Geneva Healthcare Limited

Disability Support Provider

Support Worker, Mr J

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC01121)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In March 2008, Mr A (then aged in his late forties) suffered a severe traumatic brain injury as a consequence of an accident. He sustained a subarachnoid haemorrhage (brain bleed) and multiple fractures. Mr A's clinical history included congenital hydrocephalus and a mild form of cerebral palsy. Mr A was socially withdrawn and displayed challenging behaviours.

2. In March 2008, ACC approved funding for home help, and Mr A was discharged home in July 2008. Mr A indicated that he was not willing to go into residential care. He was at times difficult to engage and often refused home care. Mr A exhibited perseverative behaviours and hoarding tendencies, as well as problems with short-term memory, hearing, and balance deficits.

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

4. In April 2014, Geneva Healthcare Limited (Geneva) received a referral from ACC to provide Mr A with specific home and community support services. The specific goals were to increase Mr A's level of personal hygiene, to persuade him to move unwanted items from the home, and to develop a trusting relationship with his Geneva support worker.

5. A complaint to HDC raised concerns that Mr A 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.

6. This report focuses primarily on the relationship and communications between staff of ACC, the disability support provider, and Geneva, associated system failures, and a series of events culminating in Mr A's eventual referral in August 2014 to the DHB's Mental Health Services for Older People community team.

Findings summary

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

8. Adverse comment is made that the 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 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 the disability support provider would need sufficient funding to obtain advice from other appropriate persons.

9. Further criticism is made that at the time of these events the 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 Geneva staff from the time of Geneva's involvement in 2014.

10. Adverse comment is made that Geneva did not have a clear communication agreement with the disability support provider. Furthermore, the Deputy Commissioner is critical that there was a period of around one month where no support worker provided services to Mr A. Geneva did not have an effective system for monitoring the attendance of its employees, and therefore failed to detect that Mr A had not been receiving contracted services for that period. Accordingly, Geneva failed to ensure quality and continuity of services for Mr A and breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights.[1]

11. The Deputy Commissioner is critical of the manner in which Geneva support worker Mr J communicated his decision to stop providing care to Mr A because of hygiene issues and associated risks. This was a contributing factor in Mr A subsequently receiving no contracted home care for over a month.

12. 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.

Complaint and investigation

13. HDC received a third party complaint about the standard of supported living assistance and home and community support services provided to Mr A.

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

15. The following issues were identified for investigation:

- *Whether the disability support provider provided Mr A with an appropriate standard of care from 2012 onwards.*
- *Whether Geneva Healthcare Limited provided Mr A with an appropriate standard of care from 2012 onwards.*

16. The investigation was extended to include:

- *Whether support worker Mr J provided care of an appropriate standard to Mr A.*

[1] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

17. The key parties involved in the investigation are:

Mr A	Consumer
Mr B	Complainant, social worker
Ms C	Consumer's sister[2]
Mr D	Neuropsychologist
Geneva Healthcare Ltd	Provider
Disability support provider	Provider
Mr E	Support worker, disability support provider
RN F	Clinical coordinator, registered nurse
Mr G	Support worker, disability support provider
Mr H	Support worker, disability support provider
Mr I	Team leader, the disability support provider
Mr J	Support worker, Geneva
Ms K	Care co-ordinator, Geneva
Dr L	General practitioner

Also mentioned in this report

Ms M	ACC Service Coordinator
Ms N	ACC Service Coordinator
Ms O	Assessor
Ms P	ACC Team Manager
Ms Q	Support worker
Mr R	Support worker

18. Information was also reviewed from:

ACC
The DHB
Public Trust

Information gathered during investigation

Introduction

19. Mr A's clinical history included congenital hydrocephalus.[3] In 2000, after having neurosurgery involving a ventricular-peritoneal shunt[4] placement to reduce intracranial pressure, Mr A was left with a mild form of cerebral palsy.

[2] Mr A's Enduring Power of Attorney (EPOA) for personal care and welfare. Ms C supports the complaint. An EPOA for property documentation was drawn up by the Public Trust, with the Public Trust named as EPOA for property.
[3] An abnormal build-up of cerebrospinal fluid (CSF) in the brain. Often the fluid is under increased pressure and can compress and damage the brain.
[4] The excess cerebrospinal fluid in the brain runs through the shunt to another part of the body, usually the abdomen. From there, the fluid is absorbed into the bloodstream.

20. Mr A was socially withdrawn and displayed challenging and obsessive compulsive behaviours, including a reluctance to pay some of his utility accounts.

21. In March 2008, Mr A (then aged in his late forties) suffered a severe traumatic brain injury. He sustained a subarachnoid haemorrhage (brain bleed) and multiple fractures.

22. At that time, Mr A was unemployed and lived in his own home. Mr A had not been employed for several years.

23. General practitioner (GP) Dr L told HDC that from 2008 he saw Mr A infrequently for minor medical issues and benefit administration assistance. Dr L said that Mr A lived independently and had good general health. Mr A was on no regular medications.

24. Mr A's sister, Ms C, told HDC that her brother has no insight into his health and welfare, and she considered that he was vulnerable in his home situation. She said that often he would refuse help or deny that he had any issues, and that his memory of events is unreliable. She told HDC that Mr A exhibits Asperger-type tendencies, can become fixed on certain topics, and has perseverative behaviours, hoarding tendencies, and problems with short-term memory. He also has right hearing loss and balance deficits.

25. This report focuses primarily on the events leading up to Mr A's referral to the DHB's Mental Health Services for Older People (MHSOP) community team in 2014, while making reference to relevant earlier events and Mr A's background. In 2014, a complaint to HDC raised concerns that Mr A had not been receiving adequate support at home, was not able to care for himself independently, and had unhygienic living conditions.

Background summary 2008–2012

26. In March 2008, Mr A's ACC claim in relation to the accident was accepted.

27. Mr A's claim was managed by ACC's National Serious Injury Service (NSIS), which manages claims for people who have experienced serious injuries to the spinal cord, traumatic brain injuries, and other severe injuries. The NSIS helps clients to access support and services, involving its support and service coordinator staff.

28. Ms C (who lived in another region at the time) liaised with ACC on behalf of her brother. On 20 March 2008, Mr A was discharged to the care of a brain injury unit — specialists in assisting individuals with significant brain injury.

29. Ms C went overseas for a period in mid-2008 and, at that time, ACC staff had difficulty engaging with Mr A, particularly in relation to negotiating his recovery goals and plans. On 25 June 2008, the brain injury unit prepared a rehabilitation pathway plan with a view to discharging Mr A home. The brain injury unit noted that Mr A had memory and attention deficits. The unit also undertook a social

rehabilitation assessment of Mr A. ACC approved funding for some home help,[5] and Mr A was discharged home in July 2008.

30. Mr A's ACC approval for home help expired in January 2009, as the assistance he was seeking (primarily transportation) was deemed not to be injury related.

31. In June 2009, Mr A applied to ACC for lump sum compensation. On 16 July 2009 Mr A was advised that ACC had assessed him as having an impairment of 18%.

32. In January 2011, following changes to its NSIS, ACC sent Mr A a draft rehabilitation plan. On 11 March 2011, owing to concerns raised by a neighbour that Mr A had very little money, his benefit had lapsed, and he could not fill out appropriate documents, a visiting DHB social worker and ACC arranged a Support Needs Assessment, which was completed on 20 April 2011.

33. Mr A's impairments (including short-term memory and problem-solving limitations) had affected his ability to manage his financial, social, and personal affairs, including difficulty accessing support from Work and Income New Zealand (WINZ). On 5 May 2011, it was recommended by ACC that Mr A receive three hours of attendant care[6] per week and six hours of home help.

34. Ongoing concerns about Mr A's financial management (including unpaid fines) resulted in ACC considering obtaining assistance from the Public Trust to manage this. ACC also considered obtaining an independent neuropsychological assessment.

35. From 9 August 2011 until 5 March 2012, a nursing, homecare, and disability support staff agency provided Mr A with nine hours of home help and attendant care per week.

36. At that time, Mr A indicated that he was not willing to go into residential care. Mr A was at times difficult to engage, and often he refused home care and would not allow home help carers into his home.

37. On 15 March 2012, ACC began arranging for Mr A to receive supported living assistance[7] (in addition to home help), to include help with budgeting and community engagement. An ACC Service Coordinator[8] (Ms M) met with Mr A on 22 March 2012.

[5] Home help is provided to assist clients to manage domestic activities — for example, grocery shopping, meal preparation and cooking (or delivered meal services), and home cleaning.
[6] "Attendant care" is the term used by ACC to describe help from another person who performs tasks a client cannot do for him- or herself because of injury. These tasks include personal care, tasks of daily living, and protection from further injury.
[7] From the disability support provider.
[8] Service coordinators in ACC's serious injury teams enable people to maintain long-term independence. NSIS team managers have direct oversight of teams, which may have both service and support coordinators. NSIS technical claims managers provide support and expert advice to serious injury coordinators and team managers.

38. On 27 March 2012, ACC approved home help (six hours a week) and attendant care (three hours a week) for a further six months. On the same day, funding was also approved for the supported living assistance.

39. On 28 March 2012, a representative of the Supported Living Assistance provider met with Mr A and completed the referral documentation.

40. On 2 April, the representative attempted to meet Mr A at home, but he would not open the door to her. On 4 April, the representative returned to Mr A's house, and she reported that he exhibited sexually inappropriate behaviour toward her. Ms M suggested that supported living be put on hold until a neuropsychology assessment had been completed.

Neuropsychological assessment

41. ACC organised for Mr A to undergo a comprehensive post-injury assessment with neuropsychologist Mr D.

42. In his report dated 30 April 2012, Mr D recommended that a multidisciplinary meeting be arranged with ACC staff, and that a clinical psychologist be engaged to improve understanding of the brain injury and identify rehabilitation strategies. Mr D also recommended that Mr A have a neuropsychiatric assessment, and that routine structure and systems be introduced to improve Mr A's functional living to assist in establishing his treatment plan. The multidisciplinary meeting was also to discuss management of finances and decision-making (such as PPPR Act[9] application and support) with regard to Mr A's future life planning.

43. Mr D's report stated that Mr A was "incapable of managing his own finances, making rehabilitation related decisions, and organising and planning daily living".

44. Mr D later told HDC[10] that in his opinion Mr A lacked capacity to make these types of decisions, hence his recommendation.

Multidisciplinary meeting

45. The multidisciplinary meeting was held on 15 June 2012. Mr D chaired the meeting. Attendees included Mr A, Ms C (by telephone), the DHB social worker, Ms M of ACC, and Mr A's support worker (Mr E).

46. ACC records note that the following was discussed at the meeting:

- That Mr A required a routine, and assistance with personal hygiene.
- Mr A had been eating regularly.
- The difficulty in accessing Mr A's house.
- That Mr A was not capable of managing his finances.

[9] Protection of Personal and Property rights Act 1988.
[10] In January 2017.

- Whether an application under the PPPR Act to appoint a Welfare Guardian was required to help manage Mr A's finances.
- That Mr A's supported living assistance was to continue.
- That Mr A would be referred to a clinical psychologist.
- A care and rehabilitation assistance package was to be developed.

47. Mr A told the meeting that he was not depressed and did want any medications; and it was decided that Mr A did not need a referral for a neuropsychiatric assessment.

48. ACC assigned the disability support provider the task of looking into making an application under the PPPR Act. ACC said that it would have expected significant progress on the matter within six to eight weeks of the plan being in place, and for ACC staff to follow up progress with the disability support provider. However, that follow-up did not occur.

Key ACC contractual obligations

49. ACC contracts with a wide number of healthcare and disability service providers in order to perform its rehabilitation functions.

50. ACC explained that prior to 1 July 2014, its provider relationships were managed under master agreements[11] that set out the parties' roles. Obligations, duties, and unit pricing were set out in appended service schedules. Standard terms and conditions were introduced on 1 July 2014, and they, like master agreements, were to be read in conjunction with any appended service schedules.

51. Contracts contain key expectations and obligations to be agreed to by suppliers who provide services to ACC.

52. Key contractual obligations for providers include:

- To advise ACC immediately of any matter that may change or delay the performance of services;
- To provide services in accordance with all current clinical, ethical, and professional standards;
- To manage risks;
- To provide oversight of staff;
- To report any issue with service delivery immediately; and
- To ensure that communication is maintained with all services that are provided to the client concurrently, in order to ensure a co-ordinated and collaborative approach.

[11] Copies provided to HDC.

The disability support provider

Supported living assistance

53. In July 2012, the disability support provider was contracted by ACC to provide Mr A with supported living assistance. The agreement with ACC to provide supported living services was outlined in a master agreement.

54. The disability support provider stated:

> "Our Supported Living agreement with ACC requires us to assist clients to become and/or retain as much independence and autonomy in everyday life as possible through support for gaining new life skills, increasing the use of natural supports and community participation …"

55. The relevant "Service Specifications for the Supported Living Service"[12] state:

> "The objective of the Supported Living Service is to increase Client independence through facilitating natural 'circles of support', community participation and teaching of life skills. The Supported Living Service will reflect the following operating principles:
>
> - Client-centred delivery based upon the individual Client's needs, taking into account their preferences, potential, abilities and interests.
> - Support, especially natural supports, to maximise independence in all aspects of adult life including the Client's relationships with others, personal development, self advocacy, leisure and recreation.
> - Planning that clearly states objectives, actions, time frames and outcomes.
> - Assist the client to exercise their right to choose, if they wish, to change the direction of their programme, or change support people.
> - Reduction in reliance on funded services and paid carers as social supports and replacement of these with enduring natural supports …"

56. The disability support provider told HDC that it was not contracted to provide home help or attendant care, and that ACC contracted other organisations to provide such services.

57. ACC told HDC that the Supported Living Service is designed to assist clients to achieve as much independence and autonomy in everyday life as possible, and that underpinning the supported living service is the New Zealand Disability Strategy[13] Vision of a fully inclusive society where people are integrated into community life on their own terms. The service is based on a collaborative approach, and contingent on developing strong partnerships.

[12] Part B of the "Service Schedule Supported Living Service".
[13] 2001. See http://www.odi.govt.nz/documents/publications/nz-disability-strategy.pdf. The strategy was revised and relaunched on 29 November 2016 as the New Zealand Disability Strategy 2016–2026.

58. ACC also has "Supported Living — Operational Guidelines",[14] which make the following key points:

- The guidelines assist in the interpretation of the Supported Living Service Schedule.
- ACC purchases Supported Living Services (the Service) to provide individualised support for people with complex and/or challenging needs, and/or physical disabilities.
- The Service is to enable a person to become more independent in everyday life.
- The Service includes: completion of an individual support plan (by provider with client); provision of services to support client outcomes as approved by ACC; completion of an initial outcome report; completion of an outcome report six months later, and prior to the client's exit from the Service.
- Case conferences are hosted by ACC to agree the approach and the roles and responsibilities of the parties, and identify issues regarding the client's needs, abilities and objectives.

Supported living assistance commencing July 2012

59. The disability support provider stated that its support for Mr A commenced in July 2012.

60. On 9 July 2012, ACC wrote to Mr A to advise him that funding had been approved for the disability support provider to provide him with supported living services.

61. ACC identifies a client's individual plan objectives.[15] The disability support provider was required to support Mr A to set service plan objectives consistent with his individual plan objectives set by ACC.

62. According to the disability support provider, the service plan objectives are usually reviewed every three to six months (or sooner if required), and a closure report is provided every six or 12 months. ACC then supplies a fresh purchase approval (which states the number of hours the support providers deliver before a new episode of support can commence).

63. The disability support provider said that after the original referral, it received approval for six hours of support per week (three hours on two days a week), to work with Mr A to achieve his goals primarily in relation to:

- Structure with daily routines and activities of daily living;
- Protection of personal and property rights; and
- Community integration.

[14] 2010.

[15] As per the ACC referral, Mr A's individual plan objectives were to engage in a daily routine emphasising personal and home care (home and living), and by the end of September 2012 to have all his finances managed by an independent, trustworthy finance agency (community participation).

64. The disability support provider did not have any policies and procedures regarding the PPPR Act, and it had not provided its staff with any training on this issue.

65. ACC told HDC that the provider is required to contact ACC if the client is unable to meet his or her goals and/or desired outcome within expected timeframes, and that this should occur as soon as this is evident to the provider.

Key staff

66. The disability support provider's contract with ACC required the disability support provider to employ staff with specific experience and training to work directly with clients. In 2012, Mr A's initial support worker was Mr E.

67. Mr H supported Mr A from 30 September 2013 to 16 April 2014, and Mr H was then replaced by Mr G.

68. The Team Leader, Mr I, was the main ACC contact person.

Managing risk

69. The disability support provider told HDC that the quality framework it uses is based on Ministry of Health guidelines.[16]

70. The disability support provider had a "Client Risk Management Policy" to guide staff on risk management. The policy had been developed for clients with mental health or addiction issues, but was also being used for clients under ACC contracts. The disability support provider had no ACC client-specific policy document at the time of these events.

2012

71. Mr E developed a service plan, which included that the goals for the next three months were to engage Mr A in daily routines (stressing hygiene and home care) and to have his finances managed by an independent agency — with Mr A to be involved in selecting the agency.

