# Compliance with the 2012 Home and Community Support Sector Standard

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Home and Community Support Services:
Strengthening Quality Assurance Project

10-Aug-12

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# Acknowledgement


This document has been developed in collaboration with the working group of the Strengthening Quality Assurance Project. Representatives on this group are listed below:

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- Karina Kwai
- Katrina Lenzie-Smith
- Nancy Stewart

Ministry of Health

- Karen Smith
- Jac Lynch
- Pam Fletcher
- Tim Spackman
- Heather Harlow

Designated Auditing Agencies

- Jim DuRose

NZ Home Health Association (NZHHA)

- Julie Haggie
- Andrea McLeod

Shared Support Agencies

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# Introduction

## Purpose

This report identifies the changes that home and community support service (HCSS) providers may need to make to their governance structures and operational policies and procedures, in order to gain a certificate of conformance with the revised Home and Community Support Sector Standard (NZS 8158:2012), which was released in April 2012.

A separate exercise is being led by DHB Shared Services to assess the cost implications of funders requiring contracted HCSS providers to have a certificate of conformance with NZS 8158:2012 and the introduction of a national service specification for DHB contracted HCSS.

## Background

The Home and Community Support Sector Standard was first released in 2003 and covers home and community support services provided in a person's home or in their community. It applies to organisations contracted to deliver home and community support and the staff or contractors who work for them. Compliance with the Standard is currently voluntary, although increasing numbers of HCSS providers hold certificates of conformance with the Standard.

Since 2003 there have been significant changes in health and disability policy and practice affecting home and community services. These changes have included a move towards person-centred support, self-determination and a focus on quality of life outcomes.

There has been support across the sector for the Standard to be updated to reflect these changes and for the Standard to be made compulsory.

HCSS providers have been able to gain certification against NZS 8158:2012 since April 2012. Certification against NZS 8158:2003 is being phased out with no certificates being issued after 31 August 2012 and certification against NZS 8158:2003 no longer being recognised after 1 September 2013.

In its pre-election manifesto, the Government committed to set a minimum standard for quality of care that HCSS providers deliver to older New Zealanders.

The usual method of demonstrating compliance with a standard is through an audit leading to certification against the standard. Mechanisms such as certification are also accepted internationally as a means of promoting and maintaining quality in health and disability support services.

Nine DHBs already require conformance with the Standard as does ACC and Ministry of Health Disability Support Services (DSS). However, they do not necessarily require external certification against the Standard[1]

ACC has introduced a requirement in its contracts with HCSS providers for certified compliance with the Standard and it is intended that DHBs and DSS will introduce a similar requirement by 1 September 2013.

The sector was invited to comment on a draft of the Impact Assessment. There was a low response rate (15 responses of which 13 were HCSS providers). Feedback has been incorporated in this version as has subsequent information provided by funders.

## Sector profile

Home and community support services include a wide range of activities to support people to look after themselves or others, move around, communicate, find out about things and make decisions. This can include contributing to a person achieving their education, employment, vocational, social and recreational goals, as well as assisting with activities of daily living.

There are a variety of support models for people living in their own homes, including traditional task-based personal care and household management services, goal-based restorative and rehabilitation approaches, and other goal-based supports aimed at achieving independent living and a good quality of life.

Additionally, people are choosing to live in their own homes longer, with increasingly complex needs that

[1] Some funders accept conformance demonstrated through self-declaration or contractual audit.

require more coordinated service responses than traditional household management and personal care.

Most service providers are either non-government or for profit organisations, but four DHBs also provide services[2]. There are two large national organisations (HealthCare New Zealand, and Access) and the remainder work across various regions or localities. Several HCSS providers have contracts with DSS and one or more DHBs as well as a contract or sub-contract with ACC.

From information available as at 30 July 2012 it is estimated there were 75 home care providers contracted by District Health Boards. This number included four retirement villages and one rest home operating under a pilot programme to provide home and community support services. There were also around 17 Māori providers.

DSS currently contracts with 60 HCSS providers. ACC has awarded new contracts for HCSS services which has reduce the number of providers they contract with down to 6. Most of these 6 providers will sub-contract with other providers to ensure adequate coverage.

Several providers contracted by a DHB, DSS and/or ACC are known to have a certificate of conformance to the Standard and the majority of the remaining providers are required by their contract with at least one funder to comply with the Standard (Table 1).

**Table 1: HCSS provider conformance to NZS8158:2003 (as at 30 July 2012)**

| Status | DHBs | DSS | ACC | Total** |
|---|---|---|---|---|
| | N | N | | N |
| Known to be certified against the Standard | 39 | 37 | 5 | 40 |
| Requirement to comply with the Standard* | 22 | 23 | 1 | 24 |
| Not required to be compliant | 14 | | | 14 |
| **Total Providers** | **75** | **60** | **6** | **78** |

Note numbers are approximate as contracted HCSS providers change over time

* a contractual requirement that may be demonstrated in various ways. Assumed to apply to all funders contracting with the provider regardless of which funder specified the requirement

** Providers with contracts across funders counted only once

[2] Canterbury, Hawke's Bay, Waikato and West Coast DHBs.

There are also a small number of providers that either provide privately funded services, or home help through contracts held with the Ministry of Social Development or Veterans Affairs. This number changes as contracting relationships change relatively frequently.

The New Zealand Home Health Association (NZHHA) requires HCSS members to hold a certificate of conformance to the Home and Community Support Sector Standard. As at 30 July 2012 the Association had 47 members certified against NZS 8158:2003, most of whom had a contract with DSS, ACC and/or one or more DHBs.

# The 2012 Standard

## What the Standard covers

The Standard sets out what people receiving support in their home or community setting can expect from services and describes the minimum requirements for delivering services.

