MINISTRY OF HEALTH
MANATŪ HAUORA

HealthCERT

HealthCERT Bulletin

Information for the sector

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New Zealand Government

Welcome to the November 2015 edition of the HealthCERT team's bulletin, which highlights our upcoming Work Programme 2016: Pressure Injury Prevention and Management.

HealthCERT Work Programme 2016: Pressure Injury Prevention and Management

As pressure injuries (PIs) have a significant impact on an individual's quality of life, HealthCERT has developed a work programme for 2016 to incorporate pressure injury prevention and management (PIPM) into the audit process of aged residential care facilities. It is important to note that the programme's aim is to better understand PIPM within the aged residential care sector. It will not add to audit requirements for providers.

Ministry of Health: Office of the Chief Nurse

The Ministry, Accident Compensation Corporation (ACC) and the Health Quality and Safety Commission have agreed in principle on a partnership approach to a national PI reduction programme, and are scoping a project plan. The HealthCERT work programme will be a part of this project.

Already the three agencies have worked together with the New Zealand Wound Care Society to provide education resources for *Stop Pressure Injury Day* on 19 November. This day aimed to raise awareness of PIs in order to decrease harm from them. Key messages were that:

- with the right knowledge and care, pressure injuries can be avoided
- all health professionals, carers, family and whānau members, and patients have important roles to play in prevention
- skin care matters.

Prevention will be a key focus. The 'love your SSKIN' bundle of preventative care identifies five key strategies for PI prevention:

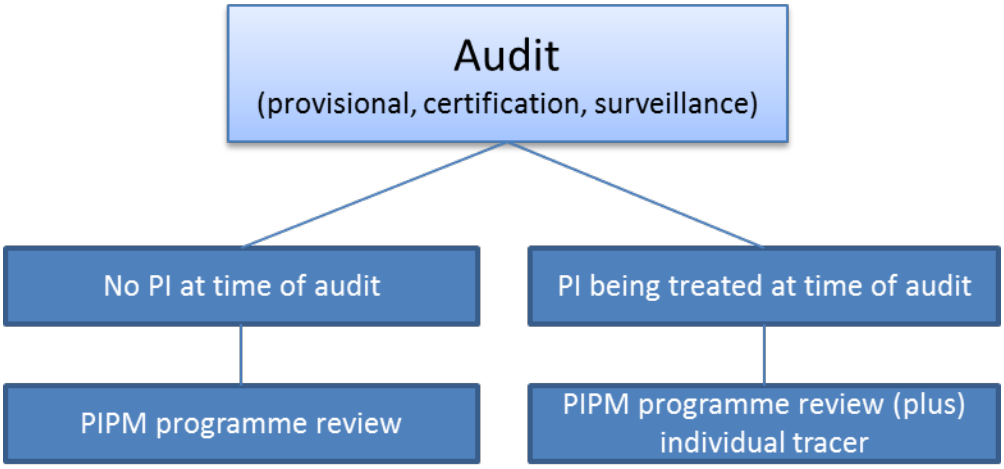
- **S**urface
- **S**kin inspection
- **K**eep moving
- **I**ncontinence
- **N**utrition.

For more information on how to prevent, identify and document PIs, see the New Zealand Wound Care Society website: www.nzwcs.org.nz/pressure-injuries-ulcers/worldwide-stop-pressure-injury-day. It offers a PowerPoint presentation; a brochure for people at risk and their carers; a guide to the stages of pressure injuries; and links to patient stories.

HealthCERT Work Programme: A two-pronged approach

If you are an aged residential care provider and have a provisional audit (in respect of a sale), certification audit and/or an unannounced surveillance audit in 2016, the audit team will discuss aspects of your PIPM programme with you. The approach will take one of two possible directions.

- If, at the time of audit, you have no residents with a PI, the audit team will review your PIPM programme as part of the audit.
- If you have a resident with a PI at the time of audit – because they either acquired it in your facility or were admitted with a PI – the audit team will use this resident as a tracer. In addition, they will review your PIPM programme.



