Submission on the "Review of the Health and Disability Commissioner Act 1994 (the Act) and the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights Regulations 1996 (the Code)

Provided by a New Zealand Nurses Organisation (NZNO) group of delegates in a Health NZ district

2 July 2024

Introduction

Under their Health NZ Te Whatu Ora and New Zealand Nurses Organisation (NZNO) Collective Agreement as enabled under the Employment Contracts Act 2000 (ECA), NZNO members are empowered and encouraged to elect member representatives (delegates), to advocate with the Employer for work-place and worker issues.

Another form of worker representative is the Health and Safety Representative (HSR), a role enabled under the Health and Safety at Work Act 2015 (HSWA). HSR's are elected by members of an employer-defined work group (generally all workers within a work area) and where union affiliation (or not) is irrelevant.

This submission arises from NZNO delegate and HSR involvement with a workplace matter in late 2022 involving a health consumer (the Patient) in a public hospital, where matters of concern were experienced with a whānau member and then with the Employer/Health and disability services provider (the Provider). Its duration covered approximately three months.

The purpose of providing a summary of this situation is to highlight issues worker advocates came up against in the pursuit of a consumer's rights and how we believe the Act and Code can be improved upon for the safeguarding of those rights, as well as protections for those advocating on behalf of a consumer.

Section 1: A lived-experience example

The situation

The Patient was a tāngata whaikaha Māori wahine residing in the family home, who was diagnosed with a life-threatening (but curable) condition.

The Patient had affected decision-making capacity and met criteria for a vulnerable adult as defined under the Crimes Act 1961 i.e. a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person. (This definition is in reference to sections 151, 195 and 195A).

A whānau member had previously applied for guardianship but this had been declined by the Family Court and there was no legal guardianship, EPOA or other formal advocacy arrangement in place.

Treatment decision

The Provider reviewed the relevant circumstances with whānau from both a routine part of an Ao Māori perspective and the required consideration of the views of other suitable persons interested in the Patient's welfare due to their affected decision-making capacity.

The Provider decided that it was in the best interests of the Patient to initiate treatment under clause 7(4) of the Code, and this was not opposed by whānau. The Patient did not have an independent advocate i.e. a person who solely represented their interests in this decision.

The Patient was admitted to a specialist ward, alongside arrangements to allow full support from the whānau i.e. two adults (and two children) were permitted to board overnight on an ongoing basis, with other whānau regularly visiting to provide support.

The arrangement was somewhat unusual in that children of a supporting adult were permitted to live-in and that the Patient had (or would develop as a result of treatment), a compromised immunological status. Food, fuel and parking vouchers were supplied to the whānau as needed.

The two adults were both assigned a special status by the Provider under its "Whānau as partners in care" policy to be a "whānau partner in care", a role acknowledged as playing an important part in creating safer patient care and facilitating manaakitanga, alongside hospital staff providing their cares and treatments.

A "Whānau partner in care" is a person trusted by and familiar with the patient who will help, reassure and advocate, being available to provide patient-centred support during a health care stay. They are entitled to be present at all times and expected to take part in a range of tasks contributing to an enhanced healthcare experience.

The treatment regime consisted of a series of separate defined inpatient stays in a specialist clinical area (due to the required nursing competencies for provision of the care required) of which there was one Adult ward (Ward A) that specifically treats this condition and second ward (Ward B) that manages a similar disease process with similar medication protocols, and are therefore reasonably familiar with care and treatment of this condition.

Admission one - starting treatment

The Patient was admitted to Ward A and from day one, the senior of the two adult boarders (who also held the position as "leader" of the family group), engaged in behaviour that was immediately concerning to staff when the patient presented to the ward.

As time progressed and this whānau member became more familiar with hospital processes, their behaviours towards staff continued, escalated and extended i.e. affecting other hospital employees such as cleaners, medical staff, and ward catering and public cafeteria staff employed by an external contractor.

The behaviour included verbal abuse, serious threats to harm i.e. threat to kill, bullying, interfering with or disrupting/delaying the actual treatment, abusing boarder privileges, abusing support privileges ignoring or refusing to comply with the reasonable requests of staff, denying staff access to the health consumer when they needed to do so, blacklisting nurses who had challenged their conduct with senior nursing management, preventing the patient from interacting with the staff to the level that they were capable of (and v/v), misleading staff as to the level of communication ability that the patient was capable of, placing inappropriate notices on the patient room door and blocking vision of staff (and sometimes access) into the patient room.

