

8 July 2021

NZ Health Justice

By email: fyi-request-15556-9@xxx

Ref: H202106408

Tēnā koe NZ Health Justice

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) on 25 May 2021 for information pertaining to audits, certification and surveillance of HealthCare NZ Limited.

On 22 June 2021, the due date for responding to your request was extended under section 15A of the Act as further consultation was required.

Information in response to each part of your request is as follows. The table in Appendix 1 also outlines the documents for release.

“A timetable of certification, surveillance and verification audits of HealthCare NZ Limited under NZS 8158:2012 since 2017”

The Ministry of Health (the Ministry) does not formally receive the audit schedule timetables from the conformity assessment bodies (CABs) for Home and community providers. However, we note the following audits have occurred and are pending for Healthcare of New Zealand Holdings Limited:

- June 2017 certification audit
- 2017 verification audit
- March 2019 surveillance audit
- 2020 certification audit is pending (deferred due to COVID-19 pandemic).

“A copy of the most recent certification, surveillance or verification audit undertaken of HealthCare NZ Limited under NZS 8158:2012;” and “An explanation of how these audits are completed and the Ministry's role”

Please refer to Document 1 attached to this letter for a copy of the ‘*Home and Community Support Services Audit Report*’.

It is important to note that HealthCERT does not regulate or certify Home and Community Support Services (HCSS) providers under the Health and Disability Services (Safety) Act 2001.

HealthCERT's role is to provide an administrative function in terms of maintaining a central repository for home and community provider audit reports (where they are funded) and to help facilitate review of certification audit reports between the Independent Assessment Committee and the CAB.

Further information regarding the requirements for CABs that are auditing and certifying providers of HCSS against the HCSS Standard (NZS 8158:2012) is publicly available on the Ministry website: www.health.govt.nz/publication/auditing-requirements-home-and-community-support-sector-standard-nzs-81582012.

The Ministry also contracts service providers to provide HCSS through a Needs Assessment Service Coordination (NASC) service. Ministry-funded HCSS help disabled people to live at home and include household management and personal care. Further information about this is available at the following address: www.health.govt.nz/your-health/services-and-support/disability-services/types-disability-support/home-and-community-support-services.

"A copy of any formal correspondence addressed to the Ministry under section 59 of the Health & Disability Commissioner, or other relevant provisions of the Act, in respect of HealthCare NZ Limited in the past 12 months. Where any such referrals have been made, please disclose what follow-up action the Ministry has taken. If no action has been taken then please provide an explanation."

Please refer to Documents 2 to 8 for information within scope of this part of your request. These documents are listed in Appendix 1 with copies enclosed. The table in Appendix 1 also lists the specific grounds under which information has been withheld.

I trust this information fulfils your request. Please accept my apologies for the delay in providing this information.

Under section 28(3) of the Act you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā



Emma Prestidge
Group Manager, Quality Assurance and Safety
Health System Improvement and Innovation

Appendix 1: List of documents for release

#	Date	Title	Decision on release
1	March 2019	Home and Community Support Services Audit Report	Released with some information withheld under section 9(2)(a) of the Act, to protect the privacy of natural persons
2	September 2020	Letter from the Health and Disability Commissioner to the Director General of Health	
3	November 2020	Letter from the Health and Disability Commissioner to the Chief Executive Officer of HealthCare NZ	
4	November 2020	Letter from the Health and Disability Commissioner to the Director General of Health	
5	2020	Summary table of complaints raised against HealthCare NZ	
6	2020	Updated table of complaints raised against HealthCare NZ	
7	February 2021	Memorandum: Update to Deputy-Director General about actions taken in response to HDC complaint dated 23 September	Released in full
8	2021	Excerpt of quality record minutes about actions taken in response to the HDC complaint	

Home and Community Support Services Audit Report (version 1.0)

Introduction

This audit was conducted against the Home and Community Support Sector Standard 8158:2012. Instructions:

- Refer to the Conformity Assessment Body document for Home and Community Support Services audits.
- When completing this template standard level reporting is used i.e. criteria only have evidence reported where there is a non-conformity or continuous improvement (fully attained ratings do not have evidence reported at criterion level).
- For a surveillance audit: refer to paged 6-7 of the Conformity Assessment Body document for Home and Community Services audits.
- A recommendation is an opportunity for improvement for a fully attained criterion.
- Sample totals: these represent staff employed, total FTE and number of consumers receiving services across the total organisation (not just the audited sites).
- Submit the final report together to the Ministry of Health (refer separate instructions).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Supplier name:	Healthcare of New Zealand Holdings Limited
Contract name(s):	Healthcare of New Zealand Holdings Limited (HCSS)
Contracts held with:	ACC; Ministry of Health; Auckland; Counties Manukau; Lakes; Bay of Plenty; MidCentral; Canterbury

Designated Auditing Agency:	The DAA Group Limited
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Types of audit:	Surveillance Audit
Premises audited:	Healthcare of NZ Christchurch; Healthcare of NZ Hamilton; Healthcare of NZ New Plymouth; Healthcare of NZ Auckland; Healthcare of NZ Tauranga; Healthcare of NZ Palmerston North
Dates of audit:	Start date: 18 March 2019 End date: 18 April 2019

Home and Community Support Service Audit Team

Lead Auditor	Karen Davis	Hours on site	72	Hours off site	24
Other Auditors	Joy Hickling	Total hours on site	72	Total hours off site	24
Technical Experts	Click here to enter text	Total hours on site	0	Total hours off site	0
Consumer Auditors	Click here to enter text	Total hours on site	0	Total hours off site	0
Peer Reviewer	Joanna Harper			Hours	3

Sample Totals

Total audit hours on site	144	Total audit hours off site	51	Total audit hours	195
Number of consumers interviewed (face to face)	41	Number of field based staff interviewed	59	Total FTE equivalent staff employed	0
Number of consumers interviewed (telephone)	8	Number of office based staff interviewed	19	Number of managers interviewed	22
Number of consumer records reviewed	97	Number of staff records reviewed	106	Number of relatives interviewed	5
Total number of consumers receiving services	41212	Total number of staff employed	3550	Number of health professionals interviewed	19

Executive Summary of Audit

General Overview

HealthcareNZ Limited (previously called Healthcare Holding Ltd) provides home and community services throughout New Zealand via HealthCare of New Zealand Limited (previously known as Healthcare of New Zealand Ltd and Healthcare Rehabilitation Ltd). Community mental health services have been provided in five locations under the name Mental Health NZ.

Since the last audit, there has been a formal merger of Healthcare New Zealand Ltd and Healthcare Rehabilitation Ltd and renaming of the organisation. This has resulted in significant change with two out of a three-stage restructuring programme completed. A divisional chief executive officer has been appointed to HealthCare of New Zealand. The first stages of the restructure included restructuring of the area manager and national operation roles and the next tier of management. There are now six regional operations managers (ROMs) that are responsible for all services provided within their geographical location. Six regional clinical managers have been appointed aligned geographically with each regional operations manager to assist with clinical governance. New roles have been developed, including national service development manager, and a service improvement manager role (currently vacant). Thirteen locality managers have been appointed (previously called branch managers). Clinical service managers or service managers are responsible for services provided to rehabilitation clients in each location. The title is different between some locations based on size of the service. There are designated service managers for the mental health services. All of the locality managers of the localities audited were appointed to the role in September 2018 although most held branch manager roles previously with one of the previous service entities. The regional operations managers all held senior management roles prior to the restructure and have now expanded responsibilities. A new company called 'My Skills' is responsible for overseeing the staff learning and development framework for the three services included in this audit.

This is the first occasion all home and community services have been incorporated into one certification programme for HealthCare New Zealand. Six localities (Albany, Penrose, Palmerston North, Hamilton, Tauranga and Christchurch) were included in this audit along with the mental health services provided in Hamilton, Tauranga and Christchurch.

All mental health services now use 'recordbase' as the electronic client management system. Work has commenced and is ongoing to merge all other community and rehabilitation services to one client management system (Care Call). Along with this, electronic time and attendance records (replacing timesheets) for staff are being slowly introduced.

Work has been ongoing to standardise and align policies, procedures and quality and risk systems across all the home and community services.

The home and community services provided are funded by Accident Compensation Corporation (ACC), District Health Boards (DHBs), the Ministry of Health (MOH), Veterans Affairs and by privately paying consumers. In some locations, a restorative model of care is being implemented where this is contractually required by individual DHBs.

There are 2,073.38 staff employed in the community services, 1, 447.60 staff employed in the rehabilitation services, and 30 recovery facilitators in mental health. All consumers and family members interviewed were satisfied with the services received.

During the previous three audits (Mental Health New Zealand in 2016), Healthcare New Zealand (June 2017) and the Healthcare Rehabilitation verification audit (November 2017), there were 28 areas identified as requiring improvement with some only related to one service. The areas for improvement raised related to managing client finances, policies and processes related to entering consumers' homes, monitoring organisation performance, consulting with mental health consumers and family /whanau, incident management, developing access/entry criteria for mental health clients along with a sufficiently detailed admission agreement, and exit/discharge processes for mental health clients have been addressed. One client management system is now used in mental health, ensuring community staff maintain client information in a confidential manner, monitoring of non-signing clients, the afterhours service/client and staff/client rostering, aspects of medicine management, developing and implementing a policy for self-administering of medicines by clients, infection control policies and procedures, and staff training on challenging behaviour have also been addressed.

At this audit, eight areas continue to require improvement. These relate to complaints management, undertaking internal self-assessments/snapshot audits, corrective action planning, identifying priority clients in an emergency, staff training, staff competency assessments/performance appraisals, review of clients' progress towards achieving their goals, and ensuring service plans are reviewed at least annually.

Outcome 1: Consumer Rights

Systems and processes are in place to ensure that clients' rights are maintained. A copy of the Code of Health and Disability Services Consumers' Rights (the Code), together with information about the Nationwide Health and Disability Advocacy Service is provided to the client on entry to the service. There are opportunities for discussion if the client so wishes. Education relating to clients' rights is included in staff orientation.

The individual preferences, values and beliefs of clients along with specific cultural/spiritual requirements are identified and incorporated into the service delivery plan. A copy of the plan is provided to the client and is available to guide support workers during service delivery.

Systems and processes are in place to ensure that clients and staff are informed of the complaints process. Clients confirmed any complaints have been addressed. Policies and procedures are available to guide staff practices related to concerns clients may be at risk of abuse or neglect.

Open disclosure principles are followed.

Outcome 2: Organisational Management

The service is governed by a board of directors and is managed by an experienced divisional chief executive with the support of regional operations managers, regional clinical managers, and locality/service managers. Processes are in place to monitor the organisation's progress to achieving their goals and objectives.

The organisation's quality and risk management system includes quality improvement projects, complaints, compliments, client experience surveys, identification and monitoring of risk and adverse event reporting. Open disclosure is documented as occurring. Complaints, incident and

health and safety data are monitored by locality and service as well as nationally with themes and trends identified and communicated. The organisation is an accredited employer by Accident Compensation Corporation (ACC) at tertiary level.

Organisation policies and procedures have been reviewed and standardised for the community services. Document control processes are implemented.

Support workers are aware of the need to maintain any client information in a secure and confidential manner. One client records management system is now in use in mental health services. Clients and their family/whanau where applicable are consulted about services delivered.

Outcome 3: Human Resources

A comprehensive induction/orientation programme is available for new staff relevant to their roles and responsibilities.

An on-going training programme is in place, including support to complete level two and three of an industry approved qualification. The support worker competency framework has been reviewed.

All registered health professionals have current annual practising certificates and access to relevant ongoing education. Support workers and recovery facilitators have access to advice and support where required both during business hours and afterhours.

Outcome 4: Service Delivery

Service agreements include all the requirements of the standard. Service plans are focused on maintaining and supporting independence and recovery. The service plans for the three service streams are in different formats. Clients and families interviewed expressed their satisfaction with their involvement in the development of their or their relatives' service plans and the review process whenever it occurs. They also expressed their satisfaction with the standard of services provided to them and the reliability of the service.

Staff reported they receive good support from managers, coordinators and RNs. There are systems in place for contingency planning in the event of an emergency.

The medicine management policies and procedures have been reviewed and ratified. The services at the branches visited have developed close links with a range of support agencies including district health boards (DHBs), primary health organisations (PHOs), the Accident Compensation Corporation (ACC) and veterans' affairs, to ensure services are coordinated with other service providers working with each client.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	15	0	1	4	0	0
Criteria	0	54	0	2	6	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	11
Criteria	0	0	0	0	0	0	0	48

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HCS.2012	Standard 1.9: Complaints	The consumer's right to make a complaint is understood, respected, and upheld.	PA Moderate	Click here to enter text.		
HCS.2012	Criterion 1.9.3	An up-to-date complaints register is maintained that documents and includes all complaints, dates, and actions taken.	PA Moderate	Where complaints are open more than 20 working days, communications with the complainant are not consistently occurring or documented as occurring. Communication with the complainant on the outcome of complaints is not always noted or has not included all aspects in the complaint.	Ensure the investigation includes all aspects of the complaint and the complainant is advised of the outcome. Ensure ongoing communications occur with the complainant in the event a complaint is unable to be addressed within 20 working days.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HCS.2012	Standard 2.3: Quality and Risk Management	Consumers receive services that reflect continuous quality improvement principles through the organisation having an established, documented, and maintained quality and risk management system.	PA Moderate	Click here to enter text.		
HCS.2012	Criterion 2.3.4	A process to measure achievement against the quality and risk management plan is implemented.	PA Low	Some staff undertaking self-assessments have not been trained in the process and follow-up action required. There is variation across services / branches in how the results of self-assessments are documented, the frequency they are conducted, the documentation of results, and the development and follow-up of action plans in response to self-assessment findings. There is no systematic analysis of staff exit interview data and an organisation wide plan to address findings has not been developed.	Provide applicable staff with training on undertaking self-assessments. Ensure self-assessments are undertaken in the required timeframes, the results documented in a consistent manner, action plans developed where applicable and implemented and monitored for effectiveness. Analyse staff exit interview data in a timely manner and develop an action plan to address findings.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HCS.2012	Criterion 2.3.5	The development and implementation of corrective action plans that address areas identified for improvement.	PA Moderate	The corrective actions taken in response to some incidents, complaints, self-assessments and staff exit survey data are not always documented or followed up in a timely manner. Where advice is sought from the complex issues group or national care and protection team, recommendations received are not always linked to the client record or incident management system.	Ensure corrective action plans are consistently developed in a timely manner where areas for improvement are identified, are implemented, and monitored for effectiveness. Ensure feedback received from the complex issues group or national care and protection team are linked to the client's record / incident management system.	90
HCS.2012	Standard 2.7: Essential and Emergency Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	Click here to enter text.		
HCS.2012	Criterion 2.7.2	The organisation, in consultation with the consumer, identifies and implements an appropriate plan relevant to the consumer's needs in an emergency.	PA Low	Mental Health Christchurch has a list of client addresses and phone numbers; however, a priority list based on risk has been not been developed.	Expand the list of client addresses and phone numbers to include a priority list based on risk for use in an emergency.	90
HCS.2012	Standard 3.2: Orientation, Induction, Ongoing Development, and Competency	Consumers receive services from service providers who are trained and assessed	PA Moderate	Copies of industry approved qualification records / certificates are obtained for the staff records where		

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		as competent to provide services.		employees have qualifications at employment.		
HCS.2012	Criterion 3.2.2	A developed, implemented, and recorded training plan relevant to the service provider's scope of practice is maintained.	PA Moderate	Whilst a training plan has been developed for recovery facilitators working in Christchurch, training is not consistently being provided. Records are not available to demonstrate that staff working in this service have completed training on abuse and neglect, management of actual or potential aggression /challenging behaviour training, and infection prevention and control.	Implement a training plan relevant to the service and include topics detailed above.	90
HCS.2012	Criterion 3.2.3	There is a system to determine and develop the competencies of the organisation's service providers to meet the needs of consumers. This shall be achieved by, but is not limited to: (a) The service provider's competency is assessed against the organisation's policies and procedures;	PA Moderate	Some support workers are overdue annual performance appraisals in all locations audited except mental health services and Hamilton community services. Some support workers, including those caring for clients with traumatic brain injuries, spinal cord injuries are overdue annual competency review in	Ensure staff consistently complete competency requirements and records are retained. Undertake annual performance appraisals for staff	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		(b) Competency gaps between consumer's needs and service provider's competency are identified; (c) Specialist advice, training, information, and oversight are provided by individuals who are trained/qualified and competent to undertake this role.		all locations audited except Hamilton community services.		
HCS.2012	Standard 4.11: Review of Service Delivery	Consumers are supported to achieve their goals through regular monitoring and review of service delivery.	PA Moderate	Click here to enter text.		
HCS.2012	Criterion 4.11.2	Reviews are documented, consumer focused, indicate the degree of achievement or response to the support and progress towards meeting the consumer's goals.	PA Moderate	Although progress has been made, reviews of goals in the rehabilitation and community services do not consistently indicate the progress towards meeting the client's goals.	Ensure service plan reviews are documented, client focused and indicate the progress towards meeting the client's goals.	180
HCS.2012	Criterion 4.11.4	There is formal evidence of a review occurring in line with the organisation's policy.	PA Moderate	Apart from the mental health service, not all reviews meet the required timeframes in the rehabilitation and community services.	Complete overdue reviews in the rehabilitation and the community services.	180

Recommendations Report

Code	Name	Description	Attainment	Recommendation
HCS.2012	Standard 2.1: Governance	Consumers receive services that are planned, co-ordinated, and appropriate to their needs.	FA	Organisation meeting minute templates be made available to managers and their use encouraged.
HCS.2012	Standard 3.2: Orientation, Induction, Ongoing Development, and Competency	Consumers receive services from service providers who are trained and assessed as competent to provide services.	PA Moderate	Copies of industry approved qualification records / certificates are obtained for the staff records where employees have qualifications at employment.

