Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 23HDC02211)

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Introduction

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

2. The report discusses the care provided to Mrs A by Access Community Health Limited.

3. Mrs A was diagnosed with motor neurone disease[1] in 2008. Her complaint concerns the availability of support workers, and care that was cancelled, late, or missed, which on occasion left her without support. Mrs A also complained about inadequate communication and a lack of back-up plans, co-ordination of care, trained support, and a dedicated contact for urgent/emergency assistance.

[1] A condition that affects the nerve cells that control the voluntary movement of muscles. The condition causes progressive loss of mobility in the limbs, and difficulties with speech, swallowing, and breathing.

Names (except Access Community Health Limited) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

4. The following issue was identified for investigation:

- *Whether Access Community Health Limited provided Mrs A with an appropriate standard of care between 1 January 2023 and 26 March 2024 (inclusive).*

5. The parties directly involved in the investigation were:

Mrs A	Consumer
Access Community Health Ltd	Group provider

6. Further information was received from Whaikaha|Ministry of Disabled People (Whaikaha).

Events leading up to complaint

Background

7. Mrs A, aged in her seventies, was diagnosed with motor neurone disease in 2008. Mrs A told HDC that after her diagnosis, her needs were assessed by the Ministry of Health, and she started to receive support from Access Community Health Limited (Access) from December 2009 under 'an enabling good lives package[2]'. Mrs A's care is funded by Whaikaha and covers both personal and home management cares.

8. Mrs A's health has deteriorated over the years, and she is now bedbound and lives alone in her own home. Mrs A's goal is to live as independently as possible, to do as much for herself as she can, and to stay in her own home.

9. Mrs A requires full support with most activities of daily living. A schedule provided to HDC by Access dated October 2023 included support workers providing care over seven days a week as follows:

9am until 1.30pm:	Personal cares and meal assistance (with Mondays and Thursdays receiving an extra support worker from 11am until 12pm for shower assistance)
3pm until 3.30pm:	Toilet assistance
5pm until 6pm:	Toilet assistance and dinner
9pm until 9.45pm:	Night settle

10. Mrs A explained that during initial discussions about her care when she was first diagnosed, she was asked whether she needed her day to begin at 6am, 7am, 8am or 9am. Mrs A decided on the 9am start. It was explained to her that by having her care start at 9am, in the rare event that her planned support worker became sick or was otherwise unavailable,

[2] Enabling Good Lives was developed by members of the disability community. It is a foundation and framework to guide positive change for disabled people, families, communities, and governance structures. Its approach is to ensure that disabled people have greater choice and control over their lives and supports, so they can plan for the lives they want.

Access would likely be notified by 7am or 8am, which would allow time for them to ensure that an alternative trained support worker turned up at 9am. Mrs A stressed to Access that by 9am, she was in need of a toilet visit, her medications, drink, and food.

11. In 2015 a 'blue book' was put together by Mrs A, which sits in Mrs A's home. The book sets out Mrs A's routine and tasks to assist support workers. Access was kept updated with what went into the blue book to ensure that there was no health and safety risk to staff and that staff had been trained appropriately to carry out the tasks.

12. In response to the provisional opinion, Access clarified that the 'blue book' was put together by Mrs A and not by Access. Access said that its support plan was the only document that covered off health and safety risk, and also the only document that Access considered met the needs of the referral as assessed by its nurse. Access stated:

> 'The training [Mrs A] describes, is to ensure [support workers] understood her preference for things … It does not correspond to Access' training and induction framework, competencies or NZQA frameworks for training.'

13. Mrs A's condition is progressive, and she has limited use of her hands and arms, limited energy and strength, and very limited upper limb and neck mobility, and often she may feel exhausted and unwell. At her Support Plan assessment on 29 July 2020 (the Support Plan assessment) she was classified by Access with a vulnerable monitoring score[3] of V1, which means that care '***must*** be provided within [one] hour of the scheduled time' and a contingency plan must be completed. As discussed in more detail below, Mrs A's contingency plan included 12 back-up support workers.

14. In relation to her support cares, the Support Plan assessment also highlighted that as Mrs A 'gets very tired and feels dizzy' due to her condition, she is at risk of falls and must be fully supported when walking or transferring. It also states that Mrs A suffers from pain in her entire body 'but mainly on the neck, shoulders, feet, back and her legs'.

Whaikaha's involvement

15. After receiving Mrs A's complaint, HDC made a public interest referral to Whaikaha on 30 August 2023. As the funder of Mrs A's disability support, Whaikaha was well placed to address any performance issues with Access under the terms of its service agreement with the provider.

16. In its reply to HDC dated 17 October 2023, Whaikaha confirmed that it had spoken to both Access and Mrs A.

[3] The National Clinical Group identified tangata-specific circumstances and activities that are likely to increase the person's vulnerability and need for essential care. They are grouped into four categories with scheduled response time, ie, V1 (being the highest category with the fastest response time required due to risks for the individual) to V4 (where the care does not need to be provided within the same day and can be scheduled for another day/time).

17. Whaikaha said that it apologised to Mrs A for the service delivery failure, and Mrs A told Whaikaha that her trust in Access had diminished, but there had been consistent support since her complaint. Whaikaha stated that Mrs A expressed that 'in the past Access ha[d] improved service after a lapse of reliability, but this [was] not always maintained over the long term'.

18. Whaikaha also commented that Access provided a detailed description of the corrective actions it implemented in response to Mrs A's complaint. Whaikaha stated that Access acknowledged that it had 'let [Mrs A] down and recognised that there were significant service delivery and communication failures'. Whaikaha said that Access acknowledged that having provided support to Mrs A for 15 years, the missed support may have been due to a 'sense of complacency about Mrs A's increasingly high needs'. Access also told Whaikaha that it would work with Mrs A 'to ensure her needs [were] recognised and the support team [was] adequately resourced and trained to provide supports as needed'.

Access's policies and processes

19. Access provided HDC with its 'Vulnerable Person Monitoring — V Score' Policy (the VPM — V Score Policy) dated 15 June 2023 (summary attached as Appendix A). This specifies that the time frame for response for a V1 client is that care must be provided within one hour of the scheduled time (as noted above).[4]

20. Access's VPM — V Score Policy states that V1 clients such as Mrs A are likely to suffer from a 'physical or mental decline and/or be admitted to hospital acutely' as a result of not being provided care within one hour of the scheduled time.

21. The VPM — V Score Policy also states that it is the responsibility of the Regional and National Contact Centres and Regional Operations Managers to ensure that there are adequate resources for an appropriate response to vulnerable tangata and their scheduled activities. They also are responsible for ensuring that staff are available to provide a rapid response to V1 tangata.

22. Access's Shift Cover flowchart (see Appendix A) states that the usual process to be followed when a call is received that a support worker has not arrived is that the client is to be called with an amended time if it has been less than 30 minutes since the expected arrival time. However, the flowchart states that if it is more than 30 minutes, the support worker should be replaced.

23. Access's Afterhours Escalation Process policy dated 1 December 2022 (also summarised and attached at Appendix A) states that once the one-hour mark of the care time has passed where replacement care has not been found for a V1 client, the initial procedure is to escalate to staff, including the On Call Clinician and Shift Supervisor. If a carer cannot be found, there are two levels of notification groups of staff (Level 1 and, if no response, Level 2) where a teleconference is to be requested and scheduled to discuss the situation.

[4] Access's previous policy, dated 7 January 2016, specified the same timeframe.

24. If staff are unable to find a replacement support worker, the next step in Access's Afterhours Escalation Process is to request an ambulance. Staff are to advise the reason why the ambulance is required — in Mrs A's case, being unable to resource cares for a high-needs client.

Relevant standards and guidelines

25. Relevant sections of Standards New Zealand's Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (H&DSS) are attached as Appendix C. Summarised below are the expected Outcomes from the H&DSS.

26. In Outcome 1, the H&DSS stipulates the expectations for providers in relation to service delivery. These include knowing and understanding the client's rights, providing service in a manner that complies with those rights, and facilitating support in accordance with the client's wishes. Outcome 1 also states that service providers shall be responsive to a client's identity, which includes their disability and responding in a manner that respects their dignity, privacy, confidentiality, and interdependence. There should also be effective communication, where service providers listen and respect clients and provide information that is easy to access, understand, and use or follow.

27. In Outcome 2, the H&DSS stipulates that service providers shall ensure that the day-to-day operation is managed to deliver effective person-centred and whānau-centred services. This includes ensuring that there are always sufficient healthcare and support workers on duty to provide clinically safe services. Service providers are also to ensure that those healthcare and support workers 'have the skills, attitudes, qualifications, experience and attributes for the services being delivered'.

28. Outcome 3 of the H&DSS relates to the transition, transfer, and discharge of a client's care and stipulates that service providers shall work alongside the client to provide and coordinate a supported transition of care or support, and the service provider shall implement a process for a 'safe, timely, seamless transition, transfer'.

Responses to provisional opinion

Mrs A

29. Mrs A was given an opportunity to respond to the 'Events leading up to complaint' and 'Changes made since complaint' sections of the provisional opinion. Mrs A said:

> 'I never intended to harm Access. Instead I just wished they would improve their mostly good support so that bedbound and high needs clients, often already struggling with a challenging, difficult condition, could depend upon *always* receiving the essential, *punctual* support they need to protect their safety, health and wellbeing.'

30. Mrs A told HDC that she feels that Access implied that some of her needs were 'unrealistic and unreasonable' and that she was 'unreasonably demanding and particular about the support workers sent for training'. Mrs A said that this was absolutely not the case. She stated:

> 'My need for reliability, punctuality and Support Workers who are suitable and adequately trained is universal for all clients living with my situation or a similar difficult situation, especially those who need help with toileting, medication and other support which needs to be punctual — often as well as being challenged with a difficult condition.
>
> For many years this was understood by [Access].'

31. Mrs A also said she feels that some of Access's management had an 'absolute lack of understanding of [her] condition and [Access's] care for [her wellbeing]'.

32. Mrs A stated that she wishes 'Access, their staff and particularly all their clients very best wishes for their futures'.

Access

33. In its response to the provisional opinion, Access stated:

> '[Access was] privileged to care for [Mrs A] for over 15 years, during which time we [did] our utmost best to enable her to live her best life. We were saddened to find ourselves in a situation where the expectations from [Mrs A] did not align with the funding or care type we were contracted to provide.'

