MINISTRY OF HEALTH
MANATŪ HAUORA

HealthCERT

HealthCERT Bulletin

Information for the sector

Issue 16 – June 2016
ISSN 2423-0523

New Zealand Government

Welcome to this quarter's edition where our focus continues to be on the 2016 Work Programme: Pressure Injury Prevention and Management.

HealthCERT Work Programme 2016: Pressure Injury Prevention and Management (PIPM)

We are now six months into the PIPM Work Programme. Again we would like to extend our thanks for your ongoing contribution to the collection of data from both the section 31 (s31) notifications and the audit reports.

In our bumper PIPM edition this month, you'll read about a systems approach from the Office of the Chief Nursing Officer and get an overview of the data we have seen in the aged residential care facility audit reports. Our Clinician's Corner focuses on nutritional considerations and pressure injuries.

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Office of the Chief Nursing Officer: What reduces pressure injuries in aged residential care?

The Office of the Chief Nursing Officer in the Ministry of Health was pleased to hear from our friends in the HealthCERT team that recent audits show many age-related residential care (ARRC) facilities have good systems in place to reduce pressure injuries. Local and international evidence shows ARRC facilities can move from good to great and prevent almost all pressure injuries.

In a 2015 systematic review, New Zealand nurses Mandy Pagan, Henrietta Trip, Beverly Burrell and Deborah Gillon conclude that pressure injury programmes in ARRC can reduce pressure injury rates. For those looking at where to start such a programme or what else to do, they draw on the review to make the following recommendations.

- To establish a successful programme, first assess your facilities to determine the readiness for change, your organisation's culture and potential barriers and facilitators for the programme.
- Use evidence-based pressure injury programmes in ARRC to increase staff knowledge and skills to improve resident care and reduce pressure injury rates.
- Use continuous quality improvement methods as an adjustable and effective process to plan, implement, evaluate and sustain your programme. Audit and feedback are essential to motivate staff and monitor adherence.
- Allow sufficient time to implement, measure and evaluate your programme.
- Engage, involve and update key ARRC stakeholders – including administrators, managers, nurses, health care assistants, doctors, residents and family – before, during and after implementing your programme.
- Use multiple programme interventions to implement your programme more effectively and achieve better outcomes.
- To increase staff engagement, use staff incentives when developing, implementing and evaluating your programme.
- Plan a flexible, realistic and achievable programme in anticipation of staff turnover and the demands of resident care and administrative work.
- Involve project teams and/or champions to build staff confidence and skills, provide leadership and guide your programme to become self-sufficient with a sense of staff ownership. Consider including enrolled nurses and health care assistants in these roles to work alongside registered nurses. Managers and staff alike need to support these roles.
- Use expert external mentors to help facilities and staff to identify practice issues, develop the programme and model and guide best practice.
- Make your programme part of compulsory staff training schedules so that current and new staff routinely receive evidence-based updates.

The authors conclude:

> organisational culture and preparedness can equate to programme success or failure, and influence future sustainability and should not be underestimated when implementing programmes. The use of continuous quality improvement approach, within a positive organisational culture, possessing supportive management and leadership, can empower

health care workers and managers to implement programmes effectively, gain outcomes and sustain programmes (Pagan et al 2015, p 58).

For more on an evidence-based pressure injury prevention programme, you'll also find some useful resources on the New Zealand Wound Care Society website listed below. In the next bulletin, we will provide suggestions about continuous quality improvement methods. In the meantime, keep up the good work and continue to strive to do even better for the benefit of the people who live in your facilities and their families.

References and further information

Pagan M, Trip H, Burrell B, Gillon D. 2015. Wound programmes in residential care: a systematic review. *Wound Practice and Research* 23(2): 52–60.

New Zealand Wound Care Society website: www.nzwcs.org.nz

PIPM Work Programme: audit report data

HealthCERT's 2016 PIPM has now been operating for six months. You will be aware HealthCERT has been collecting two streams of data. These are:

- section 31 notifications received from aged residential care providers of pressure injuries (PIs) at stage 3 and above
- defined PIPM data reported during an audit.

Here we offer an overview of the data provided in audit reports completed between 1 January and 3 March 2016.

