Pasifika Integrated Health Care Limited

Caregiver, Mr D

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC01204)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr B, aged 35 years, has a significant intellectual impairment. At the time of these events he was living at home with his mother, who was his primary caregiver. Mr B has limited eyesight in his left eye, but is independent with his personal cares. He speaks very little English, which is his second language.

2. On 30 March 2007 Pasifika Integrated Health Care Limited (Pasifika) was contracted to assist Mr B with daily activities in the community for two days per week. Pasifika utilised "Personal Care" funding to provide a "Community Engagement" programme for Mr B.

3. In June 2010 Pasifika arranged for Mr B's services to be provided by Mr D. Mr D speaks very limited English and does not speak any of Mr B's first language. Mr B and Mr D communicated by way of signs, gestures and simple English words. Mr D had not undertaken any disability focused training.

4. On multiple occasions Mr D took Mr B to his (Mr D's) home, where Mr B watched television for lengthy periods. On one occasion Mr D slept while Mr B watched television.

5. On a number of occasions Mr D pinched Mr B's ears, hit him on the head and engaged in rough play. Mr D told Mr B to clean the toilet after Mr B had used it. While Mr D was fishing he left Mr B in a vehicle and, on some occasions, went into shops leaving Mr B alone in a vehicle. Mr D also took Mr B with him while Mr D did his son's paper round.

6. On 4 March 2013 Mr B's sister, Mrs C, complained to Pasifika about the services provided to her brother. Pasifika conducted an investigation but did not interview Mr B. On 8 July 2013, Mrs C attended a resolution meeting at Pasifika's premises, which was unsuccessful.

Findings

7. Mr B was a vulnerable consumer who needed social contact through community engagement. Mr D did not provide Mr B with adequate stimulation, in that Mr B watched television for extended periods of time. Mr D engaged in inappropriate physical contact with Mr B and left him unattended. In addition, Mr D failed to comply with Mr B's care plan or Pasifika's policies. Mr D failed to provide services to Mr B with reasonable care and skill and breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

8. Pasifika failed to have in place adequate systems and processes to provide safe and appropriate services for Mr B with regard to its care planning, monitoring and review, allocation of Mr B's services to Mr D, allowing Mr D to take Mr B to his home

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

without adequate oversight, and lack of staff training. Pasifika also failed to provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

9. In addition, Pasifika failed to respond to Mrs C's complaint in an appropriate manner, and failed to facilitate a resolution meeting that was consistent with acceptable standards. Pasifika failed to facilitate the fair, simple and speedy resolution of the complaint and, accordingly, breached Right 10(3)[2] of the Code.

Complaint and investigation

10. The Commissioner received a complaint from Mr B's family about the services provided to him by Mr D and Pasifika Integrated Health Care Limited. The following issues were identified for investigation:

- *Whether Mr D provided an appropriate standard of care to Mr B.*
- *Whether Pasifika Integrated Health Care Limited provided an appropriate standard of care to Mr B.*

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

12. The parties directly involved in the investigation were:

Mrs A	Consumer's mother
Mr B	Consumer
Mrs C	Consumer's sister
Mr D	Provider
Pasifika Integrated Health Care Limited	Provider

Also mentioned in this report:

Mrs D	Mr D's wife
Ms F	Service manager

13. Information was also reviewed from:

The Ministry of Health
The Nationwide Health and Disability Advocacy Service

14. Independent expert advice was obtained from nurse practitioner Bernadette Paus (**Appendix A**).

[2] Right 10(3) states: "Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints."

Information gathered during investigation

Mr B

15. Mr B, aged 35 years, has a significant intellectual impairment. At the time of these events he was living at home with his mother, who was his primary caregiver. Mr B has limited eyesight in his left eye, but he is independent with his personal cares. He speaks very little English, which is his second language.

16. Mr B attended a workshop[3] three days per week, which he enjoyed and referred to during an interview with HDC as his "work".

Referral to Pasifika

17. On 30 March 2007, a Needs Assessment and Co-ordination Service (NASC)[4] referred Mr B to Pasifika. The reason given for the referral was "to assist client with daily activities out in the community due to Intellectual Disability". Pasifika is a provider of home-based support services. Its website states:[5]

> "Pasifika Integrated Health care is serious when it comes to '***Delivering the Best Quality Support***' at home. Home Community Support services are designed to help clients to stay independently in their own home and help clients with the challenge they face in their day to day lives by delivering expert care to their every individual needs. We do our best to match the support worker with your needs, i.e. someone who can converse in a language you can understand and all the support workers are referenced and police checked, before they are employed."

18. Pasifika was unable to supply the NASC authorisation forms prior to 2010; however, the service description on the forms provided is "personal care". In 2007 Pasifika completed a registration form that states as the reason for referral: "To assist client with daily activities out in the community due to Intellectual Disability."

19. Pasifika utilised "Personal Care" funding to provide a "Community Engagement" programme for Mr B. Between 2007 and 2010 Mr B's services were provided by a number of Pasifika service providers and, by 2010, Mr B had requested that his services not be provided by a female service provider.

20. On 20 June 2010 Pasifika completed a "Risk Assessment Management" form which noted that Mr B became emotional and upset easily if he was unsure of anything. A form titled "Identified Risks — Plan of Action" noted as a risk that the "client cannot be alone at any time". The preventative action was noted to be "carer is with him".

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[3] This workshop supports people with physical and other needs to participate in community life. The support provided includes leisure centre activities, a gym, a massage centre, community outings, an art centre and work projects.

[4] NASCs are contracted by the Ministry of Health to work with disabled people to help identify their needs and outline what disability support services are available to them. NASCs allocate Ministry-funded support services and assist with accessing other support.

[5] http://www.pihc.co.nz/index.htm.

21. During the time that Pasifika provided services to Mr B, a number of its staff were involved in monitoring or were aware of the services being provided, including at least two service co-ordinators and the service manager, Ms F.

Mr D

22. Mr D had been employed by Pasifika since September 2008, and had provided home help to a number of clients. On 20 June 2010 Mr B was allocated as one of Mr D's clients. Mr D speaks very limited English, and does not speak any of Mr B's first language. Pasifika said that Mr D was employed to assist with clients who spoke the same language, and can converse in English if the person speaking to him speaks slowly using simple English. Pasifika stated that in the past Mr D had provided services to other consumers similar to Mr B, and that his attitude towards disability clients was good in that he listens and makes sure his clients are safe.

23. As Mr B speaks little English also, Mr D advised HDC that he and Mr B communicated by way of signs, gestures and simple English words.

24. Pasifika has a policy that all support workers have two weeks' orientation, and that "all service users receive care and support from qualified accredited workers". Mr D's file contains orientation checklists signed in 2008 and May 2013. The Workers Competency Form provided to Mr B on 20 June 2010 stated that Mr D's training/qualification was "7 yrs [e]xperience in care of disability. On the job training, orientation & supervision by experience[d] [service co-ordinator]".

25. Pasifika has a compulsory requirement that all staff complete NZQA Level 3 and 4 certificates in the Care of the Older Person, and other in-house training is offered from time to time. Staff are required to acquire a current certificate in CPR (cardiopulmonary resuscitation) and First Aid, and are expected to attend some form of training at least three or four times a year.[6]

26. In response to my provisional opinion, Pasifika stated that its staff attended training on a number of topics including (amongst other things) challenging behaviour, positioning and manual handling, stress management, restraint, abuse and neglect, the Code of Rights and literacy. Pasifika stated that Mr D "refuse[d] to attend any training, until he was forc[ed] to attend some of the basic training".

27. Pasifika supplied HDC with Mr D's employment progress notes. There is no evidence that Mr D undertook any disability focused training or that he completed the required NZQA qualifications. However, Pasifika stated that all staff receive information in their orientation package regarding appropriate attitudes and treatment of clients, for example:

> "Your attitude towards the clients must include politeness also your tone of voice and body language must be calm and comfortable. Always ask [the] client how they want things done … you must familiarise yourself with the Code of Rights …

[6] Employees Handbook and Home Support Worker Orientation Manual.

> A copy of the Code of Rights must be kept in your bag … Refer to the policies on the Code of Rights."

28. On 24 February 2012 the service manager, Ms F, telephoned Mr D regarding his enrolment for training[7], as was required by policy. Mr D told Ms F to contact his wife, Mrs D (apparently because of his difficulties with training owing to his inability to communicate in English). Mrs D responded that she would let Ms F know prior to the end of the month whether Mr D would attend the training. On 12 March 2012 Pasifika sent a letter to Mr D regarding his attendance at a Workers' Site Quarterly meeting on 26 April 2012. It is noted: "[A]lso contacted [Mr D's] wife to ask her if she could explain, due to language difficulty."

29. Pasifika stated that with regard to Mr D's training, "[d]ue to his English skills[,] [h]is wife [Mrs D] … has assist[ed] him with his language skills. His teenage children [have] taken over that task of helping him." In response to my provisional opinion, Pasifika said that managing employees with English as a second language is the hardest task for providers like itself.

30. On 7 May 2013, Ms F again contacted Mr D to ask him to attend the NZQA Level 3 certificate on Supporting Older People. On 29 May 2013 he was again contacted and reminded about the training. On 30 May 2013 he attended training on the Code of Health and Disability Services Consumers' Rights.

31. On 13 August 2013 there is a further entry in Pasifika's records: "[W]orker still encourage[d] to attend his [literacy and other] training on a Thursday evening." On 18 September 2013 Pasifika contacted Mr D again to make sure he attended his training and, on 30 October 2013, there is a record that the "training was OK his daughter/and family helped him".

Support provided to Mr B

Support plan

32. Mr B's progress notes record that a new service co-ordinator took over Mr B's file on 8 March 2011. On 5 July 2011 Mr B's mother signed the Individual Service Agreement Document, Cultural Assessment Form and Management Care Plan. Mr B signed a Client Informed Consent Form.[8]

33. The Workers Competency Form advised that the support for Mr B was for five hours each day on the two days he did not attend the workshop, and that the worker would assist Mr B with:

> "Personal care. Reading, Drawing, Exercise, Take him out for community engagement. [Mr B] likes going to shopping malls, playing in the park with carer. Health carer has to assist him."