Information relating to your PIPM programme will be reported against standard 3.3 in the audit report. The findings related to this standard are not published on the Ministry of Health's website.

Audit focusing on PIPM programme in aged residential care facility

An audit will check that the PIPM programme includes the following components.

- A policy guides staff on maintaining residents' skin integrity and wound management. The *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide* (see the link under 'Research of interest' below) may be useful in ensuring your operating documents meet best practice.
- The internal audit programme may include audit of wound management and/or resident files. In this case, you should develop corrective action plans if improvements are required.
- Minutes from meetings – such as quality meetings, staff meetings and/or registered staff meetings – record discussion on PIPM.

- The adverse/incident event process includes reporting of PIs and is part of monthly data collection on clinical indicators.
- The annual training programme includes topics such as skin integrity, wound care and, perhaps, a dedicated session on PIPM. You may also offer opportunistic training related to PI prevention; be sure to highlight any such initiatives to the audit team.
- Equipment and supplies are sufficient to support residents' needs. Refer to the *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide* (see the link under 'Research of interest' below) to check if you are using equipment and supplies that meet best practice guidelines.
- A sample of care plans will be reviewed as part of the audit. Even if you do not have a resident with a PI, these plans will cover aspects such as skin integrity, mobility, diet and pain management as part of PIPM.
- Staff interviewed as part of the audit will report an understanding of PIPM, including how to access and involve wound care specialists in a timely manner.

Audit of aged residential care facility that has a pressure injury at the time of audit

The audit team will want to know about all cases of PI in the facility at the time of audit. As the sample below indicates, they will be asking for:

- the total number of residents with PI
- the stage of each PI
- PI acquired in the facility and acquired elsewhere
- the assessed level of care for each resident with a PI.

Sample of PI information that could be collected in an audit

Pressure injury (PI)		**1 Dec 2015** *(example only)*
No. of PI on day of audit		04
Facility-acquired PI		01
Non-facility acquired PI		03
Stage (S) of PI		
SI	Stage 1	02
SII	Stage 2	01
SIII	Stage 3	01
SIV	Stage 4	
SV	Unstageable (depth unknown)	
SVI	Suspected deep tissue injury	
Assessed level of care		
	Hospital	03
	Rest home	
	Dementia	01
	Psychogeriatric	
	Young person	

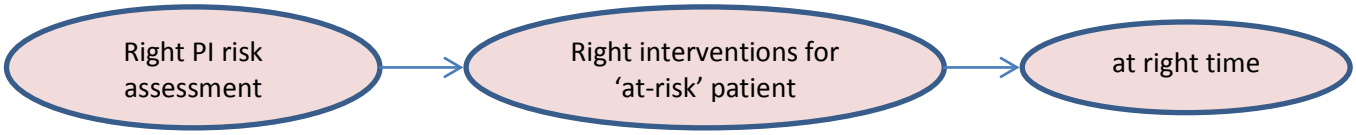
One of the residents with a PI will be chosen as a tracer. If you are managing more than one PI, the tracer will be undertaken on the resident who has the most significant injury; in the example above, that would be the resident with the stage 3 injury. The tracer will involve reviewing the resident's file, considering assessments such as (but not limited to) wound, pain, nutrition, mobility and skin integrity. The care plan should reflect the resident's needs and provide evidence that appropriate wound care (and evaluation) is in place. Involvement of a wound nurse specialist (or the like) should be recorded. Staff will also be interviewed and the expectation is that they will understand the PIPM programme.

In addition, the PIPM programme will be reviewed.

Clinician's Corner

This section offers a senior clinician's view on how to support the prevention of PI. Thanks to Paula McKinnel, for this issue's content.

Pressure injury prevention



PIs, also known as 'pressure ulcers' or 'bed sores', are a care sensitive indicator that needs every health professional's attention. The good news is most PIs are preventable and we can do more to stop harm to patients when they are in our care.

