New Zealand Nurses Organisation

Submission to the Department of Labour

on the

A Principal's Guide to Contracting to Meet the Health and Safety in Employment Act 1992

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SUMMARY

1. The New Zealand Nurses Organisation (NZNO) thanks the Department of Labour (DoL) for this opportunity to comment on the *Principal's Guide to Contracting to meet the Health and Safety in Employment Act 1992.*

2. NZNO is the leading professional body and nursing union in Aotearoa New Zealand, representing over 41 000 nurses, midwives, kaimahi hauora, students, health care assistants and other health professionals. Nurses comprise the largest part of the health workforce, and work in a range of healthcare settings, including communities, homes and hospitals.

3. We have, therefore, both an industrial and professional interest in this document as it affects the health and safety of members employed by contractors, and as it affects the delivery of safe public health care.

4. Generally, we believe this Guide is necessary because there is a discrepancy between the standards of safety and care and conditions of employment in some contacted services. The Guide is well constructed and useful, particularly in using examples to illustrate significant points, and providing templates.

5. We suggest however, that both the content and design could be broadened to reflect health and safety issues in a wider range of industries, with less emphasis on the construction industry. We note that the Accident Compensation Corporation has identified seven high risk industry groups: Forestry, Agriculture, Metal Manufacturing, Public Health, Road Transport, Meat Processing, and Construction and it may be useful to include examples from all these areas.

6. NZNO believes that the Guide has the potential to make a significant difference to the protection of health workers and patients by ensuring that the principal contractors for health, the District Health Boards (DHBs) and the government, cannot devolve responsibility for health and safety for contracted services.

7. We discuss how this is happening in the health sector currently, particularly in aged care and some community services, and make recommendations around:

   - Safe staffing;
   - Auditing;
   - Standards; and
   - Good management and education.

DISCUSSION

8. NZNO notes that the guide does not mention safe staffing and believes that is a serious omission. Back strain for instance is a major cause of injury for nurses and most often the injury has occurred not for lack of knowledge or training about how to lift a patient safely, but simply because there are not enough staff available for the work. (Or, where there is equipment, it is not useable – aged care residences are still being built where the doorways are not wide enough to admit lifting equipment). As one nurse working in Residential Care commented, "If you find a elderly patient who has fallen while trying to get out of bed and there is no-one else available to help, you do not leave her lying there, no matter what the risk of back injury is." Such situations are not rare, particularly in aged care facilities where NZNO research conducted in 2005 showed that staffing levels for both nurses and caregivers were well below even the lowest indicator level (as recommended in the New Zealand Standards handbook *Indicators for Safe Aged-care and Dementia-care for Consumers 2005*) 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.

9. Clearly staffing is a significant health and safety issue and the Guide should include advice regarding adequate and appropriate staffing levels and skill-

mix, which are benchmarked against published standards and/or industry codes. While District Health Boards (DHBs), as principal contractors, can contract out services, particularly in the largely privatised aged care sector but also in other areas of community health, without binding the contractor to appropriate standards of health and safety for workers and patients, the latter will continue to be at risk.

10. The many high-profile cases of inadequate staffing in aged care that have been highlighted over the past few years, such as Winifred Clemens who bled to death at St Helena's Rest Home, having not even been offered first aid, testify to the risk to patients. (The Coroner's Report (Mclrea, 2006) 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.)

11. But what is largely unseen and unreported is the emotional and physical stress on nurses as they try to cope with unsustainably heavy workloads and responsibility. It is not uncommon for one nurse to be responsible for the care of 50+ patients, supervising several untrained caregivers who each may have up to 14 residents that they have to lift, dress, bath, feed, walk etc. Under the Health Practitioners' Competencies Assurance Act 2003, the focus of competency rests entirely with the nurse, regardless of circumstances, leaving individual nurses vulnerable to being held accountable for systemic failures such as inadequate staffing and poor supervision or training. While there is no requirement to monitor either outcomes or staffing levels, the health and safety of both patients and healthcare workers are severely compromised.

12. With an aging population, medical advances and changes in the delivery and primary focus of healthcare, these issues will become more rather than less pertinent. In particular, prioritising primary healthcare including supporting people at home longer means that more care will be delivered outside traditional hospital settings, more acute and chronic dementia care will be

provided in residential homes and retirement villages, and hospitals will be managing a higher proportion of more acutely sick people for shorter periods. It is essential, then, that the obligation of the principal contractor – in most cases DHBs - should be very clear and there should be no latitude regarding health and safety for services which are contracted out, as there is now.

13. The DHBNZ Aged Related Residential Care Agreement's requirements for health and safety, for instance, are phrased in the broadest terms and there is no provision for staffing to be matched to the needs of the client base, which, as indicated may be vastly different in terms of acuity. The requirement to simply employ one registered nurse is the only form of accountability in terms of regulated health professional staffing. The Agreement includes sections relating to risk management, but when the only auditing tool, the New Zealand Standards handbook *Indicators for Safe Aged Care and Dementia Care for Consumers* is disregarded, what protection is there for patients and workers? Indeed, one multimillion dollar aged care provider recently claimed that no such standards existed!

14. NZNO therefore welcomes Section 1.3 of the Guide which states "The overall test is: What would a reasonable and prudent person do in all the circumstances?" and suggests that codes of practice approved under the HSE Act and guidance produced by the DoL, Standards (sic) and industry-developed guidance are all pertinent. NZNO believes this should be phrased more strongly and advise meeting good health and safety standards, even if they are not mandatory. Most Health and Safety sections in employment contracts refer to compliance with legislation and regulation, but there are many situations, as in healthcare, where safety is dependent on a number of factors which are too complex for blanket prescription. In such situations, standard indicators for safety, often industry-developed, are important tools against which to measure such generic concepts as *adequate, appropriate, sufficient, reasonable*. NZNO suggests the Guide should direct contractors to

refer to such specific standards where they could be legitimately required, so that safety is tied to something real and measureable.

