

**ORIGINAL ARTICLE**

# Nursing staff and nursing managers' experiences of using the interRAI ID instrument in assessing the service needs of persons with intellectual disabilities in housing services

Hanna Kangasniemi  | Iina Ryhtä | Minna StoltDepartment of Nursing Science,  
University of Turku, Turku, Finland**Correspondence**Hanna Kangasniemi Department of  
Nursing Science, University of Turku,  
20014 Turku, Finland.  
Email: [hanna.m.kangasniemi@utu.fi](mailto:hanna.m.kangasniemi@utu.fi)**Abstract**

The assessment of service needs among persons with intellectual disabilities (ID) is important to identify a person's needs, strengths and preferences. One commonly used instrument for service needs assessment is Resident Assessment Instrument Intellectual Disabilities (interRAI ID). However, there is limited evidence of the experiences of using interRAI ID for assessing the service needs of persons with ID from nursing staff and nursing managers' perspective. The aim of this study was to explore the suitability of the interRAI ID instrument (version Fi2020.1) for assessing the service needs and functional development of persons with ID as described by nursing staff and nursing managers working in a housing service. The data were collected using focus group interviews ( $n = 3$ ) in May 2020. The interviews were conducted in units providing housing services for persons with ID ( $n = 6$ ). The interview groups consisted of nursing staff ( $n = 22$ ) and nursing managers ( $n = 6$ ). The data were analysed using inductive content analysis. The experiences of nursing staff and nursing managers fell under three main categories: (1) the assessment process; (2) possibilities to use the assessment data and (3) implementation experience. The interRAI ID instrument is suitable and useful for the systematic assessment of the health, functional capacity and service needs of persons with ID. In the future, effective and evidence-based methods are needed to promote the assessment skills of nursing staff and to use assessment data in nursing practice as well as nursing management.

**KEYWORDS**

assessment, housing services, ID, interRAI ID, practice, service needs

**INTRODUCTION**

Intellectual disability (ID) is a disability characterised by significant limitations in intellectual functioning and adaptive behaviour, which cover many everyday social and practical skills. This disability originates before the

age of 22 (American Association on Intellectual and Developmental Disabilities [AAIDD], 2021) and its prevalence is often quoted at 1% (McKenzie et al., 2016) of the population. The situations and health needs of people with ID are often very complex. People with ID are at risk for a number of health problems (Heutmekers

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et al., 2018). Identifying the problems can be challenging. The most common problems are functional deficits, behavioural symptoms, nutritional problems and social challenges (Carfi et al., 2019). Life expectancy has increased for people living in middle- to high-income countries, including people with ID. People with ID also have many health problems associated with ageing at an earlier age (Navas et al., 2019), such as depression (Eaton et al. 2021), psychiatric disorders and challenging behaviour (Ashworth et al., 2008) and dementia (Zeilinger & Stiehl, 2013). Given the high rates of health problems among people with ID, regular assessment of service needs (service assessment refer to planning a person's care and access supports corresponding to needs) is important to support their everyday lives and health.

Using the Resident Assessment Instrument Intellectual Disabilities (interRAI ID) instrument to assess the service needs of persons with ID has many advantages for residents and professionals. Service assessment provides information about a person's strengths, preferences and needs. Assessment data can be used to better understand the complexity of service needs, identify problems and make matters visible, such as the use of medicines. Assessment data help to promote, predict, restore, maintain and maximise functional ability. It is possible to compensate for the lack of functional capacity by targeting support and promoting the person's quality of life (Carfi et al., 2019; Martin, 2005). Services can be planned and the person can access support and services corresponding to their needs (Martin, 2005; Martin & Ashworth, 2010; Martin et al., 2007) and treatment and rehabilitation become more goal-oriented (Martin & Cobigo, 2011). Assessment provides a common language; it promotes co-operation between social and healthcare services. The instrument serves to facilitate communication between professionals in social, developmental and healthcare sectors and therefore, the potential to contribute to efficient and quality-driven services is therefore enhanced (Ashworth et al., 2009; Martin et al., 2007).

