NZS 8134.0:2008

New Zealand Standard

Health and Disability Services (General) Standard

Superseding NZS 8134:2001, NZS 8141:2001, NZS 8142:2000, and NZS 8143:2001

NZS 8134.0:2008

MINISTRY OF HEALTH
MANATŪ HAUORA

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NZS 8134.0:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (GENERAL) STANDARD

Superseding NZS 8134:2001, NZS 8141:2001, NZS 8142:2000, and NZS 8143:2001

ISBN 1-86975-095-0

PREFACE

Tēnei te mihinui kia kotou katoa

The Health and Disability Services Standards support the safe provision of services to consumers. The Standards have been revised and are now clearer, and include some sector-agreed updates. In addition, the new structure means it will be easier to review parts of the Standards to keep pace with new trends and developments.

A lot of things haven't changed. The Standards remain focused on the outcomes consumers experience when services are of good quality. They support a culture of continuous quality improvement in services. The Standards are not intended to be prescriptive. Rather, they recognise that there are different ways to improve service quality.

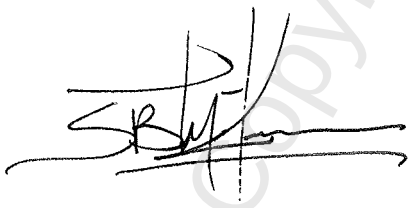
These sector-agreed Standards are the result of three years' extensive collaboration with many groups including consumers, providers, government and non-government agencies, and the Ministry of Health. I commend the Expert Committee and Standards New Zealand for their dedication and hard work while overseeing the revision of these Standards. It is clear that the health and disability sector remains committed to improving the safety and quality of services for the benefit of consumers.

The Standards cover many aspects of service provision including consumer rights, service governance and management, infection control, and minimising restraint. Providers, auditors, and the regulator will need to exercise good judgement about which Standards and criteria apply to any given service. Services range from small and straightforward to large and complex, therefore not all Standards will apply to all services.

I expect all providers to monitor their services in order to continuously improve outcomes for consumers. It is only when providers focus on consumer outcomes that genuine service improvements can be made.

I sincerely thank all who have contributed their time and expertise to revising these Standards, whether through direct involvement or through submissions. I appreciate your efforts to make a difference to consumer outcomes and I am very satisfied with the much improved Health and Disability Services Standards.

Nāku noa, nā



Stephen McKernan
Director-General of Health

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ACKNOWLEDGEMENT

Standards New Zealand gratefully acknowledges the contribution of time and expertise from all those involved in revising and updating these health and disability service Standards. The significant input provided by the expert committee whose experience and knowledge have made the development of this work possible, is particularly recognised.

Acknowledgement is also made of the organisations and people who contributed during the public comment phase.

Special thanks to the Ministry of Health for funding this revision.

COMMITTEE REPRESENTATION

This Standard was prepared by Technical Committee P 8134 for the Standards Council established under the Standards Act 1988.

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REVIEW

This Standard was approved by the Minister of Health following a review of all the health and disability services standards under section 24(2) of the Health and Disability Services (Safety) Act 2001. This Standard replaces NZS 8134:2001 *Health and disability sector Standards*, NZS 8141:2001 *Restraint minimization and safe practice*, NZS 8142:2000 *Infection control* and NZS 8143:2001 *National mental health sector Standard*.

It is intended that NZS 8134:2008 remains dynamic, reflecting current accepted good practice. Regular reviews of the Standard will be undertaken to ensure that this is achieved, and that the Standard remains appropriate and applicable.

NOTES

HEALTH AND DISABILITY SERVICES (GENERAL) STANDARD

1. FOREWORD

NZS 8134 *Health and disability services Standards* are designed to establish safe and reasonable levels of services for consumers, and to reduce the risk to consumers from those services. The Standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001.

The Standards provide the foundation for describing good practice and fostering continuous improvement in the quality of health and disability services. They set out the rights for consumers and ensure services are clear about their responsibilities for safe outcomes.

Earlier health and disability service Standards were published in 2000 and 2001. These were:

(a) NZS 8134:2001 – *Health and disability sector Standards;*

(b) NZS 8141:2001 – *Restraint minimization and safe practice;*

(c) NZS 8142:2000 – *Infection control;*

(d) NZS 8143:2001 – *National mental health sector Standard.*

The four Standards have been reviewed over the past three years. The main aim of the review was to reduce duplication between the four Standards and to update the content to reflect current accepted good practice.

Based on consultation with the sector, NZS 8134:2001 and NZS 8143:2001 have been amalgamated to form NZS 8134.1:2008 *Health and disability services (core) Standards*. This amalgamation has significantly reduced duplication between the two Standards.

Each of the NZS 8134 Standards is to be read in conjunction with NZS 8134.0:2008 *Health and disability services (general) Standard* as this contains the definitions and audit framework information applicable across the health and disability suite.

WHAT CAN YOU BUY

NZS 8134 may be purchased as a set, that is loose-leaf, four-hole punched, and shrink wrapped for insertion in a binder with room for:

NZS 8134.0 – *Health and disability services (general) Standard*

NZS 8134.1 – *Health and disability services (core) Standards*

NZS 8134.2 – *Health and disability services (restraint minimisation and safe practice) Standards*

NZS 8134.3 – *Health and disability services (infection prevention and control) Standards.*

2. REFERENCED DOCUMENTS

Reference is made in this document to the following:

NEW ZEALAND STANDARDS

NZS 8143:2001	National mental health sector Standard

JOINT AUSTRALIAN/NEW ZEALAND STANDARDS AND HANDBOOK

AS/NZS 4187:2003	Cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities
AS/NZS 4360:2004	Risk management
SAA HB 436:2004	Risk management guidelines – Companion to AS/NZS 4360:2004

OTHER PUBLICATIONS

Age Concern New Zealand Incorporated. *Promoting the rights and well-being of older people and those who care for them* (An Age Concern Resource Kit). Wellington: Age Concern New Zealand Incorporated, 1992.

Association of Perioperative Registered Nurses. AORN standards, recommended practices and guidelines 2007. Denver: AORN, 2007.

Centers for Disease Control and Prevention. 'Guideline for hand hygiene in healthcare settings: recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/ SHEA/ APIC/ IDSA Hand Hygiene Task Force.' *Morbidity and Mortality Weekly (MMWR)* 5I (2002): 1 – 44.

Drinka, T J K. & Clark, P G. *Health care teamwork: Interdisciplinary practice & teaching*. Westport, CT: Auburn House, 2000.

Mental Health Commission (1998). B*lueprint for mental health services in New Zealand: How things needs to be*. Wellington: Mental Health Commission, 1998.

Ministry of Health. *He korowai oranga: Māori health strategy*. Wellington: Ministry of Health, 2002

Ministry of Health. *New Zealand disability strategy*. Wellington: Ministry of Health, 2001.

NEW ZEALAND LEGISLATION

Care of Children Act 2004

Health and Disability Services (Safety) Act 2001

Intellectual Disability (Compulsory Care and Rehabilitation) [ID(CCR)] Act 2003

Protection of Personal and Property Rights Act 1988

LATEST REVISIONS

The users of this Standard should ensure that their copies of the above-mentioned New Zealand Standards are the latest revisions. Amendments to referenced New Zealand and Joint Australian/New Zealand Standards can be found on http://www.standards.co.nz.

CODE

Code of Health and Disability Services Consumers' Rights 1996

WEBSITES

Health and Disability Commission	http://www.hdc.org.nz
Ministry of Health	http://www.moh.govt.nz
Office for Disability Issues	http://www.odi.govt.nz

3. HEALTH AND DISABILITY SERVICES STANDARDS FRAMEWORK

The NZS 8134 *Health and disability services Standards* are made up of four overarching Standards. Table 1 provides a summary of the type of information contained within the Standards and outlines which Standard is superseded.

Table 1 – Health and disability services Standards framework

Standard number	Standard name	Includes...	Supersedes...
NZS 8134.0	Health and disability services (general) Standard	The general and reference information for the NZS 8134:2008 Health and disability services Standards, including definitions and audit framework.	The general information from: – NZS 8134:2001 – NZS 8141:2001 – NZS 8142:2000 – NZS 8143:2001
NZS 8134.1	Health and disability services (core) Standards	• General and reference information for NZS 8134.1 • Required outcomes, Standards, and criteria	– NZS 8134:2001 – NZS 8143:2001
NZS 8134.2	Health and disability services (restraint minimisation and safe practice) Standards	• General and reference information • Required outcomes, Standards, and criteria	– NZS 8141:2001
NZS 8134.3	Health and disability services (infection prevention and control) Standards	• General and reference information for NZS 8134.3 • Required outcomes, Standards, and criteria	– NZS 8142:2000

Figure 1 outlines the Standards' structure. A full list of the Standards can be found in Appendix A.

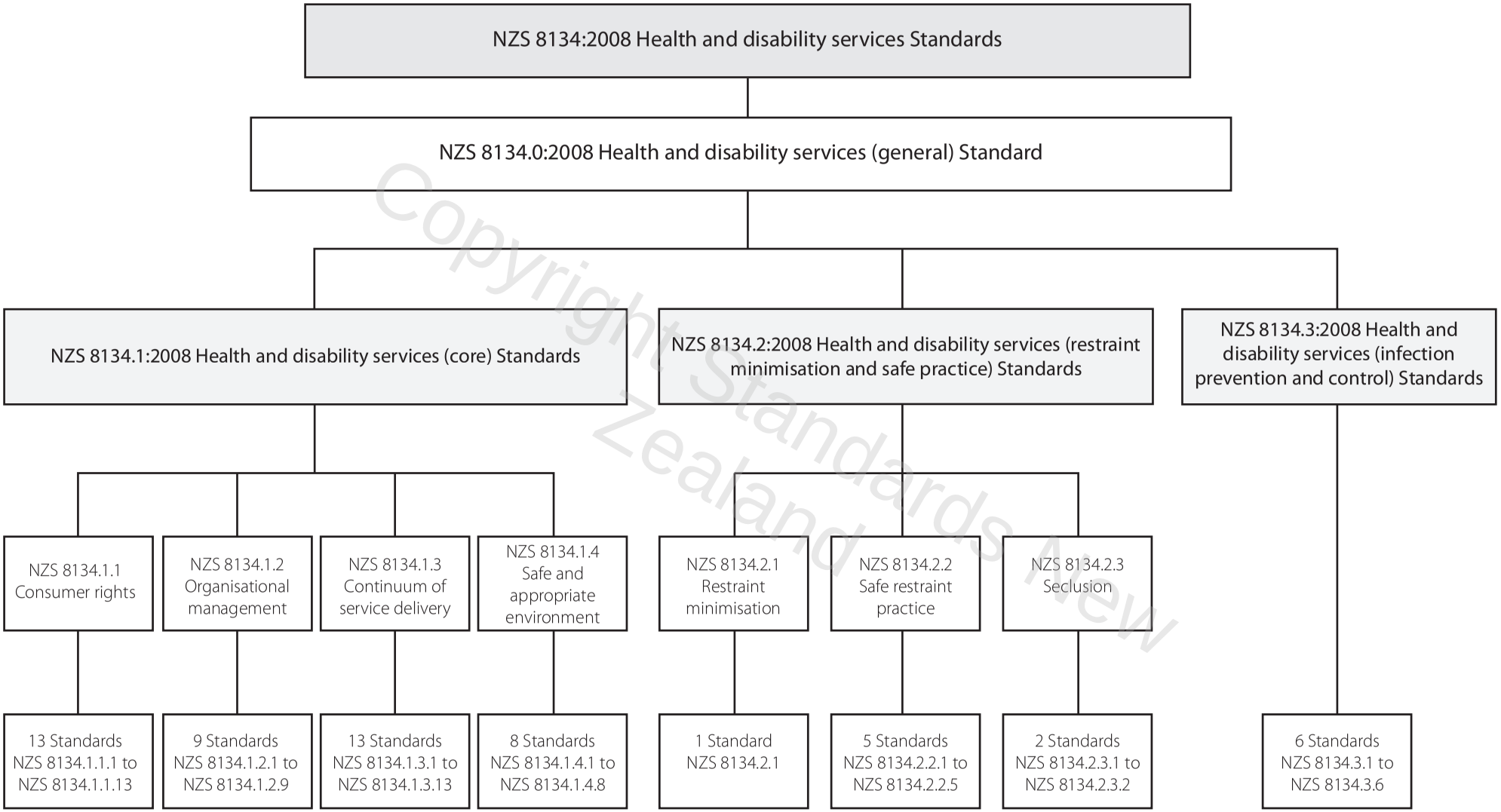

Figure 1 – Health and disability services Standards flow diagram

4. SCOPE

The Standards are applicable to a wide range of specialties, age groups, and service settings within the health and disability sector.

Under the Health and Disability Services (Safety) Act 2001 relevant certified services shall comply with these Standards. Services that are not required to be certified under the Health and Disability Services (Safety) Act 2001 should consider adopting these Standards as they promote current accepted good practice.

5. CODE OF HEALTH AND DISABILITY SERVICES CONSUMERS' RIGHTS 1996 (THE CODE)

The Health and disability services Standards will assist providers in meeting their obligations under the Code of Health and Disability Services Consumers' Rights 1996, a regulation under the Health and Disability Commissioner Act 1994. These Standards should be interpreted in a manner that is consistent with consumers' rights and providers' duties and obligations under the Code. Every person or service required to meet these Standards should be knowledgeable about and comply with the Code. Refer to http://www.hdc.org.nz for a copy of the Code.

6. MĀORI HEALTH

To achieve Māori health improvement and the reduction of Māori health inequalities, NZS 8134 focuses on:

(a) Ensuring accessible and appropriate services for Māori;

(b) Providing quality improvement systems that focus on Māori receiving health services commensurate with their health needs; and

(c) Enabling Māori and whānau involvement in health decisions.

NZS 8134 builds on the framework and principles for the public sector to take into account in supporting the health status of Māori as set out in *He korowai oranga: Māori health strategy*. Refer to http://www.moh.govt.nz.

7. DISABILITY STRATEGY

NZS 8134 supports the New Zealand Disability Strategy 2001 which presents a long-term plan for changing New Zealand from a disabling to an inclusive society.

Disability is not something individuals have. What individuals may have are impairments. These may be physical, sensory, neurological, psychiatric, intellectual, or other impairments.

Society is built in a way that assumes everyone can see signs, read directions, hear announcements, reach buttons, has the strength to open heavy doors and has stable moods, thinking, and perception. Barriers are created when society takes no account of the impairments people may have.

New Zealand will be inclusive when people with impairments can say they live in a society that highly values their lives and continually enhances full participation. Disabled people will be integrated into community life on their own terms, their abilities will be valued, their diversity and interdependence will be recognised, and their human rights will be protected.

To advance New Zealand towards a fully inclusive society, the New Zealand Disability Strategy includes fifteen objectives. The objectives and the complete New Zealand Disability Strategy can be found on the website of the Office for Disability Issues http://www.odi.govt.nz.

8. INTERPRETATION

The broad diversity and uniqueness of the health and disability sector has necessitated the use of generic phrases and terminology throughout the Standards. It is not the intention however, to standardise terminology throughout the different parts of the health and disability sector. Rather it is expected that each service provider will interpret the intent of the statements used in the Standards in relation to the service provided. For example, the expression 'service delivery plan' could be interpreted to mean care plan, lifestyle plan, clinical pathway, support plan, placement plan, clinical or patient record depending on the service setting.

General guidance on how to meet the criteria for each Standard in NZS 8134 is included throughout, and prefixed by the letter '**G**'. The purpose of the general guidance is to assist with the interpretation of the criteria for each Standard by providing examples. However, these examples are general only, and do not necessarily include all methods that can be used to meet the criteria of each Standard.

Health and disability services that are required to be certified under the Health and Disability Services (Safety) Act 2001 must comply with all relevant Standards. Not all Standards or criteria within NZS 8134 are relevant to all services. The relevance of a Standard or criterion assessed as being not relevant to a service will be recorded as being 'not applicable' on any audit report.

A Standard or criterion may apply to only some health or disability services. For example, some parts of NZS 8134 will apply only to:

(a) Intellectual disability services;

(b) Mental health and addiction services; or

(c) Acute, secondary, or tertiary, services.

The notations 'ID', 'MHA', and 'S' identify those parts of the Standard which only apply to those particular services. See table 2 for a code description.

Table 2 – Service code description

Code	Applicable to
ID	Intellectual disability services
MHA	Mental health and addiction services
S	Acute, secondary, or tertiary services

Although other providers are not required to comply with these parts of the Standard, services may consider adopting them.

In these Standards:

(a) An 'Informative' Appendix is for information and guidance. Informative provisions do not form part of the mandatory requirements of this Standard.

(b) The word 'shall' refers to practices that are mandatory for compliance. 'Shall' is also used for practices that are already mandated in other documents. The word 'should' refers to practices that are advised or recommended.

Throughout the Standards good practice is referred to. The definition of good practice is the current accepted range of safe and reasonable practice that result in efficient and effective use of available resources to achieve quality outcomes, and minimise risk for the consumer.

Current accepted good practice should also reflect standards for service delivery where these exist. This may include but is not limited to:

(c) Codes of practice;

(d) Research/evidence/experience-based practice;

(e) Professional standards;

(f) Good practice guidelines;

(g) Recognised/approved guidelines; and

(h) Benchmarking.

9. OUTCOME-FOCUSED STANDARDS

As a part of the interpretation of these Standards and the outcomes they describe, the context for service provision must be considered. This context includes both the specific needs of the individual and the overarching aim to support well-being and quality of life. Overall well-being is related to positive, supportive links with peers and families/whānau, and to inclusion in communities. Service providers are expected to recognise this.

Previous Standards, particularly NZS 8143:2001 *National mental health sector Standard*, explicitly specified how they would apply to a population range. In the development of NZS 8134, there was a decision to move away from extensively detailing specific inputs, instead concentrating on the outcome to be achieved.

Rather than detailing similar inputs for each population, or explicitly including the progression from knowledge/understanding and policy to practice, the outcome could be achieved through various inputs. For example, to achieve the outcome of criteria 3.1.4 in NZS 8134.1.3, services would need to demonstrate their communications were appropriate to their particular audiences. In children's services, this could include providing information in an age appropriate manner such as through story books. When services are for Māori, this could include information and resources in Te Reo Māori as well as English.

10. AUDIT FRAMEWORK

Health and disability services are required to meet service Standards relevant to the type of health and disability services they provide. An audit of compliance with NZS 8134 is required to determine a service's level of attainment for relevant Standards.

AUDIT APPROACH

The audit process requires the service to determine the level of attainment it currently achieves for each relevant criterion. The levels of attainment (see table 3) are based upon a continuous quality improvement model and are incremental.

The stages range from unattained (**UA**) through to continued improvement (**CI**).

Table 3 – Audit framework attainment levels

	Attainment level	Interpretation
CI	Continued Improvement	*Having fully attained the criterion the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings, and improvements to service provision and consumers safety or satisfaction as a result of the review process.*
FA	Fully Attained	*The service can clearly demonstrate implementation (such as practice evidence, training, records, visual evidence) of the process, systems or structures in order to meet the required outcome of the criterion.*
PA	Partial Attainment	*1. There is evidence of appropriate process (such as policy/procedure/guideline), system or structure implementation without the required supporting documentation; or* *2. A documented process (such as policy/procedure/guideline), system or structure is evident but the organisation or service is unable to demonstrate implementation where this is required.*
UA	Unattained	*The organisation or service is unable to demonstrate appropriate processes, systems or structures to meet the required outcome of the criterion.*
NA	Not Applicable	*The service can demonstrate that the outcome Standard or criterion is not relevant to the service and therefore does not apply.*

USING THE RISK MANAGEMENT MATRIX

This process requires the facility or service (internal or external) to identify the degree of risk to consumers' safety associated with the level of attainment achieved by the service for each criterion.

The 'risk' should be assessed in the first instance in relation to the possible impact on consumers, based on the consequence and likelihood of harm occurring as a result of the criterion not being fully implemented.

The Risk Management Matrix (table 4) should be used when the audit result for any criterion is partially attained (**PA**) or unattained (**UA**).

To use the Risk Management Matrix you should:

(a) Consider the consequence on consumers/support persons safety of the criterion being only Partially Attained (**PA**) or Unattained (**UA**) – ranging from extreme/actual harm to no significant risk of harm occurring;

(b) Consider the likelihood of this adverse event occurring as a result of the criterion being only Partially Attained (**PA**) or Unattained (**UA**) – ranging from the occurrence being almost certain to rare;

(c) Plot your findings on the Risk Assessment Matrix in order to identify the level of risk – ranging from Critical to Negligible;

(d) Prioritise risks in relation to severity (for example Critical to Negligible);

(e) Take appropriate action to eliminate or minimise risk within the time frame indicated by the 'Action Required' column.

Table 4 – Risk management matrix

		LIKELIHOOD					
	Level of risk	The likelihood of this occurring is **almost certain**	The likelihood of this occurring is **likely**	The likelihood of this occurring is **moderate**	The likelihood of this occurring is **unlikely**	The likelihood of this occurring is **rare**	**Action required**
CONSEQUENCE	The consequence of these criteria not being met would put consumers at **extreme risk of harm or actual harm is occurring**	**Critical**	**Critical**	**High**	**Moderate**	**Low**	**Critical** This would require immediate corrective action in order to fix the identified issue including documentation and sign off by the auditor within 24 hours to ensure consumer safety
	The consequence of these criteria not being met would put consumers at **significant risk of harm**.	**Critical**	**High**	**Moderate**	**Low**	**Negligible**	**High** This would require a negotiated plan in order to fix the issue within one month or as agreed between the service and auditor
	The consequence of these criteria not being met would put consumers at **moderate risk of harm**	**High**	**Moderate**	**Moderate**	**Low**	**Negligible**	**Moderate** This would require a negotiated plan in order to fix the issue within a specific and agreed time frame, such as six months
	The consequence of these criteria not being met would put consumers at **minimal risk of harm**	**Moderate**	**Low**	**Low**	**Low**	**Negligible**	**Low** This would require a negotiated plan in order to fix the issue within a specified and agreed time frame, such as within one year
	Risk of harm is insignificant even if these criteria are not met.	**Low**	**Low**	**Negligible**	**Negligible**	**Negligible**	**Negligible** This would require no additional action or planning

EVALUATION METHODS

One or more evaluation methods or processes may be chosen to audit criteria and/or provide evidence of compliance. The service should identify the methods most appropriate to evaluate its service considering the service setting and consumer groups. The options set out in table 5 have been developed to assist with recording the evaluation method chosen for each criterion.

Table 5 – Review process evaluation options

D	**Documentation/record review**
I	**Interview** **SI** = Service provider interview (Governance or Management) **STI** = Staff interview **MI** = Manager interview **CI** = Consumer interview **MaI** = Māori-focused interview
V	**Visual inspection**
Q	**Questionnaire** **CQ** = Consumer questionnaire **SQ** = Service provider questionnaire **STQ** = Staff questionnaire
Ma	Māori-focused audit
L	Linked services, family, and referral services interview

11. SELECTED EVIDENCE WEBSITES

The following websites provide useful information on current accepted good practice.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

AHRQ research provides evidence-based information on healthcare outcomes, quality, and on cost, use, and access.

http://www.ahrq.gov/

BEST TREATMENTS – FREE FOR ALL NEW ZEALANDERS VIA NEW ZEALAND GUIDELINES GROUP WEBSITE

This site for consumers provides reliable up-to-date evidence-based information about treatments proven to work, as well as the risks, benefits, and side effects.

http://www.besttreatments.net/btgeneric/home.html

CENTRE FOR REVIEWS AND DISSEMINATION (CRD)

CRD produces the renowned Database of Abstracts of Reviews of Effects (DARE), National Health Service Economic Evaluation Database (NHS EED) and Health Technology Assessment (HTA) databases which are widely used by health professionals, policy makers and researchers. The centre also undertakes methods research and produces 'Hitting the Headlines', providing busy health professionals with a rapid and reliable analysis of the evidence behind news reports on health interventions.

http://www.crd.york.ac.uk/crdweb/

CLINICAL EVIDENCE

This site provides a compendium of the best available research findings on common and important clinical questions, updated and expanded every six months. Questions that address the effects of preventive and therapeutic interventions are addressed. Structured summaries emphasise the balance between benefits and harms of different interventions. Contributions are written by practising clinicians with expertise in evidence-based medicine.

http://www.clinicalevidence.com/ceweb/conditions/index.jsp

COCHRANE LIBRARY – FREE FOR ALL NEW ZEALANDERS VIA NZGG WEBSITE

The Cochrane Database of Systematic Reviews (protocols and completed reviews of the effects of healthcare prepared and kept up-to-date by the Cochrane Collaboration), the Database of Abstracts of reviews of Effectiveness (critical assessments and structured abstracts of good systematic reviews published elsewhere), the Cochrane Controlled Trials Register (bibliographic information on controlled trials) and other sources on the science of reviewing research and evidence-based healthcare (see also NICS Guide to the Cochrane Library http://www.nicsl.com.au/cochrane/).

