A Disability Service Company

A Disability Service

Manager, Mr D

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC07675)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Ms A has cerebral palsy and severe spastic quadriplegia and is dependent on receiving full care. In April 2006, Ms A went to live at a residential disability facility. On 19 July 2006 she weighed 26kg. On 20 April 2007, Ms A (then aged 22) was transferred from the disability service to a public hospital. It was recorded that she was malnourished, dehydrated and weighed 17kg.

The general manager of the disability service during this time was Mr D. Ms A's parents made a number of complaints to Mr D concerning their daughter's weight loss, her deterioration in health, and the shortage of trained staff available to provide her with the specialised care her condition required. Registered nursing staff and caregivers employed at the disability service, and Ms A's GP, also documented similar concerns, and requested that Ms A be weighed and then assessed by a dietitian.

As a result of concerns, the Ministry of Health (MOH) conducted an issues-based audit of the disability service, and installed a nurse manager to run the facility.

Following her discharge from the public hospital, Ms A did not return to live at the disability service.

Complaint and investigation

On 7 May 2007, a complaint was forwarded to the Health and Disability Commissioner (HDC) from a District Health Board social worker, on behalf of Mrs B, about the services provided to Mrs B's daughter, Ms A, by a disability service. Mrs B and Ms A's father, Mr C, are the joint complainants. The following issues were identified for investigation:

- *The appropriateness of care provided by the disability service company to Ms A from April 2006 to April 2007.*
- *The appropriateness of care provided by the disability service trust to Ms A from April 2006 to April 2007.*
- *The adequacy of the disability service's complaints procedures and whether this was used appropriately to address complaints raised by Ms A's family concerning her care at the disability service between April 2006 and April 2007.*
- *The appropriateness of the care provided by Mr D to Ms A from April 2006 to April 2007.*

The investigation was delegated to Tania Thomas, Deputy Health and Disability Commissioner, and an investigation was commenced on 11 July 2007.

The parties directly involved in the investigation were:

Ms A	Consumer
Mrs B	Complainant, Ms A's mother
Mr C	Complainant, Ms A's father
Mr D	Provider
Dr E	General Practitioner / Provider
Mr F	Trustee, the disability service
Ms G	Registered nurse
A disability service	Provider
A District Health Board	Provider

Information received

Ms A's medical practice and hospital records were reviewed. The information and responses received from Mrs B, Mr C, Mr D, the disability service and the MOH were carefully considered.

Independent expert advice was obtained from Ms Sharon Brandford, a registered clinical psychologist with extensive experience in monitoring standards of care for people with disabilities. This advice is included as **Appendix 1**.

The MOH provided a copy of the report of its May 2007 audit of the disability service. As the disability service company and Mr D were unable to provide the documentation required, I have used the MOH's audit report to provide me with an overview of the operation of the disability service under Mr D's management. The executive summary of this report is attached as **Appendix 2**.

Background information

The disability service is a community residential support service for people with physical disabilities. It has 18 full-time beds and two respite beds. The disability service, which was established by a trust (the Trust), is a community residential support service.

In the time covered by this complaint, the general manager of the disability service was Mr D, who has a master's degree in psychology and a background in training and health service management. The sole trustees were Mr F, an accountant with no health care experience, and Mr D. Mr F was responsible for the financial operations of the Trust and the disability service company (the Company), and was the sole director of the Company, which employed all the disability service staff, including Mr D.

The MOH Disability Services service specifications contract
Residents are referred to the disability service by the Needs Assessment Service Co-ordination Agency (NASC), and funding is provided mainly through the MOH. The contract specifies that the disability service is expected to provide accessible services in a home-like environment and cater for a range of residents with different levels of complexity and support needs.

Within two months of a resident's entry into the facility, the disability service is obliged to develop an individual care plan and review this six-monthly. The plan is expected to cover the resident's level of functioning and his/her abilities and well-being. It should identify his/her specific support needs, including any requirements for supervision or assistance with daily living, and activities such as toileting, hygiene and eating. It is expected to include short- and long-term goals, and an outline of the steps and services required in order to achieve these goals.

