HealthCERT Bulletin

Information for Designated Auditing Agencies

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Welcome to the August 2012 edition of the HealthCERT team's quarterly bulletin. This edition summarises some key topics covered at the designated auditing agency (DAA) workshop held in July 2012 and draws attention to some other information that may help in completing audits and audit reports correctly.

In this issue

Changes to auditing for residential disability services

Work began in September 2010 to consider how best to integrate certification audits, developmental evaluations and associated monitoring of residential disability services into one framework. The aim was to reduce unnecessary duplication in the auditing/monitoring of residential disability services, and to improve the disability focus within certification audits.

The team involved in this work sought a framework that was consistent with recommendations from the Social Services Select Committee Inquiry into the Quality of Care and Services Provision for People with Disabilities (September 2008), as well as with the New Zealand Disability Strategy. It explored several options before deciding to retain the integrity of both the audit and developmental evaluation processes in one framework.

The resulting changes are specific to residential disability providers except for psychiatric providers or providers who have a residential disability service combined with another service such as aged residential care.

From 1 October 2012 certified residential disability providers will have developmental evaluations at the midpoint of their certification period. It is important to be aware that:

- only those criteria against the Health and Disability Services Standards (HDSS) relevant to residential disability services will be audited at certification
- a summary audit report will be published on the Ministry of Health website (effective 2013)
- an on-site surveillance audit at the mid-point of certification will be replaced by a reporting system
- the report will include specific information on what corrective action a provider must undertake and what it must report to a DAA
- surveillance audits will only occur as an exceptional event or where the prior certification audit identified high-risk criteria or unmet standards.

For developmental evaluations specifically, please note that:

- these evaluations will be scheduled for the mid-point of certification
- a systematic process for determining the number of houses subject to a developmental evaluation has been established
- providers may choose to complete a self-assessment before a developmental evaluation
- providers will include recommendations or requirements from the developmental evaluation in their corrective action reporting to a DAA
- a summary report will be published on the Ministry website.

Importantly:

- both DAAs and developmental evaluators will review each other's reports as part of information sharing to assist each party in preparing for any audit, developmental evaluation or monitoring activities.

Changes to auditing requirements

Auditing requirements have changed in the following areas.

1. Relevant criteria

The approach will be similar to that used for Infection Prevention and Control in residential disability services and Highly Relevant Criteria in aged residential care.

Evidence will be populated against each HDSS standard but does not need to be populated against each criterion within the standard.

- The standard-level statement should contain triangulated evidence.
- Criteria rated as not applicable or fully attained do not require evidence at criteria level.
- Where a criterion is partially attained, the criterion must include evidence recorded within the reporting template against that specific criterion with a finding statement, corrective action and timeframe.
- Where a criterion is rated continuous improvement, the criterion must include evidence recorded within the reporting template against the specific criterion.

2. Multi-site sampling

Use a square root formula (as set out in the *DAA Handbook*) to determine the minimum number of homes to be audited. The sample should be stratified to consider other factors such as:

- variations in the size of the service and number of service users
- complexity of the activities undertaken
- service type
- geographical location (grouped within district health board localities or regional management structure)
- homes where issues concerning service delivery have been identified
- the number of homes that were not audited at the last certification audit or visited as part of a developmental evaluation within the last certification period.

The sampling plan needs to be agreed with the Ministry and may be subject to variation by the Ministry.

3. Publications

Published summaries will follow the same format (style and content) as for aged residential care. They will only be updated in response to an on-site surveillance audit or certification audit. Developmental evaluations may lead to the publication of a collective summary of providers evaluated. Note that individual homes must not be identified in these summaries.

4. Progress reporting

Progress reporting requirements are unchanged. The provider will receive a copy of the corrective action plan template which it must complete and submit as part of the surveillance reporting if an on-site surveillance audit is not required.

A provider or DAA can use an alternative template if the information required in the template is equivalent to that required in the Ministry template. A template should include a request for information about any actions the provider is taking in regard to developmental evaluation activities.

5. Surveillance report

For the surveillance report, a provider submits to its DAA:

- a declaration
- a copy of its corrective action progress report
- a copy of its most recent developmental evaluations.

After reviewing the information, the DAA:

- requests further information from the provider if necessary
- speaks with the developmental evaluator if indicated
- submits a surveillance report to HealthCERT using the standard template.

6. When a surveillance audit is required

Providers who offer combined services (aged residential care and residential disability services, for example) must still have on-site surveillance audits.

Residential disability providers who offer intellectual, physical or sensory services are not automatically subject to an on-site surveillance audit unless such a surveillance audit is a condition of certification.