The 61 ARRC audit reports covered certification, surveillance and provisional audits. Each audit team reported on:

- the number of PIs being treated at the facility at time of audit
- whether PIPM is incorporated into the facility's quality and risk management systems.

Number of PIs at the time of audit

In all, the audit reports noted 96 PIs. Within that total:

- 37 of the 61 facilities had residents with PIs
- 83 PIs were acquired at the facility and 13 elsewhere
- 69 PIs were at stage one and two
- 26 PIs were at stages three to six (one PI did not record a stage)
- for 71 PIs, residents were assessed as requiring hospital-level care
- 3 residents had multiple PIs.

PIPM and the seven systems aspects

When the PIPM Work Programme began, the following seven systems aspects were defined for consideration during an audit.

1. Policy – Is the provider implementing a policy/guideline that is sufficient to support the prevention and (if required) management of PI?
2. Internal audit programme – Does the provider include monitoring of PIPM and/or wound care in the annual audit schedule?

3. Meeting minutes – Do the provider's clinical/staff meeting minutes record PIPM strategies and/or treatment of those residents with PI?
4. Adverse events – Is it the provider's practice to report PIs through the adverse event/incident reporting programme?
5. Annual training programme – Does the provider include training related to PIPM in its annual training schedule?
6. Equipment – Is there a range of PIPM equipment available or in use at the facility?
7. Staff interview – Are there formal opportunities for staff to discuss strategies to minimise the occurrence of PI?

Table 1 shows that over 90 percent of providers had embedded the aspects concerning policy, training, equipment and staff interview (aspects 1 and 5–7) into their quality system. The aspects of internal audit, meeting minutes and adverse event reporting (aspects 2–4) appeared less consistently within the providers' quality frameworks.

Table 1: Number and percentage of providers that included each systems aspect in their quality aspect

Aspect	**Number (and percentage) of providers**	
	Aspect present	**Aspect absent**
1. Policy	57 (93%)	4 (7%)
2. Internal audit	51 (84%)	10 (16%)
3. Meeting minutes	46 (75%)	15 (25%)
4. Adverse event	49 (80%)	12 (20%)
5. Annual training	56 (92%)	5 (8%)
6. Equipment	60 (98%)	1 (2%)
7. Staff interview	60 (98%)	1 (2%)

Table 2 focuses on the number of facilities that did not have a given systems aspect at audit (in the second column) and how many of those facilities were treating PIs at that time (in the third column). For example, for the first aspect, four providers did not have a policy sufficient to support the prevention and (if required) management of PI; and, of those four providers, two were treating PIs at the time of audit.

Table 2: Number of facilities treating PIs where aspect absent

Aspect	**Number of facilities**	
	Aspect absent	**Treating PIs where aspect absent**
1. Policy	4	2
2. Internal audit	10	5
3. Meeting minutes	15	8
4. Adverse event	12	7

5. Annual training	5	3
6. Equipment	1	Nil
7. Staff interview	1	Nil

As this data relates to only 61 audit reports, it is difficult to draw any firm conclusions at this stage. We will continue to watch for trends in PIs in relation to the presence or absence of systems aspects as the year progresses. We'll also report back on the data on section 31 notifications in the next issue.

If you have any other questions you would like us to consider as we review the data, please email your ideas to Donna Gordon (donna_gordon@moh.govt.nz).

Who can I talk to?

If you have any queries or concerns about PIPM or just want to discuss this work programme, please feel free to contact Donna Gordon on (04) 496 2429 or via email donna_gordon@moh.govt.nz in the first instance.

Clinician's Corner

This section offers a senior clinician's view on good nutrition to support wound healing. Thanks to Liz Beaglehole (Canterbury Dietitians) for this contribution.

Nutrition and wound healing

Good nutrition is an important factor in assisting wound healing. The processes involved in healing a wound require specific nutrients at different stages. To heal well, you need to eat well.

Sufficient dietary protein is required to heal a wound. Protein requirements increase as people age and are further increased with a pressure injury. For those without pressure injuries, the requirements are about 48 g of protein per day for a 60 kg adult and about 60 g for an older person, aged over 65 years. But an adult with a pressure injury requires from 75–90 g of protein per day, depending on the stage of the injury. To put that in perspective; an 80 g serving of meat provides around 25 g of protein, one egg 6 g, a glass of milk 7 g and a serving of cheese 10 g.

