Recommended changes to draft standard

To: Standards New Zealand PO Box 1473 Wellington 6140 **Email:** SNZPublicComments@mbie.govt.nz	**From**: (Your name and address) Sue Gasquoine 11 Blake Str Ponsonby Auckland 1150 Email: sue.gasquoine@nzno.org.nz	
	Closing date for comment **13 January 2020**	Date of your comments 13/1/21
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 Nurses Organisation (NZNO) represents more than 50,000 Registered Nurses, Enrolled Nurses and healthcare workers most of whom work in the health and disability sector and on whom the sector relies for meeting any standards that are set. This submission is informed by members who work with care recipients of the health and disability services to which these draft standards would apply and on which NZNO members have been consulted. Some of the feedback from members addresses the detail and practicalities of the proposed standards and is used to support this submission. Members of the College of Child Health and Youth Nurses and the College of Gerontology Nursing have provided detailed feedback along with the Aged Care Sector Group delegates.

NZNO supports implementation of a set of standards that are sufficiently detailed to support service users, service providers and people working within services to expect a nationwide standard that is achievable and enforceable.

Many changes have occurred in the health and disability sector over the 17 years since the voluntary requirements for minimum staffing were established. The growth of need in the aged care sector for comprehensive palliative care is the most significant example along with the increased acuity of residents with significant co-morbidities requiring more complex nursing care.

'The problem in aged care now is that residents are coming through the door requiring complex care. Palliative residents deserve and require to be made as comfortable and pain-free as possible, their body language speaks for them when they no longer can. It's about assessing, implementing an evaluating them throughout this journey.' (RN)

This and other 'shifts' in the health and disability sector are predicted as the population ages, the impact of a global pandemic continue and the health workforces ability to adapt to new challenges is compromised by underfunding.

NZNO members would like their concerns about the timing of the standards consultation and feedback process noted. The aged and disability care sectors have experienced the greatest impact from the events of 2020 so the timing of the feedback on the draft standards over the festive season seems unrealistic. The standards, and the mandatory nature of many of them, have the potential to significantly improve the care and work environment for both care recipients and workers in aged and disability care and so incorporation of feedback from the workers who deliver that care to the standards is what will mean the standards are meaningful and effective.

Tōpūtanga Tapuhi Kaitiaki o Aotearoa (NZNO) uses an equity framework and the Ministry of Health definition of equity when making submissions. NZNOs framework asks:

- how Māori are represented,
- how organisational culture supports Māori values
- how unintended consequences will be managed and
- who will benefit from a proposal

The draft standards, specifically Part 1, Section 1 Pae Ora Healthy Futures present appropriate priorities for the standards and the comprehensive list of terms including, te reo Māori terms, and their definitions will be useful for users of the standards

One for the significant challenges for the health and disability sector into the future is meeting the needs of increasingly diverse care recipients.

'To meet the standards, of our changing clients and their health needs - they are a lot more challenging than in the past which means more time and care but no time to do that care to the standard ...the health funding needs to be in line with this but it also needs to state the safe number of staff this requires at the moment it's not how much ***care*** *is needed but how many residents are in a care home'*

Conclusion

Member feedback, a small sample of which is shared below, captures the urgency of the need for a comprehensive set of standards for health and disability services. NZNO members welcome a methodology to underpin their ability to raise issues about equitable access to safe care and care quality both of which depend in large part on nursing expertise, adequate staffing levels and commitment of resource with funding decisions based on the changing (increasing) care needs of service users.

'I am a RN with a Masters degree and almost 30 years experience as a nurse with 17 years of specialist palliative care experience. I recently left my role as a Care Home Manager as despite the fact that I am passionate about aged care and palliative care in the residential aged care setting, it was impossible to ensure the provision of quality care due to constant staff shortages and high RN turnover and I constantly felt as the most senior RN on site, that my practicing certificate was on the line. I think that minimum staff to resident ratios are imperative to provide for the ever increasing complexity of patients, many of whom die within months of admission. I was so sad to leave the aged care environment and whenever I am tempted to return to this sector, I remind myself that no matter how much I try and how hard I work, in the current situation in the ARC environment, I will never be able to provide the level of care and service that is required to ensure the safe and effective care we should be providing to our ageing population.'

