NZSTA submission:
Ngā Paerewa Health and Disability Services Standard consultation 2026

Submitted by: New Zealand Speech-language Therapists' Association (NZSTA)

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This submission provides targeted criterion-level drafting suggestions for Sections 1–6 of NZS 8134:2021, focused on communication access (including communication disability, alternative and augmentative communication (AAC) and interpreting) and swallowing/eating-drinking safety and efficiency (dysphagia). The intent is to reduce variability in interpretation by making these requirements explicit where they are essential to rights, safety, equity and quality.

1. About NZSTA and the scope of this submission

NZSTA is the professional association for speech-language therapists (SLTs) in Aotearoa New Zealand. SLTs support people across the lifespan with communication and swallowing (eating and drinking) needs, including accessible communication supports, augmentative and alternative communication (AAC), and safe swallowing management.

2. Summary of key themes

- Communication access is a safety requirement that underpins consent, assessment, treatment fidelity, de-escalation, participation, equity and quality.
- Access to services which support the safety and efficiency of eating and drinking (including assurance of staff competence and safe environments) is a consumer safety and infection prevention issue.
- Systems (governance, risk, workforce capability and information management) must reliably identify, record and respond to consumer communication and swallowing needs.

3. Detailed recommendations by section

Section 1: Ō Tātou Motika – Our Rights

NZSTA position: Section 1 is broadly appropriate. Suggested changes clarify that communication access includes communication disability support (not only language interpreting) and operationalises supported decision-making.

Recommended amendments

- Require services to provide accessible, low-burden ways for people (and/or whānau/support partners/other professionals) to give feedback about communication access barriers across the care pathway (referral, intake, appointment, assessment, treatment, discharge).
- 1.6.5: Expand 'interpreter services' to 'interpreting and communication support services' to explicitly include NZSL/spoken-language interpreters and communication supports for people with communication disability (e.g., alternative augmentative communication (AAC) support, trained communication partners).
- 1.6.6: Clarify that 'easy to access, understand, and use' includes accessible formats and communication supports, as required.
- 1.7.3: Link supported decision-making to practical communication supports (including additional time and accessible information, as required).

Draft wording

Feedback access (new): "I can raise concerns or give feedback about communication access barriers in ways that work for me (e.g., text, email, phone, NZSL/video, supported communication), including through a support person if I choose, and the service will respond and work with me to improve access."

- 1.6.5: "Appropriate interpreter and communication support services shall be provided to me."
- 1.6.6: "…easy for all people to access, understand, and use (including through accessible formats and communication supports as required)."
- 1.7.3: "I have a right to supported decision-making, enabled through appropriate communication supports."

Section 2: Hunga Mahi me te Hanganga – Workforce and Structure

NZSTA position: Section 2 is generally fit-for-purpose but should more explicitly embed communication access (including communication disability) and swallowing safety within governance, risk, workforce capability, and information systems.

Recommended amendments

- 2.1 (Governance): Explicitly include communication access competence within governance/clinical governance expectations.
- 2.2 (Quality and risk): Require risk frameworks (where relevant) to identify and manage risks arising from communication barriers (e.g., *informed consent and shared decision-making failures, miscommunication of symptoms/needs, missed safety cues*) and, where services provide eating/drinking support, swallowing safety risks (e.g., choking/aspiration).
- Require an accessible feedback mechanism for reporting communication access issues (including from whānau/support partners and other professionals) and use this data to improve patient-facing processes.
- 2.3 (Service management): Specify that workforce development includes communication partner skills, working with interpreters, and use of AAC/accessible information; and, where

relevant, dysphagia-related competence appropriate to the setting (including diet/fluid modification and mealtime safety).

- 2.4 (Health care and support workers): Require role descriptions and induction to include responsibilities for communication access (including how to obtain interpreters/communication supports) and, where relevant, mealtime safety expectations.
- 2.5 (Information): Require information systems/records (where relevant) to capture and make available 'need-to-know' communication support requirements and swallowing/mealtime plans.
- Safeguard against inappropriate discharge/decline: Before declining, discharging, or closing a referral due to 'non-attendance', 'non-compliance' or 'lack of engagement', services must consider whether communication access barriers contributed and must attempt reasonable communication access adjustments where indicated.
- Require periodic review of patient-facing processes (referral, intake, scheduling, check-in, assessment, treatment, follow-up, discharge) for communication access, using feedback and survey data.

