telephone interviews (TI 1 – 4) were held with assessors who were unable to attend FG-2. The interview schedule was the same as the FG-2 topic guide and interviews lasted between one and one and a half hours.

Data management and analysis

Client Evaluation Questionnaires were entered into SPSS (Statistical Package for Social Sciences). A descriptive analysis comprising frequencies and percentages was undertaken to outline sample characteristics. The impact of care setting on responses was investigated using the Kruskal-Wallis H test. It tests whether several independent samples are from the same population.

Focus groups and telephone interviews were audio-taped and transcribed verbatim. The content of transcripts was analysed manually to identify recurrent themes, similarities and differences in participants' responses to the topic areas under discussion (Silverman, 2001; Bowling, 2002). Data extracts were assigned codes that related to the content of the extract of talk. Data were indexed to bring together all extracts pertinent to a particular topic or hypothesis (Coffey & Atkinson, 1996). Transcripts were also analysed holistically to track the narrative flow of individuals' contributions (Bloor *et al*., 1998). Two members of the research team studied the transcripts to verify the coding and categorization of the data and to enhance rigour.

Ethical issues

Ethical approval was granted by the Local Research Ethics Committee. Assessments were undertaken at least 24 hours after consent was given to allow the person to change their mind. All participants were given written information about the study and they signed consent forms. They were reassured that they could withdraw from the study at any point. Assessors gave their consent to participate in the focus groups and agreed to respect the confidentiality of the content of discussions. Completed assessments and tape-recordings were anonymised and

data that could identify participants were stored separately.

Findings

Assessments were undertaken with 119 older people, 54 living in residential homes, 30 in nursing homes and 35 in hospital no longer requiring consultant-led care. Their ages ranged from 66 to 94 years and 83 women and 34 men took part. The ethnic origin of participants was white British / European and the preferred first language of 26 older people was Welsh. EASY-Care Client Evaluation Questionnaires were completed by 104 older people, 15 fewer than those who were assessed because either they asked for the assessment interview to end after the assessment itself or because in the judgement of the assessor the older person was too tired to continue.

Ease of use

The measures used in the client questionnaires to assess ease of use were the complexity of the questions asked and the time taken to undertake the assessment. Seventy four per cent of older people disagreed that assessment was made too complicated when using EASY-Care, whereas 22% thought the tool made it complex with four per cent neither agreeing nor disagreeing (see Table 1).

Table 1: Ease of use

The tool made the assessment too complicated					
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
EASY-Care	18%	56%	4%	18%	4%
The tool made the assessment process too long					
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
EASY-Care	19%	50%	4%	20%	7%

Table 1 also shows that 69% of older people disagreed with the statement that the assessment process was too long, 27% agreed with the statement and 4% were neutral. Assessors kept records of the duration of assessments and the mean length of time to conduct an assessment using EASY-Care was 47 minutes, compared to 39 minutes suggested by the tool developer. The setting in which the older person was situated was not statistically significant in relation to ease of using these measures.

Focus group interviews explored nurses' views on the topic areas which they found worked well and those that did not. Discussion covered the type of questions, the order of questions on the form and the language used in the tool. Differences emerged with some nurses finding that the open-ended questions in the opening sequence of questions created confusion and were difficult to ask and difficult for older people to answer. One assessor in FG-1 argued that open-ended questions, for example about personal and spiritual fulfilment in Module 1 of EASY-Care, were especially difficult:

> *'You can have so many different answers to the questions. It can be quite difficult sometimes to get patients to elaborate and get them to understand what you're asking them' (FG-1).*

Another assessor commented 'they look at you as if to say what are you talking about?' (FG-1). When faced with asking questions about 'personal fulfilment' another assessor stated that she sometimes rephrased such topics 'into their language more [it was] a bit complex at times' (TI-3).

One assessor commented that in order to improve the conversational flow with some individuals she altered the order in which the EASY-Care modules were administered:

> *'I find . . . they tend to clam up so I start with number two [EASY-Care's Module 2 about clinical background]. I put number one [Easy-Care's Module 1 Service User's Perspective of Current Needs] right at the end because they've sort of talked about themselves a bit by the time they get to that stage before you start talking about spiritual fulfilment and such things' (FG-1).*

EASY-Care's questions about cognitive function and memory prompted both positive and negative comments. The EASY-Care approach was praised as a valuable means to test cognition and memory, but some assessors pointed out that the questions were also a cause of concern 'if the person was not too well, it made it more difficult for them to answer' (TI-4).

