Care Coordinator, Ms A
Disability Service

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC00874)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a boy by a care coordinator and a disability service in May 2018. On the relevant date, the boy (in his early teens), who has total blindness, was due to be picked up from a public bus terminal by a support worker after school. A support worker did not attend, and the boy was left at the terminal on his own, until a member of the public noticed the boy by himself and telephoned his mother for him.

2. The disability service conducted an internal investigation, which found that the scheduled support worker had advised the care coordinator that he would be unable to attend the shift, and the care coordinator had taken actions to book a relief support worker, however did not communicate with the proposed relief support worker or inform the boy's mother of the changes to the shift.

Findings

3. The Deputy Commissioner found that by failing to arrange a support worker to attend the boy — a vulnerable consumer — the care coordinator did not provide services to the boy with reasonable care and skill, and breached Right 4(1) of the Code. While the care coordinator's error was administrative and unintentional, it was a fundamental aspect and requirement of her role, and resulted in the boy being placed in a vulnerable and potentially dangerous position.

4. The Deputy Commissioner did not find the disability service in breach of the Code.

Recommendations

5. The Deputy Commissioner recommended that the care coordinator provide HDC with her reflections and learning from the incident, and provide a written apology to the boy and his mother.

6. While the disability service was not found in breach of the Code, the Deputy Commissioner considered that valuable learning could be taken from the case. She recommended that the disability service provide HDC with an update on the implementation and effectiveness of various initiatives and changes made; provide evidence of, or the outcome of, its consideration of further initiatives for improvement in relation to leave processing and systems improvement for arranging relief support workers; consider the possibility of further systems improvement in relation to communication by support workers to care coordinators when they are unable to attend a shift, to further minimise the risk of human error; provide evidence of the outcome of its consideration of the expert advisor's further comments about communication with clients and whether relevant changes can be made for service improvement; review the effectiveness of systems in place to raise issues with senior staff, and provide the outcome of this review; and use the findings of this complaint as a basis for training staff at the disability service.

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Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her son, Master B, by the disability service. The following issues were identified for investigation:

- *Whether the disability service provided Master B with an appropriate standard of care in May 2018.*
- *Whether Ms A provided Master B with an appropriate standard of care in May 2018.*

8. This report is the opinion of Deputy Health and Disability Commissioner Rose Wall, and is made in accordance with the power delegated to her by the Commissioner.

9. The parties directly involved in the investigation were:

Ms A	Provider/care coordinator
Mrs B	Complainant/consumer's mother
Disability service	Provider/disability service provider

10. Independent expert advice was obtained from Ms Suzanne Win, a disability services advisor (Appendix A).

Information gathered during investigation

Introduction

11. This report concerns the care provided to Master B, a boy in his teens who has total blindness.

12. Master B's mother, Mrs B, told HDC:

> "My totally blind son was left at a public bus terminal after getting off the school bus as [the disability service] had failed to find relief cover for his afternoon cares … My son was left in a potentially life threatening situation as he is vulnerable …"

13. The disability service delivers support services in the community. Ms A was a care coordinator working for the disability service at the time of events.

14. The disability service's position description for a care coordinator states:

> "[T]he care coordinator holds a portfolio of clients who require personal care, home help, child care, palliative care (or a combination of these cares) in the client's own home. In addition to co-ordinating appropriate care for clients, the care coordinator also co-ordinates the work schedule for homecare support workers, ensuring that they have the desired level of work and support to achieve that."

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15. Master B's Service Plan[1] with the disability service noted his pre-existing medical condition as "Total Blindness" due to Norrie Disease.[2] The Service Plan also noted that he was a falls risk and needed "constant supervision to be safe".

16. At the time of events, the disability service was supporting Master B with personal cares, as well as assistance to develop personal care skills for long-term independence. Support included being picked up after school in the afternoons, Monday to Thursday.

7 May 2018 — the incident

17. On Monday 7 May 2018, Master B was due to be picked up from a public bus terminal by a support worker at 3.30pm. He caught the bus and arrived at the terminal. A support worker did not attend, and Master B was left at the terminal on his own.

18. A member of the public noticed Master B by himself, and telephoned Master B's mother, Mrs B, for him. Mrs B told HDC that she had not been informed of any change to this shift.

19. The disability service told HDC that it conducted an investigation to determine how this event occurred. The disability service advised the following:

a) The scheduled support worker for this shift had advised the care coordinator, Ms A, that he was unable to attend that shift.

b) Ms A used the disability service's software system and reviewed the availability of support workers known to Master B (i.e., those who had attended him previously) to provide cover for this shift. She undertook the booking system component and adjusted Master B's roster in the Client Management System to reflect the available support worker.

c) However, Ms A did not communicate with the proposed relief support worker to confirm the booking. Therefore, the proposed relief support worker was not made aware to attend this shift.

d) Further, no contact was made at the time by Ms A to advise Mrs B of the changes to this shift.

20. Ms A confirmed that the support worker had called her to say that he would be unable to work that day, so she had informed the support worker that she would take him out of the shift. She recalled that as soon as she had finished with that call, she received another call, and was "inundated with more issues", and that this was where she unfortunately made her "regretful and terrible mistake". She recalled that she failed to remove the support worker from the shift. By not doing this, her computer system did not update accordingly, and this resulted in Master B having missed care.

