New Zealand Nurses Organisation

Submission to the Department of Labour and Standards New Zealand

On the

Home and Community Support Sector Standard, Draft Number: DZ 8158

November 4, 2011

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ABOUT NZNO

The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 45 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is "Freed to care, Proud to nurse". Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

RECOMMENDED CHANGES TO DRAFT STANDARD

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the draft Home and community support sector Standard, DZ 8158.
2. NZNO has consulted its members, staff and specialist Colleges and Sections in the preparation of this submission. Our feedback is informed in particular by responses from the New Zealand College of Primary Health Care Nurses, which encompasses a large number of nurses and allied health workers, including health care assistants, working across all home and community health settings, the Gerontology Section, the Enrolled Nurse Section, the Aged Care and Primary Health Sector Groups, Te Runanga, and NZNO's professional nursing, industrial, policy, and research advisers. (Incidentally health care assistants –HCA- is the term NZNO members in this category like to use, to differentiate themselves from unpaid carers.)
3. In general NZNO **supports** this necessary document and recommends that you have due regard for the following comments.
4. NZNO fully supports the NZNO Enrolled Nurse Section's submission and recommendations that:
    - the Home and Community Support Sector Standard be a mandatory document for all organisations that provide services to consumers with in the community and the residential care setting;
    - safe staffing/healthy workplace practises are introduced into all residential facilities and home support services, and are made mandatory;
    - having regard for the devolution of more services into the community as per the government's health policy of "Better sooner more convenient", appropriate skill mixes are utilised of Nurse Practitioner, Registered Nurse, Enrolled Nurse and HCA roles to provide care to people with

chronic health conditions, palliative care, gerontology care, long term disabilities care;

- that ongoing professional development is available for the regulated workforce and appropriate ongoing education for the unregulated workforce in this sector;

- Face to face Registered and Enrolled Nurse initial assessment is essential with ongoing re-assessment by Registered and Enrolled Nurses.

5. The Enrolled Nurse Section submission is appended to this document.
6. NZNO is pleased to see attention being given to addressing consistent standards for the home and community support sector, but is concerned that the role of registered health professionals (HPs) and their interface with the sector is not explicit in this document, the implication being that the service provider will be responsible for making decisions as to the level of health care provided. Such knowledge cannot be assumed as is evident from the private provision of residential aged care where clinical input and surveillance is by no means guaranteed.
7. NZNO's recommendation is that there is a clear requirement for assessment and periodic checks by a registered health practitioner, who should be also be available to advise, to ensure the right care is given at the right time by the right person. These include Registered and Enrolled Nurses, and members of other health professions regulated under the Health Practitioners Competence Assurance Act 2003. If someone needs home support, they need expert assessment initially; those employed as HCAs should be working under the direction of qualified health worker and should always be able to refer to one.
8. Graphic representation - through flow charts for example - which illustrate the 'chain of command' and associated responsibility, would greatly assist. This would also clarify at what point clinical care and responsibility is assumed. We note, for instance, that there is an increasing tendency not only to rely on 'natural' providers i.e. families but also to use HCAs to provide rehabilitation which requires expert input - a lot of damage can be done with inappropriate activity, while without proper care recovery can be delayed and suboptimal. It is not fair to expect untrained HCAs, however skilled, to undertake professional work by default, or to give them the responsibility for knowing when medical referral is appropriate. HCAs must be supported by safe clinical supervision and sound training. NZNO refers you to our position statements on unregulated HCAs and a framework for unregulated HCA education.
9. We also note that there is no reference to appropriate or adequate staffing and we question whether it is possible to commit to "continuous quality improvement" when no guidance is given to the most important aspect of service delivery i.e. having enough people with the right training and skills to meet the work demand. NZ Standards must be aware of the significant problems in the aged care sector where the lack of specific requirements for staffing has resulted in highly unsafe care, high staff turnover, overwork, low wages and low morale. That has not been a recipe for safe quality care and there is even higher risk in the home and community sector if the same lack of provision for safe, fair working conditions prevails. Continuous quality improvement can only be assured with continuous safe staffing and healthy work practices. "Updating policies and procedures " is rarely an effective way of assuring safety as indicated in Dr Mary Seddon's Review: *Safety of Patients in New Zealand Hospitals: A Progress Report*, published in October 2007 by the Health and Disability Commissioner. She noted that hospitals were overflowing with documented policies and procedures but they did not influence what was happening on the hospital floor which was directly affected by staffing. We strongly recommend that safe staffing guidelines, safety provisions around workloads are developed. It is important to note that current demographics which show an aging population which is healthier for longer, but which requires more acute care on entry to a residential facility or hospital indicates that home and community care must be able to accommodate older, sicker people requiring more care.