All patients need a PI risk assessment when admitted to a health care service as this identifies 'at-risk' patients as well as giving us a baseline assessment to plan care from. Ongoing assessment is essential, especially when the patient's condition changes to make them more vulnerable to PI.

The right PI risk assessment identifies the 'at-risk' patient

A comprehensive PI risk assessment consists of three parts.

- A **skin check or inspection** gives the earliest indicator of skin damage.
- A **PI risk assessment tool** (eg, Braden or Waterlow) predicts risk and determines interventions needed.
- **Clinical judgement** links up the contributing or confounding 'at-risk' and 'whole patient' factors.

When all three of these parts are used together, they guide how best to implement evidence-based clinical interventions.

Health professionals need to ensure the right interventions for all patients

Do you understand the SSKIN care bundle?

A care bundle is a set of evidence-based interventions that, when used together, significantly improve patient outcomes. These interventions are not new to nursing but in combination they provide a simple approach to coordinating PI prevention care interventions.

- **S – Surface**
  - Make sure the patient has the right supportive surface mattress, cushions and correct fitting medical devices in place to prevent harm.
  - Patient risk factors to consider when selecting equipment are: PI risk level as determined by assessment tool; patient's mobility and their ease of getting in and out of bed or a chair safely; patient weight; PI location or area at PI risk; skin temperature; bed frame; and budget (best system approach – buy in or rent?).

Best PI prevention equipment does not replace other important SSKIN interventions.

- **S – Skin inspection**

  Conducting a regular skin check provides the earliest indicator of pressure damage. The frequency of this check depends on the individual patient's risk factors, particularly if their condition deteriorates.

  The three-step skin check approach is as follows.

  1. Ask, *Does the patient feel pressure or localised discomfort at pressure points*?

     If the patient is unable to communicate, start at step 2 and carry on to step 3.

  2. Educate the patient, family and staff on SSKIN interventions with a focus on moving frequently to relieve pressure

  3. Do the skin inspection. If the answer to step 1 is 'yes', check areas at high risk of PI; if the answer is 'no', check elbows and ankles to show how important and easy a skin check is.

- **K – Keep moving**

  - Patients need to change their position often.
  - In bed, move the patient from back to side using the 30 degree tilt. Move them at least every two to three hours, depending on the condition of their skin.
  - In a chair, small changes every 30 minutes are important. The 'at-risk' patient should not sit out all day and any activities requiring sitting should be patient focused.
  - Protect the patient's heels with correctly fitting shoes, and elevate the heels with pillows correctly or by using heel devices.

- **I – Incontinence**

  - Keep the patient's skin clean and dry.
  - Use appropriate incontinent interventions to prevent skin damage.
  - Educate staff on how to identify the difference between a PI and incontinent-associated dermatitis so that they can implement the correct interventions.

- **N – Nutrition**

  - Ensure that patients are eating properly and are well hydrated.
  - Mouth issues such as ill-fitting teeth, dry mouth or poor swallow will require other interventions to ensure the patient has adequate nutrition and hydration.
  - All patients with an 'at-risk' malnutrition score or with a PI wound must be assessed by a dietitian.

Documentation

Documentation is key to PIPM. Think about escalating the intervention when care at the bedside is ineffective, and discuss the PI care plan with all members of the multidisciplinary team. For PI prevention to be successful, a patient-centred approach is required.

Website resources

Go to:

- the STOP PI 2015 page on www.nzwcs.org.nz for a lot of resources
- www.woundsinternational.com for best practice principles on incontinent associated dermatitis.

Paula McKinnel
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Capital & Coast District Health Board

Section 31 reporting: Stage 3 +

As a certified provider, you will be aware that, under section 31 (s31) of the Health and Disability Services (Safety) Act 2001, you are required to report certain events to the Ministry of Health (specifically, HealthCERT) and your district health board. These events include police investigations and deaths that are reported to the Coroner.

As part of this PIPM work programme, HealthCERT is requiring providers to report, as a s31, all PIs at stage 3 and above. That is, this covers all stage 3 PIs, stage 4 PIs, unstageable PIs and suspected deep tissue injury. Reporting is required irrespective of where the PI was acquired.

