



Lessons learned from the introduction of the Comprehensive Clinical Assessment (interRAI) in Aged Residential Care (2011-2015) – a post project review

Final Report

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Prepared for

Michele McCreddie
General Manager
interRAI Services (TAS)

Prepared by

Dr Dilhani Bandaranayake and Michael Campin
Senior Consultants
Evaluation Consult

Contact details

Dr Dilhani Bandaranayake
Evaluation Consult
Phone: 027 545 2939
Email: dilhani@evaluationconsult.com

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Glossary

Activities – Tasks, sets of tasks and other actions that are completed. Activities lead to outputs.

ARC – Aged Residential Care.

ARC Provider – Aged Residential Care provider.

ARC Facility – Aged Residential Care Facility. A facility from which specialised care is provided to resident older people, for instance, a rest home. This does not include independent living within a retirement village.

CANZ – Care Association New Zealand. CANZ is a representative group for Aged Care Facilities.

CAPs – Clinical Assessment Protocols. Risk issues triggered by the data input into the system. These help identify possible interventions.

CCA – Comprehensive Clinical Assessment. A comprehensive assessment tool developed by the interRAI network to improve ARC. This has been introduced in New Zealand and was made mandatory for ARC from 1 July 2015.

Central DHBs – Capital and Coast, Hawke's Bay, Hutt Valley, Mid-central, Wairarapa and Whanganui District Health Boards.

DHB – District Health Board – there are 20 DHBs within New Zealand grouped regionally.

Grey Power – A mass-membership advocacy organisation for New Zealanders aged 50 and older.

HOP – Health of Older people.

Home Care Assessment – Refers to an interRAI assessment designed for people with more complex needs who can live at home. Once a certain level of need is identified, the person is referred to residential care. This can make up part of the CCA.

Impacts – The positive and negative changes produced by an organisation/programme/project both direct, indirect, intended and unintended. Also see Outcomes/Impacts above.

interRAI – International resident assessment instrument. The name refers to both a suite of assessment instruments and the organisation that developed them. The organisation is a collaborative network of 60 researchers in over 35 countries engaged in improving healthcare for persons who are elderly, frail or disabled. Membership of interRAI includes obligations to share anonymous data internationally and to provide support to other members.¹

interRAI (project) – Refers to the implementation process for the interRAI assessment tools, namely the CCA within New Zealand.

interRAI New Zealand Governance Board - The coordination and governing body for interRAI processes within New Zealand. Secretariat support is provided by Central TAS.

¹ interRAI Steering Group (2013). *An introduction to interRAI*.

interRAI Services – The business unit responsible for the rollout of interRAI processes in New Zealand.

KIIs – Key informant interviews. Interviews that have been used at the early stages to frame and scope the review.

LTCF Assessment – The Long Term Care Facility tool (the tool) is a comprehensive clinical assessment of medical, rehabilitation and support needs and abilities such as mobility and self-care. It was designed for residents in ARC facilities to develop and update their care plans. The assessments share 80% of the items with Home Care, Community Health, and Contact Assessments.² The LTCF Assessment is the primary assessment tool for ARC facilities and makes up a part of the interRAI Comprehensive Clinical Assessment (CCA).

Measure – The determination or estimation of ratios, quantities, or levels of quality that is how an indicator is tracked/measured. Can be based on either or both quantitative and qualitative information.

Midland DHBs – BOP, Lakes, Tairāwhiti, Taranaki and Waikato District Health Boards.

Momentum – Canadian healthware company that has developed the interRAI software package being used in New Zealand.

NASCs – Needs Assessment and Service Coordination services.

NiSS – National interRAI Software Service. A national platform to support the integrated suite of interRAI assessments.

Northern DHBs – Auckland, Counties Manukau, Waitemata and Northland District Health Boards.

NZACA – New Zealand Aged Care Association. A not-for-profit national membership organisation which represents all parts of the aged residential care sector.

NZGG – New Zealand Guidelines Group. The New Zealand Guidelines Group (NZGG) was an independent, not-for-profit organisation, set up in 1999 to promote the use of evidence in the delivery of health and disability services. The NZGG went into voluntary liquidation in mid-2012.³

Outcomes – Positive and negative, primary and secondary effects (changes) produced by an intervention, directly or indirectly, intended or unintended. *NOTE:* Outcomes and impacts can be used interchangeably, but in general outcomes often refer to the intended changes, and Impacts refers to all changes that occur (such as positive or negative unintended changes).

Outputs – The products, capital goods and services that result from an intervention. It may also include immediate changes resulting from the intervention which are relevant to the achievement of the outcomes.

Result – An output, outcome or impact. I.e., the ‘result’ of ‘doing’ something (such as an activity).

RN – Registered Nurse.

Rubric – A document or matrix that articulates expectations by listing the criteria, or what counts, and describing levels of quality from excellent to poor.

² interRAI Steering Group (2014) *Realising the benefits of interRAI comprehensive clinical assessment*.

³ Ministry of Health. *New Zealand Guidelines Group*. Retrieved from <http://www.health.govt.nz/about-ministry/ministry-health-websites/new-zealand-guidelines-group> 20 July 2016

Systems Clinicians (SCs) – employed by DHBs during the project (but now employed by TAS) to support the ongoing use of the interRAI system for LTCF and Home Care. Assist lead practitioners in education/training and facilitation and assessments within the service and transfer information between home care and aged care facility.

Southern DHBs – Canterbury, Nelson-Marlborough, South Canterbury, West Coast and Southern District Health Boards.

Sustainability – The extent to which the results of a project, programme, or activities undertaken by an organisation, are likely to continue/endure after formal assistance/support stops.

TAS – Central Region's Technical Advisory Services Ltd.

Theory of Change – Identifies and explains all the key building blocks or steps required to achieve or realise a long-term or high level goal or goals (i.e., outcome(s)). This can then be captured diagrammatically with a 'model'. The theory of change includes identifying the assumptions being made to achieve the goal(s), including those about causation, attribution, contribution, or correlation

Executive summary

The Comprehensive Clinical Assessment (interRAI) in Aged Residential Care (ARC) project started in July 2011, with the goal of establishing the use of a standardised assessment tool (namely the interRAI LTCF assessment tool – the ‘assessment tool’) in New Zealand. A post-project review of the project from pre-project establishment through to 30 June 2015, (July 2011-July 2015) was conducted in 2016. The main aims of the review were: to assess whether the project to implement the LTCF assessment tool met its intended objectives; identify the project enablers and barriers; and identify the learnings and recommendations to be taken forward. Residents of ARC facilities and any interface with primary or tertiary health, were not in the review scope as the focus was on the ARC providers and facilities to establish the impact of introducing the LTCF assessment tool to the ARC sector.

Lessons learned

Implementation and communication

Improved consultation with the sector as well as collecting structured ongoing feedback from the beginning of the project (not just at the close out) would have been beneficial to monitoring the project’s impact and progress. It would have provided relevant feedback to help alleviate some of the negative perceptions during implementation, particularly with respect to the transition from voluntary to mandatory use of the assessment tool.

Clear communication about the benefits and expectations around the timing of the realisation of some of the benefits would have been beneficial. Providers questioned the actual benefits of the assessment tool and interRAI system given that they take on a large proportion of the costs. This includes how the data collected from the assessment tool can be used to benefit them – at resident, facility, provider and sector levels.

Training

Access to training has been an issue for providers and facilities, from a waiting time perspective and the numbers of RNs allocated for training. In addition, RN turnover in the sector results in facilities needing to train new RNs (if an interRAI trained RN can’t be hired) which is an additional cost that the facility has to account for.

Adoption of strong adult learning principles in all training, recognition that many RNs work on the training for a significant amount of their own time including days off and juggling life activities, would lead to a uniformly more positive training experience.

Efficiency

There appears to be two models of LTCF assessment process in facilities. One is a compliance audit model where LTCF assessments are done by one or a select group of staff who do all the assessments as a compliance measure. The other more emergent integrated care model is one where all RNs are LTCF trained and are completing assessments for the residents/patients they are assigned to. For interRAI to work more efficiently in the facilities, all the nurses dealing with residents need to be interRAI-trained so that the interRAI workload does not fall solely on the few who are.

For several reasons interRAI is not being used in the way it has been designed – as an electronic web-based system. Using multiple technology (especially paper-based) is not likely to be the most efficient way of completing an assessment. In addition, enhancing the interoperability of the interRAI platform should improve efficiency.

Strategic and operational recommendations

Implementation and communication

1. A communication strategy is put in place that includes a collaborative consultation process with all stakeholders for new projects piloting other interRAI assessment tools. (*Strategic*)
2. Evaluation and adaptive management incorporated from the planning phase for new projects/pilots and not just at the end of the pilot or project. (*Strategic*)
3. A simple ongoing evaluative ('track as you go') process is established for the LTCF clinical assessment tool so that progress and issues can be tracked and resolved as required. This process also enables the people using the tool to give feedback and have a voice. (*Operational*)
4. interRAI Services communicate how the data collected now from the LTCF clinical assessment tool can benefit the sector. (*Operational*)

Training

5. Investigate a more sustainable interRAI LTCF clinical assessment tool training model in New Zealand. (*Strategic*)
6. Review training feedback mechanisms to collect and utilise both information about the LTCF clinical assessment tool and the training process itself. (*Operational*)

Efficiency

7. Decide upon a preferred process model for the interRAI LTCF clinical assessment tool. A compliance model has been widely practiced to date due to the nature of an implementation with a large workforce. An integrated model where the interRAI assessment is completed by the RN assigned to the person and actively used in the care planning process may be a more optimal process model going forward due to increased resident/person knowledge. (*Strategic*)
8. Work with DHBs to improve consistency with NASC processes. (*Strategic*)
9. Demonstrate efficient application of the LTCF clinical assessment tool (*Operational*)
10. Investigate the feasibility of allowing bidirectional information flows between the LTCF clinical assessment tool and the number of resident management and care plan options available. (*Operational*)

Key findings and conclusions

Relevancy

The need for a standardised clinical assessment tool for aged residential care was widely acknowledged by the stakeholders involved. However, the process by which the assessment tool was introduced and then made mandatory had a negative impact on how the tool is viewed. The sector was mandated to use a tool that only some of them had implemented.

Efficiency

Lack of interoperability between interRAI, care planning, and patient management systems as well as duplication of assessment information and double entry of data, is having an impact on the efficient use of the interRAI system. Addressing the issues regarding interoperability will assist with usability and embedding the assessment tool. NASC managers identified an efficiency gain from the introduction of the assessment tool as it enabled remote acceptance of a change in level of care, therefore reducing the need to go to facilities and undertake assessments.

Effectiveness

Overall, the project was effective in meeting its set objectives, including training the required number of RNs based on the ratio of one nurse to 15 beds. It also effectively communicated the implementation of the interRAI system and what was required from facilities. NASC managers noted that the introduction of the LTCF assessment tool has meant that the same terminology is used when discussing residents thereby improving consistency. The project was less effective in conveying the actual benefits of the assessment tool and how the data collected via online assessment can be used to improve quality of care and benchmarking against the sector.

Impact

One of the biggest impacts has been on interRAI trained RNs, including: time away from resident care; additional workload stress; and working in their own time to complete interRAI assessments or competency training requirements. Another impact was the cost to providers of implementing the interRAI tool, for both large and small providers. The true extent of these costs does not seem to have been anticipated or acknowledged when the assessment tool was implemented. NASC managers have seen an improvement in their relationships with facilities since the introduction of the tool which has had a positive impact on how they work with facilities.

Quality and safety of care/health and equity

Aspects of the assessment tool, such as the resident care triggers generated and the systematic and more consistent application of a comprehensive clinical assessment were positive in regards to quality of care. Additionally, nurses have up skilled their clinical knowledge through the training process. However, unintended consequences are having a negative impact e.g., interRAI trained RNs' time away from the floor to enter data, leaving less experienced nurses to care for residents was impacting on quality and safety.

Value for money

Looking to the future, there are indications that the assessment tool has provided some value for money to the wider sector, particularly for DHBs and the NASC process. However, so far providers and facility managers indicated that the introduction of the assessment tool has provided little or no value for money. It has been costly to implement and these costs currently outweigh any benefits for most providers and their facilities.

Sustainability

Although the use of the assessment tool is mandatory, providers felt that it is not sustainable long term with respect to its current impact on cost and time. Increasing the interoperability of the interRAI system and reviewing ways to increase the capacity of facilities to complete interRAI assessments and lessen workload stress (e.g., increasing trained RN quotas or examining training models) would have a positive effect on the ongoing sustainability of the assessment tool.

1. Introduction

1.1. Background to the review

The Comprehensive Clinical Assessment (interRAI) in Aged Residential Care project began in New Zealand in July 2011. The original goal of the project was *“to achieve overall improvement in the quality of care planning which will, in turn, increase the quality of care provided to New Zealanders in residential aged care facilities”*⁴ The purpose and some of the outputs of the project have changed over the course of the project, mainly due to changes in the scope. The original project charter⁵ indicated that the purpose of the project is *“to reduce the variation in the quality of assessments within residential aged care services by the introduction of a standardised assessment process and tool”*. The Steering Committee approved a revised project plan in September 2012, following a change in project management and training approach. The project’s aim was *“to have 630 (90%) of ARC facilities trained and using the interRAI LTCF as their primary comprehensive clinical assessment for all new residents (and subsequent reassessments) by 30 June 2015”*.⁶

On 19 October 2012, the Associate Minister of Health announced that the use of the interRAI Comprehensive Clinical Assessment (CCA) would become mandatory, thereby changing the project scope. The new targets were: by June 2014 100 percent of aged residential care facilities would be participating in the project and by July 2015 all facilities would be using the assessment as their primary means of assessing residents.⁷

The Comprehensive Clinical Assessment (interRAI) Project (the project) was tasked with establishing the use of a standardised assessment tool (namely the LTCF assessment tool) that uses software, designed to improve the care of older people in aged residential care facilities. The introduction of the LTCF assessment tool was ARC sector led with the New Zealand Aged Care Association (NZACA) being the main driver with support from the DHBs.⁸

The main objectives for introducing the CCA assessment tools were to:

- deliver best practice assessment that consistently covers all the important domains without accidental omissions
- provide support for clinical decisions, intervention and care planning decisions that raise the quality of care for older people
- provide consistent data for better informed policy and funding decisions at both local and national levels⁹
- minimise duplication of assessments
- provide a holistic assessment that is multi-disciplinary and resident focused.¹⁰

Evaluation Consult was commissioned by interRAI Services, Central Region’s Technical Advisory Services Ltd New Zealand (TAS) to undertake a review of the progress of the project from pre-project establishment through to 30 June 2015. This document reports the main findings from the Post-Project Review (the review) of the interRAI project as well as outlining the objectives of the review and the approach, methodology and tools that Evaluation Consult used.

⁴ Telford, H., Cree, A and Steering Group (2011). interRAI Comprehensive clinical assessments - Project Charter (August draft)

⁵ Telford, H., Cree, A and Steering Group (2011). interRAI Comprehensive clinical assessments - Project Charter (August draft)

⁶ interRAI steering Group. (2012). *Aged Residential Care Comprehensive Clinical Assessment interRAI Project Plan - A plan for the Aged Residential Care interRAI Steering Group*

⁷ interRAI steering Group (Aug 2015). *Comprehensive Clinical Assessment (interRAI) in Aged Residential Care – Project Close Report 2011-2015*

⁸ Telford, H., Cree, A and Steering Group (2011). interRAI Comprehensive clinical assessments - Project Charter (August draft)

⁹ interRAI steering Group. (2012). *Aged Residential Care Comprehensive Clinical Assessment interRAI Project Plan - A plan for the Aged Residential Care interRAI Steering Group*, p.6.

¹⁰ interRAI steering group. (2013). *An introduction to interRAI*.

1.2.Overall aims of the review

The overall review aim was to conduct a post-project review of the Comprehensive Clinical Assessment (interRAI) Project (July 2011-July 2015) to assess whether the project to implement the LTCF assessment tool met its intended objectives; identify enablers and barriers and identify learnings and recommendations that can be taken forward. The review also aims to inform interRAI Governance and managers, funders, implementers, and interRAI users of the project's progress, and to inform future decision-making, as well as meet accountability requirements.

1.3.Review requirements

1.3.1.Information objectives

In approaching the research, we have divided the **overall purpose of the review** into four broad-based information objectives as articulated below:

- **Formative:** Identify the context, need, and intent of the interRAI project as well as the intended outputs and outcomes
- **Process:** Identify what was done with the implementation of the interRAI project, including the processes used, the progress made, enablers and barriers
- **Summative:** Ascertain whether the stated objectives (outputs) of the interRAI project were achieved and how this changed across the different phases of the project, as well as unintended results, coverage, contribution and effectiveness
- **Lessons learned:** Identify the strategic and non-strategic (operational) learnings and recommendations to provide for future design and support of interRAI and similar projects going forward.

1.3.2.Purpose

This review examines the progress of the project from pre-project establishment through to project close on 30 June 2015. The **purpose** of the review has been divided into **four areas each aligning with an information objective** and associated activities as follows:

- **Formative – Document project stages and progress:**
 - document the pre-project establishment process
 - summarise the project activities including governance of the project
 - document changes to the project scope and expectations of the sector
 - collate key documents as a reference point.
- **Process – Evaluate process and achievements:**
 - summarise implications, especially financial implications, on the sector from implementing the tool
 - summarise additional activities arising from the project implementation
 - summarise the outputs of the project.
- **Summative – Report on findings:**
 - report on the extent that the project achieved its intended aims
 - inform the interRAI New Zealand Governance Board about any areas that may to be incorporated into future strategic planning
 - inform interRAI Services (TAS) about any areas that may be incorporated into future operational planning.
 - review the positive and negative impacts on the sector

- **Lessons learned** – *Identify lessons learned*:
 - review the implications for:
 - ARC providers and facilities
 - DHBs e.g. changes to business processes
 - providers e.g. cost of implementation, internet requirement, mandatory training
 - Governance Board e.g. change to the governance Board structure
 - Ministry of Health
 - interRAI Services (TAS) e.g. national delivery of interRAI services
 - identify any significant lessons learned to share with the sector
 - identify any major recommendations to share with the sector.

1.3.3.Scope

The review team considered the following when developing and conducting the review:

- the objectives of the project
- scope changes to the project i.e. the project re-scope in response to the Government Directive for mandatory implementation (from voluntary), including associated budget changes
- any implications for the project/sector, especially financial, of scope change
- additional requirements for the project arising from Ministerial or sector requests; for instance, the '19 items' letter
- measures of success
- phases of the project (engagement, training and embedding)
- service delivery options explored
- project outputs.

1.3.4.Stakeholders

The review sought to involve and inform the stakeholders listed below, as advised by interRAI Services, in addressing future decision making in the interRAI project:

- the interRAI Services management team - interRAI Services (TAS)
- the interRAI New Zealand Governance Board
- DHBs (including NASC Managers)
- ARC providers and facilities
- the Ministry of Health
- New Zealand Aged Care Association (NZACA)
- Care Association New Zealand (CANZ)

As agreed with interRAI Services, residents of ARC facilities and primary and tertiary health interfaces are not in the scope of this review. The focus of the review is interRAI Services, ARC providers and ARC facilities, to establish the impact of the LTCF assessment tool on the ARC sector.

