HealthCERT Bulletin

Information for Designated Auditing Agencies

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Introducing the HealthCERT Bulletin

Welcome to the first edition of the HealthCERT team's quarterly bulletin. Through this bulletin we intend to provide auditors with updates, research and information to help answer commonly asked questions.

In this issue

Updating progress notes

It is widely accepted good practice to update progress notes concerning residents and other health consumers at least daily. As the Deputy Health and Disability Commissioner (2008) has noted, they provide a picture of a resident's wellbeing on a continual, 24-hour basis and therefore should highlight any changes of condition or care.

The Office of the Health and Disability Commissioner have raised concerns about brief and irregular reporting in progress notes. In a 2008 decision on a case concerning an aged care facility, the Deputy HDC expressed concern about the facility's lack of progress notes to record information on the care for and wellbeing of residents.

So what are the key features of effective, informative progress notes? Below are some guidelines drawn together from standards and guidelines published in and for the health and disability sector.

- Document each assessment, event, visit, treatment, intervention, procedure and consultation as soon as practicable after an event (Standards New Zealand 2001).
- Include the time of recording and current information on the person's care and condition (Standards New Zealand 2001).
- Document as frequently as the person's clinical condition indicates is necessary (Standards New Zealand 2001).
- Document each client contact in the health record, or one entry per shift, whichever is more appropriate (Standards New Zealand 2001).
- Provide consumer information that is uniquely identifiable (Standards New Zealand 2008).

- Record information in an accurate and timely manner, appropriate to the service type and setting (Standards New Zealand 2008; NCNZ 2009).
- Use up-to-date and relevant consumer records (Standards New Zealand 2008).
- Maintain confidentiality of information (Standards New Zealand 2008; NCNZ 2009).
- Maintain records within a legal and ethical framework (NCNZ 2009).

References

Deputy Health and Disability Commissioner. 2008. Case Manager, Ms I, an Aged Care Facility, an Aged Care Facility Company. Case 07HDC17647.

NCNZ. 2009. *Competencies for Registered Nurses: Ki te whakarite i nga ahuatanga o nga Tapuhi e pa ana mo nga iwi katoa – Regulating nursing practice to protect public safety.* Wellington: Nursing Council of New Zealand.

Standards New Zealand. 2001. NZS Health Records Standard 2001. Wellington: Standards New Zealand.

Standards New Zealand. 2008. *Health and Disability Services Standards: Consumer Information Management Systems.* Wellington: Standards New Zealand.

Roles, responsibilities and best practice in medication management

At HealthCERT we receive various inquiries asking us to clarify key aspects of medicine management – prescribing, transcribing and administration. Here you'll find an overview of the roles and responsibilities involved, and broad guidelines for best practice. For more detailed guidance, please refer providers to the documents listed in the references section.

Pivotal roles in medication management are the:

- **prescriber** – the health practitioner (ie, doctor, registered midwife or nurse practitioner) who is responsible for generating the prescription
- **administrator** – the health practitioner (ie, registered nurse) who is responsible for administering the medication to the patient
- **dispenser** – the health practitioner (only authorised prescribers, pharmacists or pharmacy technicians) who dispenses (makes available) a prescription medicine.

All of these roles are involved in **charting**. The prescriber, dispenser and administrator record medication-related information on a medication chart (Safe Medication Management Programme 2009a). The **medication chart** lists the prescribed medicines that a patient is currently taking, or is intended to be taking.

Medicine reconciliation is standardised process, of identifying the most accurate list of all medications (including name, dose, frequency and route) that a patient is taking, and using that information to provide safe, effective care to that patient at all transition points within the health and disability service. This process includes:

- eliciting a medication history (including herbal and other over-the-counter preparations) from the patient (or their representative)
- where necessary, verifying this history with the consumer's community pharmacist or GP.

It is the prescriber who is responsible for prescribing medicines as a result of the **medicine reconciliation** process (Safe Medication Management Programme 2009b). The purpose behind medicine reconciliation is to identify any discrepancies. It is not concerned with transcribing medications.

Transcribing is not specifically defined under legislation or the standards but it can include 'Writing out a patient's current medication on to a Medication Administration Record Chart that is used as an audit record of medicines that have been administered' (NZNO 2007).

Transcribing medication is not a recommended practice for nurses. The New Zealand Nurses Organisation (NZNO) does not recommend it due to the risks that staff could:

- make errors during the transcription, which may not be picked up by the prescriber
- come to rely on secondary sources rather that the original medication order form, resulting in incorrect medication administration.