[7] The training institute is a provider of NZQA qualifications for support workers employed in the health and disability sector with a Category 1 NZQA status.

[8] Mr B's Coda file, which Pasifika provided to HDC, does not contain earlier versions of this documentation.

34. On 10 July 2012 a service co-ordinator visited Mr B's home. Mr B's mother signed the Workers Competency Form to indicate that she agreed with the arrangement and, that day, Pasifika prepared a Management Care Plan, which listed under the heading "personal care plan" the tasks of "reading, drawing, exercise, community activities, play, fishing, walking". The plan stated that no household management was required, and the plan for identified risks was "to assist client with tasks allocated to avoid accident".

35. On 10 July 2012 a Client Individual Service Plan was also completed, which noted that Mr B has a problem with his eyesight and needs assistance most of the time to avoid accidents. The goals in the plan include Mr B having more activities in the community, learning how to draw and read, and mingling with other people.

36. The Client Individual Service Plan stated: "[C]lient place is safe, but he cannot be left alone. Always communicate with family if any changes with his support." It was noted that he would always bring his own food and drinks, that he was not allowed to have any food or drink anywhere else, and that he was to be at home before dark.

37. The Client Individual Service Plan noted that the carer was to pick up and drop off Mr B on the allocated days, and that the family had agreed and consented to the carer entering their home when visiting Mr B and attending to his cares. Pasifika stated that Mr D was given copies of his clients' care plans to follow but did not outline what steps were taken to explain those plans to Mr D in light of his inability to speak English. However, during Pasifika's investigation into this complaint (see below), Mr D acknowledged that he was aware that the care plans stated that Mr B needed to be actively engaged in community activities.

38. Pasifika has not provided to HDC any specific Community Engagement programme prepared for Mr B. In response to my provisional opinion, Pasifika stated that it accepts responsibility for the service co-ordinator who did not complete the care plan and activity plans properly, and also for its management of the Community Engagement programme. Pasifika said that there was no existing training on community engagement for support workers or service co-ordinators. In its view, the support activities available to Mr B were compromised because of the limited resources available.

Services provided to Mr B

39. Mr D did not complete any progress reports or other documentation of the services he provided to Mr B.

40. During an interview with HDC, conducted with interpretation assistance provided by his mother and sister, Mr B indicated that a typical day with Mr D involved watching television at Mr D's home.

41. Mr B said that Mr D would collect him and take him down the road to Mr D's house. They would watch television and not do much else. Mr B said that "sometimes [Mr D] would shut his eyes". Mr B indicated that sometimes Mr D left him alone in the

house while he went out to eat or went outside to feed his chickens, but mostly he would stay in the house with Mr B and watch television.

42. Mr B stated that once in a while they went fishing or shopping. He said that he enjoyed fishing but he would have to sit in the car for several hours and watch Mr D fish. Mr B said he enjoyed walking around the mall because it got him out of the house and out of the car. However, he said that on some shopping trips Mr D would leave him in the van and go into the shops alone. Mr B also said that sometimes he did a paper run with Mr D, and that the paper run was meant to be done by Mr D's son, but while the son was at school Mr D would get Mr B to go with him and help. Mr B said that he "had to put the paper in the post boxes".

43. Mr B indicated that once when they were watching television, Mr D asked him to stand and hold Mr D's leg because it was sore. Mr B stated that while watching television with Mr D there were "bad" movies and things he did not like. Mr B said they watched these things more than once, and that he "watched something with blood once and didn't like it". Mr B was not sure whether it was a DVD or just on television but confirmed that he saw naked people on the television.

44. Mr B told HDC that Mr D got cross with him and swore at him, hit him on the head, pinched his ears and pushed his legs together. Mr B said he did not tell Mr D that he did not like rough play, but told his mother about it when he went home.

45. Mr B's mother told HDC that Mr B was happy at first but, during the last year and a half to two years, he said he did not want to go with Mr D anymore.

Complaint

46. Mr B's sister, Mrs C, said she became concerned about the care being provided to her brother. On 4 March 2013 she complained to Pasifika by telephone about her concerns. Mrs C then emailed Pasifika on 11 March 2013 to advise that those concerns included Mr D having done the following to Mr B:

- pinched his ears on a few occasions;
- hit him on the head;
- exposed him to pornographic material on television;
- asked him to clean the toilet after Mr D had used it;
- required him to assist with a paper run and not tell his mother;
- required him to hold Mr D's foot for a long period of time on one occasion because it was sore; and
- taken off his shirt and rubbed his stomach on Mr B's head after having watched pornography.

47. Mrs C said that she was concerned by the lack of response she received from Pasifika. Because of this, Mrs C consulted a Nationwide Health and Disability Advocate, who wrote to Pasifika on 16 April 2013 advising that the time in which it was required to

acknowledge the complaint had expired.[9] On 7 June 2013 the advocate received from Pasifika a response letter and an investigation report, which she provided to Mrs C.

Investigation report

48. On 5 March 2013 Pasifika interviewed Mr D with the assistance of an interpreter, and he denied all the matters in the complaint. The investigation report dated 9 April 2013 stated that Mr D said that he had always treated Mr B like his own son. Mr D stated: "[A]ll the activities that allowed [Mr B] to participate in with my own [teenager] were strictly supervise[d] by myself and sometimes my wife was there to ensure they were safe." Mr D said that his son was the right age "to associate with [Mr B]" and that he would "engage [Mr B] in walking with my son while I deliver pamphlets". Mr D said: "[Mr B] loves to play rough as all clients who have intellectual disability like to do."

49. Mr D told Pasifika that he instructed Mr B: "[W]hen you go and use the toilet and mess it up you clean your mess. That's a routine we have with our children." Mr D stated to Pasifika that his wife and 16-year-old daughter assisted with Mr B's supervision, and that they did not watch television all the time because his children had a lot of church activities outside the home.

50. Mr D stated to Pasifika that he did not watch pornographic material, but also added: "I don't know what the words mean."

51. Pasifika's findings in the investigation report were that the complaint was a result of Mr B's misinterpretation of Mr D's good intentions, given Mr B's "intellectual understanding". The report stated that bumping into each other, pushing playfully and "doing a rugby type tug to his tummy" and pretending to fall over are an accepted part of socialising. It stated: "As a result of our support worker's assistance [Mr B] has improved quite dramatically in his communication skills. He is able to be more vocal in the presence of others." The report found that the accusation that Mr D watched pornographic material was "absurd and is fabricated" because he did not know what the word meant and his family had a strong commitment to church activities.

52. In response to my provisional opinion, Pasifika stated that it did not at any time indicate that it supported Mr D's actions. Pasifika also stated that "Mr D went on to apologise about all the activities that he thought were good for [Mr B]".

53. Mr B was not interviewed as part of Pasifika's investigation. In response to my provisional opinion, Pasifika stated that it "take[s] responsibility for not interviewing [Mr B]". Pasifika told HDC that the service manager did not have an opportunity to interview Mr B as they were occupied with Mr D's reaction to and denial of the allegations. Pasifika also said that it trusted Mrs C's complaint.

[9] Right 10 of the Code states that every provider must have a complaints procedure that ensures that a complaint is acknowledged in writing within five days of receipt, decide whether the complaint is justified within 10 days of the written acknowledgment, and inform the consumer about progress on the complaint at intervals of not more than one month.

54. Pasifika's investigation report had stated that Mr D had been granted two weeks' annual leave "to recover from the stress this complaint has on him and the rest of his family".

Suspension

55. In contrast to the investigation report, Pasifika told HDC that Mr D was suspended from working as a community support worker from 4 March 2013 for 14 days. The suspension was lifted on 15 March 2013, and he resumed work on 18 March. When he resumed work he was restricted from attending to any intellectually disabled clients until he completed further training and he worked under the supervision of the service co-ordinator.

Responses to investigation report

56. A copy of the investigation report was provided to the Ministry of Health. On 29 April 2013, the Relationship Manager Family and Community Disability Support Services, wrote to the General Manager of Pasifika stating that he was concerned that the report was not a proper investigation, as it was based on the interview with the support worker and there had been no communication with Mr B. He pointed out that Pasifika might need to consider reviewing its policy on support workers taking clients home, as there is considerable risk when a support person takes an individual to the support worker's home.

57. In her response to Pasifika's investigation report, Mrs C noted that services to Mr B were provided from 10am to 3pm, and so it was unlikely that Mr B would have been supervised by Mrs D, or that his child would have been present. Mr B told Mrs C that the only time he left Mr D's home was to go to the mall, collect shopping, and go fishing, and that he sat in the van while Mr D collected goods or went fishing.

58. Mrs C noted that Mr B is able to use the toilet independently, and does not make a mess. She stated that Mr B had complained that he had to clean the toilet after Mr D had used it.

59. Mrs C noted that the family is aware that Mr B does not enjoy rough play, and does not like others in his personal space. She noted that Mr B remembered watching TV much of the time and, on one occasion, Mr D went to sleep in the room while Mr B watched TV. Mr B also told her that he was asked to close his eyes when "pornography" was on the TV.

60. At the time of Pasifika's internal investigation, Mrs C said that she would be willing to attend a resolution meeting with the advocate's support.

Resolution meeting

61. A resolution meeting was arranged for 8 July 2013 at Pasifika's premises. The advocate advised HDC that prior to the meeting Pasifika had told her that Mr D would like the support of a language interpreter at the meeting, and that Pasifika would arrange that. However, when the meeting started, Pasifika advised that the interpreter could not attend the meeting, and that Mr D had arranged for his local pastor to act as an interpreter for him.