NZS 8158:2012 has four sections: Consumer rights, Organisational management, Human resources and Service delivery. Each section consists of associated specific standards and criteria (31 specific standards and 110 criteria). These state the intended outcome and describe items (e.g. systems, policies and procedures) and actions that are required in order to meet the standard. Most, but not all parts of the Standard apply to all services.

NZS 8158:2003 consists of six sections with a total of 33 specific standards and 110 criteria, many of which map to requirements in NZS 8158:2012. Appendix 1 provides a detailed comparison between the 2003 and 2012 Standard.

The key changes in NZS 8158:2012 are:

- Refocusing the specific standards to support the achievement of good outcomes for people rather than the previous focus on service provider processes (reflecting the change towards a goal-based, person-centred approach.
- A more explicit focus on involving consumers in decision-making (reflecting a move towards

restorative models of care and an emphasis on optimising consumers' independence.

- A closer alignment with the Health and Disability Services Standards, where appropriate (e.g. in relation to consumer rights; human resources; and open disclosure of adverse, unplanned or untoward events in service provision).
- More explicit inclusion of requirements for monitoring people who have higher needs or are at greater risk of adverse outcomes (e.g. requirements relating to safe use of equipment, medication management, skin integrity, nutrition and safe food management, and management of behavioural symptoms.
- A new emphasis on emergency planning and management, which is consistent with many funders' contracts.

### Areas that are now less explicit

NZS 8158:2012 does not mention obligations to provide consumers with copies of policies and procedures on dealing with breaches of confidentiality of information. However, an obligation around confidentiality of information is covered through a requirement in the Standard for providers to comply with the Privacy Act 1993 and Health Information Privacy Code 1994. Complaints management is also covered by requirements in both the 2003 and 2012 Standard, which will also have some relevance to where there has been a breach of confidentiality and a complaint is made. It is also possible that, as part of an open disclosure process, policies and procedures may be provided or referenced in information to a consumer.

NZS 8158:2012 is also less explicit about obligations to complete assessments for individual service planning. Assessment is referred to in the context of ensuring plans reflect an individual's assessment and a requirement that there is on-going monitoring of a consumer's service plan[3].

[3] An individual service plan is a plan agreed with the consumer that specifies their goals and how these will be met.

### Summary

Overall the differences between NZS 8158:2003 and NZS 8158:2012 represent a shift in philosophy, current models of care and the increasing complexity of care needs of people who are being supported to live at home rather than moving into residential care.

Most providers will need to implement changes or additions to policies and procedures to meet the new requirements in NZS 8158:2012. However, the additional requirements will not be extensive if the provider is already providing services that are person-centred, goal-based and outcome-focused.

Impacts are discussed in more depth in the section below within the context of a contractual requirement to hold certification.

## Impact of requiring conformance with NZS 8158:2012

### Benefits

Certification against NZS 8158:2012 is an effective means to:

- improve the quality of supports and services as providers meet the Standard
- reduce risks for service users
- stimulate and improve integration between services, improving linkages and opportunities for service users to achieve their goals
- achieve organisational development through self-assessment, team building and benchmarking
- establish a comparative data base that can drive continuous improvements
- manage service costs by focusing on increased efficiency and effectiveness of services
- target education needs of staff
- strengthen public confidence in the quality of supports and services
- receive an external objective assessment of structure, process and outcomes
- receive an exemption from routine contractual inspection or audit[4].

[4] subject to approval by the funder and match of the Standard to the relevant contract.

## Challenges

The level of change that a HCSS provider will need to make to demonstrate conformance with NZS 8158:2012 will vary depending upon the extent to which provider characteristics align more closely with the positive or negative factors set out in Table 2.

**Table 2: Potential impacts for providers**

| Factor (+) | Low | Medium | High | Factor (-) |
|---|---|---|---|---|
| Currently certified to the Standard | ⟷ | | | Not currently certified to the Standard |
| Service model is person-centred, goal focused & outcome-based | ⟷ | | | Service model is traditional providing task based services |
| Holds contracts similar to the Standard | ⟷ | | | Does not hold a contract similar to the Standard |
| Governance, management, quality & risk management systems are mature | ⟷ | | | Governance, management, quality & risk management systems are immature |
| Adequately resourced or access to resources | ⟷ | | | External resources required |
| Service is broader than HCSS but aligned with another Standard | ⟷ | | | Service is broader than HCSS and not aligned with another Standard |

In addition, ensuring an adequately trained and supervised workforce could be a particular challenge for many providers. The Standard requires that consumers receive services from staff that are trained and assessed as competent to provide those services. The Standard does not specify a particular qualification, but requires there to be a developed, implemented and recorded training plan relevant to each worker's scope of practice.

Final Draft

A survey[5] funded by Careerforce[6] in 2011, found that 61 percent of support workers had no formal qualification with 31 percent having a level 2 qualification on the NZQA framework. The sample size was small so the percentages are only indicative, however, it is known that the numbers of people seeking and completing qualifications have increased in recent years.

DHBs monitor whether providers meet training requirements as set out in contracts, however, these requirements are not consistent across DHBs. Given that formal qualifications for all staff may not be required to meet the Standard, the demand for training and consequently the impact on providers can only be quantified by undertaking for each provider an analysis of:

- the gap between the skill mix required for its client population and the skill mix of its staff
- the cost of addressing that gap (e.g. training cost[7] and release of staff time)
- the difficulties that might be experienced by HCSS providers in engaging unqualified staff in training (e.g. capacity of training providers and/or workplace supervisors).

The challenges outlined in Table 2 are discussed in more detail in the following scenarios. The first scenario is that of a HCSS provider that has a certificate of conformance with NZS 8158:2003 and is operating within a person-centred, goal-focused model of care. These providers will experience the least change in conforming to NZS 8158:2012. Other providers will need to undergo greater change, with uncertified providers operating in a traditional, task-based model of care needing to change the most. A certification audit will represent a new cost to this group.[8]

[5] NZHHA Skills Strategy: Survey for New Zealand Home Healthy Association April 2011

[6] The Industry Training Organisation for social services and the non-regulated health and disability sectors.