For information from the Ministry of Health website, which includes a link to the s31 notification form, go to: 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. Alternatively search 'section 31' on the website home page.

Who can I talk to?

We appreciate this article has covered a significant amount of information. If you have any queries or concerns, or just want to discuss this work programme, please do not hesitate to contact Donna Gordon on (04) 496 2429 or via email donna_gordon@moh.govt.nz in the first instance.

Research of interest: PIPM

As HealthCERT has an established work programme for 2016 relating to pressure injury management, our research of interest will focus on this topic. The links below may be of interest to your service:

- New Zealand Wound Care Society Inc: www.nzwcs.org.nz
- International Wound Infection Institute: www.woundinfection-institute.com
- *Prevention and Treatment of Pressure Ulcers: Quick Reference Guide*: http://nzwcs.org.nz/images/International_PUG/Quick_Reference_Guide_V3.pdf
- National Pressure Ulcer Advisory Panel, *Pressure Ulcer Root Cause Analysis (RCA) Template*: www.npuap.org/resources/educational-and-clinical-resources/pressure-ulcer-root-cause-analysis-rca-template
- Stacy Ackroyd-Stolarz, 'Improving the prevention of pressure ulcers as a way to reduce health care expenditures': www.ncbi.nlm.nih.gov/pmc/articles/PMC4081234/pdf/186e370.pdf. One under-recognised opportunity for both reducing health care expenditures and improving patient care is better prevention of pressure ulcers. Although the prevention and care of pressure ulcers may have been viewed historically as a nursing care problem, it is a useful barometer of system-level quality and patient safety. Physicians across the continuum of care have a pivotal role to play in leading system change for the improvement of quality and safety.

Operating matters

New Senior Advisor HealthCERT: Katrina Lenzie-Smith

The HealthCERT team welcomes Katrina to the role of Senior Advisor, based in the Auckland office. She comes to us from Waitemata District Health Board, where she was Portfolio Manager for Health of Older People. Her personal goal is to manage programmes that deliver the best possible outcomes for all peoples of New Zealand.

Hospital – medical (non-acute) certification

District health boards, ACC and the Ministry of Health have, over time, developed a variety of funding contracts resulting in admission to aged residential care facilities. These contracts include:

- Long Term Support Chronic Health Conditions for under 65s (LTSCHC)
- Community Residential Services within Aged Care Facilities for Younger People with Life Long Disabilities
- Transition Funding (for non-weight bearing rehabilitation (over 65s))
- Primary Options for Acute Care (POAC)
- Interim care scheme (short term)
- Rehabilitative.

The needs of these residents tend to be complex, requiring a high level of clinical oversight, including (but not limited to) time-limited rehabilitation, complex wound care, peg feeding, and oxygen therapy. For this reason, HealthCERT requires providers to be certified for hospital – medical (non-acute) services.

HealthCERT requirements for hospital – medical (non-acute) certification

HealthCERT requires providers who hold contracts such as those listed above to be certified for hospital – medical (non-acute) services. Providers face no additional audit requirements when gaining certification for hospital – medical (non-acute) services.

- If you are currently certified for hospital – geriatric services and wish to add certification for hospital – medical, please ask your designated auditing agency (DAA) to include it in your next audit.
- If you are a new provider of hospital-level care, please consider if you require hospital – medical on your certificate; and if you do, add this service type to your application form.

Auditing for hospital – medical (non-acute) certification

When auditing for hospital – medical (non-acute) certification within an aged residential care facility, the audit team will consider the following Health and Disability Services Standards (HDSS).

- Quality and Risk Management Systems (standard 2.3): The service develops policies and procedures that are aligned with current good practice.
- Human Resource Management (standard 2.7): Appropriate service providers are appointed to safely meet the needs of consumers.
- Service Provider Availability (standard 2.8): A clearly documented and implemented process determines service provider levels and skill mixes in order to deliver services safely.
- Service Provision Requirements (standard 3.3): Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.
- Service Delivery/Interventions (standard 3.6): Appropriate links are developed and maintained with other services and organisations that are working with consumers and their families.

