Community Health Service
Support Worker, Ms A

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC00081)

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation....3
Relevant standards....16
Opinion: Ms A — breach 16
Opinion: Community health service — adverse comment....18
Changes made following complaint....20
Recommendations....21
Follow-up actions 22
Appendix A: Independent clinical advice to the Commissioner 23

Executive summary

1. This report considers the home-support care provided to an elderly man by community health services. The report highlights the importance of support workers attending their scheduled appointments with clients, many of whom are very vulnerable. It also emphasises the importance of service providers conducting thorough investigations into complaints received.

2. A support worker stated that on Saturday she attended her scheduled session with the man at his home. However, GPS data showed that she was not located at or around the man's home at all on this day, and was at her own home (located 11km away) at the time she said she attended to the man.

3. On Sunday, the scheduled support worker attended, but the man did not answer the door. The man's next of kin was contacted, and the community health service was advised that if there were no concerns, the support worker could leave.

4. On Monday, the scheduled support worker attended, but again the man did not answer the door. The support worker gained entry to the house and found the man unconscious on the floor in a distressed state. He was admitted to hospital but died shortly afterwards.

5. When the man's family contacted the community health service following his death, the service did not treat the enquiry as a complaint, and determined that no further investigation into the family's questions about support-worker attendance was required. When the man's family escalated their concerns to the funding district health board, other than seeking confirmation from support workers of their attendance and reviewing self-reported log-in data, the community health service did not enquire into the matter further. It was not until six months after the incident, and following a complaint to HDC, that the community health service interviewed Ms A and identified discrepancies in the information she had provided.

Findings

6. The Deputy Commissioner considered it more likely than not that the support worker did not attend the man. The Deputy Commissioner found her in breach of Right 4(1) of the Code.

7. The Deputy Commissioner criticised the community health service's investigation into the incident and into the family's concerns. She considered that the investigation was inadequate, delayed, and piecemeal.

Recommendations

8. The Deputy Commissioner recommended that the support worker provide a written apology to the man's family.

9. The Deputy Commissioner recommended that the community health service consider whether the support worker would benefit from further training on the virtual assistance (VA) application, logging her attendance, or any other relevant topics; audit her VA and log-

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

in data; and consider whether staff attendance at clients' homes should be monitored routinely and/or audited randomly as part of continuous improvement processes.

10. Additionally, the Deputy Commissioner recommended that the community health service report back to HDC regarding its engagement with an external specialist to develop and deliver more detailed training on management of complaints, investigations, and privacy; report back to HDC on the creation of a dashboard that more easily allows the community health service to identify support workers who have logged into a client visit from a location other than the client's house, and on the new "Stop and Watch" tool to enable support workers to observe and report any apparent changes in a client's behaviour or health and escalate for clinical review; circulate and use the anonymised version of this report to promote a positive consumer-centred culture within the community health service; and provide a written apology to the family.

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Mr C about the services provided to his father, Mr B (deceased), by a community health service. The following issues were identified for investigation:

- *Whether the community health service provided Mr B with an appropriate standard of care in 2018.*
- *Whether Ms A provided Mr B with an appropriate standard of care in 2018.*

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

13. The parties directly involved in the investigation were:

Community health service	Provider
Ms A	Support worker
Mr C	Complainant

14. Also mentioned in this report:

Ms D	Support worker
Ms E	Support worker
Ms F	Regional manager

15. Further information was received from:

The Coroner
The District Health Board (DHB)

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

16. Independent expert advice was obtained from a disability services provider, Mr John Taylor (Appendix A).

Information gathered during investigation

Introduction

17. This report concerns the care provided by the community health service to Mr B (aged in his eighties at the time) in 2018. In particular, the report discusses whether Mr B received appropriate care in the days prior to being found in a distressed state in his home, and subsequently passing away. The report also considers the community health service's management and investigation of the incident following Mr B's death.

Background

18. At the time of these events, Mr B was living alone and was receiving in-home support services from the community health service. Mr B had stage three kidney disease, osteoarthritis,[1] deep vein thrombosis,[2] atrial fibrillation,[3] and a history of urosepsis.[4]

19. The community health service had been providing home and community support services to Mr B since 2015 under a service agreement with the DHB. Mr B had been assessed as requiring 1.5 hours of personal care every day (including meal preparation), and 1.5 hours of home help (including cleaning and laundry assistance) per week.

20. In 2017, Mr B chose to be discharged from the hospital to his home after three months of care for a fractured femur, which unfortunately did not heal, and he continued to receive support services from the community health service.

Events leading to Mr B's adverse event and death

Friday 14 Month1[5]

21. On 14 Month1, a support worker attended to Mr B's cares. The support worker said that on this date, she had no reason to be worried or have concerns about Mr B.

22. Mr B's neighbour advised that on this date, Mr B pulled his curtains, and the neighbour did not witness them being opened again. On the other hand, in a statement to the community health service,[6] support worker Ms A said that when she arrived the following day, she could see Mr B through the window and he was sitting on his chair in the lounge.

[1] A condition that affects joints.
[2] A blood clot that forms in a major vein of the body.
[3] An irregular and often rapid heart rate.
[4] An infection that originates in the urinary tract and affects the bloodstream.
[5] Relevant months are referred to as Months 1–2 to protect privacy.
[6] Dated 18 March 2019.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Saturday 15 Month1

23. On 15 Month1, Ms A was rostered to provide personal cares to Mr B from 12pm to 1.30pm. There are discrepancies in the information provided to HDC about whether Ms A did, in fact, attend Mr B on this date. This is discussed further below.

Sunday 16 Month1

24. On 16 Month1, support worker Ms D arrived at Mr B's home. Mr B did not answer his door, and the door was locked. The community health service told HDC that Ms D proceeded to look through the windows but could not see anyone. At 11.52am, Ms D telephoned the Contact Centre to report that Mr B appeared not to be at home. The community health service telephoned Mr B's daughter-in-law regarding this. During the conversation, Mr B's daughter-in-law noted that often Mr B liked to sleep in on Sundays until approximately 2pm. It was agreed that Ms D would take a look around the house and, if she did not have any concerns, then she could leave.

25. In response to the provisional opinion, Mr B's family told HDC that on this day, Mr B's daughter-in-law informed the community health service that they could leave because she believed Mr B had had his scheduled visit on 15 Month1. The family said that if they had been made aware that Mr B had not been attended to on 15 Month1, they would have insisted that the support worker enter the property.

17 Month1

26. On 17 Month1, support worker Ms E was scheduled to provide support to Mr B. Ms E said that when she arrived, she knocked on the door and received no response. As no one opened the door for her, she entered the house via the garage door. She found Mr B in his bedroom on the floor, and asked him if he was all right, but he was unresponsive. Ms D telephoned an ambulance and the community health service's Contact Centre, and spoke to a care coordinator, who documented the telephone call as follows:

> "[S]poke with [Ms E] called and advised she had attended to client [Mr B] and found client semi-conscious, ambulance was called — paramedics questioned [support worker], advised [support worker] last visit we made was Saturday midday and Sunday afternoon client was not answering door correct follow up was made."