2. Review framework and methodology

2.1. Review framework

The key components that compose the comprehensive framework for this review: background and context; the theory of change for the project; a results model; and project assumptions are described in detail in *Appendix One*.

The review team has, in collaboration with interRAI Services, developed a results-focused model as part of the review plan, outlining the key activities, inputs, outputs, and outcomes of the interRAI project. This approach is underpinned by Purposeful Program Theory.¹¹

The results model on page 9 visually maps the theory of change for the interRAI project as understood by the review team and interRAI Services. It is a currently a working model only, having not been the focus of this review. The model describes the resources and activities that contribute to a project and the logical links that lead from project activities to the project's expected outcomes. The results model for the interRAI project outlines the inputs and activities of the project and links them to the intended project outputs and outcomes as well as wider health outcomes related to the health of older people. The model provided an important foundation and dialogue tool for the review team to utilise during the review process.

In addition, the review team used the New Zealand Triple Aim for quality improvement concept (*Figure 1*) to inform the review on how the interRAI project and clinical tool have impacted at the individual, system and population levels with respect to the information objectives in section one.



Figure 1: New Zealand Triple Aim for quality improvement

¹¹ Rogers, P. 2011. *Purposeful Program Theory: Effective Use of Theories of Change and Logic Models*. Queensland: Jossey-Bass

2.2.Review criteria

Based on the components of the approach outlined in *Appendix Two*, the main review criteria are:

- **Relevancy** – The extent to which the interRAI project is suited to the needs, priorities and policies of providers, facilities DHBs and other funders (for instance the Ministry of Health).
- **Efficiency** – Efficiency measures the outputs (qualitative and quantitative) in relation to the inputs.
- **Effectiveness** – Measure of the extent to which the interRAI project has attained its objectives.
- **Impact** – The positive and negative changes produced by the introduction of the interRAI assessments, directly or indirectly, intended or unintended.
- **Sustainability** – Whether the benefits of the introduction of the interRAI tool are likely (and able) to continue.
- **Value for Money** – Whether the interRAI project produced better value for public health system resources.
- **Quality and safety of care** – Whether the interRAI project is creating improved quality, safety and experience of care.
- **Health and Equity** – Whether the interRAI project is resulting in improved health and equity for all populations.

The review team used these criteria to inform the interview and survey questions. They also form the basic structure of the review findings.

(Working draft) interRAI Results Model



Post Project Review model

Vision

Older People participate to their fullest ability in decisions about their health and wellbeing and community life. They are supported in this by co-ordinated and responsive health and disability support programmes. (NZ HoOP Strategy 2002)

InterRAI ARC Project (pilot)

Key:

Out of initial scope

Key project outcomes

Wider context

National Health Outcomes

Indirect

Preventative Medicine

Holistic Care

Information driven care practice, planning and policy (Operational)

Reduced Service Management (10)

Casemix classification systems (10)

Improved IT capability of the sector

Direct Project Outcomes

Improved Care Plans

Objective Assessments

Identifying relative risk of adverse outcomes (10)

Targeting priority groups using screening algorithms (10)

Provide quality improvement and monitoring measures (10)

Facilitated cross sector communication (10)

Reduce variability of assessments

Reduced duplication (10)

Funding

Clinical decision support for nurses and doctors

Nurse developed Individualised resident Care Plan (10)

Managers use the care plan for operational decisions

Standardised InterRAI Assessments

Data

Outputs

Assessments and re-assessments are undertaken

InterRAI Trained Nurses

interRAI informed managers

interRAI trained managers

IT Provided

DHBs, NASCs, MOH requirements changed because of InterRAI

Activities

Training of ARC Nurses

Changes to the aged residential care contract

interRAI customisation to New Zealand

IT capacity/ capability development

Training of ARC Management

Facility embedding the use of the assessment into their culture

Inputs

Family/ caregivers

Other health clinicians

Registered Nurses

ARC Resident

InterRAI platform

ARC Providers (Management)

NASCs

Funding

Policy (Assessment Practice of older people)

2.3. Methodology

The methodological approach used for the review was a **Rapid Evaluation Appraisal Method (REAM)** mixed methods approach. This review included using both quantitative and qualitative REAM methods that were developed for and used in evaluation of international development assistance initiatives. This is a recognised data collection approach for completing evaluations and reviews in a robust, fit-for-purpose and timely manner.¹² The advantage of this approach is that it uses a selection of qualitative methods and simple quantitative methods.

The mixed method research design ensured that reliable information was gathered from multiple sources, and was informed by key stakeholders involved in the interRAI project.

The data collection methods used were:

- **a document review and relevant background meetings**
- **key informant (stakeholder) interviews** to inform the review plan and tools
- **a survey** of 678 Aged Care Residential facilities – (This was delivered to the email addresses of facility managers held by TAS.)
- **interviews** with representatives from large/medium/small **ARC providers** in select areas.
- **Interviews** with a sample of **NASC Managers/Assessors**

Table 1: Sample Frame

Stakeholder group	Data collection method				
	Background interviews	Key informant interviews	Survey	Provider interviews	NASC Manager interviews
InterRAI Services senior management team - interRAI Services (TAS)	3				
interRAI governance board		2			
National aged care representatives	1*	3 (includes 2*)			
DHBs (including Health of Older People steering group)	1*	2 (includes 1*) & 1 group interview			4 (2 North Island, 2 South Island)
Ministry of Health		2			
ARC Steering Group		2*			
ARC facilities		2	297/678		
ARC providers		2*		18 (including 3 group interviews and 6 pair interviews)	
TOTAL NUMBER	4	10	297 (43.8%)	18	4

*Interviewee(s) represented in more than one stakeholder group. Therefore, total number will be less than the numbers indicated in the table

Eighteen interviews were carried with Providers. Criteria for selecting providers included:

- Whether a given provider was an independent facility or a multi-location conglomerate
- Facility size of independent providers (small – 1-30 beds, medium – 31-80 beds, large – 81+ beds)
- Provider location (North island vs South Island, Rural vs Urban)

¹² Patton, M. (2002). *Qualitative Research and Evaluation Methods*. California: Sage Publications

Table 2: Total number of interviews (over the phone and face to face) by location

Location	Total no. of facilities	Breakdown of facility size		
Auckland	6	Large: 4	Medium: 1	Small: 1
Christchurch	4	Large: 3	Medium: 1	
Wellington	4	Large: 2	Medium: 2	
Rural/Remote (2 North Island/ 2 South Island)	4	Large: 2		Small: 2
Total	18	11	4	3

Telephone interviews were conducted with a purposeful sample of NASC managers from DHBs in both the North and South Islands. Four telephone interviews were conducted in total, with NASC managers from two North Island NASC services and two South Island. One of the interviews included two senior level people from the same NASC service. The interviews were included as an additional data source after initial data collection had been completed, at the request of the interRAI NZ Governance Board. It was agreed that the views of NASC managers should be sought, particularly regarding how they use interRAI LTCF clinical assessments when considering changing levels of care for ARC and the feedback from ARC providers about lack of consistency between District Health Boards (DHBs) in confirming changes in level of care.

The methodology incorporated information objectives and review criteria. An overview of each research method is provided in *Appendix Three*.

The viewpoints of LTCF trained assessors were collected in the provider interviews which were attended by 12 assessors/clinical leaders in conjunction with their manager/management group. The views of assessors were also gathered in the survey where the facility manager completing the survey is or has been a qualified LTCF assessor, or where the facility manager had passed the survey to an assessor to complete. As the survey was of facilities not individual roles within the facility the exact numbers in these groups is unknown.

2.4.Limitations of the review

We conducted 18 interviews in total with a purposeful sample of all ARC providers at each category level (small/medium/large provider size). We conducted face-to-face interviews with providers from Wellington, Auckland and Christchurch where the five largest providers have head offices and where there is also access to a cluster of medium and small providers. This sampling reflected a pragmatic decision based on areas where we would find a mix of providers. However, to ensure coverage of more rural and remote area providers we will select a sample for phone interviews. We also undertook a survey of all ARC facilities to improve coverage.

2.5.Assumptions of the review

The following assumptions have been made in designing this review:

- The facility managers are the best qualified position to represent each individual facility.
- Provider representatives who are interviewed are best able to comment on behalf of their provider.
- The review team have been provided with the relevant documentation to fully inform the review.

3. Review findings

3.1. Introduction

The following section presents the main findings from the post project review of the comprehensive clinical assessment (interRAI) in aged residential care project. It addresses the implications and impact of the implementation of the interRAI LTCF assessment tool; whether intended objectives were met; the key enablers and barriers; effectiveness of the implementation and the LTCF assessment tool; perceived value for money; and sustainability.

The review findings are based on data and information from:

- **A review of key documents** (*Appendix six*)
- **Key Informant interviews** (n= 10 – including one group interview)
- An **online survey of facility managers** at 678 ¹³Aged Residential Care (ARC) facilities (n=297; 44% response)
- **Interviews with a purposeful sample of ARC Providers** (n = 18). This sample included interviews with a mix of small, medium and large providers in both urban and remote settings.
- **Interviews with a purposeful sample of NASC Managers/Assessors** (n = 4). This sample included interviews with NASC Managers from DHBs in both the North Island and South Island.

The findings of the review are summarised primarily under key areas identified in the review criteria outlined in *Appendix Two* and underpinned by the information objectives described in section 1.3.1.

The LTCF clinical assessment tool was introduced on a voluntary uptake basis in July 2011. The project was co-sponsored by NZACA and Ministry of Health. The project aim at that time was to engage 90 percent of ARC facilities in the voluntary use of the LTCF clinical assessment (interRAI) as the primary assessment to inform a resident's care plan across all DHBs by July 2012.¹⁴ In October 2012, the project scope was changed when the Government announced that the LTCF assessment tool would become mandatory from July 2015 and all ARC providers would be required to use the assessment tool for all aged care residents. The review examines the impact that this change in scope had on the stakeholders involved.

In addition, we have looked at whether size of providers has any impact on the information gathered from the sector. Provider size was based on our own definition as there is no definition for small, medium and large providers in the sector. We classed small providers as less than 35 beds; medium as 36 – 80 beds and large as greater than 81 beds.

Unless otherwise stated, any quotes provided in the report are from the ARC provider interviews.

¹³ Based on a distribution list of all ARC facility managers, provided by interRAI Services on 8 August 2016

¹⁴ interRAI steering Group (Aug 2015). *Comprehensive Clinical Assessment (interRAI) in Aged Residential Care – Project Close Report 2011-2015*

3.2.Relevancy

The extent to which the interRAI project was suited to the needs, priorities and policies of providers, facilities, DHBs and other funders (for instance the Ministry of Health) was considered.

- Most of those surveyed and interviewed indicated that there was a **need for the introduction of a standardised clinical assessment tool**. (Survey returned between 50 percent and 64 percent affirmed a need under the purposes provided in graph 1)

“I was very keen to see a standardised and evidenced based tool and linking through to community with NASC too”.

“I think we managed well in the past. But with new technology and requirement to meet standards. I think it was time to do something like this”.

“Standardised tools generally improve safe and health for everybody because people have a common language and baseline for what is there”.

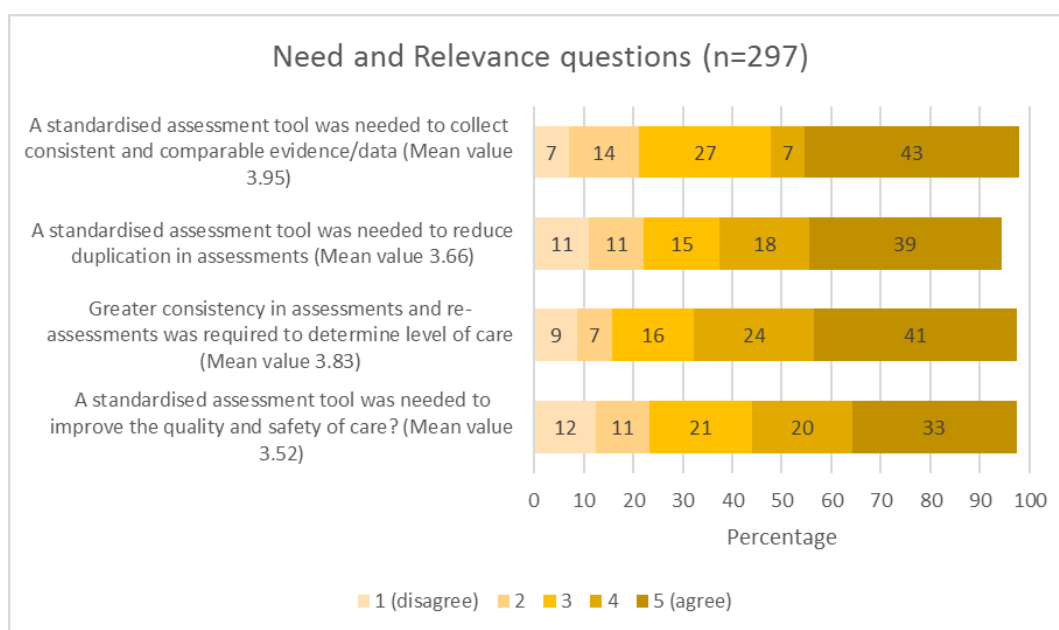
*“Absolutely, I think interRAI provides some objectivity and some standardisation of the process... introducing interRAI means everyone is measured by the same yardstick”
(NASC Manager)*

- While a standardised assessment tool was seen as important for the sector, there were concerns from the ARC providers about interRAI LTCF clinical assessment tool being the appropriate tool or the process not being consistent enough. However, no alternatives (other than providers’ existing assessment tools) were specified by the providers interviewed.

“I don't know that interRAI is the right tool which is giving the answers [we] need”

“I thought it was something [that] was needed so everyone could talk together..... I think that there was a need for the tool, but not sure that interRAI is that tool”

“The [LTCF assessment] tool is a tool and it is seen as a good thing but the execution of the process is the problem”



Graph 1: Results for Need and Relevance survey questions

- A portion of the providers interviewed believed that the Ministry of Health (MoH) led the introduction and implementation of the LTCF assessment tool not the ARC sector. This was likely due to the shift from voluntary to mandatory being seen as driven by the MoH and therefore no longer a sector led voluntary project. Others felt that while it was originally seen as sector-led it was only led by a sub group within the sector. This influenced engagement and “buy-in” from providers.

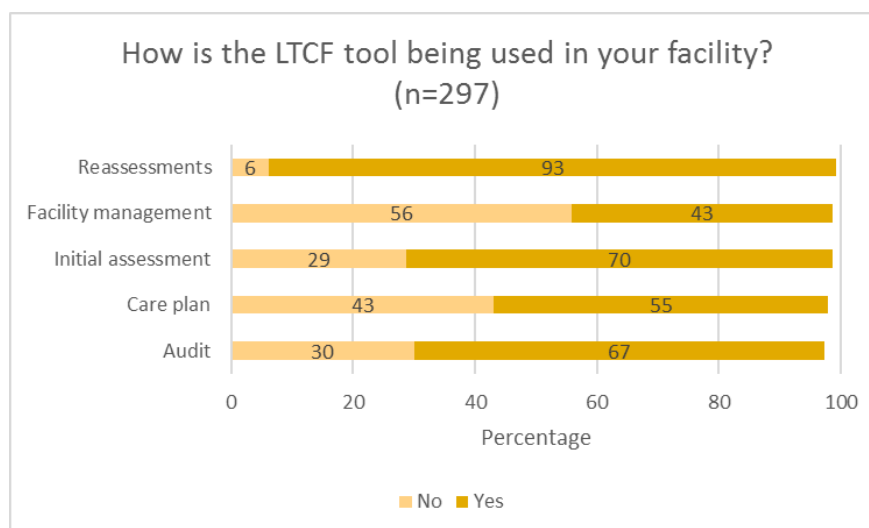
“I don’t think there was any discussion whatsoever over whether the sector wanted the tool, it was a dictum from the Ministry of Health”.

- Providers indicated that the implications of introducing the interRAI LTCF assessment tool were not fully thought through and there was limited consultation with providers. There was also concern that the primary users of the tool, the **registered nurses, were not consulted** prior to the introduction to adequately identify the impact of introducing the LTCF assessment tool on those using it.

“When it was introduced we were told it was brought about because of a downfall in care planning. I was surprised about this, if nurses were consulted, it would have been about time and resources, I think implementing an assessment that took 6-8 hours was counterproductive”.

- Providers noted that there was still a need to look at the language as some of the **language and terminology** of the LTCF assessment tool was Canadian and not seen as appropriate to the New Zealand context. The language was also seen as “clunky” with the system not accepting notes if not written in a certain way.

- The **national interRAI software care plan was not used** by the majority of providers interviewed. They found the care plan was too long and not practical for resident care. Most providers used their own care plans in both electronic and paper based form. Some were investigating other electronic care plan options. It should be noted that the use of the national interRAI software care plan was not part of the project or education programme after the first year as it was seen as commercially unfair on other residential care software vendors.¹⁵



Graph 2: Results for survey question – How is the LTCF being used in your facility

3.3.Efficiency

The review assessed the outputs in relation to the inputs to ascertain whether efficiency gains were evident.

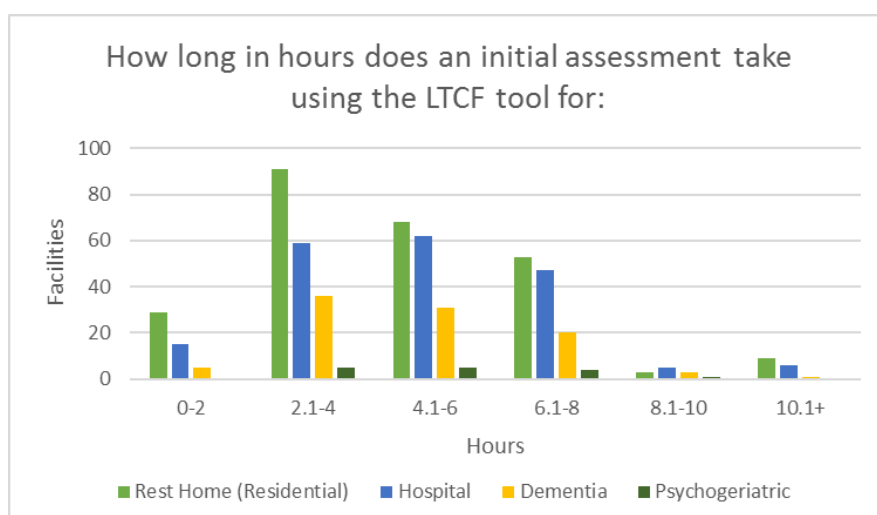
- **Time taken¹⁶** to complete an initial interRAI assessment was seen by providers and facility managers as too long. The NASC managers interviewed, also noted that the LTCF clinical assessment tool was more time consuming for staff in facilities. Graph 3 shows that 84 percent of facilities estimate that the initial assessment takes between two and four hours for residential level care. A provider communicated that initial assessments were taking longer than the two hours they were initially told during the introduction of the interRAI LTCF assessment tool. Providers felt that interRAI assessments took materially longer to complete than their previous assessments. The time taken to complete an initial assessment is influenced by: the way the information is collected and entered; who is entering the information; and the level of detail entered by the RN¹⁷. The time taken to complete a re-assessment was estimated to be shorter at just over 2.5 hours for a rest home (residential) level care.

