HealthCERT Bulletin

Information for Designated Auditing Agencies

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http://www.moh.govt.nz/certification

Welcome to the March 2011 edition of the HealthCERT team's quarterly bulletin. The focus of this edition is on the topics covered at the designated auditing agency (DAA) workshop held on 2 March and on information that may help answer some commonly asked questions.

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Meeting the Standard for Nutrition, Safe Food, and Fluid Management (criteria 1.3.13.1 and 1.3.13.2): Further guidance

What is required for compliance with Standard 1.3.13?

Standard 1.3.13 requires that, 'A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.' Meeting this standard involves compliance with the following criteria.

- Criterion 3.13.1 requires that 'food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group'. Complying with the Ministry of Health's food and nutrition guidelines, regularly monitoring the weight and nutritional status of individual consumers, and managing unexpected weight loss are measures mentioned as helping to meet this criterion.
- Criterion 3.13.2 requires that 'consumers who have additional or modified nutritional requirements or special diets have these needs met'. Many residents in aged care facilities will fit into this category. Guidance for meeting this criterion includes asking registered dieticians for their input on menus and diets.

The age-related residential care contract also requires providers to have a food service providing meals and refreshments that are appropriate for older people and that reflect their nutritional requirements. It would be expected that any review of menus by a registered dietician would identify areas needing improvement, and that providers would act on this advice.

Conclusion

Residents in aged care facilities are likely to be frail. Additionally they will more often fit the profile of 'consumers who have additional or modified nutritional requirements or special diets', as set out in Criterion 3.13.2. Meeting the needs of these residents requires specialist dietary input.

If auditors find no evidence that dieticians are providing input to menu planning generally, or to any review of requirements for residents who have additional or modified nutritional requirements or special diets, then they will need other evidence to demonstrate how this criterion is being met. In particular, they will need evidence that:

- the menu planner has sufficient expertise in this area, including the ability to undertake menu reviews, and understands recognised nutritional guidelines for older people, including the requirements identified in *Food and Nutrition Guidelines for Healthy Older People*,[1] and complies with those guidelines
- they are undertaking individual assessments of residents' nutritional status, and are updating them and following up appropriately where required including through dietician referral.
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Many providers do undertake a nutritional assessment of residents when they are admitted to a facility. Waitemata DHB has developed a booklet, *An RN Care Guide for Aged Residential Care*, which includes information on nutrition and hydration as well as an initial screening tool: the Mini Nutritional Assessment for the elderly. Dietician referral is identified where nutritional problems are identified. Waitemata DHB has made this booklet available to aged care providers, and can be downloaded from http://www.waitematadhb.govt.nz/HealthProfessionals/RACIPcareguides.aspx

First steps in a residential disability project

In October 2010 the Minister of Health Tony Ryall announced the start of a project to develop a short-, medium- and long-term approach to introducing immediate improvements and longer-term changes to the residential disability sector. As his media statement explained, the aim of the new streamlined regime is to reduce duplication, while improving the quality of audits and ongoing monitoring of providers. A key focus is to develop a system that will improve outcomes for service users.

In response a Reference Group has been convened, made up of representatives from the sector and the Ministry of Health. The first Reference Group meeting was held in October 2010. Since then it has been working with the Ministry to develop the following 'quick wins', which are being or have been implemented.

1. Verification and Partial Provisional Audits are processed within eight working days of the report being submitted. An audit of reports received between November 2010 and February 2011 demonstrated the average processing time was six working days.

2. Draft infection control guidelines for designated auditing agencies have been developed to provide guidance on auditing infection control standards within a residential disability environment. The guidance document has been circulated to the designated auditing agencies and representatives from the National Committee of Infection Control Nurses working in primary health care. It is anticipated the guidance will be ready for use following the April meeting of the Reference Group.