Transfer to DHB

27. Mr B arrived at the Emergency Department (ED) via ambulance at 1.57pm. At 2pm, an initial nursing assessment noted: "[F]ound on floor — ? been there 2 days." At approximately 2.50pm, Mr B was assessed by an ED consultant and his registrar, who documented their impression as:

> "? Mechanical fall
> fall off bed
> >24hrs laying on floor"

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

28. In response to the provisional opinion, Mr B's family noted that the above facts were based on information that the community health service had provided to the attending paramedics.

29. The ED consultant told HDC:

> "In summary [Mr B] was critically unwell with signs of a recent large myocardial infarction, acute renal failure,[7] urinary tract sepsis,[8] hypothermia,[9] and delirium.[10] There were examination findings consistent with having been lying in one position for a prolonged period of time."

30. After assessment and investigation, Mr B's care was transferred to the General Medicine Team at 7.36pm.

31. In Mr B's family's complaint to HDC, they noted that "all doctors involved (three seen by the family) asserted that [Mr B] ha[d] been lying on the floor for several days".

32. Mr B passed away on 18 Month1 at 2.30pm. The DHB told HDC that the ED staff did not consider there to be anything suspicious about Mr B's presentation or injuries, and therefore the Police were not notified.

Community health service's management of adverse event

Ms A and attendance of care on 15 Month1

Telephone conversation with Ms A on 17 Month1

33. On 17 Month1, the regional office called Ms A to confirm whether she had attended Mr B on 15 Month1. A voice recording between the community health service and Ms A was provided to HDC. In the recording, Ms A confirms that she visited Mr B on 15 Month1. She said that Mr B had declined a shower and had a meal prepared for dinner. The conversation was brief, and no further information was exchanged at this time.

Notes from community health service's initial interviews with Ms A

34. Following receipt of the HDC complaint, on 13 February 2019, community health service management conducted a formal interview with Ms A. A copy of the meeting minutes was provided to HDC. At that meeting, Ms A confirmed again that she attended Mr B's home on 15 Month1. It was noted that Ms A recollected that there was a strong smell of urine on Mr B, and his mouth smelt of cigarette smoke, which Ms A considered unusual.

35. At the meeting, it was noted that Ms A was asked whether she had called the Contact Centre on 15 Month1. Ms A stated that she believes she did so, primarily to inform the community health service that Mr B had refused a shower.

---

[7] Kidney failure.

[8] An infection that originates in the urinary tract and affects the bloodstream.

[9] A significant and potentially dangerous drop in body temperature.

[10] Confused thinking and reduced awareness of surroundings.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

36. The community health service advised that it was unable to find a record of a call from Ms A to the Contact Centre around this date. The community health service told HDC: "[I]t is our view that [Ms A] likely did not make this call, mainly based on the fact that there are no recorded notes from any such call."

37. Ms A was interviewed again on 12 March 2019. A copy of the meeting minutes was provided to HDC. The minutes document that GPS data for Ms A was shown and discussed with Ms A. The GPS[11] data indicated that when Ms A was logging in and out of her visit to Mr B, she was not located at Mr B's address. It was noted that Ms A confirmed that she did attend to Mr B's care on 15 Month1, but that it was a common practice for her to log in and out whilst travelling between clients. Her recollection for the day was that she likely logged in to Mr B's visit whilst she was still at the previous client's home.

Ms A's statement dated 18 March 2019

38. On 18 March 2019, Ms A provided her first written statement to the community health service. She confirmed again that she attended personal cares for Mr B at approximately 11am on 15 Month1. She said that although she attended at 11am, she logged in according to the normal time she was rostered to attend, which was 12pm to 1.30pm.

39. Ms A told the community health service:

> "I can confirm that I knocked on the door and rang the doorbell. I could see [Mr B] through the window. He was sitting on his chair in the lounge. It took approximately 15 minutes for [Mr B] to open the door … I can confirm that on Saturday 15 [Month1], [Mr B] advised me that he did not want a shower and that he had everything he needed for dinner."

40. Ms A also told the community health service that she recalled Mr B advising her that he did not feel well, and stated:

> "[Mr B] was coughing, and had a very smelly mouth. He smelt of cigarette smoke. He did not look well. I have never smelt smoke on [Mr B] before. I noticed he was short of breath. He was wheezy. It was not unusual for [Mr B] to be wheezy."

Further interview between community health service and Ms A in October 2019

41. On 4 October 2019, the community health service had a telephone interview with Ms A and asked her about her recollection of the care provided to Mr B on 15 Month1 2018. During the call, Ms A said that she did not have any concerns about Mr B's health during her visit on 15 Month1 — directly contradicting her statement made in March. The notes from the interview state:

> "[Ms A] replied that he told her he didn't want a shower and that he had everything for dinner … [Ms F] asked if [Ms A] noticed any health problems, [Ms A] did not have any concerns with his health.

[11] Global Positioning System.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Ms F] asked if [Ms A] was concerned with his mobilising, [Ms A] stated she wasn't worried.

[Ms F] asked if there was anything else she would like to add, [Ms A] said no."

Ms A's statement to HDC

42. On 21 May 2020, Ms A provided the following statement to HDC:

"… I went to [my fourth client, Mr B] roughly at 11am and as I earlier mentioned[ed] I knocked on the door and he opened and refused care and then I came back home."

43. Ms A said that she does not remember the exact time that she entered and left Mr B's house. She told HDC:

"I can remember that he opened the door for me and stated that he was tired and already had his shower that day so he refused his hygiene. As for the smelly breath and cough it did not seem anything concerning with short of breath, [as] he walked to open the door for me and it is quite common for elderly client to be bit out of breath after few steps. He was alert and did not complain of any pain. I seriously did not notice anything life-threatening or any major change in [Mr B], otherwise I would have definitely escalated the matter to the office."

44. Ms A stated: "[S]ince that day I deeply regret that [I did] not pick [up] any signs and if I had known I would have done my best to help [Mr B]."

Further information

45. The community health service stated:

"[The community health service] accepts [Ms A's] statement that she did visit [Mr B] on Saturday 15 [Month1]. [Ms A] is a well-respected support worker and she is generally well regarded by her clients, colleagues and management. [The community health service] has not had any issues with her performance in the past, and there are no complaints on her file."

46. The community health service has not verified with HDC that the community health service in fact checked Ms A's Virtual Assistance (VA)[12] data against her required client visits.

47. The community health service told HDC:

"Whilst it is not ideal that [Ms A] did not log in and out of this visit in real time as expected and required under [the community health service] policy, we do not consider this as misconduct or relevant to what occurred [to] [Mr B] in terms of his apparent fall at home and subsequent death."

[12] A smartphone application.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

GPS data

VA application

48. At the community health service, support workers utilise VA to facilitate the delivery of services to clients and the preparation of electronic timesheets reflecting the work for which the support worker is to be paid. VA was developed to record visits made to clients by support workers. It records support workers' arrival at, and departure from, a client's home. VA gathers relevant data in the process, specifically location and timing. The data is used to verify that the support worker is physically in attendance at the client's home (location data), and in attendance for the rostered time of the visit (timing data). The data verifies support-worker attendance and hence allows the community health service to identify when a support worker does not attend a scheduled visit.