Nursing staff also witnessed and reported on verbal abuse and emotional manipulation of the Patient by this whānau member.

Nursing staff attempts to communicate their concerns with the this whānau member were unsuccessful. The whānau member declined to engage with any of the Provider's Māori health liaison team.

The senior district Allied Health (Social Worker) clinical lead for vulnerable patients was informally notified that the Patient had been admitted and that staff were working through some issues but for unknown reasons around this time, the nursing directorate management instructed the Social Worker team "not to get involved", which had downstream ramifications.

The primary treating clinician in charge of the patient's care had an alternating month on/month off work roster which necessitated periods where medical responsibility obviously had to be delegated to other colleagues.

This medical delegation did not work well in practice in this situation as the on-duty medical staff did not intercede as the treatment team lead (or delegated lead).

Problem reported (or not)

The concerns re the behaviour was consistently verbally reported to nursing management, the medical team, documented in the Patient's clinical record and reported via the Provider's online incident reporting system.

There was clear evidence of significant harm being incurred by nursing staff from the ongoing exposure to the behaviours from this individual.

While the medical staff were subject to a much lesser degree of exposure compared to the nurses, a number of medical staff were observed to be visibly distressed, however medical staff did not report these concerns via the organisation's incident reporting system (or in any other official forum).

Abuse of other workers outside the ward within the hospital was known about but was not "officially" recorded or linked up to the situation in the wards.

There was increasing nursing staff dissatisfaction shown by increased absenteeism and allocation of the patient was not sought due to the highly stressful and tangled behaviour of the whānau member.

Action taken by the Provider

There was a noted reluctance to intervene. What efforts were made appeared to be short-acting, not reviewed or followed-up and just as quickly abandoned.

There was no move to review the "Whānau as partners in care" status provided to this individual.

The Multi-Disciplinary Team was unable to (and failed) to agree upon a suitable plan that would apply the appropriate control measures needed for this situation.

The absence of the Provider to accept responsibility and accountability to manage became increasingly distressing for the nursing workforce.

The health district has a formal documented policy and process for assessing vulnerable patients and which is usually completed by Social Workers.

Due to previous exclusion of the Social Worker team, this process was not completed until its absence/omission was identified many weeks later when NZNO delegates became actively involved. This notification was subsequently completed by nursing staff.

Up until this was submitted, the district vulnerable person specialist was unaware that the Patient had a significant absence of personal advocacy and representation, or of the allegations that the Patient was being subjected to abuse by whānau.

Independent action taken by workers

Running out of options, a HSR of the local work group submitted a formal recommendation to the Provider.

NOTE: An HSR making a recommendation is an exercise of one of this role's delegated functions/powers under HSWA. An Employer in its role as a PCBU under HSWA upon receiving an HSR Recommendation is obligated to respond. (PCBU = Person Controlling a Business or Undertaking).

The recommendation set out the reasons that a management plan was required and made suggestions about measures considered appropriate to include.

The Provider's response was lukewarm and nothing was put in place to effectively manage the concerns. Due to the time taken for this process of communication, the Patient's first treatment session was completed and they were discharged until the next scheduled treatment.

Some nursing staff initiated transfer requests and others were considering resignation.

Admission two - continuing treatment

To manage "staff concerns" in Ward A, senior medical and nursing management decided to have the Patient admitted to Ward B for their next round of treatment.

In the intervening period prior to this next admission, the Provider made no progress in the implementation of a management plan.

Nurses in Ward B were aware of the challenges that their colleagues in Ward A had undergone.

When the same/similar behaviours were presented, the nursing staff also found themselves unable to reason with the whānau member but did seek earlier NZNO support, resulting in a firmer line of consultation being taken with the senior directorate management.

The processes to get management to this point i.e. to the table to discuss was frustratingly slow and took a very significant amounts of time (outside of paid work-time by NZNO delegates and staff) to develop and provide feed-back to the Directorate on "its" plan.

NZNO (using the expertise of the Ward A and B nursing staff) provided all the base draft documentation for the various sections required in what was a reasonably complex plan involving other services e.g. after-hours management and security and the in-house external contractor providing patient food and cafeteria services.