Draft wording

- 2.2.4: Include communication barriers and swallowing/eating-drinking safety as examples of risks to identify and address (where relevant).
- 2.4.1 / 2.4.7: Add 'communication access responsibilities' as a minimum element of role expectations and induction.
- 2.5.1–2.5.3: Add examples of critical information accessible to the workforce, including communication support requirements and swallowing/mealtime plans (where relevant).
- Safeguard: Before discharging or declining a referral due to 'non-attendance', 'non-compliance' or 'lack of engagement', any possible communication access factors must be considered and addressed first.

Section 3: Ngā Huarahi ki te Oranga – Pathways to Wellbeing

NZSTA position: Section 3 sets strong generic expectations for timely assessment and coordinated support. Amendments are needed to ensure communication and swallowing needs are explicitly identified, planned for, and transferred across settings.

Recommended amendments

- 3.1 (Entry and declining entry): Require early identification of communication understanding/expressive needs (e.g., interpreter, AAC, supported decision-making) at first contact, and provision of information in accessible formats.
- 3.2 (My pathway to wellbeing): Require assessment and care/support planning to explicitly include communication function and supports (including AAC/communication passports/interpreters) and, where relevant, swallowing/eating-drinking safety needs and escalation pathways.
- 3.3 (Individualised activities): Require participation to be supported through communication supports as needed (e.g., staff communication partner skills, AAC availability, interpreting).

- 3.5 (Nutrition to support wellbeing): Add explicit swallowing and safe mealtime support expectations where swallowing difficulty is suspected or identified.
- 3.6 (Transition, transfer and discharge): Require transition documentation to include communication supports and swallowing/mealtime plans (where relevant).

Draft wording

- 3.1: Add 'communication access requirements' as an explicit element of entry processes (including interpreter/AAC needs).
- 3.2: Add 'communication supports required for participation and decision-making' and 'swallowing/mealtime supports required for safety' as explicit components of care/support plans (where relevant).
- 3.6: Require transition summaries to include communication support requirements and swallowing/mealtime plans (where relevant).

Section 4: Te Aro ki te Tangata me te Taiao Haumaru – Person-centred and Safe Environment

NZSTA position: Section 4 is sound but should more explicitly cover communication-friendly environments and accessible emergency/security communication, and make mealtime safety supports more explicit where dining spaces are referenced.

Recommended amendments

- In larger services (e.g., hospitals and EDs), a documented escalation pathway is required for additional communication access support when standard supports are insufficient, with staff training on recognition and access (including after-hours where relevant).
- 4.1 (The facility): Clarify that 'safe and accessible' includes communication access (e.g., signage/wayfinding, quieter spaces, acoustics/lighting, access to AAC/communication supports).
- 4.1.3 (Adequate spaces): Strengthen dining-area expectations to include safe mealtime supports where relevant (e.g., appropriate seating/positioning, capacity for safe assistance, reduced distraction options).
- 4.2 (Security of people and workforce): Require emergency/security arrangements to be communicated in accessible formats and modes, as required.
- 4.2.5 (Call system): Ensure call systems have accessible options for people who cannot use a standard call bell.
- 4.2.2–4.2.3 (Emergency): Include how staff support people with communication needs during emergencies (communicating instructions and enabling the person to express needs).

Draft wording

- 4.1.2: Add "including communication-accessible environments" (signage, acoustics, lighting, quieter spaces, access to AAC/communication supports).
- 4.2.8: Add "in accessible formats and communication modes, as required" when explaining emergency/security arrangements.

Section 5: Te Kaupare Pokenga me te Kaitiakitanga Patu Huakita – Infection Prevention and Antimicrobial Stewardship

NZSTA position: Section 5 is broadly fit-for-purpose. NZSTA recommends targeted additions to ensure infection prevention and antimicrobial stewardship measures remain accessible and safe for people with communication disabilities, and that shared communication equipment and assisted feeding/oral care are included in IP systems where relevant.

Recommended amendments

- 5.4.5 (HAI communication): Specify that communication with people who develop/experience a healthcare-associated infection is accessible for people with communication disabilities (e.g., supported communication, interpreters, AAC, accessible formats).
- 5.2.1(d) (Multidisciplinary IP expertise): Include SLT input as an example where services provide close-contact communication support, assisted feeding, or dysphagia-related care.
- 5.2.3 (IP policy suite) and 5.2.9–5.2.10 (decontamination/audits): Explicitly include shared communication devices/AAC equipment as 'shared equipment' requiring cleaning protocols and audit.
- 5.2.4 (Pandemic/ID response): Include maintaining communication access when PPE is required (e.g., accessible communication processes; considering clear masks where appropriate).
- 5.5.3 (Cleaning processes): Include shared communication devices and high-touch communication surfaces as examples in cleaning schedules and monitoring (where relevant).

