HealthCERT Bulletin

Information for Designated Auditing Agencies

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In this issue

interRAI in residential care

Cheryl Bowen, National Training Manager, interRAI, gave presentations at both DAA workshops about the interRAI project which will be rolled out nationally over the next four years. Here we summarise the key information she provided.

History

interRAI stands for inter (national) Resident Assessment Instrument. It began in the United States in the 1980s, initiated by a non profit consortium of international clinicians and researchers interested in improving the care provided in residential facilities. Studies show that the best way to improve quality of care is to start with best practice in assessment. The interRAI group set about designing an assessment tool, now known as interRAI. interRAI is recognised internationally, with fellows and associate fellows in more than 30 countries across the United States, Canada, Europe, Asia and the Middle East.

interRAI provides a suite of assessment instruments across the continuum of care. It works on the premise that standardised assessments provide crucial information about patient/client/resident needs, depending on the setting.

interRAI provides advantages for clinicians, service administrators and policy makers. It opens up the opportunity for improved clinical information, electronic information sharing, clinical decision support, greater reliability and consistency, less paperwork, caseload profiling and benchmarking.

Within New Zealand, reports have identified large gaps between current and best practice in the assessment of older people. The interRAI pilots in Christchurch and Bay of Plenty have identified positive strengths in support of rolling out the project nationally. The Ministry of Health, district health boards (DHBs), the New Zealand Aged Care Association and the residential care sector have been involved in the project. In the first year of the four-year roll-out, 110 facilities will come on board. The roll-out will be

supported by an expert practitioner in each of the facilities or groups, who will teach other registered nurses to use the tool with the aim of improving national consistency in assessments.

The tool

With interRAI's suite of assessment instruments, care providers can address key factors in the resident's life. interRAI uses the same language, clinical concepts and measurements across all the assessments. It enables stakeholders to follow a resident's progress across settings and time, avoids repetition and improves the resident's journey.

Just as for other assessments, using this tool involves a form for collecting information and data. However, with interRAI the assessor codes each item to note the older person's current performance/status in a range of domains such as activities for daily living, or skin condition. The codes then create a variety of assessment information that is directly relevant to care planning.

The four broad areas covered by interRAI are:

- functional performance
- cognition and mental health
- social support
- clinical issues.

Clinical Assessment Protocols (CAPs) are 22 areas that identify either opportunities for improvement or areas of risk for the older person. These CAPs are triggered by the codes that the assessors input during the assessment. The CAPs guide the plan of care to resolve problems, reduce the risk of decline or increase the potential for improvement.

The goal of the health professional is to use the information provided in the CAP guideline to arrive at a plan of care, provide that care or make an appropriate referral. The development of a care plan should be a collaborative effort between the registered nurse, the resident and their enduring power of attorney (EPoA) as well as the other members of the team caring for that resident.

Limitations

The current tool contains no specific assessment areas for cultural or spiritual needs. However, such needs may be listed within other aspects of the tool, which will indicate CAP triggers. This issue could also be addressed separately in the care plan.

The evaluation aspect of the tool is limited in response, capable of only a one-line 'resolved'. Providers using the tool may use their own evaluation documentation.

interRAI is not a decision-making tool; rather it is a decision support tool. Moreover, interRAI does **not** replace the care plan; it is an assessment tool to guide planning.

Providers should be using one care plan system, not a dual system.

Practical implications for auditing

The interRAI assessment tools are comprehensive, validated and reliable. The CAP summary will indicate what part of the assessment is completed.

Care plans are printed for staff use. The headings on the care plan report are:

- focus
- related factors
- expected outcomes
- interventions
- disciplines.

Look for documentation of resident and EPoA involvement in care planning.

Auditors will not need to view a computer screen, but may request that information is provided in print form if required.

If you have any questions or concerns contact HealthCERT, (04) 496 2000.

Environmental restraint guidelines

Residents should not be subject to environmental restraint unless it is clearly supported by clinical assessment and when no other solutions are available. To clarify this intention, guidance notes have been added as Appendix A to the Restraint Minimisation and Safe Practice Standard (NZS 8134: 2:2008).

The following advice is offered to help auditors interpret these guidelines consistently.

Where a provider has a locked door (not in a secure unit), include the following criteria in the audit.

Under HDSS 2.1 Restraint minimisation, criterion 2.1.1.1 specifically refers to policies and procedures in relation to restraint.

- Is the locked door rationale documented?
- What minimisation strategies are implemented? These may include staffing rationales and use of alternative interventions.
- What are the risks associated with a locked door and with an unlocked door?
- How often is the locked door rationale reviewed?

