The Standards  
Review

Scoping Workshops - Summary

August 2019

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## **Executive Summary**

Seven scoping workshops have now been held exploring the breadth of change required to three standards considered as part of this review. Common themes have emerged across the stakeholder groups:

* A modular approach is supported – with outcome based standards and service specific guidance
* Interest in a ‘health’ standard and a ‘disability’ standard
* Reviewed standards are to incorporate ‘aspirational’ aspects of service delivery
* The language of the standards should be strengths based and person centric, examples include: safeguarding, spirit of care, overarching principles instead of standards and signposts instead of guidance
* Preference for a codesign approach, particularly within the people’s rights aspects of the standards
* An overarching standard pertaining to the rights of Māori, with Māori health being woven throughout the standards, there is interest in specific guidance being developed for Kaupapa services
* Strengthening governance within the standards to incorporate:
  + Clinical governance
  + Cultural diversity – including feedback loops from consumers and whānau
  + Requirement that the consumers voice is heard at governance level
* Communication aspects of the standards to be ‘fleshed-out’, with participants looking to inclusion of health literacy
* Quality improvement methodology is to be woven throughout the standards with evaluation being focused on outcomes
* Health and safety aspects of the standards to be strengthened incorporating new legislation
* Critical thinking to be a component of training for the workforce
* Medication management, informed consent and restraint minimisation and safe practice need close consideration with involvement from specialist personnel
* A requirement for the inclusion of technology systems
* Review of the Infection Prevention and Control standards be undertaken by specialist staff
* Widen regulation to include day stay services (ie. Outpatient services)



## **Purpose**

The purpose of this document is to provide a high level summary of the feedback received across the scoping workshops. The aim being to inform the Operative Alliance in the formation of working groups.[[1]](#footnote-1)

## **Background**

The Health and Disability Services (Safety) Act 2001 (the Act) prescribes the requirement to review the relevant standards[[2]](#footnote-2) at least every four years. The initial review undertaken in 2017 showed the standards require amendment in order to meet contemporary health practice. At this time the Home & Community Health Association registered interest in considering the Home and community support service standard as part of this review, which was agreed. A two-year work programme is now well underway.

## **The scoping workshops**

Seven scoping workshops were held between April and August 2019 to consider the breadth of change required to the standards[[3]](#footnote-3). Following each scoping workshop participants were sent a summary of the resulting discussion with feedback required in five working days. A *Final Scoping Report* was then prepared for the Operative Alliance. Table 1 shows the scoping workshops held.

Table : Scoping workshops

|  |  |
| --- | --- |
|  | **Workshop Date** |
| Fertility services | 15 April 2019 |
| District Health Board inpatient hospitals, Private Surgical Hospitals, Birthing Units, Hospices[[4]](#footnote-4) | 20 May 2019 |
| Residential mental health and alcohol and addiction services (MHA) | 31 May 2019 |
| Aged residential care | 31 July 2019 |
| Residential Disability | 6 August 2019 |
| Aged residential care | 9 August 2019 |
| Home and community support sector | 12 August 2019 |

A summary against each of the standards is provided in the following.

## **Fertility Services Standard**

The fertility services scoping workshop was held 15 April (2019) with feedback being focused on three aspects summarised below.

1. Amendment

The current standard has not been reviewed since implementation, and workshop participants were unanimous that amendment is required to *reflect the changing dynamic of family structures, … surrogacy and cross-border reproduction.*

1. Reproductive Technology Accreditation Committee Code of Practice (the Code)

Workshop participants discussed the duplication between the Code and the Fertility services Standard, but also acknowledged the specificities of the New Zealand context – particularly responsibility to Māori, and the Health and Disability Commissioner’s Office Code of Consumer Rights, noting neither are a component of the Code.

There was general interest in using the Code as the ‘relevant standard’ (as per the Act). In response the Ministry of Health sought legal advice to determine if the Act is sufficiently flexible to support the concept. The legal team acknowledged the purpose of the Code[[5]](#footnote-5) aligns well with the current fertility standard noting the standard was developed to be consistent with the 2005 version of the Code. Since this time the Code has been reviewed five times. In order for the Code to be used as the ‘relevant standard’, approval from the Minister of Health would be required. This approval would be required each time the Code is updated. The preference would therefore be to look to the Code as best practice guidelines that could be referenced within a reviewed standard ensuring the most current Code remains appropriate.

1. Modular approach to standards review

Workshop participants agreed in principle to the concept of modular standards, noting there are aspects of the Fertility services standard (FSS) and the Health and disability services standard (HDSS) that are the same - Table 2 offers an example.

Table 2: Standards that match across HDSS & FSS

|  |  |
| --- | --- |
| HDSS | 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence |
| FSS | 1.5: Personal Privacy and Dignity  The personal privacy and dignity of the consumer is respected and met during service provision |

## **Health and Disability Services Standards**

Five scoping workshops were held to discuss the breadth of change required to the HDSS. The workshops invited participation from various health and disability services. Workshops were held in Wellington, Christchurch, Auckland and Hamilton. The feedback has been summarised against each ‘Part’ of the HDSS – eg. Part 1: Consumer Rights, Part 2: Organisational Management. The detailed feedback is attached in Appendix A.

### Part 1: Consumer rights

Workshop participants agreed the reviewed standards should have a dedicated section on consumer rights with the consumers’[[6]](#footnote-6) voice being foremost. There was agreement that overarching standards (or high level principles (*Disability, Aged residential care)*) could be acceptable for all health and disability services with supporting guidance being developed specific to each service type. Participants at the Disability workshop were interested in this section being titled ‘Human Rights’.

There was strong interest in a codesign approach to this section. Workshop participants agreed the powerful nature of language and want the reviewed standards to use strengths based language incorporating terms such as ‘The people we support..’ *(Disability)*, and ‘I can expect to receive ...’ *(Aged residential care);* ensuring the ‘power’ of the relationship remains with the consumer.

Within Part 1 there was discussion around standard 1.1.4 (Recognition of Māori Values and Beliefs) and standard 1.1.9 (Communication). All participants agreed to an overarching standard relating to Māori with recognition of Tino Rangatiratanga *(Disability)* and reference to Māori health being woven throughout the standards. Te Tumu Whakarae *(DHB et al)* reported: *Te Tiriti o Waitangi needs to be weaved throughout the whole of the document, referring to and utilising the articles of Te Tiriti as the foundation and connection to Māori health and the health systems responsibility to meet the needs of Māori (including aspirations).* Communication was reported as being a key issue across health and disability services particularly the notion of effective communication *(Disability)*. All participants consider communication to be broader than is currently reported in the standard, and there was interest in exploring inter-professional communication, comprehension, and understanding into an overarching standard. The importance of service specific guidance was emphasised.

There is a reported requirement to strengthen diversity within the reviewed standards with inclusion of age, gender, ethnicity and sexual orientation. This was thought to sit against current standard 1.1.6 (Recognition and respect of the individual’s culture, values and beliefs). Strengthening diversity was supported by the Rainbow community.

Informed consent was an area of interest with participants wanting consent specific to resident ability *(Aged residential care).* Links to enduring power of attorney and decision making responsibilities were also considered important and requiring strengthening in reviewed standards (*Aged residential care)*. Feedback indicated this is a complex standard and needs to be ‘unpacked’ (*Disability)*.

### Part 2: Organisational Management

Workshop participants agreed standards contained within Part 2 are applicable to all health and disability services. The language used needs to favour a people centric approach *(Disability)* with the use of ‘I’ statements and ‘quality of life’ ideation *(Aged residential care)*. A codesign approach was favoured by some *(Aged residential care).*

Strengthening governance was a view of the majority of participants with inclusion of clinical governance *(DHB, Aged residential care)* and a link between governance and cultural diversity *(Disability)*, healthy workplace and staff safety *(MHA, Disability)*. Quality improvement was a particular focus at all workshops with interest in seeing the inclusion of evaluation of outcomes *(Aged residential care),* and a sharing of learningsin the reviewed standards *(DHB)*. Each of the groups were asked if standards 1.2.5 (Consumer participation) and 1.2.6 (Whānau participation) – currently MHA services only – should be applied across all health and disability services. There was general agreement that consumer and whānau participation is relevant for all service types with an interest in feedback from these groups being fed up to governance *(MHA)*.

When discussing standard 1.2.7 (Human resource management) participants would like to see the inclusion of critical thinking in education programmes *(Aged residential care)* and the evaluation of training outcomes being strengthened in the standards. MHA participants want the peer support role retained being mindful not to over professionalise the workforce.

The emerging use of technology in health and disability services was well discussed across all workshops, with agreement there should be inclusion of measuring and monitoring such technologies in the standards *(DHB, Disability, Aged residential care)*.

### Part 3: Continuum of Care Delivery

All workshop participants agreed to the concept of all health and disability services having the same outcome focused standards, with service specific guidance being developed – acknowledging the notion of a ‘health standard’ and a ‘disability standard’ presented at the Disability workshop. The importance of language was again raised suggesting the following: patient centred and determined *(DHB, Aged residential care)*, person centric *(MHA, Disability)*. There was an interest in the development of specific criteria relating to Kaupapa services *(MHA),* seeing an equity lens overlaying these standards *(DHB),* and having standards that are sufficiently flexible to meet future models of care *(Aged residential care)*.

All workshops discussed the following standards as a ‘cluster’ - standard 1.3.3 (Service provision requirements), 1.3.4 (Assessment), 1.3.5 (Planning), 1.3.6 (Intervention) and, 1.3.8 (Evaluation). There was agreement that standard 1.3.3 could be an overarching standard with the remaining sitting underneath. Specific guidance for different health and disability services is required.

Standard 1.3.7 (Planned activities) is the first identified that could be considered a ‘module’. The DHB workshop participants saw this as an ‘opt out’ standard. All other workshops saw the standard as relevant to their particular health and disability service setting. There was some thought that this standard should be moved to Part 1: Consumer rights to shift the focus from provider led activities to meeting individual preferences *(Aged residential care)*. Participants were strong in the view the activities needed to be meaningful *(Disability, Aged residential care*) and fulfilling *(Disability*) to the individual. The other current standard that was agreed as a service specific module was standard 1.3.11 (Electroconvulsive therapy (ECT)), noting the MHA group would be interested in guidance on Post ECT support.

Standard 1.3.12 (Medication management) requires review – again the concept of an overarching standard with service specific guidance being the preference. The residential disability services *(MHA, Disability)* raised the management of over the counter medications, and the use of ‘alternative’ health modalities (eg. Supplements) as current issues to be included in the reviewed standard/ guidance. There is an interest in strengthening the standard in respect of ‘chemical restraint’ and covert administration *(Aged residential care),* noting ‘chemical restraint’ is both outdated and stigmatising *(Aged residential care)*.

The last standard within the Continuum of Service Delivery - 1.3.13 (Nutrition, Safe food, and Fluid Management) requires amendment. Workshop participants support the current standard being separated – one to guide nutritional support for the individual, the second food (and kitchen) safety and Food Control Plans *(Disability, Aged residential care)*. Aged residential care want stronger definition around intentional and unintentional weight loss to be considered.

### Part 4: Safe and Appropriate Environment

There was general agreement there are standards within Part 4 that interface with infection prevention and control. Participants want standard 1.4.1 (Management of waste and hazardous substances) *(Aged residential care)* and 1.4.6 (Cleaning and laundry) *(Aged residential care, DHB)* moved into infection prevention and control standard/s. There was general support for the inclusion of sustainability and recycling practices in the reviewed standards *(MHA, DHB)*.

The residential workshops emphasised the need for service relevant guidance *(MHA, Disability)* to ensure the purported models of care is being delivered *(MHA)*. Participants stressed that residential services are people’s homes and standards should be sufficiently flexible so as not to negatively impact this philosophy *(MHA, Disability)*. Aged residential care participants also reflected this notion: the environment standards need to reflect quality of life and individual needs, noting these services are the residents’ home.

### Restraint Minimisation and Safe Practice

All participants reported a restraint standard is required, noting the language needs to be reconsidered moving to a positive framing eg. keeping safe (+ve) vs restraint (–ve) *(DHB)*. MHA workshop participants suggested terms such as: Safety for All, Harm Prevention, and Safety Support - noting at the same workshop the consumer view was that the title should remain unchanged as it is the practice of restraint that is occurring. The Disability workshop participants preferred language such as: positive behaviour support strategies. Workshop participants reminded that the views of the individual are paramount particularly around the use and duration of restraint *(Disability).*

All participants agree the definitions relating to restraint be reviewed as they are currently perceived to be too narrow *(MHA, Aged residential care),* and clarity is to be sought around restraint and enablers *(Aged residential care).* All participants want to see the current structure of the standards – ie. Approval of restraint, assessment, safe use (monitoring) and evaluation, remain in some form.

There was discussion around the importance of training with the inclusion of verbal de-escalation *(DHB)*, and staff safety *(MHA),* and the requirement to have a workforce strategy to support staff competency *(Disability)* included in this standard*.* There was general agreement that chemical restraint could hold a stronger profile in the reviewed standards *(Aged residential care, MHA),* and the work of the Ombudsman’s Office should not be duplicated *(Aged residential care).*

### Seclusion

This is essentially a practice contained to the DHB health services and the general view is this should be a ‘module’ that can services can ‘opt out’ of. MHA workshop participants noted there may be instances where seclusion occurs and would therefore invite the definition to be extended to this group.

### Infection Prevention & Control

All workshop participants agreed dedicated infection prevention and control standards are required for all health and disability services with guidance particular to service types *(MHA, Disability).* There is interest in consideration being given to national initiatives *(DHB)* and that the language of the standards include terms such as ‘evidenced based practice’ and ‘appropriate’ *(Aged residential care)*. It was recommended that a dedicated working group be formed specifically for IPC standards comprising IPC specialist staff *(DHB)*.

## Home and Community Support Services Standard

The home and community support services scoping workshop was held 12 August (2019) with workshop participants considering the suitability of adopting a modular approach to standards review. Feedback can be seen as Appendix B.

### Part 1: Consumer rights

Workshop participants agreed a dedicated section on consumer rights be part of a new suite of standards, noting standards need to be outcome focused. Throughout the workshop participants raised the emerging models of care, particularly individualised funding and the impact on audit/ monitoring against the standard.

Workshop participants were interested in seeing the language of the standards reviewed with terms such as: overarching ‘spirit of care’ statements with ‘sign-posts’ to guidance particular to service types. There is agreement to a strengths based approach to language adopted.

When discussing standard 1.1.4 (Recognition of Māori Values and Beliefs) participants supported an overarching standard relating to Māori, with inclusion across other parts of the standard. There was also interest in strengthening the standards for Kaupapa services noting ACC are ‘doing a lot’ of work in this regard. The group were interested in standard 1.3 (Individual values and beliefs) being broadened to include all forms of diversity*.*

Workshop participants discussed standard 1.6 (Communication) at length, noting communication is two-way, and the consumer needs to have a voice. There was general agreement that the quality and risk aspects of standard 1.9 (Complaints) could move to standard 2.3 (Quality and risk management).

### Part 2: Organisational Management & Part 3: Human Resources

Workshop participants want stronger guidance around standard 2.1 (Governance) and interest in having complaints and adverse event processes embedded into current standard 2.3 (Quality and risk management) with measurement of the quality system demonstrating a participatory and outcome model.

The group thought standard 2.5 (Entry to and exit from services) should be aligned to Service Delivery (Part 4), and would prefer “access” in the title. The three standards within Part 3 relate to recruitment, induction and competency of the workforce, and health and safety. The group are looking for guidance within the standard that is inclusive of the new employment legislation. In addition there is interest in seeing health and safety being included at governance with agreed understanding of meaning and intent.

### Part 4: Service delivery

Workshop participants again emphasised the importance of the language used, recommending simplifying where able – suggested: ‘What matters to you’, ‘Living well’. The group believe reviewed standards should be sufficiently flexible to meet future models of care – in particular individualised funding. Participants noted whānau is missing throughout the standards and the concept needs to be embedded with defined outcomes included.

