West Coast District Health Board

Te Poari Hauora a Rohe o Tai Poutini

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5 March 2019

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RE Official information request WCDHB DHB 9261

We refer to your email dated 19 December 2018 requesting information under the Official Information Act from Canterbury DHB regarding the Waitangi Tribunal Research Report on disabled Māori. **Specifically:**

1. How does the DHB involve disabled Māori in decision-making, specifically:

(i) **What proportion of the DHB Board membership are:**

- **Māori.** - 2
- **Non-Māori.** - 9
- **Disabled Māori.** - 0
- **Disabled non-Māori.** - 0

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(ii) **How do the membership requirements of the DHB's statutory committees ensure participation by disabled Māori? Please provide how many members per committee are:**

- **Māori.** - 3
- **Non-Māori.** - 14
- **Disabled Māori.** - 0
- **Disabled non-Māori.** - 0

(iii) **How do the membership requirements of the DHB's clinical governance group(s) and consumer advisory group(s) ensure participation by disabled Māori? Please provide how many members of these groups are:**

- **Māori.** -
- **Non-Māori.** -
- **Disabled Māori.** -
- **Disabled non-Māori.** -

(ii) The West Coast Clinical Governance Group and Consumer Council does not hold information specifically about ethnicity or disability for its members. (Declined under section 18(g) of the Official Information Act).

(i) **How are disabled Māori supported to participate in the DHBs Māori relationship board (or equivalent)?**

(ii) **How are disabled Māori supported to participate in the DHB's alliance leadership teams? Please also provide how many members are:**

- **Māori.** -
- **Non-Māori.** -
- **Disabled Māori.** -
- **Disabled non-Māori.**

The West Coast Alliance does not hold information specifically about ethnicity or disability for its members. (Declined under section 18(g) of the Official Information Act).

One role on the Alliance Leadership Team has the specific need to be an expert in Māori Health that is also connected in with local iwi and this role is filled on nomination by our DHB Mana Whenua Advisory Group, Tatau Pounamu.

2. **What support (e.g. financial or travel assistance) does the DHB provide to disabled Māori to ensure they're able to fully participate in its committees and advisory groups?**

All Board and Committee members are entitled to: meeting fees; mileage; and parking costs. Special arrangements, if required, can also be provided.

3. **Does the DHB offer the Board, statutory committees, alliance leadership teams and clinical governance groups any training to build their skills and expertise in cultural safety/ competence and in disability responsiveness? Please provide evidence of this.**

Board

At the beginning of each Board term, induction workshops are held. All Members are made aware of their obligations and duties as set out in the Health & Disability Act which is provided as part of this induction and also includes appropriate cultural training.
Additional training is available to Board members throughout their term, with members encouraged to request this at any time. Such requests are dealt with on an individual basis, with the type of training provided dependent on what is requested.

During the Board's term, if it is believed that Board members (or a specific member) would benefit from additional training in a specific area, this will be arranged. Again, the type of training will be dependent on what is required.

Committees

No specific training is provided for Committee members, however, training will be provided on request, or where it is believed that members would benefit from additional training.

The West Coast Alliance

The West Coast Alliance Leadership Team has not received any specific training on disability responsiveness.

The West Coast DHB regularly provides Cultural Competency training through the Māori Health team and this is available to anyone working within the DHB or the wider Health System. The DHB is also supporting staff to compile Takarangi Cultural Competency portfolios; this has been in place since 2018.

In May 2014, the West Coast Alliance Leadership Team developed a set of guiding questions which specifically include *“Do we know if our decisions are improving equity of outcomes for Māori?".*

Following the adoption of the Canterbury and West Coast Health System Strategic Health Disability Action Plan in July 2016, another question was added*; "Do we know if our decisions are improving equity of outcomes for people with disabilities?”.* These questions are considered each time a new project plan or report is reviewed by the Team.

4. **What other mechanisms does the DHB use to ensure disabled Māori are involved in DHB strategy, policy, implementation, service design, delivery, evaluation and monitoring? Please provide any terms of reference or relevant supporting documents.**

Canterbury and West Coast DHB’s have a Transalpine Disability Action Plan which has the strategic objectives identified by disabled people, their whanau and disability providers from wide consultation through 2015/16. The Plan also includes priority actions to achieve these objectives for 2017/18 and these actions are currently being refreshed through ongoing engagement with the disability community. Both these processes are inclusive of disabled Māori.

The implementation of the priority actions is being led by the Canterbury DHB Disability Steering Group in Canterbury and on the West Coast the Alliance Leadership Team has taken a lead role along with DHB divisions whose scope is transalpine e.g. People and Capability, Quality and Patient Safety. Consistent with the Action Plan implementation has focused on raising disability awareness for staff, employing more people with a disability, improving the way we communicate and having accessible buildings and services. The priority actions of the Transalpine Disability Action Plan 2016 – 2026 are currently being refreshed with the Canterbury and West Coast disability community and this process will inform the priorities for implementation over the next 2 years, 2019-21.

Please refer to Appendices (below)
Appendix 1 - Transalpine Disability Action Plan 2016-2026
Appendix 2 – WC ALT Disability AP August 2018

5. **What strategies and policies are in place specifically to give effect to the DHB’s obligations to disabled Māori under the following:**

- **NZ Public Health and Disability Act 2000.**
- **NZ Health Strategy 2016.**
- **NZ Disability Strategy 2016-2026.**
- **He Korowai Oranga 2014.**
- **Whaia Te Ao Mārama 2012-17 and 2018-22.**

Refer to **Appendix 1**. The Transalpine Disability Action Plan which identifies all of these strategies and policies as core documents used to inform the content of the Action Plan.

In addition to this the West Coast and Canterbury DHBs have a relationship based on Te Tiriti o Waitangi with Ngāi Tahu through Manawhenua ki Waitaha in Canterbury, and with Tatou Pounamu on the West Coast. The DHB seeks advice and guidance through reference groups, such as Te Kahui O Papaki Kā Tai in Canterbury. The DHB supports Māori who are members and provide input to groups under the Canterbury Clinical Network (CCN) through the CCN Māori Caucus. The DHBs collaborate with the other South Island DHBs through bodies such as Te Herenga Hauora o te Waka a Maui (the South Island Regional DHB Māori Managers Network) and the South Island Alliance.

6. **How are the requirements for compliance with the Ministry of Health Operational Policy Framework 2018/19 met with respect to disabled Māori (especially with regard to Sections 3.9 to 3.13)?**

The West Coast DHB uses equity tools generally in its. It has not explicitly used these tools in planning for disability services, but follows their principles in the process of planning for and improving services for disabled people through the Canterbury and West Coast Health Disability Action Plan. The Canterbury and West Coast Health Disability Action Plan was developed with specific reference to He Korowai Oranga and Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Service, among other documents. The Canterbury and West Coast Health Disability Action Plan includes a strategic focus on working towards equitable outcomes for Māori with disabilities.

The West Coast DHB regularly monitors health outcomes for Māori compared to non-Māori (or the total population, depending on the data source). The DHB does not have sufficient data on disability affecting Māori or others, for example because it does not have a suitable marker to systematically identify those who have a disability. This prevents monitoring of health equity with respect to disability for Māori. The Canterbury and West Coast Health Disability Action Plan includes a priority action to "Develop high quality ethnicity data sets by having processes in place that enable all data collected and collated to capture information specific to the Māori population with a disability." The West Coast DHB is not aware of any research on disability affecting Māori in the district. The West Coast DHB supports Māori capacity through development of a Māori provider, though this provider that the West Coast DHB contracts with are focused specifically on disability. The West Coast DHB aims to increase the number of people with disabilities that it employs, which will include Māori. There is an intention for Project Search, a Canterbury DHB-supported initiative to equip people with disabilities to join the workforce which includes disabled Māori.

The West Coast DHB works to improve cultural competency through programmes such as courses on Understanding the Treaty of Waitangi in Health, and on Tikanga Māori. It monitors health consumer's satisfaction generally, though processes such as the Patient Experience Survey, but does not monitor satisfaction of people with disabilities specifically on a routine basis. The Canterbury and West Coast Health Disability Action Plan includes a priority action that "All the priority actions of this plan are to include culturally appropriate actions for Māori with a disability and their whānau, and that this promotes and supports whānau ora and rangatiratanga." Under the Plan's objective to develop and implement training that enhances disability awareness among staff there is a priority action that "Training packages are developed and implemented in partnership with Māori people with disabilities and their whānau, to ensure cultural competency is inclusive of any training delivered."

The West Coast DHB consults and involves iwi and the Māori community generally through relationships with Tatou Pounamu. The West Coast DHB supports Māori who are members and provide input to groups under the Alliance Leadership Team. The West Coast DHB collaborates with the other South Island DHBs through bodies such as Te Herenga Hauora o te Waka a Maui (the South Island Regional DHB Māori Managers Network) and the South Island Alliance Project Office (e.g. Te Waipounamu Māori Leadership Group for cancer services).

7. **What strategies and policies are in place to ensure compliance with the following requirements?**

- **Accessibility of DHB buildings and facilities under NZS4121:2001.**

The Canterbury and West Coast DHBs has Accessibility as one of the four priority actions of their Transalpine Disability Action Plan, while this includes the DHBs services and building, there is also a commitment to promote the wellbeing and inclusion of people of all ages and abilities.

Objective 16 of the Disability Action Plan 2016- 2026 reads as follows:

Actively promote and influence at all levels of society to address stigma and discrimination, increase universal design for public spaces and advocate for a fully inclusive society

The West Coast DHB supports the position of the Disability Leaderships such as the Earthquake Disability Group (EDLG) that the current Building Code does not adequately ensure that new and renovated buildings will meet the needs of people all types of disability, especially in health care settings. NZS4121 is an improvement over the Building Code, but it is out of date and not mandatory.

To progress fulfilling the Action Plans objective staff from the WCDHB is an active member of the West Coast Accessibility Coalition which formed in 2017 to develop a vision and strategic action plan on making the West Coast the most accessible locality in New Zealand. The Coalition have completed the development of the Te Tai Poutini West Coast Accessibility Strategic Plan and have now had local and regional council sign off on the strategy and action plan.

The two West Coast Runanga have also formally endorsed the Te Tai Poutini West Coast Accessibility Strategic Plan. The next step is for the Coalition members to present the strategy and plan to the West Coast DHB in early 2019 with the aim that the Executive Management and the West Coast DHB Board will endorse the plan and become an ongoing member of the West Coast Accessibility Coalition.
Refer to **Appendix 3**

- **Accurate ethnicity data recording and reporting under the Ministry of Health HISO 10001:2017 Ethnicity Data Protocols.**

The West Coast DHB has used the Ministry of Health HISO 10001:2017 Ethnicity Data Protocols in the planning and ongoing implementation of the South Island Patient Information Care System, which is currently being introduced across the South Island. It also uses the Ethnicity Data Protocols in informing and training staff in the proper collection of ethnicity data.

- **Accessibility of public consultation for disabled Māori (for example, Ministry of Health Guide to Community Engagement with People with Disabilities 2017).**

West Coast DHB consults with Māori, and with disabled people in general, this is evidenced during the consultation on the development of the Disability Action Plan. This consultation conducted in 2016 and the current re-engagement with the disability sector on the priority actions in the Plan which commenced in 2018 and will continue into 2019, actively plans engagement meetings in accessible locations, uses a range of mediums to accommodate different abilities, uses plain language and technologies, such as facilities with hearing loops and sign language interpreters, to remove barriers to engagement wherever possible.

- **Implementation of NZ Web accessibility standard 1.0. and usability standard 1.2**

West Coast DHB does have a policy for its public website www.wcdhb.health.nz to comply as far as is reasonably possible with NZ Web accessibility standard 1.0. and NZ Web usability standard 1.2. In October 2018 West Coast DHB launched a new public website and as part of a process, had a key objective of significantly improving compliance with these two standards.

We continue to work towards better compliance by working to improve our online services and processes, and have consulted Access Advisors NZ (a subsidiary of the Blind Foundation) throughout for advice on the best approach to providing accessible online services. We recognise that some elements of the web standards are very challenging and involve significant operational and cultural change within our organisation. This will take a sustained commitment to achieve but as an organisation West Coast DHB is working to continually improve how it provides information in a more accessible way.

- **Compliance with the Code of Health and Disability Services Consumers' Rights, particularly, Right 4 and Right 5.**

Right 4 (Right services of an appropriate standard)

Contained in the Transalpine Disability Action Plan 2016 – 2026 is:
Objective 3: Offer interventions with individuals and their family/whanau which are evidence based best practice and that these restorative, recovery focused approaches will result in people living lives to their full potential. Some examples of the programmes and initiatives are as follows:

For Canterbury and West Coast DHBs the Quality and Patient Safety Division have requested of the national Health Quality and Safety Commission that questions on disability be added to the patient experience survey for both the experience in hospital settings and Primary Care. This was agreed in principle by the Commission and they are progressing in their Inpatient Experience Survey Governance Group in the first instance and will also be include it for the primary care patient experience survey. The preferred method will be the use of the Washington Short Set Questions.

This introduction will enable the health system the ability to determine if and when people with a disability have a negative experience in our services and we can focus on areas where quality improvement is required.

The Disability Action Plan have two other key objectives which are targeted to improving the ensuring people are getting appropriate treatment:

a). Objective 4

Develop and use a range of new and existing quality measures for specific groups and services that we provide for people with disabilities, and develop system and processes to respond to unmet need e.g. consumer survey
Actions within this objective have included reviewing the complaints and compliments process for appropriate language for people with a disability and seeking feedback on our services is planned as part of the refresh of the priority actions for 2019-21

b. Objective 13

Develop and implement orientation and training packages that enhance disability awareness among staff, in partnership with the disability sector.
Actions within this area has been the development of e-learning training packages on working with people with an intellectual disability and ensuring consumer rights, which include treating people with dignity and respect, is included in everyones orientation to the organisation.

Right 5 (Right to effective Communication)

Effective communication is a priority for the West coast DHB as evidenced below from the Priority Actions for effective communication contained in the Disability Action Plan 2016 - 2026

Objective

Promote and provide communication methods that improve access and engagement with people with disabilities e.g. use of plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology. Expand the use of sign language.

Priority Actions

10.1 Engage with Canterbury and West Coast communications staff to review health system websites and identify any parts of them which are not fully accessible for people who use communication devices.

Outcome: External accessibility review completed by the Blind Foundation and external website upgraded and launched in November 2018

10.2 Build on the partnership with the disability sector by having the Disability Strategy and a version of this Plan made available in Easy Read format.

Outcome: In plain language, not yet in easy read format

10.3 Develop a Canterbury and West Coast policy on the use of sign language and access to interpreters. Policy completed January 2019 and attached as **Appendix 4**

8. **How much did the DHB spend per year for the past five financial years on health services, specifically for:**
   - **Māori.** -
   - **Non-Māori.** -
   - **Disabled Māori.** -
   - **Disabled non- Māori.** -

9. **What proportion of the funding for disabled Māori was used to fund services (all and disability-specific services) by Māori owned, Māori governed health providers?**

The West Coast DHB does not fund services specifically for disabled Māori only.

10. **What accountability mechanisms does the DHB use to ensure that all of the services that the DHB contracts are appropriate and effective for disabled Māori?**

There is no accountability requirement or process that is specifically for disabled Māori however please refer to **Appendix 5** for excerpt from the Contract which has collated the clauses which appear in all West Coast DHB contracts in relation to Māori. It is expected that compliance with these clauses for Māori will be inclusive of disabled Māori.

11. **Please provide evidence and examples of how contracts require equity for disabled Māori in workforce, and in outcomes?**

There is no accountability requirement or process that is specifically for disabled Māori however please refer to **Appendix 5** excerpt from the Contract which has collated the clauses which appear in all West Coast DHB contracts in relation to Māori. It is expected that compliance with these clauses for Māori will be inclusive of disabled Māori.

12. **How does the DHB ensure disabled Māori are able to access Māori-centred health and disability services?**

The West Coast DHB contracts an NGO (Poutini Waiora) to deliver a wide range of kaupapa Māori health services for Māori. While not specifically designed for those with disabilities services are delivered for Māori whānau from a wide range of backgrounds and age groups and are inclusive of those who live with a disability. Services are designed for whānau to access culturally appropriate support to meet their health needs.

13. How many complaints or letters of feedback have been received in the last five years from disabled Māori or regarding services applicable to disabled Māori? What were the issues raised and how did the DHB work to resolve them? Please provide evidence.

The West Coast DHB does not capture ethnicity or disability as part of the complaints process. Declined under section 18(g) of the Official Information Act.

14. Please provide the number of DHB employees, by category of profession, who are:

- **Māori.** -
- **Non-Māori.** -
- **Disabled Māori.** -
- **Disabled non-Māori.** -

The West Coast DHB does not capture ethnicity or disability as part of the complaints process. Declined under section 18(g) of the Official Information Act.

15. What does the DHB do to build capacity and capability for disabled Māori to work in the health and disability sector?

There is no specific programme targeted at disabled Māori to enable them to work in the health and disability sector provided West Coast DHB

16. How much did the DHB spend per year, for the past five financial years, on services (including consultancy) provided by disabled Māori?

While West Coast DHB pays particular attention to, and references the provision of all services to Māori. Throughout its planning and reporting documentation and processing there is no provision made within this for information to be broken down further to reference disabled Māori. This is due in no small measure to the DHB having no direct responsibility for provision or contracting of disability services for under 65's.

17. What was the DHB total spend per year, for the past five financial years on services (including consultancy)?

Please refer to **Table two** (below) for the total West Coast DHB spend per financial year, for the past five years, for all services.

Table two:

Financial year	$'000
2013/14	$138,118
2014/15	$140,908
2015/16	$142,186
2016/17	$143,572
2017/18	$152,099

Note: Data taken from West Coast DHB Annual Report

18. **What training does the DHB offer staff to build their skills and expertise to provide appropriate services to disabled Māori, for example, cultural safety / competence training and disability responsiveness training? Please provide evidence.**

- Disability Responsiveness (new course 2018 – healthLearn)
- Working with People with an Intellectual Disability who have Challenging Behaviour (healthLearn)
- HDC Consumer Rights (healthLearn)
- HDC Open Disclosure (healthLearn)
- Treaty Of Waitangi (face to face)
- Tikangi Best Practice (face to face)

Note: The numbers of people completing the courses is not available.

19. **What proportion of the DHB's total training budget was spent on training and development for this purpose, for each of the past five years?**

There is no specific proportion of the training budget allocated for this purpose.

20. **What proportion of staff (by profession) have undergone 1) cultural safety / competence training, 2) disability responsiveness training and 3) both cultural safety / competence and disability responsiveness training?**

We do not hold this data. (Declined under section 18(g) of the Official Information Act.)

21. **How do DHB policies align with the UNCRPD, particularly with regard to the following articles? Please provide evidence:**

Article 12. Equal recognition before the law: No specific policy
Article 17. Protecting the integrity of the person: Personal Privacy and Dignity Procedure Attached as **Appendix 6**
Article 19. Living independently: Home Alone Guidelines Attached as **Appendix 7**
Article 20. Mobility: Falls Prevention and Management Policy Attached as **Appendix 8**
Article 21. Freedom of Expression: Interpreting For Patients Procedure Attached as **Appendix 10**
Article 22. Respect for privacy: Attached as **Appendix 9**
Article 25. Health: The Code of Conduct Attached as **Appendix 15**
Article 26. Habilitation and rehabilitation: No specific policy
Article 30. Participation in cultural life, recreation, leisure and sport: No specific policy.
Article 31. Statistics and data collection: Ethnicity Data Collection Procedure Attached as **Appendix 16**
West Coast DHB policies reflect the:

- Code of Health and Disability Services Consumers Rights which is for all consumers and is not limited to those with disability.

- Health and Disability Services Act which focuses on provision of services to a person receiving a health or disability service.

- Health and Disability Services Standard 2008 which includes support for the New Zealand Disability Strategy.

The West Coast DHB vision is for an integrated health system that keeps people well and healthy in their own homes. A system that provides exceptional quality, providing the right care and support, by the right person, at the right time, in the right place, with the right patient experience.

Specific policies demonstrating alignment with United Nations Convention on the Rights of people with Disabilities are outlined below.

22. How do DHB policies align with the United Nations Declaration on the Rights of Indigenous Peoples? Please provide evidence.

The West Coast DHB does not have anything specific but the UN Declaration on the Rights of Indigenous People principles are very aligned to the treaty rights of Māori and the relationship between West Coast DHB and Poutini Nga Tahu.

The West Coast DHB has staff trained in Tikanga best practice, has an MOU with iwi and TOR for Tatau Pounamu, there is currently a Māori health policy under development

Please refer to the following Appendices:

Appendix 11 Tikanga Best Practise Flipchart
Appendix 12 Tikanga Best Practise Guidelines
Appendix 13 Ta Tau Pounamu MOU
Appendix 14 Ta Tau Pounamu TOR

23. How does the DHB identify and collect information on disabled Māori and their needs (including for DHB staff)?

While we collect information for Māori the West Coast DHB does not collect information specifically on disabled Māori. (Declined under section 18(g) of the Official Information Act).

24. How does the DHB determine health priorities for disabled Māori in its district?

We do not determine health priorities for disabled Māori as separate from non-disabled Māori (Declined under section 18(g) of the Official Information Act).

25. How does the DHB monitor its performance for disabled Māori compared with:
- **Māori.**
- **Non-Māori.**
- **Disabled non-Māori.**

Please provide relevant monitoring reports for each of the past five years.

The West Coast DHB does not hold sufficient data to monitor its performance for disabled Māori, or for comparator groups. The DHB does not have a suitable marker to systematically identify those who have a disability. (Declined under section 18(g) of the Official Information Act).

How are disabled Māori supported to participate in the DHBs Māori relationship board (or equivalent)?

The Tātau Pounamu are the West Coast DHB Treaty Partner group who also have Māori representation but not specifically disabled Māori.

Tatau Pounamu represent both Hapu i roto e te Tai O Poutini me nga Maata Waka hoki. They meet at least 6 weekly with representatives of the WCDHB. Over the years many issues and kaupapa have been discussed at this forum. Various members over the years have themselves had disabilities as has their whanau. People with disabilities is often discussed, last year the group was consulted regarding the West Coast and Canterbury Disability plan and they gave very worthwhile feedback to this.

26. How does the DHB ensure that its health promotion programmes, and that of its Public Health Units (if applicable) are appropriate and effective for disabled Māori, for example, how does it ensure its campaigns are accessible for kāpō Māori?

At Community and Public Health we focus on the following principles of public health work: focusing on the health of communities rather than individuals; influencing health determinants; prioritising improvements in Māori health; reducing health disparities; basing practice on the best available evidence; building effective partnerships across the health sector and other sectors; and remaining responsive to new and emerging health threats.

We engage with communities to promote health and wellbeing, modify the determinants of health which affect those communities most directly and support community action by strengthening self-determination (Tino Rangatiratanga). There can be significant differences between the issues which have most priority for communities and those which have priority for health and other services. Creating space for communities to identify and articulate the priorities they deem more important requires health promoters to adopt the values of community development – respect, equity, inclusion, meaningful collaboration and hope. These align closely with the emphasis of the Whānau Ora approach – strengths-based, flexible, relational, aspirational and acknowledging the unique situation of each whānau. Te Pae Māhutonga identifies the creative tension between the two lead stars – Te Mana Whakahaere (autonomy) and Ngā Manukura (leadership) – communities need to be able to exercise agency whilst receiving the support they need.

