Access Community Health Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC01227)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by Access Community Health (Access), and highlights the importance of having adequate policies and procedures in place to ensure the safety of high-risk clients.

2. At the time of events in 2018, the woman was frail and elderly, with multiple co-morbidities, and was classified as a high falls risk. She lived on her own and required twice-daily cares and safety checks to be performed by Access to ensure that she was safe in her own home.

3. At 8.10am, a support worker presented to the woman's house to provide her with her morning cares and safety check, to find that she was not answering the door. The support worker notified the Call Centre, and the Access "client not home" process was followed. The Call Centre attempted to call the house, then both her next of kin, but there was no answer. A call was made to the hospital, but it advised that the woman was not a patient. The support worker was advised to move on.

4. This process occurred two more times — later that day at 4.13pm, and at 10am the following morning — with the same results. At 11am the next day, a support worker finally gained access to the woman's home using a neighbour's key.

5. The woman was found in bed, having suffering a significant cardiac event and a stroke, and she passed away shortly afterwards.

Findings

6. The Deputy Commissioner found that by failing to have an adequate process for staff to follow in the event that a client was not at home or not answering the door, Access failed to ensure that the woman was safe, and denied her the opportunity for earlier medical intervention. As such, the Deputy Commissioner found Access in breach of Right 4(1) of the Code.

Recommendations

7. It was recommended that Access Community Health: (a) provide a written apology to the family; (b) provide training to all Call Centre and support work staff on the new "Client not Home" process; (c) randomly audit cases of when the "Client not Home" process has been applied, to assess whether the policy was followed and whether a timely and desired outcome was achieved; (d) develop an alert system so that individuals who require safety checks have their files flagged for special attention; (e) include a prompt in the support plan template to ensure that important information for emergencies, such as spare keys or further contact information, is recorded; and (f) develop a clear definition of a safety check in conjunction with the DHB, and raise any issues regarding policy guidance at the DHB's Home and Community Support Services regular meeting.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his mother, Mrs A, by Access Community Health Limited (trading as Access Community Health). The following issue was identified for investigation:

- *Whether Access Community Health Limited provided Mrs A with an appropriate standard of care in 2018.*

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

10. The parties directly involved in the investigation were:

Mr B	Complainant
Ms C	Complainant
Access Community Health	Provider

11. Independent expert advice was obtained from a disability provider, Mr John Taylor, and is included as Appendix A.

Information gathered during investigation

Introduction

12. At the time of events, Mrs A was a frail elderly woman with multiple co-morbidities, including impaired vision owing to left eye blindness and right eye macular degeneration,[1] mild to moderate aortic valve stenosis,[2] and chronic obstructive pulmonary disease.[3] She also suffered from impaired balance and breathlessness on exertion, and was identified as a high falls risk.

13. Mrs A lived by herself, and her main goal was to be supported to remain in her own home. Access Community Health[4] (Access) was contracted by the district health board (DHB) to provide Mrs A with twice-daily home-based support to facilitate this goal. The DHB supplied Access with a Care Plan Report, which outlined Mrs A's co-morbidities.

14. Access support workers were responsible for helping Mrs A with personal cares, oversight of her medication, and home management tasks, and for performing a safety check at each visit to ensure that Mrs A was safe in her home. The Access Support Plan stated that the safety check was to include confirming that Mrs A had everything that she needed for

[1] An eye disease that causes vision loss.
[2] Narrowing of the valve in the large blood vessel branching off the heart.
[3] A type of obstructive lung disease characterised by long-term breathing problems and poor airflow.
[4] Access Community Health is a healthcare provider that specialises in home-based health care and support.

the day, reminding her to wear her personal medical alarm,[5] and checking that the windows and doors were locked at night.

15. This report concerns the care provided to Mrs A in 2018, and the adequacy of Access's procedure for what to do when a client is not at home.