15. Providers are increasingly recruiting from overseas as they experience difficulties in finding and retaining New Zealand staff because of the disparity in conditions compared with those in the DHB Multi Employer Collective Agreement (MECA). When they apply for accredited employer status to fast-track the process, Immigration New Zealand accepts in good faith that the DHB *Residential Care Agreement* is evidence of a "high standard of safety". Thus effectively the DHBs, the principal contractors, have devolved responsibility for health and safety of patients and nursing staff to private providers and that often means, in practice, simply to one registered nurse, who may not even be on the premises!

16. Similarly, agreements with iwi and other community health providers where conditions or employment for workers are not matched to those under the DHB MECA, have led to disparities of up to 25% in wages and conditions, making it difficult to attract and retain staff and ensuring existing staff are overburdened.

17. NZNO's experience is that compliance with health and safety requirements under the Act often means having a plethora of written policies and systems in place for auditing purposes, but that such policy is rarely put into practice.

18. We note that last year Dr Seddon's report in response to the Health and Disability Commissioner's question to all (DHBs):

    "What safeguards are in place to prevent a case like the tragic death of a 50-year-old at Wellington Hospital in September 2004, occurring at your hospitals?" makes the same point: " Another observation was the plethora of policies that almost all DHBs have produced. For example, one DHB has eight policies relating to smoking. The other feature was how rarely adherence to policies was audited, some DHBs apparently thinking that having a written policy was an end in itself, where in fact the effort of writing

and continuously reviewing policies highlights an area of waste in our DHBs, if these policies are not accompanied by an education programme and compliance auditing. Many DHBs could stop writing policies tomorrow and not see a drop in the quality of care that they deliver." (Seddon, 2007).

19. NZNO particularly draws your attention the Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry (2006) which described seven interrelated elements to achieve safe staffing and healthy workplaces for nurses and consumers, namely:
    - The requirement for nursing and midwifery care
    - The cultural environment
    - Creating and sustaining quality and safety
    - Authority and leadership in nursing and midwifery
    - Acquiring and using knowledge and skills
    - The wider team
    - The physical environment, technology equipment and work design.
20. A unit has been set up to implement the Report's recommendations to achieving the above and NZNO suggests that this holistic approach could be used to highlight the concept that occupational health and safety is everyone's responsibility. This would also be in line with trends in health and safety towards greater collaboration between employers, unions, employees, as can be seen, for example with the Joint Action Committees in the health sector, and ACC's Safer Industry Sector Forums.
21. New Zealand has a particularly high level of migrant participation in the health workforce: around 50% of our doctors are overseas born or trained and around 30% of nurses and an increasing number of caregivers are new migrants. That is having a very real and sometimes extremely negative effect on workplace environments and the safety of both New Zealand and migrant workers. NZNO is aware of increasing racial tension and unpleasantness in some healthcare settings where migrant workers are a significant proportion of the workforce. These situations are almost wholly avoidable with good

planning and education for both workers and management. The guide could include some recommendations for ensuring that where there are large number of migrant staff, provision is made for mentoring and education.

CONCLUSION

22. In conclusion NZNO congratulates DoL on this document which we believe makes a valuable contribution to clarifying the responsibilities of principal contractors. We recommend that you note that :

- examples and images from a wider selection of occupations would be useful, particularly from the industries identified as high risk by ACC which includes public health;
- safe staffing protocols are essential and must be integral to health and safety standards;
- **section 1.3** which refers to the need to be aware of safety standards should be strengthened by advising that the standards apply *even when they are not mandatory* . A more appropriate example could be used to illustrate the intention that good safety means acting on evidence rather than regulation;
- **Section 4 Monitoring contractor performance** should recommend referring to specific auditing tools against which performance is to be monitored especially if there are existing DoL, Standards NZ, or industry approved standards for which tools are available. This is to avoid energy being put into writing policies rather than implementing good safety standards; and
- Encouraging recognition and management of the health and safety issues where significant numbers of migrants are involved.

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REFERENCES

NZNO, (2005), *A Snapshot of Staffing Levels in Aged Care Services*, NZNO, Wellington

McElrea, Richard, (2006), *Findings of the Coroner in the Matter of an Inquest into the death of Winifred Constance Clements*, Coroners Court, Christchurch

Seddon, Mary. 2007 Safety of Patients in New Zealand Hospitals: A Progress Report as retrieved from http://www.hdc.org.nz/files/hdc/seddon-full-review-DHB-responses.pdf

Safe Staffiing/Healthy Workplaces Committee of Inquiry. 2006. *Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry* retrieved January 2007 from http://www.nzno.org.nz/Site/Campaigns/safestaffing.aspx

Standards New Zealand, (2005), *New Zealand Handbook*: *Indicators for Safe Aged-care and Dementia-care for consumers*, SNZ HB 8163:2005, NZ Standards Council

ABOUT THE NEW ZEALAND NURSES ORGANISATION

1. NZNO is a Te Tiriti o Waitangi based organisation. It is the leading professional body and nursing union in Aotearoa New Zealand, representing over 41 000 nurses, midwives, kaimahi hauora, students, health care assistants and other health professionals. Te Runanga o Aotearoa NZNO comprises Māori membership and is the arm through which our Treaty based partnership is articulated.
2. The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand through ethically based partnerships. Our members are united in the achievement of their professional and industrial aspirations.