Under HDSS 1.3.3, where a door is locked for a specific resident, that resident's care plan should detail clinical justification for the restraint. Rationale, interventions and review may be evidenced in the short-term or long-term care plan. The audit evidence is recorded in 1.3.3 or 1.3.6.1. Consider links to medicine management (1.3.12) for therapeutic medicine management.

Tracer methodology can be applied unless there are other priority areas for the audit.

For a number of residents, using a locked door as an environmental restraint is clinically justified. However, there must be evidence of appropriate assessment and/or referral to external agencies for reassessment, where applicable.

Where there is a locked door for a resident (or a group of residents), interviews with other residents and families should validate that those other residents can freely enter and exit the facility.

Audit evidence must verify the locked door is linked to fire systems (HDSS 1.4.7.3).

Where a provider has a locked door but it is used only in emergencies, the rationale should be noted within policy. In addition, the protocol for such use should be documented.

As with any audit type, the scope of the audit can be widened – refer section 7.4 of the *DAA Handbook* (August 2011).

Note: If there is a fenced property with a locking gate mechanism and the external door to the facility is unlocked, the guidelines still apply.

First aid training

HealthCERT has received two serious complaints (both substantiated) about the competence of care staff to manage emergencies. One situation concerned basic first aid skills and the other CPR management. Both situations resulted in death of the residents involved.

Registered nurses do not automatically have current competence in all areas of emergency care simply because of their qualification as a registered nurse. Emergency situations can be life threatening, and registered nurses need to demonstrate proficiency. For this reason, training and ongoing competence are required.

For audits against HDSS 1.4.7.2, HealthCERT advises that the provider should have staff with current first aid training on site at all times.

Not for Resuscitation orders revisited

Following the publication of information about Not for Resuscitation (NFR) orders in *HealthCERT Bulletin 3* (March 2011), some auditors have asked for clarification in this area.

The key message is that:
In the course of treatment planning, the 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.

The medically initiated NFR order can only be made as a result of individual assessment and treatment planning by the doctor responsible for the patient's care. It must not be assumed that all residents should have NFR orders that are then signed by the facility doctor without the individualised assessment and treatment planning, and without discussion with relevant people such as family members.

Bulk supply of medications in rest homes

Auditors have also asked for clarification as to whether bulk medication can be kept in premises where a provider has one certificate for both rest home and hospital care.

The guidelines to HDSS 3.12 refer to the publication *Safe Management of Medicines: A guide for managers of old people's homes and residential care facilities.* This document has recently been replaced by the *Medicines Care Guides for Aged Residential Care*.

The *Medicines Care Guides* state:
'Bulk supply of medication is only suitable for facilities with hospital certification'.

Alongside this, Section 44(d) of the Medicines Regulations 1984 refers to Bulk Supply for Hospital only. A hospital is defined in the Health and Disability Services (Safety) Act 2001. Therefore, bulk supply of medication should not be held in a Rest Home setting. Medications should be dispensed for individual residents only.

Infection control auditing for residential disability providers

As part of the national project to integrate contract evaluation and certification audits, agreement has been reached to report audit outcomes against the Infection Control Standard (NZS8134.3:2008) to standard level for residential disability providers certified to deliver intellectual disability, physical disability and/or sensory disability services. The audit report should be populated as follows.

Certification audits

1. Where all criteria against a standard are fully attained, audit evidence is reported at standard level only.
2. Where one criterion within a standard is partially attained, evidence is to be provided against that criterion and at standard level.
3. If the attainment level against one criterion is rated as Continuous Improvement, evidence is to be provided against that criterion and at standard level.

Surveillance audits

1. Where only prescribed criteria (including partially attained criteria from certification) are being reviewed, the evidence is to be reported at criteria level.

Note these changes do not apply to providers certified as residential disability – psychiatric.

Summary of recurring issues

1. Auditing reconfigurations and/or increased capacity

Providers can apply for a proposed increase in capacity or reconfiguration by completing a self assessment form on the Ministry website.

The self assessment reviews aspects within the HDSS such as consumer rights, human resources, nutritional requirements, environment and infection prevention and control.

HealthCERT reviews the application and decides whether the proposed changes to the service are low or high risk. This decision is based on the information provided, the previous certification period, complaints or interagency information, and the proposed changes. If the changes are considered to be low risk, HealthCERT sends the provider a letter asking it to have the reconfiguration or increased capacity verified at the next routine audit (certification or surveillance). A copy of the letter is sent to the DAA.