62. The advocate stated that the pastor did not act solely as an interpreter during the meeting, but gave his own opinions and interpretations of the issues and displayed discomfort and disbelief. A support person for Mr D, who had a relationship with Mr D and Pasifika, was also present at the meeting. The advocate stated that during the meeting the support person denied the accusations and behaved in a defensive manner.

63. Mr B's family was also concerned by the lack of professionalism of the senior Pasifika staff, and said they arrived late, did not have the appropriate documentation with them, and took no notes during the meeting.

64. At the meeting Mr D said that his uncle and sometimes his wife and children were present when he was providing services to Mr B. Mr D said that he did not tell Mr B to clean the toilet, but did tell him to wash his hands after using the toilet. Mr D stated that when they went fishing, he "told [Mr B] to sit in the car due to the day's weather (rain or too hot)". Mr D denied sleeping while Mr B was watching television. Mr D said that he was playful with Mr B, and pinched his ears and hit his head in a playful manner. Mr D denied watching pornography or a sex channel on television, and said that he did not tell Mr B to shut his eyes while watching television with him.

65. Mr D said that he is able to understand basic English "with slow conversation and actions", and that he and Mr B could understand each other with simple words.

Pasifika's policies

66. Pasifika's "Guidelines for Managing Special Needs Dependency Clients" states that the community engagement programme is designed to encourage special need clients to live independently and as near to a normal life as they possibly can. The guidelines also state that community engagement includes involving clients in "community based activities such as sports, entertainment, music and assist with basic sociali[s]ing skills and integrate with other people".

67. In addition to the orientation and training policies outlined above (see paragraphs 24 and 25 above), Pasifika provided the following information about its policies. Pasifika stated that all service users receive care and support from qualified accredited workers. Pasifika also stated that performance appraisals are carried out annually for two years, and every two years after that.

68. The "Support Worker Taking Service User to their Own Home" policy provides that support workers are not permitted to take service users to their own home without seeking permission from their service co-ordinator, and approval can be granted only once the service co-ordinator has discussed it with the service user's next of kin.

69. The service co-ordinator is required to assess the support worker's current living arrangements to ensure the health and safety of the environment to which the service user might be exposed, and an agreement must be signed by all parties prior to the support worker taking the service user to his or her own home. The policy requires that every visit is closely monitored by the service co-ordinator by way of:

- Phone contact (unscheduled).
- Personal visit to the home.
- Next of kin contacted by phone.
- Proof of activities matched against the care planned and activity planned.

70. HDC has been provided with no evidence that Pasifika had granted approval for Mr B to go to Mr D's home, or that the service co-ordinator took any of the actions outlined above during the times Mr B was at Mr D's home. Furthermore, Mr B's progress notes do not include any reference to the service co-ordinator discussing the matter with Mr B's mother, as is required by the policy.

71. The "Service User Personal Care Policy" states that no service user is to be left unattended or unsupervised, or allowed to participate in any activity without the support and attendance of the support worker.

72. Pasifika also had a policy of having an annual review of services. In addition, the policy required a monthly review of the services provided. However, Mr B's care was rolled over unchanged at each annual review, and often months passed between the service co-ordinator's contacts with Mr B's mother.

73. In response to my provisional opinion, Pasifika accepts responsibility that the service co-ordinators "did not perform their duties according to policies".

Response to notification

Mr D

74. On 9 May 2014 Mr D responded to the notification of HDC's investigation via an advocate. He stated that on most days he would pick up Mr B at around 10am, and they would go to his home as he did not have enough funds for petrol to take Mr B out.

75. Mr D said they would then watch television, and he always made sure he asked Mr B what he would like to watch, and there was never anything inappropriate. Mr D said that usually Mr B would watch cartoons, and, at the end of the day, Mr D would take Mr B home.

76. With regard to communication with Mr B, Mr D stated that he would communicate using simple English phrases that both he and Mr B could understand, plus gestures and body language. Mr D stated that he did not consider that there was a problem with their communication styles.

77. With regard to pinching and hitting Mr B, Mr D stated that the pinching was a "gentle stroke", and the hitting more like a "gentle pat". These were used to gain Mr B's attention, so they could communicate with simple sentences and gestures. With regard to rough play, Mr D stated that it was a boisterous man-to-man/male bonding type of interaction, with no harm done or intended. He said that Mr B was not a little child but

a grown man with special needs, so he did not baby him like a little child, but kept him safe from harm.

78. Mr D stated that he believed that his role was to look after Mr B and keep him occupied, and make him feel appreciated and happy, to enable his mother to have a break from looking after him.

79. Mr D said he knew that there were rules and policies about taking clients home, but there were times when there were insufficient funds to take Mr B out, so he would improvise and ask Mr B if he would like to go Mr D's house, as Mr B enjoyed the time at his home.

80. On 9 May 2014 Mr D advised HDC that he had decided to leave Pasifika because of the stress and health issues he was experiencing.

Pasifika

81. On 14 October 2013 Pasifika responded to HDC that both its service manager and general manager had investigated the complaint.

82. Pasifika stated that during its investigation Mr D had agreed that he pinched Mr B's ear and hit him on the head on a number of occasions, but only in a joking manner, and he did not intend to hurt Mr B. Mr D told Pasifika staff that rough play is part of socialising, and Mr B is a 35-year-old man, and he needed to grow up.

83. Pasifika said that Mr D agreed that he slept while Mr B watched television on one occasion when he was unwell, and said he required Mr B to clean the toilet if he messed it up, but not to clean it after Mr D had used it.

84. Mr D told Pasifika that he took Mr B with him while he did a paper round, but Mr B "was not given any papers to put in mail boxes". Mr D said that he showed Mr B his sore foot, but did not require Mr B to hold it. Mr D denied anything to do with pornography, said he did not rub his stomach on Mr B's head, and added that "they were playing rough and teasing each other, doing [a] rugby type move".

85. Mr D agreed that he left Mr B in the van while he was fishing, and stated that he does not do the family shopping, as his wife does it. Mr D said that he took his own children to the mall, and took Mr B to the mall on a different day.

86. Pasifika stated that Mr D's support person attended the resolution meeting as a support person for Mr D. Pasifika agreed that both Mr D and his support person overreacted and were defensive at the meeting, and apologised for the support person's behaviour, which it said was "unprofessional and totally unacceptable". Pasifika denied that its staff arrived late or were unprepared, and said that it was Mr D and his supporters who were late and brought no documentation with them, so the managers had to photocopy documents for them.

87. In response to my provisional opinion, Pasifika stated that it "accept[s] responsibility for the process of how the meeting was conducted. The two managers were nervous

and unsure as this is the first time they encountered such an experience." Pasifika said that Mr D and his support person were informed about the meeting and were reminded to bring copies of documents to the meeting. Pasifika stated: "They deliberately in [Pasifika's] opinion came in late, unprepared and to sabotage the meeting." Pasifika also said that the two service managers present did not know how to manage the support person's "sudden outburst" and "apologise profusely about what had unexpectedly happened".

88. Pasifika stated that the delays in managing the complaint were caused by Mrs C rather than Pasifika, in that she took time to respond. However, there is no evidence from the documents or records supplied by Pasifika that Pasifika responded to Mrs C regarding her email of 11 March 2013 until 14 May 2013.

89. On 17 March 2014 Pasifika further responded to HDC and stated that service managers do make regular unscheduled visits to see clients and workers, but "the nature of home base care does not make it possible for the service co-ordinators, or service managers to attend to every single worker". Pasifika stated that it was aware that Mr D was taking Mr B to his home on occasion, but it believed that this was because Mr B's mother was not at home to receive Mr B if Mr D or Mr B needed to use the bathroom, have a break, or have something to eat.

90. Pasifika stated that Mr D was selected to provide services to Mr B because "he has a similar way of speaking. They understand each other well", and because Mr D's "father figure role helps clients see him [as] a protective older person when they go out on community engagement activities".

91. Pasifika said that following its investigation it told Mr D that it was unacceptable to engage Mr B in activities he did not like, or to take Mr B to Mr D's home and watch television.

Current situation

92. Since Mrs C made the complaint, Mr B no longer receives any services on the two days per week when he does not attend the workshop.

Responses to provisional opinion

93. Responses to my provisional opinion were received from Mrs C and Pasifika, and have been incorporated into the "information gathered" section where appropriate.

94. Mr D told HDC that he has been deeply troubled by this incident and has no further comments to make.

Opinion: Breach — Mr D

Factual findings

95. Mrs C complained about a number of aspects of the care that Mr D provided to Mr B. With regard to these assertions, I make the following factual findings.

Television viewing

96. Mrs C complained that Mr D took Mr B to his home and left him to watch television for long periods while Mr D slept, and exposed him to pornographic material on television. Mr B stated that he spent a lot of time watching television, that there were "bad" movies and things he did not like on television, that they watched these things more than once, that he "watched something with blood once and didn't like it", and that he saw naked people on television.

97. Mr D denied watching pornography or a sex channel on television with Mr B, but acknowledged that he took Mr B to his house to watch television, and said he did so because he did not have enough funds for petrol to take Mr B out.

98. Mr B stated that while he was watching television, Mr D would sometimes shut his eyes or leave him alone. Pasifika stated that during its investigation, Mr D acknowledged that on one occasion when he was unwell, he had slept while Mr B watched television.

99. I find that Mr D took Mr B to his home on multiple occasions, and that Mr B watched television for lengthy periods. I accept that the content of some of the television programmes was distressing to Mr B in that he saw blood and naked people. However, on the balance of probabilities, I am unable to find that Mr D watched pornography or a sex channel with Mr B.

Physical contact

100. Mrs C complained that Mr D pinched Mr B's ears, hit him on the head, and engaged in rough play. Mr B said that Mr D got cross with him, swore at him, hit him on the head, pinched his ears, and pushed his legs together.