At Community and Public Health, our health promoters use a project plan template based on the Te Pae Māhutonga framework. Best practice health promotion prioritises Tino Rangatiratanga as crucial to the advancement of Māori health aspirations. We prioritise Hauora Māori by:

- continued upskilling of health promoters to better understand Te Ao Māori, the history of Aotearoa and the systematic racism which has created current health inequity
- the continued development of work within Marae, supporting Mana Whenua to achieve their aspirations, and
- ensuring that all project plans are peer reviewed using the Te Tiriti Peer Support tool or similar to ensure that all work to support community action also promotes equity/ Ōritetanga.
- employing to specific Māori health promotion positions.

Community and Public Health liaise directly with local mana whenua organisations and Māori health providers (e.g. Mana Whenua Ki Waitaha in Canterbury and Poutini Waiora on the West Coast) to ensure equity is prioritised.

I trust that this satisfies your interest in this matter.

If you disagree with our decision to withhold information you may, under section 28(3) of the Official Information Act, seek an investigation and review of our decision from the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the West Coast DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

CANTERBURY AND WEST COAST HEALTH DISABILITY ACTION PLAN

A plan for improving the health system for people with disabilites and their family/whānau

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Foreward

The Canterbury and West Coast Health Disability Action Plan has been developed with people with disabilities, their family/whānau, providers of disability services and our Alliance partners from across the health system. The Plan will be implemented with the ongoing engagement of all these key stakeholders using existing processes, and through developing new ways of working together.

Contents

Developing our Disability Action Plan 2016 - 2026

In 2016 we began the development of a Canterbury and West Coast Health Disability Action Plan for 2016 - 2026.

The draft document, approved for wider consultation, was developed in line with the New Zealand Disability Strategy 2001 and the United Nations Convention on the Rights of People with Disability.

Disabled People Organisations are those recognised by the New Zealand Office of Disability Issues as representing the collective voice of people with disabilities. All such recognised groups have received and been invited to provide feedback on the draft Plan and the priority actions for 2016 - 2017.

Feedback was received via attendance at face to face meetings, forums and network meetings, and through written feedback. This feedback has been incorporated into the final Plan.

Development of the Plan included the review and incorporation of the key elements of core New Zealand documents relating to people with disabilities. Those core documents can be found in Appendix A.

The importance of the United Nations Convention on the Rights of Persons with Disability was consistently referred to by people with disabilities and their supports. These guiding principles are included as Appendix B.

For the purposes of this Plan, disability is defined according to the United Nations Convention on the Rights of People with Disability. It describes disability as resulting ‘from the interaction between persons with impairments

and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'
(UN General Assembly 2007).

This definition distinguishes the impairment or health condition from the restrictions on participation in society (e.g. unemployment due to discriminatory recruitment practices). These restrictions are not an inevitable consequence of the impairment; they are a result of unfair and avoidable barriers which results in many of the differences in health status between people with a disability and people without a disability. Using this definition the Plan is applicable to all people with disabilities regardless of age or the type of impairment.

The principles of partnership, participation and protection have been central to the development of the strategic objectives and priority actions in this Plan. These principles are consistent with the Treaty of Waitangi and demonstrate our commitment to working with Māori as treaty partners. This is especially important because Māori have higher rates of disability and poorer health outcomes than non-Māori. While there is a specific objective to achieve equitable outcomes for Māori within the Plan, each of the identified priority actions will have identified actions that are inclusive and culturally appropriate.

The Plan includes a Canterbury and West Coast position statement which addresses the critical issues relating to human and civil rights, treatment, and services and programmes for people with disabilities and their family/whānau. This statement is to inform our population and other agencies of the prevailing organisational view on key issues for people with disabilities.

Progress on achieving the stated objectives and priority actions in this Plan will be reported back to the disability community through a range of tactics including forums, electronic information and written communication. The Plan will be refreshed at least annually and priority actions will be developed and amended as necessary to ensure we continue to strengthen our engagement and inclusion of disabled people in the transformation of our health system.
*Refer to Appendix C for a summary of the consultation process and feedback.

Position Statement

Promoting the health and wellbeing of people with disabilities

Purpose

This position statement summarises our commitment to actions aimed at improving the lives of people with disabilities in Canterbury and on the West Coast. It will be used in making governance, planning, funding, and operational decisions. The Plan reflects this position statement and provides details of how it will be implemented.

Key points

We recognise that a significant proportion of the New Zealand population experience impairments, which may result in disability and disadvantage. In addition, the population is aging which will increase the number of people experiencing impairment. Accessibility and inclusion are rights to be protected. They are also catalysts for new ideas and innovation that can lead to better services and outcomes.

We make the following commitments to people with disabilities, their families and whānau, to:

1. Collect their feedback about the services we deliver
2. Understand their perspectives and needs
3. Deliver appropriate specialist, general and public health services, in a way that suits them
4. Uphold the rights of people with disabilities, and counter stigma and discrimination
5. Equip and upskill staff to meet their needs.

We will also incorporate the perspectives and needs of people with disabilities when we:

1. Contract other organisations to deliver services
2. Employ people with disabilities
3. Design and build our facilities
4. Monitor and report on how well we are doing, and plan for improvements
5. Partner with our communities to improve population health and wellbeing.

CANTERBURY AND WEST COAST HEALTH DISABILITY ACTION PLAN

2016 - 2026

Vision

The Canterbury and West Coast strategic vision for people with disabilites is of a society that highly values lives and continually enhances their full participation. Through this strategic vision, we will ensure that all people with disabilities experience a responsive and inclusive health system that supports them to reach their full potential by providing equitable access to services that focus on keeping people safe and well in their homes and communities.

Safety and Autonomy

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I am safe in my home, community and work environment. I feel safe to speak up or complain and I am heard. Those assisting me (professionals and others) have high awareness and I do not experience abuse or neglect.

Our Strategic Focus

People with disabilities and their family/whānau/carers are listened to carefully by health professionals and their opinions are valued and respected. Individuals are included in plans that may affect them and encouraged to make suggesti or voice any concerns by highly aware staff.

We will...

1. ***Integrate services for people of all ages with a disability***

   Work with people with disabilities and their family/whānau/carers to identify opportunities for achieving an integrated and co-ordinated approach between cross government services and local providers, so that infants/children and youth with impairments and adults with a disability, including those with age related conditions, can live lives to their full potential. (8, 10, 11 – These numbers relate to objectives in The NZ Disability Strategy 2001, see Appendix D).

2. *Improve health literacy*

Improve access to health information in a form that works for them. This includes access to their personal health information. Support is provided when required so that the individual/family/whānau can use information to manage their own health, share in decision making, provide informed consent, and make choices and decisions that are right for them and their family/whānau. (3, 8, 10, 11, 12)

3. *Offer appropriate treatment*

Offer interventions with individuals and their family/whānau which are evidence-based best practice, such as restorative, recovery focused approaches. (6, 7, 10, 11)

4. *Monitor quality*

Develop and use a range of new and existing quality measures for specific groups and services that we provide for people with disabilities, and develop systems and processes to respond to unmet needs e.g. consumer survey. (6, 10, 13, 14)

Wellbeing

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I feel dignity and cultural identity through a balance of family/community, mental, physical and spiritual wellbeing.

Our Strategic Focus

The wellbeing of people with disabilities is improved and protected by recognising the importance of their cultural identity. Health practitioners understand the contribution of the social determinants of health.

We will...

5. Measure and progress

Develop measures and identify data sources that will provide baseline information about people with disabilities who are accessing the health system. Using the Health System Outcomes Framework for each strategic goal, use data analysis to understand the population and evaluate progress towards improving health outcomes for people with disabilities. (1, 8, 13)

6. Improve access to personal information

Enable people with disabilities to have increased autonomy in making decisions that relate to their own health by developing processes that enhance communication e.g. access to their medical records through patient portals. People with disabilities will be given support to do this if they are unable to do this on their own. (2, 14)

7. Work towards equitable outcomes for Māori

Work with Māori people with a disability, whānau and the Kaupapa Māori providers to progress the aspirations of Māori people as specified in He Korowai Oranga, Māori Health Strategy. Apply our Māori Health Framework to all the objectives of this action plan in order to achieve equitable population outcomes for Māori with a disability and their whānau. (11, 13, 15)

8. Implement a Pasifika disability plan

Work with Pasifika people, their families and Pasifika providers to action the Ministry of Health National Pasifika Disability Plan 2014 - 2016 which identifies nine specific objectives for Pasifika people with a disability and ‘Ala Mo’ui: Pathway to Pacific Health and Wellbeing 2014 - 2018 which is aimed at improving culturally appropriate service provision with emphasis on improved access to Primary Care. Canterbury Pasifika Health Framework 2015 - 2018 will also be used as a core document to inform the work required. (12, 13, 15)

9. Develop better approaches for refugee, migrant and culturally and linguistically diverse groups

Work with people with disabilities and their families who are from different refugee, migrant and other culturally and linguistically diverse groups to identify and implement responsive processes and practices. This includes information being appropriately translated and an awareness by staff of how disability is viewed from different cultural perspectives. (9, 13)

Self Determination

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I make my decisions myself, based on my aspirations. I have access to information and support so that my decisions are informed.

Our Strategic Focus

People with disabilities contribute to their own health outcomes as they and their family/whānau receive the information and support which enables them to participate and influence at all levels of society.

We will...

10. Provide accessible information and communication

Promote and provide communication methods that improve access and engagement with people with disabilities such as using plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology, and expanding the use of sign language. (1)

11. Develop leadership of people with disabilities who have a role in the health system

Identify and support opportunities for leadership development and training for people with disabilities within the health system. This includes further development of peer support as a model of care for people with long term conditions. (5)

Community

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I feel respected for my views and my contribution is received on an equal basis with others.

Our Strategic Focus

People with disabilities experience equal workplace opportunities. The health system supports access, equity and inclusion for those living with impairments, their family/whānau, carers and staff.

We will...

12. Be an equal opportunity employer

Increase the numbers of people with disabilities being employed and supported in their role within the Canterbury and West Coast health system. (4) Develop and implement an appropriate quality tool for current employees who identify as having a disability, that can inform and identify opportunities to improve staff wellbeing. (2, 4, 10)

13. Increase staff disability awareness, knowledge and skills

Develop and implement orientation and training packages that enhance disability awareness of all staff, in partnership with the disability sector e.g. people with disabilities, their family/whānau/carers, disability training providers and disability services. (1)

14. Services and facilities are designed and built to be fully accessible

Services and facilities will be developed and reviewed in consultation with people with disabilities and full accessibility will be enhanced when these two components work together to ensure people with disabilities experience an inclusive health system that is built to deliver waiora/ healthy environments. (6)

Representation

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

Disabled People's Organisations (DPO) represent collective issues that have meaning for me (based on lived experience) in a way that has influence.

Our Strategic Focus

The collective issues that emerge from people with disabilities' lived experience of the health system are actively sought and used to influence the current and future Canterbury and West Coast health system.

We will...

15. Implement the plan in partnership

Work with the Canterbury and West Coast Consumer Councils to ensure a network of disability-focused consumer groups who are empowered to actively engage with health service providers and be partners in health service improvement and redesign. This network will support the implementation and evaluation of the Canterbury and West Coast Health Disability Action Plan. (1)

16. Promote the health, wellbeing and inclusion of people of all ages and abilities

Actively promote and influence at all levels of society, to address stigma and discrimination, increase universal design for public spaces, and advocate for a fully inclusive society. (1, 4, 13)

Priority Actions 2016 - 2017

Key

Will be progressed in 2016 - 2017

Will be progressed in the future as opportunities emerge

Safety and Autonomy

1. Integrate services for people with a disability of all ages

Objective

Work with people with disabilities and their family/whānau/carers to identify opportunities for achieving an integrated and co-ordinated approach between cross government services and local providers so that infants/children and youth with impairments and adults with a disability, including those in related to age related conditions, can live lives to their full potential.

Priority Actions

1.1 Map the pathway for people with disabilities and long term chronic health conditions (LT - CHC) to available services, and work with Disability Support Services and the Needs Assessment and Service Co-ordination Services to improve processes as people transition between health and disability services.

1.2 Work with other providers of services for children and youth to address the gap in service provision for respite for 0-19 year olds with complex needs and for those living in rural communities.

1.3 The agreed pathways across funders and service providers will be placed on HealthPathways.

1.4 Where gaps in service provision are identified, engage with the key stakeholders to identify opportunities and actions that can be progressed.

Outcomes

- Increased planned care and decreased acute care
- Decreased wait times
- Decreased institutionalisation rates.

2. Improve Health Literacy

Objective

Improve access to health information in a form that works for people with disabilities. This includes access to their personal health information. Support is provided when required so that the individual/family/whānau can use information to manage their own health, share in decision making, provide informed consent, and make choices and decisions that are right for them and their family/whānau.

Priority Actions

2.1 People will better understand their health status through the development of the electronic patient portal in collaboration with people with disabilities and relevant experts to ensure that when the electronic patient portal is implemented it is accessible to people with disabilities, including those who use communication devices.

2.2 With the involvement of people with disabilities and their family/whānau, explore the potential for HealthOne as the electronic shared record between primary and secondary care, as the repository for information that people with disabilities want communicated about how best to support them when they are accessing a health or disability service. Evaluate the potential effectiveness of this with the disability community.

Outcomes

- Improved environments support health and wellbeing
- Increased planned care and decreased acute care.

3. Offer appropriate treatment

Objective

Offer interventions with individuals and their family/whānau which are evidence based best practice and that these restorative, recovery focused approaches will result in people living lives to their full potential.

Priority Actions

3.1 Explore opportunities and identify how to support a timely response for people with disabilities and their families/whānau who require

- Aids to daily living
- Housing modifications
- Driving assessments.

Outcome

- Improved environments support health and wellbeing.

4. Monitor Quality

Objective

Develop and use a range of new and existing quality measures for specific groups and services that we provide for people with disabilities, and develop systems and processes to respond to unmet need e.g. consumer surveying.

Priority Actions

4.1 Trial the use of feedback at the time of treatment within an identified service and explore whether this can include asking people if they have a long term impairment.

4.2 The quality of life for people with disabilities while in Canterbury and West Coast long term treatment facilities is measured and monitored and that actions occur to address any identified areas of improvement quality actions occur.

4.3 Ensure people with disabilities and their family/whānau know about and understand the Canterbury and West Coast DHBs’ complaints and compliments process by describing the process in Easy Read format, placed alongside existing signage within wards and reception areas.

Outcomes

- No wasted resource
- The right care, in the right place, at the right time, delivered by the right person.

Wellbeing

5. Measure and Progress

Objective

Develop measures and identify data sources that will provide baseline information about people with disabilities who are accessing the health system. Using the Health System Outcomes Framework for each strategic goal, analyse data to understand the population and evaluate progress towards improving health outcomes for people with disabilities. (1, 8, 13)

Priority Actions

5.1 The disability population will be identified by developing an inventory of available data and potential data sources that can be used to better understand those with disability who access the health system.

5.2 Identify additional data collection required to inform further service improvement and ensure that baseline data are developed and used as measures of success. (These processes are inclusive of the actions specified for Māori and Pasifika in 7.1 and 8.1 of this plan).

6. Improve access to personal information

Objective

Enable people with disabilities to have increased autonomy in making decisions that relate to their own health by developing processes that enhance communication e.g. access to their medical records through patient portals. People with disabilities will be given support to do this if they are unable to do this on their own.

Priority Actions

6.1 The process for identifying the solution for a patient portal in primary care includes how the needs of people with disabilities will be met.

7. Work towards equitable outcomes for Māori

Objective

Work with Māori people with a disability, whānau and the Kaupapa Māori provider to progress the aspirations of Māori people as specified in He Korowai Oranga, Māori Health Strategy. Apply our Māori Health Framework to all the objectives of this Plan in order to achieve equitable outcomes for Māori with a disability.

Priority Actions

7.1 Develop high quality ethnicity data sets by having processes in place that enable all data collected and collated to capture information specific to the Māori population with a disability.

7.2 All the priority actions of this plan are to include culturally appropriate actions for Māori with a disability and their whānau, and that this promotes and supports whānau ora and rangatiritanga.

Outcome

- Delayed/avoided burden of disease and long term conditions.

8. Implement a Pasifika Disability Plan

Objective

Work with Pasifika people, their families and Pasifika providers to action the Ministry of Health National Pasifika Disability Plan 2014 - 2016 and ‘Ala Mo’ui: Pathway to Pacific Health and Wellbeing 2014 - 2018 which are aimed at improving culturally appropriate service provision with an emphasis on improved access to primary care. Canterbury Pasifika Health Framework 2015 - 2018 will also be used as a core document to inform the work required.

Priority Actions

8.1 Develop high quality ethnicity data sets by having processes in place that enable all data collected and collated to capture information specific to the Pasifika people with a disability. To develop and implement local responses appropriate to Canterbury and the West Coast.

8.2 Strengthen the culturally appropriate service responses, as Canterbury is one of the target DHBs working to achieve the four priority outcomes* of ‘Ala Mo’ui, and transfer strategies.

*1. Systems and services meet the needs of Pasifika people
2. More services are delivered locally in the community and in primary care
3. Pasifika people are better supported to be healthy
4. Pasifika people experience improved broader health determinants of health.

West Coast only: The West Coast will engage with Canterbury to identify and strengthen its service responses in line with ‘Ala Mo’ ui.

Outcome

Delayed/avoided burden of disease and long term conditions.

9. Develop better approaches for refugee, migrant and culturally and liguistically diverse (CALD) groups

Objective

Work with people with disabilities and their families who are from different refugee, migrant and other culturally and linguistically diverse groups to identify and implement responsive processes and practices. This includes information being appropriately translated and an awareness by staff of how disability is viewed from different cultural perspectives.

Priority Actions

9.1 Engage with the Migrant Centre and CALD Co-ordinator Resettlement Service to explore opportunities for including the needs of CALD people with disabilities in the way we communicate.

9.2 Use the local Canterbury and West Coast networks to establish communication processes to disseminate health and disability-related information and advice to CALD communities. There will be a focus on Asian communiti

Outcome

- Delayed/avoided burden of disease and long term conditions.

10. Provide accessible information and communication

Objective

Promote and provide communication methods that improve access and engagement with people with disabiliti e.g. use of plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology. Expand the use of sign language.

Priority Actions

10.1 Engage with Canterbury and West Coast communications staff to review health system websites and identify any parts of them which are not fully accessible for people who use communication devices.

10.2 Build on the partnership with the disability sector by having the Disability Strategy and a version of this Plan made available in Easy Read format.

10.3 Work with communications staff to identify which key communications will be made available in plain language and circulated to a network of disability organisations and key contacts.

10.4 Develop a Canterbury and West Coast policy on the use of sign language and access to interpreters.

10.5 Undertake a stocktake within the Divisions of the DHBs which will be aimed at identifying where people with lived experience are providing peer support to service users, and recommend areas for further development.

Outcome

- Improved environments support health and wellbeing.

11. Develop leadership of people with disabilites who have a role in the health system

Objective

Identify and support opportunities for leadership development and training for people with disabilities within the health system. This includes further development of peer support as a model of care for people with long term conditions.

Priority Actions

11.1 Engage workforce development training providers from the disability sector to identify opportunities to support people with disabilities and their family/whānau who are providing a voice for people with disabilities within the health system. This will include exploring options for appropriate leadership training.

Outcome

- Improved environments support health and wellbeing.

Community

12. Be an equal opportunity employer

Objective

- The number of people with disabilities being employed and supported in their role within Canterbury and West Coast health will increase.
- Develop and implement an appropriate quality tool for current employees who identify as having a disability, which can inform and identify opportunities to improve staff wellbeing.

Priority Actions

12.1 Work with Work and Income NZ and the Ministry of Social Development in achieving employment of people with disabilities

12.2 Develop and implement an affirmative action plan that will result in more people with disabilities being employed in the Canterbury and West Coast health system.

12.3 Explore how to use the Staff Wellbeing Survey to ask staff how Canterbury and the West Coast DHBs can continuously improve their support of people with disabilities employed in either DHB.

Outcome

- Understanding health status and determinants.

13. Increase staff disability awareness, knowledge and skills

Objective

Develop and implement orientation and training packages that enhance disability awareness among staff, in partnership with the disability sector e.g. people with disabilities, their family/whānau/carers, disability training providers and disability services.

Priority Actions

13.1 Identify Disability Champions across our health systems. These champions will form a network that will disseminate disability-related information and resources and be an essential part of implementing the priority actions.

13.2 Work with the Learning and Development Unit and professional leaders to identify relevant education programmes that are already developed and offered by disability-focused workforce development organisations e.g. Te Pou.

13.3 Work with the Learning and Development Unit and professional leaders to progress the development of an eLearning tool that can then be placed on the healthLearn website and promoted for staff.

West Coast only: The West Coast will work with Canterbury to ensure applicability to the West Coast.

13.4 Training packages are developed and implemented in partnership with Māori people with disabilities and their whānau, to ensure cultural competency is inclusive of any training delivered.

Outcomes

- Delayed/avoided burden of disease and long term conditions
- Access to improved care.

14. Services and facilities are designed and built to be fully accessible

Objective

Services and facilities will be developed and reviewed in consultation with people with disabilities and full accessibility will be enhanced when these two components work together to ensure people with disabilities experience an inclusive health system.

Priority Actions

14.1 Site Redevelopment and Communications will work together to develop a communication plan for the disability community to receive quarterly updates on the development of Canterbury and West Coast health facilities. This will be in formats that are user-friendly for those with disabilities.

14.2 The communication plan will include information on how people with disabilities and their family/whānau can provide feedback and input when they have or potentially will experience barriers to access.

14.3 We will engage experts at key stages of the design, build and fit out of the building or rebuild of facilities e.g. barrier-free and dementia friendly.

Outcomes

- Delayed/avoided burden of disease and long term conditions
- Community capacity enhanced
- Access to care improved.

Representation

15. Implement the Action Plan in partnership

Objective

Work with our Consumer Councils to ensure a network of disability focused consumer groups who are empowered to actively engage with health service providers and be partners in health service improvement and re-design. This network will support the implementation and evaluation of the Canterbury and West Coast Health Disability Action Plan.

Priority Actions

15.1 Establish a Disability Steering Group that has members from the disability community who will provide leadership in the implementation of the plan.

15.2 A communication plan is developed and actioned, and this includes regular engagement with the disability sector including people with disabilities, their family/whānau and Disabled Peoples Organisations.

15.3 Monitor progress against the priority actions to be undertaken quarterly and communicated to the sector as a key part of the communication plan.

15.4 The priority actions will be refreshed annually within the health system and the disability sector with engagement and input from the people with disabilities, family/whānau and the wider disability sector.

Outcome

- Building population health, capacity and partnerships.

16. Promote the health, wellbeing and inclusion of people of all ages and abilities

Objective

Actively, promote and influence at all levels of society, to address stigma and discrimination, increase universal design for public spaces, and advocate for a fully inclusive society.

Priority Actions

16.1 Community and Public Health for both DHBs continues to co-ordinate submissions on behalf of Canterbury and West Coast DHBs. However, they will use the Plan's underpinning principles to inform their submissions.

16.2 In conjunction with Disabled Peoples Organisations, Disability Support Services, the Ministry of Social Development and the Ministry of Education, set an annual seminar which presents new developments and initiatives for people with disabilities.