“The LTCF is probably more time consuming. It has impacted on the frontline staff to try and get reviews done on time” (NASC manager)

¹⁵ An assessment of the national interRAI software care plan itself is outside the scope of the review.

¹⁶ Time taken is the estimate of the survey respondent. It was typically provided as a range. In these instances the review team have taken the midpoint of this range.

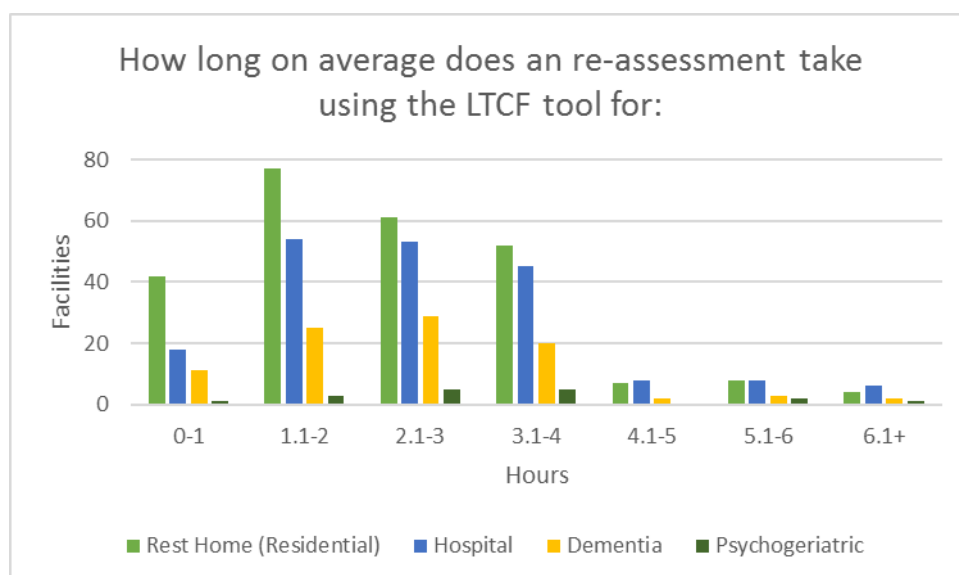
¹⁷ The review team is unable to qualify what respondents included or excluded from their estimates. However estimates for facilities using paper based forms and laptops were very similar indicating that time to double enter was likely not included in the estimate.



Graph 3: Results for survey question – How long in hours does an initial assessment take using the LTCF tool?

Table 3: Time taken for initial assessments using the LTCF tool

Care category – Facilities answered	Mean time estimate	Range & Median
Rest Home (Residential) – 253	5.19 hours	1 – 24 & 4.5
Hospital – 195	5.63 hours	1.25 – 24 & 5
Dementia – 96	5.24 hours	1 – 20 & 5
Psychogeriatric – 15	5.47 hours	3 – 9 & 5



Graph 4: How long on average does a re-assessment take using the LTCF tool?

Table 4: Time taken for re-assessments using the LTCF tool

Care category – Facilities answered	Mean time estimate	Range & Median
Rest Home (Residential) – 251	2.62 hours	0.5 – 8 & 2.5
Hospital – 192	2.94 hours	0.5 – 8 & 2.5
Dementia – 92	2.80 hours	0.75 – 7 & 3
Psychogeriatric – 17	3.44 hours	1 – 7 & 3

- **Duplication of assessment information** was identified during provider interviews and from the survey. Seventy-three percent of facilities surveyed indicated that they used another tool in addition to the LTCF assessment tool for initial assessment, while 48 percent are using another tool in addition to the LTCF assessment tool for reassessment.

The key reasons given by providers for duplication of assessment included:

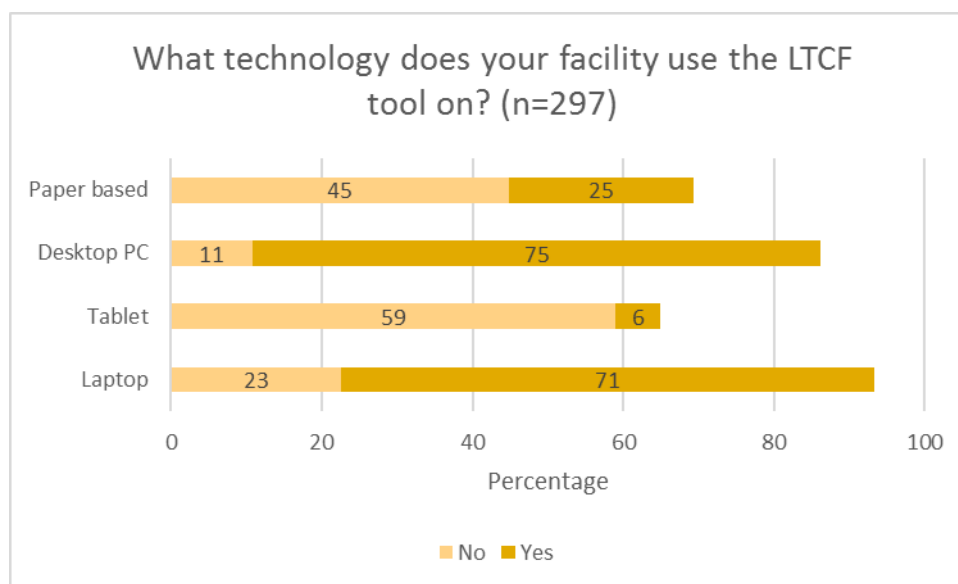
- A perception that an interRAI LTCF assessment cannot be completed until the resident had been at the facility for three weeks. Therefore, there was a need to do a separate initial assessment upon arrival so that the resident's needs were ascertained as soon as possible and a care plan developed. It should be noted that the ARRC contract states that interRAI assessments should be completed within 21 days. There is no instruction that facilities have to wait 21 days. There is also a belief that the information from the home care assessment that comes with the resident does not provide the level of detail required. The reliability of this information from the home care assessment interRAI was also questioned by providers. Some providers used only the demographic information.
- In some instances, additional specialised assessments were used to compliment the interRAI LTCF assessment, such as the Waterlow Pressure Area Risk Assessment, falls risk assessment, Braedan scale assessment and other skin assessments.
- the LTCF assessment does not provide enough nuance, therefore additional assessment tools were required to provide enough information for care planning. This resulted in duplication of some information.

“Our internal assessment forms give far more appropriate and useful information when formulating the care plan, etc.” (Facility survey)

- Some providers indicated that they preferred using their own clinical assessment tool (in addition to the interRAI LTCF assessment tool). The LTCF assessment tool was used for compliance and audit purposes only by several providers both large and small.

“For us it is essentially another assessment all together” (Multi-facility Provider)

- **Double entry of data** was noted during the provider interviews. Several providers did not have the capacity or infrastructure to work directly on to laptops. However, in contrast the survey results showed that 71 percent of facilities used a laptop at some point in the assessment process. It should be noted that many facilities are using a combination of technology. Twenty-five percent of the 297 facilities surveyed are using paper based forms at some point in the assessment process. Paper based assessments are then required to be entered into interRAI by a trained RN. In addition, because not all nurses are interRAI trained, the nurse who assesses the resident is not always the same nurse that enters the information into the interRAI system. In some instances, this means that a highly experienced RN is functioning in a data entry role.



Graph 5: Results for survey question – What technology does your facility use the LTCF tool on?

- **Interoperability** concerns were noted in both the provider interviews and facility survey. While interRAI is designed to be fully interoperable with care plans some providers still expressed frustration at not being able to have information flow from the LTCF assessment tool to the care plan software. Providers also communicated that they were uncertain about which programs would work well with the interRAI software.
- The LTCF clinical assessment tool was identified by some NASC Managers as **enabling remote acceptance of change of level of care**, reducing the need to go to facilities and undertake assessments, thereby increasing efficiency at the NASC.

“For me it has made looking at them and approving them a lot easier and faster”
(NASC manager)

- The interviews with both NASC managers and ARC providers indicated that there was **variability between DHBs in the length of time for NASC assessors to complete a change in level of care request**. The time depended on the urgency of the case and level of complexity, whether extra information was required in addition to the LTCF assessment, whether the assessor needed to visit the resident and the assessor’s case load at the time. Some NASC assessors indicated it took between one to five working days, with the less complex done in less than three days. However, one did indicate it took them between three days (urgent cases) and one month (non urgent).

“We have an answer within five working days. Usually one to two....Case load impacts the turnaround time” (NASC manager)

“It depends on the urgency.....really unsafe and wandering then within 72 hours.....one month for non urgent” (NASC manager)

3.4.Effectiveness

Measure of the extent to which the interRAI project has attained its objectives.

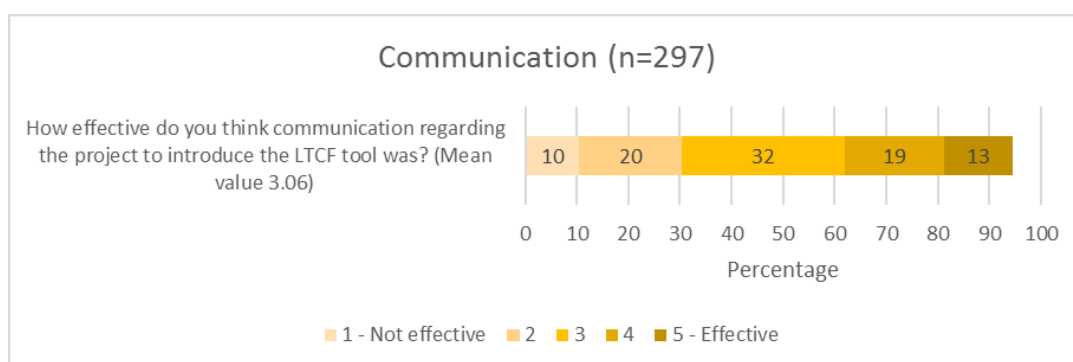
- The project has **met its intended target of 2,370 registered nurses trained** and competent in the use of the interRAI LTCF assessment tool. The actual total at the close of the project was 2511.¹⁸
- The introduction of the LTCF assessment tool has meant that all those using it are **using the same terminology when discussing residents**; therefore, consistency has improved in this respect.

“I think it has meant that we are all talking the same language. We can talk about outcome scores and CAPS being triggered” (NASC manager)

“Key success is that we are all speaking the same language and looking at things the same way” (NASC manager)

- Overall, **communication** to providers and facility managers in regards to the introduction of the LTCF assessment tool **was seen as effective**. Facilities which had implemented the LTCF assessment tool voluntarily (22 percent of 297 facilities) were both slightly more positive and negative about whether the communication regarding the introduction of the LTCF assessment tool was effective. Facilities which came in at the mandatory phase were more neutral regarding the communication (34 percent of mandatory facilities rated a three as opposed to 24 percent for voluntary). Twenty-one percent of facilities in the voluntary period rated the communication a five – effective, compared to 11 percent for those who introduced in the mandatory period.

¹⁸ interRAI steering Group (Aug 2015). *Comprehensive Clinical Assessment (interRAI) in Aged Residential Care – Project Close Report 2011-2015*



Graph 6: Results for survey question regarding communication

- Some providers indicated that the benefits of the interRAI tool were ‘oversold’ to the sector initially and **the tool had not delivered on what was promised**. This included: the benefits of using interRAI, the use of the data collected, the time taken to complete assessments and the financial cost to do training.

“In parts it was really good – but it didn’t deliver on what they said it would be/do” (Single facility provider)

- Providers have indicated that it is **unclear how the data collected is being shared and used** to improve the sector. Benchmarking their own facilities/organisations against the sector as a whole for key indicators would be useful.
- Sixty percent of facility managers surveyed have indicated that they **have attended the facility managers’ training**. The majority of the providers interviewed stated that they had found the managers’ training useful. Ninety percent of those who had attended the managers training found the training helpful to understand the tool better and the requirements placed on their RNs. Some facility managers indicated that they are using the interRAI data for management and quality purposes.

3.5.Impact

The positive and negative changes produced by the introduction of the interRAI LTCF tool assessments, directly or indirectly, intended or unintended.

The impact of the introduction of the tool have been categorised by organisational impacts and financial impacts.

Organisational

- Training of RNs** was seen as a positive impact as it provides them with new or improved skills and time to meet with RNs from other facilities.

“We have upskilled our workforce in IT. This has been really good for us” (Multi-facility provider)

- Some nurses involved in the provider interviews indicated that while the training overall is useful, it needs to be based more on adult learning principles and acknowledge that RNs have other responsibilities so **flexibility in training requirements and assessments** is important. While feedback from the provider interviews about the RN training experience was on the whole positive; there were instances where providers complained about how the training was conducted.
- NASC managers also provided some feedback regarding the training of RNs, indicating that **the RNs needed more support**. Some of the NASC Managers interviewed indicated that the introduction of the LTCF clinical assessment tool and the training accompanying it would have been more effective if NASC assessors (who had experience in other interRAI tools) has been utilised to assist and advise ARC facilities because of their experience.

“Training for aged care nurses was rushed and not a lot of support. Our lead assessor had to help and support this. DHB lead practitioners have helped in other DHBs too..... DHB assessors are used as a go to person and to support” (NASC manager)

“I think that if the NASCs had been more involved it would have been good”

- The **NASC managers** interviewed were asked how the introduction of the LTCF clinical assessment tool has impacted on their role, as well as how it has impacted on how they work with the ARC facilities. All indicated that, from their point of view, **the introduction of the LTCF clinical assessment tool has improved their relationship with facilities**.

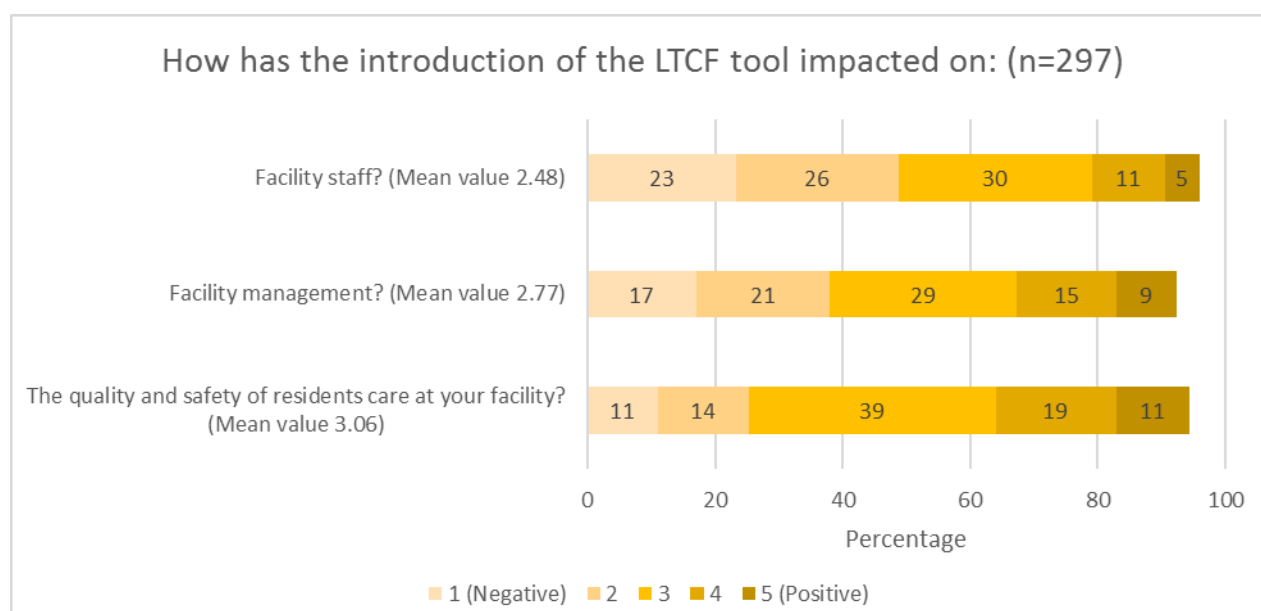
“I think it has increased a positive way of working together”

“We now try and work with them. It is more empowering and acknowledging”

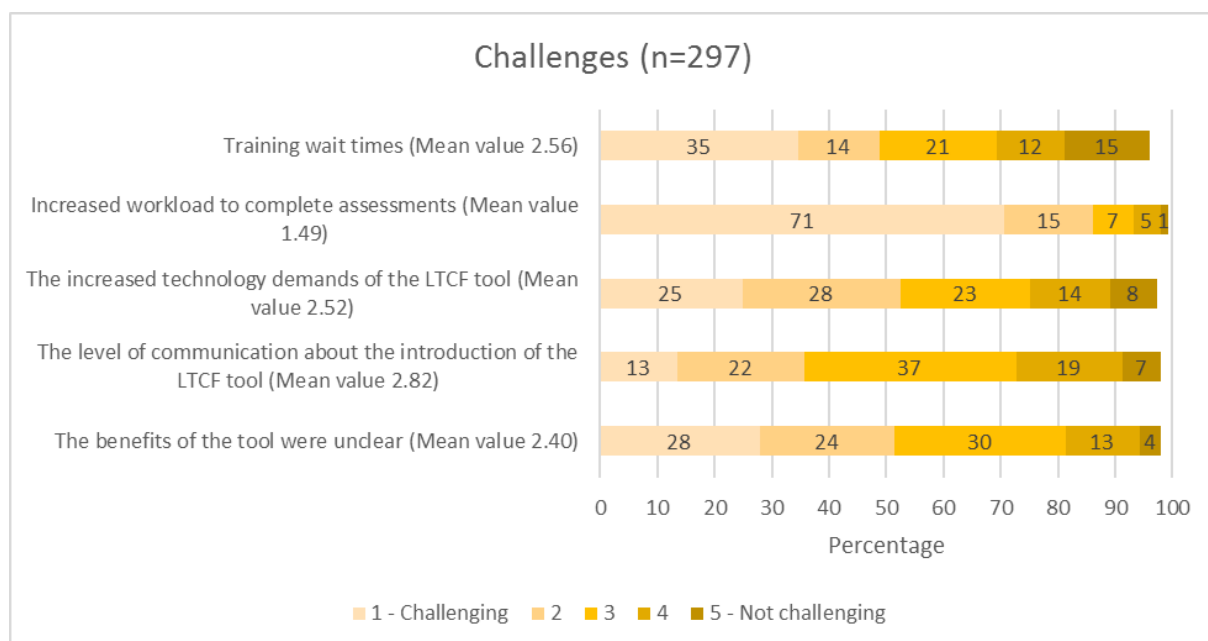
- **Staff stress** from both functional and technical perspectives was mentioned by a few of the providers as one of the reasons for registered nurses (RNs) leaving the sector. This included frustrations with computers and/or the LTCF clinical assessment tool . One of the other reasons given by some of the providers was that trained staff were moving to DHBs after becoming interRAI trained. Graph 7 below shows that the impact on facility staff was largely seen as negative. At a sector level, the loss of clinical knowledge was seen as a significant impact. Some providers also thought that in some instances the updating of the sector through staff turnover was a positive. In addition, there is additional stress placed on those RNs who are interRAI trained as they are the only ones permitted to enter information. The workload is therefore not evenly distributed. This creates a bottleneck on interRAI trained RNs and a greater dependency of the facility on this group. The increased workload was also the most challenging aspect of the LTCF assessment tool with 86 percent of facilities rating it challenging.