101. At the resolution meeting on 8 July 2013, Mr D stated that he was playful with Mr B, and pinched his ears and hit his head in a playful manner. In contrast, on 9 May 2014 when responding to the notification of my investigation, Mr D said that the pinching was a "gentle stroke", and the hitting more like a "gentle pat". He said that these were used to gain Mr B's attention, so they could communicate with simple sentences and gestures. With regard to rough play, Mr D stated that this was a boisterous man-to-man/male bonding type of interaction. He said that Mr B was not a little child, but a grown man with special needs, so he did not baby him but did keep him safe from harm. Pasifika stated that during its investigation Mr D said that rough play is a part of socialising, and that Mr B is a 35-year-old man who needed to grow up.

102. Having considered these varying accounts, I find that on a number of occasions Mr D pinched Mr B's ears, hit him on the head, and engaged in rough play with him.

Leaving Mr B alone

103. Mrs C complained that Mr D took Mr B fishing and left him in the van. Mr B said that he enjoyed fishing, but he would have to sit in the car for several hours and watch Mr D fish. At the resolution meeting, Mr D acknowledged that when they went fishing, he "told [Mr B] to sit in the car due to the day's weather (rain or hot)". Mr D also acknowledged to Pasifika that he left Mr B alone in the van while he was fishing.

104. Mrs C alleged that Mr D took Mr B on outings for Mr D's own benefit. Mr B said that Mr D sometimes took him to the mall, and that he enjoyed walking around the mall because it got him out of the house and the car. Mr B also said that on some shopping trips Mr D would leave him in the van and go into the shops alone.

105. I find it more likely than not that Mr D left Mr B unattended in a vehicle on a number of occasions.

Other issues

106. Mrs C complained that Mr D required Mr B to assist with a paper run and not tell his mother. Mr D agreed that he took Mr B with him while he and his son delivered pamphlets.

107. Mrs C also stated that Mr D told Mr B to clean the toilet after Mr D had used it, on one occasion required Mr B to hold Mr D's sore foot for a long period of time, and that Mr D took off his shirt and rubbed his stomach on Mr B's head after having watched pornography.

108. Mr D variously said he told Mr B to clean the toilet after he (Mr B) had used it, and also that he did not tell Mr B to clean the toilet but did tell him to wash his hands after using the toilet. Mr D said he showed Mr B his sore foot, but did not ask Mr B to hold it, and denied rubbing his stomach on Mr B's head, saying they were playing rough and teasing each other.

109. I find it more likely than not that Mr B accompanied Mr D on his son's paper run, and that Mr B put at least some of the papers or pamphlets into the post boxes. I also find that Mr D told Mr B to clean the toilet after he (Mr B) used it, but have not found sufficient evidence that Mr B was required to clean the toilet after Mr D had used it. As I have been unable to conclude that Mr D watched pornography, I do not find on the balance of probabilities that Mr D took off his shirt and rubbed his stomach on Mr B's head after having watched pornography. In addition, I have been unable to conclude that Mr D asked Mr B to hold Mr D's leg or foot because it was sore.

Services provided

110. Mr B was a vulnerable consumer who needed the stimulation of community engagement. It is clear that being left alone posed a risk to Mr B's safety. The services Mr D provided to Mr B were minimal, and largely consisted of watching television. There is very little evidence of activities to develop Mr B's social skills or engagement with the community, as was required by the Client Individual Service Plan, of which Mr D was aware.

111. It is concerning that Mr D had little understanding of the requirements of his role. He stated that he believed that his role was to look after Mr B and keep him occupied and make him feel appreciated and happy, to enable his mother to have a break from looking after him.

112. Mr D was not carrying out the activities identified in Mr B's care plans, or activities consistent with community engagement. Additionally, Mr D was engaging in activities that were not part of the care plans, for example, taking Mr B to his home to watch television for long periods of time, and taking Mr B with him while he delivered pamphlets.

113. My expert advisor, nurse practitioner Bernadette Paus, advised that the standard of care Mr D provided to Mr B deviated from Pasifika's organisational standards and policies for providing community engagement, which were intended to increase Mr B's life skills and give him the opportunity to meet and socialise with peers and new people. She stated that, in her opinion, Mr D's departures from acceptable standards were severe.

Taking Mr B home

114. Mr D stated that, on most days, he collected Mr B at around 10am and took him to his home, where they would watch television. Mr D said that he knew there were rules and policies about taking clients home but, as he had insufficient funds to pay for petrol to take Mr B out, he would take Mr B to his house because Mr B enjoyed being there.

115. The "Support Worker Taking Service User to their Own Home" policy provides that support workers are not permitted to take service users to their own home without seeking permission from their service co-ordinator, and that approval can be granted only once a service co-ordinator has discussed the proposal with the service user's next of kin. The service co-ordinator is required to assess the support worker's current living arrangements to ensure the health and safety of the environment to which the service user might be exposed, and an agreement must be signed by all parties prior to the service worker taking the service user to his own home.

116. The policy requires that every visit is closely monitored by the service co-ordinator by way of unscheduled telephone contact, personal visits to the home, contact with next of kin by telephone, and proof of activities matched against the care and activity planned. Pasifika provided no evidence that it had granted approval for Mr B to go to Mr D's home, or that the service co-ordinator had assessed the safety of Mr D's home, monitored the visits, or consulted Mr B's next of kin. Accordingly, it was a departure from Pasifika's policies for Mr D to take Mr B home without Pasifika's approval and the assessment and monitoring required by Pasifika's policy.

Physical contact and professional conduct

117. I have found that Mr D pinched Mr B, hit him on the head, and engaged in rough play. Ms Paus advised me that "in the role of a community support worker 'playing rough' including pinching [Mr B] on the ear and lightly hitting him on the head is totally

unacceptable and is a severe departure from acceptable standards". Ms Paus noted that playing rough is not appropriate for a person in the role of a community support worker, and stated that it was serious misconduct and, technically, was assaultive behaviour. I agree with Ms Paus that it was totally inappropriate for Mr D to pinch, hit, and play roughly with Mr B, and I consider that the behaviour amounted to inappropriate physical contact.

118. Mr D stated that he treated Mr B like his own son, and that his teenage son was the right age to associate with Mr B. In my view, Mr D failed to appreciate that Mr B was an adult with visual and intellectual impairments, not a child and/or a member of his family. Mr D was working in an official capacity in that he was employed to provide community support services and, therefore, I consider that his treatment of Mr B was inappropriate.

Leaving Mr B alone

119. I have found that on a number of occasions — while he was fishing and when he undertook personal shopping — Mr D left Mr B alone in a vehicle. Furthermore, I have found that on at least one occasion, rather than supervising Mr B, Mr D slept while Mr B was watching television.

120. Ms Paus advised me that "under no circumstances is it acceptable to leave someone with a significant intellectual disability in a vehicle unattended. In addition to having [a] significant level of intellectual impairment [Mr B] had a visual impairment." Ms Paus noted that Mr B's risk plan clearly states that he cannot be left alone at any time, and advised that to leave Mr B in a vehicle unattended was a severe departure from acceptable standards of care.

121. I agree and, in my view, a similar concern applies to the occasion on which Mr D slept while Mr B watched television.

Conclusions

122. Overall, I am of the view that the services Mr D provided to Mr B were seriously suboptimal. Mr D failed to provide Mr B with adequate stimulation, in that Mr B watched television for extended periods of time. Mr D failed to comply with the care plans or Pasifika's policies. In addition, Mr D engaged in inappropriate physical contact with Mr B and left him unattended.

123. I am left with the impression that the services provided were little more than "babysitting" and provided minimal community engagement for Mr B. Accordingly, I find that Mr D failed to provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Breach — Pasifika Integrated Health Care Limited

Structure of service and care planning

124. On 30 March 2007 the NASC referred Mr B to Pasifika to assist him with a programme of daily activities in the community. Pasifika is an organisation that predominantly provides home-based support services.

125. Pasifika utilised "Personal Care" funding to provide a "Community Engagement" programme for Mr B. Ms Paus advised me that Mr B did not have support needs that warranted a personal care allocation, as he was mostly independent with his personal cares. Ms Paus advised that, in her opinion, Mr B's needs indicated that he required Disability Support Services funded day programmes/vocational skills focused on maximising his life skills, particularly his social skills, as opposed to personal care (home help services). Ms Paus noted that the use of personal care funding in this way "is a concern and could be the basis for the root cause of the problems identified in this investigation". In particular, she noted that there is not an expectation that caregivers who provide "personal care" under "home-help" services undergo the same level or type of training as those providing specialised daily living and vocational support to people under the Ministry of Health's Disability Support Strategy (DSS). Despite this, if Pasifika was providing community support, it was its responsibility to train its staff adequately.

126. Ms Paus further stated:

> "I would expect that people with development disabilities like [Mr B] would receive vocational/day services from a disability NGO who is contracted and accredited to provide specialised day services. Such services do not allow staff to support people in isolation as has occurred in this situation. Vocational services are run as a team programme with regular monitoring of staff by suitably experienced and qualified managers."

127. Ms Paus noted that the Client Individual Service plan for Mr B and his Management Care Plan are very basic. She stated that the structure of the care planning was more consistent with that expected for someone receiving personal care services, and is not consistent with that expected of a provider of disability services. Ms Paus advised that the care planning fell below an expected standard for disability support.

128. I agree with this advice and consider that Pasifika's minimal care planning, lack of structure of activities, and inadequate review of services for Mr B was suboptimal, and contributed to the inadequate services provided by Mr D. Pasifika has accepted responsibility for its service co-ordinator who did not complete the care plan or activities plan properly or monitor the provision of service.

Selection of Mr D

129. Mr B speaks very little English. Similarly, Mr D also speaks minimal English. Mr D said that he and Mr B communicated by way of signs, gestures and simple English words.

130. Pasifika stated that Mr D was selected to provide services to Mr B because Mr D "has a similar way of speaking. They understand each other well." Ms Paus advised me that based on the language issues, she does not believe that Mr D was an appropriate fit to be working with Mr B, who needed someone who could communicate with him and help him to develop his English language and communication skills.