34. Access said that its Chief Executive Officer had 'visited with [Mrs A] personally in the past to acknowledge and apologise for the instances where [Access] let her down'.

35. Access stated:

> '[O]ne of the major concerns through this period and the biggest contributing factors to the timeliness of support workers was, in [Mrs A's] words "suitably trained and competent" staff. All the staff that were rostered to [Mrs A's] home had received the required training and competencies to perform that task. We understand and accept that it can be unnerving and tiresome having a new support worker arrive for care, but when there are options of a trained and competent support worker that you don't know versus no support at all, we will always try to find someone to assist. We know this wasn't [Mrs A's] preference and we acknowledge that, however we strongly believe it was in her best interest to receive timely support on those days.'

Opinion: Access Community Health Limited — breach

Introduction

36. First, I acknowledge the difficulties encountered by Mrs A and her courage in bringing her concerns to the attention of HDC and Whaikaha, and I commend her for this. I also acknowledge her honourable reason for bringing the complaint, in that she wishes to instigate change for other bedbound clients who use Access's service.

37. Mrs A is showing great fortitude in choosing to maintain her independence in the face of an increasingly debilitating health condition, and her situation is an inspiration to other people facing similar personal challenges.

38. Access was contracted to provide services to Mrs A under the Enabling Good Lives Package, which is intended to ensure that disabled people have greater choice and control over their lives and support. The weekly home support of 50.25 hours (out of the contracted 50.5 hours) four times daily provided by Access included personal cares, meal assistance, toilet assistance, shower assistance, and home management tasks. Mrs A is an extremely vulnerable consumer in that she is bedbound and lives alone in her own home, and therefore she is entirely reliant on staff to assist her with activities of daily living in a timely manner to keep her well and safe.

39. I have undertaken a thorough assessment of the information gathered, and I consider that Access Community Health Limited breached Rights 4(2) and 4(3) of the Code of Health and Disability Services Consumers' Rights (the Code). I am extremely critical of the care provided to Mrs A by Access. I set out below a detailed discussion of the key issues raised by Mrs A, and the reasons for my decision**.**

Failure to provide support

Mrs A's concerns

40. Mrs A's primary complaint to HDC was in relation to an incident on Sunday, 13 August 2023. Mrs A stated that no support worker arrived for her 9am essential morning shift until 2pm, and until this time, she had been 'waiting to be taken to the bathroom, provided with essential medications, food, drink, etc'. Mrs A described five hours without having support as 'dangerous and cruel'.

41. Mrs A stated that this was not the first occasion of failures in her care by Access. She said that during her 15 years with Access (at the time of the complaint), and due to periodic serious lapses in care, she had found it necessary to write to Access on many occasions explaining her needs so that they would be understood. Mrs A said that having to do this was exhausting and not good for her health.

42. Mrs A told HDC that after her initial complaint made on 19 August 2023, there were further instances of cancelled, late, or missed care as follows:

a) On 29 October 2023 her care was late by two hours (a support worker arrived at 11am for a 9am shift).

— Mrs A told HDC that her sons had planned to take her to the hospital on 31 October 2023, but she had to postpone this as she had passed out (Access believes this is in reference to exhaustive fatigue rather than an unconscious state[5]) on 29 October

[5] In response to the provisional opinion, Access said that it has no record of Mrs A 'passing out'. Access stated that had Mrs A become unresponsive at any point, Access would have expected an ambulance to be called and a recommendation for further medical help, for example at hospital, to be made.

2023. She explained that if her limited strength and energy is managed carefully, she is fine, but if it is not managed when she goes without support, she is not.

b) On 24 November 2023 her care was late by 10 minutes (the support worker arrived at 3.10pm for the 3pm shift).

c) On 11 December 2023 her care was late by 15 minutes (the support worker arrived at 9.15pm for the 9pm shift because the roster had incorrectly stated 9.15pm).

d) On 12 December 2023 her care was late by 15 minutes (the support worker arrived at 9.15pm for the 9pm shift, again because the roster incorrectly stated 9.15pm).

e) On 16 December 2023 her care was late by 17 minutes (a relief support worker arrived at 3.17pm for the 3pm shift).

f) On 3 January 2024 her care was late by 30 minutes (a relief support worker arrived at 5.30pm for the 5pm shift).

g) On 8 January 2024 her care was late by 2 hours 15 minutes (the support worker arrived at 11.15am for the 9am shift).

h) On 25 January 2024 her care was late by 20 minutes (the support worker arrived at 5.20pm for the 5pm shift).

i) On 11 February 2024 her care was late by 2 hours (a relief support worker arrived at 11am for the 9am shift).

— Mrs A highlighted to Access that she was left to 'wait, very uncomfortable and distressed, bedbound for 2 hours unable to sit up, go to the bathroom, take medications, drink or eat'.

j) On 16 February 2024 her care was late by 55 minutes (a relief support worker arrived at 5.55pm for the 5pm shift).

— Access had tried to call Mrs A to notify her of the late cares but were able to reach her only by email at 5.26pm. Mrs A explained that she had been 'lying in bed, desperate for the bathroom after her afternoon rest' and this incident left her feeling very unwell.

43. Mrs A told HDC that her expected outcome in relation to Access's care was to have secure punctuality from support workers every day at 9am, 3pm, 5pm, and 9pm. Mrs A stated that she, and all bedbound clients, should always have the telephone number of a senior, knowledgeable person who can answer the phone promptly between 8am and 10pm every day and make suitable arrangements when necessary.

44. Mrs A described sometimes being 'left feeling anxious, wondering if someone [would] turn up on time or not'. She stated that she is placed at serious risk when a support worker does not turn up. As well as making her unwell, exhausted, and stressed when she has to wait for long periods to go to the bathroom, she has had problems with urinary tract infections because of not receiving punctual support. Mrs A confirmed that this can be very painful for her and especially difficult as she is bedbound. She feels that Access does not understand that vulnerable people are not receiving the appropriate care from Access.

45. Mrs A told HDC that she was concerned for herself and other high-needs bedbound clients who need 'quality, dependable, punctual support to ensure they can be safe, comfortable, stay in their own homes and have a satisfactory quality of life'.

46. Mrs A recognised that there are many 'very kind, pleasant, responsible people' at Access. She said that she had had several permanent support workers and was 'enormously grateful' and very appreciative of their support. However, she said that she could not understand the attitudes of some at Access, who would leave her, as a high-needs bedbound client, 'without care and neglected'.

Access's response

47. Following the incident on 13 August 2023, Mrs A complained directly to Access and copied HDC into her email complaint. In its initial response to Mrs A on 15 August 2023, Access stated the following:

a) It apologised and said that it was doing everything in its power to reduce the likelihood of it happening again;

b) It cannot pay a support worker to be on call to cover her cares;

c) It always talks to Mrs A's support team to ask if they will be available in an emergency, but it cannot influence a team member not being available on the day;

d) It cannot provide a dedicated point of contact within the local team for after-hours care, but the after-hours team should be equipped with the information and resources to manage issues as they arise;

e) It can influence the size of the team and contingency plan information with which the after-hours team can work;

f) It had two advertisements out for support worker roles to grow her team; and

g) Staff in Mrs A's support worker team are asked to complete the motor neurone disease for caregivers training module.

48. In a later response to HDC, Access acknowledged that on 13 August 2023 it did not provide care to Mrs A within one hour of the scheduled time in accordance with its own V1 process. Access stated that this was unacceptable and explained that when it became aware that the relief support worker was unable to work on 13 August 2023, a call was made to Mrs A's next of kin. The call was not answered, and so a message was left at 9.33pm on 12 August 2023 advising that Access would be looking for relief for her care the following day. Access is now aware that this message did not reach Mrs A.

49. In response to the provisional opinion, Mrs A told HDC that she feels that Access's comments regarding 12 and 13 August are 'mostly inaccurate'. She said she cannot understand why her son, and next of kin, was called, as she had told Access previously that he does not have good health. Mrs A also clarified that she had told Access repeatedly that she was always available on her preferred method of communication, namely email or text, and that her landline is obsolete.

50. Access explained that Mrs A was called at 9.24am on 13 August 2023 by its National Communications Centre to advise that Access was still trying to find a relief support worker. Access stated that when a relief support worker was identified at around midday, it communicated this to Mrs A, although Access acknowledged that it was not made clear to Mrs A that the relief support worker was required to attend another high-needs client on the way. This in turn meant that the relief support worker arrived much later than Mrs A had expected.

51. Access told HDC that the relief support worker was due to finish with the other high-needs client at around 12.30pm, after which the support worker was to travel to Mrs A's home, which was approximately 20 minutes away. However, Access explained that there were delays with the delivery of care to the other client, and the relief support worker could not leave the other client as there would have been an 'imminent safety risk' for that client, and so the relief support worker left only at 1.40pm. Access acknowledged that at this point, Mrs A had to call the Communications Centre again to find that the relief support worker was on her way.

52. Access said that the relief support worker did not report Mrs A asking her to assist with medications, or any other significant tasks, or report that Mrs A had soiled herself prior to being taken to the bathroom when she arrived. Access commented that it is unsure how Mrs A managed her toileting or medications prior to the assistance from the relief support worker. However, Access acknowledged that repeated long periods of neglect could result in the development of pressure injury, and that because Mrs A had no fluids available to her, there may have been a risk of dehydration.

53. Access told HDC that the cause of Mrs A's urinary tract infections is outside its scope to confirm or comment on. However, Access stated that it understands 'the discomfort that [Mrs A] describes if bathroom cares are late, with complaints being made when cares are 15 mins behind schedule'. Access advised that it requested Mrs A's permission to meet with her GP to understand how to manage this better.

54. Access said that it had been committed to providing Mrs A with reliable care, but it acknowledged that she was not always provided with the level of service expected. Access accepted that because of this, Mrs A lost faith and trust in Access, which it worked hard to repair. Access sincerely apologised for the continued frustration, stress, and anxiety it had caused Mrs A and her whānau.

55. Access confirmed that the total weekly care delivered to Mrs A was 50.25 of 50.5 funded hours and that this had been approved in line with Mrs A's request for how and when to allocate the funding. Access confirmed that Mrs A had had a team of nine support workers, and five of these had been trained and approved by Mrs A. She also had had 12 approved back-up support workers. Access stated that most care was provided by a particular support worker because of Mrs A's preference and expectations.