Free access for New Zealanders from http://www.nzgg.org.nz

GUIDELINES INTERNATIONAL NETWORK (G-I-N)

This site G-I-N is a major international initiative that seeks to improve the quality of healthcare by promoting systematic development of clinical practice guidelines and their application into practice. The network has the world's largest Guideline Library and is regularly updated with the latest information about guidelines of the G-I-N membership. As at April 2008 more than 4,400 documents were available on its site.

http://www.g-i-n.net

INFORMED HEALTH ONLINE

This website is run by the German Institute for Quality and Efficiency in Health Care and includes information for consumers based on the Institute's own scientific publications, as well as on topics it chooses itself.

http://www.informedhealthonline.org

NATIONAL INSTITUTE OF CLINICAL EVIDENCE (NICS)

This site is Australia's national agency for improving healthcare by helping close important gaps between best available evidence and current clinical practice. NICS has produced a wide range of resources.

http://www.nhmrc.gov.au/nics/asp/index.asp

NATIONAL LIBRARY FOR HEALTH (UK) INCLUDES HITTING THE HEADLINES

http://www.library.nhs.uk/default.aspx

NEW ZEALAND GUIDELINES GROUP (NZGG)

This site provides trusted links to healthcare evidence sites, as well as a rich source of evidence developed for healthcare practitioners and consumers. There is free access for New Zealanders to Best Treatments and the Cochrane Library from the NZGG website.

http://www.nzgg.org.nz

SUMSEARCH

This search engine, hosted by the University of Texas Health Science Center, determines which is the best resource for a query, formats it and performs the search. Among the databases and resources that may be searched are the Merck Manual, Canadian Taskforce on Preventive Health Care, Practice Guidelines from the National Guideline Clearinghouse, Medline, AHCPR, and DARE.

http://sumsearch.uthscsa.edu/

TRIP DATABASE

This resource, hosted by the Centre for Research Support in Wales, aims to support those working in primary care. The database has 10,000 links covering 30 resources and allows both boolean searching (AND, OR, NOT) and truncation.

http://www.tripdatabase.com/

12. DEFINITIONS

For the purpose of the Health and Disability Services Standards, the following definitions shall apply:

Abuse

Material/financial abuse
Illegal or improper exploitation and/or use of funds or other resources

Physical abuse
Infliction of physical pain, injury or force

Psychological/emotional abuse
Behaviour including verbal abuse which causes mental anguish, stress and fear

Sexual abuse
Sexually abusive and exploitative behaviours involving threats, force or the inability of the person to give consent

('Promoting the rights and well-being of older people and those who care for them'. (An Age Concern Resource Kit)

Chemical restraint
The use of medication, solely to ensure compliance or to render a consumer incapable of resisting

Access

Ability of a consumer or potential consumer to obtain a service when needed within an appropriate time

Activities

Planned events to provide meaningful social, recreational, cultural and/or spiritual support to enable community participation wherever possible and/or appropriate

Accountability

Where an organisation has to account for, or is liable for fulfilling an action whether or not that action is carried out by that organisation

Advance directive

A written or oral directive:

(a) By which a consumer makes a choice about a possible future health procedure; and

(b) That is intended to be effective only when they are not competent

Adverse event

Events with negative or unfavourable reactions or results that are unintended, unexpected, or unplanned

Airborne infection isolation

Airborne precautions are used for known or suspected infections spread by airborne particles 5 microns or smaller in size. The room should be a negative pressure room, personnel should wear respiratory protection while in the room and the ventilation should exhaust away from people and not be recirculated

Assessment

A systematic and ongoing process for the collection and analysis of information that describes the needs of the consumer in order to:

(a) Determine eligibility for a service; or

(b) Develop and review individual service delivery plans when the consumer enters the service.

	The assessment process shall meet current standards for assessment and shall include input from the consumer, family/whānau or other representatives where appropriate
Authority	The proper powers to carry out an action, whether granted directly or delegated
Best practice guidelines	Based on expert opinion these are generally used when evidence is limited, of poor quality or conflicting
Care manager	A person designated under s.141 of the ID (CCR) Act
Care recipient	A person subject to a compusory care order under the ID (CCR) Act
Cleaning	The removal of visible soil and debris from objects. Usually achieved by using water with detergents or enzymatic products. Cleaning must precede disinfection or sterilisation
Clinical governance	The assurance of clinical quality, safety, and efficacy through implementation of a transparent system of self-accountability participated in by clinical staff in an organisation, and at all levels throughout the organisation, with ultimate governing body responsibility
Community	This may be defined in terms of a geographical locality, social characteristics, or service needs
Community residential	The part of the organisation which includes overnight accommodation and may include associated support services as a component of its service provision
Competent	Demonstrating the required ability, knowledge, or authority
Consumer	A person who uses/receives a health or disability service
Contact precautions	Are intended to reduce the risk of transmission of organisms by direct or indirect contact with the consumer or the patient environment
Cough etiquette	See definition of respiratory hygiene
Criteria	Descriptive statements which can be assessed and which reflect the intent of a competency in terms of performance, behaviour, and circumstance
Cultural safety	Practices which ensure that those receiving the service feel that their culture is respected

Culture

Culture includes, but is not limited to, age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual belief; and disability

De-escalation

A complex interactive process in which the highly aroused consumer is re-directed from an unsafe course of action towards a supported and calmer emotional state. This usually occurs through timely, appropriate, and effective interventions and is achieved by service providers using skills and practical alternatives

Disability

A functional limitation or impairment. This can include a physical, visual, hearing, intellectual or cognitive impairment and can be of a temporary or permanent nature

Discrimination

Discrimination is an act or belief that results in the systematic unfair treatment of a person or a group because they are different

Disinfection

The inactivation of non-sporing organisms using either heat or water (thermal) or by chemical means.

The effectiveness of any disinfection procedure is controlled by the:

(a) Nature and number of contaminating micro-organisms (bioburden);

(b) Amount of organic matter present (spores, soil, faeces, blood);

(c) Type and condition of medical and surgical material to be disinfected;

(d) Temperature.

There are various degrees of disinfection; this is dependent on the type of micro-organisms killed (Definition taken from AS/NZS 4187)

Droplet precautions

Droplet precautions are used for known or suspected infections spread by large droplets of greater than 5 microns. Service providers are required to wear a surgical mask

Education/Training

Education/training encompass teaching and learning specific skills, knowledge, and attitudes. This includes imparting and acquiring knowledge, positive judgement, and wisdom through a variety of mechanisms including education technology, critical reflection, and feedback

Enablers

Equipment, devices or furniture, voluntarily used by a consumer following appropriate assessment, that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety.

Example 1
A consumer voluntarily uses raised bedsides to assist their mobility in bed, to aid in the positioning of pillows for comfort or to prevent them falling from the bed

Example 2
A consumer voluntarily uses a fixed tray in front of their chair to assist them to independently have a meal

Example 3

Equipment, devices or furniture is used, following appropriate assessment, to assist in the physical positioning of a consumer without limiting their normal freedom of movement. These interventions are not considered a form of restraint, but rather are a normal component of the consumer's day-to-day life

NOTE – The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Entry

The point at which the consumer attends the first appointment or consultation or receives the first episode of service delivery

Epidemic

A disease affecting or tending to affect an atypically large number of individuals within a population, community or region at the same time

Evaluation

A formal process for determining the extent to which the planned or desired consequences of an action are attained. The organisation routinely assesses service delivery to groups of people who have prolonged or frequent engagement with the health and disability sector

Event reporting

Includes the recording/reporting of:

(a) Accidents and incidents;

(b) Adverse clinical events;

(c) Complaints and suggestions;

(d) Infections/notifiable diseases;

(e) Other events as indicated by statute, regulation or professional practice standards

Evidence-based guideline

Has the following characteristics:

(a) Is based on evidence which is explicitly stated with the levels of evidence;

(b) Is a tool for transferring research findings into a guide for clinical practice;

(c) Follows a clear format and process which is described within the guideline so it can be readily replicated;

(d) Can include an algorithm or flowchart to provide easy to follow steps that reflect the recommendations outlined in detail within the guideline

Evidence-based practice

The conscientious, explicit, and judicious use of current best evidence that takes into account the needs and circumstances of each consumer.

Evidence-based practice is also applicable to decisions about the planning and provision of services. Evidence encompasses a range of qualitative and quantitative methodologies including indigenous methodologies and consumer experiences

Facility

The physical location, site, or building within or from which the service is provided

Family – in relation to another adult	Family includes a consumer's extended family/whānau, their partners, friends and advocates, guardian or other representatives nominated by the consumer
Family – in relation to a child or young person	A group including an extended family/whānau in which there is at least one adult member with whom the child or young person has a biological or legal relationship; or to whom the child or young person has a significant psychological attachment; or the child or young person's whānau or any other culturally recognised family/whānau
Good practice	The current accepted range of safe and reasonable actions that result in efficient and effective use of available resources to achieve quality outcomes, and minimise risk for the consumer. Current accepted good practice should also reflect standards for service where delivery these exist. This may include but is not limited to: (a) Codes of practice; (b) Research/evidence/experience-based practice; (c) Professional standards; (d) Good practice guidelines; (e) Recognised/approved guidelines; and (f) Benchmarking
Governance	Taking responsibility for the overall direction of the organisation, including the development of policy, which determines the purpose and goals of the service
Governing body	The organisation's highest decision-making body
Guideline	Can be recommendations based on consensus agreement, expert opinion or experience. Some forms of evidence may also be included. The guideline provides the recommended approach but not the practical 'how to' details specified in a protocol or pathway
Hand hygiene	A general term that applies to either hand washing, antiseptic handwash, antiseptic handrub, or surgical hand antisepsis Refer to: 'Guideline for hand hygiene in healthcare settings' (Centres for Disease Control and Prevention)
Hapū	A section of a particular tribe
Infection	Condition in a host resulting from the presence, invasion and damage by micro organisms

Infection control committee

A group of two or more individuals representing relevant disciplines within the organisation and providing overview of the infection control programme. Relevant disciplines are likely to include, but are not limited to, the infection control team/personnel, clinicians, management, pharmacy, occupational health risk management, estate/facilities management, and quality management.

In a large, complex organisation (such as a hospital) it is usual for an infection control committee to oversee the strategic issues, supported by infection control team/personnel responsible for day-to-day practice. In smaller and less complex organisations (such as in larger residential facilities) fewer staff are involved and the role may be a component of another committee, for example, a quality/risk management team

Infection control management

A set of systems and structures which organisations must have in place to safeguard and improve the quality of care

Infection control programme

A document outlining what will be done, taking into account the organisation's size, activity, and population group, to ensure that the risk of spreading infection by or to staff and consumers is reduced and kept to a minimum

Infection control team/personnel

An individual/group of health professionals competent in infection control who have responsibility for the implementation of the infection control programme. If there is no specific infection control team, service providers will have access to appropriately qualified infection control personnel/specialists when required.

Team member(s) shall include a qualified health professional(s) with access to a network of appropriately qualified infection control personnel/specialists. The structure of the team should be based on current accepted good practice

Informed consent

As in the Code of Health and Disability Services Consumers' Rights 1996 (the Code), informed consent is a process rather than a one-off event, involving effective communication, full information, and freely given, competent consent (Rights 5, 6 and 7 respectively). A signature on a consent form is not, of itself, conclusive evidence that informed consent has been obtained

Interdisciplinary

Drinka and Clark define the Interdisciplinary Health Care Team (IHCT) as 'a group of individuals with diverse training and backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve consumer problems that are too complex to be solved by one discipline or many disciplines in sequence. In order to provide care as efficiently as possible, an IHCT creates 'formal' and 'informal' structures that encourages collaborative problem solving. Team members determine the team's mission and common goals: work interdependently to define and treat consumer problems; and learn to accept and capitalise on disciplinary differences, differential power and overlapping roles. To accomplish these they share leadership that is appropriate to the presenting problem and promote the use of differences for confrontation and collaboration.' Health Care Teamwork: Interdisciplinary Practice & Teaching (Drinka and Clark, p47)

Iwi

A tribe with a common ancestor, canoe and region(s)

Key worker

This term is broadly used and applied in health services. The role and depth of responsibilities may vary between providers, however generally key workers:

(a) Are service providers who coordinate communications and activities for the consumer in order to meet their treatment/care plan;

(b) Ensure the consumer can participate in the planning of their care and ensures their voice is heard;

(c) Ensure consumer's documents/records are maintained, regularly reviewed, and reach the right people at the right time so decision makers are properly informed;

(d) Are the single or main point of contact for the consumer/family/whānau, during service provision.

The key worker can sometimes be known as Case Manager, Primary Carer/ Nurse or similar

Legal representative

A person who has legal authority to make decisions about the care and welfare of the consumer, including the entitlement to give consent to health or disability services on behalf of that consumer. A legal representative includes:

1. A 'welfare guardian' appointed under the Protection of Personal and Property Rights Act 1988 (PPPR Act). A welfare guardian has certain obligations under the PPPR Act, including a duty to promote and protect the welfare and best interests of the consumer, but does not have the power:
   (a) To refuse consent to the administering to that person of any standard medical treatment or procedure intended to save that person's life or to prevent serious damage to that person's health;
   (b) To consent to the administering to that person of electro-convulsive treatment;
   (c) To consent to the performance on that person of any surgery or other treatment designed to destroy any part of the brain or any brain function for the purpose of changing that person's behaviour; or
   (d) To consent to that person's taking part in any medical experiment other than one to be conducted for the purpose of saving that person's life or of preventing serious damage to that person's health.
2. Where the consumer is 'mentally incapable' (as defined in the PPPR Act)* a person holding 'enduring power of attorney' under the PPPR Act. However, note that the same restrictions apply to the powers of the attorney as apply to welfare guardians (PPPR Act, sections 98, 99, 107).
3. A guardian of the consumer under the Care of Children Act 2004

* Refer to section 94(1)(b) of the PPPR Act. A consumer is 'mentally incapable' if they:

(i) Lack, wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions on matters relating to their personal care and welfare; or

(ii) Have the capacity to understand the nature, and to foresee the consequences, of decisions on matters relating to their personal care and welfare, but wholly lack the capacity to communicate decisions on such matters.

Management — Implementing the policy determined by the governing body and coordinating the day-to-day service activities, which achieve the purpose and goals of the organisation

Mātua — A parent or an elder within the family, community or an organisation providing services to Pacific people. The role of the mātua is to facilitate and strengthen the relationships between Pacific consumers, their families, and the organisation

Based on identified needs, roles may include providing advice on: ethnic/pan Pacific protocols, cultural and spiritual practices and beliefs; interpretation and translation; supporting of Pacific individuals and families; bridging relationships between the organisation and communities

Medicine — A substance or combination of substances that:

(a) Is presented as having properties for treating or preventing a disease, ailment, defect, or injury in human beings;

(b) May be used in human beings with a view to making a medical diagnosis or to restoring, correcting, maintaining or modifying physiological functions; or

(c) Is declared to be a medicine by the regulatory authority in New Zealand

Medicine reconciliation — A standardised process of identifying the most accurate list of all medications, (including name, dose, frequency, and route) that a consumer is taking, and using that to provide safe/effective care to that consumer at all transition points within the health and disability service. The process should include eliciting a medication history (including herbal and other over-the-counter preparations) from the consumer (or their representative) and where necessary, verifying this with the consumer's community pharmacist or GP

Mental health and addiction service — An organisation that provides, as its core activity, assessment or treatment or support to people with mental illness or mental health problems and/or alcohol and drug problems

Monitor — To check, supervise, observe critically or measure the progress of an activity, action or system on a regular basis in order to identify change from the performance level required or expected

Monitoring — A programmed series of challenges and checks, repeated periodically, and carried out according to a documented policy or procedure, which demonstrates that the process being studied is both reliable and repeatable

Multidisciplinary — Members from various disciplines who work together to determine goals, evaluate outcomes, and make recommendations

National health index (NHI) unique identifier — Designed to uniquely identify individuals within the health system in New Zealand. For the purposes of health informatics, the NHI allows easy electronic matching between varying data sets in the health sector

Neglect	*Active neglect* Conscious and intentional deprivation of basic necessities, resulting in harmful physical, psychological, material, and/or social effects *Passive neglect* Refusal or failure by service workers, because of inadequate knowledge or disputing the value of the prescribed services, to provide basic necessities, resulting in harmful physical, psychological, material, and/or social effects Definitions taken from 'Promoting the rights and well-being of older people and those who care for them' (An Age Concern Resource Kit)
Office-based practice	The provision of healthcare services in sites not involved in complex patient procedures and processes. Such sites include private consultant rooms and health clinics
Open disclosure	A timely and transparent approach to communicating with, and supporting consumers when things go wrong. This includes a factual explanation of what happened, an apology, and actions that deal with the actual and potential consequences. An important aspect of open disclosure is explaining to consumers how the incident has been reviewed and what systems will be put in place to make sure similar incidences will not happen again
Operational plan	A plan that provides information on how the strategic plan will be accomplished
Organisation	Associations, agencies, groups, independent practitioners, and/or individuals accountable for the delivery of services to the consumer
Outbreak	An increase in occurrence of a complication or disease (infection) above the background rate. Thus, an outbreak may be one episode of a rare occurrence or many episodes of a common occurrence
Pacific people	Diverse consumer group including people from Tonga, Samoa, Fiji, Cook Islands, Tokelau, Tuvalu, Niue, and Kiribati
Pandemic	An epidemic (sudden outbreak) that becomes very widespread and affects a whole region, a continent, or the world
Pandemic planning	Is the process of planning for a pandemic event
Pathway	The pathway takes the evidence-based recommendation and the 'how to' instructions of the protocol to the individual consumer. It has a focus on the process and outlines precisely how the consumer will move through the treatment pathway clearly indicating when there is a deviation from this. A pathway can be helpful in informing providers and consumers about what to expect and can formalise the inclusion of treatments and interventions of most likely benefit to the particular consumer. A pathway can also serve as a care plan or the pathway can be a part of the overall consumer care plan

Peer support	Peer support is social/emotional, non medical support that is mutually offered or provided by persons who have used health and disability services themselves. Peer support is based on the knowledge that people who have faced and overcome adversity are able to develop genuinely empathic relationships based on shared experience
Personal protective equipment (PPE)	Equipment designed to reduce the risk of disease transmission between consumers and service providers. Such equipment typically involves gloves, eye protection, apron/gown, and masks and may include ventilation device modifications/types
Policy	A services plan or course of action, intended to influence and determine decisions, actions, and other matters
Procedure	Written instructions conveying the approved and recommended steps for a particular act or sequence of acts such as the administration of medication. Written instructions may be referred to as guidelines and/or work instructions
Protective environment	An air conditioned room (with specific air filtering, air exchange, and a cleaning regime for the minimisation of dust particles) for patients who have Hematopoietic Stem Cell Transplantation (HSCT)
Recovery	Recovery is defined as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience). 'Blueprint for Mental Health Services in New Zealand: How things need to be' (Mental Health Commission)
Representative	Used in this document to refer to the legally appointed representative including enduring power of attorney. A spouse, parent, or next of kin can only make legal decisions on behalf of a consumer who lacks mental capacity with specific authorisation or an appropriate order from the Family Court. Legal representation is achieved through application of relevant legislation (the Protection of Personal and Property Rights Act 1988 (PPPR)). Information about the provisions in the Act should be made available when needed to family members, friends, and relevant service providers
Residential services	The part of the organisation that includes overnight accommodation and may include associated support services as a component of its service provision
Respiratory hygiene (or cough etiquette)	The use of tissues to cover the mouth and nose when coughing or sneezing, prompt disposal of the tissues after use, followed by regular hand hygiene (a general term that applies to hand washing or the use of alcohol gels or rubs to decontaminate)
Responsibility	Where a service provider carries out an action

Restraint

The use of any intervention by a service provider that limits a consumer's normal freedom of movement

(For interventions that limit a consumer's freedom of movement voluntarily see definition of Enablers.)

Personal restraint
Where a service provider uses their own body to intentionally limit the movement of a consumer. For example, where a consumer is held by a service provider

Physical restraint
Where a service provider uses equipment, devices or furniture that limits the consumer's normal freedom of movement. For example: where a consumer is unable to independently get out of a chair due to: the design of the chair, the use of a belt, or the position of a table or fixed tray

Environmental
Where a service provider intentionally restricts a consumer's normal access to their environment. For example, where a consumer's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as a wheelchair) denied

Seclusion
Where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit

Restraint episode

For the purposes of restraint documentation and evaluation on, a restraint episode refers to a single restraint event, or, where restraint is used as a planned regular intervention and is identified in the consumer's service delivery plan, a restraint episode may refer to a grouping of restraint events

Review

A formal process of updating and amending or replanning based on evaluation of outcomes

Risk

The chance of something happening that will have an adverse impact on objectives (AS/NZS 4360 and SAA/SNZ HB 436)

Risk management

The culture, processes, and structures that are directed towards realising potential opportunities while managing adverse effects (AS/NZS 4360 and SAA/SNZ HB 436)

Safe

Freedom from preventable illness or harm to an individual's physical or non-physical well-being after a consumer has gained entry to a service

Safety

Being safe and free from abuse, exploitation, danger, risk, harm or injury.

Cultural safety
The provision of a service to a person or family from another culture that meets the needs of that culture, as determined by that person or family. Culture includes, but is not limited to: age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

The person providing the service will recognise the impact that their personal culture has on their practice. Unsafe cultural practice includes any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual

Safe environment
The environment is free from physical hazards including structures, fittings, as well as harmful compounds and toxic substances.

A service also provides a safe environment through a respectful and strength-based approach that places consumers first

Organisational safety
Risks within the organisation that have the potential to compromise safety are identified, monitored, evaluated, recorded in a risk register, and managed to acceptable levels

Serious harm

An event during care or treatment that has resulted in an unanticipated death or major permanent loss of function not related to the natural course of an illness or underlying condition, pregnancy or childbirth. Major permanent loss of function is defined as sensory, motor, physiological or intellectual impairment that as a result of an event during care, requires continued treatment or lifestyle change. Permanent loss of function includes an increase in the level of disability where the consumer has a pre-existing disability or disabilities

Serious infection control related issue

A serious infection control related issue refers to an actual or perceived significant risk of transmission of infectious agents within a facility or of the acquisition of agents which may prove difficult to eradicate (such as antibiotic resistant bacteria)

Service

The provision of assessment, treatment, care, support, teaching, research, promotion of independence, and other inputs provided to the consumer by the organisation

Service delivery

The act of service provision by the organisation or service provider to the consumer

Service delivery plan

The documentation describing the assessment, planning, implementation, evaluation, review, and exit processes of service delivery

Service provider

An individual who is responsible for performing the service either independently, or on behalf of an organisation. This includes the provision of direct and indirect care or support service to the consumer and covers all service providers and management who are:

(a) Employed;

(b) Self-employed;

(c) Visiting;

(d) Honorary;

(e) Sessional;

(f) Contracted;

(g) Volunteer service providers; or

(h) Anyone who is responsible or accountable to the organisation when providing a service to the consumer.