Outcomes

- Improved environments support health and wellbeing
- Access to improve care.

APPENDICES

Appendices

APPENDIX A

CORE DOCUMENTS

The core documents referenced in the development of this Plan include:

- New Zealand Disability Strategy 2001
- New Zealand Disability Action Plan 2014 - 2018
- New Zealand Disability Action Plan 2014 - 2018. Updated December 2015
- He Korowai Oranga, Māori Health Strategy 2014 - 2018
- Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Service 2012 - 2017
- Faiva Ora National Pasifika Disability Plan 2014 - 2016
- Ala Mo'ui: Pathway to Pacific Health and Wellbeing 2014 - 2018
- United Nations Convention on the Rights of People with Disabilities (ratified by New Zealand 2007)
- Second Report of Independent Monitoring Mechanism of the Convention of the Rights of Disabilities, August 2014
- United Nations Convention on the Rights of the Child (ratified by New Zealand 2008)
- Human Rights Act 1993

APPENDIX B

GUIDING PRINCIPLES OF THE CONVENTION

There are eight guiding principles that underpin the Convention:

1. Respect for inherent dignity and individual autonomy, including the freedom to make one's own choices and be independent
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of a diverse population
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

APPENDIX C

CONSULTATION PROCESS AND SUMMARY OF FEEDBACK

Recommended amendments to the Draft Canterbury and West Coast Health Disability Action Plan

All feedback received to date, both written and verbal, has endorsed the vision and objectives of the Plan with some recommended amendments. The respondents stated that the principles of the New Zealand Disability Strategy 2001 of participation, partnership and protection of the rights of people with disabilities were present throughout the document.

Respondents unanimously commended the development of a Disability Action Plan and the process undertaken to seek the opinions of people with disabilities, their family/whānau and other key stakeholders on the Plan and the priorities for implementation over the next two years.

The consultation process has resulted in a number of recommendations on how the draft Plan could be strengthened in terms of the language used, and by broadening the scope of some of its stated goals.

These include:

1. The New Zealand Disability Strategy 2001 is considered an important landmark document but it is fourteen years old and requires updating. It is recommended that, in addition to identifying the alignment with the New Zealand Disability Strategy, each objective should also be aligned with the Articles of the United Nations Convention on the Rights of People with Disabilities and that the language used is consistent with the relevant articles.
2. Include with the dissemination of the Plan the definition of disability we used, and the Position Statement.

3. The draft Plan is primarily adult-focused and it is recommended that the United Nations Convention on the Rights of the Child (UNCROC) be included as a core document to inform the development of the final Plan and the priorities for action.
4. The Plan needs to place more direct emphasis on addressing the health disparities for people with disabilities compared with those people without a disability. It is recommended that the need to have a targeted approach to addressing the barriers of access to healthcare is explicitly stated.
5. Feedback from Māori Advisory Groups both in Canterbury and on the West Coast was that for each of the strategic goals there needs to be inclusion of what would be an appropriate objective for Māori.
6. Wherever possible the language is amended to ensure it is explicit that the objectives are inclusive of all people with disabilities. This will require careful consideration, as feedback has also complimented the Plan on recognising the diversity of the people with disabilities by identifying the different population groups. There was consistent feedback that the Plan needed to reference Asian people specifically.
7. Outcomes need to be identified for each objective including how their achievement will be measured. Measures will form part of the work plans that are developed.
8. Amend the vision statement to include a statement about supporting people with disabilities to reach their full potential.
9. Amend the draft Objective 4 so that the goal positively promotes the use of only appropriate treatments rather than a goal that is more about stopping inappropriate treatments.
10. An additional objective needs to be added under the heading of an Equal Opportunity Employer which states health system employers will take affirmative action to increase the number of people with disabilities employed within the organisations.

11. Add into the Strategic Goal for Safety and Autonomy the commitment to addressing stigma and discrimination.
12. To include families/whānau as a central part of the Plan, including the identification of needs, gaps in services and how to implement and monitor progress.
13. Amend draft Objective 14 that accessibility is more than just buildings and facilities, so that this objective reads as accessible services and buildings.
14. Significant concern was expressed at the number of high level strategic objectives contained in the Plan, but it is less clear how these will be achieved. There was support for identifying the priorities for action and concentrating on progressing a limited number of objectives to avoid the risk of spreading resources too thinly.
15. Feedback on the consultation process showed appreciation for the plain language version being available electronically to networks within the disability community. It has been recommended that the final approved version also be made available in other formats such as large print and on CD.
16. There was concern that those individuals who don’t belong to any specific disability groups did not have the opportunity to comment. Those within the disability sector recognise that reaching people with disabilities is one of the significant challenges within the sector, as they are often an invisible part of the community due to the very barriers this Plan has been developed to address. Further planning and ongoing engagement about how to reach this group is required.
17. It is recommended that a process for amending the Plan should be put in place to ensure opportunities for improving the Plan or priorities for action that have not yet emerged, can be added at a later date.
18. The Plan requires ongoing engagement with people with disabilities and their supports on the emerging issues for them. As a minimum, an

annual refresh of the priority actions and any amendment to the overall strategy would occur.

Identifying the Priorities for Action

The key themes and opportunities for priority action

The following areas have been consistently raised by those providing feedback on the priority areas for action:

1. Accessibility of buildings and facilities

- Increasing engagement – providing regular updates in the form of a newsletter, written in a way that is accessible for people with disabilities.
- Identifying and promoting the process for people with disabilities to provide feedback and input when accessibility is impacted e.g. parking, after hours security, etc.
- Designing above code – having experts audit and make recommendations at key stages of the design and fit-out of new buildings and rebuilds e.g. barrier-free, dementia-friendly.

2. Promoting disability awareness

- Develop a network of Disability Champions at a service level across the Canterbury and West Coast health systems. These people will be the conduit for disseminating disability-related information and resources available to staff when working with people with disabilities.
- Work with the Learning and Development Unit and professional leaders of the Canterbury and West Coast health system to identify appropriate and relevant education programmes that are already developed and offered by disability-focused workforce development organisations e.g. Te Pou. This is initially envisaged as an e-learning tool available on healthLearn. Any education tool developed will have input from people with disabilities and their family/whānau.

3. *Communication*

- The use of plain language, Easy Read and formats such as large print will be promoted and expanded for all forms of health information available across the health system.
- Appropriate formats are used when disseminating information to the Canterbury and West Coast population so that it is readable by communication devices.
- Health Passports are a mechanism where people with disabilities can have their individual needs specified. Identify, within the growing suite of information technologies, the best way this information can be included and made available when people with disabilities are accessing any part of the health system e.g. through HealthOne.
- The Patient Portal is being developed in a format that meets the needs of people with disabilities.
- Making information available in different languages, including increased use of sign language interpreters, is also a priority.

4. *The Canterbury and West Coast health system as employers of people with disabilities*

- Under the heading of an Equal Opportunity Employer state that the Canterbury and West Coast health system employers will increase the numbers of people with disabilities being employed and supported in their role within Canterbury and West Coast health.

5. *Specific feedback which related to particular population groups*

- Ensure timely access to equipment that is necessary to enable people to live lives to their full potential.
- Work together with Disability Support Services to develop improved access to appropriate respite opti for children with complex conditions.
- Understand and improve the experience of health services for people with learning disabilities

- Work to achieve equitable outcomes for Māori.
- Work with Pacifika people, their families and Pacifika providers to improve engagement.

6. Other Opportunities

- Establish a Disability Action Group that has a membership of people with disabilities and their family/whānau who can contribute to progressing the identified actions.

APPENDIX D

OBJECTIVES FROM THE NEW ZEALAND DISABILITY STRATEGY 2001

The objectives are to:

1. Encourage and educate for a non-disabling society
2. Ensure rights for disabled people
3. Provide the best education for disabled
4. Provide opportunities in employment and economic development for disabled people
5. Foster leadership by disabled people
6. Foster an aware and responsive public service
7. Create long-term support systems centred on the individual
8. Support quality living in the community for disabled people
9. Support lifestyle choices, recreation and culture for disabled people
10. Collect and use relevant information about disabled people and disability issues
11. Promote participation of disabled Māori
12. Promote participation of disabled Pacific peoples
13. Enable disabled children and youth to lead full and active lives
14. Promote participation of disabled women in order to improve their quality of life, value families, whānau and people providing ongoing support.

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

FOR ALT RECOMMENDATION/GUIDANCE

TITLE	**Update on the Transalpine Disability Action Plan**
PREPARED BY	Kathy O'Neill, Team Leader Planning and Funding, Canterbury and West Coast DHB's
DATE	9 August 2018
ALT Action	To provide advice on future Governance Structure and identify opportunities for wider implementation

1. BACKGROUND

In March and April 2016 the West Coast and Canterbury DHB Boards approved the Transalpine Strategic Disability Action Plan 2016 -2026 and subsequently approved in September 2016 that the governance structure would sit within the Alliance Leadership Team.

It was envisaged that this approach would expand the scope of the plan to the wider health system not just the DHB's. Implementation of the plan would occur wherever applicable, using the existing alliance structure of the Workstreams. It is important to note however that this did not mean that the implementation and evaluation of the Action Plan would sit solely with ALT as many of the objectives require progressing within the DHB.

This report provides ALT with an update on the progress of achieving the objectives of the Transalpine Health Disability Action Plan for the DHBs and the wider health system.

2. SUMMARY OF THE PLAN

The Disability Action Plan has been designed to recognise that many of the objectives require substantial and sustained focus and effort to achieve the transformational change required. Therefore the plan has three distinct and essential component; the strategic vision and position statement; the overarching objectives for the 10 year period of 2016 -2026 and priority actions for a two year period to 2018 (that are necessary to begin to achieve the overarching objectives of the plan).

All of these components were developed following consultation with people with disabilities, their families and providers of services for people with a disability in Canterbury and the West Coast districts.
The priority actions are focused into four main areas:

- Employing more people with disability
- Improving disability awareness for all staff
- Accessible buildings and services
- Improving communication – content, technology and language style

A summary update is provided on each of these areas and identifies areas for future work.

3. HIGHLIGHTS

Improving disability awareness for all staff

There are currently four disability focused modules on the eLearning website, Healthlearn which is available to all West Coast DHB, Primary Care and NGO staff. Two of the modules are mandatory for all DHB staff (Health and Disability Consumer Rights and Open Disclosure) and two are voluntary (Working with People with an Intellectual Disability and Disability Responsiveness, Working with People with a Disability). The later module has been added in the last six months in a purposeful effort to meet this objective of the action plan.

There are plans to improve the modules offered on Health learn and to expand the training being offered beyond this platform as it is known that some staff groups are less likely to access Healthlearn or find the learning method appropriate for their needs. This work is being led by People and Capability who are forming a Canterbury and West Coast Diversity Moderation Group to review and recommend content of modules and also to identify other training opportunities where disability awareness training can be added or enhanced.

This group will include Māori and Pacific members along with other members who will bring different perspectives that reflect our diverse communities. It is likely that their role will expand to include elements of disability awareness to other learning modules - not necessarily those that are only disability focused. The development of the Diversity Moderation Group forms part of the 2018/19 District Annual Plan and will require implementation and evaluation during the coming 12 months.

Accessible building and services

a. Accessible Buildings

The following summary has been provided by Mark Newsome, West Coast DHB

“The new hospital and IFHC has been built to comply with New Building Standard, NZ building code, Grey District Council requirement and takes into account the Australasian Health Facility Guidelines.
Access to the Hospital and IFHC is via accessible pathways and doorways. Patient spaces and rooms have been designed and built with accessibility in mind in regard to room sizes, bathrooms and toilets, along with corridor widths and doorways, and car parking. Wayfinding follows the 2015 DHB Strategy and Guidelines which accounts for the different needs of people with a disability or temporary impairment”.

Further to this consideration needs to be given to furniture and fittings which can transfer an accessible building footprint into a layout that is not accessible for many of our community. Advice has been provided to Site Development to include an audit as soon as is practical by those recognised as specialists in the area of disability related accessibility, Be Accessible of Barrier Free.

b. West Coast Accessibility Coalition – Accessibility Strategy

Over the last year members of the West Coast DHB and a range of NGO’s along with Councils, have formed a West Coast Accessibility Coalition which has developed a draft Strategy and Action Plan for an accessible West Coast.

The Coalition has members represented from across the district including Council, local health and social service providers. The draft Strategy is to be circulated for community consultation following the Coalitions next meeting on 9 August 2018. The DHB will be asked for their feedback once the Strategy and action plan are finalised.

In the future it is hoped by the current Coalition members that the DHB and other health providers will formally identify their membership to be part of the Coalition and that they will become a signatory to the West Coast Accessibility Strategy, which will commit to having actions to include accessibility as a priority for their organisations

Employing more people with a disability

During the consultation phase in the development of the Transalpine Disability Action Plan the need for DHB’s to be a leader in employing people with a disability was one of the most frequently expressed priorities for the DHB to action. People and Capability (P&C) who are a Division which cover both Canterbury and the West

Coast DHB's along with the Canterbury DHB Disability Steering Group have been identifying ways to improve performance in this area.

There are several projects underway which will be transferable to the West Coast once they are operational.

a. Project Search

Project Search is an internationally successful programme which started in a hospital setting in the United States. Project Search is targeted at school leavers (up to age 24 years) with a disability who enter an internship in employer organisations that adopt the Project Search framework. The framework supports both the intern and the employer for on the job training and experience e.g. it is a mixture of skill development and work experience and uses established funding streams to pay the intern a meaningful wage. The ultimate goal is that the internship will lead to permanent employment in either the host organisation or in one similar.

Project Search is commencing in Canterbury DHB through a collaboration between the DHB, CCS Disability Action and the Blind Foundation. The Canterbury DHB will be the host employer organisation and has employed a Project Search Co-ordinator to engage with managers, ensure processes are in place to support the intern within the Project Search framework and to work with schools etc. to identify suitable interns.

CCS Disability Action and the Blind Foundation have purchased the license for Project Search so are sponsors of the programme and are invested in achieving successful outcomes for the interns. As all parties in the collaboration are transalpine it is anticipated that Project Search could become a programme offered to school leavers on the West Coast as well. The Canterbury DHB Disability Steering Group is hoping the Project Search programme can be widened to include more than school leavers.

b. West Coast DHB as an employer

Members of the Canterbury DHB Disability Steering Group have identified a range of resources that will be used to inform hiring managers (within the Canterbury and West Coast DHB's) on appropriate approaches and processes that will provide greater equity for people with a disability who seek and are successful in being employed by the DHB. These resources will be developed into a training module and it is hoped that this training will become mandatory for all managers within the DHB's who have the responsibility to recruit new staff. This resource would be made available more widely.

Improving communication – content, technology and language style

a. Communication Plan

A Transalpine Disability Communication Plan is identified as a priority in the Action Plan. Regular communication to the disability sector in Canterbury on all relevant disability related issues and events is occurring however implementation on the West Coast has been delayed due to a lack of a dedicated local resource. It is anticipated this will be resolved very soon.

b. Accessible Website

The DHB's Communications Team identified that the Canterbury and West Coast DHB websites were not accessible for people with a range of sensory and cognitive disabilities. The Executive Management Teams approved a review of these sites and this was completed by the Blind Foundation. Based on the recommendations the websites have been/are being upgraded to meet accessibility standards.

c. Easy Read

Transferring documents into easy read also forms part of the Disability and the Communication Plan. The most efficient and sustainable way to achieve this is to train members of the Communications team on how to transform standard text into full easy read. This action requires further consideration before progressing.

Additional Points of Note

- The Director of Quality and Patient Safety Canterbury and West Coast DHB formally recommended to the Health Quality and Safety Commission that the identification of whether the person has a disability should be included as part of the patient demographic information collected on the Patient Satisfaction Surveys. The rationale was that we have no way of identifying whether people with disabilities and their families have a different experience to those without a disability. The recommendation has been agreed by the Commission and they have included this in their work plan.

- The Ministry of Health is currently seeking submissions on changes to the NHI. One element being proposed is that disability status is collected as part of the other demographic information. The outcome of consultation will be of great interest as currently being able to understand the journey and experience of the health system for people with a disability generally relies on 'people stories'. While these narratives are powerful, the absence of qualitative data makes systems planning and evaluation for people with a disability more challenging.
- A priority action in the West Coast Canterbury Health and Disability Action plan is to develop a Canterbury and West Coast Policy on the use of sign language and access to interpreters (10.4, page 23). The Corporate Quality and Patient Safety Team has assisted in reviewing the current Clinical Management – Booking and requesting interpreters and an updated draft is currently out for consultation.
- The Work Plans of the Work Streams and Service Level Alliances do not always evidence a focus on disability however, as part of the Alliance Leadership Teams four key lenses, where opportunities present the needs of people with disabilities is included.
  For example following a question from the West Coast Advisory Committee, a review of the B4 School Check (B4SC) process was undertaken with the B4SC Coordinator, Planning & Funding and the Service Manager, Ministry of Education (MoE). The review sought to understand the current process for families invited to a B4SC where the child has a disability that might affect the way a B4SC is completed for them. There was agreement that an additional question would be asked at the time of initial contact to draw out any considerations. It was also agreed that the MoE services could approach these families to seek consent to share information with the B4SC team regarding how best to support access to a B4SC. This might be arrangement to complete the check at home or at a time that works better around other needs or in an environment that is quieter than the one-stop shop model often provides. It is anticipated that this two-sided approach will encourage more families to take up a B4SC as well as making the experience a positive one.
- The priority actions are currently being refreshed with a survey to the disability community and other key stakeholders to be circulated in the next few months of 2018. This refresh will need to consider the wider impact of national initiatives such as DSS System Transformation and different priorities identified by DSS such as access to respite services.

5. CONCLUSION

While there has been progress against each of the four priority areas it is timely to consider the current governance and implementation structure. Despite limited disability focused actions it is recommended that ALT remains as a part of the governance structure. Opportunity clearly exists for further engagement with ALT on the achievements to date and how we can better engage with the Workstreams.

Given there is also work occurring in Canterbury through the Disability Steering Group that is likely to be transferrable to the West Coast, it seems prudent to explore whether having members from the West Coast on the Steering Group will invite earlier engagement in projects and processes. There is also the potential to have those members engaged in earlier conversations about approaches and projects being developed and whether they are appropriate for implementation on the West Coast. It is proposed both these elements are worked through in more detail as a part of a refresh of the plan and that this comes back to ALT for their endorsement following consultation. Please note that this update and questions posed here, is being repeated to the DHB Board Committee, West Coast Advisory Committee and the Consumer Council.

Draft Accessible Te Tai Poutini West Coast Strategic Plan

2018 - 2021

Vision

The West Coast is an enabling and inclusive society.

Mission Statement

Working together to make the West Coast safe and accessible for everyone

Foreword

We are thrilled to introduce the Accessible Te Tai Poutini West Coast Strategic Plan.

The West Coast is a people-centred community and we want to encourage and enable everyone to contribute and participate. However, for an increasing proportion of our population, participation in society can be limited by physical and social environments that are not designed to cater for a diversity of needs and abilities.

This Plan's purpose is to meet the objectives of accessibility specified in Article 9 of the United Nation's Convention on the Rights of People with a Disability. It focusses on improving inclusion, opportunity and independence through improved accessibility. It aims to support people and partnerships to reduce and eliminate social and physical barriers in facilities, services and programmes to enable participation, and advocates for availability of communications including communication technologies and systems

We believe this Plan will influence West Coast-based organisations and services to keep accessibility in mind at all times.

All West Coasters and visitors will benefit from a more Accessible West Coast.

Poipoia te Kakano
Kia puawai
Nuture the seed and it will blossom

Buller District Mayor

Grey District Mayor

Westland District Mayor

Chair Regional Council

Chair West Coast District Health Board

Te Runanga o Ngati Waewae

Te Runanga o Ngati Mahaki Makaawhio

Coalition members

Introduction

Development of the Accessible Te Tai Poutini West Coast Strategic Plan has received support and input from a wide catchment of interested groups and community members including the disability sector, older person's communities, councils, and health and community services (Appendix 1).

A West Coast wide coalition was formed in late 2016 to bring together a wide range of organisations and stakeholders to develop the Strategic Plan. The Coalition is tasked with influencing change through six key themes including; advocacy and influence, acting as a watch-dog, having a collective voice, listening and understanding, storytelling, and monitoring. See Appendix Three for the Coalition's Terms of Reference.

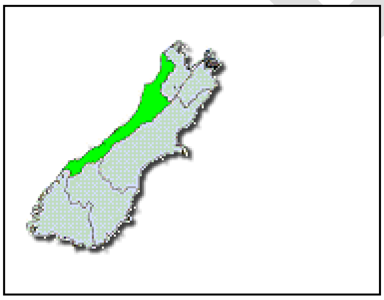
Background

Providing accessible services, communication channels, transport, buildings and public spaces can make Te Tai Poutini West Coast (the Coast) a more inclusive place for everyone. Improved accessibility will improve lives, enhance diversity and help the region remain attractive to residents and visitors of any age and ability.

Adopting the principle of universal design allows us to consider access for everyone. This includes people with disabilities, parents with children in pushchairs, and older people with mobility and/or sensory impairment.

We want to build a reputation as an inclusive and socially responsible region that is accessible, safe, and easy to get around. This Plan will guide activities to enhance people's independence, and ability to participate, engage in and benefit from key services.

Te Tai Poutini West Coast



At the 2013 Census the Coast was home to a resident population of 32,134 people, less than 1% of the total New Zealand resident population.

The population is spread across a large geographical area with a high proportion of people living in highly rural/remote areas. Fewer West Coasters have access to a motor vehicle than other New Zealanders, while 3.4% of West Coast households have no telecommunication systems; this is the highest proportion of any region in New Zealand.

The population is expected to remain static or decline in the short term however the proportion of people 65 years of age and over is expected to increase.

Population percentage 2013 Census	Maori % West Coast	Maori New Zealand	Total West Coast	Total New Zealand
Under 15	33.2	33.8	19.1	20.4
65 and over	6	5.4	16.1	14.3

The West Coast region has the lowest population percentage of Māori: 9.1% compared with 14.11% nationally. From 2006 to 2013 the region has become more ethnically diverse (Pacific up 67%, Asian up 71%, MELAA up 136%), with over 60 nationalities currently residing here.

The Coast has a higher proportion of people 65 years of age and over and a lower proportion of people under 15 years of age compared to total New Zealand. While Māori population percentages for these age groups closely reflects that of Māori in New Zealand, Māori on the Coast are significantly younger than the total West Coast population with just over 33% aged under 15 years compared to 19.1% for total West Coast. Only 6% of the West Coast Māori population are aged 65 and over compared to 16.1% of the total West Coast population.

Mana whenua over the Coast is held by the two Poutini Ngāi Tahu hapu: Ngāti Waewae in the north and Ngāti Mahaki Makaawhio in the south. Poutini Ngāi Tahu comprises about 60% of the Māori population. The remaining 40% are members of iwi from throughout New Zealand.

According to the 2013 Disability Survey 27% of people on the Coast live with a disability compared with 24% of the New Zealand population. Just over half of all people living with a disability have more than one type of impairment.

Development of the Strategic Plan (Workshops)

A series of Community Collaborative Workshops was held across the Coast during 2016-17. Participants were tasked with identifying ‘What’s working well?’, ‘What’s not working so well’, and ‘Where to next?’ in relation to accessibility on the Coast for both residents and visitors.