Energy needs are also increased with wound healing. Unwanted weight loss may indicate that a person is not eating enough calories. Eating sufficient calories is important as otherwise the body will use its own stores, including muscle protein, for energy.

Other specific nutrients in addition to protein are known to have an important role in the wound healing process. These include vitamin C, zinc, vitamin A, copper, thiamine (vitamin B1) and manganese.

The best way to ensure the diet is providing all the nutrients needed for wound healing is by eating foods from the four food groups every day. These food groups are: meat and meat alternatives; breads and cereals; milk and milk products; and fruits and vegetables.

Table 3 below shows the important nutrients required for wound healing and good food sources for each one.

Table 3: Nutrients needed for wound healing and their food sources

Nutrient	Food sources
Protein	Meat, fish, chicken, milk and milk products, legumes (cooked dried beans, lentils, chickpeas), nuts, seeds
Vitamin C	Fruits, vegetables, fruit juices
Vitamin A	Red, dark-green or orange fruits and vegetables, animal liver; plus some available in dark-blue-top milk, cheese and eggs
Vitamin B1	Wholegrain breads, nuts, meat
Zinc	Seafood, red meat, chicken, cheese, milk, peanuts, wholegrain breads
Copper	Liver, meat, nuts, seeds, legumes, wholegrain breads and cereals
Manganese	Widely distributed in foods, including vegetables, fruits and organ meats

Aim for three meals a day plus small snacks between meals. Include protein-rich foods at each meal and snacks if possible. Skipping breakfast, or having a breakfast that consists of only toast or fruit or just tea or coffee, will not offer sufficient protein, calories and other nutrients to contribute to wound healing. Breakfast ideas to boost protein intake are: cereal with milk; milk drinks such as hot chocolate; yoghurt; eggs; baked beans; fresh or tinned fish; chicken or tofu.

Ideas for lunches include:

- canned fish, eggs or baked beans on toast
- quiche
- cold meats or chicken with salad
- mince on toast
- macaroni cheese or other meals made with cheese
- sandwiches with protein-rich fillings such as peanut butter, cheese or cold meats.

A lunch that consists of a tomato sandwich or a cup of soup with toast will not offer enough protein for the body to help with wound healing.

At the main meal, try to include some meat, chicken, pork, fish or meat alternative, such as legumes, tofu or eggs. Even if the lunch meal included a protein-rich food, aim to include another serving of a protein-rich food in this meal. Having a protein-rich dessert – such as custard, ice cream, mousse or yoghurt with tinned or fresh fruit – with a meal is another way to boost protein intake. But remember: cream offers no protein!

Protein-rich snacks between meals could include: yoghurt; small sandwiches with protein-rich fillings; cheese or hummus with crackers; milk drinks; smoothies; or a small handful of nuts.

Fluid intake and hydration

Dehydration can impact on the wound healing process by causing the skin to become more fragile, less elastic and prone to further breakdown. Leaking wounds, fever and infection increase fluid requirements further. A good fluid intake is around 2 litres per day.

Remember all fluids count – including tea, coffee, milk, soup, fruit juice, ice blocks, jelly and other foods high in liquid content. Drinking regularly and sipping fluids throughout the day will help meet fluid requirements.

Poor appetite and not eating well

To meet the higher protein, calorie and nutrient needs, it is important to eat regular meals and snacks. This is difficult when a person has a poor appetite, which tends to lead them to reduce their food intake.

In this case, the person should continue to try to eat small meals regularly over the day, focusing on protein-rich foods. For example, they might try to eat around six small meals in the day. Some people find that drinks such as milkshakes, smoothies and hot milky drinks are easier to consume than foods when their appetites are low. Moving the main meal to the middle of the day may also improve food intake if people are finding it too difficult to prepare and/or eat the main meal at night.

Nutritional supplements

Nutritional supplements such as Complan, Vitaplan, Sustagen, Fortisip and Ensure Plus can be useful. These nutritional supplements are high in calories and protein and are fortified with vitamins and minerals. They are particularly helpful when a person has a reduced appetite or is unable to increase their food intake. To help preserve a good food intake, it is recommended that the person take the nutritional supplements between meals, or at least after trying a meal.