The disability service is responsible for ensuring that every service user has an identified primary support worker to co-ordinate the implementation of the resident's plan. The primary support worker is provided orientation, training and ongoing support for this role. The service is expected to provide registered nurse support for residents with identified high medical needs, and a system for external referrals to appropriate services for specialised assessment. The disability service is also expected to:

- manage risk by adequately documenting crisis situations, ensuring incident reports are completed and maintaining an Incident Register;
- have a complaints process, maintain a complaints register and ensure access to an independent advocacy services;
- provide or access funding to purchase equipment required for general use.

A residential service provider with five or more residents is required to be certified under the Health and Disability Services (Safety) Act 2001.[1] This certification is for up to three years. The disability service was re-certified in late 2006 to late 2009 on the condition that, by January 2008, it validated staff professional qualifications and significantly improved its management of residents' medicines. This was achieved in January 2008.

Ms A's residence and care at the disability service

Ms A

Ms A suffers from epileptic seizures, impaired vision, and poor circulation. She is unable to sit up or hold up her head without support. She has considerable physical difficulties with eating and drinking, and in particular swallowing, and cannot speak. For a number of years Ms A attended school.[2] The principal said that Ms A is conscious of her surroundings, recognises people and communicates in a limited fashion with those who know her well. Ms A responds to the moods of those around her. She enjoys talking, laughing or singing with people, and withdraws from anger,

[1] The purpose of this Act is to promote the safe provision of health and disability services to the public through consistent and reasonable standards.

[2] The school is for students with physical disability, primarily those with cerebral palsy. It provides speech language therapy, occupational therapy and physiotherapy, and has registered nurses on its staff.

irritation or impatience. Ms A is dependent on caregivers to provide all aspects of her care.

Ms A's mother, Mrs B, has been her daughter's long-term caregiver, and holds Enduring Power of Attorney.

From 2004 to 2006, Ms A stayed at the disability service for short periods (two to four weeks) of respite care. However, in April 2006, Ms A was admitted to the disability service as a full-time resident.

Ms A's Resident Care Plan

Mrs B provided the disability service with a copy of a comprehensive 15-page care plan that she had developed. The disability service used this as its care plan and it was attached to Ms A's clinical record. The plan identified Ms A's dietary requirements, and stated that a trained carer could take up to three-quarters of an hour to feed Ms A, and that she liked to be involved and informed about what was going on. It describes some of the communication techniques best suited to gaining Ms A's co-operation. Mrs B wrote on behalf of her daughter, "I need to be fed with a dessert spoon. I need to be prompted to open my mouth for food and drink. It helps if you let me see the spoon."

On 1 September 2006, the clinical manager reviewed Mrs B's care plan and wrote a five-page residential care plan for Ms A. This re-stated Ms A's reliance on receiving good nutrition, and indicated that, for ease of eating, her food was to be puréed. One of the identified goals was to maintain her weight at 28kg.[3] A further review was set down for 1 March 2007.[4]

On 24 October 2006, Ms A underwent a feeding assessment at her school (which Ms A attended until December 2006). The assessment report noted that Ms A demonstrated impaired jaw and tongue movements and had difficulty in holding puréed food in her mouth without spillage occurring. It was also noted that Ms A required her head to be supported in order to eat and swallow effectively. Ms A was not weighed at this time.

Mrs B provided the disability service staff with two training sessions on caring for Ms A. It is not recorded when these occurred but Mr D said that they were initiated because:

> "I asked [Mrs B] whether there could be training difficulties between our staff and [Ms A], and if some training could alleviate these. … [Ms A's] efforts to

[3] This was an estimate. She was weighed at school on 19 July 2006. The school uses calibrated scales, which are accurate, and Ms A's weight was then 26kg. This was her only recorded weight until April 2007.

[4] The clinical manager resigned in December 2006. There is no record that a further care plan review took place.

> communicate could easily be misinterpreted and may have resulted in staff thinking [she] was either full or not hungry. There had also been some confusion around what mood [Ms A] was experiencing."

April 2006 to April 2007

The disability service provided a computerised log of Ms A's daily progress notes dated from April 2006 to April 2007. The notes, although detailed, do not identify the person who entered the information.[5] They describe Ms A's eating, drinking, sleep patterns, hygiene care, general appearance, clinical care, mood effect and any significant events such as family visits.