[1] Dated 28 November 2017.

[2] A rare X-linked disorder caused by a genetic mutation. The main symptom is retinal degeneration, which results in blindness.

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21. Ms A told HDC that she regrets what happened, and that "as coordinator this undoubtedly falls on [her] …"

The disability service's policies and procedures

22. The disability service's "Response Timeframe Guidelines" indicated the expectation that a client should be advised of a support worker not being able to attend, that a replacement should be arranged, and that the shift should be confirmed with a support worker immediately after confirming with the client, within a short timeframe upon receiving this information.

23. The disability service stated that the care coordinator (Ms A) became aware of the non-attendance of the support worker for the scheduled shift at approximately 4pm. Upon receipt of this information, contact was made with Mrs B.

24. The disability service's process for client management manual (the Manual) provided the following:

> "Workflow of Communication — Support Worker
>
> [The Coordinator]:
>
> - Takes the phone call or voicemail e.g. S[upport] W[orker] has concerns or updates about client, advise that they are running late or changing the day and time of shift.
> - Event Note the conversation into the Support Worker file.
> - Coordinator — Contact client or N[ext]O[f]K[in] to follow up and event note the conversation (within 15 mins of the phone call).
> - Follow up with Support Worker and text S[upport] W[orker] accordingly e.g. changing of day and time."

25. The Manual also provided:

> "When confirming a job with a S[upport] W[orker]
>
> 1. Check the S[upport] W[orker] schedule to ensure that the S[upport] W[orker] is available for the job you are offering.
> 2. Call or Text the SW to ask whether they are interested.
> 3. If they say yes then you need to load the budget or the shift.
> 4. Text the client's information, the days and times they will be working and the last day of care for the client."

26. The disability service considers that it had comprehensive training and resource materials available, and that the training manual included clear instructions for confirmation of shifts and communication with clients/family. The disability service provided evidence of the training Ms A received on these policies and procedures (outlined further below).

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Orientation, training, and support

Ms A

27. Ms A told HDC that she began her employment at the disability service in February 2018. Her initial training was for two weeks, with one of these weeks including completion of payroll adjustments. She recalled that due to a scheduling issue, the training session on the client management system did not occur, so she tried to teach herself instead, and it was not until approximately three to four weeks into the role that she received this training because she requested it.

28. Ms A said that after two weeks, she was given her portfolio to manage. She recalled being told when she was hired that her clients would be elderly, not vulnerable children, and that one week prior to the school holidays she was informed that some of her clients were children. She considers that she should have been given intensive training on how to manage clients who are children, to get to know them and understand their service plans and relevant conditions. She also said that she did not receive proper handover from the coordinator she was replacing. She recalled that there was a lot of turnover at the time, and there were no allocated leaders to guide staff.

29. Ms A recalled that the disability service care coordinators were also asked to answer telephone calls from clients nationwide, which doubled her workload.

30. Ms A stated that she felt under pressure and stress in this role. She said that she felt this was due to a lack of training, and that this resulted in the incident with Master B. She said that the disability service did not have intensive supervised training in place when she started. She considers that had she been given this training, she would have been aware of all of her vulnerable clients.

31. Ms A stated that she has no doubt that her mistake caused this, which she deeply regrets, but felt this mistake would not have occurred if she had received adequate training and support.

Disability service

32. As noted above, the disability service completed an internal investigation. It advised that the root cause of the incident was a performance matter by the individual concerned.

33. The disability service told HDC that each care coordinator is trained in the requirements of the leave process through their employment commencement and orientation training, and thereafter through education and meeting activities undertaken within their role. Comprehensive training and resource materials are available, and the training manual clearly includes instruction for confirmation of shifts and communication with clients/family.

34. The disability service advised that it is explicit in its standard operating procedures that a care coordinator must communicate with support workers when new shifts are booked for relief purposes. It advised that Ms A's failure to arrange a support worker was unexpected, particularly in the context of recent training and support she had received.

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35. The disability service stated that the fundamental aspects of coordinator training were consistent with the expectations of the developed training framework now in place.

Training for Ms A

36. The disability service advised that Ms A participated in an initial week-long orientation as scheduled. Ms A's orientation was reviewed at approximately four, eight, and twelve weeks after she commenced employment. During the training process and at each of the reviews, there was nothing to indicate any concerns with Ms A's ability, and she seemed comfortable raising any requirements for further assistance or training.

37. The disability service also has a client management checklist that lists the various matters that care coordinators must be competent to manage. This, and the record of Ms A's orientation and training, were completed and signed off in full (including client management system training) by Ms A and the Learning and Development Manager (who is also an experienced care coordinator) on 6 April 2018. The disability service provided HDC with evidence of this.

38. The disability service stated that subsequently further training and reviews were provided to Ms A. In addition, Ms A was buddied with another experienced care coordinator, who provided her with further training specific on the disability service's services in the region. After her formal orientation and training, Ms A continued to receive on-the-job support, particularly from her team leader.

39. The disability service noted that Ms A indicated that she knew what she was required to do in respect of shift management for Master B, and that tasks of this nature are a fundamental and almost daily task undertaken by care coordinators, and she had completed many shift changes of this exact nature prior to this incident. The disability service does not agree that a lack of training was the root cause of the incident.