Location and timing data

49. VA collects precise location data. For example, when a support worker opens VA, location and timing data will be collected as the support worker travels from one client to another. However, location is not recorded when VA is closed or when GPS on the phone is switched off. Therefore, the collection of location data is in the control of the user.

50. Location data is collected in several ways, including from the GPS on the user's phone, triangulating between cellular networks and Wi-Fi hotspots. The collection of location data may occur when VA is not actively open but is running in the background.

51. The community health service told HDC that VA was developed primarily as an electronic attendance tool, and stated:

> "[T]he app is not principally designed as an electronic tracking system although clearly it is. GPS enables and gathers information on the location of the support worker while the app is turned on … historically we have not actively checked the movements of support workers and we have only investigated when we had cause to."

Data from Ms A's VA app on 15 Month1

52. Ms A's VA location and timing data on 15 Month1 was provided to HDC. On this date, Ms A was rostered to visit seven clients. Mr B was scheduled to be Ms A's fourth client. In summary, the VA data shows:

    a) Ms A did not record her visit as per rostered schedules, or record her care when she was at the homes of her other clients.

    b) Ms A was located at or around all other six clients' homes at one point some time on this date, except for Mr B's home.

    c) Ms A was not located near or at Mr B's home at all on 15 Month1.

    d) Ms A was located at her own home at 10.41am, 11.07am, 11.53am, 12.13pm, 12.38pm, 1.05pm, 1.06pm, and 1.33pm.

53. The VA data also shows that Ms A recorded that her care of Mr B finished at 1.34pm, and that she input the "Visit End Time" retrospectively at 1.52pm. The reason for this was

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

recorded as having forgotten to record the visit when leaving Mr B's home. However, the VA location data placed Ms A at her own home at 1.34pm (11km south of Mr B's home).

54. The community health service also provided HDC with a summary of the VA visits for other support workers who provided care to Mr B from 11 to 17 Month1. Apart from Ms A's visit on 15 Month1, all the other support workers logged their visits at Mr B's home, and the VA app identified that they were at Mr B's home.

Ms A's response to the VA data

55. Ms A accepted that she did not log her time at the time of her visit. She told HDC that often her work would finish before the allocated time, and she would go straight to her next client and, by doing so, she finished her work earlier than the rostered time.

56. Ms A was asked about the VA data. She told HDC:

> "… I was at home at 11.07am and 11.53am as per the GPS tracking, I might be leaving my house to go to the client and logged out when I came home for break. This is what I used to do that when I leave home and put the client's address in the GPS and I will sign in at the same time and sign out when I am back at home or I am at the next client's house."

57. Ms A also told HDC: "[A]s for the GPS tracking I have notified [the community health service] on multiple occasions that the VA app does not show the correct location and there is always discrepancies …"

Response from community health service to Ms A

58. The community health service told HDC that it does not agree with Ms A's view that the VA does not always show the correct location. The community health service said that all data received and analysed by the VA app is collected via the support worker's mobile device, and the community health service "consider[s] that the data collected is consistently accurate due to the technical processes relied on". The community health service said that its recent internal audit indicated that Ms A's client visits (in May 2020) were all recorded as expected in real time, and indicate accurate locations.

59. The community health service stated: "[I]t is our view that the VA app has effective and appropriate measures in place to ensure that it only captures accurate data within the prescribed 200m range."

Escalation of care

60. The community health service told HDC that it believes that if Ms A did attend to Mr B on 15 Month1, she would have provided an appropriate standard of care. The community health service stated:

> "With respect to whether [the community health service] provided [Mr B] with an appropriate standard of care, we do believe we met the relevant standard leading up to [Mr B's] transfer to hospital and subsequent death. With the exception of [Ms A] not entering her visit data in real time … On review, and in hindsight, [the community health

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

service] does not believe events would have occurred any differently [i]f the same set of facts were presented again …"

61. The community health service said that Ms A should have escalated any concerns she had about Mr B's health, but noted that it appears that at the time, Ms A did not actually have such concerns about Mr B's condition.

Communication with Contact Centre

62. At the meeting between the community health service and Ms A on 13 February 2019, it was noted that Ms A was asked whether she contacted the Contact Centre, and she stated that she believed she had done so, primarily in order to inform them that Mr B had refused a shower.

63. The meeting minutes on 12 March 2019 document that Ms A was asked to clarify her recollection about whether or not she had contacted the Contact Centre after her visit on 15 Month1, and Ms A was informed by the community health service that management had not found any record of any such contact being made. It was noted that Ms A's response was that she did believe she had contacted the Contact Centre, but she could not be sure when the call was made.

64. The community health service told HDC that it has not identified any evidence of such contact by Ms A to its Contact Centre on 15 Month1, and stated: "[I]t is our view that [Ms A] likely did not make this call, mainly based on the fact that there are no recorded notes from any such call."

Relevant community health service policies for support workers

65. The community health service provided HDC with a copy of its Support Worker Handbook (the Handbook). The Handbook states that support workers can get support or information from its support worker line phone number, its website, and also its roster online portal. The Handbook also states:

"2.3 Communicating with your support centre

For [the community health service] to be successful in providing our service, we must have strong lines of communication. Here are some of the things you should contact your care coordinator about:

…

- There is a change in your client's health, wellbeing or circumstances …

If anything arises that is different from the tasks in the support plan, please discuss with your care coordinator. They always welcome your call.

If you feel that some aspects of care for your client should change, never act on this alone. Instead discuss the matter with your care coordinator who will often have access to information of which you are unaware … Any decision by you to act on your own

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

outside the terms of the designated support plan could put you, the nurse, and/or the client, at risk.

…

2.5 Client rights under legislation

[The community health service] follows the Health and Disability Commission[er's] Code of Rights for all people receiving a health or disability service. This means that all [community health service] staff must act within the guidelines detailed below …

- Proper standards. Clients have the right to be treated with care and skill, and to receive services that reflect their needs. All those involved in their care should work together for them …
- Support. Clients have the right to have someone with them to give them support in most circumstances …
- Complaints. Complaints are welcome — they help us improve our service. It must be easy for clients to make a complaint, and it must not have an adverse effect on the way they are treated.

4.4 What to do when …

You are turned away from work: If you arrive for work and for any reasons are turned away contact your care coordinator immediately."

Community health service's management of Mr B's family's complaint

Initial concerns raised by Mr B's family

66. Mr B's family told HDC:

"Due to the variety of unexplained concerns around [Mr B's] road to passing away, [the family] contacted [the community health service] and was eventually connected to [the Regional Manager] … She connected him [to the] [14 Month1] caregiver. However, she provided zero satisfaction with the largest remaining question which was, whether [Mr B] had been seen on [15 Month1]."

67. The family considered that there remained a contradiction between the Contact Centre stating that Mr B was seen on the 15th, and the medical evidence that Mr B had been on the floor for several days, in addition to Mr B's neighbour's observation that his curtains had been closed since the night of the 14th. The communication between the family and the community health service about these concerns was by telephone.

68. On 24 Month1, notes from the Contact Centre document that Mr C called and asked to speak to Ms F, the Regional Manager, regarding the last interactions his father had with Ms A.

69. On 1 Month2, the Contact Centre notes show that Mr B's family requested a call back regarding their query about their father's last interaction with Ms A. Ms F then returned the

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

call and spoke with Mr B's son, and confirmed that Mr B was attended to by Ms A on 15 Month1.