Moreover, transcribing would not meet safe practice guidelines as defined under Health and Disability Services Standard 1.3.12.1. Although prescriptions are the responsibility of the authorised prescriber, nurses are accountable for their actions (NCNZ 2009) and where errors occur, any such transcribing practice would be called into question.

Where do accountabilities lie?

The accountability for correct medication management is contingent on the organisational systems in place to support medication administration. Accountability in some form is attached to each of the following three roles.

1. The employer is responsible for providing appropriate resources, training and information about risk management processes that staff can contribute to or participate in. Additionally an employer must provide safe systems (storage, administration), job descriptions, guidelines and policy to facilitate safe medicine management.
2. The doctor should only prescribe drugs or treatment when they have adequate knowledge of the patient's needs and are satisfied that the drugs or treatment are in the patient's best interests (Medical Council of New Zealand 2009).
3. The registered nurse is responsible for administering or delegating administration of medicines, and does not generate prescriptions. For an outline of medico-legal issues and useful references for guidance related to medicines administration in New Zealand, see the New Zealand Nurses Organisation's medicines administration booklet (NZNO 2007).

More generally, a health care provider has a responsibility for providing training, guidance and policy that incorporates the roles and responsibilities outlined in this article, with the aim of ensuring safe medication management is implemented.

References

Medical Council of New Zealand. 2009. *Good Prescribing Practice*. Wellington: Medical Council of New Zealand.

NCNZ. 2009. *Competencies for Registered Nurses: Ki te whakarite i nga ahuatanga o nga Tapuhi e pa ana mo nga iwi katoa – Regulating nursing practice to protect public safety.* Wellington: Nursing Council of New Zealand.

NZNO. 2007. *Guidelines for Nurses on the Administration of Medicines*. New Zealand Nurses Organisation.

Safe Medication Management Programme. 2009a. *District Health Boards Medications Charting Standards*. Lower Hutt: Safe Medication Management Programme.

Safe Medication Management Programme. 2009b. *Standards for Medicine Reconciliation*. Lower Hutt: Safe Medication Management Programme.

Provisional audit: the interview with the prospective provider

Whenever a rest home changes hands, auditors are involved in undertaking a provisional audit. Through this process they establish:

- how well the prospective provider is prepared to provide a health and disability service
- how closely the existing provider conformed to requirements before the service changed hands.

A necessary part of this process is to interview the prospective provider (or contact person). If this person is not present for the full audit then an off-site interview is acceptable.

During the interview, the auditor needs to determine whether the prospective provider meets all of the following criteria.

- The prospective provider knows and understands the consumer rights that it must adhere to.
- The prospective provider has an established organisational structure (governance/management) and a predetermined lead-in time. It has identified any changes to key personnel (involving governance, organisational management, clinical management down to team leader level) that will occur after taking ownership of the service.
- The prospective provider has developed a transition plan if required, allowing timeframe for processing.
- Where changes are planned within the service that may affect the service's capacity to meet the requirements of the Health and Disability Services Standards, the prospective provider is aware of the issues and taking steps to ensure it will continue to meet those requirements.
- Any plans for environmental changes to the service comply with legal requirements.
- There are no legislative compliance issues (for example, concerning health and safety, employment, local body) that could affect the service.
- The prospective provider will produce an annual quality plan and has established quality management systems including schedules for internal audit, changes and continuity.
- The prospective provider is planning activities that will contribute to continuous quality improvement.
- The prospective provider has a practicable policy regarding staff skill mix, including contractual obligations and acuity of consumers within the service.
- The prospective provider has established plans for service management, such as determining who will cover when rostered staff are absent and managing staff changes.
- Where changes are being made to existing operational (management and clinical) policies or procedures the prospective provider has ensured the changes will meet the requirements of the Health and Disability Services Standards.

Dementia services: a summary of auditing requirements

The Designated Auditing Agency (DAA) workshops in June covered a range of issues of practical assistance in auditing dementia services. In this article we summarise the key points arising in regard to the particular needs of residents with dementia in terms of their consumer rights, requirements for organisational management and for a continuum of service delivery, the provision of a safe environment for residents and staff, and some practical features of an effective dementia unit.