131. I agree with that advice and consider it unacceptable for Mr B to have spent days with a community support worker who could not speak to him effectively, and who provided services that lacked the stimulation of frequent community engagement.

132. I agree with Ms Paus's advice that Pasifika failed to provide Mr B with a culturally safe service by having his care provided by someone who could not communicate with him effectively, and who was not educated to understand expected levels of professional care and support.

Mr D's training

133. According to Pasifika, all support workers have two weeks' orientation, and all service users receive care and support from qualified accredited workers. In addition, Pasifika advised that "it is a compulsory requirement for [staff] to complete an NZQA level 3 and 4 certificate in Care of the Older Person", and that "other in-house training will be offered from time to time".

134. Pasifika also stated that it is a "compulsory requirement to acquire [a] current certificate in CPR and First Aid", and "[staff] are expected to attend some form of training at least three or four times a year". Furthermore, performance appraisals are undertaken annually for two years, and every two years after that.

135. Ms Paus advised that this training is consistent with what would be expected when providing home help services, but is not consistent with what would be expected when providing Disability Support Strategy funded specialist services for people with a developmental disability.

136. Mr D's file contains orientation checklists signed in 2008 and 2013. However, there is no evidence to show that before providing services to Mr B, Mr D undertook any disability focused training or the training outlined above. The only evidence of Mr D's training and orientation is on the Worker Competency Form, which states that he had "7 years [e]xperience in care of disability. On the job training, orientation & supervision by experience[d] [service co-ordinator]."

137. In my view, Pasifika should have been aware that Mr D lacked the necessary training and skills to provide an adequately stimulating environment for Mr B. There is no evidence that Mr D undertook any relevant training.

138. From 24 February 2012 the service manager, Ms F, contacted Mr D at regular intervals regarding his enrolment for training, as was required by the policy. However, it was not until 30 October 2013 that there is evidence that he had begun training.

139. I appreciate that training was difficult for Mr D because of his language difficulties. However, I agree with Ms Paus that Pasifika needed to ensure that its staff and the service co-ordinators had an adequate level of training in disability issues in addition to the generic training for people providing home help services. It was not appropriate for Pasifika to allow Mr D to avoid undergoing training, while continuing to provide disability services to Mr B for almost three years.

Mr D taking Mr B to his house

140. Pasifika was aware that Mr D was taking Mr B to his home, and said that this happened because Mr B's mother was not at home to receive him if Mr D or Mr B needed to use the bathroom, have a break, or have something to eat. I do not accept this submission. It is clear that Mr D routinely took Mr B to his home, rather than providing community engagement.

141. The "Support Worker Taking Service User to their Own Home" policy provides that support workers are not permitted to take service users to their own home without seeking permission from their service co-ordinator, and approval can be granted only once the service co-ordinator has discussed it with the service user's next of kin. I have been provided with no evidence that these actions took place.

142. Furthermore, the service co-ordinator is required to assess the support worker's current living arrangements to ensure the health and safety of the environment to which the service user might be exposed, and an agreement must be signed by all parties prior to the support worker taking the service user home. The policy requires every visit to be closely monitored by a service co-ordinator by way of unscheduled telephone contact, personal visits, contact with next of kin, and proof that activities match the care plan and activity planned. There is no evidence that the service co-ordinators took any of these actions.

143. Pasifika responded that service managers do make regular unscheduled visits to see clients and workers, but "the nature of home base care does not make it possible for the service co-ordinators, or service managers to attend to every single worker". Ms Paus advised me that taking Mr B home in these circumstances was a departure from Pasifika's policies, as was the service co-ordinator's failure to carry out the safety check/monitoring. Ms Paus advised:

> "[I]n my opinion the responsibility for the failures in this circumstance sit with the service co-ordinator and the senior management team who knew [Mr D] was supporting [Mr B] in his home. These failures were a severe departure from their own organisational policies and acceptable standards. They are serious failings as they left a vulnerable young man in a potentially unsafe situation. The service co-ordinator role is the safety net to protect vulnerable people. In my opinion this departure played a significant role in the poor standard of service provided to [Mr B]."

144. I agree with this advice. In my view, Pasifika failed to take sufficient steps to ensure that Mr B was safe.

Monitoring, documentation and assessment

145. During the time that Pasifika provided services to Mr B, a number of its staff were involved in monitoring or were aware of the services being provided, including at least two service co-ordinators and the service manager, Ms F.

146. Pasifika had a policy of having an annual review of services. Ms Paus advised that this is reasonable if there is adequate monitoring and review occurring between the full reviews. However, she noted that Mr B's service plan was rolled over without any changes.

147. The service co-ordinators did not monitor or review Mr B's service provision on a monthly basis, as was required by Pasifika's policy. Often months elapsed between contacts with Mr B and his mother. There is scant evidence that the service co-ordinators evaluated Mr B's goals or his individual planning. In addition, Mr D made no written progress reports about the services he provided to Mr B. Pasifika stated that its service co-ordinators did not "perform their duties according to policies" and that Pasifika accepts responsibility for this.

148. Ms Paus advised that Pasifika's failures to monitor and review Mr B's progress and supervise Mr D were a severe departure from accepted standards. I agree with Ms Paus that the responsibility for the failures in monitoring, documentation and assessment sit with the service co-ordinators and the senior management team, who knew that Mr D was providing services to Mr B in his home. Consequently, Mr B was left in a potentially unsafe situation.

149. In my opinion, the lack of oversight played a significant role in the poor standard of services Mr D provided to Mr B, and were missed opportunities to ascertain whether the services were providing Mr B with adequate stimulation and community engagement.

Response to complaint

150. Right 10(3) of the Code requires that every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints. I am concerned about a number of aspects of Pasifika's management of Mrs C's complaint.

Communication

151. Initially Mrs C complained to Pasifika on 4 March 2013. She followed up with an email on 11 March 2013. Mrs C said that she was concerned by the lack of response from Pasifika, and so she consulted a Nationwide Health and Disability Advocate, who wrote to Pasifika on 16 April 2013 expressing concern about the failure of Pasifika to respond to the complaint. The advocate advised that on 7 June 2013 she received a written response from Pasifika, enclosing its investigation report dated 9 April 2013. The response letter and report had not been sent to Mrs C, so the advocate provided her with a copy. On 7 June Mrs C responded to Pasifika and indicated that she was willing to meet.

152. Pasifika stated that the delays in communicating its management of the complaint were caused by Mrs C rather than by Pasifika. I do not accept that this was the case.

Pasifika's obligations are clear. Right 10(6)(a) of the Code provides that a complaint must be acknowledged in writing within five working days of receipt, and Right 10(7) requires that, within 10 working days of giving written acknowledgement of a complaint, the provider must decide whether or not it accepts that the complaint is justified. If more time is needed to investigate the complaint, the provider must determine how much additional time is needed and, if more than 20 working days are required, the provider must inform the consumer of that decision and the reasons for it. Furthermore, Right 10(4) states that every provider must inform the consumer about progress on the complaint at intervals of not more than one month. It is clear that Pasifika did not comply with the requirements of Right 10 of the Code.

Investigation report

153. I am concerned that Pasifika investigated a serious complaint about the services provided to Mr B without speaking to him. Mr B is able to express his views with the assistance of an interpreter. In my view, Pasifika showed disrespect for Mr B by excluding him from the process.

154. Furthermore, Pasifika concluded in its investigation report that the complaint was a result of Mr B's misinterpretation of Mr D's good intentions, because of Mr B's level of "intellectual understanding". The report also stated that bumping into each other, pushing playfully, and "doing a rugby type tug to his tummy" and pretending to fall over are an accepted part of socialising.

155. I find these conclusions extraordinary. I agree with Ms Paus that physical contact such as playing "rough", pinching Mr B on the ear and hitting him on the head were totally unacceptable and a severe departure from acceptable standards.

Resolution meeting

156. On 7 June 2013 Mrs C indicated that she would be willing to attend a resolution meeting with Pasifika, and the meeting was arranged for 8 July 2013 at Pasifika's premises. Pasifika undertook to arrange an interpreter for Mr D at the meeting. However, the interpreter could not attend, so Mr D arranged for his local pastor to act as an interpreter.

157. During the meeting, Mr D's support person denied the accusations and behaved in a defensive manner. Pasifika stated that the support person attended the meeting as a support person for Mr D but agreed that both Mr D and his support person overreacted and were defensive at the meeting. Pasifika stated that the support person's behaviour was "unprofessional and totally unacceptable".

158. However, Pasifika denied that its staff arrived late and were unprepared, and said that it was Mr D and his supporters who were late and brought no documentation, so the manager had to photocopy documents for them.

159. Ms Paus advised that it was a conflict of interest for the support person to be present at the meeting, because of the nature of the support person's relationship with Mr D and Pasifika. Ms Paus stated: "[T]his was not appropriate and deviates from the standards expected in a resolution meeting." Ms Paus advised that when the support

person began overreacting, this should have been managed actively. I agree and, in my view, Pasifika appears to have managed the resolution meeting poorly, which did not facilitate the resolution of the complaint.

Conclusions

160. Pasifika did not have in place a structure that provided safe and appropriate services for Mr B with regard to its care planning, monitoring, documentation, assessment and allocation of Mr B's services to Mr D, particularly in light of the language difficulties, allowing Mr D to take Mr B to his home without adequate oversight, and lack of staff training. Accordingly, I find that Pasifika failed to provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

161. In addition, Pasifika failed to respond to the complaint in an appropriate manner, and failed to facilitate an appropriate resolution meeting that was consistent with acceptable standards. Accordingly, I find that Pasifika failed to facilitate the fair, simple, and speedy resolution of the complaint and, accordingly, breached Right 10(3) of the Code.