Standard 4.1 (Service agreement) is a required standard noting the alignment with the contract. Discussion around consolidating standard 4.2 (Promoting and supporting independence) and 4.3 (links with other groups), however there was concern that by consolidating, important aspects may be ‘watered down’. A similar discussion was held around standards 4.4 (Service delivery planning), 4.5 (Implementation of individual service plan) and 4.11 (Review of service delivery), participants prefer these remain as dedicated standards with person focused language – “My plan”.

In respect of standard 4.6 (Medicine management) the group acknowledged this is a complex area that needs further discussion, with an interest in e-prescribing being implemented within this sector. There is also interest in retaining current standards 4.7 (Infection prevention and control), 4.9 (Nutrition and safe food management), 4.10 (Skin integrity) and 4.12 (Challenging behaviour).

## Appendix A: Scoping Workshops pertaining to Health and Disability Services Standards

Scoping Workshops Summary:

District Health Board Inpatient Hospitals, Private Surgical Hospitals, Birthing Units, Hospices (20 May 2019)

Residential Mental Health and Residential Alcohol and Drug Addiction (31 May 2019)

Aged Residential Care – Christchurch (31 July 2019)

Residential Disability (6 August 2019)

Aged Residential Care – Hamilton (9 August 2019)

### General Comments

##### DHB Hospitals, Private Surgical Hospitals, Birthing Units, Hospices (20 May 2019)

* Thread Treaty and consumer (HQSC) throughout standards.
* Update guidance with standards.
* Co-design approach to standards.
* There was agreement to suggested changes and improvements with all groups.
* Modular approach appealed.
* Language across the standards to better represent patient centred and self-management approach.
* Can we keep this generic in some way as not all users of health service facilities are patients? (NZ College of Midwives).
* Strong (HQSC) consideration be given to regulation of day stay and outpatient services and community based services (HQSC).
* Growing focus on community based services (even though not regulated) therefore consideration of:
  + Transition between services.
  + Role of PHOs.
  + Interface between services.
  + Transparency with patients – particularly in respect of communication, and ‘open records’.
  + Future focused (technology) (HQSC).
* Stronger emphasis on outputs as opposed to inputs when developing the standards (NZHPA).
* Weave consumer rights standard into expectation of all standards (HQSC).
* Review auditing process to assist in greater standardisation and reduced cost (HQSC).
* IPC standard to be reviewed with a specific working group (refer notes on standard) (HQSC).
* As the NZCOM (NZ College of Midwives) representative a key point of feedback is that there is also the need to consider human factors ‘thinking’ when considering operational systems. Human factors identifies that systems need to be designed to support the human’s working within them to work optimally. It can help identify the barriers and enables to optimal quality of care – which can be due to lack of staff, appropriate and up to date skills or difficulty in escalating concerns etc.  this may fit with standard 1.2.8 Service Provider availability but also under organizational management, human resources (Link: 1.2.3, 1.2.7, 1.2.8).
* Agree Te Tiriti o Waitangi needs to be weaved throughout the whole of the document, referring to and utilising the articles of Te Tiriti as the foundation and connection to Māori health and the health systems responsibility to meet the needs of Māori (including aspirations). I also believe that rather than delete the specific section we should keep it as a specific focus.  Having both strengthens the place of Māori across. I would also like to see strength based language throughout the document (Te Tumu Whakarae).

##### Residential Disability Mental Health & Residential Alcohol and Drug Addiction (31 May 2019)

* Strong emphasis on model of care influencing how providers can meet the standards – shared home – and it’s important for the auditors to understand this when they come on site.
* Links and alignment with contracts – a number of these agencies are being audited multiple times by other government agencies – MSD, Corrections.
* Agree to use of modular approach to service types - contextualise to the service type.
* Engagement with Māori is throughout standards.
* Kaupapa services – should have a higher accountability for providing services to Māori.
* AoD need strong mental and physical health service.
* Recognition that there are multiple contracts and service types with this group, need to consider crises intervention, respite, social residential services – with some clients being under treatment orders.
* Mention about detoxifications services – it would seem it is varied out in the service delivery – need to consider non medication therapies related to this.
* Recovery focused programme.
* It is important that the standards are written in a way to ensure the appropriate requirements for all services, particularly to provide sufficient flexibility for different models of care and NGOs (hospital, community-based, small and large), not just DHB hospital settings which are larger and have specific teams (QA, IPC) and service user advisory groups at their disposal (Ashburn Clinic).
* It is important that the standards are written in a way to ensure consistency of interpretation by auditors, with some capacity to determine level of relevance/applicability from service to service, e.g. infection control risks/requirements in a surgical setting versus a NGO MHA service (Ashburn Clinic).
* Mental Health and Addictions facilities have additional standards/requirements, e.g. consumer and family/whānau participation - ideally they would apply to all services, e.g. Standard 3.1.5 Prioritise referrals and asses consumer risks, Standard 3.3.5 provision of information to family/whānau re consumers, Standard 3.8.4 Service delivery evaluation? (Ashburn Clinic).
* Consider duplication of audits of a single service, e.g. overlap between H&DSS, contract, health and safety, and food safety audits. Are there ways of integrating or taking account of other audits to reduce the demands and costs of the many audits that services are required to complete? (Ashburn Clinic).
* Probably outside the scope of the review but there needs to be a link between the training required by the standards and training available through clinical (e.g. nursing) and other professional training, e.g. peer support provision/training is a requirement of the standards and DHB provider contracts, but it is up to the NGOs to find/fund it (Ashburn Clinic)*.*

##### Aged Residential Care (31 July 2019)

* Section on rights (for consumers):
  + Interest in co-design and;
  + Support use of ‘I’ statements.
* Need to be consumer centric.
* Health literacy individuals and staff in terms of understanding of intent.
* Māori values and beliefs – support dedicated standard, however could be more robust and woven into other standards.
* Interest in having overarching principles supporting the standards such as:
  + Communication (including understanding)
  + Restorative care (and alignment to the overall health strategy)
* Consider language across the standards – interest in terms such as: ‘Community’s in which you belong’.
* Interest in reducing duplication.
* Dental services looking for inclusion of oral health assessment (initial/ongoing).
* Funding and contractual issues – in particular re respites services, will be taken back to Association for follow-up with relevant agency’s.
* Interest in seeing aspirational aspects included in standards.
* Concept of ARC being an extension of DHB’s discussed – in particular when DHB moves into ‘code red’ residents transferred to ARC (implementation has funding implications).
* Flexible service delivery models require staff with critical thinking skills.
* Work being undertaken by Ombudsman to be incorporated into standards.
* Alignment to contract/s.
* Focus on Wellbeing and Quality of Life.
* General comment: On behalf of the New Zealand Speech-language Therapists' Association, I would like to voice our interest in the Review and in participating in the next phase of workshops. One third of aged care residents have swallowing difficulties and receive modifications to their meal service and support with mealtimes. They are a high risk population due to choking risk and malnutrition. As speech-language therapists, we are aware of the inadequacies in current Standards and inadequacies in auditing of meal service for these at risk residents. Mandatory training and kitchen and dining room auditing is required to support the Aged Care sector to prioritise speech-language therapy input. Currently the only requirement is an annual off-site menu audit with a dietitan. This is not sufficient. We are very willing and able to support the current review and welcome the opportunity to provide a voice for aged care residents with communication and swallowing difficulties. (A.Miles, Senior Lecturer, Speech Science).
* General Comment: This didn’t come up at the scoping meeting, but we need to clarify 2.9.1 and 2.9.2. Many GPs have said that they do not feel that they should have to attend/admit a patient who is stable and is arriving in ARC within 48 hours. They feel that if they attend the facility once a week then this should be OK to see the patient then. When you look at 2.9.1 and 2.9.2 I am not sure that it actually says that the GP has to visit – just that the information regarding the patient needs to be entered within 48 hours. There is the question of who the responsible person is if something happens. Do we need to clarify…. -facility enter the information within 48 hours, -notify GP who becomes the lead carer (if they aren’t already), and they agree to be responsible for prescribing and be able to be notified in the event of any deterioration. Do the standards actually say that the GP must visit within 48hours or has that become “norm”, and something that ARC has just started doing? How is this actually audited-what is the actual measurement??? (R.McArthur, RNZCGP).
* General Comment: There was some discussion re aspirational intentions. In order to reflect this I think several new issues need to be considered (no doubt I’ll think of others):
  + Having difficult conversations and delivering difficult messages.
  + Interagency protocols (especially when contemplating more movement between sectors and providers e.g. who is responsible at various parts of that process?).
  + The changing role of general practice (E.Boger, Eldernet).

##### Residential Disability (6 August 2019)

* Difference between health and disability discussed, noting disability often stems from a social model.
* Interest in having a ‘health’ standard and a ‘disability’ standard, noting the view some folk who ‘straddle’ both may fall between both standards.
* Support for a modular approach – question around implementation where providers have dual services which fit into multiple modules.
* Language is powerful.
* The rehabilitation model doesn’t fit with residential disability – a dedicated (certification) service type would be preferred – could include immediately post discharge (from injury) through to slow stream rehabilitation (could be up to 5 years).
* Paediatric disability environment does not necessarily fit into current standards.
* Standard needs to reflect a more needs based approach rather than one size fits all.
* Language needs to be simplified and more reflective of the variety of settings the standards apply to.
* The language of the standards does not portray a consumer voice. Whilst it refers to items being inclusive of consumer need(s) it does not read like there is a consumer voice. Would be good to see how this is ‘languaged’ in other standards? (FM, IP&C Nurse specialist).
* Quite a lot of the Safe Environment standard could be transferred into the IPC Standard (FM, IP&C Nurse specialist).
* I think captures the shift in thinking for future proofing the standards. Great to see and hear so much focus on individual choice and self-determination. Looking forward to see the developments and progress from here (A.Lucas, Ryder Cheshire Foundation).

##### Aged Residential Care (9 August 2019)

* Aspirational standards.
* Term consumer is singular – a broader term is preferred as ARC support whānau.
* How will the new standards be measured – ie. In the current fashion: FA, PA (etc) with a risk score (low, moderate).