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

RELEASED UNDER THE
OFFICIAL INFORMATION ACT 1992

NZS 8158:2012: Home and Community Support Sector Standards

Outcome 1: Consumer Rights

Every consumer's values, dignity, and culture are recognised and supported; their choices respected; and their rights upheld.

Standard 1.1: Consumer Rights Under Legislation (HCS.2012:1.1)

Consumers receive services in accordance with their rights.

Attainment and Risk: FA

Evidence:

The organisation has a client code of rights policy that meets the requirements of the standard and guides staff practice.

The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Clients' Rights (the Code), the Code of ACC Claimant Rights together with information about the HDC Advocacy Service information are required to be given to each client in the three services by way of each individual's service guide and agreement booklet for ACC clients and service agreements for rehabilitation and mental health services. The allocated service coordinators, recovery facilitators, service managers and/or registered health professionals provide this information at the time of the first face-to-face meeting and outline the client's rights and responsibilities. There is opportunity for further discussion/clarification during this time and at any time following. Clients are informed of their right to have a support person/advocate present during all contacts and should they wish to make a complaint.

As required by the organisational informed consent policy, signed consents were sighted in the client's individual files reviewed. Any additional consents are recorded in files as required.

Training in the Codes and Advocacy Services occurs at orientation and on an ongoing basis for support workers and recovery facilitators. Support workers and recovery facilitators demonstrated a sound understanding of the Code and how this is used to guide their day-to-day work.

Clients interviewed across the service streams were complementary of the way services are delivered, stated that their rights are respected and they are fully informed and involved in all decisions relating to their service delivery.

Recommendation:

[Click here to enter text.](#)

Criterion 1.1.1 (HCS.2012:1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.2 (HCS.2012:1.1.2)

Information about the Code and other rights is provided at the earliest opportunity in languages and formats suited to the needs of consumers who are using the service.

Attainment and Risk: FA

Evidence:

Click here to enter text.

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.3 (HCS.2012:1.1.3)

There are opportunities for discussion, explanation, and clarification of the information with service providers.

Attainment and Risk: FA

Evidence:

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Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.4 (HCS.2012:1.1.4)

Consumers are informed of the availability of advocates, particularly in the event a complaint is made.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

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Corrective Action:

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Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.5 (HCS.2012:1.1.5)

Consumers have the right to have an advocate/support person present.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

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Corrective Action:

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Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.6 (HCS.2012:1.1.6)

Consumers have the right to make an informed choice and give informed consent to actively participate in decision making and in support service delivery.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.1.7 (HCS.2012:1.1.7)

The service provider is able to demonstrate that consent is obtained where required in accordance with the Code.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2: Individual Privacy, Dignity and Respect (HCS.2012:1.2)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, confidentiality, and independence.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 1.2.1 (HCS.2012:1.2.1)

Services are provided in a way that maintains and respects privacy, dignity, and the consumer's independence.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.2 (HCS.2012:1.2.2)

Consumers' information is maintained in a confidential manner.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text.

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3: Individual Values and Beliefs Respected (HCS.2012:1.3)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, and spiritual values and beliefs.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text.

Recommendation:

Click here to enter text.

RELEASED UNDER THE OFFICIAL INFORMATION ACT 1982

Criterion 1.3.1 (HCS.2012:1.3.1)

Consumers receive services in a manner that takes into account their individual cultural values and beliefs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.2 (HCS.2012:1.3.2)

The consumer is consulted on individual values and beliefs. Family/whānau of choice or other representatives are involved at the consumer's request.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

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Corrective Action:

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Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4: Recognition of Maori Values and Beliefs (HCS.2012:1.4)

Māori consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural values and beliefs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 1.4.1 (HCS.2012:1.4.1)

Service providers understand and respect the key principles outlined in relevant health and disability strategy documents, and demonstrate a commitment to these principles in the provision of services.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.2 (HCS.2012:1.4.2)

Māori consumers have access to appropriate services. Barriers to access within the control of the service provider are identified and eliminated.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.3 (HCS.2012:1.4.3)

Māori consumers receive services consistent with their cultural values and beliefs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

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Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.4 (HCS.2012:1.4.4)

The right of Māori consumers to practice their cultural values and beliefs while receiving services is acknowledged and facilitated by service providers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

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Corrective Action:

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Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.5 (HCS.2012:1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.5: Recognition of Pacific People’s Values and Beliefs (HCS.2012:1.5)

Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural values and beliefs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 1.5.1 (HCS.2012:1.5.1)

Service providers understand and respect the key principles outlined in relevant health and disability strategy documents, and demonstrate a commitment to these principles in the provision of services.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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Criterion 1.5.2 (HCS.2012:1.5.2)

Services for Pacific peoples recognise the dignity and the sacredness of life are integral in the delivery of services.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.5.3 (HCS.2012:1.5.3)

Pacific people receive services that are co-ordinated and culturally competent.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.5.4 (HCS.2012:1.5.4)

The service provider facilitates access to a Pacific recognised/accredited trained advocate and interpreter to advocate on cultural issues on behalf of Pacific people receiving care and support.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.6: Communication in a Manner that the Consumer can Understand (HCS.2012:1.6)

Information is communicated to consumers in a manner that the consumer can understand.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 1.6.1 (HCS.2012:1.6.1)

Consumers have a right to full and frank information and open disclosure.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.6.2 (HCS.2012:1.6.2)

Service providers allow sufficient time for discussions to take place.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.6.3 (HCS.2012:1.6.3)

Service providers identify themselves to consumers when visiting their home.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text.

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.6.4 (HCS.2012:1.6.4)

Wherever necessary and reasonably practicable, interpreter services (including a New Zealand Sign Language interpreter) are provided.

Attainment and Risk: Not Audited

Evidence:

Click here to enter text.

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.7: Freedom from Abuse or Neglect (HCS.2012:1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation, abuse (physical, psychological, sexual, or financial), or neglect.

Attainment and Risk: FA**Evidence:**

Policies and procedures that include all elements required by this standard are provided to guide staff, including signs and indicators of abuse and neglect. These documents have been recently updated. A new policy has been developed 'vulnerable children and child protection policy' and a care and protection team established to provide advice and support within the organisation where applicable. All incidents of discrimination, abuse or neglect, either suspected or observed, are required to be reported. Training on this topic is included in the orientation programme for new support workers, recovery facilitators, office-based staff, and managers with one exception (refer to the area for improvement raised in 3.2.2). This topic is also included in the ongoing education programme for staff who are working towards an industry-approved qualification. Staff are required to report any concerns about a client at risk of abuse or neglect to either the service manager, the coordinator, the registered health professional or the locality / line manager, and applicable events are also reported via the incident management system. The support workers and recovery facilitators interviewed demonstrated a good understanding of their responsibilities. Where staff had reported concerns to their line manager these concerns had been investigated and followed up in a timely manner, as observed during audit. Communication with the funder and other applicable external agencies has also occurred when appropriate.

Support workers and recovery facilitators interviewed demonstrated a sound understanding of professional boundaries. These are discussed during orientation and the Code of Conduct given to staff to review and sign as a component of the employment process. Suspected or identified breaches in maintaining professional boundaries are reported via the incident management system and followed up by the applicable manager.

Team meetings are held at various frequencies in the homes of rehabilitation clients with complex care needs. The discussions include any areas of concern or client / family safety.

The information provided to new clients includes information on the professional conduct required of support workers. All clients interviewed reported being satisfied with their support workers or recovery facilitators and confirmed they have not experienced any sort of abuse or neglect from staff.

Recommendation:

[Click here to enter text.](#)

Criterion 1.7.1 (HCS.2012:1.7.1)

There are policies and procedures to ensure consumers are not subjected to discrimination, coercion, harassment, sexual, financial, or other exploitation, abuse (physical, psychological, sexual, or financial), or neglect.

Attainment and Risk: FA**Evidence:**

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.7.2 (HCS.2012:1.7.2)

Service providers maintain professional boundaries and refrain from acts or behaviour which could benefit the service provider or organisation at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.7.3 (HCS.2012:1.7.3)

All allegations of discrimination, abuse, or neglect of any kind are managed and recorded according to the organisation's policies and procedures, and link to the quality and risk management system.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.7.4 (HCS.2012:1.7.4)

A process is established to record and report incidents of discrimination, abuse, or neglect.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.7.5 (HCS.2012:1.7.5)

Abuse and neglect prevention awareness is included in the induction programme for all service providers and is updated regularly to maintain knowledge.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.8: Consumers' Belongings, Property, and Finances are Respected and Protected (HCS.2012:1.8)

Consumers' belongings, property, and finances are respected at all times.

Attainment and Risk: FA

Evidence:

Policies and procedures protect the client's money, belongings and property during service delivery, including entering the homes of clients.

Service coordinators stated in the branches visited that all clients on the high-risk registers have been reviewed and the numbers of clients remaining on the registers has decreased significantly. Review of the electronically held high-risk registers confirmed this. Support workers reported they are not involved in money matters with clients if possible. Clients who require shopping either go on an outing with the support worker to undertake the shopping directly with assistance if required. Some clients order

groceries from supermarkets or buy food boxes online and pay for the items online directly with the supplier. Support workers can collect the items if required on behalf of the client or the items can be delivered to the client's home. Clients' families/EPOA are also encouraged to support the client with shopping, especially for larger items.

If shopping is required to be undertaken by a support worker, a specific form is utilised to document each transaction including the cash given, receipt total and change given and that the totals align. Entries are signed by the client / nominated representative and the support worker. Organisation policy requires that the specific arrangements and monitoring process must be clearly documented in the support plan. All service/support plans reviewed evidenced the specific arrangements and monitoring. Senior service coordinators/managers are responsible overall for monitoring the high-risk registers and any changes to a client's situation is discussed fully with the client and other staff and the register updated.

Staff, if required, are provided with information on how to enter a client's home. This includes knowledge of the location of a hidden key or knowing the pin number of a lock box or medicine storage box. On rare occasions, a support worker may have a key to the client's home. In this situation, information is documented in the client's electronic file and on the high-risk register.

Support workers demonstrated they know of the requirements set out in policy and stated they always knock and wait for a response before entering a client's home. The stated exceptions include when the client is known to require staff assistance to get out of bed and another family member may not be present. In this event, the support workers note they will knock and enter and call out to the client that they have arrived. The support workers stated this is only undertaken at the request of the client / family and with the prior knowledge of the specific service coordinator. Policies and procedures protect the client's money, belongings and property during service delivery, including entering the homes of clients.

New clients are provided with information on policies and the process around management of money (if applicable), access to their home and protection of property during their initial contact with the service. Clients reported that support/care workers carry out procedures as described. The finding from the verification audit in 2017 has been addressed and is now closed.

'Access to a Person's Home' policy is a mental health service policy and provides guidance for staff accessing a client's home which is agreed to by the client. The policy also includes whether the client has any preferences, for example removing shoes before entering the client's home. This information is documented in the client's personal file. Hazards are identified in a hazard assessment checklist. Review of clients' files and hazard checklists confirmed this. The service managers reported recovery facilitators do not hold keys to clients' homes who are using mental health services, as it is not considered appropriate.

Recovery facilitators demonstrated they are knowledgeable with regards to knowing what the procedure is for ensuring the safety of clients and/or staff. The service manager for the Hamilton and Tauranga branches reported two staff always attend the first home visit and includes either a recovery facilitator or the service manager and a clinical key worker from the DHB mental health team. In the Christchurch branch, the service manager and a recovery facilitator undertake the initial visit.

The finding from the mental health certification audit in 2016 and the verification audit in November 2017 have been addressed and are now closed.

Recommendation:

[Click here to enter text.](#)

Criterion 1.8.1 (HCS.2012:1.8.1)

There are policies and procedures for the protection of consumers' money and property during service delivery.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.8.2 (HCS.2012:1.8.2)**

There are clear policies about entering the homes of consumers.

Attainment and Risk: FA**Evidence:**

Click here to enter text.

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.9: Complaints (HCS.2012:1.9)**

The consumer's right to make a complaint is understood, respected, and upheld.

Attainment and Risk: PA Moderate**Evidence:**

The policy and procedure for complaints includes definitions of complaints and describes how complaints are to be reported and includes the process and timeframes for managing and responding to a complaint. The documents meet the requirements of this standard and Right 10 of the Code. The service managers, and the locality managers, are responsible for the overall management of complaints, with the assistance of the coordinators and registered health professionals as applicable / required. Complaints are required to be reported electronically. This is via Promapp for all community clients excluding the mental health services where complaints are recorded on 'Recordbase', (the mental health client management programme). Complaints are also to be referenced within the client's individual file. Promapp and Recordbase are utilised as the complaints registers.

Progress updates were not consistently evident for complaints open more than 20 working days. Some complaints did not have sufficiently detailed investigation and responses. This was raised as an area for improvement in the 2017 certification audit and continues to be an area requiring improvement. There are escalation processes to ensure applicable local, regional and national managers are advised of significant complaints. There have been three complaints received via the Health and Disability Commissioner since January 2018 in the branches audited. A complaint was received in Christchurch in February 2019 and is currently being investigated. Two other

complaints received related to services provided in Palmerston North (March 2018) and in Penrose (February 2018), were not formally investigated and referred to the HDC advocate for resolution. Both complaints were resolved to the complainant's satisfaction via the advocacy process.

Regular reports are issued from the quality and risk team at national office summarising complaints and the themes and trends over time to the quality safety and clinical governance and individually to each region and service type (community, rehabilitation and mental health).

The information pack for all new clients includes information on the complaints process. Clients interviewed reported they knew how to make a complaint if needed, and any concerns raised had been followed up.

Recommendation:

[Click here to enter text.](#)

Criterion 1.9.1 (HCS.2012:1.9.1)

An easily accessed, responsive, and fair complaints process, which complies with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights is documented and implemented. This shall include, but is not limited to:

- (a) The service operates the complaints process in a fair and appropriate manner, including the involvement of advocacy services, where appropriate;
- (b) The organisation encourages consumers to use the complaints process when they have a complaint about service providers;
- (c) Service providers attend training on how to receive and manage complaints;
- (d) Clearly written guidelines for service providers on what constitutes feedback or complaint;
- (e) A link to the quality and risk management system.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.9.2 (HCS.2012:1.9.2)

Information about a consumer's right to complain and the complaints process is available to consumers prior to service commencement, and they are supported in their right to use the complaints process.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.9.3 (HCS.2012:1.9.3)

An up-to-date complaints register is maintained that documents and includes all complaints, dates, and actions taken.

Attainment and Risk: PA Moderate

Evidence:

The complaints management processes were reviewed in each branch audited and included community health, rehabilitation and mental health services (where applicable). Some complaints have been managed very well with clear communication occurring with the complainant and all issues being investigated and responded to in a timely manner. The rehabilitation service in Tauranga managed the sampled complaints well. However, complaints are not always being responded to in timeframes that align with the Code. Examples were sighted in Penrose, Palmerston North, Hamilton and Tauranga of complaints that have been or are open for more than 20 working days. Communications with the complainant about additional time required to complete investigations and respond to the complaint are not documented as occurring, although some managers advise verbal communications had occurred, but conversations have not been documented.

The Tauranga locality manager has undertaken an internal audit of the investigation and response to all complaints received in 2018 and developed an action plan in response to findings. Three localities managers advised they are now utilising the services complaints management tool kit to assist in ensuring a more robust complaints management process.

An adverse events manager was appointed in January 2019 on a 12 month contact for Albany and Penrose offices to assist the applicable staff and managers in investigating and responding to incidents and complaints in a timely manner.

Four complaints sampled in Hamilton and one in Albany did not have all aspects of the complaint investigated or the response / outcome clearly communicated to the complainant. (refer to 2.3.5)

Finding:

Where complaints are open more than 20 working days, communications with the complainant are not consistently occurring or documented as occurring.

Communication with the complainant on the outcome of complaints is not always noted or has not included all aspects in the complaint.

Corrective Action:

Ensure the investigation includes all aspects of the complaint and the complainant is advised of the outcome. Ensure ongoing communications occur with the complainant in the event a complaint is unable to be addressed within 20 working days.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 2.1: Governance (HCS.2012:2.1)

Consumers receive services that are planned, co-ordinated, and appropriate to their needs.

Attainment and Risk: FA

Evidence:

The service is governed by a board of directors who monitor the organisation's performance. The HealthCare of NZ divisional chief executive reports on a regular basis to the HealthcareNZ Limited chief executive.

A sample of service manager, locality manager, clinical services manager and regional operations manager monthly reports reviewed, as well as other documentation showed information to monitor performance is regularly reported on topics including financial performance, legislative changes/compliance, business development, emerging risks, human resources/staff training and operational/business issues, quality, client care needs as part of meeting the organisation's national business/strategic plan (2017-2019).