72. The disability support provider told HDC that in July 2012 Mr A experienced plumbing problems in his home. The disability support provider attempted to resolve the issues, and advised ACC that Mr A required assistance to repair his toilet. The disability support provider said that it met with tradesmen to support access to Mr A's home, assisted Mr A to unblock his toilet and mop up overflow, and supported Mr A to access funds for repairs.

73. The disability support provider's progress notes document that Mr E visited Mr A on 11 July 2012, and they discussed a water leak in Mr A's garage. Mr E arranged for a tradesperson to visit on 13 July 2012.

[16] It cited: *Improving Quality (IQ): A systems approach for the New Zealand Health and Disability Sector*. Ministry of Health, 2003.

74. On 17 July 2012, Ms M arranged a referral for Mr A to be assessed by a clinical psychologist, with a view to providing insight into his brain injury, improving his hygiene, and managing his challenging behaviours.

75. On 20 July 2012, Mr E met with Mr A to discuss his support plan. Mr E discovered that Mr A's water pump was not working. Mr E helped to get the pump working.

76. On 1 August 2012, Mr E emailed Ms M advising that he had concerns about the condition of the house and Mr A's plumbing. ACC arranged additional cleaning services over the next three weeks.

77. ACC told HDC:

> "While the updates and advice [the disability support provider] provided to ACC during this period did make it clear that [Mr A] was facing significant issues with his house, they did not specifically state that the situation was beyond [the disability support provider's] ability or control. Nor was there a request for ACC to intervene."

78. However, ACC also said that there were red flags in the information that should have alerted its staff that the situation required greater input from them, and that its staff appeared to take comfort from the steps being taken by Mr E.

79. On 29 August 2012, Mr E met with a lawyer for advice about the documentation required in relation to a PPPR Act application.

80. A three-month progress report to ACC was due to be completed by 27 September 2012.[17]

81. Mr E arranged a repairman and plumber for 15 and 19 October 2012, to make further repairs to the water connection and hot water overflow respectively.

82. On 24 October 2012, ACC received an email from the disability support provider stating that Mr E had been doing some "great work" with Mr A in relation to the water system issues, and that Mr E had built up a good rapport and level of trust with Mr A in line with his supported living goal.

83. On 19 November 2012, ACC wrote to Mr A advising him that Ms N would be his new ACC Service Coordinator. Mr E arranged a meeting with Ms N to discuss continuing support for Mr A.

84. ACC told HDC that during Ms N's management of Mr A's claim, she did not review Mr D's neuropsychological report of 12 April 2012, and that over time a sense that Mr A's presentation was attributable to a pre-existing condition crept into the thinking of those handling the ACC claim.

[17] ACC told HDC that although it holds a copy of that report on file (it was forwarded to ACC with an associated closure report in January 2013), it is unclear whether ACC received a copy of the report at the time it was completed.

2013

85. On 17 January 2013, Mr E completed a closure report for ACC. It is noted that the process to arrange for Mr A's finances to be managed had been commenced but had been hampered by Mr E spending time dealing with the urgent plumbing repairs.

86. On 31 January 2013, Mr E emailed Ms N requesting approval for further supported living, as Mr A's invalid benefit from WINZ had been cut off. Ms N prepared a further Supported Living Referral ongoing support form.

87. On 15 February 2013, Mr A and Mr E met with Ms M and Ms N. It is documented that Mr E requested some further funded hours per week to allocate to his organising of Mr A's PPPR Act application. The notes record that Mr A said that he would like his sister to act on his behalf, but that she had declined to do so.

88. The notes also record that it was suggested that the Court might appoint an independent lawyer for Mr A, or that the Public Trust might assist.

89. On 18 February 2013, the disability support provider contacted ACC and stated that Mr A's plumbing repairs required further attention.

90. Mr E completed the Supported Living Referral form that had been prepared on 31 January 2013 by Ms N. This included some further objectives, such as Mr A engaging in a daily routine stressing personal health and home care, Mr A appointing someone to manage his finances, and his having community outings.

91. On 19 February 2013, Ms N wrote to Mr A and the disability support provider advising that funding for further supported living assistance had been approved (two hours, three times a week).

92. In March 2013, Mr E assisted Mr A to see his GP to obtain a medical certificate, and to apply to WINZ to have his benefit reinstated.

Public Trust

93. On 25 March 2013, Mr A and Mr E attended a meeting at the Public Trust[18] to discuss Mr A's will and his financial affairs.

94. Public Trust documentation records the following:

> "… [Mr A] arrived with his carer … Mr [A] has fluid on the brain and is vulnerable to people taking advantage of him. [W]e discussed the PPPR [A]ct but I believe Mr [A] has enough capacity to instruct [Public Trust] to set up [Enduring Powers of Attorney] and appoint [Public Trust] to manage his affairs for him. [H]e needs someone to pay his accounts. [H]e has … investments … and a house … he has money in the bank at the moment but not sure how much but he has not been receiving his benefit lately … he forgets to renew his benefit. Will instruction taken as well as Mr [A] said he doesn't have a will. We will discuss things next week regarding fees and PA instructions because this session was

[18] With a Public Trust Senior Relationship Advisor.

> taxing on Mr [A]. I advised the costs but we will need to determine how the costs get paid and from what accounts."

95. The Public Trust advisor did not have access to, nor was she was aware of, the April 2012 neuropsychological report.

96. On 25 March 2013, Public Trust prepared an Enduring Power of Attorney (EPOA) for personal care and welfare document, which appointed Ms C as her brother's EPOA for personal care and welfare (in the event that it was formally activated). Mr A and Ms C signed the EPOA.

97. The same day, 25 March 2013, the Public Trust also prepared an EPOA for property document, which was signed by Mr A. The Public Trust is listed as the EPOA for property.

98. On 3 April 2013, Mr A visited the Public Trust and signed his will.

Care provided April–December 2013

99. Progress notes on the disability support provider's file for 26 April 2013 and 10 May 2013 indicate that Mr A's toilet had flooded, and that Mr E had mopped the floor and cleaned it. The disability support provider contacted ACC about this on 2 May and 8 May 2013.

100. Mr A was still refusing home help cares, and was not allowing home help carers on to his property.

101. On 8 May 2013, Mr E's email to Ms N included that Mr A had executed his will.

102. On 11 June 2013, repairs to the toilet plumbing and the hallway flooring were completed. On 28 June 2013, Mr A and Mr E met with the builder again, as some of the building work required adjustment.

103. ACC records reflect that on 2 July 2013 Ms N telephoned Mr E for an update, and was told about the repairs and also that Ms C had visited her brother the previous month. Mr A's landline telephone had been disconnected due to an unpaid account.

104. On 5 July 2013, Mr E recorded in the progress notes that he had spoken to Mr A about visiting the Public Trust again. Entries in the notes for August and September record Mr A's reluctance to leave the house and attend appointments regarding his financial affairs.

105. Public Trust records for 2 August 2013 state:

> "Spoke with [Mr E] (social worker), things seem to be in order at the moment. No hurry for [Public Trust] to step in, however [Mr E] says they will re-evaluate in September."

106. On 31 August 2013, Ms C moved overseas.

107. On 30 September 2013, Mr E met with Mr A and introduced him to his new support worker, Mr H. Mr H's entries in the progress notes for October and November refer to Mr A being disinterested in going out into the community.

108. On 27 November 2013, Mr H forwarded a three-monthly progress report to ACC. Regarding the goal of Mr A agreeing to have his finances managed by an appropriate agency, it states that progress was being made, but that Mr A was reluctant to make the necessary arrangements.

109. On 10 December 2013, Mr H prepared a report for ACC.[19] The report states that Mr H had concerns about the level of Mr A's home help. Mr H requested a meeting with ACC to discuss this.

110. The disability support provider told HDC that no further issues occurred with Mr A's plumbing until 2014.

January–March 2014

111. On 6 January 2014, Mr H prepared a client risk management plan, which states that Mr A's key risks were his balance while walking (he was refusing to use a stick and preferring to use a shopping trolley), some inappropriate behaviours towards women, and his personal hygiene. ACC told HDC that it did not receive a copy of this plan, and it was not aware of the balance issues.

112. A meeting with ACC to discuss caregiver home support scheduled for 24 January 2014 was cancelled because Mr A was unavailable. Mr H's progress notes for 3 February 2014 state that the meeting was re-scheduled for 10 February 2014, but again the meeting was cancelled and had to be re-scheduled.

113. On 18 February 2014, Ms C emailed Ms N that she now lived overseas and wanted to be kept informed of her brother's progress.

114. On 13 March 2014, Ms N wrote to the disability support provider advising that further funding for supported living assistance had been approved.

Meeting with ACC staff

115. On 18 March 2014, Ms N met with Mr H, but Mr A did not attend. Ms N and Mr H discussed the issue of having Mr A's finances managed by an appropriate agency, which had not been achieved. Regarding the home help situation, Ms N agreed to arrange a new support needs assessment for Mr A. Ms N suggested that organised agency care would be preferable for home care support.

[19] ACC told HDC that Mr H was mistaken in believing that the supported living plan expired on 19 December 2013, as it was actually due to expire on 19 February 2014.

Home and community support, 2014

Needs assessment

116. On 27 March 2014, ACC carried out a support needs assessment (involving Mr A, Mr H, and assessor Ms O). Ms N discussed with Ms O Mr A's need for home help and equipment to assist with his balance and mobility.

Ms O's report

117. Ms O's report states that Mr A's mobility had declined since 2011, and that essentially he was housebound. He required prompting for grooming tasks, and it was suggested that he have support for social interactions. He had difficulty with problem solving and short-term memory due to his injury, tended not to seek out nutrition unless he was supported to do so, and his orientation was variable. He did not want any neuropsychological testing or attendant care in relation to his memory and cognitive ability (as he was happy using a diary). He indicated that accessing the community by going to the local shops three times per week was adequate for his needs. He was able to conduct simple banking interactions.

118. Mr A reported feeling down sometimes, and vulnerable, but not lonely. Ms O felt that Mr A had limited insight or ability to compensate for his impairments, and did not like change. He was able to shower and groom himself but showed little inclination to do so. Mr A told Ms O that he had had problems with his toilet plumbing for over a year.

119. Despite the history of Mr A being opposed to home help carers coming into his house, Ms O suggested that Mr A would be open to receiving assistance if Mr H facilitated it.

120. The report states that Mr A told Ms O that he did not want to live in a shared living situation; however, Ms O states that he was at risk of falling and had limited ability to obtain assistance because he had no telephone. Ms O reported that sometimes Mr A displayed aggression (if tired), inappropriate sexual behaviour and comments, repetitive speech, and disinhibited social behaviour.

121. Ms O recommended that Mr A receive 11 hours and 10 minutes of care per week. She also recommended that he be supplied with a kitchen trolley and a pacer stroller.

Geneva Healthcare Limited

122. On 1 April 2014, Geneva Healthcare Limited (Geneva)[20] received a referral from ACC to provide Mr A with home and community support services, in accordance with Ms O's recommendation.[21] The referral mentioned a history of home help care provision being unsuccessful because of Mr A denying access to his house. The referral noted that a supported living programme was being provided by the disability support provider. Geneva's support commenced the following day.

[20] The funders of Geneva's service include ACC, Ministry of Health, and four DHBs. Geneva advised that it is a member of the Home Health Association and is audited by Health & Disability Auditing New Zealand (HDANZ).

[21] An ACC referral form. The ACC Service Coordinator for Mr A was Ms N.

123. Geneva told HDC that it considered that it was engaged as a secondary provider. Geneva understood the disability support provider to be the lead agency providing community living support and having a longer term relationship with Mr A.

Service schedule

124. The agreement between ACC and Geneva to provide Home and Community Support Services[22] includes the "Service Schedule Home and Community Support Services".

125. The service schedule includes:

> "**1. PURPOSE**
>
> 1.1. The purpose of the Home and Community Support Services ('HCSS') is to provide high quality, flexible home and community support services for Clients in their Homes and community to support rehabilitation from their covered injury and to achieve, and sustain, their maximum level of participation in everyday life.
>
> 1.2. The Supplier will have a philosophy and service delivery system that promotes and maintains the Client's independence which is Client centered and goal orientated, and seeks to build on the Client's strengths to support their ability to remain living in their Home …"

126. The services are purchased as support hours and may include:

> "… 1.4.1. Personal support, for example, assistance with personal hygiene and grooming, toileting, transfers and mobility.
>
> 1.4.2. Household support, for example:
>
> (a) Assistance with tasks normally performed in and around the Home.
>
> (b) Support to develop and maintain natural and community supports …"

127. ACC told HDC that, in addition to the contractual obligations, its expectation was that where a provider encounters difficulties or requires assistance, the issues should be raised with ACC immediately.

128. Geneva told HDC that ACC has clear expectations around the scope of home care support that its providers supply, and that nothing in the agreement between ACC and Geneva permits Geneva to incur additional expenditure.

Liaison with the disability support provider

129. Geneva told HDC that, as the disability support provider had built up a key relationship with Mr A, the support provided to Mr A was to be through communications with the disability support provider and Mr H.

130. Ms N's ACC referral form[23] to Geneva states:

[22] Service Schedule Number HACS715. A variation to the contract (primarily in pricing) was made from 1 September 2014.

> "Please note that the carer/s will have to initially liaise with Supported Living Key worker to build up the relationship with [Mr A] to allow easy access.
>
> All communication is via Supported Living Key worker — [Mr H]."

131. In response to the provisional opinion, Geneva stated that it was tasked with very specific responsibilities in relation to the care in the context of Mr A's existing relationship with the disability support provider.

Allocation — home and community support

132. The requirements of Geneva's care were to increase Mr A's level of personal hygiene, to get him to allow the support worker to move unwanted items from the home into the garage, and to develop a trusting relationship between Mr A and his Geneva support worker.

133. The home and community support services were to be provided for a total of 288.6 hours over a period of six months.[24] Geneva allocated 11 hours of support per week. Geneva liaised with the disability support provider, and support was provided on a regular basis — Monday to Thursday 3.30pm to 6pm and on a Friday between 3.30pm and 4.30pm.

134. Mr H was Mr A's key support person, and attended all initial interactions with Mr A, including a service planning visit.

135. Geneva told HDC that it had responsibility for the following:

- To implement care within 48 hours of receipt of the referral from ACC.
- To ensure that all communication, access and support were channelled through the disability support provider.
- To complete a service plan in conjunction with Mr A and the disability support provider, which identified the goals Mr A wanted to achieve through the support from Geneva.
- To liaise with Mr A through Mr H, to try to increase Mr A's personal hygiene, remove rubbish from the home and place in the garage, and develop a good relationship with Mr A.
- To monitor Mr A's progress and provide prompt reports should Mr A require an extension to his allocated package of care.
- To communicate with the ACC Case Manager if Mr A's support needs changed so that a reassessment could be arranged.

136. Neither Geneva nor the disability support provider arranged or drew up a documented communication agreement in respect of Mr A.

[23] The referral lists Mr H as an alternative contact for Mr A.
[24] Until 29 September 2014.

137. In response to the provisional opinion, Geneva stated that while it agreed that multi-agency agreements are best practice (and it has now implemented procedures so that such agreements are entered into where appropriate), in 2014 it was not industry practice to enter into such agreements. Geneva also considered that as ACC and the disability support provider had been providing services to Mr A for several years, they were best placed to initiate a multi-agency agreement.

138. Geneva further stated that when it developed Mr A's service plan (see below) it involved the disability support provider in the planning, and sent a copy of the plan to ACC.

Monitoring systems in place

139. Geneva told HDC that it accepts that the monitoring systems it had in place when Mr A was under its care could and should have been better in certain respects, but outlined that it had in place a system to monitor clients and ensure support worker attendance, which was standard practice across the industry at the time. The system included the following:

- Clients identified as vulnerable to be placed into a category of identified client risk groups, per Geneva's "Vulnerable People Management" process.[25] The process states: "For those clients who are most at risk timesheets must be monitored weekly."
- A key support person, either a relative, family member, friend or advocate, to be designated as the key communications person to raise any concerns if the person is unable to provide his or her own feedback.
- Support workers unable to attend a client for any reason to be contractually required to notify their care co-ordinator immediately so that a replacement support worker can be sourced (see below).
- Clients and their whānau to be instructed to call their care co-ordinator if a support worker does not arrive within 10 minutes of the scheduled time.
- Each week any timesheets submitted for less or more than the allocated weekly hours are to be queried.
- Care co-ordinators to follow up by phone and text any missing timesheets.
- Care co-ordinators to follow up with the support workers and clients if the timesheet does not reconcile with the allocated hours and they have not been informed of a non-attendance.

2014

140. On 31 March 2014, Ms N wrote to Mr A to advise him that home and community support had been approved until 29 September 2014. Ms N also sent Mr A a copy of the needs assessment prepared by Ms O.

[25] 13 January 2014 version. This includes group 1, "Severe TBI clients with no EPOA or close family (natural supports)".

