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Dear Ms Cooper

Review of Health and Disability Sector Standards

Thank you for the opportunity to comment on the three draft revised standards. As Health and Disability Commissioner, one of my functions under section 14(1)(d) of the Health and Disability Commissioner Act 1994 is to make public statements in relation to any matter affecting the rights of health and disability service consumers. These standards are of wide application and clearly play an important role in ensuring that consumers receive services in a manner that is consistent with the rights under the Code of Health and Disability Services Consumers' Rights (the Code).

I set out below my comments on each of the three standards. I also sought comments from Tania Thomas, Deputy Commissioner and the HDC Consumer Advisory Group. Their comments have been incorporated below. I also acknowledge that the Director of Advocacy, Judi Strid, represents this Office on the Health and Disability Committee.

General

“Notes” have been used throughout the draft standards. It is not clear what effect or status these notes are meant to have. In most instances they seem to be matters which should actually be included in the standard, the criteria or the commentary.

The revised standards are less prescriptive of how the standards and criteria should be met. Most of the comments are drafted along similar lines stating that fulfilling a criteria or standard “may include, but is not limited to” carrying out certain steps. It is desirable for providers to have flexibility in some respects, however it is also in the interests of consumers to have clear minimum standards in some areas. I suggest that this point should be reconsidered when the standards are going through the next stage of revision.

Concern has also been expressed that the consumer participation requirements previously in the Mental Health Sector Standard have been watered down too much in the revised core standard. I agree that the standards in Part 2 of the core standard are less comprehensive than Standards 9

and 10 of the Mental Health Standard and suggest that consumer participation is given greater prominence and more emphasis.

It is very pleasing to see that the Disability Strategy has been included as a key point of reference at the beginning of the standards.

Health and Disability Services (Core) Standard

Introduction

The previous version of this standard included a paragraph entitled “Scope” which set out some general matters regarding the applicability of this standard. The revised “Scope” section does not seem to cover these matters and I suggest that it may be helpful to include an equivalent section at some point in the introduction.

C1.3.1

I suggest that these comments are expanded to include some of those in the previous standard including the ability to have private interaction with visitors and visual privacy when attending to personal hygiene requirements.

C1.3.2(e)

There may be situations in which a consumer is not able to specifically request family involvement. This should not preclude consultation with family.

C1.3.2(f)

This comment about affording privacy to consumers whose death is imminent, would appear to more appropriately fit under 1.3.1 which deals with privacy, rather than 1.3.2 which deals with beliefs relating to culture etc. Affording a dying consumer privacy would seem to be a general practice, rather than something that is included as a comment in relation to responsiveness to culture etc.

C1.3.7

A policy of open disclosure should also apply in this context.

Criteria 1.4.1

Rather than saying that Maori consumers receive services “in line” with their cultural values and beliefs, using the words “consistent with” or “that take into account” would seem more in keeping with the Code and language used elsewhere in the standard.

Criteria 1.4.2

It is unclear what the inclusion of the words “including access” is intended to cover in this criteria. C1.4.2(g) appears to simply repeat this criteria.

Standard 1.5

I suggest that this standard should also refer to social values and beliefs, which would be consistent with Right 1(3) of the Code.

Standard 1.6

This standard should also include reference to financial exploitation.

Criteria 1.6.1

I suggest that this should be amended to read “consumers are not subjected to discrimination, coercion, harassment and sexual or other exploitation.” The accompanying comment can then specify that “discrimination” means discrimination that is unlawful by virtue of Part II of the Human Rights Act 1993.

C1.6.2(c)

I suggest clarifying what code is being referred to here. For example, “the appropriate code of conduct or code of ethics for the service provider”.

Standard 1.8

This standard should refer to “effective communication” rather than “good communication”.

Criteria 1.10.8

This criteria should be reworded to read “processes and policies are in place to ensure that any storage or use of body parts and/or bodily substances is in accordance with Right 7(10) of the Code.”