People with ID need various services and are known to be at increased risk for medical and psychiatric care (Ashworth et al., 2008, 2009; Martin, 2005, 2008; Martin et al., 2007). Assessment data provide evidence-based information that can be used in decision-making (Martin, 2005, 2008; Martin et al., 2007), in a person's relocation (Martin, 2008; Martin & Ashworth, 2010) and in the formulation of social and health policy guidelines (Martin, 2005). Moreover, assessment data help to estimate the need for services and the associated costs (Fries et al., 2019) and promote the effective use of staff time and targeted actions (Carfi et al., 2019).

Assessment data have been used to study the effects of care environment reorganisation on persons with ID

(Ashworth et al., 2010; Martin, 2008; Martin & Ashworth, 2010; Martin et al., 2012), to examine the implementation of social inclusion (Martin & Cobigo, 2011), the prevalence of pica symptoms (Ashworth et al., 2008) and the characteristics associated with Down syndrome (Carfi et al., 2019). The scales embedded in interRAI ID can help identify symptoms of dementia (Zeilinger & Stiehl, 2013) and depression (Langlois & Martin, 2008).

Evidence of the experiences of nursing staff or nursing managers related to the use of the interRAI ID instrument is limited. Some studies have been conducted. However, these focus mainly on addressing experiences of the interRAI Long-Term Care Facilities Assessment System (Boorsma et al., 2013; Hansebo et al., 1998; Smith et al., 2013; Vanneste et al., 2013; Vuorinen, 2020) or the interRAI Home Care Assessment System (Smith et al., 2013).

Previously, technology-related challenges, such as a lack of computers or laptops and problems with logging in and connecting to the Internet, have emerged (Boorsma et al., 2013; Hansebo et al., 1998; Smith et al., 2013; Vannaste et al., 2013; Vuorinen, 2020). Challenges related to the use of time were reported, especially as morning shifts were felt to be busy (Boorsma et al., 2013; Vuorinen, 2020). Implementing assessment requires ongoing training from the organisation as well as an understanding of why assessment data are collected and how it can be utilised. In addition, staff must have adequate support in the use of the assessment instrument as well as in the technology (Smith et al., 2013). In general, the interRAI instrument was regarded as comprehensive and the assessment was considered to have a positive effect on the quality of care (Boorsma et al., 2013; Hansebo et al., 1998; Smith et al., 2013; Vanneste et al., 2013; Vuorinen, 2020). Staff attitudes towards interRAI were largely positive. InterRAI assessment increased caregivers' knowledge of the person and thereby helped in planning care (Hansebo et al., 1998; Vuorinen, 2020). The assessment was considered important for highlighting changes in a person's ability to function and condition (Vuorinen, 2020) and providing a new perspective on a person's situation, thereby an understanding of behaviour (Hansebo et al., 1998). The assessment also increased communication and co-operation between relatives and caregivers (Hansebo et al., 1998). In sum, nursing staff and nursing managers' experiences of using interRAI are positive. However, little is known about how nursing staff and nurse managers perceive the use of interRAI ID in housing service settings while assessing the service needs of persons with ID.

The aim of this study was to explore the suitability of the interRAI ID instrument for assessing the service needs and functional development of persons with ID, as

described by nursing staff and nursing managers working in a housing service.

## METHODS

### Design, setting and participants

A qualitative descriptive design was applied. In Finland, the municipality is responsible for organising care services for persons with ID by either providing services itself, together with other municipalities or buying services from a private organisation (Finlex, 2021a; 710/1982; Ministry of Social Affairs and Health, 2021). The service needs assessment is based on legislation (Finlex, 2021b; the Social Welfare Act 1301/2014; the Disability Services Act 380/1987; the Act on Intellectual Disabilities 519/1977; the Act on the Status and Rights of Social Welfare Clients 812/2000). Despite the importance of assessment, there is no nationally agreed instrument for assessing the needs of people with ID. Therefore, each organisation can select and use different kinds of instruments. However, a strong emphasis has been placed on using interRAI ID in housing service settings.