[7] Currently Level 2 Foundation Skills on the NZQA framework (basic training for support workers) costs between $800 and $1,200 per trainee

[8] Costs are discussed more fully under the Auditing Agency section of this document.

Small providers are also more likely to experience greater difficulty than larger providers, as they are likely to have less mature systems in place and fewer resources to develop them.

## Scenario 1. Currently certified providers working within a person-centred, goal-focused model of care

Under this scenario, providers are operating within a restorative model or social model of care that is consistent with the philosophy of NZS 8158:2012. The impact on these providers of a requirement for certified conformance with NZS 8158:2012 is assessed as low.

Approximately 40 providers contracted by either a DHB, DSS or ACC hold certification to NZS 8158:2003. However, it is not known how many of these are using a person-centred, goal-focused model of care

It is likely that providers that are operating within a model of care that is consistent with the philosophy of NZS 8158:2012 will need to:

- revise or develop new policies and procedures[9] including safe use of equipment, aids and enablers, medication management, skin integrity, nutrition and safe food management, management of people with behavioural symptoms and open disclosure
- provide staff training to implement the revised or newly developed policies and procedures

Time required to develop and implement new policies and procedures and embed them within current quality and risk management systems is likely to take a minimum of three months.

Transitioning to the revised Standard could be achieved at the provider's next surveillance audit where the scope could be expanded to enable upgrading to NZS 8158:2012[10].

[9] Most of these policy and procedure requirements are complementary to current service delivery and requirements under contracts. It is unlikely that completely new policies and procedures will be required.

[10] See *Auditing Requirements. Home and community Support Sector Standard* currently in draft



It will be possible for a currently certified provider to achieve certification against NZS 8158:2012 where an auditing agency issues Corrective Action Requests against the additional requirements of the 2012 Standard[11].

## Scenario 2. Currently certified providers working within a traditional service model

The main difference between providers in this scenario and scenario 1 is the philosophical shift needed to move from a traditional task-based care model to a person-centred approach that aligns with the Standard. The impact for these providers is assessed as medium given the cultural shift that is likely to be required.

Providers will need to:

- develop the policies identified in Scenario 1
- develop policies and procedures focused on person-centred planning and delivery of services
- significant staff training in the new philosophical approach
- undertake risk assessments that are more clinically focused (this may be contract dependent to some extent).

Providers have until 1 September 2013 to achieve this shift. As with Scenario 1, providers could transition to the 2012 Standard at their next surveillance audit and could achieve certification against the revised Standard with Corrective Action Requests against the additional requirements of NZS 8158:2012. They are, however, likely to have more Corrective Actions to address.

## Scenario 3. Providers working within a traditional service model and required to comply with the Standard

Most HCSS providers that are not certified against the Standard will have a requirement in their current contracts with either DSS, ACC or a DHB to meet the intent of the Standard. Around 24 providers are in this category. These tend to be small providers of HCSS, some of which are large multi-service providers, such

[11] Providers can be issued a certificate with Corrective Action Requests attached that set out conditions that must be met to fully comply with all sub-standards and relevant criteria. Providers then develop a plan of action to address the issues identified.

as an iwi service provider, health trust or NGO service provider.

The National Health Board audited 5 DSS contracted providers in the first half of 2012 against NZS 8158:2003 and has offered a pre-certification gap analysis to other currently uncertified providers, six of which have accepted.

Most of these providers will also have had at least one contract audit by a DHB that has included auditing against NZS 8158:2003 either in full, or focusing on the most relevant aspects. These providers should be aware of what NZS 8158:2003 requires and have systems that support compliance.

Others may hold ISO9001 accreditation demonstrating that they have established and implemented management systems. Even if a provider does not hold any certification, it is bound by the requirements of its contract, including minimum requirements for service provision such as the need to have quality, risk and management systems.

In order to be sustainable and respond to changes across the sector, most if not all providers will be aware that models of care and support have been changing and they can expect their current contracts to reflect new service models in the near future. This means most providers will be poised to change to reflect new philosophies.

Moving to a new service philosophy may take time as a cultural shift is required. However as previously discussed, this should not prevent certification to the revised Standard if there has been adequate work undertaken that can demonstrate how and when changes will occur to achieve the shift.

A provider in this situation is likely to need to:

- develop the policies and procedures identified in scenario 2
- revise quality and risk management systems to meet requirements of NZS 8158:2012
- significant staff training in the new philosophical approach.

The provider would then apply for certification through a Designated Auditing Agency. The cost of the certification audit will depend on:

- the size of the service
- the provider's level of preparedness.

The impact for these providers is assessed as medium. The process of developing new policies and procedures and then ensuring they are implemented and supported by staff training could take several months. Providers have until 1 September 2013 to achieve this shift.

### Scenario 4. Smaller HCSS providers not required to comply with the Standard

Approximately 14 DHB-contracted HCSS providers are currently not required by the DHB to comply with the Standard and do not have contracts with either DSS or ACC. Eight of these are retirement villages or residential care facilities, three are DHB providers. The others have small contracts for HCSS with three DHBs.

The impact for these providers is assessed as high.

The policies and procedures they currently use may not be specific to home and community support services, however they will be specific enough to meet the requirements of their current contract for home and community support services. The provider will also be complying with other legislation which is complementary to meeting the requirements of the 2012 Standard (for example, Health and Safety, Employment and Privacy legislation).

However, quality and risk management systems that are adequate for the contract may need further development to meet the requirements of NZS 8158:2012.