141. On 2 April 2014, Mr H introduced Mr A to the Geneva support worker Mr J. Mr H told HDC:

> "I was asked by a person at Geneva to be present to facilitate an introduction to [Mr A] and the new support worker [Mr J] as I was very aware of [Mr A's] anxiety to meet strangers and his anxiety around a stranger coming into his home. I met the caregiver on the road, and took time to explain to the caregiver some of the problems [Mr A] was experiencing in terms of his home environment. I explained to him that the household management was outside my scope of duties but that I found it challenging to work with [Mr A] on his goals due to the physical environment and mobility problems.
>
> I introduced the Geneva worker to [Mr A]. I explained the Geneva caregiver's role to [Mr A] as [Mr A] would not listen to him. The three of us then reached agreement that Geneva would support [Mr A] and the care giver agreed which areas to start on first. I showed him around the house and which areas needed attention. At this time his toilet needed a general clean, and he needed some laundry done. His bedroom also needed a bit of tidying up.
>
> I agreed to meet the Geneva person at [Mr A's] home the following day. When I visited the next day the caregiver was doing the laundry and cleaning the toilet."

142. Mr J told Geneva:[26]

> "When I arrived there in the first week with [Mr H] ([the disability support provider]) the place is unbearable for someone to live. The smell inside is awful especially the room he sleeps. The toilet, as I was told just finishes repaired but no water runs to the flushing system. The client uses a bucket to bring water from bathroom to flush the toilet … The laundry was filled with unwashed clothes and therefore stinks because the client hates having shower[s] … The kitchen is alright but still in bad condition. Outside environment wasn't bad but the grass was growing wild. The garage was messed up with old stuff that needs to go to the rubbish. The condition of this house for someone to live where 1 is very bad and 5 is excellent, I would say 2."

143. Geneva's progress notes record that, on 7 April 2014, Mr H spoke with Geneva Care Coordinator Ms K and said that he was happy with how Mr J was assisting Mr A.

Geneva service plan visit
9 April

144. The Clinical Co-ordinator, registered nurse (RN) RN F, prepared Geneva's ACC funded Home and Community Support Services (HCSS) Service Plan for Mr A. On 9 April, Mr H and RN F both visited Mr A at home to develop and complete the service plan. Mr H stated:

[26] In an email to Care Coordinator Ms K dated 16 December 2014.

> "I was very aware of [Mr A's] anxiety to meet strangers and his anxiety around a stranger coming into his home. [Mr A] would not talk to people he didn't know and needed prompting to remember things. I explained to the nurse some of the problems [Mr A] was experiencing in terms of his home environment. I also showed this lady around [Mr A's] house and outside. During this visit the house was in a clean state, the laundry was done, the toilet was clean. [Mr A's] bedroom was still the same as the previous week."

145. In relation to her first visit to Mr A, RN F stated:

> "Upon arrival to the home I noticed the grounds, gardens and general condition of house rather unloved and unkempt. The entrance to the property itself was rather hidden and overgrown. I met with the CSW and we entered the property together. The CSW had to knock 3 times on the window of [Mr A's] room to let him know we were there and we were about to come in to his home. This was apparently the 'norm' so [Mr A] didn't have to get up and answer the door.
>
> Once we entered the house I soon realised the [squalid] conditions that this man had been living in. The house itself was littered to the ceiling in what appeared to be electrical and communication equipment. There was no obvious furniture that could be used and no amount of cleaning or upkeep within the house had been done for a considerable amount of time. The windows were all shut and the curtains were thick with dust. The smell was rather potent. It was a three bedroom home and all rooms were full to the brim with hoarded items. The kitchen had rotting benches and the cupboard doors were either missing or broken. There were the usual items in the kitchen (oven, fridge etc) but none of them were in working order. The only working thing in the kitchen was the microwave. I went down to the bathroom which was also very dirty and unkempt. The bathroom had a bath which Mr A had clearly been using as a toilet and also to wash his clothes in. The toilet itself was non-functioning. The floor boards were clearly rotten/wet and some had been replaced. According to the CSW [Mr A] was using a bucket filled with water from the bath and carrying it to the toilet and using that to flush. I was taken down to the main bedroom where [Mr A] was laying in his bed. [Mr A] was very pleasant in manner and clearly happy to see me, although was uneasy about having someone new in his home. I sat on his bed to talk with him and noted how old and very hard his bed was. I wondered if there was even a mattress under there. The sheets, blankets and pillows were all extremely old, dirty and mouldy. The room was very cluttered and had no ventilation at all.
>
> We went through his service plan and talked about having a Geneva carer come in and help tidy his home up and support him with some of his cares. The CSW explained that they were coming in daily to help [Mr A] with some areas of his care. As [Mr A] is unable to drive a car they were taking him down to the bank to withdraw money to purchase food for him daily as he had no way of storing his food safely and no way of cooking it apart from the microwave. [Mr A] agreed to this although knowing he had suffered a brain injury I was fully aware of his memory loss.

> [Mr A] appeared physically well at the time of the visit although the effects of the brain injury were evident. He was very forgetful and perseverative. He needed very clear instructions in order to complete a task. He has obvious hearing deficit and was quite unsteady on his feet. He was using a walking stick and holding on to furniture to get around his house. He appeared quite guarded in his behaviour and appeared oblivious to the circumstances he had found himself him. He had no family support although I did have the number for [his sister].
>
> After the visit I completed his service plan and emailed it off to his ACC case manager [Ms N]. I outlined in my email the concerns I had as I felt it was my duty of care to ensure [Mr A] at the very least had a flushing toilet. All the risks regarding his home were clearly stated in his risk assessment. I specifically requested ACC to do a further assessment of [Mr A] ASAP. I assumed that from then on these concerns would be dealt with by ACC."

April 2014

146. On 15 April 2014, RN F emailed the completed service plan to ACC. The service plan refers to Mr A's home being cluttered and unhygienic, and to his hoarding and obsessive compulsive behaviour. It notes his poor memory and his seeming unawareness of the need for basic cleanliness.

147. Mr A's long-term goal is stated to be: "I want to remain in my own home." The service plan records Mr H as an emergency contact. The plan notes a visit to Mr A every day by a the disability support provider support worker.

148. The short-term goals in the service plan are for Mr A to develop a trusting relationship with the Geneva carer, to remove unwanted items from the home, and to allow the carer to assist Mr A with showering at least three times a week. The document notes Mr A's ability to toilet himself independently. The review date for the plan was October 2014.

149. In response to the provisional opinion, Geneva stated that the three specific tasks above were developed in the context of the broader support already being provided by the disability support provider, and that these were all of the tasks formally allocated to Geneva. It reiterated that Geneva became involved in Mr A's care later in time, to assist Mr A with those specific targeted goals.

150. RN F's email to ACC concludes:

> "… Please be aware that I have many concerns about this client's living environment. I have outlined my concerns within the service plan but the non-functioning toilet is of particular concern. I feel a duty of care that I pass my concerns on to you and suggest ACC provide a further needs assessment as soon as possible …"

151. On 17 April 2014, Ms N replied to RN F:

> "Thank you for the service plan and also your concerns around [Mr A's] living environment. Attached is the latest needs assessment, unfortunately, we have tried our best to assist [Mr A] over the past many years, [Mr A] has not been very cooperative. With [Mr A's] increasing age and instability, the supported living key worker has insisted that we put some cares and equipment in place. It was agreed with the assessor and the keyworker that the repairs to [Mr A's] home [are] his responsibility and he has been advised to start saving."

152. ACC told HDC that the needs assessment of 27 March 2014 and the email from Geneva to ACC failed to elicit an appropriate response from ACC staff.

Actions taken by Geneva

153. Geneva told HDC that, with the facilitation of the disability support provider, it began supporting Mr A with his personal hygiene, removing rubbish from the home, and developing a relationship with Mr A.

154. Geneva said that it identified a number of hazards in the home, which was cluttered and posed a falls risk for Mr A. On 2 April 2014, the disability support provider provided ACC with a further supported living service plan. The service plan objectives were that Mr A have structured daily routines and activities of daily living, as well as routine interactions in the community.

155. Geneva noted in its records that the toilet was not working and Mr A was using a bucket to flush the toilet, and that RN F had advised ACC of her concerns.

156. Geneva told HDC that from 9 April until 18 July it made telephone calls to the disability support provider about the repair of the toilet, and continued to communicate with the ACC Case Manager.

157. Despite Mr A's EPOAs having already been signed in 2013, the service plan records that Mr A was to have a PPPR application put in place and completed.

Support worker

158. Mr G told HDC that he made his first support worker visit to Mr A on 22 April 2014, and arranged to see Mr A twice a week, on Tuesday and Thursday afternoons.

159. Mr G stated:

> "My understanding of the role was to support clients to live independently. [Mr A's] support plan identified community engagement, starting a daily routine and putting a PPP & R in place. I found it difficult to engage [Mr A] on these goals; he often said he didn't want to go out. I also began to have concerns about his physical and mental wellbeing that eclipsed those goals. I passed these concerns onto my manager.
>
> In terms of mobility I saw that [Mr A] held onto the furniture in his house to move around. Until he had an appropriate walker I didn't feel he was stable

> enough to take to shops … I noticed that [Mr A] would forget how much money he had even while counting it and he was distracted from tasks easily.
>
> Throughout the time I supported [Mr A] he was reluctant to shower or attend to his personal hygiene. He lay in his bed for long periods and often wore soiled clothes. I encouraged [Mr A] to change them and when he had no new clothes some of my colleagues donated clothes for him …"

160. On 28 April 2014, the disability support provider Team Leader Mr I emailed Ms N asking about the provision of a walker to Mr A as per Ms O's needs assessment. Ms N replied the next day confirming that funding for a walker and kitchen trolley had been approved. The walkers were delivered to Mr A on 1 May 2014. Mr G documented that Mr A was not willing to test the walkers.

161. On 2 May 2014, Mr I emailed Ms N and Ms P (ACC Team Manager, NSIS) that he was concerned that when Mr G had visited the previous day, Mr A had refused to get out of bed, and that Mr A had little food in the house. Mr I told Mr G that he should not shop for Mr A, as that was not his role, and the disability support provider staff were not permitted to handle client money.

162. On 6 May 2014, Mr G visited Mr A. Mr A had to be reminded about Mr G's previous discussions with him.

163. On 7 May 2014, Mr I telephoned Ms N and discussed Mr A not going out to do food shopping. Mr I had also spoken to Geneva staff, who had decided to do menu planning and consider using frozen meals. Mr I commented that supported living key workers should not purchase food, as Mr A could become reliant on that.

164. Ms N advised Mr I that Mr A was not receptive to the home care supports, and that if Mr A did not participate, ACC might have to cancel the services.

Further events

May 2014

165. Mr G emailed Mr I on 8 May 2014 indicating that Mr A had agreed to have a plumber fix the toilet, and on 27 May 2014 referring to the toilet not working and difficulty getting the toilet fixed as Mr A had forgotten what he had agreed to and had indicated that he could not afford the repairs.

166. Mr G was concerned that there was a risk of Mr A being subject to financial abuse, that Mr A's mobility was affecting his ability to get to the toilet in time, that he was at risk of falling, and that he was resistant to the idea of having a St John alarm.

167. On 27 May 2014, Mr I forwarded to Ms N the email received that day from Mr G.

168. Geneva told HDC that its staff understood that the disability support provider was responsible for facilitating the repair of the toilet. Geneva said that the situation did not prevent its staff from providing the required support for Mr A, and at that time it considered that the support was progressing well through Mr J.

June 2014

169. On 3 June 2014, Mr G visited Mr A. The toilet was full of paper and waste and, when Mr G told Mr A that he needed to get it fixed, Mr A shrugged his shoulders. Mr G discussed with Mr I the possibility of contacting the mental health crisis team and/or a residential placement for Mr A.

170. On 4 June 2014, Ms N arranged a "super stroller" walker for Mr A.

171. On 5 June 2014, Mr A told Mr G that he did not want to do anything about the toilet. Mr I then spoke to Mr A and offered to arrange for a plumber's quote.

172. On 5 June 2014, the disability support provider telephoned Ms P and informed her of the need for repairs to Mr A's toilet and the challenges being faced, given that Mr A had refused to pay for the repairs. Ms P said that she would instruct Ms N to take the necessary action to manage the situation.

173. Geneva's records are limited, but on 6 June 2014 record that Mr J telephoned Geneva. At 4.50pm a call centre staff member emailed Geneva staff Ms K and Ms Q regarding Mr A's toilet having been blocked for two weeks. The email reads:

> "Hi. [Mr J] phoned re [Mr A], apparently he has already spoken to you ([Ms K] and [Ms Q] regarding a blocked toilet at [Mr A's] house. This has now been blocked for two weeks. I have left a message for [the disability support provider] as per instructions on IQX but if either of you have any idea if a plumber is being arranged please let [Mr J] know as this is a health risk."

174. A telephone message was left for the disability support provider asking whether a plumber was being arranged. The progress note indicates that the toilet was a health risk.

175. In response to the provisional opinion, Geneva stated that it does not dispute that Mr J made one call to it after hours on 6 June 2014 outlining that there was a problem with Mr A's toilet, but that there is no record of Mr J saying that he would not be able or willing to provide services.

176. The disability support provider said that given the lack of action from ACC, on 10 June 2014, with Mr A's consent, it made arrangements for a plumber to assess the situation. The disability support provider then updated ACC.

177. Mr G told HDC: "I [usually] used an approach that encouraged [Mr A's] independence … After [Mr A] had left his toilet blocked for a few weeks, I took a more direct approach, in his company, I called a plumber …"

178. On 14 June 2014, Ms C emailed Ms N for an update and, on 16 June 2014, Ms N responded:

> "… [Mr A] is currently being supported by Supported living keyworker from [the disability support provider] and home help is provided through Geneva Health. Both the agencies are working together to achieve [their] goals.

> One of the issues was the wrong type of walker issued to [Mr A], we have arranged for a walker with brakes so [Mr A] is able to safely walk when out in the community with his key worker.
>
> There [are] a lot of hygiene issues which we are trying to sort out through Geneva health, however, we are unable to support [Mr A] with his home maintenance and repairs as this is the client's responsibility …"

179. On 17 June 2014, Mr G visited Mr A again, following which Mr G emailed Mr I and other disability support provider staff raising a number of concerns about Mr A — namely, that he seemed incapable of sorting out the toilet issue, his personal hygiene was poor, he was very demanding, and there was a risk of financial abuse. Mr G wrote: "It is very difficult to do any of the tasks outlined in the support agreement and I don't feel the current situation is good for me or [Mr A]."

180. On 19 June 2014, Mr I telephoned Ms N and asked whether ACC could provide funding to assist with the toilet plumbing repairs. Ms N replied that Mr A had all the injury related supports in place, and that ACC could not fund home maintenance as this was the client's responsibility. Ms N asked whether Ms C could assist with maintenance.

181. On 20 June 2014, Mr G had a discussion with a plumber, who advised that he could not repair the toilet as it needed to be removed, and a builder would have to repair the floor and one wall. Mr G updated ACC with this information.

182. On 24 June 2014, couriers attempted to deliver Mr A's walker, but he did not answer the door.

183. On 26 June 2014, Mr G visited Mr A. Mr G called the Public Trust to try to ascertain whether Mr A had a "trustee". Mr G documented that the Public Trust "could not disclose much information" to him, but said that Mr A had no power of attorney. Mr G documented that Mr A had acknowledged the toilet issue and that the house was odorous. Mr G noted that he decided to leave Mr A's house "due to health and safety" and because there was nothing further he could do to assist Mr A.

184. On 27 June 2014, Mr G again called Ms P to express concerns about the need to fix the toilet, and said that Mr A was now using the bath as a replacement toilet. Ms P explained again that it was the client's responsibility to make repairs, but agreed that it was a dangerous situation. Ms P agreed to provide finance for Mr A to stay in a motel for the weekend until the toilet could be fixed (via insurance or WINZ).

185. On 28 June 2014, Mr I travelled to Mr A's home to offer him the option of moving into a motel. After four hours of discussion, there was initial agreement from Mr A, and Mr I assisted Mr A to pack his belongings. However, Mr A then refused to leave his home.

186. On 30 June 2014, Mr I informed Ms P of Mr A's refusal to leave his home. Ms P telephoned Ms C, who said that she felt that her brother should be in a residential facility but she could do little to assist because she was overseas.

187. Ms P telephoned Dr L, who said that Mr A had not seen him for about a year. Dr L said that he would arrange for a community worker to see Mr A. Dr L sent an urgent referral on 2 July 2014. He said that, at that point, he had not been aware that it was such a dire situation.

188. Ms P contacted Ms N, and it was agreed that Ms N would follow up with the Public Trust about whether Mr A had sufficient funds to pay for the plumbing repairs. Mr I was told of the calls Ms P made to Ms C and Dr L, and he waited for contact from a community worker.

July 2014

189. On 1 July 2014, Mr G visited Mr A and told him that ACC might arrange for him to move out for a few days while the toilet was repaired.

190. On 1 July, Mr I emailed the disability support provider and informed staff of the telephone conversation he had had with ACC staff.

191. On 3 July 2014, Mr G attempted a further visit, and knocked on the window. Mr A did not come to the door.

192. On 5 July 2014, Mr I emailed Ms P, as he had not been contacted by a community worker.

193. The disability support provider told HDC that on 5 July 2014, an appointment was arranged for Mr A to meet with WINZ to discuss financial support to repair the toilet. This is not documented in its progress notes.

194. On 8 July 2014, Mr G visited Mr A. Mr G's progress notes record that the toilet was still malfunctioning, and that Mr A smelled. Mr G noted that he advised Mr A to shower before the next visit.