The management plan was effectively completed but then senior directorate management vacillated and then as previously, due to the time taken for this process, the Patient completed their second treatment session and were discharged.

Consequences of no action being taken by directorate management

The continuing action by the Provider to not accept responsibility and accountability to manage this workplace violence situation added to the harm being incurred and nursing staff felt abandoned.

Significant medical staff dis-satisfaction was observed up to SMO level but this group remained silent and chose not to speak up, from what appeared to be due to the effects of hierarchical rigidity and the personal risks of exposure to retaliatory/exclusionary behaviours that could impact on future developmental and employment opportunities.

Ward B staff had also now incurred significant harm from the exposure to the behaviours (exactly as Ward A). The situation was deemed completely intolerable from the perspective of NZNO members NZNO delegates and ward HSR's.

Senior medical and nursing management declined to inform the nurses where the patient would be admitted for their next period of treatment, of which would realistically only be Ward A or B.

The concern was escalated via HSWA in the form of a formal notice to the Provider (as the PCBU), in that the nurses in both Ward A and Ward B were ceasing to perform unsafe work i.e. declining to provide care of the Patient while the whānau member causing all the safety concerns, was present.

Any worker has the right under HSWA to cease or refuse to perform unsafe work. The decision of the workers was provided as a formal notification so that that the relevant information was communicated to the PCBU in clear and unambiguous terms i.e. that no nurse would accept or provide care to the Patient if this whānau member was present and involved most nursing staff on both these wards.

In addition, a cessation of work notification was prepared (but not yet issued) for a specialist team of experienced nurses (they work rostered duties, do not have an allocated ward and are assigned at the beginning of the shift to fill short-notice vacancies), due to their experiences when working on Ward A and Ward B during this time.

Action taken by the District executive

Executive management of the health district took the following action on being informed that workers were exercising their right to cease or refuse to complete unsafe work i.e.

1. Placed the re-admission of the Patient on hold in what seemed to be an understanding that they (the Provider) wished to avoid breaching HSWA if they admitted the Patient for care while they continued to support attendance of the whānau member but
2. Refrained from taking any action in regard to the conduct of the whānau member as though to stare the nurses down in a bizarre game of "chicken" and force retraction of the cessation of work using moral pressure as the lever.

Apart from the Provider's entrenched reluctance to care for its nursing staff, the absence of its concern for the welfare of the Patient was alarming as the Patient's welfare now became relegated as a mere secondary concern.

NZNO relayed multiple communications to the Provider about its member's concerns held for the welfare of the Patient due to the risks of delaying treatment, which were heard but ignored.

Workers seek help from external agencies

Given this inflexible stance taken by the Provider, the NZNO delegates used the HDC standard complaint form, re-titled it into a Protected Disclosure and submitted this to WorkSafe NZ and the Health and Disability Commissioner (HDC).

WorkSafe was asked to investigate the alleged breach of HSWA in respect of the Providers' responsibility as a PCBU to implement effective controls means for the known hazards that its workers were being exposed to.

HDC was asked to advocate for the Patient as nursing staff were concerned that the Provider was abdicating its obligations to a vulnerable adult i.e. treatment was being unnecessarily delayed, there an increasing risk of relapse prior to any next treatment and that relapse would be un-survivable.

WorkSafe accepted the Protected Disclosure, investigated and issued Te Whatu Ora an Improvement Notice that required it to promptly remedy its breach of HSWA.

HDC accepted the Protected Disclosure, sought to engage with the senior management of health district to ascertain the situation and (what was hoped for), advocate effectively for the health consumer to be treated without further delay.

All of this bureaucratic communication and process took time and the delay to treatment for the Patient continued to extend.

Last resort measure - NZ Police

While the Protected Disclosure was having some impact, the process was having difficulty breaching the Provider's bureaucratic bulwark and the obstinacy of the Provider was in itself causing severe angst and distress to ward nursing staff and now the NZNO delegates (all nurses).

As a last resort measure, the NZ Police were approached and discussions held in relation to the legal obligations held by the Provider under the Crimes Act 1961. On their advice an "Information File" was initiated and documentation started being provided to the Police for this file.

Using local informal networks, a non-NZNO employee of Health District involved with this matter who had links to the local in-house legal team was informed that an Informational File had been initiated with the NZ Police over this situation.

The HDC Officer responsible for HDC management of the Protected Disclosure was also informed that this action had been taken with the Police.