From the workshops the following list of strengths and weakness were identified:

Areas of Strengths:

- The Coast is a made up of many small places; people often know each and work together using established networks and relationships to get things done.
- Community flexibility and resilience is very effective locally.
- There is an inclusive attitude toward addressing disability with community projects such as new walkways and cycleways.
- Some infrastructure (eg housing, transport schemes; St Johns, Westland Taxi Scheme & Total Mobility) is in place to support accessibility however it is not necessarily appropriate or suitable.
- Stakeholders are close to decision making processes and end-users.

Areas of Weakness:

- Buildings and other infrastructure (footpaths, road crossings, shopping areas and green spaces) are generally old and were designed when lower access standards applied so do not support good accessibility.
- Remoteness from experts and agencies that specialise in, and can advocate for, Disability and Accessibility issues.
- Rurality, limited public transport and lack of inter-region connectivity affects the ability to appropriately meet the needs of people with disability.
- A lack of consistent health resources.
- An insular and silo-ed approach to resources and activities can result in a fragmented, non-collaborative way of working.
- A lack of effective leadership and/or strategic direction means good intentions are usurped or lost by established networks, reinforcing the silo effect.
- Limited awareness and understanding of people experiencing disabilities in the community

Three priority areas were decided upon for future focus:

- Ease and safety of travel across and around the West Coast
- Access to information, services and venues on the West Coast
- Community participation in decision making on access issues.

Principles

Actions within this Strategic Plan are underpinned by the commitment to ensure the Coast is an inclusive and universally accessible region where all residents and visitors can fully participate in community and civic life. The Strategic Plan supports outcomes for places, people and partnerships that will:

- Reduce and eliminate social and physical barriers in our facilities, programmes, services, communication and information streams
- Provide best-practice examples in planning for universal access and service delivery as well as in the development and implementation of policies
- Provide awareness and development opportunities that will help enhance the community's understanding and delivery of this Plan
- Strengthen advocacy and partnerships within government departments and other community stakeholders to address and eliminate barriers to participation
- Reinforce a culture that celebrates the diversity of all people who live, work, and study in or visit our region.

These outcomes are framed in the following six groupings, each with their own particular goal and specific actions:

1. Social, sports and recreation
2. Civic Engagement and decision making
3. Ease of travel across and around the Coast
4. Arts and culture
5. The built environment and open spaces
6. Economic development

Action Plan

The Coalition will work towards creating vibrant, diverse and inclusive communities where people feel safe, valued, welcomed and respected. The following activities will enhance the Coast's reputation as an inclusive and socially responsible region that is accessible, safe and easy to get around.

The Action Plan is a starting point for coordinating current and future work. It makes recommendations of key actions for the Coalition to implement over the next three years. It is expected that members of the Coalition will have their own organizational action/ implementation plan to assist in achieving the Strategy's goals.

The Coalition will effect change using the following methods:

- Advocacy & influence
- Acting as a watch-dog
- Having a collective voice
- Listening and understanding
- Story telling
- Monitoring

The Action Plan is consistent with the following documents:

- New Zealand Disability Strategy 2016- 2026 (NZDS)
- United Nations Convention on the Rights of Persons with Disabilities 2007 (Disability Convention) – ratified in New Zealand in 2008.
- Te Tiriti o Waitangi 1840
- Grey District Council's Equity and Access for People with Disabilities Policy (including older persons)

These foundation documents and the Action Plan are based on the social model of disability and on a vision of a fully inclusive society that protects and promotes the human rights of people with disabilities. The Action Plan will help deliver on several of the following NZDS outcomes:

Education
We get an excellent education and achieve our potential throughout our lives.

Employment and economic security
We have security in our economic situation and can achieve our full potential.

Health and wellbeing
We have the highest attainable standards of health and wellbeing.

Rights protection and justice
Our rights are protected; we feel safe, understood and are treated fairly and equitably by the justice system.

Accessibility
We access all places, services and information with ease and dignity.

Attitudes
We are treated with dignity and respect.

Choice and control
We have choice and control over our lives.

Leadership
We have great opportunities to demonstrate our leadership.

The **Disability Convention principles** as set out by the United Nations Convention on the Rights of Persons with Disabilities 2007 are:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons.
- Accessibility, and full and effective participation and inclusion in society.
- Non-discrimination, respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.
- Equality of opportunity, and between men and women.
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

The Action Plan is also consistent with the Treaty of Waitangi 1840, Universal Declaration of Human Rights 1948, New Zealand Sign Language Act 2006, and New Zealand Building Act 2004.

How will we know when the West Coast is an accessible region?

The Plan will be effective when people are able to carry out community and civic activities without being impeded by social, physical and cultural barriers, and residents and visitors have:

- Ready access to information they require e.g. transport options, business and social services, employment, entertainment, hospitality, events, education, recreation, etc
- Reliable access to services and amenities such as accessible transport, and business, social, recreational and cultural services
- Easy access to buildings, green spaces and other shared public space.

The Plan will be monitored and reviewed annually through a variety of means including the meeting process, with outcomes being reported to the community as part of the Coalition's annual report.

Social, Sports and Recreation

Strategic Goal: Participation in social, sports and recreational opportunities is accessible to all.

Everyone should be able to participate in and enjoy life as they choose and facilities, programmes and events on the Coast should offer a range of options to encourage and support participation.

Outcome: Everyone has access to information and resources to enable them to participate in social, sports and recreation opportunities of their choice.

Civic engagement and decision making

Strategic Goal: Living with impairment is no barrier to participation in civic activities and involvement in decision-making.

Everyone has a right to be involved in civic life and decisions that affect them.

Outcome: People from diverse communities on the Coast are able to participate in civic activities and decision-making.

Ease of travel across and around the West Coast

Strategic Goal: Transport networks on the Coast are increasingly more accessible and inclusive.

Transport is essential in supporting people to do what they want and/or need to do. It supports people to be involved in education, work, recreation and social activities that enhance their quality of life and supports their independence.

Outcome: People are able to use a method of transport that suits them and the journey they are making.

Arts and Culture:

Strategic Goal: Participation in the cultural life of the Coast is accessible to all.

Rationale: Involvement in arts and culture contributes enjoyment, learning and the development of a sense of identity. Creating opportunities for inclusion in cultural and creative programmes and events requires accessible facilities and accessible programmes.

Outcome: People are supported to contribute to and participate in cultural and creative programmes and events of their choosing.

The built environment and open spaces:

Strategic Goal: Everyone is able to access, use and enjoy public spaces.

Access to and use of public spaces supports business, education, and health and recreation activities and is therefore important to all of us. Incorporating the principle of universal design will ensure these spaces are accessible to all.

Outcome: The built environment and open spaces on the Coast are accessible to all who need or want to use them.

Economic Development:

Strategic Goal: Everyone is able to access, use and enjoy business, education and employment opportunities.

A diverse workforce will support the future growth of the Coast.

Outcome: Education, business and employment opportunities are accessible to all.

Appendix 1: List of agencies & organisations involved in the process.

Autism New Zealand
Blind Foundation
Brain Injury Association
Buller District Council
Buller REAP
Cancer Society
Canterbury District Health Board
CCS Disability Action
Community and Public Health
Department of Conservation
Department of Internal Affairs
Grey District Council
Grey Power
Ministry of Social Development
New Coasters
New Zealand Police
PACT Group
Poutini Waiora
Potikohua House- Number 37, Westport
Presbyterian Support Services
Sport Canterbury West Coast
Te Hā o Kawatiri
Te Runanga o Makaawhio
Te Runanga o Ngati Waewae
West Coast Disability Resource Service
West Coast District Health Board
West Coast Primary Health Organisation
West Coast Regional Council
West Coast Stroke Support Group
Westland District Council
West REAP

Special thanks to the following individuals:
Brian Ericksen: Taranaki Disabilities Information Centre Trust
Elinor Stratford MNZM: New Zealand Federation of Disability Information Centres

Appendix Two: Explanation of key terms

Accessibility
A general term used to describe the degree to which a product, device, service, or environment is available to as many people as possible. In this context it refers to the removal of barriers that prevent people with impairments participating fully in community and civic life.

Accessibility is a very broad term covering all aspects of participation and includes: getting around, democratic activities, technology, sources of communication and media to ensure information. Designing products and services that are accessible and benefit everyone, which includes families with young children as well as people with age-related impairments.

The term ‘accessibility’ is also used in the Convention on the Rights of Persons with Disabilities as well as the term ‘universal design’.

Accessible journey
Routes connecting destinations and services where approachability, accessibility and usability are enabling for people with disabilities.

Accessible tourism
Tourism and travel that is accessible to all.

Barrier-free
The removal of barriers, whether physical, social or sensory, and therefore allow the opportunity for people with disabilities to participate. (United Nations)

Built environment
Built Environment refers to human-made surroundings that provide the setting for human activity, ranging from buildings to parks. This also includes but is not limited to road corridors, footpaths, road pavement, kerb and channels, and paved areas.

Disability
A process that occurs when ‘one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have’.

‘Impairments’ include physical, sensory, neurological, psychiatric, intellectual and any other impairment and encompass people with permanent, intermittent, temporary and perceived impairments.

Disability sector
All organisations and people whose purpose focuses on people with disabilities.

Inclusion
Enabling residents and visitors to participate in a full range of activities with as few barriers as possible.

Open spaces
Open space areas are parks, green spaces, and other open areas. They can range from playing fields to highly maintained environments to relatively natural landscapes. They are commonly open to public access.

Universal design
Refers to broad-spectrum ideas meant to produce buildings, products and environments that are inherently accessible to both people with disabilities and those without.

The term ‘universal design’ was coined by the architect Ronald L. Mace to describe the concept of designing all products and the built environment to be aesthetic and usable to the greatest extent possible by everyone, regardless of their age, ability or status in life.

Curb cuts or sidewalk ramps, essential for people in wheelchairs but also used by all, are a common example. There are also cabinets with pull-out shelves, kitchen counters at several heights to accommodate different tasks and postures, and amid many of the world's public transit systems, low-floor buses that ‘kneel’ (bring their front end to ground level to eliminate gap) and/or are equipped with ramps rather than on-board lifts.

Usability
Describes the extent to which a product (eg device, service or environment) can be used by specified users to achieve specified goals with effectiveness, efficiency and satisfaction.

Watchdog

The Coalition will maintain an overview on Accessibility within the Region and inform relevant organisations, agencies or communities of any potential or actual issues.

Appendix Three:

Accessible Te Tai Poutini West Coast Coalition
Terms of Reference

Background: The issue of accessibility is wide ranging and will require all stake holders to work collaboratively to achieve the **vision of a more enabling inclusive society.**

Mission Statement: Working together to make the West Coast safe and accessible for everyone.

Purpose: To collectively increase and share understanding of accessibility issues, opportunities and effect positive change.

Outcomes:

Long term:

- The West Coast is safe and accessible for everyone

Short term:

- Increased awareness of accessibility issues across the West Coast.
- A Strategy and Implementation Plan and Monitoring Framework to address the issues

Key activities: The Coalition will effect change through the following actions:

- Advocacy & influence
- Acting as a watch-dog
- Having a collective voice
- Listening and understanding
- Story telling
- Monitoring

Accountability

- The Coalition will be accountable to the communities of the West Coast via an annual report.

Membership

- The Coalition will formally come into effect upon sign-off from Mayors and CEOs of stakeholder organisations of the Terms of Reference.
- Membership is open to individuals and organisations committed to working collaboratively to achieve the vision of a more enabling inclusive society.
- Coalition membership will be identified by ongoing attendance and participation at meetings.

Meetings

- There will be four meetings a year across the Region with a host decided on/ assigned at the prior meeting. Meetings will be held from10-30 to 12-30 to allow time for travel.

Roles and Responsibilities:

- West Coast Disability Resource Service (WCDRS) will send out minutes, reminders and take apologies.
- WCDRS will be responsible for maintaining the email distribution list and other relevant information to members
- Meeting hosts will arrange venue, refreshments, take and compile minutes and chair meeting.
- The Coalition will provide an annual report to the group to inform the Coalition's annual report
- The Coalition will develop and implement a Strategic Plan to inform, guide, review and monitor its activities.

Guiding Documents

- The Coalition will be informed by and linked to the following:
  - The New Zealand Disability Strategy 2016-2026
  - The West Coast DHB Disability Strategy
  - Grey District Council Equity and Access for People with Disabilities Policy (including older persons)

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Man & Child: littlecherubs.im

Procedure for Booking and Requesting Interpreters

Contents

Purpose

The use of interpreters is crucial to ensure people with limited or no spoken English or with hearing impairment or deaf can access services, receive an appropriate standard of care, and enhance their understanding of treatment and follow up instructions.

The decision on whether to call a professional interpreter is the responsibility of the health professional involved in the care of the patient.

Family, friends and untrained staff members may only be used in circumstances which;

- Are acute;
- Involve information that is not clinical, technical or confidential;
- Do not breach any other Canterbury or West Coast DHB Policy or Procedure.
- and used only until an approved interpreter can be located.

Interpreters are free to patients who are eligible for publicly funded healthcare at the CDHB. If a client is a non-New Zealand resident, and requires interpreting services, this will be incorporated in any hospital charges incurred.

This procedure describes the process for the limited or non-English speakers or hearing impaired or deaf to access interpreters in a timely manner, enabling full patient participation while in care.

Scope/Audience

Canterbury and West Coast DHB services, both in and outpatient and patients receiving services in the community.

- All Christchurch based hospitals use approved interpreters provided from the interpreter service based at the Christchurch Hospital Campus.
- Asburton Hospital, Rural Hospitals and West Coast DHB use the national NZ interpreters service

Associated documents

- Code of Health & Disability Services Consumers' Right Regulation 1996 Right 5
- New Zealand Sign Language Act 2006 No 18 (as at 30 June 2008), Public Act. "…declaring New Zealand Sign Language to be an official language of New Zealand."
- Tikanga policy – Legal and Quality

Definitions

Interpreting: Processing oral language so that the meaning, tone and register of the original language is preserved, without adding or deleting anything from one language to another.

Interpreter: A person who translates orally (or by sign language) from one language into another. All approved face to face interpreters have a signed contract outlining CDHB responsibilities and confidentiality agreement.

Patient: A person currently or previously having received care. This includes a person's representative, such as a parent or guardian of a person under 16 or someone with activated enduring Powers of Attorney (EPOA) for Care and Welfare.

Health professional: Includes doctors, nurses, midwives and allied health staff.

1 Assessment of interpreter need and language

All clinical staff will ensure that an approved interpreter is used when a consumer has limited (or no) use of the English language or has a hearing impairment or deaf.

1.1 The need for an interpreter is assessed at following contact points

- **Referral:** by referring agency or general practitioner recommendation, or
- **Earliest contact:** For example, if during the course of a telephone conversation, the staff member is alerted to a possible language barrier, the staff member should make an assessment of a possible need for an interpreter by:

1.2 Assessment:

- Ask an open question that requires the patient to answer in a sentence.
- Avoid closed questions, that can be answered 'yes' or 'no' or a very familiar question such as, "Where do you live?"
- Ask if a relative in the house has English language skills, ask to speak with them to provide initial details, and confirm language/dialect required (e.g. Mandarin or Cantonese).

Use of an interpreter is indicated if, in responding to these questions, the patient

- does not construct a sentence in English
- has a hearing impairment **and** uses New Zealand Sign Language
- If you have any doubts about a patient's ability to communicate in and comprehend English, or if the patient requests it, an interpreter should be used.

If unable to establish language need, refer back to GP Practice for confirmation or for Christchurch based hospitals, contact the Interpreter Service (Ext 80669) to check if patient has previously required an interpreter.

Note: If the patient does not speak English and cannot inform you what language he or she speaks, Communication Cards are available to assist in face to face interactions.

1.3 Interpreter is declined

If the patient declines to use an interpreter and the health professional has assessed the patient as requiring an interpreter, it is a clinical decision to continue treatment with or without an interpreter.This decision must be discussed with the clinical leader or a senior medical officer and clearly documented in the clinical record by the attending clinician.

Once treatment has been agreed to (in the absence of an interpreter) the Communication Cards and signs should to be used to communicate. Use of these pictorial explanations is documented in the clinical record.

Note It is not appropriate to use staff who may speak the language unless in an emergency situation, as this creates a power imbalance. It is also not appropriate to use family members where what is being interpreted can not be quantified or confirmed. For some cultures, family may not want to interpret what the patient needs to "hear".

1.3 Interpreter request

Christchurch Hospitals

Following agreement that an interpreter is indicated, send the interpreter request to InterpreterBookings@cdhb.health.nz .or telephone **Ext: 80669.** Document this in the patient's record.

CDHB Ashburton and Rural Hospitals and West Coast DHB Hospitals

There is no interpreter service based at CDHB Ashburton, Rural Hospitals or West Coast DHB.

To access Health interpretation Service staff are required to phone **Interpreting New Zealand**, a 24 hour/7 day telephone interpreting service.

The toll free contact number is: **0508 468 377**.
Inform operator of:

- The language required
- Brief outline of purpose of call
- Location, name and designation

2. Booking Process

As soon as you become aware that an interpreter may be required please follow process outlined below for both emergency or urgent appointments.For planned appointments, please request interpreter 4 to 6 weeks in advance and no later than 72 hours of the patient's appointment date.

2.1 Christchurch Hospitals

During business hours (Mon –Fri 0800 -1630hrs), contact the Interpreter Service directly on **Ext: 80669** or after hours, weekends and public holidays contact the Duty Manager/Shift or Service Coordinators outlined in the App 1.

Interpreter Service requires the following information on the electronic 'Interpreter booking form' via email on InterpreterBookings@cdhb.health.nz , before an Interpreter can be arranged for a face to face approved interpreter:

- Patient's full name & NHI number
- Date and time of appointment

- Language required (if not known, then indicate country of origin)
- Location of the appointment
- Duration – only if the appointment will be longer than an hour
- Your Cost Code/Department for Interpreter payment purposes

2.1.1 Interpreter time sheets – Face to Face only

Once the Interpreter has been arranged by Interpreter Services, an Interpreter's time Sheet ("Pink Form") is completed and will be forwarded to the ward/department making the request.

2.1.2 Telephone Interpreter Service

The NZ interpreter telephone service is used by Christchurch based hospitals as per 2.2. ONLY in exceptional circumstances when it has been confirmed that no approved interpreter is available.

2.2 CDHB Ashburton and Rural Hospitals and West Coast DHB Hospitals

Use **Interpreting New Zealand**, a 24 hour/7 day telephone interpreting service

Toll free phone number is: **0508 468 377**.

Inform operator of brief outline inclusive of

- The language required
- Reason for appointment
- Expected duration of booking
- Location
- Staff name and designation
- Consumers date of birth

3 Following appointment

3.1 Completing Interpreters appointment

When the appointment has concluded the Interpreter and the attending staff member must ensure that the Interpreter's time sheet is signed confirming the start and finish time of the appointment and returned to the staff with responsibility for facilitating Interpreter Services

Completed forms are then forwarded once confirmed as correct by the staff with responsibility for facilitating Interpreter Services to the accounts department for issuing of payment for interpreter services.

3.2 Subsequent appointments

If the staff member, patient and interpreter agree on a further booking for the patient that suits all parties then the staff are responsible for recommencing process as per booking interpreters service 2.

Document this action in the patient clinic record to prevent double booking.

3.3 Maintenance of the Interpreters Contact List

Maintenance of the Interpreters contact list is managed by the Interpreter Services Coordinator at the Christchurch Campus. This list has personal staff details and remains confidential and is NOT to be copied or distributed.

A current list will be held by the Interpreter Services staff and after hours staff.

4. Interpreter Evaluation

In accordance with national Standards of Practice for health care interpreters and the Canterbury District Health Board 'Interpreter Code of Ethics, as a basis for performance evaluation and on-going quality assessment, individual interpreters and treating health professionals will be surveyed at least annually.

Evaluation aims to demonstrate how professional interpreters respond to ethical and other considerations in the performance of their duties, and demonstrate 'best practice' for all consumers.

Appendix

Interpreter Service facilitation

Christchurch based Hospitals

An interpreter service based at Christchurch Campus facilitates interpreters for all Christchurch based Hospitals and dedicated staff are appointed for facilitating the service out of hours as displayed in table below.

Hospitals located in Christchurch			
	Business Hours (Mon –Fri 0800-1630hrs)	**After hours**	
Hospital	**Phone**	**Phone/Cell Phone**	**Pager**
ChCh Public, Outpatients, Psych Emergency Services Burwood, Dental Services,	80669 or (03) 364 0669	89000 (ChCh Duty Nurse Manager)	8304 (ChCh Duty Nurse Manager)
The Princess Margaret Hospital (PMH)	80669 or (03) 364 0669	66852 or 027 538 6237 (Clinical Team Coordinator)	
Specialist Mental Health Services (SMHS)	80669 or (03) 364 0669	027 541 4484 (Duty Nurse Manager)	4814 (Duty Nurse Manager)
Christchurch Women's Hospital	80669 or (03) 364 0669	85715 (Clinical	

(CWH)		Coordinator Birthing Suite)	

If follow up contact arising from acute emergency presentations and community is required, then email InterpreterBookings@cdhb.health.nz.or leave message at **Ext: 80669** for this to be actioned during normal business hours.

Ashburton and West Coast DHB

There is no interpreter service based at CDHB Ashburton, Rural Hospitals or West Coast DHB.

To access Health interpretation Service staff are required to phone Interpreting **New Zealand**, a 24 hour/7 day telephone interpreting service

The toll free contact number is: **0508 468 377**.
Inform operator of:

- The language required
- Brief outline of purpose of call
- Location, name and designation

Appendix 5 Exerts from Canterbury DHB Contract Document

B2 Treaty of Waitangi and Māori Health Statement

B2.1 The Treaty of Waitangi establishes the unique and special relationship between iwi, Māori and the Crown. As a Crown entity the District Health Board considers the Treaty of Waitangi principles of partnership, proactive protection of Māori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which the internal organisation of the District Health Board responds to Māori Health issues.

MĀORI HEALTH

B4 Māori Health Priority

Both of us will abide by the Māori Health statement set out in clause B2 of these Standard Conditions.

B4.1 You agree that Māori Health is a specifically identified health gain priority area. You must therefore establish and implement a Māori Health policy that reflects that fact. In developing this policy, and without limitation, you must take into account our strategic direction for Māori health in terms of minimum requirements for Māori health based on the Treaty of Waitangi, Crown objectives for Māori health and specific requirements negotiated from time to time with us.

B4.2 You must specify how you intend to implement this policy. In particular, you will identify those services you will deliver as explicit contributions to Māori health gain priorities, how these services will be measured to ascertain what benefit is evident and other additional opportunities that may exist for furthering Māori health gain.

B4.3 On commencement of the Agreement, you must develop your Māori health policy and operational plans after consultation with us, subject to agreement between both of us to our respective responsibilities for ensuring that the plans are adequately resourced within the current levels of funding.

C9 Services Meet Needs of Māori

C9.1 Your services will meet the diverse needs of Māori, and apply any strategy for Māori Health issued by the Minister.

C10 Māori Participation

C10.1 Māori participation will be integrated at all levels of strategic and service planning, development and implementation within your organisation at governance, management and service delivery levels.

