HealthCERT Bulletin

Information for Designated Auditing Agencies

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Tracer methodology

Tracer methodology is an evaluation method where individuals are selected to demonstrate the provision of care and services across an organisation. The auditor re-traces specific care processes of an individual by observing, talking with others and reviewing records, which results in the auditor assessing compliance against standards. It also allows the auditor to follow systems and processes of an organisation, and gain a clear sense of day-to-day issues affecting the care of individuals.

At the quarterly Designated Auditing Agency (DAA) workshop on 1 September 2010, tracer methodology was discussed and its application within the HDSS audit process. Workshop participants were divided into three groups, where they either:

- wrote up evidence in an audit report from audit field notes
- developed ideas for an audit tool to collect tracer evidence
- determined the methodology for collecting evidence, based on a synopsis of a rest home resident.

There was significant variation in the style of audit reporting. Care should be taken not to write a long narrative about an individual, as the individual event should be linked to trends and demonstrated systems and processes across an organisation.

It was discussed that evidence can be recorded in several places and depends on the level of non-compliance. However, it was agreed that evidence should reference tracer methodology in either Standard 3.3 (Service Provision Requirements) or 3.6 (Service Delivery Interventions).

Points raised at the workshop included the following.

- Tracer methodology changes the focus from examining written policies and procedures in isolation to the delivery of care. It enables observation and assessment where the auditor can look for trends that might point to potential system level issues within an organisation. The organisation also has a good opportunity to share examples of current practice.
- Auditors must get individuals' consent for their participation.
- Individuals should be current residents or patients who have recently been or are receiving multiple or complex services.

Tips for tracer methodology

- Involve as many people as possible.
- Include more than one tracer example and use these to look for trends.
- Ask staff to show you data, policies and procedures that relates to the individual.
- Focus on staff members, not management.
- Ask open-ended questions.
- Use findings to reinforce good practice as well as non-compliance.
- Take good field notes.
- Summarise/validate findings.
- Provide feedback.

Understanding informed consent, advanced directives, welfare guardian

1. Informed consent

> *'Consent is not a single act but a process involving communication in which the practitioner openly and honestly provides full information in an environment, and in a manner, in which the consumer can understand it.'* (Ref: Health Care and the Law, 4th NZ edition)

Effective communication and full information are key to informed consent.

Right 5: Right to effective communication

Communicating effectively with consumers is paramount.

1. Language and manner improves understanding – consider the environment, for example, aged care, residential disability, cultural considerations.
2. The environment needs to enable open and honest communication.

Right 6: Right to be fully informed

Provide consumers of health services with information that enables them to make positive choices about services.

1. When giving information to an individual discuss treatment options, risks, any side effects, etc.
2. An individual has the right to honest and accurate answers to questions relating to their care and services.

Right 7: Right to make an informed choice and give informed consent

This is the culmination of the informed consent process. Services can only be provided if the individual has an informed choice and gives informed consent.

Note: some legislation overrides the Code of Health and Disability Services Consumers' Rights, for example:

- Alcoholism and Drug Addiction Act 1966
- Health Act 1956 (2007 amendment re drinking-water)
- Criminal Investigations (Bodily Samples) Act 1995
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Tuberculosis Act 1948.

What's needed for informed consent to be correct?

- Enough information to make a decision.
- The information is understood.
- The person is competent to decide.
- A decision is made without pressure or coercion.

Health and Disability Services Standards informed consent Standard 1.10 – what to look for at audit

1. Policies/procedures:
   - policies and procedures identified include informed consent, emergency situations, DNR, advance directives, teaching
   - information (and documentation) provided to consumer including admission pack containing information on (but not limited to) advocacy, admission agreement, code of rights, complaints, informed consent
   - families and residents interviewed can recall that they were well informed during the admission process
   - policies are in place to guide practice when no Enduring Power of Attorney (EPOA) is in place.

2. Provide the information that consumers need to have to be actively involved:
   - evidence of advocate involvement, interpreters, information in languages other than English
   - information available in other formats, eg, tapes.

3. Information is made available:
   - an information sheet about informed consent, how it is obtained and the rights of the resident to exercise choice (sighted) is in the resident/family information booklet given to the resident and the family on admission
   - the RN (interviewed) discusses the process with the resident and family during the admission process
   - residents and families interviewed indicate satisfaction with information given, and respect shown for their choices
   - records sighted indicate that the effectiveness of the informed consent process is ongoing and is evaluated in a number of ways. This includes family surveys, performance reviews and training outcomes, resident/whanau feedback, the quality deficits and complaints process, annual review of residents' records and consent forms, six-monthly review of care plans and review of all complaints.