The provider will need to become familiar with NZS 8158:2012 and see how they can apply it. Reviewing current systems, making changes, supporting these with training, and then monitoring their effectiveness is likely to take several months. The provider may need to undertake a structured work programme to systematically demonstrate conformance with the Standard.

DHB Shared Services and the Ministry will work with DHBs to identify:

- what each provider would need to do to be ready for certification against NZS 8158:2012, and
- options for responding to identified gaps.

For example, smaller providers that lack infrastructure and established quality and risk management systems may look to consolidate through mergers, joint ventures or cooperatives in order to operate under a more efficient system.

## Managing impacts on service providers

The impact on HCSS providers of transitioning to conformance with NZS 8158:2012 will be dependent upon the approach taken to introduce the revised Standard and requiring conformance with it. These include transition timeframes and processes, and assistance from others.

For example, cost and effort can be reduced by setting a transition timeframe for currently certified HCSS providers that fits with their current auditing regime and providing uncertified providers with information about resources available to them to help them develop the necessary policies, processes and documentation.

As part of this process, the New Zealand Home Health Association has run a series of seminars in the main centres on the process for transitioning to the 2012 Standard.

NZS 8158:2003 will be withdrawn on 1 September 2013. During the intervening period all certified HCSS providers would normally be scheduled for a recertification audit or a surveillance audit, either of which can be used to transition to NZS 8158:2012 prior to 1 September 2013.

The Ministry is currently finalising requirements for Auditing Agencies undertaking certification audits against NZS 8158:2012 for HCSS providers contracted by DHBs, DSS or ACC. These requirements will provide auditing agencies with a consistent and reliable approach.

This includes:

- enabling currently certified service providers to transition to conformance with NZS 8158:2012 through a transitional surveillance audit if their next certification audit is after 1 September 2013 (see next section)
- establishing a certification period of three years with a single, mid-point surveillance audit (rather than annually)
- specifying key components of the audit process, including the sampling methodology to be used
- specifying the standards and related criteria to be included in an audit
- aligning certification and contract audit components to reduce or remove duplication in auditing
- a process for developing an audit summary suitable for publication
- requiring audit reports to be completed using a standard template and submitting reports to a prescribed database.

### Minimising transition costs for currently certified providers

Offering a transitional surveillance audit option and requiring only one surveillance audit at the mid-point of certification will assist in reducing the cost burden on providers without compromising assurance of conformance to the Standard.

The recommended transition process is outlined in Table 3.

Table 3: Recommended transition process

| Provider status | Best option | Flexibility |
|---|---|---|
| Currently certified to NZS 8158:2003 & certificate expires before 1 September 2013 | Re-certify to the new Standard | Auditing agency may extend the current period of certification by up to 6 months if expiry occurs before October 2012 to ensure the provider is conversant with the revised Standard |
| Currently certified to HCSS Standard & certificate is not due to expire before 1 September 2013 | Elect to have a transitional surveillance audit | Another option would be to request an early certification audit.<br><br>Surveillance audit could be brought forward to meet this date if necessary (unlikely to be necessary) |
| Not certified | Certification audit completed before 1 September 2013 | |

### Using a surveillance audit to transition to NZS 8158:2012

Typically a surveillance audit includes the on-site review of:

- a sample of consumer records
- any non-conformities raised at the last certification audit
- internal audits
- complaints
- effectiveness of the management system
- progress of activities aimed at continuous improvement
- operational control
- changes made since the last certification audit
- use of any marks or references to certification (e.g. how a provider can advertise they hold certification).

Evidence is collected through observation, interviews and reviewing documents and files.

Within the home and community support sector, a surveillance on-site audit is usually 6.5 hours to 2 days[12] depending on the number of sites and non-conformities raised from the last audit.

In order for an auditing agency to transition a provider to the 2012 Standard the agency may need to:

- complete a document review of any new policies, procedures, forms or templates, and records of training in relation to these. This could be done off-site prior to the audit as part of the preparation stage for a surveillance audit. This would not incur any disbursements for the provider such as travel.
- interview management and staff about the changes made or proposed to respond to the revised Standard and verify this through observation and/or review of files on site. Cost impacts should be minimal if these interview elements are incorporated into the audit within usual activities and timeframes consistent with a surveillance audit.

Note that auditing agencies negotiate a cost for their services directly with providers. Although a transitional surveillance audit is likely to cost more than a usual surveillance audit, the costs should not be substantively different and this transition approach is likely to be the most cost effective option for those providers upgrading from the 2003 to the 2012 Standard.

## Assistance for any provider to achieve conformance to NZS 8158:2012

There is a range of ways in which service providers can prepare for a certification or transitional surveillance audit. One method available to providers with reasonably developed quality assurance processes is to undertake a self-assessment. There is also a range of support potentially available from other sources.

### Self-assessment

In preparing to meet NZS 8158:2012, providers may choose to undertake a self-assessment against the Standard. This could be included within the provider's current internal audit systems and would assist in identifying areas where change is required. Working

[12] National provider surveillance audits may take more than 2 days because of the need for multi-site sampling.

within a quality framework, the provider would then develop and implement an action plan prior to their next surveillance or certification audit.

### Assistance from others

There are several forms of assistance available from agencies including but not limited to:

- NZHHA (e.g. seminars, networking, forums)
- Other providers (e.g. in the form of peer review or complementary sharing of information)
- Funders (e.g. advice, networking, forums)
- Other agencies (e.g. Māori Health Business Unit of the Ministry of Health)
- Websites
- Consultants
- Auditing agencies[13]
- Developmental evaluators.

## Implications for funders

If funders are to require and recognise certification against NZS 8158:2012 as meeting some of their contractual monitoring obligations, a match between the contract and revised Standard will need to be undertaken[14].

Funders need to consider how they will support HCSS providers to meet requirements of the Standard. The Ministry will make available a simple tool that helps identify and prioritise what changes are required together with a toolkit that assists providers in meeting requirements.