195. On 10 July 2014, Mr G attempted to visit Mr A but could not gain entry as there was no response to knocking at the window. On 11 July, Mr G arranged for a professional cleaning service to clean the house the following week, and Mr G communicated this to Ms N on 14 July 2016.

196. On 15 July 2014, Mr G met with a cleaning service staff member. They discussed arranging for a local church group to assist with some work on the property. Mr G arranged to meet a church representative later that week.

197. Mr G visited Mr A and noted that Mr A's clothes were soiled. Mr G helped Mr A to find some other clothes, and assisted him to go to the shops and the bank.

198. On 16 July 2014, Mr I emailed ACC advising that Mr A had given his consent for work to be done at his house. Mr I's understanding was that Mr G would be visiting

Mr A the next day, and would meet with a suitable tradesperson so that a physical assessment of the work required could be done.

199. Mr I included in his 16 July 2014 email to Ms N:

> "[Mr G] has mentioned to me that the toilet is now completely overflowing with body waste. When [Mr G] arrived yesterday, [Mr A] had soiled himself and Mr G suggested [Mr A] takes a shower. [Mr G] observed that there was a lot of faeces at the bottom of the shower that did not wash away. After the shower, [Mr A] said that he had no underwear and they were all soiled. [Mr G] managed to find a pair, not clean, but at least not soiled. [Mr G] found this quite distressing. Despite working with [Mr A] for several months now, [Mr A] repeatedly asked him if he was his new 'carer'. All of this raises some serious questions about the support [Mr A] is getting from Geneva Health, if indeed they support him with household management and personal cares. A neighbour came up to [Mr G] yesterday and reported that [Mr A] has approached them on several occasions and asked them to take him shopping.
>
> I am starting to wonder if [Mr A's] problems are not just restricted to the lack of toilet facilities and if there is a biological reason for this incontinence. [Mr A] has reported to [Mr G] that he falls in the shower and has to hold on to things to stay upright (which could be another reason for him not showering). I am concerned that this was not picked up in the last assessment. I will ask [Mr G] to try and persuade [Mr A] to make a GP appointment and for [Mr G] to support [Mr A] to go and explain our concerns for [Mr A's] physical and cognitive abilities."

200. On 17 July 2014, Ms N confirmed that Dr L was Mr A's GP. She also telephoned Geneva and spoke to Ms K. Ms N's file note recorded:

> "…[Phone call] to [Ms K] at Geneva, regarding cares for [Mr A], she advises that carers are going in the afternoon from 3:00–5:00 and assisting [Mr A] with meal prep and shopping and also with whatever they are able to. The care plan includes moving clutter to the garage, Meal prep/kitchen and shopping. Advised that I have received an email from [the disability support provider] concerned about the cares [Mr A] is receiving. Advised that [Mr A] may need assistance with personal cares. [Ms K] will talk to her carers and if [Mr A] allows them, the carers will be able to. [Ms K] will talk to the carers and will email me. Also advised [Ms K] that [the medical centre is] also involved and will try and assist [Mr A] with repairing the toilet."

201. There is no record of this discussion in the information supplied by Geneva to HDC.

202. Ms N emailed Mr I and updated him. Mr G saw Mr A on 17 July. Mr G recorded in the progress notes that he had met a representative from the church to assess the level of work required in the garden, and it was arranged that church members would clear the garden on 13 September 2014.

203. Mr G also noted that he spoke to a Geneva staff member (Ms Q) and was told that Mr A's allocated support worker (Mr J) had not been to see Mr A because of the toilet problem. Mr G recorded: "Geneva seemed to indicate to writer that they had not been aware that the service had stopped." Ms Q recorded an entry on the Geneva system that she had called Mr H and left a message.

204. In response to the provisional opinion, Geneva stated that Mr G's impression is consistent with Geneva's belief that it did not know that Mr J was not attending Mr A.

205. The disability support provider told HDC that Mr G rang Geneva on 17 July 2014 to enquire about Mr A's support. Mr G left a message for an appropriate person to make contact with him, and the call was returned on 18 July 2014. The disability support provider said that during this conversation, Mr G was informed that Geneva was no longer supporting Mr A because of the issues with his toilet.

Non-attendance of Geneva support worker

206. The Geneva support worker orientation booklet[27] includes a job description section and a section "Protecting your client in the workplace".[28]

207. The job description section[29] of the booklet includes:

> "Responsibilities
>
> Completion of assigned tasks
>
> - Reporting of all Incidents, Accidents and concerns
> - Observing the Code of Rights in all transactions with clients
> - Effective communication with clients, family and all parties related to the client care
>
> …
>
> - Adherence to Geneva Policies …"

208. Page 48 of the orientation booklet also states:

> "Once you have accepted an assignment, we expect your commitment to see that assignment through. Please arrive at the client's home at the agreed upon time and remain on duty for the full duration of their assigned care. If you are likely to have any difficulty completing the arranged care, please contact us with as much notice as possible."

209. The one-page homecare support worker job description document[30] includes as one of its key tasks, "reliable attendance at prearranged client appointments".

[27] August 2013 edition.
[28] Page 78.
[29] Page 7.

210. The section of the orientation booklet headed "Protecting your client in the workplace" states that in order to identify and reduce risk, support workers should immediately notify care coordinators of any issues not identified in the service plan, and of any area where it is felt that improvement is required.

211. The Geneva individual employment agreement[31] outlines:

> "9. Punctuality
>
> a) You will be punctual at all times, optimally arriving five minutes early in order to prepare for your shift.
>
> b) You must advise Geneva as soon as possible where you will be late. Lateness, especially persistent lateness, may result in disciplinary action.
>
> …
>
> 19. Abandonment
>
> a) If you are absent for three working days without authorisation and without contacting Geneva, you will be deemed to have terminated your employment …
>
> 32. Absences
>
> a) Unauthorised absences from work for any reason must be reported to Geneva as soon as possible and in any event before your scheduled starting time on the day of any such absence …"

212. Mr J's signed individual employment agreement[32] states:

> "…
>
> 4. Difficulty in assignments
>
> 4.1 Should you encounter a situation in your Assignment you are not sure how to handle, you will contact Geneva immediately for assistance.
>
> 5. Completion of assignments
>
> 5.1 You are expected to complete all assignments you accept.
>
> 5.2 Should you find for any reason whatsoever that you are unable to complete an assignment; you will give Geneva a minimum of twenty four (24) hours notice …"

213. Geneva told HDC that it first identified that there had been a period during which its support worker, Mr J, had not attended to Mr A, via its timesheet review system as, in

[30] April 2014.
[31] A generic document with an attached schedule for particular roles.
[32] November 2012 template. Copy provided to HDC.

the week beginning 14 July 2014, it discovered that there were no timesheets for Mr J for a period of four weeks.

214. Geneva told HDC that Mr J had not told his care co-ordinator that he was not providing cares to Mr A, and that, on 17 July 2014, Ms K attempted to contact Mr J and the disability support provider.

215. Mr G told HDC that he contacted Geneva to ascertain Mr A's home help arrangements. The disability support provider's progress notes record:

> "… [T]he Geneva representative said that the support worker [Mr J] had now stopped seeing [Mr A] due to the hygiene risk from the toilet. Geneva said they had informed ACC."

216. Geneva told HDC that it had difficulty contacting Mr J. Geneva wrote to Mr J on 25 July 2014, requesting that he contact them regarding the non-attendance. A further letter was issued to Mr J on 15 September 2014, as he had not responded to calls from Geneva.

217. Geneva said that it was not able to contact Mr J until mid-September 2014, when Mr J told Geneva that he had decided not to attend the client, and did not provide Mr A's cares because of the condition of the toilet and bathroom at Mr A's home. Mr J said that he did not want to put himself in an unsafe situation. Geneva told HDC that Mr J said at the time that he had "not bothered" to advise his coordinator. There is no documentation pertaining to this alleged statement.

218. According to Geneva, later on in its investigation process, Mr J said that he had called them after hours and left a message.

219. Geneva told HDC that disability support provider staff had not contacted Geneva about the non-attendance of Mr J until 17 July 2014.

220. Geneva said:

> "Given [Mr A's] history of challenging behavior and [the disability support provider's] close established relationship with [Mr A] I have been unable to identify the rationale as to why [the disability support provider] did not inform Geneva of the non attendance of our support worker, particularly as we continued to communicate with them regarding the blocked toilet and its repair subsequent to the support worker not attending to [Mr A]."

Mr J

221. Geneva told HDC that Mr J provided an appropriate standard of support, as he was working well with Mr A, maintaining access to Mr A's home, and making endeavours to improve his hygiene.

222. Mr J told HDC that he made a decision not to turn up for Mr A any more, because he had emailed Geneva about the condition of Mr A and his house. (Mr J provided HDC with an email he sent to Ms K, but it is dated 16 December 2014.[33])

223. Mr J said that he also informed Geneva that he was going to report the matter to a social worker to try to assist Mr A.

224. Mr J stated that when he informed Geneva about the situation regarding the toilet blockage, Geneva responded that it would send someone to fix it. Mr J said that it was not part of his job to fix the toilet. He said that during a telephone conversation with Geneva he had become frustrated and told them that they were not caring enough for clients.

225. Mr J stated:

> "When I went in for my next shift, still no sign of fixing the problem, and thought I was going to inform them for the last time if nothing was taking place then there was no point for me to carry on this job if Geneva does not respond with action to the needed situation for a healthy living standard."

226. Mr J said he then informed Geneva that he was not going to go to Mr A's home any more, and he presented no more timesheets and ceased his duties.

227. In contrast, Geneva said that Mr J accepted that he had deviated from the Geneva policy and had not communicated to Geneva that he was not attending Mr A. However, Geneva also said that even if Mr J communicated his non-attendance, it is unclear whether the company would have been able to provide an alternative support worker, owing to the home sanitation issue.

Delay in detection of Mr J's absence

228. Geneva told HDC that its weekly review of rosters generated versus timesheets submitted could be problematic. It said that many support workers, including Mr J, did not submit timesheets on a weekly basis, and submitted three or four weeks' timesheets together. Geneva said that this made it difficult for the co-ordinators to have an easy and transparent real time view of attendance and non-attendance.

229. Geneva said that in one part of its business it uses Panztel, which is a system where support workers dial in with a number to register that they are at a client's home and when they leave. However, Geneva had found this system fraught with problems, as clients were not always willing to allow support workers to use their telephone, and many clients did not have a landline.

230. Geneva told HDC that its records and feedback indicated that the provision of services to Mr A was progressing well. Mr J established a good rapport with Mr A and was supporting Mr A with his goals from the service plan. Mr J reported the problem with

[33] Metadata provided.

the toilet to Geneva, and raised it as a health and safety issue for him in the workplace.

231. Geneva stated:

> "As a result of the positive feedback we had been receiving and the ongoing communication we had with [the disability support provider] … Geneva had no cause to be concerned that [Mr J] was not attending [Mr A]. As a result it was assumed the timesheets were merely late."

232. Geneva also said that support workers are required to report to Geneva immediately if they are unable to attend shifts. In the event that the support worker does not attend and does not report to Geneva, the client reports the non-attendance to Geneva. If the client is unable to do so, then the designated next-of-kin, EPOA, or key liaison person reports the non-attendance.

233. Geneva told HDC that the timesheet system did not work in Mr A's case, as it was reliant on the designated key worker from the disability support provider telling it that Mr J not attended, because Mr A was incapable of doing this himself.

Replacement Geneva support worker

234. Geneva attempted to organise a replacement support worker for Mr A. It is recorded on 18 July 2014 that Mr R had been booked in for a 10am–2pm shift that day. Following his shift, Mr R telephoned Ms Q at Geneva.

235. Ms Q made a note of the conversation:

> "Received a concerning call from support worker that was booked in for a 4 hours shift 10am–2pm today. [Mr R] confirmed that he could smell the house before he could see it. He entered house and the amount of faeces that are in the client's home is unbearable and highly disgusting to say the least. [Mr R] confirmed the smell is dreadful and it has contaminated his whole household. The toilet has more faeces then water due to the blockage and [Mr A] has now started using the bath tub which is connected to the shower as new area of going toilet. The support worker is happy to finish shift today and clean up what he can as he does not want to leave the client if he can help with anything but has said he will not return to shift until the toilet issue is resolved. I have contacted ACC ([Ms N]) and [the disability support provider] ([Mr G]) and confirmed this also and they both understand. I have said that it is a health hazard for any of our support workers to enter home with these concerns — [Ms N] confirmed and said that she too couldn't even stand being inside the house when she went to do the assessment so stood outside while it took place."

236. Ms N made a file note on 18 July regarding the above discussion.

237. Ms K sought advice from a manager and was instructed to withdraw Mr R, due to health and safety reasons, and to inform ACC. Geneva told HDC that the escalation of the issue appears to have stopped at that level, and it was not reported any further. In

response to the provisional opinion, Geneva stated that the lack of escalation was an individual error, and that the individual is no longer employed at Geneva.

ACC guidelines

238. ACC's "Home and Community Support Service: Complaints and Reportable Events Guidelines" encourages a standardised approach for its contracted HCSS suppliers to advise ACC of any client and support worker complaints and/or reportable events. The guidelines[34] provide an outline of how ACC would like HCSS suppliers to communicate these events to ACC. The guidelines identify that an issue such as an "[i]nterruption in service delivery resulting in a threat to client's safety (at home)" would be classified as a "major" risk, and ACC should be notified within hours of the risk being identified.

Further events

239. On 21 July 2014, Mr G was advised that church members had arranged to work on Mr A's garden on 13 September 2014.

240. The disability support provider completed a Client Risk Management Plan, which included identifying risks associated with Mr A falling, his neglect of self-care, the state of the home, injury to staff if moving Mr A, and financial abuse.

241. Mr G alerted Mr I and other disability support provider staff by email that the medical centre had indicated that Mr A or WINZ would have to pay to fix the toilet. Mr G told the disability support provider that Geneva staff would not visit again until the toilet was fixed.

242. On 22 July 2014, Mr G recorded that he had arranged an appointment for Mr A to see WINZ later in the week.

243. On 23 July 2014, Mr G emailed his colleagues, Mr I and a care coordinator with some updated information, including:

> "… Geneva withdrew their support some months ago due to the health and safety risks, without informing ACC (they said ACC should have noticed that they are not billing for [Mr A] anymore). Risk is that on days we couldn't persuade [Mr A] to go shopping we left it as we believed Geneva would do it … he has been approaching neighbours … [Mr A's] washing machine is broken … staff have brought in some of their own clothes to donate …We need to get [Mr A] to WINZ to investigate if they could fund fixing the toilet … [Mr A's] GP is doing a home visit …"

244. In response to the provisional opinion, Geneva disputed that it said that ACC "should have noticed they are not billing for [Mr A] anymore". Geneva stated that the note did not specify who at Geneva is alleged to have made that statement, or when the statement was made, and that Geneva has no record of such a conversation. Geneva

[34] The Guidelines draw on the Home and Community Sector Complaints Categorisation Pilot 2013/2014 document.

also said that it would not expect ACC to identify client-level information from invoices.

245. On 23 July 2014, Mr G assisted Mr A with shopping and a haircut.

246. Mr I telephoned Ms P at ACC to express ongoing concerns about the repairs required and the other recent events. Mr I said that he was concerned about a lack of information received from ACC staff. Ms P advised that she would follow up with Ms N and the Public Trust.

247. Mr I's file note records that Dr L was to visit and assess Mr A in six days' time on Tuesday 29 July.

248. Ms P called Geneva. In contrast to Geneva's responses to HDC, Ms P's ACC file note for 23 July makes reference to Mr J having contacted Geneva previously:

> "… [S]poke with [Ms Q], she advises that cares had stopped on 06/06/14. The carer had left a message on the after hours phone line and that was not passed onto the care coordinator. A carer went in on 18/07/14 and no one has gone in since. [Ms Q] said she had spoken to [Mr G], carers will resume once the situation with the bathroom and toilet improves."

249. In response to the provisional opinion, Geneva stated that it does not believe that the file note accurately reflects what happened, and that even if Ms Q did relay information to ACC along the lines of the file note, it believes that she may have misinterpreted or misunderstood the information, as nothing in Geneva's records indicate that on 6 June Mr J notified Geneva that he was withdrawing services. Geneva said that the idea that it would simply withdraw care without taking further action is inconsistent with the steps it did take when it became aware (on 17 July) that care was not being provided.

250. On 23 July 2014, Dr L wrote to WINZ in support of a request for financial assistance in order to repair Mr A's plumbing.

251. Ms P spoke with Dr L, and he agreed to assess Mr A on 25 July 2014 (brought forward from 29 July), and asked that a supported living worker be present at that time. Ms P called Mr I and updated him.

252. The disability support provider told HDC that it asked ACC to make a referral to Mr A's GP for assistance and assessment and, when this was not actioned by 22 July, it instigated the referral itself and was the driving force behind making contact with Dr L.

253. On 25 July 2014, Mr I made enquiries with a company regarding the removal of the toilet and the rebuild of the wall and floor.

254. Mr I told HDC that overall he had responded to all concerns raised with him by staff who reported to him, by consulting with his manager, informing ACC, and/or taking appropriate action as required, which included numerous calls and actions,

and meeting personally with Mr A on occasion to assess his situation to ensure that ACC received a full description of the concerns.

