Recommended changes to draft standard

To: Standards New Zealand PO Box 1473 Wellington 6140 **Email:** SNZPublicComments@mbie.govt.nz	**From**: Simon Wallace, Chief Executive New Zealand Aged Care Association PO Box 12481 Wellington 6144	
	Closing date for comment **13 January 2021**	Date of your comments **12 January 2021**
DZ 8134 **Committee:** P8134 *Health and disability services* **Title:** *Health and disability services standard*		

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General comment

Type your general comments in the box. The comment box will automatically expand to accommodate comments of any length.

The New Zealand Aged Care Association (NZACA) appreciates the opportunity to comment on the Health and Disability Services Standards Review 8134. At various stages through the process of the Review, the NZACA, its Nursing Leadership Group (NLG) and its members have had the opportunity to provide input to inform the work being led by the Ministry of Health (MOH) and Standards New Zealand.

The Association understands a review of the Health and Disability Services Standards was necessary, given it has been more than a decade since the Standards were previously updated. At the same time amalgamating three standards into one is sensible and over time, will lead to less duplication. However, at an overall level, the NZACA is concerned that the revised Standards in their present form will have an adverse impact on our membership who represent over 36,000 beds of the country's rest home industry, or about 91% of the total supply.

The Standards are aspirational which is laudable, but there comes a point where aspiration needs to give way to reality when funding is capped as it is in the ARC sector and many other parts of the health system. Setting an aspiration in a standard that cannot be met because of funding constraints is counter-productive to both providers and their patients/residents.

ARC providers are committed to the principles of Te Tiriti and by and large do their best to commit to these principles, as evidenced in the body of the submission that follows. However, some of the requirements that plan to be introduced would be onerous, costly, and indeed impractical at the coalface in an ARC facility. The sector would require solid resource, support, guidance, and funding in order to meaningfully implement the requirements.

There are other aspects of the Standards that also raise concerns for the NZACA membership, and these have been identified in the submission. They include the cost of compliance as well as transition times to make the changes that are being proposed - many smaller ARC facilities will struggle with these changes and therefore their ability to meet the new Standards. Some requirements around governance do not reflect the diverse ownership nature of providers in the sector and these will need to be changed.

Going forward, we see an opportunity for both the Association and the NLG to work with the MOH and Standards New Zealand on sector solutions for ARC providers that could also be used by the designated auditing agencies.

In the submission that follows, we have provided comment specific to clauses across the six main parts of the Review:

Part 1 – Our Rights
Part 2 – Healthcare and support workers and structure
Part 3 – Pathways to Wellbeing
Part 4 – Person-centred and safe environment
Part 5 – Infection prevention and antimicrobial stewardship
Part 6 – Restraint and Seclusion.

Thank you for the opportunity to comment and we look forward to working with you on refining these Standards.

Simon Wallace
Chief Executive, New Zealand Aged Care Association (NZACA)

Dr Frances Hughes
Chair, Nursing Leadership Group

Specific comment

Insert the number of the clause, paragraph or figure. Do not preface the number with words (that is, '1' not 'clause 1'). If there is no clause number, use the section heading (such as Preface). Insert the page, paragraph, and line number as appropriate. Use a new row for each comment.

The rows will automatically expand to accommodate comments of any length. Remove unused rows, or insert additional rows as required. To insert extra rows at the end of the table, go to the last cell and press the TAB key.