40. The disability service advised that its client management system clearly identifies the care coordinator who is responsible for each client. It noted that it has no record of Ms A raising client allocation or any related issues as a matter of concern, including at her three orientation reviews where she was asked whether she had any concerns. The disability service noted that during reviews, Ms A also did not give any indication that she felt unsupported. On the contrary, she indicated that she had good relationships with her team, and that she was "feeling confident" in her role.

41. The disability service noted that Ms A had previous contact with Mrs B in her capacity as Master B's care coordinator. The disability service advised that care coordinators within her team are responsible for a variety of people of different ages, and a review of policies related to children was included in orientation, and signed off by Ms A. The disability service said that there is one centralised system for coordinating care, which applies for all clients and does not differentiate care coordination pathways for different ages.

42. The disability service stated that all care coordinators are required to manage multiple tasks from time to time, and this is recognised in the job description. The disability service said that assisting with phone calls was a standard part of every care coordinator's job, and

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it was included in Ms A's job description and was not additional to her usual role. It noted that there is no record of Ms A raising any concerns about her case load.

43. The disability service stated that in relation to Ms A's concerns about turnover, arrangements were made to take on the responsibilities of those positions and provide support in the interim. The disability service said that it has a good record of retention at senior levels, and that as with all organisations, staff turnover is inevitable, and it does its best to manage it appropriately and support operational staff. The disability service noted that its culture and values focus on excellence in leadership and support of its staff, and it always takes staff concerns about stress seriously.

44. The disability service considers that it took reasonable steps to provide Ms A with appropriate training and support. It also advised that it reviewed whether she had an increased case load, or if there were any other factors that could indicate that she might not have been able to fulfil her usual functions as a care coordinator. The disability service confirmed that Ms A's case load of clients and support workers was standard, and it had no reason to believe it was unreasonable.

Changes made since incident

45. The disability service stated that it is constantly focused on making improvement to its systems to ensure that its clients receive the best possible services. The disability service told HDC that this matter was raised with all teams as a learning opportunity and to reiterate the importance of achieving the requirements.

Master B's Service Plan

46. A review of Master B's Service Plan occurred following this incident, to include strategies that will assist in keeping Master B safe, such as the mobile application technology utilised via his cell phone, to ensure safety options should an event occur outside the disability service's control, and to increase confidence in the provision of effective service. Ongoing communication with Mrs B is underway to ensure that the level of communication and service delivery is occurring as expected.

Job descriptions and expectations

47. The disability service has updated the job description for care coordinators to emphasise the importance of seamless care and timely communication.

48. The disability service developed a campaign to highlight and assist in visualising the attributes of a care coordinator, which will be finalised and used for both existing and new care coordinators to promote and improve their understanding of the required attributes and expectations.

Orientation, training, and support

49. As mentioned above, the disability service advised that it developed and implemented a new process, which was rolled out in 2018, and that subsequently further developments and improvements have been made. The process enables staff to familiarise themselves

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with the disability service's policies and procedures, usually within the first two weeks of employment.

50. During the first two weeks, an initial explanation of the rostering of support workers and shift confirmation with clients is provided. Demonstration of the understanding of this process is verified through the checklist process, to ensure that it is in line with expectations and standard operating procedures.

51. After the initial two-week orientation period, a client portfolio is allocated to the care coordinator, with full oversight by the respective team leader and continued support by the Learning and Development Manager. The team leader provides further training around the disability service's expected level of communication, response timeframes when managing telephone calls and emails, and the process of managing client feedback and concerns.

52. A new coordinator remains in this orientation process for eight weeks, and verification and assessments occur periodically to ensure that learning is achieved at the expected levels. During this period, staff are also required to complete the disability service's online training courses, and continue to have access to this training platform throughout their employment, to complete any additional training or refresher courses. They are also provided with a hard copy of the process for client management manual. New staff members attend orientation sessions with each of the key internal departments to explain the wider organisation's involvement in the delivery of service to clients, and how the client management system is utilised across all teams.

53. The disability service then works to verify the continued training provided to staff members through the orientation checklist, completed at four, six, and eight weeks. Regular meetings are had about a staff member's progress and competence. Further verification of learning occurs via the client management checklist, which supports the orientation process to ensure that processes around new staff members' probationary period are met; with reviews occurring at 30, 60, and 90 days. Once a staff member successfully completes their orientation training, attaining all expected levels, the staff member then graduates and is able to join their respective team.

54. Ongoing coaching and monitoring of care coordinators occurs, and the coaching/mentoring policy and Leadership Manual guide the team leader to continue an individual's learning and improve management of their teams.

Technology

55. In addition to its other lines of communication, the disability service has developed an online portal that allows clients and nominated family members to view care schedules online, send messages, and request preferred support workers. The disability service noted that Mrs B was offered this, and she took it up in July 2019.

56. The disability service stated that an existing mobile app for support workers that provides close to real-time information about support worker attendances and helps to identify any non-attendance promptly, has been promoted and rolled out more widely over time. The

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disability service said that approximately 80% of all weekly shifts are now being processed through this app.

57. The disability service also advised that it continues to adapt and improve policies and procedures, and is currently working on further initiatives for improvements.

Further information

Mrs B

58. Mrs B told HDC: "This company is continually failing in their organisation and communication with their clients and or families of clients." She feels that the incident was not solely the coordinator's fault, and that the disability service should take responsibility, look at its systems, and make changes.