This will include:

a) consultation with, and involvement of, Māori [1] in your strategic, operational and service processes,

b) development of a monitoring strategy in partnership with Māori that reviews and evaluates whether Māori needs are being met by your organisation, including:

    i. removal of barriers to accessing your services;
    ii. facilitation of the involvement of whanau and others;
    iii. integration of Māori values and beliefs, and cultural practices;
    iv. availability of Māori staff to reflect the consumer population
    v. existence, knowledge and use of referral protocols with Māori service providers in your locality.

c) Education and training of staff in Māori values and beliefs and cultural practices, and in the requirements of any Māori Health Strategy,

d) Support and development of a Māori workforce

C11 Quality Plan

C11.1 You will have a written, implemented and at least annually reviewed Quality Plan designed to improve outcomes for consumers. This plan may be integrated into your business plan. It will describe how you manage the risks associated with the provision of services. The plan will outline a clear quality strategy and will identify the organisational arrangements to implement it. The plan will be of a size and scope appropriate to the size of your service, and will at least include:

i) how you will address Māori issues including recognition of:

    i. Māori participation with Strategic, Governance, Management and Service Delivery planning, implementation and review functions,
    ii. Māori as a Government Health Gain priority area,
    iii. The Pathways set out in any Māori Health Strategy issued by the Minister,
    iv. Māori specific quality specifications,
    v. Māori specific monitoring requirements,
    vi. Māori service specific requirements.

C19 Support for Māori

You will facilitate support from whanau/hapu/iwi; kuia/kaumatua; rongoa practitioners; spiritual advisors; Māori staff and others as appropriate for Māori accessing your service.

C22.2 You will incorporate Māori principles/tikanga into your organisation. These may be explained in the following ways:

Wairua	Spirit or spirituality	A recognition that the Māori view of spirituality is inextricably related to the wellbeing of the Māori consumer
Aroha	Compassionate love	The unconditional acceptance which is the heart of care and support
Turangawaewae	A place to stand	The place the person calls home, where their origins are. Must be identified for all Māori consumers
Whanaungatanga	The extended family	Which takes responsibility for its members and must be informed of where its member is
Tapu/Noa	Sacred/profane	The recognition of the cultural means of social control envisaged in tapu and noa including its implications for practices in working with Māori consumers
Mana	Authority, standing	Service must recognise the mana of Māori consumers
Manaaki	To care for and show respect to	Services show respect for Māori values; traditions and aspirations
Kawa	Protocol of the marae, land, iwi	Determines how things are done in various circumstances. Respect for kawa is very important. If the kawa is not known the tangata whenua should be consulted.

C24 Consumer/Family/Whanau and Referrer Input

C24.1 You will regularly offer consumers/families/whanau and referrers the opportunity to provide feedback as a means of improving the outcomes for consumers. When you obtain feedback from consumers by means of written surveys, you will comply with the Ministry of Health Guidelines for Consumer Surveys. Consumer input will be reflected in the maintenance and improvement of quality of service, both for the individual consumer and across the service as a whole. You will actively seek feedback from Māori by appropriate methods to improve

organisation responsiveness to Māori. When requested you will make available to us the results of such surveys.

C26 Complaints Procedure

C26.1 You will enable consumers/families/whanau and other people to make complaints through a written and implemented procedure for the identification and management of Complaints. This procedure will meet the H&DC Code requirements and will also ensure that:

a) the complaints procedure itself is made known to and easily understandable by consumers,

b) all parties have the right to be heard,

c) the person handling the complaint is impartial and acts fairly,

d) complaints are handled at the level appropriate to the complexity or gravity of the complaint,

e) any corrective action required following a complaint is undertaken,

f) it sets out the various complaints bodies to whom complaints may be made and the process for doing so. Consumers will further be advised of their right to direct their complaint to the H&D Commissioner and any other relevant complaints body, particularly in the event of non-resolution of a complaint,

g) complaints are handled sensitively with due consideration of cultural or other values,

h) Māori consumers and their whanau will have access to a Māori advocate to support them during the complaints process,

i) consumers who complain, or on whose behalf families/whanau complain, shall continue to receive services which meet all contractual requirements,

j) complaints are regularly monitored by the management of the service and trends identified in order to improve service delivery,

k) it is consistent with any complaints policy as we may notify from time to time.

C28 Ethical Review

C28.1 If you conduct research and innovative procedures or treatments you will have written and implemented policies and procedures for seeking ethical review and advice from a Health and Disability Ethics Committee in accordance with the current "National Standard for Ethics Committees" (or any replacement publication). You will consult with and receive approval from Māori for any research or innovative procedures or treatments which will impact on Māori.

Personal Privacy and Dignity Procedure (Home Based Support Services)

1. Purpose

Clients must at all times have control over their own home, emotional and physical environment. This involves asking clients permission for preferences about how the assigned support will be carried out and ensuring this information is documented.

2. Application

This procedure is to be followed by all Coasters Home Based Support Staff

3. Responsibilities

Staff will follow procedures that ensure the safety and dignity of people when supporting them in intimate care.

Intimate support will constitute assisting clients with showering/bathing, dressing/undressing, use of the toilet and/or other services which are specified in the service plan.

4. Resources required

Knowledge of client's personal preferences

5. Process

Staff will receive training at Orientation and Induction on respecting the rights of service user's to personal privacy and dignity.

Support plans will include consultation with the client. Family/whanau or an advocate will be invited to participate unless the client requests that this does not occur.

When entering a client's home, or private room, staff will respect their privacy by knocking and/or requesting entry.

All clients, as noted in the Client Information booklet have the right to request a support worker that they prefer.

Clients have their rights in relation to complaints clearly explained on admission to the service. A written copy of the complaints process is given to all clients in the Client Information Booklet, on admission to service.

6. Precautions and Considerations

Nil

7. Cross References Policies

WCDHB Compliance with the Code of Health & Disability Services Consumer Rights Procedure (Clin#23).

8. Related Documents

NZS 8158:2012 – Standard 1.2 Individual Privacy, Dignity and Respect.
Tikanga Best Practice Guidelines (Clin#68).

9. Quality Indicators

- Client/Family/Whanau involvement and feedback
- Client involvement in Service Planning

Revision History	Version:	2
	Developed By:	Manager Home Based Support Services
	Authorised By:	Nurse Manager Community Services
	Date Authorised:	September 2014
	Date last Reviewed:	August 2016
	Date of next Review:	August 2018

RELEVANT LEGISLATION

S.453. Summary Offences Act 1981: -

"10B. LEAVING CHILD WITHOUT REASONABLE SUPERVISION AND CARE

> Every person is liable to a fine not exceeding $1,000 who, being a parent or guardian or a person for the time being having the care of a child under the age of 14 years, leaves that child, without making reasonable provision for the supervision and care of the child, for a time that is unreasonable or under conditions that are unreasonable having regard to all the circumstances."

We are under: -
Summary Offences Act 1981, Section 10B
Legally bound to report to either the Police or Children and Young Persons Service any children we may see who are "under the age of 14 years" and have been left alone without reasonable supervision.

IF THE CHILDREN ARE ALONE

1. Do not enter the house
2. If possible find out where the parents/caregivers are.
3. Wait in the car. ½ hour maximum.
4. If the parents return with that ½ hour period -
   - Discuss the ramification of leaving children home alone
   - Contact the Police or CYF, if necessary
5. If the parents do not return -
   - Contact the Police or CYF
6. If someone rings you with a "Home Alone" complaint -
   - It is their responsibility to report to either the Police or Children & Young Persons Service and we should encourage them to do so.

REFERENCE

Home Alone Checklist Information, supplied by CYF Community Liaison Officer.

Revision History	Version:	1
	Developed By:	Clinical Nurse Manager Community Services
	Authorised By:	DONM
	Date Authorised:	June 2015
	Date Of Next Review:	June 2017

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Falls Prevention and Management Policy

1. Universal Falls Prevention

- Familiarisation of the patient to the environment
- Ensuring the patient can demonstrate the use of the call bell
- Ensuring the call bell is within reach
- Keeping the patient's possessions within reach
- Lowering the bed when the patient is resting
- Raising the bed when the patient is being transferred
- Keeping the patients bed and wheelchair brakes locked where appropriate
- Ensuring only non-slip footwear is worn by patients (non-slip socks)
- Using nightlights and supplementary lighting
- Keeping floors clean and dry and clearing up spills promptly
- Keeping the patients' area uncluttered
- Follow safe patient handling practices
- Ensure safety in bathrooms, offer assistance, reinforce need for vigilance of falls risk

2. Post Fall Management Guidelines: Nursing

Immediate Care:

- Do not move patient initially, reassure patient
- Call for assistance
- Immobilise cervical spine if head/neck pain is reported or suspected
- Check for other potential injuries
- Safe patient handling techniques should be used to prevent further injury (i.e. hoist where appropriate)
- Vital signs taken (BP, Pulse, Resp Rate,O2 sats ,BGL, Temperature and pain scale, neuro obs q30/60 mins)
- In unwitnessed falls, if the patient is on anti coagulant therapy, neurological observations and assessments should be considered for a period of 72 hours post fall.
- Call for RMO if patient meets criteria for prompt care (eg obvious #NOF or altered NZ EWS, or if any significant injury is suspected)
- Consider need for analgesia and offer as indicated
- Obtain relevant investigations as requested by RMO/SMO (eg ECG, CT, X-ray, blood tests)
- Patient placement in the ward should be considered for closer observation.
- Consider the need for additional staffing support (i.e. sitter for safety)
- Clean and dress wounds as required. (consider tetanus)

Within 6 hours Post Fall:

- Record vital signs and neurological observations as directed by RMO.(If a head injury is suspected Q 30min-1hourly recordings for 4 hours then review)
- Promptly action any deviation in vital signs outside of patients normal parameters (NZ EWS)
- Observe for delirium and new or worsening confusion, headache, amnesia, vomiting or change in level of consciousness

- Continue with investigations and treatment as ordered by RMO/SMO
- Notify next of kin, and provide patient/family/whanau with falls risk management education
- Review FRAT on TrendCare, and if not already identified as a falls risk, complete FRAT and document in nursing care plan. Document fall in clinical notes, also place falls sticker in clinical file.
- Make relevant changes to nursing care plan.
- Refer to relevant Allied Health services as deemed appropriate
- Communicate event to relevant staff (CNM in hours and DNM afterhours)
- Complete post fall Clinical Pathway and place in patients file
- Complete Safety1st. (Include mechanism of fall, witnessed or unwitnessed, location, time, injury and actions taken, and any other relevant information).

6-12 hours Post Fall:

- Continue to monitor Patient vital signs and record MEWS Q4 hourly
- Continue to monitor and record neurological status (LOC)
- Notify RMO/SMO of any changes in patient condition
- Modify environment to reduce further falls, as documented in the Universal Falls Prevention

72 hours Post Fall:

Continue to monitor neurological status, document and action any deviation in LOC.
Neuro observations/AVPU to continue as clinically appropriate.

3. Scope and Purpose

The West Coast District Health Board promotes best practice relating to Falls Prevention and Management across inpatient and community settings.
The West Coast DHB complies with the Health and Disability Standards (SNZ HB 8163:2005, NZS 8143.1.3 & 1.4.)

- “Zero” harm as a result of a fall.
- Minimise falls risk and harm as the result of a fall.

4. Application

This Policy is to be followed by all nursing staff, Allied Health staff, and medical staff throughout the Inpatient settings within the WCDHB.

5. Definition

The World Health Organization defines a fall as “an event which results in a person coming to rest inadvertently on the ground or other lower level”. This means that as long as a person falls unintentionally onto a lower level, whether or not it is on the ground, it is considered a fall.

6. Responsibilities

For the purpose of this Policy:

All Nursing Staff are required to:

- Complete a Falls Risk Assessment (FRAT) on TrendCare or as part of the nursing history
- Complete Post Fall Clinical Pathway documentation
- Always practice using universal falls prevention strategies
- Maintain accurate documentation, including planning and outcomes of individual patients falls prevention strategies
- Notify Allied Health or relevant other agencies as appropriate.

All Medical Staff are required to:

- Follow the falls Management pathway
- Maintain accurate documentation, including Falls prevention planning and outcomes of individual patients falls prevention strategies
- Complete the Post Fall Clinical Pathway documentation

7. Resources Required

- Falls Risk Assessment Tool (FRAT)
- Post Fall Clinical Pathway
- Safety1st.
- Post Fall Sticker Alert
- ACC documentation

8. Process

- All facilities must provide a safe environment in accordance with Health and Safety standards
- All patients must be assessed for their risk of falling at presentation to a WCDHB facility
- All inpatients identified as "at Risk" of falling via the FRAT; either in TrendCare or via patient history documentation, must have appropriate falls prevention strategies put in place
- Patients identified as "at risk" may have a red arm band attached to their wrist to indicate that they are unsafe to move around without supervision
- Falls risk must be recorded on Trendcare as part of the inpatient shift data record
- Falls prevention strategies must be documented in the patient's clinical record and on the nursing care plan
- Reassessment of falls risk must occur every 3 days, and in particular: - if the health status of a patients has changed
    - When the patient transfers to another environment such as change of room/ward etc.
    - After any near miss fall or actual fall

- The patient and where practicable the family/whanau/carer must be included in the falls risk assessment process and falls prevention strategies including being provided with appropriate educational material
- In the event of a patient fall, adherence to the Post Fall Management guidelines is mandatory
- A Safety1st form must be completed for all patient falls with appropriate documentation in the clinical record
- ACC documentation must be completed for all falls patients
- All staff and contracted personnel involved in patient contact must be provided with education on falls and falls risk assessment, prevention and management on induction and on a regular basis
- Full information relating to a patients "falls risk" and associated fall prevention strategies must be included in any transfer/discharge documentation
- Patients identified as "at Risk" of falling on discharge must be referred to a Community-based falls prevention programme in accordance with current Allied Health referral guidelines

9. Related Documents

- Incident reporting Procedure (Safety1st)
- Risk Management Policy
- Restraint Approval Lap Belt
- Restraint Use (Non Mental Health) Policy
- Post Fall Management Pathway: Nursing
- Falls Coalition Terms of Reference
- HDC Code of Rights

10. References

CDHB Falls Prevention and Management Policy. 2015
Department of Health, Western Australia. Post Fall Management Guidelines 2005
Lippincott (Hyperlink)

Version Number:	3
Authorised by:	Director of Nursing Director of Midwifery
Issued:	May 2018
Review Date:	May 2020

Personal Privacy and Dignity Procedure (Home Based Support Services)

1. Purpose

Clients must at all times have control over their own home, emotional and physical environment. This involves asking clients permission for preferences about how the assigned support will be carried out and ensuring this information is documented.

2. Application

This procedure is to be followed by all Coasters Home Based Support Staff

3. Responsibilities

Staff will follow procedures that ensure the safety and dignity of people when supporting them in intimate care.

Intimate support will constitute assisting clients with showering/bathing, dressing/undressing, use of the toilet and/or other services which are specified in the service plan.

4. Resources required

Knowledge of client's personal preferences

5. Process

Staff will receive training at Orientation and Induction on respecting the rights of service user's to personal privacy and dignity.

Support plans will include consultation with the client. Family/whanau or an advocate will be invited to participate unless the client requests that this does not occur.

When entering a client's home, or private room, staff will respect their privacy by knocking and/or requesting entry.

All clients, as noted in the Client Information booklet have the right to request a support worker that they prefer.

Clients have their rights in relation to complaints clearly explained on admission to the service. A written copy of the complaints process is given to all clients in the Client Information Booklet, on admission to service.

6. Precautions and Considerations

Nil

7. Cross References Policies

WCDHB Compliance with the Code of Health & Disability Services Consumer Rights Procedure (Clin#23).

8. Related Documents

NZS 8158:2012 – Standard 1.2 Individual Privacy, Dignity and Respect.
Tikanga Best Practice Guidelines (Clin#68).

9. Quality Indicators

- Client/Family/Whanau involvement and feedback
- Client involvement in Service Planning

Revision History	Version:	2
	Developed By:	Manager Home Based Support Services
	Authorised By:	Nurse Manager Community Services
	Date Authorised:	September 2014
	Date last Reviewed:	August 2016
	Date of next Review:	August 2018

Procedure for Booking and Requesting Interpreters

Contents

Purpose

The use of interpreters is crucial to ensure people with limited or no spoken English or with hearing impairment or deaf can access services, receive an appropriate standard of care, and enhance their understanding of treatment and follow up instructions.

The decision on whether to call a professional interpreter is the responsibility of the health professional involved in the care of the patient.

Family, friends and untrained staff members may only be used in circumstances which;

- Are acute;
- Involve information that is not clinical, technical or confidential;
- Do not breach any other Canterbury or West Coast DHB Policy or Procedure.
- and used only until an approved interpreter can be located.

Interpreters are free to patients who are eligible for publicly funded healthcare at the CDHB. If a client is a non-New Zealand resident, and requires interpreting services, this will be incorporated in any hospital charges incurred.

This procedure describes the process for the limited or non-English speakers or hearing impaired or deaf to access interpreters in a timely manner, enabling full patient participation while in care.

Scope/Audience

Canterbury and West Coast DHB services, both in and outpatient and patients receiving services in the community.

- All Christchurch based hospitals use approved interpreters provided from the interpreter service based at the Christchurch Hospital Campus.
- Asburton Hospital, Rural Hospitals and West Coast DHB use the national NZ interpreters service

Associated documents

- Code of Health & Disability Services Consumers' Right Regulation 1996 Right 5
- New Zealand Sign Language Act 2006 No 18 (as at 30 June 2008), Public Act. "…declaring New Zealand Sign Language to be an official language of New Zealand."
- Tikanga policy – Legal and Quality

Definitions

Interpreting: Processing oral language so that the meaning, tone and register of the original language is preserved, without adding or deleting anything from one language to another.

Interpreter: A person who translates orally (or by sign language) from one language into another. All approved face to face interpreters have a signed contract outlining CDHB responsibilities and confidentiality agreement.

Patient: A person currently or previously having received care. This includes a person's representative, such as a parent or guardian of a person under 16 or someone with activated enduring Powers of Attorney (EPOA) for Care and Welfare.

Health professional: Includes doctors, nurses, midwives and allied health staff.

1 Assessment of interpreter need and language

All clinical staff will ensure that an approved interpreter is used when a consumer has limited (or no) use of the English language or has a hearing impairment or deaf.

1.1 The need for an interpreter is assessed at following contact points

- **Referral:** by referring agency or general practitioner recommendation, or
- **Earliest contact:** For example, if during the course of a telephone conversation, the staff member is alerted to a possible language barrier, the staff member should make an assessment of a possible need for an interpreter by:

1.2 Assessment:

- Ask an open question that requires the patient to answer in a sentence.
- Avoid closed questions, that can be answered 'yes' or 'no' or a very familiar question such as, "Where do you live?"
- Ask if a relative in the house has English language skills, ask to speak with them to provide initial details, and confirm language/dialect required (e.g. Mandarin or Cantonese).

Use of an interpreter is indicated if, in responding to these questions, the patient

- does not construct a sentence in English
- has a hearing impairment **and** uses New Zealand Sign Language
- If you have any doubts about a patient's ability to communicate in and comprehend English, or if the patient requests it, an interpreter should be used.

If unable to establish language need, refer back to GP Practice for confirmation or for Christchurch based hospitals, contact the Interpreter Service (Ext 80669) to check if patient has previously required an interpreter.

Note: If the patient does not speak English and cannot inform you what language he or she speaks, Communication Cards are available to assist in face to face interactions.

1.3 Interpreter is declined

If the patient declines to use an interpreter and the health professional has assessed the patient as requiring an interpreter, it is a clinical decision to continue treatment with or without an interpreter.This decision must be discussed with the clinical leader or a senior medical officer and clearly documented in the clinical record by the attending clinician.

Once treatment has been agreed to (in the absence of an interpreter) the Communication Cards and signs should to be used to communicate. Use of these pictorial explanations is documented in the clinical record.

Note It is not appropriate to use staff who may speak the language unless in an emergency situation, as this creates a power imbalance. It is also not appropriate to use family members where what is being interpreted can not be quantified or confirmed. For some cultures, family may not want to interpret what the patient needs to “hear”.

1.3 Interpreter request

Christchurch Hospitals

Following agreement that an interpreter is indicated, send the interpreter request to InterpreterBookings@cdhb.health.nz .or telephone **Ext: 80669.** Document this in the patient’s record.

CDHB Ashburton and Rural Hospitals and West Coast DHB Hospitals

There is no interpreter service based at CDHB Ashburton, Rural Hospitals or West Coast DHB.

To access Health interpretation Service staff are required to phone **Interpreting New Zealand**, a 24 hour/7 day telephone interpreting service.

The toll free contact number is: **0508 468 377**.
Inform operator of:

- The language required
- Brief outline of purpose of call
- Location, name and designation

2. Booking Process

As soon as you become aware that an interpreter may be required please follow process outlined below for both emergency or urgent appointments.For planned appointments, please request interpreter 4 to 6 weeks in advance and no later than 72 hours of the patient’s appointment date.

2.1 Christchurch Hospitals

During business hours (Mon –Fri 0800 -1630hrs), contact the Interpreter Service directly on **Ext: 80669** or after hours, weekends and public holidays contact the Duty Manager/Shift or Service Coordinators outlined in the App 1.

Interpreter Service requires the following information on the electronic ‘Interpreter booking form’ via email on InterpreterBookings@cdhb.health.nz , before an Interpreter can be arranged for a face to face approved interpreter:

- Patient’s full name & NHI number
- Date and time of appointment

- Language required (if not known, then indicate country of origin)
- Location of the appointment
- Duration – only if the appointment will be longer than an hour
- Your Cost Code/Department for Interpreter payment purposes

2.1.1 Interpreter time sheets – Face to Face only

Once the Interpreter has been arranged by Interpreter Services, an Interpreter's time Sheet ("Pink Form") is completed and will be forwarded to the ward/department making the request.

2.1.2 Telephone Interpreter Service

The NZ interpreter telephone service is used by Christchurch based hospitals as per 2.2. ONLY in exceptional circumstances when it has been confirmed that no approved interpreter is available.

2.2 CDHB Ashburton and Rural Hospitals and West Coast DHB Hospitals

Use **Interpreting New Zealand**, a 24 hour/7 day telephone interpreting service

Toll free phone number is: **0508 468 377**.

Inform operator of brief outline inclusive of

- The language required
- Reason for appointment
- Expected duration of booking
- Location
- Staff name and designation
- Consumers date of birth

3 Following appointment

3.1 Completing Interpreters appointment

When the appointment has concluded the Interpreter and the attending staff member must ensure that the Interpreter's time sheet is signed confirming the start and finish time of the appointment and returned to the staff with responsibility for facilitating Interpreter Services

Completed forms are then forwarded once confirmed as correct by the staff with responsibility for facilitating Interpreter Services to the accounts department for issuing of payment for interpreter services.

3.2 Subsequent appointments

If the staff member, patient and interpreter agree on a further booking for the patient that suits all parties then the staff are responsible for recommencing process as per booking interpreters service 2.

Document this action in the patient clinic record to prevent double booking.

3.3 Maintenance of the Interpreters Contact List

Maintenance of the Interpreters contact list is managed by the Interpreter Services Coordinator at the Christchurch Campus. This list has personal staff details and remains confidential and is NOT to be copied or distributed.

A current list will be held by the Interpreter Services staff and after hours staff.