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Outcome 1.1:** Consumer Rights: Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and belief | | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| * Outcome around consumer rights agreed, however re-write to reflect patient centred approach | | * Agree to section focusing on ‘consumer’ * People/whānau centred * Consumer voice/consumer centric * Describes experience of care * Consumer integrated throughout – ‘what does it mean for the person’ * When crafting standards: put outcome statement first – I feel – then standards with supporting criteria * Need flexibility within guidance (rather than service specific) * Language may be different with different service types * Currently compartmentalising patients journey, consider framing standards to reflect journey | | | * This section is required, reinforces focus as the resident * Support for ‘I’ statements – more powerful/ respectful approach – consider weaving throughout * Interest in co-design approach for this section * Be mindful of those with cognitive impairment – particularly in terms of implementation, there may be need for support in understanding for residents; and the evidence needed for providers (re audit) * Health literacy an aspect for attention – resident, whānau, staff (note staff may not know standards or their meaning) * I note this already aligns quite well with the HDC. When is code due to be reviewed? My thoughts follow (EB, Eldernet) | | | * Agreed an dedicated section on rights * Language could be improved, (current) guidance good – language in ARC can be overwhelming * Consumer means wider than individual – whānau * “I” statements considered – mixed view: could result in ‘lip service’ vs could ‘empower’ residents | | | * Duplication across some standards noted * A section on people’s rights required – consider title of ‘Human Rights’ (for example) * Interest in high level principles that apply across sector – and include:   + Include us in design   + Universal design   + Support decision making   + Reasonable accommodation * Language is powerful and to be considered – eg. The person/people we support, My provider will, My understanding is * Disability – need to emphasise meaningful living (as opposed to health outcomes) * Interest in codesign * Overarching section on rights (ie. Same across all service types), differentiate service types through ‘guidance’ | | |
| **Standard 1.1.1:** Consumer Rights During Service Delivery HDSS(C)S.2008:1.1.1): Consumers receive services in accordance with consumer rights legislation. | | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| * Commitment to equity in respect of Tangata Whenua and other marginalised groups was discussed: Tangata Whenua: suggest a ‘stand-alone’ standard that includes responsibility in respect of the Treaty of Waitangi, then specific criteria embedded into each standard. Q: where do ‘whānau’ sit. Consideration of marginalised groups needs to factor into standards * Link to Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (HDC CoR) was noted, consideration be given to linking to the Code (rather than repeating in the standards) * A consistent approach is needed – with particular attention to language: Patient centred so the patients voice is foremost. Link to United Nations re indigenous peoples * Could merge Standard 1.1.1 and 1.1.2 (below) – when amending be cognisant of lanuaging with particular regard to patient/consumer and equity * Co-design was tabled as concept, approach to be included (HQSC) * Demonstrate quality improvement from patient feedback (HQSC) | | * Linked to Code of Rights * Q: how come mental health specific criteria do not apply to all service types * Standards to be adaptable to different models of care * Flexible approach to hearing consumer view (eg. Committees) * Guidelines currently too prescriptive (eg. Not all services have consumer advisory groups) * Need to engage whānau * Concepts such as: respect, inclusion, consumer voice discussed * Need to consider a wider range of options for consumer feedback. | | | * Mixed view re merging with 1.1.2, mixed view, could combine at standard level with criteria specific to staff and resident below * Be clear on who is being targeted – ie. Resident vs provider * EPOA important issue * Also note comments above | | | * Agree relevant standard * Could merge with 1.1.2 (and link to consent) * Understanding is impacted by capacity (67% folk in ARC have cognition issues), compounded by international workforce * Need to consider different abilities re understanding and processing of information * Consider whānau involvement | | | * 1.1.1 & 1.1.2 reflective of code – still need to consider both * Potential to merge 1.1.1 and 1.1.2 (with ‘criteria’ to support different service types) – for example the requirement to display the Code of Rights in a person’s home is not particularly relevant for residential services, need to move to an outcome based model and understand ‘how people are informed’ * 1.1.1 is audited more from service provider perspective, while 1.1.2 from people receiving services | | |
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| **Standard 1.1.2:** Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2): Consumers are informed of their rights. | | | | | | | | | | | | | |
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| * Refer above narrative, potential merger of standard 1.1.1 & 1.1.2 * Note comment above re Tangata Whenua: suggest a ‘stand-alone’ standard that includes responsibility in respect of the Treaty of Waitangi, then specific criteria embedded into each standard. | | * Consolidate with Standard 1.1.1 and link to HDC. | | | * Note comments against 1.1.1 * Mixed view re combining, noting consumers being informed is complex   + Welfare guardians & whānau discussed and link to keeping cognitively impaired residents informed of rights - I think this came out of a discussion about consent – the point I think was that even someone considered not competent overall and EPOA activated and/or Welfare Guardian appointed, consent should still be sought in all situations as the person might be competent in some situations but not others (LR, Alzheimers NZ). * Link to HDC, general agreement that standards could link to HDC Code so that if changes occur to code these standards remain current | | | * Refer comments against 1.1.1 | | | * See 1.1.1 * Standards are individual focus (ie. Consumer) rather than whānau * Q: How are people informed | | |
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| **Standard 1.1.3:** Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3): Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | | | | | | | | | | | | | |
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| * Standard needs rewording to include equity (Tangata Whenua & equity for all) and the consumer voice * Consider inclusion of culturally competent staff – what would this look like * As currently written potentially difficult to measure * Discussion around how the provider would measure meeting standard * Note comment above re Tangata Whenua: suggest a ‘stand-alone’ standard that includes responsibility in respect of the Treaty of Waitangi, then specific criteria embedded into each standard. | | * Add consumer facing comment in every standard: eg, How consumer feels etc. * Add a cultural lens * Add: compassion, kindness, respect: Q: what do these terms mean in the context of the standards * Inclusion of spirituality (vs religion) * Consider gender identity (Q: does this link to standard 1.1.5). | | | * Need to keep as standard * Ensure written as consumer centric * Q: is privacy an issue in sector – can be in respect of sexuality (further discussed against individual rights (1.1.6) and discrimination 1.1.7) * Standard a good reflection of the Code | | | * Comment: (eg. move standard to a different part, merge with a different standard) * Discussed possibility of merging with 1.1.1 and 1.1.2 – question: is it important enough to have a dedicated standard * Use of ‘I’ supported with family and whānau inclusion * Link to EPOA | | | * Core to service delivery – noting language to reflect disability: could include terms such as Safeguarding… * Interdependence is not really considered – eg. With folk with complex care and carers being heard, noting no one exits in isolation * Inclusion of whānau | | |
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| **Standard 1.1.4:** Recognition of Māori Values and Beliefs (HDS(C)S.2008:1.1.4): Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.  ARC: I thought our discussion outcome was that should be more than “acknowledgement” e.g. includes where practical/possible (LR, Alzheimers NZ)  ARC: Option: ‘Recognition of Māori Values, Beliefs and Treaty obligations’. There is a primary relationship with Treaty partners that needs to be better managed (EB, Eldernet) | | | | | | | | | | | | | |
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| Remove as a dedicated standard (refer comment against standard 1.1.1 – ie. Dedicated standard plus integration across standards  Accessibility to services was discussed – refer Part 3 entry and exit to services. | | Apply to all service types  Recognition of Māori woven throughout the standards, with particular focus on equity  Need to be confident to meet needs – the guidance should support  Language within guidance may need to be different with different service types  Difference between guidance and prescription was discussed  Noted the number of Māori providers have reduced across time (last 10 years)  Current criterion 1.1.4.7 (the service provides education and support for tangata whaiora, whānau, hapu and iwi to promote Māori mental well-being) be applied to all service types. | | | Support a dedicated standard, however could be more robust  Interest in seeing inclusion of Māori across other areas of the standards – eg. Entry to services (1.3.1)  Some regions are doing better than others – noting in some regions providers are not seeing Māori in ARC. Where there are no residents difficult to implement – therefore potential for a modular approach (opt in / opt out) – ie. If service has Māori resident’s implementation needs to be measured (at audit): My concern was that if Māori are not represented in the facility population then why not? Maybe it is what the facility are/are not offering therefore some aspects of the standard should apply regardless of whether there are Māori residents in the ARC. I don’t think that has been captured (LR, Alzheimers NZ)  I don’t think this should be an opt out. All providers should become more familiar with Māori protocol, and how values and beliefs are expressed. This service type (with additional adaptations) may then become more relevant and better utilised in a way that fits with whānau (EB, Eldernet)  Discussed movement from prescription/’tick’ box approach – ie. Have Māori plan and connection with local iwi, to a competence approach and what that may mean  New models of care may see more Māori in ARC – for example respite services  but only if it is safe enough for them to use (EB, Eldernet)  Access to support to be factored in  Could be ‘aspirational’  Simplify – do not want standard to be too prescriptive, ensure there is the ability to cope with the variables being seen across models of care | | | Māori are going into ARC as whānau structures change  As health outcomes for Māori improve, may also result in increased Māori in ARC  Do not fall into ‘lip service’ mode  Underpins NZ  Everyone lives their own culture their own way  Needs to support the individual view (ie. What the individual aligns to)  Differences nationally were discussed, agreed that a standard should at least demonstrate cultural preparedness – consider implementation at resident level a modular approach if no residents noting this approach may impact admission criteria (ie. Additional compliance)  There are environmental considerations  Support overarching standard then woven throughout – individual needs are paramount  Reference to the audit work of TAS | | | * Include equity * Support one overarching standard and then woven throughout * Recognition of Tino rangatiratanga (rather than values & beliefs) * Include people in design – ie. Māori disabled * Self determination to be included * Criteria need to be modified – to move from a ‘tick’ box approach * Weave into organisational management particularly around cultural capability | | |
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| **Standard 1.1.5:** Recognition of Pacific Values And Beliefs (HDS(C)S.2008:1.1.5): Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.  ARC: Same as comment above re Māori (LR, Alzheimers NZ)  ARC: Or: ‘recognition and respect of diversity and the individual’s culture, values and beliefs IEP, Eldernet) | | | | | | | | | | | | | |
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| Currently Mental Health and Addictions (MHA) services only – remove as service specific as relates to all service types  Potentially merge with 1.1.6 (below) - one standard to pertain to pacific and migrant populations  Language was noted – eg, Pacific consumers have their health and disability needs … standards are written with a negative connotation (‘disabled’ are also ‘abled’)  This (and 1.1.6) need to be revisited and further discussed | | Currently applies to mental health and addition services only: apply to all service types  Diversity to be represented – may be language  ? consider wellbeing. | | | Currently mental health only – general agreement applies to ARC  Consider merging with 1.1.6 looking at an overarching diversity standard with a breakdown of particular groups at criteria level – eg. LGBTIQA, ethnicity  Need to include sexuality (see dot point above)  Consider title: Communities in which you belong  On reflection I think it’s problematic singling out Pacifica. We actually have a large number of Asian people in residential care especially in Auckland. I think this standard should be wide and inclusive. Primary relationship is between Māori and Pakeha. That needs to be addressed (EB, Eldernet) | | | Discussion around potential merging of 1.1.5 and 1.1.6 – the group questioned if we would then be doing a dis-service to the Pacific population  The group questioned if the decision should be taken back to the population group  Reference to the CALD work  General agreement there by one overarching standard supporting diversity – culture, ethnicity, gender and sexual orientation | | | Current MHA – agreed appropriate to disability  Need to adopt a global view of community  Retain a dedicated standard for Pacifica  Need standards that best meet the needs of the people  Just note the importance of consulting Pacific people around this standard (N.Berry, NZCare Group) | | |
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| **Standard 1.1.6:** Recognition and Respect of the Individual's Culture, Values, and Beliefs (HDS(C)S.2008:1.1.6): Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs | | | | | | | | | | | | | |
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| Refer above narrative, potential merger of standard 1.1.5 & 1.1.6 | | Strengthen re diversity – migrant, gender  Language around immigrants fraught  Use of definitions to support/ clarify. | | | Refer 1.1.5 | | | Refer comments against 1.1.5 | | | Consider diversity within this standard – ie. Sexual orientation, age, ethnicity, gender | | |
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| **Standard 1.1.7:** Discrimination (HDS(C)S.2008:1.1.7): Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation | | | | | | | | | | | | | |
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| It was noted there are currently three criteria that are MHA only, potentially apply to all service types  The link to HDC CoR was discussed with potential to further align  Language – noted that discrimination has a negative frame, suggest a positive reframe  Potential to embed into 1.1.3  Note comment above re Tangata Whenua: suggest a ‘stand-alone’ standard that includes responsibility in respect of the Treaty of Waitangi, then specific criteria embedded into each standard | | Consider language/title  Criterion 1.1.7.2, 1.1.7.4 and 1.1.7.5 apply to all service types. | | | Important to include in reviewed standard/s  Be cognisant of human rights and link to same  Include terms such as ‘abuse’ and ‘neglect’  Abuse – consider inclusion of intentional/ unintentional  Title: or – Human rights upheld (EB, Eldernet) | | | Agreed relevant  Need to use strengths based language (noting discrimination has a negative connotation)  Discussion: if a provider demonstrates they are meeting stds 1.1.5 and 1.1.6 should they automatically meet this standard? | | | Term discrimination too narrow – only one area of the barriers that exist, needs to relate to the context of people’s lives,  Language – ‘I am safe from …’  Reframe to a positive (deficit working now)  In terms of merging with other standards in this section: be mindful of diluting if all are linked to the Code, therefore support dedicated standard  Consider: ‘safeguarding for people ..’  Should this include all aspects of abuse (N.Berry, NZCare Group) | | |
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| **Standard 1.1.8:** Good Practice (HDS(C)S.2008:1.1.8): Consumers receive services of an appropriate standard | | | | | | | | | | | | | | |
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| Delete – incorporate into Part 3 | | | Move into other aspects – eg, Part 3 (continuum). | | | Standard ‘bit vague’  Could be merged – consider moving into Part 2 (Organisational Management) – in to quality & risk – ie. Best practice needs to be led from top ie. Governance, who drive/ require evidence based practice | | | Merge into Part 3 | | | Currently broad and essentially undefined  Noted there is often auditor variability  Q: where would innovative practice sit  Could merge into service delivery (Part 3) | | |
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| **Standard 1.1.9:** Communication (HDS(C)S.2008:1.1.9): Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | | | | | | | | | | | | | | |
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| Discussion around having a dedicated standard vs having communication woven into all standards: it was agreed communication is too important to not have a dedicated standard  Communication continues to be a key issue in respect of complaints  Not just about language – it is also the manner of delivery, non-verbal messaging, understanding  Link to health literacy  Language to give ‘power to the consumer’ – eg. I should expect ….., patient centred models of care need to be paramount, ‘sickness’ has negative connotation, is ‘consumer’ the right term, where does whānau sit  It is not just contained to communication with patients, but crosses into inter-professional communication – eg. Handover, transfer of care  Note comment above re Tangata Whenua: suggest a ‘stand-alone’ standard that includes responsibility in respect of the Treaty of Waitangi, then specific criteria embedded into each standard. | | | Q: how is it measured  Common theme in reportable events  Much broader than verbal communication  Guidance may not be relevant to all service types – eg. Wearing name badge  Language of health can be an issue  Need clear process so people feel heard and not ‘left in the dark’  Expand to include checking understanding  Need to consider patients being informed. | | | Communication could be an overarching principle  ? does this standard need to be stand alone, or could be criteria across all standards  Communication issue across a number of standards – eg. Link to 1.2.4 (Adverse Events)  Communication appears in complaints  Be mindful of resident capacity in respect of understanding and communicating to – Q: can the standard be called ‘understanding’  Language is important in terms of perception and understanding  Needs to include communication with whānau (in broadest sense)  Interface with EPOA  Noted: residents are relieved by honest and transparent communication  Interdisciplinary communication to be considered in respect of for example referral to ARC (etc)  In terms of communication consider: language, timeliness, expectation: professional vs resident.  Resident – consider wants/needs, clear information, can be time intensive  Or: communication and understanding (EB, Eldernet) | | | Agree the standard is relevant  Noting communication is often part of complaints  Good communication often de-escalates situations  Need to ‘flesh out’ meaning/ interpretation and what is measured at time of audit  Health is a changing environment and level of communication needs to change to meet same  Need to ensure the mode of communication meets the understanding of the individual  What is the interface with family, whānau and EPOA  As methods of communication change our ability to respond in various ways becomes important  There is a staff interface with this standard  Noted: communication is often linked to good relationships  Support notion of ‘resident’ centric language as may ‘flip’ the power base | | | Language to be considered  ‘Communicating effectively with consumers’ – change to: and with each other  Effective communication has been silent on the impact of cognition  Standard need to include alternatives such as easy read, sign. Be mindful the people receiving service do not pay for such assistance  This could be perceived as the provider is then responsible for the cost of all alternative communication (A.Lucas, Ryder Cheshire Foundation)  Different styles of communication – eg. Speaking vs hearing, and listening vs understanding, there is an interest in being explicit around assistive technology  The language of different cultures to be considered  Include wider whānau  Keep outcome focused with guidance having a disability focus  Suggest the outcome needs to be rewritten to ensure this standard is interpreted appropriately (N.Berry, NZCare Group) | | |
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| **Standard 1.1.10:** Informed Consent (HDS(C)S.2008:1.1.10): Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | | | | | | | | | | | | | | |
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| Consider two standards: Informed Choice, Informed Consent  Noted: a national policy in respect of informed consent is preferred  Link to advanced care planning  The concept of ‘done too vs done with’ was explored, a relationship approach is required  Be cognisant of health literacy  Staff understand ‘how to’, but patient needs to understand (link to communication)  Adopt a strength based approach  Note comment above re Tangata Whenua: suggest a ‘stand-alone’ standard that includes responsibility in respect of the Treaty of Waitangi, then specific criteria embedded into each standard. | | | Need to involve family (and opposite is true)  What does the person want  Language – ‘I’ decide  Q: is written consent the norm for industry, should it be time framed – eg. 3/12  Where appropriate allow ‘opting out’  1.1.10.8 and 1.1.10.9 – service specific (management of body parts). | | | Service type specific criteria – could be applicable to ARC: consider opt in/ opt out, ie. Criterion related to keeping of body parts (noting the is often managed by funeral director services)  Could include consideration of organ donation  Consent specific to issues and resident ability:  Outings – resident may be able to consent  Other (eg. Health matters) that resident may not have competence to determine  Q: when is consent (and particularly written consent) required: eg. Catheter change: I would certainly say yes, this is invasive. But the question is wider and reflects the complexity around consent. i.e. does everything require consent and if so how is that recorded?, or if not then how do we determine what does/doesn’t require consent (LR. Alzheimer’s NZ | | | When is consent required (and for what)  Potentially two levels of consent – activity based vs health treatments/ procedures. Could be argued this can be viewed as a continuum  Seeking clarification on areas currently perceived to be ‘grey’  Capacity should be woven into standard  Re implementation: when is consent required to be reviewed (frequency)  Noted: UK standards cover dementia well  Resuscitation status: currently updated every year, considered to be poorly understood, clarify who can make the decision, potentially link to advanced care planning (Q: should this be a standard)  It was agreed this is an important standard and time should be taken to further unpick the nuances allowing guidance to be clearer | | | Currently not strong enough for disability  Language – agreement to participate, supported decision making (etc)  Complex consenting for those that can’t – need to unpack current standard with guidance being particular to service type  Legal implications: ie. Who gets to decide in terms of consent, for example end of life decisions  Q: what are we working with people to consent to  Link to ‘safeguarding’ (refer notes against 1.1.7)  People are living own life (what do I consent for in my own life) – choice, control, flexibility are particular considerations for disability  Agreed that this standard needs extensive legal review as per the comments recorded (N.Berry, NZCare Group) | | |