Multivitamin or mineral supplementation

As highlighted above, specific nutrients are important for wound healing. People can get these nutrients by eating a good variety of meats, vegetables, fruits, milk products, eggs, grains, nuts, seeds and legumes every day. With this nutrition, they do not need additional vitamin or mineral supplementation.

A multivitamin is recommended, however, for people identified with a moderate to high risk of malnutrition, and who have a poor food intake. Supplementation with specific nutrients – for example, zinc or vitamin C – is only recommended if a nutritional deficiency has been identified or a thorough dietary analysis has highlighted a specific nutrient that is lacking in the diet.

Arginine

Arginine is an important amino acid required for the process of wound healing. While all amino acids are the ‘building blocks’ of protein, the body needs arginine in particular to help make collagen, which is the protein required for wound healing and closure. A few studies have looked at whether high doses of arginine improve wound healing. They have focused on providing 4.5–9 g of arginine per day, which is beyond the level that a person would achieve through a high-protein diet alone.

Based on these studies, recommendations are to supplement with high protein, arginine and micronutrients for adults with a pressure injury stage 3 or 4 or with multiple pressure injuries, when their nutritional requirements cannot be met with traditional high-calorie and high-protein supplements. Improvements in wound healing should be evident within two to three weeks. Discontinue the supplement if there is no sign of improvement within this time.

Weight management

Maintaining a healthy weight through a high-quality diet is important nutritional support for wound healing.

- Where people with a pressure injury are underweight, encourage them to eat high-energy and high-protein foods and snacks to boost their protein, nutrient and calorie intake and in this way promote weight gain.
- For those who are overweight or obese, now is **not** the time to encourage weight loss as it may have a negative impact on the healing process. Focusing on providing a high-quality diet remains the priority. What is important is that they cut out nutrient-poor foods and replace these with nutrient-rich foods, which will help them to maintain their current weight rather than gain more weight.

Key points

☐ To heal a wound well, you need to eat and drink well.

☐ Eat a variety of nutrient-rich foods.

☐ Eat and drink regularly through the day.

☐ Have protein-rich foods at every meal.

☐ Nutritional supplements may be useful for people with malnutrition and/or poor food intake.

☐ Consult a dietitian for more information and advice on nutrition and wound healing.

Liz Beaglehole
Canterbury Dietitians

Research of interest: PIPM

Because of HealthCERT's 2016 PIPM Work Programme, our research of interest will continue to focus on this topic. The resources below may be of interest to your service.

- Falgenhauer M, Zöscher S, Morak J, et al. 2013. A patient centered system for decubitus prevention based on nutrition, drinking, physical activity and sleep monitoring. *Studies in Health Technology & Informatics* 192: 1033. URL: http://ebooks.iospress.nl/publication/34249 (accessed 4 July 2016).
- Gruen D. 2010. Wound healing and nutrition: going beyond dressings with a balanced care plan. *Journal of the American College of Certified Wound Specialists* 2(3): 46–9. URL: www.ncbi.nlm.nih.gov/pmc/articles/pmid/24527147 (accessed 4 July 2016).
- Kennerly S, Boss L, Yap T, et al. 2015. Utility of Braden scale nutrition subscale ratings as an indicator of dietary intake and weight outcomes among nursing home residents at risk for pressure ulcers. *Healthcare* 3(4): 879–97. URL: www.mdpi.com/2227-9032/3/4/879/htm (accessed 4 July 2016).
- Litchford MD, Dorner B, Posthauer M. 2014. Malnutrition as a precursor of pressure ulcers. *Advances in Wound Care (New Rochelle)* 3(1): 54–63. URL: www.ncbi.nlm.nih.gov/pmc/articles/pmid/24761345 (accessed 4 July 2016).
- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. 2014. *Prevention and Treatment for Pressure Areas: Quick reference guide.* Osborne Park: Cambridge Media. URL: www.awma.com.au/ptpu/PPPIA-Quick-Reference-Guide-jan2016.pdf (accessed 4 July 2016).
- Posthauer ME, Banks M, Dorner B, Schols J. 2015. The role of nutrition for pressure ulcer management: national pressure ulcer advisory panel: European Pressure Ulcer Advisory