For the purpose of these Standards the informal/unpaid carer and family/whānau network are excluded

Standard precautions Precautions taken by all service providers and applied to all consumers regardless of their presumed infection status. Standard precautions recognise that blood, all body fluids, secretions and excretions (except sweat) regardless of whether or not they contain visible blood, non intact skin, and mucous membranes, may be potentially infectious, and that precautions are required to reduce risk of transmission of disease from both recognised and unrecognised sources of infection. Standard precautions include, but are not limited to, hand hygiene and use of PPE

Sterilisation A validated process used to render an object free from viable infectious agents including viruses and bacterial spores. Such processes include steam, dry heat, ethylene oxide gas, gamma irradiation, hydrogen peroxide, peracetic acid-based formulations, and liquid chemicals

Stigma Negative thoughts or feelings towards others based on their diagnosis of a mental illness

Suitably qualified Practitioners who provide services (including clinical care or judgement) to the consumer with qualifications and registration required by statute to practise, individuals with experience in the provision of care or support to the consumer and who are deemed competent to perform this function. The organisation shall be accountable for ensuring the service provider is competent to provide the service required of them

Surveillance The systematic process of data collection, collation, and analysis for the purpose of characterising risk groups and identifying control strategies and the timely dissemination and feedback of these data to those who need to know

Tangata whaiora A person seeking health and well-being. A person who experiences or has experienced mental illness or addiction and who uses or has used a mental health and addiction service

Tangata whenua People of the land, an iwi belonging to a particular place

Therapy The range of evidence-based therapeutic approaches used in treatment and support (excluding medication and other medical interventions). This could include psychotherapeutic, psycho-educational, rehabilitative, collaborative, approaches using individual and/or group methods

Tohunga Person with expert knowledge of Māori spirituality

Transition A process of change from one form, state or place to another

Transmission based precautions

These precautions are used to prevent transmission of highly transmissible or epidemiologically important infectious agents when rate of transmission is not completely interrupted using standard precautions. When used singly or in combination, they are always used in addition to standard precautions. The three categories of transmission based precautions are:

(a) Contact precautions;

(b) Droplet precautions;

(c) Airborne precautions

Treatment

Specific physical, psychological, medical, and social interventions provided by health professionals aimed at the reduction of impairment and the achievement of the best possible health for each person who receives the service

Whānau/family

The family or an extended family/group of people who are important to the person who is receiving the service

Young person

Means a boy or girl of or over the age of 14 years but under 17 years; but does not include any person who is or has been married or in a civil union

NOTES

APPENDIX A

FULL LIST OF HEALTH AND DISABILITY SERVICES STANDARDS (Informative)

This appendix outlines the complete list of Standards contained within NZS 8134:2008 *Health and disability services Standards.*

NZS 8134.0:2008 HEALTH AND DISABILITY SERVICES (GENERAL) STANDARD

NZS 8134.1:2008 HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

Standard number	Standard	Heading	Content
NZS 8134.1.1	**CONSUMER RIGHTS**		
NZS 8134.1.1.1	Consumer rights	Consumer rights during service delivery	Consumers receive services in accordance with consumer rights legislation
NZS 8134.1.1.2	Consumer rights	Consumer rights during service delivery	Consumers are informed of their rights
NZS 8134.1.1.3	Consumer rights	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
NZS 8134.1.1.4	Consumer rights	Recognition of Māori values and beliefs	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
NZS 8134.1.1.5	Consumer rights	Recognition of Pacific 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
NZS 8134.1.1.6	Consumer rights	Recognition and respect of the individual's culture, values, and beliefs	Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs
NZS 8134.1.1.7	Consumer rights	Discrimination	Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation
NZS 8134.1.1.8	Consumer rights	Good practice	Consumers receive services of an appropriate standard
NZS 8134.1.1.9	Consumer rights	Communication	Service providers communicate effectively with consumers and provide an environment conductive to effective communication
NZS 8134.1.1.10	Consumer rights	Informed consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent
NZS 8134.1.1.11	Consumer rights	Advocacy and support	Service providers recognise and facilitate the right of consumers to advocacy/ support persons of their choice

Standard number	Standard	Heading	Content
NZS 8134.1.1.12	Consumer rights	Links with family/whānau and other community resources	Consumers are able to maintain links with their family/whānau and their community
NZS 8134.1.1.13	Consumer rights	Complaints management	The right of the consumer to make a complaint is understood, respected, and upheld
NZS 8134.1.2	**ORGANISATIONAL MANAGEMENT**		
NZS 8134.1.2.1	Organisational management	Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers
NZS 8134.1.2.2	Organisational management	Service management	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
NZS 8134.1.2.3	Organisational management	Quality and risk management systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles
NZS 8134.1.2.4	Organisational management	Adverse event reporting	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
NZS 8134.1.2.5	Organisational management	Consumer participation	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
NZS 8134.1.2.6	Organisational management	Family/whānau participation	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
NZS 8134.1.2.7	Organisational management	Human resource management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation
NZS 8134.1.2.8	Organisational management	Service provider availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers
NZS 8134.1.2.9	Organisational management	Consumer information management systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required

Standard number	Standard	Heading	Content
NZS 8134.1.3	**CONTINUUM OF SERVICE DELIVERY**		
NZS 8134.1.3.1	Continuum of service delivery	Entry to services	Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified
NZS 8134.1.3.2	Continuum of service delivery	Declining referral/entry to services	Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whanau is managed by the organisation, where appropriate
NZS 8134.1.3.3	Continuum of service delivery	Service provision requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals
NZS 8134.1.3.4	Continuum of service delivery	Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner
NZS 8134.1.3.5	Continuum of service delivery	Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery
NZS 8134.1.3.6	Continuum of service delivery	Service delivery/ interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes
NZS 8134.1.3.7	Continuum of service delivery	Planned activities	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
NZS 8134.1.3.8	Continuum of service delivery	Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner
NZS 8134.1.3.9	Continuum of service delivery	Referral to other health and disability services (internal and external)	Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs
NZS 8134.1.3.10	Continuum of service delivery	Transition, exit, discharge, or transfer	Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services
NZS 8134.1.3.11	Continuum of service delivery	Use of electroconvulsive therapy (ECT)	Consumers who are administered electroconvulsive therapy are well informed and receive it in a safe manner
NZS 8134.1.3.12	Continuum of service delivery	Medicine management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines
NZS 8134.1.3.13	Continuum of service delivery	Nutrition, safe food, and fluid management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery

Standard number	Standard	Heading	Content
NZS 8134.1.4	**SAFE AND APPROPRIATE ENVIRONMENT**		
NZS 8134.1.4.1	Safe and appropriate environment	Management of waste and hazardous substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery
NZS 8134.1.4.2	Safe and appropriate environment	Facility specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose
NZS 8134.1.4.3	Safe and appropriate environment	Toilets, shower, and bathing facilities	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 requirements.
NZS 8134.1.4.4	Safe and appropriate environment	Personal space/bed areas	Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting
NZS 8134.1.4.5	Safe and appropriate environment	Communal areas for entertainment, recreation, and dining	Consumers are provided with safe, adequate, age-appropriate, and accessible areas to meet their relaxation, activity, and dining needs
NZS 8134.1.4.6	Safe and appropriate environment	Cleaning and laundry services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided
NZS 8134.1.4.7	Safe and appropriate environment	Essential, emergency, and security systems	Consumers receive an appropriate and timely response during emergency and security situations
NZS 8134.1.4.8	Safe and appropriate environment	Natural light, ventilation, and heating	Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature

NZS 8134.2:2008 HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

Standard number	Standard	Heading	Content
NZS 8134.2.1	**RESTRAINT MINIMISATION**		
NZS 8134.2.1.1	Restraint minimisation	-	Services demonstrate that the use of restraint is actively minimised
NZS 8134.2.2	**SAFE RESTRAINT PRACTICE**		
NZS 8134.2.2.1	Safe restraint practice	Restraint approval and processes	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
NZS 8134.2.2.2	Safe restraint practice	Assessment	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint
NZS 8134.2.2.3	Safe restraint practice	Safe restraint use	Services use restraint safely
NZS 8134.2.2.4	Safe restraint practice	Evaluation	Services evaluate all episodes of restraint
NZS 8134.2.2.5	Safe restraint practice	Restraint monitoring and quality review	Services demonstrate the monitoring and quality review of their use of restraint
NZS 8134.2.3	**SECLUSION**		
NZS 8134.2.3.1	Seclusion	Safe seclusion use	Services demonstrate that all use of seclusion is for safety reasons only
NZS 8134.2.3.2	Seclusion	Approved seclusion rooms	Seclusion only occurs in an approved and designated seclusion room

NZS 8134.3:2008 HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

Standard number	Standard	Content
NZS 8134.3.1	Infection control management	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
NZS 8134.3.2	Implementing the infection control programme	There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation
NZS 8134.3.3	Policies and procedures	Documented policies and procedures for the prevention and control of infection reflect correct 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
NZS 8134.3.4	Education	The organisation provides relevant education on infection control to all service providers, support staff, and consumers
NZS 8134.3.5	Surveillance	Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme
NZS 8134.3.6	Antimicrobial usage	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

NOTES

NZS 8134.1:2008

New Zealand Standard

Health and Disability Services (Core) Standards

Superseding NZS 8134:2001 and NZS 8143:2001

NZS 8134.1:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

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HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

FOREWORD

GENERAL

NZS 8134.1:2008 *Health and disability services (core) Standards* are generic in nature. They enable consumers to be clear about their rights and providers to be clear about their responsibilities for safe outcomes. NZS 8134.1 ensures:

(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

(b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner;

(c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and

(d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer.

NZS 8134.1 is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

WHAT CAN YOU BUY

NZS 8134.1 *Health and disability services (core) Standards* consists of this document plus:

(a) NZS 8134.1.1 – Consumer rights;

(b) NZS 8134.1.2 – Organisational management;

(c) NZS 8134.1.3 – Continuum of service delivery; and

(d) NZS 8134.1.4 – Safe and appropriate environment.

NZS 8134.1 comprises part of NZS 8134:2008 and may be purchased as a set, that is loose-leaf, four-hole punched, and shrink wrapped for insertion in a binder with room for NZS 8134.0 *Health and disability services (general) Standard,* NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* and NZS 8134.3 *Health and disability services (infection prevention and control) Standards.*

MENTAL HEALTH AND ADDICTION

Criteria from NZS 8143:2001 *National mental health sector Standard* were incorporated into this Standard during the 2007 review of the health and disability Standards. Seclusion criteria are incorporated into NZS 8134.2:2008 *Health and disability services (restraint minimisation and safe practice) Standards.*

Recovery is an important aspect that did not originally form part of NZS 8143. Where possible the principles and practices of recovery have been incorporated into the *Health and disability services (core) Standard* specifically highlighting examples for mental health and addiction services. It is hoped that these additions will support and assist services to enhance what they are doing currently and to enable them to demonstrate a closer alignment to recovery principles and practices.

RECOVERY

DEFINITION OF RECOVERY

'Recovery happens when we regain personal power and a valued place in our communities. Sometimes we need services to support us to get there'.[1]

Recovery is defined as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience).[2]

Each person with mental illness needs to define for themselves what 'living well' means to them. The definition is purposefully broad, because the experience of recovery is different for everyone and a range of service models could potentially support recovery.[3]

The addiction sector has a related yet different view of recovery, one that includes both abstinence and harm minimisation perspectives that have evolved over time allowing consumers to choose the approach that best represents their world view. Recovery involves an expectation/hope that people can and will recover from their addiction/unwellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services and wider community.[4]

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times the course is erratic and people may falter, slide back, regroup, and start again. The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution.[5]

Any differences in use of the word 'recovery' by particular service-user groups (for example, addiction and 12-step concepts of being 'in recovery') are compatible with other interpretations. Whether recovery is viewed as a journey or a stage or state of being, everyone will recognise and respect these shades of meaning.[6]

For some the term 'recovery' is confused with 'cure' which is not synonymous with living well.

For example, recovery does not necessarily mean a person:

(a) Will no longer have a mental illness;

(b) Will no longer have struggles;

(c) Will no longer use mental health and addiction services;

(d) Won't use medications;

(e) Will necessarily be working, off a benefit, or completely independent in meeting all of their needs.[7]

RECOVERY-ORIENTED SERVICES

The recovery approach to mental health and addiction signals a paradigm shift in the delivery of mental health and addiction services. The understanding of the efficacy of the recovery approach and how this is applied within services continues to evolve. A recovery-oriented mental health and addiction service aims to incorporate recovery principles throughout the delivery of its service. Recovery principles can be further characterised and matched to the following values:

(a) Person orientation: It is vital to understand the strengths and aspirations of every individual consumer;

(b) Person involvement: Outcomes are better for people who have an opportunity for meaningful involvement in the planning and delivery of their services;

(c) Self-determination and choice: Recovery focused mental health and addiction services live the values of choice and partnership. Coercion has the effect of diminishing, rather than strengthening individual consumers;

(d) Growth potential: Hope for the future is an essential ingredient in all recovery-oriented services. This includes evaluating progress towards growth, adjusting services to allow progress to be noticed or acknowledged, as well as altering services to improve progress. [8]

Pat Deegan, a consumer leader from the United States of America proposed that a recovery-oriented service should follow certain practices. These are set out in table 1 with evidence of recovery practices in column 1 and practices that have no recovery focus in column 2. To achieve the paradigm shift the practice needs to change to a greater focus on recovery principles and behaviours.

Table 1 – Comparison of recovery practices[7]

1. Recovery practice	2. No recovery focus
Hope is communicated at every level of service delivery	There is no communication of hope
The relationship between the service and the people accessing the service is based on compassion, understanding, and knowing each other as unique individuals and is the basis for good work to happen	Controlling, caring for, and protecting consumers is the basis of the work
Promoting high expectations for recovery, which is considered the purpose of the service	Stabilisation is the expected outcome of service
Working with individuals in ways that are purposeful and designed to assist people in their growth and recovery toward their dreams, desires and goals. The primary mechanism that supports this process is proactive, planned contact using written goals and evaluated steps toward achieving goals	Work with consumers lacks direction and is crisis-oriented. There is little or no use of planned purposeful contact. No use of written goal planning and goals are driven by service delivery or service providers
An emphasis on self-care, self-management, and education. People are supported to become experts in their own self-care. People are educated about medications, self-help, coping strategies, and symptom management. Information is openly shared and people have access to information	Compliance is desired. Professionals are seen as knowing what is best for consumers. Information is withheld on the basis that consumers do not understand or will not make good use of it
Community integration as the central focus of practice. This includes normal, integrated housing, real work experiences and work that is meaningful to the individual, linking to the community, social, and recreational activities with less emphasis on mental health and addiction service use	There is an emphasis on use of mental health and addiction programmes for work (sheltered work, pre-vocational work units, classes) social and recreational endeavours (psychosocial groups)
People being supported to take risks (failure is part of individual growth)	Protection and emotional safety are of primary concern

Table 1 – Comparison of recovery practices[7] (continued)

1. Recovery practice	2. No recovery focus
There is an encouragement and valuing of peer support and mutual self-help	Peer support and mutual self-help is not talked about or supported by service providers
The service provider anticipating crises and doing pre-crisis and crisis planning with people	Service providers do not spend time on health and wellness or wellness planning and therefore spend much time tending to crisis

NZS 8134.1 has endeavoured to incorporate the principles of recovery, encouraging services to build on good practice and current guidelines to make recovery an essential focus of service development.

FAMILIES AND RECOVERY

People who are ill are not ill in isolation.[2]

Many families wish to be involved in assisting the recovery of their family member and are often the foundation for the enhancement of the person's inner strengths, support, security, and identity.[6] This requires mental health and addiction services to be proactive, to facilitate, and empower family whānau in their role of supporting their family member. The extent to which family/whānau are involved in the consumer's recovery journey is ultimately the decision of the consumer, however family/whānau and primary caregivers have legal and other rights to some information and support.

Services need to ensure service providers have a good understanding of the impact of mental illness on the family, acknowledging family issues and assisting the family to build resilience and to identify goals for the family's own recovery. Services should ensure information is shared, that there is family involvement, and consultation in the planning and decision-making process if the family/whānau are the primary caregiver.

[1] Mental Health Commission. *Our Lives in 2014 – A recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors.* Wellington: Mental Health Commission, 2004.

[2] Mental Health Commission. *Blueprint for mental health services in New Zealand: How things need to be.* Wellington: Mental Health Commission, 1998.

[3] Mental Health Commission. *Recovery competencies for New Zealand mental health workers.* Wellington: Mental Health Commission, 2001.

[4] Ministry of Health. *Te kōkiri – The mental health and addiction action plan 2006-2015*. Wellington: Ministry of Health, 2006.

[5] Deegan P. 'Recovery: The Lived Experience of Rehabilitation'. *Psychosocial Rehabilitation Journal*, 11 (4) April 1988.

[6] Mental Health Commission. *Te hononga 2015 – Connecting for greater well-being*. Wellington: Mental Health Commission, 2007.

[7] Goscha, R. & Huff, S. *Basic case management training manual.* Kansas: The University of Kansas School of Social Welfare, 2001

[8] Farkas, et al. 'Implementing recovery oriented evidence based programs: Identifying the critical dimensions', *Community Mental Health Journal*, 41(2), April 2005.

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Reference is made in this document to the following:

NEW ZEALAND STANDARDS

NZS 3003.1:2003	Electrical Installations – Patient areas of hospitals and medical and dental practices – Testing requirements
NZS 4121:2001	Design for access and mobility: Buildings and associated facilities
NZS 4304:2002	Management of healthcare waste
NZS 8006:2006	Screening, risk assessment and intervention for family violence including child abuse and neglect
NZS 8134.0:2008	Health and disability services (general) Standard
NZS 8134.2:2008	Health and disability services (restraint minimisation and safe practice) Standards
NZS 8134.3:2008	Health and disability services (infection prevention and control) Standards
NZS 8143:2001	National mental health sector Standard (superseded by NZS 8134:2008)
NZS 8153:2002	Health records

JOINT AUSTRALIAN/NEW ZEALAND STANDARDS AND HANDBOOK

AS/NZS 2500:2004	Guide to the safe use of electricity in patient care
AS/NZS 3003:2003	Electrical installations – Patient areas of hospitals, medical and dental practices and dialyzing locations
AS/NZS 3551:2004	Technical management programs for medical devices
AS/NZS 4146:2000	Laundry practice
AS/NZS 4360:2004	Risk management
AS/NZS 4370:1996	Restraint of children with disabilities in motor vehicles
SAA HB 436:2004	Risk management guidelines – Companion to AS/NZS 4360:2004

AUSTRALIAN STANDARD

AS 2828-1999	Paper-based health care records

LATEST REVISIONS

The users of this Standard should ensure that the copies of the above mentioned New Zealand Standards and referenced overseas Standards are the latest revisions or include the latest amendments. Amendments to referenced New Zealand and joint Australian/New Zealand Standards can be found on http://www.standards.co.nz.

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NEW ZEALAND LEGISLATION

Births, Deaths and Marriages Registration Act 1995

Building Act 2004

Charitable Trusts Act 1957

Companies Act 1993

Coroners Act 2006

Crimes Act 1961

Criminal Justice Act 1985

Fire Safety and Evacuation of Buildings Regulations 2006

Fire Service Act 1975
Food Act 1981
Hazardous Substances and New Organisms Act 1996
Health Act 1956
Health and Disability Commissioner Act 1994
Health and Disability Services (Safety) Act 2001
Health and Safety in Employment Act 1992
Health Practitioners Competence Assurance Act 2003
Health (Retention of Health Information) Regulations 1996
Human Rights Act 1993
Incorporated Societies Act 1908
Land Transport Act 1998
Medicines Act 1981
Medicines Regulations 1984
Mental Health (Compulsory Assessment and Treatment) [MH (CAT)] Act 1992
New Zealand Bill of Rights Act 1990
New Zealand Building Code (NZBC) and Compliance Documents
New Zealand Public Health and Disability Act 2000
Privacy Act 1993
Protection of Personal and Property Rights Act 1988
Resource Management Act 1991
Smoke-free Environments Act 1990

LATEST REVISIONS

The users of this Standard should ensure that their copies of the above-mentioned New Zealand Standards are the latest revisions. Amendments to referenced New Zealand and Joint Australian/New Zealand Standards can be found on www.standards.co.nz.

CODES

Code of Health and Disability Services Consumers' Rights (the Code) 1996

Health Information Privacy Code 1994

WEBSITES

Health and Disability Commission	http://www.hdc.org.nz
Like Minds, Like Mine	http://www.likeminds.org.nz
Medsafe	http://www.medsafe.govt.nz
Ministry of Health	http://www.moh.govt.nz
New Zealand Food Safety Authority	http://www.nzfsa.govt.nz
New Zealand Health Information Service	http://www.nzhis.govt.nz
New Zealand Pharmacovigilance Centre	http://carm.otago.ac.nz
New Zealand Legislation	http://www.legislation.govt.nz
New Zealand Transport Agency	http://www.nzta.govt.nz
Office for Disability Issues	http://www.odi.govt.nz
Safe and Quality Use of Medicines Group	http://www.safeuseofmedicines.co.nz

RELATED DOCUMENTS AND GUIDELINES

When interpreting this Standard it may be helpful to refer to other documents, including but not limited to:

NEW ZEALAND STANDARDS

NZS 4102:1996 Safer house design – Guidelines to reduce injury at home

NZS 4121:2001 Design for access and mobility – Buildings and associated facilities

NZS 6703:1984 Code of practice for interior lighting design

NEW ZEALAND HANDBOOKS

NZMP 6004:1999 Safer electrical installations in homes for children, the elderly and people with disabilities.

SNZ 8134.5:2005 Health and disability sector Standards – Proposed audit workbook and guidance for residential services for people with dementia.

AUSTRALIAN STANDARD

AS 1668.2-2002 The use of ventilation and air conditioning in buildings – Ventilation design for indoor air contaminant control.

RELATED LEGISLATION

Children, Young Persons and their Families Act 1989

Employment Relations Act 2000

Intellectual Disability (Compulsory Care and Rehabilitation) [ID(CCR)] Act 2003

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Misuse of Drugs Act 1975

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Official Information Act 1982

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Waitemata District Health Board. *Guidance on open disclosure policies.* Auckland: Waitemata District Health Board, 2006.

WEBSITES

Best Treatments	http://www.besttreatments.net/btgeneric/home.html or free access via http://www.nzgg.org.nz
Cochrane Library	http://www.nicsl.com.au/cochrane/ or free access via http://www.nzgg.org.nz
Guidelines International Network (G-I-N)	http://www.g-i-n.net
Ministry of Health Guidelines	http://www.moh.govt.nz
Nationwide Health and Disability Advocacy Service	http://www.hdc.org.nz/advocacy
National Institute of Clinical Evidence (NICS)	http://www.nhmrc.gov.au/nics/asp/index.asp
New Zealand Guidelines Group	http://www.nzgg.org.nz
New Zealand Pharmacovigilance Centre	http://carm.otago.ac.nz
Schizophrenia Fellowship New Zealand Inc.	http://www.sfnat.org.nz

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NZS 8134.1.1:2008

New Zealand Standard

Health and Disability Services (Core) Standards –
Consumer rights

Superseding NZS 8134:2001 and NZS 8143:2001

NZS 8134.1.1:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

1.1: CONSUMER RIGHTS
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HEALTH AND DISABILITY SERVICES STANDARDS
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FOREWORD

NZS 8134.1:2008 *Health and disability services (core) Standards* are generic in nature. They enable consumers to be clear about their rights and providers to be clear about their responsibilities for safe outcomes.

NZS 8134.1 ensures:

(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

(b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner;

(c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and

(d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer.

NZS 8134.1 *Health and disability services (core) Standards* includes referenced and related documents, a section on recovery, and also includes the following Standards:

(e) NZS 8134.1.1 – Consumer rights

(f) NZS 8134.1.2 – Organisational management

(g) NZS 8134.1.3 – Continuum of service delivery, and

(h) NZS 8134.1.4 – Safe and appropriate environment.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 1 The purpose is to assist health and disability service providers to give effect to the Code of Health and Disability Services Consumers' Rights 1996 (the Code). Providers will need to be able to demonstrate how their service, as well as their practice, complies with the Code. A provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code. The onus is on the provider to prove it took reasonable actions. For clarity, 'the circumstances' means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

G 1.1.1 Education, including induction and ongoing professional development, will be provided to all service providers relevant to their role and level of contact with consumers.

G 1.2.1 The manner in which the Code of Health and Disability Services Consumers' Rights is displayed may vary according to the nature of the service.

G 1.2.2 Services may need to organise an interpreter to ensure a consumer is aware of their rights, so effective communication can occur and the consumer can be fully informed and able to make informed decisions. The Code could be put into plain language (using graphics) or talking book format.

Other rights covered by NZS 8134.1 include those outlined in the:

(a) Human Rights Act; and

(b) Privacy Act.

G 1.2.4 Information about the Nationwide Health and Disability Advocacy Service and where they exist, peer/consumer advocacy services is clearly displayed and brought to the attention of the consumer and their family/whānau of choice where appropriate. The manner in which the information is displayed may vary according to the nature of the service.

G 1.3.1 This may include, but is not limited to:

(a) Inpatient and residential settings that provide dedicated areas for consumers to keep their personal property and possessions;

(b) With the exception of clinical requirements such as an operating theatre, consumers are able to wear their own clothing;

(c) Service providers ensure the doors and curtains are closed as appropriate to provide privacy;

(d) Consumers are assured visual and auditory privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements;

(e) Moving to a more suitable area to conduct an examination, or consultation and privacy for attending to personal hygiene requirements;

(f) Consumers can meet with their family/whānau of choice where appropriate, and friends in a private space or room other than their bedroom.

G 1.3.2 Services need to be able to demonstrate how this is achieved. This may include, but is not limited to:

(a) Ensuring consumers unable to represent themselves, access input from family/whānau of choice where appropriate in order to maintain their cultural values and beliefs during service delivery;

(b) Specific training to prepare service providers to respond appropriately;

(c) Policy guidance for service providers on safe cultural practice, how to respond to culturally related requests, where to find relevant references and resources, and how to seek assistance when this is required;

(d) A dedicated Māori advisory position or group that is proactive in providing practical assistance to service providers to enable the service providers to achieve safe practice with Māori consumers and whānau;

(e) The consumer, and when requested by the consumer, the family/whānau or other representatives, are consulted about individual values and beliefs;

(f) Practices relating to the consumer's cultural or spiritual beliefs about death and dying are observed. Consumers whose death is imminent are afforded privacy and time with loved ones.

CONSUMER RIGHTS
NGĀ TIKANGA O TE KIRITAKI

Outcome 1 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 beliefs.

CONSUMER RIGHTS DURING SERVICE DELIVERY
NGĀ AHUATANGA KIA WHAKAWĀTEATIA KI TE KIRITAKI I A IA E WHAKAORANGIA ANA

Standard 1.1 **Consumers receive services in accordance with consumer rights legislation.**

Criterion The criterion required to achieve this outcome shall include the organisation ensuring:

1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporates them as part of their everyday practice.

Standard 1.2 **Consumers are informed of their rights.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.2.1 The Code of Health and Disability Services Consumers' Rights (the Code) is clearly displayed and easily accessible to all consumers.

1.2.2 Information about the Code and other rights is provided at the earliest opportunity in languages and formats suited to the needs of consumers who use the service.

1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

INDEPENDENCE, PERSONAL PRIVACY, DIGNITY, AND RESPECT
RANGATIRATANGA, WHAIARO, TŪMATAITI, MANA, ME TE MANAAKI

Standard 1.3 **Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

1.3.3 Consumers shall be addressed in a respectful manner by their preferred name.

1.3.4 Consumers have access to spiritual care of their choice. ➤

GUIDANCE

G 1.3.5 Sexual health information is readily available.

G 1.3.6 There are policies to guide service providers acting on advance directives and maximising independence when they are caring for people where this is likely to be an issue. Services for older people, people with disabilities, mental health and addiction services, and rehabilitation services are examples of where such policies would be appropriate.

G 1.3.7 Specific policies and procedures on abuse and neglect may include but are not limited to the following:

(a) Education programmes for service providers are repeated at appropriate intervals to maintain knowledge;

(b) Mechanisms to identify and respond in a timely manner to incidents of abuse or neglect;

(c) Advance directives.

For further information refer to NZS 8006, the Family violence intervention guidelines – Elder abuse, and the Family violence intervention programme.

G 1.4.1 This may include but is not limited to:

(a) A dedicated Māori advisory position or ability to access and consult with Māori;

(b) Recognising the cultural diversity and uniqueness of Māori and eliminating the risk of discrimination;

(c) Developing a monitoring strategy with iwi, hapū and whānau to evaluate services for Māori;

(d) Recognising that spirituality is inextricably linked to Māori well-being;

(e) Actively recruiting service providers that reflect the consumer population;

(f) Ensuring that Māori service providers have equal opportunity for development and training;

(g) Ensuring cross cultural training for service providers who are providing services to Māori;

(h) Māori participation at all levels of the service;

(i) Active collaboration with Māori in service delivery;

(j) Protection and improvement of Māori health status.

G 1.4.2 This may be achieved by, but is not limited to:

(a) The use of printed material or media that will effectively inform Māori about the service(s) being provided;

(b) The use of Te Reo Māori in pre-entry and entry information;

(c) Providing information to referral sources;

(d) Availability of service providers acceptable to Māori;

(e) Access to Māori support and advocacy services;

(f) Access to interpreters.

G 1.4.3 This may include, but is not limited to:

(a) Demonstration through a Māori health plan that is developed and implemented by the organisation; and

(b) Consultation with Māori/tangata whenua in all areas of service planning, development, and implementation affecting Māori.