- Medicine Management (standard 3.12): Policies and procedures clearly document the service provider's responsibilities in relation to each stage of medicine management; and medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Continuous improvement ratings

Continuous Improvement (CI) achievement, which can be awarded at standard or criterion level at the time of audit, provides the opportunity to showcase quality initiatives. HDSS 8134:2008 defines a CI rating in this way.

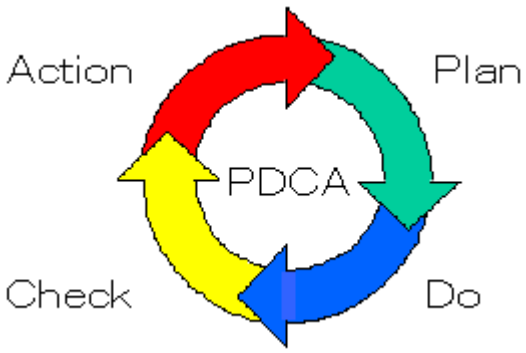
> Having fully attained the criterion the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings, and improvements to service provision and consumers' safety or satisfaction as a result of the review process.

During the audit, take the opportunity to discuss implemented initiatives with the audit team and ensure you have supporting evidence. The audit team will be interested in reviewing:

- a summary of the problem and where it originated – for example, from a complaint, an incident or resident feedback
- a description of what action was taken
- how you will know if the action taken was successful
- a process/record of ongoing evaluation and monitoring. Incorporating monitoring into your annual audit programme may be an effective way of measuring if change has been embedded into your work
- resident satisfaction, as part of the evaluation.

The audit team will need to clearly and succinctly document the CI in the audit report. They decide whether the evidence meets criterion or standard level.

The Plan, Do, Check, Action (PDCA) cycle is an easy way of thinking about how to incorporate continuous quality improvement activities into your work.



Home and Community Support Sector Standard (NZS 8158:2012)

To be certified, home and community support service providers who hold a contract with the National Health Board Disability Support Services, a district health board or ACC (funders) are required to demonstrate their compliance with NZS 8158:2012. For auditing requirements against NZS 8158:2012, as developed by key stakeholders, go to the Ministry of Health's website: www.health.govt.nz/publication/auditing-requirements-home-and-community-support-sector-standard-nzs-81582012.

Conformity assessment bodies (CABs) audit and certify providers of home and community support services. A CAB is required to be a designated auditing agency as authorised under the Health and

Disability Services (Safety) Act 2001. The certification period is three years from the date of the certification decision.

The Ministry is developing a work programme that will include revision of the audit tool and handbook.

Sector matters

Design guidelines for residential secure dementia units

Currently there are no formally agreed national guidelines for the design of secure dementia units for New Zealand. Expectations for the design of such units are also unclear.

The Ministry of Health has started a project to develop national guidelines for the design of residential secure dementia units. It is intended that the guidelines will provide best-practice guidance to all stakeholders and inform providers of aged care about what HealthCERT and district health boards expect in relation to that design.

The objectives of the project are to:

- improve the lives of people with dementia by developing secure units that are dementia friendly
- agree design principles that are evidenced based, including principles about the size of units
- implement a nationally consistent approach to the design of secure dementia units.

A discussion document summarises the international research about best practices for the design of dementia units in aged residential care facilities. It has provided useful background information for the meetings that have been held around the country with all key stakeholders – consumers, carers, providers and funders – in October and November 2015. The meetings have been well attended and characterised by lively discussion.

The research evidence and information gathered from this consultation will form the basis for the development of New Zealand best-practice guidelines for dementia care. A draft of the guide will be available electronically in late February 2016 for comment.

Guidance on electrical equipment safety in aged care and similar facilities

The electrical standards have not changed. However, Energy Safety uses the Medicines Act 1981 (section 3a) as a guideline to work out what counts as medical equipment, which can affect the nature of the compliance that is required.