56. Access acknowledged that from 1 January 2023 to 8 October 2023, out of 1,200 visits for this period, in 11 instances there were issues with Mrs A's care. Access provided HDC with

a schedule of cancelled/late or missed cares, which sets out the details of the 11 incidents as follows:

a) Three instances of care missed (including the incident on 13 August 2023, and earlier incidents on 29 January 2023 and 24 March 2023, both of which are discussed further below);

b) One instance of care delivered late by more than two hours (the 9am shift on 11 February 2023);

c) Three instances of care delivered late by more than one hour but less than two hours (the 5pm shift on 25 March 2023; the 9am shift on 15 May 2023; and the 9am shift on 26 June 2023);

d) Three instances of care delivered late by less than one hour (the 3pm shift on 18 February 2023; the 9am shift on 13 May 2023; and the 9pm shift on 17 August 2023); and

e) One instance where it was pre-arranged for Mrs A's son to cover a shift so that the rostered support could attend to another high-needs client (the 9pm shift on 7 May 2023).

57. In relation to the missed care on 29 January 2023, the schedule shows that Mrs A did not receive relief support for her 9am morning shift and was left alone without care until her support worker arrived at 3pm. On 24 March 2023, the schedule shows that Mrs A rang Access at 4.32pm and said that she needed to go to the bathroom and that she was bedbound. Mrs A's 3pm shift support worker had not turned up. Mrs A was left alone without care until another support worker turned up for the next shift at 5pm.

58. In response to Mrs A's concern regarding the delay in care on 29 October 2023 (referred to in paragraph 42 above), Access acknowledged this and apologised for the distress caused. Access explained to Mrs A that the 'volume of absences and other cares to be covered at short notice meant [that her] relief was not worked on immediately'. Access said that it was continuing to improve the cover of care relief at short notice. It mentioned that Mrs A did not escalate her concerns to management, which was part of an agreed plan so that the after-hours team knew to prioritise her.

59. In contrast, Mrs A said that it had never been part of any agreed plan for her to call the agency. She stressed that because of her condition/situation, it is 'difficult or impossible for [her] to reach [her] phone and especially when [she is] desperate for the bathroom'. Mrs A also said that sometimes it could take up to 30 minutes before the Access client phone was answered, and often it was by someone who did not know how to help.

60. Aside from the delays detailed in paragraph 56 and the 29 October 2023 delay, Access did not explicitly acknowledge or deny that the other incidents of delayed care outlined by Mrs A (and set out in paragraph 42 above) occurred. However, Access told HDC that many of these missed cares occurred on weekends, and it noted that there are staffing challenges for all community healthcare providers.

61. Access stated that it is committed to the principles of 'Enabling Good Lives' and so sometimes it had agreed to 'unachievable expectations' to meet Mrs A's requests. Access told HDC that it had not fully communicated to Mrs A some of the reasons why her requests could not always be met, despite its best intentions. These reasons are outlined in this report.

My opinion

62. One of Mrs A's expected outcomes from Access was to have secure punctuality by support workers for the four care shifts every day. I consider that this was not an unreasonable request, and I note that under Access's VPM — V Score Policy, Mrs A was classified as V1, meaning that she was to be provided with care within one hour of the scheduled shift time.

63. In addition, Outcome 1 of the H&DSS sets out the expectations for providers in relation to service delivery in a manner that complies with the client's rights and facilitates the client's wishes. Outcome 1 also stipulates that a provider shall be responsive to a client's identity, which includes the client's disability, and will provide care in a manner that respects the client's dignity.

64. Access acknowledged that it did not always provide Mrs A with the level of service expected. Access confirmed that there were 11 instances[6] where there were issues with Mrs A's care during the period 1 January to 8 October 2023. This included that Access failed to provide support workers, which resulted in either missed, late, or cancelled care, and an occasion on which Mrs A's son was asked to provide help.

65. Of the instances of missed care during this period, there were three shifts[7] where no support worker was provided by Access.[8] I note that this left Mrs A waiting for hours for the bathroom and for her medications, food, and drink, which she described as being 'dangerous and cruel'. I am extremely concerned that on two occasions Mrs A had to wait until 2pm for her first necessary cares of the day, especially given Mrs A's condition and her need of support to walk or transfer. In addition, during the same period there were four instances in which there was a delay of over an hour in Mrs A receiving care,[9] which is inconsistent with the requirement for V1 clients under Access's VPM — V Score Policy. I consider this to be unacceptable.

66. Further, I note that after Mrs A's initial complaint made in August 2023 there were further instances of late support being provided for Mrs A (as referred to in paragraph 42 above). These included instances of having to wait for over two hours on 29 October 2023, 8 January 2024, and 8 January 2024, and having to wait for 55 minutes on 16 February 2024. Access has explicitly acknowledged only the two-hour delay on 29 October 2023; however, in the

[6] 29 January 2023, 11 February 2023, 18 February 2023, 24 March 2023, 25 March 2023, 7 May 2023, 13 May 2023, 15 May 2023, 26 June 2023, 13 August 2023, 17 August 2023.
[7] 29 January 2023, 24 March 2023, and 13 August 2023.
[8] This does not include the incident in which it was pre-arranged for Mrs A's son to provide the 9pm cares; although this was a situation in which Access did not provide a support worker, with the help of Mrs A's son she still received the necessary support.
[9] 11 February 2023, 25 March 2023, 15 May 2023, and 26 June 2023.

absence of any evidence to the contrary, I accept Mrs A's account that these further instances of delayed cares occurred as outlined. Again, in my view, these delays were unacceptable. Whilst other delays in care were between 10 and 30 minutes, and I accept that some of these may have been unavoidable, any delays are not ideal, and I acknowledge the impact that even small delays had on Mrs A.

67. I note Access's explanation that the delay in Mrs A receiving care on 13 August 2023 occurred because another high-needs client required care, which if not dealt with would have been an 'imminent safety risk' for that client. This resulted in the support worker arriving at Mrs A's home only at 2pm, when she had gone without essential cares all morning. Mrs A stated that because of this, she developed a urinary tract infection. In my view, Mrs A was also a high-risk client, and if this particular relief support worker could not attend within the hour, other relief should have been sought. I am critical that this did not occur.

68. In previous HDC decisions in relation to failures by support providers, it has been noted that 'a provider who accepts the responsibility for a [consumer] with known risk factors … has always been required to take reasonable steps to minimise the risk'.[10] As in those cases, I consider that Access fell well below an acceptable standard in its care provision to Mrs A. Mrs A said that because of the delay in care, she developed a urinary tract infection and felt very unwell and exhausted. I accept that the failures and delays in providing care to Mrs A made it more likely that she would experience harm. In addition to the harm outlined by Mrs A, as Access has acknowledged, 'significantly delayed or missed cares could also result in the development of pressure injury and dehydration, if no fluids are available to the consumer'.

69. I understand that there are staffing challenges in the support sector and acknowledge that there was a surge in staff illness due to high levels of COVID-19. However, I consider that if a support provider offers a service to a vulnerable and high-needs client, it is incumbent on the provider to be able to meet that service in all foreseeable circumstances, which, in my view, includes during times of staff shortages and staff illness.

70. Access was contracted to provide appropriate and timely support for Mrs A's health and support needs for the allocated hours in accordance with her needs assessment. In my view, and as Access has acknowledged, it failed to do this for Mrs A. As detailed above, on three occasions during the period 1 January to 8 October 2023 Access failed to provide care at all, and on seven occasions during the period 1 January 2023 to 16 February 2024 Access failed to provide care within an hour of the required time. As Access has acknowledged, on multiple occasions it failed to comply with its own VPM — V Score Policy, which requires care to be delivered to V1 patients within an hour. I agree with Access's comment that this is unacceptable, especially as the policy highlights that if the policy is not complied with, clients are likely to suffer from a 'physical or mental decline'.

[10] Opinions 10HDC00356 and 13HDC00164.

71. By leaving Mrs A to wait for the bathroom, and in not giving her medication, food, and drink for hours on multiple occasions, Mrs A was left feeling distressed, unwell, and exhausted to the point of passing out. I am dismayed that this happened to Mrs A, who was extremely vulnerable, and I am very concerned that this continued to happen after Mrs A made her initial complaint.

72. I acknowledge that following Mrs A's complaint, Access made some changes to improve its services. However, given the continued late cares provided to Mrs A, clearly there were still failures in the timeliness of Access's services.[11]

Failure to provide trained support workers

Mrs A's concerns

73. Mrs A stated that when the relief support worker turned up at 2pm on 13 August 2023, she had received no briefing or training from Access, had never met Mrs A, and was unaware of Mrs A's support needs. Mrs A stated that given that there was a five-hour delay in receiving her essential cares, and because by this time she was feeling very unwell, she was unable to 'brief, guide and train' the relief support worker as to what cares she needed and how they should be carried out.

74. In her email to Access dated 19 August 2023, Mrs A also raised concern that at that stage, she had been without a shower for a week and without a hair wash for a fortnight, because the support worker who attended on Thursday (17 August 2023) had not been trained to shower her and wash her hair safely.

75. Mrs A stated that again on 7 December 2023 she was unable to have her weekly hair wash as the relief support worker provided had not been trained. Mrs A advised that on 2 and 3 March 2024 support workers who had not been shown her routine attended for morning shifts, which she said was extremely tiring for her. Mrs A stated that on 4 March 2024, she was sent a support worker who had not been shown her shower routine, and, as a result, it was not possible, or safe, for her to have a shower. Mrs A copied HDC on an email sent to Access on 27 March 2024, in which she stated that Access had sent someone who was 'untrained' and had had no briefing, resulting in the support worker knocking on her door for 15 minutes until she rang the office and the support worker received access to Mrs A's home. Mrs A said that this was stressful and exhausting for her.

76. In its response to the provisional opinion (and paragraphs 74–75 above and paragraph 100 below), Access stated:

> 'The support worker who attended was capable and trained to perform shower assists, however had not received "suitable" training by [Mrs A] over time for her personal regime she prefers. There was no health and safety risk with this.'

77. In her complaint, Mrs A highlighted that in the past when support workers had been away on annual leave, sick leave, or other leave, she had been told by Access that 'a bedbound client with Motor Neurone Disease or other serious condition who does not need medical

[11] I note that since 27 March 2024, Mrs A has been receiving support from a different healthcare provider.

intervention but does always need support to enable them to safely stay in their own home, will always have their health and well-being taken care of'.