Access Community Health's "Client not home — process confirmation" policy

16. At the time of events, Access had a "Client not home" policy, which stipulated the procedure to be followed by its Call Centre when a support worker could not gain entry into the client's home. The policy stated:

> "1. Check diary notes
> 2. Call client — if no answer — leave a voice message
> 3. Call NOK [Next of Kin] — If no answer leave a voice message
>
> All NOK's to be called, even if there are more than 1 NOK's with multiple phone numbers.
>
> 4. Call Hospital to make a patient enquiry
> 5. Advise the SW [Support Worker] that you were not able to locate the client and they are ok to move on
> 6. Send follow up (F/U) email to local placement, nursing group & [Email address].
>
> Send email to evening placement, OCC [On-Call Clinician] & [Email address]. (AFTERHOURS ONLY)"

Care provided to Mrs A in 2018

17. On the relevant date, at 8.10am, a support worker presented to Mrs A's house to provide her with her morning cares and safety check. Mrs A did not answer the door. The support worker knocked three times before ringing the Access Call Centre to advise that she was unable to access Mrs A's house. The support worker told the customer service representative (CSR) that the house was locked and the curtains were drawn, and explained that Mrs A might still be in bed, as the previous day she had not been happy to be woken up at 8am for her cares.[6]

18. According to Mrs A's client diary, on past occasions when Mrs A was not at home, often she would call Access to cancel her cares or arrange for a support worker to attend at a different time. If she did not call, often she would leave a note before going out.

19. Mrs A's son, Mr B, told HDC:

> "We know, and we believe that the regular carer knew, that whenever [Mrs A] went out, especially in the morning she would leave a note on the door that she was out."

[5] A medical alarm that when activated calls directly for assistance.
[6] Mrs A had spoken to Access multiple times advising that 8am cares were too early.

20. Mrs A had not called Access to advise that she would not be in on this day, and no note was left on the door.

21. The CSR from the Call Centre followed the Access "Client not Home" process, by first attempting to call Mrs A's home number. Mrs A did not answer, and the CSR was unable to leave a message. The CSR tried to contact both of Mrs A's listed next of kin (NOK), but neither answered the phone. The CSR left voice messages on both phones advising of the situation, and then contacted the public hospital to check whether Mrs A was a patient. The public hospital confirmed that Mrs A was not a patient at either of its facilities.

22. The CSR advised the support worker to move on, and documented in Mrs A's client diary:

> "[Advised support worker] to log out and move on to next client and I will send follow ups — email sent to local office, local nurses, [email address], OCC and evening placement."

23. A further attempt to contact Mrs A was made by the Call Centre at 11.25am, but there was no answer.

24. Later that day, at 4.13pm, another support worker arrived at Mrs A's house for her afternoon cares and safety check. The curtains were drawn and the support worker was unable to see inside, and Mrs A did not answer the door. By this time, Mrs A had not had a safety check in approximately 24 hours.

25. The support worker rang the Call Centre to advise that no one was at home. The "Client not Home" process was followed again. The CSR documented:

> "Called client — NA [no answer] — unable to [leave a message]. Called [NOK], NA — [left a message]. Called [NOK] — NA — [left a message]. Called [the public hospital] — not listed as a patient. [Advised support worker] to log out. Emailed […], nurses, OCC, evening placement and [email address] …"

26. The following day, at 10.00am, Access Call Centre received a call from a support worker to advise that Mrs A was not answering her door for her morning cares. The "Client not Home" process was followed again, and neither Mrs A nor her two NOKs could be reached. It was noted that Mrs A had a medical alarm, and that the public hospital had relayed that she was not a patient.

27. The CSR informed the support worker that he would seek advice from a nurse, and asked the support worker to return to Mrs A's house if needed.

28. The nurse was very concerned about Mrs A, and located the contact details for Mrs A's daughter, Ms C. Access documentation shows that they informed her of the situation at 10.54am; however, the family believe that Ms C was contacted at 10am. Ms C advised that she was not currently in the region, and that Mrs A's usual NOKs were out of the country at the time. Access told HDC that it was not informed that any contacts and family

members would be out of the country on holiday or unavailable. Ms C told Access that she would contact Mrs A's neighbours, and Access contacted the medical alarm service for advice.

29. The medical alarm service advised that it is unable to activate a medical alert bracelet from its end, and that it would not be able to gain access to Mrs A's house. The Access nurse relayed this information to Ms C and asked her to contact the police to request a welfare check for Mrs A. Ms C advised that she would do so.

30. The support worker returned to check on Mrs A at approximately 11am, and gained entry to the house using a spare key kept by Mrs A's neighbour. Access told HDC that it was not informed that Mrs A's neighbour had a key, so this had not been included in her support plan.