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| **Standard 1.1.10:** Informed Consent (HDS(C)S.2008:1.1.10): Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | | | | | | | | | | | | | | |
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| Consider two standards: Informed Choice, Informed Consent  Noted: a national policy in respect of informed consent is preferred  Link to advanced care planning  The concept of ‘done too vs done with’ was explored, a relationship approach is required  Be cognisant of health literacy  Staff understand ‘how to’, but patient needs to understand (link to communication)  Adopt a strength based approach  Note comment above re Tangata Whenua: suggest a ‘stand-alone’ standard that includes responsibility in respect of the Treaty of Waitangi, then specific criteria embedded into each standard. | | | Need to involve family (and opposite is true)  What does the person want  Language – ‘I’ decide  Q: is written consent the norm for industry, should it be time framed – eg. 3/12  Where appropriate allow ‘opting out’  1.1.10.8 and 1.1.10.9 – service specific (management of body parts). | | | Service type specific criteria – could be applicable to ARC: consider opt in/ opt out, ie. Criterion related to keeping of body parts (noting the is often managed by funeral director services)  Could include consideration of organ donation  Consent specific to issues and resident ability:  Outings – resident may be able to consent  Other (eg. Health matters) that resident may not have competence to determine  Q: when is consent (and particularly written consent) required: eg. Catheter change: I would certainly say yes, this is invasive. But the question is wider and reflects the complexity around consent. i.e. does everything require consent and if so how is that recorded?, or if not then how do we determine what does/doesn’t require consent (LR. Alzheimer’s NZ | | | When is consent required (and for what)  Potentially two levels of consent – activity based vs health treatments/ procedures. Could be argued this can be viewed as a continuum  Seeking clarification on areas currently perceived to be ‘grey’  Capacity should be woven into standard  Re implementation: when is consent required to be reviewed (frequency)  Noted: UK standards cover dementia well  Resuscitation status: currently updated every year, considered to be poorly understood, clarify who can make the decision, potentially link to advanced care planning (Q: should this be a standard)  It was agreed this is an important standard and time should be taken to further unpick the nuances allowing guidance to be clearer | | | Currently not strong enough for disability  Language – agreement to participate, supported decision making (etc)  Complex consenting for those that can’t – need to unpack current standard with guidance being particular to service type  Legal implications: ie. Who gets to decide in terms of consent, for example end of life decisions  Q: what are we working with people to consent to  Link to ‘safeguarding’ (refer notes against 1.1.7)  People are living own life (what do I consent for in my own life) – choice, control, flexibility are particular considerations for disability  Agreed that this standard needs extensive legal review as per the comments recorded (N.Berry, NZCare Group) | | |
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| **Standard 1.1.11:** Advocacy And Support (HDS(C)S.2008:1.1.11): Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | | | | | | | | | | | | | | |
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| Link to HDC CoR – delete as dedicated standard  Perhaps merge with Informed Consent. | | | Re Mental Health Commissioner –this aspect should sit with them  District Commissioner interface  Legal requirement  Could potentially merge. | | | Potentially merge with earlier standards (ie. Link to HDC) | | | Merge 1.1.11 and 1.1.12 and link to HDC | | | Recommend specific standard for disability services – need to consider open choice, and be non-prescriptive (such as a standard around ‘choice and control’  Self-advocacy to be included and strengthened  Family can be advocates but this is not necessarily person determined  Need access to independent trained advocates – choice and nonprescriptive  National advocacy – underutilised (and underfunded) | | |
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| **Standard 1.1.12:** Links with Family/Whānau and Other Community Resources (HDS(C)S.2008:1.1.12): Consumers are able to maintain links with their family/whānau and their community. | | | | | | | | | | | | | | |
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| Delete as dedicated standard  Perhaps merge with earlier standard. | | | ? link to 1.2.6 (Family/ whānau participation)  Consider forensic services (ie, Orders, legal constraints)  Definition of participation – person directed. | | | Essential standard  Requires strengthening | | | See entry 1.1.11 | | | Change language to active participation  Currently ‘light touch’ and fits more to a hospital based model  Consider that personal time can also be the person’s preference  Change links to connections, Include - Forming connections, Need to include natural resources, consideration to connections to health and wellbeing resources (N.Berry, NZCare Group) | | |
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| **Standard 1.1.13:** Complaints Management (HDS(C)S.2008:1.1.13): The right of the consumer to make a complaint is understood, respected, and upheld | | | | | | | | | | | | | | |
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| Split complaints into two:  Process of managing + register to Part 2 (Organisational Management)  Focus on consumer stays – link to HDC CoR, add consumer ‘lens’  Note comment above re Tangata Whenua: suggest a ‘stand-alone’ standard that includes responsibility in respect of the Treaty of Waitangi, then specific criteria embedded into each standard. | | | Relevant to all service types  Current standard is OK  Language to reflect consumer – ie. The right of the consumer to make a complaint is understood (by the consumer), …. | | | Potentially move to current Part 2 (Organisational Management) into quality and risk: as providers manage the process, embedded into Governance  If moved ensure inclusion into any HDC related standards (noting the right to complain is part of the Code) | | | Complaints could link into 1.1.9  Link to HDC  Consumer aspect could stay in Part 1 with the quality and risk aspects moved into Part 2 | | | Two parts – complaints management, and the right to complaint. Could move the process to quality & risk, plus add improvements and evaluation  Want a robust process  Separation between internal and external complaints, also staff and people’s complaints  Need a standard supporting management of ‘disagreements’ and ‘disputes’ – eg. Disagreements at home level | | |
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| **Outcome 1.2:** Organisational Management: Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner  ARC (31 July): Needs to be reflective/relevant to patient/client centric care  ARC (9 August): Relevant standard | | | | | | | | | | | | | | |
| **Standard 1.2.1:** Governance (HDS(C)S.2008:1.2.1): The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers | | | | | | | | | | | | | | |
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| Need to consider clinical governance engagement  Recognise residents receive care from two providers at one time eg. hospice/aged care – co-share relationships with providers  Treaty threaded throughout standards rather than one standard | | | Consider new Health and Safety legislation with focus on clients and staff  Recognition that liability with the legislation is with Governance – being a safe and good employer consider culture and diversity, healthy workplace and safety wellbeing – happy valued staff  Key legislation to reflect how it looks  Inclusive of Treaty aspects client, family, whānau, make of governance – consumers and staff considered  Equity - Māori, pacific and other groups  Access inclusive here also  Audit for the ‘spirit of service’ –compassionate, aroha get feedback clients and families  Both groups very focused around governance. | | | Interest in co-design approach  Ensure subjectivity is captured and outcome focus | | | Requires guidance on governance, roles and responsibilities, context, reference documents, outcome measures -noting that a number of the people sitting on the governance board of ARC are volunteers  Suggest clinical governance is separate to the governance of the organisation  Suggest explicit outcome measures for efficient and effective consumer services  Suggest consumers provide feedback on the performance, efficiency and effectiveness of the governing body  Suggest consumers have a more active role in feeding back on planned services, coordination and appropriateness | | | Question ‘Governance’ – does this need to be defined as can be interpreted differently  Needs to reflect quality of life  To add: the consumer needs to be included in the strategic planning discussions – there was some mention here about the standard being mandated and how good governance supports the mandate to comply with the standard (FM, IP&C Nurse specialist) | | |
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| **Standard 1.2.2:** Service Management (HDS(C)S.2008:1.2.2): The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers | | | | | | | | | | | | | | |
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| Delete and merge with 1.2.1 | | | Could consider moving standard to 1.2.1 | | | Organisationally efficient- approach to individual care “I”  Acknowledgement of “ Quality of Life”  Wording is of opinion not measurement, needs clarity for diverse services (NGO V Commercially large for profit etc)  Wording too vague currently | | | Possible merger with standard 1.2.1 however, this could create governance and operational confusion  Suggest flipping the organisation on its head and having the consumer at the top of the pyramid  This should represent who we are as an organisation and how we meet the needs of the consumer  Suggest explicit outcome measures for efficient and effective consumer services  Suggest a service specification for ARC, and grand parenting the ARC agreement expect for funding and definition requirements | | | Merge into 1.2.1 | | |
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| **Standard 1.2.3:** Quality and Risk Management Systems (HDS(C)S.2008:1.2.3): The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | | | | | | | | | | | | | | |
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| Responsiveness to high risk issues – robustness of processes with dealing with internal and external risks (hospital /community). Focus should extend beyond inpatient issues.  More focus on quality improvement methodology throughout criteria - lens on quality cycle activity – enlarge on how links between clinical activity can have a quality lens.  Does best or good practice terminology sit with quality management?  Ensure use or national definition – sharing.  Shared learnings – how do other areas within and external to DHB learn of improvement activities.  Risk Management guidance (ASNZS ISO Standard 31000:2009) (HQSC)  Potential for IPC focus in here (NZNO IPC) | | | Strengthen implementation of and adoption of policy and procedures = change. Mention here about IT on line/hard copy/security and infrastructure  Whole of risk monitoring. | | | Clarity and definition between quality and risk systems and quality improvement principles – two separate areas | | | Currently, too much emphasis on policy  Suggest developing quality indicators from a consumer perspective  Climate of increased expectation  Currently too prescriptive | | | Question – the word ‘risk’ has negative connotations could be replaced with ‘safeguard(ing)’ throughout the document  Question - Could incorporate H&S aspect with regard to the consumer | | |
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| **Standard 1.2.4:** Adverse Event Reporting (HDS(C)S.2008:1.2.4): All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner | | | | | | | | | | | | | | |
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| Ensure review and improvement has an educative not punitive focus  For most services in this group demonstrate (HQSC) use of National Adverse Event Reporting Policy 2017 (HQSC)  Consider open communication is completed and assessed within this area – (open disclosure) | | | Relevant standard – some provider may become risk adverse. | | | There is a gap here regarding “closing the loop” – it is just not reporting but change, evaluation outcome and report again process. Currently this is met by reporting with no action / outcome  Closing the loop following adverse events is covered in 1.2.3 around quality and risk, it would be repeated if in here as well, don’t believe there is a gap (LC, HDANZ) | | | Suggest creating a dignity and risk measure for consumer to report on  Current accountability and transparency-it works  Linked to improvement  Missing the reporting of near misses  No consumer perspective or context -this needs to be added | | | Merge into standard 1.2.3 | | |
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| **Standard 1.2.5:** Consumer Participation (HDS(C)S.2008:1.2.5): Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals | | | | | | | | | | | | | | |
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| Group considered this standard should be adopted throughout all hospital services.  Ensure organisational commitment - co-design language  Effectiveness and feedback is considered by provider with links to improvements and changes.  Consumers need to receive support and training for their role in working with providers to improve service delivery.  Improvements from consumer work is heard at governance levels  Use of codesign principles (HQSC) | | | Should be central to this service type governance, programme and service delivery. | | | Interest in co-design approach for this section- not only for mental health  Again it would be repetitive, as there already specific criteria around consumer/resident participation. Might also become difficult for those facilities that are totally dementia and PG level care to meet this standard (LC, HDANZ)  Wording change from “involved” to Input and add appropriate consultation | | | Looks odd as a standalone standard  Woven through other standards, linked to quality improvements  Applicable in ARC and possibly should be extended to ARC  Hidden in other activities such as care planning, reviews and MDTs | | | MH  Consider using Enabling Good life Principles language (N.Berry, NZCare) | | |
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| **Standard 1.2.6:** Family/Whānau Participation (HDS(C)S.2008:1.2.6): Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals | | | | | | | | | | | | | | |
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| Applicable to be assessed across all services – hospices consider this engagement important.  Potential for family and whānau engagement to be similarly developed as for consumer participation  Use of co-design language.  Challenges for Private surgical hospitals | | | Clear that family may not easily be defined – need to have wider view of whānau  Inclusive at governance and service delivery  Essential for connectedness, about what they are – recovery and identification  Family/whānau involvement (MHA standards only) - Standards 2.5/2.6 planning and evaluation of services, Standard 3.3.6 Provision of information, education and programmes to consumers and family/whānau – these requirements may conflict with service provision/contract specification in terms of resourcing, as well as prevented by other barriers such as physical distance. There is specific reference/guidance (2.6.2) to employing consumers and seeking advice from family/whānau advisory groups (which many DHBs employ). However this is not practicable or necessarily appropriate for NGOs and it doesn’t guarantee representation of the range of service users (Ashburn Clinic). | | | Interest in co-design approach for this section- not only for mental health  Merge with Standard 1.2.5: Agree so: consumer, family, whānau participation (EB, Eldernet)  Wording change “Involved” to Consultation | | | Relevant as is | | | MH | | |
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| **Standard 1.2.7:** Human Resource Management (HDS(C)S.2008:1.2.7): Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation | | | | | | | | | | | | | | |
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| Consider outcomes of mandatory and clinical training that is provided (evaluation) (HQSC)– how it build capability of simulation - differences  Competency, critical thinking and other attributes staff developments  Education links to quality risk management – improving patient safety and closing gaps | | | Need consideration of staff that bring a lived experience to these services  Recognition, organisation, employee relations relapse safe workforce  Protect peer support role don’t over professionalise them  Workplace wellness - need to strategy to grow the workforce  Training for non-crises interventions and de-escalation competencies is expensive  Need of supervision for staff – practice reflection  Organisational development cultural, equity resilience and coaching  Early intervention – modular approach to training to fit service delivery model  Communication, identify distress and health and safety. | | | Legislation should be first in the wording, followed by current terminology of Best Employment Practice  Policies and practice should demonstrate adherence | | | Keep the standard in one way or another  Not a numbers game standard  The education requirement could be fleshed out  Could include artificial intelligence and technology coming into ARC as an alternative human resource  Look more at the processes for recruitment, turnover, retention and record keeping of the same  Currently no consumer feedback on staff, staffing or recruitment | | | Merge standards 1.2.7 and 1.2.8  Need to ensure this fits for people who are employing their own staff (N.Berry, NZCare) | | |
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| **Standard 1.2.8:** Service Provider Availability (HDS(C)S.2008:1.2.8): Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | | | | | | | | | | | | | | |
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| Succession planning  Volunteers | | | Consider multi-disciplinary team – roles reflect the model of care and service type delivery.  Contract – outlines clinical minimum qualifications on site. | | | Merge with Standard 1.2.7: So possible: ‘best practice – personnel management (EB, Eldernet)  Definition of “service provider required (staff, consultant, tradesperson etc.) | | | Keep the standard in one way or another  The education requirement could be fleshed out  Could be linked with CCDM standards and anticipatory planning for populations including skills, R&R and so on  Could include artificial intelligence and technology coming into ARC as an alternative human resource  Suggest consumer feedback on timeliness and appropriateness of staff, staffing levels/skills  Suggest consumer feedback on whether the service is meeting the needs of the consumers with the compliment of staff | | | Merge standards 1.2.7  Statement would need to be reflective, if merged, to reflect changes to pay equity legislation | | |
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| **Standard 1.2.9:** Consumer Information Management Systems (HDS(C)S.2008:1.2.9): Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required | | | | | | | | | | | | | | |
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| Provider links to primary health care records – integration and interfaces (NZ CoM)  Privacy concerns for patient information - held electronically and paper.  Cyber security  Ethnicity recording  Use of national definitions across Health Information and privacy STDs for clarity  Ensure integration of health information | | | Some comment of the costs of management a safe IT system client details for these small services  Need to share client information safely - consent to share  Manage security of emails and access to information. | | | This standard should cover information data in all forms; IT systems, e-storage, security, photography etc. | | | Suggest inclusion of all ‘e’ electronic types of interfaces such as interRAi, Tonic, Medimap, e-prescribing, Facebook and so on  Privacy issues to consider further and may link or merge with other standards  Consider further access to these platforms without the current supply of energy (electricity) | | | Statement needs to reflect change in I.T innovations including, e-storage systems, security of data bases and accessibility by providers  Due to the changing environment – suggest using a high level privacy / storage principles (N.Berry, NZCare) | | |
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| **Outcome 1.3:** Continuum of Service Delivery: Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation  MHA: Reword to be person centric  RD: Use active language, Consider inclusion of whānau | | | | | | | | | | | | | | |
| **Standard 1.3.1:** Entry to Services (HDS(C)S.2008:1.3.1): Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified | | | | | | | | | | | | | | |
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| Needs to be reworded ensuring patient centred and determined  Criteria need to be transparent so patients understand nuances  Ensure equity/inequity lens (refer earlier narrative)  Where does timely ‘facilitation to appropriate service’ sit – ie. Referral to a different agency, transfer of care. Acknowledge receipt of referrals (NZCoM)  What is safe for patient outcomes  While standard may relate to all service types may need service type specificity at criteria level – eg. DHB Hospital may assess every presentation, however Birthing Units may exclude due to risk based outcomes  Link to the ‘communication’ standard and cyber security (NZCoM)  Q: should monitoring functions be in Part 2  Ability to audit access (NZCoM) | | | 1.3.1.5 apply to all service types  Inclusion of ‘where available’  Consider ‘appropriate referral’  Referral vs vacancy  Include specific criteria re kaupapa services  Ability to ‘opt out’, choice offered  Auto referral to kaupapa then ‘opt out’ (sometimes kaupapa not always referred to) – eg. Referred to Kaupapa, then ability to change to mainstream if wish  Consider emerging health issues, and discrimination, equity. | | | Merge 1.3.1 and 1.3.2 – ie. Entry, decline and exit (refer 1.3.10)  Consider terminology: Access to services | | | Agree required  Consider term ‘access’  Merge 1.3.1, 1.3.9 (referral), 1.3.10 (exit, discharge) | | | Consider merging with 1.3.2 (and 1.3.10)  Acceptance dependent on meeting the individual’s needs, it is more than a NASC assessment and standard should be multidimensional to reflect same  There are aspects of the process outside of the provider’s control (eg. Ensuring all information available at referral) | | |
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| **Standard 1.3.2:** Declining Referral/Entry to Services (HDS(C)S.2008:1.3.2): Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate | | | | | | | | | | | | | | |
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| Reword – refer comments against 1.3.1  Ensure outcome based | | | Q: merge/link with 1.3.1 | | | Refer above | | | Not relevant – modular, opt out | | | As currently written ‘falls short’ for people  Refer 1.3.1  Needs to be reworded when declining a service to include responsibilities and partnership with the funder and the persons choice (N.Berry, NZCare) | | |