10. A similar situation exists in terms of respite facilities in the community for families who have a chronically unwell or disabled child as noted by one member who writes: *The complex health requirements that some children and young people have can require 24/7 care which creates enormous pressure within the family. This high level of dependency can consist of medical, educational, developmental and behavioural needs and is generally ongoing, generating increasing stress within the family unit. Respite care alleviates this stress and supports the family to stay together. Support in the form of a carer in the home comes with the impact of having an additional person in your home and often in order to get a longer break, families leave their homes for a night or two while the child/young person stays at home with the carer. This in itself has difficulties and costs associated with it. Finding a carer that is willing and has the necessary skills and knowledge to care for a child/young person with high needs in the carer's home, and has the home equipped to do so, is a challenge. The availability of respite facilities is also a challenge. There is a real need for facilities in the community with trained staff to be available to provide respite care for these children and young people. The type of tasks required to be undertaken by carers is becoming more complex with a higher degree of expertise and responsibility. Training and support for these carers must be at a high level to protect both the staff and the child/young person*.

11. Acuity is a key indicator for the level of labour input needed - higher acuity requires more care, yet this, as with skill mix, or being responsive to inevitable changes is not part of these standards. These critical aspects of home and community care must be factored in to the standards particularly as more care is devolved into these settings. In this context, we draw your attention to the work of the Safe Staffing Healthy Workplaces Unit which is developing appropriate tools and protocols around staffing in several health settings.

12. NZNO notes and applauds recognition of the need for cultural competence. We would also like to recommend that service organizations be culturally competent and undertake to provide safe environments for their staff, particularly as this sector often attracts people from other countries, some of whose qualifications are not recognised in Aotearoa New Zealand. It is difficult to protect such workers - and NZNO has many overseas trained nurses in this category - from exploitative and discriminatory practices as they are often not aware of rights and regulations, and similarly it is possible for them to unwittingly offend New Zealanders sensibilities. Service providers should be required to ensure safe, non discriminatory work environments including education where appropriate.

13. NZNO would be very happy to discuss any aspect of the standards and can provide the professional experience and advice.

(Specific clause related comments are noted below)

SPECIFIC COMMENT

Insert the number of the clause, paragraph or figure. Do not preface the number with words (i.e. 1 not clause 1). If there is no clause number, use the section heading (e.g. 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*
0.1.2	11		Exclusions. Add registered health care professionals and define those who are pivotal to providing home and community support including GOs, nurses, district nursing services, physiotherapy etc. The relationship to and interface between registered health practitioners is pivotal in terms of the quality and safety of care. We question whether it is possible to exclude registered HPs altogether when initial assessment and ongoing monitoring of medication management, infection control etc *is* ultimately their responsibility under the health practitioners Competence Assurance Act 2003.
0.4	13		Definitions The use of 'service provider' in relation to 'organisation' is very confusing in this document. These two words are often used interchangeably but not to mean the PERSON delivering the care. The organisation is a service provider as an individual self-employed person can also be. The original 'funder/provider' split in 1991 was referring to the organisation managing and responsible for employing various health professionals and unlicensed workers who delivered the care/service. However the people delivering the care or service have their own titles and designations such as 'support worker' or 'Health care assistant' or 'registered nurse' or 'occupational therapist'. These terms should be used rather than the generic 'service provider'. Using this generic, global term and failing to differentiate between registered/licensed and unregistered/unlicensed staff serves to place all people delivering care in the same category which they are not. Responsibilities and accountabilities and scopes of these two groups differ and the document should reflect this. Unlicensed staff work under the direction, delegation and supervision of licensed health care professionals and this must be made clear also. Otherwise the document seems to imply that roles are as interchangeable as language, which they are not. Roles are clearly defined. The 'NOTE' on p.11 is clear about terminologies and relationships and should be emphasised at the beginning of the document.
1.1	p.15		Standard 1.1 should read: "Consumers receive services in accordance with their rights as outlined in relevant legislation
G1.1.1(a)	p.15		Be clear about which 'code' is being referred to. This can be done by adding 1996 after 'The Code'