31. Mrs A was discovered lying in her bed, cold and unresponsive. An ambulance was called and she was transferred to the public hospital. She was found to have suffered a large ST-elevation myocardial infarction[7] (STEMI) and a left occipital lobe stroke. The events were considered terminal, and palliative care was commenced. Mrs A passed away at 1.35am the following day.

Further information

Access Community Health

32. Following this event, Access updated its "Client not Home" policy to include an escalation process in the event that the next of kin cannot be reached. It also included a flow chart to assist staff to understand and follow the process. The new process stipulates:

> "**Client not at home process**[8]
>
> 1. SW [support worker] calls into Communications Centre — Unable to get access to client home.
> 2. Check all notes. Is client in hospital or away? Then begin making outbound calls.
> 3. Advise SW to walk around outside of client home to see if client is visible through windows
>
> 3a. YES. Client is visible and will let SW in. Advise SW to enter client's home and continue with client's care.
> 3b. YES. Client is visible but is not responsive or able to open door. Alert TL/SS right away. SW to call ambulance and remain on site until emergency services arrive.
> 3c. Advise SW to call back with update. Advise SW next clients that SW will be late. TL/SS to take over from here.
>
> Leave client diary note.

[7] A heart attack.
[8] As of 17 January 2020.

4. No sign of client.

   Call all listed Agents[9] — LAM [leave a message] if you can't get through.

5. Got through to Agent? YES

   5a. Advise agent, SW at client home and client not there. Do they know where client might be?
   5b. Advise agent that SW is there to complete cares. SW will now move on. Agent to follow up from here. CSR/CC to add client diary note and send follow up emails.
   5c. Advise SW, leave diary note, send email to [email address] for SW exception. SW to move on.
   5d. Ask agent to follow up on client not being home.

6. Got through to agent? NO.

   6a. Call local hospital — complete patient enquiry.
   6b. Check all client notes for any vulnerability information. Advise SW to move on while you complete further [follow up].

7. Is client a patient in hospital?

   7a. YES. Diary notes. Email local nurse to advise FYI client is in hospital.
   7b. YES. Advise SW. Cancel cares using CNR let [NOK] know, log in information for exception, SW to move on.
   7c. NO. CSR — Call 105 to request a welfare check on client at client address. Provide SS cell number for police to call back. Get event number.
   7d. NO. Advise SW actions taken. Log in details send [follow-up] email to local nurses, evening placement in afterhours.
   7e. NO. SS/TL to take over and wait for police to call back."

33. Access told HDC that whilst it has since made changes to its "Client not Home" policy and process, it considers that the original policy was "sufficient and appropriate" at the time of the incident involving Mrs A. Access said that in its view, the policy contained the necessary framework for appropriate support as required by its contract and legal requirements. Access stated:

> "In the absence of any detailed sector guidelines for a 'client not home' scenario, Access believes that they acted in an appropriate manner and followed an appropriate process at the time. We follow criteria as defined in our contracts and Needs Assessment referral process, none of which specify actions in these instances."

34. Access stated that during 2018 and 2019, 56 audits took place at a number of Access sites throughout New Zealand and, to date, the "client not home" process has not been identified as either having deficits or requiring corrective action. Access considers that as

[9] An "Agent" refers to anyone the client has given Access as an emergency contact.

its contracts do not specify specific actions to take in a "client not home" scenario, it acted in an appropriate manner and followed an appropriate process at the time.

35. Access wishes to acknowledge Mrs A and her family, and give assurance that it is committed to delivering the very best support to its clients. It stated that it would take learnings from this incident and aim to improve its support services as a result.

"Service Specification for Home and Community Support Services between Access Community Health and its funding District Health Boards" (DHB Service Specifications)

36. The DHB Service Specifications describe the requirements and obligations in the provision of Home and Community Support Services, and form part of the contractual framework between the parties. The Service Specifications state that Home and Community Support Services will provide services based on the individual needs of each client, and stipulate:

> "**Standards**
> B7.5 The Home and Community Support Services must comply with the Home & Community Support Sector Standard NZS 8158:2012
>
> …
>
> **Legislative requirements**
> B8.1 The provision of home and community support services is governed by a number of New Zealand regulations and legislation with which you must comply, including (but not limited to):
>
> a) the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996."