- **Trained RNs spending time away from the floor** caring for residents because they are doing data entry to complete interRAI LTCF assessment forms for compliance was identified as an issue. Graph 7 shows that while the view of facilities was slightly positive for quality and safety of care 25 percent rated it negatively. From the interviews conducted, the main reason for this was time taken away from caring. Some RNs have indicated to facility managers that they are frustrated and dissatisfied because they now spend less time with residents and more time doing data entry so that they can meet their interRAI commitments. Providers indicated that RNs felt like their clinical experience and judgement had no influence.

“RNs find their time taken up completely doing interRAI, they have no influence in doing their assessments whatsoever. They feel their clinical judgement and experience is of no influence... but if you have good clinical judgement and experience, you can pick up things without ticking boxes, interRAI doesn’t do that. You could sit in an office and make those judgements without looking. The value of interRAI assessments depends entirely on who and how they are doing it. It’s a critical missing link”.



Graph 7: Results for survey question – How has the introduction of the LTCF tool impacted



Graph 8: Results for survey questions regarding challenges

- The shift from voluntary to mandatory meant that NASC managers were able to implement processes because of the high level of compliance.

“We were able to put things in place because of high level of compliance”

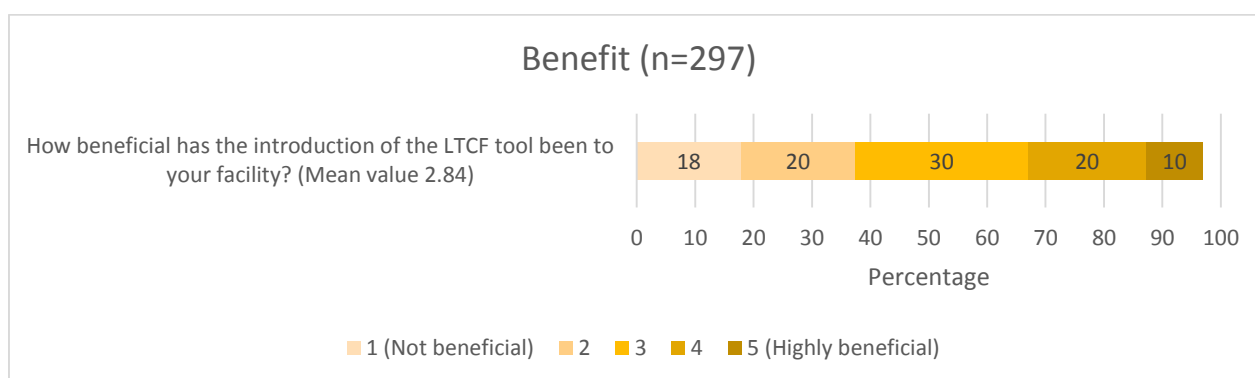
“Positive for us. We could be assured everyone was doing it. Especially in urgent situations”

Financial

- **Additional training costs** were identified as impacting on all providers. This included the costs associated with backfilling of RNs undertaking training; time away from the floor for RNs to complete the assessments required for training; RNs completing training in their own time. In addition, some larger provider organisations are now conducting their own approved interRAI training to meet the demand of interRAI trained RNs needed in their facilities. They are therefore covering the cost of this themselves.
- A number of providers indicated that they have had to factor in the **additional cost of extra RN** time every week to meet the workload demands of interRAI assessments.
- The **turnover of interRAI trained RNs** in the ARC sector impacts facilities as there are additional costs associated with training replacement RNs. Some providers indicated that they now look for RNs who are already interRAI trained so that they don't have the financial and time costs associated with training a new RN.
- Each facility received 1 laptop funded by the project regardless of facility size during the introduction of the LTCF assessment tool, providers indicated that there were **additional equipment and technical costs** involved in using the LTCF assessment tool. For some providers, this included changing entire organisational systems to accommodate interRAI.

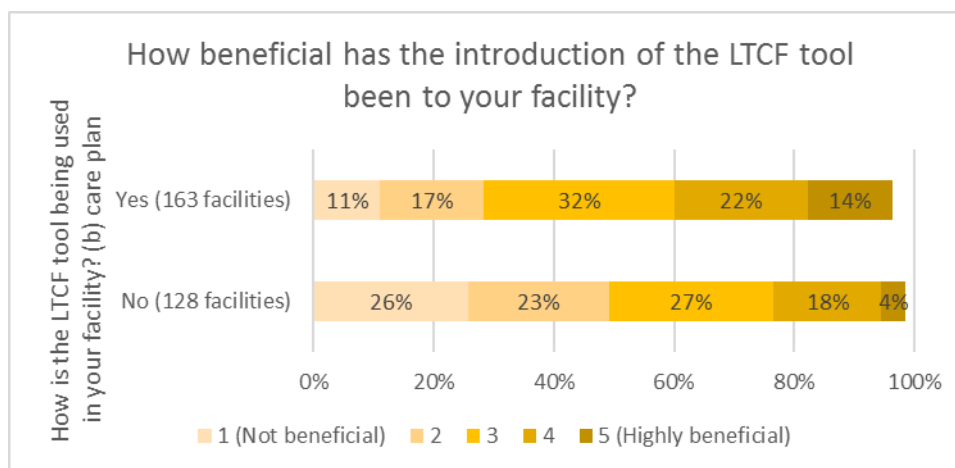
- **RNs are using their own time** to complete the training requirements as well as entering interRAI assessment information for compliance purposes.
- NASC managers interviewed also noted that the **introduction of the LTCF clinical assessment tool had resulted in additional costs for the providers and facilities overall.**

“It’s an additional resource cost. Yes they got a 5% increase but I’m not sure that this fully compensates them for the actual costs” (NASC manager)



Graph 9: Results for survey question regarding benefits

- Where the LTCF assessment tool is used for care planning facilities are much more positive (see graph 10 below - 36% positive response for use with care plan against 22% for those who don’t use the LTCF assessment tool with a care plan) about the benefits of the LTCF assessment tool.



Graph 10: Results for survey question – How is the LTCF being used in your facility

3.6. Quality and safety of care/health and equity

Whether the interRAI project is creating improved quality, safety and experience of care/whether the interRAI project is resulting in improved health and equity for all populations.

- In regards to health and equity, **using a standardised tool** so that residents are assessed in a clinically comprehensive and consistent manner wherever they are based **is beneficial sector-wide**. However, this is reliant on consistent processes across the ARC sector and the DHBs.

“I think it’s a good idea it keeps things very uniform” (Small provider)

“Overall the information gathered is of value to the ministry and DHB for transparency but it is of little value to us” (Multi-facility provider)

- The majority of NASC managers interviewed indicated that having the assessment of a resident done within the facility by someone who knows the resident is better for the resident as well as logistically.

“It just makes more sense that the assessment is done by the person who knows the person [resident]”

“We are having the assessments done by the person who knows the client.....we have better use of our clinical peopleNow they can focus on higher level decisions – specialised ones”

“We had people going in and not knowing the person. Better for the staff as don’t need to spend as much time catching up assessors”

- **Triggers in the interRAI system** were seen as useful as they prompt RNs in regards to resident care and the need for re-assessment or change in level of care.

“It’s given us a level of scrutiny over the wellbeing of our residents, and we have on occasion had conversations over what interRAI has triggered in regards to organisational stuff.... It has given us a second look on some of our practices, and it is a good comparative tool which points out things that we may miss in our day to day business”.

- Nurses are being **upskilled in both IT and clinical knowledge** via the training.

- The assessment process does mean that **RNs are interacting with patients and families** to obtain the relevant information.

“We like spending the time with the resident. The family like that we are doing this. As a nurse I like the requirement to ask the resident questions and find out who they are”.

- In some circumstances, less experienced enrolled nurses are left with resident care as only the RNs have been trained to complete the interRAI assessments. **Time away from hands on care** was seen as potentially impacting on quality of care.

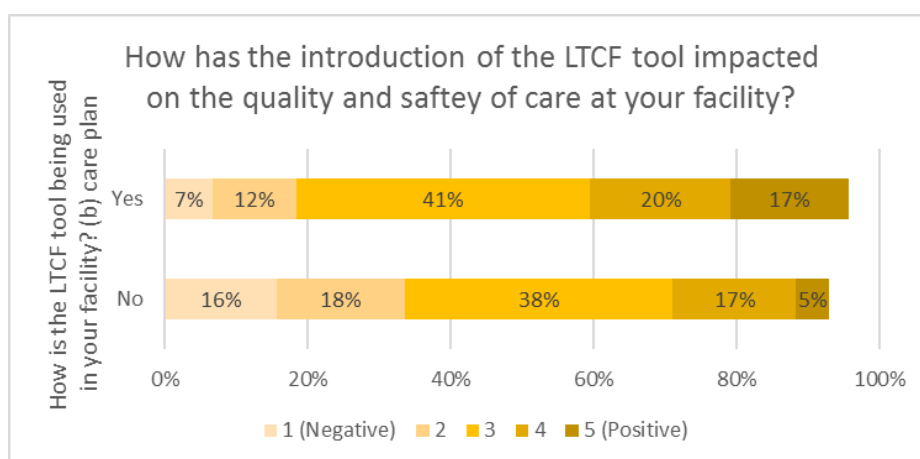
“We are a large site. We have two dedicated interRAI Assessors who do all the interRAI assessments for all clients working alongside the RNs. We will NOT allow our RNs to be taken off the floor to do interRAI Assessments thereby reducing direct hands on clinical time with the clients.” (Facility survey)

“Because we can’t get the number of RN’s we want trained; we have to register the few people we have trained on them [interRAI assessments] almost always... they are very bored because assessments are all they are doing” (Large single site provider)

- The interRAI LTCF assessment was **seen as a compliance activity** only, by some providers who rely on other assessment tools, with tick boxes being completed as quickly as possible. The quality of the information was therefore variable depending on the RN completing the assessment. However, it should be noted that variability in quality would be seen in any system.
- Some NASC assessors interviewed indicated that when the LTCF clinical assessment information is audited the focus appears to be on “ticking boxes” correctly and not on clinical quality.

“The audit standard seems to be very pedantic. It’s not about the clinical quality it’s an audit on box ticking”

- **Facilities that used the LTCF assessment tool for care planning were more positive about the LTCF assessment tool’s impact on the quality and safety of care on their residents** (see graph 11). Importantly when the LTCF assessment tool is used for care planning positive opinion outweighs the negative.



Graph 101: Impact of LTCF tool on quality and safety of care

- **Some Needs Assessment Service Coordination (NASC) assessments are more timely** because the assessors can check the LTCF assessment online and determine whether a resident needs a change on level of care, (also refer to section 3.3 on efficiency).
- **However, there is considerable variability within different DHBs** regarding the NASC assessment process, especially the time it takes to complete a review and approve a change in level of care. It was noted that although the ARRC contract (with the national guidelines for NASCs) states that a request for a change in level of care should be responded to within 5-10 days, some DHBs have specified a 21-day turnaround. There is ambiguity about the term “responded to” which could mean acknowledging receipt of the request or responding with an answer to the request, this enables inconsistent processes between DHBs. This lack of consistency was particularly frustrating for the larger multi-facility providers who had facilities nationwide dealing with different DHB requirements.

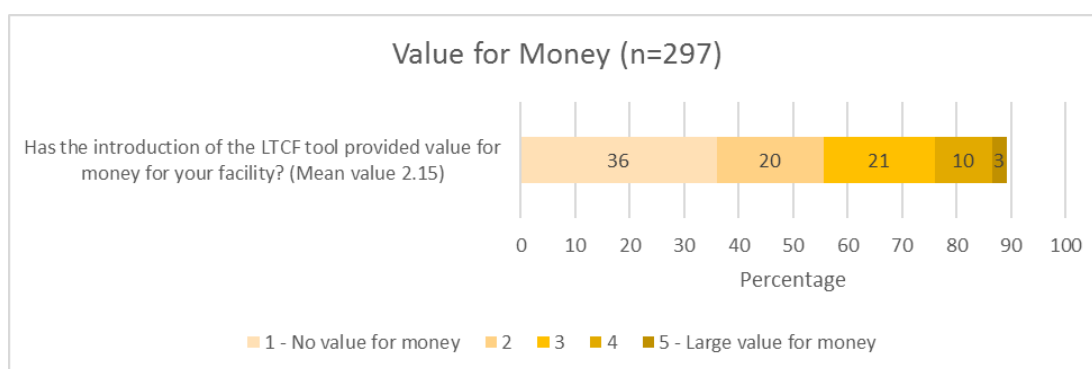
3.7.Value for money

Whether the interRAI project produced better value for public health system resources.

- The majority of providers and facility managers indicated that the introduction and ongoing use of **the LTCF assessment tool have provided little or no value for money at present**. Graph 12 shows that 54 percent of facilities evaluated the value for money of the LTCF assessment tool as little or no value. Thirteen percent saw it as providing some or high value. Providers noted that it has been costly to implement, they (and their RN’s) have had to absorb the majority of the costs relating to training, and on-going use and they are not seeing enough benefits to justify these costs or the impact it is having on staff.

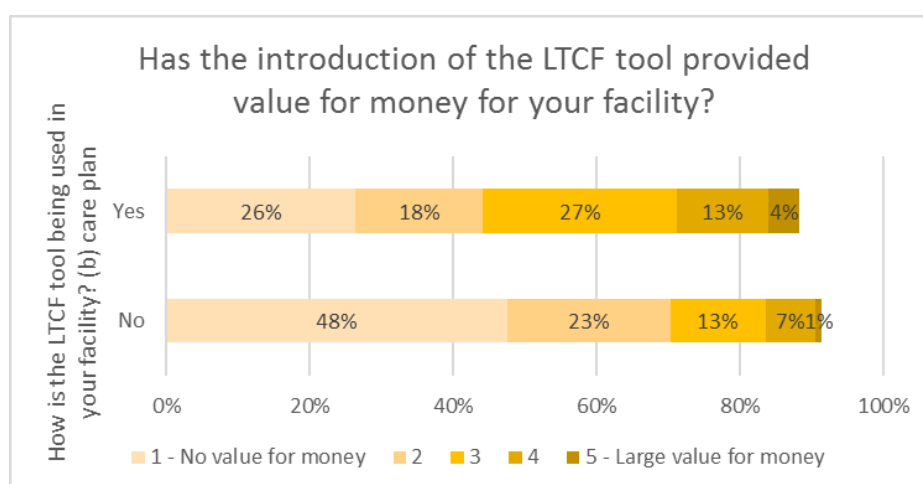
“We are just not getting the benefit out of it that we should be” (Multi-facility provider)

“What are they doing?... Where is the information?” (Multi-facility provider)



Graph 12: Results for survey question regarding value for money

- **Facilities where the LTCF assessment tool was used for care planning were generally more positive about the value for money.** Use in care planning does not distinguish between an electronically linked LTCF assessment tool and a care plan software and manually copying of information (for example copying to a paper based care plan).



Graph 13: Results for survey question regarding value for money by care plan use

- The NASC managers interviewed were positive about the potential of the LTCF clinical assessment tool if it is used as intended. Currently, however, they do not think that the facilities have used it enough, there is still a lot of duplication with some facilities still using their own assessment tools in addition to the LTCF clinical assessment tool, and that it is seen as an audit or funding tool by providers.

“I think that interRAI LTCF tool has massive potential with the other tools in the suite. It would be awful if the objections of the ARC [sector] derailed it becoming the standard tool for the health of older people..... we have to persist because the ends will justify the means”

“There is a lot of duplication that the facilities need to work through”

“If it was implemented properly it would be a really good impact”

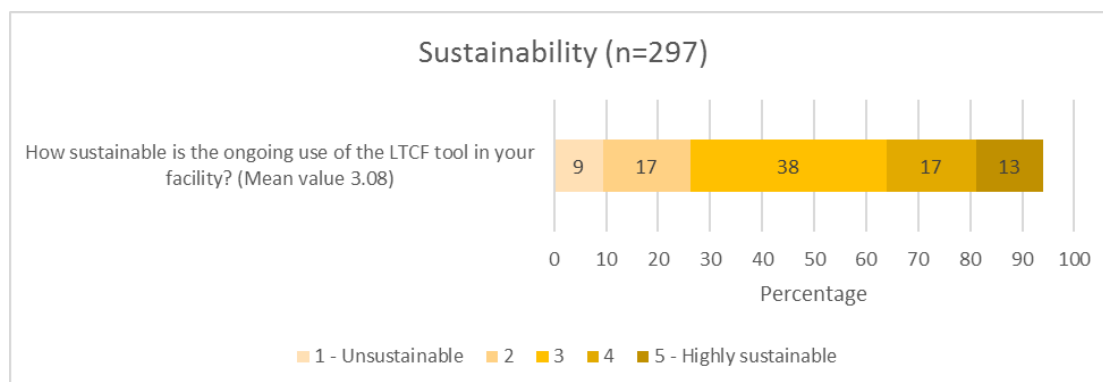
- Whether value for money is gained by funders who distribute public health resources, like the Ministry of Health and DHBs, because providers and RNs themselves bearing a significant proportion of the previously stated costs is as yet unclear. However, the NASC interviews did show that that introduction of the LTCF clinical assessment tool has been beneficial for them.

3.8.Sustainability

Whether the benefits of the introduction of the interRAI tool are likely (and able) to continue into the future.

Sustainability is, in some ways, difficult to assess and determine given that the LTCF assessment tool is mandatory.

- Most providers interviewed stated that they would continue to use the interRAI LTCF assessment tool as it was a contract requirement so they had to do it. The large proportion of facilities who indicated a neutral response of three in graph 14 likely support this statement, as they had no strong views because they have to continue using the LTCF assessment tool.



Graph 14 :Results for survey question regarding sustainability

- Some providers indicated that they would stop using the interRAI LTCF assessment tool if they were able to as it was costly from both a financial and staff impact point of view.