Ms A

59. Ms A stated that she deeply regrets that the incident happened, and is deeply apologetic to the family.

Disability service

60. The disability service sincerely apologised that the individual actions of the care coordinator resulted in Master B being left in a vulnerable position, and for the stress and anxiety created for Mrs B at this time.

Responses to provisional opinion

Mrs B

61. Mrs B was given an opportunity to comment on the "information gathered" section of the provisional opinion, and advised that she had no further comments to make.

Ms A

62. Ms A was given an opportunity to comment on the provisional opinion, but did not provide a response.

Disability service

63. The disability service was given an opportunity to comment on the provisional opinion, and advised that while it has no specific information to dispute or clarify, it would like to have recorded that the disability service recognises the importance of the learning for all staff from this matter, and will continue to educate and provide as many safety nets as possible to minimise human factors and the risk of this occurring again.

Relevant standards

64. The Home and Community Support Sector Standard 8158:2012 provides:

"2. Organisational management

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

2.1 Governance

Standard 2.1 Consumers receive services that are planned, coordinated, and appropriate to their needs.

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

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

2.1.2 The governing body shall ensure the organisational performance is aligned with and regularly monitored against the identified strategic direction and goals.

2.1.3 The governing body has processes which ensure quality improvement at all levels within the organisation.

2.2 Service Management

Standard 2.2 Consumers receive timely, appropriate, and safe services through efficient and effective service management.

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

2.2.1 The service is managed by a suitably qualified and experienced person with authority, accountability, and responsibility for the provision of services.

2.2.2 Consumers are consulted on the management of services in ways that encourage open feedback.

…

3. Human Resources

Outcome 3: Consumers receive safe, efficient, and effective services from an organisation that is a good employer and follows accepted human resource practices.

…

3.2 Orientation, Induction, Ongoing Development, and Competency

Standard 3.2 Consumers receive services from service providers who are trained and assessed as competent to provide services.

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

3.2.1 An induction process is completed by all services providers, prior to commencement of duties, and a record of the induction programme and attendance is maintained.

3.2.2 A developed, implemented, and recorded training plan relevant to the service provider's scope of practice is maintained.

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3.2.3 There is a system to determine and develop the competencies of the organisation's service providers to meet the needs of consumers. This shall be achieved by, but is not limited to:

a) The service provider's competency is assessed against the organisation's policies and procedures;

b) Competency gaps between consumer's need and service provider's competency are identified;

c) Specialist advice, training, information, and oversight are provided by individuals who are trained/qualified and competent to undertake this role.

3.2.4 Service providers understand the scope of their role and the support available to them. This shall be achieved by, but is not limited to:

a) Direct support is part of each service provider's position description and the level of assistance/intervention is clearly defined in a consumer's individual service plan;

b) Service providers clearly recognise and understand their defined role and responsibilities;

c) Service providers clearly understand how to seek assistance or advice where the limit of their competency, knowledge, or experience is reached.

…

3.2.5 The organisation ensures that all service providers access supervision and support.

3.2.6 The organisation implements a policy and procedure to assist registered health practitioners to retain their registration and operate within their scope of practice.

…

4. Service Delivery

Outcome 4: Consumers receive services that contribute to their agreed outcomes, and that support their independence, safety, and well-being.

4.1 Service Agreement

Standard 4.1 The consumer, organisation, and service provider have a full understanding of and agree to the services to be provided.

…

4.1.2 Consumers receive services at times which meet their needs and the support they require.

…

4.5 Implementation of Individual Service Plan

Standard 4.5 Consumers' goals and support requirements are met through provision of services.

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

4.5.1 The individual service plan will be delivered by service providers who:

a) Have been assessed as competent in providing the level and type of care and support;

b) Clearly recognise and understand their defined role and responsibilities;

c) Receive an appropriate level of supervision for the level of support they are providing;

d) Know how to seek assistance or advice from their supervisor when the limit of their competency, knowledge or experience is reached;

e) Can provide support that meets the needs of the consumer.

4.5.2 There is a system of recording the allocation of service providers to consumers and for maintaining records of this. This system includes processes for contingency planning in the event of emergencies or other events which would require changes to scheduled support.

4.5.3 Consumers receive first aid and emergencies are managed in line with the organisation's policy.

…"

Opinion: Ms A — breach

65. On 7 May 2018, Master B, a teenager with total blindness, was left at a public bus terminal without a support worker. Ms A, as a care coordinator, was required to provide services to Master B with reasonable care and skill.

66. Ms A was advised by the scheduled support worker for the shift that he was unable to attend. It is agreed that while she took steps to arrange a relief support worker, Ms A did not communicate with the proposed relief support worker to confirm the booking, nor did she contact Mrs B of the changes to the shift. Ms A acknowledged that there was "no doubt that [her] mistake caused this" and regrets what happened.

67. My expert advisor, Ms Suzanne Win, advised that any non-attendance of support workers in any situation is not reasonable, as the whole point of support is that it is planned to ensure ongoing service delivery. She stated that while it is accepted that from time to time staff situations will impact on the ability to provide support, in Master B's situation, this particular incident had potential implications for his personal safety.