In addition, the Reference Group has been working on a model of evaluation that will reduce duplication while improving the quality of audits and ongoing monitoring of residential disability providers. A concept paper – Creating an outcome-focused evaluation framework for residential disability services – has been widely distributed and feedback on it is sought by 15 April. To download a copy go to: http://www.moh.govt.nz/moh.nsf/indexmh/disability-keyprojects-integratedaudit
Submissions will then be considered and the model adapted accordingly.

[1] Ministry of Health. 2010. *Food and Nutrition Guidelines for Healthy Older People: A background paper.* Wellington: Ministry of Health. URL: www.moh.govt.nz/moh.nsf/indexmh/food-nutrition-guidelines-for-healthy-older-people-background-paper?Open

The why and how of writing summaries for publication

The intent behind the published summary for aged care facilities is to provide an informative summary of audit findings. With the information it contains, consumers and their families should be able to make more informed choices regarding care options and the wider public should have a stronger foundation from which they can make a risk analysis of a facility based on exception reports.[2]

Summaries are published for three audit types:
1. certification
2. surveillance
3. provisional.

Only the general overview section is published for surveillance and provisional audits.

Published summaries are consumer focused. In writing each one, a designated auditing agency should:

- review the current published certification summary on the website when completing a general overview for a surveillance audit. This will ensure information is not repeated (eg, capacity where there are no changes)
- keep in mind the intent behind the summary
- consider the reader – for many readers, this summary is their first introduction to the world of aged care
- keep within the set word limits. The overall maximum is 1400 words; the general overview section should be a maximum of 200 words.

DAAs are required to consult with the provider about the content of the summary. In addition, HealthCERT advisors review and check its accuracy. If any alteration to the audit summary is needed prior to publication, the DAA is responsible for making it, in consultation with the provider.

The general overview, as the section published for all three audit types, should:

- be grouped in 'themes' where possible, for example, 'care planning, documentation and policy development', rather than stating, for example 'eight partial attainments were identified'
- be written in plain language, without technical terms and abbreviations such as, for example, 'Medico Douglas' and 'tertiary-level ACC WSMP'[3]
- give individualised information on the provider, for example, 'The service has completed a number of building renovations since the previous audit…'
- summarise the improvements, for example, 'Improvements made since the last audit include embedding policies and procedures in place and educating staff, and implementing a varied activities programme'
- summarise the shortfalls, for example, 'the audit found one area that requires improvement, related to the safe labelling and storage of chemicals'
- provide a factual narrative, for example, 'Visual inspection of the facility provided evidence that the facility is clean, adequately heated/ventilated and is well maintained'. Avoid vague or value-laden statements such as 'meandering streams', 'picturesque rural views' or 'well-respected' facility.

What are the requirements for electrical testing?

Electrical testing needs to be part of a residential facility's safety activities. The Electricity Act 1992, the Health and Safety in Employment Act 1992 and Occupational Safety and Health regulations put the duty of

[2] Ministry of Health. 2010. *Designated Auditing Agency Handbook: Ministry of Health Auditor Handbook*. Wellington: Ministry of Health. Aspect 9.
[3] For more on writing in clear, plain English, see: Ministry of Health. 2010. *Audit Report Writing Guide.* Wellington: Ministry of Health.

care on both the employer and the employee to ensure the safety of all people using the facility, as with any other work premises.

A registered electrical inspector must undertake all testing in accordance with Australian and New Zealand Standard AS/NZS 3760 or, for medical equipment, AS/NZS 3551.

How often that testing must be undertaken ranges up to five years, depending on:

- the environment – equipment installed in a benign environment will suffer less damage than equipment in an arduous environment
- the users – if the users report damage as and when it becomes apparent, hazards will be avoided; conversely, if harm to equipment is likely to go unreported, more frequent inspection and testing are required
- the equipment type – hand-held appliances are more likely to be damaged than fixed appliances.

Standard AS/NZS 3760 specifies the frequency of testing required according to these circumstances.