The organisational chart describes the existing structure and relevant reporting lines. Regular meetings are held by locality managers and regional operations managers with direct reports. The shortfall from the 2017 verification audit has been addressed. There is variation in the content/format of minutes in some locations as the managers were unaware of meeting minute templates that are available.

Recommendation:

Organisation meeting minute templates be made available to managers and their use encouraged.

Criterion 2.1.1 (HCS.2012:2.1.1)

The structure, purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.1.2 (HCS.2012:2.1.2)

The governing body shall ensure the organisational performance is aligned with and regularly monitored against the identified strategic direction and goals.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.1.3 (HCS.2012:2.1.3)

The governing body has processes which ensure quality improvement at all levels within the organisation.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.2: Service Management (HCS.2012:2.2)

Consumers receive timely, appropriate, and safe services through efficient and effective service management.

Attainment and Risk: FA

Evidence:

The locality managers, the regional operations managers (ROMs), the service manager's for mental health, and clinical services manager or service manager for rehabilitation services in the six locations audited were interviewed. The ROMs were all appointed to this new role in October 2018, however all held similar type roles for four or more years prior to the restructuring. All the locality managers were appointed to the role in September 2018. Five of the locality managers were in similar level positions for at least one year, with one of the locality managers having worked for this organisation in various roles for 12 years. The locality manager in Albany was acting branch manager for one month prior to her permanent appointment. Staff in clinical services manager / service manager roles in rehabilitation were in similar roles prior to the restructure except for Hamilton where the rehabilitation clinical services manager was appointed in January 2019. The service manager for mental health services has been in the role since September 2016 in Hamilton / BOP and for over 36 months in Christchurch.

Role descriptions detail the roles and responsibilities for each position. The managers have relevant experience in managerial or service delivery roles (including as service coordinators), as verified during interview and / or review of the managers' curriculum vitae. The managers are required to complete monthly reports for their line manager. Examples of these were sighted and included discussion on staffing / human resources issues, contracts legislative changes, client volumes and changes, quality and risk issues and service delivery. The regional operations managers' report to the HealthCare New Zealand divisional chief executive. All managers including the division chief executive interviewed are satisfied that relevant issues that potentially impact on service delivery or related to changing risk are communicated to them in a timely manner.

Clients and family members can provide feedback on services. This includes via the client experience survey process or during regular service delivery reviews. The service aims to phone new clients three weeks after commencing services for feedback. Rehabilitation clients are also contacted for feedback after a new staff member has provided services. Further communication with clients occurs at three months (mental health services Hamilton), or where otherwise contractually required, and six months after the client enters the service. The clients / next of kin offered the opportunity to provide feedback on services at these times. This process is repeated during the service review meetings which are required at least annually although some are overdue (refer to CAR at 4.11.4).

Clients are able to contact office-based staff, or afterhours staff and make requests, or express concerns / complaints or to discuss any aspect of the services being provided at any time. The clients' files reviewed during audit in all branches demonstrated active ongoing communication is occurring with clients and applicable family members. Such communication is being recorded into the electronic records.

An annual client experience survey is conducted of mental health clients. The feedback sighted (dated October 2018) was very positive about services. An annual client experience survey (census) is also conducted of rehabilitation clients. The report was dated June 2018. For the other community clients, the client experience survey is an ongoing process with clients in each branch selected fortnightly for inclusion. However, since September 2018 until early April 2019, with the changes made to Care Call, a new extract process has had to be developed and information has been able to be collated during this time. The results of the client experience surveys are reported via a heat map process which enables the branch/service to clearly identify what their strengths are as well as opportunities for improvement, and to compare their results with that of other branches and the organisation overall.

Focus groups have been held in 2018 in Hamilton, Whakatane and Alexandra for clients over aged 65 years and (their family members) that are receiving services. The focus group outcomes informed the changes made to service provision across the organisation for clients aged over 65 years of age. The national quality manager advised the intention is to work with rehabilitation clients in 2019 to identify appropriate service outcome measures. At the 2016 mental health certification audit an area for improvement was raised for mental health services as terms of reference had been developed for the client advisory group, however no meetings held. The service has determined these meetings will not occur as there are other opportunities for clients to provide feedback on the services received including via their recovery facilitator, communication with the service managers, the client experience survey and other reviews, and these opportunities are more frequent. This meets the requirements of the standards.

Recommendation:

[Click here to enter text.](#)

Criterion 2.2.1 (HCS.2012:2.2.1)

The service is managed by a suitably qualified and experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.2.2 (HCS.2012:2.2.2)

Consumers are consulted on the management of services in ways that encourage open feedback.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.3: Quality and Risk Management (HCS.2012:2.3)

Consumers receive services that reflect continuous quality improvement principles through the organisation having an established, documented, and maintained quality and risk management system.

Attainment and Risk: PA Moderate

Evidence:

The quality and risk programme for HealthCare NZ Ltd (2018-2020) has been developed. The quality plan provides the overarching direction for quality and risk activities. The Quality, Safety and Clinical Governance Committee, meets four times per annum. The chair of this committee is the CEO of HealthCare NZ who reports to the board. The quality and risk programme are supported by relevant policies and procedures. The quality and risk programme includes a range of activities including but is not limited to, complaints, compliments, incident/event reporting, client experience surveys (refer to 2.2), conducting self-assessments (internal audits), quality improvement projects, and policy and procedure review. Policies and procedures have been reviewed and updated with common policies now being used across the home and community services. Mental Health have additional service specific policies. The documents sighted were current and have been recently released electronically for office-based staff on 'Filevision'. The paper copies of the new manuals were delivered prior to the end of this audit. The review dates are monitored nationally by a member of the quality team. The managers interviewed informed that they are advised of policies under review or being newly developed and have the opportunity to have input, and normally once finalised, the managers are advised. The managers have the responsibility of ensuring document control processes are implemented at a local level.

Self-assessments are utilised to review key aspects of service provision. There is variation in how these tools are being used, the training provided to staff and the follow-up of results. There is also some variation in the corrective action planning processes. The issues raised in the 2017 certification and verification audits continue to be areas requiring improvement.

HealthcareNZ Limited is an accredited employer by the Accident Compensation Corporation (ACC) at tertiary level. The certificate for the period 1 April 2019 to 31 March 2020 was sighted.

Processes are in place to monitor organisation risk. There is a formal area in the managers' and regional operations managers' monthly report to summarise any changes in organisation risk(s). The three regional operations managers (ROMs), and the division chief executive were confident changes in risk were being identified and reported in a timely manner as managers are expected to escalate issues to their immediate line manager at the time there is actually or potentially a significant change in risk. This includes risks associated with adverse events or complaints. The risk management profile and the risk register for Mental Health New Zealand was dated February 2019. A 'dynamic' risk register was sighted for HealthCare New Zealand. This was dated March 2019. The ROMs report risk is discussed as an agenda item at their regular meetings. In addition, an organisation wide high-risk register is maintained of clients who have staff involved with high risk activities. This includes having financial transactions completed as part of services, or staff having the knowledge of how to get into the client's home.

A quality improvement committee meets in the Christchurch office. This group is discussing quality and risk, health and safety, and human resources issues, and feedback from support workers and recovery facilitators relevant to mental health, community and rehabilitation services. In this and other branches audited quality and risk topics are also discussed in office based staff meetings, as well as support worker or recovery facilitator meetings when these occur.

A staff engagement survey was conducted in 2018. The results have been provided to managers, who advise they are reviewing the findings relevant to their area. Action plans have been developed by the two ROMs where this was discussed. Challenges with technology systems has been identified as an issue, and work is ongoing related to this issue.

A 'complex issues' group meets regularly in Waikato/BOP region to ensure that clients with complex care needs, and the staff involved with providing their care, are well supported and appropriately trained. A new complex issues group has been recently established in the lower South Island. There are 14 documented objectives for the group in the terms of reference. 'The purpose of this committee is to support and advise managers and their teams (the service) in situations where risks to clients, staff and others have been identified. The multidisciplinary team will foster a collaborative approach to addressing issues to improve the quality and safety of services to clients'. Staff and managers advise this has been an excellent forum to obtain access to additional resources / expertise and training and to have multidisciplinary input into support plans for the more complex or at-risk clients.

A number of quality improvement projects have been undertaken. These have included the mental health services Hamilton, developing a male mentoring / support programme, building stronger relationships with local kaumatua, and a recovery facilitator and her dog 'Lucy' who has been trained and is now an approved mental health therapy dog. The clinical quality team have introduced a 'STOPandWATCH' programme that provides a formal framework detailing the type of client events and possible symptoms / changes that should be reported to the coordinator, registered health professional or other designated staff member. Care and protection policies have been implemented and the medicine policy and staff competency framework reviewed and updated. The Palmerston North branch has an action plan in place aimed towards becoming a 'dementia friendly' service.

A number of quality / health and safety reports are provided nationally. Aspects monitored include client incident / accident and complaints data (including the number, risk rating, themes and trends), staff injuries per month, severity of injury, time lost, mechanism of injury and themes and trends.

Correction action planning is occurring although where areas for improvement are required, corrective action plans are not consistently developed and implemented. The shortfall from the 2017 verification audit continues to be an area requiring improvement.

Nationally two senior quality improvement advisers and two quality improvement advisors have been appointed based in Wellington. They are assisting with review of and implementing quality improvement projects including analysis of incidents and complaints, analysis of client's experience survey data, undertaking a review of the incident reporting systems across the organisation and have made recommendations on how processes can be improved. The quality team are assisting with some process mapping including the management of referrals. The team have developed the terms of reference for a client and staff safety committee (CASS) meeting. The terms of references have been developed but not yet ratified. The draft purpose is 'to provide evidence-based and timely advice to the Quality Safety and Clinical Governance (QSCG) and Healthcare NZ divisions to address identified quality and safety issues - and, as a result, to continuously improve the quality strategy and resources nationally'. The quality improvement team have summarised some of the improvements in the quality reflections 2018 document that was provided. The quality improvement team are also working with clinical staff on pressure injury prevention.

Recommendation:

[Click here to enter text.](#)

Criterion 2.3.1 (HCS.2012:2.3.1)

Development and implementation of organisational policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by the organisational policy.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.2 (HCS.2012:2.3.2)

The development and implementation of a quality and risk management system.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.3 (HCS.2012:2.3.3)

The collection, analysis, and evaluation of quality improvement data is implemented and communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.4 (HCS.2012:2.3.4)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: PA Low

Evidence:

Self-assessments are utilised to review the content of client documentation, timeliness and/or completeness of records present in both clients' files and staff personnel files and other aspects including (but not limited to) incident and complaints management, non-signing clients, and staff competency. An annual self-assessment programme has been developed detailing the aspects required each month over the year (July to June). However, there is variation in the frequency that these are occurring, who is undertaking these 'snapshots' or self-assessments and what happens with the information over time. A new manager interviewed (employed January 2019) was unaware of

these tools and the schedule. The results of snapshot audits undertaken prior to her employment could not be located during audit. The service manager mental health had only recently started to undertake these in Hamilton and Tauranga. In Hamilton, the recovery facilitators were evaluating the documentation of peers. In Tauranga the recovery facilitators were conducting self-assessments. The service manager of mental health services in Christchurch advised self-assessments have not been conducted for at least 18 months and was unaware of the self-assessment programme 'until a couple of weeks ago'. An action plan in response to the client experience survey mental health services Christchurch has not been documented (refer to 4.11). Some self-assessment templates in use note that staff are to tick if the required component has been included. There is inadequate guidance on how to record if the aspect is not applicable or not attained / incomplete. In Hamilton community services, there were five different ways that staff were recording the results where non conformities were identified. This included with a cross, a dash, a blank space, an asterisk or another method observed. There were also variations observed in other services/branches which included some staff noting aspects not applicable in the same manner as aspects that had not been completed giving an incorrect overall result. Other staff member (mental health services Hamilton and Tauranga) had noted incorrectly that some aspects were not applicable, while for some recovery facilitators a number of components were not relevant due to differences in the service's contractual requirements.

Staff undertaking the self-assessments across most branches/services audited advised they had not received any training on the requirements and process for undertaking self-assessments and the management of results. Where non conformities were identified in some locations, actions required have been documented and noted to have been implemented. In other areas it was unclear what actions had been taken in response to findings.

At a previous audit the need to implement a process for the regular review and analysis of staff exit data was raised as an area for improvement. 'Survey-monkey' is being used to collect exit interview data and the results were sighted for 2017-2019 to date. While staff turnover is being monitored on an ongoing process, analysis of this information and a clear organisation action plan to address the findings has not been developed.

Finding:

Some staff undertaking self-assessments have not been trained in the process and follow-up action required. There is variation across services / branches in how the results of self-assessments are documented, the frequency they are conducted, the documentation of results, and the development and follow-up of action plans in response to self-assessment findings.

There is no systematic analysis of staff exit interview data and an organisation wide plan to address findings has not been developed.

Corrective Action:

Provide applicable staff with training on undertaking self-assessments. Ensure self-assessments are undertaken in the required timeframes, the results documented in a consistent manner, action plans developed where applicable and implemented and monitored for effectiveness.

Analyse staff exit interview data in a timely manner and develop an action plan to address findings.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.3.5 (HCS.2012:2.3.5)

The development and implementation of corrective action plans that address areas identified for improvement.

Attainment and Risk: PA Moderate

Evidence:

The HCNZ quality framework 2018-2020 details the 'plan, do study, act' quality improvement cycle. In branches audited there were examples of corrective actions or quality improvement plans developed when areas for improvement or quality improvement opportunities were identified. This included in response to the previous certification audit findings, complaints, incidents, and results of self-assessments. For many of these, there are examples of progress being made to address the issues. However, this is not

consistent. Some areas continued to have overdue staff performance appraisals (refer to 3.2.3), overdue client reviews (refer to 4.11.4), overdue competency assessments (refer to 3.2.3), with limited evidence of progress being made in response to the findings or changing interventions to address the issue, in some cases.

Self-assessments sighted did not always include a documented action plan in response to the findings, or when an action plan was developed, evidence that the interventions had been undertaken. For example, the follow up in response to self-assessment findings and personnel files in Christchurch has not been completed approximately 12 months after self-assessment was completed. Action plans had not been developed for some self-assessments sampled including for Hamilton community services and Tauranga rehabilitation services.

Incidents reports sampled in mental health services Hamilton and Tauranga did not always contain information on the results of investigations or interventions undertaken in response to the events although staff and managers interviewed could describe some of the actions taken. In mental health services Christchurch, documented follow-up was not present for sampled events, including events that had been reported over three months prior to audit, although the service manager verbalised some of the actions that had been taken. In Hamilton and Tauranga (community services) incidents did not always include sufficient information on the investigation and / or follow-up undertaken for sampled events. This included several events related to missed medications, a staff member and professional boundaries and episodes of challenging behaviour. In Hamilton community services, where assistance was sought from the complex issues group or the national care and protection team, the feedback from these committees was not linked to or documented in either the clients' records or incident management process.

While staff turnover is being monitored on an ongoing process and ROMs are developing some strategies to address this issue, analysis of staff exit data and an organisation action plan to address the findings has not been developed (refer to 2.3.4).

A staff member has been employed in the Penrose / Albany branches to assist office-based staff in ensuring adverse events and complaints are being investigated and responded to in a timely manner. Four complaints sampled in Hamilton, and one in Albany did not have all aspects of the complaint investigated or the response / outcome clearly communicated to the complainant (refer to 1.9.3).

Meeting minute templates included detailed what actions are required as either a component of the meeting minutes or noted in an action list attached. Minutes of the previous meeting are reviewed up each meeting.

Finding:

The corrective actions taken in response to some incidents, complaints, self-assessments and staff exit survey data are not always documented or followed up in a timely manner. Where advice is sought from the complex issues group or national care and protection team, recommendations received are not always linked to the client record or incident management system.

Corrective Action:

Ensure corrective action plans are consistently developed in a timely manner where areas for improvement are identified, are implemented, and monitored for effectiveness. Ensure feedback received from the complex issues group or national care and protection team are linked to the client's record / incident management system.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.4: Adverse Event Reporting and Resolution (HCS.2012:2.4)

All adverse unplanned or untoward events are systematically recorded and reported to affected consumers and where appropriate their family/whānau in an open manner.

Attainment and Risk: FA

Evidence:

Policies and procedures detail the processes for the reporting, investigating and management of incidents or adverse events. An electronic incident management system (Promapp) is used to record incidents and accidents with exception of mental health services where incidents are reported electronically on 'Recordbase'. Support workers

are required to phone the service managers, coordinators or the after-hours service, and alert them of any incidents/events that occur. The service manager is normally responsible for entering the incident/event on to Promapp and commencing the investigation and follow-up. The recovery facilitators alert the mental health service manager of events. Recovery facilitators advise they will also discuss events amongst themselves if there is any doubt whether an event should be reported. At the 2016 mental health certification audit an area for improvement was raised in relation to the implementation of a national incident reporting system, and associated staff training for staff working in mental health services. These areas have been addressed.

The Promapp data base has fields where staff are to record the incident, investigation and follow-up. Some sampled events have been investigated and followed up in a comprehensive and timely manner, however there is some variation in this between staff / managers and locations. A number of sampled events did not contain a comprehensive investigation, or the actions taken were either not documented, or not documented in a timely manner. This is included in the area for improved raised in 2.3.5.