Panel, and Pan Pacific Pressure Injury Alliance white paper. *Advances in Skin & Wound Care* 28(4): 175–188; quiz 189–190. URL: https://cme.lww.com/files/TheRoleofNutritionforPressureUlcerManagementNationalPressureUlcerAdvisoryPanelEuropeanPressureUlcerAdvisoryPanelandPanPacificPressureInjuryAllianceWhitePaper-1426768197512.pdf (accessed 4 July 2016).

- Sernekos LA. 2013. Nutritional treatment of pressure ulcers: what is the evidence? *Journal of the American Association of Nurse Practitioners* 25(6): 281–288. URL: http://onlinelibrary.wiley.com/doi/10.1002/2327-6924.12025/full (accessed 4 July 2016).
- Smith ME, Totten A, Hickam D, et al. 2013. Pressure ulcer treatment strategies: a systematic comparative effectiveness review. *Annals of Internal Medicine* 159(1): 39–50. URL: http://annals.org/article.aspx?articleid=1700644 (accessed 4 July 2016).
- Trans Tasman Dietetic Wound Care Group, 2011. *Evidence Based Practice Guidelines for the Dietetic Management of Adults with Pressure Injuries.* URL: http://daa.asn.au/wp-content/uploads/2011/09/Trans-Tasman-Dietetic-Wound-Care-Group-Pressure-Injury-Guidelines-2011.pdf (accessed 4 July 2016).

Operating matters

Designated Auditing Agency Handbook (NZS 8134:2008)

The Designated Auditing Agency Handbook annual review is now complete. The final version is being prepared for publishing on the Ministry's website.

Before you purchase a health service – provisional audit

If you are looking to purchase a health service, you will need to first contact a Designated Auditing Agency to undertake the provisional audit for you and, if you are wanting to hold a contract, notify the funder of the service.

To register your legal entity application, please go to:
https://providerregulation.health.govt.nz/oprans
Once we get this notification, we will email you with log-in details so that you can complete the online application for your audit. Your Designated Auditing Agency will then be able to progress the audit.

Once the audit has been completed and HealthCERT has processed it, we will email the Letter of Intent to you. The Letter of Intent states that your solicitor is required to send us Confirmation of Settlement once you have settled the sale. The settlement must be confirmed within three months after the provisional audit has been submitted to HealthCERT.

Once we get this confirmation, we will issue you with a certificate and schedule that enable you to provide health services. The certificate will be for one year, while the schedule will include any outstanding corrective actions identified from the audit.

For further information, please go to:

www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services

Home and community support sector standard

Providers of home and community support services are audited against the Home and Community Support Sector Standard (NZS 8158:2012) by Conformity Assessment Bodies, which certify providers.

To help gain a national perspective on the initiatives being taken within this sector, an Oversight Committee of funder representatives has been formed. Its members represent the Ministry of Health, District Health Board Shared Services and the Accident Compensation Corporation.

The Oversight Committee's primary role is to provide oversight and direction to the certification scheme. At this stage, it meets quarterly.

interRAI assessments and audit outcomes

Central Region's Technical Advisory Services Limited informed HealthCERT that some aged residential care providers have been experiencing challenges in accessing interRAI training (see also the interRAI update under 'Sector matters'). As a result, a number of providers reportedly have been unable to meet their contractual requirements for interRAI assessments.

HealthCERT agrees with the view that providers should not be unduly penalised at audit where access to training is an issue. To this end, we informed Designated Auditing Agencies on 17 May this year:

> … where interRAI training issues arose during an audit, the evidence would be recorded against standard 1.2.7 (Human Resource Management). Where the auditor makes a finding it would be reported and rated negligible risk.

HealthCERT has agreed that where an audit report includes a finding of this nature, it will not impact on the provider's certification period.

interRAI findings

To better understand the use of interRAI assessments, HealthCERT analysed 61 ARRC provider audit reports completed between 1 March 2016 and 30 April 2016. We focused in particular on four Health and Disability Services Standards most likely to produce findings relating to interRAI assessment – specifically standards 1.2.7 (Human Resource Management), 1.3.3 (Service Provision Requirements), 1.3.4 (Assessment) and 1.3.6 (Service Delivery/Interventions). The following is a summary of what we found.