Testing to AS/NZS 3551

Unless the equipment is intended to be part of a facility that is to be used for treatment that specifically requires ‘Body Protection’ or ‘Cardiac Protection’ from electric shock, testing to Australian and New Zealand Standard (AS/NZS) 3551 is neither relevant nor necessary.

Application of the ‘test and tag’ regime of AS/NZS 3760

Mandatory regulations apply to the safe use of electricity. However, regulation 26 of the Electricity (Safety) Regulations 2010 recognises AS/NZS 3760’s test and tag regime as a safe method of achieving the general safety requirements for the use of plug-in appliances, as part of the Regulations’ risk-based architecture. For this reason, it is not mandatory to apply the regime in this instance, nor to assess an alternative safety methodology against the Standard as a minimum benchmark.

The Regulations, in citing IEC60479, recognise that residual current devices (RCDs) provide an acceptable method for protecting against electric shock. Therefore, where aged care facilities use RCD-protected supplies to provide an alternative to ‘test and tag’ and test the RCDs on a regular basis, this approach is not necessarily inadequate for compliance with the Regulations. The checks could be performed using the test facility of the RCD twice yearly at the start and end of daylight saving, when

disruption to clocks and other devices would be minimised. It is expected that this aspect of safety in aged care facilities will be considered during the next revision of the Regulations.

WorkSafe New Zealand

Reporting fractured neck of femur injuries

All incidents in the workplace that meet the definition of serious harm must continue to be reported to WorkSafe on the serious harm form.

The new Health and Safety at Work Act 2015, which comes into force on 4 April 2016, requires a Person Conducting a Business or Undertaking (PCBU) to report any notifiable injury or illness and any notifiable incident. Sections 23 and 24 of the Act set out the meanings of these terms.

Section 25 of the new Act is more explicit than the current Act in identifying the specific events arising from work that are considered to be a notifiable event.

WorkSafe, alongside the Ministry of Business, Innovation and Employment, is currently working on various publications to help PCBUs understand their obligations under the new Act.

WorkSafe New Zealand

Guidelines for Verifying Death

The Ministry of Health has worked with the Office of the Chief Coroner and sector stakeholders to enable a wider group of practitioners to verify death. The Chief Coroner recently released a new form to document the verification of death. The form lists the practitioners permitted to verify death as: medical practitioners, nurse practitioners, registered nurses, enrolled nurses, midwives, emergency medical technicians, paramedics and intensive care paramedics. Previously only medical practitioners could verify death.

When a person dies, a number of steps need to be completed, with different tasks related to different roles. For information and clinical guidance on the process for verifying death, designed for health practitioners, employers, professional bodies, the police and the funeral industry, see the Ministry of Health's *Guidelines for Verifying Death* at: www.health.govt.nz/publication/guidelines-verifying-death.

interRAI

As part of the integrated interRAI programme, the National interRAI Data Analysis and Reporting Centre (the Centre) was formally established in TAS in July 2015. The vision is for the Centre to provide regional and national stakeholders with robust information to assist them in their planning and decision-making. In its first year, the Centre will focus its energy on:

- building an interRAI data warehouse to host interRAI assessment data within the TAS environment
- establishing business systems and processes so that interRAI assessment data is stored, managed, analysed and disseminated under strict protocols for data quality, privacy and security
- developing a suite of interRAI analysis and reporting processes to meet the needs of a wide range of customers.

In October 2015, the Centre released 20 quarterly reports to all district health boards (DHBs) on a specific compliance indicator in relation to the interRAI Long Term Care Facility (LTCF) assessments. These reports were designed to help DHBs in their compliance reporting to the Ministry of Health for quarter 1, 2015/16. DHBs gave positive feedback on the reports and engaged constructively with the process.

Next, the Centre will release a detailed set of quarterly tables and charts to all DHBs, reporting on interRAI outcome measures and clinical assessment protocols covering both Home Care and LTCF assessments. These will enable DHBs to benchmark their results against other DHBs and the national average.