“If we got the choice tomorrow to go with it or not, we probably wouldn’t”

- Providers felt that, as it stands, it is not sustainable for them. This was mainly because of the high costs, time involved, and low facility benefit realised at this stage. They did however, indicate **some ways to make it more sustainable** in the future:
 - including the interRAI training as part of undergraduate nursing training as well as the competency training for overseas nurses coming to work in New Zealand would help alleviate the costs associated with sending RNs for training. A proportion of the ARC nursing workforce are foreign-trained so having interRAI incorporated into the competency course would be beneficial.
 - training all RNs, not just a quota per facility, so that interRAI assessments can be distributed amongst all RNs involved residents’ care.
 - enhanced inter-operability so that the interRAI system links with patient management systems and care plans in both directions, enabling effective sharing of information.
- The provider interviews and the survey responses also mentioned instances where hospitals had changed the level of care for a resident and then sent the resident back to the facility without completing the change in level assessment themselves. Facilities are then required to complete the interRAI reassessment for a change in level of care when they may not fully understand the triggers for it.
- The use of the tool in the hospital was also questioned.

“[the LTCF is] Supposed to be a sharing tool, yet when a resident is admitted to hospital acutely, the tool is never accessed by the hospital.” (Facility survey)

4. Review conclusions

The following section highlights the main conclusions drawn from the review. Overall, survey responses from facility managers tended to be more positive than the responses from providers' interviews. This may be influenced by an ability to ask more in depth questions in an interview that is not possible in a set online survey. Responses from NASC managers who utilise the information provided by the LTCF clinical assessment tool were more positive than either the facility managers surveyed or the providers interviewed.

4.1.Relevancy

A need for a standardised clinical assessment tool for aged residential care was widely acknowledged. However, the process by which the interRAI LTCF assessment tool was introduced and then made mandatory has had a negative impact on how the tool is viewed and a lot of the negativity is in relation to the change in requirements part way through the project. The sector was mandated to use a tool that only some of them had implemented.

4.2.Efficiency

Lack of interoperability between the interRAI, care plan, and patient management systems as well as duplication of assessment information and double entry of data are having an impact on the efficient use of the interRAI system. It is important to note that although the project ran for four years, all ARC facilities did not have to be part of it until July 2015. Some of the sector is still in the early stages of embedding the LTCF clinical assessment tool into their facilities and efficiency gains may be seen later as the tool is increasingly used and more RNs are interRAI trained.

Addressing the issues regarding interoperability will assist with usability and embedding the interRAI LTCF assessment tool. Facilities using the LTCF assessment tool for care planning are more positive about the benefits of the LTCF assessment tool. This is likely due to reduced duplication and immediately recognised benefit. NASC managers identified an efficiency gain from the introduction LTCF assessment tool as it enabled remote acceptance of change of level of care, therefore reducing the need to go to facilities and undertake assessments.

4.3.Effectiveness

Overall, the project was effective in meeting its set objectives, including training the required number of RNs based on the ratio of one nurse to 15 beds. It also effectively communicated the implementation of the interRAI system and what was required from facilities. The project was less effective in conveying the actual benefits of the tool and how the data collected via online assessment can be used to improve quality of care and benchmarking across the sector.

4.4.Impact

One of the biggest impacts indicated by providers and facility managers has been on interRAI trained RNs at a variety of levels including: time away from resident care; additional workload stress as they are they are only ones able to use interRAI; and working in their own time to complete interRAI assessments or complete training competency requirements. The other main impact has been the cost to providers of implementing the interRAI tool, for both large and small providers. The true extent of these costs was not anticipated or acknowledged when the LTCF assessment tool was implemented.

4.5. Quality and safety of care/health and equity

Aspects of the LTCF assessment tool, such as the resident care triggers generated and the systematic and more consistent application of a comprehensive clinical assessment were seen as positive in regards to quality of care. Additionally, through the training process nurses were upskilling their clinical knowledge. However unintended consequences are also having a negative impact such as, interRAI trained RN time away from the floor to enter interRAI data, leaving less experienced nurses to care for residents was seen as impacting on quality and safety.

4.6. Value for money

Overall, providers and facility managers indicated that the introduction of the LTCF assessment tool has provided little or no value for money so far. It has been costly to implement and these costs currently outweigh any benefits for the majority of providers and their facilities. Facilities that use the LTCF assessment tool for care planning are more positive about the value for money of the LTCF assessment tool. There are also indications that the LTCF assessment tool has provided some value for money to the wider sector. Particularly for DHBs and the NASC process.

4.7. Sustainability

Although the use of the LTCF assessment tool is mandatory, providers felt that it is not sustainable for them given the high costs, time taken and low facility benefit. However, increasing interoperability of the interRAI system and reviewing ways to increase the capacity of facilities to complete interRAI assessments and lessen workload stress (eg, increasing trained RN quotas or examining training models) would likely have a positive effect on the ongoing sustainability of the LTCF assessment tool.

5. Lessons learned and recommendations

This section considers the lessons learned from the Comprehensive Clinical Assessment (interRAI) in Aged Residential Care project that can be shared with the key stakeholders. It looks at the implications for: ARC providers and facilities, DHBs, the Ministry of Health and interRAI Services (TAS). This section also identifies recommendations to improve the sustainability and efficiency of the LTCF assessment tool in the sector. Although the project finished on 30 June 2015, the use of the LTCF assessment tool is ongoing and mandatory for ARC providers in New Zealand. In addition, other interRAI assessment tools exist that could potentially be used in other sectors. Recommendations have therefore been made with these two factors in mind, to guide the continued use of the LTCF assessment tool and the effective introduction of any new interRAI tools.

Lessons and accompanying recommendations are presented under the following key areas:

- **Implementation and communication**
- **Training**
- **Efficiency**

5.1. Implementation and communication

5.1.1. Lessons learned

- The project's primary focus was the roll out of the LTCF assessment tool, the IT platform for the interRAI system and training of users^{19 20}. As such, the impacts on the sector of the implementation and the changes in the process do not appear to have been fully recognised by those initially driving the project. In addition, although the transition from voluntary to mandatory was seen as necessary from an implementation perspective, this had a negative impact from a "buy in" point of view as providers believed that the use of the tool was driven by the Ministry of Health and they were mandated to use a tool that didn't easily fit with their systems for compliance purposes. Both these factors have influenced how the sector perceives the LTCF assessment tool and its impact. Improved consultation with the sector, and in particular the primary users, could have provided relevant feedback and helped alleviate some of the negative perceptions during implementation.
- Collecting structured feedback from the sector earlier in the project (and not just at the close out) would have been beneficial to monitoring the project's impact and progress. Ongoing evaluation and tracking the progress of the project as it ran would have enabled the project management team to potentially identify any problem areas early on as well as allow the providers and RNs to feedback on what works well and what needs to be improved.

¹⁹ interRAI steering Group. (2012). *Aged Residential Care Comprehensive Clinical Assessment interRAI Project Plan - A plan for the Aged Residential Care interRAI Steering Group*

²⁰ interRAI steering Group (Aug 2015). *Comprehensive Clinical Assessment (interRAI) in Aged Residential Care – Project Close Report 2011-2015*

- Providers questioned the actual benefits of the LTCF assessment tool and interRAI system given that they take on a large proportion of the costs. Clear communication about the benefits and the expectations around the **timing of the realisation of some of the longer term benefits** would have been beneficial. Providers also indicated that they would like to see how the data collected from the interRAI LTCF assessment tool can be used to benefit them – at a resident level, facility level, provider level and sector level. While a comprehensive annual report has been produced that provides a high level overview of the interRAI assessment data²¹, it is unclear if results have been distributed to the sector in a format that is easy to understand and useful.

5.1.2.Recommendations

Strategic

11. A communication strategy is put in place that includes a collaborative consultation process with all stakeholders for new projects piloting other interRAI assessment tools.

The strategy should make it clear from the start the roles and responsibilities of the stakeholders, indicate whether the process is sector led, government led or a collaboration, include a timeline, aims, success measures and acknowledge previous lessons learned.

12. Evaluation and adaptive management incorporated from the planning phase for new projects/pilots and not just at the end of the pilot or project.

This will enable feedback from the users to be gathered throughout the project/pilot. This should be part of the governance checks employed to determine the viability of a pilot before it is rolled out and to monitor the pilot as it is rolled out.

Operational

13. A simple ongoing evaluative ('track as you go') process is established for the LTCF clinical assessment tool so that progress and issues can be tracked and resolved as required.

This process also enables the people using the tool to give feedback and have a voice.

14. interRAI Services communicate how the data collected now from the LTCF clinical assessment tool can benefit the sector.

There was a noted desire for facility and DHB level benchmarking. Our understanding is that work has begun on this but the sector is unaware of this at present.

²¹ Central TAS and interRAI NZ (2016). National interRAI Data Analysis Annual Report 2014/15

5.2.Training

5.2.1.Lessons learned

- **Capacity to train** – Overall, training has been useful for both RNs and facility managers. However, access to training has been an issue for providers and facilities – from a waiting time perspective and the numbers of RNs allocated for training.
- **Training costs and quotas** – RN turnover in the sector results in facilities needing to train new RNs (if an interRAI trained RN cannot be hired), an additional cost the facility has to account for from a back filling perspective. Also, facilities' quotas – an RN is included as in the quota as full time even if they only work part time.
- Adoption of strong **adult learning principles in all training** would help ease RN stress. While some RNs found the training experience helpful, consistent feedback was that the deadlines were too strictly enforced. Recognition that many RNs work on the training for a significant amount of their own time including days off and have to juggle this with other life activities would lead to a uniformly more positive training experience.

5.2.2.Recommendations

Strategic

15. Investigate a more sustainable interRAI LTCF clinical assessment tool training model in New Zealand

Currently interRAI training occurs when the RN already has work commitments and has likely transitioned out of being a student. This was necessary for the LTCF assessment tool implementation process when a body of RNs needed to be created from the existing workforce to complete LTCF assessments in facilities, but it may not be the best or most sustainable training model moving forward. Three of the most universal complaints about the current process were: access to training; the difficulty in covering for RNs completing training; and the extra stress the training placed on the RN once in the workforce. Looking at viable ways to provide training, such as integrating it into the overseas trained nurses' competency training (CAP) in New Zealand or already established training mechanisms for New Zealand trained nurses (potentially prior to RNs entering the workforce or when they are in a transition period) will be important to improve the process. Two initial issues with this recommendation could be:

- Which version/tool of interRAI is training provided in? Would a generic course be sufficient? Would a specialised course be required? Would a combination of both be suitable?
- A large part of the training requires RNs' to do assessments on residents. If incorporated into established nursing training prior to entering the aged care workforce, access for students to a pool of residents to assess could be a barrier. This could likely be navigated by establishing partnerships where trainees conduct assessments in a local facility. Although not a key finding, it is worth noting that one provider interview did mention that RNs were going to other nearby facilities currently to get enough assessments to complete within the deadline.

16. Review training feedback mechanisms to collect both information about the LTCF clinical assessment tool and the training process itself.

Feedback after/during training is likely one of the best and more efficient ways for interRAI Services to collect both information about the LTCF assessment tool and the training process itself. When RNs are attending the training, interRAI Services is getting exposure to many years' worth of clinical experience in the New Zealand setting. Establishing a feedback conversation with the RNs at training may simultaneously enhance the engagement of RNs, increase their comfort with the tool and opinions about its use, and allow interRAI Services to identify common barriers experienced in the use of the tool by those who actually have to apply it day to day like language suitability issues.

5.3. Efficiency

5.3.1. Lessons learned

- For interRAI to work more efficiently in the facilities, all the nurses dealing with residents need to be interRAI trained so that the interRAI workload does not fall solely on the few that are. Larger providers have taken over the training to address this, at their own cost. Indications are that two models of LTCF process exist in facilities. One is a compliance audit model where interRAI is done by one or a select group of staff who do all the assessment as a compliance measure. The other more emergent integrated care model is one where all RNs are LTCF trained and are completing assessments for the residents/patients that they are assigned to.
- For a number of reasons, interRAI is not being used in the way it has been designed – as an electronic web-based system. A learning is that using multiple technology especially paper based is not likely to be the most efficient way of completing an assessment.
- Enhancing the interoperability of the interRAI platform may improve efficiency.
- There is variability between DHBs in the length of time for NASC assessors to complete a change in level of care request. Improving the consistency of NASC processes would likely benefit providers

5.3.2. Recommendations

Strategic

7. Decide upon a preferred process model for the interRAI LTCF clinical assessment tool

Currently, a large proportion of the sector is in the compliance model (see above). The compliance model comes with benefits such as RNs who are most 'proficient' (quick) at interRAI are completing assessments, reduced variability and subjectivity as the assessment is not carried out by the direct carer RN, a smaller pool of people to train and maintain. This model is quite distinct from an integrated care model in which each RN can draw on their previous 6 months of experience with the resident in a reassessment. In this model the assessment tool forms a core part of the resident's day to day care with information flowing both from and to the LTCF from the care plan which all carer staff have access to. There may also be scope for a mixed model to combine some of the benefits from both process models.

8. Work with DHBs to improve consistency with NASC processes

Improving the consistency of NASC processes would benefit providers and improve the benefits from the LTCF assessment tool. One of the initially communicated benefits was that DHBs would be able to use the LTCF assessments to approve a level of care increase. While there are legitimate reasons why a DHB would still want to conduct a full NASC, engaging with DHBs to understand the difference in wait times would aid providers.

Operational

9. Demonstrate efficient application of the LTCF clinical assessment tool

Related to recommendation 8, the variability of how the LTCF clinical assessment tool is applied from a process point of view is reducing efficiency. Setting the process for each facility is likely outside the power of interRAI Services but demonstrating efficient application of the tool will help facilities to implement this model. Evidence suggests that facilities who use the LTCF assessment tool in care planning are more positive about the benefits, value for money and impact on the quality and safety of care of the LTCF assessment tool.

10. Investigating the feasibility of allowing bidirectional information flows between the LTCF and the number of resident management and care plan options available.

Letting facilities use the LTCF clinical assessment tool and a care plan seamlessly will likely improve the sectors justification of the time they spend completing an LTCF assessment. This should improve their rating of the value for money and their overall perceived benefit ratings.

Appendix one: Detailed review framework

This section describes the key components that compose a comprehensive framework for this review: background and context; the theory of change for the project; a results model; and project assumptions.

Project history and background

Project history^{22 23}

- In 2003, interRAI assessments were identified by the New Zealand Best Practice Guidelines Assessment Processes for Older People as one of the best tools to meet the goals of the 2002 Health of Older People Strategy.
- In 2004, the interRAI home care assessment was piloted by five District Health Boards (DHBs).
- In 2007, The Chief Executives of all 20 of New Zealand's DHBs expressed support for the national implementation of the interRAI assessments for both home and community care.
- In 2008, the interRAI National DHB Implementation Project (2008-2012) commenced.
- A pilot to trial the RAI 2.0 across 18 facilities in Canterbury DHB commenced on 1 June 2009²⁴
- In 2010, the Aged Residential Care Services Review, undertaken by Grant Thornton, identified an urgent need to plan for the residential care of New Zealand's ageing population.
- In December 2010, the DHBs, in conjunction with the Aged Care Association, endorsed a business case and agreed to support the voluntary introduction of interRAI assessment in ARC through a four-year project (2011-2015).
- A project team was appointed in 2011.
- In 2011 the Ministry of Health on behalf of DHBs entered into an agreement with Momentum Healthware Ltd to supply the software to deliver a system to the required functional specifications. The selection of Momentum enabled the software to be delivered using the infrastructure developed as part of the National DHB interRAI Implementation Project (2008-2012).
- Training of the first group of nurses in the use of the CCA commenced in September 2011.
- In May 2012 there was a change in project management and training approach. A revised project plan and budget was approved by the Steering Committee in September 2012.
- In August 2012 New Zealand moved from the RAI 2.0 version of the clinical assessment to the latest interRAI version the 'integrated suite' of assessments (version 4.0). All competent assessors on the old version were provided with upgrade training to allow a smooth transition to the LTCF assessment.
- In September 2012, the Auditor General released a report on the effectiveness of arrangements to check the standard of rest home services. It emphasised the importance of comprehensive clinical assessment in monitoring the quality of care for older people.
- In October 2012, the Associate Minister of Health announced that interRAI would be the mandatory assessment used to inform a resident's care plan for all ARC providers from July 2015.

²² interRAI steering Group. (2012). *Aged Residential Care Comprehensive Clinical Assessment interRAI Project Plan - A plan for the Aged Residential Care interRAI Steering Group*. p. 7.

²³ TAS. (2016). *Consultation Paper on the proposed structure for a nationally integrated interRAI Education and Support Service*. pp21-22.

²⁴ Canterbury District Health Board (2010). *Interim Report for RAI 2.0 Pilot* p5

- New Zealand is now the first country in the world to have use of these home and community, and residential care tools nationwide. It is intended that this consistent approach to care planning for older people will provide a solid platform to further enhance services delivered in our communities.

The Long Term Care Facilities Assessment Tool and process

The LTCF assessment tool is one of the assessment tools in the interRAI suite of tools. Other tools include (but are not limited to) the Home Care and Contact assessment tools that are used in New Zealand for community based services for older people. The LTCF tool is designed to consider the older person's functioning and find opportunities for improvement and/or risks to the older person's health that form the basis of a care plan.

The assessment must be completed using the national interRAI software assessment module on the national system including the resident overview page in order to participate in the project. This enables the assessment to remain part of the national system that follows the older person and is available to all care providers. Every resident is required to have a care plan and the national interRAI software care planning module is available for use by all providers if they wish to use it. Use of another care plan is acceptable as long as the facility involved in the project ensures that the resident's current care plan is readily available at the point of care within the facility by relevant care providers and upon transfer to hospital or another provider²⁵.

The basic assessment process contains these four main steps:

1. An interRAI trained registered nurse (RN) reviews previous assessment and other resident records.
2. Structured conversations are undertaken with resident and relevant others (e.g., caregivers, family).
3. Observations and answers are coded into interRAI software (ideally on a laptop that can be synced with the database).
4. The information gathered is utilised for developing the care plan and assisting in decision-making. The assessment helps the RN identify standard care. It also identifies risks or opportunities for the resident (Client Assessment Protocols – CAPs).²⁶

²⁵ interRAI steering Group. (2012). *Aged Residential Care Comprehensive Clinical Assessment interRAI Project Plan - A plan for the Aged Residential Care interRAI Steering Group*, p.6.

²⁶ interRAI steering group. (2013). *An introduction to interRAI*.

PESTLE Analysis

A PESTLE analysis (Political, Economic, Social, Technological, Legal and Environmental) is a useful strategic tool for understanding the contextual environment²⁷ in which the review is being undertaken. It has been used to frame the scope of the review.