However, Mr D advised that all computerised entries were always logged with the coded initials and the job title of the person entering the data, as well as the time and date of the entry, from the very start of the service in 2004. He stated that no changes were made to the system thereafter.

Throughout 2006, other than a brief hospital admission on 17 July following a stomach infection, Ms A's health was recorded as stable. In general, it is documented that she was eating and drinking regularly. Although her notes recorded times when she was despondent, these were infrequent.

From January to April 2007, there were days when Ms A was recorded as having stable health and being comfortable and happy with her care, but it is evident that her health and well-being were beginning to deteriorate and a number of problems and concerns starting to emerge, including her weight loss.

Weight loss

In July 2006, Ms A was weighed at school and her weight recorded as 26kg. In January 2007, Mrs B first raised with the disability service care staff her concerns that her daughter was losing weight. In response she was told that Ms A was depressed and not opening her mouth to accept food. This conversation is not recorded in Ms A's notes. However, the January notes do record that Ms A was increasingly subdued, restless and prone to crying.

Mrs B advised that she asked for her daughter to be weighed at this time and to see a dietitian and be given a diet supplement. She said that she asked for this several times over a two and a half month period, but nothing was done.

On 10 February 2007, Mrs B visited Ms A and found her to be "traumatised (eyes blank) and … very dehydrated". She complained to the staff present and again was told that Ms A was refusing to open her mouth to eat or drink because she was

[5] In September 2006, Mr D conducted an internal review of the policy for recording computerised daily progress notes. Each entry was required to be signed and dated by the appropriate person, and their designation identified. Only senior staff using password access could view the notes and, once they were saved, they could not be altered.

depressed. Mrs B said that her daughter had never refused food because she was depressed. She was able to get her daughter to drink, and it was apparent to her that her daughter was thirsty. Mrs B acknowledged that "there were obvious efforts by a number of staff to try and get more food into [Ms A]". Ms A's notes record: "[Ms A] quite distressed during the shift and was crying virtually every time she was checked on."

On 12 February, it was recorded that "[Ms A] is very thin". On 16 February, it was recorded that staff had spoken to Mrs B and that Ms A was no longer considered to be dehydrated.

On 24 February, Ms A experienced sustained seizures and required immediate admission to hospital. She was not weighed and the hospital staff treating her did not raise any concerns regarding her eating, drinking or weight. On 27 February, once her condition stabilised, Ms A returned to the disability service.

On 8 March, Ms A attended an evening at the school camp. A teacher aide who had previously worked with Ms A, observed that she had lost weight. She helped change Ms A and noted that her stomach was concave and her hip bones sticking out. The teacher aide fed Ms A that night but was surprised that the disability service caregiver accompanying Ms A was not trained in how to feed her appropriately. The teacher aide described Ms A as ravenous.

On 16 March, Ms A was seen at the disability service by her general practitioner, Dr E, for a three-monthly review. Mrs B was present and expressed concern at her daughter's general appearance and demeanour and asked for her to be weighed and seen by a dietitian. The notes of 18 March record Dr E's instructions for "weekly weighs when weighing machine avail[able]. Or when alternative method avail[able]. Re-education of all staff with regards to feeding techniques. Referral to community dietitian input, consult with mum about [Ms A's] preference in food."

On 20 March, Ms A refused to eat and drink, clenching her teeth to prevent the feeding spoon being put into her mouth. However, her notes record that she ate well the following day. On 24 March, it was noted that Ms A appeared unwell but was still eating. On 25 March registered nurse Ms G faxed Dr E requesting she review Ms A within the week. Ms G advised Dr E that her recommendations to increase Ms A's dietary intake were being followed and that Ms A had suffered vomiting and diarrhoea the previous day. Ms G also noted that Mrs B was concerned at the ongoing decline in her daughter's health.

On 26 March, RN Ms G sent a referral to a community care organisation requesting urgent support for Ms A, stating: "Recent decline in health. Rapid weight loss. Vomiting and diarrhoea, difficult to feed as [Ms A] spit[s] food out. Originally 28kg, however, weight much less at the moment. Tending to show continuing decline in weight." On the same day an unidentified registered nurse from the disability service spoke with Dr E, and it was planned to obtain a faecal specimen for analysis.