As the matter continued to remain unresolved i.e. the Patient's treatment still being delayed, the NZNO delegates made a decision to formulate a complaint under the Crimes Act 1961 to the NZ Police, relating to Section 151 - Duty to provide necessaries and protection (for a vulnerable adult) from injury, Section 195 - Ill-treatment or neglect of child or vulnerable adult and Section 195A - Failure to protect child or vulnerable adult.

The complaint (as written) alleged that the Provider was omitting to perform their legal duty, being a major departure from the standard of care expected of a reasonable person in similar circumstances and that it had failed and was continuing to fail to take reasonable steps to protect the patient under its care from significant risk of harm.

The non-NZNO employee previously contacted was informed of the following:
1. That from the time of (this) informal notification, the Provider had 48 hours to work out a solution

whereby the Patient was to be admitted for life-preserving treatment in a manner that also provided a safe work environment for the nursing staff to provide care, and

2. If there was no appropriate solution implemented within the time-frame, a formal complaint would be laid with NZ Police under the Crimes Act 1961 and which would name the Provider and the executive leadership of the Health District as being the liable parties.

Outcome

Within the 48-hour period, the Provider served a Trespass Notice to the whānau member requiring them to stay off the premises and the Patient was subsequently admitted for continuation of their treatment. Other whānau provided support to the Patient during this admission.

We make no comment as to whether this back-door ultimatum had any effect and can only make the observation that the Provider applied this solution within the time-frame.

The Patient successfully completed their third session of treatment and was discharged home. During this session there were no further issues with other whānau.

Observations

That treatment was discontinued after the third session is a deviation from the norm i.e. the standard number of sessions for this condition is four and from information available, it does not appear if the Patient was given a choice over its potential benefit and discussion had whether to proceed with this or not.

A potential reason for this reduced treatment regime was suggested to be due to the "organisational fatigue" experienced by senior medical and nursing management.

If the Patient had an enabled advocate i.e. an independent person acting in their best interests, a fourth treatment may well have been completed.

The ability of the HDC to engage in advocacy in an active situation where a health consumer was continuing to be at high risk of harm is perhaps unusual as most of its investigations take place after an act or omission by a provider has caused harm.

The HDC official provided no feed-back as to any difficulty or obstruction they were experiencing in their engagement with the Provider, but this seemed highly likely that this was occurring, as there was no progress being made that the nurses or NZNO could see.

HDC advocacy was not seen as effective and may have had something to do with that any HDC official acting under the authority of the Director of Proceedings, has no power to require the Provider to hand over information relevant to the HDC investigation.

This matter was about as serious as it can get before harm is incurred and could have just as conceivably led to the unnecessary death of a vulnerable person.

The communications received from HDC to date whether a formal investigation is proceeding or not are vague, and if it is happening, the expected completion time appears to be about two years.

It is an observable fact that a time period delay such as this empties a judgement of its value even is correct decisions are (belatedly) made and this absence of a speedy and effective resolution creates a sense of unfairness and disparity for those harmed or advocating on behalf.

Section 2: Observations relating to advocacy for a health consumer

TOPIC 1 - Supporting better and equitable complaint resolution

People-centred approach

We unanimously support a more people-centred process and more effective communication from HDC to those seeking help.

In the real-life example provided, the Patient was not kept front-and-centre and was relegated as being of a secondary concern to the Provider's "power plays". HDC seemed to be hamstrung by an unnecessary surfeit of legal, bureaucratic and political controls.

Fast-track option

On receipt and following acceptance, the HDC allocated the task of managing to a senior HDC official. There was no communication as to whether internal escalation was considered at any point, given the continuing risk to the patient when delay in resolution continued.

This high level of concern re the continuing delay was formally communicated to the HDC official on a number of occasions.

Knowing that a complaint has been assessed and either has or has not been placed in a face-track process would have been helpful, as significant time was lost waiting for HDC to do something and given that time was of an essence, could had allowed our in-house advocacy actions to be taken earlier.

Protection against retaliation

In the example we have provided, protection (for our colleagues and ourselves) was a pivotal consideration when we sought external agency support and which is why we utilised the Protected Disclosures (Protection of Whistleblowers) Act 2022.

In large organisations such as Health NZ, is it not uncommon for there to be subtle or overt retaliation against workers and is a common occupational hazard for those that advocate on behalf of others.