During the focus groups some assessors stated that the EASY-Care format helped them to gain rapport quickly. When discussing whether the tool assisted in developing a conversation with an older person, one member of FG-1 suggested that 'EASY-Care was good at initiating discussion'. This was given further support as follows:

> *'EASY-Care [made it] easy to get on to a light kind of conversation, kind of break the ice' (TI-3).*

Although the assessors agreed that the format of a tool was a contributory factor in establishing a relationship with an older person, professional experience and confidence were more significant. Before starting an assessment, assessors encouraged the older person to relax with 'a conversational style' (TI-1). In FG-2 there was agreement that 'being a nurse broke down barriers'. Good interpersonal and communication skills were viewed as essential because 'you were effectively undertaking an assessment with a stranger' (TI-4). Most assessors stated that completing the form did not impede the engagement process with older people, but several were concerned that completing a long paper-based form could impair the conversational flow between assessor and client when discussing their needs. One assessor described how the 'shuffle, shuffle' of paperwork meant that her success at engagement was variable because of the requirement to work through prescribed questions and to record and score responses on the form before moving on to the next topic (TI-4). It was agreed that the format of the form did not leave enough room for assessors' own comments and observations about the older person which would be of value to another practitioner.

Assessors considered that the length of time to undertake assessments using EASY-Care was within acceptable boundaries. One assessor commented that 'anybody doing a comprehensive assessment is going to be there an hour anyway' and concluded that she 'wouldn't have an issue in terms of time' (TI-1). It was essential that assessors allowed older people time to think and reflect when faced with

answering detailed personal questions about their personal, social and health circumstances:

> *'They are trying to think of things as well … they don't think as quickly as us … you're asking these questions and they're trying to think' (TI-3).*

Usefulness

Usefulness was measured by asking older people whether EASY-Care helped them to think clearly about the type of support needed, whether the tool made it easier to discuss their needs, and whether using the tool made them feel their needs were really understood. Two-thirds of older people considered EASY-Care to be useful in assisting them to think clearly about their support needs. Sixty nine per cent stated that the tool made it easier for them to discuss their needs, although 19% were neutral about this statement and 12% disagreed. Sixty eight per cent of older people stated that using the tool meant their needs were understood, with 25% neutral and 7% disagreeing with this statement (see Table 2).

Table 2: Usefulness

The tool helped me to think clearly about the type of support needed					
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
EASY-Care	0%	13%	24%	53%	10%
The tool made it easier to discuss my needs					
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
EASY-Care	0%	12%	19%	62%	7%
The tool made me feel my needs were really understood					
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
EASY-Care	1%	6%	25%	54%	14%

Eighty per cent of participants in residential care reported that EASY-Care made them feel as if their needs were really understood, compared to around 55% in nursing homes or hospitals. This difference was statistically significant ($p<0.05$).

The previous section showed that nurses' views on the value of open-ended questions varied. When asked to discuss whether EASY-Care was useful in exploring the needs of older people, once again differences emerged. Some nurses felt that encouraging a person to describe their needs in their own words at the outset of the assessment interview enabled them to elicit information about the older person that extended their understanding beyond the content of the form. EASY-Care gave 'a much more holistic view of the picture of needs' (TI-1). Others suggested however that EASY-Care did not provide enough detail about a person's health needs. Here a tension emerged between an assessment that derived information in the person's own words and the desire of some nurses for 'a more factual' assessment that, in their view, would yield a more comprehensive picture of nursing needs.

The focus group discussion illustrated that nurses drew on their broad knowledge and experience to understand fully a person's circumstances and to decide whether there was a requirement for further probing or investigation. Assessors agreed that using an

assessment tool did not always elicit enough information about older people and at times it was necessary to draw on their tacit knowledge and their ability to interpret non-verbal cues. The following extract illustrates this aspect of assessment:

> *'She looked physically tired…very frail. All her non-verbals, slumped in a chair. She was tearful and uncomfortable and fidgety . . . it was how she behaved really' (FG-2).*

This assessor pointed out that EASY-Care had not indicated that this person was depressed, but that in her professional judgement she was and a fuller assessment was required. Another assessor supported this view with another example as follows:

> *'The last assessment I did, the gentleman I was interviewing was obviously depressed, but on the EASY-Care it didn't come out that he was depressed at all' (FG-1).*