Political

- In 2003, the New Zealand Guidelines Group (NZGG) undertook a process to find a common language in 'outcomes that matter to older people' to express costs and benefits, to identify outcome measures and to begin the challenge of local and national benchmarking.
 - The introduction of comprehensive clinical assessments was a result of that process.
- From 2010-2011, aged residential care in New Zealand was subject to two formal national investigations – one a review, the other a performance audit.
 - One of the recommendations from the review was to pilot new models of care that recognise differing performance of providers.
 - The Auditor-General released a performance audit in 2011. Among its recommendations was that DHBs and the Ministry of Health identify broad shared requirements and in turn progressively align their policies.²⁸
 - The Minister of Health, Tony Ryall was informed of the reports.
- In October 2012, Associate Health Minister Jo Goodhew announced that all ARC facilities would be required to use the InterRAI Comprehensive Clinical Assessment by July 2015.²⁹

Economic

- In 2004, five DHBs successfully piloted the use of the interRAI home care assessment.
 - The pilot evaluation identified that a significant training exercise was required to increase the skill level of staff involved in the process.
- In 2007, a business case was agreed to as a priority by the chief executive officers of all 20 DHBs. During 2008-2009, NZ\$19 million was allocated to DHBs to introduce the assessment.
 - This included an associated training initiative to support the determination of eligibility for long-term care services; either home-based support or aged residential services.
- In 2014, contractual disputes arose between providers and DHBs over funding allocations toward staff training and software installation.³⁰
 - An additional NZ\$18 million was allocated to the project. Several parties, while welcoming the extra funding, still regarded it insufficient.³¹

²⁷ Meehan, B., & Millar, N. (2014). Regulating the quality of long-term aged care in New Zealand. *Regulating Long-Term Care Quality: An International Comparison*, 357.

²⁸ Office of the Auditor General. (2011). *Home-based support services for older people*.

²⁹ Goodhew, J. (2012). *Fast Track for Clinical Assessments in Aged Care*. Retrieved from: <https://www.beehive.govt.nz/release/fast-track-clinical-care-assessments-aged-care>

³⁰ Castaneda, R. (2014, July 14). Crippled IT tool for the aged a trouble spot for contracts. *New Zealand Doctor Newspaper*.

³¹ Wattie, R. (2014, July 30). interRAI funding still not enough: Aged care providers. *New Zealand Doctor Newspaper*.

Social

- It is expected that demand for both ARC as well as home-based support will increase over the next few decades.
 - By 2026, New Zealand is expected to have 20 percent of a projected population of 4.7 million over the age of 65.
 - By 2051, it is predicted that 22 percent of New Zealanders over 65 will be aged 85 or older.
 - It is notable that over the past 20 years, while the population of those aged over 65 has increased by 43 percent, beds in ARC facilities overall have increased by only 3 percent. This indicates a decrease in dependency resulting from changing policy settings and an associated increase in the provision of community care services.
- A cultural framework for the assessment of Maori clients has been identified and specific guidelines for assessing this group have been incorporated into the interRAI training programme.

Technological

- Momentum Healthware, a Canadian software company, has developed and provided a national software platform that facilitates the interRAI assessments in New Zealand. It is called the National interRAI Software Service (NiSS)
 - interRAI assessments can be undertaken with this software online or into a disconnected laptop that will then synchronise upon finding a connection.
- Several facilities and RNs, prior to the introduction of interRAI, had limited interaction with web based software.³²
 - The introduction of interRAI has therefore, in some cases, been the trigger of digital inclusion.
 - Several facilities have been required to purchase both internet access and computers.
 - Several DHBs have funded the purchase of laptops for smaller ARC facilities.

Legal

- The Ministry of Health introduced a national agreement for aged residential care services from 1 June 2002.³³
 - ARC facilities were required to sign the agreement each year in order to receive public funding packages.
 - Responsibility for this contract was devolved to district health boards on 1 October 2003.
 - The contract covers rest home, dementia and geriatric hospital level care delivered in a residential care setting.
 - The contract ensures that there is a national standard of services that are provided to residents in long-term residential care.

³² Evaluation Consult. (2016). *Key Informant Interviews on interRAI post-project review*.

³³ Ministry of Health. (2013). *Age-related residential care services agreement*. Retrieved from <http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/age-related-residential-care-services-agreement>

- Each year there is a national review of the Age Related Residential Care contracts between DHBs and providers for the provision of Age Related Residential Care Services.
- Any variations agreed are included in the Aged Related Residential Care agreements.
- The 2015/2016 aged related residential care agreement was the mechanism from which interRAI was made mandatory.³⁴
- As part of the 2015/2016 agreement, to meet audit and DHB contractual obligations, ARC facilities are required to use the LTCF tool.

Environmental

- The 2014 New Zealand aged care survey³⁵ saw 600 participants in home/community aged care and nearly 300 residential age care employees return responses. Its findings included:
 - that there was a great deal of similarities across both residential and homecare aged caregivers' work experiences
 - both were on average a highly feminised and older workforce
 - most participants perceived that they had the skills and knowledge to carry out their jobs, and worked in aged care for some years
 - participants want to engage in further training and career development
 - while fewer in number, participants noted stress (including from workload) and fatigue as negative issues
 - overall, while there was a high level of satisfaction in the work they do, there was dissatisfaction with low wages, high or unclear workloads, and lack of recognition.

Results Model and Theory of Change

The **Theory of Change** is a specific type of methodology that provides a line of sight from programme components through to longer term outcomes identified for this programme. It identifies and explains all the key building blocks or steps required to achieve or realise a long-term or high level goal or goals (i.e., outcome(s)). This can then be captured diagrammatically with a 'model'. The theory of change includes identifying the assumptions in order to achieve the goal(s), including those about causation, attribution, contribution, or correlation.

³⁴ Ministry of Health. (2015). 2015-2016 *Aged Related Residential Care Services Agreement for the Provision of Age Related Residential Care*. Retrieved from <http://www.centraltas.co.nz/assets/Health-of-Older-People/ARRC-agreement-2016-17-effective-1July2016-for-website-26May2016.pdf>

³⁵ Human Rights Commission. (2014). *NZ Aged Care Workforce Survey Report*. Retrieved from https://www.hrc.co.nz/files/2614/3019/0144/NZ_Aged_Care_Workforce_Survey_report.pdf

The following steps describe the 'theory of change' for the interRAI project:

- TAS received funding from DHBs to train a selection of registered nurses in ARC Facilities to use the LTCF assessment tool.
- Training itself was free for facilities and DHBs made a contribution to the cost of backfilling the position while a registered nurse was away for training.
- Those RNs involved in the voluntary phase used the tool in their facilities to undertake initial assessments and re-assessments of residents. The use of the tool was linked to audit and contract requirements in the mandatory phase effective from July 2015 which required all ARC facilities to use the tool as the primary form of assessment.
- These assessments are used by the facility, carers, and medical staff to inform the care plan, provide support for clinical decision-making, reduce variability of assessments, and avoid assessment duplication.
- This leads to increased ability to apply preventative medicine and use holistic care principles and methods.
- Using a uniform assessment tool leads to a better standardised and consistent assessment for older people entering ARC facilities or requiring an increase in the level of care provided, leading to improved equity of service.
- At a sector level data would facilitate benchmarking of the sector.

The results model on *page 9* of the main document visually maps the theory of change for the interRAI project. The model describes the resources and activities that contribute to a project and the logical links that lead from project activities to the project's expected outcomes. The results model for the interRAI project outlines the inputs and activities of the project and links them to the intended project outputs and outcomes as well as wider health outcomes related to the health of older people.

Initial project assumptions

- The LTCF assessment tool would be the primary tool used by ARC facilities to undertake comprehensive clinical assessments and re-assessments.
- The technology to support the use of the tool would be available and accessible (internet access, hardware).
- Registered nurses would be able to use the technology that drives the tool (once trained)
- A sufficient number of registered nurses would be trained to allow all ARC facilities to carry out assessments and reassessments using the LTCF assessment tool in a timely manner by July 2015. (added in October 2012 by ministerial announcement).
- Registered Nurses and the carers would use the LTCF assessment tool to develop individualised care plans.
- Facility management would support assessments and use the data created help them manage their residents and staff requirements.
- The data collected in LTCF assessments could be used by other agencies and facilities to reduce duplication of assessment and increase overall efficiency and value for money.

Appendix two: Approach

Approach

Our way-of-working in strategy, performance management, governance, evaluation and review is underpinned by a cyclical approach called Development Outcomes Monitoring and Evaluation (DOME™). We work collaboratively and systematically with our clients around the DOME™ cycle.

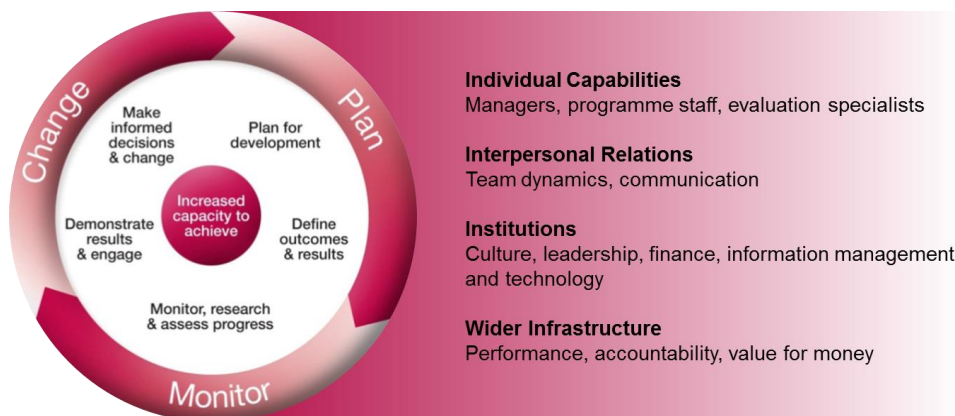


Figure 2: An outline of Evaluation Consult's DOME™ approach

DOME™ links planning, monitoring/evaluative research, reporting and change processes through a three-phased cycle. This practical approach provides timely results information, accommodates uncertainty and change, and supports regular reporting cycles for on-going decision-making. The DOME™ cycle will provide a framework to support and maintain interRAI stakeholders' focus on outcomes when considering the project's performance to support their decision-making.

Online evaluative learning management platform

To support ongoing review processes, we have developed a tailored solution: a shared online evaluative learning management platform to meet the needs of our clients to track results effectively over time. This offers a secure and unique 'fit for purpose' collaborative project workspace that can be accessed by stakeholders and utilised for secure management of documents and data in order to measure and manage outcomes and results. We have utilised these platforms both with New Zealand based and with international clients. The platform can be expanded as needed, and used going forward.

The Triple Aim for Quality Improvement³⁶

The New Zealand Triple Aim for Quality Improvement framework (please refer to Figure 1 on page 7), established by the Health Quality & Safety Commission addresses three key areas that support improvement of health services:

- improved quality, safety and experience of care (Individual)
- improved health and equity for all populations (Population)
- best value for public health system resources (System)

The review team used the New Zealand Triple Aim for quality improvement concept (*Figure 2*) to inform the review on how the interRAI project and clinical tools have impacted at the individual, system and population levels with respect to the information objectives above.

Review criteria

Based on the components of the approach outlined above, the main review criteria are:

- **Relevancy** – The extent to which the interRAI project is suited to the needs, priorities and policies of providers, facilities DHBs and other funders (for instance the Ministry of Health).
- **Efficiency** – Efficiency measures the outputs (qualitative and quantitative) in relation to the inputs.
- **Effectiveness** – Measure of the extent to which the interRAI project has attained its objectives.
- **Impact** – The positive and negative changes produced by the introduction of the interRAI assessments, directly or indirectly, intended or unintended.
- **Sustainability** – Whether the benefits of the introduction of the interRAI tool and the tool itself are likely (and able) to continue. How to make it more sustainable?
- **Value for Money** – Whether the interRAI project produced better value for public health system resources.
- **Quality and safety of care** – Whether the interRAI project is creating improved quality, safety and experience of care.
- **Health and Equity** – Whether the interRAI project is resulting in improved health and equity for all populations.

Each of the criteria was also reviewed against the overarching evaluative question of ‘What does good look like?’ These criteria have been used to inform the interview and survey questions.

Quality and ethical considerations

The review used a consultative approach and was undertaken in a professional and ethical manner. The review adhered to the Australasian Evaluation Society principles for ethical conduct for evaluations,³⁷ and OECD DAC Quality Evaluation Standards.³⁸ Standard processes to obtain informed consent were followed. The reviewers worked closely with interRAI Services (TAS) to ensure ethical standards were not breached when accessing administrative data. Where necessary we can work with and advise interRAI Services on mechanisms to obtain information ethically (e.g. anonymising data). All the work developed by the review team has been peer reviewed internally by either the Executive Director or Technical Director of Evaluation Consult, who provide technical oversight on review methodology and analysis.

³⁶ Health Quality and Safety Commission. (2011). *The New Zealand Triple Aim for quality improvement*. Retrieved from: <http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/health-quality-and-safety-indicators/>

³⁷ Australasian Evaluation Society. (2010). *Guidelines for the Ethical Conduct of Evaluations*.

³⁸ OECD. (2009). *Guidelines for Project and Programme Evaluations*.

Appendix three: Methodology

Document review and background meetings

A preliminary review of existing documentation and information gathered from background meetings were important to establish a pre-interRAI baseline³⁹ (for basic comparison), to understand the current context and to gain an initial assessment of the interRAI project. This included planning documentation (i.e., project charter, benefits realisation report, business case and project plan), pilot information, and reporting (including indicators, baselines, and targets) of the project. A list of the documents reviewed can be found in *Appendix Six*. The existing documentation was reviewed to develop the results-focused model and to gain further understanding of the current context and processes in relation to planning, monitoring, and reporting.

Background meetings were held with key people involved in the interRAI project at the senior level. This enabled us to gain an insight into the interRAI environment, inform the Key Informant Interview (KII) questions, and develop the results model and review plan.

Appendix table 1: List of individuals in the background meetings

Name	Positon	Organisation
Michele McCreddie	General Manager	interRAI Services, TAS
Dr Brigitte Meehan	National interRAI Services Manager	interRAI Services, TAS
Max Robins	Chief Executive Officer & Deputy Chair	CHT Healthcare Trust & New Zealand Aged Care Association
Jon Shapleski	Programme Director, Health of Older People	interRAI Services, TAS

Key Informant Interviews

Key Informant Interviews (KIIs) were conducted to provide the review team with a broad, varied understanding of the key elements and contextual issues with the interRAI framework that were necessary to cover in the review. The interviews were undertaken in a manner that was results-focused, collaborative, and participatory. They offered key stakeholders an opportunity to dialogue regarding the project, its intended outputs and outcomes, the scope of the review and the draft report.

The review team used the information to inform:

- the scope and processes for the interRAI project
- the review plan and development of data collection tools (including the design of a survey of all ARC Facilities and interviews with a sample of ARC providers)
- the final data analysis and review findings

The review team undertook KIIs with ten representatives (including two group interviews) from different stakeholder organisations to gain feedback to inform the review. Participants have included representatives from a series of key stakeholder groups selected in consultation with interRAI Services to ensure coverage across all levels of the project. *Table 1* includes a breakdown of the stakeholder groups interviewed.

Due to the location of most key informants, interviews were primarily undertaken over the phone. However, the two group interviews, based in Wellington, took place in person. Two interviewers were present throughout each of the interviews. The interviews were also recorded (with the consent of the informants).

³⁹ Based on previous relevant evaluations in this sector, such as: Grant Thornton. (2010). *Aged Residential Care Service Review*.

This ensured that information was captured and that there is a reliable representation of what was discussed or raised.

The questions from the Key informant interviews are outlined in **Appendix seven**.

Data collection and fieldwork

Survey

A short online survey was used to gain both quantitative and scaled/categorical qualitative information to address the key aims of the review. Questions had an option for 'other' where appropriate, which was free text but this was not the primary qualitative collection. Surveys were distributed, via an email link, to the Facility Manager (key contact person identified by interRAI Services) for each ARC facility in New Zealand. All New Zealand ARC Facilities (678 as of 8 August 2016) were invited to participate in the online survey and have an opportunity to feedback about the project. interRAI Services provided the most recent contact details (email addresses) for all the ARC facility managers to be surveyed.

The survey covered the key focus areas, and cross-cutting issues to ascertain progress, assess the need, level of utilisation, barriers, successes. As this is a survey of facilities, with the facility manager being the person identified as respondent on behalf of the facility, facility biography information (size, location and staff type) was collected as part of the survey. The invitation email and questions for the survey can be found in **Appendix ten**.

Interviews with ARC providers

The review team also facilitated a series of 18 interviews with a purposeful sample of ARC providers at each category level (small/medium/large provider size). This qualitative approach enabled us to explore in greater depth the results and relationships suggested by the quantitative data collected in the survey and also ensure the data was as broadly representative of New Zealand ARC providers as possible.

Criteria for selecting providers included:

- Whether a given provider was an independent facility or a multi-location conglomerate
- Facility size of independent providers (small – 1-30 beds, medium – 31-80 beds, large – 81+ beds)
- Provider location (North island vs South Island, Rural vs Urban)

Appendix table 2: Total number of interviews (over the phone and face to face) by location

Location	Total no. of facilities	Breakdown of facility size		
Auckland	6	Large: 4	Medium: 1	Small: 1
Christchurch	4	Large: 3	Medium: 1	
Wellington	4	Large: 2	Medium: 2	
Rural/Remote (2 North Island/ 2 South Island)	4	Large: 2		Small: 2
Total	18	11	4	3

While the basic structure of the interview was consistent for all those selected, the style of interview differed depending on the size of the provider. For large provider organisations we set up a face-to-face multi-person interview (where possible) at each provider with key senior staff (such as their Director of Operations, Clinical Quality Manager and Regional Manager). For medium and small providers, we conducted either individual face-to-face interviews or telephone interviews depending on the location. We conducted face to face interviews with a sample of providers from Wellington, Auckland and Christchurch where the five largest providers have head offices and where there was also be access to a cluster of medium and small providers. In addition, we conducted telephone interviews with a sample of remote/rural ARC providers.

Appendices eleven, twelve and thirteen contain the information sheet, consent form and questions/discussion points used to guide the interviews with ARC providers.

Interviews with NASC managers

Telephone interviews were conducted with a purposeful sample of NASC Managers from DHBs in both the North and South Islands. Four telephone interviews were conducted in total, with two NASC Managers from the North Island and two from the South Island. One of the interviews included two senior level people from the same NASC unit.

The interviews were included as an additional data source after initial data collection had been completed, at the request of the interRAI Board. It was agreed that the views of NASC Managers should be sought, particularly regarding how they use interRAI LTCF clinical assessments when considering changing levels of care for ARC and the feedback from ARC providers about lack of consistency between District Health Boards (DHBs) in confirming changes in level of care.

Appendices fourteen and fifteen contain the information sheet and questions/discussion points used to guide the interviews with NASC managers.