G 1.4.4 This may be achieved by, but is not limited to:

(a) Ensuring consumers unable to represent themselves access input from whānau, iwi, and hapū in order to maintain their cultural values and beliefs during service delivery;

(b) Identification and documentation of specific Māori cultural needs of the consumer;

(c) Developing protocols which effectively support Māori consumers in meeting their cultural needs;

(d) Involvement of kaumātua/kuia and tohunga;

(e) Validation and observance of the Māori perspective of health which includes cultural, social, spiritual, whānau, environmental, and emotional factors in addition to physical health.

1.3.5 Consumers' intimacy and sexuality are supported in a manner that ensures the rights of the individual are protected and intervention only occurs to maintain balance between the personal rights and/or well-being of the consumer and those of others.

1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

RECOGNITION OF MĀORI VALUES AND BELIEFS
TE ARO NUI KI NGĀ UARA ME NGĀ TIKANGA A TE MĀORI

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.4.1 Māori consumers receive services consistent with their cultural values and beliefs.

1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.

1.4.4 Māori consumers' right to practise their cultural values and beliefs while receiving services is acknowledged and facilitated by service providers. ➤

GUIDANCE

G 1.4.5 This may be achieved by, but is not limited to:

(a) Identifying opportunities and implementing procedures to incorporate whānau support at each point of service delivery;

(b) Identifying and eliminating barriers to whānau support and participation;

(c) Involving whānau and their knowledge of the individual during service delivery.

G 1.4.6 This may include, but is not limited to:

(a) Establishing and maintaining links with Māori stakeholders when developing new services;

(b) Demonstrating consultation with iwi, hapū, whānau and Māori community groups which have links with the service should the consumer wish;

(c) Evaluating recommendations and the level of satisfaction with service delivery by Māori consumers and their whānau using the service.

G 1.4.7 *This may include, but is not limited to:*

(a) 'Like Minds Like Mine' information displayed;

(b) Positive Māori media;

(c) Access to Māori research and writings on Māori well-being, such as Professor Mason Durie's work (refer to http://maori.massey.ac.nz/staff/mason.shtml);

(d) Public health information campaigns and programme providers are available in an appropriate form;

(e) Conference and training budgets;

(f) Evidence of service provider's education of consumer/family/whānau.

G 1.5.1 (c) *The service delivers and facilitates appropriate services for Pacific people and recognises the fundamental importance of the bond between Pacific consumers, their family/whānau of choice, their elders/mātua, religious groups, and the community where appropriate.*

G 1.5.2 *This may include, but is not limited to:*

(a) Relevant information is displayed;

(b) Positive Pacific media;

(c) Access to Pacific research and writings on the health of Pacific people;

(d) Public health information campaigns and programme providers are available in an appropriate form;

(e) Conference and training budgets;

(f) Evidence of service provider's education of consumer/family/whānau.

G 1.6.1 Documented policies and procedures are implemented that ensure the organisation delivers services in a culturally safe manner.

G 1.6.2 This may include, but is not limited to demonstrating consultation with disability community groups.

1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

1.4.6 Tangata whenua are consulted in order to meet the needs of Māori consumers.

MHA* 1.4.7 *The service provides education and support for tangata whaiora, whānau, hapū, and iwi to promote Māori mental well-being.*

RECOGNITION OF PACIFIC VALUES AND BELIEFS
WHAKAAETANGA KI NGĀ UARA ME NGĀ WHAKAPONO O TE MOANA NUI A KIWA

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.5.1 *The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:*

MHA*

(a) Developing effective relationships with Pacific people to support active participation across all levels;

(b) Where appropriate, developing services that are based on Pacific frameworks/models of health that promote clinical and cultural competence;

(c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;

(d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers. This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

1.5.2 *The service provides education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people.*

RECOGNITION AND RESPECT OF THE INDIVIDUAL'S CULTURE, VALUES, AND BELIEFS
HE MĀRAMA, HE MANAAKI I TE AHUREA, I NGĀ UARA ME NGĀ WHAKAPONO A TE TANGATA

Standard 1.6 **Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.6.1 Consumers receive services in a manner that takes into account their cultural and individual values and beliefs.

1.6.2 The consumer and when appropriate and requested by the consumer the family whānau of choice or other representatives, are consulted on their individual values and beliefs.

* applies to mental health and addiction services only

GUIDANCE

G 1.7.1 Policies and procedures need to outline the safeguards to protect consumers from discrimination, coercion, harassment, and exploitation along with the actions that will be taken if there is inappropriate or unlawful conduct and the safety of a consumer is compromised or put at risk. This relates to discrimination that is unlawful under Part 2 of the Human Rights Act.

As applicable, these policies should include, but are not limited to:

(a) Responsiveness to complaints of any form of impropriety;

(b) Management of consumer finances and personal accounts;

(c) Safety and identification of consumer property.

G 1.7.3 As applicable, these policies should include, but are not limited to:

(a) Conflict of interest (for example, policies and procedures address the accepting of gifts and personal transactions with a consumer);

(b) The appropriate code for the service provider. This may include the Code of Ethics and Code of Practice.

G Standard 1.8 Various sections within the Standard deal specifically with a consumer's right to receive services of an appropriate quality. This includes:

(a) Human resource management for employing competent service providers, ongoing education, supervision, and mentoring arrangements;

(b) Policies and procedures for providing continuity of care and cooperation between providers;

(c) Incident reporting systems that are linked to open disclosure and quality improvement processes.

G 1.8.1 The service makes available to service providers a range of opportunities which may include, but are not limited to:

(a) Reference material and resources;

(b) Conference attendance;

(c) Study days;

(d) Evidence-based guidelines;

(e) Clinical pathways;

(f) Treatment protocols;

(g) Access to mentoring, supervision, and professional development;

(h) Consumer developed and provided education;

(i) Access to professional networking opportunities for service providers to share their knowledge.

Policies and procedures should be based on evidence-based rationales, which are monitored and evaluated.

G 1.9.3 This may be achieved by, but is not limited to service providers:

(a) Identifying themselves to consumers, using appropriate communication mediums;

(b) Wearing identification badges;

(c) Displaying a photo poster of all service providers and their names in a prominent place in the area where service provision is carried out;

(d) Ensuring consumers are aware of who they should discuss any aspects of their care with.

G 1.9.4 A process for accessing interpreter services is developed. This is accessed when required.

DISCRIMINATION WHAKAPARAHAKO

Standard 1.7 **Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other explotiation.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.7.1 Services have policies and procedures to ensure consumers are not subjected to discrimination, coercion, harassment, and sexual or other exploitation.

MHA* 1.7.2 *Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.*

1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

MHA* 1.7.4 *The service does not withdraw support or deny access to treatment and support programmes when or if the consumer refuses some aspects of treatment.*

1.7.5 *The service actively works to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service and any other service it has links with.*

GOOD PRACTICE WHANONGA PAI

Standard 1.8 **Consumers receive services of an appropriate standard.**

Criterion The criterion required to achieve this outcome shall include the organisation ensuring:

1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.

COMMUNICATION TAUWHITIWHITI

Standard 1.9 **Service providers communicate effectively with consumers and provide an environment conducive to effective communication.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.

1.9.2 Service providers allow sufficient time and an appropriate space for discussions to take place.

1.9.3 Consumers are assisted to identify service providers involved in their care.

1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.

* applies to mental health and addiction services only

GUIDANCE

G 1.10.1 Consent processes identified for the following situations, may include, but are not limited to:

(a) Routine situations;

(b) Emergency situations;

(c) Electroconvulsive therapy (ECT);

(d) Do-not-resuscitate situations;

(e) Consumers who are unable to consent;

(f) Children and young people;

(g) Involvement in teaching;

(h) Involvement in research;

(i) Storage, disposal, and return of body parts/tissues and bodily substances;

(j) The use of advance directives;

(k) Meeting the needs of consumers;

(l) Other situations appropriate to the service where informed consent is required.

G 1.10.2 The consumer is provided with understandable, written and verbal information on the potential benefits, adverse effects, alternatives, costs, and predictable inconvenience associated with a particular treatment or therapy. With the consumer's informed consent, their family/whānau of choice may be provided with the same information where this is required. This may include, but is not limited to:

(a) Use of interpreters and advocates;

(b) Provision of information in a variety of languages and formats;

(c) A system of checking the information is understood;

(d) Provision of information suggesting other available methods of treatment or therapy.

G 1.10.3 It is well recognised that the provision of information is an ongoing process and not a one-off event. A system should be in place to check consumers understand the information.

G 1.10.5 This may be achieved by, but is not limited to ongoing training and education in the principles and practice of informed consent.

G 1.10.6 The choices and decisions recorded and acted on may vary according to the nature of the service. This may include but is not limited to:

(a) Identifying and recording consumer's desired outcomes;

(b) Significant decisions such as changing homes or major financial decisions.

G 1.10.7 An advance directive is a written or oral directive:

(a) By which a consumer makes a choice about a possible future care procedure;

(b) Is effective only when the consumer is not competent.

In some situations an advance directive will not be valid. When deciding whether to follow an advance directive the clinician should consider:

(c) Was the consumer competent to make the advance directive?

(d) Did the consumer make the decision to prepare an advance directive of their own free will?

(e) Was the consumer sufficiently informed to make the decision?

(f) Does the advance directive apply to the present circumstance? Is it different from the time when the directive was made/put in place?

(g) Is the advance directive out of date?

The service should communicate with service providers on how to make advance directives.

INFORMED CONSENT TE WHAKAAE I RUNGA I TE MŌHIO

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.10.1 Informed consent policies/procedures identify:

(a) Recording requirements;

(b) Information (including documentation) to be provided to the consumer by the service;

1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

1.10.3 Information is made available to consumers in an appropriate format and in a timely manner.

1.10.4 The service is able to demonstrate that written consent is obtained where required.

1.10.5 Service providers have a thorough knowledge and understanding of how to meet their duties to consumers in relation to Rights 5, 6, and 7 of the Code.

1.10.6 Consumer choices and decisions are recorded and acted on.

1.10.7 Advance directives that are made available to service providers are acted on where valid.

S* **1.10.8** *The service has processes that give effect to consumers' requests on the storage, return or disposal of body parts, tissues, and bodily substances, taking into account the cultural practices of Māori and other cultures.*

1.10.9 *Where a service stores or uses body parts and/or bodily substances, there are processes and policies in place that meet Right 7(10) of the Code.*

* applies to acute, secondary or tertiary services only

GUIDANCE

G 1.11.1 The information should be provided in a way the consumer is able to understand.

G 1.12.1 Consumers have access to visitors of their choice (including children) when the safety of the consumer and others is not compromised. The safety of consumers in the presence of visitors needs to be assured. This may include, but is not limited to:

(a) Clinical stability of consumer;

(b) Legal status of consumer;

(c) Safety in relation to room size and/or other consumers in a shared room;

(d) Appropriate behaviour of visitors – such as behaviours that impinge on the safety of the consumer, other consumers, and/or service providers.

Services should ensure all consumers' safety and well-being is not compromised by visitors to the service.

ADVOCACY AND SUPPORT MAHI TAUNAKI ME TE TAUTOKO

Standard 1.11 Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person(s) of their choice are to be present.

1.11.2 The service has policies to facilitate the presence of advocates/support persons.

1.11.3 Service providers are educated to recognise this right to have an advocate/support person present and identify and appropriately address situations where an advocate/support person is not possible or appropriate.

LINKS WITH FAMILY/WHĀNAU AND OTHER COMMUNITY RESOURCES
NGĀ HONONGA KI NGĀ WHĀNAU ME ĒTAHI ATU RAUEMI A TE HAPORI

Standard 1.12 Consumers are able to maintain links with their family/whānau and their community.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.12.1 Consumers have access to visitors of their choice.

1.12.2 Consumers are supported to access services within the community when appropriate.

COMPLAINTS MANAGEMENT TE TIROTIRO WHAKAPAE

Standard 1.13 The right of the consumer to make a complaint is understood, respected, and upheld.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

1.13.2 Information about a consumer's right to complain and the complaints process is available. Copies are provided for the consumer.

1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

NZS 8134.1.2:2008

New Zealand Standard

Health and Disability Services (Core) Standards –
Organisational management

Superseding NZS 8134:2001 and NZS 8143:2001

NZS 8134.1.2:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

1.2: ORGANISATIONAL MANAGEMENT
NGĀ WHAKAHAERE A TE UMANGA

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NOTES

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HEALTH AND DISABILITY SERVICES STANDARDS
(CORE) STANDARDS

FOREWORD

NZS 8134.1:2008 *Health and disability services (core) Standards* are generic in nature. They enable consumers to be clear about their rights and providers to be clear about their responsibilities for safe outcomes.

NZS 8134.1 ensures:

(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

(b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner;

(c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and

(d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer.

NZS 8134.1 *Health and disability services (core) Standards* includes referenced and related documents, a section on recovery, and also includes the following Standards:

(e) NZS 8134.1.1 – Consumer rights

(f) NZS 8134.1.2 – Organisational management

(g) NZS 8134.1.3 – Continuum of service delivery, and

(h) NZS 8134.1.4 – Safe and appropriate environment.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 2.1.1 This may be achieved by, but is not limited to:

(a) A written quality and risk management plan which may be separate or included in service/strategic/business plans;

(b) Clearly identifying the goals, objectives, and scope of service delivery;

(c) Including statements about quality activities;

(d) Reference to the quality model or philosophy selected by the organisation, such as the PDCA Cycle (Plan, Do, Check, Act), Accreditation, or ISO Certification.

For mental health and addiction services this may include, but is not limited to:

(e) A mission statement identifying recovery approach/principles as driving the service;

(f) Management clearly articulate, create, and maintain a recovery focus and communicate this within the organisation;

(g) Policies and standard operating procedures are compatible with the principles/practices of recovery;

(h) Business/quality planning matches proposed developments to comply with all or part of a recovery oriented service;

(i) The model of case management clearly defines compliance with recovery principles/practices;

(j) 'Knowing the people planning' framework is used in compiling the business plan.

G 2.1.2 This may include, but is not limited to:

(a) The governing body ensuring there are effective communication systems and working relationships in order to deliver coordinated services. This should occur within and across the health and disability service, and with other relevant organisations and individuals;

(b) The organisation considering the diversity and unique needs of its communities of interest, including consumers, the cultural and social groups represented in their community and this is reflected in the strategic documents.

G 2.2.1 Temporary absence includes, but is not limited to:

(a) Illness;

(b) Leave;

(c) Position vacancy.

G 2.2.2 This may be achieved by, but is not limited to, ensuring that:

(a) Adequate separation or compatibility exists between different consumer groups if they are receiving services within the same facility;

(b) Arrangements should be appropriate to the needs and interests of each consumer group without detriment to any group;

(c) Consumers (including children and young people) are provided services in a developmentally and environmentally appropriate manner.

Outcome 2 Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

GOVERNANCE TE ĀHUA O TE WHAKAHAERE WHĀNUI

Standard 2.1 The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

2.1.2 Organisational performance is aligned with, and regularly monitored against, the identified values, scope, strategic direction, and goals.

2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

SERVICE MANAGEMENT TE WHAKAHAERE RATONGA

Standard 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.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

2.2.2 Services are planned to meet the specific needs of the consumer groups entering the service.

GUIDANCE

G 2.3.1 This may be achieved by, but is not limited to:

(a) A quality improvement and risk management policy;

(b) A quality and risk plan that is coordinated or integrated with the business or operational plan, and:

(i) Describes the quality and risk structure of the organisation

(ii) Demonstrates links to the Ministry of Health IQ action plan: supporting the improving quality approach

(iii) Demonstrates how key improvement activities link to quality and risk systems such as infection control, health and safety, compliance audits

(iv) Details the quality activities and projects for services

(v) Describes the quality model in place in the organisation such as the PDCA Cycle (Plan Do Check Act), Accreditation, or ISO Certification;

(c) Minutes of quality improvement meetings that demonstrate service quality improvement and risk management activity and the tracking and monitoring of a quality improvement action plan;

(d) Reports of quality improvement activity that are communicated across the organisation;

(e) Relevant Standards or contract requirements are identified and implemented.

G 2.3.2 This may be achieved by, but is not limited to:

(a) Quality improvement and risk management activities are adequately resourced;

(b) Quality teams have multidisciplinary membership, including all levels of service providers, and management representation as appropriate;

(c) Quality improvement and risk management reports are reviewed at board level and/or senior management level and recommendations are considered and acted upon as appropriate;

(d) Key stakeholders, including consumers/family/whānau of choice are consulted on service provision and quality improvement and risk management activity, and their participation is encouraged as appropriate;

(e) Efficient use of outcome measurement tools.

G 2.3.3 This may be achieved by, but is not limited to:

(a) Ensuring the quantity and detail specified in policies and procedures is relevant to the scope and complexity of the service provided;

(b) Ensuring policies and procedures reflect current accepted good practice within the relevant sectors;

(c) Ensuring any legislative requirements are included;

(d) Having processes in place to identify when and where new policies and procedures are required;

(e) Having processes in place to develop and approve new policies and procedures prior to full implementation;

(f) Having systems in place for reviewing and updating policies and procedures regularly;

(g) Having processes in place to ensure service providers are educated on new/reviewed policies.

G 2.3.6 This may be achieved by, but is not limited to ensuring quality improvement data:

(a) Are appropriate to the organisation's needs;

(b) Analysis is accurate;

(c) Are unbiased and use acceptable analysis tools;

(d) Results are communicated to service providers; and

(e) Consider consumers' needs.

QUALITY AND RISK MANAGEMENT SYSTEMS
PŪNAHA WHAKAHAERE KOUNGA, TIROTIRO WHAKARARU

Standard 2.3 **The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

2.3.2 Management and service providers enables consumer participation and consultation wherever appropriate.

2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.

This shall include, but is not limited to:

(a) Event reporting;

(b) Complaints management;

(c) Infection control;

(d) Health and safety;

(e) Restraint minimisation.

2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

2.3.7 A process to measure achievement against the quality and risk management plan is implemented. ➤

GUIDANCE

G 2.3.8 This may be achieved by, but is not limited to:

(a) An internal audit/monitoring programme to measure achievement;

(b) Consumer/family/whānau, other representatives, service provider, and referrer satisfaction surveys;

(c) Complaint and compliment management;

(d) Formal retrospective auditing of the documentation;

(e) Peer review, multidisciplinary team review;

(f) Developing a monitoring strategy with whānau, hapū, and iwi to evaluate if Māori needs are being met.

G 2.3.9 Appropriate to the size and complexity of the organisation this may be achieved by, but is not limited to:

(a) AS/NZS 4360 and SAA/SNZ HB 436;

(b) Managing risk associated with the provision of services including:

- (i) Service environment
- (ii) Natural disaster and emergency (internal and external)
- (iii) Business continuity and recovery planning
- (iv) Occupational health and safety
- (v) Human resource management and recruitment
- (vi) Information management
- (vii) Legislative compliance
- (viii) Contractual;

(c) Reducing the risk of potential harm occurring to consumers as a result of:

- (i) Current health and/or disability status
- (ii) Clinical risk
- (iii) Support and/or diagnostic/treatment regimes
- (iv) Outdated calibration of equipment
- (v) Ability to perform activities of daily living
- (vi) Impaired capacity to make decisions
- (vii) Exposure to infection
- (viii) Harm by/to others
- (ix) Disturbing behaviour
- (x) Cultural values and beliefs not being met
- (xi) Exit, discharge, and transfer
- (xii) Mortality data;

(d) Minimising the opportunity for potential harm to occur through:

- (i) Informed consent
- (ii) Specific risk assessment tools
- (iii) Multidisciplinary team input
- (iv) Where appropriate providing relevant information and support to family/whānau of choice and carers;

(e) Analysis of data is informed by:

- (i) Quality programmes
- (ii) Education and training
- (iii) Systems for effective communication
- (iv) Recognition of Māori values and beliefs
- (v) Recognition of other ethnic/cultural/spiritual values and beliefs;

(f) Managing potential harm arising from equipment, systems, and processes.

2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

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.

GUIDANCE

G 2.4.1 This may be achieved by, but is not limited to including a process for:

(a) Investigation;

(b) Analysis;

(c) Identification of trends;

(d) Planned corrective action;

(e) Review processes.

G 2.4.2 These requirements are contained in, but are not limited to:

(a) Health Act;

(b) Coroners Act;

(c) Mental Health (Compulsory Assessment and Treatment) Act;

(d) Births, Deaths and Marriages Registration Act;

(e) Health and Safety in Employment Act;

(f) Health and Disability Services (Safety) Act;

(g) New Zealand Public Health and Disability Act;

(h) Health Practitioners Competence Assurance Act;

(i) Reporting requirements of the New Zealand Fire Service as specified in the Fire Safety and Evacuation of Buildings Regulations;

(j) Professional practice/legislation requirements.

G 2.4.3 This may be achieved by, but is not limited to recording/reporting:

(a) Accidents and incidents;

(b) Adverse clinical events;

(c) Complaints and suggestions;

(d) Infections/notifiable diseases;

(e) Other events as indicated by statute, regulation or professional practice standards.

G 2.4.4 Consumers have the right to be fully informed of all adverse events in relation to the service they receive, the implications of those events and the outcomes of any reviews.

Open disclosure:

(a) Affirms consumers and where appropriate their family/whānau of choice rights;

(b) Fosters open and honest professional relationships;

(c) Enables systems to change to improve service quality and consumer safety; and

(d) Includes guidance and support for service providers to implement the policy.

NOTE – The Health and Disability Commissioner has provided 'Guidance on open disclosure policies' to assist providers with this approach. Refer to http://www.hdc.org.nz for further information.

ADVERSE EVENT REPORTING PŪRONGO TAKAHANGA KŌARO

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.4.1 The event reporting system is a planned and coordinated process that is an integral part of the management system.

2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

2.4.4 Adverse, unplanned, and untoward events are addressed in an open manner through an open disclosure policy.

GUIDANCE

G 2.5.1 *This may include, but is not limited to:*

(a) The service encourages consumers and service providers to take part in decision-making in service delivery, and in governance, management, planning, and evaluation within all services. This may include, but is not limited to:

(i) Consultation with a consumer adviser

(ii) Consultation with a joint consumer and family/whānau advisory group

(iii) Contracting of consumer advisory services;

(b) Clear policies and procedures on consumer participation, including definitions highlighting the differences between advocacy and advisory roles;

(c) Strategic/service delivery planning is developed through a process of consultation with the consumer and the community of interest, and there is a process to provide the community of interest with a summary of the current service delivery plan content;

(d) A plan for maximising participation in the service by people receiving the service is established and implemented;

(e) The service is appropriate to the size, type, and complexity of the community;

Consumers may be involved in:

(f) Strategic planning;

(g) Quality committees;

(h) Quality improvement projects;

(i) Service development;

(j) Service provider selection and training;

(k) Policies and procedures;

(l) Advisory groups at service/team levels;

(m) Inquiries.

G 2.5.2 *This may include, but is not limited to their roles and responsibilities are clearly outlined and include areas such as accountabilities, confidentiality, and conflicts of interest.*

G 2.5.4 *This may include, but is not limited to consulting with consumers and consumer groups when developing consumer participating processes.*

G 2.5.5 *This may include, but is not limited to:*

(a) Consumer forums;

(b) Consumer satisfaction surveys;

(c) Consumer advisory groups;

(d) Focus groups;

(e) Consumers networking with local people receiving the service and consumer groups.

G 2.6.1 *This may include, but is not limited to:*

(a) Clear policies and procedures on family/whānau participation, including definitions highlighting the differences between advocacy and advisory roles;

(b) A plan is established and implemented for maximising participation in the health service by the consumer's family/whānau of choice;

Family/whānau may be involved in:

(c) Strategic planning;

(d) Quality committees;

(e) Quality improvement projects;

(f) Service development;

(g) Service provider selection and training;

(h) Policies and procedures;

(i) Advisory groups at service/team levels;

(j) Inquiries.

CONSUMER PARTICIPATION URUNGA KIRITAKI

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.5.1 *The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.*

2.5.2 *Consumers and consumer groups involved in planning, implementation, and evaluation of services have clear terms of reference and position descriptions, and are appropriately reimbursed for expenses and/or paid for their time and expertise.*

2.5.3 *The service assists with training and support for consumers and service providers to maximise consumer participation in the service.*

This shall include:

MHA*

(a) Education and/or training for service providers whose colleagues are consumers working in the service;

(b) Supervision, debriefing, and peer support.

2.5.4 *The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view.*

This shall include, but is not limited to:

(a) Employing consumers where practicable;

(b) The service assisting with education, training, and support for consumers to maximise their participation in the service;

(c) Training for service providers in working with consumers as advisors;

(d) Advisors liaising with consumer groups or networks.

2.5.5 *The service implements processes that involve consumers at all levels of service delivery.*

FAMILY/WHĀNAU PARTICIPATION URUNGA WHĀNAU

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.6.1 *The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.*

MHA*

2.6.2 *Family/whānau who participate in an advisory capacity have clear terms of reference.*

This shall include, but is not limited to:

(a) Advice is sought from family/whānau advisory groups when developing a terms of reference;

* applies to mental health and addiction services only

GUIDANCE

G 2.6.3 *This may include, but is not limited to consulting with the family/whānau of choice when developing family/whānau participating processes.*

G 2.7.1 Service providers should have a thorough understanding of key legislation that impacts on children and young people if they provide services for children and young people. For mental health and addiction services this may also include, but is not limited to:

(a) Performance review is measured against the Mental Health Recovery Competencies;

(b) Policies require that all service providers understand recovery principles and that their understanding is demonstrated in their daily practice;

(c) Supervision processes exist which support the fostering/monitoring of recovery principles/practices in the care of consumers;

(d) Ongoing training opportunities are provided to allow service providers to discuss and apply the implementation of recovery principles and use the recovery tools.

G 2.7.2 The service demonstrates effective systems for employing competent service providers with the required skills for each position. This may be achieved by, but is not limited to:

(a) Sighting and recording of practice registration/certificate renewal information;

(b) Credentialling of service providers;

(c) Privileging of service providers (awarding of practice rights);

(d) An internal process for evaluating competence.

