Caregiver, Ms C

The Masonic Villages Trust

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC01045)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This opinion relates to the standard of disability services provided to Mr A (now deceased). Mr A, aged 58, had tetraplegia. In 2006, he was admitted to a Hospital (the Hospital), which is operated by The Masonic Villages Trust (the Trust), because he was experiencing complications of his tetraplegia.

2. Health care assistant Ms C was employed by the Trust. In January 2007 Mr A moved back home, as his condition had improved. Ms C became Mr A's caregiver in his home and moved into Mr A's house with her two daughters. She remained employed by the Trust. Mr A's services were funded through an ACC serious injury contract.

3. Until 2008, nurses visited Mr A once a week to care for a wound (pressure sore). During 2007, another caregiver from the Hospital, Ms H, visited either monthly or fortnightly. Following Ms H's retirement in 2009, an enrolled nurse, Ms E, who was the Hospital's community care manager, visited Mr A occasionally.

4. Prior to March 2010 there was no care plan for Mr A, nor did the Trust have any policy about maintaining professional boundaries.

5. From 2007 until 2011, Ms C took no leave, had no respite from caring, and worked "24/7" constantly, even if she was sick. Although payment for annual leave was added to her wages, no arrangements were made to enable her to take leave.

6. Ms C and Mr A developed personal feelings for one another and, on 11 March 2009, told each other how they felt. By March 2010, staff at the Hospital and Mr A's GP knew about the relationship

7. In 2011, Mr A died. After his death his sister, Ms B, complained about the care Ms C had provided and alleged that Mr A had been coerced and exploited.

Findings

8. HDC found no evidence that Ms C failed to provide adequate disability services to Mr A or that she exploited or coerced him. It was found that Ms C did not breach the Code of Health and Disability Services Consumers' Rights (the Code).

9. The Trust failed to supervise Ms C adequately, failed to provide her with sufficient orientation and training, and did not discuss ethical issues and professional responsibilities with her when it became aware of her relationship with Mr A. The Trust took insufficient steps to minimise the risk of harm to Mr A and, accordingly, breached Right 4(4)[1] of the Code.

10. The Health and Disability Services Standard 8134:2008 requires that providers ensure that consumers are not at risk of abuse and/or neglect. Services must have policies and procedures to ensure that consumers are not subjected to exploitation, and services

[1] Right 4(4) states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

must identify, document and communicate potential risks. The Trust did not comply with those standards because it did not have such policies and procedures prior to 2010, and it failed to identify and document the potential risks to Mr A and communicate these to him and Ms C. The Trust failed to comply with professional standards, and so breached Right 4(2)[2] of the Code.

Complaint and investigation

11. Ms B complained about the services provided to Mr A. The following issues were identified for investigation:

- *Whether caregiver Ms C provided Mr A with an appropriate standard of care, and acted in accordance with ethical and other relevant standards from 1 January 2006 until his death in 2011.*
- *Whether The Masonic Villages Trust provided Mr A with an appropriate standard of care between 1 January 2006 and 27 January 2011.*

12. An investigation was commenced on 25 September 2012. This report is the opinion of Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

13. The parties directly involved in the investigation were:

Mr A	Consumer
Ms B	Complainant
Ms C	Health care assistant/caregiver
Dr D	GP
Ms E	Community care manager
Ms G	Trust manager
Mr F	Trust CEO
Also mentioned in this report:	
Ms H	Caregiver
A rehabilitation unit	
Dr I	Senior Medical Officer, palliative care service
Dr J	Rehabilitation consultant, rehabilitation unit
Dr K	Urologist, rehabilitation unit

14. Information from ACC and a palliative care service was also reviewed.

[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards".

15. Independent expert advice was obtained from Clinical Nurse Specialist Ms Karen Marshall, and is attached as **Appendix A**.

Information gathered during investigation

The Hospital

16. The Hospital is a facility operated by The Masonic Villages Trust. It provides residential care and home-based services.

Mr A

17. Mr A became tetraplegic as a result of an accident when he was 17 years old.

18. Mr A had been living in his own home, but in January 2006 he became unwell and was admitted to the Hospital. He was experiencing complications of his tetraplegia, including difficulty in maintaining his weight, breathing difficulties, and chronic pain.

19. Health care assistant Ms C was employed by the Trust from 1 June 2006. In late 2006, Mr A began returning to his home for the weekends. At that time, Ms C took Mr A home and cared for him during the day, and his previous caregiver remained with him overnight.

20. In January 2007, Mr A and the Hospital agreed that Mr A would move back home, as his condition had improved. Ms C advised that the Hospital asked her whether she would be willing to become Mr A's caregiver in his home, and she agreed to do so. Mr A's services were funded through an ACC serious injury contract.

21. Ms C moved into Mr A's house with her two daughters, then aged 10 and 12 years. Her daughters slept in a bach (sleep out) at the back of the property, and Ms C slept inside the house. She remained employed by the Trust.

Ms B's complaint

22. Ms B is Mr A's sister. Ms B lives overseas and said that she came back to New Zealand for a visit in March 2010. At that time, Ms C and Mr A announced their engagement and their plans to visit Ms B, and to get married. Ms B said that the family was very excited about this, and they were happy that Mr A had found love.

23. Ms B complained that Mr A was unable to attend his sister's funeral because his drug regimen was being changed and, when she returned to NZ in 2011 and visited Mr A, she thought that his care was inadequate.

24. Following Mr A's death, members of his family challenged the provisions in his will that benefited Ms C. Ms B stated that Ms C had pressured Mr A into making these provisions.

Nursing support

25. Ms C advised that until 2008 nurses visited once a week to care for Mr A's wound (a pressure sore) and they trained Ms C to do the dressings. From 2008 Mr A's ACC care package changed, and nursing care was not provided.

Monitoring by the Hospital 2007–2009

26. Ms C advised that in 2007 Hospital caregiver Ms H visited either monthly or fortnightly, and during the visits she would sit and chat, have a cup of tea, and ask Mr A how he was. Ms C said that Ms H did not check the house.