The study was conducted in one Finnish private care organisation consisting of approximately 400 units. Six units located in western and southern Finland were selected using purposive sampling to represent units that provided housing services. Provision of a service (support and care in daily living) as well as a house for persons with ID (enhanced service housing and/or supported housing).

The units involved in the study had introduced the interRAI ID in January 2020. The implementation process had progressed in accordance with the orientation and training protocol of the Finnish Institute for Health and Welfare (THL), which co-ordinates the implementation of Finnish versions of the RAI instruments, owns the copyright of these instruments and ensures that the instruments are used in compliance with the terms and conditions of interRAI's licence agreement (THL, 2021). Two nursing staff members (registered nurses [RNs] or licensed practical nurses [LPNs]) from each unit were selected as RAI mentor to serve as instructors and support the unit manager in RAI development work. The nursing staff of each unit was instructed to complete free RAI online education by THL. Training on the RAI ID instrument (2 × 8 h) was provided by specialist of THL to unit managers and RAI mentors. In addition, training about RAISOFT software (2 × 4 h) was provided by specialist from the organisation participating in the study.

The interRAI is a standardised and comprehensive assessment instrument. The interRAI instrument for

persons with ID is called the interRAI ID (Martin & Ashworth, 2010; Martin et al., 2007). The assessment questions cover the most important areas related to the person's life, including, for example, health status, functional capacity, medication, nutrition, memory functions and mood, rehabilitation, use of services, environment, inclusion, activity and support from relatives. The psychometric properties of the scales embedded in interRAI ID have been evaluated, and the instrument has been found to be suitable for clinical use. For example, scales Cognitive Performance, Activities of daily Living Hierarchy and Depression embedded in interRAI are internally consistent and valid among adults with ID and, criterion validity was found to be adequately of embedded measures for cognition, self-care, aggression and depression (Chan et al., 2013; Martin, 2005; Martin et al., 2007). The interRAI ID instrument was translated into Finnish in 2011 and piloted in Finland in 2013–2014 (Finne-Soveri, 2015).

### Data collection

The data were collected using focus group interviews in May 2020 (May 18–20, 2020). The interRAI ID instrument had been used about 4 months when data were collected. The focus group method was considered suitable as data were created through interactions between participants. Interactions among people was seen to support them to express and clarify their views in ways that are less likely to occur in a one-on-one interview (Gray, 2009). Focus group data are created through interactions between participants whereas data from individual interviews are created through a dialogue between the participant and researcher, whose questions set the agenda (Baillie, 2019). In focus group, the interactions are expected to prompt new thinking and provide more in-depth discussion of the subject overall (Sagoe, 2012).

Purposive sampling was applied to recruit informants who were assumed to have previous experience of the topic under study (Parahoo, 2006). Three focus group interviews were conducted: Group 1, nursing managers ( $n = 6$ ), Group 2, RAI mentors ( $n = 12$ ) and Group 3, nursing staff ( $n = 10$ ). The nursing managers group consisted of unit managers and their superiors at the regional level. The RAI mentors were named RNs or LPNs working in the units. The nursing staff were RNs or LPNs working in the units. The primary role of nursing staff participated to the study was to assist persons with ID in their daily life. The sizes of the groups (6–12 participants) followed the recommendations from the literature (Freeman, 2006).

The groups were homogeneous according to their work roles in the units. Groups were designed to be as

comfortable as possible for the participants to discuss the topic (McLafferty, 2004). The researcher informed unit managers and their superiors at the regional level about the study. They informed the staff about the study and recruited the participants. Volunteers informed their willingness to participate to the manager of their unit, who passed the information to the researcher.

The interviews were conducted online using Microsoft Teams. They were recorded with the permission of the participants. The observer participated in the interviews to assist the researcher by observing the discussion and the interaction between the participants. The observer was recruited from the organisation that participated in the study. The selected person had extensive work experience with the RAI instrument. A reflective discussion was conducted with the observer immediately after each interview (Papastavrou & Andreou, 2012).