Clause/ Para/ Figure/ Table No.	**Page No.**		**Recommended changes and reason** *Exact wording of recommended changes should be given*
1.1.1	45		Suggest remove "whatever they are" from the Standard. Our role as an aged residential care (ARC) provider is focused on enhancing wellbeing. Suggest remove "annual" from proposed Sector solutions. Annual plans apply more to government than to the private and not-for-profit sectors who have a range of plans and different reporting requirements. This fits within the context of a Māori Health Plan (which could require health equity indicators).
1.1.2	46		Suggest rephrasing or removing "My service provider shall ensure cultural safety is part of the whole concept of safety." As worded this Standard is a philosophical construct. Perhaps it means to say "cultural safety is embedded in the approach to safety" but this is still abstract and unclear.
1.1.3	46		It is conceivable that some providers in some places will not have Māori health staff due to the demographics of that location.
1.1.5	46		Suggest rewording to "there is evidence of review of workforce practice through a health equity and quality lens." A review "by the whole workforce" of their practice may be neither practicable nor useful to facilitate equity approaches. "Self-review" requires definition and may not be the best phrase.
1.2.1	48		Suggest rephrasing "their worldviews are embraced" to are "supported." The workforce must respect and support diverse cultural values, but not embrace these values as their own. We note that Pacific people with specific language needs are more likely to be concentrated in parts of the country. Whilst is it important to have written materials available in different Pacific languages, it is inappropriate to display material in multiple languages not used by residents.
1.2.2	49		Suggest replacing the word "efficient" with the word "effective." We note that "alignment with Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025" would require the delivery of cultural safety training (see page 27 Focus Area Workforce). If that is intended, then this should be clearly specified here. We further note that many of the documents referred to here and elsewhere in these Draft Standards are public sector focused documents which were not developed with the ARC context specifically in scope and so are not necessarily fit for this purpose.

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1.2.3	50		The Standard does not articulate what these Pacific models of care are nor provide a specific reference to such models. Further, Ola Manuia does not provide specific models of care, nor provide reference to such in the references and bibliography. A "Pacific plan" would likely be similar to the Māori Health Plan. Multiple plans are a public sector approach to quality improvement with multiple Ministerial reporting accountabilities. Providers may be more inclined to have a cultural safety policy and/or plan that takes specific account of Pacific peoples.
1.2.4	51		Suggest removing the word "holistic" or include clarification of what a "holistic" workforce means. We note that it is not practicable for all providers to employ leadership or training roles according to ethnicity.
1.2.5	52		We note that the ARC industry receives no funding to support these partnership activities, unlike the public sector where there are dedicated budgets for these activities. Proposed Sector Solutions risk conflating the responsibilities of individual providers with those of the District Heath Board funders. The sector solutions indicate some degree of 'scope creep'. If the ARC industry is to be assessed against a wider scope of activities, then that must be reflected in the national Age-Related Residential Care (ARRC) Services Agreement with District Health Boards. We note that *interRAI* does not have sub-categories of Pacific peoples.
1.3.1	54		We note that induction and education about the legal framework regarding rights would apply to all care staff. We further note that the End-of-Life Choice Act has not been included in the Sector Solutions legal framework list. Last, the workforce operates under a national qualifications framework and it is a matter for the qualifications authority and training providers to assess that students have achieved a baseline of knowledge and understanding.
1.3.3	56		We note that ARC is not a preferred setting for 'young people with disabilities' (YPD) (aged under 65).
1.3.4	57		Whilst ARC providers may provide support persons for YPD (under 65s) in accessing external services and activity programmes, we are not contracted to provide a support person of their choice. ARC providers do not employ trained advocates to support YPD.
1.4.4	65		These activities are beyond the scope of what ARC providers are contracted or funded to provide.
1.5.5	74		Abolishing is not the correct word in this context. Suggest "removing" is better.