Clause/ Para/ Figure/ Table No	Page No		Recommended Changes and Reason *Exact wording of recommended changes should be given*
G 1.1.2			Service providers may need to facilitate access to an interpreter on behalf of the consumer
G 1.1.7			"The service provider"...
G 1.4.5 c)	18		Commentary provided by the person delivering the care should surely be in a consumer file, rather than a timesheet?
Standard 2.2			Continuous quality improvement can only be assured with continuous safe staffing and healthy work practices. Reference needs to be made to ensuring there is an adequate number and skill mix of staff to meet demand and that they are appropriately trained.
G 2.6.2 b)	23		Codes of conduct, codes of ethics, and standards of practice are all different things. However, a code of conduct could be incorporated with an ethical code to ensure that those delivering the service/care are practising and conducting their behaviour in an ethical manner.
G 3.2.3 c)	27		Add/Should read at the end of this sentence: "i.e. registered health professionals"
G 3.2.7	28		Add d) Current Practising certificate. We suggest that ongoing training and education is an essential obligation and not something that "may" be provided.
4.4.1	30		Insert nurses
4.6.1	31		At the beginning of this section there should be a paragraph stating that the service plan must be led by a registered health professional. The health professional has overall responsibility for the development, monitoring and evaluation of the service plan which is written in conjunction with the consumer, the consumer's family/whānau and support workers and other relevant staff and other organisations if applicable.

Clause/ Para/ Figure/ Table No	Page No		Recommended Changes and Reason *Exact wording of recommended changes should be given*
G 4.7.2	33		Add at end of sentence: "...including education on administering medication for unlicensed support workers.
4.11.2			Re skin integrity: It is unclear if this document is suggesting providers most supply pressure relieving equipment and this needs clarifying.

Please note NZNO nurses all the points made in the Enrolled Nurse Section submission which is Appended overleaf.

Thank you for this opportunity to contribute to the dvelopment of this document. Please be advise that NZNO would be happy to discuss this further if required.

Marilyn Head
Policy Analyst

APPENDIX 1: ENROLLED NURSE SECTION SUBMISSION
0.1 SCOPE- PAGE 11

This Standard covers home and community support services provided in a person's home or in their community. It applies to organisations contracted to provide home and community support and service providers. People choosing to purchase their support from non-contracted organisations may also require the service providers they employ to comply with the Standard. The parts of the Standard that apply will vary according to the person, service being provided, and the context within which the support is delivered.

The populations covered by this Standard include people of any age who are receiving:

(a) Long-term support (such as people with disabilities, people with chronic health conditions, or frail older people);
(b) Short-term support (such as people recently discharged from hospital or referred by a primary healthcare provider);
(c) Palliative care.

NOTE – Where registered health professionals choose to work as support workers they are still required to comply with the responsibilities and accountabilities defined by their registration/enrolment board.

As the above statement "people choosing to purchase their support from non-contracted organisations may also require the service providers they employ to comply with the standard" . Complying with the standard should be <u>mandatory</u> for all service providers contracted and not just those purchasing from their preferred provider.

People with chronic health conditions and requiring palliative care should have the services provided to them monitored by a registered health professional and good reporting systems should be available to the person providing the support. A requirement should be that a Registered Nurse (RN) or an Enrolled Nurse (EN) does the initial assessment face to face, rather than over the telephone. We do not believe that assessments by telephone provide the real needs of the person who may require home care, for example how can you assess a client's skin integrity or a client's respiratory status over the telephone.

Follow-up face to face assessments by a Registered and Enrolled nurses are also essential. In this way the client receiving services can honestly report if the support worker is providing the care prescribed. During this process the RN and EN can assess the client's health status and if any other services are required.

Enrolled Nurses who work as Needs Assessment Service Co-ordinators (NASC) are qualified to assess clients once they completed the InteRAI assessment tools workbook and have completed a specific number of assessments.

INDIVIDUAL VALUES AND BELIEFS RESPECTED

Standard 1.3
G1.3.2 We suggest adding in the following as it is not mentioned and we see it as an important issue:

(d) Training and education is given to service providers

RECOGNITION OF MAORI VALUES AND BELIEFS

G 1.4.4 Suggest add into this:

(f) recognising alternative health/healing practices that acknowledge consumer's traditional Maori healing practices.

Also there is no mention in this document of the key Ministry of Health Maori Health He Korowai Oranga: Māori Health Strategy.

"He Korowai Oranga: Māori Health Strategy sets the direction for Māori health development in the health and disability sector. The strategy provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of whānau.

The overall aim of He Korowai Oranga is whānau ora - Māori families supported to achieve their maximum health and wellbeing."

This should be included in these standards.

G 1.4.4 (a) training of service providers – this should also include training in the Treaty of Waitangi and its associated documents.