Appendix table 3: Information objectives and associated research methods

Information objectives areas	Information objectives		Research methods					
		Document review and background meetings	Key Informant Interviews (KII)	Project monitoring data	ARC Facilities (Facility managers) survey	Focused ARC Provider Interviews	Focused NASC manager interviews	Observations
1. Formative-related objective: <i>To identify the intended line of sight and contribution between project inputs, outputs and outcomes (theory of change) to meet stakeholder objectives.</i>	What is the theory of change (planned inputs, outputs and outcomes)? What are the assumptions underpinning theory of change? What are the intended project outcomes and targets towards which progress must be maintained/sustained?	✓	✓					
	What project goals and results are priorities for stakeholders?	✓	✓		✓	✓	✓	✓
	Progress of the project from pre-project establishment through to project close on 30 June 2015		✓		✓	✓	✓	✓
	Why is the assessment system being used?	✓	✓		✓	✓	✓	✓
2. Process-related objective: <i>To understand the processes and systems (existing, planned, and requirements), this covers the needs, the tool, the technology, the training and other processes and systems</i>	Changes to the project i.e. voluntary project, project re-scope in response to the Government Directive for mandatory implementation, including associated budget changes	✓	✓			✓	✓	
	How is the clinical assessment tool being used?		✓	✓	✓	✓	✓	✓
	Who is using the clinical assessment tool?		✓	✓	✓	✓	✓	✓
3. Summative-related objective: <i>To understand impacts, efficiency, effectiveness of the clinical assessment and process</i>	What progress is being reported now towards the intended project outputs and outcomes?	✓	✓	✓	✓	✓	✓	✓
	How efficient are the project activities in contributing to intended outputs and outcomes?	✓	✓	✓	✓	✓	✓	✓
	How effective is the project in achieving the intended outcomes? How sustainable are the outcomes from the project likely to be?	✓	✓	✓	✓	✓	✓	✓
4. Lessons learned objective: <i>To identify lessons learned for the project stakeholders to support use and decision-making.</i>	What are the lessons learned for stakeholders from project activities, processes and results? National and operational levels?			✓	✓	✓	✓	✓
	What are the positive and negative impacts on the sector and the implications for: ARC Providers and facilities; DHBs; Governance Board; Ministry of Health and interRAI Services (Central TAS)?			✓	✓	✓	✓	✓

Appendix four: Communications plan

Appendix table 4: Communication management for the different stages of the review.

Communication activity	Audience			Responsibility
	Central TAS	ARC Facilities	Key Stakeholders (ARC providers)	
Stage One – Development and design of review plan				
Inception meeting	✓			TAS & EC
News bulletin to communicate review activity to stakeholders				TAS
Email to communicate interviews to key informants	✓		✓	TAS & EC
Information sheet to communicate review purpose and use			✓	EC
Key informant interviews to inform the review plan			✓	EC
Review plan	✓			EC
Stage Two – Data collection				
Invitation to contribute to the review		✓	✓	EC
Survey		✓		EC
Interviews			✓	EC
Key findings memorandum	✓			EC
Stage Three - Data analysis and reporting				
Draft report	✓			EC
Feedback from Board	✓			TAS
Final report	✓			EC

Appendix five: Ethics and Security Plan

Introduction

Evaluation Consult follows international standards and accepted best practice for the governance and management of data, to ensure that the reporting systems provide accurate and quality data reports and solutions from a secure and stable platform.

Security management and data sovereignty

Our ELM (Evaluation and Learning Management) Platform is hosted on Microsoft Office 365 which is secured to ISO 27001, EU Model Clauses, HIPAA and FISMA, and follows stringent standards for physical hosting facilities and software systems security. Our data governance practices are in line with the developing ISO/IEC 38505 series of Governance of Data standards.

The ELM Platform is hosted at the Microsoft Australia Sydney datacentre, which meets the data sovereignty and physical and logical data security requirements for at least 174 New Zealand and Australian government departments. If required, we are able to host client datasets on shore in New Zealand for clients whose data cannot be stored overseas, and this service comes at a premium cost. It should also be noted that a New Zealand datacentre will not have the level of data security or redundancy provided by off shore Microsoft data centres, and will not have the range of data handling services provided directly by the Microsoft Office 365 team that enable data to be encrypted, tracked, traced, monitored and protected, and secured from unauthorised personnel.

Quality assurance

Evaluation Consult follows an internal quality assurance process to ensure that:

- a) All work (including reports, and conclusions drawn from data) is peer reviewed internally.
- b) there is a mutual understanding on requirements for quality, and processes in place for addressing risk.
- c) Risks are identified and addressed as they arise in conjunction with the client.
- d) Capability training is provided for all authorised client staff requiring access to the Evaluation Consult reporting systems and platform.

Data collection and storage

Evaluation Consult follow stringent processes for the collection and storage of data, to ensure that the appropriate controls are in place at every stage of the process.

- a) Data is collected directly into the ELM Platform through a secure data entry portal.
- b) Data and datasets from external vendors and providers can be uploaded and integrated into the ELM Platform, as required.
- c) Data is collected following ethical and security guidelines for consent, access and inter-agency or inter-company sharing.
- d) The ELM Platform is maintained as a secure environment for data storage, and can only be accessed by authenticated users.

Reporting

Evaluation Consult ensure that reports are provided as required to identified recipients, and that personal data is anonymised if and as required.

- a) Collected data can be aggregated and de-identified to ensure privacy and confidentiality requirements are met.
- b) The ELM Platform allows for different authentication levels to be set up so that Evaluation Consult staff and client users can only see and report on the data that they have been cleared to access.
- c) Only Evaluation Consult staff trained to collect and use data will have access to reporting systems in the ELM Platform.
- d) Data collected will only be used for the pre-determined and consented purpose, unless permission is granted in advance for re-use and additional purposes.

Data ownership and copyright

Evaluation Consult ensure that:

- a) Data stored in the ELM Platform remains the property of the client. The intellectual property behind the design of the ELM Platform and associated ICT services remain the property of Evaluation Consult.
- b) Clients may request an extract of their data.

Data distribution and disposal

Evaluation Consult ensure that:

- a) Data will be distributed and disposed of as requested by clients.
- b) Data will not be held beyond the time period agreed in the way-of-working set up document.
- c) Controls are in place to ensure that data is not distributed unless authorisation has been provided for the distribution of data.

Appendix six: Document review list

The following documents were included as a part of the document review stage discussed in Appendix three and were used to inform the review

Appendix table 5: Document review list

Document name	Date of publication	Author/institution	Content of document
The nationwide implementation of interRAI. A blue print for establishing a national clinical software system	2009	Andrew Downes - National interRAI host Service, Chris Dever - Canterbury DHB, Darren Douglass - HIQ Ltd New Zealand	The blue print provides an example of how to establish a working system that can be applied to some other clinical areas. It also provides a case study to demonstrate how some of the principles of the National Health IT plan can work in crisis.
Aged Residential Care Service Review	Sep-10	Grant Thornton	The most extensive review of ARC ever taken in NZ. This has the highest provider participation of any study of ARC in the world. The models have been created so that they can be utilised going forward.
Aged Residential Care Service Review - Summary of Findings	Sep-10	Grant Thornton	Summary of above Grant Thornton review.
An introduction to interRAI	Mar-13	interRAI services	An introduction to the interRAI process.
interRAI in ARC – Project Close Report 2011-2015	Aug-15	interRAI Steering Group	Project close report for 2011-2015.
Business case for the interRAI Long-term Care facility assessment in residential care in New Zealand	Jun-10	NZACA, Michal Boyd, Cheryl Bowen, Nell Dawson, Brigitte Larkins, Nancy Stewart	Business case for interRAI.
Aged Residential Care, Comprehensive Clinical Assessment, interRAI project Plan for steering group, 2013-2015	Feb-13	interRAI Steering Group	An overview of the project structure and operational project plan.
Aged Residential Care, Comprehensive Clinical Assessment, interRAI project Plan for steering group, 2012-2015	Sep-12	interRAI Steering Group	Earlier version of the above document.
Background Paper: Establishment of interRAI assessment within New Zealand 2003-2010	May-10	Ministry of Health	Background paper on interRAI's establishment in New Zealand.

Document name	Date of publication	Author/institution	Content of document
Realising the Benefits of interRAI Comprehensive Clinical Assessment	Jun-14	interRAI Steering Group	The purpose of the paper is to realise the benefits of the approximately \$30 million investment in interRAI in NZ and how they can be achieved
Assessment Processes for Older People - Best Practice Evidence-Based Guideline	Oct-03	Ministry of Health, ACC, New Zealand Guidelines Group	This guideline was commissioned as part of the Positive ageing strategy to develop an effective and integrated assessment pathway for the health and disability needs of NZ's older population.
Assessment Processes for Older People - Best Practice Evidence-Based Guideline Summary	Oct-03	Ministry of Health, ACC, New Zealand Guidelines Group	Summary of above guidelines.
Performance audit report: Effectiveness of arrangements to check the standard of services provided by rest homes	Dec-09	Office of the Auditor-General	The Ministry of Health (the Ministry) is responsible for the auditing and certification of rest homes. In the OAG's view, certification has not provided adequate assurance that rest homes have met the criteria in the standards, and the Ministry did not respond quickly enough to address weaknesses it has known about since 2004.
interRAI Comprehensive clinical assessments - Project Charter	Aug-11	Helen Telford, Alistair Cree - Francis Group Consultants, Ministry of Health, NZ Aged Care Association, 20 DHBs	The charter defines the scope, goals, objectives, outputs and overall approach to interRAI assessment project for the NZ aged care association, the MOH and 20 DHBs. It sets out what the project is to deliver, timeframes, time constraints and means by which the project will be managed.
Project handover	Mar-12		Details costs, IT support, staff on the project, schedules, governance, the budget, scope, purchasing, communications, risks, enhancements and the adoption process.
Regulating the quality of long term aged care in New Zealand	2014	Brigette Meehan, Nigel Millar	Academic paper on the state of aged care in New Zealand.
InterRAI: Risk register	30-Mar-15	interRAI services	Risk register of the interRAI assessment process.
National interRAI Data Analysis: Annual Report 2014/15	Apr-16	interRAI services	Annual report.

Document name	Date of publication	Author/institution	Content of document
Letter to NZ Aged Care Association RE: Most concerning issues	26-Mar-13	Chris Fleming - Co Cheer of InterRAI LTCF Steering group	Letter to Martin Taylor - CEO of New Zealand Aged Care Association.
Letter to NZ Aged Care Association RE: Issues raised RE: interRAI LTCF Rollout	08-Jul-13	Chris Fleming - Co Cheer of InterRAI LTCF Steering group	Letter to Martin Taylor Re: response to each of the 19 points raised by NZ Aged Care Association.
Memorandum of Understanding between the Ministry of Health and Central Region's Technical Advisory Services Ltd.	Mar-16	Ministry of Health and Central TAS.	MOU for the purpose of providing a National interRAI service.
interRAI New Zealand Future Direction 2016-2019	2016	interRAI services	Draft three-year strategic plan currently out for comment with the interRAI NZ Governance Board
interRAI services Business Plan 2016/2017	2016	interRAI services	Final draft of 12-page business plan for next financial year.
interRAI services Business Plan 2016/2017 Diagram	2016	interRAI services	Final draft - A3 page diagram of business plan for next financial year.
Residential interRAI Pilot – Interim Report for RAI 2.0 Pilot	2010		Interim report that outlines the pilot for the implementation of the RAI 2.0 tool within the Canterbury District Health Board (Te Poari Hauora o Waitaha)

Appendix seven: Key informant interview question guide

The following form was used by Evaluation Consult staff to direct key informant interviews. This sheet was **not** given to key informants.

Key informant discussion

The key informant interviews are intended to provide the review team with a broad, varied understanding of the key elements and contextual issues with the interRAI framework that will be necessary to cover in the review. The review team will use the information to inform:

- the scope and processes for the interRAI project
- the review plan and development of data collection tools (including a survey of all ARC facilities and interviews with a sample of ARC providers)
- final data analysis and review findings

Key informant
Name
Role
Organisation
Interview Date
Interview Time
Discussion areas
Formative
1. What were the aims for the interRAI project?
2. In your opinion, why was the interRAI Long Term Care Facilities comprehensive clinical assessment tool introduced? / Relevance and need for the tool?
Process
3. (a) Who is using the LTCF clinical assessment tool? (b) How is the LTCF clinical assessment tool being used?
4. How has the use of the LTCF tool been resourced? (Government/DHBs/interRAI/facilities)
Summative
5. What do you see as the key achievements/successes of the project in establishing the use of the interRAI clinical assessment tool?
6. What were the main challenges?
7. What has been the impact of the introduction of the clinical assessment tool <ul style="list-style-type: none">- At the voluntary stage?- When it became mandatory?
Lessons Learned
8. What were the lessons learned from the interRAI project?
9. Do you have anything else to add that will help inform this review?

Appendix eight: Key informant interview email

The following is an email template that was sent to key informants inviting them to participate in an interview.

Key informant interview information email

Dear xxx

The Comprehensive Clinical Assessment (interRAI) Project was tasked with establishing the use of a standardised assessment tool that uses software. This tool was designed to enhance the care of older people in residential care facilities. Evaluation Consult has been commissioned by interRAI Services, Central Region's Technical Advisory Services Ltd New Zealand (TAS) to undertake an independent review (the Review) of the progress of the project from pre-project establishment through to 30 June 2015.

There are a number of different phases to the Review which will culminate in a report to interRAI Services. The first phase is to scope and define a review plan and develop data collection tools. interRAI services and Evaluation Consult have identified you as one of the key people who have valuable knowledge and experience which could contribute information to the Review. We are keen to hear your thoughts and would therefore like to interview you.

We would like to arrange a time to interview you over the phone/ in person on {insert date}. Would you be available anytime between xx and xx?

Further information is attached. If you have any questions or would like to discuss the interview further, please don't hesitate to contact us on 04 476 7391.

Appendix nine: Key informant interview information sheet

The following information was provided to key informants prior to the interviews. It outlines key information relating to the purposes of both the review and the interviews.

Information sheet

The Comprehensive Clinical Assessment (interRAI) project was tasked with establishing the use of a standardised assessment tool that uses software. This tool was designed to enhance the care of older people in residential care facilities. Evaluation Consult has been commissioned by interRAI Services, Central Region's Technical Advisory Services Ltd New Zealand (TAS) to undertake an independent review (the review) of the progress of the project from pre-project establishment through to 30 June 2015.

Aims of the review:

The key informant interviews are intended to provide the Review team with a broad, varied understanding of the key elements and contextual issues with the interRAI framework that are necessary to cover in the review. The review team will use the information to inform:

- the scope and processes for the interRAI project
- the collection tools (including a survey of all Aged Residential Care (ARC) Facilities and interviews with a sample of ARC providers), and;
- final data analysis and review findings.

Examples of questions that may be asked in the interview include:

- What were the aims for the interRAI project?
- In your opinion, why was the interRAI Long Term Care Facilities (LTCF) Clinical Assessment tool introduced? / Relevance and need for the tool?
- Who is using the LTCF clinical assessment tool?
- How is the LTCF clinical assessment tool being used?
- How has the use of the LTCF tool been resourced? (Government/DHBs/interRAI/facilities)
- What do you see as the key achievements/successes of the project in establishing the use of the interRAI clinical assessment tool?
- What were the main challenges?
- What had been the impact of the introduction of the clinical assessment tool:
 - *At the voluntary stage?*
 - *When it became mandatory?*
- What were the lessons learned from the interRAI project?

Ethical considerations

Interviews will be undertaken in accordance with standard research ethical principles, practices and informed consent processes to ensure your information is secure and confidential. This includes:

1. The interviewer will seek your informed (verbal) consent at the commencement of the interview and ensure you are aware of the considerations that underpin the data collection.
2. No respondents or organisations will be individually identified in reporting.
3. The interview will be digitally recorded and the interviewer may take notes. Recorded information will be kept and viewed only by the review team (staff at Evaluation Consult).
4. The information collected for this review will be held in a secure data management system that is only available to the evaluators from Evaluation Consult. Information will be removed from that system at the completion of the contract.
5. The information obtained through interviews will only be used for the review.
6. Your participation is voluntary. Participants are not obligated to answer any of the questions, and are free to leave the interview at any time.

If you have any questions regarding the review or would like to discuss this further, please feel free to contact us via email or phone at Evaluation Consult:

Dr Dilhani Bandaranayake (Senior Consultant) – Dilhani@evaluationconsult.com or Michael Campin (Senior Consultant) – Michael@evaluationconsult.com

Phone: 04 476 7391

Thank you in advance for your cooperation with this review. Michael and I look forward to hearing your views.

Dr Dilhani Bandaranayake
Senior Consultant
EvaluationConsult
tel +64 4 476 7391
mob +64 (0) 210 670 751
e Dilhani@evaluationconsult.com

Michael Campin
Senior Consultant
EvaluationConsult
tel +64 4 476 7391
mob +64 21 315 559
e Michael.campin@evaluationconsult.com

Appendix ten: Survey information email and survey questions

The following is the survey and associated information email that was sent to all ARC facility managers in New Zealand to complete electronically.

Sent from email: interRAIreview@evaluationconsult.com

Subject: InterRAI review survey

Dear Facility Manager of **facility**

The Comprehensive Clinical Assessment (interRAI) Project established the use of a standardised software assessment tool designed to enhance the care of older people in residential care facilities. Evaluation Consult has been commissioned by interRAI Services, Central Region's Technical Advisory Services Ltd New Zealand (TAS) to undertake an independent review of the progress of the project from pre-project establishment through to 30 June 2015.

We are surveying Aged Residential Care facility managers, to respond on behalf of their facility, asking about interactions with interRAI and the Long Term Care Facility comprehensive clinical assessment tool (LTCF tool). This will provide a broad scope of qualitative and quantitative data for the review team. The information will be used to:

- summarise implications on the sector from implementing the Long Term Care Facility (LTCF) tool
- summarise additional activity arising from the project implementation
- summarise the outputs of the project
- report on the extent that the project achieved its intended aims
- summarise the outputs of the project
- areas that may be incorporated into future operational and strategic planning
- review positive and negative impacts and implications of the project.

Please follow this link to take the survey. The survey is simple to complete. It will take approximately **10 minutes and needs to be completed in one session**. If you are unsure of an answer, please respond 'don't know'.

The survey closes on: 20 September 2016

We thank you in advance for taking the time to respond to the survey. It will be invaluable to informing the review, its findings, and recommendations.

Evaluation Consult are experts in results-focused governance, management, planning, monitoring, and evaluation. Our aim is to enhance organisations' ability to demonstrate their achievements and strengthen their decision-making. For further information on Evaluation Consult please visit our website.

Ethical and Privacy considerations – Data collection will be undertaken in accordance with standard research ethical principles, practices and informed consent processes to ensure your information is secure and confidential. All our staff are trained in ethical data collection and storage

and we will support respondents and stakeholders through these processes during the review. We ensure that individual respondents are not identified in published documents and that the data is stored in a secure server with restricted access to relevant team members.

We hold a Corporate membership corporate membership with the Australasian Evaluation Society (AES) and Aotearoa New Zealand Evaluation Association (ANZEA), and adhere to both organisations' ethical standards and data sovereignty principles.

If you have any questions regarding the review or would like to discuss this further, please feel free to contact us via email or phone at Evaluation Consult:

Dr Dilhani Bandaranayake (Senior Consultant) – Dilhani@evaluationconsult.com or Michael Campin (Senior Consultant) – Michael.Campin@evaluationconsult.com

Phone: 04 476 7391

Online survey questions

Evaluation Consult has been commissioned by interRAI Services, Central Region's Technical Advisory Services Ltd New Zealand (TAS) to undertake an independent review of the progress of the Comprehensive Clinical Assessment (interRAI) Project from pre-project establishment through to 30 June 2015.