Recommendations

162. I recommend that Mr D and Pasifika Integrated Health Care Limited each provide written apologies to Mr B. The apologies are to be sent to HDC within three weeks of the date of this report being issued, to be forwarded to Mr B's family to share with him as appropriate.

163. I recommend that Pasifika Integrated Health Care Limited:

a) Ensure that, with the assistance of external expertise, an appropriate staff orientation and training programme that includes core disability focused training is developed and implemented.

b) Ensure that the training programme includes annual refresher training on the elements included in the programme.

c) Implement robust procedures to monitor the performance of service co-ordinators and their compliance with policies and procedures.

d) Seek external expertise to assist with the development of an appropriate staff training programme, particularly focused on staff who are providing community engagement.

e) Seek external expertise to review the quality of support it provides to its clients. This will include an audit of planning and client review documents and processes, and the relevant policies and procedures, to ensure that they are consistent with best practice.

f) Implement a formal process to enable staff to meet with an appropriately trained person on a regular basis to discuss and provide feedback on residents' individual plans.

g) Develop a policy on conflict of interests.

h) Develop a policy on the standard of communication skills expected for staff.

164. I recommend that Pasifika Integrated Health Care Limited report back to HDC, within three months of the date of this report being issued, on the steps taken with regard to these recommendations.

Follow-up actions

165.
- Mr D and Pasifika Integrated Health Care Limited will both be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to Mrs C and Mrs A, who will be asked to share the report with Mr B to the extent that is appropriate.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Pasifika Integrated Health Care Limited, will be sent to the District Health Board, and it will be advised of Mr D's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Pasifika Integrated Health Care Limited, will be sent to the NASC and the Ministry of Health, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to take proceedings against Mr D.

The Director of Proceedings filed a claim at the Human Rights Review Tribunal which proceeded by agreement. The Human Rights Review Tribunal made a declaration that Pasifika Integrated Health Care Limited had breached Right 4(1) of the Code.

Appendix A — Independent advice from nurse practitioner Bernadette Paus

The following expert advice was obtained from nurse practitioner Bernadette Paus:

"I have read and agree to follow the Commissioners 'Guidelines for Independent Advisors'.

I am a Mental Health Nurse Practitioner with over 20 years clinical experience in Intellectual Disability Mental Health. Over this time I have held clinical, national leadership, educator and advisory roles. My clinical role is closely aligned to NGOs providing mental health and disability support so I have a good understanding of the standards expected for Disability Support Services (DSS). At the time of writing this report I am employed as a Nurse Practitioner by the Southern DHB, working full time in clinical work.

Supporting information

I have read the supporting documents provided as outlined in your letter dated 17/7/2014 and offer the following opinion on the questions requested.

The pertinent Standards that apply to this incident are:

- **Health and Disability Sector Standards**
  - **NZS8134.1.1**: **Consumers Rights**:
    - 1.6 Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs
    - 1.8 Consumers receive services of an appropriate standard of good practice
    - 1.9 Service providers communicate effectively with consumers and provide an environment conducive to effective communication
  - **NZS 8134.1.2 Organisational Management**:
    - 2.1 The governing body of the organisation ensures services are planned, coordinated and appropriate to the needs of consumers
    - 2.2 The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely appropriate and safe services to consumers
    - 2.3 The organisation has an established, documented and maintained quality and risk management system that reflects continuous quality improvement principles.
    - 2.8 Consumers receive timely, appropriate and safe service from suitably qualified/skilled and/or experience service providers
  - **NZS 8134.1.3 Service Delivery**
    - 3.3 Consumers receive timely, competent and appropriate services in order to meet their assessed needs and desired outcome/goals
    - 3.7 Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture and the setting of the service

- 3.8 Consumers service delivery plans are evaluated in a comprehensive and timely manner

- **Pasifika Integrated Health Care Limited Organisational Policies and Procedures, including Code of Conduct**

Expert Advice Requested

As a lead in to this opinion, as I believe it is a critical factor in this case, is:

1. The process of Needs Assessment that led to the allocation of 10 hours of 'Personal Care' to [Mr B] to be used in the manner it was by Pasifika Integrated Health Care Limited (PIHC). That is the utilisation of 'Personal Care' funding by PIHC to provide a 'Community Engagement' programme for people with 'Special Needs'.

It may be that an alternative model of funding and service provision operates in the area that deviates from the national model which I am familiar with. The type of support [Mr B] was being provided with by PIHC/[Mr D] does not appear to properly fit under the national model for 'Personal Care' but rather fits with the national disability strategy of 'daily living/vocational support'. Personal care is usually allocated to assist individuals with their personal care needs, for example, showering, grooming, feeding, dressing etc. Additionally Personal Care can also be utilised for accessing community based services relevant to an individual's personal health needs, for example attending health professional visits, therapy etc.

The reason why this issue is critical to this case is that there is not an expectation that care-givers who provide 'personal care' under 'home-help' services undergo the same level or type of training as those providing specialised daily living and vocational support to people under the Ministry of Health's Disability Support Strategy (DSS).

PIHC policies appear consistent with the national model which I am familiar with. PIHC's Orientation Manual (document K) outlines its definition of Personal Care

> *'The Services that PIHC is contracted with NASC to do is: …1. Personal care, which is about supporting the client with their everyday living basic needs. From showering, grooming, hair care, feed and dress them for the day and any other tasks that has directly affect the client's personal health.'… 'Passive exercise; meals and food preparation'.*

The orientation manual is consistent with what is outlined in the Employee Handbook (document I)

> *'You will assist and complete tasks that are normally performed in the home (e.g. basic home tasks, vacuum, dusting, laundry, food preparation),*

> *assist/escort the Client to community group activities, to doctor's appointments, to hospital appointments, provided the client pays for his or her transport'*

This is consistent with what they advertise on their website.

The 'Individual Service Agreement' (document P) from the Needs Assessor which allocates ten hours for Personal Care also outlines the general function of Personal Care hours:

> *'These are hours that are given to assist you to shave, shower or bath, groom you, comb your hair, shave, cut your nails, put on makeup or any other personal tasks to help improve your everyday life.'*

However, in [Mr B's] Individual Service Plan (document Q), which appears to be on PIHC's generic document/care-plan used for Personal Care support, it states under the Personal Care section '*client manages to do his personal cares but needs assistance in going out for community engagement'*.

From the documentation provided, PIHC also provides a 'Community Engagement' service to people with 'special needs'; this includes people with a developmental/intellectual disability. It appears that funding for this service (in this case) comes from an allocation of 'Personal Care' hours rather than PIHC being a contract provider for DSS supported daily living/vocational services.

PIHC's Community engagement programme involves,

> *'taking special needs client out and get them involved in the community based activities such as sports, entertainment, music and assist with basic socialising skills and integrate with other people'* (document J — Guidelines for 'Managing Special Needs Dependency Clients').

These activities are *'strictly consented by family and supervised by the support worker at all times'* and have an objective of '*Supporting [the client with] independence to meet new challenges'*. Each client is to have

> *'A programme designed to meet the individual's needs and involves taking the individual out to community activities that have facilities appropriate for your special needs'.... 'you will mix and mingle with other Clients of similar background. You befriend them and get to know them better'* documents J and I (Employee Handbook: Home and Community Services) and M (Job Description for 'Community/Home Based Support Worker: Disability Services').

Whilst allocating funding for Personal Care, the Needs Assessment & Service Coordination (NASC) service outlines the services being contracted as:

'Personal Care: Reading, drawing, exercise, take him out for community engagement. [Mr B] likes going to shopping malls, playing in the park with carer. Health carer has to assist him.'

PIHL policy states that Clients under the Community Engagement service *'must have an Individual Programme Plan'* written up by the service co-ordinator. [Mr B's] plan was,

'*Reading, drawing, exercise, community activities, play, fishing, walking'*

In my opinion [Mr B] did not have support needs that warranted a 'Personal Care' allocation. The documentation indicates that he was mostly independent with his personal care other than needing support with food preparation, but this was tended to by his mother. In my opinion [Mr B's] needs indicate a level of disability which required DSS funded day programme/vocational services focused on maximising his life skills, particularly his social skills, as opposed to Personal Care (Home-help) services.

In summary, whilst [Mr B] was allocated ten hours of 'Personal Care' funding, it appears that it was being utilised for 'Community Engagement'. I note that [Mr B] was attending a disability vocational programme on the alternative three week days. It's possible there were no vacancies available in disability vocational programmes for him to attend a full five day programme. So possibly the allocation of Personal Care for five hours a day for two days per week was plugging this gap and was a 'creative way' of funding a full day programme. However, the reality for many people with developmental disabilities in New Zealand currently is that there are not always Monday to Friday supported vocational programmes available to people who continue to live at home with their families ie, who are not in DSS NGO residential services. This is a concern and could be the basis for the root cause of the problems identified in this investigation.

Please comment on the overall standard of care provided to [Mr B] by [Mr D].

Whilst some of the allegations are disputed, [Mr D] admitted that he pinched and occasional lightly hit [Mr B] on the head. Additionally [Mr B] spent lengthy periods of time watching TV, with little evidence of activities that were further developing his functional and social skills. [Mr D] admitted to falling asleep on at least one occasion when he wasn't feeling well and leaving [Mr B] to watch the TV unattended.

Despite not having the required training (discussed further below) all staff receive information in their orientation package pertaining to appropriate attitudes and treatment of clients, for example '*Your attitude towards the clients must include politeness also your tone of voice and body language must be calm and comfortable. Always ask [the] client how they want things done…you must*

familiarise yourself with the Code of Rights…A copy of the Code of Rights must be kept in your bag…Refer to the policies on the Code of Rights'

In my opinion:

- The standard of care/support provided by [Mr D] fall well below the expected standard that is expected in a 'Community Support Worker' under DSS funded Daily Living/vocational support services.
- Additionally the standard of care provided to [Mr B] deviated from PIHC's organisational standards and policies for providing 'Community Engagement' — increasing life-skills and giving [Mr B] the opportunity to meet and socialise with peers and new people (documents B, I, J, K, and M).
- In my opinion these deviations were severe departures from acceptable standards.