The focus groups discussed the nursing staff and nursing managers' experiences of using the inter-RAI ID instrument and possibilities to use the assessment data. The interview themes, training, orientation, assessment, processing of assessment data and potential benefits of assessment data were based on the literature (Boorsma et al., 2013; Vuorinen, 2020). The themes were emailed in advance so that the participants could familiarise themselves with the topics (Krueger & Casey, 2001).

## Ethical considerations

The study followed good scientific practice (ALLEA, 2017). This study was conducted without patient involvement, so no approval by the ethics committee was required according to Finnish legislation (TENK, 2019). Participants were not considered as vulnerable population. The participants received written and oral information about the study's purpose, voluntary nature of participation, data collection, confidentiality and anonymity. Each participant gave informed consent. Suspension was possible throughout the research process. The anonymity of the participants was taken care of, and no other information was collected about the participants than their professional role and working unit. All interview questions were related to the use of the interRAI instrument. The data were only available to the author of the study and will be destroyed afterwards.

## Data analysis

After the interviews, the recorded data were transcribed with a focus on the content by the researcher. The analysis was conducted using inductive content analysis. The inductive data-based approach moves from the specific to

the general. Certain instances are detected and then combined into larger entities or general expressions. The analysis proceeded according to the three-step process: (1) data reduction, (2) data clustering and (3) abstracting, that is, the formation of theoretical concepts (Elo & Kyngäs, 2008). The analysis began by familiarisation with the data. The data were reduced and the reduced expressions were coded and grouped by work role using different text colours. The codes were grouped according to similarities and differences, then formed into sub-categories and further into categories. Finally, theoretical concepts, that is, main categories were formed. An example of the analysis process is described in Table 1.

## FINDINGS

The experiences of nursing staff and nursing managers of using the interRAI ID instrument in the service needs assessment of persons with ID fell into three main categories: (1) the assessment process, (2) possibilities to use the assessment data and (3) implementation experiences. The findings seek to form an understanding of how participants intersubjectively share their world of experience. The former emphasises the importance of interaction and joint action, so the results are examined to form an overall picture of the data. The working role of the participants can be seen after the direct quotations. The main categories of the study are illustrated in Figure 1.

### The assessment process

Residents were assessed using the RAI ID instrument and RAIssoft software. The software includes a manual to guide the assessment work. Participants described how the assessment was conducted and the factors involved. The main category based on these findings was described as *The assessment process*. It included seven categories: (1) planning of assessment work, (2) assessment instrument (RAI ID) and software, (3) recording the assessment in the software, (4) time spent on assessment, (5) significance of nursing documentation, (6) parties involved in assessment and (7) reliability of assessment data.

### Planning of assessment work

Planning varied, and the role of managers in planning was emphasised. The assessments had been marked on the calendar, but were also made spontaneously. Predefined assessment dates were sometimes found to be challenging.

TABLE 1 Example of the analysis process

Main category	Category	Sub-category	Code	Original statement
Possibilities of using the assessment data	Support of daily work	Ability to act/changes in ability to act	Demonstration of changes in ability to act Monitoring changes in ability to act The assessment highlights the resident's true ability to act	“Can change enormously in both directions for the same resident” “The next time I do [assessment], I'll see which direction it goes” “Brings out that real ability to act”
		Care and service plan	Utilisation of assessment data in updating the care and service plan The assessment data help in drawing up the care and service plan	“An RAI assessment will be carried out first and an update of the care and service plan will be based on its results” “A lot helps in making a care and service plan”

