New Zealand Nurses Organisation

Submission to the Ministry of Health on the

Continuous Improvement in Health and Disability Services

Discussion paper on the review of the Health and Disability (Services) Act 2001

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EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to respond to the preliminary discussion paper *Continuous Improvement in Health and Disability Services* relating to the review of the Health and Disability Services (Safety) Act 2001.

2. The New Zealand Nurses Organisation (NZNO) is a Te Tiriti o Waitangi based organisation which represents 39,000 health workers. NZNO is the professional body of nurses and the leading nursing union in Aotearoa New Zealand. Our members include nurses, midwives, students, health care workers, care givers and other health professionals who work in the facilities covered by the Health and Disability Services (Safety) Act 2001.

3. The Health and Disability Services (Safety) Act 2001 is concerned with the safety of healthcare services and disability support services provided in and outside buildings. This discussion paper looks at the certification and auditing of facilities but fails to address the single most important aspect of safe healthcare: safe staffing levels.

4. NZNO strongly contends that certifying the safety of healthcare facilities against auditing requirements which ignore those who deliver the healthcare is meaningless in terms of the stated purpose of the Act which is to promote the safe provision of health and disability services to the public and enable the establishment of consistent standards for their safe provision.

5. The requirement for healthcare facilities to have a Fire Evacuation Scheme, for example, without ensuring adequate staff are on hand to help those with limited mobility, offers no security of safety in emergency

situations. Formerly evacuation procedures had to be demonstrated, but under the new Fire Safety and Evacuation of Buildings Regulations, 2006, a 'scheme' is all that is required which reduces the safety regulation to "a piece of paper", according to the Fire Safety Service[1]. In this context it may be relevant to note the US National Council on Disability report on Hurricane Katrina which states: "Some of the most visible and alarming evacuation failures were the failures of some nursing homes to evacuate their residents, resulting in the deaths of at least 68 nursing home residents… some left to the mercy of floodwaters".

6. More graphic illustrations of the safety issues surrounding inadequate numbers of trained staff can be seen in the number of major inquiries into health and hospital services in several district health boards following high profile failures, such as Winifred Clemens who bled to death at St Helena's Rest Home, having not even been offered first aid. The Coroner's Report in 2006, which highlighted the fact that there is no requirement for a registered nurse to be present at all times in a rest home nor for caregivers to be formally trained in anything other than dementia care, specifically enjoined the Ministry of Health to include a requirement in the Aged Related Residential Care Agreements to ensure an adequately trained caregiver is present on each shift.

7. While there are no mandatory staffing levels, even the minimal levels outlined in the New Zealand Standards Handbook *Indicators for Safe Aged-care and Dementia-care for Consumers* are neither monitored nor universally attained, putting at particular risk the growing number of older people in need of care. The Handbook, prepared by a cross-sector committee representing business, community and government interests and drawing on the advice of an Expert Advisory Group, unequivocally

[1] Senior Fire Safety Service Officer Tony Nightingale commented that the evacuation scheme requirement was now entirely a paper exercise.

states: “The sector is in agreement that a minimum number of staff is required to ensure safe care.”

8. NZNO notes that minimum requirements for safe staffing levels formerly included in the Old People’s Homes Regulations 1987 and the Hospital Regulations 1993 were not included in the Health and Disabilities (Safety) Act 2001, not because they were deemed unnecessary, but because they were based on an outmoded system which combined medical, and ancillary administrative, cleaning and catering staff.

9. NZNO’s understanding from correspondence and discussion with successive Ministers since 1999, is that safe staffing levels have always been intended to be re-established as part of the Act once such anomalies had been resolved. (As recently as April 2007, Minister Hodgson, at the Health of Older Peoples Conference, indicated that staffing levels were under consideration.)

10. Concern has been expressed by some providers that mandatory staffing levels could not be met because of a chronic shortage of staff in some areas. The NZNO does not accept that as a valid reason to avoid setting safe staffing levels and indeed argues that ensuring conditions where staff can function safely and effectively would boost employment. NZNO is aware that many nurses do not choose to work in environments which place themselves and those they are caring for at risk.

11. Under the Health Practitioners’ Competencies Assurance Act, the focus of competency rests entirely with the nurse, regardless of the key role that the healthcare system has in shaping and enabling those competencies, leaving individual nurses vulnerable to being held accountable for systemic failures such as inadequate staffing and poor supervision or training.