68. Ms Win noted that Master B's service plan in place at the time of events documented the "need for constant supervision to be safe due to being blind", and in that regard she would view the service provided by Ms A as a severe departure from accepted practice. She considers that her peers would agree, due to the potential health and safety implications for Master B.

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69. Ms A has submitted that she received inadequate training and support for her care coordinator role.

70. Ms Win advised that based on the information provided, the disability service's training of care coordinators was adequate and consistent with the current training programme. She noted that the disability service has a suite of relevant policies and procedures relating to managing staff cover and the impact of missed care. Ms Win advised that in this case, the process failed to work due to staff not following policy.

71. I accept my expert's advice that the training and resources available to Ms A were adequate. I am critical of Ms A's omissions in arranging a relief support worker to attend Master B on 7 May 2018. While Ms A's error was administrative and unintentional, it was a fundamental aspect and requirement of her role, and resulted in Master B being placed in a vulnerable and potentially dangerous position. By failing to arrange a support worker to attend Master B, a vulnerable consumer, I consider that Ms A did not provide services to Master B with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[3]

Opinion: Disability service — adverse comment

Ms A's care

72. As a healthcare provider, the disability service is responsible for providing services in accordance with the Code. As outlined above, my expert advisor, Ms Suzanne Win, advised that the training and resources the disability service had in place at the time of events were adequate. I therefore consider that the disability service did not breach the Code directly.

73. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any acts or omissions of its employees. A defence is available to the employing authority of an employee under section 72(5) of the Act if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

74. In May 2018, Ms A was an employee of the disability service. Accordingly, the disability service is an employing authority for the purposes of the Act. As set out above, I have found that Ms A breached Right 4(1) of the Code.

75. As outlined above, Ms Win advised that the disability service's training of care coordinators was adequate. Ms Win considered that in this case, the process failed to work due to staff not following policy.

[3] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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76. In further advice provided by Ms Win in relation to Ms A's concerns about her training and support, while acknowledging Ms A's personal view and her remorse, Ms Win noted the disability service's submitted records of orientation, training, review reports, and information contained in these, and that in light of these, Ms A's comments about her orientation and training are hard to verify. Ms Win noted that there were opportunities to raise these concerns at three review occasions, as well as outside the formal processes.

77. I accept my expert's advice. I am satisfied that the disability service took such steps as were reasonably practicable to prevent this act or omission occurring, and, accordingly, I do not find the disability service vicariously liable for Ms A's breach of the Code.

Service delivery

78. While I have found Ms A in breach of the Code and the disability service not vicariously liable for her breach, I take this opportunity to remind the disability service that such events ultimately reflect on the organisation, irrespective of whether or not the event related to an individual performance matter.

79. In accordance with the Home and Community Support Sector Standard 8158:2012, the disability service is required to ensure that consumers receive services that are planned, coordinated, and appropriate to their needs; timely and safe through efficient and effective service management; and from service providers who are trained and assessed as competent to provide services. The disability service is also required to ensure that consumers' goals and support requirements are met through provision of services.

80. I am mindful of the organisational concerns raised by both Mrs B and Ms A. While the information I have available to me at present makes it difficult for me to draw any firm conclusions, such matters would be of concern to me if substantiated.

81. I note also Ms Win's advice that "it would be prudent for the disability service to ensure that the concerns are not more widespread and that systems in place to raise issues with senior staff are effective".

82. I concur. For these reasons, I have made relevant recommendations for further service improvement consistent with the disability service's continuous improvement approach to service delivery.

Recommendations

83. I recommend that Ms A:

a) Provide a written apology to Master B and Mrs B. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs B.

b) Provide HDC with her reflections and learning from this incident, within one month of the date of this report.

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84. While I have not found the disability service in breach of the Code, I consider that valuable learning can be taken from this case. I recommend that the disability service:

a) Provide HDC with an update on the implementation and effectiveness of the below, within one month of the date of this report:

i. The campaign to highlight and assist in visualising the attributes of a care coordinator;

ii. The Leadership Manual; and

iii. The changes to services made to reduce the likelihood of missed care episodes.

Please also advise of any further technological initiatives being considered to further improve policies and procedures.

b) Provide HDC with evidence of, or the outcome of, its consideration of the further initiatives for improvement in relation to leave processing and systems improvement for arranging relief support workers, within three months of the date of this report.

c) Consider the possibility of further systems improvement in relation to communication by support workers to care coordinators when they are unable to attend a shift (per Ms A's recollection of events), to further minimise the possible risk of human error, within six months of the date of this report.

d) Consider Ms Win's further comments in her addendum, particularly about communication with clients, and whether relevant changes can be made for service improvement. Evidence of the outcome of that consideration should be provided to HDC within three months of the date of this report.

e) Review the effectiveness of systems in place to raise issues with senior staff, and provide the outcome of this review within three months of the date of this report.

f) Use the findings of this complaint as a basis for training staff at the disability service, in a way that maintains the anonymity of all parties involved, and provide evidence of that training within three months of the date of this report.

Follow-up actions

85. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to Disability Support Services at the Ministry of Health, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Ms Suzanne Win, a disability services advisor:

"**Report to the Health and Disability Commissioner regarding the complaint: [Master B]/the disability service: C18HDC00874**

I have been asked to provide an opinion to the Health and Disability Commissioner on case number C18HDC00874. I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

I trained as a registered mental health nurse and then subsequently obtained my general nursing certificate although no longer hold a practising certificate. I have a Bachelor of Arts in Social Sciences with primary subjects in Nursing Administration.