27. Enrolled nurse Ms E was the community care manager from 1998 until January 2013. The first recorded visit by Ms E to Mr A is 10 July 2008. The record of that visit states that there was to be no further registered nurse input in Mr A's care package, but that he would be visited every two weeks by hospital staff. Ms E told HDC that she "would try to visit" but sometimes Ms C and Mr A said not to come, and that Mr A would come into to see her. There are two further visits by Ms E recorded for 2008.

28. On 19 March 2009, Ms H recorded a "long overdue visit". On 11 June 2009 a visit is recorded (signature illegible), which noted: "[V]isited but only spoke to [Ms C] as [Mr A] stayed inside and was not invited in. [Ms C] managing well. [Mr A] happy to ring us if any worries."

29. Ms H visited Mr A twice in October 2009. Ms C said that when Ms H retired, the Hospital sent strangers to visit, and sometimes a person from the Hospital arrived unannounced, bringing students/trainees. Mr A did not like such visits and at times refused to allow the visitors to come into the house.

30. Ms E advised HDC that she did not record every visit she made. She stated that most frequently Ms C would telephone her and ask for supplies that they required, and that she would arrange for these to be provided, rather than visit.

31. Ms C said that she never declined visits from the Hospital staff, and that Ms E did not visit for years. Despite this, Ms C said that she had no concerns about the support provided by the Hospital.

Care plan

32. There is no record of a care plan for Mr A prior to March 2010 when Ms E prepared one. The Hospital said that Ms E contacted Mr A four times between February and September 2010 to arrange for the signing of the relevant documentation, but he declined the requests.

33. However, on 28 March 2010 it is recorded in Mr A's notes that the "informed consent"[3] was not signed because Mr A was in a rehabilitation unit for three weeks. On 28 May 2010, a call was made but Ms C was not there and, on 13 September, the notes record that Mr A was advised that "forms" had to be signed by him and Ms C

[3] This was a form prepared by the Hospital to be signed by service users.

for his cares to continue. He said that he was going away but would call into the Hospital. The documentation was not signed.

Ms C's employment

34. The Hospital provided HDC with the employment contract for Ms C signed in 2006. There is no record of a variation of contract when Ms C began providing home-based care in 2007.

35. On 8 March 2007, Mr A's ACC Case Manager recorded that Ms C had claimed that she did not have an employment contract and that her pay varied a lot from week to week, although she did the same hours each week. The Case Manager noted that Ms C stated that, as she was working "24/7", she wanted to be paid for those hours.

36. The Case Manager advised Ms C that these were employment rather than ACC issues, and she needed to discuss them with Ms C's employer. The Case Manager recorded that she discussed the issues with Ms E, who said that Ms C did have an employment contract and was not being "ripped off". The Case Manager recorded that she "expressed concern that [Ms C] was the only carer and what would happen if she gets sick. [Ms E] said this is the way [Ms C] wants it but reminded [Ms E] they were the employer and of the burnout issues."

37. Ms C advised HDC that from 2007 until 2011 she took no leave, had no respite from caring, and worked "24/7" constantly, even if she was sick. Ms C advised that although payment for annual leave was added to her wages, no arrangements were made to enable her to take leave.

38. Ms E stated that in 2010 "the Hospital" wanted Ms C to enter into a new employment contract, but Mr A said that Ms C would not sign the contract and that, in his view, Ms C needed a special contract that related to caring for a spinal patient. Ms E told Mr A that all the Hospital staff worked under the contract that had been sent to Ms C, and that she had to agree to that contract. The 2010 contract was not signed.

39. Ms C had no performance appraisals between 2007 and 2011. On 29 October 2009, a letter was sent to Ms C enclosing a blank performance assessment form. The letter stated: "Text me a suitable time when you are up in [town]." This does not appear to have been responded to, and there is no follow-up recorded. When asked whether she took any steps to ensure that Ms C had a performance appraisal, Ms E advised that she did not follow up on this because there was very little support for the community manager, and no one would listen to her concerns. She advised that she felt unsupported, was on call seven days a week, and felt overwhelmed.

Personal relationship

40. Ms C advised that after she had been caring for Mr A for a couple of years they began to "develop personal feelings for one another" and, on 11 March 2009, they "told each other how they felt". She stated that staff at the Hospital knew about the relationship "pretty much straight away", and that Mr A's GP, Dr D, also knew. Dr D said that he

was aware that Mr A and Ms C were in a relationship. He was given this information by Mr A, who seemed very happy.

41. Ms C told HDC that in 2009 she told Ms E about the relationship and Ms E said it was wonderful and that she was happy for them.

42. Ms E stated that there was nothing in the house to indicate a relationship. She said she once went into Mr A's bedroom and "there was no evidence of a relationship there" in that there was only a single bed, and nothing was said about it.

43. Ms E stated that in March 2010 Ms C mentioned that she and Mr A were in a relationship. Ms E said she telephoned Mr A's ACC case manager in March 2010 to discuss the relationship, but the case manager was away and Ms E did not subsequently follow up her concerns. Ms E said she did not think the relationship was her business, but she was aware that ACC would not approve of it. Ms E said that Mr A had referred to Ms C's children as his daughters.

44. On 23 April 2010, the senior occupational therapist at the rehabilitation unit noted in her discharge report: "He currently has a single bed and would like to pursue an intimate relationship with his partner. This is not possible with the single bed situation and the physical limitations of [his] disability … He needs an electric bed with full functions and with the ability to be 'clipped' to another bed to allow intimacy".

45. On 30 December 2010, palliative care services completed an assessment of Mr A, which stated under "Personal Relationships": "[Ms C] is concerned — we are engaged & getting married!! Remaining positive." Under the heading "Patient Family Profile", it is stated: "[Mr A] & [Ms C] have a large happy family that is well blended", together with a genogram[4] including Mr A, Ms C and her children.