Appointing welfare guardians and other approaches to issues of informed consent

Auditors and providers of residential disability services have asked for clarity around the need for residents to have a welfare guardian.

It is **not a legal requirement** for a person in residential care to have a welfare guardian. There are, however, circumstances in which appointing a welfare guardian can be the appropriate option and there are alternatives to appointing a welfare guardian, as outlined below.

Parents can make decisions on behalf of their child until the child is 18 years old. Therefore, for example, if a child of or over the age of 16 years is not competent to make informed consent for medical treatment, the child's parent or guardian can give this consent. Once a child turns 18, parents are no longer guardians and they cannot make decisions for him or her (under the Care of Children Act 2004).

For people aged 18 years and over, the Family Court may appoint a **welfare guardian** (under section 12(1) of the Protection of Personal Rights and Property (PPPR) Act 1988). A welfare guardian is appointed where a person 'wholly lacks the capacity' to make decisions (as defined in section 94(2) of the PPPR Act).

If no welfare guardian is appointed, a relative or a person with an enduring power of attorney can apply for a **personal order** which can include for the subject person to enter residential care.

Under Right 7(4) of the Code of Health and Disability Services Consumers' Rights, if no personal order has been granted and no person is available to consent health care, a provider may provide services where all of the following conditions apply.

- The services are in the best interests of the consumer.
- Reasonable steps have been taken to ascertain the views of the consumer, or the decision takes into account views of other suitable people with an interest in the consumer's welfare. o.k.
- Providing the services is consistent with the informed choice the consumer would be likely to make if they were competent to do so.

Clarifying Not for Resuscitation orders

Not for Resuscitation (NFR) orders can be a source of some confusion among auditors. Here we clarify key points about the legislation and policies surrounding them.

A competent consumer may make an anticipatory 'do not resuscitate' order (a patient-initiated NFR). However, clinicians in charge of a patient's care or a person with an enduring power of attorney (EPOA) cannot make an **advance directive** declining cardiopulmonary resuscitation (CPR) for that patient.

Additionally, under section 18(1)(a) of the Protection of Personal Rights and Property Act 1988, a person with an EPOA is not entitled to refuse consent to lifesaving treatment for that patient.

In the course of treatment planning, the health professional (doctor) in charge of a patient's care may decide that future resuscitation of the patient is not clinically indicated or appropriate. Having made this assessment, a **medically initiated NFR** order may be put in place as part of the patient's future treatment plan. **The only person who can sign this order is the doctor who has made the determination.**

While medically initiated NFR orders do not require the patient's consent, many NFR policies require that health practitioners attempt to inform patients of this situation and record that this attempt has been made. Some NFR orders may be countersigned by the family to acknowledge they are aware of the order.

Certification of joint service facilities

Rest home and/or hospital care service facilities that also provide residential disability care (RDC) services to younger people with disabilities **do** need to be certified to provide RDC services if they are providing those services for five or more people.

Under section 4(1)(b) of the Health and Disability Services (Safety) Act 2001, health care services include 'residential disability care', which means 'residential care provided in any premises for 5 or more people with a [disability] to help them function independently'. These premises may also be used for providing other health care services.

Recent research and publications

These recent research reports and publications cover issues of relevance and interest to auditors working in the residential care sector.

Audit Report Writing Guide – a Ministry guideline for designated auditing agency auditors on preparing audit reports
URL: http://www.moh.govt.nz/moh.nsf/indexmh/audit-report-writing-guide-apr10

Guiding design of dementia friendly environments in residential care settings: Considering the living experiences – Sandra Davis, Suzanne Byers, Rhonda Nay and Susan Koch. 2009. *Dementia* 8(2): 185–203. doi: 10.1177/1471301209103250.

Eating well for older people with dementia (VOICES) and *Eating well for older people* (Caroline Walker Trust)
URL: http://www.cwt.org.uk/publications.html#older

Coming soon to the Ministry of Health website … Medicines Care Guide for Residential Aged Care