I have worked in the health and disability sector for 51 years, the last 15 years as an auditor and evaluator for the Ministry of Health and undertaking quality projects for Non-Governmental and Crown Organisations. I have also held a number of Governance positions relevant to the health and disability sector and am currently a Trustee of the Donald Beasley Institute and IHC Inc.

Qualifications and experience relevant to this advice include development of Home Support policies and procedures, reviewing and auditing Home and Community Support Services (HCSS) and leading audit teams in issue based comprehensive audits and conducting over 500 routine and issue based audits of services for people with disabilities.

I have no conflict of interest in regards [the disability service].

Background

[Master B] is totally blind and has been receiving home support services from [the disability service] since August 2012.

[Master B's] service plan goals are to provide

- support in personal cares, learning new skills
- accessing social environments
- support in using his cane to safely cross roads and access shops

[Mrs B] has made the Commission aware of … occasions where support was not provided as agreed in the service plan.

…

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2018

[Master B's] mother [Mrs B] contacted the Health and Disability Commissioner's office (the Commission) raising a complaint in particular relating to her son being left without support in a particularly vulnerable situation on 7 May 2018.

This situation involved [Master B] being left at a bus stop by a bus driver without any available support. Fortunately a member of the public intervened, phoning [Mrs B] to alert her to the situation. [Mrs B] informed the Commission that she was dissatisfied with [the disability service's] communication and organisational skills, noting that despite many complaints nothing gets done.

[The disability service] undertook an investigation relating to the 7 May incident informing [Mrs B] that process was not followed and they apologised.

[Master B's] Service Plan 28/11/17 which applied at the time of the May 2018 incident did not document the level of vulnerability indicating that it was not applicable. It did however document the 'need for constant supervision to be safe due to being blind'.

However the plan of 22/06/18 presumably reviewed following the incident at the bus stop described [Master B's] vulnerability as Level one. Additionally in the Hazards/risks/ vulnerabilities section there is considerable information about the need for constant supervision. The level of vulnerability at the bus stop is highlighted due to the potential safety issues associated with the neighbourhood and risk of personal belongings being stolen from him. His capacity and confidence to communicate with people other than his mother is also described as unlikely so that if his phone is stolen he will be at considerable risk.

Instructions from the Commissioner

I would be grateful if you would review the documents and provide your opinion on [the disability service's] management of this situation. In particular, it would be useful if you could address:

1. Whether the service provided by the care coordinator ([Ms A]) on 7 May 2018 was reasonable. …
5. The adequacy of policies and procedures in place at the time … in particular the system for organising relief.
6. The adequacy of the training provided to care coordinators by [the disability service].
7. Any other matters that you consider warrant comment.

For each question, it would be helpful if you would advise:

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practices, how significant a departure do you consider this to be (mild, moderate or severe)?

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c. How would it be viewed by your peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Advice

1. Whether the service provided by the care coordinator ([Ms A]) on 7 May 2018 was reasonable.

Any non-attendance of Support Workers in any situation is not reasonable as the whole point of support is that it is planned to ensure ongoing service delivery.

However it is accepted that from time to time staff situations will impact on the ability to provide support, and HCSS organisations will prioritise to ensure that services are provided to the most vulnerable and people with high needs.

However in this young man's situation this particular incident had potential implications for his personal safety.

The Service Plan of 28/11/17 indicated NA on the Vulnerability Tier and noted under the General Supervision needs '*constant supervision to be safe due to being blind*'.

In that regard I would view this as a severe departure from accepted practice.

In this particular situation [the disability service] acknowledged that there was a failure of the Care Coordinator to follow established process in arranging a relief Support Worker and informing [Mrs B].

The Incident Report relating to the 7 May nonattendance of the Support Worker documented the actions being

- An apology to [Mrs B]
- The incident escalated internally in [the disability service] to the operation manager and the human resources manager

Minimisation strategies were described as

- Monitoring of the Care Coordinator leave requirements via the Senior Team Leader
- Issue to be raised at Team Meetings
- Review of Service Plan and improved safety options

Email correspondence between management dated 18 June 2018 suggested strategies to improve safety. [Mrs B] had a GPS Application put on [Master B's] phone and there was a view that the method/type be set out in the Service Plan and also in the [disability service] system as an alert for quick and easy reference. There was also a directive that clinical coordinator discuss with [Mrs B] that [the disability service] office number and a couple of cell phone numbers (presumably of Care Coordinators) be programmed into [Master B's] phone.

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Following the 7 May incident additional information was added to the Service Plan dated 22/6/18 noting high vulnerability levels and considerably more information about the pick up by support workers.

'[Master B] is very vulnerable in the community alone as he is blind. He needs to have someone with him at all times to be safe. [Master B] has an APP on his phone called Life360 that allows his Mum to GPS track him. She can see when he has left school and when he turns up to the bus stop where he is picked up by his carers. This can only be connected to his Mum. At the bus stop [Master B] is very vulnerable to his surroundings — he is unable to defend himself and if his phone is taken he will have no way of communication. The bus stop [Master B] is dropped off at is a high risk for crime, due to work and income clients and TAB/Pubs nearby. [Master B] requires being picked up as soon as he is off the bus at 3.40pm on school days from [the] Street in the CBD. [Master B] is not likely to try and call people for help and is more likely to call his Mum if he hasn't been picked up. Please call his Mum any time of the day — leave a message if she does not answer every time you call so that she is aware of the circumstances and can cover pick up if needed in an emergency where [Master B's] care is unable to attend.