G 2.7.3 These processes may include, but are not limited to:

(a) Reference checking;

(b) Education/qualification checking;

(c) Police record checking;

(d) Recruitment and selection processes which encourage a wide range of applicants;

(e) Policies and processes accommodating the workplace needs of service providers with disabilities;

(f) Actively recruiting service providers who reflect the consumer population;

(g) Selection strategies which include assessment of the knowledge, attitudes, beliefs, and skills of service providers required to meet the need of the consumer.

G 2.7.4 This may be achieved by, but is not limited to:

(a) Appropriate orientation before a new practitioner provides care to consumers. Additional requirements may be imposed where the practitioner is new to the New Zealand health system;

(b) Service provider familiarity with:

(i) The quality improvement plan

(ii) Policies and procedures

(iii) Health and safety requirements

(iv) The authority and responsibility of the position

(v) Key functions and Standards

(vi) Organisation's vision and values;

(c) An internal process for evaluating if the service provider is competent to perform the role;

(d) For mental health and addiction services this may include education on recovery principles and practices.

G 2.7.5 This may be achieved by, but is not limited to:

(a) Identifying opportunities to improve service delivery;

(b) Identifying education needs and associated time frames to meet these;

(c) Appraisal system;

(d) Ensuring the competency of service providers;

(e) Provision of feedback to service providers which is accurate and meaningful on consumer outcomes;

(f) Promotion of a team approach;

(g) A system for service providers to provide feedback on the performance of their management team;

(h) Performance management.

(b) Roles and responsibilities shall be clearly outlined and include accountabilities, confidentiality, and conflicts of interest.

2.6.3 *The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view.*

MHA*

This shall include, but is not limited to:

(a) Employing family/whānau where practicable;

(b) The service assisting with education, training, and support for families/whānau to maximise their participation in the service;

(c) Training for service providers in working with families/whānau as advisors;

(d) Advisors liaising with family/whānau groups or networks.

HUMAN RESOURCE MANAGEMENT MAIMOA PŪMANAWA TANGATA

Standard 2.7 **Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.7.1 The skills and knowledge required of each position are identified and the outcomes, accountability, responsibilities, authority, and functions to be achieved in each position are documented.

2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.

2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.

2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

* applies to mental health and addiction services only

GUIDANCE

G2.8.1 This may be achieved by, but is not limited to:

(a) Determining service provider levels in consultation with health and/or disability professionals where the service meets a particular clinical and/or support need, particularly when the service manager has no clinical or support background;

(b) Implementing systems or processes that measure and report on resource provision in relation to consumer needs including:

(i) Support/dependency/acuity levels

(ii) Clinical indicators

(iii) Safety/security

(iv) Provision of a safe environment

(v) Responding to consumers' needs within acceptable/recognised or negotiated time frames

(vi) Responding to fluctuations in demands

(vii) Functional status

(viii) Age mix

(ix) Gender mix

(x) Meeting cultural values and beliefs

(xi) Spiritual, religious and ethical beliefs

(xii) Equipment availability;

(c) Appropriately qualified/skilled service providers/mentors are available to provide the service where professional expertise is required;

(d) Service provision reflects an appropriate skill mix, combining both knowledge and experience;

(e) Adequate and appropriate supervision/direction/support is provided in a manner that maintains public safety where required;

(f) Suitably experienced service providers are available to provide the service;

(g) For organisations that provide services for Māori, the service actively recruits and employs people with links to whānau, hapū and iwi who have relevant cultural knowledge and experience.

SERVICE PROVIDER AVAILABILITY TE ARO NUI, TE TAUTŌHITO O NGĀ TAUMATUA

Standard 2.8 **Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.**

Criterion The criterion required to achieve this outcome shall include the organisation ensuring:

2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

GUIDANCE

G2.9.1 This may be achieved by, but is not limited to ensuring all relevant information is entered into the consumer information system within 48 hours of entry to the service, or the next working day. Information should be in line with the requirements of the New Zealand Health Information Service (NZHIS), where applicable.

G.2.9.2 This may be achieved by, but is not limited to:

(a) Date of admission/entry;
(b) Full name;
(c) Preferred name;
(d) Alternative family names;
(e) Date of birth;
(f) Gender;
(g) Ethnicity (for example, NZHIS ethnicity code);
(h) Usual residential address;
(i) National Health Index (NHI) unique identifier;
(j) First contact name and contact details;
(k) Second contact name and contact details;
(l) General Practitioner (GP) or lead carer;
(m) Enduring Power of Attorney or other authorised agent or guardian;
(n) Referrer;
(o) Religion/spirituality;
(p) Date of exit/discharge/transfer/death;
(q) Exit/discharge/transfer information.

G 2.9.4 This may include but, is not limited to:

(a) Consumer records reflect the information requirements specified in the service policy;
(b) Consumer records contain adequate and appropriate information in order to facilitate safe management of records.

G 2.9.5 Information about past consumers should be kept in compliance with the Health Information Privacy Code.

G 2.9.6 This may include, but is not limited to:

(a) Health Information Privacy Code;
(b) Privacy Act;
(c) Health (Retention of Health Information) Regulations;
(d) Health Act;
(e) Human Rights Act;
(f) Companies Act;
(g) Incorporated Societies Act;
(h) Charitable Trusts Act;
(i) AS 2828;
(j) NZS 8153.

CONSUMER INFORMATION MANAGEMENT SYSTEMS
TE PŪNAHA WHAKAHAERE PĀRONGO KIRITAKI

Standard 2.9 **Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

2.9.2 The detail of information required to manage consumer records is identified relevant to the service type and setting.

2.9.3 Where the service is responsible for NHI registration of consumers, the recording requirements specified by the NZHIS are met.

2.9.4 Where the service is not required to meet the data requirements of the NZHIS adequate consumer detail is collected to safely manage consumer information.

2.9.5 The service keeps a record of past and present consumers.

2.9.6 Management of health information meets the requirements of appropriate legislation and relevant professional and sector Standards where these exist. ➤

GUIDANCE

G 2.9.7 This may be achieved by, but is not limited to ensuring:

(a) Visible information displayed on notification boards does not include sensitive information from which the health status or needs of a consumer could be determined;

(b) Sensitive information, including consumer records and service plans, is protected from unauthorised access.

G 2.9.8 This may be achieved by, but is not limited to:

(a) The service provider documenting and implementing procedures that assist service providers in meeting current information privacy requirements;

(b) Ensuring information is recorded in keeping with the organisation's, lead carer's, or specialist's delegated procedure;

(c) Ensuring service providers are briefed in, and comply with, the requirements of the Health Information Privacy Code and Health (Retention of Health Information) Regulations.

G 2.9.9 This may be achieved by, but is not limited to ensuring all entries are:

(a) Written clearly;

(b) Objective and factual, using abbreviations which are listed and approved;

(c) Authorised/signed with time and date in a legible manner by the service provider making the entry;

(d) Made in ink, electronic or other mediums acceptable under statute;

(e) Not defaced;

(f) Signed. This should be via a relevant signing register.

G 2.9.10 Where practicable, this may be achieved by, but is not limited to ensuring:

(a) Where possible all records should be in a single file/document. Where multiple volume health records exist (including departmental records) for a single consumer, the organisation should have a written policy for the management and creation of these, including guidance on how these files are linked, and which file is used for current information. Where a consumer has more than one physical file in their health record such as multiple volumes, the number of volumes should be clearly identified on the front cover of each file, for example, vol. 2 of 4;

(b) Each member of the team documents health information in a single continuous record for each consumer in a timely manner;

(c) All parts of the record, including both electronic and physical components, are clearly linked in order to locate them for retrieval;

(d) Consumer's outpatient or specialist reports are linked to the consumer's records, at the time of admission and during treatment.

2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

2.9.8 Service providers use up-to-date and relevant consumer records.

2.9.9 All records are legible and the name and designation of the service provider is identifiable.

2.9.10 All records pertaining to individual consumer service delivery are integrated.

NZS 8134.1.3:2008

New Zealand Standard

Health and Disability Services (Core) Standards –

Continuum of service delivery

Superseding NZS 8134:2001 and NZS 8143:2001

NZS 8134.1.3:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

1.3: CONTINUUM OF SERVICE DELIVERY
HE HĀTEPE TUKU RATONGA

ISBN 1-86975-099-3

NOTES

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NOTES

HEALTH AND DISABILITY SERVICES STANDARDS
(CORE) STANDARDS

FOREWORD

NZS 8134.1:2008 *Health and disability services (core) Standards* are generic in nature. They enable consumers to be clear about their rights and providers to be clear about their responsibilities for safe outcomes.

NZS 8134.1 ensures:

(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

(b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner;

(c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and

(d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer.

NZS 8134.1 *Health and disability services (core) Standards* includes referenced and related documents, a section on recovery, and also includes the following Standards:

(e) NZS 8134.1.1 – Consumer rights

(f) NZS 8134.1.2 – Organisational management

(g) NZS 8134.1.3 – Continuum of service delivery, and

(h) NZS 8134.1.4 – Safe and appropriate environment.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 3.1 For mental health and addiction services where admission is needed, the service makes every attempt to achieve voluntary admission of the person requiring the service.

G 3.1.1 This may include, but is not limited to:

(a) Service type;
(b) Location;
(c) Hours of service;
(d) Prioritisation process;
(e) Referral processes and criteria;
(f) Entry criteria;
(g) Pre-entry assessment/preparation;
(h) Related services where applicable;
(i) Out-of-hours contact information where applicable;
(j) Cost and/or financial assistance available;
(k) Service review and feedback processes.

G 3.1.2 This may be achieved by, but is not limited to:

(a) Ensuring the hours of service are appropriately communicated to facilitate consumer access to the service;
(b) Out-of-hours contact information is available where applicable;
(c) Other means appropriate to the service type/setting;
(d) Information is provided on how to access services in a crisis, including contact telephone numbers.

G 3.1.3 This may be achieved by, but is not limited to:

(a) The use of printed material or material appropriate to the communication needs/style of Māori and other consumers;
(b) Alternative formats such as Braille, large print, freephone number, translation into the different languages of likely consumer groups;
(c) Interpreter policy, including the use of sign language as appropriate;
(d) Providing information to potential referral sources;
(e) Email address;
(f) Website information;
(g) Other means appropriate to the service type/setting.

G 3.1.5 *This may include, but is not limited to:*

(a) Management of waiting lists, which is clearly communicated to consumers;
(b) Risk assessment protocol;
(c) Crisis intervention service;
(d) A relapse prevention plan;
(e) An advance directive.

G 3.2.1 Emergency situations may require more proactive action.

G 3.2.2 Feedback to consumers/family/whānau should be in a format appropriate to the needs/condition of the consumer.

CONTINUUM OF SERVICE DELIVERY
HE HĀTEPE TUKU RATONGA

Outcome 3 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.

ENTRY TO SERVICES WHAKAURUNGA KI NGĀ RATONGA

Standard 3.1 **Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.1.1 Access processes and entry criteria are clearly documented, and are communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

3.1.2 The service operates at times most appropriate to meet the needs of the consumer group.

3.1.3 Adequate and accurate information about the service is made available.

3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

MHA* & S**

3.1.5 *To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.*

DECLINING REFERRAL/ENTRY TO SERVICES
TE WHAKAPEKAINA URUNGA KI NGĀ RATONGA

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.2.1 Where a consumer is declined entry to the service this is recorded and the referrer is informed.

3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

* applies to mental health and addiction services only

** applies to acute, secondary or tertiary services only

GUIDANCE

G 3.3.1 This may include, but is not limited to:

(a) Consumers being able to access the assistance of a peer support service;

(b) For mental health and addiction services, this may include employing service providers who have a personal experience of mental illness and/or addiction;

(c) The provider having current up-to-date knowledge and experience and a level of competence appropriate to the role being performed or being adequately supervised by a service provider with the necessary competence.

G 3.3.2 This may include, but is not limited to:

(a) Offering the consumer and where appropriate their family/whānau of choice opportunities to meet with service providers to provide advice/education on service delivery;

(b) Identification and enhancement of consumer and where appropriate family strengths;

(c) Supporting the consumer and family/whānau to access community resources;

(d) Assisting the consumer and where appropriate their family/whānau of choice to identify specific goals if required.

G 3.3.3 This may include, but is not limited to:

(a) Service provision time frames are documented in order to meet consumer needs in line with time frames specified in:

(i) Clinical pathways/desired clinical outcomes

(ii) The organisation's policies/procedures

(iii) Purchaser contracts/service requirements

(iv) Applicable standards/guidelines/legislation;

(b) Negotiation with consumers;

(c) A monitoring process to ensure time frames are met;

(d) A process to identify and respond to variances/trends.

G 3.3.4 This may include, but is not limited to:

(a) Adequate handover/briefing between shifts;

(b) Promoting an multidisciplinary approach where appropriate;

(c) Rostering that promotes service provider continuity for consumers;

(d) Cooperation between providers.

G 3.3.6 *This may include, but is not limited to:*

(a) Education in family/whānau communication and problem solving skills;

(b) Family/whānau counselling and ongoing support;

(c) Support for children of parents with a mental illness.

SERVICE PROVISION REQUIREMENTS NGĀ WHAKARITENGA WHAKARATONGA

Standard 3.3 **Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

3.3.2 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate.

3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

MHA* **3.3.5** *The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.*

3.3.6 *The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.*

This shall include, but is not limited to:

(a) Consumer support group referrals;

(b) Education programmes;

(c) Consultation and liaison with community groups or relevant self-help groups.

* applies to mental health and addiction services only

GUIDANCE

G 3.4.1 This may include, but is not limited to ensuring that:

(a) Where more than one service provider is involved the assessment is coordinated;

(b) Where the service provider responsible for the assessment is different to the service provider responsible for service delivery, linkages between the two exist;

(c) Policies or protocols should be in place to ensure cooperation between service providers and continuity of service;

(d) Organisations have clear processes which encourage service providers to actively seek information from a range of sources, for example family/whānau, GP, referrer, employer;

(e) Service providers promote the reduction of multiple plans and assessments;

(f) The assessment is comprehensive, appropriate for the purpose, using evidence based and culturally safe methods and tools.

G 3.4.2 Assessments are provided within time frames identified by the organisation to safely meet the needs of the consumer. Assessments may include, but are not limited to:

(a) Assisting the family/whānau to identify specific goals if required;

(b) Supporting the family/whānau to access community resources.

G 3.4.4 Communication should be delivered in a manner that is understandable for the consumer. When communicating with children and young people, services need to consider their age and developmental stage.

G 3.5.1 Plans may include, but are not limited to:

(a) Long-term and short-term goals are identified by the consumer and where appropriate the family/whānau of choice and reviewed at regular times appropriate to the consumer's needs, in collaboration with the key worker or equivalent;

(b) Goals are measurable, challenging but achievable, and appealing;

(c) Consumers are supported to lead and update their own service delivery plans as much as practicable, for example, collaborative note writing, participation in handover, attendance at review meetings;

(d) Those community links and supports consumers are already involved in or plan to be involved in, emphasise existing community services rather then artificially segregated environments;

(e) The service having a direct emphasis on self-management as applicable;

(f) For mental health and addiction services the consumer should be given a copy of their service delivery plan.

G 3.5.2 Service delivery plans may also include crisis information, for example on the death of family/whānau/friends or pets.

G3.5.3 This may be achieved by, but is not limited to:

(a) Consumers and where appropriate their family/whānau of choice are informed of treatment and support options available;

(b) Interdisciplinary team involvement;

(c) Integration of primary and secondary services, for example with GPs attending community reviews;

(d) Effective links between services;

(e) Service coordination;

(f) Minimising duplication, and service fragmentation; and

(g) Facilitating/ensuring access to regular GP/dental care.

ASSESSMENT TE AROMATAWAI

Standard 3.4 **Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.4.1 Service providers seek appropriate information and access a range of resources to enable effective assessment.

3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

3.4.3 Assessments are conducted in a safe and appropriate setting as agreed with the consumer.

3.4.4 Assessment and intervention outcomes are communicated to the consumer, referrers, and relevant service providers.

MHA* 3.4.5 *Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.*

PLANNING NGĀ MĀHEREHERE

Standard 3.5 **Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.5.1 Service delivery plans are individualised, accurate, and up to date.

3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

3.5.3 Service delivery plans demonstrate service integration.

MHA* 3.5.4 *The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.*

3.5.5 The service delivery plan is communicated in a manner that is understandable to the consumer and service provider responsible for its implementation and with the consumer's consent, their family/whānau of choice.

* applies to mental health and addiction services only

GUIDANCE

G 3.6.1 This may include, but is not limited to:

(a) Clinical care/treatment;

(b) Direct support or interventions by the carer or service provider;

(c) Encouragement, direction, or supervision of a consumer completing an intervention themselves;

(d) Each person receiving the service is encouraged to develop and/or redevelop optimal levels of functioning to meet their own everyday living needs, within their community, using where possible community services and/or resources;

(e) For mental health and addiction services the service attempts to re-engage the recipient of the service who does not keep planned follow up arrangements and actively encourages individuals to continue their treatment through negotiation and the provision of clear information.

G 3.6.2 This includes consultation and liaison and may include, but is not limited to:

(a) Specialist and acute services;

(b) GPs;

(c) Allied health practitioners;

(d) Māori providers;

(e) Non-government organisations;

(f) Other relevant providers, including vocational providers and community recreation providers;

(g) Needs assessment service coordination;

(h) Other government agencies;

(i) Organisations that are responsible for:

(i) Maintenance of income/benefits and/or accommodation

(ii) Provisions for parenting, support of dependants, and pets

(iii) Safety of possessions.

G 3.6.3 *This may include, but is not limited to:*

(a) The right to a second opinion;

(b) The right to request change of service provider, including a clinician or support worker;

(c) Treatment and support in their home;

(d) Consideration of the preference of the person who is receiving the service and their status under the Mental Health (Compulsory Assessment and Treatment) [MH (CAT)] Act, Crimes Act, Criminal Justice Act, and other legislation as applicable.

G 3.6.4 This may be achieved by, but not limited to service providers ensuring that all planned interventions:

(a) Are in line with currently accepted good practice;

(b) Are carried out in the least restrictive manner;

(c) Maintain the safety and dignity of the consumer.

G 3.6.5 *This may include, but is not limited to assessing:*

(a) How the service is meeting the New Zealand Disability Strategy;

(b) The service's anti-discrimination policy and procedures.

This may also include, but is not limited to ensuring:

(c) Consumer groups, family/whānau, individuals, and organisations have the opportunity to be involved in aspects of these activities, such as education of the community and other services, promoting the positive image of people with mental illness (Mental Health Awareness Week), school education programmes, and public information seminars;

(d) Links with local bodies;

(e) If contacts with media organisations are established and maintained;

(f) The extent to which joint programmes are developed with other agencies.

SERVICE DELIVERY/INTERVENTIONS NGĀ WHAKARATONGA/NGĀ WHĀINGA

Standard 3.6 Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

3.6.2 Appropriate links are developed and maintained with other services and organisations working with consumers and their families.

MHA* **3.6.3** *The consumer receives the least restrictive and intrusive treatment and/or support possible.*

3.6.4 The consumer receives safe and respectful services in accordance with current accepted good practice, and which meets their assessed needs, and desired outcomes.

MHA* **3.6.5** *The consumer receives services which:*

(a) Promote mental health and well-being;

(b) Limit as far as possible the onset of mental illness or mental health issues;

(c) Provide information about mental illness and mental health issues, including prevention of these;

(d) Promote acceptance and inclusion;

(e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

* applies to mental health and addiction services only

GUIDANCE

G 3.7.1 Activities may include, but is not limited to:

(a) Occupational therapy;
(b) Diversional therapy;
(c) Social interaction;
(d) Life skills development;
(e) Exercise;
(f) Play or recreation;
(g) Music;
(h) Values and belief-related programmes where appropriate.

G 3.7.2 Service delivery plans may include, but are not limited to providing support to access opportunities within the areas of:

(a) Leisure/recreation;
(b) Work/employment;
(c) Education;
(d) Health and well-being.

Service providers actively seek to replace themselves with people in the community (community collaborators) who will continue to support consumers on their recovery journey (such as employers and community agencies).

G 3.7.3 This may be achieved by, but is not limited to giving consideration to the consumer's:

(a) Preferences;
(b) Capability;
(c) Age;
(d) Culture;
(e) Spirituality;
(f) Gender.

Consumer participation in planned activities is voluntary. It is recognised that encouragement to participate may be necessary, particularly when the programme is an essential part of the service delivery plan for the consumer.

G 3.9.1 This may include, but is not limited to referral including:

(a) Specialised therapy services;
(b) Allied health practitioners;
(c) Equipment;
(d) Community resources;
(e) Māori providers;
(f) Pacific providers;
(g) Other services appropriate to the consumer.

PLANNED ACTIVITIES NGĀ TŪ MAHI NGANGAHAU

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

3.7.2 Activities reflect ordinary patterns of life and include where appropriate the involvement of family/whānau of choice, or other representatives and community groups where appropriate.

3.7.3 The preferences of consumers are sought and inform the development of planned activities.

EVALUATION AROTAKENGA

Standard 3.8 **Consumers' service delivery plans are evaluated in a comprehensive and timely manner.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.8.1 Evaluations are conducted at a frequency that enables regular monitoring of progress towards achievement of desired outcomes.

3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

MHA* 3.8.4 *Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.*

REFERRAL TO OTHER HEALTH AND DISABILITY SERVICES (INTERNAL AND EXTERNAL) TE WHAKAPĀPĀ KI ĒTAHI ATU RATONGA HAUORA, HAUĀ HOKI (Ā-ROTO, Ā-WAHO)

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

3.9.2 The consumer's safety and right to be kept informed in a timely manner, is managed by service providers cooperating during the referral process.

* applies to mental health and addiction services only

GUIDANCE

G 3.10.1 Consumers should participate with providers to facilitate the following processes:

(a) Timely referrals;

(b) Self-discharge;

(c) Liaising with family/whānau of choice, other representatives and/or community support services where appropriate;

(d) Facilitating access to external and community support services including Māori services where appropriate;

(d) Education of service providers and consumers;

(e) Documented, timely, and appropriate multidisciplinary discharge/transfer information;

(f) Timely provision of discharge/transfer-related supplies and/or equipment;

(g) Emergency support information where appropriate;

(h) Facilitating access to allied support services;

(i) Coordinating ongoing support and follow-up services where necessary for continued recovery; and

(j) The consumer should have the opportunity to have an exit interview.

The transition, exit, discharge or transfer plan should be communicated effectively to all relevant providers and a copy provided to the consumer and where the consumer consents, to the family/whānau of choice.

G 3.10.2 The plan should ensure, but not be limited to:

(a) Discharge does not occur until arrangements for ongoing follow-up are established;

(b) Contact has been established with the next service;

(c) Identification of early warning signs of a relapse and the appropriate action to take are included;

(d) The consumer, and where appropriate, the family/whānau of choice are aware of how to regain entry to the service and who to contact at a later date if required.

G 3.11.1 *Services should refer to:*

(a) The 'Electroconvulsive therapy audit report' (MoH) for best practice guidelines on ECT;

(b) The 'Guidelines on the administration of ECT (Clinical Memorandum 12)' (Royal Australian and New Zealand College of Psychiatrists);

(c) The New Zealand Bill of Rights Act.

G 3.11.4 *The only time written consent is not obtained is when the consumer is subject to the MH (CAT) Act. It is recommended that service providers should make every effort to obtain consent.*

TRANSITION, EXIT, DISCHARGE, OR TRANSFER
TAKATAU, PUTA, WHAKAWĀTEA, WHAKAWHITI

Standard 3.10 Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.10.1 Service providers facilitate a planned transition exit, discharge, or transfer in collaboration with the consumer whenever possible and this is documented, communicated, and effectively implemented.

3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

USE OF ELECTROCONVULSIVE THERAPY (ECT) HAUMANU HIKO Ā-RORO (ECT)

(Only mental health services that provide ECT need to comply with Standard 3.11)

Standard 3.11 Consumers who are administered electroconvulsive therapy are well informed and receive it in a safe manner.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

MHA*

3.11.1 *ECT is provided according to legislation and currently accepted best practice guidelines.*

3.11.2 *There are monitoring processes in place to ensure all assessments, consents, and application of ECT comply with the currently accepted best practice guidelines, legislation, and the organisation's policies and procedures.*

3.11.3 *Consumers are given specific information on the risks and known side effects of ECT.*

3.11.4 *The consumer shall be fully informed.*

* applies to mental health and addiction services only

GUIDANCE

G 3.12 Further information on medicines can be found:

(a) At the Medsafe (New Zealand Medicines and Medical Devices Safety Authority) website: http://www.medsafe.govt.nz/profs/profs.asp;

(b) In the publication 'Safe management of medicines – A guide for managers of old people's homes and residential care facilities' available from http://www.medsafe.govt.nz/profs/regissues.asp

(c) In the Medicines Act and Regulations;

(d) At the Safe And Quality Use Of Medicines Group website: http://www.safeuseofmedicines.co.nz.

G 3.12.1 The guidelines should include the detection and management of all medication errors.

G 3.12.2 This may include, but is not limited to:

(a) Service providers operating only within their scope of practice and competency;

(b) Documentation of all current medicines prescribed (including those prescribed by other health professionals), taken, refused, disposed of, and medication errors;

(c) Informed consent for the administration of medicines.

G 3.12.4 Adverse events should be communicated to the New Zealand Pharmacovigilance Centre (http://carm.otago.ac.nz).

The service ensures a system exists which promptly provides each person with appropriate treatment for adverse effects or side effects of medication.

G 3.12.5 This may include, but is not limited to:

(a) Adequate information in a form that meets the needs of the consumer;

(b) Education on the purpose, actions, possible side effects, consequences of refusal/misuse and so on;

(c) Adequate and appropriate supervision is provided;

(d) Safe/appropriate storage is available;

(e) An administration record is maintained by the consumer.