Events reported to the afterhours service are recorded in the client record as a note, and any significant risks identified and addressed. The events are also noted on the afterhours shift summary report which is reviewed daily by the coordinators and service managers. These events are entered onto Promapp by a member of the quality and risk team and investigation and the follow-up the responsibility of the applicable line manager.

The type of events sampled across all branches/services included client falls, support worker conduct, damage or loss of property, safety concerns/hazards, medicine errors/omissions, challenging behaviours, allegations of abuse/neglect and staff injuries/accidents. Advice and support was sought from the complex issues group and the organisation's child protection team where applicable. Refer to 2.3.5 in relation to the need to link feedback received to the incidents/client record. The majority of the reported events sampled, with infrequent exception, are clearly referenced in the client's records. This is not raised as an area for improvement as it is not a systemic issue.

Members of the quality and risk team at national office provide a report on the number and type of incidents that are being reported across the organisation as well as each area. This includes identifying and reporting on the number of incidents, the categories of events and themes and trends. The top five category of reported events are noted for each area. The locality managers, service managers and the regional operations manager interviewed advise these reports are useful in helping identify if there are any areas where they have incident rates that are significantly different to national rates (refer to 2.3).

Staff related injuries and accidents are being reported and monitored by the national health and safety team members, who report on total numbers of reported events, and those requiring time off work (refer to 2.3).

Open disclosure is documented as occurring for applicable events sighted and the communications are documented. All clients and the family members interviewed confirmed they are informed of events or changes in the client's condition in a timely manner by staff.

All the managers and regional operations managers interviewed described their responsibilities in relation to statutory or contractual essential notifications/funder escalation and reporting guidelines. These are linked to legislation and contractual obligations. The reporting process was described by each locality manager, service manager, coordinator or clinical services manager and was appropriate for the type of event reported. Examples of essential notifications sighted included allegations of abuse and neglect (child and adult), client injuries during care, a client with significant challenging behaviour posing a risk to staff, non-provision of services, and other significant events that impacted on the health and safety of clients. Managers have recently been provided with training on the essential notification /escalation requirements. Essential notification communications to ACC are facilitated nationally by the client services manager.

The deaths of two clients have been reported to the Coroner in branches audited. One event has been subsequently closed with the Coroner being satisfied as to the cause of death. The other inquiry **section 9(2)(a)** remains open, with HCNZ being asked to provide information about services provided. For both these events the services provided by HCNZ are not under investigation in relation to the cause of death, but rather general information sought to inform the overall investigation.

Recommendation:

[Click here to enter text.](#)

Criterion 2.4.1 (HCS.2012:2.4.1)

The service provider documents adverse, unplanned, or untoward events including service/service delivery shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.4.2 (HCS.2012:2.4.2)

The adverse event reporting system is a planned and co-ordinated process that links to the quality and risk management system.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.4.3 (HCS.2012:2.4.3)

Adverse, unplanned, and untoward events are addressed in an open manner.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.4.4 (HCS.2012:2.4.4)

The organisation understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified when required.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.5: Entry to and Exit from Services (HCS.2012:2.5)

Consumers' entry into and exit from services is facilitated in an equitable, timely, and respectful manner.

Attainment and Risk: FA

Evidence:

The mental health service operations manual includes policies on entry to services, declining referrals and planned discharge from the service and includes a step by step procedures to guide staff. The declining referral policy was last reviewed in March 2019. The policy is clear that a referral can only be declined by the service manager and lists the reasons for declining. If a decision is made to decline, the referral status held electronically (Recordbase) is updated with the reason for decline. Review of the database confirmed this. The policy also details the method to be used to advise the referrer of the decline.

The policy documents that if the mental health service is unable to provide support due to capacity and the person requires support earlier than a wait list may be able to offer, the person will be referred to another provider as opposed to being 'wait listed'. The service manager for Hamilton and Tauranga stated they do not have waiting lists, rather the status of the person is 'pending' until all information is gathered. If the service is unable to accept the person, another organisation will be suggested. The Christchurch branch contract with the DHB is for people over the age of 65 years. The service manager stated all referrals are 'pending' initially and then go on to a wait list which is prioritised urgent or semi-urgent. People are not declined unless they have a physical disability or dementia.

Recovery facilitators demonstrated they are knowledgeable with regards to knowing what the procedure is for ensuring the safety of clients and/or staff. The service manager for the Hamilton and Tauranga branches reported two staff always attend the first home visit and includes either a recovery facilitator or the service manager and a clinical key worker from the DHB mental health team. In the Christchurch branch the service manager and a recovery facilitator attend the first home visit.

The 'Planned Discharge from Services' policy is current and was last reviewed March 2019. The policy includes a list of reasons for discharging people from the service. A planned and coordinated approach is taken on exit from services. Discharge planning is discussed with the person and their family/EPOA at the initial visit and documented in the service plan and involves the person's clinician or their GP. The service managers confirmed this. Files of people who have left the service in the Hamilton and Tauranga branches evidenced the organisation's processes were followed and included a discharge plan, a discharge checklist and a discharge letter to the person discharged from the service. In the Christchurch branch clients are discharged after 12 months. Planning for discharge starts two months prior to the discharge date. Once discharged, the case manager or the client's GP can refer the client back to the service if required. Clients can be exited prior to 12 months or they can exit the service themselves.

The finding from the last mental health certification audit in 2016 has been addressed and is now closed.

Recommendation:

[Click here to enter text.](#)

Criterion 2.5.1 (HCS.2012:2.5.1)

Access processes and entry criteria are clearly documented, and are communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.5.2 (HCS.2012:2.5.2)

There is a planned exit in co-operation with the consumer and this is documented, communicated, and effectively implemented.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.5.3 (HCS.2012:2.5.3)

The organisation operates at times most appropriate to meet the needs of the consumer group.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 2.6: Consumer Information Management Systems (HCS.2012:2.6)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Attainment and Risk: FA

Evidence:

The mental health services have all moved to using 'Recordbase' to record client records and ensure integrated records are readily accessible/available. The shortfall from the 2016 mental health certification audit has been addressed.

The other community services are using a combination of Goldcare, Caduceus and an upgraded Care Call system. There is a national programme underway to convert all the client management systems (excluding mental health) to Care Call. This requires specific planning per site, testing data sources and transfer, and review of the outcome of migration of large quantities of information. Due to the scale of this project and resources required, this is occurring in one geographical area at a time. Office based staff have access to the applicable client management systems for their branch or service.

In association with the move to Care Call for client management systems, HCNZ has introduced an electronic time and attendance record (ETAR) instead of paper-based timesheets. This is a new initiative, in the beginning stages of implementation and is currently not compulsory for staff. This will reduce the amount of client related information that support workers / recovery facilitators carry with them in paper form. Other staff are sent rosters and timesheets which contains some client information including the client name, contact details / address. However, in the interim the service requirements for maintaining the confidentiality of timesheets, rosters and other client information has been clearly communicated to staff and is noted in policy/procedures. All support workers and recovery facilitators interviewed in all branches could detail the organisation's requirements for maintaining the privacy of client information and how the information was to be destroyed when no longer required. Support workers have details of only one client on each timesheet. The theft of information from a support worker's locked vehicle and from the mail delivery services was promptly reported via the incident reporting system and investigated. The clients and/or next of kin were informed of the potential privacy breach and the funders notified. The service is managing processes well and the shortfall from the 2017 certification audit has been sufficiently addressed.

Recommendation:

[Click here to enter text.](#)

Criterion 2.6.1 (HCS.2012:2.6.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.6.2 (HCS.2012:2.6.2)

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

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.6.3 (HCS.2012:2.6.3)

A record of past and present consumers is maintained.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.6.4 (HCS.2012:2.6.4)

Management of health information meets the requirements of appropriate legislation and relevant professional and sector Standards where these exist.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.6.5 (HCS.2012:2.6.5)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.6.6 (HCS.2012:2.6.6)

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

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.6.7 (HCS.2012:2.6.7)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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Standard 2.7: Essential and Emergency Systems (HCS.2012:2.7)

Consumers receive an appropriate and timely response during emergency and security situations.

Attainment and Risk: PA Low

Evidence:

The branch emergency plan is aligned to the regional plan. The electronic client management system includes information and planning relating to the individual client in emergency situations and can be accessed nationally. Each client is required to have an assigned client priority level based on assessed risk to facilitate priority emergency response. The client's plan considers their level of mobility, independence and the individual's living situation, whether living alone or with others. This information is linked to the branch and the disaster management activities, nationally.

The Hamilton and Tauranga branches have a 'Grab and Go' file that has been developed and includes all information for an emergency, should the electronic management system fail.

The mental health service Christchurch has an emergency list of clients, with their address and phone numbers. The service manager reported they do not have a priority rating for clients. Clients' service plans contained instructions and information for use in the event of an emergency. Clients interviewed using mental health services knew about their individual information relating to emergency situations. The finding from the mental health service certification audit of 2016 remains open.

Recommendation:

[Click here to enter text.](#)

Criterion 2.7.1 (HCS.2012:2.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency situations. This shall include fire safety and emergency procedures.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.7.2 (HCS.2012:2.7.2)

The organisation, in consultation with the consumer, identifies and implements an appropriate plan relevant to the consumer's needs in an emergency.

Attainment and Risk: PA Low

Evidence:

The mental health service is included in the branch emergency plan and is aligned to the regional plan depending on where the branch is situated. The electronic client management system (Recordbase) includes information and planning relating to the individual client in emergency situations and this information can be accessed nationally. Each client is required to have an assigned client priority level based on assessed risk to facilitate an emergency response. This is reviewed as part of the client reviews and updated if required. The client's plan and emergency rating considers their level of mobility, independence and the individual's living situation, whether living alone or with others. This information is linked to the branch and the disaster management activities, nationally.

The mental health service Hamilton and Tauranga have a 'Grab and Go' file. This file includes priority codes, emergency phone numbers, contact family numbers and clients' numbers. The file is a 'back-up' should a situation occur where due to an emergency, the electronic management system has failed.

The mental health service Christchurch has an emergency list of clients, with their address and phone numbers which is updated monthly. The service manager reported they do not have a priority rating for clients. The service manager advised that during the latest emergency in Christchurch, all clients using the mental health service were phoned to ensure they were safe and supported.

Finding:

Mental Health Christchurch has a list of client addresses and phone numbers; however, a priority list based on risk has been not been developed.

Corrective Action:

Expand the list of client addresses and phone numbers to include a priority list based on risk for use in an emergency.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.7.3 (HCS.2012:2.7.3)

Consumers who require a greater degree of supervision receive the level of support necessary to protect their safety in the event of an emergency.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 3: Human Resources

Consumers receive safe, efficient, and effective services from an organisation that is a good employer and follows accepted human resource practices.

Standard 3.1: Recruitment (HCS.2012:3.1)

Consumers receive services that are based on good employment practices and relevant legislation.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 3.1.1 (HCS.2012:3.1.1)

The skills, knowledge, and attitudes required of each position are identified and its functions, accountabilities, responsibilities, and authority as well as the outcomes to be achieved in each position, are documented.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.1.2 (HCS.2012:3.1.2)

The organisation uses a documented recruitment procedure that includes interviewing, reference checking, police record checking, and providing an employment agreement that complies with relevant legislation.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.2: Orientation, Induction, Ongoing Development, and Competency (HCS.2012:3.2)

Consumers receive services from service providers who are trained and assessed as competent to provide services.

Attainment and Risk: PA Moderate

Evidence:

A comprehensive induction / orientation programme sighted is required to be completed by all new staff prior to delivering services and introduces support workers and recovery facilitators to the organisation, key personnel, policies and procedures and their roles and responsibilities and help identify any gaps in competency. Records are maintained electronically via 'learning tree' to verify that new staff are completing the requirements. The orientation training package is then completed by the support workers / recovery facilitator. The orientation programme for support workers includes being buddied with an allocated 'buddy trainer', an experienced support worker allocated to work alongside new staff. The buddy role is a formal role and applicable staff are required to complete a one-day training programme. The buddies work with new staff for up to three days to teach the new support worker aspects of the role and then ensure the support worker can safely complete all the generic personal cares and household management tasks required via 'buddy verification'. Additional time can be allocated if required where a new support worker is identified as needing additional training/time. Following this the support worker has a meeting with either the locality manager, a coordinator or a service manager to complete the manager verification component. This includes asking the staff member questions about key aspects of service delivery to ensure the staff member understands the requirements. Both the buddy observation documents and the manager verification documents are sent through to the national learning and development service. There is some variation in processes associated with this. In some locations a copy of the buddy and manager assessments are placed on the support worker's electronic file, in other locations a copy is held in the employee's paper based personnel file, and in other areas there is no reference at all to these having been completed as the forms were submitted directly to learning and development staff in the affiliated business entity 'My Skills', who are responsible for overseeing the organisation wide generic learning and development activities. The learning and development service issue regular 'learning tree' reports to line managers detailing new employees, components of orientation completed and any outstanding activities. The staff members stay on this list until all required components have been completed. The 'learning tree' reports are considered the 'source of truth', and staff in the learning and development service are responsible for ensuring appropriate orientation records are maintained. Over time it is anticipated that line managers will be able to access the 'learning tree' databases directly, however this is not currently possible.

New support workers are also required to complete e-learning modules; your role as a support worker, take care, taking care (health and safety video) and medication (stage one) – prompting.

Support workers interviewed in the community and rehabilitation services reported that the changes made to the orientation programme has been very positive and has improved the overall orientation process, enhanced consistency and created a more positive experience for new and existing staff.

Role specific orientation programmes are in place for coordinators, registered health professionals and managers, and records are held electronically or in paper-based files. Examples were sighted of staff working to complete the orientation requirements.

Recovery facilitators in Hamilton and Tauranga have completed the organisation's mental health orientation programme and records are maintained. The service manager of mental health services in Christchurch has developed his own orientation programme for staff. This does not include all required topics, such as abuse and neglect, infection prevention and control. This is now included in the area for improvement raised in 3.2.2. New recovery facilitators are automatically enrolled in the e-learning modules

personal safety and conflict awareness, and safe lone worker. Recovery facilitators interviewed in all branches felt the orientation programme suitably prepared them for their role and responsibilities. The shortfall raised at the 2016 mental health certification audit and the 2017 verification audit have been addressed.

Placement with individual clients by the coordinator or service manager are based on the competencies achieved by support workers. Some staff are overdue annual competency assessments and performance appraisals. The shortfall raised at the 2017 certification audit and 2017 verification audit continue to be areas requiring improvement.

Ongoing training relevant to staff roles and responsibilities is planned and facilitated by the learning and development team based in the associated company 'My Skills' nationally, and by line managers. Ongoing training has not been provided to recovery facilitators working in the mental health service in Christchurch. The shortfall from the 2016 mental health certification audit continues to be an area requiring improvement.

Support workers and recovery facilitators confirmed they felt confident and supported to carry out their roles competently. They report they can contact the coordinators or services managers, or registered health professionals, and the after-hours staff when they need to. Clients and family members interviewed verified they were satisfied support workers were given appropriate training and were competent to provide their required care. Recovery facilitators have regular meetings with their service manager to discuss clients and their needs. External supervision arrangement is also in place for recovery facilitators in Christchurch.

Systems are in place to support staff members who are registered health professionals (RHPs) to maintain their registration and operate within their scope of practice. All RHPs interviewed reported being well supported to access education internally and externally and had no problems meeting the education hours required to maintain their annual practising certificates (APCs). The organisation has a professional development and recognition programme. Staff are being encouraged to complete their portfolios. Renewal of APCs is overseen nationally. A data base is maintained by an administrator in Wellington. All RHPs in the branches audited have a current APC.

Processes are in place to monitor the number of MidCentral DHB clients who are receiving services provided by a family member. Reports are issued to the DHB on a regular basis. At audit there are eight family members providing care.

Recommendation:

Copies of industry approved qualification records / certificates are obtained for the staff records where employees have qualifications at employment.

Criterion 3.2.1 (HCS.2012:3.2.1)

An induction process is completed by all service providers, prior to commencement of duties, and a record of the induction programme and attendance is maintained.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.2.2 (HCS.2012:3.2.2)

A developed, implemented, and recorded training plan relevant to the service provider's scope of practice is maintained.

Attainment and Risk: PA Moderate

Evidence:

Following induction, support workers are registered to complete level two of an industry recognised qualification if they do not already have an industry approved qualification at level two or higher. Progress in monitoring staff completion is undertaken via 'learning tree' and line managers and coordinators kept updated.

The line managers interviewed are aware of contractual requirements related to staff working with complex needs clients. Support workers are provided with the opportunity to complete a level three industry approved qualifications. Several support workers interviewed were currently working to complete a level four industry approved qualification.

A variety of e-learning programmes have been developed and are available for staff on 'learning tree' or via scheduled in-service. Topics include (but are not limited to) manual handling, positive behaviours, autism, palliative care, 'open minds open doors'. Each branch negotiates ongoing education priorities with the learning and development staff or local health agencies, for example, Alzheimers New Zealand and Aged Concern, based on staff need, contractual obligations, incidents and complaints and or staff request. Approximately 75% of support workers in Christchurch have completed the 'walking in other's shoes' training provided by the DHB over an eight month period.