255. The disability support provider stated:

> "Our concerns and frustration with the lack of responses from responsible agencies led us to intervene beyond the scope of our contract in an attempt to achieve the necessary outcomes."

256. ACC told HDC:

> "It has to be said that [Mr G's] involvement was instrumental to [Mr A] finally receiving the care he required. He appears to have kept excellent records of his involvement in [Mr A's] care and to have appropriately escalated concerns to his team and ACC. Despite [Mr G's] efforts, both [the disability support provider] and ACC's response to them lacked the urgency and clarity of purpose required in the circumstances. This was again the result of the continuing misapprehension as to the extent to which the issues [Mr A] was experiencing could be attributed to a pre-existing condition."

Circumstances leading to hospital admission

Dr L

257. On 25 July 2014, Dr L went with Mr G to see Mr A at his home. Dr L examined Mr A and found that he appeared well nourished, but had deteriorated since Dr L had last seen him. Mr A was orientated but his memory was poor and his feet were in poor condition. His clothes were soiled.

258. Dr L's notes record that the toilet was blocked, the kitchen bench was broken, and the house was littered with dirty clothing and smelt offensive. Owing to the conditions he found at Mr A's home, Dr L decided to refer Mr A to the DHB's Mental Health Services for Older People (MHSOP) community team. Dr L also contacted the District Medical Officer about the unhygienic state of the house. A cleaning company representative viewed the house and indicated that the company would provide a quote for cleaning. Mr A refused to leave the house while repairs were made.

259. On 28 July 2014, Dr L emailed Mr I advising that he had completed a referral to MHSOP, and that the first step was to get Mr A assessed medically (as Dr L felt that there was probably a dementia process occurring), and then to consider possible alternative living arrangements for Mr A. Mr I acknowledged Dr L's email and copied in Ms P.

260. On 30 July 2014, a disability support provider staff member was unable to contact Mr A when he visited. The next day, Mr I emailed Ms P and Dr L about this. They agreed that if Mr A did not answer the door the next day, the Police should be called.

261. On 1 August 2014, the disability support provider staff member documented that he had been unable to get a response from Mr A again when he arrived at his house that day. A community health coordinator had arrived while he was there, and she also

was unable to contact Mr A. The Police were called. In the interim, Mr A responded, and subsequently the callout was cancelled. Mr A appeared to be in a satisfactory condition but said that he wanted to stay in bed as he was cold.

262. On 4 August 2014, Mr I contacted Ms N and advised her of the events of 1 August. He said that there would be a psychogeriatric assessment of Mr A the following day, and that the company would be at the property that week to remove the toilet and install a new toilet. Mr I confirmed that Mr A's bank statements showed that he had sufficient funds to pay for the work. Mr I said that he would attend the psychogeriatric assessment because Mr G was on leave.

MHSOP

263. On 5 August 2014, Mr A was visited and assessed by MHSOP staff, who convinced him to go to hospital, where he was admitted. Mr I informed Ms N, Dr L, and Ms C, who was in New Zealand at that time, that Mr A had been admitted to hospital.

264. A multidisciplinary meeting was held at the public hospital on Thursday 14 August 2014, involving a DHB social worker, medical and nursing staff, Ms N, a Public Trust representative, and Ms C. It was concluded that Mr A was not fit to live on his own in the community.

265. On 15 August 2014, Mr I emailed to the Public Trust a quote for having the toilet removed.

EPOA activation

266. The EPOAs for personal care and welfare and for property (which had been drawn up on 25 March 2013) were formally activated by the legally required medical certification on 18 August 2014.[35]

Subsequent events

267. Mr A was discharged from hospital four weeks later and placed in full-time residential care, funded by ACC for a three-month period initially. ACC later funded Mr A's residential care for a further 12 months. ACC reported that Mr A was satisfied with the support being provided to him at the facility. Ms C also told HDC that Mr A was comfortable with his new living situation.

Geneva review

268. Geneva told HDC that it undertook a review of this incident from the point it received the referral from ACC.

269. Geneva told HDC:

> "The blocked toilet was evident at the commencement of the request for support. I have been unable to establish for how long the toilet had been blocked, however

[35] A consultant psychiatrist at the DHB completed the appropriate documentation deeming Mr A as unable to make or understand the nature of decisions relating to his personal care and welfare and unable to foresee the consequences of such decisions.

it appears this was the case for some time, prior to Geneva Healthcare becoming involved.

Following the RN's service plan, Geneva consistently raised our concern with the disability support provider and ACC about the blocked toilet and the smell. There appears to be some significant lack of clarity regarding who was responsible for getting the toilet repaired. Geneva became drawn into this debate as a result of inactivity and despite our best attempts were unable to establish whose responsibility it was to get the toilet unblocked."

270. Geneva also said:

"This was an extremely unusual situation for Geneva, in that we were providing support for an individual, yet all communication was being facilitated by [the disability support provider] because of the challenging nature of the client. As a result of this I believe there were assumptions made in relation to the scope of responsibility for a) advocating on behalf of [Mr A] and b) taking responsibility for [Mr A's] home hygiene situation."

Changes and improvements to service

Geneva

271. Geneva said that Geneva took the situation with Mr A seriously, and there have been a number of learnings the organisation and individual staff have taken from his case. Geneva stated that changes have been implemented as follows:

- Where Geneva is placed in a similar situation with another organisation it will enter into a written agreement between it and the other supporting organisation which defines the lines of responsibility of each organisation. Geneva has introduced a Multi-Agency Service Provision policy and agreement.[36]
- Geneva identified the need to implement a significant new technology platform to enable real time transparency of attendance and non attendance. The first part of this technology has been new document management software.[37] It plans to implement documents including timesheets that will be available on smart phones; GPS tracking; communication of shortest travel routes between clients; and real time notification of non-attendance by its staff. This technology will support the care co-ordinators' ability to monitor attendance and non-attendance in real time. Geneva has also introduced a Missed Care Policy and Procedure.[38]
- Geneva conducted an electronic timesheet review and rolled out Panztel to a greater number of clients.

[36] Document HC-008. July 2015.
[37] Called "M Files".
[38] Document OP-022. 26 February 2015.

- Geneva developed a Vulnerable People Management policy and procedure.[39] The policy identifies at-risk groups using a "Tier Status" system that is now built into its software to identify "at risk" clients more clearly.
- Changes have been made to Geneva's reporting structure and delegating lines of responsibility. In relation to this incident, escalation appeared to stop at a Manager level, and information was not reported any further. It has changed reporting lines of responsibility, to provide clearer lines of delegated authority and responsibility for escalation..
- Geneva has introduced a new procedure entitled "Unhygienic or Unsafe Situations",[40] which outlines which individuals within Geneva are responsible for each part of escalating concerns about work environments.
- Geneva reviewed all other ACC client rosters to confirm that there were no other examples of missed care. It is confident that what occurred with Mr A was an isolated incident.

272. Between 2 and 4 December 2014, Geneva underwent a certification audit against the home and community support sector standard NZS 8158:2012.[41] The designated auditing agency was Health and Disability Auditing New Zealand Ltd (HDANZ). Certification was recommended by HDANZ subject to Geneva reporting progress on areas identified for improvement — namely: the development of a quality plan, up-to-date records, an updated service agreement, a medication policy update, an infection control update, and consistent reviews for service plans.[42]

The disability support provider

273. The disability support provider stated that its response to HDC served as its internal review. In its view, the standard of care provided met the duties required of providers and exceeded the requirements of its Supported Living contract with ACC. It reiterated:

> "When we identified that action was required to be taken by other parties who held the mandate to do so we informed them of our concerns without delay. When faced with a lack of appropriate responses from these parties we were unrelenting in our attempts to influence them to take action. When we lost faith that these parties would intervene we stepped outside the scope of our agreement with ACC and took action ourselves."

274. In reviewing Mr A's client notes held within its Client Management System, the disability support provider said it identified that it had inconsistently documented the

[39] Document OP-044. 26 February 2015.
[40] Copy provided to HDC.
[41] Copy provided to HDC. The audit was completed on 13 January 2015.
[42] Matters relevant to this case were categorised as low risk. A surveillance audit was then undertaken on 18 September 2016, and it was noted that the matters identified had been addressed. ACC also confirmed that the HDANZ audit resulted in minor corrective actions for Geneva that have since been addressed and were unrelated to the issues with Mr A's care. ACC commented that the audit results showed that Geneva had fully achieved against standards for risk management and service delivery processes and systems.

actions taken when issues relating to the complaint were identified, and had rarely recorded any discussions held during review meetings with ACC. Feedback, training, and supervision in relation to documentation has been provided to appropriate personnel, and this learning will influence training and supervision practices in the future.

275. The disability support provider stated that its review also highlighted the importance of consistent, regular communication with all parties involved in a client's care, particularly when complexities are present. It has strengthened the lines of communication and the relationship with designated ACC Supplier Managers, as it sees them as key to ensuring collaboration between services. The disability support provider has developed a corrective action plan with ACC and clarified its escalation process.

276. Gaps in relation to ACC service delivery-specific policies and processes were also addressed as a matter of priority.

277. The disability support provider has reviewed its processes to reinforce that staff need to seek clarification to identify the lead agency where two or more are involved. It utilises an expert forum of people who have experienced receiving services, who review all policy and practices developed. It has developed a mobile community support checklist and is reviewing its lone worker safety policy.

ACC review

278. ACC completed a comprehensive review of the events surrounding Mr A's care. It advised that the management of Mr A's claim was challenging and complex. It concluded that the standard of service delivery provided to Mr A was below the standards expected by ACC, and highlighted recurrent themes.

279. ACC acknowledged that service failings extended not only to the disability services provided, but also to the management of the claim by ACC staff. It stated that it had taken ownership of the issues identified. ACC did not consider that this was reflective of case management practices generally, but rather was an isolated example of extremely poor practice.

The disability support provider

280. ACC found that disability support provider staff worked to address issues that were present in relation to Mr A's claim, but did not escalate them in the manner required, and this appeared to give ACC staff a false sense of security.

281. ACC is of the view that had appropriate and timely action been taken in respect of applying for an order under the PPPR Act, many difficulties experienced could have been avoided. When asked to attend to the PPPR Act application, the disability support provider' response (given its lack of training and policy on the issue) should have been to advise ACC that it would be more appropriate to refer the task to another provider, or to provide an assurance that staff would be given appropriate guidance and support from a suitably qualified person in order to complete the task, but that did not happen.

Geneva

282. ACC found that care worker Mr J made a decision to stop providing services owing to the state of Mr A's house. While this was related to the hygiene issues associated with the house, as well as Mr A's variable willingness to accept help (including refusing entry to his home), Mr J's decision to withdraw services of his own volition was not acceptable.

283. ACC found that while there were some limited occasions when Mr A's home help carers requested ACC funding of temporary hours to address the hygiene issues, they did not do so in a sufficiently proactive manner, failed to advise ACC of the extent of the issues they were encountering, and failed to escalate those matters in the manner expected.

284. ACC also found that Geneva did not adopt a collaborative approach and, despite there being a plan in place for Geneva to liaise and engage with the disability support provider with regard to accessing the house, this process was sporadic.

285. In summary, ACC's review concluded the following:

- In 2008/2009 ACC staff had relied on information from Ms C regarding Mr A's pre-injury health, without obtaining clinical corroboration.
- ACC staff and providers repeatedly attributed behaviours encountered to a pre-existing condition, when a focal issue was a deficit as a result of a brain injury.
- New ACC staff managing the claim did not consider critical clinical information.
- ACC tasked a provider (the disability support provider) with obtaining an order under the PPPR Act, and then failed to follow up on progress.
- The disability support provider did not advise ACC that it was not equipped to assist Mr A in obtaining the order, and failed to obtain an order in a timely manner. Once this was apparent to ACC staff, they did not escalate the matter.
- There was a lack of co-ordination and communication between providers.
- Care providers did not have appropriate oversight of their staff.

ACC corrective actions

286. Following its review, ACC examined how claims involving vulnerable clients were handled.

287. In summary, the main corrective actions taken were:

- ACC undertook a project to assist and educate staff on "vulnerable client" claims.
- It provided further training and resources to staff.
- It sought explanations from Geneva and the disability support provider, and emphasised their contractual obligations and service delivery expectations.

- It undertook disciplinary processes and performance management of certain ACC staff.
- It instigated performance management and improvement programmes for Geneva and the disability support provider.
- It implemented a review of ACC's contractual arrangements with all its lead healthcare and disability service providers.

288. In relation to Mr A:

- ACC formally apologised to Mr A for the service he experienced from ACC and its providers.
- ACC staff met with Mr A's new providers to develop an appropriate care plan, and maintains regular contact with Ms C. Mr A's residential care is reviewed regularly.

Further information regarding ACC corrective action

289. ACC updated HDC with further details in relation to its corrective actions. The key developments are summarised below.

290. After consulting service users and staff in late 2013, ACC developed its "Shaping Our Future" strategy. The strategy forms part of its programme of improvements to customer services and outcomes. In 2015, ACC commenced a customer experience programme ("Tika") to build customer vision and values across ACC teams.

291. ACC considers that the following key changes will make a significant difference to clients in situations similar to Mr A:

- ACC has created a Vulnerable Situation Policy and Indicator to ensure that staff are routinely able to identify vulnerable clients and track and monitor their needs. The policy sets out a range of circumstances, including mental health or behavioural issues that some clients may experience. Staff are better trained to recognise and identify a vulnerable situation, and are required to report it to their manager immediately. This will activate a Vulnerable Situation Indicator and implement a risk management plan, including a red flag on the client's record.
- As part of its review of provider services, ACC reviewed quality standards and initiated a corrective action plan for the disability support provider that covered:
  - better process for agreeing client goals and referring back to ACC where goals are outside the scope of practice;
  - training staff on the PPPR Act and related legislation;
  - better oversight of reporting timeframes; and
  - improved escalation pathways and risk management.

  The plan was signed off in February 2016.
- In 2014 ACC initiated a corrective action plan with Geneva to:

— improve monitoring of service provision (including specific policy for managing complex or vulnerable clients, and real-time alerts when staff caring for such clients do not log in or out of a shift);

— improve escalation pathways;

— develop a communication plan for clients who have multiple agencies involved in their care; and

— implement technology changes to support staff oversight and escalation of issues.

The plan was completed in 2016. ACC meets with Geneva monthly to monitor performance (as it does with all its lead providers of home and community support services), and works closely with HDANZ.

- ACC acknowledged its duty to ensure that its staff have access to information and advice. It implemented training for all case managers on their ongoing obligations to identify and support vulnerable clients, and on the use of the PPPR Act and monitoring of pending PPPR Act orders. These modules are compulsory for new frontline staff. ACC also utilises tools to support effective case management (such as workflow management).

292. In addition:

- ACC discussed Mr A's case with all its lead suppliers to reinforce the key lessons learned.
- ACC reviewed the arrangements with other Home Care Support Services (HCSS) suppliers and, in particular:

  — updated reportable event guidelines;

  — created new operational guidelines to include sections on vulnerable clients;

  — carried out onsite review of suppliers and how each maintained oversight; and

  — placed requirements on suppliers to report six monthly on any incidents experienced, to be discussed quarterly.
- In March 2016 ACC made changes to its Standard Terms and Conditions for all suppliers contracted to ACC, particularly strengthening provisions related to health and safety of clients, providers, and ACC staff. All HCSS providers now have a vulnerable client policy in place. Strengthening of contractual requirements for management of vulnerable clients will occur at contractual review times.
- ACC implemented a provider management framework to provide a consistent and structured approach on how staff manage supplier relationships and performance. Its provider service delivery team implemented a new Customer Relationship Management Tool that will increase its oversight of any performance issues.

Relevant standards

New Zealand Health and Disability Services (Core) Standards[43]

293. The New Zealand Health and Disability Sector (Core) Standards state that the standards are to enable consumers to be clear about their rights, and providers to be clear about their responsibilities, for safe outcomes.[44]

294. NZS 8134 requires the following:

a) Consumers receive safe services of an appropriate standard that comply with consumer rights legislation.

b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner.

c) Services are managed in a safe, efficient, and effective manner which complies with legislation.

d) Services are provided in a clear, safe environment which is appropriate for the needs of the consumer.

295. NZS 8134 includes the following:

> "Standard 1.3 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy and independence.
>
> …
>
> Standard 2.8 Consumers receive timely, appropriate, and safe services from suitably qualified/skilled and/or experienced service providers.
>
> …
>
> Standard 3.5 Consumers' service delivery plans are consumer focused, integrated and promote continuity of service delivery."

296. The Health and Disability Services (Core) Standards[45] also place an obligation on providers to ensure that "[c]onsumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect".

[43] NZS 8134.1:2008.
[44] The Standards are mandatory for those services subject to the Health and Disability Services (Safety) Act 2011. Standards New Zealand explains standards on its website as follows: "Standards are agreed specifications for products, processes, services, or performance. New Zealand Standards are developed by expert committees using a consensus-based process that facilitates public input. New Zealand Standards are used by a diverse range of organisations to enhance their products and services, improve safety and quality, meet industry best practice, and support trade into existing and new markets."
[45] NZS 8134.1:2008, standard 1.3.7.