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1.8.3	94		NZACA believes that the HDC needs to be better resourced to process complaints in a more appropriate timeframe.
2.1.1	102		These are too prescriptive and should not be in Standards. The makeup of governance bodies is the decision for those bodies themselves. Requirements around governance do not reflect the diverse ownership nature of providers in the ARC sector and a one size fits all solution will not work.
2.1.5	104		The Standard to improve outcomes that achieve equity for Māori does not line up neatly with the proposed Sector solution to refer to Ministry of Health and government strategic documents in planning documents. The Sector solutions are outlined in 1.1 above and what is relevant at a governance level.
2.1.7	105		The Standard lacks specificity. Does it mean to state "to address barriers to *equitable* service delivery?" The proposed Service solutions focus on equity.
2.1.9	106		The Standard is problematic as it fails to account for complex organisations with multiple accountabilities and services beyond the provision of services covered by these Health & Disability Standards. It is beyond the scope of these Standards to specify that "Governance bodies shall have meaningful Māori representation on all organisational (governing) boards." Suggest removing the word "all" or replacing with "relevant."
2.2.1	109		Suggest rewording to "evaluate progress against quality *outcomes.*"
2.2.4	111		Assume the "Framework" and the "Plan" are in fact integral not separate parts of a documented quality improvement and risk assessment process. There is a tendency with the draft Standards for a proliferation of separate plans when there could be just one overall plan.
2.2.5	112		Sector solutions are overly lengthy and do not all relate directly to the Standard. Suggest "to reduce preventable harm by supporting systems learnings" fits better under Sector solutions.
2.2.7	115		This Standard appears to be a repetition of what is outlined in 1.1.

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2.3.1	117		Suggest replacing “rationale” with “process”.
2.3.2	119		Note that Sections 9 to 20 and Schedule 2 of the Care and Support Workers (Pay Equity) Settlement Act 2017 are repealed on 1 July 2022.
2.3.3	120		We note that our residents speak a wide range of languages.
2.3.6	124		The proposed Service solutions appear to be overly aspirational. For example, suggest “support the development of expertise in te reo Māori for all staff” could read “Support all staff in the development of te reo Māori.” Of course, it is not necessary to have te reo expertise to share or understand Māori health information. Expertise in te reo is beyond the scope of generalist ARC providers. We note that for a significant proportion of our staff the main initial aim is to develop their expertise in English as it is their second language.
2.4.1	126		The proposed Service solution “Interview panels include Māori representation (across all roles)” is impractical and does not directly relate to the Standard. It is desirable, but not possible in many parts of the country to have a suitably qualified and knowledgeable individual present at interviews. It is more correct to require that an assessment of cultural competency be part of the interview process. We note that health care and support workers are not unregulated, they are unregistered. They are however regulated, including by these Standards. Therefore, the use of the term “unregulated” to describe the Kaiāwhina workforce is objectionable.
3.1.4	145		“Warm handover” needs a definition. Not common language in ARC.
3.1.5	145		It is unclear if this criterion is only required for Māori. Suggest it could read “Service providers demonstrate routine analysis to show entry and declines rates. This must include specific data for entry and decline rates for Māori.”
3.1.6	146		Increasing requirements regarding Tikanga Māori is supported in principle, however ARC providers complying to these prescriptive requirements will be difficult without access to appropriately trained and approved people and/or resources.
3.2.6	158		“Remove barriers that prevent tangata whaikaha and their whanau of choice from independently accessing information”, clarification is required on the intent of this criterion.

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3.2.7	158		Given the te reo throughout this document, a glossary needs to be included to ensure consistent translation / interpretation of the intended outcome is understood.
3.3.4	162		This is interpreted as being relevant for both Māori residents and Māori staff. Is this intended to be over and above the current leave provision? Will the MOH be partnering with other agencies e.g., Te Puni Kōkiri to set training resources and opportunities for ARC to access? There will be great support and partnership required to meet the goals of these Standards.
3.4.1	165		"Service providers demonstrate a holistic approach to understanding a person's needs without making assumptions, such as for gender and sex characteristics", what is the issue this is intended to solve, and evidenced how?
3.4.5	169		Suggest rewording to "Based on prescriber instructions, service providers shall provide ongoing support for people's understanding of their medicines."
3.5.2	176		We have concerns over how the point "Service providers encourage people receiving services and, where appropriate, their whanau to be involved in food preparation" may be interpreted. It is not appropriate for family/whanau or residents to decide if/when they be involved in the activities mentioned. There are IPC and Health and Safety factors to consider and risks to mitigate. Providers must ensure any activities are in line with MPI controlled food plans and evidence compliance. This could prove challenging for bigger sites and those who have contracted services provide their meal.
3.5.7	179		The ARC sector would require support to ensure compliance is possible and can be evidenced. Providers attempt to do this, but often run counter to the food safety standards and infection control requirements. Funding, resource, and guidance from MOH would be required.
4.1.1	195		(g) equipment is calibrated and checked before use - Is there an expectation that seated scales or sphygmomanometers for example will be calibrated and checked before each use? That is not practical or necessary. Should be initial use then annually, or more frequently if there is an indication of an incorrect reading based on previous or expected readings. The layout and design of an ARC facility is restricted by cost and the existing physical layout of a building. Training in the use of medical equipment is to be conducted by "suitably qualified personnel". This is open to interpretation and appears to exclude peer training or "train the trainer" type education.