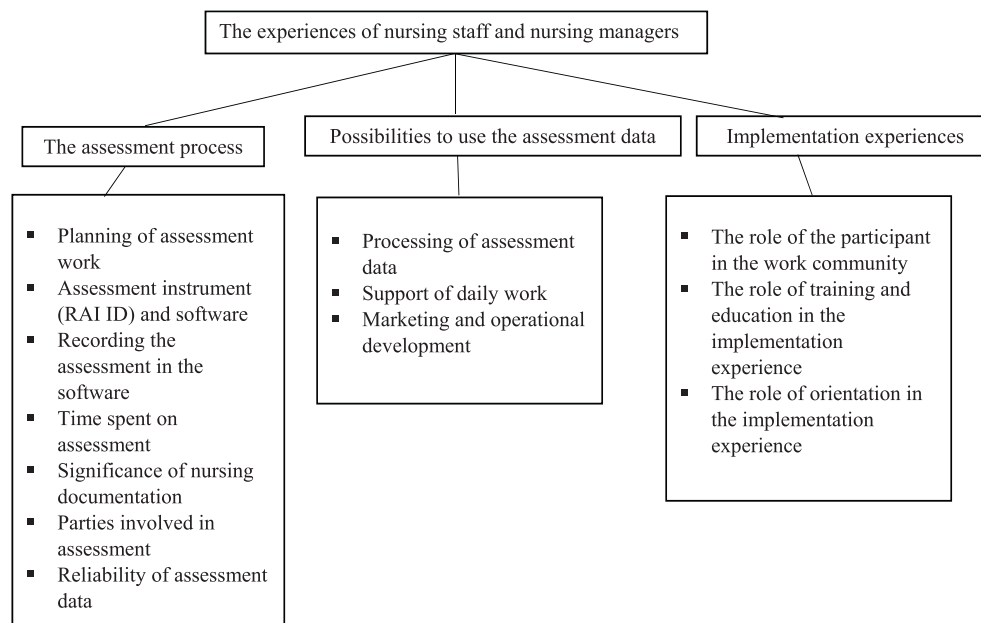


FIGURE 1 The experiences of nursing staff and nursing managers

At first we were given these assessment times, but it didn't come to anything when the situation of the unit varied so much. (Nursing staff)

It's [manual] useful, but if you have to think more about some of the questions, it's good to have that colleague. (RAI mentor)

### Assessment instrument (RAI ID) and software

The assessments were recorded in the RAIssoft software that was generally considered to be easy to use. The manual guided the interpretation of the questions but did not replace work community support or eliminate the need for training, education and orientation.

### Recording the assessment in the software

Practices for recording the assessments varied. Assessment times were arranged, for example, during shift planning or taking advantage of the time between the morning and evening shifts. Unless time had been arranged for the assessment work, nursing staff found self-direction difficult. Recording the assessments



alongside one's own work was found to be challenging due to constant interruptions. The assessments were also recorded for night shifts, as there were fewer distractions. The assessment was either completed at once or recorded in parts. It was typical that the resident was unable to focus on the assessment at once. An unfinished assessment was perceived to be burdensome.

It is hoped that time will be set aside for this, not in addition to our own work, we have at least spent so much time on this. (Nursing staff)

### Time spent on assessment

The time taken for the assessment ranged from 2 h to more than 10 h. The assessment was seen to consist of many aspects, so the exact time was difficult to determine. Participants agreed that the first assessment always took relatively longer than subsequent ones. Participants who had not participated in training or received orientation found the assessment laborious, time-consuming and difficult. It took longer to do the assessment alone than with a colleague. The elapsed time of the assessment varied between residents. For communicating residents, the conversation could lose focus on the topic. For residents who did not communicate, data collection was more challenging. RAI assessments are updated every 6 months or when there is a significant change in the resident's condition. The update interval divided the opinions of the participants.

Assessment was the subject of a team meeting, that you document well and pay attention to these, then of course kind of spend more time, but how its working time then counts. (Manager)

### Significance of nursing documentation

Accurate and descriptive documentation was considered important in the assessment work, the quality of the documentation was seen to improve with follow-up assessment. However, duplicate recording of the same data into multiple different programmes caused frustration.