I believe that my peers would view this as a severe departure due to the potential health and safety implications for [Master B].

…

5. The adequacy of policies and procedures in place at the time …, in particular the system for organising relief.

The standard of care and accepted practice across the industry and indeed in the Policy and procedures of [the disability service] are that for Support Worker sickness or arranged annual leave another Support Worker will be approached to cover the relevant shifts and duties and contact the client to ensure they are aware of the change.

As a HCSS provider [the disability service] has Certification under Standard HCSS 8158:2012 so meets industry standards.

[The disability service] has a suite of relevant policies and procedures relating to managing staff cover and impacts of missed care.

The Annual Leave process has clear responsibilities for the support worker, the coordinator and payroll. This document contains the requirement of the Coordinator to

- action the leave request and arrange staff relief
- provide the roster to the relief support worker
- advise the client of the changes

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The Process Policy has been expanded to ensure that the Care Coordinator responsibilities are step by step and has greater guidance reading each step of the process.

The process for contacting the clients is

- call the affected client and advise of the leave
- establish requirements for any replacement support worker
- confirm any special requirement or hazards and confirm service plan on site and current roster in place

Further there is a confirmation process which includes

- letting the client know the Support Worker's name
- shift time and dates
- cares needed
- fill the shift on the client's schedule and note confirmation in the client's file

In [Mrs B's] case this process failed to work due to the staff not following policy.

The process for client management manual response timeframe guidelines expectations of Coordinators are to

- contact the client within 15 minutes after receiving a call from a Support Worker that they cannot attend a shift
- arrange relief cover within 2 hours of contacting the client (unless the shift starts earlier than 2 hours
- confirm the shift with the Support Worker immediately after confirming with the client

The missed care policy is utilised to ensure that an effective procedure is in place to identify, rectify and analyse episodes on missed care. This policy requires the Care Coordinator to investigate the reason for missed care, contact the client and resolve the issue immediately or alternative arrangements as required. The Care Coordinator is also responsible to complete the documentation and escalate to the senior management team where the incident was Severity 1, (Being where [the disability service] failed to take any steps for any reason whatever to fill shift/job).

6. The adequacy of the training provided to care coordinators by [the disability service].

Based on the information provided, [the disability service] training of Coordinators is adequate and as a certified provider meets industry standards.

Prior to the current system as described below training and orientation was managed by the team leader supported by the operations manager. The fundamental aspects were consistent with the current training and development programme although did not have the processes, technology and systems. Care Coordinators at that time were buddied by experienced staff members.

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The current system is that Care Coordinators are inducted using [an orientation] Process which involves approximately 8 weeks of supervision by the organisation's Learning and Development Manager who undertakes verification and assessment during this period.

Staff access [an online system].

In the first two weeks the areas learned relevant to this complaint are

- Service management
- Vulnerable people
- Missed care policy
- Escalation policy
- Communication policy
- Annual leave policy for support workers

During the orientation period face to face meetings are held with internal departments to explain wider organisational involvement in service delivery and also how the Client Management System is utilised.

After two weeks the Care Coordinator is assigned a client portfolio and is supervised by the Team Leader and has continued support of the Learning and Development Manager. This involves being verified at 4, 6 and 8 weeks and includes regular meetings with the Team Leader.

Each Care Coordinator under induction is assessed against a client management checklist which is designed to support the [orientation] Processes with reviews occurring at 30, 60 and 90 days.

The coaching and monitoring policy requires that Care Coordinators have periodic coaching and monitoring. This policy is under review to better align with a newly developed [Leadership Manual].

There is also a performance development process.

…

The Care Coordinator involved in the 7/5/2018 incident was referred to the human resources manager and supervision by the senior team leader was implemented.

7. Any other matters that you consider warrant comment.

Consent and Agreement Form

It is noted that the Responsibilities of the Client in the Consent and Agreement signed by [Mrs B] has as a client responsibility

'To inform [the disability service] if you will not be home at the arranged time so that we can make alternative arrangements'.

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There is no corresponding responsibility listed under the [disability service] obligations to ensure Clients are informed of staff failure to attend their shifts.

It is accepted that there are policies and procedures in place regarding support worker leave, communication, and missed cares etc. and communication normally occurs.

However providing assurance in a written Consent and agreement Form to clients that [the disability service] has an obligation to communicate would make the process more transparent and keep Care Coordinators aware of their obligations. In that light I recommend that [the disability service] considers the inclusion of communication expectation in their obligations.