That retaliatory action by an employer is all too common is acknowledged by inclusion of worker protections against this conduct in the Health and Safety in Employment Act 2015 and the Employment Relations Act 2000.

The Health and Disability Act Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights move within very similar circles.

We unanimously support the insertion of a "protection against retaliation" clause into Right 10 of the Code.

TOPIC 2 - Making the Act and Code effective for and responsive to, the needs of Māori

Te Tiriti clause

We unanimously support this, and especially so in the inclusion of a te Tiriti clause to assist the normalisation of tikanga Māori in the NZ health environment.

Kāwanatanga

Instead of a Deputy HDC for Māori, cannot the Health and Disability Commissioner role be a shared position or is this a politically unpalatable option in the current climate?

Complaint management

We would like to see trauma-informed and restorative justice processes being a normal part of how the Act and Code operate in respect of dealing with complaints. While these resonate with aspirational Māori values, we believe that their inclusion will benefit other consumers, regardless of race or culture.

TOPIC 3 - Making the Act and Code work better for disabled people

In respect of the example we provided it is unclear what follow-up (if any) occurred for the (our) Patient i.e.

- Has the legal guardianship issue been left unresolved?
- Barriers still exist in the home that may prevent this person from a freer participation in how they may wish to live their life i.e. is likely to have reduced "person-rights".
- Given that the patient is in higher-risk home environment, who is looking out for this person in a culturally appropriate way?

TOPIC 4 - Considering options for a right to appeal HDC decisions

The right to appeal a decision made by a public entity affecting an individual is considered to be a basic right. Overall, we regard the HDC as a very ethically-driven organisation and value the very significant contributions the Commission makes for the betterment of country's health and disability services.

Human Right Review Tribunal (HRRT)

We support a re-balancing of the threshold of health consumer access to the HRRT, as we currently perceive it to be almost discriminatory against health consumers.

Prior to consideration of this kind of change, if the Act or Code had better defined resolution processes (for health consumers) i.e. mediated processes (including restorative justice), these practical face-to-face encounters could assist to re-balance the perception of disparity.

TOPIC 5 - Minor and Technical improvements

Maximum fines

There is no information provided to indicate that the $3000 fine is no longer a significant deterrent to a Provider - do the number of issued fines indicate that providers are happy to accept a "slap on the wrist" to that value?

Rather than simply increase a fine amount, what about introducing a less blunt tool e.g.

- Ability to issue spot fines for the hindering/obstruction of a HDC investigation in progress
- Significantly increase the fine amount for an entity other than an individual person (as in HSWA)
- Build in criteria for severity of harm incurred.

Section 73 does not provide any information about the processes that HDC must take prior to issuing a fine and it is a not well-known function or publicised endeavour.

Aggrieved person

We unanimously support that this definition be included in the Act and Code.

We also believe it needs to be made clear it that must include a clinical practitioner or other person advocating on behalf of a consumer.

It is noted that in our example, the patient was never approached/asked/aware or informed that nurses were advocating on their behalf.

Power of the Director of Proceedings to request information

We unanimously support the addition of this power for the Director of Proceedings. Their ability to exercise this is a common-sense and practical application of their role and we consider that this is a necessary and naturally ordered step to better meet the express purpose of the Act as per Section 6.

Written consent for sedation equivalent to anaesthetic

Yes! Another common-sense and practical change. We see this as driving a higher level of accountability and quality across the board, particularly in community non-hospital care settings.

Serious adverse effects

We agree that this needs to be included and suggest that a definition would also be useful here and could include things such as:

- That the consumer now has a permanently disability from the treatment injury
- Harm incurred by therapeutic/diagnostic efforts taken to prevent a permanent disability, including mental harm
- A treatment injury disability which will take six or more months to resolve
- An injury or effect which the consumer was unaware of its possibility or probability prior to a consented treatment

Section 3: Appendix 2 - Draft Code Changes

Changes to 7(4)(c)(i)

Query: Should there be any note made in respect of a Provider being required to ensure that this process is adequately documented in order to withstand a robust scrutiny by any person authorised to view?

Right 10

Observation: Clause (9) does not provide any note as to what step or steps can be taken, or what other recourse is available to the patient or their advocate, if it is perceived that a Provider is engaging in retaliatory conduct.

Thank-you.

A group of NZNO delegates in a health district