- For standard 1.2.7, no audit reports in the sample noted a lack of interRAI-trained staff.
- For standard 1.3.3, 20 reports indicated that interRAI assessments were either overdue or completed outside the required timeframe. In two instances, issues were reported around access to training.
- For standard 1.3.4, 12 reports noted interRAI assessments were not completed. In one instance, registered nurse turnover was evidenced as a contributing factor.
- For standard 1.3.6, no reports presented any evidence of a lack of interRAI-trained staff.

Section 31 incident notification

When notifying HealthCERT of a section 31 incident, please use the current form. You can download it from:

www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-or-other-matter-required-under-section-31

The following scenarios offer two examples of how to complete the section entitled 'Incident Description and Improvements made as a result of the incident, inclusive of future risk minimisation'. Please also be sure to include, in the declaration at the bottom of the form, the contact details of the person completing the form.

'Incident Description and Improvements': Scenario One

A resident managed to exit the secure dementia area. Staff followed policy by undertaking an initial search of the building and grounds without success and then the EPOA and Police were notified and started a low-priority search. Police located the resident later that day. The resident suffered no adverse effects from the walk.

A full investigation has been carried out, all the secure doors were checked and were found to function correctly. Analysis indicates that the resident exited by following a visitor out through the secure doors. None of the unit staff had been out of the unit around that time, but other staff and visitors have access.

Improvements: A debrief has resulted in reinforcing vigilance by staff and a communication to resident families. Changes to the system include installation of a notice at every secure exit door, alerting visitors/contractors when they are exiting to check door closures and potential opportunities for residents to exit after them. An electronic monitor is being trialled for the resident involved, and staff are aware of the need to monitor.

'Incident Description and Improvements': Scenario Two

Resident sustained an unwitnessed fall. Resident has cognitive loss and is unable to explain what happened. Injury pain left hip, transferred to base hospital, no fracture and resident has returned to home, seen by GP and pain management in place.

Improvements: Risk prevention strategies in place, mobile resident wearing hip protectors. Falls prevention care and pain management care plan in place following reassessment by physiotherapist. Trialling sensor mat by bedside to minimise future risk.

Note: Reinforcement that the resident must use the call bell is not an acceptable way of minimising risk.

Sector matters

interRAI update

Training

As a result of a concerted focus on meeting the demand for initial training of interRAI assessors in aged residential care, a range of measures has been introduced to address waiting times and ensure vulnerable facilities are first in line to have their nurses trained.

TAS has been using a prioritisation process, agreed with aged care representatives, to ensure facilities with an urgent need can access training as soon as possible. TAS is also recruiting additional educators to work for a fixed term in Auckland, Christchurch and Dunedin.

Demand for initial training continues to be high, with a number of facilities now wishing to have more interRAI-competent nurses on site. So far, TAS has trained over 3100 nurses to use the tool, including those who were trained during the implementation project. All 689 aged residential care facilities have had at least one nurse trained and about 60 more are trained each month.

Alongside the nurse assessors, over 330 facility managers have now been trained in the use of software tools and reporting capabilities for monitoring and reviewing interRAI activity. With this information, they then produce resident and operational summary reports to support the implementation of interRAI in their facility.

Audits

Processes are in place that recognise non-compliance with interRAI assessments may well be due to matters beyond the control of the facility/provider (see the information on interRAI assessments under 'Operating matters'). Facilities will still need to comply with all other requirements under their contracts.

Auditors follow the interRAI guidance in the *Designated Auditing Agency Handbook*, which is set out in section 14.8 (pages 52–54).