The development of assessment tools designed to capture a person's own words follows policy and professional guidance (DoH, 1991; DoH, 2002; RCN, 2003) but was a source of disagreement amongst assessors. Discussion focussed on whether encouraging a person to express their needs in their own words was a help or a hindrance in achieving an accurate assessment. There was overwhelming agreement that EASY-Care adhered to Department of Health guidance on the need for assessment to be 'person-centred', with the individual being 'active partners … in the assessment of their needs' and that their views 'should shape the assessment process' (DoH, 2002). One assessor stated that with EASY-Care 'you get that person's story' (TI-4), with another adding 'EASY-Care was much more person-centred' and explaining that it 'was from the client's perspective of their problems and how much help they needed' (FG-1). One assessor explained her preference in these terms:

> *'I think it's helpful. What people identify as their main problem we probably wouldn't. For instance, they want to go home but can't because there's no key holder next door. That basically is their main problem, not so much that they have got coronary heart disease or whatever. They will say their shopping is their main problem, not their condition, which I think we have always tried to medicalise things, don't we?'(FG-1).*

Other assessors were not confident that the information gathered in EASY-Care would give a 'true picture medically' (TI-4). Respondents reflected on the challenge for all assessors of conducting a person-centred assessment with people coping with changing circumstances including failing health and growing support needs. There were concerns about the reliability of information gathered solely from an older person 'sometimes they are unrealistic, what they expect of themselves' (TI-3) and for a number of reasons may be 'lacking in insight' (TI-1), this respondent went on to highlight the importance of drawing upon carers' knowledge 'for people who lack insight or are not very objective about their needs' (TI-1). However, she added that she would 'still go through the process, I always ask the patient about how things are for them. Ultimately, who are we planning care for?' (TI-1).

From the outset of discussions, respondents agreed that EASY-Care performed well in assessing social care needs 'I would use it for going into people's homes…for looking at their social needs…family support' (FG-2),

and accordingly would be appropriate for use in the community. One assessor felt that EASY-Care was good for both newly admitted residential home clients because 'it goes into much more detail of services that you've had in the past' (FG-1), but it was generally considered less useful for assessing the needs of elderly people in nursing homes.

Acceptability

The term 'acceptability' covers the appropriateness of the questions to deal with sensitive issues. The majority of older people (89%) stated they were not upset when assessed via EASY-Care, with 5% stating that EASY-Care asked too many sensitive questions and 6% neither agreeing nor disagreeing (see Table 3).

Table 3: Acceptability

The tool upset me by asking too many sensitive questions					
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
EASY-Care	23%	66%	6%	2%	3%

Setting was not statistically significant in terms of acceptability. On all three practicability measures, significant differences did not emerge between women and men or between people whose preferred first languages were English or Welsh.

Although most older people did not consider that the tools upset them, the focus groups revealed areas that had the potential to upset older people and how the assessors coped when a person became distressed. While EASY-Care was considered by nurses to be generally acceptable there were some exceptions where it was necessary to draw on psycho-social communication skills. Triggers centred on aspects of loss (such as losing independence or losing contact with family members). One assessor explained that:

> *'The people we're assessing have been newly admitted and they haven't come to terms with the fact that they have gone into a nursing home, and you're asking them all these very personal questions about how they feel about giving up their home. A couple of mine have been reduced to tears and are very, very upset by the questions' (FG-1).*

She went on to explain how she responded to such distress by moving on to a different 'line of questioning and had to go back into it and [giving the older person] a cuddle' (FG-1). Despite liking EASY-Care's assessment of a person's cognitive function, there was general agreement that the memory test could provoke anxiety in some individuals. To counter this, assessors used humour: 'you make it light hearted' (FG-1) and 'say I can't do this myself' (FG-2). There was also general agreement that the questions posed in EASY-Care around alcohol consumption could cause distress. Once again an assessor explained the value of humour (TI-3) to introduce the questions. There was consensus that the number of questions about alcohol was excessive and the language used could be perceived as accusatory 'the way it flows together, as if you're accusing them' (TI-3) which could affect

disclosures about behaviour. As one assessor pointed out, 'if you asked me if you had ever felt guilty about the amount you drink, I don't think anybody would admit even if they did' (FG-1). The EASY-Care developers have removed these questions from the latest version.