4. Interpreter Evaluation

In accordance with national Standards of Practice for health care interpreters and the Canterbury District Health Board ‘Interpreter Code of Ethics, as a basis for performance evaluation and on-going quality assessment, individual interpreters and treating health professionals will be surveyed at least annually.

Evaluation aims to demonstrate how professional interpreters respond to ethical and other considerations in the performance of their duties, and demonstrate ‘best practice’ for all consumers.

Appendix

Interpreter Service facilitation

Christchurch based Hospitals

An interpreter service based at Christchurch Campus facilitates interpreters for all Christchurch based Hospitals and dedicated staff are appointed for facilitating the service out of hours as displayed in table below.

Hospitals located in Christchurch			
	Business Hours (Mon –Fri 0800-1630hrs)	**After hours**	
Hospital	**Phone**	**Phone/Cell Phone**	**Pager**
ChCh Public, Outpatients, Psych Emergency Services Burwood, Dental Services,	80669 or (03) 364 0669	89000 (ChCh Duty Nurse Manager)	8304 (ChCh Duty Nurse Manager)
The Princess Margaret Hospital (PMH)	80669 or (03) 364 0669	66852 or 027 538 6237 (Clinical Team Coordinator)	
Specialist Mental Health Services (SMHS)	80669 or (03) 364 0669	027 541 4484 (Duty Nurse Manager)	4814 (Duty Nurse Manager)
Christchurch Women’s Hospital	80669 or (03) 364 0669	85715 (Clinical	

(CWH)		Coordinator Birthing Suite)	

If follow up contact arising from acute emergency presentations and community is required, then email InterpreterBookings@cdhb.health.nz.or leave message at **Ext: 80669** for this to be actioned during normal business hours.

Ashburton and West Coast DHB

There is no interpreter service based at CDHB Ashburton, Rural Hospitals or West Coast DHB.

To access Health interpretation Service staff are required to phone Interpreting **New Zealand**, a 24 hour/7 day telephone interpreting service

The toll free contact number is: **0508 468 377**.
Inform operator of:

- The language required
- Brief outline of purpose of call
- Location, name and designation

INTRODUCTION

The flip chart summarises the approved West Coast DHB Tikanga Recommended Best Practice Guidelines document that outlines key traditional principles of tikanga and recommends ways to encompass Maori values and beliefs into frontline service delivery.

It is noted that this document is not for all tribal affiliations/iwi who may have differing protocols.
The aim is to ensure the wairua (spiritual), hinengaro (psychological) and tinana (physical) wellbeing of Maori patient/clients (turoro/tangata whaiora) and their whanau (family and extended family group) is upheld.

These guidelines can also be made available and delivered to all consumers of health care services regardless of ethnicity, as they include best practice standards of care.

These guidelines apply to all West Coast DHB staff, including contracted staff, and apply to all West Coast DHB facilities.

INTRODUCTION

KARAKIA

For many Māori, karakia are essential in protecting and maintaining their spiritual, mental, emotional and physical health – particularly in a health-care setting.

Staff action: Verbally offer the Tūroro and their whānau the choice of having karakia at all stages of the care process including heightened situations (e.g. psychotic incidents), and pending death.

Support this by:

- Allowing time for karakia
- Not interrupting karakia unless the physical care of the Tūroro is compromised.
- In extreme cases where karakia cannot occur, explaining why in a sensitive manner and discuss possible options.
- Providing access to appropriate water and containers for the purpose of spiritual cleansing.
- Tūroro or whānau member may request a minister or lay person of their choosing.

KARAKIA

WHANAU SUPPORT

Family and extended family is of fundamental importance to Māori. The concept of family and friends extends beyond the nuclear or biological family concept. Whānau support can be crucial to the Tūroro wellbeing.

Staff action
The Tūroro and their whānau should be actively encouraged, supported and included in all aspects of care and decision making.

Support this by
Sharing a copy of the care plan with the Māori Tūroro and whānau

- Asking the Tūroro and/or whānau if they wish to nominate a person to speak on behalf of the whānau.
- Acknowledgement and involving the person nominated (if any).
- Including appropriate Māori staff (e.g. Kaiāwhina) in the care and decision making process, if this is agreed to by the Tūroro and whānau.
- Where possible, finding private space and adequate time when consulting with whānau throughout the care process and checking with whānau about suitable meeting times and their needs.
- Being flexible about visiting times and visitor numbers where possible
- Being supportive of whānau visiting when death is expected or imminent.

WHANAU SUPPORT

INFORMATION & SUPPORT

The aim is to provide health care in an environment that is culturally sensitive to those using it. This is done out of respect for different cultural perspectives and needs, and also to support the total health (whaiora) of the person receiving health care.

<u>Staff action</u>
Make sure the Tūroro and their whānau understand what is happening, and what resources and support are available, including speakers of te reo Māori, patient advocates, kaiawhina and chaplains.

<u>Support this by</u>
- Clearly introducing yourself and your role/service
- Ensuring that all information is given clearly and is understood by the Tūroro and/or their whānau.
- Understanding that for Māori the concept of “next of kin” may be broadly interpreted at registration.
- Notifying appropriate Māori staff of the Tūroro in their care as soon as possible (e.g. on admission/referral)
- Offering an interpreter where appropriate.
- Ensuring the Tūroro and whānau are aware of the available WCDHB accommodation services, preferably prior to admission.
- Keeping an up-to-date list of resources that are available (e.g. patient advocacy services, whānau rooms and other dedicated spaces, Māori chaplain, external Māori providers and support services), and informing the Tūroro and their whānau about these.
- Ensuring that the Tūroro and whānau have access to any Māori support information available to wards.

INFORMATION & SUPPORT

FOOD, LINEN & BEDPANS

Tapu and Noa are key concepts that underpin many practices. For example, it is important to keep things that are tapu (sacred) separate from things that are noa (not-sacred). In many cases, these align with good health and safety procedures that should be practised by staff.

Staff action

Become familiar with the basic principles of tapu and noa, and practical ways of respecting those concepts.

Support this by

- Not passing food over a person's head.
- Not using pillowcases for any other purpose, supporting whānau if they bring their own pillowcases.
- Using different flannels for washing the head and washing the body – where possible use different coloured flannels to differentiate.
- Washing the body in a strict order starting from the neck to genital and then anal area.
- Keeping separate from food anything that comes into contact with the body or body fluids, for example:
- Combs and brushes should not be placed on a surface where food is placed.
- Don't sit on the tables or workbenches, particularly on surfaces that are used for food or medication.
- Microwaves used for heating food will not be used for heating anything that has come into contact wit the body.
- Fridges or freezers used for food or medication storage should not be used for any other purpose.
- Receptacles used for drinking water should be used solely for this purpose.
- Tea towels will only be used for drying dishes and will be washed separately from all other soiled linen.
- Bedpans/urinals and food will not be present at the same time.
- Bedpans/urinals must be placed on the correct equipment (not where food trays are placed) and always stored in their own designated area.

TAONGA/VALUABLES

Taonga are extremely important to Māori, and have much more significance than just sentimental value.

Staff action
Be aware and respectful of Taonga, and discuss any need to handle Taonga with the Tūroro and/or their whānau.

Support this by

- Where possible, securely taping Taonga to the body of the Tūroro rather than removing it.
- If risk is involved, obtaining the consent of the Tūroro before removing Taonga.
- Giving the Tūroro or their whānau the option of removing it themselves.
- Giving the whānau the option of caring for any Taonga.
- Informing the Tūroro and whānau of the risk of storing Taonga and how it will be stored (in the identified valuables safe, where provided).

TAONGA/VALUABLES

WHANAU ROOMS & DESIGNATED AREAS

Some areas will be governed by Māori protocol and Tikanga Māori should be observed by all staff and other people using the facility e.g.

- Area designated as a whānau room for specific purposes.
- Area or room used for whānau group conferences.
- DHB Boardroom and other service facilities where powhiri ceremonies are conducted.
- Rooms where a Māori death has taken place.
- Chapel or viewing room when it is occupied by the tupapaku.

Staff Action

Staff must respect these areas set aside permanently or on occasion. All staff are made aware or appropriate Māori protocol at their orientation.

WHANAU ROOMS & DESIGNATED AREAS

BODY PARTS/TISSUES/SUBSTANCES

Staff action

As with any Tūroro, the correct process should be followed for fully communicating with the Tūroro about the procedure and consulting with the Tūroro about options for removal, retention, return or disposal. Informed consent must be obtained where required.

In addition, staff should consider the following points where a Māori Tūroro is concerned:

- Offering the option of further support from the appropriate Māori staff e.g. Māori support worker where possible, this must happen prior to any intervention.
- Returning of body parts/tissue/substances in a way that is consistent with Tikanga and in consultation with appropriate Māori staff. For example, body parts/tissue/substances should be returned in containers that are durable and reflect Tikanga best practices.
- Recording and carrying out the wishes of the Tūroro and/or whānau if the original purpose of retention changes. Returns should follow Tikanga best practises and protocols determined in consultation with Māori staff.
- Returning unconsented body parts/tissue/substances is expected to follow existing protocols. If return or retention is not requested, staff should discuss and agree to disposal and/or burial of the body parts/tissue/substances with the Tūroro and/or whānau. This should be carried out in a considered and consultative manner that respects tikanga processes.
- Documentation in the clinical notes is highly recommended.

Organ and Tissue Donation

Refer to WCDHB Tikanga Best Practice Guideline Procedure.

BODY PARTS/TISSUES/SUBSTANCES

PENDING & FOLLOWING DEATH

As for any patient, family/whānau should be notified, supported and involved where the death of a Tūroro is expected.

In addition, when a Tūroro is involved, staff should:

- Immediately notify support staff (e.g. Kaiāwhina) involved in the care of the Tūroro.

Tupapaku (Deceased)
(Mandatory)

- Where possible, do not leave the body unattended following death. It is acknowledged this is generally not possible in a Coroner's Case.
- Immediately notify Kaiāwhina involved in the care of the Tūroro.
- Be guided by whānau on the cultural and spiritual practices for them at this time.
- Give whānau the opportunity to perform cultural and spiritual rites for "karakia tuku i te wairua" before the Tūpāpaku is removed, and in particular before a post mortem.
- A karakia should be performed in the area the Tūroro died as soon as possible after the Tūpāpaku is removed. From a Māori perspective the room is not spiritually cleansed until an appropriate karakia and cleansing with water has been performed.
- Do not take food or drink into the room following death.
- Where possible allow the whānau to take their Tūpāpaku to a designated area e.g. viewing rooms or chapel.
- Exiting of Tūpāpaku to designated areas must avoid public corridors and food outlets.
- Always transport the Tūpāpaku feet first.

PENDING & FOLLOWING DEATH

Glossary

Term	Description
Hapū	(1) Sub-tribe of a large tribe (2) Pregnancy
Hinengaro	Psychological, thoughts, intellect
Iwi	Kinship group, tribe, nation, people, nationality, Often refers to a large group of people descended from a common ancestor.
Kai	Food
Kaiāwhina	Helper, assistant, contributor Designated Māori staff whose role is to provide support to Tūroro and whānau using hospital services.
Karakia	Prayer, to pray or recite a prayer
Mana	Prestige, influence, status. The more prestigious the event or person, the more Mana it has.
Muru Hara	To restore Tapu by addressing and repairing violation.
Muru Hē	To restore and heal a wrong.
Noa	Be free from the extensions of Tapu, ordinary, unrestricted.
Pōwhiri	Formal Māori welcome ceremony
Rongoā	To treat, apply medicines
Taonga	Treasure, valuables, something prized
Tapu	Sacred, prohibited, restricted.
Te Tiriti o Waitangi	The Treaty of Waitangi
Tikanga	Correct procedure, custom, habit, method, manner
Tinana	Physical body
Tūpāpaku	Deceased person
Tūroro	Sick person, invalid, patient
Wairua	The spirit, spiritual element
Whānau	Family, extended family, family group.

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Tikanga Best Practice Guidelines

1. Purpose

This Procedure provides assistance to West Coast District Health Board (WCDHB) staff members for the provision of cultural appropriate care to patients/residents/clients of WCDHB who identify as **Māori**.

2. Application

This Procedure is to be followed by all WCDHB staff members.

3. Definitions

Term	Description
Hapū	• (1) Sub-tribe of a large tribe (2) Pregnancy
Hinengaro	• Psychological, thoughts, intellect
Iwi	• Kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor.
Kai	• Food
Kaiāwhina	• Helper, assistant, contributor Designated **Māori** staff whose role is to provide support to **Tūroro** and **Whānau** using hospital services.
Karakia	• Prayer, to pray or recite a prayer
Mana	• Prestige, influence, status. The more prestigious the event or person, the more **Mana** it has. Health Services must empower **Tūroro** and their **whānau**, in doing so the service's own mana is enhanced.
Muru Hara	• To offend, cause offence
Muru Hē	• To restore and heal a wrong.
Noa	• Be free from the extensions of **Tapu**, ordinary, unrestricted. In the positive sense, it is the state of freedom of mind and spirit that comes about through being acknowledged, enhanced, restored and healed.
Pōwhiri	• Formal **Māori** welcome ceremony
Rongoā	• To treat, apply medicines **Māori** methods of healing including **Mirimiri** (massage), **Te Reo** (language), **Karakia** and herbal remedies.
Taonga	• Treasure, valuables, something prized
Tapu	• Be sacred, prohibited, restricted Restrictions and prohibitions that protect **Tapu** (well being, dignity and sacredness) from violation.
Te Tiriti o Waitangi	• The Treaty of Waitangi
Tikanga	• Correct procedure, custom, habit, lore, method, manner
Tinana	• Physical body
Tūpāpaku	• Deceased person
Tūroro	• Sick person, invalid, patient
Wairua	• The spirit, spiritual element, spiritual part of a person that exists beyond death
Whānau	• Family, extended family, family group.

4. Responsibilities

For the purposes of this Procedure:

All WCDHB Staff Members are required to:
- Comply with the requirements of this Procedure

5. Resources Required

These Guidelines requires no specific resources.

6. Process

1.00 Objectives

1.01 **Tikanga** Best Practice Guidelines aim to help staff within the hospital to provide culturally responsive health and disability services to **Māori Tūroro** (Māori patients) and their **Whānau** (family, extended family). These guidelines are underpinned by Māori values, protocols, concepts, views of health and **Te Tiriti o Waitangi**.

1.02 Central to the guidelines is the expectation that **Whānau** are treated in ways that respect their diversities as well as their values and beliefs. This is a reciprocal arrangement requiring of **Whānau** using the services, the same respect for hospital protocols and systems.

2.00 Guiding Principles

2.01 As soon as **Tūroro** and their **Whānau** are involved with a healthcare service they are deemed to be in a state of disempowerment. Acknowledging a person's rites/rights and respecting their beliefs restores the **Mana** of **Tūroro** and their **Whānau**.

Tapu and **Noa** are key concepts that underpin many practices. For example, it is important to keep things that are **tapu** (sacred) separate from things that are **noa** (not-sacred). In many cases, these align with good health and safety procedures that should be practised by staff.

2.02 Permission must always be asked for and an explanation given prior to any intervention.
If informed consent and compliance with **Tikanga** is not carried out in a respectful manner during the care of **Tūroro** then a **Mahi Hē** (offence) has been committed. This is regardless of how small the **Mahi Hē** may appear. Another action is then required to correct the **Mahi Hë** to bring about **Muru Hē** (restoration and healing).

2.03 **Tikanga** Best Practice Guidelines are primarily focused on **Māori** as they reflect **Māori** values and concepts. However, they can also be made available and delivered to consumers of health services regardless of ethnicity as they include best practice standards of care.

Central to the policy is the expectation that all users of health services are treated with dignity and respect. In turn, users of health services are expected to behave respectfully. In exercising the principles of the policy it is anticipated that the awareness and confidence of the health workforce will be raised and in doing so staff will demonstrate consideration of wider cultural needs and expectations.

2.04 **Tikanga** Best Practice Guidelines offers choice to the community about how health care is delivered. The document outlines processes for all staff to follow that are integral to best practice and will assist in the delivery of quality health services within the WCDHB.

3.00 Karakia (blessings/incantation/prayer)

3.01 Where possible, **Tūroro** and **whānau** will be verbally offered (from early in the care process) the choice of having karakia. In particular this needs to be offered before and after surgery.

3.02 Staff will make arrangements for the chaplain to attend if required. This will be offered to all **Tūroro** and **whānau**.

3.03 Staff will support the need for **karakia** at all times during **Tūroro** care.

3.04 Staff will endeavour to offer and support **karakia** in a variety of heightened situations e.g. psychotic incidents. This may involve discussion with **whānau** and/or appropriate **Māori** staff.

3.05 Time will be allowed for **karakia**.

3.06 **Karakia** will not be interrupted unless the physical care of **Tūroro** is compromised.

3.07 If **karakia** cannot occur due to extreme circumstances, staff will explain the reasons in a sensitive manner and discuss alternative options.

3.08 Access to water in culturally appropriate containers will be made available for the purpose of spiritual cleansing.

4.00 Whānau Support

4.01 **Tūroro** and **whānau** will be actively encouraged, included and supported by staff to be involved in all aspects of care and decision making. This includes care plans, discharge planning and multi disciplinary team meetings. A copy of the care plan may be shared with the **Tūroro** and **whānau**.

4.02 Staff will ask **whānau** and/or **Tūroro** if they wish to nominate a person to speak on behalf of the **whānau**.

4.03 Staff will acknowledge and actively involve the nominated person.

4.04 In agreement with **Tūroro** and **whānau**, staff will include the appropriate **Māori** staff e.g. **Kaiāwhina** in the care and decision making process.

4.05 A private room and adequate time will be allocated for **whānau** consultation and decision making throughout the care of **Tūroro**.

4.06 Staff will consult with **whānau** regarding suitable meeting times and needs.

4.07 Flexibility will be given to visiting times and visitor numbers where possible.

4.08 Staff will give serious consideration to a **whānau** member requesting to stay overnight with the **Tūroro**.

4.09 Staff will give serious consideration to **whānau** who ask to be present during a surgical procedure. Health and Safety and Infection Control considerations will be explained in this situation.

4.10 Staff will be especially supportive of **whānau** visiting when death is expected and/or imminent.

4.11 Where appropriate, staff will support and encourage **whānau** to bring food and share meals with the **Tūroro** Particular food may be requested by the **Tūroro**. It is important that staff support **whānau** in this and especially when death is expected and/or imminent.

5.00 Information and Support

5.01 During all initial encounters, staff will introduce themselves and explain their role and service to the **Tūroro** and **whānau**.

5.02 When obtaining registration details, staff will accept that the **Māori** concept of "next of kin" may be broadly interpreted.

5.03 Where appropriate, staff will ensure that **Tūroro** are offered an interpreter.

5.04 Staff will ensure that the **Tūroro** and **whānau** are aware of accommodation options, preferably prior to admission and make referrals when requested.

5.05 Staff will notify the appropriate **Māori** staff of **Tūroro** in their care as soon as possible e.g. on admission/referral.

5.06 Staff will inform the **Tūroro** and **whānau** of internal and external resources e.g. **whānau** rooms and dedicated spaces to support **whānau** wellbeing, external **Māori** providers, primary providers, support services and relevant agencies outside of the health sector.

5.07 The **Māori** health service will maintain a current list of contacts to assist **Tūroro** and their **whānau**.

5.08 Staff will offer the choice of having the chaplain attend. Staff will make the arrangements if this is requested.

5.09 Information will be delivered clearly and in terms the **Tūroro** and **whānau** understand.

5.10 Staff will ensure the **Tūroro** and **whānau** understand the information given.

5.11 Information will be provided in more than one way where possible e.g. spoken and written, **Māori** and English.

5.12 Staff will inform **Tūroro** and **whānau** of the advocacy service provided by Advocacy Services

5.13 If a health advocate is required, staff will make the arrangements unless stated otherwise by **Tūroro** and **whānau**.

5.14 Staff will provide verbal and written information and support regarding complaints procedures.

6.00 Specific Needs

6.01 Staff will ask **Tūroro** and **whānau** if they have any special cultural, spiritual, language or other needs.

6.02 These needs will be documented in the relevant notes e.g. treatment plan, needs assessment, clinical file. Staff will actively seek to ensure they are met.

6.03 Staff will respect and support the importance and use of **Rongoā** (**Māori** methods of healing) during **Tūroro** care.

6.04 Staff will be prepared to negotiate, document and work collaboratively with **Māori** healers, **Tūroro** and **whānau** regarding the use of **Rongoā**.

6.05 Staff will ensure they attempt to pronounce **Māori** names correctly and ask when unsure.

6.06 Staff will endeavour to use the preferred name of the **Tūroro**.

6.07 A simple request and explanation will be given and consent obtained from **Tūroro** and/or whānau before touching **Tūroro** anywhere on the body and especially on the head.

7.00 Food

7.01 Food will never be passed over the head.

7.02 Fridges/freezers used to store food or medication for human consumption will be clearly identified and not used for any other purpose.

7.03 Microwaves used for food will not be used for heating anything that has come into contact with the body.

7.04 Tea towels will only be used for the purpose of drying dishes.

7.05 Tea towels will be washed separately from all other soiled linen.

7.06 Anything that comes into contact with the body or body fluids must be kept separate from food e.g. combs or brushes should not be placed on surfaces where food is placed.

7.07 Receptacles used for drinking water will be solely used for this purpose.

7.08 Staff will not sit on tables or workbenches and particularly on surfaces used for food or medication.

8.00 Taonga/Valuables

8.01 Only remove **Taonga** (valuables/heirlooms) if leaving them on places **Tūroro** at risk; wherever possible **Taonga** will be taped to their person, if not the reason for this explained.

8.02 If there is any risk is involved, consent will be obtained from the **Tūroro** or **whānau** before removing **Taonga**.

8.03 **Tūroro** and **whānau** will be informed of the risk of storing **Taonga**.

8.04 **Tūroro** and **whānau** are to be given the option of removing **Taonga**.

8.05 **Whānau** will have the option of caring for **Taonga**.

8.06 If **whānau** are not caring for the **Taonga**, it will be kept in the identified valuables safe, where provided.

9.00 Bedpans/Urinals

9.01 Bedpans/urinals and food will never be present at the same time.

9.02 Excreta and food will always be kept separate. Excreta will not be placed on surfaces where food is placed e.g. bedpans/urinals will not be placed on surfaces used for food trays.

9.03 Bedpans/urinals will not be placed on top of the bedside lockers or nightingales.

9.04 Always place bedpans/urinals on the equipment used for this purpose.

9.05 Always store bedpans/urinals in the designated area.

10.00 Linen

10.01 Different coloured **pillowcases** will be used to differentiate pillows for the head and those used for other parts of the body. **(White for above the waist and blue for below the waist)**.

10.02 Pillowcases will not be used for any other purpose.

10.03 Staff will support **whānau** if they bring their own pillowcases.

10.04 Where possible different coloured **pillows** will be used to differentiate pillows for the head and those used for other parts of the body.

10.05 Different flannels will be used for the washing of above the waist and below the waist. Where possible use different coloured flannels to differentiate. Washing will follow a strict order starting from the neck to genital and then anal area.

10.06 All below waist pillow cases and wash clothes are to be put into the red linen bag for processing by the laundry.

11.00 Māori Specific Areas

11.01 These are areas observing **Tikanga Māori**. This includes both current and future areas permanently governed by **Māori** protocols e.g. **Māori** accommodation services, Marae.