Home and community support sector standard[46]

297. NZS 8158:2012 includes the following:

> "Standard 1.7 Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation, abuse (physical, psychological, sexual, or financial), or neglect.
>
> …
>
> Standard 2.1 Consumers receive timely, appropriate, and safe services through efficient and effective service management.
>
> …
>
> Standard 2.3 Consumers receive services that reflect continuous quality improvement through the organisation having an established, documented, and maintained quality and risk management system.
>
> …
>
> Standard 2.4 All adverse unplanned or untoward events are systematically recorded and reported to affected consumers and where appropriate their family/whānau in an open manner.
>
> …
>
> Standard 3.2 Consumers receive services from service providers who are trained and assessed as competent to provide services.
>
> …
>
> Standard 3.3 Consumers receive services that promote the health and safety of the consumer and service providers.
>
> …
>
> Standard 4.3 Consumers receive continuity of service through effective links with other groups.
>
> …
>
> Standard 4.12 Consumers with behaviours that challenge are treated with respect and receive services in a manner that has regard for their safety, dignity, privacy, and independence."

[46] (NZS 8158:2012) Standards New Zealand's website comments that NZS 8158 supports nationally consistent quality expectations across the health and disability sector by aligning with the Health and disability services standards (NZS 8134) where this is appropriate. It also recognises that providing support in a person's home or in the community has implications for relationships between both parties. The Standard ensures that organisations are assessed on outcomes achieved for people receiving services and on compliance with procedures that support good outcomes. NZS 8158 applies to organisations and service providers who are either publicly or privately contracted to provide home and community support. It covers people receiving home and community services for long-term support (such as people with disabilities or chronic health conditions, or frail older people), short-term support (such as people recently discharged from hospital), and palliative care.

Responses to provisional opinion

298. The parties provided HDC with responses to the relevant sections of the provisional opinion. Where appropriate, those responses have been incorporated into the report.

299. Mr B and Ms C had no further comments to make in relation to the content of the "information gathered" section of the report.

300. The disability support provider stated that it accepts the adverse comments, recommendations, and follow-up actions outlined in the report. It is confident that the implementation of its remedial actions and changes, and the improved communication and processes with ACC, will prevent a similar incident occurring.

301. ACC advised that it does not dispute the information gathered about ACC during the investigation, or the preliminary conclusions drawn on the basis of that information, and it accepts the proposed recommendations and follow-up actions. It said that this is an important report for ACC, and the case itself has had a big impact on how ACC looks after its most vulnerable clients.

302. ACC stated:

> "ACC unreservedly apologises to [Mr A] and his family for the poor standard of care and support provided to him. The care and support provided to [Mr A] did not meet ACC's standards and the way ACC managed [Mr A's] care and support was inconsistent with ACC's practices at the time.
>
> In response to this case, ACC completed its own review of the factors that caused the service failure. Our review identified a number of improvements we have since implemented to avoid such a failure happening again.
>
> ACC is confident these improvements mean we are better at meeting the needs of our most vulnerable customers and can quickly identify problems if they arise."

303. Geneva acknowledged that it did not have adequate monitoring systems in place at the time to identify promptly that Mr J ceased providing care.

304. Geneva stated:

> "Geneva … accepts that we did not provide services to [Mr A] in accordance with Right 4(5) of the Code of Health and Disability Services Consumers' Rights … We would like to reiterate our sincere regret that [Mr A] did not receive better services in the community. I would also like to assure you that Geneva appreciates the importance of cooperation among providers, as required by Right 4(5) of the Code, in order to ensure quality and continuity of services to consumers. This investigation and review process has highlighted the importance of such cooperation, particularly in situations where care is being provided to

> vulnerable consumers, and has led to a number of changes within our organisation. Geneva has previously offered to apologise directly to [Mr A], and we will do so in accordance with your recommendation."

Opinion: preliminary comment

305. I have carefully considered the standard of disability services provided to Mr A, particularly the care provided in 2014.

306. I am mindful of the comment made by my expert advisor, John Taylor:

> "The disability care environment of New Zealand is characterised by siloed and highly specified forms of funding. This is very problematic for the coordination of services to individuals."

307. First, I acknowledge that this was a complex situation. Mr A's clinical condition and his frequent refusal of care and services, together with his home environment, presented many difficult challenges to support workers, care workers, and other individuals co-ordinating Mr A's supported living assistance, and his home and community support services.

308. Secondly, based on the evidence gathered and the sequence of events, which on the whole is not in dispute, I have few doubts that some of the support workers and care workers assisting Mr A were aware of his degree of vulnerability, had his best interests in mind, and recognised the risk to Mr A (and to themselves and their co-workers) when his home plumbing/hygiene issues worsened in 2014.

309. As HDC's in-house clinical advisor, GP Dr David Maplesden, advised in another case:[47]

> "This is an extremely complex case that raises fundamental issues over perceptions of what is a reasonable standard of living, the rights of an individual to live as they want provided they are not an overt threat to themselves or others … the role of the family in advocating for another family member and the role of community based organisations in attempting to provide support for the choices of a patient."

310. In my view, given Mr A's clinical history and background, it was necessary to have an effective system of co-operation and communication across all organisations. When his home hygiene issues worsened, the situation demanded prompt escalation, co-ordination, and appropriate decision-making undertaken in a timely manner. This did not occur.

311. Mr Taylor opined that there was "a series of poor decisions being made, boundaries being protected, communication failing to happen in an effective manner and an

[47] 11HDC00647 (10 June 2013) available at www.hdc.org.nz.

apparent indifference to the urgency of the problem". Mr Taylor said that this lack of planned communication is a significant failing in a service characterised by the need for strong partnerships and a collaborative approach.

312. Mr A required continued appropriate co-ordination of his supported living assistance and home and community support services to meet his needs and keep him safe. The system in place failed to function effectively and respond in a timely manner to the concerns raised about Mr A's home environment, his behaviours, and the associated risks to him. There was also a degree of confusion and assumptions made by all parties as to who had responsibility for advocating on behalf of Mr A and taking overall responsibility for dealing with the situation.

Competence

313. Despite having limited family support (as his sister did not reside in the same region and then moved overseas), Mr A wished to remain in his own home. New Zealand law is clear that a competent person has the right to make informed choices and refuse services.[48]

314. It is undisputed that, between 2012 and 2014, Mr A's ability to care for himself was of concern and that, by 2014, he was living in squalid and unsanitary conditions. In accordance with Right 7(2) of the Code, a consumer is presumed competent to make an informed choice and give informed consent to treatment and/or services (including refusing consent to treatment and/or services). Right 7(3) of the Code provides that where a consumer has diminished competence, the consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence. If a consumer is not competent, treatment decisions may be made by a person who is legally entitled to consent on behalf of that consumer. Where appropriate, the courts may appoint a Welfare Guardian under the PPPR Act for that purpose.

315. On 15 March 2012, ACC arranged for Mr A to undergo an assessment by neuropsychologist Mr D, whose report was completed on 30 April 2012. He reported that, linked to his injury, Mr A was incapable of managing his own finances, making rehabilitation and health-related decisions, or organising and planning daily living. Mr D recommended that ACC arrange a neuropsychiatric assessment.

316. A multidisciplinary meeting was held on 15 June 2012 to discuss the support to put in place for Mr A. A plan was made to "look into" organising an application for an order under the PPPR Act. It was also decided that a neuropsychiatrist assessment was not required. ACC staff gave the disability support provider the task of looking into an application for an order under the PPPR Act, but failed to follow up the outcome with the disability support provider. In addition, disability support provider staff did not have the ability, skill, or experience to undertake this application.

[48] Right 7 of the Code states that consumers have the right to make an informed choice and give informed consent, and Right 7(7) provides the right to refuse services and withdraw consent to services.

317. As no psychiatric assessment took place, it is not known whether, in 2012, Mr A wholly lacked competence.

318. The PPPR Act provides for a competent person to give an EPOA to one or more other people, which will come into effect when the person becomes incompetent. The PPPR Act[49] provides that the person may authorise that the EPOA for property is to have effect while he or she is still mentally capable, and to continue to have effect if he or she becomes mentally incapable.

319. The EPOAs for personal care and welfare and for property (which had been drawn up on 25 March 2013) were formally activated by the legally appropriate medical certification on 18 August 2014.

320. While Mr A had made it clear that he wished to remain in his own home, it was also increasingly clear that the services that were being provided did not meet his needs, and the state in which he was living presented a very real risk to his health and safety. I do not consider it tenable to say that Mr A chose to live in the circumstances in which he lived.

ACC — adverse comment

321. I am critical of the shortcomings of ACC staff once they had been clearly alerted to concerns about Mr A's circumstances. Mr A was a vulnerable consumer with significant disabilities arising from a traumatic brain injury. ACC's National Serious Injury Service is charged with assisting clients to access support and services appropriate to the client's needs.

322. ACC has acknowledged that there were red flags in the information about Mr A's ability to cope in his living situation that should have alerted its staff that the situation required greater input from ACC from as early as 2012.

323. I am concerned that in a situation where it was appropriately reported by the disability support provider to ACC that Mr A had little food in the house and that he did not go shopping, ACC's response was that Mr A was not receptive to the home care supports, and that if Mr A did not participate, ACC might have to cancel the services.

324. ACC chose to categorise reports about extreme insanitary living conditions as a household maintenance issue. When alerted by RN F that a further needs assessment was required urgently, ACC replied:

> "Thank you for the service plan and also your concerns around [Mr A's] living environment. Attached is the latest needs assessment, unfortunately, we have tried our best to assist [Mr A] over the past many years, [Mr A] has not been very cooperative. With [Mr A's] increasing age and instability, the supported living key worker has insisted that we put some cares and equipment in place. It was agreed with the assessor and the keyworker that the repairs to [Mr A's] home [are] his responsibility and he has been advised to start saving."

[49] Section 97(4).

325. ACC had an obligation to ensure that Mr A's needs were assessed appropriately, and that appropriate services were put in place in accordance with his needs. Those services were not in place, and, despite receiving reports that Mr A was living in circumstances that raised serious health and safety concerns, it failed to take appropriate action to ensure that Mr A's needs and competence were reviewed.

326. ACC's review concluded that the standard of contracted provider service delivered to Mr A was short of the standards it expected, but it acknowledged that service failings also extended to the management of the complex claim by its own staff. I agree. It is evident that ACC staff failed to act on information received, and to escalate the issues.

327. I consider that it was inappropriate for ACC to delegate to the disability support provider the task of looking into making an application under the PPPR Act. I accept that ACC was not responsible for repairs to Mr A's house. However, the squalid conditions in which he was living were indicative that his competence may have been reducing.

328. As stated by the English Court of Appeal: "[I]f the capacity of the patient is seriously in doubt it should be assessed as a matter of priority." The Court stated that in "serious or complex cases involving difficult issues about the future health and wellbeing or even the life of the patient", the issue of capacity should be examined by an independent psychiatrist. The Court considered that a presumption of competence is of little consequence where there are serious doubts about a patient's capacity to make an important decision.

329. I accept that ACC was not in a position to assess Mr A's competence. However, in 2012 it referred Mr A to Mr D, who recommended that Mr A undergo a neuropsychiatric assessment. In my view, ACC should have referred the matter to Dr L or arranged for an assessment by a psychiatrist. The disability support provider and Geneva made their concerns about Mr A clear to ACC, and ACC should have recognised the need to take action, and should have done so.

330. ACC stated that it has taken ownership of the issues identified regarding its staff's management of Mr A's claim. I note that ACC's review was comprehensive and has resulted in a strategy of remedial and corrective actions, at individual and organisational levels.

331. ACC subsequently provided HDC with follow-up information on the changes to practice it has implemented.

Opinion: Disability support provider — adverse comment

332. The disability support provider, as a provider of disability support services (in this case supported living assistance) was responsible for providing services to Mr A in accordance with the Code.

333. The disability support provider undertook to provide services to Mr A in accordance with his assessed requirements, and its contractual obligations to ACC. As described above, the key contractual obligations with ACC included:

- Advising ACC immediately of any matter that may change or delay the performance of services;
- Providing services in accordance with all current clinical, ethical and professional standards;
- Managing risks;
- Providing oversight of staff;
- Immediately reporting any issue with service delivery; and
- Ensuring that communication is maintained with all services that are concurrently provided to the client in order to ensure a co-ordinated and collaborative approach.

334. The Supported Living Service's operating principles include client-centred delivery based upon the individual client's needs, taking into account the client's preferences, potential, abilities, and interests. ACC told HDC that the service is based on a collaborative approach, and contingent on developing strong partnerships.

335. I consider that there were areas where the supported living assistance provided to Mr A by staff fell below what was expected, as outlined below.

PPPR issue

336. On 27 March 2012, ACC approved funding for Mr A to receive supported living assistance. the disability support provider was contracted to work with Mr A to achieve his goals, primarily in relation to:

- Structure with daily routines and activities of daily living;
- Protection of personal and property rights; and
- Community integration.

337. A multidisciplinary meeting was held on 15 June 2012 to discuss the support to put in place for Mr A. The plan developed was for the disability support provider to look into organising an application for an order under the PPPR Act.

338. ACC said that its expectation was that significant progress on the application would be made within six to eight weeks, and that ACC staff would follow up progress with the disability support provider. ACC said that providers are required to contact it

promptly if the client is unable to meet his or her goals and/or desired outcomes within expected timeframes.

339. The disability support provider took the following steps:

- On 29 August 2012, Mr E met with a lawyer.
- On 17 January 2013, Mr E completed a closure report for ACC. In relation to making an application under the PPPR Act, it was noted that the process had been begun but had been hampered by dealings to do with the urgent plumbing repairs.
- On 15 February 2013, Mr A and Mr E met with ACC staff. Mr E requested some further funded hours per week that he could allocate to the PPPR Act issue.
- Mr E completed the Supported Living Referral form. This included an objective for Mr A to appoint appropriate persons to manage his finances.
- On 25 March 2013, a meeting was held with the Public Trust to discuss and set up the administration of Mr A's financial affairs. The Public Trust determined that Mr A was competent to instruct it at that time, and he executed an EPOA appointing Ms C as EPOA for personal care and welfare, and the Public Trust as EPOA for property.
- Entries in the notes for August and September record Mr A's reluctance to leave the house and attend appointments regarding his financial affairs.
- On 27 November 2013, Mr H forwarded ACC a three-monthly progress report, which states that Mr A was reluctant to have his finances managed by an appropriate agency.
- On 18 March 2014, Ms N met with Mr H and discussed that the issue of having Mr A's finances managed independently had not yet been fully resolved.

340. It is evident from the content of Mr D's April 2012 neuropsychological assessment, performed for ACC's purposes, that Mr A's level of competence was queried at that time. Mr D recommended that a neuropsychiatric assessment be undertaken, but subsequently it was decided by the multidisciplinary meeting not to do so.

341. In my view, the disability support provider was not the appropriate agency to look into Mr A's competence and status. The relevant "Service Specifications for the Supported Living Service" relate to increasing client independence through community participation.

342. Furthermore, the Home and community support sector standard NZS 8158:2012 includes:

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

343. The disability support provider did not have policies relating to the PPPR Act and its clients, and it had not provided its staff with training on the issue. In my view, the

disability support provider's acceptance of responsibility for looking into an application under the PPPR Act required it to ensure that its staff were adequately informed about the steps needed.

344. The disability support provider should have communicated with ACC about the expected parameters of its role. It would have been wise for the disability support provider to have advised ACC to refer the task of looking into applying for an order under the PPPR Act to another more suitable provider, or to have advised ACC that the disability support provider would need sufficient funding to obtain advice from other appropriate persons. However, I note that staff did keep ACC informed about its difficulties when attempting to encourage Mr A to have his finances managed.

Policy shortcoming

345. Mr A was at risk of financial exploitation and harm caused by his unhygienic living conditions. As outlined above, key contractual obligations between ACC and providers include that providers need to manage risk.

346. In a previous report, this Office noted that "a provider who accepts the responsibility for a [consumer] with known risk factors … has always been required to take reasonable steps to minimise the risk".[50]

347. Home and community support sector standard NZS 8158:2012 includes:

> "Standard 2.3 Consumers receive services that reflect continuous quality improvement through the organisation having an established, documented, and maintained quality and risk management system."

348. The disability support provider has acknowledged that it had in place a Client Risk Management Policy that was an organisational document to guide risk management, but it said that the policy had been developed for clients with mental health or addiction issues, and was also being used for clients under ACC contracts.

349. In my view, it was suboptimal for an ACC client-specific policy document relating to managing client risk not to be in use by the disability support provider at the time of these events.

350. The disability support provider advised that specific ACC service-delivery policies and processes have been addressed as a matter of priority as a result of this case.

Actions in response to hygiene issues

351. The disability support provider told HDC that it had taken various actions to attempt to resolve Mr A's plumbing/toilet problem.

2012/2013

352. The following actions in 2012 and 2013 are evident from the records provided:

[50] See Opinion 10HDC00356 (published on 25 June 2012).