'*I have worked in aged care for 5 years. I have seen the negative impact on our elderly when staffing levels are low … a colleague and I worked a morning shift, 2 of us and 28 residents! Having to wait for the toilet, soiling yourself, no dignity. Falls because there's no one to 'watch the floor' leading to injuries, possible infections and possibly death! Bells ringing for assistance, not be able answer promptly. Our elderly have contributed to our community in many ways, let's give them their dignity and the respect they deserve*.'

'I'm an RN in an ARC facility and i am often left in charge of 40 residents and staff members often i am left with a skeleton crew consisting of 1 RN (myself) and normal 2-3 staff members and thats it. We have 30+ hospital level patients and we are all often left exhausted, burnt out and it becomes unsafe when doing this all the time. Something needs to change now for the safety of the residents and all the staff member involved!'

'I think if the MoH is serious about supporting a strategy that provides consistent quality & person centred care, then they will make safe staffing levels mandatory. This will ensure residents do get the attention they deserve, the time will not be task focused but person focused, proper health outcome and goals can be improved.'

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* *NZNOs proposed changes to wording is in* ***bold, italicised and underlined***
1.3.1	54		Include specific mention of consent and competence in ***children*** – Gillick competence rule/test
1.5.2	70		• Family violence screening should include specific mention of ***'intimate partner violence'*** – for some service users abuse may be occurring within the family *and* their relationship • *Elder abuse,* ***neglect/****violence screening is undertaken*
1.7.5	82		Written consent is required in some in clinical situations eg insertion of contraceptive devices. The draft standards don't specify written consent. Verbal consent that is documented may be necessary in some situations.
2.1.3	104		Include – ***'Managers appointed in aged care shall be experienced registered nurses.'***
2.1.4	104		This standard needs to be strengthened to reflect the responsibility of PCBU governance to provide a safe workplace for employees including a commitment *of resource* to minimise and mitigate the impact of abuse, threats and violence on workers and service users.
2.2.1	109		*'the executive team or clinical quality governance group (include)* ***includes a registered nurse in aged care*** *and assures and reports progress to the governance body'*
2.3.1	117		Add a bullet – ***'service providers will engage with residents and their whānau when proposing changes to the number and qualifications of staff.'***

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2.4.2	129		Service providers ensure there is: ***(a) as a minimum, at least one RN on duty at all times and the distribution of care staff over a 24 hour period shall be in accordance with the needs of residents as determined by an RN*** **NB**: Residents not eligible for care in ARC facilities are being placed there with agreement by facility managers, and resourced by separate funding sources, however the staffing is not adjusted (strengthened) to accommodate meeting those residents' additional and specific needs. Such residents include those aged under 65 years with physical and other disabilities, who have needs that can be quite different from ARC rest home residents. NZNO is aware of a recent MOH decision to allow the retention of a hospital level care resident in the rest homes of ARC facilities, again with no apparent consideration of how the care needs of such hospital-level care residents will be met. Such decisions have the potential to compromise these proposed standards. RN member feedback – '*Care givers play a crucial role but they are NOT nurses and cannot do nursing tasks at a safe level'* *'We currently work on an algorithm that is based on the numbers of "bums on bed" not actual acuity. our NASC is reluctant to increase residents level of care especially if they are palliative and only expected to last a few weeks. This means if they are RHLC and have an event and become HLC/Palliative we are only receiving funding for RHLC and those numbers dictate staffing levels. This puts staff under undue pressure and residents do not get the care they deserve/need. The staffing allocation and numbers should be as the senior RN deems necessary when these changes occur without having to complete/wait for GP visit + InterRAI asssessment + CNL and NASC input (can take up to 2 weeks). The staffing numbers should be fluid and changeable based on that acuity.'*
3.5.3	178		Service providers consider the kind of support people need when they eat (include) ***and provide the number of staff required to assist residents respectfully and in a timely way with meeting nutritional needs***.