46. Trust CEO Mr F advised that the Hospital did not know of the personal relationship until January 2011, and became aware of it then only because of a letter from Dr I, Senior Medical Officer at the palliative care service, stating: "[T]hey told me they had plans to get married soon and perhaps move to the countryside for more peace and quiet."

Exit from Service

47. On 7 January 2011, an ACC Case Manager emailed Ms E advising that Ms C and Mr A had called to say that they wished to be independent of the Hospital "as they are receiving no support". Subsequently Ms C resigned from her employment with the Hospital, effective 27 January 2011, but continued to care for Mr A.

48. However, Ms C advised HDC that the reason for exiting from the Hospital's services was that she and Mr A were planning to move to another region, rather than their dissatisfaction with the services provided by the Hospital.

[4] A genogram is a pictorial display of a person's family relationships and medical history.

Deterioration

49. From 2010, Mr A began to deteriorate, which was recognised by a number of clinicians including Dr J, a rehabilitation consultant at the rehabilitation unit, Dr K, a urologist at the rehabilitation unit, and GP Dr D. Mr A was admitted to the rehabilitation unit from 8 March 2010 until 28 March 2010, and was accompanied by Ms C.

50. Dr D said that despite adjusting Mr A's medications and attempting to give him calorie-rich foods, he progressively lost weight and condition. Mr A was unable to be sat up for long periods because he became very short of breath and light-headed with low blood pressure. This contributed to his recurrent chest infections and inability to clear secretions, which necessitated the suctioning of his throat.

51. Dr D advised that from the end of January until mid-March 2011, Mr A was quite unwell with ongoing chest infections, despite having antibiotics, chest physiotherapy, suctioning of his airways and using a nebuliser. Dr D advised that he adjusted Mr A's pain medication to try to get on top of his pain.

52. Mr A had eight doctor visits between 8 July 2010 and 15 March 2011, and five nurse visits between 23 December 2010 and 5 February 2011, excluding the palliative care team visits by a doctor and nurse. Dr D said that Mr A's breathing finally failed and, later that year, Mr A died.

Oversight of Ms C

53. Trust Manager Ms G advised that Ms E was responsible for overseeing the care provided by Ms C to Mr A. There are no records of Ms C having had any orientation or in-service training. Mr F said that Ms C was invited to attend training but did not do so, and that no action was taken to enable her to attend. Mr F advised that Ms C declined respite assistance, and no action was taken to ensure that she received support, although the Hospital was aware that Ms C was working 24/7.

54. When asked whether precautions were taken to ensure that Mr A was receiving appropriate care, Mr F advised that the Trust believed that Mr A would have raised any concerns with his GP, the nurse care manager, or any of the other allied health providers who were providing services in the home. Mr F advised that the Hospital heard of no issues from any of those sources or from Mr A's family.

55. Ms E advised that when she visited Mr A she would talk to Mr A and Ms C together and ask whether everything was all right. She stated that she would sit in the kitchen with them, have a cup of tea, and ask whether Mr A was happy. Ms E said she never saw Mr A alone. She stated that, in her view, Ms C did not dominate or pressure Mr A, and that Ms C is "a good person and a good carer".

56. Ms E advised that she was aware that Mr A smoked marijuana and cigarettes heavily and she "sees no problem with it".

Policies

57. Ms G and Mr F advised that before 2010 there was no policy dealing with boundary issues, but that once the change in Mr A's and Ms C's relationship was known to Ms E in March 2010 a policy was developed. When asked why he had stated that the Trust was not aware of the relationship until 2011, Mr F said that Ms E's knowledge "was by inference in conversation", they were not aware of anything else, and there was "no evidence of cohabitation in the house".

58. The Therapeutic Boundaries Policy created in March 2010 stated that caregivers were not permitted to be in personal relationships with services users. The Standards of Integrity and Conduct and the Therapeutic Relationships and Boundaries Guidelines documents were issued to Ms C, who was asked to sign and return a copy. She did not do so, but the Hospital took no steps to follow up the matter.

Supervision

59. The purchase agreement for residential support services between the Hospital and ACC required that non-qualified and trained care assistant staff must be overseen by a supervisor.

60. The supervisor must be either a registered nurse or a registered allied health professional. The permitted allied health professionals were dieticians, physiotherapists, speech language therapists, clinical psychologists, neuro psychologists, and occupational therapists who were members of their relevant professional associations and held current practising certificates. Supervision could also be provided by social workers who were members of their professional association, had a disability rehabilitation qualification, were expert in traumatic brain injury, and had demonstrated behaviour management expertise.

61. When asked whether it was appropriate for Ms E to oversee Ms C, in light of this contractual requirement, Ms G stated that it was appropriate because Ms E is a registered enrolled nurse, and although she has no rehabilitation qualification she underwent training at the rehabilitation unit before 2007.

Relevant standards

62. The Health and Disability Services Standard 8134: 2008 states:

"1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

…

1.7.1 Services have policies and procedures to ensure consumers are not subjected to discrimination, coercion, harassment, and sexual or other exploitation.

…

1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.

…

2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

…

2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services.

…

2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.

…

2.9.2 The detail of information required to manage consumer records is identified relevant to the service type and setting

…

2.9.8 Service providers use up-to-date and relevant consumer records.

Organisational safety

Risks within the organisation that have the potential to compromise safety are identified, monitored, evaluated, recorded in a risk register and managed to acceptable levels.

…"

Opinion: No Breach — Ms C

63. Ms C began working at the Hospital in 2006 and, in 2007, it was agreed that she would become Mr A's full-time home-based caregiver. Ms C worked for 24 hours a day seven days a week from 2007 until 2011 and, during that period, she had no leave and no respite care, and worked constantly even if she was sick.

64. The evidence from Ms E, who visited the home from time to time, and from Mr A's GP, Dr D, is that Ms C provided excellent care to Mr A, and that Mr A was happy with the arrangement.