On 28 March, Dr E saw Ms A (at Mrs B's request) and recorded that Ms A's eating was better but that she needed to be weighed. Dr E recorded that the requested faecal specimen had not been obtained. The same day another registered nurse sent a fax to a dietitian stating: "[Ms A] has been losing weight 'Dramatically'. Need help from dietitian to assist in gaining weight." On 29 March, the disability service staff suspected that Ms A was dehydrated and increased her fluids.

On 30 March 2007, Ms A was admitted to hospital with severe constipation and a urinary tract infection. Dr E's letter of referral stated that Ms A's condition had been deteriorating gradually since July 2006, and that she was concerned about Ms A's weight loss, and added: "[The disability service] at the moment are very short staffed, and I am concerned about their ability to cope with [Ms A] at present." Ms A's [public] Hospital admission notes record that she is a "very thin girl … alert, interacts with carer". There was no record that she was weighed. Ms A was treated with enemas and discharged to the disability service the following day. Caregivers were provided a step-by-step care plan on the use of enema treatments for Ms A.

On 6 April, Ms A's notes state that she weighed 17kg (a weight loss of 11kg in the seven months since she was weighed at the school) but it is unclear whether she was actually weighed on this date. The notes instruct that she be weighed weekly to monitor any weight fluctuation. On the same day it was noted that "[Ms A] is taking fluids well and is eating but I feel there is something WRONG and I am quite worried". On 8 April, Ms G contacted Dr E to report progress on the hospital discharge plan.

On 14 April, as there were no scales at the disability service, Ms A was weighed using the scales at the next-door facility. Her weight was recorded as 17kg. It is not clear whether the scales were calibrated or whether this weight is accurate. Ms G provided this information to Mrs B on 20 April. Mrs B said that she was upset by the delay in passing the information on to her and by the severe weight loss experienced by her daughter. Mrs B stated that she had been asking for Ms A to receive food supplements and an urgent referral to a dietitian for at least two weeks. This had not eventuated.

On 20 April, Mrs B contacted Dr E, who referred Ms A to [the public] Hospital. She was admitted that day. Dr E's referral stated: "I have been increasingly concerned with [Ms A's] weight loss, which I believe has now reached critical level." At [the] Hospital Ms A was found to be suffering from malnutrition.

On 23 April, Ms A was weighed at 22kg. [The Hospital] dietitian who reviewed Ms A that day, observed that Ms A appeared malnourished and dehydrated. The dietitian noted that Ms A, already slight, had lost a significant amount of her body weight. This implied that she was likely in a state of starvation, with her body drawing protein from muscle, and this could have impacted on the health of her organs. However, the dietitian is not persuaded that Ms A weighed 17kg on admission to [the] Hospital. It is likely that she had gained between 2–4kg since she was weighed at the disability service, and that some of this may have been due to re-hydration.

Ms A was discharged to a private hospital on 2 May 2007, weighing 24kg, and did not return to the disability service. She went to live with her mother on 16 May 2007. Mrs B stated that she is now living at another hospital where she is happy. Ms A now weighs 29kg.

In response to this complaint, Mr D said that it was the responsibility of the registered nurses to manage and resolve Ms A's loss of weight. In summarising this complaint Mr D noted:

> "There is no doubt [Ms A] did not receive care suitable for her needs, … I believe a cascade of systemic issues contributed to this situation and, while all involved did as they were able, there were gaps in the provision of services."

Related information

The disability service's management of complaints
The disability service prospectus outlines a complaints process stating that residents are provided with a copy of the Code of Health and Disability Services Consumers' Rights. All complainants are provided with details of the health advocacy service and the Health and Disability Commissioner. All complaints are documented. A written acknowledgement of the complaint is made within five working days and the complaint followed up within 14 days. This information is entered in the resident complaints and resolution record held in the office of the general manager, who is responsible for ensuring that the complaint is investigated. The progress of the complaint and any resolution points achieved are logged in the complaints record.

Mr D stated that the disability service received very few complaints and that these (and the responses to them) were located in a central file. Generally, Mr D said he was able to resolve residents' concerns by speaking directly with them. He also said that he maintained an open-door policy for residents and their family to discuss their concerns directly with him.