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| **Standard 1.3.3:** Service Provision Requirements (HDS(C)S.2008:1.3.3): Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals | | | | | | | | | | | | | | |
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| Retain as main standard with the following standards being converted into criteria:   * + 1.3.4 Assessment   + 1.3.5 Planning   + 1.3.6 Intervention   + 1.3.8 Evaluation   May need to adopt ‘modular’ approach to crafting criteria content  Discussion about ‘rehabilitation’ – consider dedicated standard but opt-in/opt-out | | | 1.3.3.5 & 1.3.3.6 across all service types  Language – mental illness  Assuming capacity when planning  Default to include patient  Potential with one overarching (1.3.3) with inclusion of 1.3.4 (assessment), 1.3.5 (planning), 1.3.6 (intervention), 1.3.8 (evaluation). Need to strengthen for addiction services. | | | Requirement to complete interRAI needs to stay  Assessment is time intensive, may be pressure for ARC if acute services do not complete interRAI prior to discharge   * + I didn’t really understand this part of the conversation- I always required an InterRai prior to admission- otherwise how can we be sure that the person is being admitted to the right service level (LR, Alzheimer’s NZ)   Duplication with 1.3.3 and 1.3.4, 1.3.5, 1.3.6, 1.3.8 – essentially 1.3.3 (timeliness) covers everything with repetition when auditing  Consider some degree of merging above suite with overarching ‘timeliness’ standard, potentially shorten statements relating to 1.3.4, 1.3.5, 1.3.6 and 1.3.8:   * + Agree, combine as described 1.3.3-1.3.9, possible: ‘the service provision journey’ (EB, Eldernet)   + Keep the Nursing Process so it flows (LC, HDANZ)   Noted: there is a link to ARC contract with prescribes timeframes  Dental services recommend oral health assessment on admission (then included in regular review processes)   * + This is an input rather than an outcome, would be good for focus to shift to shift to outcomes rather than identify each input individually (LR, Alzheimer’s NZ)   It was noted HCSS have care pathways/ key areas of care (eg. Skin integrity, challenging behaviour) as dedicated standards  View that current standards meet needs of all admissions – also case for different ARC service types – eg. Rest home, hospital, dementia, psychogeriatric services  Discussion about respite services:   * + Timeframe requirements can be burdensome   + The intent and definition to be considered   + Respite residents are often complex as respite offers ‘relief’   + Definition of respite used to be restorative   + Link to national contract review (to be taken to NZACA)   Consider restorative health in definitions/ standards | | | Consider language – what is ‘timely’ and ‘appropriate’  Looking for outcome based standards  Clinical pathway concept discussed – all presentations can be covered by outcome based standards, pathways not required  A risk assessment approach for all presentations is the preferred option  Would like to see better links to DHB in respect of transitioning – noting the ‘push’ from DHB’s often create the most risk as everyone is pressured (etc)  Role of Nurse Practitioner – fantastic  Current workforce creating challenges  Agree concept of 1.3.3 as overarching with 1.3.4, 1.3.5, 1.3.6, 1.3.8 as subset. | | | Language specific for disabled people, ensure disability focus (as opposed to a health focus)  Focus on the user of service (as opposed to the provider), discussion around not having a Part 3 and embedding all aspects into [current] Part 1 (ie. Consumer rights). Agreed while some aspects could fit into consumer rights there are aspect of service delivery that stand alone  Considered having standard 1.3.3 as overarching with currently 1.3.4, 1.3.5, 1.3.6 and 1.3.8 sitting ‘underneath’ – agreed in principle as long as there is disability specific guidance, and the implications for implementing for ‘mixed model’ services – eg. Aged residential care and disability | | |
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| **Standard 1.3.4:** Assessment (HDS(C)S.2008:1.3.4): Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner | | | | | | | | | | | | |
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| Refer Standard 1.3.3 | Strengthen for addiction | | | Refer comments against 1.3.3 | | | Refer comments 1.3.3 | | | Refer 1.3.3 | | |
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| **Standard 1.3.5:** Planning (HDS(C)S.2008:1.3.5): Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | | | | | | | | | | | | |
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| Refer Standard 1.3.3 | Patient involvement/directed. | | | Some criteria MHA specific   * + Could go across ARC as variety of residents being admitted into services   + Complex folk   + Maybe modular   Also refer notes against 1.3.3 | | | Refer comments 1.3.3 | | | Refer 1.3.3 | | |
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| **Standard 1.3.6:** Service Delivery/Interventions (HDS(C)S.2008:1.3.6): Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | | | | | | | | | | | | |
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| Refer Standard 1.3.3 | Refer comment 1.3.3 | | | Refer comments 1.3.3 – support overarching with care planning, implementation, evaluation | | | Refer comments 1.3.3 | | | Refer 1.3.3 | | |
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| **Standard 1.3.7:** Planned Activities (HDS(C)S.2008:1.3.7): Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service**.** | | | | | | | | | | | | |
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| Consider as modular – does not align with current wording to services at workshop | Plans need to represent patient interest/s, be meaningful, and personalised  Patients need to be able to opt-out. | | | Or: person centred, meaningful activities (EB, Eldernet)  ? move into consumer rights, this may shift the focus from the provider running the programme, to meeting the individuals preferences  Activities need to be meaningful to the individual (as opposed to staff &/or family) and person directed  Need to understand what is meaningful for the resident, otherwise activities just become entertainment  Quality and knowledge of person supporting the activities programme was discussed, noting the expressed view was that activities are part of everything, everyone has responsibility – suggested the staffing aspect of activities could be included in 1.2.7 (Human Resource Management)  Be mindful of social isolation and loneliness  Engagement with staff and other residents can also be meaningful – noting time constraints on staff and the busy nature of services  Discussed different service types – rest home and dementia, hospital and psychogeriatric   * + The challenges are more evident when individual do not meet the ARC model   + Activities need to be based on individual needs/desires   + Could also link components to activities within the nursing process to meet ‘daily routines’ in care planning (LC, HDANZ) | | | Q: do we need a dedicated standard or should these aspects move across to care planning (link 1.3.3)  Agreed meaningful activities are required: but what does this mean  Standard needs work to meet current needs – consider language eg. Leisure/ recreation  Language should be resident centric  Current standard no different for dementia/ specialist hospital services – stay away from dementia specific requirements  Dual services (eg. Hospital, rest home) challenge when developing/ implementing activities programme/s, likewise with different contracts – eg. YPD  Social isolation discussed – some folk may be overlooked | | | Q: should activities be planned?  Language – terms such as: fulfilling, meaningful need to be included, actively support to …, individually tailored  Need the ability to reflect ‘life’ – which is not always timetabled, and a person changes their mind about attendance/ participation, the choice to change  Sometimes staffing restricts flexibility  Activities are generally part of a flexible service delivery plan  Need to include spontaneous opportunities with provider facilitating  Insinuates people have to ‘go out’ but this is not always meaningful to the individual  Individualised plan  Variability within group – disability – activities unstructured, rehab – structured  Use Enabling Good Life Principles e.g. providing opportunities, life tasting experiences, activities that are interesting and meaningful for the person, developing of skills etc. (N.Berry) | | |
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| **Standard 1.3.8:** Evaluation (HDS(C)S.2008:1.3.8): Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | | | | | | | | | | | | |
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| Refer Standard 1.3.3 | Refer comment 1.3.3 | | | Refer comments 1.3.3 – support overarching with care planning, implementation, evaluation | | | Refer comments 1.3.3 | | | Refer 1.3.3 | | |
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| **Standard 1.3.9:** Referral to Other Health and Disability Services (Internal And External) (HDS(C)S.2008:1.3.9): Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs | | | | | | | | | | | | |
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| Merge: 1.3.9 & 1.3.10  Link to 1.2.9  Link to accessibility and consumers  Ensure transition across services (internal and external)  Discussion re an electronic standard:  Data integrity/security (etc)  Perhaps aspirational – MoH to take lead (?)  ? dedicated DHB  Data sovereignty to be considered | Include social and physical health referrals  Link to 1.3.1  Include equity  Community supports – formal and informal. | | | Restorative model/concept could sit in consumer rights and reflect individual independence  Restorative model could be a resourcing issue  External – including allied health (eg. Speech language therapist)  Aspirational – looking to a ‘rehab’ model, maybe need to look at standard with more consideration, may lead to provider flexibility. The Standards therefore need to be sufficiently flexible to meet future models of care.  Flexible service delivery models require staff with critical thinking skills – eg the RN recognises the need to contact other health professionals (eg. Dieticians)  Consider ARC as extension of DHB’s:   * + When DHB moves into a ‘code red’ situation move residents across to ARC   + This may support locality placement   + Implementation of this concept links to funding issues   Government – looking to keeping people at home, consider longer periods of respite – eg. six week blocks in order to support improve state of health resulting in longer period at home (before requiring ARC placement)  Insure review aligns with the work of the Ombudsman in respect of dementia and psychogeriatric services  Alignment to contract | | | Merge 1.3.1, 1.3.9 (referral), 1.3.10 (exit, discharge) – all under access  Relationship considered to be component of successful referral  Understanding the threshold for referral (can be difficult to measure)  The stigma of ARC can be challenging in terms of timely response to referral – prioritisation occurs based on resource  Funding interface  ARC not always responsible to outcome (ie. Referral not accepted)  Access to specialist services difficult  Measurement currently – meet standard if referral sent, consider outcome based approach | | | Required standard – need to include social and community  Retain appropriately facilitated  Noting: cannot meet every person’s needs, referral is often inevitable | | |
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| **Standard 1.3.10:** Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10): Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | | | | | | | | | | | | |
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| Merge: 1.3.9 & 1.3.10 | Community supports – formal and informal  Consider transition at patients pace, not ‘service funding’ pace  Assumption prescribed transition – need to address. | | | Merge with Access to services (refer comment against 1.3.1) | | | Discussion: denial vs exit  Merge 1.3.1, 1.3.9 (referral), 1.3.10 (exit, discharge) – all under ‘access’ | | | Refer comments against 1.3.1 – potentially merge (.3.1, 1.3.2)  Provider is not mentioned in the statement  Include ‘timely’  May be instances of unplanned exit – eg. Police involvement  Not always the provider not working in a planned way – may be involvement of other agencies  Needs to link to contracts  Should this include end of life planning (N.Berry), NZCare) | | |
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| **Standard 1.3.11:** Use Of Electroconvulsive Therapy (Ect) (HDS(C)S.2008:1.3.11): Consumers who are administered electroconvulsive therapy are well informed and receive it in a safe manner.  (Only mental health services that provide ECT need to comply with Standard 3.11) | | | | | | | | | | | | |
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| DHB only module | Note standard states: ‘use’ of – need to include residential arm – maintenance occurs at residential service  Include: whānau, patients who access, who goes with, post ECT care | | | Modular with ARC opt out | | | Modular – opt out | | | Opt out  Mental health providers at workshop indicated interest in a post ECT recovery standard | | |
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| **Standard 1.3.12:** Medicine Management (HDS(C)S.2008:1.3.12): Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | | | | | | | | | | | | |
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| Amendment required – did not fully explore due to time constraints | Interest in seeing a medication plan  Specific to MH residential  Criterion 1.3.12.7 – relevant to all services  Consider inclusion of Rongoa  Address over the counter medications and prescription management specifically on transfer between agencies | | | Policy aspects could move to (current) 1.2.3 (quality & risk), and staff training/competency to 1.2.7 (human resources)  Current gap is the provider being responsible for GP practice (i.e. GP review completed outside of prescribed timeframe)   * + Q: contract for service (ARC & GP practice) is not considered at audit – should it be   + Individual practitioner issue – where does this accountability lie   + Does facilitating GP reviews sit within RN scope   Consider inclusion of: ‘appropriately prescribed medicines’ – this should cover aspects such as chemical restraint and reconciliation   * + Don’t think the word “chemical restraint’ is acceptable terminology. All the literature I have read shows it has not been acceptable for 20 years. The terminology itself is stigmatizing. In no other medical condition are drugs referred to as “chemicals.” Moving away from the historical concept of chemical restraints and toward an understanding that medications are instead used to treat the condition of agitation and its underlying causes is current good practice. Antipsychotics are not being used so that residents are unable to move, communicate, or to impair the patient’s ability to appropriately interact with their surroundings. I would suggest we do not mention ‘chemical restraint’ in this document and review of the standards. It is sufficient to state…. Consider inclusion of: ‘appropriately prescribed medicines’ – this should cover aspects such as antipsychotics and reconciliation. (LC, HDANZ)   Some services undertake regular review of antipsychotic use  Criterion 1.3.12.7 currently pertains to MHA, confirmed applicable to ARC (noting the variety of individuals they support in ARC) | | | Work to be done on this standard  Currently some duplication re documentation (eg. Policy)  Electronic prescribing (etc) to be included/considered  Standard not currently outcome focused  Re prn – is the effectiveness checked, could do this better – frequency, intention  Currently some providers using two systems – electronic and paper based (for short term admissions)  Need for standard to support quality of life  The ‘process’ of safe medication could be moved to 1.2.3 with individual related aspects remaining in Part 3  Consider inclusion of reconciliation  Use of covert medication – link to consent  Q: should RN competency be completed annually (noting medication guides suggest yes)  Discussion re caregiver competencies: re controlled drug administration (in particular fentanyl spray)  Discussion standing order   * + Just one really the question of making RNs complete medication administration competency training annually. It wasn’t a question of should they do it. It was a firm recommendation that there is no need to do it justified by     - Errors have reduced with electronic prescribing (ie medications errors were process not individual driven)     - RNs administer meds every day up to 3x a day – they do not forget how to do it by the end of the year     - RNs have a competency process – an annual practicing certificate run by the professional body     - RNs who do  not work for residential care do not do an annual competency assessment – so we are discriminating professionally based on where you work     - It is only in the care guide because it was in the standard and ARRC contract – chicken/egg     - (J.Daltrey, Nurse Practitioner, WDHB) | | | Discussion around whether this should be included in the ‘health’ standard and not the disability – agreed that there are aspects of medication management that relate to disability. Dedicated standard is important for staff in terms of safe practice  Self-administration to be included  Need guidelines specific to residential services – current are not ‘fit for purpose’  Language: ‘… are supported to…. Safe medication  Some aspects could move to Part 2 (quality & risk)  Some issue around alternatives – eg. Health supplements that a person wants to take, however the GP won’t prescribe, and the guidelines are not permissive at the moment. Same goes for over the counter medication  Chemical restraint: noted a definition is included in current standards (within ‘foreword’ of RMSP) – prescribing to be considered – eg. Including indications for use for prn, and minimum and maximum doses (within 24 hour period) | | |
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| **Standard 1.3.13:** Nutrition, Safe Food, and Fluid Management (HDS(C)S.2008:1.3.13): A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | | | | | | | | | | | | |
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| Amendment required – did not fully explore due to time constraints  Clarification required re ward food fridges (HQSC) | Inclusion of healthy eating  Dietary needs to be provided for  Timing of meals – eg, Ramadan | | | Two aspects to this current standard  Nutritional support for the individual  Food safety – including food plans, potentially move to Part 4  Ensure differentiation between explained and unexplained weight loss (eg. Palliative individuals may have anticipated weight loss, which is not reflection on service delivery  Dental – need a strategy for formally assessing oral health on admissions (and thereafter)  Noted that the ‘Food and nutrition guidelines (age specific)’ relate to the health older adult | | | Q: should individual food services be linked into care planning (link 1.3.3)  Organisational approach to food for individuals needs consistency  Differentiation between intentional and unintentional weight loss  Support separating food control aspects (? Into Part 2) from individual needs  Discussed new: IDDSI framework (SLT) | | | Discussion – could this be a component of service delivery  Consider moving aspects relating to the Food Act into Part 2, and keep this standard focused on individual requirements  Need to be inclusive of nutritional requirements for those that don’t eat and/or eat a modified diet  Need to include compliance with the Food Act 2014 & National Healthy Food and Drink Policy, developed by the National District Health Board Food and Drink Environments Network in 2016. Note: there could be an updated version, Need to add informed choice / decision making relating to this, Include compliance with specialist reports (N.Berry, NZCare) | | |
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| **Outcome 1.4:** Safe and Appropriate Environment: Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.  ARC 31 July:   * Interest in modular approach for this section ARC only * Focus on different levels of care within ARC (DSS, LTC, restorative, palliative, bariatric etc) * Reflective of quality of life and individual needs * “Home” focus rather than institutional * Cleaning and Laundry to be merged with IPC * Add environments are “it for purpose” and remove standard 1.4.2 * Merge standard 1.4.6 to IPC   RD: Needs to be reflective of home environment  ARC 9 August:   * Relevant standard-needs amending to include definitions, criteria and the consumer perspective * No guidance on what this should include and how much safe and appropriate spaces are required. * No guidance on what amenities are essential, and or nice to have, in or out of this space. * Suggest consumer involvement with determining and or measuring an independence outcome * Suggest consumer measure to determine if the environment meets their needs. * No objective definition of how to meet this standard | | | | | | | | | | | | |
| Standard 1.4.1: Management of Waste and Hazardous Substances **(**HDS(C)S.2008:1.4.1): Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **DHB/PH/Hosp/BU** | | | **DHB/PH/Hosp/BU** | | | **DHB/PH/Hosp/BU** | | | **DHB/PH/Hosp/BU** | | |
| Ensure management of protective equipment, expand specifics for (HQSC) cytotoxic waste & align with new health and safety legislation (HQSC)  Cross over with IPC standard on waste management (NZNO IPC) | Need to be relevant to the service being provided  System or waste management – consider sustainability/recycling. | | | Sustainability, Green Planning (emissions), recycling etc., to be added  Non-hazardous waste to be merged with IPC (clean/dirty and design etc)  Separate Hazardous from non-hazardous waste | | | Relevant standard in this changing world | | | Move 1.4.1 to IPC  Consideration needs to be given to number of clients/residents in premises or own homes  Define/split hazardous waste/volume  ? merge into the IPC Standard (FM IP&C Nurse Specialist).  If a client is in a rental home vs their own home the responsibilities of fit for purposes and ongoing maintenance will differ. The dilemma of compliance from someone who owns their own home and chooses to not comply with the standard, does owning one’s own home provide an opt out for compliance with the safe environment standard? On the basis that it their home to do with what they please? (FM, IP&C Nurse specialist)  Hazardous waste discharged from a resident’s home is governed by council bylaws. Where there is a large volume discharged as kerbside waste the council may intervene. On the other hand, blood and body fluid waste is discharged domestically by just about every household. Need to revisit the definition of hazardous waste and assess whether the client is going to discharge a large volume of hazardous waste, in which case waste segregation and different coloured bags may need to be assessed. (FM, IP&C Nurse specialist) | | |
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| **Standard 1.4.2:** Facility Specifications (HDS(C)S.2008:1.4.2): Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | | | | | | | | | | | | |
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| Recognition of aged buildings, maintenance and earthquake proofing (at present if built prior to standard except which is contributing to lack of transparency ) (HQSC)  Consider carbon footprint in respect of environmental and support system management, recycling  Cross over with IPC specifications on safe buildings from IPC perspective (NZNO IPC) | Lots of discussion here- there seems to be different interpretations around the facility specs for providers.  Inclusive of health and safety programme  Maintenance programme is responsive  Need to consider ligature points – alignment with services being delivered  Mention of hot water monitoring!! | | | “Fit for purpose” covered in Main standard statement so remove this standard | | | Requires guidance on what this should include and no definition of an appropriate, accessible physical environment.  Requires guidance on what amenities are essential, and or nice to have, in or out of this environment.  Requires consumer involvement with determining and or measuring appropriateness, accessibility, and fit for purpose.  Requires an objective definition of how to meet this standard. Currently, this leaves it open to a broad or narrow interpretation by the provider and auditors.  Should ‘fixtures and fittings’ be included at every audit?  Should the ‘up-to-date ‘maintenance schedule’ be included for all fixtures and fittings at each audit? | | | Delete as statement should be included in main statement  Amend rather than delete. I think the point here was that the group agreed that good governance would include this and should be part of describing what good governance looks like for this part of the sector. (FM, IP&C Nurse specialist) | | |