65. In March 2009, a personal relationship developed between Ms C and Mr A. In many cases it would be ethically inappropriate for such a relationship to exist between a consumer and a paid caregiver. However, I accept that:

- Ms C told staff at the Hospital, palliative care services, and the rehabilitation unit about the relationship. Additionally, Mr A discussed the relationship with Dr D.
- Ms C had no training about boundary issues, received no performance appraisals, and received minimal support from the Hospital.
- Ms C was not aware that it was potentially unethical for her to be in a personal relationship with Mr A while she was his paid caregiver.

66. Dr D stated that Mr A's deterioration between the end of January 2011 and mid-March 2011 involved ongoing chest infections. I have been provided with no evidence that Mr A's deterioration was caused by a lack of care, or poor care, by Ms C. In addition I have received no evidence supporting the allegation that Ms C coerced Mr A to include the provisions in his will.

67. I conclude that when the personal relationship developed, Ms C took reasonable steps by advising staff at the Hospital, including her supervisor, Ms E, of the relationship. Despite Ms C's difficult working conditions, she cared for Mr A to the best of her ability. Accordingly, I find that, in these particular circumstances, Ms C did not breach the Code.

68. Ms C accepted the findings in my provisional report and made no other comments.

Opinion: Breach — The Masonic Villages Trust

69. The Masonic Villages Trust, as the employer of Ms C and the governing body of the Hospital, had the overall responsibility to ensure that Mr A received care that complied with the Code. In order to do so, the Trust needed to provide its employees with adequate policies and procedures to guide their actions and ensure they received adequate training. In addition, the Trust needed to monitor staff compliance with the policies and procedures and actively identify, monitor, evaluate, and manage risk.

70. Despite the complaint from Ms B, during the course of this investigation this Office has not received evidence that suggests that Ms C neglected Mr A or treated him inappropriately. However, the Trust had a duty to recognise and manage the risk that Ms C might "burn out" if she was working under unreasonably onerous conditions, which in turn could adversely affect the care she was able to provide for Mr A.

71. I accept that Mr A wanted to remain in his own home. Although he would have been able to complain if he were neglected, his focus on living independently, plus his relationship with Ms C, could have inhibited him from doing so. In these circumstances, the Trust should have been proactive in supporting Ms C and overseeing the services provided to Mr A.

Personal relationship

72. Ms C was employed by the Hospital to provide home care services to Mr A. During the course of this employment she and Mr A formed a personal relationship. I have received differing evidence as to when Hospital staff became aware of the personal relationship. Ms C stated that they began to develop personal feelings for one another over time and, on 11 March 2009, told each other how they felt. She stated that staff at the Hospital knew about the relationship "pretty much straight away", and that she told Ms E about the relationship in 2009.

73. Ms E stated that in 2010 Ms C mentioned that she and Mr A were in a relationship. However, the CEO of the Trust, Mr F, stated that the Hospital did not know about the personal relationship until January 2011, and became aware of the relationship only because of a letter from Dr I stating that Ms C and Mr A had told Dr I that they had plans to get married.

74. I find it more likely than not that, by 2010, some staff at the Hospital, including Ms E, were aware of the personal relationship between Ms C and Mr A. I note that Ms E said that Mr A had referred to Ms C's children as his daughters, and that Ms E saw no problem with the personal relationship between Mr A and Ms C.

75. Ms C received no orientation or structured ongoing training. As an unqualified caregiver, Ms C lacked awareness of the ethical issues arising in this situation. In my view, once Hospital staff became aware of the personal relationship, there was a duty to take reasonable steps to ensure that Ms C received training about her ethical and professional obligations, and that Mr A was not at risk of sub-optimal care as a result of that relationship, including abuse, neglect or exploitation. This was particularly important as Ms E knew that Mr A was not visited frequently by his family, and that Mr A wished to live in his own home.

76. I am not satisfied that, after the Trust became aware of the personal relationship in 2010, it took adequate steps to train Ms C about her obligations, or to proactively ensure that Mr A was not being abused, exploited or neglected. In March 2010, a care plan was developed for Mr A, and the Trust stated that Ms C was sent an employment contract and documents relating to "Standards of integrity and conduct", and "Therapeutic relationships and boundaries guidelines". None of the documents were signed, and the Trust did not follow up.

77. Ms C does not recall receiving the documentation. I note that Mr A was admitted to the rehabilitation unit from 8 March 2010 until 28 March 2010, and was accompanied by Ms C.

78. From 2010, ongoing processes should have been instituted to ensure that Mr A was receiving adequate care and was not being abused, exploited or neglected by Ms C. I do not consider it was sufficient to have assumed that the other agencies that had contact with Mr A would have identified any concerns, or that Mr A would have complained himself if there was a problem. I consider that the Trust should have done more to ensure that Mr A was receiving appropriate care, and that he was regularly reviewed. At the very least, the Trust should have ensured that Mr A was seen alone

by visiting staff, and that careful records were being maintained of the questions asked and Mr A's responses. I do not accept that it was appropriate, or a sufficient discharge of the Trust's duty, to post documentation to Ms C with no discussion, explanation or follow-up.

79. Ms E advised that she contacted Mr A's ACC case manager to discuss the personal relationship, but the case manager was away and Ms E did not follow up the matter.

80. Between 2009 and 2011, Ms E recorded that she made only four visits to Mr A. Ms C said that Ms E did not visit for years. However, Ms E advised HDC that she did not record every visit. I find it more likely than not that the visits were infrequent. Ms E acknowledged that when she did visit, she did not speak to Mr A alone, as Ms C was always present.

81. In my view, it is essential that employers of unqualified, unregistered caregivers provide adequate training to staff, including information about the maintenance of professional boundaries. This is particularly important when the care is being provided in the consumer's home.

