Lack of continuity between contracted disability service providers
14HDC01121, 3 October 2017

Disability support service ~ ACC ~ Brain injury ~
Health and Disability Service Standards ~ Right 4(5)

In 2008, a middle-aged man suffered a severe traumatic brain injury as a consequence of an accident. He sustained a brain bleed and multiple fractures. His clinical history included congenital hydrocephalus and a mild form of cerebral palsy. He was socially withdrawn and displayed challenging behaviours.

ACC approved funding for home help, and the man was discharged home. The man indicated that he was not willing to go into residential care. He was at times difficult to engage and often refused home care. The man exhibited perseverative behaviours, as well as problems with short-term memory, hearing, and balance deficits.

In 2012, a disability support provider was contracted by ACC to provide the man with supported living assistance, primarily to work with the man to achieve goals in relation to structure with daily routines and activities of daily living; protection of personal and property rights; and community integration.

In 2014, a second disability support provider received a referral from ACC to provide the man with specific home and community support services. The specific goals were to increase the man's level of personal hygiene, to persuade him to move unwanted items from the home, and to develop a trusting relationship with his support worker.

A complaint to HDC raised concerns that the man had not been receiving adequate support at home, was not able to care for himself independently, and had been living in unhygienic, hazardous, and squalid living conditions.

The Deputy Commissioner's report focuses primarily on the relationship and communications between staff of ACC and the two disability support providers, associated system failures, and a series of events culminating in the man's eventual referral to a Mental Health Services for Older People community team.

Findings summary

Adverse comment is made about the conduct of ACC staff once they had been alerted to concerns about the man's home circumstances. ACC acknowledged that there were red flags in the information about the man's ability to cope in his living situation that should have alerted its staff that the situation required greater input from them.

Adverse comment is made that the first disability support provider did not have policies, and that it had not provided its staff with training, in respect of some of the tasks it was contracted to carry out. It was considered that it would have been wise for the first disability support provider to have advised ACC to refer tasks that it was not qualified to undertake to another more suitable provider, or to have advised ACC

that it would need sufficient funding to obtain advice from other appropriate persons.

Further criticism is made that at the time of these events the first disability support provider did not have an ACC client-specific policy document relating to managing client risk, and that it did not proactively instigate a clear written agreement for collaboration with the second disability support provider staff from the time of its involvement in 2014.

Adverse comment is made that the second disability support provider did not have a clear communication agreement with the first. Furthermore, the Deputy Commissioner is critical that there was a period of around one month where no support worker provided services to the man. The second disability support provider did not have an effective system for monitoring the attendance of its employees, and therefore failed to detect that the man had not been receiving contracted services for that period. Accordingly, the second disability support provider failed to ensure quality and continuity of services for the man and breached Right 4(5).

The Deputy Commissioner is critical of the manner in which the second disability support provider's support worker communicated his decision to stop providing care to the man because of hygiene issues and associated risks. This was a contributing factor in the man subsequently receiving no contracted home care for over a month.

The Deputy Commissioner made a series of recommendations requesting follow-up information and evidence of the effectiveness of remedial and corrective actions taken by the organisations involved in this complex case.