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| **Standard 1.4.3:** Toilet, Shower, and Bathing Facilities (HDS(C)S.2008:1.4.3): Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirement | | | | | | | | | | | | |
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| Consider including improvements for patient safety – coloured toilet seats for aged and dementia patients  Handwashing areas are for handwashing only  Isolation challenges – with toilets/ showers in hospitals  Cross over with IPC specifications on safe buildings from IPC perspective (NZNO IPC) | No issues | | | Add appropriate for needs (reflective of services offered)  Reverse with standard 1.4.4 placed in front of this standard | | | Requires an objective definition of how to meet this standard. Currently, this leaves it open to a broad or narrow interpretation by the provider and auditors.  Requires a definition for adequate.  Requires consumer involvement with determining and or measuring the adequacy of toilet /shower /bathing facilities  Requires consumer choice about which toilet/bath/shower to frequent, and preferences for when to have a shower/bath  Requires the consumer perspective related to their privacy when attending to, or receiving assistance with personal hygiene.  Requires inclusion of hot water temperature monitoring over time  Think this is quite important around privacy of the resident as often see residents being wheeled up the hallway with a towel wrapped round them following a shower but their backsides exposed. Possibly needs to be linked to Section 1.1 Consumer Rights (C.Ropati, CHT) | | | Needs to reflect residents who live in a smaller home environment  ‘Accessibility and independence’ needs to be included in statement  ‘Fit for purpose’ – to reflect non-institutionalised facilities | | |
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| **Standard 1.4.4:** Personal Space/Bed Areas (HDS(C)S.2008:1.4.4): Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | | | | | | | | | | | | |
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| No comment  Cross over with IPC specifications on safe buildings from IPC perspective (NZNO IPC) | Need to consider the therapeutic rationale in respect of the environment - conversation about this client group often need to develop skills with others – there illness often makes them isolated and engagement and working with others is included in model of care. | | | Access to space and amenities  Specific to areas of care (bariatric, palliative, DSS, psychogeriatric ) etc. | | | Requires a definition for adequate.  After initial audit, does this need to be audited at every audit? | | | Covered in main statement under facilities specifications. | | |
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| **Standard 1.4.5:** Communal Areas for Entertainment, Recreation, and Dining (HDS(C)S.2008:1.4.5): Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | | | | | | | | | | | | |
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| Ensure suitability of spaces for patients, families.  Cross over with IPC specifications on safe buildings from IPC perspective (NZNO IPC) | These areas are really important areas for engagement to ensure model of care is being delivered. | | | Appropriate access, amenities, furniture, specific to each level of care provided  Design has quiet spaces and whānau rooms separate from communal areas | | | Requires consumer involvement with determining and or measuring the adequacy, appropriateness and accessibility of each communal area  Requires consumer involvement with determining and or measuring the degree that communal spaces meet their relaxation, activity, and dining needs | | | Question – remove ‘Age’ from appropriate’  Include ‘physical needs’ into statement  Recreational /quiet spaces separate from main integrated areas | | |
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| **Standard 1.4.6:** Cleaning and Laundry Services (HDS(C)S.2008:1.4.6): Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | | | | | | | | | | | | |
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| Need to raise importance of cleaning services – regular monitoring and auditing of service delivery – responsiveness across all services  Consider move to IPC standard (HQSC + NZNOIPC) | Need to consider safety – balance with client undertaking laundry and staff support.  Recovery based programme  ‘Home is shared’ – provider to keep the standard  Home like environment – for some clients under treatment orders more support and need to have duty of care. | | | Merge standard 1.4.6 to IPC  Cleaning- inclusive of equipment cleaning in-between multi usage ( wheelchairs etc.)  Laundry – inclusive of IT systems now used in this area | | | Lost items and shrinkage rate high on the complaints items of many facilities  Suggest consumer satisfaction with the laundry services, the smell of clothes, cleanliness of clothes, shrinkage and lost items | | | Merge in to IPC  Needs to be reflective of home environment where appropriate | | |
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| **Standard 1.4.7:** Essential, Emergency, and Security Systems (HDS(C)S.2008:1.4.7): Consumers receive an appropriate and timely response during emergency and security situations. | | | | | | | | | | | | |
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| Staff training in emergency management.  Use of CCTV, staff security in and outside hospital environment  Need future proofing. | Confusion about first aid trained staff being on duty. | | | Provide an appropriate and approved functional emergency plan  The plan to include being a recipient of consumers from other facilities in times of emergency (e.g. flooding in an area/region) | | | Requires ‘fleshing out’  Back up plans are not audited and could be included in the requirements of the standard  Requires a better understanding of the how, what, when, who occurs during power cuts-e.g. no access to medimap, Tonic, interRAI, e-prescribing, heating/ cooling, light and so on  After initial audit, does the emergency plan need to be audited at every audit? | | | No Change | | |
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| **Standard 1.4.8:** Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8): Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature | | | | | | | | | | | | |
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| Smoke free environment strengthened and managed for hospital  Cross over with IPC specifications on safe buildings from IPC perspective (NZNO IPC) | No issues. | | | This standard to include all areas of the facility (bathrooms, kitchen, etc.)  Climate change plan taken into consideration, adverse weather conditions | | | Temperature control in modern glass ARC buildings, and older ARC buildings is becoming challenging during hot summers and cold winters(particularly for residents that are bed bound).  Suggest specific guidance in the standard re safe and comfortable temperatures in bedrooms and communal areas.  Consider perceptions of heat within this context | | | Comment: Group divided on this statement; some felt it could be deleted as felt it was covered under 1.4.2, 1.4.4 and 1.4.5 others felt it stays as is but needs to be inclusive of home like environments and fit for purpose meeting a minimal standard | | |
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| **Outcome 2.1:** Restraint Minimisation: Services demonstrate that the use of restraint is actively minimised.  ARC 31 July: As the sector is moving towards ‘restraint-free’ environments, should we move to a standard titled: Challenging Behaviour and Management, should be a different focus for ARC – ie. Restraint free. Thoughts regarding a possible standard title change, please ensure we use the appropriate language, ‘behaviour’ that is challenging is an expression of distress, so an example of wording would be: ‘behaviour that challenges staff in providing care’ (S.Holland, Gerontology NS). Ombudsman using the word ‘detention’ in their work in the sector. Possible change: ‘detention, restraint and constraint minimisation’. While detention sounds alarming, constraint is gentler and gets to the heart of the issue of encouraging personal expression and freedoms (LB, Eldernet)  RD: Whatever the look of a new standard, resident rights need to be maintained  ARC 9 August: Relevant standard, Lot of work to do aspects to consider: environmental restraint, freedom of choice, enabler use and role of EPOA, chemical restraint and covert use of medication (also link 1.3.12) | | | | | | | | | | | | |
| **Standard 2.1.1:** Restraint minimisation (HDS(RMSP)S.2008:2.1.1): Services demonstrate that the use of restraint is actively minimised. | | | | | | | | | | | | |
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| Language – restraint has negative connotation consider: provide an environment to keep patients safe  Keeping safe (+ve) vs restraint (-ve)  Include verbal de-escalation & include training  Modular approach  Agreement standard needs amending  Keep nursing process concept – assessment through evaluation. | Discussion re title: should the standard be ‘Safety for All’; ‘Harm Prevention’, ‘Safety Support’: CONSUMER VIEW: restraint is what is occurring, keep current title  Definitions currently narrow  What is restraint  Include definition of chemical restraint  Consider different levels of restraint – ie, ‘taken to floor’ at extreme end  What is ‘appropriate restraint  Too prescriptive  ? categories: personal restraint, physical restraint  Language needs to reflect degree of physical restraint  Need overarching principle – include obtaining consent, safety support plan  Operating policy needs to be open and transparent  Actions taken – should vary based on levels of restraint taken (operating policy should reflect)  Language to be more accessible to public  Incorporate staff safety  Consider CTO – which enforcing treatment  Enabler use to be considered – question as to whether it should be included in restraint definitions at all (different approach/purpose) or more appropriately included as a support in 1.3.3 or 1.3.6 (Ashburn Clinic)  All current processes – assessment, monitoring, de-escalation, review for inclusion  MH & Addiction do it well – other areas opportunity to improve  Right to feel safe – and others around us  Episodes of restraint could be an incident report with a link to governance/ recording/trending etc.  Agree a register would be helpful to retain  Training: define, include de-escalation/debrief  Quality review to include consumer feedback  Incorporate equity  Restraint definition (pg. 30) - add sub-categories to definition of personal (amend Ashburn) restraint to reflect the degree of restraint and assist incident reporting. Currently we record the type of hold (SPEC training) but not all services will utilise this training model (Ashburn Clinic)  Service provider definition (pg. 31)– too vague, especially where training requirements (e.g. restraint) are concerned. Probably the intent is for nursing/carer staff but many services have a range of service providers (staff who work for the service) who would not be required to meet a specific standard as it does not apply to their practice, e.g. non-clinical, psychiatrists, psychotherapists, OTs. (Ashburn Clinic) | | | Consideration of chemical restraint could be considered against 1.3.12 (see comments against same)   * + Do not agree this should be mentioned as such (LC, HDANZ)   Definitions to be revisits – being clearer between a ‘restraint’ and an ‘enabler’ – link to health literacy (note earlier comments also)  Leave enabler use within the restraint standard – this aspect of care still needs to be managed  With regards to enabler use – clearer definition as EPOA can provide consent for an enabler. Is this then ‘voluntary’ (E.Lear SIAPO)  Interface with the Ombudsman needs to be apparent  Restraint (use and minimisation) is still significant enough to have a dedicated standard (noting interest in name change above)  Q: where does the person centred approach factor – discussion around health professionals having a ‘duty of care’ where individuals are not competent: Thanks for capturing this – when does the duty of care become more important than what the person wants, also competency varies etc … complex area (LR, Alzheimer’s NZ)  Services need to manage the risks related to restraint – this aspect could be included in the ‘care delivery’ part of standards  Structured process to remain – ie. Approval, assessment, safe use (monitoring),evaluation  Monitoring - timeframes related to risk  Refer comments against 2.2.5 (restraint monitoring & quality review) | | | Definitions and guidance need work  Not restraining can create other tensions – eg fall rate increase  Consider language – promoting safety  Language currently punitive – reframe  Enabler use – what is an enabler (and interpretation at audit)  Where does the compassionate support sit – eg hand holding  Key to what is restraint is the ‘intent’  Monitoring should be a risk based approach – more guidance required  Retain current assessment, monitoring, review processes (noting review should also be risk based – ie. Each ‘episode’ may not require review)  Discussion – different between chairs that restrain and therapeutic seating: agreed linked to intent  Need to look at bigger picture  Chemical restraint discussed – linked back to intent | | | Discussion restraint vs enabler – philosophically different (noting auditor variation)  Enablers: need to enable a more fulfilling life  Q: does enabler fit – could move to service delivery (Part 3) perhaps with a dedicated standard: mixed view  Definitions require review to minimise interpretation   * + I do have one other comment around restraint: enablers are defined as restraint a person agrees to. Physical restraint is the use of equipment etc and the person may not be able to provide consent therefore it is restraint but if a person has cerebral palsy and requires a lap belt and chest harness etc for appropriate seating and safety- why is this considered as restraint? (J.Hampton, Brackenridge)   Locked units and environmental restraint discussed  Decision to restrain is made by a third party (ie. Individual does not determine), could link to Informed Consent  Views of the individual paramount – use, duration,  Degree of monitoring of restraint to be linked to risk associated with the restraint being used  Isolation – to be considered as can be perpetuating and lead to challenging behaviours  Actively minimising restraint is NOT ENOUGH, service should demonstrate that restraint is the last resort, and evidence steps taken (eg. De-escalation) to be restraint free – need to understand why the behaviour is occurring  Challenging behaviour is derogatory – language – and can perpetuate the behaviour  Consider: ‘positive behaviour support strategies’  Workforce level of competency – providers need a workforce strategy  Standard does not define physical restraint – eg. Holding hand through to full hold. Now seeing more full holds in disability   * + Is this not considered Personal restraint? Restraint needs to be clearly defined to avoid the opportunity for misinterpretation. Personal restraint is monitored to meet the training criteria ie. MAPA (J.Hampton, Brackenridge)   Service specific guidance  Agreed reviewed standard include components: assessment, monitoring, review, evaluation (as currently listed), with an organisational strategy to minimise | | |
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| **Outcome 2.2:** Safe Restraint Practice: Consumers receive services in a safe manner. | | | | | | | | | | | | |
| **Standard 2.2.1:** Restraint approval and processes (HDS(RMSP)S.2008:2.2.1): Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | | | | | | | | | | | | |
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| Refer 2.1.1 | Refer 2.1.1 | | | Refer comments against 2.1.1 | | |  | | | Refer standard 2.1.1 | | |
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| **Standard 2.2.2:** Assessment (HDS(RMSP)S.2008:2.2.2): Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | | | | | | | | | | | | |
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| Refer 2.1.1 | Refer 2.1.1 | | | Refer comments against 2.1.1 | | |  | | | Refer standard 2.1.1 | | |
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| **Standard 2.2.3:** Safe Restraint Use (HDS(RMSP)S.2008:2.2.3): Services use restraint safely | | | | | | | | | | | | |
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| Refer 2.1.1 | Refer 2.1.1 | | | Refer comments against 2.1.1 | | |  | | | Refer standard 2.1.1 | | |
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| **Standard 2.2.4:** Evaluation (HDS(RMSP)S.2008:2.2.4): Services evaluate all episodes of restraint. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| Refer 2.1.1 | Refer 2.1.1 | | | Refer comments against 2.1.1 | | |  | | | Refer standard 2.1.1 | | |
|  | | | | | | | | | | | | |
| **Standard 2.2.5:** Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5): Services demonstrate the monitoring and quality review of their use of restraint. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| Refer 2.1.1 | Refer 2.1.1 | | | Consider language  Potentially move to current 1.2.3 (quality & risk), provides opportunity for restraint-free services to showcase work programmes services are implementing to continue to be restraint free  Note: if a services is not restraining at time of audit, this Outcome (2.2 Safe Restraint Practice) is not audited, therefore quality initiatives are not always captured | | | Could move quality aspect to 1.2.3 | | | Move to Part 2 – this would enable providers who do not restrain to ‘showcase’ improvement activities undertake to remain restraint-free | | |
|  | | | | | | | | | | | | |
| **Outcome 2.3:** Seclusion: Consumers receive services in the least restrictive manner. | | | | | | | | | | | | |
| **Standard 2.3.1:** Safe Seclusion Use (HDS(RMSP)S.2008:2.3.1): Services demonstrate that all use of seclusion is for safety reasons only. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| DHB modular  NB: expect this to be relooked at the MHA scoping workshop and to consider HQSC improvement work (HQSC) | Some RD-ID services may seclude  Wrap around restraint – definition. | | | Modular  Be cognisant of definitions – seclusion: 1 person/ 1 room (as opposed to secure units): Again my point here was that providers have made the definitions – how would a person with dementia define a secure unit if they did not have dementia? My example was that we don’t put people with the same medical condition regardless of the condition in one facility/ area EXCEPT for people with dementia, I define that as seclusion (LR, Alzheimer’s NZ) | | | Modular – opt out | | | Opt out | | |
|  | | | | | | | | | | | | |
| **Standard 2.3.2:** Approved Seclusion Rooms (HDS(RMSP)S.2008:2.3.2): Seclusion only occurs in an approved and designated seclusion room. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| Refer Std 2.3.1 | See above. | | | Modular | | | Modular – opt out | | | Opt out | | |
|  | | | | | | | | | | | | |
| **Outcome 3.1:** Infection Prevention and Control | | | | | | | | | | | | |
| **Standard 3.1:** Infection control management (HDS(IPC)S.2008:3.1): There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| This response relates to al IPC STDS.  General discussion – need to review all six standards - to ensure standards are suitable for all health and disability providers – from small homes for disability residents to acute public hospitals.  Strongly recommended a separate (HQSC) Working group specifically for these STDs with representative for IPC clinical nurse specialists (public, private, ARC) (NZNO IPC), ID physicians, microbiologists, antimicrobial leads, IPC Chairs in hospitals, community based IPC specialists, HQSC. Representatives from lead IPC organisations (NZNO IPC)  Update surveillance and antimicrobial STDs for current use  More clarity and specificity with standards e.g. IPC programme plan, training, IPC team, and quality improvement feedback.  Need to consider national initiatives  Some discussion of Australian standards that are more clinically focused.  A number of the 1.4 STDs (Safe Environment) have close links to IPC  The need for more clarity in the standard- there is confusion between functions of the committee and the IPC plan. (NZNO IPC)  HQSC Sepsis 6 for maternity – consider a focus on such initiatives or at least reference (NZCoM) | Pretty happy with all these standards – seen in the light that these services are more a home environment than clinical area.  Recognise the ‘at risk’ client groups for these services – caring for people with Hepatitis and HIV.  Close link with Health and Safety processes. | | | Overarching standard for all services  clarification of “size” and “scope” of service | | | Refer to standard 1.2 suggest separate clinical governance  Difficulty keeping up-to-date with IPC info e.g. CRO/CPO/CRE | | | Statement does not cover home environment  Governance structure needs to be incorporated into main statement  Size and scope of service needs to be defined  ‘Modular’ approach to this standard | | |
|  | | | | | | | | | | | | |
| **Standard 3.2:** Implementing the infection control programme (HDS(IPC)S.2008:3.2): There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| Refer Std 3.1 | Refer comments 3.1 | | | No change for this standard | | | Issues re access to IPC resources and in some areas support from the DHB  NZNO-Offer free IPC updates  Access to IPC education is an issue | | | Does not reflect services provided outside organisations  Statement does not include meeting the consumers’ needs | | |
|  | | | | | | | | | | | | |
| **Standard 3.3:** Policies and procedures (HDS(IPC)S.2008:3.3): Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| Refer Std 3.1 | Refer comments 3.1 | | | Change to wording – replace “good practice” with evidenced based practice and “practical” with appropriate | | | Relevant standard-remove the last sentence | | | Statement not reflective to clients/residents living in smaller ‘home like’ environments | | |
|  | | | | | | | | | | | | |
| **Standard 3.4:** Education (HDS(IPC)S.2008:3.4): The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| Refer Std 3.1 | Refer comments 3.1 | | | add relevant and ongoing education from best practice guides to statement | | | Suggest consumer feedback on IPC information  Consider annual competencies  Education comes at a cost-who pays? | | | Statement needs to reflect best practice and on-going practice  Needs to be relevant to ‘end-users’ | | |
|  | | | | | | | | | | | | |
| **Standard 3.5:** Surveillance (HDS(IPC)S.2008:3.5): Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| Refer Std 3.1 | Refer comments 3.1 | | | Addition of co-ordination with other providers e.g. GP  “Closing the quality loop” missing from standard, add need to take remedial action, evaluate etc. | | | ARC requires different IPC surveillance programme, these need to be targeted, relevant and collecting and collating relevant data | | | Statement needs to be inclusive of primary health providers  Flexibility based on ‘type’ of service as different challenges / needs based | | |
|  | | | | | | | | | | | | |
| **Standard 3.6:** Antimicrobial usage (HDS(IPC)S.2008:3.6): Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians. | | | | | | | | | | | | |
| **DHB/PH/Hosp/BU** | **Residential MH/AoD** | | | **ARC (31 July)** | | | **ARC (9 Aug)** | | | **Res Dis (6 Aug)** | | |
| Refer Std 3.1 | NA | | | No change except the inclusion of all prescribers | | | Not appropriate (as it stands) for ARC  ARC require an awareness but this should not be a requirement  Change the title to Antimicrobial Stewardship-teaching nurses to question prescribing habits  Include a policy requirement so that ARC nurses ask the questions about the use of antibiotic | | | Inclusion of primary /all prescribers needs to be included  NB: General comment from IPC representative that the IPC standard needs to be reviewed separately with relevant professional bodies and consumers. | | |