A lot of attention has been paid to documentation; the same things are basically documented as before, but the way those are opened in the text is quite different than before. (RAI mentor)

### Parties involved in assessment

Residents' participation in the assessment varied, because of problems with concentration, lack of interest or communication difficulties. An assessment made by one caregiver was feared to be a subjective view of a resident's situation. If residents did not communicate by speech, alternative ways to find out the resident's opinion were needed. Relatives rarely participated in the assessments. The role of relatives was seen to be emphasised if the resident did not communicate.

The resident would not have responded if I had asked, then I sent the questions in an email and the resident responded to me. (RAI mentor)

### Reliability of assessment data

Factors that increased reliability included training, orientation and utilisation of the manual. Opinions were divided on whether the RAI assessment instrument is suitable for assessing non-communicating residents. If the resident was either unwilling or unable to answer the questions, it caused frustration. The assessment questions were perceived as difficult to understand and unsuitable as such for residents with ID. A simplified-language version of the questions was hoped for (easy-to-understand communication). Participants had reformulated questions so as to be easier to understand, but this was perceived to be laborious and time-consuming.

We can observe what it seems, but is it then the experience of the resident when it is our view, how can we really know? (Nursing staff)

### Possibilities for use of the assessment data

The assessment situation of the units varied. There had been only a short time to process the assessment data. The assessment data had not been used, but possible ways to utilise that were discussed. The third main category, *the possibilities for use of assessment data* included three categories: (1) processing of assessment data, (2) support of daily work and (3) marketing and operational development.

### Processing of assessment data

It was unclear how assessment data should be processed or utilised; support and training were required. It was

considered important to review the assessment data and there were recognise meeting practices, but having time to review the assessment data should be taken into consideration.

When assessment results should be looked at, the knowledge runs out. (Manager)

### Support of daily work

It was considered that the assessment data could be used in daily care. The overall situation of the resident became clearer, and their wishes and thoughts were clarified. The assessment data were believed to indicate the resident's ability to act, their resources and their need for support. The assessment was seen as providing particularly valuable information on new residents. Assessment data can be used in care, rehabilitation and service plans, as well as in setting and monitoring goals of care. The assessment was also believed to provide information that might otherwise go unnoticed.

As a whole it shows what the resident's need for support is and the next time I do [assessment], I will see which direction it is going. (Nursing staff)

### Marketing and operational development

The assessment provides evidence-based information about the resident's situation and need for support and care. This information can be used, for example, in planning care, pricing, training and assessing the need for human resources. The assessment data highlight the differences: good care does not always mean equal support for all, but support according to each individual need. The assessment data compile an overall picture of the unit's residents and makes nursing and rehabilitation work visible.

Able to see the opinion of the resident more broadly, not just a presumption of things. (Nursing staff)

### Implementation experiences

The main category *implementation experiences* included three sub-categories: (1) the participant's role in the work community, (2) the role of training and education in the implementation experience and (3) the role of orientation in the implementation experience.

### The participant's role in the work community

Participants described their role in the work community. The managers felt that they were primarily enablers, RAI mentors were instructors and nursing staff were responsible for practical assessment work.

Managers saw their own role in providing resources for assessment work as essential, some found the implementation difficult and burdensome. The situation of the unit, such as staffing, was seen to affect implementation, as there was difficulty finding time for the assessment work. The RAI mentor's role was seen as important. Managers were prepared to provide the RAI mentors with additional financial compensation and hoped RAI mentors would also access regular external support from the organisation. While the RAI mentor was considered to be responsible for the orientation, the assessment was most often seen as the task of the resident's primary caregiver. The RAI mentor's role might be exhausting, and experiences of inadequacy emerged. The nursing staff's attitudes towards the assessment instrument and support received from the manager varied. A low level of management support and negative attitudes towards the assessment instrument were related to the load experienced. Managers considered that they had a significant role in utilising assessment information, for example, in pricing and assessing sufficient human resources. The RAI mentors were considered to support management as reviewers of assessment data. The RAI mentors know the residents through their daily work, so are able to assess the reliability of the assessment data.