As part of the review we are surveying all Aged Residential Care facility managers asking about your facility's interactions with interRAI, to provide a broad scope of qualitative and quantitative data to the review team. The information you provide will be invaluable to informing the review, its findings, and recommendations.

The survey will take approximately **10 minutes and needs to be completed in one session**. If you are unsure of an answer, please respond 'don't know'. Please note, you are answering on behalf of your facility (about the facility as a whole) rather than your position.

We thank you in advance for taking the time to respond to the survey.

Facility information			
Facility Name:	Freetext	Current total bed count	Number
Facility Provider (if different):	Freetext	Current rest home (Residential) bed count	Number
DHB Located in:	List of DHBs	Current hospital bed count	Number
Current interRAI qualified RNs:	Number	Current other bed count (eg, dementia, psychogeriatric)	Number
Length of time you have been facility manager with the current named facility:	Number of years		

Information objective	Question	Response
Formative-related objective: To identify the intended line of sight and contribution between project inputs, outputs and outcomes (theory of change) to meet stakeholder objectives.	Thinking about the sector prior to the introduction of the Long Term Care Facility comprehensive clinical assessment tool (LTCF tool), to what extent do you agree or disagree with the following statements? <ul style="list-style-type: none"> • A standardised assessment tool was needed to improve the quality and safety of care • Greater consistency in assessments and re-assessments was required to determine level of care • A single standardised assessment tool was needed to reduce duplication in assessments • A standardised assessment tool was needed to collect consistent and comparable evidence/data 	1 – 5 scale (1= disagree and 5 = agree) / Don't know 1 – 5 scale (1= disagree and 5 = agree) / Don't know 1 – 5 scale (1= disagree and 5 = agree) / Don't know 1 – 5 scale (1= disagree and 5 = agree) / Don't know
Process-related objective: To understand the processes and systems (existing, planned, and requirements), this covers the needs, the tool, the technology, the training and other processes and systems (Process part 1)	How effective do you think communication regarding the project to introduce the LTCF tool was?	1 – 5 scale (1= effective and 5 = not effective) / Don't know
	When did your facility begin using the LTCF tool?	Voluntary phase (pre 19 October 2012), Mandatory phase (post 19 October 2012)
	Do you have staff awaiting interRAI training?	Yes/No

Information objective	Question	Response
Training (process part 2)	If so how long are they waiting on average (months)?	Number of months/Don't know
	Is there currently a backlog off assessments due to the number of trained staff in your facility?	Yes/No
	If yes, how many?	Number of assessments pending/Don't know
	Have you attended managers' training in the LTCF tool?	Yes/No/Booked in
	If yes, have you found this training useful for? (can select both or none, or don't know)	a) Understanding the tool and the requirements of your RNs b) Managing your facility using the data generated
Assessment and Technology (process part 3)	How is the LTCF tool being used in your facility?	Radio boxes of use options (audit, care plan, initial assessment, facility management, re-assessment), other and comment option
	How long on average does an initial assessment take using the LTCF tool?	Number of hours (Options for different care categories (x4)), Don't know
	Does your facility also use another tool in the initial assessment?	Yes/No
	How long on average does a re-assessment take using the LTCF tool?	Number of hours (Options for different care categories (x4))/Don't know
	Does your facility also use another tool for re-assessment?	Yes/No
	What technology does your facility use the LTCF tool on? (tick all that apply)	Laptop, Tablet, Desktop PC, Paper-based
Summative-related objective: To understand impacts,	How has the introduction of the LTCF tool impacted on the quality and safety of residents' care at your facility?	1 – 5 scale 1 (negative), 5 (positive), Don't know

Information objective	Question	Response
efficiency, effectiveness of the clinical assessment and process.	How has the introduction of the LTCF tool impacted on facility management?	1 – 5 scale 1 (negative), 5 (positive), Don't know
	How has the introduction of the LTCF tool impacted on facility staff?	1 – 5 scale 1 (negative), 5 (positive), Don't know
	How beneficial has the introduction of the LTCF tool been to your facility?	1 -5 scale 1 (not beneficial), 5 (highly beneficial), Don't know
	What barriers, if any, were encountered by your facility in the introduction of the LTCF tool? And how challenging were they for your facility?	Top 5 barriers mentioned in KIIs, other, and comment. 1 (challenging), 5 (not challenging), (the benefits of the tool were unclear, the level of communication about the introduction of the tool, the increased technology demands of the tool, increased workload to complete assessments, training wait times), Don't know
	Overall how useful do you think the LTCF tool is?	1 (not useful), 5 (highly useful) , Don't know
Sustainability	Has the introduction of the LTCF tool provided value for money for your facility ?	1 (no value for money), 5 (Large value for money), Don't know
	How sustainable is the on-going use of the LTCF tool in your facility?	1 (unsustainable), 5 (highly sustainable), Don't know
Other comment	Is there any further comment you would like to make on behalf of your facility regarding the introduction and on-going use of the LTCF tool?	Free text (optional)

Survey email reminder

The following is the survey and associated information email reminder which was sent three times to ARC facility managers in New Zealand which hadn't yet completed the survey.

Sent from email: interRAIreview@evaluationconsult.com

Subject: Reminder - interRAI review survey

Dear Facility Manager of **{insert facility}**

We are emailing you to follow up on our invitation, sent on 16 August, to participate in a survey that informs the review of the Comprehensive Clinical Assessment (interRAI) Project.

Evaluation Consult has been commissioned by interRAI Services, Central Region's Technical Advisory Services Ltd New Zealand (TAS) to undertake an independent review of the progress of the project from pre-project establishment through to 30 June 2015.

We are surveying Aged Residential Care facility managers, to respond on behalf of their facility, asking about interactions with interRAI and the Long Term Care Facility comprehensive clinical assessment tool (LTCF tool). This will provide a broad scope of qualitative and quantitative data for the review team. The information will be used to:

- summarise implications on the sector from implementing the Long Term Care Facility (LTCF) tool
- summarise additional activity arising from the project implementation
- summarise the outputs of the project
- report on the extent that the project achieved its intended aims
- summarise the outputs of the project
- areas that may be incorporated into future operational and strategic planning
- review positive and negative impacts and implications of the project.

Please follow this link to [take the survey](#). The survey is simple to complete. It will take approximately **10 minutes and needs to be completed in one session**. If you are unsure of an answer, please respond 'don't know'.

The survey closes on: 20 September 2016

We thank you in advance for taking the time to respond to the survey. It will be invaluable to informing the review, its findings, and recommendations.

Evaluation Consult are experts in results-focused governance, management, planning, monitoring, and evaluation. Our aim is to enhance organisations' ability to demonstrate their achievements and strengthen their decision-making. For further information on Evaluation Consult please [visit our website](#).

Ethical and Privacy considerations - Data collection will be undertaken in accordance with standard research ethical principles, practices and informed consent processes to ensure your information is secure and confidential. All our staff are trained in ethical data collection and storage and we will

support respondents and stakeholders through these processes during the review. We ensure that individual respondents are not identified in published documents and that the data is stored in a secure server with restricted access to relevant team members.

We hold a Corporate membership corporate membership with the Australasian Evaluation Society (AES) and Aotearoa New Zealand Evaluation Association (ANZEA), and adhere to both organisations' ethical standards and data sovereignty principles.

If you have any questions regarding the review or would like to discuss this further, please feel free to contact us via email or phone at Evaluation Consult:

Dr Dilhani Bandaranayake (Senior Consultant) – Dilhani@evaluationconsult.com or Michael Campin (Senior Consultant) – Michael.Campin@evaluationconsult.com

Phone: 04 476 7391

Appendix eleven: ARC provider information email and information sheet

ARC provider interview information email

The following is an email template that was sent to participants in the ARC provider interviews inviting them to partake in an interview.

Dear xxx

The Comprehensive Clinical Assessment (interRAI) Project was tasked with establishing the use of a standardised assessment tool that uses software. This tool was designed to enhance the care of older people in residential care facilities. Evaluation Consult has been commissioned by interRAI Services, Central Region's Technical Advisory Services Ltd New Zealand (TAS) to undertake an independent review (the Review) of the progress of the project from pre-project establishment through to 30 June 2015.

There are a number of different phases to the Review which will culminate in a report to interRAI Services. Currently, we are in the process of collecting qualitative data from various ARC providers. interRAI services and Evaluation Consult have identified you as one of the key people who have valuable knowledge and experience from your interaction with the interRAI project which could contribute information to the Review. We are keen to hear your thoughts and would therefore like to interview you.

We would like to arrange a time to interview you over the phone/ in person on {insert date}. Would you be available anytime between xx and xx?

Further information is attached. If you have any questions or would like to discuss the interview further, please don't hesitate to contact us at 04-476-7391.

ARC provider information sheet

The following is an information sheet that was sent to potential participants for the ARC provider interviews.

InterRAI review provider interviews - information sheet

The Comprehensive Clinical Assessment (interRAI) Project was tasked with establishing the use of a standardised assessment tool that uses software. This tool was designed to enhance the care of older people in residential care facilities.

Evaluation Consult has been commissioned by interRAI Services, Central Region's Technical Advisory Services Ltd New Zealand (TAS) to undertake an independent review of the progress of the project from pre-project establishment through to 30 June 2015.

Aims of the provider interviews and the review:

The ARC provider interviews are intended to provide the review team with a broad scope of qualitative data. The review team will use the information to:

- build on the information currently being collected via an online survey to all ARC facility managers
- summarise implications on the sector from implementing the tool
- summarise additional activity arising from the project implementation
- summarise the outputs of the project
- report on the extent that the project achieved its intended aims
- summarise the outputs of the project
- identify areas that may be incorporated into future operational and strategic planning
- review positive and negative impacts and implications of the project.

Examples of questions that may be asked in the interview include:

- Thinking about the sector **prior** to the introduction of the Long Term Care Facility comprehensive clinical assessment tool (LTCF tool), do you think there was a need to introduce a standardised assessment tool? If so, why?
- Did your organisation introduce the tool in the voluntary phase or mandatory phase?
- How effective do you think communication regarding the project to introduce the LTCF tool was?
- What is your organisation's experience of the training process?
- How has the training process specifically impacted your organisation, both positively and negatively?
- How is the LTCF tool being used by your organisation? Who uses it?
- Does your organisation use another assessment tool in conjunction with the LTCF tool? If so, why?
- Describe any significant barriers or challenges experienced by your organisation in introducing the LTCF tool?
- How has the introduction of the tool impacted on your organisation in regards to: quality and safety of resident care, facility management, and staff in your facility/facilities?
- How beneficial has the introduction of the tool been to your organisation? Can you give examples?
- Overall how useful do you think the tool is, and why?
- Has the introduction of the tool provided value for money for your provider organisation? If so how?
- How sustainable is the on-going use of the tool? What are your reasons for this view?

Ethical considerations

Interviews will be undertaken in accordance with standard research ethical principles, practices and informed consent processes to ensure your information is secure and confidential. This includes:

1. The interviewer will seek your informed (verbal) consent at the commencement of the interview and ensure you are aware of the considerations that underpin the data collection.
2. No respondents or organisations will be individually identified in reporting.
3. The interview will be digitally recorded and the interviewer may take notes. Recorded information will be kept and viewed only by the review team (staff at Evaluation Consult).
4. The information collected for this review will be held in a secure data management system that is only available to the evaluators from Evaluation Consult. Information will be removed from that system at the completion of the contract.
5. The information obtained through interviews will only be used for the review.
6. Your participation is voluntary. Participants are not obligated to answer any of the questions, and are free to leave the interview at any time.

If you have any questions regarding the review or would like to discuss this further, please feel free to contact us via email or phone at Evaluation Consult:

Dr Dilhani Bandaranayake (Senior Consultant) – Dilhani@evaluationconsult.com or Michael Campin (Senior Consultant) – Michael.Campin@evaluationconsult.com
Phone: 04 476 7391

Thank you in advance for your cooperation with this review. Michael and I look forward to hearing your views.

Dr Dilhani Bandaranayake
Senior Consultant
Evaluation Consult
tel +64 4 476 7391

e Dilhani@evaluationconsult.com

Michael Campin
Senior Consultant
Evaluation Consult
tel +64 4 476 7391
mob +64 21 315 559

e Michael.campin@evaluationconsult.com

Appendix twelve: ARC provider interview consent form

The following is a consent form. Every person who took part in a face to face, ARC facility interview were asked to complete this.

interRAI post-project review ARC provider interview consent form

Please read the statements below and circle '**YES**' or '**NO**'. If submitting electronically please delete, underline, or ~~strike through~~ accordingly.

1. I have read and understood the Information Sheet, and have had the details of the review explained to me if/where required. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time. **YES / NO**

2. I understand that my participation is voluntary, that I may decline to answer any or all of the questions and that I may withdraw from participating at any stage. **YES / NO**

3. I agree to the interview being digitally voice recorded. **YES / NO**

Signature: _____ Date: _____

Name: _____

Email: _____

Appendix thirteen: ARC provider interview question guide

Interview information	
Date and Time:	
Location:	
Provider (include category):	
Provider representative(s) (include position(s) held)	
Interviewer:	

Information objective	Question	Response
Need	Thinking about the sector prior to the introduction of the Long Term Care Facility comprehensive clinical assessment tool (LTCF tool), do you think there was a need to introduce a standardised assessment tool? If so, why?	
Process part one	Did your organisation introduce the tool in the voluntary phase or mandatory phase?	
	How effective do you think communication regarding the project to introduce the LTCF tool was?	
Training (process part two)	What is your organisation's experience of the training process?	
	How has the training process specifically impacted your organisation, both positively and negatively?	
Assessment and Technology (process part three)	How is the LTCF tool being used by your organisation? Who uses it? <i>Technology platforms, use points, Who uses it?</i>	
	Does your organisation use another assessment tool in conjunction with the LTCF tool? If so, why?	

Information objective	Question	Response
	(ask if and of their individual facilities are using other tools)	
	Describe any significant barriers or challenges experienced by your organisation in introducing the LTCF tool?	
Summative and impact	How has the introduction of the tool impacted on your organisation in regards to: <ul style="list-style-type: none"> • quality and safety of resident care • facility management • staff in your facility/facilities? 	
	How beneficial has the introduction of the tool been to your organisation? Can you give examples?	
	Overall how useful do you think the tool is, and why?	
Sustainability	Has the introduction of the tool provided value for money for your provider company ? If so how?	
	How sustainable is the on-going use of the tool? What are your reasons for this view?	
Other comment	Is there any further comment you would like to make on behalf of your provider company regarding the introduction and on-going use of the tool?	

Appendix fourteen: NASC manager interview information email

The Comprehensive Clinical Assessment (interRAI) Project was tasked with establishing the use of a standardised assessment tool that uses software. This Long Term Care Facility comprehensive clinical assessment tool (LTCF tool) was designed to enhance the care of older people in aged residential care (ARC) facilities. Evaluation Consult has been commissioned by interRAI Services, Central Region's Technical Advisory Services Ltd New Zealand (TAS) to undertake an independent review (the Review) of the progress of the project from pre-project establishment through to 30 June 2015.

Aims of the Review:

The discussion is intended to provide the Review team with a broad, varied understanding of the key elements and contextual issues with the interRAI framework that are necessary to cover in the review. The review team will use the information to inform:

- the scope and processes for the interRAI project
- final data analysis and evaluation findings

Examples of questions that may be asked include:

- *Thinking about the sector prior to the introduction of the Long Term Care Facility comprehensive clinical assessment tool (LTCF tool), do you think there was a need to introduce a standardised assessment tool? If so, why?*
- *How do you see ARC facilities using the LTCF clinical assessment tool?*
- *In your role, how you interact with and use the LTCF clinical assessment tool?*
- *How has the introduction of the LTCF assessment tool impacted:*
 - *your role as a NASC assessor/manager?*
 - *how you work with ARC facilities and providers?*
 - *the sector in general?*
- *What do you see as the key achievements/successes of the project in establishing the use of the LTCF clinical assessment tool?*
- *What were the main challenges in implementing the LTCF tool?*
- *How long does it take for NASC assessors to approve a change in level of care utilising the interRAI LTCF tool? What factors impact the time taken?*
- *What were the lessons learned from the interRAI project?*
- *How did the shift from voluntary to mandatory use of the LTCF tool affect NASC Assessors/Managers?*

Ethical considerations

The discussion will be undertaken in accordance with standard research ethical principles, practices and informed consent processes to ensure your information is secure and confidential. This includes:

1. The facilitator will seek your informed (verbal) consent at the commencement of the discussion and ensure you are aware of the considerations that underpin the data collection.
2. No respondents or organisations will be individually identified in reporting.
3. The discussion may be digitally recorded and notes will be taken. Recorded information will be kept and viewed only by the review team (staff at Evaluation Consult).
4. The information collected for this evaluation will be held in a secure data management system that is only available to the evaluators from Evaluation Consult. Information will be removed from that system at the completion of the contract.

5. The information obtained through the discussion will only be used for the review.
6. Your participation is voluntary. Participants are not obligated to answer any of the questions, and are free to leave the discussion at any time.

If you have any questions regarding the review or would like to discuss this further, please feel free to contact us via email or phone at Evaluation Consult:

Dr Dilhani Bandaranayake (Senior Consultant) – Dilhani@evaluationconsult.com or Michael Campin (Senior Consultant) – Michael@evaluationconsult.com

Phone: 04 476 7391

Thank you in advance for your cooperation with this review. Michael and I look forward to hearing your views.

Dr Dilhani Bandaranayake
Senior Consultant
Evaluation Consult

tel +64 4 476 7391

e Dilhani@evaluationconsult.com

Michael Campin
Senior Consultant
Evaluation Consult

tel +64 4 476 7391

mob +64 21 315 559

e michael@evaluationconsult.com

Appendix fifteen: NASC manager interview question guide

Interview information	
Date and Time:	
DHB:	
NASC representative(s) (include position(s) held)	

Information objective	Question	Response
Need	Thinking about the sector prior to the introduction of the Long Term Care Facility comprehensive clinical assessment tool (LTCF tool), do you think there was a need to introduce a standardised assessment tool? If so, why?	
Process	How do you see ARC facilities using the LTCF clinical assessment tool?	
	In your role, how you interact with and use the LTCF clinical assessment tool?	
Summative and impact	How has the introduction of the LTCF assessment tool impacted: <ul style="list-style-type: none"> • your role as a NASC assessor/manager? • how you work with ARC facilities and providers? • the sector in general? 	
	What do you see as the key achievements/ successes of the project in establishing the use of the LTCF clinical assessment tool?	
	What were the main challenges in implementing the LTCF tool?	
	How long does it take for NASC assessors to approve a change in level of care utilising the interRAI LTCF tool? What factors impact the time taken?	
	How did the shift from voluntary to mandatory use of the LTCF tool affect NASC Assessors/ Managers?	
Lessons learned	What were the lessons learned from the interRAI project?	
Other comment	Is there any further comment you would like to make regarding the introduction and on-going use of the tool?	