Funders will also need to receive a copy of each audit report and relevant progress reports either directly from the auditing agency or the provider.

There will be implications for the collection, analysis, comparison, publication and active feedback of data on performance of providers by the funders. This may have some information technology requirements or require a short term work-around whilst systems are put in place.

Note that a project [15]is currently underway to support implementation of NZS 8158:2012 and includes consideration of the collection of information and publication of any material. Experience from the Ministry of Health Provider Regulation team will also be used to inform decision making.

## Implications for auditing agencies

Currently, designated auditing agencies undertake the majority of Home and Community Support Sector certification audits. They are able to take different approaches to the certification auditing process as they are not bound by any regulation and only need to work within their third party accreditation if they are accredited under a scheme that includes home and community support services.

Auditing agencies will need to respond to the revised Standard to ensure auditors and the audit approach reflects the intent of the Standard. This is likely to require additional knowledge of new models for providing support services.

If funders require contracted service providers to hold a certificate of conformance to NZS 8158:2012, there are implications for auditing agencies, as funders will have specific requirements. For example:

- consistency of approach to allow for comparison between audits of the same provider and across providers
- a defined audit scope (e.g. number of standards and relevant criteria, level of reporting)
- the composition of the audit team (e.g. to include a consumer for certification audits of disability providers, and auditor qualifications and experience)
- process requirements (e.g. document review as part of preparation, role of provider self-assessment, peer review of audit reports, format of audit reports, supervision, level of liaison with the funder, surveillance requirements)

[13] Note: auditing agencies may be limited in the amount of assistance or advice they provide due to conflicts of interest.

[14] Note: The service specification under development for the National Service Framework has been matched to the 2012 Standard.

[15] Home and Community Support Services: Strengthening Quality Assurance

- publication requirements (e.g. style and level of detail reported specifically for publication).

Funder requirements of auditing agencies such as the above, are not uncommon and are usually described in a conformity assessment body (auditing agency) requirements document. An Auditing Requirements report is currently being finalised for distribution to funders (DHBS, DSS and ACC) for endorsement.

Auditing agencies will continue to issue certificates of conformance to the Standard as there is no regulation of the home and community support sector.

## Conclusion

There are clear benefits for both consumers and the HCSS sector from provider certification against NZS 8158:2012. There are however, cost and time implications for HCSS providers. These implications are relatively low for providers that hold certification against NZS 8158:2003 and that are working within a person-centred, goal-based and outcomes-focused model of care.

Other providers will need to make more significant changes but will have adequate time to achieve these changes by 1 September 2013. Providers have the opportunity to take a phased approach to implementing these changes, as certification can be achieved with corrective action requirements that need to be met within a specified time period (usually 3-12 months) following certification.

There are also implications for funders and auditing agencies which will be addressed as part of implementing the quality assurance project.

# Appendix 1: Comparison between the 2003 and the revised draft[16] Standard

Notes:

- Where there are multiple options to match, the best match is recorded.
- The comparison was made to the postal ballot version of the revised Standard which differed only slightly from the final published version of the Standard.
- Although this match has been validated with two members of the Standard's committee, the match should be used as a guide only.

**Table 4: Standard level comparison**

| **Draft revised Standard** | | | **Current Standard** | | |
|---|---|---|---|---|---|
| **Specific standards** | | **No. of Criteria** | **Specific standard** | | **No. of Criteria** |
| 1.1 | Consumers receive services in accordance with their rights. | 7 | 1.1<br><br><br><br>1.9 | Service users receive services in accordance with consumer rights legislation.<br><br>Service user consent is obtained in compliance with the requirements of the Code of Health and Disability Services Consumers' Rights 1996. | 6<br><br><br><br>4 |
| 1.2 | Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, confidentiality, and independence. | 2 | 1.6<br><br><br><br>1.8 | Service user confidentiality is maintained.<br><br>The personal privacy and dignity of the service user is respected and met during provision of services. | 3<br><br><br><br>1 |
| 1.3 | Consumers receive culturally safe services which recognise and respect their ethnic, cultural and spiritual values and beliefs. | 2 | 1.4 | Service users receive services in a manner that recognises their values and beliefs. | 5 |

[16] Draft for Postal Ballot dated 27 January 2012.

| Draft revised Standard | | | Current Standard | | |
|---|---|---|---|---|---|
| 1.4 | Māori consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural values and beliefs. | 5 | 1.2 | Service users who identify as Māori have their support needs met in a manner that respects and acknowledges their individual values and beliefs. | 11 |
| 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. | 4 | 1.3 | Pacific people receive services in a manner that recognises, respects and acknowledges their specific cultural values and beliefs. | 9 |
| 1.6 | Service providers ensure effective communication with consumers in a manner that the consumer can understand.<br><br>(Open disclosure is new) | 4 | | (Criteria from other sub-standards now match to this new standard) | |
| 1.7 | Consumers are free from any discrimination, coercion, harassment, sexual, financial or other exploitation, abuse (physical, psychological, sexual or financial) or neglect. | 4 | 1.5 | Service users are not subject to abuse and neglect as a result of service delivery. | 4 |
| 1.8 | The consumer's belongings, property, and finances are respected at all times. | 2 | 6.2 | The money and property of service users is protected during the provision of support. | 1 |
| | | | 6.3 | Service user safety is not compromised as a consequence of service delivery. | 4 |
| 1.9 | The consumer's right to make a complaint is understood, respected and upheld. | 3 | 1.10 | Service users are aware of and can access the complaints procedure in accordance with the Health and Disability Commissioner's Code of Consumers' Rights. | 3 |