78. Mrs A had concerns that some of her regular support workers were being asked to train new support workers when she felt that they had not been trained properly themselves, and she was worried they would pass on poor practices. Mrs A gave examples of support workers not knowing how to make or change a bed and not taking care when vacuuming. Mrs A said that filters on her clothes drier, dish washer, and washing machine were not cleaned, which could lead to a fire hazard. However, she recognised that two of her regular support workers were able to brief a new support worker.

79. Mrs A said that she did not have enough suitably trained support workers to meet all eventualities. She explained that the support workers who showered her and washed her hair (every Monday and Thursday) needed to keep her safe and work efficiently. She said that if this did not happen, her condition would lead her to become weak and exhausted and at risk of passing out, 'as ha[d] happened on at least four occasions, several times resulting in hospitalisation'.

Access's response

80. Access told HDC that it understood that Mrs A preferred support workers who had been inducted into her home and had been shown her specific routine. Access explained that the induction process 'normally takes three visits culminating with a shower care'. Access said that it was happy to facilitate the induction process to enhance Mrs A's experience and make care time less tiring for her, but Access's view is that it was not a clinical requirement to ensure her safety. Access advised that during 2023, in total 21 people were rostered on shifts with Mrs A, and all had been subject to the three-day induction period except for the relief support workers utilised on 25 March and 13 August 2023.

81. In response to the provisional opinion, Access reiterated that it provided a 'competent and fully trained support worker' to be rostered to Mrs A's home. Access stated: 'We cannot hold a workforce of multiple backup staff that have been assessed or vetted by individual clients.'

82. In response to the provisional opinion, Mrs A said that she felt that there was 'an absolute need' to have an induction process, and that this showed a 'lack of understanding or concern for those with Motor Neurone Disease or other challenging conditions' by Access.

83. Mrs A stated that she kept a note of all staff who were sent for the three-shift training, and this was 'far fewer' than the 21 suggested by Access. Mrs A explained that after the first visit, some staff had been rejected by the other support worker 'trainer' and herself as being unsuitable for a high-needs client. She stated:

> '[T]he only Support Workers inducted three times were those who were intended to be rostered for [three] of the [four] shifts. Ie. only once per shift. This is satisfactory for most suitable candidates.
>
> …

> As each shift is different, if a Support Worker will be rostered for several or all of the shifts, they need to be shown all the shift for which they will be responsible.'

84. Access told HDC that 13 August 2023 was during a surge in staff illness due to high levels of COVID-19 affecting several high-needs clients in the region, so relief options were limited. Access said that the relief options were also limited because of Mrs A's expectations around support workers being inducted into her home to learn her routine. Access stated that the relief support worker who was sent on 13 August 2023 was suitably qualified and experienced to be able to provide care for Mrs A. Access acknowledged that it can be exhausting for Mrs A to explain her routine to a relief support worker but said that this was not unsafe.

85. In relation to the ability to roster staff to Mrs A, Access reiterated that this was significantly limited due to Mrs A's requests about who and how people entered her package of care. Access stated:

> '[We do not believe the provisional report reflects] the difference between [Mrs A's] "competent" or "trained" versus industry standards. On multiple occasions we could have provided [Mrs A] with a support worker trained in general competency, medication competencies etc who could have provided the necessary urgent support such as assisting her to walk or transfer to wheelchair to assist her to the bathroom, however [Mrs A] preferred a very strict and limiting process for Access to adhere to which made relieving support workers very difficult to source.'

86. In response to Mrs A's concern that not all tasks were completed on 13 August 2023 and that this had placed her at serious risk, Access stated that the relief support worker who attended at 2pm followed Mrs A's instructions. The support worker said that she was directed to prepare a meal and take Mrs A for a bathroom visit, tasks that were completed successfully. As noted in paragraph 52 above, Access said that the relief support worker was not asked by Mrs A to assist with medications or any other significant tasks.

87. Access told HDC that it considers that Mrs A did not require 'complex care', and all support workers had been trained appropriately to manage her needs. Access stated that Mrs A's restrictions on who she accepted, and how care was delivered, contributed to difficulties with providing urgent relief. Access advised that the view of its national team on the best way to staff Mrs A's package of care was that it could be covered safely with just five to six support workers, whereas at the time Mrs A had 12 support workers recognised in her contingency plan.

88. In response to the provisional opinion, Mrs A told HDC that during the period 2023/early 2024 there were only a few suitable support workers available on her team as opposed to the 12 suggested by Access. Mrs A gave examples of where several were on leave during this time and explained that if the few regular reliable support workers she had were on leave, she considered it would have been 'obvious to management, or anyone, that it would be difficult or impossible to arrange reliable backup/contingency' plans.

89. In response to the provisional opinion, Access stated:

> 'The difference between the [five] "fully trained" and remaining [seven] "approved" support workers was whether or not [Mrs A] had found the[m] suitable for hair washing or not. Considering this task was only twice weekly, it would not be reasonable, nor required to have them all trained to that degree as hair washing is not an essential care.'

90. In response to the provisional opinion, Mrs A said that she felt it was not 'accurate to say [her] support is not complex'. She stated: '[I]t is not difficult or unpleasant but it is certainly more complex than the ability of many of the candidates sent and calls for a wide variety of skills.' Mrs A reiterated her concern that some of the support workers sent to her were not suitable or suitably trained to meet her needs and carry out the necessary cares.

91. Internal meeting notes provided by Access in relation to Mrs A's care contain an entry on 20 July 2023 that refers to an occupational therapist's review of Mrs A's care, which notes that support workers were 'rushing and not taking their time with care'. The meeting notes for 27 July 2023 recognise that because of some of the specific tasks for Mrs A due to her condition, support workers need to show 'compassion and patience'.

92. Access stated that whilst there was one main support worker who cared for Mrs A, Access planned to spread out the care and induct more staff into the team to reduce the risk of staff needing to cover many shifts at short notice.

93. Access told HDC that Mrs A's complaint was the first time it had received feedback about the quality of home management services. Access advised that 'home management tasks are not a cleaning service and therefore may not align with the quality that [Mrs A] expects'. Access stated that it encouraged Mrs A to bring forward any examples of concerns so that it could investigate.

94. In response to the provisional decision, Mrs A said that for Access to suggest that she had 'unreasonably high standards with regard to house management [is] unfair and untrue'.

95. Access told HDC that all Mrs A's team had completed the motor neurone disease for caregivers training module and were due to have face-to-face training.

96. In addition, Access said that Mrs A lives at home with her son, and he would assist with cares when support workers were running late or Access had been unable to find timely relief. However, Mrs A said that this is not the case, as she lives alone at her home. She told HDC that both her 'wonderful, very kind sons' are able to provide only limited support because of their own family commitments and own serious health conditions. This is confirmed by the support plan, although Mrs A confirmed that sometimes one of her sons stays with her.

97. In response to the provisional opinion, Mrs A clarified that there was never an arrangement with Access that either of her sons would be available to provide support when Access was unable to. She said:

> 'I … told Access many many times, verbally and in writing, that my sons are often not available and sometimes they are both out of [the region]. During Covid lockdown one of my sons stayed with me and helped where he could but his help is limited and he cannot attend to all tasks.'

98. In its response to the provisional opinion, Access stated:

> 'This is a routine part of contingency planning and onboarding. Both [Mrs A] and her son accepted this and [it] is common practice in times of need. In the course of [Mrs A's] 15 years with Access, this was used infrequently.'

My opinion

99. Outcome 2 of the H&DSS states that service providers shall ensure that healthcare and support workers 'have the skills, attitudes, qualifications, experience and attributes for the services being delivered'.

100. Access stated that Mrs A's care was not complex, and support workers were trained appropriately to manage her needs. However, Access acknowledged that on 25 March 2023 and 13 August 2023 whilst competent and fully trained relief support workers attended Mrs A, they had not been subject to the three-day induction training period attended to care for Mrs A's specific needs.

101. Whilst Mrs A's needs are specific to her, I acknowledge that the relief support workers who attended on 25 March 2023 and 13 August 2023 were suitably qualified and experienced to provide support and cares generally. However, given that Mrs A had expressed how stressful and exhausted she could become if cares were not provided in an appropriate and timely way by support workers trained for her specific needs, I am of the view that this is something Access should have taken into consideration.

102. I note that Mrs A advised that after her initial complaint, Access continued to send further relief support workers who she considered did not have relevant training specific to her needs — on 24 November 2023, 7 December 2023, and 2, 3, 4 and another date in March 2024. Whilst again I note Access's statement that the relief support workers provided were competent and fully trained, I reiterate my comments around Access not meeting Mrs A's 'specific needs'.

103. As noted above, Access's VPN — V Score Policy states that if cares for a V1 client have not been received within the hour, the client is likely to suffer from a physical or mental decline and/or be admitted to hospital. Mrs A told HDC that delayed cares left her feeling very unwell and not in a position to brief or train her relief support workers.

104. I am also concerned that Access needed to ask Mrs A's son to assist with cares when it was unable to find suitably trained relief support workers. Mrs A has made it clear that although sometimes one of her sons stays with her, he does not live with her permanently. Mrs A also stated that there was never an arrangement with Access for her sons to be contacted by Access to provide relief support. She also confirmed that support by her sons was limited, which is noted in Access's care plan. I acknowledge that there is a discrepancy between the

accounts of Mrs A and Access as to whether there was an agreement for Mrs A's son to provide care if needed as part of contingency planning. I accept that Access's view is that informed consent was obtained, and that Mrs A's son was called upon only infrequently to provide relief support. However, in my view, Access was contracted and paid to provide trained support workers, and it should have met that commitment, and responsibility for this should not have been passed to her sons. Given that some of the cares needed were for intimate personal cares such as toileting and showering and required a certain level of training, I consider this to have been less than ideal for Mrs A.

105. Access referred to Mrs A's restrictions on the carers she would accept and how care was to be delivered, and her expectations around support workers being inducted into her home. Access stated that this contributed to difficulties with providing urgent relief.

106. Outcome 1 of the H&DSS stipulates that support should be facilitated by the provider in accordance with the client's wishes. In my view, Mrs A's support plan and blue book (which I acknowledge was written by Mrs A only, and not by Access) set out those wishes clearly.