70. The community health service told HDC that Ms F "did not believe an investigation was required at the time because it did not appear that anything out of ordinary had occurred, and no complaint had been received". The community health service said that Ms F "was aware that the family were not satisfied with her responses, but she did not believe any further action was required at the time".

71. The community health service told HDC that whilst it acknowledges that it may have been useful for them to treat the concerns raised by the family as a formal complaint at this early stage, it is the community health service's view that Ms F exercised her judgement based on the information available and, accordingly, believed that she had answered the concerns raised and that no further inquiry was required.

Subsequent investigation by DHB

72. On 4 Month2, Mr B's family made a formal complaint to the DHB about the care provided by the community health service, in particular whether Mr B was cared for by a support worker on 15 Month1. The DHB investigated the family's concern, and on 11 Month2 notified the community health service about the family's complaint to the DHB.

73. On 24 Month2, the community health service responded to the DHB. The community health service stated:

> "15th [Month1] [the support worker] attended cares at usual time, she states that [Mr B] was ok, but a bit 'grumpy and reluctant to shower, this is normal' … The [support worker] stated that she was not concerned as he did not appear sick or unstable on his feet."

74. Among other documents, the community health service provided the DHB with a copy of the carer visit record for 15 Month1 — this record is completed manually by the support worker. The community health service did not provide the DHB with its VA data of Ms A's location and the discrepancies of time logged by Ms A for her visit on 15 Month1.

75. On 12 December 2018, the DHB provided its investigation outcome to the community health service and Mr B's family. In summary, the DHB's Incident Review report stated:

- It was unable to substantiate the allegation that the support worker did not provide cares to Mr B on 15 Month1.
- While the community health service did respond to all of the family's queries and concerns in a timely manner, there was no evidence that this was identified and treated as a complaint. The family's concerns could potentially have been alleviated somewhat if the community health service had treated their concern as a formal complaint.

76. Following Mr B's family's complaint to HDC, the community health service provided further information to HDC, including a statement from Ms A and the discrepancies in Ms A's log-in

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

time and when she advised that she attended Mr B. This information was sent to the DHB. The DHB told HDC:

> "[The DHB] is also very concerned about the lack of open disclosure by [the community health service] to [the DHB's] initial request for information in [Month2]. Of particular concern are the discrepanc[ies] between the time the Support Worker logged when she attended to [Mr B] and the actual time she attended to him; the time of day she actually logged her hours for 15 [Month1]; and the discrepancy between the Support Worker's accounts of [Mr B's] condition that day."

77. The DHB told HDC that it based its initial findings on the information that was provided from the community health service. The DHB said that the new information the community health service provided to HDC would have changed the outcome of its investigation significantly and "raised serious concerns about the community health service's complaint process, electronic logging of attendance for its support workers, and plausibility of the support worker's statements and attendance on 15 [Month1]".

78. The community health service told HDC:

> "In hindsight … we do accept that the investigation was brief and did not inquire further than speaking to the employees involved and reviewing the rostered visit times. If the Regional Manager had enquired further into the time entries and GPS data related to the various client visits on the days in question, she likely would have discovered much earlier that there were discrepancies to be further looked into."

79. However, the community health service stated:

> "[W]hilst we acknowledge that the Regional Manager's investigation could have been more detailed, which would have provided a fuller response to [the DHB] and family, we do not agree that we failed to properly investigate, and we also do not agree that there was any breach of the expected standard in this regard."

80. The Chief Operating Officer (COO) told HDC:

> "I am confident that [the community health service] has provided accurate responses to all questions raised, with the information we had at the time. We place a large amount of trust in our workforce, and do our best to ensure they are working professionally."

Subsequent interviews

81. Following receipt of the complaint to HDC — six months after the incident — the community health service conducted a more formal interview with Ms A on 12 March 2019, and obtained a written statement from her on 18 March 2019. On 4 October 2019, the community health service conducted a further telephone interview with Ms A. The information from these interviews and statements has been summarised above.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Complaints policy

82. The Complaint Management policy (December 2016) states:

> "What is a Complaint?
>
> A complaint can be defined as any expression of dissatisfaction on a client's behalf to a responsible party. Complainants may not always use the word complaint — it may be couched as a comment, concern, or opportunity for improvement — it is important to recognise these as complaints under the complaint process. Examples of complaints that your organisation might receive are … [a] staff member manages their time poorly (for example, frequently arriving late at a client's home) or even not turning up at all, without warning or good reason …"

83. The "Client Accident/Incident Management" policy (February 2017) states:

> "4. Procedure
>
> …
>
> b. Reporting and recording:
>
> …
>
> ii. Support Worker process: SWs are to ring their CC/CSR and report the accident/ incident. The CC/CSR records it as reported in Riskman[13] asking and recording responses from the SW to complete all fields. The CC/CSR copies and pastes the event and action into the AC4.5 diary notes with details of the Riskman Incident number …
>
> C. Investigation
>
> i. Must occur for any accident/incident that caused or might have caused injury or harm to a client …
>
> iv. Must be completed as far as reasonably possible, within 7 days of the incident occurring."

84. The RiskMan Incident Entries (Month1) states:

> "Is the event to do with a Client? → Adverse Client Event e.g. Falls, Unwell, Medication Error, Behaviour of Concern, Unexpected Client Death resulting from Staff error → Medication Error or client Fall that directly involves a Support Worker → Yes needs to be a Riskman Entry for Investigation."

85. The community health service told HDC: "[W]e consider that our policies are comprehensive and appropriate for the level of worker tha[t] we employ and the services that they deliver." The community health service also said that its "policy clearly states what is expected regarding investigation of incidents, and the flow diagram gives quick guidance on

---

[13] Incident management software.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

requirements around certain incidents". The community health service stated that there is no contradiction between its RiskMan Incident Entries and "Client Accident/Incident Management" policy, as the requirements are determined by the nature of the event.

Further information

Ms A

86. Ms A told HDC:

> "My sincere condolences to the family of [Mr B] … I sincerely apologise to the family if I would have known that he was in any sort of danger and suffering, I would have done my best to help him."

Community health service

87. The community health service told HDC:

> "[The community health service] wishes to acknowledge the very tragic and sad circumstances surrounding [Mr B's] death. Our team were very sorry to hear of his death, and the circumstances leading to it, including how he was discovered at home."

Response to provisional opinion

88. Mr B's family, the community health service, and Ms A were given an opportunity to respond to relevant parts of the provisional opinion. Their comments have been added throughout the report where relevant, or summarised below.

Mr B's family

89. Mr B's family told HDC that they believe Ms A did not attend on 15 Month1, and, as a result, Mr B lost his life. They said they were incredulous that the community health service's statements appear to contradict this belief, and also that the community health service did not find it relevant to check Ms A's GPS location when they received the complaint initially.

Ms A

90. In response to the provisional opinion, Ms A reiterated that she attended to Mr B on 15 Month1 and he refused care on this day. She said that when she attended, there were no indications that he had fallen. Ms A said that now, if there are any minor changes in a client's condition, or a client refuses care or does not open the door, she reports this.