I've been a driver of it and showed it to the place, time and space: yes, the RAI mentors helped and mentored, but yes, I had to show. (Manager)

The implementation caused quite a lot of annoyance, I felt quite incapable when the implementation was being questioned. (RAI mentor)

The resident's primary caregiver has the main responsibility for the assessment, but the working group would be involved. (Nursing staff)

### The role of training and education in the implementation experience

Regular and ongoing training and education for all members of nursing staff were seen as important in both ensuring competence and maintaining motivation. All

managers and most RAI mentors participated in online education organised by the THL and in training on the RAI ID instrument and RAIssoft software. Participation was related to the management of the unit. The wish was for the training to be practical and shorter training days were required. More training about assessment questions and typical misinterpretations was hoped for. Individual and unit-specific assistance from the trainer was desired.

This is such an ongoing process and requires constant training and familiarisation. (Manager)

## The role of orientation in the implementation experience

The nursing staff knew little about the backgrounds or objectives of the implementation and reported their fear of additional work being caused by the assessment. The support they received from the RAI mentors varied. Participants felt that the RAI instrument is extensive, this may initially cause anxiety. Conducting the assessment without orientation and support was time-consuming and difficult.

We were just told to do things like this. (Nursing staff)

## DISCUSSION

This study provided novel findings from nursing staff and nursing managers' perspectives of the suitability of the interRAI ID instrument for assessing the service needs and functional development of persons with ID. Based on the results, nursing staff and nursing managers' attitudes towards the RAI assessment instrument were mainly positive. However, many challenges and difficulties comprehending usage and functionality were identified. It was not clear to everyone why the assessment was conducted and how the assessment data could be used in planning services for people with ID. The instrument had only been in use for about 4 months in units. This has certainly contributed to the results.

According to the results, the interRAI ID instrument was considered to be comprehensive and useful in practical care and guidance work, to promote the quality of care and indicate changes in the resident's condition. The assessment data were seen as assisting the service and care plan. Through the assessment, the staff became acquainted with the resident's situation and the assessment helped to see things that might not otherwise be noticed. The assessment was found to be particularly useful for new residents. The results are in line with previous

studies (Boorsma et al., 2013; Hansebo et al., 1998; Vuorinen, 2020) supporting the benefits of comprehensive needs assessment.

The principle of the RAI assessment, that the resident has a significant role as an informant, was perceived as positive. The value of the assessment instrument was questionable for non-communicating residents. There were fears that the assessment results would be unreliable if the resident's own voice had not been heard. These results support the previous findings where the interRAI instrument was welcomed if staff believed that the resident would benefit from the assessment (Vuorinen, 2020). Despite this, the nursing staff and managers considered systematic and uniform assessment of every person with ID to be important.

The importance of clear terminology in the questions in the interRAI ID was highlighted. The assessment questions were sometimes perceived as difficult to understand and thus were seen as problematic in terms of the reliability of the assessment data. Simplified-language questions would promote the possibility for residents to participate in the assessment, and thus make the assessment instrument more useful to a wider group of residents. Problems relating to terminology have been demonstrated previously (Boorsma et al., 2013; Vuorinen, 2020), revealing problems in understanding some of the questions. Complex or unclear terminology lead to negative experiences of the assessment instrument. Therefore, in the future, interRAI ID could benefit from a revision of the item wording to promote the regular use of the instrument.

Inviting relatives to assess and discuss service needs was quite rare. Using interRAI ID can be challenging if relatives do not participate in treatment, but on the other hand, the instrument was seen to promote co-operation between relatives and nursing staff (Hansebo et al., 1998). However, non-participation of relatives was not perceived as a challenge in this study.

Based on the results, time-related resources were considered challenging. Participants regarded that finding time for assessment was problematic, and learning to use interRAI ID took time. However, the assessment became easier and faster as the instrument became more familiar. Challenges related to lack of time were also reported in other studies (Boorsma et al., 2013; Hansebo et al., 1998; Smith et al., 2013; Vanneste et al., 2013; Vuorinen, 2020). The nursing staff felt pressured to complete the assessment on time. In the future, it is important to allocate time to familiarising nursing staff with using the instrument and in that way decrease the feelings of uncertainty among nursing staff. Based on previous evidence, adequacy of time is related to having sufficient staff numbers (Boorsma et al., 2013). Moreover, the staff considered it important to have a clear framework for assessment work.