12. NZNO notes that there has been a move away from staffing formulas and towards ‘outcomes-based’ assessment, primarily based on research showing that a comprehensive mix of skills and systems, which narrow staffing formulas may not identify, is needed to deliver quality healthcare. This rationale overlooks the fact that indicators, which measure specific outcomes against quality guidelines, are the auditing tools needed to set and inform, not to replace, safe staffing levels.

13. While there is no requirement to monitor either outcomes or staffing levels, both patient safety and the ability of healthcare workers to maintain professional standards of care are severely compromised.

14. NZNO recognises that with an aging population, a stronger focus on rehabilitative care and low unemployment, staffing may continue to be problem. NZNO suggests that mandatory safe staffing levels could be used to incentivise increased investment in the sector; for example in new monitoring technologies, where there is evidence that they may alleviate some of the workload of nurses and caregivers.

15. NZNO endorses moves towards a regulatory regime that encourages performance improvement through incentives and intervenes with appropriate sanctions where necessary.

16. NZNO is comfortable with extending the Act to cover all residential disability care excluding people looking after their own family members.

17. NZNO endorses removing the part of the definition for hospital care that says “for continuous periods of 24 hours or longer”, so that day surgery would be covered by the Act.

18. NZNO favours a single, stand alone government Designated Audit Authority to ensure consistency across the sector and avoid potential conflicts of interest.

19. NZNO notes that the complexity of audits impose considerable strain on members primarily through the amount of time and preparation they require, and that they do not necessarily reflect the quality of healthcare provided year round. NZNO is aware that, in some instances, staff are being employed for short periods principally to cover programmed audits and that auditing may not reflect year-round care.

20. NZNO considers that auditing processes should be straightforward, robust and flexible to minimise disruption and cost, with more emphasis placed on listening to the experiences patient and staff, rather than form-filling.

21. NZNO notes that standards relating to the Act which are mandated are complied with, but where recommended standards are voluntary, they are not put into practice. For example, in terms of education, mandatory minimum orientation training does take place but voluntary further education to continuously improve the quality of healthcare generally does not.

NZNO RESPONSES TO DISCUSSION QUESTIONS

The proposed infringement and reward regime

Question 1. Should The Ministry of Health be able to issue fines to encourage providers to comply with the Act, for example to reapply for certification on time and report to the Ministry when required?

22. NZNO agrees with having an infringement regime that acknowledges the seriousness of transgressions but is not convinced that fines are

appropriate for “low risk” infringements, for example failure to meet a reporting date, which may unduly disadvantage smaller care providers. A compliance regime which supports providers to meet requirements and maintain services with minimum disruption to staff and residents is favoured.

Question 2. If so about how much should those fines be?

23. See above. NZNO recommends that fines should only be used for serious or repeat offences and that they should be commensurate with the size of the facility.

Question 3. What impact if any would an infringement regime have on you or your organization?

24. NZNO welcomes the enforcement of standards for safe, quality care.

25. NZNO acknowledges, however, that strict penalties may disrupt or force closure of facilities, particularly in the Aged Care sector, which are already in short supply. There is a risk that an infringement regime may simply increase the pressure on those in an already overworked and undervalued sector, so care must be taken to facilitate compliance in the first instance, with sanctions imposed at a later stage.

26. Penalties may also discourage response to frequent calls for urgent placement, adding to the burden on emergency services.

Question 4. How could the Ministry reward and encourage exceptional quality and safety?

27. Longer periods between compliance audits, lower fees and some form of national recognition could be effective ways in which the Ministry could encourage exceptional quality and safety.

Extending the coverage of the Act

Question 5. Should the Act apply to residential disability care services with fewer than five residents?

28. NZNO supports coverage of residential disability care services with fewer than five residents to discourage evasion of scrutiny.

29. NZNO recommends that requirements for such facilities should reflect their smaller size.

Questions 6. If so, should there be a lower limit (e.g. applying the Act to services fro three or more people)? Would a change in the numbers affect your service? If so how, and what would be the size of the impact?

30. No comment

Question 7. Should the Act apply to day surgical services? Would this affect your service? If so, how and what would be the size of the impact?

31. NZNO supports extending the coverage of the Act to apply to day surgical services.

Provisions around Designated Audit Agencies (DAAs)

Questions 8. Do you think the current model of having several DAAs to choose between should be changed? Why or why not? How would such a change affect you and what would be the size of the impact?

32. NZNO is aware that there are discrepancies and inconsistencies in the auditing processes carried out by different DAAs and sees a potential conflict of interest with DAAs being dependent on the auditing fees providers pay.