To prepare for audits, assessors in facilities can refer to their copy of the *Long Term Care Facilities (LTCF) Comprehensive Clinical Assessment Nurse Assessor Workbook*, which provides guidance on what to make available for audits. Suggestions include:

- Assessment Summary Report – the link between the interRAI LTCF assessment and the care plan
- Face Sheet – all the bio-demographic information about the resident, under the 'Reports' section in the 'Resident overview'
- Care Plan Report – if your facility's nurses use the interRAI software system's Momentum Care Plan template, you can make that available. If you don't use this Care Plan, make the one you use available
- Client Summary Report – key resident summary information from the LTCF assessment, including the health summary, diagnoses, conditions and changes in the last 90 days, formal care received, and the CAPs and outcomes scores
- MDS Comments – the notes the assessor writes during the assessment to provide more information about the residents' needs.

Data

The National interRAI Data Analysis and Reporting Centre is providing a range of reports to district health boards (DHBs) and has released the first Annual Data Report based on nationally aggregated interRAI data. You can read this report on the interRAI New Zealand website listed below.

Website development

A new interRAI website is in development. It will be more user-friendly, have greater functionality and provide up-to-date information for the whole sector. It is hoped to have the new site launched within the next couple of months.

Further information

interRAI website: http://interrai.co.nz

The Nationwide Health and Disability Advocacy Service

The Health and Disability Commissioner Act 1994 (HDC Act) established a Nationwide Health and Disability Advocacy Service (Advocacy Service) and set out the legislative functions of advocates. Since 2007, the National Advocacy Trust (a charitable trust) has been contracted to provide the Advocacy Service, as the HDC Act requires the Health and Disability Commissioner and the Advocacy Service to operate independently of each other.

The Advocacy Service has 23 community-based offices throughout New Zealand. Each year, it expects to receive and close approximately 3600 complaints and visit all certified rest homes and certified residential disability facilities at least once (and many more than once). It also delivers more than 2000 education sessions to consumers and providers on the Code of Health and Disability Services Consumers' Rights (the Code) and responds to an estimated 8000 enquiries.

After 15 months in the Advocacy Service, advocates work towards its qualification, approved by the New Zealand Qualifications Authority. Through their training, advocates achieve positive outcomes for consumers, and develop professional and respectful working relationships with providers and consumers of all backgrounds and abilities. Advocates apply defined complaint resolution processes and use interactive adult education skills when promoting the rights set out in the Code. In addition, they demonstrate a thorough knowledge and understanding of the Code, including its application and impact, along with other relevant legislation and standards.

The role of the advocate in complaint resolution is to help consumers to identify what is needed to achieve resolution and then to support them in their chosen actions. Advocates consistently help consumers to resolve over 90 percent of the complaints made to the Advocacy Service. Another benefit is that they are frequently able to support consumers to rebuild relationships, which is particularly important where the consumer and provider need to have ongoing contact.

Advocacy is a very successful way to achieve early resolution as it often involves face-to-face contact between the parties. Consumers frequently want to ensure that what happened to them will not happen to someone else. After getting this feedback face to face, many providers comment on how profound it is to hear from the consumer as they had not realised the impact of their actions or remarks.

The high rate of resolution, and high levels of consumer and provider satisfaction with the advocacy process, reflect the strong consumer-centred approach of the Advocacy Service and the significant commitment of providers to the process.

To contact the Nationwide Health and Disability Advocacy Service

Phone: 0800 555 050
Email: advocacy@advocacy.org.nz
Website: advocacy.hdc.org.nz

Awanui Rest Home achieves the Silver Rainbow Seal

The facility that can claim to be the first in New Zealand (and possibly the world) to achieve the Silver Rainbow Seal is Awanui Rest Home in Mt Wellington. Management, staff, residents and

members of the original Silver Rainbow work group celebrated this landmark achievement on Monday 9 May at Awanui Rest Home when Julie Watson, Silver Rainbow programme leader, handed the Silver Rainbow Seal to Jackie Jones, Awanui's manager. The Silver Rainbow Seal is in recognition of the facility's commitment to providing all-inclusive aged care.

'Silver Rainbow' began as a project at the School of Nursing, The University of Auckland. Initial research indicated that lesbian, gay and bisexual (LGB) elders have almost no visibility in aged residential care and that carers have little awareness of specific LGB needs, let alone any knowledge of how to manage homophobic behaviour from other residents. While carers themselves generally claim to be accepting of LGB residents, the research also hinted at a lack of self-awareness of personal prejudice.