91. Ms A said that she is committed to her job and does her best to look after her clients. She stated that she understands that they are vulnerable and at risk. Ms A said that she offers her sincerest condolences to Mr B's family for the loss of their loved one.

Community health service

92. In response to the provisional opinion, the community health service told HDC that it had no further comments to make.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Relevant standards

93. Standards New Zealand's Home and Community Support Sector Standard NZS 8158:2012 (the HCSS) stipulates:

> "Standard 1.9 The consumer's right to make a complaint is understood, respected, and upheld.
>
> 1.9.1 An easily accessed, responsive, and fair complaints process, which complied with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights is documented and implemented. This shall include, but is not limited to:
>
> a) The service operates the complaints process in a fair and appropriate manner, including the involvement of advocacy services, where appropriate;
>
> b) The organisation encourages consumers to use the complaints process when they have a complaint about service providers;
>
> …
>
> Standard 2.4 Adverse event reporting and resolution
>
> 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."

Opinion: Ms A — breach

Attendance on 15 Month1

94. Ms A said that she visited Mr B at around 11am, but retrospectively logged in to VA that she provided care to Mr B from 12.14pm to 1.34pm.

95. The key issue in relation to Ms A is whether she attended to Mr B on 15 Month1. Based on the narration of facts set out above, there appear to be two possible scenarios. The first, adopting Ms A's version of events, is that she attended Mr B at approximately 11am on the 15th. The second, consistent with VA and GPS data, is that Ms A did not attend Mr B on the 15th.

96. Having considered the evidence, in my view it is more likely than not that Ms A did not attend Mr B on 15 Month1. I set out my reasons below.

97. Ms A consistently told HDC and the community health service that she attended to Mr B's care on 15 Month1. However, I note that there are several inconsistencies in the evidence provided by Ms A:

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Ms A accepted that she did not log her rostered time as per her actual visit time as stated by her. She logged in that she provided care from 12.14pm to 1.34pm, when she said that she attended care at 11am.
- She logged in that she provided care for around 1.5 hours, when it was unlikely that it took her that long (if the visit did occur), as she said that Mr B refused care, saying that he did not want a shower and had everything prepared for dinner.
- Ms A stated that she telephoned the Contact Centre to advise that Mr B refused his care/shower, but there is no record of this call having occurred.
- Initially, Ms A did not raise any concerns about Mr B's health. Ms A then said in her statement dated 18 March 2019 that Mr B was coughing, did not look well, and was short of breath and wheezy. Subsequently, in her telephone interview on 4 October 2019, it was noted that she said that she did not have any concerns about Mr B's health.

98. In addition, the VA and GPS data does not place Ms A near Mr B's home at any time during 15 Month1, and places her at home around the time she states that she visited Mr B. I have not found Ms A's statement that the VA app is inaccurate compelling, given that, other than Mr B's visit, it has accurately placed her at her other client's addresses, and has done so for all other colleagues using the app on this date.

99. Expert advice was obtained from Mr John Taylor, who advised: "If [Ms A] did not support [Mr B] then that is a severe breach of the expected level of care."

100. I accept Mr Taylor's advice, and am very critical that Ms A did not attend Mr B on 15 Month1.

101. For completeness, I note that Mr Taylor is critical that if Ms A did in fact visit Mr B, she did not use the tools available at the community health service to record her visit accurately. He advised that this "in turn means the employer — [the community health service] — has no ability to determine if the work was actually carried out as required". Mr Taylor stated: "I considered [Ms A's] failure to correctly record her visit as a severe departure from the expected standard given she had multiple ways in which to do this."

102. As I am of the view that Ms A did not attend Mr B on 15 Month1, I acknowledge Mr Taylor's comment but do not consider further comment on this scenario necessary.

Conclusion

103. As outlined above, I have found it more likely than not that Ms A did not attend Mr B on 15 Month1. This is very concerning given that vulnerable clients, such as Mr B, rely on the provision of services from their support workers to ensure that they receive adequate personal cares or, at the very least, are checked on to ensure that they are safe and well. This would have enabled correct escalation procedures to be followed, and safety-netting measures to be instigated.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

104. Accordingly, I find that Ms A did not provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[14]

105. I note that despite my finding above, I am unable to comment, nor consider it necessary for the purposes of this investigation, to find whether a visit by Ms A on 15 Month1 would have resulted in Mr B being found incapacitated earlier. The clinical documentation on Mr B's assessment following his fall is not sufficiently clear for me to determine precisely when Mr B may have fallen. I also note that this was not the purpose of the clinical assessments undertaken.

Opinion: Community health service — adverse comment

106. The community health service is responsible for providing disability support services to its clients in accordance with the Code. The community health service was contracted by the DHB to provide Mr B with home support. This was to include personal care every day, and home help (including cleaning and laundry assistance).

107. Mr Taylor advised:

> "Organisations like [the community health service] have to operate with a high level of trust in their workforce because they cannot directly oversee each worker. In this environment it is important to have clear guidelines for staff to follow in all aspects of their work."

108. Mr Taylor said that the community health service's system of electronic logging of attendance for support workers was appropriate. He advised: "In my opinion our peers would agree that [the community health service] was operating within the accepted standard of care in this regards."

109. I accept Mr Taylor's advice. The community health service also provided HDC with GPS data that showed that from 11 to 17 Month1, the GPS identified that other support workers attended Mr B's home. Accordingly, I consider that the failure by Ms A to attend Mr B on 15 Month1 was an individual omission by Ms A, and that her breach of Right 4(1) of the Code did not indicate broader systems or organisational issues at the community health service in relation to care attendance. However, I do have concerns about the community health service's response after Mr B was discovered, and his subsequent death. I discuss this below.

Response to adverse event

110. After Mr B's death, his family began to request answers from the community health service about the care provided to their father in the days leading up to his decline. Having been

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

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

dissatisfied with the community health service's initial response, the family complained to the DHB, and then eventually to HDC.

111. In summary, I set out the following observations about the community health service's response to the incident:

- When Mr B's family raised concerns directly with the community health service in Month1, it was not treated as a complaint, and it was determined that no further investigation into their questions about support worker attendance/cares was required.
- When Mr B's family escalated their concerns to the DHB in Month2, other than seeking informal confirmation from support workers of their attendance, and reviewing self-reported log-in data, the community health service did not inquire further into the matter. The DHB's investigation did not prompt the community health service to interview or seek written statements from the individuals involved, or cross-reference log-in details with its VA data.
- It was not until six months after the incident and following a complaint to this Office that the community health service interviewed Ms A, requested a formal statement, reviewed its VA data, identified discrepancies in the information provided previously, and held further meetings with Ms A in relation to these discrepancies.

112. The Client Accident/Incident Management policy states that investigations must occur for any accident/incident that causes, or may have caused, injury or harm to a client. The Complaint Management policy states that "complainants may not always use the word complaint", and that an issue that should be considered a complaint may be that a staff member has failed to turn up for care.

113. The HCSS standard 1.9 states that support services must operate their complaints process in a fair and appropriate manner. Standard 2.4 states that all adverse unplanned or untoward events are to be recorded systematically and reported to affected consumers and, where appropriate, their family/whānau, in an open manner.