11.02 For these areas staff will ensure that **Māori** protocols are followed and that **Tikanga** governs.

12.00 General Areas

12.01 These are areas used on occasion for a **Māori** specific purpose. This includes rooms that are not permanently governed by **Māori Tikanga** and protocols except on specific occasions.

12.02 On these occasions staff will ensure that **Tikanga** governs and **Māori** protocols are followed e.g. **Pōwhiri**. All areas used in the care of **Tūpāpaku** e.g. **Whānau**/Family Rooms, will follow the outlining the procedures for **Tūpāpaku** (Deceased Person).

13.00 Whānau/Family Room

13.01 **Whānau**/Family Rooms are designated rooms located on the ward. All **Whānau**/Family Rooms are governed by tikanga principles and protocols. This room supports the needs of whānau/family of Tūroro on the ward. The **Whānau**/Family Room is available to all Tūroro, staff, and whānau/families regardless of ethnicity.

13.02 Staff will ensure the following principles have priority in the **Whānau**/Family Rooms:

- **Whānau** caring for **Tūroro** throughout the process of dying.
- When the **Whānau**/Family Room is occupied by **Tūpāpaku**, staff will ensure that the **Tikanga** Recommended Best Practice outlining the procedures for **Tūpāpaku** are followed.

13.03 **Whānau**/Family Rooms will be guided by the following:

- Everyday use of the **Whānau**/Family Rooms will be determined by consultation between ward staff and appropriate **Māori** staff
- Staff will negotiate with **whānau** the use of the space for other meeting purposes.

14.00 Research

14.01 **Te Tiriti o Waitangi**/The Treaty of Waitangi principles of partnership, participation and protection will be actively addressed and undertaken in good faith. This will occur from the outset of the project i.e. from the negotiating and formulation of the research to the final outcome.

14.02 Researchers must address how the research will benefit **Māori**, including how information will be shared with **Māori**.

14.03 Before research is initiated, consent may be required from iwi groups, particularly if the research may potentially breach **Tikanga** or involve sensitive issues. This is over and above individual consent.

14.04 Some issues may also require consent from **Iwi** and/or **Hapū** especially where ownership may belong to collective stakeholders.

14.05 Informed consent (written and verbal) must be sought from **Māori** participants and/or **whānau** involved in the research. This includes requests for body parts/tissue and/or substances (including genetic material) to be collected for research purposes.

14.06 Return, retention or disposal procedures will be discussed and agreed to by participants. This will be documented.

14.07 Time will be allowed for consultation and decisions to be reached.

14.08 Confidentiality will be maintained, in particular where individuals may be identifiable.

15.00 Removal, Retention, Return or Disposal of Body Parts and/or Tissue and/or Substances including Placenta

15.01 Regardless of how minor the part/tissue or substance is perceived to be by staff, the following process will be followed. All discussions will be non-directive and follow an informed process.

15.02 Staff will talk with the **Tūroro** and/or **whānau** giving a true and clear verbal explanation regarding the full procedure and options as early as possible.

15.03 Staff will offer the option of further support from the appropriate **Māori** staff. Where possible this must happen prior to any intervention.

15.04 Staff will offer the option of **karakia** and make the arrangements if required.

15.05 Staff will give a clear verbal and written explanation to the **Tūroro** and/or **whānau** regarding the interpretation of the terms body parts, human tissue and substances.

15.06 The removal, retention, return or disposal of body parts/tissue/substances will follow WCDHB Procedures and written information will be made available to **whānau** and/or **Tūroro** where applicable.

15.07 Staff will ensure that the **Tūroro** and/or **whānau** have the correct information to make an informed choice. This is especially critical when staff request body parts/tissue be retained and/or examined.

15.08 Staff will consult with the **Tūroro** and/or **whānau** regarding their intentions for removal, retention, return or disposal.

15.09 The process used to discuss this will be done in a sensitive, non-judgmental and consultative way.

15.10 Time will be allowed for the **Tūroro** and/or **whānau** to consult and reach a decision unless immediate physical care is severely compromised e.g. urgent amputation.

15.11 Explicit consent must be obtained (in writing) for the removal of body parts and tissue.

15.12 Explicit consent must be obtained for the retention of body parts.

15.13 Informed acceptance must be obtained for the retention of tissue.

15.14 Where retention is consented to, the purpose for retention will also be agreed to through an informed consent process i.e. for the purpose of education and teaching. This will be documented.

15.15 Future use will **only** be the original purpose as agreed to by **Tūroro** and/or **whānau**.

15.16 In most cases informed acceptance will be obtained (verbally) for the collection, retention, return and or disposal of substances e.g. blood.

15.17 Staff will respect all decisions made by the **Tūroro** and/or **whānau**.

15.18 Staff will document all discussions and decisions in the clinical notes, using the appropriate documentation.

15.19 Staff will ensure all body parts/tissue and substances are correctly labeled and documented. This is especially crucial if returns are requested.

15.20 All body parts/tissue/substances will be returned when requested if this does not involve a high risk to safety.

15.21 Staff will ensure any special requests regarding the retention, return or disposal of body parts/tissue/substances are documented and monitored.

15.22 Where body parts/tissue/substances are not immediately returned, they will be retained for a reasonable time to allow for the **Tūroro** and/or **whānau** to consent to a process for return, retention or disposal. Flexibility will be allowed.

15.23 Staff will make every attempt to ensure body parts/tissue and substances are returned quickly.

15.24 Staff will inform the **Tūroro** and/or **whānau** of any necessary safety precautions regarding the handling and disposal of the returned body parts/tissue/substances.

15.25 The return of body parts/tissue/substances will be carried out in a way that is consistent with **Tikanga** and in consultation with appropriate **Māori** staff.

15.26 Body parts/tissue/substances will be returned in containers that are durable and reflect **Tikanga** practices. This will be determined in consultation with appropriate **Māori** staff.

15.27 Staff will record and carry out the wishes of the **Tūroro** and/or **whānau** for the return or disposal of body parts/tissue/substances if the original purpose for retention changes e.g. later found unsuitable for use. Returns will follow **Tikanga** practices and protocols determined in consultation with **Māori** staff.

15.28 Staff will offer the return of all hair, fingernails and toenails. This will be documented in the clinical notes.

15.29 These will be saved in a patient labeled snap closure plastic bag and returned to the **Tūroro** and/or **whānau**.

16.00 Pending Death

16.01 Where possible, **whānau** will have the choice of taking their terminally ill relative home.

16.02 Where death is expected imminently, **whānau** will be notified immediately.

16.03 Where death is expected imminently, support staff involved in the care of the **Tūroro** will be notified immediately.

16.04 Staff will make every attempt to ensure a single room is available.

16.05 Staff will make every attempt to allow **whānau** to be present at all times.

16.06 Staff will facilitate access to appropriate staff e.g. chaplain and facilities (Chapel).

16.07 If there is the potential for involvement from the coroner, **whānau** will be informed at the earliest opportunity.

16.08 If there is the potential of a post mortem request, **whānau** will be consulted immediately.

17.00 Movement of Tūpāpaku

17.01 The wishes of the **whānau** will always be respected as to how the **Tūpāpaku** is moved.

17.02 Whānau will be able to accompany the **Tūpāpaku** when moved.

17.03 Staff will always handle the **Tūpāpaku** in a sensitive and respectful manner.

17.04 The **Tūpāpaku** will always be transported feet first.

17.05 Transportation of **Tūpāpaku** will be conducted discreetly.

17.06 All services will have a pre determined "pathway" for **Tūpāpaku**.

17.07 Staff will ensure all linen, food cupboards, inpatient and staff pantry and toilet doors are closed during the moving of **Tūpāpaku**.

17.08 The movement of **Tūpāpaku** through public areas will be avoided wherever possible. If not, staff will use the shortest route, **avoiding food and waste areas**. This will be carried out in an efficient, respectful and dignified manner.

17.09 Staff will ensure that the designated lifts are used.

18.00 Following Removal of Tūpāpaku

18.01 Where possible, **karakia** will be performed in the room/area as soon as the **Tūpāpaku** is removed.

18.02 Where possible, the room will not be physically cleaned until **karakia** has occurred.

19.00 Autopsy

19.01 When a post mortem is required by the coroner, or requested by staff a true explanation will be given to **whānau**.

19.02 At all times staff will continually update and inform **whānau**. This will be done as soon as possible so **whānau** are prepared and informed.

19.03 Staff will respect the privacy of **whānau** during discussions.

19.04 A quiet, private area will be allocated to **whānau**.

19.05 Support staff will be notified as soon as possible

19.06 The removal or cutting of **Tūpāpaku** hair is to be avoided unless absolutely necessary to any post mortem. **Whānau** will be notified of this prior to the procedure and offered the option of retaining the hair.

19.07 Staff will make every attempt to ensure a speedy release of the **Tūpāpaku**.

19.08 If a non-coronial post mortem is requested, staff will ensure **whānau** have the correct information to make an informed choice and if agreed, give informed and written consent.

19.09 Time will be allowed for the **Tūroro** and/or **whānau** to consult and reach a decision.

19.10 The retention of body parts/tissue/substances must follow the **Tikanga** Best Practice Guidelines.

19.11 Discussion with **whānau** will also include information on the use of photography. Informed consent for this must be obtained.

19.12 All procedures will be discussed in a sensitive, non-judgmental non-directive and consultative way.

19.13 Staff will document all discussions and decisions in the clinical notes and appropriate documentation.

19.14 All body parts and/or tissue will be returned as soon as possible and follow the **Tikanga** Best Practice Guidelines outlining their return.

19.15 All consents will be clearly documented. A record of parts/tissue retained will be kept.

19.16 In coronial cases staff must ensure that **whānau** have access to information regarding the autopsy procedures, it is for the coroner's office to ensure this information is provided. When body parts and/or tissue are required for further analysis in determining death it is the responsibility of the pathologist to ensure that appropriate liaison and/or consultation with the family/ **whānau** occurs

19.17 Informed consent will be obtained for any procedures other than those needed to establish cause of death.

19.18 Body parts, tissue and/or substances will only be taken if needed to determine the cause of death.

19.19 Return, retention or disposal will follow the **Tikanga** Best Practice Guidelines.

19.20 Retention of body parts and/or tissue from post mortems beyond the agreed and/or required examination time will not be retained unless written and verbal informed consent has been obtained.

19.21 All consents will be clearly documented. A record of parts/tissue retained will be kept.

19.22 All body parts and/or tissue will be returned as soon as possible and will follow the **Tikanga** Best Practice Guidelines outlining their return.

7. Precautions and Considerations

- ➔ Patients/residents/clients must be allowed to identify themselves as **Māori**.
- ➔ When treating **Māori** it is important for staff members to acknowledge their cultural values and. beliefs in relation to the four cornerstones of **Māori** health care.
- ➔ Cultural assessments can be provided as part of the interdisciplinary team approach to care and are to be undertaken by a suitably qualified and experienced staff member.

8. References

There are no references associated with this Procedure.

9. Related Documents

WCDHB Return of Body Parts Procedure

WCDHB Informed Consent Procedure

WCDHB Ethics Procedure

WCDHB Compliance with the Code of Health and Disability Services Consumer Rights Procedure

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TATAU POUNAMU KI TE TAI O POUTINI
Manawhenua Advisory Group

Ko ngā mātāpono e whakahaere nei i ngā mahi me ngā tikanga a Te Rūnanga o Ngati Waewae raua ko Te Rūnanga o Makaawhio me Te Poari Hauora ki Te Tai Poutini.

MEMORANDUM OF UNDERSTANDING

BETWEEN

TE RŪNANGA O NGATI WAEWAE AND TE RŪNANGA O MAKAAWHIO

AND THE

WEST COAST DISTRICT HEALTH BOARD

West Coast
District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Te Rūnanga o Ngāti Waewae

Te Runanga o Makaawhio

TABLE OF CONTENTS

1 Ngā Mana

Parties

"Te Rūnanga O Ngati Waewae raua ko Te Rūnanga O Makaawhio"

"Kia eke a Poutini Ngāi Tahu ki te whakaoranga tonutanga"

"Raise up the wellbeing and restore health of the people of the West Coast"

1.1 For the purposes of this relationship Te Rūnanga o Ngati Waewae and Te Rūnanga o Makaawhio agree that together they will comprise Poutini Ngai Tahu and be represented in their relationship with the West Coast District Health Board by Tatau Pounamu Manawhenua Advisory Group.

1.2 This Memorandum of Understanding is signed on behalf of Poutini Ngai Tahu by the respective chairs' of Te Rūnanga o Ngati Waewae and Te Rūnanga o Makaawhio.

1.3 This Memorandum of Understanding recognises the special relationship and obligations upon the West Coast District Health Board in exercising its Treaty partnership with Poutini Ngai Tahu, as represented by Te Runanga o Makaawhio and Te Runanga o Ngati Waewae.

"West Coast District Health Board"

"Whānau ora ki te Tai Poutini"

"Health and wellbeing for families of the West Coast"

1.4 The West Coast District Health Board has statutory objectives and functions set out in the New Zealand Public Health and Disability Act 2000 and has particular objectives to improve, promote and protect the health of people and communities and for reducing health disparities by improving health outcomes for Maori and other population groups - see Appendix 1: New Zealand Public Health and Disability Act 2000 Section 22(1)(a)-(h).

1.5 This Memorandum of Understanding is signed by the chair on behalf of the West Coast District Health Board.

1.6 This agreement between the parties does not affect the West Coast District Health Board from ability to interact and enter into relationships with other stakeholders in the region including Māori from other iwi living within the West Coast District Health Board's region.

2 Te Take

Purpose

2.1 This document articulates agreed principles to improve health outcomes for Māori consistent with the philosophy of the New Zealand Public Health and Disability Act 2000, and sets the guidelines for an enduring collaborative relationship between the parties.

3 Te Putake

Foundation

3.1 The parties acknowledge that the Treaty of Waitangi is a founding document of Aotearoa/ New Zealand and as such lays an important foundation for the relationship between the Crown and Māori. The parties wish to record their agreed understanding of how this Treaty based relationship, focused on health, will improve Māori health outcomes.

4 Ko Ngā Matāpono O Te Nohongā Tahi

Principles of the relationship

The following principles will guide the relationship:

4.1 Acknowledgement of the importance of the Treaty of Waitangi (as referred to in clause 3.1);

4.2 Acknowledgement of the shared interest of all parties in the development and implementation of policy and legislation in the health sector on behalf of the community;

4.3 Commitment to work together within an environment of trust (whakapono) honesty (pono), respect (whakaute), and generosity (manaakitanga) towards each other, recognising and understanding the capabilities and constraints each party brings to the relationship.

4.4 Both parties acknowledge their role as guardians and stewards for generations that will follow. It is recognised that each party will have different lines of accountability enabling each party to develop and grow in its own way while recognising and acknowledging difference.

4.5 To provide a framework for the parties to work together towards improving Māori health outcomes by:

a) Efficient use and allocation of resources;
b) Effective representation;
c) Discussing and reaching agreement on key issues of West Coast District Health Board strategic plans in respect to Māori.
d) Acknowledging and respecting the accountabilities of each party in the planning and decision making process.

5 Ko Ngā Tikanga Mo Te Mahi Tahi

Process for working together

5.1 The process for all parties working together is outlined in the Tatau Pounamu Terms of Reference (see Appendix 2).

6 Ngā Āhuatanga Me Ngā Kawenga

Roles and responsibilities

6.1 The West Coast District Health Board and Tatau Pounamu will work together on activities associated with the planning of health services for Māori in Te Tai Poutini rohe.

6.2 The West Coast District Health Board and Tatau Pounamu will take responsibility for the activities listed below:

6.2.1 The West Coast District Health Board will:

- a) Involve Tatau Pounamu in matters relating to the strategic development and planning and funding of Māori health initiatives in the Te Tai Poutini rohe;
- b) Establish and maintain processes to enable Maori to participate in, and contribute to strategies for Maori health improvement
- c) Continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori
- d) Include Tatau Pounamu in decision making process that may have an impact on Poutini Ngāi Tahu; and
- e) Feedback information to Tatau Pounamu on matters which may impact on the health of Māori in Te Tai Poutini rohe.

6.2.2 Tatau Pounamu will:

- a) Involve West Coast District Health Board in matters relating to the development and planning of Māori health and disability.
- b) Feedback information to Ngā Rūnanga o Poutini Ngāi Tahu as required;
- c) Advise West Coast District Health Board on matters which may impact on the health of Māori in Te Tai Poutini rohe;
- d) Assist West Coast District Health Board to acquire appropriate advice on the correct processes to be used so as to meet Poutini Ngāi Tahu kawa (custom/protocol) and tikanga (rules of conduct).

7 Ngā Hui

Meetings

7.1 All meetings shall be consistent with the guidelines as described in the Tatau Pounamu Terms of Reference.

7.2 Establish a relationship between the chair Tatau Pounamu and chair and/or deputy chair, West Coast District Health Board through meetings held (three times per annum); the chair and/or deputy chair of the West Coast District Health Board shall be invited to attend no less than one Tatau Pounamu meeting per annum.

7.3 Tatau Pounamu will invite the West Coast District Health Board bi-annually to meet on a marae.

8 Nga Rawa

Resourcing

8.1 The West Coast District Health Board will provide administrative support resources for this relationship as outlined in the Tatau Pounamu Terms of Reference.

8.2 Tatau Pounamu members will be paid meeting fees and actual and reasonable expenses associated with attendance at meetings as stated in the West Coast District Health Board and committee members manual.

9 Ko Ngā Rawa Hei Whakatutuki I Ngā Mahi I Raro I Ngā Ture

Statutory and contractual obligations

9.1 The parties acknowledge that this Memorandum of Understanding is not legally enforceable, but that this does not diminish the intention of the parties to meet the expectations and undertakings of this Memorandum of Understanding.

10 Te Mana Kokiri

Authority to speak

10.1 The parties agree that they will not make any statement on the other's behalf to any third party without the express authorisation of the other party.

11 Te Noho Matatapu

Confidentiality

11.1 The parties agree that unless otherwise required by law, or by mutual agreement, they will keep confidential all information acquired as a result of this agreement.

11.2 The parties specifically acknowledge that information relating to or produced by the relationship may be required to be released under the Official Information Act 1982.

12 Tirohanga Hou Me Ngā Whitinga

Review and variation

12.1 This Memorandum of Understanding records a commitment to an enduring collaborative relationship. The parties acknowledge that over time the nature and focus of the relationship may evolve to reflect changing circumstances. Therefore, the parties will meet solely for the purpose of reviewing this Memorandum of Understanding in two years, and every three years subsequent for a review of the Memorandum of Understanding to be undertaken;

12.2 The parties may at any time amend this agreement

13 Whakataunga Raruraru

Problem resolution

13.1 In the event of any dispute arising out of the subject matter of this Memorandum of Understanding the parties agree to the following process:

a) In the first instance the chairs of the parties will meet and use their best endeavours to resolve the dispute;

b) If following a) the dispute is not resolved, the parties will engage in mediation through an agreed process.

14 Term of Memorandum of Understanding

14.1 This Memorandum of Understanding commences upon signing by both parties;

14.2 This Memorandum of Understanding may be terminated by mutual agreement or by either party giving three months notice to the other party.

TATAU POUNAMU KI TE TAI O POUTINI

Manawhenua Advisory Group to the West Coast District Health Board

TATAU POUNAMU
Terms of Reference

TABLE OF CONTENTS

1. Mission Statement

1.1 "Whakapiki ake te hauora Māori ki te Tai o Poutini."

This mission statement is reflective of the belief that:

1.1.1 Good health and wellness outcomes for Māori will be advanced through the West Coast District Health Board (WCDHB) working with Iwi/Maori community.

1.1.2 Individuals will want to maximise their own health, wellbeing and independence.

1.1.3 Promoting health and preventing illness or injury is an essential investment.

1.1.4 People's fundamental rights and responsibilities should be the focus of all services.

1.1.5 Tatau Pounamu Manawhenua Advisory Group (Tatau Pounamu) will have significant involvement in planning processes, which will help make better and more informed planning decisions.

1.1.6 Open decision making will contribute to Iwi/Maori community confidence.

1.1.7 Improved access to services should be fair and based on need.

1.1.8 Improved co-ordination and integration of health providers and services will improve outcomes and contribute to reducing inequalities.

1.1.9 The spirit of all relationships should be collaborative and co-operative.

1.1.10 Working intersectorally (e.g. local government, education, employment and housing) is necessary to achieve improved health outcomes.

1.1.11 Good information will improve decision-making.

1.1.12 Iwi/Maori community throughout the region have a right to an efficient and effectively performing committee.

2. Mission and Objectives

2.1 Tatau Pounamu will focus on:

2.1.1 Strategic planning of service initiatives that positively impact on Māori for the region.

2.1.2 Specific cultural policy development for West Coast District Health Board.

2.1.3 Provision of Māori cultural guidance and support to West Coast District Health Board.

3. Role of Tatau Pounamu Manawhenua Advisory Group

3.1 The West Coast District Health Board and Tatau Pounamu will work together on activities associated with the planning of health services for Māori in Te Tai Poutini rohe, in accordance with the Memorandum of Understanding between WCDHB and Tatau Pounamu.

3.2 The West Coast District Health Board and Tatau Pounamu will take responsibility for the activities listed below:

3.2.1 The West Coast District Health Board will:

a) Involve Tatau Pounamu in matters relating to the strategic development and planning and funding of Māori health initiatives in the Te Tai Poutini rohe;

b) Establish and maintain processes to enable Maori to participate in, and contribute to strategies for Maori health improvement

c) Continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori

d) Include Tatau Pounamu in decision making process that may have an impact on Poutini Ngāi Tahu; and

e) Feedback information to Tatau Pounamu on matters which may impact on the health of Māori in Te Tai Poutini rohe.

3.2.2 Tatau Pounamu will:

a) Involve West Coast District Health Board in matters relating to the development and planning of Māori health and disability;

b) Feedback information to Ngā Rūnanga o Poutini Ngāi Tahu as required;

c) Advise West Coast District Health Board on matters which may impact on the health of Māori in Te Tai Poutini rohe;

d) Assist West Coast District Health Board to acquire appropriate advice on the correct processes to be used so as to meet Poutini Ngāi Tahu kawa (custom/protocol) and tikanga (rules of conduct).

4. Composition of Tatau Pounamu

4.1 Membership

The total membership of Tatau Pounamu shall be seven (7) and the composition shall be determined as follows:

4.1.1 Tatau Pounamu is the recognised manawhenua advisory group regarding Māori health for Te Tai o Poutini

4.1.2 Each Papatipu Rūnanga of Tai Poutini, that being Te Rūnanga O Ngati Waewae and Te Rūnanga O Makaawhio will select 2 representatives each from respective hapu (4).

4.1.3 In addition Tatau Pounamu will select 2 Māori community representatives (2) from Tai Poutini communities.

4.1.4 One member of the West Coast District Health Board to be appointed by the West Coast District Health Board to the Tatau Pounamu Manawhenua Advisory Group.

4.1.5 Elected members not resident in Te Tai O Poutini costs may be met by their nominated body.

4.1.6 Alternatives or proxy voting will be allowed for Committee members.

4.1.7 Committee members will be provided with a copy of the New Zealand Public Health and Disability Act 2000 Whakatataka, He Korowai Oranga, and West Coast District Health Board Māori Health Plan.