107. I note that Access stated that Mrs A had a team of nine support workers, and that five of these were trained and approved by Mrs A. Access also said that one main support worker cared for Mrs A, and its intention was to spread out the care and induct more staff into the team to reduce the risk of staff needing to cover many shifts at short notice. In my view, ideally all nine support workers and the 12 approved back-up support workers should have been fully trained to meet Mrs A's specific needs in the eventuality that relief was required, such as on the dates referred to in paragraph 75 above. This included an instance of a relief support worker who had received no briefing knocking on Mrs A's door for 15 minutes until she rang Access and the support worker was told how to gain entry. I acknowledge that this must have been very frustrating for Mrs A. Given that Mrs A had been with Access for 16 years, and the actions to reduce risks were taken only after Mrs A made her complaint, I am critical of this.

108. Whilst I acknowledge that relief options were limited on 13 August 2023 due to COVID-19 in the region, and that there are staffing challenges for all community healthcare providers, Access had committed to the Enabling Good Lives package for Mrs A. In my view, Access should have been meeting its commitments and ensuring that relief support workers were trained appropriately to meet Mrs A's wishes and specific needs.

109. I am pleased that Access ensured that the support workers in Mrs A's team completed the motor neurone disease caregivers training module, which will be helpful to other clients of Access who have this condition.

Contingency plans and co-ordination of support workers

Mrs A's concerns

110. Mrs A also raised concerns that Access did not have appropriate contingency plans in place to cover situations when her support workers were unavailable, and that there was poor co-ordination of the support workers. With respect to the incident on 13 August 2023, Mrs A stated that one of her regular support workers told her that she had notified Access on the

previous Thursday (10 August 2023) that she was unwell and was uncertain of her availability for Mrs A on 13 August 2023. Mrs A said that this regular support worker confirmed to Access on Friday, 11 August 2023 that she would be unavailable to provide Mrs A's care on 13 August 2023.

111. Mrs A feels that because Access received confirmation from the support worker on 11 August 2023 that she would not be available, Access was forewarned. She considers that Access could have organised a standby relief support worker in readiness for her 13 August 2023 morning care shift.

112. Mrs A told HDC that on 13 August 2023, the same relief support worker who had attended her home at 2pm arrived again at 5.30pm. However, Mrs A's regular 5pm shift support worker had also turned up at the usual required time of 5pm. Mrs A commented that this was a waste of resources.

113. Mrs A gave HDC the following further examples of what she considered was poorly coordinated care and insufficient contingency plans:

- On 30 October 2023, she contacted Access after being advised that her usual Tuesday to Thursday 5pm shift support worker was on leave. The support worker informed Mrs A that she had given three weeks' notice to Access. However, the online roster had still not been updated with cover.
- On 14 December 2023, a support worker due to have training from another support worker at 9pm turned up only at 9.20pm because her roster had been incorrect and two earlier clients had been scheduled at the same time.
- On 25 January 2024, she highlighted to Access that she was aware that a delay of 20 minutes in her 5pm cares was because the support worker had been scheduled to be with another client (who lived 20–30 minutes away) from 4pm to 5pm, and the roster had not allowed for travel time.
- On 29 February 2024 she emailed Access with concerns that one of her regular support workers was showing on her roster even though leave had been booked, and no relief support worker was showing on her roster for that evening and the following evening for the 9pm shift.

114. When complaining to Access, Mrs A mentioned a period where 'Rapid Relief Support Workers' were employed and trained by Access to cover shifts for individual high-needs bedbound clients when required. Mrs A stated that this system greatly improved the situation for a while.

Access's response

115. Access explained that it was aware that Mrs A's main support worker was on annual leave on 13 August 2023, and the relief support worker who had been pre-approved by Mrs A advised Access at 9.30pm on 12 August 2023 that she was unwell and unable to work the following day.

116. Access stated that out of the 12 approved relief support workers in Mrs A's contingency plan, none were able to cover Mrs A's shift on 13 August 2023 because of planned or unplanned leave, no response, unavailability, or an already full roster.

117. Access acknowledged that Mrs A's contingency plan for the weekend of 13 August 2023 was 'insufficient', and that it did not comply with its own after-hours process.[12] Access expressed its disappointment at this, when it felt that it had been working hard with Mrs A to put a 'stable plan' in place. Access apologised that this occurred and commented that 'the time it took to find and provide relief was unacceptable and not in line with [its] own policies and expectations' for clients with a vulnerability score of 1.

118. Access did not explicitly acknowledge or deny that the other incidents of poorly coordinated care and insufficient contingency plans as outlined by Mrs A (and set out in paragraph 113 above) occurred. However, Access told HDC that it cannot always predict traffic and other factors, but appropriate travel time is rostered where possible.

119. In response to the provisional opinion, Mrs A reiterated her concern that rosters did not account for travel time, including for peak-hour traffic.

120. Access also noted that it had only one rapid relief support worker in the region where Mrs A resides, and that support worker is available to cover only Mrs A's 3pm care. Access said that it intends to grow its rapid relief capability in the region.

My opinion

121. Despite Access having a contingency plan in place, Mrs A experienced late, missed, or cancelled essential cares on numerous occasions, as outlined above. In my view, this demonstrates that the contingency plan did not work effectively, and I note that Access has acknowledged the insufficiency of the contingency plan for 13 August 2023.

122. Outcome 2 of the H&DSS states that service providers shall ensure that the day-to-day operation is managed to deliver effective person-centred and whānau-centred services, including ensuring that there are 'always' sufficient healthcare and support workers on duty to provide clinically safe services.

123. I note that support workers appear to have told Mrs A that they had notified Access of a likelihood of being unable to attend to provide cares, or that they would be on leave, giving enough time for relief support workers to be arranged.

124. In my view, the instances of 13 August and 14 December 2023 mentioned above by Mrs A suggest poor co-ordination of the rosters of relief staff, and I note that Access has not denied that these incidents occurred.

[12] As set out in paragraphs 23–24 above, the policy requires that after care has been delayed by over an hour and replacement care has not been found, there should be an initial escalation to staff, including the On Call Clinician and Shift Supervisor. If cares cannot be found, then there are two levels of notification groups of staff (Level 1 and, if no response, Level 2) where a teleconference should be requested and scheduled to discuss the situation. The final step is for an ambulance to be called.

125. I also note Mrs A's concern that Access was not allowing adequate travel time for support workers between clients and/or not allowing sufficient breaks in the day, as described in paragraph 113 above. I recognise that Access has stated that 'appropriate travel time is rostered where possible'.

126. In addition, in the information provided to HDC I identified that Access's rosters had errors, which meant that support workers were arriving late or leaving early. For example, I note that on 26 May 2023, the rosters had to be updated because they had an incorrect time for support workers to leave after the morning cares (the rosters incorrectly had 1pm instead of 1.30pm). Mrs A also said that she received late cares for the 9pm shift on 11 and 12 December 2023 because the roster stated an incorrect time of 9.15pm.

127. I note that Access stated that it cannot always predict traffic and other factors, but that 'appropriate travel time is rostered where possible'. The 'where possible' comment concerns me. Whilst I cannot determine with certainty from the information provided whether the delays in Mrs A's care occurred because insufficient travel time had been included in the rosters or because of other factors, nonetheless I am concerned at this possibility. Access should consider adjusting rosters to allow for appropriate travel time always, not just 'where possible', otherwise it will have a domino effect for other clients. I have made a recommendation around this below.

128. I acknowledge that Access has referred to a high turnover in the 'complex team' role. However, as mentioned above, Access was contracted to ensure that Mrs A's needs were met, and this included ensuring that staff were available and rostered to work the hours identified, as well as ensuring that relief staff were available to cover shifts. There appear to have been several errors and failures in relation to the roster, where staff were allocated unnecessarily or given insufficient time to travel to Mrs A, which caused delays in her care. In my opinion, Access failed to comply with Outcome 2 of the H&DSS and I am also critical of this.

129. It concerns me that when suggesting an arrangement where individualised funding could be used for Mrs A to have direct oversight of her support workers, Access acknowledged that support workers being assigned to other people's care contributed to some of the delays in support workers reaching her. In my view, this also demonstrates that appropriate relief arrangements were not in place.

130. Mrs A stated that the 'rapid relief' support workers improved the situation for her for a time, and I note that Access has indicated its intention to grow the rapid relief capability in the region. I have made a recommendation about this below.

Communication and information provided

Mrs A's concerns

131. When her support worker failed to turn up on 13 August 2023, Mrs A called the after-hours contact team to report this at around 10.15am.[13] Whilst Mrs A praised the manner of the

[13] As noted in paragraphs 48 and 139, Access said that it left a message with Mrs A's son the previous night, but it is now aware that this message did not reach Mrs A.

after-hours staff member, she said that it was clear that no instruction had been given in relation to providing her with immediate 'adequate support'.

132. Mrs A stated that when she was called by Access just before noon, she was told that the relief support worker would be with her in approximately half an hour because of the travel distance. Mrs A said that she was told that this support worker had visited her previously, but this was not the case.

133. Mrs A said that at around 1.30pm when the relief support worker had not arrived, she made a further call to Access and was told that it would be another half hour or so, and this time she was told that the support worker would be travelling from another area.

134. Mrs A can access an online roster schedule called 'MY ACCESS Records' to see which support worker has been scheduled. However, she stated that when this lapse of care occurred, the online roster for 13 August 2023 contained inaccurate information that the support worker who had turned up at 2pm had been present for the 9am to 1.30pm shift, instead of stating 'failure to provide a support worker'.

135. Mrs A told HDC that on 29 January 2023, when she had not received her morning cares, she made several calls to Access. One call was made at approximately 11.51am (nearly three hours after her carer had not arrived) and she was advised that Access was still looking for relief. She made a further call around an hour later and stressed that she needed to go to the bathroom straightaway. Access's Care Coordinator asked Mrs A if Access could send a relief cover to undertake all her cares together that day. Mrs A said that she had to explain to the Care Coordinator that she needed cares at 9am, 3pm, 5pm, and 9pm daily. A relief support worker arrived to provide cares for Mrs A only for her 3pm shift, and so the morning care was missed completely.

136. Mrs A said that at 2.30pm on 16 December 2023, she received communication from Access's after-hours service that a relief support worker would be arriving 17 minutes late for the 3pm shift, but she understood that the support worker had notified Access at 1.35pm that they would be unable to attend the shift.

137. Mrs A stated that at 5.13pm on 3 January 2024, she had to send an email to ask where her 5pm shift support worker was, as she had received no communication from Access about a delay.

138. Mrs A also stated in an email to Access on 27 March 2024 that on a previous occasion when she had not received a support worker for two hours, the Access telephone number for clients was not answered for 35 minutes. Mrs A said that she did not receive a reply from any of the numbers she had been given.