Responses to provisional opinion

37. Access was provided with the opportunity to comment on the provisional opinion. It did not accept that there was a severe departure from the accepted standard of care or common practice in the Home and Community Support sector. Access stated:

> "[I]t remains our view that our policy and process at the relevant time reflected a sufficient framework for appropriate support and safety as required by our contract and legal requirements."

38. Mrs A's family were provided with the opportunity to comment on the "information gathered" section of the provisional opinion, and their comments have been incorporated where relevant. They also stated:

> "We believe that as a national company with many sites across the country that Access should be prepared for a wider group of scenarios (worst case) that could occur with the wide range of people they service."

Relevant standards

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

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

40. Disability Support Services Tier Two Service Specification (Home and Community Support Services) (the Ministry Service Specifications) provides the overarching Service Specification for all Home and Community Support Services funded by Disability Support Services. It stipulates:

> "**3. Service Objectives**
>
> The Person receives Home and Community Support Services to support them in everyday life.
>
> Successful services occur when:
>
> …
>
> d) The potential for further injury, harm, or decline in the Person's health is prevented or reduced."

Opinion: Access Community Health Limited — breach

Introduction

41. Access was contracted by the DHB to provide Mrs A with twice-daily home supports. The home supports were to include personal cares, oversight of taking medication, home management tasks, and a safety check. When a support worker presented to Mrs A's home for her morning cares, she found that Mrs A did not appear to be at home.

42. My expert advisor, Mr John Taylor, advised that it is a common occurrence across the entire disability support sector for a client not to be at home at the time the support worker arrives, and every agency needs a clear policy on what the support worker should do.

43. At the time of these events, Access had a policy in place for what its staff should do if a client does not appear to be at home. The policy required the Call Centre to telephone the client and the client's next of kin, and to enquire whether the client was in hospital. Having completed these steps, the Call Centre would advise the support worker that the client

could not be located, and to move on to the next client. Follow-up emails were sent to the local placement team and nursing group to let them know that the client was not home.

Lack of escalation

44. Over two days, when Mrs A was found not to be answering her door, the above process was followed three times. Each time, Mrs A did not answer her phone, both her recorded next of kin were unable to be reached, and the hospital advised that she was not a patient. By 4.13pm on the first day, it had been approximately 24 hours since a safety check had been performed on Mrs A, and her curtains were still closed. However, the same "Client not Home" process was followed. It was not until approximately 11am on the second day that any escalation occurred, when Mrs A's daughter was contacted by Access and informed of the concerns. Ms C subsequently called the police to request a welfare check on her mother, who was discovered unresponsive in bed having suffered a heart attack and a stroke.

45. Mr Taylor advised:

> "I consider the lack of immediate safety oversight in the policy and procedure is a severe departure from the expected standard of care and would be considered as such by our peers. It is severe because there is no escalation in contact urgency in the procedure."

46. I concur and I am critical of the lack of escalation in Access's policy. In my view, this allowed the process to be repeated multiple times without ensuring the safety of the client, and denied Mrs A the opportunity of earlier medical care.

Lack of differentiated process for different risk profiles

47. Mrs A was a frail elderly woman with multiple co-morbidities, including impaired vision, aortic valve stenosis, and chronic obstructive pulmonary disease. She also suffered from impaired balance and breathlessness on exertion, and was identified as a high falls risk. Access's "Client not Home" policy did not reflect Mrs A's high needs, and was used for all clients, regardless of their risk profile.

48. Mr Taylor advised:

> "[Access's 'Client not Home' policy and process] needs to be able to accommodate specific risks and vulnerabilities associated with specific people. This would require that one of the steps in the process was for the support worker and/or contact centre staff to refer to the client's specific risks and vulnerabilities information. In the case of [Mrs A] that would have included that she was frail, at risk of falling, and was frequently out of breath …
>
> If something like that had been in place then it would have been quickly apparent to the care coordinator that leaving messages with next of kin and waiting until the next shift, or the next day, would have been inadequate."

49. I agree with Mr Taylor. I acknowledge that the process may have been adequate for supporting someone with no imminent safety risk. However, Mrs A required twice-daily checks to ensure that she was safe, owing to her multiple co-morbidities, and the application of Access's policy allowed for the safety checks not to be completed.