G 3.12.6 Where medicine is prescribed as PRN the indication for use is clearly identified for the consumer and is used as part of a continuum strategy.

MEDICINE MANAGEMENT TE WĀHANGA TIAKI RONGOĀ

Standard 3.12 Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

3.12.2 Policies and procedures clearly document the service provider's responsibilities in relation to each stage of medicine management.

3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.

3.12.4 A process is implemented to identify, record, and communicate a consumer's medicine-related allergies or sensitivities and respond appropriately to adverse reactions or errors.

3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.

3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

MHA* **3.12.7** *Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.*

* applies to mental health and addiction services only

GUIDANCE

G 3.13.1 This may be achieved by, but is not limited to:

(a) Complying with 'Food and nutrition guidelines' (age specific) from the Ministry of Health;

(b) Regular monitoring of individual consumer's weight and nutritional status;

(c) Management of consumer's unexplained weight loss or gain.

G 3.13.2 This may be achieved by, but is not limited to ensuring:

(a) Input into menus and diets from registered dieticians;

(b) Special/modified dietary information is considered.

G 3.13.3 This may be achieved by, but is not limited to:

(a) Consumers have food of their choice brought in for them, unless it is clinically contra-indicated;

(b) Meals are enjoyable;

(c) Meals reflect community norms;

(d) Meals meet social, cultural, and religious needs;

(e) The dignity of the consumer is maintained during meal times;

(f) The menu range is appropriate to those receiving the service;

(g) Consumers have input into the range and choices;

(h) The presentation and texture is appropriate to the individual consumer;

(i) Consumers have adequate time to eat and assistance to meet their nutritional needs;

(j) Meals are served at times that reflect community norms.

G 3.13.4 This may include, but is not limited to providing:

(a) Modified cutlery/crockery;

(b) Non-slip mats;

(c) Feeding cups;

(d) Straws.

G 3.13.5 This may be achieved by, but is not limited to, complying with:

(a) Food Act;

(b) Standard criteria and manual for implementing a food safety plan. Refer to http://www.nzfsa.govt.nz for further information.

NUTRITION, SAFE FOOD, AND FLUID MANAGEMENT
KAI TŌTIKA, KAI HAUMARU, WHAKAHAERENGA KŪTERE

Standard 3.13 A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.

3.13.3 The personal food preferences of the consumer are met where appropriate.

3.13.4 Special equipment is available as required.

3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

NZS 8134.1.4:2008

New Zealand Standard

Health and Disability Services (Core) Standards –

Safe and appropriate environment

Superseding NZS 8134:2001 and NZS 8143:2001

NZS 8134.1.4:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

1.4: SAFE AND APPROPRIATE ENVIRONMENT

HE TAIAO ORA, TAIAO PAI

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NOTES

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NOTES

HEALTH AND DISABILITY SERVICES STANDARDS
(CORE) STANDARDS

FOREWORD

NZS 8134.1:2008 *Health and disability services (core) Standards* are generic in nature. They enable consumers to be clear about their rights and providers to be clear about their responsibilities for safe outcomes.

NZS 8134.1 ensures:

(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

(b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner;

(c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and

(d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer.

NZS 8134.1 *Health and disability services (core) Standards* includes referenced and related documents, a section on recovery, and also includes the following Standards:

(e) NZS 8134.1.1 – Consumer rights

(f) NZS 8134.1.2 – Organisational management

(g) NZS 8134.1.3 – Continuum of service delivery, and

(h) NZS 8134.1.4 – Safe and appropriate environment.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 4.1.1 This may be achieved by, but is not limited to meeting the requirements of the:

(a) Resource Management Act;

(b) NZS 4304;

(c) NZS 8134.3;

(d) Health Act; and

(e) Hazardous Substances and New Organisms Act.

G 4.1.2 This may include, but is not limited to:

(a) Spills of biological material;

(b) Needle stick injuries and similar incidents;

(c) Contamination; and

(d) Managing hazardous waste.

G 4.1.3 This may include, but is not limited to prompt action and early management (including prophylaxis) of waste and hazardous substances incidents such as:

(a) Biological waste;

(b) Human tissue waste;

(c) Chemical waste;

(d) Cytotoxic waste;

(e) Hazardous waste;

(f) Laboratory waste;

(g) Pharmaceutical waste;

(h) Radioactivity/radioactive waste;

(i) Sharps; and

(j) Animal waste.

SAFE AND APPROPRIATE ENVIRONMENT
HE TAIAO ORA, TAIAO PAI

Outcome 4 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.

These requirements are superseded, when a consumer is in seclusion. See NZS 8134.2.3.

MANAGEMENT OF WASTE AND HAZARDOUS SUBSTANCES
TE WHAKATAUTE PARA ME NGĀ MEA PŪMATE

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

4.1.2 All incidents involving infectious material, body substances or hazardous substances are reported, recorded, investigated, and reviewed.

4.1.3 A procedure or emergency plan to respond to significant waste, or hazardous substance management issues, and/or accidents is documented, implemented and its effectiveness monitored.

4.1.4 Service providers involved in the management of waste and hazardous substances receive training and education to ensure safe and appropriate handling.

4.1.5 All hazardous substances are correctly labelled to allow for easy identification and safe use in line with current hazardous substance identification regulations and territorial authority requirements.

4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

GUIDANCE

G 4.2.1 This may be achieved by, but is not limited to:

(a) The organisation demonstrating that the maintenance programme ensures all buildings, plant, and equipment are maintained to an appropriate standard or specification where a Standard exists;

(b) Meeting manufacturers' specifications where a Standard does not exist;

(c) A process is in place for upgrading and replacing equipment as required;

(d) Safe storage of medical equipment;

(e) Service providers receive training in the safe use of medical equipment by suitably qualified personnel;

(f) Equipment is checked before use;

(g) Meeting the following Standards:

(i) AS/NZS 3551

(ii) NZS 3003.1

(iii) AS/NZS 3003

(iv) AS/NZS 2500

(v) NZS 4121.

G 4.2.3 This may be achieved by, but is not limited to ensuring:

(a) Amenities, fixtures, equipment, and furniture meet infection control requirements, and are easy to clean and maintain;

(b) Non-slip surfaces or other safe effective means of minimising slipping are provided in areas frequently exposed to moisture or slippery substances;

(c) Consumers, specialists, Māori and other key stakeholders as appropriate are consulted when selecting:

(i) Furniture and equipment appropriate to the needs of the consumer group

(ii) Equipment that maximises the independence of consumers wherever possible;

(d) A product/equipment evaluation and implementation process is in place;

(e) Input is sought from key stakeholders prior to facility development or refurbishment.

G 4.2.4 Where practicable (particularly in acute mental health settings), this may be achieved by, but is not limited to providing gender specific areas.

G 4.2.7 The may include, but is not limited to:

(a) Policies and procedures for mobility vehicles. Refer to AS/NZS 4370;

(b) Accessing/exiting vehicles;

(c) Use of hoists;

(d) Driver training and responsibilities where transporting consumers;

(e) Ensuring policies and procedures comply with New Zealand Transport Agency (NZTA) rules and legislation. Refer to http://www.nzta.govt.nz for further information.

FACILITY SPECIFICATIONS NGĀ RAWA ME NGĀ TAPUTAPU E TIKA ANA

Standard 4.2 **Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.2.1 All buildings, plant, and equipment comply with legislation.

4.2.2 Where there is a requirement under the New Zealand Building Code there is

(a) A current Building Warrant of Fitness for older buildings; or

(b) A code of compliance certificate and certificate of public use for new buildings.

4.2.3 Amenities, fixtures, equipment, and furniture are selected, located, installed, and maintained with consideration of consumer and service provider safety, needs, and abilities.

4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

4.2.5 Where the facility is the consumer's home, rooms are provided that allow for familiar furnishings and personal possessions, while maintaining safety.

4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.

4.2.7 Where a consumer is required to be transported by vehicle, there are policies and procedures which minimise risk.

GUIDANCE

G 4.3.1 This may include, but is not limited to:

(a) Meeting the requirements of the New Zealand Building Code;

(b) Meeting the recommendations in the 'Australasian health facility guidelines' (HCAMC);

(c) Consumers can access toilet, shower and bathing facilities appropriate to meet their needs and abilities;

(d) Where the toilet/shower/bathing facility is communal, there is a system that indicates if it is engaged or vacant; or

(e) A safe locking system that provides for privacy but allows service providers access in the case of emergency;

(f) Making available other equipment/accessories to promote consumer independence.

G 4.3.2 This may be achieved by, but is not limited to providing delivered hot water in line with the requirements of Acceptable Solution G12/AS1 or an Alternative Solution for NZBC Clause G12/AS1.

G 4.3.4 This may include, but is not limited to:

(a) Floor surfaces and coatings are maintained in good order;

(b) There are non-reflective floor surfaces if reflective surfaces are detrimental to the consumer group;

(c) Transitions between surfaces or coverings are without abrupt change in level or gradient;

(d) Ramps meet the requirements of NZS 4121;

(e) Floor surfaces likely to be slippery when wet are kept dry or clearly identified when wet.

TOILET, SHOWER, AND BATHING FACILITIES
NGĀ WHAREPAKU, NGĀ HĪRERE ME NGĀ WĀHI KAUKAU

Standard 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 requirements.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

4.3.2 Hot water for showering, bathing, and hand washing is provided at the tap at a safe and appropriate temperature that minimises the risk of harm to consumers.

4.3.3 Consumers, service providers and visitors are provided with adequate hand washing facilities to ensure compliance with infection control policies.

4.3.4 Fixtures, fittings, floor, and wall surfaces are constructed from materials that can be easily cleaned, which are in line with infection prevention guidelines.

4.3.5 Toilets/shower/bathing facilities have clear and distinguishable identification when appropriate to the consumer group and setting unless contra-indicated by the consumer group.

PERSONAL SPACE/BED AREAS WĀHI WHAIARO/NGĀ WĀHI MŌ TE MOENGA

Standard 4.4 **Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely manoeuvre with the assistance of their aid within their personal space/bed area.

4.4.2 Where consumers are required to be transported or transferred between rooms or services in their beds, doorways, thoroughfares, lifts, and turning areas can readily accommodate the bed, attached equipment, and any escorts.

GUIDANCE

G 4.5.1 This may be achieved by, but is not limited to meeting the requirements of the New Zealand Building Code.

G 4.5.2 This may be achieved by, but is not limited to ensuring the arrangement of seating is appropriate to the consumer group, their collective choices and the setting in which the service is provided.

G 4.5.3 This may be achieved by, but is not limited to ensuring these areas are not combined unless they can be easily divided into their respective activities when required.

G 4.6.1 This may be achieved by, but is not limited to the service meeting:

(a) The NZBC;

(b) The 'Laundry guidelines for rest homes and small hospitals' (MoH);

(c) AS/NZS 4146.

COMMUNAL AREAS FOR ENTERTAINMENT, RECREATION, AND DINING
WĀHI WHĀNAU MŌ NGĀ MAHI WHAKANGAHAU, HĀKINAKINA, ME TE KAI

Standard 4.5 **Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

4.5.2 Consumers are able to move freely within these areas either independently or with the assistance of one or more persons, or mobility aides.

4.5.3 Areas designated for communal services, such as a lounge or dining room, if combined, do not impinge on consumer choices, rights, or privacy.

CLEANING AND LAUNDRY SERVICES
TE RATONGA HOROI TAPUTAPU, HOROI PŪERU

Standard 4.6 **Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.6.1 Written policies and procedures are implemented and describe each cleaning and laundry process appropriate to the service setting and consumer group.

4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

GUIDANCE

G 4.7.1 This may be achieved by, but is not limited to:

(a) Meeting the requirements of the Fire Safety and Evacuation of Buildings Regulations;

(b) Ensuring emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting;

(c) Acute or hospital services have access to oxygen and suction equipment that is maintained in a state of readiness for use in emergency situations.

G 4.7.2 This may be achieved by, but is not limited to ensuring first aid and emergency treatment is appropriate and timely.

G 4.7.5 The call system needs to be easily identifiable, accessible, and appropriate to the needs of the consumer group and the service setting.

G 4.8.1 To ensure the interior environment is ventilated and heated appropriately, the service should meet NZBC Clause G4 and G5.

G 4.8.2 To ensure the interior environment is lighted appropriately the service should meet NZBC Clause G7.

G 4.8.3 This may be achieved by, but is not limited to meeting the requirements of the Smoke-free Environments Act 1990.

ESSENTIAL, EMERGENCY, AND SECURITY SYSTEMS
NGĀ PŪNAHA WHAKAMARU, WAIWAI ME TE MATE WHAWHATI TATA

Standard 4.7 **Consumers receive an appropriate and timely response during emergency and security situations.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

4.7.2 Service providers are able to provide a level of first aid and emergency treatment appropriate for the degree of risk associated with the provision of the service.

4.7.3 Where required by legislation there is an approved evacuation plan.

4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.

4.7.5 An appropriate 'call system' is available to summon assistance when required.

4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

4.7.7 Consumers who require a greater degree of supervision receive the level of support necessary to protect the safety of the individual, the consumer group, service providers, and visitors to the service.

NATURAL LIGHT, VENTILATION, AND HEATING
NGĀ WHAKAMĀRAMA MĀORI, NGĀ WHAKAHAUHAU ME NGĀ WHAKAMAHANA

Standard 4.8 **Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.

4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

4.8.3 Consumers are not put at risk by exposure to environmental tobacco smoke.

Approval of Minister of Health received on 25 September 2008. Approved by the Standards Council on 25 September 2008 to be a New Zealand Standard pursuant to the provisions of section 10 of the Standards Act 1988.

First published: 8 October 2008

The following SNZ references relate to this Standard:

Project No. P 8134
Draft for comment No. DZ 8134
Typeset by: Standards New Zealand
Printed by: The Colour Guy

NZS 8134.2:2008

STANDARDS NEW ZEALAND
PAEREWA AOTEAROA

New Zealand Standard

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Superseding NZS 8141:2001

NZS 8134.2:2008

MINISTRY OF HEALTH
MANATŪ HAUORA

MINISTRY OF HEALTH
MANATŪ HAUORA

Appendix A

Ministry of Health's clarification of NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards *environmental restraint*

Environmental Restraint

It is apparent that routine locking of exit doors is occurring in some health and disability care facilities which are not designated 'locked units'.

The impact of locking devices on doors is restriction of a consumer's normal freedom of movement. This practice constitutes 'environmental restraint'.

Restraint must not be used as a routine measure. It is a serious intervention of last resort requiring robust clinical justification and oversight. All restraint use is subject to Part 2 of the Restraint Minimisation and Safe Practice Standards therefore in facilities other than those designated as a 'locked unit', whenever the use of locking devices on doors restricts a consumer's normal freedom of movement, the service provider must satisfy the requirements of the Standards. These requirements include the service provider demonstrating that:

(a) the use of restraint adheres to the principles of least restrictive practice and the rights, safety and dignity of the consumer are upheld
(b) there are clear organisational responsibilities and clinical justification for the use of restraint
(c) there are documented individual consumer restraint minimisation and safe practice assessments and evaluations including the clinical rationale for restraint use and the impact of restraint use
(d) the use of locking devices on doors does not restrict the normal freedom of movement of consumers for whom restraint is not intended
(e) they comply with fire and safety standards
(f) if the use of environmental restraint is not effective in maintaining the safety of the consumer or meeting the needs of the consumer then alternative management strategies will be investigated and utilised
(g) there are provisions to ensure the needs of consumers are re-assessed when clinically indicated, through an external assessment process, to determine the most appropriate level of care required.

<u>Locked units</u>
The following information is provided in the foreword of NZS 8134.2:2008:

'In a "locked unit" the locked exit is a permanent aspect of service delivery to meet the safety needs of consumers who have been assessed as needing that level of containment. Although by definition the locking of exits constitutes environmental restraint the requirements of this Standard are not intended to apply to the locking of exits in 'locked units', where the unit:

(a) is clearly designated a "locked unit";
(b) has clear service entry criteria against which consumers are assessed prior to entry;
(c) can ensure consumers using the service continue to meet the service criteria following entry; and
(d) can ensure any consumer that does not meet the service criteria has the means to independently exit the unit at any time.

Therefore when all of (a) – (d) are met, the practice of locking exit doors in "locked units" is not covered by this Standard. However, in the absence of any of the above points, the locking of exit doors should be treated as environmental restraint.'

The following statement is provided by the P 8134 workshop committee:

The 'locked units' clause contained in the foreword of NZS 8134.2:2008 was intended to relate specifically to contracted services, such as those providing dementia level residential care, where locked exit doors are an accepted and permanent aspect of service delivery and where consumers are independently and comprehensively assessed prior to entry.

The practice of controlling exit doors in a 'locked unit' was deemed exempt from the requirements of the Restraint Minimisation and Safe Practice Standards as in these units there is no requirement to:

- minimise the practice of locking exit doors as this is a permanent aspect of service delivery
- demonstrate an approval process for the practice of locking exit doors as this is an accepted aspect of service delivery
- undertake individual consumer restraint minimisation and safe practice assessment and evaluation, in relation to the practice of locking exit doors, as prior to entry consumers are considered to have been independently and comprehensively assessed as requiring this level of containment.

Environmental restraint

The following information is provided in the foreword of NZS 8134.2:2008:

'Where a service provider intentionally restricts a consumer's normal access to their environment, for example, where a consumer's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as wheelchair) denied.'

Issued: July 2011

NZS 8134.2:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

ISBN 1-86975-094-2

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FOREWORD

The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.

Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context.

This Standard covers all forms of restraint and supersedes NZS 8141:2001.

WHAT CAN YOU BUY

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* consists of this document plus:

(a) NZS 8134.2.1 – Restraint minimisation;

(b) NZS 8134.2.2 – Safe restraint practice;

(c) NZS 8134.2.3 – Seclusion.

NZS 8134.2 comprises part of NZS 8134:2008 and may be purchased as a set, that is loose-leaf, four-hole punched, and shrink wrapped for insertion in a binder with room for NZS 8134.0 *Health and disability services (general) Standard*, NZS 8134.1 *Health and disability services (core) Standards*, and NZS 8134.3 *Health and disability services (infection prevention and control) Standards.*

ETHICAL AND LEGAL CONSIDERATIONS

Practice is guided by ethical principles that include acting for the consumer's good (beneficence), avoiding harm to the consumer (non-maleficence), avoiding harm to self and others, and respecting the dignity of the consumer and the consumer's human rights.

The Standard should be implemented in ways that respect these and other ethical principles and at all times promote the interests, safety, and well-being of all involved.

Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard, and seek legal advice if necessary.

Seclusion and restraint shall not be used by providers for punitive reasons.

MEDICATION

The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of NZS 8134.2.

All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

RESTRAINT MINIMISATION AND SAFE PRACTICE

GENERAL

The use of restraint is a clinical decision. It is not a treatment in itself but is one of a number of strategies used at a particular time with a particular goal in mind. Restraint should be used only in the context of good clinical practice. Practices and training in restraint should ensure that any techniques are firmly grounded in this context.

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* expect restraint to be used only after all less restrictive interventions have been attempted and found to be inadequate. Proactive approaches should be used at all times. Where reactive strategies become necessary, de-escalation should be used before restraint. More intrusive interventions such as restraint should only be used where they are indicated. However, the reduction of restraint will rely on good assessment and planning processes, which provide early identification of a possible need for restraint and therefore assist in planning interventions that best reduce the likelihood of restraint being required.

It is crucial that organisations subject their use of restraint to rigorous internal and external review by consumers, family/whānau, professionals, and relevant professional bodies.

ENABLERS

Both enablers and restraint limit the normal freedom of movement of the consumer. It is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint but rather the intent of the intervention. Where the intent is to promote independence, comfort and safety, and the intervention is voluntary, this constitutes an enabler.

Additionally, the use of enablers should be the least restrictive option to safely meet the needs of the consumer.

Services that have no reported restraint use do not need to comply with NZS 8134.2.2 or NZS 8134.2.3. However, if and when a restraint event occurs NZS 8134.2.2 automatically applies to that event.

INDICATION FOR RESTRAINT USE

Restraint is a serious intervention that requires clinical rationale. It should not be undertaken lightly and should be considered as one of a range of possible interventions in the care setting, and always in the context of the requirements of this Standard, and current accepted good practice. Restraint should be applied only to enhance or maintain the safety of consumers, service providers, or others.

Service provider training and competency is critical, both to the appropriate and safe use of restraint, and to minimising the use of restraint.

ETHICAL AND LEGAL CONSIDERATIONS

Any unauthorised restriction of a consumer's freedom of movement could be seen as false imprisonment and could result in an action for assault. Organisations should develop clear policies and procedures to guide service providers and seek legal advice to ensure the practice they are specifying is legal.

OBSERVATION AND CARE DURING RESTRAINT

The organisation's policies and procedures should guide services in ensuring adequate and appropriate observation, care, dignity, respect, and on-going assessment occurs to minimise the risk of harm to consumers during restraint.

The frequency and level of observation and assessment should be appropriate to the level of risk associated with the restraint procedure, and the setting in which it is occurring. They should reflect current accepted good practice and the requirements of this Standard.

NIGHT SAFETY ORDERS

'Night safety orders' are not covered by this Standard. 'Night safety orders' is a term used to describe the practice of locking the entry to a consumer's bedroom overnight at the request of the consumer or locking the entry to an inpatient unit or residential service at night for the general safety of all. Organisations need to develop clear policies and procedures to guide them in these practices particularly in the event of a fire.

NOTE – Night safety orders are not covered by NZS 8134.2.

LOCKED UNITS

In a 'locked unit' the locked exit is a permanent aspect of service delivery to meet the safety needs of consumers who have been assessed as needing that level of containment. Although by definition the locking of exits constitutes environmental restraint the requirements of this Standard are not intended to apply to the locking of exits in 'locked units', where the unit:

(a) Is clearly designated a 'locked unit';

(b) Has clear service entry criteria against which consumers are assessed prior to entry;

(c) Can ensure consumers using the service continue to meet the service criteria following entry; and

(d) Can ensure any consumer that does not meet the service criteria has the means to independently exit the unit at any time.

Therefore when all of (a) – (d) are met, the practice of locking exit doors in 'locked units' is not covered by this Standard. However, in the absence of any of the above points, the locking of exit doors should be treated as environmental restraint.

SECLUSION USED AS 'TIME OUT'

Seclusion should not be used as a component of a consumer's service delivery plan to modify unwanted behaviour. Seclusion may only be used to manage safety.

DOMESTIC SECURITY

Domestic security is the practice of locking external doors at night for general security.

NOTE – Domestic security is not covered by NZS 8134.2.

APPLICATION

All services shall meet NZS 8134.2.1. NZS 8134.2.2 and NZS 8134.2.3 will be assessed as being not applicable to a service where restraint and seclusion are not used.

NZS 8134.2.2 is only relevant for services where restraint (including the use of seclusion) is used. However, services shall comply with this Standard if and when a restraint event occurs, in relation to that event and any subsequent events.

Services shall comply with NZS 8134.2.2 and NZS 8134.2.3 where seclusion is used.

NZS 8134.2.1	Restraint minimisation	All services shall meet this Standard
NZS 8134.2.2	Safe restraint practice	All services where restraint is used (including seclusion) shall meet this Standard.
NZS 8134.2.3	Seclusion	All services which use seclusion shall meet this Standard.

NZS 8134.2, NZS 8134.2.1, NZS 8134.2.2, and NZS 8134.2.3 are to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

REFERENCED DOCUMENTS

Reference is made in this document to the following:

NEW ZEALAND STANDARDS

NZS 8134.0:2008 Health and disability services (general) Standard

NZS 8134.1:2008 Health and disability services (core) Standard

JOINT AUSTRALIAN/NEW ZEALAND STANDARD

AS/NZS 4360:2004 Risk management

OTHER PUBLICATIONS

Ministry of Health. *He korowai oranga: Māori health strategy*. Wellington, Ministry of Health, 2002.

Ministry of Health. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health, 2008.

NEW ZEALAND LEGISLATION

Code of Health and Disability Services Consumers' Rights 1996 (the Code)

Health and Disability Services (Safety) Act 2001

Health and Disability Commissioner Act 1994

Intellectual Disability (Compulsory Care and Rehabilitation) [ID(CCR)] Act 2003

Mental Health (Compulsory Assessment and Treatment) [MH(CAT)] Act 1992

Protection of Personal and Property Rights Act 1988

LATEST REVISIONS

The users of this Standard should ensure that their copies of the above-mentioned New Zealand Standards are the latest revisions. Amendments to referenced New Zealand and Joint Australian/New Zealand Standards can be found on http://www.standards.co.nz.

WEBSITES

Health and Disability Commission	http://www.hdc.org.nz
New Zealand Legislation	http://www.legislation.govt.nz
Office for Disability Issues	http://www.odi.govt.nz

RELATED DOCUMENTS AND GUIDELINES

RELATED STANDARDS AND HANDBOOKS

When interpreting this Standard, it may be helpful to refer to the following:

NEW ZEALAND STANDARD AND HANDBOOK

NZS 8134.3:2008	Health and disability services (infection prevention and control) Standard
SNZ HB 8134.5:2005	Health and disability sector standards – Proposed audit workbook and guidance for residential services for people with dementia

AUSTRALIAN STANDARD

AS 2828:1999 Paper-based health care records

NEW ZEALAND LEGISLATION

Births, Deaths and Marriages Registration Act 1995

Building Act 2004

Children, Young Persons and their Families Act 1989

Coroners Act 2006

Crimes Act 1961

Criminal Justice Act 1985

Employment Relations Act 2000

Health (Retention of Health Information) Regulations 1996

Health Act 1956

Health Practitioners Competence Assurance Act 2003

Human Rights Act 1993

Injury Prevention, Rehabilitation and Compensation Act 2001

Local Government Act 2002

Medicines Act 1981

New Zealand Bill of Rights Act 1990

New Zealand Building Code (NZBC) and Compliance Documents

New Zealand Public Health and Disability Act 2000

Official Information Act 1982

Privacy Act 1993

RELATED DOCUMENTS

Drinka, T J K. & Clark, P G. (2000). *Health care teamwork: interdisciplinary practice & teaching*. Westport, CT: Auburn House, 2000.