Draft wording

- 5.4.5: Add "in accessible formats and communication modes, as required" to HAI communication processes.
- 5.2.3(h): Add "including shared communication devices and AAC equipment" as examples for decontamination/reprocessing policies.

Section 6: Here Taratahi – Restraint and Seclusion

NZSTA position: Section 6 aligns with a restraint- and seclusion-free intent. NZSTA recommends making communication access an explicit prevention and safety strategy across assessment, de-escalation, monitoring, documentation, debrief and evaluation.

Recommended amendments

- 6.1.2 (Oversight): Ensure lived experience input includes, where relevant, people with communication disabilities and/or expertise in communication access.
- 6.1.5 (Holistic assessment): Explicitly include assessment of communication needs and barriers (including AAC/interpreter needs) as part of prevention planning.
- 6.1.6 (Training): Include communication partner skills, use of communication supports/AAC, and working with interpreters as core elements of least restrictive practice and de-escalation training.

- 6.2 (Safe restraint): Require de-escalation to include communication supports as needed (including spoken and nonverbal communication). Monitoring must include the person's ability to communicate distress and any deterioration in communication capacity. Debriefing must be person-centred and delivered in the person's preferred communication mode, consistent with trauma-informed practice.
- 6.2.7 (Evaluation): Require explicit consideration of communication breakdowns or unmet communication needs as contributing factors, and incorporate communication strategies/supports into preventive plan updates.
- 6.4 (Seclusion): Where seclusion applies, ensure environment and processes enable accessible communication (requesting help, understanding information), and reviews consider whether communication supports were available/used.

Draft wording

- 6.1.5 / 6.1.6: Include communication needs assessment and communication partner/AAC/interpreter training as core restraint prevention measures.
- 6.2.5–6.2.6: Add "conducted in the person's preferred communication mode, with communication supports as required" to debrief expectations.

Appendix A: Collated proposed insertions (summary table)

The table below lists the practical drafting insertions recommended by NZSTA. It is intended as a quick reference for editors.

Criterion (or subsection)	Proposed insertion/clarification (NZSTA)
Section 1 (feedback)	Require clear, communication-accessible pathways for feedback/concerns across the care pathway, including via whānau/support partners if the person chooses.
1.6.5	Replace/expand to: "Appropriate interpreter and communication support services shall be provided to me."
1.6.6	Clarify 'easy to access/understand/use' includes accessible formats and communication supports, as required.
1.7.3	Clarify that supported decision-making is enabled through appropriate communication supports.
2.2.4	Include communication barriers and swallowing/eating-drinking safety as examples of risks to identify and address (where relevant).
2.4.1 / 2.4.7	Add minimum expectations for communication access responsibilities in role expectations and induction.
2.5.1–2.5.3	Specify records include communication support requirements and swallowing/mealtime plans (where relevant) and are accessible to the workforce.
3.1	Require early identification of communication needs at entry and provision of accessible information.
3.2	Require communication supports and, where relevant, swallowing/mealtime safety to be assessed and included in care/support plans.
3.5	Add swallowing and safe-mealtime support requirements when swallowing difficulty is suspected or identified (where relevant).

3.6	Require transition documentation to include communication supports and swallowing/mealtime plans (where relevant).
Section 4 (communication escalation)	Require a documented escalation pathway for additional communication access support in larger services when standard supports are insufficient, plus staff training on recognition and access.
4.1.2	Clarify ‘safe and accessible’ includes communication-accessible environments (signage, acoustics, lighting, quieter spaces, access to AAC/supports).
4.2.8	Add: emergency/security arrangements are explained in accessible formats and communication modes, as required.
5.2.3 / 5.2.9–5.2.10	Include shared communication devices/AAC equipment as shared equipment that requires cleaning protocols and audits.
5.4.5	Add: HAI communication processes are accessible for people with communication disabilities (supported communication, interpreters, AAC, accessible formats).
6.1.5 / 6.1.6	Include communication needs assessment and communication partner/AAC/interpreter training as core restraint prevention measures.
6.2.5–6.2.6	Debrief conducted in the person’s preferred communication mode, with communication supports as required.
6.4	Ensure a seclusion environment and reviews support accessible communication, and consider communication supports as alternatives.