114. Mr Taylor advised that it appears that the community health service took people at their word rather than checking the facts, and that the service failed to investigate properly. He said that the service failed to get any resolution or to further investigate the inconsistencies in Ms A's statements and in the GPS data. He stated:

> "My key issue with [the community health service] was, and still is, the poor investigations. Because nothing was initially investigated it has left no-one knowing what really went on … So the systemic issue that I see for [the community health service] is its lack of desire to check on its own performance."

115. I accept Mr Taylor's advice. I consider that overall, the community health service's investigation into the incident and into Mr B's family's concerns was inadequate, delayed, and piecemeal. In light of the events that transpired, the community health service had a responsibility to fully investigate the family's concerns from the outset, and treat their

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

complaint with the seriousness it warranted. This was an opportunity for learning and improvement, and to apply the learnings to many vulnerable clients going forward. I remind the community health service that having a policy for complaints management is futile if it is not followed, and that adequate management of complaints is essential to continuous quality improvement.

Changes made following complaint

Ms A

116. Ms A told HDC that as a result of this incident she made the following changes:

a) She logs in only when she arrives at a client's house, and logs out as she is leaving the client's house. She asked the community health service to provide training to all employees regarding this, "so that this does not happen in the future as I have learnt my lesson the hard way".

b) If she has finished her job earlier than the allocated time, she calls the Contact Centre to ask whether she can go to the next client.

c) If she notices any changes in a client's health, she will report this to the Contact Centre immediately, as well as complete an entry in the communication book.

Community health service

117. The community health service told HDC that following these events, it considered and/or made the following changes:

a) Currently it is considering whether it should revise its policy in respect of client Communication Books, in order to ensure that it retains access to the information, and can review it and provide copies when required in a process such as this.

b) A key learning from this case has been the importance of ensuring that support workers log their client visits in real time. The community health service continues to message this importance, and its expectations to support staff, during staff orientation.

c) The community health service has continued to develop the VA app so that GPS data is as accurate as possible, and this assists any inquiries that need to be made in terms of the location of support workers at certain times.

d) It has created a "dashboard" that more easily allows it to identify support workers who have logged into a client visit from a location other than the client's house, and also displays graphically the movements of the support worker during any day.

e) Its management team is regularly reminded to refresh its understanding of the community health service's complaints management policy and expected practice. It has engaged an external specialist to develop and deliver more detailed training for management on complaints management, investigations, and privacy.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

f) In 2019, the new Regional Manager implemented a "Stop and Watch" tool that enables support workers to observe and report any apparent changes in a client's behaviour or health, and assists in escalating for clinical review.

Recommendations

118. I recommend that Ms A provide a written apology to Mr B's family for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr B's family.

119. I recommend that the community health service:

a) Consider whether Ms A may benefit from further training in relation to the community health service's VA application, logging her attendance, or any other relevant topics arising from this report, and report back to HDC within one month of the date of this report.

b) Audit Ms A's VA and log-in data within the last month from the date of this report, and report back to HDC on the result of the audit within six months of the date of this report. Where the audit result does not show 100% compliance, the community health service is to discuss with Ms A the audit findings and what improvements she can make.

c) Consider whether staff attendance at clients' homes should be monitored routinely and/or audited randomly as part of continuous improvement processes. The community health service is to report back to HDC on the consideration of this within three months of the date of this report.

d) Report back to HDC regarding its engagement with an external specialist, as stated above at paragraph 117.e), and provide details about what further changes have been made following this engagement, within three months from the date of this report.

e) Report back to HDC regarding the creation of a dashboard and the new "Stop and Watch" tool (as stated above at paragraphs 117.d) and 117.f), and provide details of the effectiveness of these tools and any further improvement that has been made, within three months of the date of this report.

f) Circulate and use the anonymised version of this report to promote a positive consumer-centred culture within the community health service. This case study should be used to emphasise the important contribution staff make on a day-to-day basis, the reliance vulnerable consumers place on staff, and the impact on consumers when lapses occur. Specifically, this report should be used as a basis for staff training, focusing on support-worker attendance and accuracy of logging in/out and responding adequately after an adverse event has occurred. The community health service should provide evidence of this training to HDC within six months of the date of this report.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

g) Provide a written apology to Mr B's family for the adverse comment identified in this report. The apology is to be sent to HDC within three weeks of the date of this report.

Follow-up actions

120. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to HealthCERT (Ministry of Health) and the DHB, and they will be advised of the name of the community health service.

121. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from Mr John Taylor:

"**Re: Care of [Mr B] C19HDC00081**

I have been asked by the Deputy Health and Disability Commissioner to provide an opinion on case number C19HDC00081 that relates to the care provided to [Mr B] by support worker [Ms A] and [the community health service]. I have read and agree to abide by the Commissioner's Guidelines for Independent Advisors.

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

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

Experience: Over 33 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 my opinion to the Deputy Health and Disability Commissioner regarding whether I consider the care provided to [Mr B] by [Ms A] and [the community health service] was reasonable in the circumstances. In particular I have been asked to comment on:

Regarding [Ms A]:

1. Whether [Ms A] appropriately escalated her concerns about [Mr B's] condition on 15 [Month1]
2. The appropriateness of [Ms A's] logging [Mr B's] visit from her own home location and inaccurately recording the time of her visit to match the rostered time
3. Any other matters that I consider require comment or amount to a departure from acceptable standards

Regarding [the community health service]

1. The adequacy of the policies in place relating to the electronic logging of attendance for support workers
2. The adequacy of the process used to monitor support workers' actual attendance to client visits, in particular the electronic tracking system in place
3. The adequacy of [the community health service's] response to the complaint when concerns were raised

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

4. Any other matters I consider could be made to improve the monitoring of support worker attendance.

I have based my opinion on the information listed below:

- The complaint information
- [Community health service's] response dated 18 March 2019
- [Community health service's] response dated 28 March 2019
- [DHB's] response dated 29 April 2019
- [DHB's] response dated 19 September 2019
- [Community health service's] response dated 29 October 2019

Did [Ms A] appropriately escalate her concerns about [Mr B's] condition on 15 [Month1]?

From the information I have read it appears that there are two distinct versions from [Ms A] regarding her assessment of [Mr B's] condition on 15 [Month1]. Although [Ms A] made no comment at the time, when asked by [Ms F] on 4 [Month2] she said that she had no concerns.

However, in the signed statement [Ms A] made on 18 March 2019 she states [Mr B] 'was coughing, and he had a very smelly mouth. He smelt of cigarette smoke. He did not look well … I noticed he was short of breath. He was wheezy … [Mr B] did not appear happy.'

If the first statement is correct, then [Ms A] had nothing to report and therefore no escalation was required.

If the second statement is correct, then [Ms A] should have reported her concerns as per the very clear procedures and expectations provided to her by [the community health service]. Not doing so appears to be, in my opinion, a moderate departure from the expected standard of care.

I have noted this as 'moderate' because, even though the outcome was severe, the support plan [Ms A] was working from only listed a 'Fall' as requiring immediate escalation.

The appropriateness of [Ms A's] logging [Mr B's] visit from her own home location and inaccurately recording the time of her visit to match the rostered time.

When using electronic/web-based rosters and recording systems there are often occasions when a staff person cannot access them at the time they need them. Therefore, there appears to be a general acceptance that recording visits after the event can occur and is acceptable.