According to PIHC, [Mr D] acknowledges that he played rough with [Mr B], but states 'he is a 34 year old man. Some time he got to rough it up'. Please comment on the appropriateness of [Mr D's] behaviour and his response to this allegation.

Whilst playing 'rough' is acceptable in some cultures, including [Mr D's] culture, it is not appropriate in the role of a community support worker — such roles are reserved for family and friends. In the role of a community support worker 'playing rough', including pinching [Mr B] on the ear and lightly hitting him on the head is totally unacceptable and is a severe departure from acceptable standards. Furthermore it constitutes serious misconduct and is technically assaultive behaviour.

Whilst disputed, the allegations of being exposed to pornographic material on the TV and the issue of stomach rubbing, are serious and required police involvement.

In light of PIHC's policies, was it appropriate for [Mr D] to take [Mr B] to his house?

It would have been consistent with PIHC's policy on '*Support Workers Taking Service Users to their Own Home*', if it had been written in [Mr B's] support plan by the service co-ordinator and approved by the family and if appropriately supervised. There was no evidence of documentation that directed home activities to be carried out in [Mr D's] home. However, PIHC point out in their investigation review (document F) that they were aware that [Mr D] was taking [Mr B] home. Despite this the service co-ordinator did not monitor the home-based support as per PIHC's policy (document G).

- Without the care planning directing home-based activities in [Mr D's] home, to do so is a departure from his organisation's policies.
- Failure to carry out the safety checks/monitoring by the service co-ordinator was a serious departure from PIHC's policies.

- In my opinion the responsibility for the failures in this circumstance sit with the service co-ordinator and the senior management team who knew [Mr D] was supporting [Mr B] in his home. These failures were a severe departure from their own organisational policies and acceptable standards. They are serious failings as they left a vulnerable young man in a potentially unsafe situation. The service co-ordinator role is the safety net to protect vulnerable people. In my opinion this departure played a significant role in the poor standard of service provided to [Mr B].

Was it appropriate for [Mr D] to take [Mr B] fishing and leave him in the vehicle?

Under no circumstances is it acceptable to leave someone with a significant intellectual disability in a vehicle unattended. In addition to having a significant level of intellectual impairment [Mr B] had a visual impairment. In the 'Identified Risks' plan it clearly states 'Client cannot be alone at any time'.

Furthermore, PIHC's policies are clear about being client focused and based on the needs and likes of the client. They state '*do not force any activities on the client'* which they do not like.

[Mr D's] rationale was that he was trying to offer fishing as an alternative and potentially enjoyable activity for [Mr B]. He explains that he left him in the van in the hope that [Mr B] could observe and hopefully become attracted to the idea of fishing and thereby venture out of the van and engage in the fishing. He explains the delight [Mr B] experienced when he took a fish home to his mother. There would have been more appropriate alternatives for exposing [Mr B] to fishing to spark interest for him without leaving him in a van. For example, he could have taken [Mr B] with him to the river. Alternatively they could have gone on walks where other people were fishing. [Mr B] is known to enjoy walks.

In my opinion:

- To leave [Mr B] in a vehicle unattended whilst [Mr D] went fishing fell well below an appropriate standard of care/support and is a severe departure from acceptable standards of care.
- If [Mr D] could not directly observe [Mr B] whilst he was fishing, then this elevates the concern from one of neglect to an unsafe/risky action with the potential to cause serious harm given [Mr B's] level of intellectual impairment and identified need for direct supervision at all times.

Please comment on whether the care provided by [Mr D] was reflected by the actions set out in [Mr B's] care plan.

The care plan for [Mr B] (Client Individual Service Plan (document N) and Management Care Plan (document Q) are very basic. The type of care-plan format is more consistent with what you would see for someone receiving 'Personal Care' services and not consistent with that which is expected of disability NGOs.

NASCs identified needs: *Reading, drawing, exercise, take him out for community engagement. [Mr B] likes going to shopping malls, playing in the park with carer. Health carer has to assist him.*

Service Co-ordinator's care plan: '*Reading, drawing, exercise, community activities, play, fishing walking'*

PIHC's Community Engagement programme is supposed to be based on engagement in community activities that allow disabled people to meet and socialise with their peers.

[Mr D] did not appear to be carrying out all the activities identified in the care-plan or activities consistent with the Community Engagement programme. Additionally he was engaging in activities that were not part of the care plan, for example, taking [Mr B] home and leaving him to watch the TV for long periods of time, doing a paper-run. As outlined above he also deviated from the risk management plan of not leaving [Mr B] alone.

- In my opinion the care-plan fell below an expected standard for disability support.
- Additionally the care provided to [Mr B] by [Mr D] deviated from the care-plan.

[Mr B] speaks minimal English, if any. [Mr D] also speaks minimal English. In light of the language barrier, please comment on whether [Mr D] was the appropriate support worker to care for [Mr B].

Based on these language issues I do not believe that [Mr D] was an appropriate fit to be working with [Mr B]. [Mr B] needed someone who could communicate with him and who could also help him to further develop his English language and communication skills.

Please comment on the overall standard of care provided to [Mr B] by PIHC. In answering this question, it would helpful for you to comment on the following:

What type of service would you expect to see in this type of circumstance?

I would expect that people with developmental disabilities like [Mr B] would receive vocational/day services from a disability NGO who is contracted and accredited to provide specialised day services. Such services do not allow staff to support people in isolation as has occurred in this situation. Vocational services are run as team programme with regular monitoring of staff by suitably experienced and qualified managers.

The adequacy of the client assessment, goal setting, care plans, monitoring, documentation and evaluation.

It is PIHC's policy to do a full review of services annually — this is reasonable if there is adequate monitoring and review continuously occurring in between.

There is evidence of the annual Service Allocation form being provided to [Mr B's] mother. [Mr B's] service plan was rolled over without any changes.

The monitoring/reviewing by the service co-ordinator did not occur on a monthly basis as per PIHC's policy. There was often several months between contacts/visits with [Mr B] and his mother. There was no written evidence in the Progress Notes of robust evaluation of goals or individual planning from the service co-ordinator. Neither could I find any progress reports from [Mr D]. It is difficult to know how [Mr D], who spoke little English could have written adequate progress notes.

I could not see any evidence of [Mr D] being monitored by the service co-ordinator whose role it was to oversee the achievement of goals and monitor the client's progress and supervise the support staff.

As outlined above, the client assessment, goals, care-planning and documentation were more consistent with what you would see for people getting basic 'Home help' services for specified tasks. They are not consistent with the standard expected of disability NGOs. Disability NGOs generally have a process of regular monitoring and evaluation, along with a comprehensive annual review of the client's goals via an Individual Support Plan review. There is an expectation that families, significant others, along with the client participate in these reviews.

Do you consider that [Mr B's] care plans and assessments were reviewed in a timely manner?

PIHC's policies stipulate that the care plans are developed under supervision of an experienced service co-ordinator who takes the lead role in 'Managing Special Needs Dependency clients'. They are expected to conduct a monthly review (document J). Additionally the support worker is to 'observe and report on progress and identify gaps for improvement with a goal of reviewing activities regularly and reporting on progress' (document M).

The progress entries by the Service Co-ordinator do not show any entries which are evaluating [Mr B's] progress/life-skills development nor do they show any progress notes from [Mr D].

- Monitoring and reviewing of [Mr B's] progress by the service co-ordinator or [Mr D], deviated from PIHC's organisational standards and policies and fall well below the expected standards.

Please comment on the adequacy of PIHC's supervision and oversight of [Mr D]. In particular, PIHC note that staff were aware that [Mr D] took [Mr B] to his house. Do you consider this was appropriate?

According to PIHC's policies there should have been daily contact by the service co-ordinator for days [Mr D] was taking [Mr B] to his own home. Additionally, according to PIHC's policies [Mr D] should have been getting monthly supervision from his service co-ordinator:

- As discussed previously, failure to monitor and review [Mr B's] progress by the service co-ordinator and failure to supervise [Mr D], deviated from PIHC's organisational standards and policies and was a severe departure from expected standards.

When asked about 'breaking the rules' as part of the investigation [Mr D] was given feedback that he 'could have contacted your service co-ordinator and asked for advise' (document F). In my opinion this is abdicating responsibility from the service co-ordinator whose role it is to monitor, supervise and provide oversight.

Please comment on the training provided to [Mr D] by PIHC.

PIHC has an organisational policy that all support workers have two weeks orientation and,

> *'all service users receive care and support from qualified accredited workers'.*

In addition,

> 'It is compulsory requirement for [staff] to complete an NZQA level 3 and 4 certificate in Care of the Older Person'… 'other in-house training will be offered from time to time'… It is a '*Compulsory requirement to acquire current certificate in CPR and First Aid'* and '*you are expected to attend some form of training at least three or four times a year.'* '*Performance appraisals are done annually for two years and every two years after that'*. (Employees Handbook, document I and Home support Worker Orientation Manual, document K)

The expected training requirements outlined above are consistent with what would be expected when providing 'Home-help' services, but are not consistent with what would be expected when providing DSS funded specialist services for people with a developmental disability.

PIHC do state that there are additional requirements for working with the '*Special needs Clients'* who are '*much more complex and require special trained professionals to manage their needs'* and outline the need to undertake a certificate in Disability support.

There is no evidence to show that [Mr D] undertook any disability focused training. Nor did he appear to have completed the training outlined above. The only evidence I could find of [Mr D's] training and orientation is on the workers Competency Form which indicates that he had '7 years experience in care of disability on the job training, orientation and supervision by experience s/c'. Document F states he underwent two orientation training programs, but there is no expansion on what these included. There is no evidence of him completing any formal disability focused training.