| Draft revised Standard | | | Current Standard | | |
|---|---|---|---|---|---|
| | | | 2.6 | The service has a complaint management system that is accessible and complies with legislation. | 6 |
| 2.1 | Consumers receive services that are planned, coordinated, and appropriate to their needs. | 3 | 2.1 | The service provider has effective and efficient governance. | 2 |
| 2.2 | Consumers receive timely, appropriate and safe services through efficient and effective service management. | 2 | 2.2 | The service is managed in an efficient and effective manner that ensures the provision of timely, appropriate and safe services to service users. | 3 |
| | | | 2.3 | Service users have input into the planning, implementation and evaluation of the service. | 2 |
| 2.3 | The consumer receives services that reflect continuous improvement principles through the organisation having an established, documented and maintained quality and risk management system. | 5 | 2.4 | The service provider has a quality improvement and risk management system that reflects continuous quality improvement principles. | 9 |
| 2.4 | All adverse unplanned or untoward events are systematically recorded and reported to affected consumers and where appropriate their family/whānau in an open manner. | 4 | 2.5 | The service provider systematically records all adverse, unplanned or untoward events. | 2 |
| 2.5 | Consumers' entry into and exit from services is facilitated in an equitable, timely and respectful manner. | 3 | 3.1 | Service users are provided with comprehensive information that clearly describes the services they are to receive. | 2 |

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| | | | 4.7 | Service users experience a planned and coordinated exit, discharge or transfer from services. | 2 |
| 2.6 | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | 8 | 5.1 | The health, best interests and rights of service users are safeguarded by maintaining an accurate and confidential record of service delivery. | 7 |
| 2.7 | Consumers receive an appropriate and timely response during emergency and security situations.(includes some new requirements) | 3 | | (Criteria from other sub-standards now match to this new standard) | |
| 3.1 | Consumers receive services that are based on good employment practices and relevant legislation. | 2 | 2.7 | Human resources management processes are conducted in accordance with good employment practice and comply with relevant legislation. | 9 |
| 3.2 | Consumers receive services from a service provider who has been through a formal induction process, demonstrates competence for the level of tasks they undertake and has access to on-going development opportunities. (includes a new criteria related to scopes of practice) | 6 | | Included in 2.7 above | |
| 3.3 | The consumer receives services that promote the health and safety of the consumer and service providers. | 2 | 6.1 | The health, safety and welfare of service users and support workers is promoted and protected. | 3 |

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| 4.1 | The consumer, organisation, and service provider have a full understanding of the services to be provided and the rights and responsibilities of each party are demonstrated in a written service agreement. | 3 | 2.9 | Service users receive flexible, consistent and reliable support services. | 3 |
| | | | 4.2 | Each service user has a written agreement with the provider for the provision of service. | 2 |
| 4.2 | Consumers maintain their independence during the course of service delivery by being supported to exercise choice and control over their lives. | 4 | 1.11 | Service users are supported to exercise choice and control over their lives and in maintaining their independence during the course of service delivery. | 3 |
| 4.3 | Consumers receive continuity of service through effective links with other groups. | 4 | 1.7 | Service users maintain links with their family and/or whānau and their community. | 1 |
| | | | 2.10 | Service users receive continuity of service through effective links with other service providers. | 4 |
| | | | 4.6 | Service users are advised of their options to access other health and disability services where indicated and requested. | 1 |
| 4.4 | Consumers have an individual service plan that describes their goals, support needs, and requirements. The plan reflects an individual assessment, | 3 | 4.1 | The needs of the service user are individually assessed and documented in an individual service plan before service provision commences. | 7 |

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| | identification and management of any risks in service provision. | | 4.3 | Each service user has an individual service plan that describes their support needs and requirements. | 4 |
| 4.5 | The consumer's goals and support requirements are met through provision of services. | 3 | 2.8 | Service users receive timely, appropriate and safe service. | 2 |
| 4.6 | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. (new requirements) | 4 | | (Criteria from other sub-standards which are implicit now match to this new standard) | |
| 4.7 | Consumers and service providers are protected from infection through maintenance of a clean home environment, early reporting of infectious disease and use of current infection control practices. (new requirements) | 2 | | (Criteria from other sub-standards which are implicit now match to this new standard) | |
| 4.8 | Consumers are supported to safely use any required or prescribed equipment, aids or enablers. (new requirements) | 2 | | (Criteria from other sub-standards which are implicit now match to this new standard) | |
| 4.9 | The consumer's nutrition and hydration is supported by service delivery. (new requirements) | 4 | | | |

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| 4.10 | Consumer's skin integrity is maintained. (new requirements) | 2 | | | |
| 4.11 | Consumers are supported to achieve their goals through regular monitoring and review of service delivery. | 5 | 4.4 | Individual service plans are evaluated in a comprehensive and timely manner. | 4 |
| | | | 4.5 | Service delivery is reviewed to reflect the findings of the evaluation process. | 1 |
| 4.12 | Consumers with behaviours that challenge are treated with respect and receive services in a manner that has regard for their safety, dignity, privacy and independence. | 3 | | (Criteria from other sub-standards now match to this new standard) | |
| | | 110 | | | 130 |

Table 5: Criteria level comparison

| Standard heading | Criteria Reference revised draft Standard | Match to current Standard[17] |
|---|---|---|
| Consumer Rights | 1.1.1 Providers demonstrate knowledge & understanding of COR | 1.1.2 & 1.9.3 |
| | 1.1.2 Info about the COR is provided to service users | 1.1.1 & 1.1.3 |
| | 1.1.3 Opportunities for discussion, explanation and clarification of information | 1.1.1 (implicit) & 1.1.3 (implicit) & 1.1.4 |
| | 1.1.4 Consumers informed of availability of advocates | 1.1.5 |
| | 1.1.5 Consumers right to advocates | 1.1.6 |
| | 1.1.6 Consumer right to make informed choice & give informed consent | 1.9.1 |
| | 1.1.7 Provider demonstrates consent obtained in accordance with COR | 1.9.2 & 1.9.4 |
| Individual privacy, dignity | 1.2.1 Maintains & respects privacy, dignity, consumer independence | 1.8.1 |
| | 1.2.2 Info in a confidential manner | 1.6.1 |
| Values & beliefs | 1.3.1 Services take into account individual cultural values & beliefs | 1.4.1 & 1.4.4 |
| | 1.3.2 Consulted on individual values & beliefs | 1.4.2 & 1.4.5 (implicit) |
| Māori | 1.4.1 Understand & respects principles of He korowai organga | 1.2.1 & 1.2.2 |
| | 1.4.2 Māori have access to services, barriers to access identified & eliminated | 1.2.5 |
| | 1.4.3 Services consistent with cultural values & beliefs | 1.2.4 |