The importance of nursing documentation was highlighted in this study. The participants considered documentation to have been improved due to the systematic assessment, and accurate documentation was seen to facilitate the assessment work. However, the duplicate recording of the same data into multiple different programmes caused frustration, in line with a previous study (Vuorinen, 2020). Functional software integrations could be the solution to this.

The possibilities of using the assessment data were unsystematic. Participants identified the possible ways to utilise the assessment data, but practical experiences were still limited. In the future, to increase the assessment rates, units could benefit from educating staff about the meaning and use of the assessment data as part of comprehensive holistic care. In this study, the less support there was, the more negative attitudes emerged. The importance of education and orientation was also strongly highlighted in previous studies (Smith et al., 2013; Vuorinen, 2020). Future research could focus on developing the assessment skills of nursing staff and practices for utilising the assessment data.

### Strengths and limitations

The trustworthiness of this study was ensured following the criteria of credibility, dependability and transferability (Graneheim & Lundman, 2003). With regard to credibility, during the entire research process, including the data collection method, sizes of interview groups, design of focus groups, building the interview themes, data analysis and reporting were reviewed by the research team. When assessing the utilisation of the assessment data, the interval between the data collection and the implementation should have been longer. Participation in the study was voluntary. Thus, participants who experienced the implementation more positively than average may have self-selected for the study.

With regard to dependability, the study process, data collection and analysis were reported carefully. Researcher preconceptions, researcher choices, time spent in the research process and encounters with participants may have influenced the research results. Reflectivity was increased through debate with the research team and the observer who participated in the interviews.

With regard to transferability, this study draws a rich understanding of experiences from nursing staff and nursing managers related to the suitability of the interRAI ID instrument for assessing persons with ID. However, the study sample was small and in only one organisation. As such, the results cannot be generalised to a larger set or transferred to another environment. Nevertheless, the study findings can be used to promote assessment of the service needs of persons with ID and provide a basis for future research.

## CONCLUSIONS

According to nursing staff and nursing managers, the interRAI ID instrument seems to be suitable for the systematic assessment of the health, functional capacity and need for services of persons with ID. Through systematic assessment, it is possible to promote the quality of life of persons with ID. Assessment data can be used to develop services and the service system as well as identifying situations that a person is able to cope with independently. Assessment data provide common language between professionals in the social, developmental and healthcare sectors, and, therefore, the potential to contribute to efficient and quality-driven services is therefore enhanced. In addition, systematic assessment data allow for comparison at both the national and international levels. Assessing the need for a service helps identify an individual need for support and assistance. Through personalised services, a person receives the help they need, while avoiding unnecessary interventions. In this way, services can be provided not only in high quality but also cost-effectively. The design of services should be based not only on evidence-based practices but also on the wishes of the person with an ID themselves. Based on this study, nursing staff are actively involved in assessing the service needs of people with ID, but their assessment skills and utilisation of assessment data vary. Assessment may remain a separate part of nursing practice without adequate support. Experiences of nursing staff can be used to planning and developing support as well as training. In the future, effective and tested methods are needed to promote the assessment skills of nursing staff and to use assessment data in nursing practice and nursing management.

### CONFLICT OF INTEREST

The authors declare no conflict of interest.

### ETHICS STATEMENT

The study followed good scientific practice (ALLEA, 2017). As this study was conducted without patient involvement, no approval by ethics committee was required according to Finnish legislation (TENK, 2019). The participant received written and oral information about the study purpose, data collection, confidentiality and anonymity. Each participant gave written informed consent.

### ORCID

Hanna Kangasniemi  <https://orcid.org/0000-0001-9234-2881>

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