Mental Health Commission. *Our lives in 2014, A recovery vision from people with experience of mental illness.* Wellington: Mental Health Commission, 2004.

Mental Health Commission. *Procedural guidelines for physical restraint*. Wellington: Ministry of Health, 1993.

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Ministry of Health /Health Funding Authority. *Guidelines for clinical risk assessment and management in mental health services*. Wellington: Ministry of Health, 1998.

Ministry of Health. *Consent in child and youth health – Information for practitioners.* Wellington: Ministry of Health,1998.

Ministry of Health. *Guidelines for the support and management of people with dementia – National advisory committee on health and disability*. Wellington: Ministry of Health, 1997.

Ministry of Health. *He taura tieke: measuring effective health services for Māori*, Wellington: Ministry of Health, 1995.

Ministry of Health. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health, 2008.

Ministry of Health. *Standards for needs assessment for people with disabilities,* Wellington: Ministry of Health, 1994.

Ministry of Health. *Standards for traditional Māori healing*. Wellington: Ministry of Health, 1999.

Neal, L J. 'Neal theory of home health nursing practice.' *Journal of Nursing Scholarship* 31, no. 3 (1999): 251 – 252.

WEBSITES

Mental Health Commission	http://www.mhc.govt.nz
Ministry of Health	http://www.moh.govt.nz
Nationwide Health and Disability Advocacy Service	http://www.hdc.org.nz/advocacy
New Zealand Guidelines Group	http://www.nzgg.org.nz
New Zealand Health Information Service	http://www.nzhis.govt.nz

NZS 8134.2.1:2008

New Zealand Standard

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Restraint minimisation

Superseding NZS 8141:2001

NZS 8134.2.1:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

2.1: RESTRAINT MINIMISATION
WHAKAITINGA TAUTĀWHI

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FOREWORD

The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.

Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context.

This Standard covers all forms of restraint and supersedes NZS 8141:2001.

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* includes referenced and related documents and guidelines, guidance on restraint minimisation and safe practice, and on the application of the Standard, along with the following Standards:

(a) NZS 8134.2.1 – Restraint minimisation

(b) NZS 8134.2.2 – Safe restraint practice

(c) NZS 8134.2.3 – Seclusion.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite

ETHICAL AND LEGAL CONSIDERATIONS

Practice is guided by ethical principles that include acting for the consumer's good (beneficence), avoiding harm to the consumer (non-maleficence), avoiding harm to self and others, and respecting the dignity of the consumer and the consumer's human rights.

The Standard should be implemented in ways that respect these and other ethical principles and at all times promote the interests, safety, and well-being of all involved.

Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard, and seek legal advice if necessary.

Seclusion and restraint shall not be used by providers for punitive reasons.

MEDICATION

The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of this Standard.

All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

GUIDANCE

G 1.2 This may include but is not limited to:

(a) Collaborative assessments, which include input from the consumer and/or their family/whānau, that identify:

(i) Current and possible future risks

(ii) Any existing underlying causes of relevant risk related behaviour

(iii) Any triggers that may increase the likelihood of a relevant risk related behaviour

(iv) Any signs and symptoms that may indicate a relevant risk related behaviour or condition is present

(v) Assistance given to the consumer in the past that may have avoided the use of restraint;

(b) Collaborative care planning, which includes input from the consumer and/or their family/whānau, that includes:

(i) Any relevant advance directives

(ii) How future crises will be best avoided and as necessary managed

(iii) How any underlying causes of relevant risk related behaviour will be remedied or managed

(iv) How triggers that may increase the likelihood of a relevant risk related behaviour will be avoided;

(c) Consumers and/or their family/whānau are informed of the organisation's restraint policy;

(d) Referral to other services as appropriate.

G 1.3 This may include but is not limited to:

(a) Consumer assessment;

(b) Identifying when enablers are agreed to be used for the individual consumer;

(c) Monitoring to ensure consumer safety;

(d) Evaluation within the consumer's service delivery plan.

RESTRAINT MINIMISATION
WHAKAITINGA TAUTĀWHI

Outcome 1 Consumers receive and experience services in the least restrictive manner.

Standard 1 **Services demonstrate that the use of restraint is actively minimised.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.1 The service has policies and procedures that include, but are not limited to:

(a) The commitment to restraint minimisation, which may include but is not limited to:

(i) The service's philosophy on restraint

(ii) How the service communicates its commitment to restraint minimisation

(iii) How the service ensures its commitment is carried out in practice;

(b) The definition of restraint which is congruent with the definition in NZS 8134.0;

(c) The process of identifying and recording any restraint use is transparent and comprehensive;

(d) How it will meet the responsibilities specified in NZS 8134.2.2 if and when restraint is used;

(e) The definition of an enabler which is congruent with the definition in NZS 8134.0;

(f) The process of assessment and evaluation of enabler use.

1.2 The service ensures risk assessment processes and the consumer's service delivery plans support the delivery of services that avoid the use of restraint. This shall include, but is not limited to assistance given to the consumer in the past, which may have prevented the use of restraint.

1.3 Where enablers are used the organisation ensures service providers are guided in their safe and appropriate use.

1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. ➤

GUIDANCE

G 1.5 This may include but is not limited to:

(a) Education tailored to both current and new service providers;

(b) A method of assessing the level of knowledge gained by service providers;

(c) Defining how often service providers are required to undertake education.

1.5 Ongoing education, relevant to the service setting, is provided to service providers, which includes, but is not limited to:

(a) The service's restraint definition, restraint minimisation policy and process for identifying and recording restraint use;

(b) The service's enabler use policy and procedure;

(c) The service's responsibility to meet NZS 8134.2.2 if and when restraint is used;

(d) Alternative interventions to restraint;

(e) Prevention and/or de-escalation techniques.

Threats of restraint or seclusion shall not be used to achieve compliance.

1.6 Services that have no reported restraint use do not need to comply with NZS 8134.2.2 and NZS 8134.2.3. However, if and when a restraint event occurs, NZS 8134.2.2 automatically applies to that event.

NZS 8134.2.2:2008

New Zealand Standard

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards –

Safe restraint practice

Superseding NZS 8141:2001

NZS 8134.2.2:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

2.2: SAFE RESTRAINT PRACTICE
TIKANGA TAUTĀWHI HAUMARU

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This Standard covers all forms of restraint and supersedes NZS 8141:2001.

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* includes referenced and related documents and guidelines, guidance on restraint minimisation and safe practice, and on the application of the Standard, along with the following Standards:

(a) NZS 8134.2.1 – Restraint minimisation

(b) NZS 8134.2.2 – Safe restraint practice

(c) NZS 8134.2.3 – Seclusion.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite

ETHICAL AND LEGAL CONSIDERATIONS

Practice is guided by ethical principles that include acting for the consumer's good (beneficence), avoiding harm to the consumer (non-maleficence), avoiding harm to self and others, and respecting the dignity of the consumer and the consumer's human rights.

The Standard should be implemented in ways that respect these and other ethical principles and at all times promote the interests, safety, and well-being of all involved.

Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard, and seek legal advice if necessary.

Seclusion and restraint shall not be used by providers for punitive reasons.

MEDICATION

The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of this Standard.

All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

GUIDANCE

G 2.1.1 This may include but is not limited to:

(a) Approval process including consultation with and/or advice from:

(i) Consumers, family/whānau, peer, advocate and/or legal representative;

(ii) Internal and external health professionals relevant to the practice setting;

(iii) Cultural input;

(iv) Specialist/technical input relevant to the practice setting;

(b) Approval determination should consider, but is not limited to:

(i) Whether this is the least restrictive intervention available for the proposed indications;

(ii) The legal and ethical implications of the application of any restraint; and

(iii) Whether related policies, procedures, protocols, or guidance meet the requirements of this Standard and current, accepted good practice standards.

G 2.1.3 This may include but is not limited to:

(a) The frequency for reviewing approval is determined by the nature and level of risk posed, both to consumers and service providers when the approved restraint is applied. Each restraint type should be reviewed at least every two years;

(b) An approval review process is documented and followed;

(c) A system is implemented to alert the organisation to future approval review dates; and

(d) A process exists to obtain comprehensive feedback from consumers, family/whānau, service providers, and other key stakeholders.

G 2.2.1 Assessments should help identify key factors, which contribute to the possibility that restraint might be considered. A service provider should consider the following factors, which may influence the decision to use restraint or not:

(a) The consumer's physical and psychological health, including any adverse health effects;

(b) The consumer's gender and culture;

(c) The degree of risk to the individual, others, and the environment;

(d) The consumer's service delivery plan;

(e) The experience of the individual and possible compromise to the future therapeutic relationship; and

(f) Legal considerations for the use of restraint.

G 2.2.2 Input may include the use of 'advance directives'.

Outcome 2 Consumers receive services in a safe manner.

RESTRAINT APPROVAL AND PROCESSES
TE WHAKAAETANGA ME TE HĀTEPE WHAKAITA

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.1.1 The responsibility for the restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

2.1.2 Approved restraints will be documented, along with alternatives to restraint, and made known to service providers.

2.1.3 The approval for each restraint type is reviewed regularly.

ASSESSMENT TE AROMATAWAI

Standard 2.2 **Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

(a) Any risks related to the use of restraint;

(b) Any underlying causes for the relevant behaviour or condition if known;

(c) Existing advance directives the consumer may have made;

(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

(f) Maintaining culturally safe practice;

(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

(h) Possible alternative intervention/strategies.

2.2.2 In assessing whether restraint will be used, the consumer and/or the family/whānau is informed and their input sought as practical.

GUIDANCE

G 2.3.1 This may include but is not limited to:

(a) Policies and procedures identifying how often assessment for the continuation of restraint occurs;

(b) Consumer's service delivery plans identify factors which indicate that the restraint is no longer required;

(c) Written guidance for service providers on the steps to take when a restraint has to be discontinued for safety reasons;

(d) Restraint should be discontinued when:

(i) There is no longer any justification to continue using restraint

(ii) The risks to the consumer or service providers outweigh the benefit of its use.

G 2.3.2 Appropriate alternative interventions will vary depending on the type of restraint being considered and current accepted good practice. De-escalation should always be attempted prior to initiating restraint where indicated.

When determining whether a restraint is safe and appropriate to use, the service provider should consider the following:

(a) Is there a less restrictive method of achieving the desired outcome?

(b) Is there a likelihood of serious harm to the consumer, service providers, or others (whether physical, psychological, or cultural) if the restraint is not applied?

(c) Does the risk of serious harm to the consumer, service providers, or others (whether physical, psychological, or cultural) when applying or removing the restraint outweigh the necessity for its use?

(d) Are the organisation's policies and procedures being followed?

(e) The consumer's service delivery plan and any known 'advance directive'?

Service providers should follow written plans (based on consultation with family/whanāu and significant others) when the use of restraint requires the removal of objects/items of cultural significance, for example a headscarf.

G 2.3.3 The greater the risk associated with the use of a restraint, the greater the degree of monitoring will be required.

The frequency and extent of monitoring of a consumer during restraint is documented in the organisation's policies and procedures and the consumer's individual service delivery plan.

Monitoring requirements consider all aspects of the restraint use, including:

(a) The physical support needs of the consumer, for example, health, nutrition, hygiene, comfort, and safety;

(b) The psychological needs of the consumer, for example, support, reassurance, company, privacy, respect and dignity, orientation to time and place, and communication;

(c) The cultural needs of the consumer, for example, access to culturally appropriate support, access to family/whānau, peers, advocate, legal representative, and respectful removal of cultural objects.

SAFE RESTRAINT USE WHAKAMAHI WHAKAITA HAUMARU

Standard 2.3 Services use restraint safely

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.3.1 The need for continued use of the restraint is continually monitored and regularly reviewed, to ensure it is applied for the minimum amount of time necessary.

2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

(a) Only as a last resort to maintain the safety of consumers, service providers or others;

(b) Following appropriate planning and preparation;

(c) By the most appropriate health professional;

(d) When the environment is appropriate and safe for successful initiation;

(e) When adequate resources are assembled to ensure safe initiation.

2.3.3 The frequency and extent of monitoring of the consumer during restraint is determined by the risks associated with the consumer's needs and the type of restraint being used.

2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

(a) Details of the reasons for initiating the restraint, including the desired outcome;

(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

(c) Details of any advocacy/support offered, provided, or facilitated;

(d) The outcome of the restraint;

(e) Any injury to any person as a result of the use of restraint;

(f) Observations and monitoring of the consumer during the restraint;

(g) Comments resulting from the evaluation of the restraint.

2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. ➤

GUIDANCE

G 2.3.6 For all restraints this may include, but is not limited to:

(a) A record of education is kept for each service provider, which details when competency is retested;

(b) Service provider competency is assessed regularly;

(c) New staff receive training before using restraints;

(d) Education adequately covers:

(i) How to recognise the possible physical, psychological, and cultural risks associated with each restraint

(ii) The minimisation/avoidance of restraint including how to respond to escalation (focusing on preventing its use and only using restraint as a last resort)

(iii) Recognition of the increase in consumers' needs in relation to their rights, dignity, privacy, personal and cultural safety during restraint

(iv) Consideration of the increase in family/whanāu needs in relation to their rights, dignity, privacy, personal and cultural safety during restraint

(v) Recognition of the need for timely access to cultural expertise and knowledge during restraint

(vi) Involving the consumer in all aspects of the restraint process and their family/whānau as far as reasonably practicable

(vii) Individual planning of care that recognises the increased or special needs of consumers during restraint

(viii) Effective risk assessment and decision-making on restraint

(ix) Legislative and documentation requirements

(x) The organisation's policies and procedures

(xi) The use of effective debriefing strategies following a restraint episode

(xii) Value of peer support and advocacy for the consumer.

Additionally, where personal restraint is approved for use, education may include, but is not limited to:

(e) The organisation's philosophy, goals, and methods for reducing restraint;

(f) Relevant techniques for physically holding a consumer;

(g) Communication techniques, including de-escalation skills, which avoid/reduce the need for restraint.

G 2.4.3 Every consumer has a right to have a support person of their choice. This may include but is not limited to family/whanāu, peer, advocate, or a legal representative.

2.3.6 Each service provider has an individual record of education and competency in relation to restraint minimisation and safe practice.

EVALUATION AROTAKENGA

Standard 2.4 Services evaluate all episodes of restraint.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

(a) Future options to avoid the use of restraint;

(b) Whether the consumer's service delivery plan (or crisis plan) was followed;

(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

(d) Whether the desired outcome was achieved;

(e) Whether the restraint was the least restrictive option to achieve the desired outcome;

(f) The duration of the restraint episode and whether this was for the least amount of time required;

(g) The impact the restraint had on the consumer;

(h) Whether appropriate advocacy/support was provided or facilitated;

(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

(j) Whether the service's policies and procedures were followed;

(k) Any suggested changes or additions required to the restraint education for service providers.

2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whanāu.

2.4.3 Following each episode of restraint or at defined intervals, the consumer and where appropriate their family/whānau, receives support to discuss their views on the restraint episode.

GUIDANCE

G 2.5.1 This may include but is not limited to:

(a) Quality review being conducted by suitably skilled service providers;

(b) Analysis of any regular audits conducted and restraint register information;

(c) Feedback from consumer, family/whānau, service providers, and others;

(d) Consideration of any current guidance and good practice standards.

Where restraint is regularly used, this is reviewed regularly (for example, six-monthly).

RESTRAINT MONITORING AND QUALITY REVIEW
AROTAKE KOUNGA ME TE AROTURUKI WHAKAITA

Standard 2.5 Services demonstrate the monitoring and quality review of their use of restraint.

Criterion The criterion required to achieve this outcome shall include the organisation ensuring:

2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

(a) The extent of restraint use and any trends;

(b) The organisation's progress in reducing restraint;

(c) Adverse outcomes;

(d) Service provider compliance with policies and procedures;

(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

(g) Whether changes to policy, procedures, or guidelines are required; and

(h) Whether there are additional education or training needs or changes required to existing education.

NZS 8134.2.3:2008

New Zealand Standard

Health and Disability Services (Restraint Minimisation and Safe Practice) Standards – Seclusion

Superseding NZS 8141:2001

NZS 8134.2.3:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

2.3: SECLUSION
NOHO MŌWAI

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FOREWORD

The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practised, restraint occurs in a safe and respectful manner.

Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices, and training should be firmly grounded in this context.

This Standard covers all forms of restraint and supersedes NZS 8141:2001.

NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards* includes referenced and related documents and guidelines, guidance on restraint minimisation and safe practice, and on the application of the Standard, along with the following Standards:

(a) NZS 8134.2.1 – Restraint minimisation

(b) NZS 8134.2.2 – Safe restraint practice

(c) NZS 8134.2.3 – Seclusion.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite

ETHICAL AND LEGAL CONSIDERATIONS

Practice is guided by ethical principles that include acting for the consumer's good (beneficence), avoiding harm to the consumer (non-maleficence), avoiding harm to self and others, and respecting the dignity of the consumer and the consumer's human rights.

The Standard should be implemented in ways that respect these and other ethical principles and at all times promote the interests, safety, and well-being of all involved.

Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard, and seek legal advice if necessary.

Seclusion and restraint shall not be used by providers for punitive reasons.

MEDICATION

The term chemical restraint is often used to mean that rather than using physical methods to restrain a consumer at risk of harm to themselves or others, various medicines are used to ensure compliance and to render the person incapable of resistance. Use of medication as a form of 'chemical restraint' is in breach of this Standard.

All medicines should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only.

GUIDANCE

G 3 *Seclusion is a form of restraint that can only be used within the Mental Health (Compulsory Assessment and Treatment) [MH (CA and T)] Act 1992, and the Intellectual Disability (Compulsory Care and Rehabilitation [ID(CCR)] Act 2003.*

Seclusion can be legally implemented subject to the conditions specified in the MH (CA and T) Act. The legal basis of seclusion for consumers under MH (CA and T) Act is set out in s71 of the Act and s148 of ID(CCR) Act. Seclusion should be used for as short a time as possible and is best conceived as a safety mechanism rather than a therapeutic intervention or treatment. The decision to seclude should be an uncommon event, used as a final alternative and subject to strict review. The information in NZS 8134.2.3 is provided with the expectation that although seclusion is legal, services will be proactive in reducing and minimising/avoiding its use.

Seclusion should not occur as part of a routine admission procedure or for punitive reasons. The MH (CA and T) Act requires that, except in an emergency, seclusion shall be used only with the authority of the responsible clinician. If not involved in the immediate decision, the responsible clinician must be informed of the seclusion as soon as possible, at least at the start of the next working day, and should review the decision. A doctor must assess the secluded consumer as soon as possible; this should be within two hours. The specificity of the assessment shall be appropriate to the level of risk and likelihood of harm occurring to the consumer. Wherever practicable, the two clinicians involved should be the consumer's own nurse and doctor.

The ID (CCR) Act requires that, except in an emergency, seclusion may only be used with the authority of a care manager who must ensure the care recipient is not secluded for longer than is necessary to achieve the purpose of secluding the care recipient.

G 3.1.1 *Procedural guidelines for the use of seclusion can be found on http://www.moh.govt.nz.*

G 3.1.2 *Seclusion should only be used to prevent violent behaviour compromising safety.*

G 3.1.4 *Seclusion should only be used with great caution, and with intensive monitoring in the following circumstances:*

(a) Where the consumer has had escalating requirements for medication and there is:

(i) Evidence of serious recent side effects

(ii) Likelihood of serious side effects;

(b) Physical deterioration;

(c) Where the consumer is in need of intensive assessment and/or observation, especially where there is a history suggestive of trauma, ingestion of unknown drugs/substances, or organic diagnosis.

G 3.2.4 *In addition to the environment being safe, wherever possible:*

(a) Doors should open outwards;

(b) While in seclusion consumers should be able to wear their own clothing and retain some of their personal possessions if their safety is not compromised.

(c) Items are provided if required by the consumer, if their safety is not compromised.

(d) A means of orientation (time, date, news, and other information) is provided;

(e) The service provider facilitates timely access to washing, showering, and toilet facilities in or adjacent to the area;

(f) There is access to a safe external area to assist with reintegration.

Outcome 3 *Consumers receive services in the least restrictive manner.*

Seclusion shall only be used by services with approved seclusion facilities. All use of seclusion shall comply with NZS 8134.2.2 and NZS 8134.2.3.

SAFE SECLUSION USE WHAKAMAHI MŌWAI HAUMARU

Standard 3.1 **Services demonstrate that all use of seclusion is for safety reasons only.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.1.1 *The service has policies and procedures on seclusion that meet the requirements contained in 'Seclusion under the Mental Health (Compulsory Assessment and Treatment Act 1992' (MoH).*

MHA* & ID**

3.1.2 *Consumers are subject to the use of seclusion when there is an assessed risk to the safety of the consumer, to other consumers, service providers, or others.*

3.1.3 *There exists a legal basis for each episode of seclusion.*

3.1.4 *Any factors that may require caution must be assessed for each episode.*

3.1.5 *The likely impact the use of seclusion will have on the consumer's recovery and therapeutic relationships is considered and documented.*

APPROVED SECLUSION ROOMS RŪMA MŌWAI KUA WHAKAAEA

Standard 3.2 **Seclusion only occurs in an approved and designated seclusion room.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.2.1 *The seclusion room provides adequate lighting, room temperature, and ventilation.*

3.2.2 *The seclusion room allows the observation of the consumer and allows the consumer to see the head and shoulders of the service provider.*

3.2.3 *The seclusion room provides a means for the consumer to effectively call for attention.*

3.2.4 *The seclusion room contains only furniture and fittings chosen to avoid the potential for harm.*

* applies to mental health and addiction services only

** applies to intellectual disability services only

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The following SNZ references relate to this Standard:

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NZS 8134.3:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards

Superseding NZS 8142:2000

NZS 8134.3:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

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FOREWORD

The aim of NZS 8134.3 is to facilitate quality and consistently safe health and disability services by identifying practices designed to reduce the rate of infections in the health and disability sector.

NZS 8134.3 is applicable to all health and disability services. The Standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001. Other health and disability services, should consider adopting them as they promote current accepted good practice.

The benefits and desired outcome of implementing NZS 8134.3 are:

(a) Improved safety for consumers, staff, and visitors;

(b) Increased attention to the basic principles of infection control;

(c) Identifying a consistent and applicable infection control baseline for services.

This document is intended to be generic and address the basic principles and systems that are the foundation for effective infection control. It is not intended to be an infection control manual or educational tool.

NZS 8134.3 is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

WHAT CAN YOU BUY

NZS 8134.3 *Health and disability services (infection prevention and control) Standards* consists of this document plus:

(a) NZS 8134.3.1 – Infection control management

(b) NZS 8134.3.2 – Implementing the infection control programme

(c) NZS 8134.3.3 – Policies and procedures

(d) NZS 8134.3.4 – Education

(e) NZS 8134.3.5 – Surveillance, and

(f) NZS 8134.3.6 – Antimicrobial usage.

NZS 8134.3 comprises part of NZS 8134:2008 and may be purchased as a set, that is loose-leaf, four-hole punched, and shrink wrapped for insertion in a binder with room for NZS 8134.0 *Health and disability services (general) Standard*, NZS 8134.1 *Health and disability services (core) Standards,* and NZS 8134.2 *Health and disability services (restraint minimisation and safe practice) Standards.*

REFERENCED DOCUMENTS

Reference is made in this document to the following:

NEW ZEALAND STANDARDS

NZS 8134.0:2008	Health and disability services (general) Standard
NZS 8134.1:2008	Health and disability services (core) Standards

JOINT AUSTRALIAN/NEW ZEALAND STANDARDS AND HANDBOOK

AS/NZS 4146:2000	Laundry practice
AS/NZS 4187:2003	Cleaning, disinfecting and sterilising reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities
AS/NZS 4360:2004	Risk management
AS/NZS 4815:2006	Office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment
SAA HB 436:2004	Risk management guidelines – Companion to AS/NZS 4360:2004

OTHER PUBLICATIONS

Ministry of Health. *He korowai oranga: Māori health strategy*. Wellington: Ministry of Health, 2002.

Office for Disability Issues. *New Zealand disability strategy*, 2001.

NEW ZEALAND LEGISLATION

Code of Health and Disability Services Consumers' Rights 1996

Health and Disability Commissioner Act 1994

Health and Disability Services (Safety) Act 2001

Health Information Privacy Code 1994

Privacy Act 1993

LATEST REVISIONS

The users of this Standard should ensure that their copies of the above-mentioned New Zealand Standards are the latest revisions. Amendments to referenced New Zealand and Joint Australian/New Zealand Standards can be found on http://www.standards.co.nz.