4.1.8 A quorum shall consist of not less than four (4) members and must include at least one (1) member from each of the Poutini Papatipu Rununga

4.2 Chairperson

4.2.1 The appointed Chairperson must be from one of the Poutini Ngai Tahu Runanga and rotate between Runanga every 3 years and will remain in this position until such time as:

4.2.2 The Chairperson ceases to be a member of the Committee; or

4.2.3 The Chairperson is removed from the chair by a consensus vote within Tatau Pounamu

4.2.4 The Chairperson is responsible for the efficient functioning of the Committee and sets the agenda for meetings.

4.2.5 The Chairperson must ensure that all Committee members are enabled and encouraged to play a full role in the activities of the Committee and have adequate opportunities to express their views.

4.2.6 The Chairperson is responsible for ensuring that all Committee members receive timely information to enable them to be effective Members.

4.2.7 The Chairperson is also the link between Committee members and the General Manager, Māori Health of the West Coast District Health Board.

4.3 Co-opted Membership

4.3.1 Tatau Pounamu may co-opt additional members to the Tatau Pounamu from time to time, for specific Kaupapa for specific periods and purposes as it deems necessary to assist the Committee.

4.4 Sub Committees

4.4.1 Tatau Pounamu may form sub committees from time to time, from within its members and co-opt experts in the specified fields for specified periods and purposes as it deems necessary to assist the Committee.

5. Term of Office

Membership is determined as in Clause 4.

5.1 Members of this Committee will remain in office for the period of three (3) years or until such time as;

5.1.1 A member resigns from the committee.

5.1.2 A member is removed from the committee either by its members or the appointing body

5.2 Accountability

5.2.1 Tatau Pounamu and its members are accountable to the respective bodies who appointed them ie; Papatipu Rununga, in the case of the Maori community representatives to Tatau Pounamu.

5.2.2 The Tatau Pounamu Chair will ensure that performance reviews are conducted of the Tatau Pounamu members, annually or sooner if the Chair and appointing committee deems it necessary.

5.3 Attendance at Committee Meetings

5.3.1 West Coast District Health Board members and members of the public will be welcome to attend meetings. Tatau Pounamu may on occasion go into public excluded meetings for discussion of a sensitive nature. These meetings will only be open to members and invitees.

5.4 Management Reporting

5.4.1 The West Coast District Health Board management will be responsible for providing information / reporting on issues requested by Tatau Pounamu to the West Coast District Health Board.

5.5 Administrative Support

5.5.1 The Māori Health Unit and chair of Tatau Pounamu will be responsible for the co-ordination and facilitation of Committee meetings.

5.5.2 The Māori Health Unit will ensure adequate administrative support for Tatau Pounamu.

5.5.3 Internal secretarial, legal, financial, analytical and administrative staff will also support Tatau Pounamu.

6. Annual Workplan

6.1 Tatau Pounamu will develop an annual work plan that outlines planned activity for the year.

The annual work plan will be monitored at committee meetings and a report written against the set objectives bi-annually and annually.

Key elements are:

6.1.1 Communication strategy – reciprocal reporting to statutory committees, primary health organisation and back to appointing bodies.

6.1.2 Prioritise Māori strategies/projects

6.1.3 Monitor Māori health gains

6.1.4 Joint Board / Manawhenua Advisory Group meetings scheduled

6.1.5 Budget management

6.1.6 Leadership and succession planning

6.1.7 Monitor Implementation of Maori Health strategies

7. Collective Responsibility

7.1 Members recognise that at times there may be tension between the concepts of collective accountability of Tatau Pounamu and individual accountability to Iwi/Maori.

Members agree to support and abide by the following principles:

7.1.1 Members may clearly express their Iwi views at Tatau Pounamu hui and endeavour to achieve a particular decision and course of action. However, members accept that once a decision has been formally reached by Tatau Pounamu, this decision is binding.

7.1.2 It is inappropriate for a member to undermine a decision of Tatau Pounamu once made, or to engage in any action or public debate, which might frustrate its implementation.

7.1.3 Individual members will not attempt to re-litigate previous decisions at subsequent hui, unless a majority of members agree to re-open the korero.

7.1.4 Members' personal actions should not bring Tatau Pounamu into disrepute or cause a loss of confidence in the activities and decisions of Tatau Pounamu.

8. Tatau Pounamu Agendas

8.1 Requests for Items to be placed on Tatau Pounamu Agendas

8.1.1 Members with a request for an item to be placed on the Agenda must notify the minute secretary no later than 48 hours prior to the hui. Personal agenda items; members must seek the support of its appointing body prior to it being placed on the agenda.

8.1.2 No new items will be accepted on the agenda, but placed on the agenda for the next scheduled meeting.

8.1.3 It is accepted that at times certain kaupapa will command priority. In these instances Tatau Pounamu will exercise its' own discretion and proceed accordingly.

8.1.4 The Agenda will be structured to ensure that decision papers have priority with information papers included under a separate section.

9. Behavior and Attendance

9.1 Behaviour and Attendance at Hui

9.1.1 Members undertake to have read and familiarise themselves with the minutes of the previous hui.

9.1.2 Members will only make a point if it has not already been raised and is relevant to the kaupapa.

9.1.3 Members will not interrupt each other or talk while another member is speaking.

9.1.4 Issues will be raised in an objective manner no personal reference or innuendo will be made to persons associated with the matter being raised.

9.1.5 Members will endeavour to achieve closure on one point before another point is raised.

9.1.6 Cell phones will be on silent during Tatau Pounamu hui.

9.1.7 Members, the Chair and the General Manager of Māori Health will endeavour to clarify questions, issues, and requests before taking actions or responding.

9.1.8 Will not use their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducements and which could compromise the Mana of Tatau Pounamu.

9.1.9 Will exercise care and judgement in accepting any gifts, and advise the Chair and/or the Tatau Pounamu of any offer received.

9.1.10 Non-attendance at three (3) consecutive hui without extenuating circumstances is deemed unacceptable resulting in notification to the Chair of their Iwi/ appointing body of their unavailability along with a request for consideration for a replacement.

9.1.11 All members will assist the Chair to uphold the behaviour protocols agreed to by Tatau Pounamu.

10. Conflict of Interest

10.1 The New Zealand Public Health and Disability Act 2000 sets out the definition and procedure for disclosure of member's interests:

10.1.1 A member who is 'interested in a transaction' of the West Coast District Health Board must, as soon as practicable, disclose the nature of the interest to Tatau Pounamu.

10.1.2 The member must not take part in any deliberation or decision of Tatau Pounamu relating to the transaction.

10.1.3 The disclosure must be recorded in the minutes and entered in a separate interest's register.

10.1.4 Recognise that where an interest is declared (or where considered that there is a clear "perception of interest") the normal practice is for the member concerned to leave the room. Tatau Pounamu can, however, exercise it's discretion in allowing the member to remain. In such circumstances the member may have speaking rights but would not participate in any decision.

11. Public Statements

11.1 Communications from the committee with the public and the media will be subject to the following principles:

11.1.1 Only the Chairperson or delegated spokesperson may speak on behalf of Tatau Pounamu.

11.1.2 If a dissenting member is approached by the media for comment after a hui the member is bound by the general decision, but may expand on an issue or point raised personally by the member at that particular hui.

11.1.3 The focus is to remain on the issue and not personalised in any way that is critical of employees or other members of Tatau Pounamu.

11.1.4 Members will advise Tatau Pounamu if they are contacted by or intend to speak to the media.

11.2 Should an opinion be sought from the media members should:

11.2.1 Make clear the capacity in which they are speaking; i.e. personal views and not those of Tatau Pounamu.

12. Training

12.1 Members are required where possible:

12.1.1 To be familiar with the obligations and duties of a member of Advisory Committees and avail themselves of opportunities for training in areas deemed appropriate. This may include courses and or training provided by West Coast District Health Board.

13. Review

13.1 Tatau Pounamu may review these Terms of Reference at any time.

SIGNED ON BEHALF OF

THEIR RESPECTIVE ORGANISATIONS

Name: ....

Chairperson:...

For Tatau Pounamu

Date: ....

Name: ....

Chief Executive Officer:...

For West Coast District Health Board

Date: ....

Witnessed by: ....

Name: ....

Date: ....

West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Code of Conduct For Staff

1. Purpose

The West Coast District Health Board (WCDHB) has established this staff Code of Conduct to ensure that staff have a clear indication of behaviour expectations.

2. Application

This Procedure is to be followed by all staff throughout the WCDHB.

3. Definitions

There are no definitions associated with this Procedure.

4. Responsibilities

For the purposes of this Code every WCDHB staff member has three primary obligations under this Code of Conduct:

i) a duty of care to observe all professional and legal standards;
ii) an obligation to WCDHB in terms of responsible stewardship of its resources and protection of its reputation in the wider community;
iii) an obligation to act appropriately when a conflict of interest arises.

5. Resources Required

This Code requires no specific resources.

6. Process

1.00 This Code of Conduct is intended to guide WCDHB staff members to identify and resolve issues of ethical conduct that may arise out of their employment. It is designed to guide staff in their dealings with their colleagues, patients/clients, WCDHB and the wider community.

1.01 This Code of Conduct is written as a set of general principles rather than a detailed prescription. The Code of Conduct stands beside but does not exclude or replace the rights and obligations of staff members under common law. Breaches of the Code of Conduct should be read in conjunction with the WCDHB Staff Discipline, Suspension and Dismissal Procedure.

1.02 It is the responsibility of all practitioners to know the provisions of the Health Professionals Competency Assurance Act as their governing legislation.

1.03 It is the responsibility of all practitioners to notify the employer if there is any change in scope of practice that impacts on ability to practice, which includes:

- Not being in possession of an annual practising certificate or any other professional practising requirement where required by legislation and/or falsely claiming reimbursement from the WCDHB; or
- Failure to notify the WCDHB of a change in their scope of practice that

may have an effect on their ability to carry out the duties and functions of your position.

1.04 With respect to their duty of care, all WCDHB staff members will at all times:

- undertake professional clinical practice in accordance with the requirements of the Code of Health and Disability Services Consumers Rights;
- treat other WCDHB staff members with respect;
- not breach any professional/clinical Code of Practice or Code of Ethics that governs the staff member's professional practice
- comply with all lawful and reasonable instructions and to work as directed;
- not allow personal relationships to affect professional relationships;
- not enter into sexual or inappropriate relationships with a patient/client;
- refrain from all forms of harassment; as detailed in the WCDHB Prevention of Harassment Procedure;
- abide by all WCDHB Policies, Procedures, Guidelines and Regulations;
- give due credit to the contributions of other WCDHB staff members;
- consider carefully the desirability of intervening constructively where a colleague's behavior is clearly in breach of this Code, and be prepared to report any suspected fraud, corruption, criminal or unethical conduct to a General / Senior manager;
- consider the impact of one's own decisions and actions on the well-being of others (both staff and patients/clients) especially with regard to safety;
- respect an individual's (staff and patient/clients) right to privacy and under-take to keep personal information in confidence in accordance with relevant WCDHB Policies, Procedures and Guidelines, as well as the requirements of the Privacy Act (and Amendments) and the Health Information Privacy Code.

1.05 With respect to their obligation to WCDHB, staff members will at all times:

- refrain from representing themselves as spokes-persons for the WCDHB unless authorised to do so;
- refrain from representing themselves as acting for, or on behalf of WCDHB unless authorised to do so;
- refrain from engaging in any outside activities that would compromise the integrity and standing of WCDHB;
- avoid improper use of the resources of WCDHB for private gain or for the gain of a third party;
- not incur any liability on the part of WCDHB without proper authorisation;
- not disclose confidential WCDHB information or information relating to any of its activities, and shall use their best endeavours to prevent the publication or disclosure of the same.

1.06 With respect to conflict of interests, WCDHB staff members should take suitable measures to avoid, or appropriately deal with, any situation in which they may have, or be seen to have, a conflict of interest arising out of their relationship with another staff member or client/patient.

1.07 Where both a supervisory role and significant relationship between WCDHB staff members exists, supervision must be openly seen to be of the highest professional standard and should not unfairly advantage or disadvantage the WCDHB staff member being supervised.

1.08 All WCDHB staff members must take care that their financial and other pecuniary interests and actions do not conflict or seem to conflict with the obligations and requirements of their position of employment.

1.09 Where a staff member finds themselves in a situation of a conflict or potential conflict of interest, they should declare this in writing to their Manager. The staff member should deliberately exempt themselves from any decision-making or approval process associated with situations where a conflict of interest might arise.

7. Precautions and Considerations

Every WCDHB staff member has three primary obligations under this Code of Conduct:

i) a duty of care to observe all professional and legal standards;
ii) an obligation to WCDHB in terms of responsible stewardship of its resources and protection of its reputation in the wider community;
iii) an obligation to act appropriately when a conflict of interest arises.

8. References

WCDHB Staff Discipline, Suspension and Dismissal Procedure.

9. Related Documents

WCDHB Staff Discipline, Suspension and Dismissal Procedure.

Revision History	Version:	9
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West Coast
– District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Ethnicity Data Collection Procedure

Please note: This Procedure is currently under review by ISG (and Planning & Funding) as part of a Transalpine approach to policy alignment with the CDHB. If you have any questions regarding this document please contact the Chief Information Officer in the first instance.

1. Purpose

This Procedure outlines the process whereby the West Coast District Health Board (WCDHB) will undertake collection of ethnicity data in order to comply with its accountability obligations in the Crown Funding Agreement, Operational Policy Framework, and as part of its responsibility to implement the WAVE Report.

2. Application

This Procedure is to be followed by all WCDHB staff members.

3. Definitions

For the purposes of this Procedure:

Ethnicity is taken to mean the ethnic group or groups that people identify with or feel they belong to. Therefore ethnicity is <u>self-perceived</u> and people can belong to more than one ethnic group. In addition, people can and do change their ethnic affiliation, both over time and depending upon the context in which they are asked to state their ethnicity.

Ethnic Group is taken to mean a social group whose members have the following four characteristics:

- share a sense of common origins;
- claim a common and distinctive history and destiny;
- possess one or more dimensions of collective cultural individuality;
- feel a sense of unique collective solidarity.

4. Responsibilities

For the purposes of this Procedure:

The ***WCDHB*** will ensure that its provider arm (WCDHB) and providers with whom it has contracts collect ethnicity data in an accurate manner, according to the requirements of this Procedure.

WCDHB Staff Members are required to collect ethnicity data in a manner that is respectful, cultural appropriate and mindful of the individual's rights to privacy and confidentiality.

5. Resources Required

This Procedure requires:

i) WCDHB Ethnicity Question
ii) Ethnicity Collection Training Standards developed by Statistics NZ, the NZ Health Information Service and the Wellington School of Medicine.

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iii) WCDHB Ethnicity Data Collection Audit Tool
iv) WCDHB Ethnicity Collection Information Pamphlet

6. Process

1.00 The WCDHB will ensure that its provider arm (WCDHB) and providers with whom it has contracts collect ethnicity data in an accurate manner, according to the requirements of this Procedure.

1.01 Ethnicity is a vital demographic and social variable. Users of statistics, including health and disability service agencies and providers, require reliable, consistent and relevant data on ethnicity in order to measure differences in social well-being, social interaction and social change.

1.02 The WCDHB undertakes to use ethnicity date for the following purposes:

- i. As a basis for monitoring and reporting changes and disparities in outcomes and utilisation among ethnic groups over time;
- ii. To assist in monitoring progress with implementing the obligations of the Treaty of Waitangi;
- iii. To monitor the changing ethnic diversity of our population, so that service delivery can be appropriately targeted;
- iv. Population estimates and projections for Mäori, Pacific, European and Asian populations can be calculated;
- v. The impacts and costs of central and local government policies on the economic, health and social well-being of ethnic groups evaluated and
- vi. Expenditure forecasts and funding allocations for services for particular groups on the basis of need can be developed
- vii. To assist in the delivery of services in a culturally appropriate way and to plan social services which meet the special needs of ethnic groups.

1.03 Factors that may contribute to or influence a person's ethnicity, and that are often interrelated, include:

- i. ancestry: people from whom a person is descended
- ii. culture: broadly speaking, a person's way of life, which may include language, music, literature, values and beliefs, family life, religious ceremonies, and celebration days/events which have particular cultural significance
- iii. where a person lives and the social context: e.g. rural or urban
- iv. race: descendants of a common ancestor; often refers to physical characteristics such as skin colour

v. nationality: membership of, or belonging to, a particular nation; a group or set having the character of a nation
vi. country of birth: country where a person is born, regardless of ethnic group
vii. citizenship: the status of being a citizen
viii. religion and language: religion and/or language can be a marker of an ethnic group.

1.04 While any of the above factors can be important influences on a person's ethnicity, they do not necessarily determine a person's ethnicity. The standard outlined above should be applied.

1.05 Ethnicity should be collected by means of self-identification. Where this is not possible, for example, in the case of a death, the family/whanau spokesperson should be asked to respond.

1.06 The Ethnicity question should be updated on the same time cycle as patients/clients are asked to update their address or other personal details. Generally this is will occur on an annual basis.

1.07 The WCDHB will ensure that its provider service agreements reserve its rights to monitor and audit ethnicity data collection Procedures, processes and performance.

1.08 Patients/clients are to be given the opportunity to complete the ethnicity question themselves. If an individual needs help or wants more information, they are to be provided with the information pamphlet

1.09 For Maori, they are to be asked whether they wish to provide iwi affiliation. Up to 3 iwi may be entered if the data collection and reporting capability exists.

1.10 When asking patients/clients the question directly, staff members are to be confident and matter-of-fact, saying something like:
We are currently updating our patient information and adding ethnicity to our patient register. Would you mind completing this form/answering this question?
Staff members should also reassure each patient/client about confidentiality.

1.11 Staff members are not to question an individual's response.

1.12 When a child/young person is capable of understanding the concept of ethnicity, they are to be given an opportunity to complete the question themselves.

1.13 Staff members are to avoid transferring ethnicity data from another source

1.14 If the patient/client does not wish to answer the Ethnicity question, the response should be recorded as "not stated"

Please note: This Procedure is currently under review by ISG (and Planning & Funding) as part of a Transalpine approach to policy alignment with the CDHB. If you have any questions regarding this document please contact the Chief Information Officer in the first instance.

1.15 In some circumstances, the patient/client may be unable to complete the questionnaire for him or herself. In this instance, a proxy response is desired and the method for data collection is described below.

i. *Disability* Where the respondent has a disability that will hinder their ability to complete the ethnicity question, appropriate aid should be provided.
ii. *Incapacity* If the respondent is unable to complete the ethnicity question, where possible the next of kin should answer the ethnicity question on behalf of the responder. If there is no one accompanying that person, the following steps should be taken
iii. Track and notify the personal representative to provide a proxy response, or
iv. Wait until the respondent is able to complete the ethnicity question.
v. *Deceased* The personal representative should provide a proxy response of the ethnicity of the deceased.

1.16 Up to 3 ethnic identities should be able to be recorded, and reported, in the agreed single/combination minimum output format recommended by Statistics NZ.

1.17 Providers must have suitable systems to ensure accurate and detailed ethnicity data information is captured, particularly on groups of policy interest

1.18 The priority recording and ranking systems for input, developed by Statistics NZ, must be used (See Guidelines)

1.19 Input prioritisation is to take place at processing. Therefore a practical and easy to administer system must be developed for both automatic and manual coding.

1.20 Where possible, the collection of iwi affiliation (up to 3 iwi)for Maori should be recorded, and be able to be reported.

1.21 Where NHI data is used, the ethnicity question should still be asked to check the accuracy of that field, and any updated response entered.

1.22 Providers are responsible for ensuring that initial training and regular training updates are available for all clinical and administration staff who are responsible for the collection of ethnicity data to ensure they understand the rationale for data collection, the policy details, standards, processes, reporting and accuracy required

1.23 Training programmes must reflect the standards advised by Statistics NZ, the NZ Health Information Service and the Wellington School of Medicine.

1.24 Training programmes should include the importance for Maori of recording iwi identification, and the impact this information can have on supporting cultural assessment, treatment, service planning and delivery to improve Maori Health outcomes over time.

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7. Precautions and Considerations

- ➔ The WCDHB will ensure that and its provider arm (WCDHB) and providers with whom it has contracts collect ethnicity data in an accurate manner, according to the standards set out in this
- ➔ The Ethnicity question should be updated on the same time cycle as patients/clients are asked to update their address or other personal details. Generally this is will occur on an annual basis.
- ➔ Providers are responsible for ensuring that initial training and regular training updates are available for all clinical and administration staff who are responsible for the collection of ethnicity data

8. References

Te Karangatanga Tangata", pamphlet developed by Health Utilisation Research Alliance, 2001.

9. Related Documents

WCDHB Ethnicity Data Collection Audit Tool.

10. Guidelines

Ethnicity Hierarchical Classification

Ethnicity is a hierarchical classification with five levels. Level zero has 4 categories, level one has 6 categories, level two has 25 categories, level three has 41 categories while level four has 231 categories. Providers should be able to capture, and if necessary, report ethnicity data to at least **Level 3**.

Level 0

The Level zero categories are:

1. European	2. Mäori
3. Pacific Peoples	4. Other Ethnic Groups

Level 1

The Level one categories are:

1. European	2. Mäori	3. Pacific Peoples
4. Asian	5. Other Ethnic Groups	

Level 2

The Level 2 categories are:

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10 European (nfd)[1]	11 NZ European/ Pakeha	12 Other European	21 Mäori
30 Pacific Peoples (nfd)	31 Samoan	32 Cook Island Maori	33 Tongan
34 Niuean	35 Tokelauan	36 Fijian	37 Other Pacific Peoples
40 Asian (nfd)	41 Southeast Asian	42 Chinese	43 Indian
44 Other Asian	51 Middle Eastern	52 Latin American/ Hispanic	53 African (or cultural group of African origin)
54 Other	96 Repeated Value	97 Response Unidentifiable	98 Response Outside Scope
99 Not Stated			

Level 3

The Level 3 categories are:

100 European (nfd)[2]	111 NZ European/ Pakeha	12o Other European nfd	121 British & Irish
122 Dutch	123 Greek (incl. Greek Cypriot)	124 Polish	125 South Slav (formerly Yugoslav)
126 Italian	127 German	128 Australian	129 Other European
211 Mäori	300 Pacific Peoples (nfd)	311 Samoan	321 Cook Island Maori
331 Tongan	341 Niuean	351 Tokelauan	361 Fijian
371 Other Pacific peoples	400 Asian (nfd)	410 Southeast Asian (nfd)	411 Filipino
412 Khmer/ Kampuchean/ Cambodian	413 Vietnames	414 Other Southeast Asian	421 Chinese
431 Indian	441 Sri Lankan	442 Korean	444 Other Asian
511 Middle Eastern	521 Latin American/ Hispanic	531 African (or cultural group of African origin)	541 Other
966 Repeated Value	977 Response Unidentifiable	988 Response Outside Scope	999 Not Stated

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ETHNICITY QUESTION

Which ethnic group do you belong to? ***Mark the space or spaces which apply to you***

○ NZ European
○ Maori
Iwi affiliation (optional, depending on data collection & reporting capability)

○ Samoan
○ Cook Island Maori
○ Tongan
○ Niuean
○ Chinese
○ Indian
○ Other [such as Dutch, Japanese, Tokelauan]. Please state:

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