50. I note that the DHB Service Specifications stipulated that Access was to provide services based on the individual needs of each client. I am critical that the "Client not Home" policy did not accommodate the differing individual needs, risks, or vulnerabilities of their clients, and was contrary to these obligations. It is concerning that in light of this case, Access considered its old policy to have been sufficient for Mrs A.

"Client not Home" policy and sector expectations

51. Access believes that its "Client not Home" policy contained the necessary framework for appropriate support as required by its contractual and legal requirements, as its contracts do not specify specific actions to be taken in a "client not home" scenario. Access stated:

> "In the absence of any detailed sector guidelines for a 'client not home' scenario, Access believes that they acted in an appropriate manner and followed an appropriate process at the time. We follow criteria as defined in our contracts and Needs Assessment referral process, none of which specif[y] actions in these instances."

52. Mr Taylor advised: "[I]n our sector we are expected to bring a certain level of experience and expertise in working with vulnerable people to our operation." He acknowledged that there are many situations where Ministry of Health requirements are vague, undefined, or open to interpretation, and advised that in these circumstances providers are expected to use their experience and knowledge to provide services that, at the very least, minimise harm and optimise the quality of life of consumers.

53. The DHB Service Specifications stipulate that Home and Community Support Services must comply with relevant standards and legislative requirements, such as the HCSS and the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

54. Outcome 4 of the HCSS stipulates that consumers must "receive services that contribute to their agreed outcomes, and that support their independence, safety, and well-being". In addition to the DHB Service Specifications, the Ministry Service Specification stipulates that successful services occur when "the potential for further injury, harm, or decline in the Person's health is prevented or reduced".

55. Guided by Mr Taylor's advice and the above service specifications and standards, I do not accept that Access's "Client not Home" policy met sector expectations, as Access contends.

Conclusion

56. In my opinion, Access did not have clear and robust policies in place for its support work and Call Centre staff to follow, and, as a result, a service delivery failure occurred when Access was put on notice that Mrs A had not been answering her door.

57. As discussed above, I am critical that the policy lacked an escalation mechanism and a differentiated process for clients with different risk profiles. In addition, it did not align with the service specifications and sector standards. Additionally, by failing to have in place an adequate process for staff to follow in the event that a client was not at home or not answering the door, Access failed to ensure that Mrs A was safe, and denied her the opportunity for earlier medical intervention. As such, Access Community Health did not provide Mrs A services with reasonable care and skill, and I find it in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[10]

58. I acknowledge the changes that Access has made since these events. My expert advisor considers the changes to be useful improvements to the policy, and believes that under the new policy, Mrs A's outcome would have been much more positive.

Recommendations

59. I recommend that Access Community Health Limited:

a) Provide a written apology to the 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.

b) Provide training to all Call Centre and support work staff on the new "Client not Home" process. Evidence that this has been done is to be sent to HDC within four months of the date of this report.

c) Randomly audit, over three months, 25 cases of when the "Client not Home" process has been applied, to assess whether the policy was followed and whether a timely and desired outcome was achieved. Evidence that this has been done is to be sent to HDC within four months of the date of this report.

d) Develop an alert system so that individuals who require safety checks have their files flagged for special attention, as per Mr Taylor's advice. Evidence that this has been done is to be sent to HDC within six months of the date of this report.

e) Include a prompt in the support plan template to ensure that important information for emergencies, such as spare keys or further contact information, is recorded.

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

Evidence that this has been done is to be sent to HDC within six months of the date of this report.

f) At the DHB's Home and Community Support Services regular meeting, raise any concerns regarding policy guidance, and develop a clear definition of a safety check using Mr Taylor's advice and the relevant service specifications and standards referenced in the report as guidance. Access is to report back to HDC on the outcome of these discussions within six months of the date of this report.

Follow-up actions

60. A copy of this report with details identifying the parties removed, except the name of Access Community Health Limited (trading as Access Community Health) and the expert who advised on this case, will be sent to the Ministry of Health and the DHB, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Mr John Taylor:

"I have been asked by the Deputy Health and Disability Commissioner to provide an opinion on case number C19HDC01227 that relates to the care provided to [Mrs A] by Access Community Health (Access). 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: Over 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 my opinion to the Deputy Health and Disability Commissioner regarding the adequacy of Access' 'Client not Home' policy and whether the appropriate action was taken by the support worker and contact centre regardless of the existing policy.