Access's response

139. With respect to the incident on 13 August 2023, Access acknowledged (as discussed in paragraphs 48, 50, and 51 above) some issues in its communication with Mrs A at the time, specifically:

- Its message to Mrs A's son on 12 August 2023 informing him that the usual support worker was not available for the following day and that it was looking for a relief support worker did not reach Mrs A.
- When it contacted Mrs A after identifying a relief support worker at midday on 13 August 2023, it was not made clear to her that the relief support worker was required to attend another high-needs client on the way, which meant that the relief support worker arrived much later than Mrs A had expected.
- Mrs A had to call the Communications Centre again at approximately 1.40pm to find that the relief support worker was on her way after further delays.

140. Access also stated: '[I]t [was] not the intention [to] withhold information from [Mrs A], and [we] understand the discomfort caused by the late arrival of our [support worker].'

141. The schedule provided to HDC by Access also showed late, short notice, or failed communications to Mrs A on 10 occasions between 29 January 2023 and 17 August 2023. Whilst these are described as 'late communications', it appears that in most cases it was Mrs A who had to call Access to find out where her support worker was, and generally after the time the support worker should have arrived. In other words, often Access did not proactively communicate with Mrs A about anticipated delays to her care being provided.

142. The Client Diary Note Reports provided by Access to HDC contain an entry for 26 May 2023 in which Mrs A queried why her weekend morning shift finished at 1pm instead of 1.30pm. In addition (as referred to in paragraph 126 above), according to a further entry on 26 May 2023, a message was sent by the Senior Care Coordinator to Mrs A's team advising them that support workers should in fact be leaving at 1.30pm and not 1pm, and that the 'rosters ha[d] been updated'.

143. In relation to communication of new relief where a support worker had failed to turn up (eg, 16 December 2023), Access told Mrs A that a call to her at 2pm (in other words, an hour before the shift in question was due to start) notifying of finding relief is 'in line with [Access's] expectations of communication timelines'. Access recognised that Mrs A wanted her team to arrive punctually and 'on the hour' but said that 'in times when [Access was] looking for relief at short notice, this [was] not always … possible'. Access explained that it had to 'juggle' some of the clients on the relief support worker's roster so that she could attend to Mrs A, which made advising Mrs A earlier not feasible.

144. Access told HDC that Access and the clinical team offered to meet with Mrs A to conduct a review of her cares, but she did not commit to a visit. Access confirmed that the last home visit by the clinical team occurred in February 2022, and the last clinical review of Mrs A's care occurred on 12 September 2022 over the phone.

145. In response to the provisional opinion, Mrs A stated that when Access had offered to visit her again to discuss her needs, she was already 'exhausted and unwell, having struggled for a very long time to secure the *reliable punctual* support' she needed. She had also had a very recent meeting on 12 October 2023 from Access's nurse.

146. Access stated that it agreed to provide Mrs A with details of her weekend roster on Thursdays, including who would cover her shifts in the event of absence, to provide her with some reassurance in advance. Access stated that it agreed to do this because of Mrs A's lack of trust in Access, even though the request was outside normal process, which was for her to contact the National Communications Centre.[14]

147. Access stated that it understood that if no one was scheduled on Mrs A's roster on 'MY ACCESS', this would heighten her anxiety. However, Access told HDC that because of continued capacity issues, at times the information was not available on a Thursday and could be confirmed only closer to the care time, and so Access was 'unable to give her the peace-of mind she request[ed] on a Thursday'.

148. Access advised that there is no code on its 'MY ACCESS' system to input failure to provide a support worker. Instead, it uses 'Coordination Error', and notes are attached to the shift cancellation explaining what has happened. Access said that both the instances of inaccurate information raised by Mrs A in relation to her online roster (referred to in paragraphs 113 and 134 above) were recognised and have since been corrected.

149. Access accepted that its phone wait times can be long and confirmed that Mrs A had the personal contact number of the Chief Executive Officer and Director of Access Community Health, who had advised her that she could call her any time. Access also stated that Mrs A had the after-hours contact information for the Regional Manager, Regional Operations Lead, and Care Co-ordination Team, whom she had contacted on weekends in the past and had received assistance. Access considers that this was over and above what was required. Access confirmed that none of these people were contacted by Mrs A regarding any issues on 13 August 2023.

150. In response to the provisional opinion, Mrs A stated that she appreciated the mobile telephone numbers provided to her by Access. However, she stated that she 'did not ever want to, or have the energy to call a string of numbers, or any at all' and would certainly not have required them, had her support been reliable and the after-hours client number answered promptly.

My opinion

151. Outcome 1 of the H&DSS states that service providers shall listen and respect clients using effective communication about their choices and provide information that is easy to access, understand, and use or follow.

152. On many occasions Mrs A had to call Access to find out where her support was, and sometimes she was given inaccurate information about when the relief support worker would arrive and from where the support worker would be coming. I note that on 29 January 2023 and 13 August 2023 Mrs A made several calls when she had been left all morning without essential cares. I consider that Access should have been contacting Mrs A

[14] Access's National Communications Centre hours are 6am–10pm daily, including weekends and public holidays. There is also an after-hours escalation process available to the national care coordination team when it struggles to provide relief.

proactively and updating her continuously when it was looking for a support worker to cover a shortfall, or when it was aware that cares might be delayed. I am critical that it did not do so on several occasions.

153. I note from the 29 January 2023 communication Mrs A had with Access that she had to explain to the Care Coordinator that it was not possible for a relief support worker to cover all her cares at the same time after this was suggested. Access also acknowledged that on 13 August 2023 information about when the relief support worker would arrive was not made clear to Mrs A, and it accepts that this was much later than Mrs A had been expecting. I note that these were not the only occasions on which this happened,[15] and it must have been very frustrating and distressing for Mrs A. I am critical of this.

154. I also note that the message left by Access with Mrs A's son on 12 August 2023 did not reach her, and, in my view, Access should have followed up to ensure that Mrs A was aware that there were difficulties with finding a support worker for her for the following day.

155. Mrs A also raised concerns with Access about her online roster not reflecting accurate information, including when a support worker was on leave and/or not being updated to show that support workers had not arrived.

156. Access acknowledged that there were errors on Mrs A's roster, which subsequently were corrected. Access said that because of continued capacity issues, it was not always able to give Mrs A peace of mind by updating her weekend roster by Thursday. Given that Mrs A's wishes were to have reassurance that there was cover, especially when she had been let down many times, I consider that having accurate information on her roster was not an unreasonable request.

157. Whilst Access agreed to give Mrs A her weekend roster on a Thursday, despite normal process being to contact its National Communications Centre, Mrs A stated that in March 2024 she spent 35 minutes waiting for someone to answer her call when she had not received a support worker for two hours. Mrs A said that often it was the case that the person who answered the phone was unable to help. Access accepted that telephone wait times can be long. I am concerned that if this is normal process for clients, a wait time of 35

[15] Further instances referred to from Access's schedule of late/missed/cancelled cares include:
24 March 2023 — Mrs A was told at 3.01pm that Access was trying to source relief cover for her 3pm cares, and no support worker turned up;
25 March 2023 — Access had tried to call Mrs A at 4.32pm to advise that relief was to be sourced for her 5pm cares. Mrs A called at 5.14pm to locate the support worker and Access ascertained that the support worker could not complete the call;
13 May 2023 — Mrs A was told at 9.21am that the support worker was approximately 15 minutes away and eventually the support worker arrived an hour later than the scheduled support rostered time;
15 May 2023 — At 9.45am Mrs A received a follow-up to an email she had sent and her missed call that no support worker had arrived for her 9am shift. Access explained that it was on the back foot as the support worker had rung at 7.25am to advise that she would be unable to attend. Mrs A was advised that Access would get someone to provide support as soon as possible, and eventually cares were provided 90 minutes late; and
26 June 2023 — Mrs A called at 9.45am to advise that her 9am carer had not turned up and was told that Access would organise a relief carer. The Regional Manager missed a call from Mrs A and then called her back. Access's schedule indicates that a relief support worker had been found by 10.40am.

minutes was not acceptable for Mrs A, and nor is it acceptable for other clients. I am critical of this and have made a recommendation below.

158. I acknowledge that Access provided Mrs A with after-hours contact information for senior staff at Access and told her that she should escalate concerns to management. However, Mrs A disagreed that she was told this, although I note that in an email of 27 March 2024, Mrs A stated that she had not received a reply from any of the numbers she had been provided with after having waited 35 minutes for the National Communications Centre. In any event, this 'agreed plan' with Mrs A was against Access's own after-hours escalation process and shift cover process. I am unable to conclude whether this was agreed with Mrs A, but if Access did provide this service to Mrs A, I am concerned about what may be happening with wait times for other clients in its service.

Transfer of care

159. In response to the provisional opinion, Access stated that it met with Mrs A at her home in 2023 due to 'repeated issues with being able to sustain staff in Mrs A's home, often due to the tasks being requested being over [and] above what was expected of them in most other homes'. Access said that it began to engage with Mrs A in person to discuss 'how [Access] could do better to support her (alongside her quite intensive regimes) and if that meant a transition to another supplier [Access] would do that'. Access told HDC: '[Mrs A] repeatedly declined every request to meet.'

160. On 25 January 2024, Access suggested by email that it might need to exit as Mrs A's care provider formally if it could not find resolutions to her ongoing concerns. Access suggested an arrangement in which individualised funding could be used for Mrs A to have more direct oversight of her own support workers (discussed further below). Following this suggestion by Access, Mrs A raised concern about managing her own roster, as she felt that this was the role of Access.

161. In response to the provisional opinion, Access said that '[t]his was not a sudden decision on 25 January 2024 in retaliation to a complaint' and that it was 'quite the opposite'. Access stated:

> '[A]fter much discussion with all stakeholders it was determined a fresh start for [Mrs A] would be beneficial. We worked closely with the N[eeds] A[ssessment] S[ervice] C[o-ordination (NASC)] [16] over many months to ensure a smooth as possible transition occurred including offering our staff to train with her new provider's staff. [Mrs A's] family, the NASC and Motor Neurone Disease Association were included in the transition conversations.'