Employment arrangements

82. Ms C was working in a demanding role, and there was a risk that she would become exhausted. In 2010, the Trust wanted Ms C to enter into a new employment contract. However, the Trust advised that Mr A said that Ms C would not sign because he was of the view that Ms C should have a contract specific to spinal cares. From that period, Ms C either worked without a contract or remained on the contract she had signed in 2006. Ms C advised that she was working 24 hours for seven days per week, and that she was not at any time provided with respite or able to take holidays, and there was no provision made for sick leave.

83. Ms C's file has no record of her undergoing any orientation or in-service training. Mr F stated that Ms C was invited to training sessions but was not required to attend, and no steps were taken to arrange respite care or other facilities to enable her to attend. In my view, the Trust had a responsibility to require staff to attend training, and should have ensured that the necessary practical steps were instituted to enable that to occur.

84. Ms E acknowledged that she was aware that Ms C was working in an environment where there was heavy smoking of cigarettes and marijuana. Ms E stated: "I see no problem with it." There were risks to Ms C's health and safety from working in that environment, which the Trust should have addressed and managed.

85. I note that the Trust was on notice that Ms C's situation was a risk, in that it had the potential to compromise Ms C's well-being and Mr A's safety. In 2007, Mr A's ACC case manager had raised with Ms E concerns that Ms C was the only carer, and had enquired what would happen if Ms C became sick. The case manager also raised concerns about the possibility of Ms C becoming burnt out. There is no evidence of any action taken in response to those concerns.

86. Mr A was vulnerable and at risk of harm. From 2010, when Ms E was aware of the personal relationship between Ms C and Mr A, appropriate steps should have been taken to manage that. The Trust should have acted more proactively to ensure that he was receiving safe and appropriate care, and should have provided much better support and assistance to Ms C.

Supervision

87. The purchase agreement for residential support services between the Hospital and ACC required that non qualified care assistant staff such as Ms C were overseen by a supervisor who was either a registered nurse or a registered allied health professional. Ms E was an enrolled nurse who does not have a disability rehabilitation qualification and was not qualified to supervise Ms C.

Conclusions

88. The Trust failed to adequately supervise an unqualified caregiver. It did not provide Ms C with orientation, training or adequate support. When it became aware of a personal relationship between Mr A and Ms C it failed to discuss with her the ethical issues and her professional responsibilities, and did not visit Mr A regularly and take sufficient steps to ensure that he had an opportunity to speak freely without Ms C being present.

89. I do not consider that the Trust took sufficient steps to minimise the risk of harm to Mr A. Accordingly, in my view, the Trust breached Right 4 (4) of the Code.

90. The records of the services provided to Mr A are minimal. The Health and Disability Services Standard 8134:2008 requires that providers ensure that consumers are not at risk of abuse and/or neglect. Services must have policies and procedures to ensure consumers are not subjected to exploitation, and services must identify, document and communicate potential risks. The Trust did not comply with those standards because it did not have such policies and procedures prior to 2010, and it failed to identify and document the potential risks to Mr A and communicate these to him and Ms C. I consider that the Trust failed to comply with professional standards and so breached Right 4(2) of the Code.

Recommendations

91. In my provisional report I recommended that the Trust provide written apologies to Ms C and Ms B for its breaches of the Code. I requested that the apologies be sent to HDC for forwarding.

92. In response, the Trust provided formal written apology letters to Ms C and Ms B and these were forwarded on to the parties.

93. In my provisional report I also recommended that the Trust:

- develop an appropriate staff orientation and training programme that includes core disability focus training such as boundary issues, human rights, advocacy, and communication;
- ensure that the training programme includes annual refresher training on the elements included in the programme;
- ensure that procedures are put in place to enable caregiving staff to attend training programmes;
- implement robust procedures to monitor compliance with policies and procedures;
- institute an effective system for the provision of respite for caregivers, and ensure that all caregivers are provided with respite;
- develop a policy on conflicts of interest;
- reviews its policy on performance reviews; and
- obtain external expertise to review and audit consumers' individual care plans and its policies and procedures, to ensure they are consistent with best practice.

94. I recommended that the Trust report to HDC on the steps it had taken including a report from the external reviewer.

95. The Trust responded that it had exposed its community services to external scrutiny by having the service audited against the Home and Community Support Sector Standard NZS 8158:2012. The audit occurred on 6 December 2012, conducted by an external agency registered with the Ministry of Health.[5] The audit concluded that the Trust complied with all elements of the standard, but had seven areas where a partial attainment was recorded – all seven being recorded as low risk.[6] The audit indicated that corrective actions were to be completed within six months.

96. The Trust provided copies of its service plan templates that are used for community clients as well as more detailed plans setting out services allocated to clients.

97. The Trust outlined that, in 2012, ACC placed all its community work out to tender, resulting in the pool of 86 providers being reduced to four. The Trust no longer holds a contract with ACC and instead is now a sub-contractor to another company. Consequently the Trust has, as required by the new company, adopted the new company's policies and procedures in many of the areas highlighted in HDC's provisional report, which the Trust considers represents industry best practice. For example, in relation to developing appropriate staff orientation the Trust provides training and orientation using the new company's "Support Worker Orientation" programme which contains content on client rights, ethics and boundaries.

98. The Trust now operates a regular monthly compulsory training session for its community staff. Training times and dates have been set to maximise attendance. This forum provides an environment for refresher training and compliance monitoring.

[5] Copy provided to HDC.

[6] The audit outlined full attainment against Standard 1.7 "Freedom from abuse and neglect". All elements of Standard 3.2 (Orientation, Induction, Ongoing Development and Competency) were fully attained, with 3.2.2 (a developed, implemented and recorded training plan for support workers) being partially attained.

99. The Trust's policy on Therapeutic Relationships and Professional Guidelines has been reviewed.[7] It addresses the risk of conflicts of interest in patient care.

100. The Trust has reviewed its policy on performance reviews (staff appraisals) along with staff appraisal performance planning guidelines.[8]

101. I recommend that the Trust update me by **31 July 2013** on the corrective actions it has taken to ensure that those areas identified by the December 2012 audit as partially attaining the standard, fully attain the standard.