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			We do not see it appropriate that, “People receiving services, specialists, Māori and other key stakeholders” be consulted when selecting furniture and equipment. These are clinical and commercial decisions made by the provider.
4.1.3.	199		Suggest removing (d). While ARC providers do consider their residents and stakeholders when developing/refurbishing, this is not a practical requirement to meet. We note that handrails inside the building are already covered in the building regulations (code).
4.1.4	201		Suggest removing point regarding lighting across different spaces, this is a clinical matter and should not be determined by auditors. Service providers adhering to contractual requirements is a given and does not need to be stated within these Standards. The requirement to comply with other related legislation and contractual requirements used to be included in the standards pre-amble and not specified in a range of different areas.
4.1.4	201		Life Mark standards implementation has cost implications – who is funding these and which one(s) will be enforced through audit? This is going beyond the scope of a safety-based standard. The points around renovating have been duplicated and could be one point.
4.1.5	202		The ability of the provider to offer these facilities and their specific location is constrained by funding.
4.1.6	202		Mobility aids could be deemed to include electric scooters. These should be exempted and noted as transport rather than mobility. These cause a number of issues for ARC providers currently with damage to buildings/property.
4.1.8 and 4.1.9	203		These criteria will not feasible for all providers in the capped funding environment in which ARC operates.
4.2.5	207		There will be difficulty in monitoring call system response time with legacy systems that do not have automated monitoring. There are still a lot of older manual systems in smaller facilities. How is this going to be measured and what evidence will be required to be deemed compliant?
5.1.5	211		It is not entirely clear what this Standard means by the term “health literacy” or to whom that is directed – staff, residents, or visitors.

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5.2.4	214		We note that in the event of a pandemic such as COVID-19 there may be an international and national shortage of PPE. Supply in these circumstances depends to a large part upon the DHBs and the MOH.
5.2.6	215		We note that visitors should be included in this Standard as they are a significant vector of infections.
5.2.9	216		The Māori health agency or another suitable body may provide this for all ARC providers.
5.4.1	222		We note that this Standard applies to prescribers.
5.4.2	223		We note that this standard is out of scope for ARC providers and more the province of public health authorities and DHBs.
5.5.8	228		We note that the proposed Sector solution for critical equipment track and trace to the person receiving service is not practicable in ARC and would require significant additional and unnecessary recording.
6.1.1	230		We note the presumption that restraint is used. In ARC restraint is rare. Restraint is likely to be environmental, for example by the locking of doors so that people with severe dementia are kept safely in the facility.
6.1.3	231		Suggest rewording the Standard to “restraint minimisation and elimination is *maintained*”.
6.1.4	232		The Standard mistakenly presupposes that there will be aggregated data to report.

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6.1.5	233		There is not a need for “a restraint monitoring committee” in ARC.
6.1.8	237		For ARC this is fully covered by 6.2.3.
6.2.3	242		Suggest the Standard be shortened to “Each episode of restraint shall be documented in people’s records in sufficient detail to provide an accurate rationale for use, intervention, duration, and outcome of the restraint” with the rest of the text moved to the Service solution.
6.2.6	244		Suggest the Standard be shortened to “Each episode of restraint shall be evaluated” with the rest of the text moved to the Service solution.
6.3.1	248		Suggest the Standard be shortened to “Service providers shall conduct comprehensive reviews at least six monthly of all restraint practices used by the service” with the rest of the text moved to the Service solution.

END.