162. Access's email also said that the 'team' felt a huge sense of failure when staff were unable to attend at exact times on the roster and stated: '[T]o arrive "on the hour" is proving

[16] A team who carries out needs assessments for people who are living with a disability, are 65 years or older, or have mental health problems. NASC teams work with relevant people and their families to provide the support they need to help them to stay independent or get the best possible help to maintain their quality of life. See: https://www.govt.nz/browse/health/help-in-your-home/needs-assessment/#what

unachievable in our current contracting environment.' Access confirmed to HDC that it did not cease to provide support for Mrs A until a new provider had been found.

163. When Mrs A raised concerns around individualised funding meaning that she would be overseeing her own care, on 31 January 2024 Access advised Mrs A that it accepted that it might not be the 'right fit for [her]' and offered to meet with NASC to discuss other options.

164. Access met with NASC on 8 February 2024 and confirmed to Mrs A that Access would be transferring her care to another provider. The Cease Notice provided to Mrs A was dated 5 March 2024.

165. On 13, 15, and 26 February 2024, Mrs A asked Access via email if any major changes, such as the transfer of her care, could be done 10 days after some hospital appointments she had on 11 and 26 March 2024 in order to cause her less stress, as these appointments left her feeling tired. She also asked for a 'smooth, seamless changeover to protect her health and well-being'. Mrs A said that despite this, Access planned for her transfer to take place on 26 March 2024. She said that after almost 17 years of being with Access, she felt it was 'very unkind and uncaring of them'.

166. Access confirmed that on 6 March 2024 a meeting was held at Mrs A's home to discuss the timing of her transfer of care. Mrs A's long-term carer was on leave and was needed to train new support workers for Mrs A, and consideration needed to be given to Mrs A's upcoming hospital appointment on 26 March 2024. Access stated that it had already extended the handover date to 26 March 2024 and had already re-deployed its support workers to a different client after that date. Access arranged for the new provider's support worker to shadow Access's support worker on the last day (26 March 2024) so that the transition could happen on the following day, 27 March 2024.

167. Access stated: '[I]t is not the outcome we wanted after so many years together, but feel a fresh start may be a good way forward.'

168. On 10 and 13 February 2024 Mrs A again expressed her concerns to Access about the transition to another provider. She said that she could not understand the reasons for being transferred as she did 'not require anything outside contractual obligations' and she felt that it was not unreasonable to need reliable and punctual support. Mrs A also said that because of her condition, it would be 'considerably exhausting and a difficult situation' for her to pursue a new provider.

169. On 27 March 2024, Mrs A's care commenced with another agency. Mrs A told HDC that she felt optimistic that the new agency would be reliable and punctual.

170. Mrs A feels that she has been adversely affected because of raising her various concerns with Access and because of her complaint.

My opinion

171. Access confirmed that it was only after many months and discussions with all stakeholders, including attempts to meet with Mrs A, that it then emailed Mrs A on 25 January 2024

suggesting that a 'fresh start' with another care provider outside of Access might be a better option for her. Access also mentioned its staff's sense of failure when they were unable to attend at exact times and said that 'to arrive "on the hour" was proving unachievable in their current contracting environment'.

172. It is clear that Mrs A did not want a change of provider, and on numerous occasions she stated that she wanted only for 'quality, dependable and punctual' support workers to turn up when she needed them and in accordance with the agreed scheduled times. Despite Mrs A being against the change, Access proceeded with the transfer of her care to another provider because it could not meet her needs. Mrs A feels that she has been adversely affected by this, and I am concerned that this was the action Access felt was necessary because it could not meet her needs. I recognise that Access offered opportunities to meet with Mrs A and she declined. However, I also accept Mrs A's reasoning for her preferred method of communication by email or text. I also acknowledge that discussions were had by Access with all stakeholders. However, as the client, Mrs A's views should also have been taken into account when making the decision to transfer her care, and I am concerned that given Mrs A's feelings about the transfer, such consideration may not have occurred.

173. Notwithstanding that Access did attempt to involve Mrs A in discussions, I remain concerned that nonetheless it decided to proceed with the transfer against her wishes. I have made a recommendation about this below.

174. When Mrs A realised that she would have no choice but to transfer to another provider, she asked whether this could be done 'smoothly and seamlessly' so as not to cause her harm or distress. I note that on 13, 15, and 26 February 2024 Mrs A asked Access not to make the change to the new provider until 10 days after 26 March 2024 because of how exhausted she would be from her hospital appointments. However, Access continued with the transfer on 26 March 2024, being the date of one of Mrs A's hospital appointments.

175. Outcome 3 of the H&DSS stipulates that service providers shall work alongside consumers to provide and coordinate a supported transition of care or support, including a safe, timely, seamless transition. Access's decision to proceed with the transfer despite the concerns raised by Mrs A and her reasonable request for it to be delayed by less than two weeks meant that the transfer was not seamless and potentially was unsafe.

Conclusion

176. As Access will be aware, the Enabling Good Lives principles outline what good support should look like for both the consumer and the provider. In particular, its approach is to ensure that disabled people have greater control over their lives and supports, with the principles aiming to promote greater choice, control, and inclusion. Access is aware that this is no longer a 'one-size-fits-all' approach and should be more person-centred and responsive to individual needs.

177. In my opinion, as a service provider, Access did not fulfil its obligations to Mrs A to meet her needs under its contract and the Enabling Good Lives Package. I am very concerned that by not providing an appropriate service to Mrs A, Access caused harm to her when she was

already managing the challenges of her condition. I find that Access breached Mrs A's Rights under the Code as follows:

Failure to provide support; failure to provide trained support/contingency plans; and co-ordination of support workers

178. Right 4(3) of the Code states that every consumer has the right to have services provided in a manner consistent with his or her needs.

179. Access acknowledged that it did not provide services that were consistent with Mrs A's needs, including missed or delayed cares and poor contingency plans, which significantly increased the risk that she would become exhausted and unwell. I consider that for a person who is entirely reliant on others to use the bathroom, significant delays in receiving those cares would have been distressing for Mrs A. I note that she has described waiting five hours to use the bathroom and receive other cares as 'cruel'. Access also should have taken into consideration Mrs A's 'specific' needs in providing suitably qualified and experienced support workers.

180. I consider that Access failed to comply with Outcomes 1 and 2 of the NZHDSS standards as well as its own VPM — V Score Policy for a V1 client and its after-hours policy, by failing to provide care within one hour of the scheduled support time or to request an ambulance for Mrs A after this time. These deficiencies represent an overall failure to provide care to Mrs A in a manner that was consistent with her needs. Accordingly, I find that Access breached Right 4(3) of the Code.

Communication and information/transfer of care

181. Right 4(2) of the Code states that every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

182. By failing to ensure that Mrs A received accurate and timely communication regarding her support and her roster, resulting in delays or shortened care times, Access failed to comply with Outcome 1 of the NZHDSS standards.

183. Access also ended Mrs A's care following her complaint, despite her being against this change in provider. By failing to listen to her concerns about when the transfer should take place, Access failed to comply with Outcome 3 of the NZHDSS standards. Accordingly, I find that Access breached Right 4(2) of the Code.

Changes made since complaint

Access

184. Access told HDC that to get on top of what appeared to be an escalation of issues, on 6 July 2023 Access's Regional Manager initiated a weekly meeting. This was attended by all their relevant coordination, management, support worker team lead, and clinical support workers. Access explained that in this meeting, 'all stakeholders engage[d] to work through a planned review of [Mrs A's] care as a result of concerns she had been raising that had remained unaddressed'.

185. Access told HDC that in the inaugural meeting, staff discussed engaging with Mrs A with a view to improving future service in areas of focus, such as engaging with Motor Neurone Disease New Zealand,[17] growing the team, training the existing team, enhancing rosters, providing resources and information to the after-hours team, and growing its rapid relief capability in Mrs A's region.[18]

186. Access stated that as a result of the telephone message to Mrs A's son not reaching Mrs A on 12 August 2023, the team updated the warning note on her file to make clear that communications must go through Mrs A's preferred escalation pathway.

187. Access told HDC that it is carrying out a national review of home management services to ensure that staff are 'well-trained and competent to deliver home management and personal care'. Access has also updated its policies and procedures and added competency assessments for specific home management tasks such as 'cleaning, laundry and waste management', and 'food preparation and assisting with meals', to reflect the requirements of clients.

188. Access stated that it introduced control measures to improve performance in relation to short-notice absences and communication with clients.

Recommendations

189. I recommend that Access Community Health Ltd:

a) Provide a written apology to Mrs A for the breaches of the Code and failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Reflect on the deficiencies in care identified in this case, particularly around not meeting contractual requirements to be able to provide support in accordance with Mrs A's wishes, and provide a written report to HDC on its reflections and any further changes instigated as a result of this case. This information is to be provided to HDC within six months of the date of this report.

c) Undertake an audit of cares for 10 randomly selected V1 clients in the area to identify/determine:

   i. the degree of late/missed or cancelled cares for each client for the month of January 2024; and

   ii. the degree of compliance with its after-hours escalation policy as applicable for each client for the month of January 2024.

   A summary of the findings with corrective actions to be implemented is to be provided to HDC within six months of the date of this report.

[17] A charitable trust dedicated to making time count for people living with motor neurone disease. This includes funding research, improving care, and providing support for people with motor neurone disease and their families and carers.

[18] Full details of what Access intends to do to improve these areas of focus can be found at Appendix B.

d) Undertake a review of all its V1 clients transferred to another service provider during the period January 2023 to January 2024 to determine how many complaints those clients made and whether the complaints were a contributing factor to the transfer. This information is to be provided to HDC within six months of the date of this report.

e) Provide HDC with the outcome of the national review of home management services and a summary of the findings, with any corrective actions to be implemented, within 12 months of the date of this report.

f) Audit the records of 20 V1 clients to ensure that the staff working with them over the last three months have passed the necessary competency assessments to meet the requirements of those clients. A copy of the new competency assessment framework and a summary of the audit findings, with corrective actions should non-compliance be identified, is to be provided to HDC within 12 months of the date of this report.

g) Carry out a review of late cares of V1 clients over a month-long period to ascertain whether enough travel time was allocated for support workers in their rosters. A summary of the findings, with any corrective actions identified, is to be provided to HDC within six months of the date of this report.

h) Undertake an audit of wait times of calls to its National Communications Centre over a month-long period to identify an average wait time for clients who call its service. A summary of the findings, with corrective actions to be implemented, is to be provided to HDC and Whaikaha|Ministry of Disabled People within six months of the date of this report.

i) Evaluate whether the relief worker system is appropriate and meets the needs of clients. A summary of the findings and any corrective actions to be implemented is to be provided to HDC within six months of the date of this report.