102. I recommend that the Trust update me by **31 July 2013** on what steps it has taken to institute an effective system for the provision of respite for caregivers, and ensure that all caregivers are provided with respite.

Follow-up actions

103. A copy of this report with details identifying the parties removed, except the expert who advised on this case, and The Masonic Villages Trust, will be sent to the DHB and the Ministry of Health.

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

[7] 30 May 2013.
[8] May 2013.

Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from Clinical Nurse Specialist Ms Karen Marshall:

"This report is written by Karen Marshall RN MN, Clinical Nurse Specialist […].

Purpose

To provide independent expert advice whether [Ms C] and the Masonic Villages Trust provided on appropriate standard of care to [Mr A].

Supporting Information

1. Complaint Letter
2. Further information from [Ms B]
3. Notification Letters
4. Information from Masonic Villages Trust 19 January 2012
5. Information from Masonic Villages Trust 12 June 2012
6. Information from Masonic Villages Trust 16 November 2012
7. Interview Notes ([Ms C])
8. Information from [Ms C's] lawyer
9. Interview notes ([Ms E])
10. Interview notes ([Ms G] and [Mr F])
11. GP Notes

Expert Advice Required

1. What standards apply in this case?
2. What steps should [Ms C] should have taken, if any, once she commenced a personal relationship with [Mr A]?
3. Was it appropriate for [Ms C] to have her children living at [Mr A's] house?
4. What steps should have been taken once the Masonic Villages Trust was on notice of a personal relationship between [Ms C] and [Mr A]?
5. Did the Masonic Villages Trust take adequate steps to ensure [Mr A] was receiving an appropriate standard of care, and to ensure he was not being abused or exploited? In particular please comment on the following:
   a. Frequency and nature of the visits from the community coordinator.
   b. Training and performance reviews for [Ms C].
   c. Respite and holidays for [Ms C].
   d. Acceptance of marijuana use and smoking within the home/workplace.
6. What policies and procedures need to be in place in these circumstances (home based care), to ensure the consumer is receiving an appropriate standard of care and protect against abuse and exploitation?

[Outline of facts deleted for brevity.]

1. What standards apply in this case?
RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
3) Every consumer has the right to have services provided in a manner consistent with his or her needs…
4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

2. What steps should [Ms C] should have taken, if any, once she commenced a personal relationship with [Mr A]?
[Ms C] should have informed her employer [the Hospital] in March 2009 that she had commenced a personal relationship with [Mr A].

According to [Ms C's] statement 'No one at [the Hospital] spoke to [Ms G] about it being inappropriate. They said it was wonderful — happy for us — told [Ms E] in 2009.'
'No one ever suggested it was inappropriate to be in a personal relationship while being paid to be his caregiver.' '[Dr D] knew. [The rehabilitation unit] knew.'
'It did not occur to [Ms C] that it was inappropriate for her to be in a personal relationship with [Mr A] while being paid to be his caregiver.'

In an interview with [Mr F] and [Ms G] on 22 February 2013 they state that '[Ms E] says she was aware in March 2010, [Mr F] — was by inference in conversation, not aware of anything else. No evidence of cohabitation in house. But — [Ms E] said he treated [Ms C's] girls as his and [Ms E] was pleased he had found someone who cared for him.

A phone call record from [an HDC investigator] with [Ms B] on 10/4/2012 1455 hours states '[Ms B] said she came back to NZ for a visit in March 2010. [Ms C] and [Mr A] announced their engagement, and planned to [go overseas] and get married. [Ms B] said the family was very excited about this and they were happy for [Mr A] that he had found love.'

3. Was it appropriate for [Ms C] to have her children living at [Mr A's] house?
As far as I am aware this is an unusual circumstance. There is not enough information provided to determine if this arrangement was appropriate as the personnel who discussed the initial arrangement with [Ms C] and [Mr A] are no longer employed by [the Hospital].

4. What steps should have been taken once the Masonic Villages Trust was on notice of a personal relationship between [Ms C] and [Mr A]?
[The Hospital states] they became aware of the relationship in March 2010 and sent [Ms C] a copy of the Standards of Integrity and Good Conduct and therapeutic Relationships and Boundaries Guideline, and [Ms C] was asked to sign and return a

copy. [Ms C] does not recall seeing these documents and in her evidence states 'I definitely have not seen that before.' 'I was not asked to sign anything.' 'They did not post information to me.' 'Once they bought wine but was annoyed because he didn't drink. (Xmas present).'

According to [the Hospital] training records [Ms C] never received any education or training from [the Hospital] on boundary issues. Between 2007–2010 — No evidence of policy around boundary issues in [the Hospital's] policies.

[Ms E] states she contacted then ACC case manager in 2010 when [Ms C] mentioned they were in a relationship. The case manager was away and [Ms E] states she never followed this up. Her manager at the time did not speak to [Ms C] about it. According to his statement [Mr F] said the information about the personal relationship — 'by inference in conversation, not aware of anything else'. At this time in 2010 [Ms C] had been the sole carer 24/7 since January 2007.

In order to support [Ms E], [Mr A] and [Ms C] the Manager of Masonic Villages Trust should have made an appointment to meet in person with [Ms C] and [Mr A] to clarify the information that they had received.

5. Did the Masonic Villages Trust take adequate steps to ensure [Mr A] was receiving an appropriate standard of care, and to ensure he was not being abused or exploited? In particular please comment on the following:

a. Frequency and nature of the visits from the community coordinator

On discharge from the inpatient facility [Mr A] was receiving frequent visits from a variety of team members by [the Hospital] including registered nurses for catheter and wound care and 3 monthly visits from the community coordinator. According to the documentation these visits seem to be recorded in different places on the nursing notes and family contact forms as the dates do not run consecutively. There are no designations/titles or written names to identify who has made theses entries.