This is neither consistent with PIHC's organisational policies for staff training, nor is it consistent with the standards under the DSS for NGOs providing services

to clients with developmental disabilities. Outlined below in **Appendix one** is an example of the type of staff training and education programme that disability NGOs have in place to ensure staff have adequate and appropriate training. This is the level expected when provided DSS to people with developmental disabilities.

Do you consider that PIHC should have done more to ensure their staff had the appropriate skills required to provide a quality service?

Yes. In expanded the parameters of the Personal Care support into Community Engagement for clients with developmental disabilities PIHC needed to ensure that the staff providing the support and the service co-ordinators attached to this component of service delivery had an adequate level of training in addition to the generic training for people providing Home-help services.

PIHC state that '*most of the workers, service co-ordinators, and service managers went though NZQA level 3 training with Well Care NZ'*. This is reflective of the standard for Home-help services. PIHC state that two of the service coordinators had 'nursing backgrounds' and training in special topics 'challenging behaviour, restraint…autism, sign language, braille…and other topics…' They also state that developmentally disabled clients are '*allocated to site teams which employ workers already trained in the area'*. PIHC, however, have not provided any information which explicitly states whether the service co-ordinator overseeing [Mr B's] care and monitoring of [Mr D] had these qualifications.

Please comment on PIHC's management of this complaint when brought to their attention, including:

The initial response to the complaint appeared appropriate and occurred within reasonable timeframes — from receiving the complaint, to talking to [Mr D] and suspending him and then asking the family to put their concerns in writing. The service manager wrote on the Notification Letter as part of the complaints documentation

> '*Worker disagreed and denied treating client in such a manner further interview is required to attempt to resolve problem. I will inform you as soon as possible'*.

They then proceeded to set up another interview. The timeframes appear reasonable, but it appears that [Mr B's] family decided at some point relatively early on that they would engage the advocacy service. Maybe this was because they had received feedback that [Mr D] was initially denying the allegations. In doing so it appears they did not respond to PIHC's requests for further engagement.

In response to the complaint PIHC indicate that 'service managers came together and met several times to discuss how to manage' the complaint and remedial actions (Document F) indicating that they took the complaint seriously and the need for corrective action.

The management of [Mr D].

The immediate suspension of [Mr D] given the type of issues raised (which constituted serious misconduct) was appropriate, however, his suspension should have continued until successful resolution of the investigation rather than for a two week period only. Additionally it appears that he may have only been suspended from working with [Mr B]. I did not have any information stating whether [Mr D] was supporting other clients on the Community Engagement programme. If he was it would have been more appropriate that he was suspended in full from the Community Engagement programme until resolution of the complaint or until appropriate supervision could be put in place.

As outlined above the issue regarding the pornography and 'stomach rubbing' required further investigation and should have been referred to the police.

Management of the resolution meeting.

[Mr D] was entitled to have a support person and an interpreter at the resolution meeting. When the interpreter was unavailable he used the local pastor. The local pastor, however, did not act exclusively as an interpreter but appears to have become involved in the content of the complaint by putting forward his own opinions and judgements. This was not appropriate and deviates from the standards expected in a resolution meeting.

There was a conflict of interest when [Mr D] had [the support person] present at the meeting […] because of [the nature of the support person's relationship with both parties]. This was not appropriate and deviates from the standards expected in a resolution meeting. Additionally when [Mr D's support person] started 'over-reacting' and denied the allegations on behalf of [Mr D] in the meeting the facilitator should have actively managed this. PIHC have acknowledged that this behaviour was unprofessional and unacceptable and apologised for it.

PIHC indicate that it wasn't the management team who were unprepared and late, but [Mr D] and his supporters and therefore abdicate responsibility for this to them. This resulted in a delay to the meeting as a result of needing to photocopy and allow reading time of documents. This is unfortunate, particularly in this type of meeting where anxiety levels can be high. Whilst some accountability sits with [Mr D], PIHC also share the responsibility of the actions of their employees and therefore needed to apologise for this. Additionally minutes should have been taken and disseminated to the family in a timely manner.

Do you consider that PIHC's policies and procedures (incident reporting, professional boundaries, complaints management) were adequate and that there were mechanisms in place to ensure that staff understood and adhered to them?

The actual complaints management policy and Disciplinary and Dismissal Policy and Procedures appear to be fairly standard and adequate. However, as discussed above PIHC's policies, including their documentation standards are not robust

enough for providing supported living/vocational support services to people with developmental disabilities — they are more consistent with a Home-help agency.

Conclusion & Recommendations

It is my opinion that the root cause of the problems in this case likely relates to PIHC expanded their service to provide community support to people with developmental disabilities ('special needs') by utilising 'Personal Support' allocated funds. In doing this, it does not appear that the service has been developed based on the standards necessary to ensure a quality disability service that reflects the standards of service provision in the national disability strategy and that which is expected of disability NGOs. It is important to note in this investigation that [Mr B] enjoys participating in the Abilities Workshop programme three days a week, which I assume is a programme run by a disability NGO. Within that programme he has meaningful activity which he perceives as his 'job' and which he enjoys. He also enjoys the socialisation with peers that occurs (HDC interview and family feedback). This highlights the difference between NGO disability services and PIHC's service which is developed on Personal Care funding.

- I would strongly recommend that the ability to utilise funding from Personal Care to provide a community daily living/vocational service should be further investigated as soon as possible.
- Additionally I would recommend that PIHC's Community Engagement programme is audited.

[Mr D]

Not withstanding that [Mr D] did not appear to have the monitoring and oversight by his service manager in accordance with PIHC's organisational policies, he significantly deviated from the care-plan and the guidelines for staff providing Community Engagement. In my opinion these deviations constituted a serious and severe departure from acceptable standards [and] resulted in [Mr B's] care falling well below an acceptable level. Additionally these deviations appear consistent with misconduct.

Service Co-ordinator PIHC Senior Management Team

In my opinion accountability for the failings in this case are strongly attributable to the Service Co-ordinator and the PIHC's senior management team.

The Service Co-ordinator

- Failed to monitor and supervise [Mr D's] performance as per the role description
- Failed to develop an appropriate care-plan consistent with the standards expected for someone with a developmental disability receiving 'Community Engagement' programme,
- Failed to carry out the documentation and evaluation requirements of their role

The Service Co-ordinators' failings in my opinion were a severe departure from acceptable standards and were central to [Mr B's] care falling below an acceptable standard.

PIHC failed to have the right organisational and service delivery structures in place to be providing daily living/vocational programmes for people with developmental disability. The services provided to [Mr B] under 'Community Engagement' were not consistent with the national disability standards/strategy nor did they reflect quality improvement principles. They failed to provide [Mr B] with a culturally safe service by having his care provided by someone who could not effectively communicate with him and who was not educated to understand professional boundaries and expected levels of professional care/support.

- They failed to ensure a structure within the organisation that provided safe and appropriate services for clients receiving 'Community Engagement'.
- They failed to ensure that staff providing services were competent to do so.
- They failed to facilitate a resolution meeting as part of the complaints procedure that is consistent with acceptable standards.
- PIHC's failings in my opinion were a severe and serious departure from acceptable standards which resulted in [Mr B's] care falling below an acceptable standard.

PIHC's Staff Training Levels

There was no evidence provided that showed whether the service co-ordinator had the disability qualifications outlined above. Nor was there any evidence to show the overall level of training and qualifications of staff within the service. Based on the seriousness of the issues raised in this case I would recommend further review of the training and qualifications of the staff currently working at PIHC who are providing 'Community Engagement' to ensure that it is consistent with expected standards.

It would be difficult for an organisation providing only a small amount of support to clients with a developmental disability to provide the level of in-house training as shown below in **Appendix one**. What small organisations often do in such circumstances is to negotiate/align with larger disability NGOs to access their staff training programme. PIHC could have done this for their staff providing 'Community Engagement'. Alternatively they could have made it policy and mandatory for their support workers, working with special needs client to undertake an NZQA in disability support as opposed to their requirement that they do a Care of the Elderly course.

Limitations

Opinion based on information provided.

Bernadette Paus

August 2014.

Appendix One

PACT

Education and Training for [area] 2013

Specific Training Sessions

Intellectual Disability

- ☐ Autism
- ☐ Achieving Success with Impossible Children
- ☐ Offenders with Intellectual Disability
- ☐ Epilepsy
- ☐ Alternative and Augmentative Communication
- ☐ Dual Diagnosis
- ☐ Relationships, Intimacy and Sexuality in People with Intellectual Disability
- ☐ Dementia
- ☐ Grief and Loss
- ☐ Palliative Care
- ☐ Anger Management
- ☐ Anxiety
- ☐ Brief Solution Focused Therapy
- ☐ Positive Practice in Behaviour Support
- ☐ PTSD — Post Traumatic Stress Disorder and Intellectual Disability
- ☐ Reactive Attachment Disorder
- ☐ ADHD — Attention Deficit and Hyperactivity Disorder
- ☐ IDCC&R Act (for staff who support Care Recipients)

Intellectual Disability and Mental Health

- ☐ Positive Notes
- ☐ Collaborative Note Writing
- ☐ BIMASHO (catch up for Service Coordinators)
- ☐ Hepatitis A B & C
- ☐ Touch
- ☐ Star Wards
- ☐ Healthy Lifestyles — Health Action Plans

Mandatory Training

- ☐ Intellectual Disability Update
- ☐ Mental Health Update Medication Policy and Procedure Update (not Medication Assessment)
- ☐ Stress Management
- ☐ Cultural Issues
    - Cultural Issues from a Contemporary Kai Tahu Perspective — an Introduction (for new staff) — Hine Forsyth

- Cultural Issues from a Contemporary Kai Tahu Perspective — work related practice (for staff who have attended Hine's Introductory Session) — Hine Forsyth
- Cultural Issues with Pact's Cultural Group

☐ De-escalation and Breakaway
☐ Challenging Behaviour (for ID staff who are new or who have not done it before)
☐ Moving and Handling."