[17] Note: new or implicit matches are highlighted

| Standard heading | Criteria Reference revised draft Standard | Match to current Standard[17] |
|---|---|---|
| | 1.4.4 Right of Māori consumers to practice values & beliefs | 1.2.6 & 1.2.7 |
| | 1.4.5 Importance of whanau recognised | 1.2.9 & 1.2.3 & 1.2.8 & 1.2.10 |
| Pacific | 1.5.1 Understands & respects key principles of Pacific strategy | 1.3.1 |
| | 1.5.2 Recognise dignity & sacredness of life | 1.3.2 & 1.3.7 |
| | 1.5.3 Receive services that are coordinated & culturally competent | 1.3.3 & 1.3.4 & 1.3.8 (weak) |
| | 1.5.4 Facilitates access to advocate/interpreter | 1.2.11 & 1.3.5 & 1.3.6 & 1.3.9 (weak) |
| Communication | 1.6.1 Full & frank information & open disclosure | new |
| | 1.6.2 sufficient time for discussion | 1.4.2 |
| | 1.6.3 Service providers identify themselves | 6.3.2 & 6.3.3 & 6.3.4 |
| | 1.6.4 Interpreter services available | 1.4.3 |
| Abuse/neglect | 1.7.1 P&P abuse, neglect, discrimination, coercion etc. | 1.5.1 |
| | 1.7.2 Maintain professional boundaries | 2.7.6 & 2.7.9 |
| | 1.7.3 Allegations of discrimination, abuse, neglect are managed & link to QRS | 1.5.3 & 1.5.4 |
| | 1.7.4 Abuse/neglect prevention awareness at induction | 1.5.2 |
| Belongings | 1.8.1 P&P protection money & property | 6.2.1 |
| | 1.8.2 Policy re-entering homes | 6.3.1 |
| Complaints | 1.9.1 Complaints process | 1.10.3 & 2.6.1 & 2.6.3 & 2.6.4 & 2.6.5 & 2.6.6 |

| Standard heading | Criteria Reference revised draft Standard | Match to current Standard[17] |
|---|---|---|
| | 1.9.2 Info about complaints process available to consumers | 1.10.1 & 1.10.2 & 2.6.2 & 2.6.6 |
| | 1.9.3 Up-to-date complaints register | 1.10.3 |
| Governance | 2.1.1 Structure, purpose, values, goals of org identified & reviewed | 2.1.1 |
| | 2.1.2 Governing body ensure org performance aligned & monitored against strategic goals | 2.1.2 |
| | 2.1.3 Governing body has processes to ensure quality improvement | 2.1.2 (implicit) |
| Service Mgmt. | 2.2.1 Managed by qualified person with accountability | 2.2.1 & 2.2.2 |
| | 2.2.2 Consumers consulted on management | 2.3.1 (weak) & 2.3.2 & 2.4.9 |
| Quality & Risk | 2.3.1 P&P good practice | 2.4.3 & 2.4.4 & 2.4.5 (weak) |
| | 2.3.2 QMS system | 2.4.8 & 2.4.1 & 2.4.2 |
| | 2.3.3 Monitoring & analysis | 2.4.6 |
| | 2.3.4 Measure performance against plan | 2.4.6 |
| | 2.3.5 Corrective action plans | 2.4.1 (implicit) & 2.4.2 (implicit) & 2.4.7 |
| Adverse Events | 2.4.1 Documents adverse events | 2.5.1 |
| | 2.4.2 Links to QMS | 2.5.2 |
| | 2.4.3 Addressed in an open manner | new & 2.5.1 (implicit) |
| | 2.4.4 Understands statutory regulatory obligations | new & 2.4.4 (implicit) |
| Entry & Exit | 2.5.1 Access & entry criteria clearly documented & communicated | 3.1.1 & 3.1.2 (implicit) & 4.1.3 (weak) |

| Standard heading | Criteria Reference revised draft Standard | Match to current Standard[17] |
|---|---|---|
| | 2.5.2 Planned exit in collaboration with consumer | 4.7.1 & 4.7.2 (implicit) |
| | 2.5.3 Operates at times to meet the needs of the consumer group | 2.8.2 (implicit) & 2.9.2 (implicit) |
| Info Mgmt. | 2.6.1 Consumer info entered into a information mgmt. system (accurate & timely) | 5.1.1 & 5.1.3 |
| | 2.6.2 Detailed info required in consumer records identified | 5.1.2 |
| | 2.6.3 Adequate consumer detail collected if no MOH requirements | new |
| | 2.6.4 Record of current & past consumers held | 5.1.1 & 5.1.6 & 5.1.7 |
| | 2.6.5 Info mgmt. system meets legislative & prof standards | 5.1.2 |
| | 2.6.6 Private information is held securely | 5.1.5 |
| | 2.6.7 Consumer records are up to date | 5.1.3 |
| | 2.6.8 Records are legible, name and designation identifiable | 5.1.4 |
| Essential Emerg Systems | 2.7.1 Appropriate info, training, equip to respond to emergency situations | new & 2.7.4 (implicit) & 2.4.8 (implicit) |
| | 2.7.2 Identifies & implements emergency plan | new & 2.4.8 (implicit) |
| | 2.7.3 Consumers receive level of support necessary in an emergency | new & 4.3.2 (implicit) |
| HR | 3.1.1 Position descriptions | 2.7.1 |
| | 3.1.2 Documented recruitment procedure includes police check | 2.7.2 |
| | 3.2.1 Induction process | 2.7.3 & 1.6.3 |