Having said that though, [the community health service] had a very robust process in place for staff to record what they did and when they did it. [Ms A] had at her disposal:

1. The VA recording system to use as expected, or

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

2. The Ezitracker from the person's home, or
3. The 'Failed Visit Entry' option on the VA
4. Notify the call centre

The fact that she used none of these and failed to record her visit in the communications book indicates a severe departure from the expected standard to work performance, which in turn means the employer — [the community health service] — has no ability to determine if the work was actually carried out as required. The latter means a severe departure from the expected standard to care, that is, that it did happen as required.

Any other matters that I consider require comment or amount to a departure from acceptable standards.

Reading through the information I was supplied I have reached the conclusion that there is significant doubt as to whether [Ms A] did attend [Mr B] on 15 [Month1].

Her two statements about her visit are contradictory. Her statement made on 18 March 2019 is [entirely] inconsistent and contains statements that stretch credulity such as: 'I cannot recall with certainty if the curtains were open or closed'; this at 11am in the morning (her claimed time of support). And her GPS tracker puts her nowhere near [Mr B's] home at the time she claims to have provided support.

If she did support him as she claims, then there may be no departure from the expected standard other than that raised in the previous two sections. If she did not support him then that is a severe breach of the expected level of care.

The adequacy of [the community health service's] policies in place relating to the electronic logging of attendance for support workers.

Organisations like [the community health service] have to operate with a high level of trust in their workforce because they cannot directly oversee each worker. In this environment it is important to have clear guidelines for staff to follow in all aspects of their work.

In my opinion [the community health service] did have clear policies and expectations relating to how staff were to use the electronic logging system. They also had a very clear set of instructions on how to use the system with backup options people could use if the system did not work as expected.

The adequacy of the process used to monitor support workers' actual attendance to client visits, in particular the electronic tracking system in place.

As I mentioned above, organisations do place a huge degree of trust on their workers in these situations. [The community health service's] VA system looks to me like a fit-for-purpose system and, from reading the instructions, it looks like it is probably fairly easy to use.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[The community health service] had put in place four different ways for support workers to log their attendance.

1. The VA electronic log, or
2. The Ezitracker from the person's home, or
3. The 'Failed Visit Entry' option on the VA, or
4. To notify the call centre

This appears to me to be good practice albeit they mostly rely on the staff person acting in good faith; but that is no different from every other organisation doing the same work. The GPS function on the VA is the only other way [the community health service] can currently check 'independently' where the worker was.

In my opinion, our peers would agree that [the community health service] was operating within the accepted standard of care in this regard. There are a few improvements they could consider but my remarks here are within the context that all systems can be improved and come with 20:20 hindsight. These may be happening but details weren't supplied. I do note that the improvements [the community health service] has made in the dashboard appear positive.

[The community health service] could consider doing regular phone calls with clients to check up on the adequacy of the support. They could extend the alert system they use for vulnerable clients to include all clients. They could consider tying their 'case notes' to the electronic logging system so that the staff person needs to write what they did as they fill out their timesheet. (My personal experience is that this leads to much greater compliance.) They could also consider occasional proactive checks on the GPS information they gather so they notice if staff are not where they need to be.

The adequacy of [the community health service's] response to the complaint when concerns were raised.

In this regard I think [the community health service] fell short of the accepted standard expected. From what I have read, when the complaint was first raised, [Ms F] phoned involved staff and asked if they could confirm they had provided support as rostered. It appears that she took people at their word rather than checking the facts.

This then led the DHB to provide unhelpful comments to [Mr B's] family and further heightened concerns. It also meant that subsequent investigations were further removed from the time of events and so more difficult.

In my opinion [the community health service] again failed to properly investigate when the HDC became involved. [The then COO] responded on 18 March 2019 with a statement from [Ms A] that was contradictory to her response to [Ms F], yet [the then COO] does not make any comment on this or other inconsistencies.

His response was no doubt informed by the meeting held on 12 March 2019 with [the then COO], [a manager], and the two support workers: [Ms A] and […]. This meeting

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

raised a number of these inconsistencies but concluded without any note of further action to be taken.

In [the community health service's] most recent communication with the HDC, [the new COO] provided some very useful information. I generally agree with her when she comments that Electronic Logging tools are generally not primarily about checking on staff attendance and with her comments on needing to trust staff. I am encouraged that they now think they are better able to monitor staff movements and so be more certain that the support is happening.

What I didn't see was any resolution to or further investigation of the inconsistencies in [Ms A's] statements and in the GPS data. To me this indicates continued substandard performance in resolving this complaint.

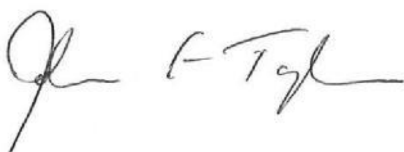
It appears to me that the key issue in the complaint was: did support happen on the days leading up to [Mr B] being found beside his bed. The family made a decision on Sunday 16 [Month1] to allow no support on the understanding their father had been seen on the previous two days. If that support did not happen, they would no doubt have made a different decision. So I imagine for them, closure of any kind is only likely to happen with clarity regarding this support. That clarity has still not been provided.

Given the nature of this complaint, that it has come about through the death of a client, I consider [the community health service's] failure to properly investigate is a severe breach of the expected standard.

Any other matters I consider could be made to improve the monitoring of support worker attendance.

This area has been covered above.

Yours sincerely



John Taylor"

The following further expert advice was obtained from Mr Taylor:

"I have been asked to provide a further opinion on case number C19HDC00081 that relates to the care provided to [Mr B] by support worker [Ms A] and [the community health service]. This second opinion is in response to feedback provided to the Deputy Health and Disability Commissioner by [the community health service]. I have read and agree to abide by the Commissioner's Guidelines for Independent Advisors.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The specific areas I have been asked to respond to are:

1. Whether it [the new documentation] causes me to amend the conclusions drawn in my initial advice, or make any additional comments.
2. The appropriateness of the care and any further comments about the care provided by [Ms A].
3. Whether I consider the issues identified to be systemic issues at [the community health service] or whether it was more attributable to an individual or both. If there are systemic issues, please elaborate on these with reference to how other support services operate in this area.
4. The appropriateness of the relevant [community health service] policies provided.
5. The appropriateness of the training/induction provided by [the community health service] to its staff.
6. Any other matters in this case that I consider warrant comment, including whether the remedial actions/further changes being implemented by [the community health service] are consistent with how other support services respond to similar issues or whether there are other actions that could be taken.

Recap of Previous Findings

I will briefly recap my previous advice from 30 March 2020 to provide context to this current advice. In that previous advice I contended:

1. Regarding [Ms A's] appropriate escalation of concerns: that if she did as she said she had and did ring the support centre, then she did the correct thing (if in fact it was necessary at all; and it may not have been giving the contradictory versions of events). If she didn't, then that is a moderate departure from the expected standard if there were concerns to be raised.
2. I considered [Ms A's] failure to correctly record her visit as a severe departure from the expected standard given she had multiple ways in which to do this. (NB: In my advice I inadvertently referred to the 'communications book' when in fact I meant the many and various ways she had to record the visit.)
3. Regarding whether or not [Ms A] did undertake a care visit on 15 [Month1], I advised that if she did then there is no issue and if she didn't then that would be deemed a severe departure from the expected standard.
4. I considered [the community health service] was operating within the accepted standard in regards to their electronic system — VA.
5. I considered that [the community health service's] investigation of this situation fell well short of the expected standard.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

1. Whether it [the new documentation] causes me to amend the conclusions drawn in my initial advice, or make any additional comments.