Recovery facilitator ongoing training is discussed and planned in the regular staff meetings in Hamilton and Tauranga. A schedule of topics for 2019 was sighted. Recovery facilitators interviewed in Hamilton and Tauranga confirmed education is provided in a timely manner including on topics relevant to their role and where a need has been identified, or when requested by staff. Recovery facilitators working in Christchurch advise they have not participated in ongoing education for approximately 18 months despite requests and the training calendar that had been developed. Management of actual or potential aggression 'MAPA' training has subsequently been scheduled for Christchurch mental health staff.

Monthly education sessions are planned and provided to registered health professionals. The topics are advised in advance and all staff nationally are invited to join via the internet or telephone.

Finding:

Whilst a training plan has been developed for recovery facilitators working in Christchurch, training is not consistently being provided. Records are not available to demonstrate that staff working in this service have completed training on abuse and neglect, management of actual or potential aggression /challenging behaviour training, and infection prevention and control.

Corrective Action:

Implement a training plan relevant to the service and include topics detailed above.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.2.3 (HCS.2012:3.2.3)

There is a system to determine and develop the competencies of the organisation's service providers to meet the needs of consumers. This shall be achieved by, but is not limited to:

(a) The service provider's competency is assessed against the organisation's policies and procedures;

(b) Competency gaps between consumer's needs and service provider's competency are identified;

(c) Specialist advice, training, information, and oversight are provided by individuals who are trained/qualified and competent to undertake this role.

Attainment and Risk: PA Moderate

Evidence:

There is a competency assessment framework which has been reviewed since the last audit and includes but is not limited to medicine management, thrombolytic embolism stockings (TEDS), testing blood glucose levels stoma management, bowel cares, catheter management, assisted cough, care of clients with fentanyl patches, and compression stockings and other clinical components relevant to individual clients. The medicine competency framework has been changed. The competency for medicine prompting is included with induction/orientation. The new stage three medicine management includes application of eye drops and eardrops, transdermal medicines and subcutaneous injections. Records are made of when staff have completed training although the annual review dates are not always noted, and this along with other work pressures have resulted in some staff being overdue for annual review. Some of the competencies are assessed individually with support workers, others assessed as a team of staff caring for an applicable client and some are undertaken in generic group sessions. For example, in Christchurch, support workers come into the office to complete a competency afternoon that includes TEDS, medicines and other components. In all locations audited excluding Hamilton community services, a number of support staff are overdue one or more aspects of their annual competency reassessment. Recovery facilitators are required to have a level four industry approved qualification as their competency assessment. Service managers advise they sight copies of the qualification certificate during staff interviews and note these, but do not always obtain a copy for the employees file. A recommendation is made that copies are consistently obtained.

In Hamilton, staff caring for children under the medically fragile contract are required to have been assessed for specific activities prior to caring for applicable children and to complete reassessment annually for a range of care activities including but not limited to use of oxygen, percutaneous endoscopic gastrostomy (PEG) devices, seizure management, care of tracheostomy, diabetes (high and low blood glucose levels), 'J tube' and low button. These were current for all applicable staff. A register is maintained to details when the applicable support workers are due to be reassessed. All support workers caring for the children under this contract are required to have a current first aid certificate, and records demonstrate this is occurring.

Support workers caring for complex rehabilitation clients including those with spinal cord injuries (SCI) or traumatic brain injuries (TBI) are required to undertake baseline, SCI and / or TBI specific competency assessments prior to caring for applicable clients and then again annually thereafter. The assessments are conducted by a registered health professional (RHP) and includes catheter management, bowel cares, suppository administration, pressure injury prevention, managing challenging behaviours and other relevant components. Records are retained of when staff are due. This includes on the support workers electronic personnel file and / or on spreadsheets maintained by designated staff. In Christchurch, staff advised the annual TBI, SCI and baseline reassessments were no longer required for applicable staff and as a result were not being completed. In all locations audited, a number of support workers caring for the complex clients are overdue one or more of these annual competency re-assessments.

Staff are required to have an annual performance appraisal. In the last 12 months the appraisal process for support workers has been streamlined / simplified. This is a focus for line managers, and some actions have been taken to improve completion rates with the number of staff overdue appraisals being monitored on a monthly basis. However, despite this a significant number of support workers in each location audited excluding staff working in Hamilton 'community' services are overdue annual performance appraisals.

Appraisals were current for all the recovery facilitators in Hamilton and Christchurch and were initially overdue for three recovery facilitators in Tauranga. The service manager advised this was due to misreading the date of the last appraisal as all other staff had been completed. The service manager subsequently provided evidence the overdue appraisals were completed prior to the completion of this audit.

Concerns were expressed by some office based staff about the time needed to complete the verifications on employment and competency assessments. Timeliness has also been impacted by the significant organisation change as well as turnover / vacancies in service coordinator and registered health professional roles in some branches.

Finding:

Some support workers are overdue annual performance appraisals in all locations audited except mental health services and Hamilton community services.

Some support workers, including those caring for clients with traumatic brain injuries, spinal cord injuries are overdue annual competency review in all locations audited except Hamilton community services.

Corrective Action:

Ensure staff consistently complete competency requirements and records are retained.

Undertake annual performance appraisals for staff

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.2.4 (HCS.2012:3.2.4)

Service providers understand the scope of their role and the support available to them. This shall be achieved by, but is not limited to:

- (a) Direct support is part of each service provider's position description and the level of assistance/intervention is clearly defined in a consumer's individual service plan;
- (b) Service providers clearly recognise and understand their defined role and responsibilities;
- (c) Service providers clearly understand how to seek assistance or advice when the limit of their competency, knowledge, or experience is reached.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.2.5 (HCS.2012:3.2.5)

The organisation ensures that all service providers access supervision and support.

Attainment and Risk: FA

Evidence:

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Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.2.6 (HCS.2012:3.2.6)

The organisation implements a policy and procedure to assist registered health practitioners retain their registration and operate within their scope of practice.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 3.3: Health and Safety (HCS.2012:3.3)

Consumers receive services that promote the health and safety of the consumer and service providers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 3.3.1 (HCS.2012:3.3.1)

Service providers are issued with, given training in, and follow a written policy that clearly identifies requirements of the Health and Safety in Employment Act. The policy shall:

- (a) Be authorised by the organisation;
- (b) Incorporate the organisation's commitment to comply with relevant legislation, regulations, codes of practice, and safe operating procedures;

- (c) Specify the organisation's responsibilities for health and safety;
 (d) Specify service providers' responsibilities for health and safety.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 3.3.2 (HCS.2012:3.3.2)

The policy shall include a process for:

- (a) The active identification and management of existing hazards (which may include consumer behaviour) associated with the service;
 (b) Regularly assessing each hazard identified (including any new hazard), determining whether or not it is a significant hazard, and if it is eliminating, isolating, or minimising it to the extent possible within the home environment;
 (c) Ensuring service providers are allocated to consumers in a way that minimises risk of injury;
 (d) Enabling service providers to have an emergency plan that meets relevant emergency service requirements to evacuate from potential emergency situations;
 (e) Responding to a health and safety incident in the workplace that may include access to first aid and emergency treatment;
 (f) Providing debriefing and post-incident support that may include counselling;
 (g) Ensuring that corrective action is undertaken on any deficiencies identified during an investigation of incidents, injuries, and work-related illnesses.

Attainment and Risk: Not Audited

Evidence:

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Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 4: Service Delivery

Consumers receive services that contribute to their agreed outcomes, and that support their independence, safety, and well-being.

Standard 4.01: Service Agreement (HCS.2012:4.01)

The consumer, organisation, and service provider have a full understanding of and agree to the services to be provided.

Attainment and Risk: FA

Evidence:

The service agreements meet the requirements of the standard. A copy of this agreement, once signed, is retained by the service and a copy provided to the client. Clients confirmed this. Clients reported they are happy with the agreement they have and are aware they can change support workers if they wish. They also reported that they were satisfied with the times their service is delivered as well as the reliability of the service.

The service coordinators, service managers, recovery facilitators and registered health professionals confirmed they can negotiate with clients to agree to a time that suits at the initial visit. Changes are made to rostered duty times to fit in with clients' wishes and attendance at activities or appointments as and when they are planned. Regular appointments and activities in the community are detailed during the service planning process and included in both service plans and support plans. Clients confirmed appropriate support is provided to attend regular activities and appointments to assist in their rehabilitation and recovery in a timely way.

The service plan for the mental health service clients has been reviewed and updated. The service plan includes services specific to the individual client and the timeframes for when the services are to occur. The service agreement for the mental health service meets all the requirements of the standard. The finding from the mental health certification audit of 2016 has been addressed and is now closed.

The service managers and operations managers reported that a national project is in place and all service agreements currently in use are being reviewed. It is envisaged that there will be one service agreement with specific attachments for the different service streams.

Service coordinators in the Palmerston North branch reported they can access the interRAI assessments for referrals from the DHB. The manager reported they are working with the DHB with regards to being provided with more information especially for people with complex clinical issues. A regional clinical manager, which is a new position, has been in the role for three months and has made a difference in terms of information sharing. An electronic programme is used to assess the level of need and this is used to triage clients. The interRAI is reviewed and any detail is forwarded to the service coordinators. This has meant the right level of support is able to be provided. InterRAI electronic communication was reviewed and evidenced detailed information.

Recommendation:

[Click here to enter text.](#)

Criterion 4.01.1 (HCS.2012:4.01.1)

Each consumer shall have a written service agreement with the organisation providing the services. The written service agreement shall be in languages and formats suited to the needs of the consumer. It shall explain the services to be provided. The agreement shall include, but not be limited to:

- (a) Name, address, and telephone number of the organisation including out of hours and emergency contact details;
- (b) Name, address, and telephone number of the consumer;
- (c) Services provided as part of the agreement, including when or how frequently, and by whom;

- (d) Any fees payable for the service, when or how frequently, by whom, and options for how payments can be made;
- (e) Rights and responsibilities of both parties;
- (f) Obligations of the consumer for the health and safety of the service provider;
- (g) Any equipment and supplies to be made available by the consumer or organisation;
- (h) The use of equipment and enablers as part of service delivery;
- (i) Consent to retain consumer's information and the purpose for which it will be used;
- (j) A statement outlining the organisation's policy on the handling of the consumer's money;
- (k) Circumstances in which the service may be cancelled by either party;
- (l) That the client should be able to ask for a different service provider if the person assigned is not right for them. This may be particularly important if the service includes personal care;
- (m) How long the service will be provided (if known) and the process for ending it.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.01.2 (HCS.2012:4.01.2)

Consumers receive services at times which meet their needs and the support they require.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.01.3 (HCS.2012:4.01.3)

The consumer receives a copy of the agreement signed by the organisation and the consumer or the consumer's representative.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 4.02: Promoting and Supporting Independence (HCS.2012:4.02)

Consumers maintain their independence during the course of service delivery by being supported to exercise choice and control over their lives.

Attainment and Risk: FA

Evidence:

The three services (community, rehabilitation and mental health) all have different service plan templates. Assessment and planning for clients document the level of support required. The mental health service plan includes a section on current strengths and future wishes. Recovery facilitators and support workers were clear about what clients wish to achieve, what they are able to achieve themselves and what support is required. Staff and clinicians involved in the initial visit to the client's home ensure clients have the support they need to make their own decisions. If a client is unable to represent themselves, their family is present and if that is not possible, another independent person. The individual service plan/support plans are completed with relevant details to indicate levels of support needed to maximise client involvement. Plans reviewed evidenced goals are set for recovery, returning to and maximising independence and for the older clients who require general household support and personal support, maintaining their levels of independence as much as possible. The service plans document accessing the wider community and there were good examples sighted in the plans reviewed.

Clients interviewed using the three different service streams confirmed they are well supported, feel in control of the services they are receiving and that they can maintain their links with family/whanau and the community.

Interviews with service managers, registered health professionals, RNs, service coordinators, recovery facilitators and support workers confirmed that staff are committed to supporting clients to maintain their independence and exercise autonomy. Staff, managers and coordinators hold regular discussions/meetings to review the levels of support required for clients as they increase or maintain their levels of independence and recovery.

Whether clients are using mental health services, rehabilitation services or community services there is a strong focus on returning clients to levels of independence experienced prior to injury, for other clients, maintaining their current level of independence and for mental health clients, recovery. Case managers and key workers work closely with the services and this enables additional support to be given to clients who would benefit from an increase or change to the type of support they receive to promote their independence.

Recommendation:

[Click here to enter text.](#)

Criterion 4.02.1 (HCS.2012:4.02.1)

Consumers are supported to make decisions about their own lives in their own homes.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.02.2 (HCS.2012:4.02.2)

Consumers are supported to undertake tasks and activities and the individual service plan documents their wishes in relation to lifestyle choices. Note: The consumer's rights and legal choices shall only be limited by clearly defined legal grounds.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.02.3 (HCS.2012:4.02.3)

When the consumer is unable to represent themselves input is sought from the consumer's family/whānau or other designated representative.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.02.4 (HCS.2012:4.02.4)

Consumers are supported to maintain links with their family/whānau and to access services within the community.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 4.03: Links with Other Groups (HCS.2012:4.03)

Consumers receive continuity of service through effective links with other groups.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 4.03.1 (HCS.2012:4.03.1)

Links are identified and maintained with key groups, including primary healthcare teams, to facilitate continuity of service.

Attainment and Risk: Not Audited

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.03.2 (HCS.2012:4.03.2)

There is evaluation of the effectiveness of their links with other key health groups.

Attainment and Risk: Not Audited

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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Criterion 4.03.3 (HCS.2012:4.03.3)

Consumers are advised of options to access services from other groups.

Attainment and Risk: Not Audited

Evidence:

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Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 4.03.4 (HCS.2012:4.03.4)

The consumer's safety and right to be kept informed in a timely manner is managed by organisations co-operating during the referral process.

Attainment and Risk: Not Audited

Evidence:

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Finding:

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Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 4.04: Service Delivery Planning (HCS.2012:4.04)

Consumers have an individual service plan that describes their goals, support needs, and requirements.

Attainment and Risk: FA

Evidence:

All clients' files reviewed had an individual service plan with support needs and short term and long-term goals clearly recorded. Clients confirmed they are very involved in the development of their goals, in the planning and how this would be achieved. Some clients spoke of involving their family members and other health professionals (e.g., from the DHB and ACC). The three service streams use different service/support plans with a mix of handwritten and scanned into the system, hard copies, an electronically

written depending on the client management system used. All plans were clear and the templates are in an easy to read format. The support workers confirmed they use the support plan to guide them in their tasks. Copies are kept in the homes of clients, so they are readily available.

Clients interviewed confirmed their active participation in the development, monitoring of their service and support plans. Family/whanau are involved in these processes, with the consent of the client.

The non-signing policy includes monitoring and review requirements. The revised policy has been implemented across the organisation. The number of 'non-signing' clients in the community service has decreased. Review of registers confirmed this. Service coordinators reported that some clients are able to sign their service agreements and service plans as they are 'one-offs', but they would find it difficult to sign documents every day. There are clients that are unable to sign support workers time sheets. However, where there is family living in the same house, they sign for the client. Service coordinators are responsible for monitoring this process and this is reviewed on a continuous basis with the register and service plan updated and clients contacted. Timesheets reviewed evidenced where a client is unable to sign, the support worker enters 'worked' and shows this to the client.

Currently in the rehabilitation service, because the care and support is continuous, if a client is unable to sign the time sheets, the support worker on the next shift signs off the previous support worker's time sheet. Team leaders also sign off if need be. The client information system used by the rehabilitation service (CareCall) records the information and has an alert feature which can be used that corresponds with the event notes.

The client management system (CareCall) has the ability to record support workers rostered shift start and finish times. This is achieved with an 'app' named 'Kahu' that support workers down-load onto their cell phones. The support worker can see their roster over a six-week period and the service coordinators can make changes in live time. The support workers use the 'app' to clock in when they arrive at a client's home and when they have finished their shift. The national programme director reported this is being used currently in a number of branches and is currently being rolled out in others. Review of the information confirmed live information is recorded at branch level and means support workers no longer need to send in time sheets. The numbers of support workers who are using the 'app' differs in the branches audited, however the up-take is increasing. It is proposed that all service streams in the organisation (excluding mental health) will eventually use 'CareCall' as the client management system.

Clients interviewed were happy with the process in place if for some reason they could not sign the support worker's time sheet.

The finding identified at the certification audit of 2017 relating to non-signing clients has been addressed and is now closed.

Recommendation:

[Click here to enter text.](#)

Criterion 4.04.1 (HCS.2012:4.04.1)

An individual service plan is developed to reflect the consumer's goals, support needs, and requirements. This shall include, but is not limited to:

- (a) Where more than one organisation is involved, the development of the individual service plan is co-ordinated;
- (b) Where the organisation responsible for developing the individual service plan is different to the organisation responsible for service delivery, linkages exist between the two;
- (c) The individual service plan reflects any natural supports/family/whānau;
- (d) The individual service plan reflects the home environment;

(e) The individual service plan reflects the consumer's support needs and goals;

(f) The individual service plan defines the use of equipment and enablers as part of service delivery and sets out service provider responsibilities.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.04.2 (HCS.2012:4.04.2)

The consumer is actively involved in consultation, planning, monitoring, and implementation of the individual service plan. With consent, family/whānau and other service providers as relevant are actively involved in any or each of these parts of the development of the individual service plan.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.04.3 (HCS.2012:4.04.3)

The individual service plan is developed and agreed with the consumer prior to commencement of service delivery and clearly details the actions to be taken by the service provider(s).