I have based my opinion on the information listed below:

- The letter of complaint dated …
- Access' response dated 30 July 2019
- the DHB Care Plan Report 1 September 2017
- Care records from Access, and
- Access' 'Client not Home' policy and 'Process Confirmation' operative pre [Mrs A]'s demise and the updated 'Process Confirmation' post her demise.

The adequacy of Access' 'Not Home' policy.
It is a common occurrence across the entire disability support sector for a client to not be at home at the time the support worker arrives. It happens for multiple reasons and every agency needs a clear policy on what the support worker should do.

An organisation such as Access works with a wide variety of support needs; from people who are able to function very autonomously in most areas of their life to people who have high and complex support needs. As such it seems to me that this will need to be reflected in their 'Client not Home' policy and processes. I did not see that.

[Mrs A] was an [elderly] woman who was referred for support due to her being frail, had respiratory issues and at risk of falling ([the DHB] Care Plan Report). [The DHB] Care Plan specifically required a 'safety check' to be undertaken both morning and night.

Given this requirement, I consider Access' 'Not Home' process to be inadequate in the form that was operative during 2018 and the new form operative from 12 December 2018. (NB: I acknowledge the process may be adequate for supporting someone with no imminent safety risk.) I consider the lack of immediate safety oversight in the policy and procedure is a severe departure from the expected standard of care and would be considered as such by our peers.

It is severe because there is no escalation in contact urgency in the procedure. At 16.03 of the first day, the same 'Client not Home' process was followed even though the support worker noted the curtains were shut and it had now been, presumably, 24 hours since anyone had checked on [Mrs A]. The 'curtain shut' alert has been added into the new 'Client not Home' process but what one should do about it is not disclosed. Given that the alert prompted no useful response in [Mrs A]'s case it does not seem a promising addition.

In my opinion Access requires a more robust 'Client not Home' policy and process. It needs to be able to accommodate specific risks and vulnerabilities associated with specific people. This would require that one of the steps in the process was for the support worker and/or contact centre staff to refer to the client's specific risks and vulnerabilities information. In the case of [Mrs A] that would have included that she was frail, at risk of falling, was frequently out of breath. It should also record that the neighbour had a spare key to her house and that she must be sighted morning and night.

If something like that had been in place then it would have been quickly apparent to the care coordinator that leaving messages with next of kin and waiting until the next shift, or the next day, would have been inadequate.

Did the care worker and contact centre act appropriately?
The care worker rang the call centre to say there was no response and commented that [Mrs A] may still be asleep as it was early — 8am. The call centre then went through the 'Client not Home' process but did not suggest any further checks.

It is entirely possible that the Contact Centre did not have information on individual clients and merely follows the same process for everyone; certainly no evidence was supplied to suggest they do have this information. If they do have information about individual clients then, given [Mrs A]'s physical health and her preference to be visited later in the morning, it is not clear to me why the support worker was not advised to return later, say in an hour or so as was done on the second day of no response. If this information was available to the contact centre then I consider the contact centre staff were severely below their expected level of performance.

If the contact centre staff had no access to individual client information then I consider that Access' operational protocol is severely below the expected level of care.

I would make a similar comment about the support worker. If the support work knew [Mrs A] and her support requirements then I would expect them to, at the least, have suggested they check back within the hour. Not doing something like that would be considered a moderate to severe departure from the expected standard of care. The reason I have reduced the severity of the performance gap is that support workers are often poorly trained and conditioned to do only what they are told to do.

If the support worker did not know [Mrs A]'s support requirements then, as with the contact centre, I would view this as a severe departure from the expected standard of care from Access Community Health because, as is clear from [the DHB's] plan, [Mrs A] was vulnerable and needed to be regularly checked and that can only happen safely if the support worker knows to do it.

Yours sincerely

John Taylor"

The following further information was obtained from Mr Taylor:

"I have been asked to respond to the feedback from ACCESS Health in their letter to Deputy Health and Disability Commissioner Rose Wall dated 15 January 2020. Below are my comments.