Discussion

Care professionals are increasingly being encouraged to share assessment information and thus it is valuable to understand the perspectives that practitioners bring to the assessment process. Assessment helps ensure responsive support and care for vulnerable people with complex needs. Older people in general reported that EASY-Care was useful, not too complex and did not upset them. Nurses' views differed in all of these areas and focus group discussion facilitated greater understanding of the use of structured assessment tools. Additional and less visible skills are required when using pre-defined assessment tools (McKenna, 1995), thus assessors used their interpersonal skills to moderate the more complex or upsetting aspects of assessment resulting in older people who were satisfied, on the whole, with the assessment process.

Assessors generally agreed that EASY-Care was useful to sustain engagement and to gather information in a participatory manner. EASY-Care enabled a holistic health and social assessment to be undertaken and was preferred by some nurses for this reason, but others saw shortcomings in that it did not fully identify nursing or medical issues that may require further exploration. This observation was supported by the statistical evidence from the Client Evaluation Questionnaires that showed that the tool was considered to be less useful for people living in a nursing home. Philp *et al.,* (2001) noted in their evaluation of EASY-Care that nurse assessors did not always welcome the broad coverage of health and social care issues in the tool. Some nurses tend to focus on medical diagnosis (Reed & Bond, 1991) and this observation was true of some of the assessors in this study.

The study findings revealed the reflexive manner in which assessors used their professional and interpersonal skills to administer EASY-Care. Clinical judgement must support a thorough assessment of needs (Cutcliffe & Barker, 2004). Despite being unfamiliar with the people being assessed prior to the assessment, nurses developed rapport and collected verbal and non-verbal assessment information. The assessors illustrated how they reflected on the content of the information provided to them and thus minimised the problem of complacency when undertaking assessments. They used knowledge and intuition to make minor adjustments to the wording and order of questions to facilitate a more person-focused assessment. Such adjustments do not affect the reliability of the tool and are suggested by the tool developer (Sheffield University, 2002). Sensitivity, empathy and patience contribute to a person-centred assessment and are highly valued by service users (Innes *et al*., 2006). A person-centred and holistic approach anticipates that practitioners will engage in a reflexive style (Kitwood, 1997). The assessors' clinical skills alerted them to signs of depression where EASY-Care did not indicate that low mood was an issue, thus supporting Hammond (2004, p.191) who noted that nurses preferred to use tools as a 'therapeutic framework'. EASY-Care prompted disclosures beyond the immediate scope of assessment items on the tool. But the assessors also suggested that the process of

administering a pre-determined printed form could act as a barrier to a more nuanced engagement. Communication skills were vital to overcome these barriers. Although the evaluation questionnaires completed by older people suggest that the majority did not experience difficulties with their assessment, focus groups revealed some potential areas of difficulty and it is essential that the difficulties older people may experience during an assessment are acknowledged. Nurses' knowledge and reflexive skills were used to establish a relationship with individuals and to gauge whether people were realistic. It is important that the format of assessment tools does not impair face-to-face relationships. Qualitative data are valuable where older people's and practitioners' views about their needs may differ (Bartlett, 1999). Closed questions are important where there may be communication difficulties with an individual, but over-reliance on them may suggest that the assessor is not interested in the individual.

Limitations

Qualitative depth interviews with older people would have revealed more detailed information about the assessment process, however these were not included in the study because of the time required to collect assessment information. Assessors were recruited to the study because of their nursing experience and skills in assessing older people, however, the findings may not be generalizeable beyond the study sample. It was not part of the study to compare social care and health practitioners' perspectives. Care plans were not developed following assessments and thus this paper does not comment on this aspect.

Conclusions

EASY-Care was generally considered to be practicable, useful and acceptable when exploring the needs of older people. Analysis of questionnaires completed by older people suggested that the majority found the tool useful when discussing their needs and it did not upset them. Most nurses considered that EASY-Care was person-centred and thus adhered to guidelines for assessment tools. However, interpersonal skills were a significant factor in conducting assessments. Some topics in EASY-Care were thought to be difficult to probe and difficult to respond to, for example, those concerning the older person's perspectives on needs and personal and spiritual fulfilment. Assessment of cognitive function and memory was considered valuable, but extra care was required when assessing these domains because of the potential for confusion where an older person was tired. Several nurses provided examples of where they used their professional judgement to identify depression in individuals where the tool did not indicate low mood. The developers of EASY-CARE should consider strengthening the tool in these areas.

This study illustrates the contributions that nurses make to the assessment process and highlights that some nurses prefer a more factual type of assessment to assess nursing needs and thus may be less comfortable when using open-ended questions to assess social, personal and spiritual needs. Shared understanding of the perspectives that practitioners bring to the assessment process is essential to improve the delivery of services to vulnerable people.

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