WEBSITES

Ministry of Health	http://www.moh.govt.nz
New Zealand Legislation	http://www.legislation.govt.nz
Office for Disability Issues	http://www.odi.govt.nz

RELATED DOCUMENTS AND GUIDELINES

ASSOCIATED STANDARDS AND HANDBOOKS

When interpreting this Standard it may be helpful to refer to other documents, including but not limited to:

NEW ZEALAND STANDARDS

NZS 4304:2002 Management of healthcare waste

NZS 4121:2001 Design for access and mobility: Buildings and associated facilities

NZS 8134.2:2008 Health and disability services (restraint minimisation and safe practice) standard

NEW ZEALAND HANDBOOK

SNZ HB 8149:2001 Microbiological surveillance of flexible hollow endoscopes

JOINT AUSTRALIAN/NEW ZEALAND STANDARDS

AS/NZS ISO 11137.1:2006	Sterilization of health care products – Radiation – Requirements for development, validation and routine control of a sterilization process for medical devices
AS/NZS ISO 11137.2:2006	Sterilization of health care products – Radiation – Establishing the sterilization dose
AS/NZS ISO 11137.3:2006	Sterilization of health care products – Radiation – Guidance on dosimetric aspects

AUSTRALIAN STANDARDS

AS 1668.2-2002	The use of ventilation and airconditioning in buildings – Ventilation design for indoor air contaminant control
AS 2828:1999	Paper-based health care records

RELATED LEGISLATION

Fire Safety and Evacuation of Buildings Regulations 2006

Food Act 1981

Hazardous Substances and New Organisms Act 1996

Health Act 1956

Health and Disability Commissioner Act 1994

Health and Safety in Employment Act 1992

Health Practitioners Competence Assurance Act 2003

Health (Retention of Health Information) Regulations 1996

Medicine Regulations 1984

Misuse of Drugs Regulations 1977

Human Rights Act 1993

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Local Government Act 2002

Medicines (Standing Order) Regulations 2002

Misuse of Drugs Act 1975

New Zealand Building Code

New Zealand Bill of Rights Act 1990

New Zealand Public Health and Disability Act 2000

Official Information Act 1982

Public Records Act 2005

Resource Management Act 1991

Smoke-free Environments Act 1990

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WEBSITES

Australian and New Zealand College of Anaesthetists	http://www.anzca.edu.au
Australian College of Operating Room Nurses (ACORN)	http://www.acorn.org.au
Australian Council of Healthcare Standards	http://www.achs.org.au
American Academy of Pediatrics	http://aapredbook.aappublications.org/
Association of Perioperative Registered Nurses (AORN)	http://www.aorn.org/
Association for Professionals in Infection Control and Epidemiology (APIC)	http://www.apic.org/
Center for Disease Control and Prevention (CDC)	http://www.cdc.gov/
European Society of Clinical Microbiology and Infectious Diseases	http://www.escmid.org
Evidence Based Practice in Infection Control (EPIC)	http://www.epic.tvu.ac.uk/
Hand Hygiene Resource Center (HHRC)	http://www.handhygiene.org/
HepNet – the Hepatitis Information Network	http://hepnet.com/news.html
Hospitals Infection Program	http://www.cdc.gov/ncidod/dhqp/index.html
Infection Control in Healthcare Settings	http://infectionctrl-online.com/
Johns Hopkins POC – IT Center	http://hopkins-abxguide.org/
Medicines and Healthcare GET_ Products Regulatory Agency	http://www.mhra.gov.uk/home/idcplg?IdcService=SS_PAGE&nodeId=5
Medscape	http://www.medscape.com/
National Nosocomial Infections Surveillance System (NNIS)	http://www.cdc.gov/ncidod/dhqp/nnis_pubs.html

National Patient Safety Agency (NPSA) – Clean your hands campaign	http://www.npsa.nhs.uk/cleanyourhands
National Resource for Infection Control (NRIC)	UK http://www.nric.org.uk
New Zealand Ministry of Health	http://www.moh.govt.nz/
Standards New Zealand	http://www.standards.co.nz/
The Cochrane Collaboration	http://cochrane.org
The Royal Institute of Public Health	http://www.riphh.org.uk
US Food and Drug Administration	http://www.fda.gov
World Health Organization	http://www.who.org

PROFESSIONAL ASSOCIATIONS

Australian Infection Control Association	http://www.aica.org.au
Community and Hospital Infection Control Association of Canada (CHICA-Canada)	http://www.chica.org/
Infection Control Association NSW Inc (ICA)	http://www.icansw.org.au
Infection Control Association (Singapore)	http://www.icas.org.sg/
Infection Control Association of Southern Africa	http://www.infection.co.za/
Infection Control Nurses Association (Europe)	http://www.icna.co.uk
International Federation of Infection Control	http://www.theific.org
NZNO National Division Infection Control Nurses	http://www.infectioncontrol.co.nz
Society for Healthcare Epidemiology of America (SHEA)	http://www.shea-online.org
The Association for Professionals in Infection Control and Epidemiology (APIC)	http://www.apic.org/Infection

MICROBIOLOGY

American Society for Microbiology	http://www.asm.org
Association of Medical Microbiologists	http://www.amm.co.uk
Bugs & Drugs on the Web	http://www.antibioticresistance.org.uk/ARFAQs.nsf/About?OpenPage
Cells Alive	http://www.cellsalive.com
Fleming Forum	http://www.flemingforum.org.uk
Gallery Electron Microscope Work. Dennis Kunkel	http://www.denniskunkel.com/
Microbe World	http://www.microbeworld.org/
National Centre for infectious diseases	http://www.cdc.gov/ncidod/id_links.htm

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NZS 8134.3.1:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards –

Infection control management

Superseding NZS 8142:2000

NZS 8134.3.1:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.1: INFECTION CONTROL MANAGEMENT
WHAKAHAERENGA WHAKATINA WHAKAPOKENGA

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FOREWORD

The aim of NZS 8134.3 is to facilitate quality and consistently safe health and disability services by identifying practices designed to reduce the rate of infections in the health and disability sector.

NZS 8134.3 is applicable to all health and disability services. The Standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001. Other health and disability services, should consider adopting them as they promote current accepted good practice.

The benefits and desired outcome of implementing NZS 8134.3 are:

(a) Improved safety for consumers, staff, and visitors;

(b) Increased attention to the basic principles of infection control;

(c) Identifying a consistent and applicable infection control baseline for services.

This document is intended to be generic and address the basic principles and systems that are the foundation for effective infection control. It is not intended to be an infection control manual or educational tool.

NZS 8134.3 *Health and disability services (infection prevention and control) Standards* includes referenced and related documents and guidelines along with the following Standards:

(a) NZS 8134.3.1 – Infection control management;

(b) NZS 8134.3.2 – Implementing the infection control programme;

(c) NZS 8134.3.3 – Policies and procedures;

(d) NZS 8134.3.4 – Education;

(e) NZS 8134.3.5 – Surveillance;

(f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 1 Infection control management is a set of systems and structures which organisations should have in place to safeguard and improve the quality of care.

G 1.1 The lines of accountability define the relationships between management/governing body, quality/risk management, clinical governance body, infection control committee, and infection control team/personnel.

There is evidence of an assessment of the organisation's needs for infection control that specifies requirements such as resources, job descriptions, and terms of reference.

G 1.3 Each organisation is unique. The content and detail of the programme should be appropriate to the size, complexity, and degree of risk associated with the services provided.

Priority is to be given to managing risk in relation to infection control and there is a process that clearly demonstrates this.

G 1.4 Relevant key stakeholders may include but are not limited to:

(a) Infection control specialists, physicians, and nurses;

(b) Clinical microbiologists;

(c) Service providers including clinical staff;

(d) Public Health Units of District Health Boards (DHBs);

(e) Quality Improvement Teams;

(f) Medical Officers of Health;

(g) Consumers.

G 1.6 The committee is a group that provides representation from relevant disciplines within the organisation and has overview of the infection control programme. For smaller organisations this committee could be part of an already established committee involved in quality or other activities.

G 1.7 This may include but is not limited to:

(a) Endorsing the infection control programme, associated policies, and procedures;

(b) Assisting in the implementation of the programme;

(c) Monitoring the progress of the infection control programme;

(d) Documenting the frequency of the review of the programme;

(e) Ensuring a process exists for timely reporting of notifiable diseases and notifiable outbreaks to the local Medical Officer of Health; and

(f) Any reporting requirements to other key stakeholders/interested parties.

G 1.8 There is a clear process for consultation and planning including infection control expertise for facility changes, including renovation and design of buildings and staffing changes, when a change in staff ratio, skill mix, or additional services will impact on infection control risk.

G 1.9 In rare situations (for example measles, avian influenza) exposed susceptible contacts will be absented from work on the advice of the service provider's general practitioner, the occupational health service and/or public health services.

Visitors may be restricted from entering healthcare facilities.

Consumers may require a transfer to an appropriate specialist service to meet their needs.

INFECTION CONTROL MANAGEMENT
WHAKAHAERENGA WHAKATINA WHAKAPOKENGA

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

1.2 Reporting lines and frequency are clearly defined within the organisation including processes for prompt notification of serious infection control related issues.

1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

1.4 The infection control programme is developed in consultation with relevant key stakeholders, taking into account the risk assessment process, monitoring and surveillance data, trends, and relevant strategies. The governing body/senior management shall approve the programme.

1.5 There is a defined process for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation.

1.6 There is an infection control team/personnel and/or committee that is appropriate for the size and the complexity of the organisation which is accountable to the governing body/senior management and monitors the progress of the infection control programme.

1.7 The role of the infection control team/personnel and/or committee shall be clearly identified.

1.8 There is a clear process for early consultation and feedback with the infection control person/team, when significant changes are proposed to staffing, practices, products, equipment, the facility, or the development of new services.

1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

NZS 8134.3.2:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards –

Implementing the infection control programme

Superseding NZS 8142:2000

NZS 8134.3.2:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.2: IMPLEMENTING THE INFECTION CONTROL PROGRAMME

WHAKATINANA I TE HŌTAKA WHAKATINA WHAKAPOKENGA

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FOREWORD

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NZS 8134.3 is applicable to all health and disability services. The Standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001. Other health and disability services, should consider adopting them as they promote current accepted good practice.

The benefits and desired outcome of implementing NZS 8134.3 are:

(a) Improved safety for consumers, staff, and visitors;

(b) Increased attention to the basic principles of infection control;

(c) Identifying a consistent and applicable infection control baseline for services.

This document is intended to be generic and address the basic principles and systems that are the foundation for effective infection control. It is not intended to be an infection control manual or educational tool.

NZS 8134.3 *Health and disability services (infection prevention and control) Standards* includes referenced and related documents and guidelines along with the following Standards:

(a) NZS 8134.3.1 – Infection control management;

(b) NZS 8134.3.2 – Implementing the infection control programme;

(c) NZS 8134.3.3 – Policies and procedures;

(d) NZS 8134.3.4 – Education;

(e) NZS 8134.3.5 – Surveillance;

(f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 2 Staffing and other resources required to implement the infection control programme should take into account the size and complexity of the organisation and its served population, and should meet the expectations of accepted infection control practices.

G 2.1 These skills and expertise may be externally contracted.

The number of staff required is not based solely on inpatient bed numbers. For example, in large complex facilities, provision should be made for the needs of outpatient services, special care units (such as intensive care units and neonatal units), community-based health services, mental health and addiction services, and exceptionally vulnerable consumers such as those with compromised immunity.

Depending on the size and complexity of the service, infection control personnel should have access to adequate resources to enable them to achieve their responsibilities. This may include but is not limited to:

(a) Office space;

(b) Secure storage for records;

(c) Access to relevant information and resources such as at least one current infection control text, relevant journals, bibliographic databases, library, the internet, and infection control personnel;

(d) Dedicated time allocated to meet the needs of the programme;

(e) Sufficient administrative, information technology (IT), and audit staff.

G 2.2 This may include but is not limited to;

(a) Implementation of infection control policies and procedures;

(b) Education;

(c) Ensuring advice and information is available on infection control and prevention;

(d) Surveillance;

(e) Ensuring links to the organisation's quality and risk management programmes are established and maintained;

(f) Reporting and making recommendations to the infection control committee/governing body/senior management on infection control and prevention.

G 2.4 Successful case finding, surveillance, and investigation of outbreaks are dependent on access to the consumer information management system. Infection control personnel should be able to access electronic data systems directly where these exist. Consumer confidentiality is maintained in line with current legislation, including the Privacy Act and Health Information Privacy Code.

IMPLEMENTING THE INFECTION CONTROL PROGRAMME
WHAKATINANA I TE HŌTAKA WHAKATINA WHAKAPOKENGA

Standard 2 **There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

2.2 The infection control team/personnel and/or committee shall facilitate implementation of the infection control programme.

2.3 The infection control team/personnel members shall receive continuing education in infection control and prevention.

2.4 The infection control team/personnel shall have access to records and diagnostic results of consumers.

NZS 8134.3.3:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards –
Policies and procedures

Superseding NZS 8142:2000

NZS 8134.3.3:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.3: POLICIES AND PROCEDURES

NGĀ KAUPAPAHERE ME NGĀ WHAKARITENGA

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(d) NZS 8134.3.4 – Education;

(e) NZS 8134.3.5 – Surveillance;

(f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 3.1 It is recommended that all policies and procedures should:

(a) Include written material relevant to the organisation;

(b) Reflect current accepted good practice and relevant legislative requirements;

(c) Have sufficient flexibility to respond to individual consumer/service needs;

(d) Be in a user-friendly format;

(e) Contain the appropriate level of technical information;

(f) Be readily accessible to all personnel;

(g) Be developed and reviewed regularly in consultation with relevant service providers; and

(h) Identify the links to other documentation within the organisation.

G 3.2 (a) Hand hygiene is a critical measure for reducing the transmission of infection. The timeliness of hand hygiene, technique, and appropriate products for the setting should be included in any hand hygiene policy or procedure;

G 3.2 (b) Standard precautions are designed to reduce the risk of acquiring and spreading infective organisms. Standard precautions should be used at all times. Standard precautions:

(a) Apply to all;

(b) Are designed to protect staff and consumers;

(c) Ensure that personal protective equipment is provided and used when in contact with blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin;

(d) Are used at all times when transmission-based precautions may be required; and

(e) Include cough etiquette, which is important in the prevention of respiratory transmissible illnesses;

G 3.2 (c) Transmission-based precautions cover:

(a) The isolation precautions required to manage those people who are diagnosed with or suspected of having infectious diseases;

(b) The management of those pathogens with clinical significance, such as multi-resistant organisms; and

(c) Providing a protective environment for severely immunocompromised persons.

G 3.2 (d) The prevention of infection and management of personnel with infectious, communicable diseases and potential pathogens of clinical and public health significance, such as chickenpox, tuberculosis, multi-resistant organisms. The policies and procedures should include:

(a) Assessment;

(b) Placement;

(c) Immunisation; and

(d) Exposure management issues.

G 3.2 (e) See NZS 8134.3.6;

G 3.2 (f) Outbreak management/pandemic planning procedures should include information on the investigation and management of suspected or actual outbreaks;

G 3.2 (g) The method of cleaning, disinfection and sterilisation should meet AS/NZS 4815 and AS/NZS 4187;

G 3.2 (h) Single use items are manufactured for a single patient or a single episode. Reprocessing is at the organisations risk, as it may pose a risk to the consumer;

G 3.2 (i) The risk of airborne infection created by environmental disturbances to consumers during renovation and construction. Services should ensure design and function is consistent with infection control principles.

G 3.3 This consultation and input may include but is not limited to:

(a) Cleaning, disinfection, and sterilisation of reusable medical devices;

(b) Kitchen or catering;

(c) Environmental services, for example cleaning;

(d) Laundry;

(e) Waste;

(f) Clinical procedures;

(g) Pandemic planning;

(h) Occupational health (needlestick injuries and other blood and body fluid exposures, pre-employment, and ongoing screening as appropriate);

(i) Ventilation and air quality systems.

POLICIES AND PROCEDURES
NGĀ KAUPAPAHERE ME NGĀ WHAKARITENGA

Standard 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.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

3.2 Policies and procedures shall include but are not limited to:

(a) Hand hygiene;

(b) Standard precautions;

(c) Transmission-based precautions;

(d) Prevention and management of infection in service providers;

(e) Antimicrobial usage;

(f) Outbreak management;

(g) Cleaning, disinfection, sterilisation, and reprocessing of reusable medical devices (if applicable) and equipment;

(h) Single use items; and

(i) Renovations and construction.

3.3 Policies and procedures (whether or not developed by contracted services or in-house services) that may affect the transmission of infection shall clearly identify who is responsible for the policy development and implementation, and shall be consistent with infection control policies and principles. Processes shall be in place to ensure ongoing infection control team/personnel involvement.

NZS 8134.3.4:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards – Education

Superseding NZS 8142:2000

NZS 8134.3.4:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.4: EDUCATION
MĀTAURANGA

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(d) NZS 8134.3.4 – Education;

(e) NZS 8134.3.5 – Surveillance;

(f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G .4.2 This may include but is not limited to:

(a) Policies/guidelines and key infection control issues relevant to the service;

(b) How staff can access current infection control information;

(c) Hand hygiene;

(d) Standard and transmission-based precautions;

(e) Blood and body fluid exposure management;

(f) Outbreak identification and management;

(g) Prudent antimicrobial prescribing;

(h) Cleaning, disinfection, and sterilisation practices of medical devices and equipment;

(i) Practice in relation to single-use items; and

(j) Surveillance.

G 4.5 This may include information and/or education for relatives and visitors, for example, pamphlets on infectious diseases such as Methicillin-resistant *Staphylococcus aureus* (MRSA).

EDUCATION
MĀTAURANGA

Standard 4 **The organisation provides relevant education on infection control to all service providers, support staff, and consumers.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

4.2 All service providers and support staff receive orientation and ongoing education on infection control that is relevant to their practice within the service or organisation.

4.3 Infection control education is evaluated to ensure the content is pertinent to the scope of service and reflects current accepted good practice.

4.4 The content of infection control education sessions is documented and a record of attendance maintained.

4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

NZS 8134.3.5:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards – Surveillance

Superseding NZS 8142:2000

NZS 8134.3.5:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.5: SURVEILLANCE
ĀROHI

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(c) NZS 8134.3.3 – Policies and procedures;

(d) NZS 8134.3.4 – Education;

(e) NZS 8134.3.5 – Surveillance;

(f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 5.1 Reference should be made to:

(a) Appendix A;

(b) The Ministry of Health mandatory hospital acquired blood stream infection surveillance programme; and

(c) The Institute of Environmental Science and Research Ltd (ESR) multi-drug resistant organism (MDRO) surveillance programme.

G 5.2 These should include but are not limited to:

(a) Multi-drug resistant organisms including:

(i) Methicillin resistant *Staphylococcus aureus* (MRSA);

(ii) Extended spectrum beta-lactamase producing enterobacteriaceae (ESBLs), and

(iii) Vancomycin resistant *enterococci* (VRE);

(b) *Clostridium difficile*.

G 5.3 Effective surveillance requires the support and cooperation of clinicians, service providers, and management who provide clinical services in which there is a risk of acquiring infection.

G 5.4 Accurate information can only be obtained if all persons involved in surveillance have the same understanding of what is meant by certain terms. Therefore standardised definitions of infection events, indicators, and outcomes are used and these increase the likelihood that any observed changes or trends are real and not due to differences in interpretation of terms.

The definitions of infection events, indicators, and outcomes used should reflect the organisation's needs and outcomes/goals. These definitions will be different for different types of facilities (see table A1 in Appendix A). In general, facilities should use or adapt definitions developed and published by national, international, or other surveillance organisations.

G 5.6 The type(s) of surveillance chosen will vary according to the objectives of the surveillance programme (see table A1 in Appendix A). In general, the larger the facility or the greater the number of events detected, the more frequent should be the surveillance and the reporting of surveillance activities.

G 5.7 The findings, outcomes, and recommendations which follow surveillance activities should be recorded and tabled at the nearest timely meeting of the infection control committee. A summary should be lodged with senior management and recommended follow up should be acted upon and supported with documentation.

Standard 5 **Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.**

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

5.2 Surveillance shall be conducted on multi-resistant organisms and organisms associated with antimicrobial use.

5.3 Senior management and all service providers shall take responsibility for surveillance activities and promote surveillance monitoring as one of the premier quality assurance programmes impacting on consumer safety.

5.4 Standardised definitions are used for the identification and classification of infection events, indicators, or outcomes.

5.5 The type of surveillance to be undertaken should be appropriate for the organisation, including:

(a) Size;

(b) Type of services provided;

(c) Acuity, risk factors, and needs of the consumer;

(d) Risk factors to service providers.

5.6 The surveillance methods, analyses, and assignment of responsibilities are described and documented.

5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

5.8 There is evidence of communication between services on consumers who develop infection.

APPENDIX A
SURVEILLANCE – ADDITIONAL INFORMATION

(Informative)

A1 Events under surveillance may be detected in a variety of ways. These may include but are not limited to, chart review, walk rounds, review of laboratory reports, medication or pharmacy records, or notification by medical staff. A surveillance programme should incorporate at least two different detection or case finding methods. If possible, one of these should entail active surveillance, where infection control personnel actively look for the events under surveillance such as on walk rounds, as opposed to passive surveillance where infection control personnel rely on others to report the events.

A2 For each type of infection event, indicator or outcome identified, the data collected should include basic consumer demographics and infection or outcome information as well as information on known consumer risk factors such as invasive devices or procedures. The frequency of data collection will depend on the type of surveillance, the event being monitored, and the size and type of the service or facility (see table A1).

A3 Data analysis may include but is not limited to a review of the quantity, frequency, source, site, and type of event. When identifying variations and trends in event occurrence, numbers of Infection events, indicators, and outcomes are not generally as useful as infection rates. Rates compensate for fluctuations in the size of the population under surveillance and are a more accurate reflection of what is occurring. The denominator used to calculate rates will be different for different kinds of surveillance and for different types of services or facilities (see table A1).

A4 Systematic surveillance refers to the regular collection, collation, and analysis of information on infection events and rates, either continuously or at regular intervals, and the timely dissemination and feedback of data. The projected use of the data shows how the data will be used to evaluate or assess infection control activities.

Surgical facilities should, as a basic minimum activity, undertake continuous surveillance of *Staphylococcus aureus* blood stream infections and conduct regular surveillance of wound infection rates following clean surgical procedures in joint replacement surgery and Caesarean sections.

TABLE A1 – SURVEILLANCE GUIDE

	Hospitals and acute care facilities	Rest home facilities	Office-based and home care	Community residential
Standardised definitions	• Usually requires laboratory confirmation or clinician diagnosis	• Usually place greater reliance on signs and symptoms and less reliance on clinician, laboratory, or radiological confirmation	• Variable, depending on type of event under surveillance	• Variable, depending on type of event under surveillance
Types of surveillance	• Larger facilities usually target specific types of events or specific high risk areas • Smaller facilities usually target specific types of events or all events facility-wide • Post-discharge surveillance for specific events such as surgical site infections (SSIs)	• Usually target specific events or all events facility-wide	• Usually target specific types of events or all events	• Usually target specific types of events or all events
Types of events typically monitored	• Surgical site infections (SSIs) • *Staphylococcus aureus* septicaemia • Pneumonias • Device-related infections • Multi resistant micro-organisms	• Lower respiratory tract infections (LRTIs) • Skin and soft tissue infections (SSTIs) (such as cellulitis, infected pressure sores) • Influenza • Urinary tract infections (UTIs) • Eye infections	• Device-associated infections • Procedure associated infections	• Gastroenteritis • Skin infections • Infestations
Data collection	• Continuous or intermittent • For acute events or in high risk areas such as ICUs, data collection may be daily	• Regular at least monthly	• Regular at least monthly	• Regular at least monthly
Data analysis: rate calculations	• As per ACHS (Australian Council of Healthcare Standards)	• Number and type of infections occurring in a defined time period	• Number and type of infections occurring in a defined time period	• Number and type of infections occurring in a defined time period
Frequency of report to governing body	• Twice a year or more frequently	• Minimum once a year	• Minimum once a year	• Minimum once a year
Frequency of programme review	• For larger facilities, usually twice a year • For smaller facilities, usually once a year	• Once a year	• Once a year	• Once a year
NOTE – This table is provided as a guide.				

NZS 8134.3.6:2008

New Zealand Standard

Health and Disability Services (Infection Prevention and Control) Standards –

Antimicrobial usage

Superseding NZS 8142:2000

NZS 8134.3.6:2008

New Zealand Standard

HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

3.6: ANTIMICROBIAL USAGE
WHAKAMAHINGA ANTIMICROBIAL

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NOTES

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FOREWORD

The aim of NZS 8134.3 is to facilitate quality and consistently safe health and disability services by identifying practices designed to reduce the rate of infections in the health and disability sector.

NZS 8134.3 is applicable to all health and disability services. The Standards are mandatory for those services that are subject to the Health and Disability Services (Safety) Act 2001. Other health and disability services, should consider adopting them as they promote current accepted good practice.

The benefits and desired outcome of implementing NZS 8134.3 are:

(a) Improved safety for consumers, staff, and visitors;

(b) Increased attention to the basic principles of infection control;

(c) Identifying a consistent and applicable infection control baseline for services.

This document is intended to be generic and address the basic principles and systems that are the foundation for effective infection control. It is not intended to be an infection control manual or educational tool.

NZS 8134.3 *Health and disability services (infection prevention and control) Standards* includes referenced and related documents and guidelines along with the following Standards:

(a) NZS 8134.3.1 – Infection control management;

(b) NZS 8134.3.2 – Implementing the infection control programme;

(c) NZS 8134.3.3 – Policies and procedures;

(d) NZS 8134.3.4 – Education;

(e) NZS 8134.3.5 – Surveillance;

(f) NZS 8134.3.6 – Antimicrobial usage.

Each is to be read in conjunction with NZS 8134.0 *Health and disability services (general) Standard*, as this contains the definitions and audit framework information applicable across the health and disability suite.

GUIDANCE

G 6.5 *Antibiotic guidelines should:*

(a) Be consistent with local resistance data;

(b) Discourage indiscriminate use of third and fourth generation Cephalosporins and older broad spectrum antibiotics;

(c) Have clear recommendations for dose, timing, and duration of surgical prophylaxis.

ANTIMICROBIAL USAGE
WHAKAMAHINGA ANTIMICROBIAL

Standard 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.**

For a residential home/unit or aged care service, it is the consumer's individual GP who is responsible for guidance on the management of antibiotic use.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

S*

6.1 *The organisation, medical practitioner or other prescriber has an antimicrobial policy which is consistent with the current accepted practice of prudent use in the treatment of infections.*

6.2 *Where prophylactic antibiotics are prescribed, a policy/guideline exists for their appropriate use.*

6.3 *Evidence of good practice guideline use, or specialist advice on antimicrobial therapy and prophylaxis can be demonstrated.*

6.4 *Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme.*

6.5 *Information on the antimicrobial susceptibility patterns of significant clinical isolates should be fed back to the infection control team/personnel and prescriber by the local diagnostic laboratory.*

* applies to acute, secondary or tertiary services only

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