190. I recommend that Whaikaha|Ministry of Disabled People consider the issues outlined in this report, including concerns about Access's capacity to provide person-centred care for high-needs clients, and report back to HDC with any actions it plans to take in response, within six months of the date of this report.

Follow-up actions

191. A copy of this report with details identifying the parties removed, except the name of Access Community Health Limited, will be sent to the Ministry for Social Development and Whaikaha|Ministry of Disabled People and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

192. A copy of this report with details identifying the parties removed, except the name of Access Community Health Limited, will be sent to ACC as the circumstances of this case will more than likely have some relevance to the high and complex needs clients it supports.

193. HDC is aware that currently the Health Quality & Safety Commission|Te Tāhū Hauora is developing a consumer home and community support services experience survey. A copy of this report with details identifying the parties removed, except the name of Access

Community Health Limited, will be sent to the Health Quality & Safety Commission| Te Tāhū Hauora with a suggestion that the report be used to inform the development of survey questions.

Appendix A: Access policies and procedures

The following sections of the 'Vulnerable Monitoring Score — V Score' Policy and the 'Afterhours Escalation Process', which includes flow charts referred to, have been outlined as relevant to this report:

Vulnerable Monitoring Score — V Score Policy

'**V1** = care ***must*** be provided within 1 hour of the scheduled time

Where activities are unable to be completed within 1 hour of the scheduled time, the tangata/person is likely to suffer from a physical or mental decline and/or be admitted to hospital acutely.

…

Responsibilities

1. **Regional Manager (RM), National Contact Centre Manager (CSRM), Regional Operations Manager**

    a. Ensure all operational staff have completed training relevant to their role, to provide effective identification, monitoring and support to vulnerable tangata

    b. Ensure adequate resource to enable identification and appropriate response to vulnerable tangata and their scheduled activities.

    c. Ensure maintenance of a roster of [Care Coordination/National Call Centre] to receive and respond to alerts and escalate appropriately

    d. Identify and document a regional/business service escalation pathway to enable staff to identify and notify the appropriate role/person where an alert has been raised and or cover for V1 to V3 tangata will not be timely

    e. Ensure tangata receive support activities as scheduled and within identified V Score timeframes

    f. Ensure a review and response plan for tangata who did not receive support activities as scheduled and within identified V Score timeframes

    g. Ensure that Funders are made aware of any concerns about a tangata using funder reporting guidelines as appropriate to that Funder

    h. Assignment of senior staff to provide advice and direction to CC/NCC where triaging of scheduled activities is required

    i. Ensure that there are staff available to provide a rapid response to V1 tangata'

Afterhours Escalation Process

'Procedure*CC/ NCC notifies their NCC shift supervisor (escalation to SS should occur at the 1-hour mark or the care time has passed)*

- NCC Shift supervisor notifies OCC and provide briefing on situation
- OCC to review
    - Possible cares to be cancelled that will not affect client
- OCC to phone tangata and/or NOK to advi[s]e of situation and discuss the plan if able to be resolved
- If unable to resolve, OCC to contact SS to notify them
- SS to send out level 1 notification group requesting teleconference
- If no response to Level 1 after 10 minutes, send out to Level 2 notification group

…

Requesting an ambulance for social admission

A request for an ambulance should always be made by a clinician where possible to avoid unnecessarily high priority responses or clinical call-back.

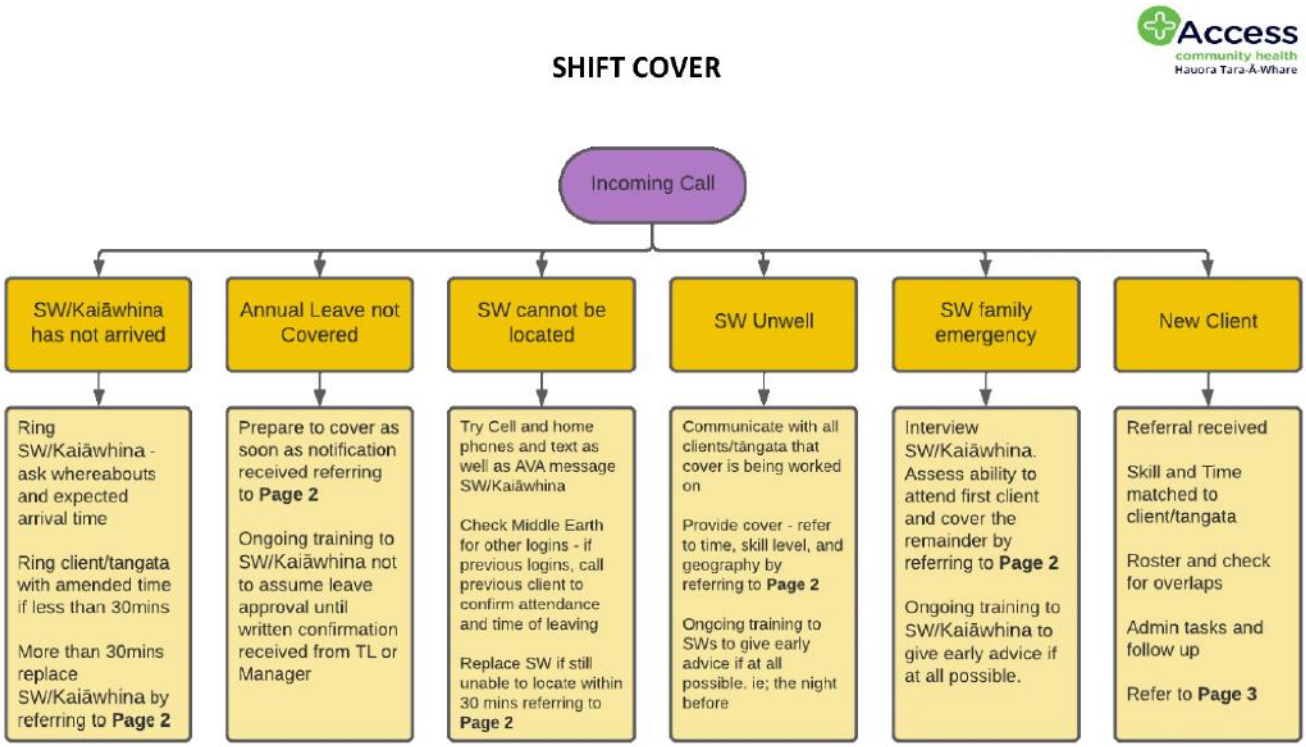
On call clinical to call ambulance services clinical referrals line (nationwide): **0800 262 665**

Information you will need:

Client;

- Address
- Phone number
- Reason for the ambulance (high needs/complex/tetraplegic client etc and unable to resource cares).
- Urgency (not life threatening so should always be a non-urgent response)
- Destination hospital/rest-home
- Name
- DOB'

Shift Cover flow chart from Access's Afterhours Escalation Process policy



Names (except Access Community Health Limited) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Primary areas of focus to improve service for Mrs A as outlined in Access's response

'a. Engage — gain a better understanding of [Mrs A] and her circumstances by engaging with the Motor Neurone Disease Association and occupational therapist;

b. Grow the team — Introduce new [support workers] to [Mrs A's] team with an emphasis on finding good personality matches. Improve upon existing advertising material for support worker roles in [Mrs A's] home;

c. Train the existing team — Meet with the team to set very clear expectations of what [Mrs A] needs and why. Engage with [Motor Neurone Disease New Zealand] to gain training opportunities for the [support workers]. As of 11 October, [Mrs A's] full team have completed the online [Motor Neurone Disease] training package and the Operations Leader for Community is engaging with [someone] from [Motor Neurone Disease NZ] to arrange face to face training;

d. Enhance the rosters — Complex care coordinators to make a deliberate effort to review not just [Mrs A's] roster but also the roster of each [support worker] that cares for her to ensure there is always appropriate travel time. The roster must also be rebalanced by sharing more of the cares between the different [support workers] in this team;

e. Provide resources and information to the after-hours team — By building up the team and enhancing the trained state of the [support workers] in the team, it will become steadily easier for the after-hours team to manage short notice relief, however this information needs to be available and accurate. The complex care coordinator is responsible for keeping the coordination contingency plan up to date; and

f. While we have an existing rapid relief [support worker] who is inducted in [Mrs A's] home, we intend to further grow our rapid relief capability in [Mrs A's] region.'

Appendix C: Relevant sections from Standards New Zealand's Ngā Paerewa Health and Disability Services Standard NZS 8134:2021

'Outcome 1: Our rights

People receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respect[ful] of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs'

'1.3 My rights during service delivery

… As service providers we provide services and support to people in a way that upholds their rights and complies with legal requirements.'

The relevant criteria for 1.3 states:

'1.3.1 My service provider shall know and understand my rights and ensure that I am informed of my rights.

1.3.2 My services shall be provided in a manner that complies with my rights.

…

1.3.4 My services provider shall facilitate support for me in accordance with my wishes, including independent advocacy.

…

1.4 I am treated with respect

…

As service providers we provide services and support to people in a way that is inclusive and respects their identity and their experiences.'

The relevant criteria for 1.4 states:

'…

1.4.2 My service provider shall be responsive to my identity, which could include my values and beliefs, culture, religion, disabilities, gender, sexual orientation, relationship status, and other social identities or characteristics.

1.4.3 My services shall be provided in a manner that respects my dignity, privacy, confidentiality, and preferred level of interdependence.

…

1.6 Effective communication occurs

…

As services providers We listen and respect the voices of the people who use our services and effectively communicate with them about their choices.'

The relevant criteria for 1.6 states:

'…

1.6.1 I shall receive information in my preferred format and in a manner that is useful for me.

…

1.6.6 My service provider shall make communication and information easy for all people to access; understand; and use, enact, or follow.'

Relevant sections of Outcome 2 regarding the quality of services received from the H&DSS are outlined below:

'2.3 Service management

…

As service providers We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.

…

2.3.1 Service providers shall ensure there are sufficient health care and support workers on duty at all times to provide culturally and clinically safe services.

2.3.2 Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience, and attributes for the services being delivered.

…

2.4 Health care and support workers

…

As service providers We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.'

Relevant sections of Outcome 3 of the H&DSS are outlined below:

'3.6 Transition, transfer, and discharge

…

As service providers We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.

…

3.6.1 Service providers shall implement a process to support a safe, timely, seamless transition, transfer, or discharge.'