July 2008 withdrawal of Community Nursing Services component from the Hospital's service by ACC. This is documented by [Ms E] in [the Hospital] notes and states that '[Mr A] and [Ms C] more than happy with us visiting every two weeks. If not going to visit please ring.' No documentation of phone calls instead of visits are noted but documentation of declined visits are detailed. In her statement [Ms C] advised that she had no concerns re the support provided by [the Hospital]. [Ms C] was taught to do the wound dressings and catheter changes for [Mr A].

Communication to and between health care providers/funders by [Mr A] and [Ms C] was through personal phone calls, texts, email, written correspondence, faxed information and home visits. Whilst the frequency of visits from the community coordinator and [the Hospital] staff decreased there were several other health care providers involved.

[The Hospital] — [Ms G] RN
[The Hospital] Home Based Services — Community Services Manager [Ms E]

GP Practice — [Dr D], [two other staff]
[The rehabilitation unit] — [Dr J], [Consultant physician]
[Palliative care services] — [RN], District Nurses, [Dr I]
[A hospice]
ACC — [Case Manager], […], [Case Manager]
[The DHB Clinical Nurse Specialist for Wound Care]
[Respiratory Physician], [a public] Hospital 21/4/10
[Respiratory Physician], [a public] Hospital 29/4/10

Whilst [Mr A's] health care providers worked collaboratively, [the Hospital] as the agency providing the carer for his ACC contracted care was not included as a recipient in any of the written documentation from any of these services because he was a community based patient. This includes the collaboration between [palliative care services], [Dr D] and [Mr A] re his withdrawal of medication on 31 December 2010.

The timeline indicates the extensive contact [Mr A] and/or [Ms C] had with these services and at no time has any of the health care providers indicated any cause for concern regarding the care provision provided by [Ms C].

The management plan now implemented by [the Hospital] includes home visits twice a month by a Community Coordinator. If a client is away the visit is rescheduled and the ACC case manager is informed. According to [Ms E] previously if a client refused there was no one at [the Hospital] for her to contact.

This increased oversight by a [Hospital] Community Coordinator will ensure that they are more informed of client health and any complications that may arise, including communication by the client with other health care providers or funders. Individual circumstances should also be taken into consideration especially in the case of a complex client such as [Mr A] who had tetraplegia and chronic complications such as pain, respiratory compromised, postural hypotension and his lifestyle choices.

b. Training and performance reviews for [Ms C]

[The Hospital] introduced the annual performance review policy in October 2009. An attempt to complete an annual performance review was undertaken on 29 October 2009 when [Ms E] posted the forms to [Ms C]. [Ms C] denies receiving form. No follow-up has been documented.

[Mr F] advises that in the first week of March 2010 all community based staff were sent the Home Visiting Procedure which included therapeutic Relationships and Professional Boundaries Guideline and a copy of the Standards of Integrity and Conduct — issued by the State Services Commission. [Ms C] denies receiving these documents. It is noted that [Mr A] was at the rehabilitation unit from 8 March to 28 March 2010.

In her statement [Ms E] advised that [Ms C] did not attend any staff education but it is now compulsory. 'She didn't turn up and no arrangements were made for transport or respite to assist her.'

[Ms E] states she did not follow up on [Ms C's] performance review. [Ms E] felt unsupported and there was very little support for the community manager — no one would listen.

c. Respite and holidays for [Ms C]

[Ms C's] employment contract signed 1/06/06 states
'14. You must take annual leave at a time agreed with us. If we cannot agree a time with you, we can specify when you take leave.
You should take annual leave with[in] 12 months after it becomes due. If we require you to take that leave and you do not take it, the leave will be lost. However, we will, if we think fit, give you written approval to carry the leave forward.'

The employment of [Ms C] as a fulltime 24 hour carer in [Mr A's] home is an unusual situation. The discussion regarding this original arrangement is unknown as the staff member involved is no longer employed at the Hospital. Therefore any information discussed regarding the provision of respite and holidays is non-existent.

[Mr A's] house was not only [Ms C's] place of employment but also her residence and thus it is unclear how the respite arrangement/annual leave was to work or what prior understanding/arrangement had been made. Was [Ms C] expected to leave her residence for her holidays/any respite care whilst another carer moved in 24/7 or was [Mr A] going to [go] into a facility for his respite care?

The only information regarding taking annual leave or respite care is from the interviews with [Ms E] and [Ms C] and they stated:
According to the information provided by [Ms C] annual leave was added onto her wages and this was organised by [Ms E].

According to the information provided by [Ms E], [Ms C] turned down respite and she wasn't required to take it.

d. Acceptance of marijuana use and smoking within the home/workplace

There is not enough information provided to determine if there was a prior discussion with [Ms C] with regards to smoking within the house or within the grounds as the personnel who discussed the initial arrangement with [Ms C] and [Mr A] are no longer employed by the Hospital.

In the document Attachment 4 included with [Ms G's] correspondence is [Ms C's] Employment agreement 1/6/06 which on page 5 states

> '4. Duty in relation to Employer's reputation or business. You must not do anything, whether in respect of the employment or not, that might seriously affect our reputation or your ability to do your job properly.'
>
> This clause thus could be applied to the smoking of marijuana as it is a prohibited substance and therefore could imply that any employees of [the Hospital] are not permitted to smoke marijuana whilst on duty in a [Hospital] facility or client's home.

6. What policies and procedures need to be in place in these circumstances (home based care), to ensure the consumer is receiving an appropriate standard of care and protect against abuse and exploitation?
The information provided by [Ms G] from [the Hospital] outlining the changes/improvements in practices since this complaint was made facilitates the answer to this question.

Management practices:
Facility Manager — Community Manager weekly oversight
This is a weekly meeting that is documented and is goal and progress focused with action points and responsibility allocated.

RN Input into Community Service Provision
As outlined in documentation above and [the Hospital] Masonic Community Care Plan which was reviewed on 1 August 2011 and includes that it is sighted by an RN.

Biweekly meetings with the Facility Manager and Community Coordinator
This is documented on an Individual Client Review Form and follow-up actions and who it is to be actioned by and the date is recorded.