- Mr E visited Mr A on 11 July 2012 and discussed with him that there was a water leak present in his garage. Mr E arranged for a tradesperson to visit on 13 July 2012.
- On 20 July 2012, Mr E discovered that Mr A's water pump was not working and helped to get the pump working.
- On 1 August 2012, Mr E emailed Ms M of ACC advising that he had concerns about the condition of the house and Mr A's plumbing. As a result, ACC arranged additional cleaning services over the next three weeks.
- The disability support provider's progress notes for August 2012 reflect that Mr A's water pump continued to have problems. Mr E arranged for the water mains to be restored.
- Mr E arranged a repairman and plumber for 15 and 19 October 2012 to make repairs to the water connection and hot water overflow.
- The disability support provider contacted ACC on 18 February 2013 and said that Mr A's plumbing repairs required further attention.
- Progress notes for 26 April 2013 and for 10 May 2013 indicate that Mr A's toilet had flooded and Mr E had cleaned up the area.
- On 31 May 2013, Mr E and Mr A met with a builder. On 11 June 2013, repairs to the toilet plumbing were completed. On 28 June 2013, Mr A and Mr E met with the builder again.

353. No further issues occurred with Mr A's plumbing until 2014.

2014

354. In 2014, Mr A again had problems with his toilet. The disability support provider took the following actions:

- On 8 May 2014, Mr A agreed to have a plumber fix the toilet, but on 27 May 2014 the toilet was still not functional and Mr G had difficulty getting the toilet fixed, as Mr A appeared to have forgotten what he had agreed to.
- On 3 June 2014, when Mr G visited Mr A, the toilet was full of paper and waste. Mr G discussed with Mr I the possibility of contacting the crisis team, and the potential for residential placement.
- On 5 June 2014, Mr A told Mr G that he did not want to do anything about the toilet. Mr I spoke to Mr A, who then agreed to Mr I arranging a quote from a plumber.
- On 5 June 2014, the disability support provider telephoned Ms P (ACC Team Manager) to advise of the need for repairs to Mr A's toilet, and the challenges being faced because Mr A had refused to pay for the repairs.
- On 10 June 2014, the disability support provider arranged for a plumber to assess the situation. On 12 June 2014, Mr G arranged a plumber.

- On 19 June 2014, Mr I telephoned Ms N at ACC and asked whether ACC could provide funding to assist with the toilet plumbing repairs. He was told that ACC could not fund home maintenance, as this was the client's responsibility.
- On 20 June 2014, a plumber advised that he could not repair the toilet as it needed to be removed, and that the floor and one wall would need to be repaired.
- On 27 June 2014, a call was made to Ms P to express again the concerns regarding the need for the toilet to be fixed, as Mr A was using the bath as a toilet. Ms P explained that it was the client's responsibility, but agreed that it was a dangerous situation. ACC agreed to pay for Mr A to stay in a motel until the toilet could be fixed.
- On 28 June 2014, Mr I offered Mr A the option of staying in a motel, to which he agreed initially, but later he refused to leave his home.
- On 30 June 2014, Dr L was contacted. Dr L said that he would arrange for a community worker to see Mr A.
- On 5 July 2014, Mr I emailed Ms P, as Mr A had not been contacted by a community worker.
- On 5 July 2014, the disability support provider arranged an appointment for Mr A to meet with WINZ to discuss financial support to repair the toilet.
- On 8 July 2014, Mr G visited Mr A and found that the toilet was still blocked.
- On 10 July 2014, Mr G attempted to visit Mr A but again could not gain entry, and, on 11 July, Mr G arranged for a professional cleaning service to clean the house the following week.
- On 16 July 2014, Mr I emailed ACC advising that Mr A had given his consent for work to be done at his house. Mr I told Ms N that Mr A's toilet was overflowing with body waste.

355. ACC's review considered that disability support provider staff worked to address the issues that were present, but did not escalate them in the manner required, because it did not specifically tell ACC that the situation was beyond its ability or control, and nor did it request specific intervention. However, ACC acknowledged that there were red flags in the information provided by the disability support provider that should have alerted ACC staff that the situation required greater input from ACC.

356. Mr Taylor is of the view that the disability support provider fell significantly short of the standard of practice that was expected of it, and that would be expected by its peers. He felt that either the disability support provider should have done better, or it should have told ACC that it was not able to do the work, and then withdrawn.

357. In my view, in 2012 and 2013 disability support provider staff made reasonable efforts to address Mr A's plumbing and building issues, in the circumstances.

358. I am concerned that the home hygiene issue continued unresolved during 2014. However, my criticism is tempered in that I consider that the steps taken in 2014 by

disability support provider staff to escalate the concerns to ACC included sufficiently explicit requests for assistance, such as those on 5 June 2014 and 27 June 2014 when Ms P was advised of the urgent need for repairs to Mr A's toilet, and the challenges being faced by disability support provider staff.

359. I am left with the impression that ACC staff considered that the problems with the house were not injury related, and thus not issues for ACC to address. However, it is not obvious that it was within the contracted role of the disability support provider to manage the issues either.

Liaison with Geneva

360. When Geneva received its 2014 referral from ACC, the referral form stated:

> "Please note that the carer/s will have to initially liaise with Supported Living Key worker to build up the relationship with [Mr A] to allow easy access.
>
> All communication is via Supported Living Key worker — [Mr H]."

361. Mr H was Mr A's key support and attended all initial interactions with Mr A, including a service planning visit. Mr H was also asked by Geneva to be present to facilitate an introduction to Mr A's new support worker, Mr J. This took place on 2 April 2014.

362. RN F prepared Geneva's ACC funded Home and Community Support Services (HCSS) Service Plan for Mr A. On 9 April, Mr H and RN F both visited Mr A at his home to develop and complete the service plan.

363. In my view, there were sufficient early opportunities for the disability support provider to proactively instigate a clear written agreement for collaboration between the disability support provider and Geneva staff from the outset, so that the lines of responsibility for each disability service provider were outlined clearly. It was suboptimal that this did not occur.

Conclusion

364. In my view, it would have been wise for the disability support provider to have considered whether Mr A's living circumstances suggested that his capacity to make decisions for himself was reducing, and either suggested to Ms C that the EPOA for care and welfare should be activated, and/or to have contacted Dr L to provide medical input and assistance to that end. Given its contractual agreement, it would also have been wise to alert ACC to any issues or concerns regarding Mr A's competence.

Opinion: Geneva Healthcare Limited — breach

365. As a provider of disability support services (home and community support), Geneva was responsible for providing services to Mr A in accordance with the Code. Geneva undertook to provide services to Mr A in accordance with his assessed requirements,

and in accordance with its contractual obligations to ACC. Geneva emphasised to HDC that it was tasked with three very specific goals, in the context of Mr A's existing relationship with the disability support provider.

366. Mr A's assessed requirements for home and community support in 2014 were primarily informed by the support needs assessment performed by ACC on 27 March 2014. The home and community support services were to be provided by Geneva for a total of 288.6 hours over six months. On 1 April 2014, Geneva received the referral from ACC for home and community support services, and support commenced the following day.

Liaison with the disability support provider — adverse comment

367. As described above, Geneva told HDC that any support provided to Mr A was to be through negotiation with the disability support provider's key worker, Mr H. This step was outlined in the ACC referral form received by Geneva:

> "Please note that the carer/s will have to initially liaise with Supported Living Key worker to build up the relationship with [Mr A] to allow easy access [to the home].
>
> All communication is via Supported Living Key worker — [Mr H]."

368. Geneva told HDC that its responsibilities included ensuring that all communication, access, and support was channelled through the disability support provider, and to complete a service plan, in conjunction with Mr A and the disability support provider, which identified the goals Mr A wanted to achieve.

369. However, Geneva also told HDC that it considered that it was engaged as a secondary provider, and that the disability support provider was the lead agency providing community living support, as it had a longer-term relationship with Mr A. In response to the provisional opinion, Geneva stated that while it agrees that multi-agency agreements are best practice, in 2014 it was not industry practice to enter into such agreements. Geneva also considers that ACC and the disability support provider were better placed to initiate a multi-agency agreement.

370. Mr Taylor advised that the contracted requirements placed on Geneva Healthcare appeared reasonable and achievable at the time these were initiated. However, he is of the view that "there was an immediate lack of coordination regarding communication".

371. I acknowledge Geneva's submission that in 2014 it was not industry practice to enter into multi-agency agreements. However, I remain of the view that Geneva should have outlined its responsibilities clearly or requested a documented communication agreement with the disability support provider, given the ACC referral information it had received.

372. Geneva told HDC that, through the facilitation of the disability support provider, it commenced provision of care to support Mr A with his personal hygiene, and to remove rubbish from his home and develop a relationship with him.

373. Despite Geneva liaising with the disability support provider regarding these issues, the process of engagement was sporadic and ineffective. This is demonstrated by Geneva's actions when support worker Mr J telephoned Geneva on 6 June 2014 regarding Mr A's malfunctioning toilet. Geneva left a telephone message with the disability support provider querying whether a plumber was being arranged. Geneva recognised that the situation was a health risk, but considered that the disability support provider was responsible for facilitating the repair of the toilet. In my view, Geneva should have done more than leave a message.

374. Home and community support sector standard NZS 8158:2012 includes:

> "Standard 4.3 Consumers receive continuity of service through effective links with other groups."

375. I am concerned that from the outset Geneva did not formalise an agreement for collaboration with the disability support provider (in line with the ACC referral to Geneva), so that the lines of responsibility for each party were clearly defined.

Systems for monitoring attendance of care staff — breach

376. It is evident from the information gathered that there was a lack of clarity about the level of service Mr A was receiving from Geneva in mid-2014.

377. Geneva's records are limited, but they record that Mr J telephoned Geneva on 6 June 2014, and that at 4.50pm a call centre staff member sent an email to Geneva staff, Ms K and Ms Q, regarding Mr A's toilet having been blocked for two weeks. The email records that Mr J advised at that time that he had already spoken to Geneva staff about the toilet.

378. In response to the provisional opinion, Geneva stated that it does not dispute that Mr J made one telephone call on 6 June 2014 outlining that there was a problem with Mr A's toilet, but it noted that there is no record of Mr J saying that he would not be able or willing to provide services.

379. On 16 July 2014, in an email to Ms N, Mr I included his concerns about the level of home care support Mr A was receiving from Geneva.

380. On 17 July 2014, Ms N telephoned Geneva and spoke to Ms K. Ms N's file note records that she told Ms K that she had received an email from the disability support provider concerned about Mr A's personal cares, and that Ms K said that she would speak with the carers.

381. There is no record of this discussion in Geneva's documentation.

382. On 17 July 2014, Mr G made a file note that he spoke to a Geneva staff member (Ms Q) and was told that Mr A's allocated support worker (Mr J) had not been to see Mr A because of the toilet problem. Mr G also recorded: "Geneva seemed to indicate to writer that they had not been aware that the service had stopped."

383. In response to the provisional opinion, Geneva stated that Mr G's impression is consistent with Geneva's belief that it did not know, at the time of Mr G's call, that Mr J was not attending Mr A.

384. Geneva said that it was not aware that the service had stopped until 17 July 2014, when it discovered, via its timesheet review system, that Mr J had not submitted timesheets for about a month. Geneva said that Mr J had not advised his care co-ordinator that he was not attending Mr A.

385. Geneva told HDC that following discovery of the situation on 17 July 2014, Ms K attempted to contact Mr J and the disability support provider.

386. The disability support provider's progress notes for 18 July 2014 record Mr G's telephone call to Geneva, indicating that he was told that the support worker (Mr J) had stopped seeing Mr A because of the hygiene risk from the toilet.

387. Geneva told HDC that it then had difficulty contacting Mr J. Geneva wrote to Mr J on 25 July 2014 and 15 September 2014 requesting that he make contact.

388. Geneva was able to contact Mr J in mid-September 2014, and he told Geneva then that he did not attend Mr A because he felt that he was unable to provide the support required as a result of the situation with the toilet and bathroom at Mr A's home. Mr J said that he felt it was unsafe.

389. On 23 July 2014, Mr G emailed colleagues Mr I and a care coordinator with some updated information, including:

> "… Geneva withdrew their support some months ago due to the health and safety risks, without informing ACC (they said ACC should have noticed that they are not billing for [Mr A] anymore) …"

390. In response to the provisional opinion, Geneva disputed that it said that ACC "should have noticed they are not billing for [Mr A] anymore". Geneva stated that the note does not specify who at Geneva is alleged to have made that statement, or when the statement was made, and that Geneva has no record of such a conversation. Geneva also said that it would not expect ACC to identify client-level information from invoices.

391. In contrast to Geneva's account that on 6 June 2014 it was not made aware by Mr J that he had decided to stop providing services to Mr A, Ms P's ACC file note made on 23 July 2014 suggests that Mr J contacted Geneva in early June 2014 to say that he was no longer willing to provide cares to Mr A:

> "… [S]poke with [Ms Q], she advises that cares had stopped on 06/06/14. The carer had left a message on the after hours phone line and that was not passed onto the care coordinator. A carer went in on 18/07/14 and no one has gone in since. [Ms Q] said she had spoken to [Mr G], carers will resume once the situation with the bathroom and toilet improves."

392. In response to the provisional opinion, Geneva stated that it does not believe that the file note accurately reflects what happened, and that even if Ms Q did relay information to ACC along the lines of the file note, Geneva believes that she may have misinterpreted or misunderstood information, as nothing in Geneva's own records indicate that on 6 June Mr J notified Geneva that he was withdrawing services.

393. Geneva also said that the idea that it would simply withdraw care without taking further action is inconsistent with the steps it did take when it became aware on 17 July that care was not being provided. There are conflicting accounts and evidence in relation to exactly when Geneva was first advised that Mr J would not be providing any further care to Mr A. Some of that information suggests that Geneva was advised as early as 6 June 2014, and some evidence suggests otherwise.

394. While it is accepted that Mr J contacted Geneva on 6 June 2014 and left a message, in the circumstances I do not consider that the information available is sufficient to make a conclusive finding that on 6 June 2014 Mr J informed Geneva that he would no longer be providing cares to Mr A.

395. In any event, it is clear that Geneva's system for monitoring attendance of care staff did not identify, until 17 July 2014, the fact that Mr J not been attending Mr A.

396. Geneva told HDC that its weekly review of rosters/timesheets submitted could be problematic because many support workers did not submit timesheets on a weekly basis, and held back timesheets for a number of weeks, then submitted three or four weeks' timesheets together. Geneva said that at that time the system for processing timesheets relied on retrospective receipt of timesheets.

397. Geneva told HDC that its records indicate that the provision of services to Mr A had been progressing well, and that Mr J reported the problem with the toilet to Geneva (on 6 June) and it had been noted as a health risk.

398. Geneva stated:

> "As a result of the positive feedback we had been receiving and the ongoing communication we had with the [disability support provider] … Geneva had no cause to be concerned … As a result it was assumed the timesheets were merely late."

399. Geneva told HDC that the system did not work in this case, as it was reliant on the designated key worker for Mr A from the disability support provider informing Geneva that Mr J not attended.

400. Home and community support sector standard NZS 8158:2012 includes:

> "Standard 2.1 Consumers receive timely, appropriate, and safe services through efficient and effective service management."

401. I accept that in the event of support worker non-attendance, feedback from the client, families, and key liaising parties plays a role in its detection. However, I have concerns that in this case Geneva did not have adequate oversight to monitor whether the care was being provided, and to detect the failure of its staff member to attend Mr A. Geneva's tolerance of the suboptimal practice of support workers failing to submit timesheets for three to four weeks contributed to its lack of oversight and detection of staff non-attendance.

402. In my view, this was an unacceptable situation. Furthermore, at the time of these events, Geneva had an over-reliance on other parties to advise it of staff non-attendance on a vulnerable client. In my opinion, Geneva needed to ensure that it had in place an effective and accurate system for proactively monitoring the attendance of its employees.

403. I note from the record that Geneva attempted to organise a replacement support worker (Mr R) for Mr A on 18 July 2014. However, because of the condition of the house, Mr R finished his shift that day and informed Geneva that he would not return until the toilet issue had been resolved.

404. Ms Q of Geneva documented contact with Ms N at ACC and Mr G at the disability support provider confirming Mr R's decision and outlining that it felt that Mr A's house was a health hazard for support staff. Ms N also made a file note about this on 18 July. Ms K sought advice from a manager and was instructed to withdraw Mr R, owing to health and safety reasons, and to inform ACC. However, Geneva told HDC that the matter was not escalated further. I am critical that the matter was not escalated further to senior managers.

Conclusion — Geneva

405. In my view, the care Geneva provided to Mr A was inadequate. There was a period of around one month where no support worker provided services to Mr A, and Geneva did not have an effective system for monitoring the attendance of its employees. Although services to Mr A ceased on 6 June, Geneva failed to detect that Mr A had not been receiving the contracted services until 17 July.

406. The replacement support worker organised on 18 July finished providing care that day, owing to the hazardous conditions faced. While initial contact was made with ACC and disability support provider staff about the issue, escalation stopped after it was reported to a manager.

407. Accordingly, in my opinion, Geneva failed to ensure quality and continuity of services for Mr A, and breached Right 4(5) of the Code.

Opinion: Mr J — adverse comment

408. Mr J's individual employment agreement, and the Geneva support worker orientation booklet and job description outline, make clear Geneva's expectation that support workers reliably attend assignments, remain on duty for the full duration of their assigned care, and, if there is any difficulty completing the arranged care, that they should contact their employer immediately.

409. The section of the Geneva orientation booklet headed "Protecting your client in the workplace" states that in order to identify and reduce risk, support workers should immediately notify care coordinators of any issues not identified in the service plan, and of any area where it is felt that improvement is required.