This research formed the basis of the next phase: designing, developing and field-testing a resource kit to educate staff who care for LGB people in aged residential care. The exercises concentrate on the effects of homophobia on elder LGB residents and their right to the same high-quality care as anyone else – irrespective of the personal beliefs of the carer.

In July 2015, Silver Rainbow came under Affinity Services' umbrella and employed a Silver Rainbow programme leader. Additional resources were developed to include transsexuals and intersex (so they now cater for LGBTI), and the Silver Rainbow Seal was launched. We all hope this achievement will inspire more people to work towards all-inclusive aged care, to make the world a better place for our LGBTI elderly.

The management and staff at Awanui Rest Home have been committed to Silver Rainbow from the launching of the resources. All the staff have attended training, and the rest home changed a lot of its documentation to be more inclusive. Jackie has found the process extremely fulfilling and hugely informative for all staff. The training has opened up good conversation among the staff, who have come up with questions they might never have asked before.

Current family members have been very happy with the changes as well. Jackie wants the focus to go beyond the Rainbow Seal so that Awanui is known for establishing an all-inclusive facility where every resident can feel at home and accepted for who and what they are. Achieving the Rainbow Seal is her way of offering a welcome mat without question – of conveying the facility's attitude that we all have the right to be just who we are. Jackie says she is very grateful to Awanui's owners, Mike and Sarah Single, who have given her the freedom to pursue this, and to the team at Awanui who were all willing to go on this journey.

Again, big congratulations to Jackie and her team at Awanui Rest Home!

Kapiti Retirement Trust: cytotoxic medication management in the aged care sector

As with many clinical specialties, cytotoxic medication management involves 'creep' into other specialties. Suddenly you have to manage a clinical event that you know is highly specialised and has significant risk associated with it, yet you have very little knowledge of it. Writing a policy on safe management of cytotoxic medication in the aged care sector that ensures staff work safely within their experience and within the scope of their practice brings these issues to the fore.

Because cytotoxic therapy is being used more often for treating autoimmune conditions, rheumatoid arthritis and psoriasis, it is increasingly common for aged care residents to be on cytotoxic medication. The research on cytotoxic medication management, however, is mostly geared towards specialist haematology and oncology units in base hospital settings for continent patients. For me, in developing a policy focused on the aged care sector, such findings raised far more questions than they answered. How do aged care providers maintain training and competency in cytotoxic management when the therapy is still used relatively infrequently and is not a specialty in the aged care setting? How do you dispose of the incontinence pads for someone on high-dose cytotoxics? How do you store and dispose of cytotoxic waste? Is the management for more commonly used cytotoxics in aged care (eg, Methotrexate or Efudix) the same as for other cytotoxics that tend to be used more frequently in haematology or oncology?

Management in the residential aged care setting seemed likely to be a difficult and expensive prospect for people on cytotoxic medication until I had a eureka moment after a discussion with Dr I Lim, a rheumatologist in Sydney, at a recent conference. He divided cytotoxic medications into low dose and high dose. The following were my key learnings from my research that ultimately supported the policy I developed.

- Low-dose cytotoxic medication is more likely to be seen in the residential aged care setting and does not need the same degree of precaution and training that high-dose cytotoxics do.
- The management of residents on high-dose cytotoxic medications requires some forward planning – specifically, staff education and purchase of equipment such as waste bins.
- All high-dose cytotoxic waste, including incontinence pads but excluding sharps, should be disposed of in a lined, hard-shell bin specifically labelled as cytotoxic waste. These bins must not be reused. Sharps are disposed of in a hard-shell sharps container specifically labelled as cytotoxic waste.
- Fluoroucil (Efudix) cream should not be administered by pregnant or breastfeeding staff.

A copy of the Kapiti Retirement Trust Policy is available on request on the proviso that, if the information is used, the Kapiti Retirement Trust be acknowledged.

The policy was developed in consultation with the Charge Nurse, Haematology and Oncology Unit, Capital & Coast DHB (CCDHB); Rheumatology Department, Hutt Valley DHB; Infection Control Unit, CCDHB; Wastecare Management; Pharmacists – CCDHB and Kapiti Lights Pharmacy; Dr Ann Evans GP.

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