## Appendix B: Draft Workshop Discussion Document (HCSS)

Scoping Workshop:

Home and Community Support Services

12 August 2019 (9am – 1.30pm)

### General Comments

* Individualised funding (IF) – when does a support worker under an IF model become a provider and therefore required to meet the standard. What is the interface with employment ‘platforms’.
* Modular and outcome focused standards are supported in principle – noting clear guidance required.
* Codesign concept supported in development of standards.
* Interested in the standard being a ‘living document’ – discussed how this could be managed, group consider stewardship of the [Home & Community Support Sector standard] would be retained by the Ministry of Health.
* Consumer participation clearly seen a governance, care and employment levels.
* Complaint and adverse event include resolution processes.
  + In the discussion in our group communication was a significant factor in adverse event and complaint resolution (L.Russell, Alzheimers NZ).
* Management of client information – mix of paper and electronic forms – clarity and guidance to include aspects of non-identifiable, privacy, security and where appropriate share that information.
  + And the issues around client accessibility (to anything about them) when electronic (L.Russell, Alzheimers NZ).
* Whanau care givers transition to employees.
* Health and safety aspects at governance, care settings, client and staff – good links between each.
* Guidance for STDs is clear.
* Service provider term is confusing.
* Agreement that most of the STDs are fit for purpose:
  + I wouldn't say that our group agreed that most of the standards are fit for purpose. There were a number of standards where significant change was recommended (B.Haines, DPA).
* I still have a concern about what is considered adequate/appropriate training for all staff involved with care and support for people with dementia and cognitive impairment. Our experience is that there is insufficient understanding of the issues associated with dementia across staff in day programmes, staff visiting homes, residential facilities and even in hospitals. These relate to communication, advice, support and generally being around people with dementia. Also missing is a requirement to consider appropriate referrals to other support services, knowledge of what other support services exist in the community, and the need for collaborative support approaches. Not sure where these are best added. (F.Blyth, Dementia NZ).

### Part 1

|  | **Relevant** | **Amend** | **Merge** |
| --- | --- | --- | --- |
| **Outcome 1.1: Consumer Rights** | | | |
| Every consumer’s values, dignity, and culture are recognised and supported; their choices respected; and their rights upheld.  Section on consumer rights agreed  Language needs to be user friendly (simply), need to consider understanding  Modular concept supported (clear guidance required)  Language suggested: Overarching ‘Spirit of Care’ statements, with clear ‘Sign Posts’ (ie. Guidance  Outcome focus supported  Consistency in terms of implementation important  *Include beliefs, could merge 1.3 Individual Values and Beliefs Respected (L.Logan, HCNZ)* | **✓** | **✓** |  |
| **Standard 1.1: Consumer Rights Under Legislation** |  |  |  |
| Consumers receive services in accordance with their rights.  *[Standard 1.1.1: Consumer Rights During Service Delivery HDSS(C)S.2008:1.1.1): Consumers receive services in accordance with consumer rights legislation]* | **✓** | **✓** | **✓** |
| Comment: (eg. move standard to a different part, merge with a different standard)  Could look to combining some aspects eg. Code of Rights and Advocacy  Need to ensure the consumer voice/ disability lens is not lost  Overarching ‘spirit of care’ statement  Individualised funding model discussed – could be covered in ‘relevant modules’. How is monitoring of this type of service managed?  Consumers need to be aware of standards – language needs to support consumer understanding of same  Transparency of information important |
| **Standard 1.2: Individual Privacy, Dignity and Respect** |  |  |  |
| Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, confidentiality, and independence.  *[Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3): Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence]* | **✓** | **✓** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Relevant standard |
| **Standard 1.3: Individual Values and Beliefs Respected** | | | |
| Consumers receive culturally safe services which recognise and respect their ethnic, cultural, and spiritual values and beliefs.  *[Standard 1.1.6: Recognition and Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6): Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs]* | **✓** | **✓** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Language of standard to be people centric  To include: gender, sexual orientation, *age (HCNZ)* diversity: for some specificity is requested, for others a risk when specifying as not future proofing: suggest ‘all forms of diversity (could add: including but not limited to …)  Need tangible measures – to be designed by consumers  “Spirit of Care” |
| **Standard 1.4: Recognition of Maori Values and Beliefs** |  |  |  |
| Māori consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural values and beliefs.  *[Standard 1.1.4: Recognition of Māori Values And Beliefs (HDS(C)S.2008:1.1.4): Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.]* | **✓** | **✓** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Interest in an overarching standard and then woven throughout  Outcome needs to be strengthened to reduce variability  Strengthen for Kaupapa services (noting different care offered/provided) – ACC doing a lot of work re this: principles, language, whanau ora approach  No reference to Te Tiriti *or Tino Rangatiratanga (L.Logan HCNZ)*  National Service Specification discussed  *Equity focus (L.Logan, HCNZ)* |  |  |  |
| **Standard 1.5: Recognition of Pacific People’s Values and Beliefs** |  |  |  |
| Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural values and beliefs.  *[Standard 1.1.5: Recognition Of Pacific Values And Beliefs (HDS(C)S.2008:1.1.5): Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.]* | **✓** | **✓** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  HCSS framework is specific re Maori & Pacific  Health workforce planning includes specific Pacifica  There are other cultures coming in – could open to all – links back to diversity (refer comments 1.3)  Consider areas of deprivation (in respect of cultural responsiveness)  *Co-design approach, Equity focus (L.Logan, HCNZ)* |  |  |  |
| **Standard 1.6: Communication in a Manner that the Consumer can understand** |  |  |  |
| Information is communicated to consumers in a manner that the consumer can understand.  *[Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9): Service providers communicate effectively with consumers and provide an environment conducive to effective communication.]* | **✓** | **✓** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Support overarching standard, then woven through (noting a view the standard could be deleted if communication is woven through)   * + I wasn’t in this group but our group discussed communication as an overarching statement because it is a central component in all of the standards (L.Russell, Alzheimers NZ)   + If we have an overarching standard and it woven through then there is a potential for audit evidence to be repeated rather than streamlined. Suggest communication is important in all aspects of care then woven within a number of standards at a criterion level would meet the intent (L.Cochrane, HDANZ)   Communication is a two way flow of information - important to have people’s input into, rather than just listening to  Discussion around support workers not turning up (particular note re rural settings) – finding support workers may be a challenge  Cost/ funding discussed  Consumer needs to have a voice  Interest in the UNCRPD (United Nations Convention on the Rights of Persons with Disabilities) language/ requirements being included  Issue of understanding discussed – particularly with cognitive decline (I did understand, but don’t anymore)  *People are supported to communicate their responses – ensuring their voice is heard and their needs are met (L.Logan, HCNZ)*  *Consider need for non verbal communication or communication that is easily understood for people with cognitive impairment … DPA – Easy to read guide concepts (V.Russell, Lakes DHB)* |  |  |  |
| **Standard 1.7: Freedom from Abuse or Neglect** |  |  |  |
| Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation, abuse (physical, psychological, sexual, or financial), or neglect.  *[Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7): Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation]* | **✓** | **✓** | **✓** |
| Comment: (eg. move standard to a different part, merge with a different standard)  Retain the financial aspect – financial abuse continues to be a problem  Support use of ‘safeguarding’ as term  Language to be considered (strengths based, positive)  Don’t want standard to be too prescriptive – noting old standard very prescriptive  Want to include safety for staff – how to keep safe, how to escalate  *Audit identifies findings around the ‘process shortfalls’ rather than experience of abuse/ neglect (L.Cochrane, HDANZ)*  Need guidance for HCSS  Potential to consolidate with 1.8 (NOT merge) – do not loose intent  *There are other types of abuse and neglect such as medical, educational/vocational – advise not to be so prescriptive in the overarching standard and outline subtypes in the guidelines (L.Logan, HCNZ)*  *New WorkSafe : Managing the Risk of Violence in the Health & Disability sector guidance - will influence need for minimising risk of violence to support workers (V.Russell, Lakes DHB)* |  |  |  |
| **Standard 1.8: Consumers' Belongings, Property, and Finances are Respected and Protected** |  |  |  |
| Consumers’ belongings, property, and finances are respected at all times.  [Link 1.1.7] |  |  | **✓** |
| Refer comment 1.7 (above) |  |  |  |
| **Standard 1.9: Complaints** |  |  |  |
| The consumer's right to make a complaint is understood, respected, and upheld.  *[Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13) The right of the consumer to make a complaint is understood, respected, and upheld* | **✓** | **✓** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Discussion re referencing Complaints Categorisation (date estimate 2014) – general discussion around keeping standards current when documents (that may outdate) are referenced  Benchmarking across the sector may be a reality – rationale for referencing a document such as above  Support taking quality and risk aspects across to quality & risk, keep a consumer focused standard re complaints   * + *The process of client communication and understanding of the complaint process remain within the consumer rights standard 1.1. What the service does with complaints and how that links to quality improvements and outcomes could be moved to Part 2 (Quality & Risk) (L.Cochrane, HDANZ)*   Process inclusive of resolving issues and disputes before a complaint is formalised – making a complaint client becomes identified  *Outcome focus (L.Logan, HCNZ)* |  |  |  |