ORIENTATION, INDUCTION, ONGOING DEVELOPMENT, AND PERFORMANCE

Standard 3.2

Agree with everything as listed in standard 3.2 as we believe that everyone is entitled to:

- a good orientation to the organisation they are going to work for.
- Access to appropriate ongoing education appropriate to their job description , scope of practice (if a regulated health professional) and that there is a professional development

plan for the regulated health professional so they are being supported in their ongoing professional development.

HEALTH AND SAFETY

Standard 3.3 - We support this standard as we believe that consumers and service providers are entitled to services that promote health and safety. Regular auditing of hazards and good documentation are essential by the organisations providing he services to the consumer either in the community or the residential facility. We see the continuation of DHB spot audits as an essential tool to ensuring that not only health and safety is monitored but all care and services provided to the consumer by organisations.

This standard should be compulsory.

4 SERVICE DELIVERY

SERVICE AGREEMENT

Standard 4.1

G 4.1.1 We suggest that an extra point is included in here –

"that the written service agreement with the organisation providing services is explained to the client face to face, and if necessary with family members".

This will assist with confusion over the services that are to be provided by the client and family.

SERVICE DELIVERY PLANNING

Standard 4.5 – Suggest changing this standard to read as follows:

"Consumers will have an individual service plan that describes their goal, support needs and requirements. This will reflect an individual face to face assessment, identification, and management of any risks in service provision"

G 4.5.2
(a) suggest change to the following:
"the consumer and where appropriate, their family/whanau, will meet with the organisation to have input into the development of the plan"

It should be compulsory for the client to have input into developing their own plan, after all they are the one who is to receive the service.

IMPLEMENTATION OF SERVICE PLAN

Standard 4.6 .1
(b) suggest adding in the following:

(b) clearly recognise and understand their job description, scope of practice if regulated health professionals (unqualified support workers do not have a scope of practice they have job descriptions).

G 4.6.1 (a) suggest change to the following:

(c) service providers having access to position descriptions, policies, and training that ensures they understand their job description or scope of practice for regulated health professionals.

MEDICATION MANAGEMENT

Standard 4.7

G 4.7.2 (a) We suggest the following for;

(a) Service providers operating within their scope of practice, competency as a regulated health professional and within their job description as an unregulated worker.

G 4.7.4 (C) we suggest the following:

(c) Adequate and appropriate supervision is provided by a regulated health professional

SKIN INTEGRITY

Standard 4.11 Consumer's skin integrity is maintained
G.4.11. 2 we suggest the following be added to this

Service providers implement preventive measures to promote skin integrity utilising evidence based assessment tools.

We suggest that evidence based assessment tools for skin integrity are included in this section on skin integrity. The elderly, especially when they are unwell, are susceptible to the development of pressure ulcers. There is extensive empirical evidence that if pressure ulcer risk

assessments are undertaken by the health professional and the identified areas of risk are addressed with evidenced based practice interventions then pressure ulcers should not develop. Prevention interventions should include: good assessment, repositioning, keeping the heels floating, suitable support surfaces, good skin care, attention to good nutrition and hydration, and staff education.

There should be appropriate care plans developed for the patient by a qualified health professional with daily or more frequently reviews of a patient/consumer's skin integrity. Education and training should be able to be assessed by regulated health professionals to continually update their knowledge and skills in regards to management and care of patient's skin integrity whether it is in the community or the aged care residential facility.

CONCLUSION

The National Enrolled nurse Section would like to see the following;

- The Home and Community Support Sector Standard as a mandatory document for all organisations that provide services to consumers with in the community and the residential care setting.

- That it be a mandatory requirement that safe staffing healthy workplaces is introduced into all residential care facilities.

- That appropriate skill mixes are utilised of NP, RN, EN and HCA and that ongoing professional development is available for the regulated workforce and appropriate ongoing education for the unregulated workforce.

- With more health care of New Zealand's population being directed to the community due to the present government's health policy of "Better sooner more convenient " .The right skill mix of NP, RN and EN to provide care to people with chronic health conditions, palliative care, the frail elderly, people with long term disabilities is essential.

- Face to face Registered and Enrolled Nurse initial assessment is essential with ongoing re-assessment by Registered and Enrolled Nurses.

We thank you for the opportunity to comment on this standard.

Robyn Hewlett
Chairperson
NZNO National Enrolled Nurse Section

REFERENCES:

InteRAI is an assessment and care planning tool which is being implemented in every DHB in New Zealand. http://www.interai-au.org www.ithealthboard.health.nz

Better, Sooner, More Convenient, Health policy, New Zealand government Health Policy, 2009 enacted by the Ministry of Health..