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

Click here to enter text.

Corrective Action:

Click here to enter text.

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 4.05: Implementation of Individual Service Plan (HCS.2012:4.05)

Consumers' goals and support requirements are met through provision of services.

Attainment and Risk: FA**Evidence:**

Support workers and recovery facilitators are carefully matched with clients around the skills the support worker and recovery facilitators have. This is documented in the service plans.

Health and safety checks are carried out on site and these were sighted in individual files reviewed. Tasks are well documented. One-on-one training is put in place for any new support workers for those clients with complex needs. The service managers and service coordinators are responsible for the allocating of support workers and recovery coordinators and for maintaining records of these allocations. Rosters are managed electronically and a pool of back up support workers or other members of a support team are available for all clients if the regular rostered staff are not available. The use of a buddy system for new staff for more complex clients, ensures relevant tasks are able to be completed as appropriate for everyone. Communication books are also used as required for support workers to pass on relevant information where several workers are a part of a team involved in supporting the client.

Advice and assistance from senior staff is available as needed and support workers confirmed this is readily accessed. Support workers and recovery facilitators interviewed confirmed a good understanding of scopes of practice, limits of responsibility and what to do in an emergency.

Clients reported they felt their support workers and recovery facilitators were well trained and the communication processes in place keeps them informed of any changes in rostered support during office hours.

The national programme director reported the after-hours service has been reviewed and the technology behind the system has been upgraded. Two customer service representatives are now based in Palmerston North and they take calls, solve problems and co-ordinate staff. An RN was expected to join the team on-call during the audit. The service has been extended and is available seven days a week, 5pm to 9pm. A staff member answers a cell phone from 9pm until the staff member goes to bed. Following this, clients leave a message.

The national programme director advised a handover period was introduced during this audit. The system is currently being rolled out to branches across the country in a staged way, so that all branches will eventually be using the same after-hours system. Currently, there is a mix of after hour services across the three service streams using different after-hours systems. For example, in the Christchurch branch the community service is using the new system, rehabilitation and the mental health services use their own systems.

For the services using the improved system, the after-hours staff have access to all the client databases across HCNZ. The after-hours service provides a report daily to the branches of calls and outstanding issues, and a report on Monday morning to summarise the weekends. A summary of all reported events is forwarded to the quality and risk team at the national office for entering in to an electronic system (Promapp). This system differs from the other systems currently in use. For example, in the mental health service Christchurch, the service is client resolvent based and problems are resolved by the clinical mental health manager for older adults. The service manager advised they are made aware of after-hours contact and are phoned after hours if needed.

Clients and support workers interviewed stated there has been a significant improvement with regards to the after-hour service. Clients stated they no longer must wait in a queue to have their call answered. Replacement support workers are made available in a timely manner with the support worker being clear about what tasks are expected of them.

An electronic 'mapping tool' linked to rostering has been implemented nationally to track travel time between appointments for support workers. Service coordinators can enter the addresses of clients the support worker is visiting on the day and the programme shows in real time through google maps the route the support worker should take and the time it takes to travel between appointments. The programme also has alerts in red when there are problems with the route and times require adjusting, so that the client can be notified of a delay if needed. Clients and support workers reported this has helped with traveling times and stress levels for both clients and support workers.

The findings from the last certification audit in 2017 relating to the after-hours service and travel time has been addressed and is now closed.

Recommendation:

[Click here to enter text.](#)

Criterion 4.05.1 (HCS.2012:4.05.1)

The individual service plan will be delivered by service providers who:

- (a) Have been assessed as competent in providing the level and type of care and support;
- (b) Clearly recognise and understand their defined role and responsibilities;
- (c) Receive an appropriate level of supervision for the level of support they are providing;
- (d) Know how to seek assistance or advice from their supervisor when the limit of their competency, knowledge, or experience is reached;
- (e) Can provide support that meets the needs of the consumer.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.05.2 (HCS.2012:4.05.2)

There is a system of recording the allocation of service providers to consumers and for maintaining records of this. This system includes processes for contingency planning in the event of emergencies or other events which would require changes to scheduled support.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

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Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.05.3 (HCS.2012:4.05.3)

Consumers receive first aid and emergencies are managed in line with the organisation's policy.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 4.06: Medicine Management (HCS.2012:4.06)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

Attainment and Risk: FA

Evidence:

The new medication policy has been reviewed by the director of nursing and the national clinical services team and provided to all the branches. Interview of the director of nursing and review of the policy confirmed this. The policy and framework include self-administration. Responsibilities at each stage of medication management are clear. Flowcharts for administration include photos and are easy for support workers to understand. An early warning tool, 'Stop and Watch' has been designed for support workers

to use if they identify any changes while working with a client. The support worker is required to circle the change and send in to their line manager. There is also an 'Adverse Medication Reactions Procedure' that includes response guidelines for mild allergic reaction or life-threatening anaphylaxis. The requirement from the certification audit in 2017 has been addressed and is now closed.

The medication management competency and training framework procedure has been implemented. The framework is clear and has good guidance for staff to follow. There are four stages relating to the management of medicines; self-administration, prompting, administration and administration plus. Self-administration is where the person is fully responsible for the management of their medicines. Prompting is where the person requires reminding, but the support worker does not assist in any way. The support worker is required to sign the medication sheet. Administration is where the person needs assistance with opening the blister pack, selecting the right dose and time, and assisting the person to take the medicine. The support worker is required to sign the medicine sheet. Once competent, support workers may administer including, but not limited to, nasal sprays, ear and eye medicines, topical ointments and creams. Administration plus is where additional training with an RN is required to demonstrate competency. Staff who have current competencies can undertake more complex tasks (e.g., oxygen therapy, PEG medication, subcutaneous insulin injections and fentanyl patches).

Training and competency of staff is a 'work in progress' and is currently being implemented across the branches (see link to 3.2.3). There was good evidence of signing sheets being completed fully and returned to the offices at the end of each month. Monitoring and review is undertaken by service coordinators. If there are gaps in the signing sheet, it is the responsibility of the senior service coordinator to follow up. Review of medicine signing sheets and interview of senior coordinators confirmed this. Support workers are encouraged to contact the service coordinators and document in the communication book and signing sheet if there are issues around medicine management for clients. Any medication errors are entered into an electronic system (Promapp).

The different templates for service plans have a section to record medicine management. Allergies are also documented and the electronic CareCall client management system has an alert in red (if entered) that appears on the first screen if a client has an allergy to either medication or food.

The service managers, mental health service, reported recovery facilitators are not involved in medicine management. If a client requires some form of medicine support, a clinical team member from the DHB visits the client and manages this.

The Hamilton branch has an RN who has a specialist role relating to medicine oversight. The RN receives referrals from the DHB and MoH for clients including those with dementia or a disability. The RN visits the client, liaises with the pharmacy and trains support workers to the competency framework. The RN documents in the service plan under medication actions and is involved in annual reviews. Interview of the RN confirmed this.

Recommendation:

[Click here to enter text.](#)

Criterion 4.06.1 (HCS.2012:4.06.1)

A medicines management system is implemented that complies with legislation, protocols, and safe practice guidelines. The system shall include the detection and management of all medication errors.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.06.2 (HCS.2012:4.06.2)

Policies and procedures clearly document the service provider's responsibilities at each stage of medication management.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.06.3 (HCS.2012:4.06.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.06.4 (HCS.2012:4.06.4)

The facilitation of safe self-administration of medicine by consumers where appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 4.07: Infection Prevention and Control (HCS.2012:4.07)

Consumers and service providers are protected from infection through promotion and implementation of current infection prevention and control practices.

Attainment and Risk: FA

Evidence:

The Infection, Prevention and Control policy is based on standard precautions and includes guidance on infectious disease management. Information is comprehensive and includes who the recovery facilitator is to notify, including the service manager and regional infection control coordinator. If an outbreak is suspected, the local public health unit is notified. Documentation sighted for recovery facilitators includes knowing when a person may have an infection and lists of common infections. Staff support clients to contact their own GP if a client is suspected of experiencing an infection. The service managers stated recovery facilitators report to the service manager daily over any issues including those concerned with infection prevention and control.

Currently, the RNs in the branches are utilised should advice be required relating to infections or the clinical services team. The national clinical quality advisor reported that a job description for regional infection control coordinators is yet to be ratified by the board, and once this has occurred, regional infection control coordinators positions will be advertised.

The induction/orientation includes prevention and controlling infections. Recovery facilitators have attained a relevant level 4 NZQA qualification and have completed on-going training and have current competencies in both the Hamilton and Tauranga branches. Recovery facilitators and review of records confirmed this. The recovery facilitators in the Christchurch branch have not received on-going education in the last 12 months.

The finding from the mental health certification audit of 2016 is now included in 3.2.2.

Recommendation:

[Click here to enter text.](#)

Criterion 4.07.1 (HCS.2012:4.07.1)

Policies and procedures exist to support current infection prevention and control practices. Policies and procedures shall cover the:

- (a) Identification and reporting of notifiable diseases;
- (b) Management of common infectious diseases;
- (c) Appointment of an infection prevention and control officer.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.07.2 (HCS.2012:4.07.2)

Each service provider is competent in current infection prevention and control practice. This shall include:

- (a) Use and knowledge of personal protection equipment;
- (b) Use and knowledge of cleaning and disposal techniques;
- (c) Knowledge of signs and symptoms of common infectious diseases;
- (d) Use and knowledge of basic infection prevention and control practices.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 4.08: Equipment, Aids and Enablers (HCS.2012:4.08)

Consumers are supported to safely use any required or prescribed equipment, aids, or enablers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 4.08.1 (HCS.2012:4.08.1)

Consumer-specific information and training is made available to service providers in the use of equipment, aids, and enablers, including definitions and descriptions of each.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 4.08.2 (HCS.2012:4.08.2)

All equipment, aids, and enablers are used safely and as required or prescribed to support the consumer to maintain their independence, dignity and respect.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 4.09: Nutrition and Safe Food Management (HCS.2012:4.09)

The consumer's nutrition and hydration is supported by service delivery.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 4.09.1 (HCS.2012:4.09.1)

Consumers are monitored for signs and symptoms of dehydration and malnutrition and interventions implemented as needed.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.09.2 (HCS.2012:4.09.2)

Consumers who require special or modified diets are supported to meet these needs.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.09.3 (HCS.2012:4.09.3)

Consumers with enteral feeding tubes have their needs met by service providers with specific training and demonstrated competencies.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.09.4 (HCS.2012:4.09.4)

Consumers are safe from disease caused by unsafe food storage and preparation. Service providers are oriented to safe food-handling practices.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 4.10: Skin Integrity (HCS.2012:4.10)

Consumers' skin integrity is maintained.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Recommendation:

[Click here to enter text.](#)

Criterion 4.10.1 (HCS.2012:4.10.1)

Consumers are monitored for signs of skin breakdown.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 4.10.2 (HCS.2012:4.10.2)

Service providers implement preventive measures to promote skin integrity.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 4.11: Review of Service Delivery (HCS.2012:4.11)

Consumers are supported to achieve their goals through regular monitoring and review of service delivery.

Attainment and Risk: PA Moderate

Evidence:

There was evidence of progress in all branches visited around reducing the numbers of reviews that are overdue. The three service streams have different requirements relating to review timeframes and how the reviews are documented.

Three monthly reviews are completed with the clients using the mental health service branches and include a case manager from the DHB mental health clinical team in the Hamilton and Tauranga branches. The service manager Christchurch branch advised there is no requirement to report to the DHB under the current contract. Review of the clients' files evidenced regular monitoring and reviews. The electronic programme also provides useful percentages and graphs showing progress towards meeting the client's goals.

A 'client experience survey' is completed annually for the mental health service and the last one was in June/July 2018. Feedback is also sought from the case managers from the DHB mental health clinical team. Collated results showed high satisfaction with the service, however, corrective actions identified have not been developed and implemented. (See link 2.3.5) The finding from the 2016 mental health service certification audit is closed.

Clients using the rehabilitation service have different timeframes for reviews depending on the length of time using the service and the complexity. Reports are completed and sent to ACC. The reports are comprehensive and showed detailed progress. An exception report is generated when goals are not able to be achieved. Not all annual reviews of service plan goals in the branches visited were up to date. Not all reviews reflected the degree of achievement towards meeting the goals.

The community service uses a client management system ('Caduceus'), apart from the Tauranga and Christchurch branches who currently use a different one (Goldcare). Clients who are not under ACC receive phone reviews at set intervals and this is facilitated by the service coordinators. An annual review of the client's goals is required to be completed at the client's home. Reviews were often a tick in a box with no narrative or a new service plan completed with different goals.

The services in each branch had evidence of a 'bring-up' system that shows what clients are due/overdue for reviews.

If there is a change in need identified, a new service plan is completed. Support workers confirmed they alert the office if they note any changes or an increase in needs. If this does occur, a visit is made and changes required are responded to.

Recommendation:

[Click here to enter text.](#)

Criterion 4.11.1 (HCS.2012:4.11.1)

To keep individual service plans up-to-date, service delivery is reviewed:

(a) Regularly, relative to the complexity of the consumer's support needs and risks;

- (b) At the request of the consumer; or
- (c) If a change in need occurs.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.11.2 (HCS.2012:4.11.2)

Reviews are documented, consumer focused, indicate the degree of achievement or response to the support and progress towards meeting the consumer's goals.

Attainment and Risk: PA Moderate

Evidence:

Progress with reviewing overdue client's goals is a focus at all the branches visited and review of the registers evidenced in-roads are being made in some branches.

In the mental health service, review of the client management system (Recordbase) evidenced regular monitoring and reviews. This electronic programme also has the capability of producing a percentage, so that recovery facilitators can see how far the client has progressed to meeting their goals. The programme also generates graphs which show progress.

In the rehabilitation service a 'progress/exception/completion' report is completed and provided to ACC. The reports are comprehensive and show detailed progress towards meeting the goals. An exception report is generated when goals are not able to be achieved. Long term clients have a different process whereby if there are concerns raised, a multidisciplinary meeting with ACC, client and family is held. Reviews are completed every 26 weeks and the service and support plans are updated. The reviews are scanned into the client management system (CareCall). There was a mix of entries for reviews including 'on going' and 'no change' rather than documenting progress. (See also 4.11.4)

The community service uses a client management system ('Caduceus'), apart from the Tauranga and Christchurch branches who currently use a different one (Goldcare). Clients who are not under ACC have phone reviews at three weeks and six weeks and this is facilitated by the service coordinators. An annual review of the client's goals is completed at the client's home. The Hamilton branch reviews had been completed apart from one from 2016, however, there remains inconsistency across the branches. The template for the community service plan reviews does not encourage service coordinators to document progress towards meeting the client's goals. A 'tick box' in the service plan template has three levels to note the level of progress made and this was not completed in a significant number of service plans reviewed. Where it had been completed, there was always commentary to indicate progress or any changes or if the goals needed updating. In some instances, a new service plan had been completed with totally different goals.

The finding from the certification audit of 2017 remains open.

Finding:

Although progress has been made, reviews of goals in the rehabilitation and community services do not consistently indicate the progress towards meeting the client's goals.

Corrective Action:

Ensure service plan reviews are documented, client focused and indicate the progress towards meeting the client's goals.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.11.3 (HCS.2012:4.11.3)

Feedback from family/whānau and other providers is sought as part of the input for the review, where appropriate.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.11.4 (HCS.2012:4.11.4)

There is formal evidence of a review occurring in line with the organisation's policy.

Attainment and Risk: PA Moderate

Evidence:

The mental health service completes three monthly reviews with the client, their family and may involve other service providers if appropriate. The reviews are attended by the case manager from the DHB mental health clinical team. Review of the client management system (Recordbase) evidenced regular monitoring and reviews. The finding from the 2016 certification audit is now closed.

The rehabilitation service completes reviews at least six monthly and the support plans annually. The reviews are scanned into the client management system (CareCall). Not all reviews in the branches visited are up to date.

The community service uses a client management system ('Caduceus'), apart from the Tauranga and Christchurch branches who currently use (Goldcare). Clients who are not under ACC have phone reviews at three weeks and six weeks and this is facilitated by the service coordinators. An annual review of the client's goals is completed at the client's home. There are significant numbers of reviews that are not current. The Hamilton branch annual reviews had been completed apart from one from 2016. (See link to 4.11.2).

The finding from the mental health certification audit of 2016 is closed, however the finding from the Certification audit of 2017 remains open.

Finding:

Apart from the mental health service, not all reviews meet the required timeframes in the rehabilitation and community services.

Corrective Action:

Complete overdue reviews in the rehabilitation and the community services.

Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.11.5 (HCS.2012:4.11.5)

Where progress is different to that expected, the service provider responds by initiating changes to the individual service plan.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 4.12: Challenging Behaviours (HCS.2012:4.12)

Consumers with behaviours that challenge are treated with respect and receive services in a manner that has regard for their safety, dignity, privacy, and independence.

Attainment and Risk: FA

Evidence:

The policy and procedures related to the prevention, minimisation and management of challenging behaviours meet the requirements of the standard. A process for identification, documentation and referral for specialist input is used when required. Any specialist behavioural management plans are included in the individual's service plan.

A fact sheet for recovery facilitators gives good guidance on managing challenging behaviour. If a client enters the mental health service with challenging behaviour, a risk management plan is developed. A 'How to Guide' has a section on challenging behaviour and includes who to contact re escalation. Event notes concerning challenging behaviours evidenced updating of the service plan.