1. I would like to preface my succeeding comments with acknowledging that ACCESS Health has made a very useful improvement to the 'Client not at Home' policy. They have removed the assumption that the person is not at home so that this is checked before the staff person moves on. In doing this I think they have also resolved the previous contradiction between the information in the Support Workers' Handbook (4.4) and the Client not at home policy. I congratulate them on this and I also acknowledge the difficulty of working with such a diverse clientele as they do.

2. In their response ACCESS commented that they 'consider that [their Client not at Home policy] was sufficient and appropriate at the time of the incident.' I again take issue with this. [Mrs A] did not survive the application of their policy so it is very hard for me to imagine how it was either sufficient or appropriate. Under their new policy I think the outcome would have been much more positive.

3. In the service specification they operate under, the stated objective of the service is that: The Person receives Home and Community Support Services to support them to live an everyday life. (Disability Support Services, Tier Two Service

Specification, Home and Community Support Services. Page 3. Emphasis added.) Therefore I think the fact that the policy did not provide sufficient checks to ensure [Mrs A] survived is grounds to comment that it is a severe departure from the outcome the Ministry of Health was expecting.

4. ACCESS questions my experience in providing HCSS services. The organisation I operate does provide HCSS services so I do have an acceptable level of understanding. I did not refer to the documents previously as part of my brief is to only use the documents I am presented with.

5. ACCESS comment on several occasions that they are unclear as to what a 'safety check' might entail as there are no specific guidelines provided from the funders. To recap: [Mrs A] was an [elderly] woman who was referred for support due to her being frail, having respiratory issues and being at risk of falling. [The DHB's] Care Plan specifically required a 'safety check' to be undertaken both morning and night, and it is true they did not define what the safety check was.

6. In our sector we are expected to bring a certain level of experience and expertise in working with vulnerable people to our operations. There are many situations where Ministry of Health requirements are vague, poorly or undefined, or open to interpretation. In these instances we as providers are expected to use that experience and knowledge to provide services that, at the very least are '*provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer*.' (HDC Code of Health and Disability Services Consumers' Rights 4(4))

7. So I would expect that in this context a 'safety check' would mean checking that [Mrs A] is safe. That is: she hasn't fallen over, that she is breathing adequately and that she is alive. I am not convinced that it is necessary for the NASC or the Ministry of Health or the DHB to define this for it to be a reasonable interpretation of a 'safety check'.

8. ACCESS disagrees with me regarding the need for a safety oversight process. To be clear, what I mean by this is that for people who are at risk of harm due to medical or other conditions, this should be highlighted somewhere in the process so that extra care can be taken. As I implied in my initial feedback, I think the ACCESS process was probably adequate for many of the people they support, but not for the likes of [Mrs A]. It is the lack of a differentiated process that I find inadequate. That is, in the process operating at the time, there was no mechanism I could see that required that [Mrs A] received more immediate attention than say a young man with cerebral palsy who only required some house cleaning. The new process I think will assuage my reservations.

9. In their response ACCESS reported that both the contact centre staff and the direct support workers have access to client information and support plans. In this case I would expect them to know of [Mrs A]'s situation. Given that this knowledge did

not prompt an effective response I find it difficult to understand how they can then claim *'so our operational protocol is at the expected level of care'* (p4 ACCESS letter dated 15 January 2020).

10. What I would suggest is that as well as their improved 'Client not at Home' process, they develop an alert system so that individuals, who are medically or in other ways vulnerable, have their files flagged for special attention. That way when support workers are '*expected to follow strict guidelines for their interactions with clients …'* somewhat dictated by '*financial implications*' they may feel more empowered to take the extra time required to ensure safety as it is, by virtue of the flag, now within their remit.

11. ACCESS mentions audits have not previously shown up the problem with their policy as indicative that it is adequate. This is a classic 'Ignorance fallacy' argument (because something hasn't been proven therefore it isn't) and does not prove anything of the sort.

12. In several places ACCESS asks what standards I am applying when I claim their policy was sub-standard. I have mentioned two above but the main standard I apply to all the work we do in the disability sector is derived from the Hippocratic injunction: *primum non nocere* (above all, do no harm). In this case: ensure policies and procedures ensure the safety, to the greatest extent possible, of the people being supported.

Yours sincerely

John Taylor"