33. While the *Designated Audit Agency Handbook* details the basic requirements for the different types of audits there is a degree of latitude in the auditing process. Some DAAs will provide a draft report for feedback, for instance, while others will not. Similarly different DAAs will place more or less importance on particular criteria. The Treaty of Waitangi component, for example, is regarded by some as essential and by others as of no consequence.

34. DAAs can use their own auditing tools if approved by the Ministry of Health and providers may choose either to be audited these or against the standards using the sector developed audit tools. However, there seems to be no mechanism for assessing or standardising these tools between DAAs.

35. There is little evidence to suggest that competition through multiple DAAs has lowered auditing costs or effected better health outcomes.

36. Accordingly NZNO favours one DAA.

Questions 9. If you think we should keep the current model of several DAAs, how can we improve the consistency and quality of audits?

23. NZNO does not support keeping the current model of multiple DAAs but recommends a peer review process, with Ministry input, to ensure consistency and establish 'best practise' auditing processes.

24. The development of standardised auditing tools should be a priority.

25. NZNO is aware that some facilities rearrange staffing schedules specifically for the auditing period so the audits do not give a true reflection of year-round care. Random audits should be encouraged to minimise this risk.

Questions 10. If you think we should keep the current model of several DAAs, how can we manage the perceived conflict of interest due to providers being 'clients' of DAAs?

26. Regardless of the model, NZNO considers that while providers pay for audits, there is no way in which the perceived conflict of interest can be mitigated.

Questions 11. If there were just one DAA, what sort should it be and why? For example it could be:

- Within the Ministry of Health
- A stand alone government agency
- A private company.

27. NZNO favours a stand alone government agency for reasons of consistency and impartiality.

Questions 12. Have you encountered concerns with the quality of audits? If so how often and what sort of problems?

26. N/A

Questions 13. Do you have a view on the frequency of audits, including surveillance audits?

28. The most frequent complaint about audits is that they are too long and too time-consuming. Attention should be given to streamlining the process and/or having more frequent, shorter audits.

29. The frequency of audits could be dependent on the service contract funding amount and size of the organisation (larger providers would be audited more frequently and smaller providers less often or using different auditing methods).

Other issues / comments

Questions 14. Do you have any further comments to make that have not been covered in the questions set out above?

30. NZNO notes that the discussion paper covers “certain aspects of the review” of the Act, but there is no indication of what other aspects will be considered for review. Without a comprehensive overview of the complex factors that impact on safety in healthcare, there is an increased risk of systemic failure from reliance on paper and procedures rather than people and performance. NZNO regards the inclusion of mandatory levels for safe staffing in the Health and Services (Safety) Act as the essential ‘bottom line’ for safe healthcare.

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31. NZNO notes that a two year period following the 2005 issue of the handbook Indicators for Safe Aged-care and Dementia-care for consumers was allowed to give time for data to be collected and tested by means of a trial (pilot) of indicators. The Ministry of Health was required to consider the trial results in the expectation that "the data generated will enable informed decisions to be made on the full adoption of the handbook as a National Standard or as a component of NZS 8134". The NZNO is unaware of any such data collection or trial taking place and urges that priority be given to its collection to facilitate informed decision making and monitor progress.

37. In September 2005 the NZNO carried out a snapshot of a variety of aged care sites to examine whether they work within the indicators and found that staffing levels for both nursing and caregiver were well below even the lowest indicator level across all sites. In rest homes, staffing levels for nurses were at 53 percent of those expected by the indicators, and although total caregiver hours were at 95 percent of indicator levels in the hospitals, the staffing skill mix was not optimal. Clearly voluntary staffing levels are not ensuring safe healthcare.

38. NZNO urges the inclusion of the minimum mandatory safe staffing levels as recommended in the New Zealand Standards handbook *Indicators for Safe Aged-care and Dementia-care for Consumer* in the HDSA and that priority be given to updating and regulating minimum safe staffing levels across the sector.

39. Regarding specific standards arising from the Act, NZNO recommends

- That in Standard 1.5 ethnic groups besides Maori and Pacific Island who add a significant number to our current permanent population

base, for example Asian, should also be identified to ensure Standards are multicultural.

- Where mental health criteria do not apply, the mental health sections should allow 'not applicable' rather than not achieved.; and notes that
- In Standard 1.10.5 the term "valid" is not clear in reference to Advanced Directives. Similarly, in connection with restraints, the voluntary nature of the use of an enabler is unclear when family, rather than the consumer, has requested it.

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