Recovery facilitators in the Hamilton branch were last provided with management of actual or potential aggression (MAPA) training February 2019 and the Tauranga branch in April 2019. Interview of recovery facilitators and review of training records confirmed this. The service manager from the Christchurch branch reported the recovery facilitators have not been provided with any training relating to challenging behaviour. The service manager advised because of the age group is over 65 years, this has not presented as an issue. If it was, a risk management plan would be developed. (See link to 3.2.2).

The finding from the last mental health certification audit in 2016 is now closed.

Recommendation:

[Click here to enter text.](#)

Criterion 4.12.1 (HCS.2012:4.12.1)

Policies and procedures exist to support consumers with challenging behaviours to ensure their safety, dignity, privacy, and independence are maintained. Policies and procedures shall cover:

- (a) Initiation of appropriate assessment of the consumer to determine the presence and nature of any challenging behaviours;
- (b) Identification and documentation within the individual service plan of support required in the home and/or in community environments;
- (c) Documentation of behaviours in the individual service plan;
- (d) Reporting protocols;
- (e) Escalation protocol if behaviours present an immediate threat to the client, service provider, or others;
- (f) Management of any deterioration in behaviour including protocols for initiating specialist intervention services.

Attainment and Risk: FA

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.12.2 (HCS.2012:4.12.2)

Consumers with behaviours that challenge are supported by suitably trained and competent service providers.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): [Choose an item.](#) (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 4.12.3 (HCS.2012:4.12.3)

Service providers working with consumers with behaviours that challenge receive adequate and appropriate supervision.

Attainment and Risk: Not Audited

Evidence:

[Click here to enter text.](#)

Finding:

[Click here to enter text.](#)

Corrective Action:

[Click here to enter text.](#)

Timeframe (days): Choose an item. *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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23 September 2020

Dr Ashley Bloomfield
Director-General of Health
Ministry of Health

By email: ashley.bloomfield@health.govt.nz

Tēnā koe Dr Bloomfield

Complaint: HealthCare New Zealand
Our ref: E20HDC01461/AKA

We have recently received a number of complaints raising concerns about HealthCare New Zealand (HCNZ).

At the time of writing, there have been 16 complaints received since 1 February 2020, with half of these received after 1 August 2020.

An anonymised table summarising the complaints with this Office is **enclosed** for your information. I note that four of these complaints involve care provided in the Manawatū-Whanganui region, with three in the Bay of Plenty and Canterbury regions respectively. In addition, there are five open complaints which we are in the process of assessing.

For some of these complaints, we have not been able to identify whether they relate to services funded by the Ministry of Health, the relevant District Health Board (DHB) or Accident Compensation Corporation (ACC). Therefore, we have also provided an anonymised summary of these complaints to both ACC and the relevant DHBs, as the other major funders of services provided by HCNZ. If you approach our Office, we will endeavour to work with you to identify the complaints that relate to the services you fund.

In addition to the complaints received by this Office, we have recently received a notification from the Nationwide Health and Disability Advocacy Service about a number of other complaints received by that service. We are in the process of assessing this information.

The current complaint activity is of concern not least on account of the relative number involved but also in light of the particularly vulnerable consumer groups receiving community support services.

The main concerns raised since February 2020 are of a similar nature and mainly relate to:

- Communication with the call centre, including response times to calls impacting on the timeliness of delivery of care;
- Inconsistency in the service coordination and provision of carers, including carers not attending to offer cares at expected times or, in some instances, not at all; and
- Quality of services provided, including training and conduct of staff.

In light of the volume of complaints and the recurring themes, I have decided that it is desirable in the public interest to refer these complaints and the issues they raise to the Ministry of Health for its consideration. This referral is made in accordance with section 59(4) of the Health and Disability Commissioner Act 1994.

I will leave the Ministry of Health to determine what action, if any, is taken in this instance but would appreciate being advised of the outcome of this referral.

Correspondence should be sent to hdcresponses@hdc.org.nz.

HDC is continuing to assess its open complaints and the cumulative concerns raised about HealthCare NZ's services, and I will keep you abreast of any further developments in due course. I thank you for your assistance in the meantime.

Nāku iti noa, nā



Rose Wall
Deputy Health and Disability Commissioner

Enc Table of anonymised complaints
Copy correspondence to HCNZ

cc HCNZ

Complaint no.	Complaint Reference and Name	Date received	Region	Type of care	Concerns raised	Stage
1	s 9(2)(a)	13 February 2020	Wellington	ACC funded for injury	Support person not showing up or showing up on incorrect days/times. Support person not adequately trained.	Provider referral.
2		19 February 2020	Bay of Plenty	High needs disability	Concerns about changes to call centre which result in delay in clients accessing care.	S38(1) – no action.
3		3 March 2020	Canterbury	Unclear	Support worker not showing up. Ongoing issues.	Provider Referral
4		11 March 2020	Wellington	High needs disability	Diet changed without agreement. Alleges staff are bullying him.	Formal referral to Advocacy
5		25 March 2020	Bay of Plenty	High needs disability	Home help services discontinued with insufficient warning during COVID-19/coronavirus lockdown.	S38(1) – no action.
6		12 May 2020	Canterbury	Aged care-home help	Medication administration error on three separate occasions.	Reviewing further information.
7		17 June 2020	Manawatū-Whanganui	Unclear	Concerns about new call centre system. Cannot get through to change carer times. Carers are often late as they do not allow travel time between clients.	Provider Referral.

8	s 9(2)(a)	23 June 2020	Otago	High needs disability	Difficulty accessing carers. Sent many different carers – too young, inappropriate, leave shortly after they start. Inconsistency of care.	Reviewing further information.
9		3 August 2020	Manawatū-Whanganui	Aged care – home help	Medication administration errors. Carers not turning up. HCNZ give no notice when carers are not available.	Awaiting further information.
10		3 August 2020	Manawatū-Whanganui	Unclear	Consumer not had support worker turn up for 3 weeks, despite calling HCNZ.	Formal Referral to Advocacy.
11		10 August 2020	Hawke's Bay	ACC funded for injury	Four occasions over short period of time where carer has not turned up.	Formal Referral to Advocacy.
12		10 August 2020	Manawatū Whanganui	High needs disability	Lack of coordination of care. His carer provided advanced notice of his lack of availability on a particular date, but HCNZ failed to arrange a replacement. Consumer soiled himself and sat in dirty clothing all night.	Formal Referral to Advocacy.
13		13 August 2020	Waikato	Aged care – residential service	Reports that HCNZ has centralised communication with call centre in Auckland and she does not have a coordinator appointed at present to contact to make changes.	Provider referral.
14		24 August 2020	Nelson	ACC funded for injury	Reports sexual harassment/abuse, threats and inappropriate/rude communication with staff member(s), a lack of available staff on afternoon shifts and record-keeping.	Formal Referral to Advocacy.
15		31 August 2020	Bay of Plenty	Aged care – retirement village	Reports that the quality of care has declined since HCNZ's recent reorganisation. Concerns she no longer receives a roster informing her of when cares will be undertaken and by whom. Detailed an instance of a worker not showing up and one where two carers showed up due to	Obtaining further information.

					miscommunication by HCNZ.	
16	s 9(2)(a)	1 September 2020	Canterbury	Aged care – retirement village	Concerns of a threatening comment made to the complainant and she ended up falling, which had not been reported. Reported difficulty with getting hold of provider on the phone.	Obtaining further information.

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23 September 2020

Vanessa Dudley
Chief Executive Officer (CEO)
HealthCare New Zealand

s 9(2)(a)

Tēnā koe Ms Dudley

Enquiry: HealthCare New Zealand complaints
Our ref: E20HDC01461/AKA

We have recently received a number of complaints raising concerns about your organisation.

At the time of writing, this Office has received 16 complaints since 1 February 2020, with half of these received after 1 August 2020. A table summarising the complaints with this Office is **enclosed** for your information. I note that four involve care provided in the Manawatū-Whanganui region, with three in the Bay of Plenty and Canterbury regions respectively. In addition, there are five complaints we are in the process of assessing.

In addition, we have recently received a notification from the Nationwide Health and Disability Advocacy Service about a number of other complaints received by that service. We are in the process of assessing this information.

The current complaint activity is of concern not least on account of the relative number involved but also in light of the particularly vulnerable consumer groups receiving community support services.

The main concerns raised since February 2020 are of a similar nature and namely relate to:

- Communication with the call centre, including response times to calls impacting on the timeliness of delivery of care;
- Inconsistency in the service coordination and provision of carers, including carers not attending to offer cares at expected times or, in some instances, not at all; and
- Quality of services provided, including training and conduct of staff.

In light of the volume of complaints and the recurring themes, I have decided that it is desirable in the public interest to refer these complaints and the issues they raise to ACC, the relevant District Health Boards and the Ministry of Health.

Please note that this referral includes the five complaints that remain open with this Office and is made in accordance with section 59(4) of the Health and Disability Commissioner Act 1994.

Nāku iti noa, nā



Rose Wall
Deputy Health and Disability Commissioner

Enc Table of complaints
Cc s 9(2)(a) [REDACTED]
Ministry of Health, ACC, and Relevant DHB

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Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

6 November 2020

Josephine Gagan
Chief Executive Officer (CEO)
HealthCare New Zealand

COPY

By email: .

Tēnā koe Ms Gagan

Enquiry: HealthCare New Zealand complaints
Our ref: E20HDC01461/AKA

Thank you for your email to my colleague, Alexia Kapranos, dated 20 October 2020.

Since I wrote to you on 23 September 2020, this Office has received a further six complaints about your service (see the **enclosed** updated table). In addition, the Nationwide Health and Disability Advocacy Service (Advocacy Service) has reported concerns about HealthCare New Zealand (HCNZ) to this Office. This information was provided under section 30(k) of the Health and Disability Commissioner Act 1994.

The report from the Advocacy Service refers to 34 complaints the service has received about HCNZ from across the country, since September 2019. The second report contains 11 complaints. I **enclose** a summary table of these complaints for your information. Please note that you have been notified of six of these complaints previously. For ease of reference, I have set out the duplications below (the column on the left is the Advocacy complaint number that corresponds to the HDC complaint number in the right hand column):

Complaint number in table	
Advocacy	HDC
15	4
22	6
31	16
33	11
35	14
37	10

I note that the Advocacy Service complaints stem from 16 different branches, and include nine complaints relating to Canterbury, eight to Manawatū-Whanganui, four to the Auckland area, and four to the Hawke's Bay region.

I appreciate the volume of complaints may not seem excessive in the context of the number of consumers HCNZ supports on a day to day basis. However, the nature of the consumers involved, the unexpected change in complaint activity over a relatively short period of time, and the consistency of concerns raised, has led me to consider more intensive follow up is warranted.

While I note that you have recently taken over as CEO, and are leading work to improve the level of service, my Office is continuing to receive complaints relating to service changes introduced since June 2020, in particular, concerns about the new call centre. Moreover, I am also mindful of the high volume of complaints the Advocacy Service received before June 2020. These complaints focus on similar themes surrounding communication, as well as scheduling and attendance of carers.

In light of the current pattern of complaints including both the volume and recurring themes, I have decided that it is desirable and in the public interest to refer these additional complaints, and the issues they raise, to Accident Compensation Corporation (ACC), the Ministry of Health and the relevant District Health Boards (DHBs). Please note that this is in accordance with section 59(4) of the Health and Disability Commissioner Act 1994.

Updates/amendments to HDC table:

Please note that in the summary table attached to my last letter, there was a discrepancy in the description of complaint number 4, which is more accurately reflected in the description from the Advocacy Service's summary table. It was not reported that a staff member bullied the complainant, but rather that a fellow resident was bullying the complainant, and that staff did not effectively intervene. I apologise for this oversight. I will flag this with all agencies accordingly.

Please also note that number 9 on the table has been expanded upon to include additional information. In addition, the stages of the complaints have been updated to reflect the current position.

Your response:

HDC is continuing to assess its open complaints and the cumulative concerns raised about HCNZ's services.

I note that you were due to provide a response on 30 October 2020. **Please update our Office on this.**



I look forward to receiving information about the corrective actions you are currently undertaking.

Nāku iti noa, nā



Rose Wall
Deputy Health and Disability Commissioner

Enc Updated table of complaints from HDC
Summary table of complaints from the Advocacy Service
Copy of letters to Ministry of Health and ACC

Cc Ministry of Health, ACC, and Relevant DHB

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6 November 2020

Dr Ashley Bloomfield
Director-General of Health
Ministry of Health

By email: ashley.bloomfield@health.govt.nz

Tēnā koe Dr Bloomfield

Complaint: HealthCare New Zealand (HCNZ)

Our ref: E20HDC01461/AKA

I write further to my letter of 23 September 2020, and your response of 16 October 2020.

Since I wrote to you on 23 September 2020, this Office has received a further six complaints about HCNZ's service (see the **enclosed** updated table). In addition, the Nationwide Health and Disability Advocacy Service (Advocacy Service) has reported concerns about HCNZ to this Office. This information was provided under section 30(k) of the Health and Disability Commissioner Act 1994.

The report from the Advocacy Service refers to 34 complaints the service has received about HCNZ from across the country, since September 2019. The second report contains 11 complaints. I **enclose** a summary table of these complaints for your information. Please note that you have been notified of six of these complaints previously. For ease of reference, I have set out the duplications for you below (the column on the left is the Advocacy complaint number that corresponds to the HDC complaint number in the right hand column):

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33	11
35	14
37	10

I note that the Advocacy complaints stem from 16 different branches, and include nine complaints relating to Canterbury, eight to Manawatū-Whanganui, four to the Auckland area, and four to the Hawke's Bay region.

My Office is continuing to receive complaints relating to the service changes introduced since June 2020, in particular, concerns about the new call centre. Moreover, I am also mindful about the high volume of complaints the Advocacy Service received before June 2020. These complaints focus on similar themes surrounding communication, as well as scheduling and attendance of carers.

While I note that you are looking into these issues, and will be following up with HCNZ, ACC and the relevant District Health Boards (DHBs), I wished to ensure that you had a fuller picture of the issues my Office is assessing.

In light of the current pattern of complaints including both the volume and recurring themes, I have decided that it is desirable and in the public interest to refer these additional complaints, and the issues they raise to, Accident Compensation Corporation (ACC) and the relevant DHBs. Please note that this is in accordance with section 59(4) of the Health and Disability Commissioner Act 1994.

Updates/amendments to HDC table:

Please note that in the summary table attached to my last letter, there was a discrepancy in the description of complaint number 4, which is more accurately reflected in the description from the Advocacy Service's summary table. It was not reported that a staff member bullied the complainant, but rather that a fellow resident was bullying the complainant, and that staff did not effectively intervene.

Please also note that number 9 on the table has been expanded upon to include additional information. In addition, the stages of the complaints have been updated to reflect the current position.

Your response:

HDC is continuing to assess its open complaints and the cumulative concerns raised about HCNZ's services. I appreciate that the healthy ageing team will report back to this Office once it receives a response from the above organisations. Correspondence should be sent to **hdcresponses@hdc.org.nz**. I will keep you abreast of any further developments at my Office.

I look forward to hearing from your team again in due course.

Nāku iti noa, nā



Rose Wall
Deputy Health and Disability Commissioner

Enc Updated table of complaints from HDC
Summary table of complaints from Advocacy
Copy letter to HCNZ
Cc HCNZ

ADVOCACY SERVICE

Complaint No.	Complaint Reference And Name	Date Received	Region	Concerns raised	Stage
1	s 9(2)(a)	16 September 2019	Taranaki	<ul style="list-style-type: none"> Relief carer did not wash consumer properly Relief staff often unavailable to cover or help main caregiver Manner and communication from coordinator 	Resolved – provider got a new coordinator, two new trained carers and updates Mr Muir’s care plan.
2		23 September 2019	Manawatū-Whanganui	<ul style="list-style-type: none"> Lack of communication with family Inadequate care – consumer was unwell and no one had put a pull up on her Inadequate care – consumer became increasingly unwell. Ended in hospital coronary care unit. 	Withdrawn from Advocacy. OPEN at HDC [REDACTED] – drafting s 38 provisional
3		26 September 2019	Canterbury	<ul style="list-style-type: none"> Lack of communication about reduced care Inadequate response to complaint 	Not resolved – didn’t wish to engage further with provider. Closed with Advocacy.
4		25 October 2019	Manawatū-Whanganui	<ul style="list-style-type: none"> Mistreated by carers Disrespected and patronised by care staff Lack of support to find paid employment 	Resolved – Advocacy liaised with support funder to move consumer to a new flat
5		30 October 2019	Bay of Plenty	<ul style="list-style-type: none"> Scheduled carers not coming Lack of communication about carers not coming Manner and communication from coordinator 	Resolved – provider responded to concerns in writing
6		2 December 2019	Canterbury	<ul style="list-style-type: none"> Scheduled carers showing up late Lack of communication about carers being late Not notified when new staff were filling in 	Resolved – provider responded in writing
7		19 December 2019	Canterbury	<p>HDC section 37 referral to Advocacy</p> <ul style="list-style-type: none"> Lack of communication about care plan Consumer only had one visit and no further contact 	Withdrawn – Advocacy lost contact with consumer and complainant.

	s 9(2)(a)				
8		23 January 2020	Otago	<ul style="list-style-type: none"> Manner and communication of caregiver Caregiver returned against consumer's wishes 	Withdrawn – Advocacy advised she speak with provider directly. No further action
9		24 February 2020	Canterbury	<p>Continuation of her previous complaint about communication.</p> <ul style="list-style-type: none"> Lack of communication about who was providing her care Lack of regular carers 	Resolved – provider responded to concerns.
10		24 February 2020	East Coast	<ul style="list-style-type: none"> Carers not coming Lack of communication about carers not coming 	Resolved – Advocacy supported Mr Ford to speak with provider. Provider responded in writing
11		3 March 2020	Bay of Plenty	<ul style="list-style-type: none"> Disclosure of mental health notes to her carer who cares for physical injuries only 	Resolved – provider responded in writing
12		4 March 2020	Bay of Plenty	<ul style="list-style-type: none"> Carers cancelled on short notice and without a replacement arranged Lack of communication about carers being cancelled 	Withdrawn
13		9 March 2020	Manawatū-Whanganui	<ul style="list-style-type: none"> Carers not arriving at arranged time Lack of communication about carers being delayed Carers not listening to consumer 	Withdrawn – service improved
14		30 March 2020	Waikato	<ul style="list-style-type: none"> Disabled consumer discharged to care of elderly parents Lack of communication about this decision 	Resolved – mentoring for self-advocacy.
15		29 April 2020	Wellington	<p>HDC section 37 referral to Advocacy</p> <ul style="list-style-type: none"> Failure to intervene when he reported his flatmate was bullying him Privacy breach concerning medication 	Not resolved – provider met resolution outcomes but consumer did not accept the complaint was resolved.
16		7 May 2020	Southland	<ul style="list-style-type: none"> Inconsistent care provided for his scabies – carers giving different care instructions Inadequate response to complaint Carers late 	Not resolved – provider responded in writing, but consumer declined meeting.