Consumer rights

- Residents with dementia have specific needs in relation to consumer rights. Information for family and Enduring Power of Attorney (EPOA) is essential in relation to the Code of Rights, informed consent and the specific needs within a secure unit.
- Educating staff on the Code of Rights, cultural safety, intimacy and sexuality, abuse and neglect is particularly relevant to dementia care.
- Providers need to be aware of how to obtain EPOA status where there is none, and how to make referrals to appropriate agencies when EPOA abuse is suspected.
- Advocacy services need to understand the specific needs of dementia residents and their families.

Organisational management

- A service's organisational philosophy and strategic plan need to reflect dementia care and a family-centred approach. Management needs to establish or maintain an environment that allows for a diversity of behaviours.

- Before having sole charge responsibility, staff need to have completed the dementia training, as per the Aged Related Residential Care (ARRC) contract, and the related New Zealand Qualifications Authority (NZQA) unit standards.

Continuum of service delivery

- From pre-entry through to the time they exit a service, dementia residents and their families have special needs in relation to that service.
- Through early assessment, planning and interventions developed in consultation with the EPOA or family, a provider will reduce the risks associated with the admission.
- A provider must evaluate its interventions regularly so that the care planning meets the changing needs of each individual resident.
- If a provider offers respite care, it must conduct an assessment review with each admission.
- A 24/7 holistic approach to activities is essential. Consideration of the resident's life history and past routines will help to establish the most appropriate therapies at times of increased restlessness or agitation.
- When transporting residents for outings, appointments or acute care, a provider should consider who to send as the most appropriate support person in terms of their ability to relay information.
- Medication reviews in consultation with a psychogeriatrician are essential considering the progressive nature of the disease.
- A provider can meet the nutritional needs of dementia residents by making food and fluids available on a 24-hour basis, monitoring their weight regularly and getting specialist dietary advice.

Safe and appropriate environment

- The environment should be designed to distract residents from staff-only areas while maximising the visibility of safe areas.
- Corridors and outdoor areas that are easy to navigate encourage purposeful walking. The ARRC agreement, section E 3, lists aspects of environmental design that are required.
- Staff, visitors and tradespeople need to be aware of the hazards in dementia units.
- Emergency personnel and planners must consider the unique needs of dementia residents if they are to appropriately manage an emergency.
- In the event of a crisis, staff must have access to immediate back-up.
- Staff need to be aware of dementia residents' valuable personal items and, where a resident hides or disposes of any such item, relatives need to be advised.

Practical tips for dementia units

Some features of great practical value in a dementia unit are:

- spaces inside and out that allow maximum freedom of movement, while promoting safety for residents to pace
- artificial light that minimises glare, and enhances the domestic feel of the facility
- sensor lighting for internal areas such as bathrooms
- installation of cut-off switches for electrical appliances
- reduction in disruptive noise for residents with dementia (eg, television or music volume)
- visible cues for toilets and bathrooms
- personal rooms that are identifiable to the resident
- a range of living spaces that are domestic and homelike
- an emergency alarm is available for support staff when needed.

Emergency management: Is an alternative water source available?

In an emergency in which the main supplies fail, the provider must have an alternative supply of water available, consistent with Health and Disability Services Standard 1.4.7.4. An audit report must include evidence as to whether such a supply is available.

To be consistent with civil defence advice, a provider should have at least three litres of drinking water available for each person in the service to last for three days. In addition, they should have at least one litre of water for each of the following:

- washing food and cooking for each meal
- washing dishes after a meal
- personal washing.

Regional, district and city councils are responsible for civil defence emergency management. For more information about storing water, refer providers to their local council. The relevant contacts are available on the Ministry of Civil Defence and Emergency Management website:
http://www.civildefence.govt.nz/memwebsite.nsf

Recent research and publications

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

- **2009 postgraduate student dieticians' New Zealand rest homes malnutrition research project** – the scope of and findings from this multi-centre project
  http://nutrition.otago.ac.nz/__data/assets/file/0003/5592/2009_AbstractBk.pdf

- **Balancing independence and safety: the challenge of supporting older people with dementia and sight loss** – a research paper.
  In *Age and Ageing* 2010 39(4):476–480
  http://ageing.oxfordjournals.org/cgi/content/abstract/afq054

- **Rehabilitation for older people in long-term care** – a Cochrane review examining whether there is evidence that physical rehabilitation benefits older people in long-term care
  http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD004294/pdf_fs.html

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

Coming soon ...

The DAA handbook is being updated and will be on the Ministry website early August.

Look out for:

- new guidance on the publication of addendums
- changes to the residential disability auditing processes.