410. Mr J told HDC that he made a decision not to provide cares to Mr A any more, and informed Geneva about the condition of Mr A and his household by email. (As mentioned above, Mr J provided HDC with an email sent to Ms K on 16 December 2014.)

411. Mr J told HDC that he informed Geneva about the situation regarding the toilet malfunction, and Geneva told him that it would send someone to fix it, and that it was not part of his role to fix it. He said that during a telephone conversation with Geneva he had become frustrated and told Geneva that it was not caring enough for clients. He said that when he went to Mr A's house for a further shift, no action had been taken, so he informed Geneva that he would not be going to Mr A's house anymore. He no longer presented any shift payment timesheets.

412. As mentioned previously, Geneva's records are limited, but they record that Mr J telephoned Geneva. Following the call, a call centre staff member sent an email (at 4.50pm on 6 June 2014) to Geneva staff Ms K and Ms Q regarding Mr A's toilet having been blocked for two weeks.

413. There are conflicting accounts and evidence in relation to exactly when Geneva was first advised that Mr J would not be providing any further care to Mr A. Some of the information suggests that Geneva was advised as early as 6 June 2014, and some evidence suggests otherwise. While it is accepted that Mr J contacted Geneva on 6 June 2014 and left a message, in the circumstances I do not consider that the information available provides sufficient evidence to make a conclusive finding that on 6 June 2014 Mr J informed Geneva that he would no longer be providing care to Mr A.

414. In any event, in my view it was not sufficient for Mr J merely to leave a voicemail message regarding the concerns he had. I accept that Mr J made a decision to stop providing care because of the hygiene issues and risks associated with the house. However, I am critical that he withdrew services of his own volition and did not speak to his manager or another senior person from Geneva. By not making direct contact with his co-ordinator about the issue, he failed to comply with his employment agreement obligations. That was a contributing factor in Mr A subsequently receiving no contracted home care for over a month.

Recommendations

415. I recommend that Geneva provide a formal written apology to Mr A. The apology is to be sent to HDC within three weeks of the date of this report.

416. I recommend that within three months of the date of this report, Geneva provide HDC with the following:

a) A qualitative update (including anonymised examples) on the effectiveness of the Multi-Agency Service Provision policy and agreement, and the Missed Care Policy and Procedure.

b) An update report on the progression of all aspects of its technology platforms, including management software, GPS, timesheet review and non-attendance detection, and use of Panztel.

c) An update report on its Vulnerable People Management policy and procedure and details of identification of at-risk clients.

d) Details of all changes made to its escalation procedures, reporting structure, and delegating lines of responsibility as a result of this incident.

e) The results of its 2016 surveillance audit by HDANZ.

417. I recommend that within three months of the date of this report, the disability support provider provide HDC with the following:

a) Details of the steps taken to improve lines of communication and relationships with ACC coordination staff and Supplier Managers.

b) Details of the introduction of an ACC client-specific policy document relating to managing client risk, developed in conjunction with ACC.

c) Updates on the mobile community support checklist developed, and the review of the lone worker safety policy.

d) The steps taken to ensure that there is sufficient oversight in place when supported living assistance plans and their timeframes are not being met, and that this is flagged clearly and attended to.

Follow-up actions

418. A copy of this report, with details identifying the parties anonymised except for the expert advisor in this case, ACC, and Geneva Healthcare Limited, will be sent to HealthCERT (Ministry of Health), and the relevant district health boards.

419. A copy of this report, with details identifying the parties anonymised except for the expert advisor in this case, ACC, and Geneva Healthcare Limited, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Deputy Commissioner

"I have been asked by the Deputy Health and Disability Commissioner to provide an opinion on case number 14/01121 that relates to the care provided to [Mr A] by various disability support providers between 2012 and 2014 leading up to [Mr A] being referred by his GP to [the DHB's] Mental Health Services for Older People community team. I have read and agree to abide by the Commissioner's Guidelines for Independent Advisors.

I have the following qualifications and experience to fulfill this request.

Qualifications: MPhil (Distinction) in Disability Studies, Education and Evaluation; DipPGArts (Distinction) Social Work; BSc (in ethics and science); LTh.

Experience: 30 years of working within the disability sector including the following roles: direct support worker, agency management (over 10 years), agency governance, behaviour specialist (over 10 years), national sector roles such as Chair of NZDSN, National Reference Group for the MoH's New Model, National Leadership Team for Enabling Good Lives, a range of contracted roles and I have helped set up a number of support agencies and disability related businesses.

I have been asked to provide advice to the Deputy Health and Disability Commissioner regarding the adequacy of the systems in place in relation to the disability services provided to [Mr A] during the period above.

In particular I have been asked to make comment on:

- the reasonableness of the expectation placed on [the disability support provider] and Geneva Healthcare in relation to the nature of the care they were to provide [Mr A];
- the reasonableness of a split approach to provision of supported living assistance and home cares for [Mr A];
- the adequacy of the systems in place at the time to deal and respond to [Mr A's] presenting conditions, behaviour, and home circumstances; and
- the quality of communication between ACC, [the disability support provider], and Geneva Healthcare in relation to [Mr A].

I have based my opinion on the information listed below:

- Doc 1: The original complaint from [Mr B]
- Doc 2: A summary of the information gathered

The reasonableness of the expectation placed on [the disability support provider] and Geneva Healthcare in relation to the nature of the care they were to provide [Mr A].

In general I think that the expectations placed on [the disability support provider] and Geneva Healthcare (Geneva) could have been reasonable but, because they were very poorly planned and executed by all three organisations, they became unreasonable.

This situation involved 3 agencies — ACC, [the disability support provider] and Geneva — in supporting [Mr A] to 'increase client independence through facilitating natural "circles of support", community participation and teaching new life skills' (Doc 2) through the utilisation of supported living, with ancillary home support. The implementation of the above reads as one of a series of poor decisions being made, boundaries being protected, communication failing to happen in an effective manner and an apparent indifference to the urgency of the problem.

The latter is particularly pertinent as, with regard to the key issue of the toilet malfunctioning, it took from 2 April 2014 (Doc 2) when the toilet ceased to flush until 5 August 2014 for [Mr A] to be removed from the situation. By this stage his house was '… extremely unhygienic. Faeces was piled up in the toilet bowl and bathtub and tracked through the house, there was no running water … The house was very unclean with fleas and rats and bedbugs' (Doc 1). '[Mr A] had also been wearing the same clothes for three weeks and these were soaked in urine and feces' (Doc 1).

[The disability support provider] [was] contracted by ACC to provide 6 hours of supported living services to [Mr A]. These were initially set as two three-hour sessions reviewed quarterly or biannually. Later this was set as three two-hourly sessions with the same review structure.

From what I have understood as the presenting needs of [Mr A] it is my opinion that this was below an acceptable standard of care. I say this for two reasons. Firstly it appears to me that 6 hours of support is inadequate to address the issues that were presented by [Mr A's] support needs, particularly by 2014. It can take a long time to work with people who habitually hoard and struggle with personal care. It was also borne out by events such as the initial worker — [Mr E] — commented that he was unable to progress support for [Mr A's] financial matters due to the time taken with urgent plumbing repairs (Doc 2).

Secondly, the decision by ACC to require the 6 hours to be delivered in two three-hour blocks of time, or three two-hour sessions is poor practice for supported living. The nature of supported living is to match the support to the requirements of the person being supported. As such any decision about the use of the hours of support should be directly negotiated with the individual being supported and the support team.

The situation as described in January and February 2013, that important work relating to [Mr A's] financial affairs not being accomplished, including his Work and Income benefit lapsing, should have triggered both [the disability support provider] and ACC to reassess the amount of support offered to [Mr A]. It appears that [the disability support provider] did in fact request more support time but ACC's response was to offer the same number of hours but with three two-hour sessions.

In my opinion this is a significant departure from the standard to support coordination one should have expected from ACC and I believe their peers would view it similarly. As the Case Manager ACC should have been much more engaged in understanding the complexities of the situation and actively checking that [Mr A] was getting what he required. It may have been that they were too concerned about only funding the accident related needs and not considering [Mr A] as a whole (Doc 2). If there were concerns about where the funding responsibility sat then it was incumbent upon ACC to seek input from another appropriate funder.

In relation to the contracted requirements placed on Geneva Healthcare, they look reasonable and achievable at the time they were initiated. However there was an immediate lack of coordination regarding communication. ACC's own Operational Guidelines for supported living services claims that it is [ACC's] responsibility to host case conferences 'to agree the approach and the roles and responsibilities of the parties, and identify issues regarding the client's needs, abilities and objectives' (Doc 2). Geneva also had the responsibility of 'advising ACC immediately of any matter that may change or delay the performance of services' (Doc 2). Neither appeared to meet these expectations. Both appeared to rely on [the disability support provider] to mediate but without any communication plan to agree this (Doc 2).

This lack of planned communication is a significant failing in a service characterised by the need for strong partnerships and a collaborative approach (Doc 2). It reveals an apparent lack of knowledge on behalf of ACC staff and capability on behalf of Geneva.

The reasonableness of a split approach to provision of supported living assistance and home cares for [Mr A].

The disability care environment of New Zealand is characterised by siloed and highly specified forms of funding. This is very problematic for the coordination of services to individuals. However, given that this was the current accepted state, my opinion is that ACC did follow the usual and accepted practice in this instance.

The common practice is for the commissioning agent — ACC in this case — to contract separate providers to undertake different aspects of a client's care. In fact it is more common for supported living assistance and home care assistance to be contracted to different providers than not. In part this is because the staff skill-set and organisation are very different for these two services and rarely work easily within a single agency.

In this aspect I consider the process followed was within the accepted practice of the time and appropriate to the circumstances.

The adequacy of the systems in place at the time to deal and respond to [Mr A's] presenting conditions, behaviour, and home circumstances.

I will answer this question by referring to each agency as a separate heading.

ACC

There are clear indications that ACC either lacked adequate systems or failed to follow adequate systems in the case of [Mr A]. In particular this relates to their role as coordinating and purchasing supports that kept [Mr A] safe and helped him engage with the community.

The indications are that their Case Manager did not allocate sufficient support hours in the first instance, which may speak to an inadequate assessment process. They did not insist that a Welfare Guardian, or some other system for managing [Mr A's] affairs was enacted. They then failed to react adequately to requests for more support and finally, when their worker [Ms N] did visit the home for another assessment (Doc 2), she still did not understand ACC had a responsibility to act.

In particular, it is hard to accept that the report from the [RN F] (Doc 2) and the personal visit by [Ms N] did not occasion an immediate response from ACC. One would expect a health and safety alert system to be in place for this sort of notification.

ACC also did not appear to know that Geneva Healthcare had ceased supporting [Mr A]. There may have been an internal system flaw that meant the invoicing section did not alert the case manager of no invoices for expected work. There also is no evidence of a system where the case manager regularly checks in to see how organisations are doing with a complex situation. ACC appears to have expected to take a more passive role (Doc 2).

It is not acceptable for a service funder to be so disengaged with what is happening to a client of theirs that it gets to this state.

[The disability support provider]

[The disability support provider] was operating as a supported living provider. One of the key characteristics of supported living is the high level of service coordination and staff oversight. In their support for [Mr A] there is no indication that these systems were in place to the accepted standard.

From what I read it looks like [Mr A's] support requirements were indeed complex but not outside the realm of the usual. His situation should have received a comprehensive support plan, a safety plan and a senior staff person to oversight the implementation. Instead of that it appears that the direct support worker was the only person at any time to be managing [Mr A's] situation. [Mr I's] input appears to have been from one step removed, that is, working off the information related to him by his staff.

It appears the staff 'normalised' the conditions within his house to the extent that both employees from Geneva Healthcare reported a very different presentation of the house than the [the disability support provider] staff. This can easily happen and is one of the reasons why there needs to be a senior person checking in on supports, not just receiving reports. Even [Mr G], who was the one who finally got [Mr A's] GP involved, commented that he left the toilet blocked for 2 weeks before deciding to

take action (Doc 2). He did this in the belief that it was important not to impose on [Mr A's] independence. A laudable but, in my opinion, a mistimed approach.

[The disability support provider] should also have had in place a Health and Safety audit of the home [Mr A] lived in for the benefit of their staff as well as [Mr A]. This should have indicated areas of concern, of which there were clearly several, and reacted to address these. There is no evidence of this approach occurring, or at least not successfully.

It is my opinion that [the disability support provider] fell significantly short of the standard of practice that was expected of them and that would be expected by their peers. It is not acceptable to leave a person living in the condition that [Mr A] was reportedly living in. It constituted a health hazard for him and the staff [the disability support provider] sent to support him. They should have either done better or told ACC they were not able to do the work and withdrawn.

Geneva Healthcare Ltd

Geneva Healthcare had a number of processes in place to monitor their work in a situation such as [Mr A's]. However it seems they did not use them. Of the six key steps they say they will take once a person has been identified for their 'Vulnerable People Management' process (Doc 2), at least 3 were not followed through. This failing meant that they were not aware their worker was no longer showing up to support [Mr A] for four weeks.

That aside, the notes do indicate that Geneva Healthcare made numerous attempts to raise the issue of the toilet and other health issues with ACC and [the disability support provider]. Unfortunately, when Geneva Healthcare took the, in my opinion, appropriate decision to no longer provide support due to the health issues this was not communicated with ACC due to an internal systems issue (Doc 2). This failing meant that they just left the situation without anyone being formally alerted therefore no-one became responsible to deal with the issues.

In my opinion Geneva Healthcare's systems and communications let them down. They made some good decisions in this situation regarding safety but were not monitoring their staff to an acceptable level nor did they inform ACC as expected. Both of these failings would be considered well below the accepted standard of care. In general though I think their remedial actions (Doc 2) should greatly improve these.

[Mr J]

[Mr J] was the support worker who unilaterally decided to stop supporting [Mr A] due to the unsanitary conditions relating to the toilet. There is a difference of opinion as to whether he notified Geneva Healthcare of his decision or not.

[Mr J] claims to have left a message on an after-hours phone number. Geneva told HDC that they were not notified by [Mr J] of his decision and, in another report to ACC, they say that he did leave a message. If [Mr J] did leave a message then it appears Geneva Healthcare's systems were inadequate to pick up and react to the message. I do think his action to stop working within an unsafe environment was

appropriate. I do not think that this is an acceptable level of communication to his employer about a man in his care.

In the event that he didn't notify Geneva Healthcare, then he has not acted in an acceptable manner for someone trusted to assist vulnerable people. This in no way lightens the burden on Geneva Healthcare though. The support of [Mr A] remains primarily their responsibility not that of [Mr J]. Their systems should be sufficient to know what their workers are doing in relation to anyone the organisation has contracted to support.

The quality of communication between ACC, [the disability support provider], and Geneva Healthcare in relation to [Mr A].

The impression I gained from reading through the information gathered was of an inadequate or absent communication plan and that each organisation assumed the others would take the lead. There was evidence that both [the disability support provider] and Geneva Healthcare did raise issues with ACC but these were not resolved in an appropriate way.

The comments from both [Geneva] on behalf of Geneva Healthcare (Doc 2) and from ACC (Doc 2: 'There was a lack of co-ordination and communication between providers') indicate that each party continued to see the communication issue as primarily belonging to others.

In a situation where there are several parties involved in the support of a person who is challenging to support it is usual practice to have a clear communication plan, a designated lead agency/person for that plan and periodic reviews to ensure all parties are well informed. I saw no evidence of this and so consider that all three organisations failed to reach the expected standard for communication. The level of failure was more significant, in my opinion, for ACC and [the disability support provider] as the two agencies with the longest history of working with [Mr A].

Further comments and recommendations.

One of the most disturbing aspects of this situation is that everyone involved recognised that there was a significant health and hygiene problem but saw it as someone else's to solve. Each of the agencies and staff have a general duty of care that should have overridden such resource protection and dealt with the condition of the toilet in particular, the moment it appeared. This should have been done for the protection of their staff if not for [Mr A].

The facts of the situation are that the toilet ceased to flush from the cistern at some stage prior to 2 April 2014. [The disability support provider], and presumably ACC, staff accepted and normalised the use of a bucket to perform the flush for one or two months rather than just a few days, and this is unacceptable. This situation appears to have remained the status quo until the toilet ceased to work at all by 3 June 2014. There was another 2 months before anyone properly reacted to the fact that the toilet and bathtub were full of faeces and [Mr A] was unable to shower or clean his clothes.

The lack of action frankly defies belief and all parties have, in my opinion, grossly failed in their duty of care to [Mr A]. The two most significant failings are the lack of coordinated effort, principally through ACC not undertaking its role adequately, and the adherence to rules and specifications that prevented all parties considering [Mr A] as the man. All appeared to view him as [Mr A] the client; for whom they had limited responsibility.

I would recommend the following actions to avoid a repeat of such a situation.

1. When there are more than two agencies involved, one agency is formally recognised as the lead agency and is responsible for communication and the coordination of the efforts of all agencies.
2. That [the disability support provider] and Geneva Healthcare review their operational policies and practices so they reflect a person centric approach rather than a client centric approach.
3. That ACC ensures that its Case Managers have a whole-of-life view of the individuals they are working with and that they actively engage other funders if there appears to be conditions that fall outside of their responsibility.
4. That all three agencies review their Health and Safety guidelines and procedures to ensure they can react more quickly in a situation where a client and/or staff are being put in danger.

Yours sincerely

John Taylor”