				<ul style="list-style-type: none"> Lack of communication about carers being late 	
17	s 9(2)(a)	17 June 2020	Hawke's Bay	<ul style="list-style-type: none"> Carer not showing up Lack of communication about carers not coming 	Resolved – provider responded in writing
18		18 June 2020	Northland	<ul style="list-style-type: none"> Unable to get permanent carers Carers not showing up 	Resolved – provider arranged for a temporary support person until a permanent one was found
19		18 June 2020	Manawatū-Whanganui	<ul style="list-style-type: none"> Lack of communication – unable to get through Lack of communication about contact number changing Lack of communication about changing support staff for her children 	OPEN
20		23 June 2020	Hawke's Bay	<ul style="list-style-type: none"> Scheduled carers not showing up Lack of communication about carers being late or not coming Inadequate response to complaint 	OPEN
21		29 June 2020	Auckland	<ul style="list-style-type: none"> Scheduled carers not showing up Lack of communication about carers not coming Restructuring of Healthcare NZ making it difficult to contact them 	Resolved – care worker confirmed
22		1 July 2020	Canterbury	<ul style="list-style-type: none"> Carer mixing up medication Carers showing up late 	Withdrawn OPEN with HDC [REDACTED] reviewing section 14 response
23		2 July 2020	South Canterbury	<ul style="list-style-type: none"> Carers not coming or are late Lack of communication about carers not coming or being late 	Resolved – meeting with provider
24		6 July 2020	Auckland	Carers often off sick with no cover arranged	Resolved – provider apologised and carers began to show up regularly
25		13 July 2020	Taranaki	<ul style="list-style-type: none"> Lack of communication about carer changing Inadequate care from carer Manner and communication of carer 	Resolved – provider responded to concerns

				<ul style="list-style-type: none"> Lack of communication – unable to reach provider 	
26	s 9(2)(a)	17 July 2020	East Coast	<ul style="list-style-type: none"> Scheduled carers not arriving Lack of communication about carers not coming 	Resolved
27		21 July 2020	Canterbury	<ul style="list-style-type: none"> Scheduled carers not arriving Lack of communication – provider not responding to concerns Lack of communication – unable to reach provider 	OPEN
28		21 July 2020	Manawatū-Whanganui	<ul style="list-style-type: none"> No relief carer scheduled when usual carer is unavailable Lack of communication – unable to reach provider Inadequate response to complaint – not responded to in a timely manner 	Resolved – provider responded to concerns
29		23 July 2020	Auckland	<ul style="list-style-type: none"> Manner and communication of carers Threatening behaviour from carer 	Resolved – provider met with consumer
30		30 July 2020	Auckland	<ul style="list-style-type: none"> Scheduled carers not showing up No alternative support arranged Delayed/lack of communication about carer not coming 	OPEN
31		7 August 2020	Canterbury	<ul style="list-style-type: none"> Manner and communication of carer Threatening behaviour from carer Inadequate response to complaint 	Referred to HDC OPEN with HDC [REDACTED] – drafting section 14
32		7 August 2020	Otago	<ul style="list-style-type: none"> Scheduled carers not coming Lack of communication – unable to reach provider Inadequate response to complaint 	OPEN
33		28 August 2020	Hawke's Bay	HDC section 37 referral to Advocacy <ul style="list-style-type: none"> No relief carer arranged when permanent carer went on leave Lack of communication about carer going on leave 	OPEN

				<ul style="list-style-type: none"> Lack of communication – unable to reach provider 	
34	s 9(2)(a)	31 August 2020	East Coast	<ul style="list-style-type: none"> Carers not coming or coming late Lack of communication about carers not coming or coming late 	OPEN
35		07 September 2020	Nelson	HDC s 37 FRA () <ul style="list-style-type: none"> Inappropriate communication from RN Manner and communication 	OPEN
36		09 September 2020	South Canterbury	<ul style="list-style-type: none"> Caregiver not following care plan Carer refusing to assist with reading and laundry 	Resolved – provided response
37		09 September 2020	Manawatū-Whanganui	HDC s 37 FRA () <ul style="list-style-type: none"> Carers not coming No replacement carers arranged Lack of communication Unable to contact provider 	Resolved – provided written response
38		18 September 2020	Wellington	<ul style="list-style-type: none"> No replacement carers arranged Carers often cancelled Inconsistencies in care plan 	OPEN
39		23 September 2020	Hawke's Bay	<ul style="list-style-type: none"> Carer not changing consumer's schedule when requested "Erratic" care – carers not showing up 	OPEN
40		02 October 2020	Otago	<ul style="list-style-type: none"> Carers arriving late without explanation Carers not coming Unable to contact provider Long phone wait times 	OPEN
41		05 October 2020	Canterbury	HDC s 37 FRA () <ul style="list-style-type: none"> Carers showing up late 	Resolved – withdrawn as provider addressed concerns with him directly
42		07 October 2020	Manawatū-Whanganui	<ul style="list-style-type: none"> Carers not coming Consumer ended up in hospital 	Withdrawn – consumer being reassessed and may move rest home
43		13 October 2020	Canterbury	<ul style="list-style-type: none"> Carers arriving late Inconsistent information regarding student nurse 	OPEN

44	s 9(2)(a)	21 October 2020	Manawatū-Whanganui	<ul style="list-style-type: none"> • Carer not coming • Lack of communication about carers not coming • Unable to contact provider due to long phone wait times 	OPEN
45		23 October 2020	Taranaki	<ul style="list-style-type: none"> • Carers not showing up • Carers showing up late • Carers not staying for proper period of time • Inadequate response to complaint 	OPEN

Complaint no.	Complaint Reference and Name	Date received	Region	Type of care	Concerns raised	Stage
1	s 9(2)(a)	13 February 2020	Wellington	ACC funded for injury	Support person not showing up or showing up on incorrect days/times. Support person not adequately trained.	Provider referral.
2		19 February 2020	Bay of Plenty	High needs disability	Concerns about changes to call centre which result in delay in clients accessing care.	S38(1) – no action.
3		3 March 2020	Canterbury	Unclear	Support worker not showing up. Ongoing issues.	Provider Referral
4		11 March 2020	Wellington	High needs disability	Diet changed without agreement. Reports being bullied by fellow resident and lack of effective intervention by staff.	Formal referral to Advocacy
5		25 March 2020	Bay of Plenty	High needs disability	Home help services discontinued with insufficient warning during COVID-19/coronavirus lockdown.	S38(1) – no action.
6		12 May 2020	Canterbury	Aged care-home help	Medication administration error on three separate occasions.	Awaiting further information.
7		17 June 2020	Manawatū-Whanganui	Unclear	Medication administration error on one occasion and not given at prescribed times. Concerns about new call centre system. Cannot get through to change carer times. Carers are often late as they do not allow travel time between clients.	Provider Referral.

8	s 9(2)(a)	23 June 2020	Otago	High needs disability	Difficulty accessing carers. Sent many different carers – too young, inappropriate, leave shortly after they start. Inconsistency of care.	Preparing a further referral to advocacy
9		3 August 2020	Manawatū-Whanganui	Aged care – home help	Medication administration errors. Carers not turning up. HCNZ give no notice when carers are not available.	Awaiting further information.
10		3 August 2020	Manawatū-Whanganui	Unclear	Consumer not had support worker turn up for 3 weeks, despite calling HCNZ.	Formal Referral to Advocacy.
11		10 August 2020	Hawke's Bay	ACC funded for injury	Four occasions over short period of time where carer has not turned up.	Formal Referral to Advocacy.
12		10 August 2020	Manawatū Whanganui	High needs disability	Lack of coordination of care. His carer provided advanced notice of his lack of availability on a particular date, but HCNZ failed to arrange a replacement. Consumer soiled himself and sat in dirty clothing all night.	Formal Referral to Advocacy.
13		13 August 2020	Waikato	Aged care – residential service	Reports that HCNZ has centralised communication with call centre in Auckland and she does not have a coordinator appointed at present to contact to make changes.	Provider referral.
14		24 August 2020	Nelson	ACC funded for injury	Reports sexual harassment/abuse, threats and inappropriate/rude communication with staff member(s), a lack of available staff on afternoon shifts and record-keeping.	Formal Referral to Advocacy.
15		31 August 2020	Bay of Plenty	Aged care – retirement village	Reports that the quality of care has declined since HCNZ's recent reorganisation. Concerns she no longer receives a roster informing her of when cares will be undertaken and by whom. Detailed an instance of a worker not showing up and one where two carers showed up due to	Awaiting further information.

					miscommunication by HCNZ.	
16	s 9(2)(a)	1 September 2020	Canterbury	Aged care – retirement village	Concerns of a threatening comment made to the complainant and she ended up falling, which had not been reported. Reported difficulty with getting hold of provider on the phone.	Awaiting further information.
17		27 September 2020	Hawke's Bay	High needs disability	HCNZ service changed and she was asked to call the Auckland office. She experiences long call waiting times and failure to return her calls, plus inconsistent carers and poor communication.	Awaiting further information.
18		28 September 2020	Canterbury	Unclear	Concerns that nurses do not attend at consistent times and it is difficult to coordinate with his sleep needs. His nurse ignored his concerns about his wound pain on one occasion, and his scar opened up afterwards.	Formal referral to Advocacy
19		30 September 2020	Canterbury	Unclear	Concerns about inadequate response to a complaint about inadequate treatment from support staff.	Obtaining further information
20		14 October 2020	Otago	High needs disability	Concerns about incompleteness of rosters, waiting times with new call centre, lack of communication regarding changes to her care, qualifications of staff and going without cares.	Formal referral to Advocacy
21		14 October 2020	Manawatū Whanganui	Unclear	Concerns about the circumstances surrounding and escalation of a fall.	Obtaining further information
22		27 October 2020	Southern	High needs disability	Concerns about difficult getting hold of provider by phone and carers do not attend at consistent times.	Obtaining further information

Memo

Update on quality issues at Healthcare NZ

Date:	16 February 2021
To:	Adri Isbister, Deputy Director-General, Disability
Copy to:	Clare Perry, Acting Deputy Director-General, Health System Improvement and Innovation Jim Nicolson, Manager, Healthy Ageing, Health System Improvement and Innovation
From:	Amanda Bleckmann, Group Manager Operational Performance, Disability
For your:	Information

Purpose of report

1. This memo updates you on actions taken in response to correspondence from Rose Wall, Deputy Health and Disability Commissioner (HDC) on 23 September 2020 about the quality of services provided by Healthcare NZ (HCNZ).

Background and context

2. The HDC has received several complaints about the services provided by HCNZ. The general theme of the complaints was workers not turning up on time and an inability to contact HCNZ.
3. The correspondence from HDC was a representative sample numbering sixteen complaints. The services are funded by District Health Boards (DHBs) (five complaints refer), ACC (three complaints refer) and the Disability Directorate at the Ministry of Health (five complaints refer). The funder was unclear for three of the complaints.
4. The underlying issue largely relates to the move to a national call centre that began in the third quarter of 2019 resulting in poor communication between HCNZ support workers and coordinators, and HCNZ clients and the call centre.
5. Dr Ashley Bloomfield responded to Rose Wall stating the funders would work collectively with HCNZ to resolve the issues.
6. We contacted the HCNZ Chief Executive, Vanessa Dudley, who provided a remediation plan on 11 November 2020. The plan was provided to all funders and outlined the HCNZ response to the complaints. Vanessa Dudley subsequently resigned from the CE position and Josephine (Jo) Gagan, CE of the parent company New Zealand Health Group assumed the role of acting CE of HCNZ.
7. In December 2020, ACC advised that the remediation plan HCNZ provided sufficient comfort that HCNZ have addressed the issues raised in complaints made by ACC clients. Communication between DHB regional Planning and Funding General Managers and Disability concluded that

further information was needed from HCNZ for the funders to have confidence that issues were being appropriately managed.

8. DHB and Disability representatives agreed to meet with Jo Gagan on 28 January 2021. Following further complaints between 1 December 2020 and 17 January 2021, ACC also joined the meeting. Attendees were Ally Emerson from ACC, Kate Sladden, Nicola Ehau, Sandra Williams and Jason Power representing DHBs, Jon Shapleski and Maria Shcherbakova from TAS, Martin Anderson representing Disability and Jo Gagan from HCNZ.

Outcome of 28 January 2021 meeting

9. Jo reported that HCNZ has continued to act on the initial complaints made to the HDC office and the subsequent complaints (of a similar nature) that HCNZ had received. HCNZ is regularly updating the remediation plan. Jo agreed to provide the meeting attendees with a copy of the most recent version of the remediation plan. The version to the end of January 2021 is attached for your information.
10. Jo advised that within HCNZ, complaints are expected to be managed as close to the source of the complaint as possible. Senior management is often unaware of complaints that have not been escalated to the regional manager level. Jo asked the funder representatives to inform the regional manager or her of any complaints that are not being resolved within an acceptable timeframe. As per HCNZ policy, complainants are informed of steps taken to resolve the complaint.
11. We have planned meetings for each of the next three months to track the progress HCNZ is making against the remediation plan.
12. The Disability directorate continues to have concerns about the systems in place at HCNZ to facilitate communication between clients and coordinators and between support workers and coordinators. We continue to receive complaints relating to these issues and we will continue to raise our concerns in meetings with HCNZ.
13. The next meeting is on 26 February 2021.
14. We will provide you with a further update will following the April meeting. Please advise if you wish to be updated sooner.

Recommendations

It is recommended that you:

1.	Note	Yes/No
	The content of this update	

Signature 
 Amanda Bleckmann
Group Manager Operational Performance, Disability

Date: 17/02/2021

Signature _____
 Adri Isbister
Deputy Director-General, Disability

Date:

Excerpt of Quality record minutes about actions taken for this complaint

Provider	Complaint Description	Complaint lead	Portfolio Manager	Opened	Date closed	Update	Update	Update	Update	Update	Update
Healthcare NZ	Letter dated 6/11/20 from Health & Disability Commissioner to Ashley Bloomfield re a table of 34 complaints received about HCNZ from across the country since Sep.19	Martin	Bella	9/12/2020	7/05/2021	7/5/21. Representatives from funders (DHBs, ACC and Disability) met on 29 April and considered the most recent Performance Improvement Plan received from HCNZ. The funders have agreed that HCNZ is making good progress to resolve the issues that are behind the complaints, and monthly meetings with Jo Gagan are no longer required. Any quality issues should be managed locally now. This outcome is to be communicated to the Director-General by Martin Anderson on behalf of the 3 funders. This can be closed	22/3/21. A meeting with Jo Gagan was held on 26 January where Jo provided a verbal update on actions. This was followed up with an update to the written performance improvement plan, received on 19 March and to the end of February. Reports that progress is being made on staffing the call centres and bedding in new systems and practices. Report shared with Quality team and Portfolio Manager for review.	14/2/21 Updated performance plan from Jo Gagan has been received in order to update Ashley about the progress.	17/2/21 Another meeting scheduled for 26 Feb. Performance Improvement Plan from HCNZ has been requested, and MoH will be meeting with them every three months.	2/2/21 Had a meeting with Jo Gagan the last Thursday and have agreed that MoH should let the Regional Manager know of any incidents etc. We have scheduled monthly meetings with Jo for the next 3 months and hope to resolve issues by then.	15/12/20 Agreement with DHBs that a meeting will be held with Josephine Gagan to discuss the issues raised in the complaints, and the HCNZ plan to address these. ACC is considering how it will respond to the issues. A meeting prior to Christmas has been requested. Martin Anderson

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