C1.12.1

I suggest including mention of the need to help visitors access affordable parking nearby. This is a practical issue that has been mentioned to this Office as hindering the ability of people to visit consumers.

Criteria 2.3.5

The key components listed under this criteria should include open disclosure.

C2.4.4

Consideration should be given as to whether to include the Health Practitioners Competence Assurance Act 2003 in the list of relevant statutes.

C3.2.1

The criteria regarding a consumer being declined entry to a service is accompanied by a “note” that “emergency situations may require more proactive action.” In my view an emergency situation will always require immediate action and the “note” should be amended accordingly.

C3.3.2

This criteria should also refer to shared decision making and taking a consumer-centred approach.

C3.4.1(b)

The reference to “linkages” is vague. It would be more helpful to state that necessary policies or protocols should be in place to ensure cooperation between service providers and continuity of service.

C3.5.1

It should be specified that the consumer will be given a copy of the service delivery plan.

C3.6.1

The references to “restrictive practices” and “non-labelling language” do not seem very helpful in terms of providing guidance on meeting the relevant criteria. It is not clear what either of these terms means and they are not defined in the glossary of terms.

Health and Disability Services (Restraint) Standard

Introduction

The introduction to this standard should clearly state that seclusion and restraint cannot be used by providers for punitive reasons.

The reference to prescribed medications should state that they should only be prescribed and used for valid therapeutic indications. The meaning of this final sentence in this paragraph is somewhat unclear.

“May” vs “Shall”

As commented above, there are instances where the steps necessary to comply with a standard should be set out more unequivocally. There are several parts of this standard where activities should be categorised as in the “shall” category rather than the “may” category. For example, C1.1.2, C1.1.3 and C2.1.1.

Criteria 1.1.3

The “note” to this criterion is more than just explanatory and makes important points about the use of enablers. I suggest that it should be included as a separate criteria.

Standard 2.1

This standard should refer to reviewing as well as determining approval for restraint.

Standard 2.2

The emphasis in standard 2.2 needs to be changed so that it is clear that restraint is only used where indicated for therapeutic purposes. I suggest that it should state that, where it appears that restraint may be indicated, services shall ensure a rigorous assessment of each consumer is undertaken prior to any use of restraint. Also the reference to “suitably skilled service providers” in Criteria 2.2.1 is somewhat vague. The accompanying comment should specify who would qualify as a suitably skilled service provider and what training or skill set is required.

Use of restraint should be regularly reviewed. Where there is ongoing use of restraint, for example use of lapbelts in aged care, services should take steps to ensure that the durations is not longer than necessary and that adverse effects to health (such as decreased mobility and pressure areas) are addressed.

The standard should also clearly refer to the need to use proactive strategies to prevent situations arising that could lead to a situation where restraint may be required. Approaches that have worked in the past should be taken into account.

The commentary in C2.2.3 and C2.3.3 refers to the “desired outcome” of restraint. I suggest that instead they should refer to the point at which there is no longer any therapeutic justification to continue using restraint.

Criteria 2.3.3

The focus of the account should be on the indication for use and duration. Also, the commentary should require that the account of the restraint should be made available to the consumer in formats suited to their needs.

Standard 3.1

Rather than stating only those services which have approved seclusion facilities shall comply with Part 3:Seclusion, I suggest that this should read “Seclusion may only be used by services with approved seclusion facilities. The use of seclusion must comply with Part 3:Seclusion”.

C3.2.5

Comment (c) should go further and state that consumers should actually be allowed to have clothing. Also, in relation to point (f), there should be an emphasis on having a toilet facility in the seclusion area.

Health and Disability Services (Infection Control) Standard

C1.1.4

Consumers should be included as another group of relevant stakeholders.

Standard 4.1

Information and education about infection control measures needs to be made available in appropriate formats for consumers.

I hope that these comments are of assistance.

Yours sincerely

Ron Paterson
Health and Disability Commissioner