### Part 2

|  | **Relevant** | **Amend** | **Merge** |
| --- | --- | --- | --- |
| **Outcome 2: Organisational Management** | | | |
| Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner. |  |  |  |
| **Standard 2.1: Governance** |  |  |  |
| Consumers receive services that are planned, co-ordinated, and appropriate to their needs.  *[Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1): The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Better guidance to assist new providers – as for HDSS  Inclusion of consumer and equity at governance/ organisation level |
| **Standard 2.2: Service Management** |  |  |  |
| Consumers receive timely, appropriate, and safe services through efficient and effective service management.  *[Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2): The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers*  *Loose link: Standard 1.2.5: Consumer Participation (HDS(C)S.2008:1.2.5): Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  As for HDSS include -delegation process for when manager absent  *We did discuss this but I’m wondering whether we should be putting in this level of prescription rather than an outcome focused statement around ensuring the management needs of the service are met at all times, or something (L,Russell, Alzheimers NZ)*  *Define appropriate as this can be subjective (L.Logan, HCNZ)* |
| **Standard 2.3: Quality and Risk Management** |  |  |  |
| Consumers receive services that reflect continuous quality improvement principles through the organisation having an established, documented, and maintained quality and risk management system.  *[Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3): The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Consideration given that complaints or adverse event processes included here rather than unique STDs.  Consumer experience central to QRM system – clients should feel they are receiving a quality service.  Identification and management of risk is clearly understood by providers, clients and carers  QRM able to measure a participatory and outcome model |
| **Standard 2.4: Adverse Event Reporting and Resolution** |  |  |  |
| All adverse unplanned or untoward events are systematically recorded and reported to affected consumers and where appropriate their family/whānau in an open manner.  *[Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4): All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Note resolution in the STD – no guidance provided in respect of this.  Ensure resolution of event is demonstrated by the provider – inclusive of feedback loop and review inclusive of client and staff.  DHB contract has outlines responsibilities for providers also.  *Outcomes focus - learnings and strategies to reduce the likelihood of the event reoccurring (L.Logan, HCNZ)* |
| **Standard 2.5: Entry to and Exit from Services** |  |  |  |
| Consumers’ entry into and exit from services is facilitated in an equitable, timely, and respectful manner.  *[Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1): Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified*  *Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10): Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Language to be considered – support ‘Access’ as title  Need a standard level of care across all DHB’s – delivery of service should be equal  Standard – should be ‘accessible and easy’  Consider transition – ie. People may come into a service, discharged and return. Person needs understanding of what the service is that is to be delivered during current episode of care  Equity lens needs to include  Standard needs to be ‘high level’ (with contracts specifying timeframes) in order for providers to meet same  Standard weighted on providers expectations  Some difficulty accessing services in different areas, contingency planning discussed  Q: how much reliance on natural support should there be  Noted: an ethical framework being developed by CDHB  Support moving to Part 4: Service Delivery – agree  *Planned and facilitated (L.Logan, HCNZ)* |
| **Standard 2.6: Consumer Information Management Systems** |  |  |  |
| Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.  *[Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9): Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  The majority of information should be in client’s home. Challenge to keep updated  Use of paper and electronic reporting.  Protection for client and staff member required  Issues when provider not supplying IT/phones for client information   * + *Discussed but not, I think, an issue for standards review- another input rather than outcome. The standard I think should be about uniquely identifiable, factual, objective, available, accessible, maintenance of privacy, etc rather than defining the whats and hows (L.Russell, Alzheimers NZ)*   Security, sharing and privacy of client information a concern.  Use and management of photographs  *Secure storage of information and greater ability for consumers to decide what information is held and accessed by who (L.Logan, HCNZ)* |
| **Standard 2.7: Essential and Emergency System** |  |  |  |
| Consumers receive an appropriate and timely response during emergency and security situations.  *[Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7): Consumers receive an appropriate and timely response during emergency and security situations]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Holding and sharing of information with DHB/Civil Defence in emergency.  Consider home environment in emergency, client and staff caring is in isolation – health and safety aspects  Equipment required for client needs is available.  Provider has details on at risk clients – alerts inclusive of staffing and supplies  *Integrated response with Civil Defence (L.Logan, HCNZ)* |
| **Outcome 3: Human Resources** |  |  |  |
| Consumers receive safe, efficient, and effective services from an organisation that is a good employer and follows accepted human resource practices. |  |  |  |
| **Standard 3.1: Recruitment** |  |  |  |
| Consumers receive services that are based on good employment practices and relevant legislation.  *[Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7): Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation*  *Loose link: Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8): Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Role of family/whanau carers in the client/provider relationship –recognition of prior learning. Management of skill shortages  Staff to be skilled at the first engagement with client – client should have expectation of this.  Individual client funding aspects – client the employer, ensure processes are flexible. Employment and allocation of support workers to clients – required engagement of both parties.  *Need to consider family carers are paid at same rate as non family employed carers therefore would expect similar levels of employment requirements and safe work practices. Seems to be an assumption that family carers already know how to look after family member – but this overlooks that there can be gaps in what is best practice, use of other disciplines etc. (V.Russell, Lakes DHB)* |
| **Standard 3.2: Orientation, Induction, Ongoing Development, and Competency** |  |  |  |
| Consumers receive services from service providers who are trained and assessed as competent to provide services.  *[Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7): Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Clear requirements for care giver training established and accessible.  Client feedback in respect of care giver performance, allocation and appraisal   * + *Suggest not using the word care giver, change to support worker as used in this environment (L.Cochrane, HDANZ)*   Guidance inclusive of new employment legislation. Good access to specialist when required  *Lots of issues around family/friend caregivers etc. Is there a legal position on where providers/ funders sit in relation to this? If not, should there be? (L.Russell, Alzheimers NZ)*  *Consider competency reassessment timeframes (L.Logan, HCNZ)*  *Clear requirements for care givers to be orientated to role, skills required, client need before responsible for providing care to a client independently - employer responsibility to mitigate risk of harm to self or others / client does not seem to be well understood in service (V.Russell, Lakes DHB)* |
| **Standard 3.2: Orientation, Induction, Ongoing Development, and Competency** |  |  |  |
| Consumers receive services that promote the health and safety of the consumer and service providers.  *[Standard 1.2.3: Quality and Risk Management Systems (HDS(C)S.2008:1.2.3): The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles:*  *Criterion – 1.2.3.9: Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:*  *(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;*  *(b) A process that addresses/treats the risks associated with service provision is developed and implemented]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Health and safety is inclusive at governance, environment and care giver and client relationships. Clear understanding of all parties on health and safety risks and management. Any shared risk is clearly stated.  Health Safety pathways go up and down from governance to the client home.  Needs to “light touch” – home is not an institution.   * + *However, identified risks/hazards need to be identified for the safety of the support worker going into the home ie: dogs, slippery steps. H&S needs to be identified at both the home and organisational level (L.Cochrane, HDANZ* |
| **Outcome 4: Service Delivery** |  |  |  |
| Consumers receive services that contribute to their agreed outcomes, and that support their independence, safety and well-being. |  |  |  |
| **Standard 4.1: Service Agreement** |  |  |  |
| The consumer, organisation, and service provider have a full understanding of and agree to the services to be provided.  *[Loose link: Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3): Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals*  *Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4): Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Language – simplify – ‘What matters to you”…  Communication important  Prescriptive standard at the moment – with a lot aligning with contract – which align  Ensure consent is included  Level of risk mitigation to be considered  Service availability – be clear  A lot of detail in service agreement – people often ‘zone out’  *I think a service agreement is where “I” language could/should be used for more understandable information – “ I can expect”….”I will receive”…… (L.Russell, Alzheimers NZ)*  *Clarity to consumer on what included & excluded in service delivery – management of consumer / family expectations – tasks vs supporting health ageing approach, including recognising provider need for flexibility around when service delivered / by whom in light of changing workforce availability / increasing client volumes / increasing complexity of client need (V.Russell, Lakes DHB)* |
| **Standard 4.2: Promoting and Supporting Independence** |  |  |  |
| Consumers maintain their independence during the course of service delivery by being supported to exercise choice and control over their lives.  *No immediate link* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Language to align with – empowerment and autonomy  Suggested: ‘living well’  Choice & control are ‘old’ terms  Whanau missing – need to be evident throughout – need concept as an outcome (not only words)  *As for previous comment. “I” statements here makes it clearer where responsibility sits acknowledging that supporting independence cannot be passive on the part of the client (L.Russell, Alzheimers NZ)*  *Supported to develop and maintain independence (L.Logan, HCNZ)* |
| **Standard 4.3: Links with Other Groups** |  |  |  |
| Consumers receive continuity of service through effective links with other groups.  *[Loose link: Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9): Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Discussion about consolidating with 4.2 mixed view – concern this may ‘water down’ importance of supporting independence  ‘effective’ subjective – should be determined by the individual, however isn’t necessarily the case  Looking for better integration across services – could be strengthened  Language move from health system language to person focused  *Consider connections rather than links, and connections with their community (this encompasses a range of services and organisations) (L.Logan, HCNZ)* |
| **Standard 4.4: Service Delivery Planning** |  |  |  |
| Consumers have an individual service plan that describes their goals, support needs, and requirements.  *[Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5): Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Discussed consolidating planning (4.4), implementation (4.5), review (4.11) – little perceived benefit, prefer leaving as separate standards  Language – goal/service plan to ‘My plan..’  *Consider pathways for clients receiving personal cares in comparison to household chores (L.Cochrane, HDANZ)* |
| **Standard 4.5: Implementation of Individual Service Plan** |  |  |  |
| Consumers’ goals and support requirements are met through provision of services.  *[Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6): Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes*  *Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8): Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Skills of support worker discussed – perhaps strengthen and break down by levels of care   * + *Approaching issues around regulation, support re health professional input. Lots more discussion/thought around this required. We hardly touched on this yesterday but it is a significant issue for home and community groups who are now managing more complex clients in these situations (L.Russell, Alzheimers NZ)*   Refer comments against 4.4 |
| **Standard 4.6: Medicine Management** |  |  |  |
| Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.  *[Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12): Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Agreed standard relevant  Discussion around reconciliation – is it the role of the provider to reconcile medications, or the GP (as primary prescriber)   * + The RN completing the care plan must also reconcile what is prescribed against what medication in the home before they can direct a support worker in the care plan to administer medication. I think it very risky to only put this on the GP (L.Cochrane, HDANZ)   Interest in e-prescribing to be implemented  Arrangement for transition of care discussed – eg. DHB to community  Agreed complex area requiring further discussion  *And more outcome based statements rather than inputs which reduce innovation and individuality (L.Russell, Alzheimers NZ)*  *Refer to new Medication Guidelines for the HCSS (L.Logan, HCNZ)*  *Medication reconciliation requires someone to match what is prescribed, with what is dispensed and what the person actually takes. HBSS provider is in no position to do this – whereas GP & pharmacists are. Providers probably should be encouraged to raise any concerns about client medication to GP or pharmacist (V.Russell, Lakes DHB)* |
| **Standard 4.7: Infection Prevention and Control** |  |  |  |
| Consumers and service providers are protected from infection through promotion and implementation of current infection prevention and control practices.  *[Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1): There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.*  *Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3): Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Err on side of caution – regularly review IPC needs don’t set them and forget them  Availability of equipment in the home client and caregivers understand requirement to use it.  Communicable diseases challenges to monitor and track – need good system.  Training and education essential for care giver and client. |
| **Standard 4.8: Equipment, Aids and Enablers** |  |  |  |
| Consumers are supported to safely use any required or prescribed equipment, aids, or enablers.  *[Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2): Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose]* |  |  |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Ensure equipment is safe tested and monitored.  Client and care giver both can safely use within prescribed thresholds  Access to training – competencies. |
| **Standard 4.9: Nutrition and Safe Food Management** |  | **Delete** |  |
| The consumer’s nutrition and hydration is supported by service delivery.  *[Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13): A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Discussion as to whether this needs to sit in general care plan.  Often only used if there is a specific need required of care givers  *Supported by service delivery based on a person’s needs (L.Logan, HCNZ)* |
| **Standard 4.10: Skin Integrity** |  |  |  |
| Consumers’ skin integrity is maintained.  No direct link: for ARRC contract requirement | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Big component of care – retain  Particularly in respect of pressure injury management  Need stronger guidance  This (plus 4.12) important aspects of service – ‘hot topic’  Looking for positive strengths based language  *Consumer/family/whānau education focus (L.Logan, HCNZ)* |
| **Standard 4.11: Review of Service Delivery** |  | **Amend/ Delete** |  |
| Consumers are supported to achieve their goals through regular monitoring and review of service delivery.  *[Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8): Consumers' service delivery plans are evaluated in a comprehensive and timely manner]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Having a review is mutually beneficial  Increased focus on goals being met in partnership with person: ‘I will …’  This standard results in the most findings at audit – as managing timeframe expectation (contractual) can be difficult  Partnership design  *?evaluation in this standard statement also, poss instead of review (L.Russell, Alzheimers NZ)* |
| **Standard 4.12: Challenging Behaviours** |  | **Delete?** |  |
| Consumers with behaviours that challenge are treated with respect and receive services in a manner that has regard for their safety, dignity, privacy, and independence.  *[Linked to RMSP standard]* | ***✓*** | ***✓*** |  |
| Comment: (eg. move standard to a different part, merge with a different standard)  Don’t like title - change to positive behaviour support – cognition   * + *Could possible just be called ‘Behaviour Support’ (L.Logan, HCNZ)*   Once again could be included in other standards.  Wonder why it is separate due to changes in home and community care there are a lot of clients that issues with cognition.  *Ensuring staff receive training and education based on positive behaviour support principles – improving people’s quality of life, understanding of why the behaviour occurs, teaching alternative skills for ensuring people’s needs are met through positive approaches (L.Logan, HCNZ)*  *Purpose is to see provider staff understand what is important for the client, how they prefer support to be provided, what difficulties they may have in communicating their views / preferences and therefore what staff need to know to avoid creating stress, anxiety or anger. A separate section is not unreasonable considering cognitive impairment / memory loss / changes in reasoning, understanding, communication is relevant to range of HCSS settings / funders and balance common perception that support is only required for those who have a physical impairment. Work behaviour should be avoided - is not disability friendly and reflects medical / institutional model of health (V.Russell, Lakes DHB)* |

1. The working groups will be tasked with amending/ writing the standards. [↑](#footnote-ref-1)
2. The relevant standards are the Health and Disability Services Standards (NZS 8134: 2008) and the Fertility Services Standard (NZS 8181:2007). [↑](#footnote-ref-2)
3. For the purpose of this document ‘the standards’ means the Fertility Services Standard (NZS 8181:2007), Health and Disability Services Standards (NZS 8134: 2008) and the Home and community support services standard (NZS 8158: 2012). [↑](#footnote-ref-3)
4. Referenced in the remaining document as: DHB. [↑](#footnote-ref-4)
5. The purpose of the Code is to promote continuous improvement, provide a framework and set criteria for the auditing process, and to ensure the auditing process is carried out independently. [↑](#footnote-ref-5)
6. The term ‘consumer’ is yet to be agreed. [↑](#footnote-ref-6)