Documents reviewed

Letters and emails from HDC to [the disability service]
Letters and emails from [the disability service] to HDC
… Complaint to HDC from [Mrs B] (undated)
Incident/Accident Reports 7/5/18
… Email from [Mrs B] to HDC 22/07/2018
Process for client management manual
[Orientation] Process
[Orientation] Checklist
Coordinator Orientation Checklist
Client management checklist
[#] Coaching and monitoring policy
[Leadership Manual]
Communication logged into client management system (7 May 2018 …)

Suzanne Win
Expert Advisor
19 August 2019"

The following further advice was received from Ms Win:

"**Addendum to the report to the Health and Disability Commissioner regarding the complaint: [Master B]/[the disability service]: C18HDC00874**

I have been asked to provide an addendum to the opinion provided in August 2019 to the Health and Disability Commissioner on case number C18HDC00874. I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

Further Advice sought

Further advice sought was to review the responses and advise whether any of the explanations/information provided changes the previous advice. I was also asked to comment on:

- Training in both scenarios — based on [the disability service's] information given and then that based on [Ms A's] version; and

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- The supervision/support [Ms A] received.

Consideration of changes to the opinion provided in August 2019

There is no specific information provided that would change my opinion in regard to the findings and recommendation. I note that [the disability service] believes that providing a communication expectation in the Consent and Agreement would not prevent a missed care episode and to a certain extent I agree.

However it seems that there are clear expectations on the client to communicate which they agree to in writing and it seems one sided that the organisation does not do the same in inclusion of their obligations to communicate in the Consent and Agreement.

I agree there are a number of staff expectations regarding communicating with clients in the previous and updated care coordinator job descriptions, policies and staff training but they are not specific to communication about staff absences in service provision. Yet this area is the one reported by many providers and clients across the industry as being the most problematic.

The staff orientation document under effective communication notes 'The right to be listened to and understood and to receive information in whatever way the client needs'. That is very general in its approach and given the complaint substance is communication about support workers not attending to provide the service, greater detail to clients about how communication regarding covering support will occur might be helpful to clients so that they know what to expect.

It is appreciated and indeed commented on in my original report that the step by step guidance for care coordinators regarding this area of their work has been strengthened.

It is also noted that [the disability service] has worked with [Mrs B] to strengthen communication including signing up for website based instant communication.

Training in both scenarios — based on [the disability service's] information given and then that based on [Ms A's] version

As previously reported [the disability service's] training of Coordinators is adequate and as a provider certified under the HCSS Standards 8158:2012 meets industry and contractual standards.

Prior to the current system training and orientation was managed by the team leader supported by the operations manager. The fundamental aspects were consistent with the current training and development programme although did not have the processes, technology and systems. Care Coordinators at that time were buddied by experienced staff members.

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The more recent and current system for orientation and training has continued to refine and improve policies, procedures and training approaches. This should be business as usual as systems develop and in reaction to emergent issues. According to the disability servicethere has been a positive impact on the missed cares statistics.

The supervision/support [Ms A] received.

[Ms A] indicated in her response that she had not received adequate training, in particular management of the client management system and it was not until about 3 to 4 weeks when she was able to have training. Given [Ms A] commenced employment in February 2018 and the [disability service] response indicates the client management system training was provided within 6 weeks so this should have no material influence on the particular incident on 7 May. However given the client management system is the system for allocations this should ideally be completed in the orientation.

The review reports conducted with the manager following orientation are positive in regards to [Ms A's] contribution, team work and her reporting an understanding of her role.

There was no mention of the client management system specifically at the reviews conducted with the manager at 4, 8 and 12 Weeks following orientation.

The orientation agenda and signed records by the Team Leader indicated that [Ms A] had covered off areas relating to this complaint being; allocation of support workers, confirmation with support workers, relief manager support worker availabilities confirming shifts with clients and missed cares.

The orientation record was signed by [Ms A] as to her orientation being completed and that she understood what is expected in the role in relation to each area. There is also an undated document which is initialed by [Ms A] indicating that she had read the policies in particular

- Telephone policy
- Missed care policy
- Vulnerable people
- Child protection policy

In light of the orientation records and written reviews during the orientation period [Ms A's] comments about her orientation and training is hard to verify. I accept that this is her personal view and also she is very remorseful and apologetic about the incident affecting [Master B] on 7 May 2018. She has been open about what led to that particular incident and admits culpability. Had [Ms A] been struggling to do her job there were opportunities to raise these on three review occasions as well as outside of those formal processes.

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Further I note that [Ms A's] claim that she was moved to [another region] created stress yet there was a positive comment at the 12 week review regarding her work environment 'feeling more productive being in city with support'.

Other matters of concern raised by [Ms A] regarding her supervision are work load and senior staff support due to changes in personnel. The [disability service's] response provides an explanation as to the situation and is satisfied that there was adequate supervision due to reallocation of existing staff. I am not in a position to make a judgment on this matter.

I have not been requested to comment on the other matters raised by [Ms A] but note that the disability service has provided explanations and evidence to refute these claims.

General comment

Given that there have been a number of matters raised subsequently as a result of this incident by [Ms A] it could be viewed as a protective mechanism. However it would be prudent for [the disability service] to ensure that the concerns are not more widespread and that systems in place to raise issues with senior staff are effective.

Documents reviewed

Letter of 8 November 2019 from [the disability service] to HDC
Letter of 6 December 2019 from [the disability service] to HDC
[Online package] Brochure
Care Coordinators job descriptions
Code of Health and Disability Services Consumers Rights — training module
Letter and email from [Ms A]
[Ms A's] orientation agenda, records and reviews

Suzanne Win
Expert Advisor
15 January 2020"

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