Community Home Visit Guideline — Management
This flow [chart] has been developed [and] is a guide for the monthly assessment visit. A copy is also in place in the client's Blue Community Folder. This form ensures documentation is in a client's progress notes, home communication book, home visit register [the Hospital] and to ACC case managers if visits are missed.

Regular Client Visits from Facility Manager (RN, MN)
This advises that all clients are met and visited and all folders, care plans and patient satisfaction surveys reviewed. Clients are advised they can call the Facility Manager at any time.

Organisation/Planning Whiteboard in Office
This whiteboard details the type of package the client has, when the package expires, review dates of care plans, primary care provider name, and date of last personal contact.

Annual Staff performance reviews
All staff have a performance [review] after three months and then annually by the appropriate personnel. There is no specific mention of adherence to 'The Masonic Villages Trust Staff Responsibilities and Code of Conduct' (Evidence appendix Q8.18 — this could be included as a bullet point under the section of 'General'.)

Staff Orientation.

Orientation Workbook

A robust Orientation system is in place which was implemented in 2010 and this includes a buddy system, formal orientation programme and an extensive Orientation Workbook. On Page 7 in Section 1 there is a box for 'Mission Statement/Code of Conduct'. This could be changed to 'The Masonic Villages Trust Mission Statement/ The Masonic Villages Trust Staff Responsibilities and Code of Conduct". There is no mention of the specific flyer Standards of Integrity and Conduct or [the Hospital] Masonic Hospital and Community Care Service Therapeutic Relationships and Professional Boundaries Guideline. This should be included as a boxed item in the Orientation Booklet.

Annual Clinical Skills Update

Core Community Staff receive an annual clinical update with a buddy in the hospital setting which focuses on practical clinical skills with certification provided.

Blank Client Folder for Review

Information provided in this folder is detailed on page 4 of the letter from [Ms G] and [Ms E] to [the HDC investigator] dated 12/6/12. The Masonic Villages Trust Staff Responsibilities and Code of Conduct the flyer Standards of Integrity and Conduct and [the Hospital] Masonic Hospital and Community Core Service Therapeutic Relationships and Professional Boundaries Guideline should also be included as information in the client's folder.

The client folder includes [the Hospital's] Masonic Community Care Staff A–Z (information book for staff orientation (app 08.7). To maintain consistency under code of conduct it should read 'To maintain professional integrity, a copy of the Masonic Villages Trust Staff Responsibilities and Code of Conduct is available in the Policy Manual. There is no mention of the spec flyer 'Standards of Integrity and Conduct' or '[The Hospital] Masonic Hospital and Community Care Service Therapeutic Relationships and Professional Boundaries Guideline', and this should be included under section T. For quality purposes this A–Z guide should have footer with the date of implementation and review date as all the other documents have.

Staff Training

Compulsory Staff Training Records are now being kept and this includes family members employed by [the Hospital].

Audits

Audits are undertaken as part of in-service education. Client Care information is addressed as part of the annual performance review as an indicator includes a section 'Attains and maintains the proper standards of care and wellbeing for all residents'.

Documentation

The Masonic Villages Trust & [the Hospital] Community Care Agreement to provide Personal Cares, Home-management, Community Support

A Service Agreement between the Client and The Masonic Villages Trust and [the Hospital] Community Care is comprehensive. It could include an outline of the Blue Client Information Folder and a list of its contents and an outline of the Client's

responsibilities for participating in document sign off for informed consent, care plans etc.

Blue Client Information Folder
As previously discussed — it is not mentioned if [Mr A] had one of these. All correspondence from any health care provider in any form such as phone calls, texts, emails and letters need to be recorded and kept in this client information folder so that they are seen by [the Hospital's] Community Care Manager or RN or Facility Manager to ensure that the information is disseminated.

Care Plan Review and Signing Sheet
This now includes RN sign off.

Communication
Community Newsletter
This is a bimonthly publication.

Annual Performance Appraisal
A detailed pathway to ensure these are undertaken.

The documentation and practices detailed above are deemed appropriate to ensure the consumer is receiving an appropriate standard of care and protection against abuse and exploitation.

At the time of the incident:
Appropriate RN supervision regarding the inference of a relationship between [Ms C] and [Mr A] was not provided to [Ms E].

Follow-up regarding the completion of [Ms C] compulsory staff training and annual performance reviews was not documented if it was undertaken.

Communication between other providers did not include the Community Care Manager nor RNs at [the Hospital] Masonic Villages Trust.

If, in answering any of the above questions, you believe that [Ms C] and/or the Masonic Villages Trust did not provide an appropriate standard of care, please indicate the severity of the departure from that standard.
At the time of the incident:

Appropriate RN supervision regarding the inference of a relationship between [Ms C] and [Mr A] was not provided to [Ms E]. This is a mild departure from the standard as supervisory support for [Ms E] would have facilitated the clarification of the relationship and appropriate disclosure to [the Hospital] Management and/or ACC. It would then be up to [the Hospital] and ACC, [Ms C] and [Mr A] to consider all the information and consequences of the relationship and ongoing carer provision.

Management Practices now implemented by [the Hospital] would resolve any departure from the standard for any future clients.

Follow-up regarding the completion of [Ms C's] compulsory staff training and annual performance reviews was not documented if it was undertaken. This is a mild departure from the standard as the now compulsory staff training was not compulsory at the time of the incident and the annual performance review policy was only

introduced in 2009. There were no indicators at this time re any concerns regarding the care provided by [Ms C] to [Mr A].

Management Practices now implemented by [the Hospital] would resolve any departure from the standard for any future clients.

Communication between other providers did not include the Community Care Manager nor RNs at [the] Masonic Villages Trust. This is an observation by the expert advisor and cannot be considered a departure from any of the standards.

Management Practices now implemented by [the Hospital] would resolve any potential departure from the standard for any future clients and in particular pertains to Right 4, No 5."