In brief; no it does not cause me to alter my original advice. I do however have additional comments to make that I will weave into the ensuing discussion.

2. The appropriateness of the care and any further comments about the care provided by [Ms A].

The new documents provided by [the community health service] still do not, and now cannot, given the elapsed time, provide any conclusive evidence as to whether or not [Ms A] did attend [Mr B] on Saturday 15 [Month1]. This is directly attributable to [the community health service's] poor investigation and to [Ms A's] poor recording.

I would add that, based on the new documents, it appears:

1. [The community health service] believes [Ms A] did not make a call to the contact centre as she thought she did.
2. [The community health service] believes that the GPS data is likely to be correct therefore [Ms A] was not with [Mr B] at the time she said she was.
3. [Ms A] is generally well respected and has now improved her compliance with these protocols.

None of these resolves the situation but the last bullet point, that is that [Ms A] is 'generally' well respected, does offer me more hope that the visit did occur as stated. What would have been useful from [the community health service] was evidence of an investigation that confirmed [Ms A] had visited the other people that day that she said she did. They do say: 'there are no reports of missed cares from any of her clients [from that day].' However, as this is the first time this has been offered it is not clear whether this was actively solicited, that is people were asked at the time, or passively obtained by noting a lack of complaints at some later point. An active gathering of this information at the time would have led to a greater degree of confidence in [Ms A's] claim.

3. Whether I consider the issues identified to be systemic issues at [the community health service] or whether it was more attributable to an individual or both. If there are systemic issues, please elaborate on these with reference to how other support services operate in this area.

My key issue with [the community health service] was, and still is, the poor investigations. Because nothing was initially investigated it has left no-one knowing what really went on. By the time they got around to the first investigation, let alone succeeding ones, the information had been deleted and memories faded. So the systemic issue that I see for [the community health service] is its lack of desire to check on its own performance.

I make this comment based on [the community health service's] repeated, and unreasonable, claim that no investigation was required as no complaint had been made.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The accepted standard in our sector, and the required standard as per our contract with the Ministry of Health, is to institute a system of continuous quality improvement. Further, the Ministry of Health requires that organisations that contract to them report critical incidents and their resolution to the Ministry of Health, and [Mr B's] situation certainly falls within this domain.

Given that a person became critically, and in fact terminally, unwell during their support of that person, I would expect that the contractual imperatives would have sufficed to stimulate a thorough investigation even if the questions asked by family did not. The claimed need for a complaint to stimulate an investigation following such an event is strange.

I still find their investigations both inadequate and a severe breach of the required and contractual standard. I further find their defence of this inadequacy to be perverse.

I am however hopeful that something of this lesson was learned, despite their need to maintain they did carry out an adequate investigation. They commented: 'Another key learning from this case is the importance of responding to concerns and complaints and carrying out appropriate and sufficient investigations soon after the events in question.' (p14 [the community health service] Letter 9/6/20)

4. The appropriateness of the relevant [community health service] policies provided.

Regarding the policies that [the community health service] provided I would say that they are both comprehensive and incomprehensible. They are comprehensive in the sense that they do cover the required scope. The language and grammar used though would be a significant barrier to anyone understanding them. As an example I offer this:

'Support Worker process: SWs are to ring their CC/CSR and report the accident/incident. The CC/CSR records it as reported in RiskMan asking and recording responses from the SW to complete all fields. The CC/CSR copies and pastes the event and action into the AC 4.5 diary notes with details of the RiskMan Incident number. Automatic email alerts are then sent to relevant RM for delegation to the appropriate person to complete an investigation. If the incident has, or could have resulted in a reportable event e.g. SAC 1, an automatic email alert is sent to the COO/GM and CEO immediately or in the case of clinical incidents, to the NCM who will relevantly escalate to the CEO and appropriate external agencies.' (Appendix 18)

If [the community health service] has this policy in place to guide support workers then I would offer the observation that the average reading age of New Zealand adults is 12. In our sector we tend to attract people with below educationally average achievement and/or people with English as a second language. One can make the reasonable assumption then that these staff people will likely have a reading age of no more than 12 and likely lower.

I would contend that the above quote would be unintelligible to most support workers in our sector, or in fact to almost anyone when they first come upon it (therefore new

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

staff) without repeated reading to make sense of the various abbreviations and internal references. Just to be clear, I am not suggesting that a senior staff person who knows [the community health service's] operation well would have any difficulty in reading this, it is those who are new and or/have poor reading skills who would.

The other observation I would make of the policies I read is that, with regard to investigating a situation such as [Mr B's], their policies seem potentially contradictory.

In the first instance in [the community health service's] policy on incidents they say the following:

'Investigation

i. **Must** occur for any accident/incident that caused or might have caused injury or harm to a client …

iv. Must be completed as far as reasonably possible, within 7 days of the incident occurring.' ([The community health service's] Accident/Incident Management as per Appendix 18)

But in the flowchart for the Riskman (presumably risk management??) it says that a 'Riskman Entry' is only required if an 'adverse client event' occurs when a staff person is present. (Riskman Incident Entries, appendix 21)

If the incident policy takes precedence then one is left with the impression that, according to their own policies, an investigation should have occurred immediately. If the Riskman flowchart is to be believed then, inexplicably, investigations only occur if a staff person is present for the 'adverse client event.'

5. The appropriateness of the training/induction provided by [the community health service] to its staff.

I cannot make comments on their training and induction as I have not seen the content of these. However I can say that attendance at these events is well recorded.

6. Any other matters in this case that I consider warrant comment, including whether the remedial actions/further changes being implemented by [the community health service] are consistent with how other support services respond to similar issues or whether there are other actions that could be taken.

There are a couple of inconsistencies in the letter from [the community health service] dated 9 June 2020 that I mention as they may demonstrate the difficulty of examining events well after they have occurred.

Firstly, on p4 [the COO] says of the phone call to the contact centre, that [Ms A] was 'informed at this meeting [meeting of 12 March 2019] that management had not found any record of any such contact being made, as more than three months has passed and we no longer had access to these recordings.'

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In fact, according to the minutes of that meeting, [Ms A] was indeed told there was no record of such a call. However, [the then COO] and investigator, asked for the phone number [Ms A] called from and then 'explained that the phone call will prove [Ms A] had attended the client.' The implication is that there is still some hope that the record was available.

Secondly, on p10–11 The COO says that there is no requirement for support workers to record information in a communication book and that its only purpose is to provide useful information about daily events. In the investigation meeting of 12 March 2019 (appendix 3) [the community health service] 'reiterated the importance of writing in the communication book when there are issues or concerns with a client.' This may indicate a change in the importance of the communication book over the past year or may indicate a difference in emphasis between different managers, with the corresponding potential for confusion for support workers.

…

Yours faithfully, John Taylor"

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.