4. Written consent is obtained where required.

5. Service providers know how to meet their duties to consumers (Rights 5, 6, 7)

   Resources
   - The Code of Health and Disability Services Consumers' Rights
   - The Human Rights Act 1993
   - The PPPR Act 1988 and amendments (Enduring Power of Attorney).

6. Choices and decisions are recorded:
   - Identify situations within the organisation where written consent will be sought, for example, decisions that have a major impact on the life of a service user (eg, moving residential placement, lifestyle planning).
   - Provider encourages establishment of EPOA under PPPR Act 1988.
   - Residents/EPOA are assisted in their understanding of decision-making and its outcomes.
   - Policies are in place to guide practice when no EPOA is in place.

- Resident/EPOA have an opportunity to participate in decision-making.
- An EPOA is identified for each person.
- Those people most familiar with the service user should be involved in recording the most suitable process for the individual giving consent.
- Review this process on a regular basis and at least annually.

7. Available advance directives are acted on:
   - the GP assesses and documents the resident's competence to give informed consent and make an advanced directive. Where an advanced directive is in place it is held in the resident's record for staff reference (sighted). Records are flagged for ready identification.

Enduring Power of Attorney (EPOA)

A resident can only have one attorney for their personal care and welfare (EPOA) and this power of attorney is only activated once the resident is judged as not being able to care for themselves.

2. Advance directives

Right 7(5) of the Health and Disability Commissioner's Code of Consumer Rights gives the right to consumers to use an advance directive in accordance with the common law (ie, there is no specific legislation relating to advanced directives).

An advanced directive is:

> *'a written or oral directive –*
>
> *a) by which a consumer makes a choice about a future health care procedure: and*
>
> *b) that is intended to be effective only when he or she is not competent'.*

An advanced directive is sometimes referred to as a living will, that is, a written declaration of the treatments and procedures a person would accept or reject if in danger of death or incapable of decision-making.

There is no guarantee that views expressed in an advance directive is legally binding but the likelihood is increased if the person who has EPOA and/or the person's GP is involved.

Note: An advance directive is a negative right, that is, the person cannot request that certain treatment *is* given.

Ensure advance directives are only signed by the resident (if deemed competent). They cannot be signed by the EPOA or GP.

Any advance directives made before loss of competence stand (including Not for Resuscitation orders).

Mental capability

The question of mental capability must be decided by a health practitioner who is qualified to carry out this assessment.

Diminished competence

People with diminished competence should still be allowed to make informed choices and give informed consent, to the fullest extent they're able. Health providers have a duty to support them to do this.

3. Welfare guardian

If a person has no EPOA and is no longer competent to appoint one, then the Family Court can appoint a welfare guardian.

Where there is no EPOA and a mentally incompetent consumer, a clinical decision based on the best interests of the person is made for them.

The family's wishes can be considered in relation to best interests.

Team leaders/lead auditors

DAAs are reminded that upon completion of a recognised lead auditor qualification, the auditor should be assessed by their DAA for their ability to lead and manage an audit team, in addition to competently working as a quality auditor themselves. The DAA Handbook outlines the roles and responsibilities of a team leader/lead auditor) and there is also additional information in ISO/IEC 19011.

Note that there may be auditors who have completed training that qualifies them to be a lead auditor but who do not have enough experience and skill, and so should not be appointed into a team leader/lead auditor role.

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.

Healthy Mouth, Healthy Ageing: Oral Health guide for caregivers of older people

The New Zealand Dental Association in conjunction with the Ministry of Health has produced an resource for caregivers of older people to provide information on how to better care for older people's oral health http://www.healthysmiles.org.nz/assets/pdf/HealthyMouth,HealthyAgeing.pdf

A complex intervention to support 'rest home' care: a pilot study

In *Journal of the New Zealand Medical Association* 2010 1308 (123)
http://www.nzma.org.nz/journal/123-1308/3948/

HealthCERT website update

The 'Increase Capacity' and 'Reconfiguration of Certified Services' providers self-assessment forms have been updated. Providers are required to notify HealthCERT about plans to increase their capacity or reconfigure their services.