| Standard heading | Criteria Reference revised draft Standard | Match to current Standard[17] |
|---|---|---|
| | 3.2.2 Training plan | 2.7.4 |
| | 3.2.3 Competency development | 2.7.5 |
| | 3.2.4 Scope of role | 2.7.7 |
| | 3.2.5 Supervision | 2.7.8 |
| | 3.2.6 Assist health practitioners to retain registration & operate within scope of practice | new & 2.7.9 & 2.7.7 (implicit) |
| | 3.3.1 Training in Health & Safety & follow policy meeting HSE Act | 6.1.2 |
| | 3.3.2 P&P hazards, risk, emergency plan, incident in workplace, de-briefing, corrective actions | 6.1.1 & 6.1.2 & 2.8.1 & 2.8.2 & 2.5.1 & 4.1.4 & 4.1.5 & 4.1.7 |
| Service Delivery | 4.1.1 Written service agreement | 2.9.1 (weak) & 4.2.1 |
| | 4.1.2 Receive services at times they require | 2.8.2 & 2.9.2 (implicit) |
| | 4.1.3 Consumer receives a copy of their agreement | 4.2.2 |
| | 4.2.1 Supported to make own decisions | 1.1.4 (implicit) & 1.11.1 |
| | 4.2.2 Supported to undertake tasks & activities | 1.11.2 |
| | 4.2.3 Representative sought if unable to represent self | 1.11.3 |
| | 4.2.4 Consumers supported to maintain links with family and to access services within the community | 1.7.1 |
| | 4.3.1 Links identified & maintained with key groups & to maintain continuity of service | 2.10.1 & 2.10.2 & 2.10.3 &2.9.3 (implicit) & 2.2.3 & 4.3.1 |
| | 4.3.2 Evaluation of effectiveness of links | 2.10.4 |

| Standard heading | Criteria Reference revised draft Standard | Match to current Standard[17] |
|---|---|---|
| | 4.3.3 Advised of options to access services from other groups | 4.6.1 (weak) & 4.7.1 (weak) |
| | 4.3.4 Safety & right to be kept informed during referral process | 4.7.2 (implicit) |
| | 4.4.1 Individual plan developed to reflect goals, needs | 4.1.1 (weak) & 4.1.6 (weak) & 4.3.1 & 4.3.2 |
| | 4.4.2 Consumer actively involved in consultation, planning, monitoring of plan | 4.3.2 (implicit) |
| | 4.4.3 Developed & agreed with consumer, clearly details actions | 4.3.3 & 4.3.4 (implicit) |
| | 4.5.1 Competent service providers, recognise own scope | 2.7.6 & 2.7.7 |
| | 4.5.2 System of recording allocation of service providers to consumers | 2.8.2 |
| | 4.5.3 Receive First Aid & emergencies managed according to policy | 2.7.5 (weak) & 2.8.2 (weak) |
| | 4.6.1 Medicine management system implemented that complies with legislation, protocols, safe practice | new & 2.4.4 (implicit) |
| | 4.6.2 P&P responsibilities at each stage of medication mgmt. | new & 2.4.4 (implicit) |
| | 4.6.3 Competent to perform medication mgmt. | new & 2.7.7 (implicit) |
| | 4.6.4 Facilitation of self-medication where appropriate | new & 2.7.7 (implicit) |
| | 4.7.1 P&P support infection control | 2.4.3 & 2.4.4 & 2.5.1 (weak) |
| | 4.7.2 Competent in current infection control | 2.7.3 |

| Standard heading | Criteria Reference revised draft Standard | Match to current Standard[17] |
|---|---|---|
| | 4.8.1 Consumer specific information & training to service providers in use of equipment, aids | 6.1.2 (weak) & 2.7.7 |
| | 4.8.2 All equipment, aids, enablers used safely as required or prescribed maintaining dignity, independence | 6.1.2 (weak) & 2.7.7 |
| | 4.9.1 Monitor signs & symptoms of dehydration, malnutrition & interventions implemented as needed | new |
| | 4.9.2 Special or modified diets identified & supported to meet these | new |
| | 4.9.3 Enteral feeding have needs met by providers with specific training & demonstrated competencies | 2.7.7 |
| | 4.9.4 Safe from disease caused by unsafe food storage & preparation | new |
| | 4.10.1 Monitored for signs of skin breakdown | new |
| | 4.10.2 Implement preventative measure to promote skin integrity | new |
| | 4.11.1 Individual plans kept up to date | 4.3.2 (implicit) & 4.3.4 & 4.4.4 |
| | 4.11.2 Reviews documented, consumer focused, degree of achievement | 4.4.1 |
| | 4.11.3 Feedback from family sought as part of review | 4.4.3 |
| | 4.11.4 Formal evidence of a review occurring as per policy | 4.4.2 & 4.5.1 |

| Standard heading | Criteria Reference revised draft Standard | Match to current Standard[17] |
|---|---|---|
| | 4.11.5 Progress different to expected, service provider responds initiating changes to service plan | 4.4.4 |
| | 4.12.1 P&P to support consumers with challenging behaviours | 2.7.7 & 6.1.2 |
| | 4.12.2 Consumers with challenging behaviour supported by suitably trained & competent providers | 2.7.7 |
| | 4.12.3 Service providers receive supervision when working with consumers with challenging behaviour | 2.7.7 & 2.7.8 |