The auditors need to reference verification of the services on the front of the audit template. If the relevant aspects are attained, the auditors should write one or two sentences within the general overview. Where shortfalls are identified, the auditors should note them under the relevant criterion.

2. Integrated notes

Some auditors have sought clarification regarding the audit evidence in HDSS criterion 1.2.9.10 (all records pertaining to individual service delivery are integrated). The guidance for that criterion states: ‘Where possible all records are in a single file. Where multiple files exist, the organisation should have a written policy for the management and creation of those files, including how they are linked …’.

3. Timeframes for corrective actions

If an audit identifies a shortfall in practice that must be rectified immediately, a dual timeframe should be set to embed the practice. A recent example concerned medicine transcribing. The audit finding documented, ‘state X of X medication charts evidenced transcribing occurring on the RN medication signing sheets’. The Corrective Action Requests form stated, ‘practice of transcribing to cease immediately’. In such circumstances, the timeframe needs to reflect the immediate action and embedding of that action; in this example, it would identify ’immediately and then one month’.

4. Standards ‘met’ or ‘not met’ at surveillance

A standard-level statement may be written, but unless all criteria are audited at surveillance, where the scope has been widened (DAA Handbook, aspect 7.4), then the standard does not require an attainment

rating of ‘met’ or ‘not met’. In such cases, the standard-level attainment in the published summary reflects ‘traffic lights’ for aged care providers.

5. Audit report template

When completing the audit template for submission, the lead auditor and peer reviewer need to ensure that all details are correct. The services and capacity section on the audit template must reflect the service needs accurately. This requirement includes situations where aged care providers also care for Young People with Disabilities (YPD) residents.

6. Aged care providers caring for Young People with Disabilities

Where a provider has YPD residents at the premises, auditors must verify that the provider is meeting the needs of that client group. To do so, they stratify the service types when looking at consumer rights, community involvement, nutrition, activities and care.

7. Calibration of equipment

When auditing to verify that equipment (ie, sphygmomanometers, scales, oxygen) is tested, check that the testing is conducted using best practice. It has come to light that some providers have been testing their equipment by internal comparison only.

8. DHB pre-audit information

Before an audit, the DAA is required to notify the DHB of the upcoming visit to a provider. This communication provides an opportunity for the DHB to request a review of specific aspects of the Age-Related Residential Care Contract if necessary. If the DHB makes such a request, please reference the evidence in the audit report as ‘requested by DHB’. Similarly, where the Ministry of Health has requested a review of specific criteria, reference the evidence as ‘requested by the Ministry of Health’.

The timeframe for informing the DHB of an impending audit is:

- at least 20 days prior to a certification/surveillance audit
- at least 10 days prior to a provisional, partial provisional or verification audit (DAA Handbook, aspect 7).

9. Admission agreements

The Age-Related Residential Care (ARRC) agreement states that the resident admission agreement must be signed on the date of admission. This requirement is not being met in all cases, and there has been some inconsistency in the way DAAs are interpreting it. HealthCERT has informed the District Health Boards of New Zealand ARRC group of the provider difficulties in compliance with this requirement in some circumstances and the issue has been tabled for discussion.

10. High and critical risk ratings

Where critical risks are identified, HealthCERT and the DHB (where the provider has a DHB contract) must be notified in writing within 24 hours of the audit. This requirement is set out in the DAA Handbook (aspect 9.3).

The same notification requirement applies where there are multiple high-risk ratings that pose an increased level of risk. In either situation, the DAA needs to forward a copy of the Corrective Action Requests to the DHB within 24 hours of the on-site audit completions.

Publications of interest

The World Health Organisation’s Europe Division has published *Palliative Care for Older People: Better Practices*.

The publication provides examples of palliative care practices that range from a whole health system to individual examples of better education or support in the community and elsewhere. While some examples

are yet to be fully evaluated, they suggest options to plan and support the most appropriate and effective services for the care and quality of life of older people.

The document is available from:
www.euro.who.int/en/what-we-publish/abstracts/palliative-care-for-older-people-better-practices

Another publication of interest is a report commissioned by Eldernet to review the experiences of aged care providers affected by the Canterbury earthquakes. The report, written by Sue Carswell, PhD, outlines how aged care providers responded to the emergencies, what was learned, and how this knowledge will be useful for future emergency preparedness and responses.

The report can be viewed at:
http://www.eldernet.co.nz/IM_Custom/ContentStore/Assets/7/98/b45068e6b3f6d8180db28b092133d87d/2011-07-31%20Cant%20EQ%20Research%20FINAL%20.pdf