After a DAA has submitted a surveillance report, HealthCERT may identify the need for an on-site surveillance audit. In such cases, the DAA must undertake the surveillance audit within 30 working days of being notified by HealthCERT. It should follow the same format as current surveillance audits.

DAA Handbook

A compendium will be added to the *DAA Handbook* to provide information about the new framework for residential disability audits.

Tracer methodology revisited

The purpose of a 'tracer' is to assess the care, treatment and services provided to an individual resident/consumer against the provider's quality systems. A tracer focuses on the individual at the centre of care and identifies transitions, relationships and themes.

Tracer methodology can be used to:

- provide an accurate assessment of day-to-day function
- compare practice with policy
- observe outcomes
- identify gaps or risk points that could affect quality or safety of care between steps of a process **or** at interfaces between processes.

Technical experts/auditors follow the experience of individual residents/consumers in each tracer. They select these individuals according to the service groups they represent and priority focus areas (which may be identified during the documentation review as required by the HDSS).

A tracer includes an interview with the resident/consumer (and/or with family if the individual cannot participate fully), interviews with staff caring for the resident/consumer, and a review of the clinical record of the resident/consumer. Tracers focus on the total experience of the selected residents/consumers.

Residents/consumers selected for tracers should have experienced complex care and treatment. For example, they may be:

- a resident in an aged care service who has transferred to a higher level of care
- a resident in an aged care service who has returned to the home following an acute hospital admission
- a consumer who is in a general ward of a public hospital after receiving services through a specialist unit.

Information gathered from the tracers should align with the HDSS. It should take two to three hours to complete the clinical file review, interview the resident/consumer (and/or family if required), and interview staff caring for that resident/consumer. Information gathered during the tracer should be verified against a wider sample of documentation such as consent forms, consumer records and medication records. It is important to advise staff of the time required for this process.

Tracer tips

- Ensure the resident/consumer is able to discuss their care or, if they cannot, their family can talk on their behalf.
- Ask staff to show you through the clinical documentation process.
- Focus on the staff and do not let managers or ‘experts’ answer all the questions.
- Clarify with staff as to who does what and where.
- Validate discrepancies from policy, practice, or system failures.
- Triangulate evidence.

- Provide informal feedback on tracer findings, such as whether the provider has an isolated incident or a validated problem.
- State positive findings as well as areas that may require further review.
- Be succinct and do not personalise findings.

Tracer pitfalls

A major pitfall is to focus on the clinical detail (resulting in clinical audit) rather than on tracing the process of care for the resident/consumer. The focus should be on care processes, handovers, system breakdowns, documentation meeting policy requirements, and outcomes as required by the HDSS.

Other pitfalls include:

- providing evidence with no identification or summary of findings
- providing evidence that has not been validated or confirmed as an isolated event
- failing to augment the tracer with additional incidental sampling
- failing to link to the HDSS so information gathered cannot be translated to audit evidence
- failing to provide feedback to staff
- failing to take notes.

DAA Handbook

The *DAA Handbook* will be updated to provide further guidance on timeframes for completing tracers and how best to complete them.

Updated *Standing Order Guidelines*

The regulatory requirements for countersigning the administration or supply of medicines under a standing order were amended in August 2011. These changes to the Medicines (Standing Order) Regulations 2002 prompted a review of the Ministry's *Standing Order Guidelines*.

The guidelines are amended to reflect the changes around countersigning, make the document more user-friendly, and include a standing order template guide.
The guidelines are published on the Ministry's website www.health.govt.nz/publication/standing-order-guidelines

Other matters

Peer review

Auditors who peer review reports before submitting them to HealthCERT should ensure that reports are factual, accurate and free from repetition. All reports should meet the standards for reporting audit evidence (see Section 8 of the *DAA Handbook*).

Combined audits

There are five audit types – certification, surveillance, verification, provisional and partial provisional. A certification or surveillance audit can be combined with a verification audit. A partial provisional audit can be done at the same time as a certification or surveillance audit, but it must be reported on a separate audit template. This is because a partial provisional audit is related to a proposed new service type which may not eventuate.

Timeframes and risk ratings

Risk ratings that auditors have determined on site are unlikely to be altered unless HealthCERT identifies a discrepancy in the evidence it reviews. HealthCERT will discuss any changes to risk ratings or timeframes with the DAA.

Published summaries

Refer to the *DAA Handbook* and the Ministry's *Audit Report Writing Guide* when writing summaries for publication. Any summaries submitted to HealthCERT that do not meet the required standards will be scanned and sent back to the auditors, who must then revise and resubmit them within 10 days.

Note: Not all items in this bulletin will be relevant to all auditors; their applicability depends on an individual auditor's field of practice.