Both Mrs B and Mr C said that they had made written and verbal complaints on behalf of their daughter, and Mr D did not respond to these in a timely manner. On the other hand, Mr D said that he had responded to their concerns and implemented actions to address the matters they raised. In particular he stated:

> "[Ms A's] weight, nutrition, feeding and fluids were raised during group supervision. This served to remind staff that she required extra input to make up the ground she had lost. Food supplements were provided, along with mixing charts and encouragement at handover to check that fluids were being maintained. … training was instituted to show staff how best to understand and feed [Ms A]."

Mrs B disputed Mr D's submission that he responded to her written complaint. She said he did not respond to her "at all, either verbally or in a written letter". A nurse at the disability service showed Mrs B a memo that Mr D had circulated to all staff about

her complaint. Mrs B recalls that in the memo Mr D stated that it was fortunate that Mrs B had not reported her concerns to HDC. She said that this prompted her to do so.

Mrs B said that she saw no evidence that Ms A was provided with food supplements.

The disability service was not able to provide this Office with a copy of their complaints log or copies of complaints concerning Ms A's care.

The disability service management
Mr F employed Mr D as the general manager of the disability service. Mr D was responsible for setting up the organisational structure and management systems for the operation of the Trust and the disability service. The general manager's job description identifies that he or she is responsible for ensuring that the care and services provided at the disability service comply with the Health and Disability Sector Standards, and the MOH contract, including implementing and monitoring all reporting functions. As general manager, Mr D was also responsible for human resource management, including employment, staff orientation and ongoing training, and for ensuring that there were adequate staffing levels to maintain operational safety. Mr D also had the responsibility to record, manage and resolve complaints.

Mr D
Mr D accepted that he set up the organisational structure of the disability service but said that the policies and systems he put into place were not always followed by staff. He said his role was primarily to develop the business brand. He did not have expertise or practical experience in caring for people with physical disabilities, and employed registered nurse clinical managers to oversee clinical care. From 2006 (after Ms A had moved permanently into the disability service) Mr D believed his relationship with the service had become increasingly "untenable" and his communication with Mr F was poor.

Mr D said that he asked Mr F to clarify the relationship between the Trust and the disability service, in particular with Mr D being general manager and Mr F sole director, and the conflict of interest this may have had on matters of trust governance, and trustee responsibilities and accountabilities, particularly as the trust did not have a resident or consumer representative as a trustee.

In December 2006, the clinical manager resigned and Mr D said that he had difficulty finding a suitable replacement for her. In Mr D's view, the Company provided him with insufficient finances and resources to recruit good quality clinical staff. This also made him increasingly reliant on agency staff to run the disability service, which affected the provision of continuity of care. Mr D believed it was the appropriate time to replace his role of general manager with that of a nurse manager.

Mr D said that he raised these concerns with Mr F, who did not respond or initiate any action to address any of the identified problems. Mr F denied that these concerns were ever raised with him. He said that he was not provided with "much" information by

Mr D, and was shown only parts of audit reports, which indicated that the disability service was meeting its contractual and service obligations.

In May 2007, Mr D met with Ministry of Health, Health & Disability National Services Directorate staff and raised similar concerns. Mr D was aware that the MOH were about to conduct an issues-based audit on the disability service.

Mr D advised that when he went to the MOH to inform it of his concerns, particularly around governance, lack of clear structures, delineation of roles and lack of funding for core items, he did not know there was to be an audit. Mr D said that he had contacted the MOH the previous week to make an appointment and, during that time, was advised of the proposed audit. He said his comments were made because of his concerns for the residents.

On 18 May 2007, Mr D resigned as general manager of the disability service and subsequently withdrew as a trustee.

The disability service: staffing levels

During Ms A's residence, the disability service had 18 to 20 residents (aged between 22 and 64 years of age) with moderate to high physical disability needs. Mr D stated that from 2004 until his resignation, the disability service had retained a core group of approximately 10 full-time caregivers and three part-time staff. Eight to 10 staff resigned over this time, with the average length of stay being approximately 12 months. Mr D acknowledged that he had been unable to maintain sufficient experienced staff.

Mr D said it was the responsibility of the registered nursing staff to monitor the delivery of all clinical care. His role was to oversee that they met the requirements of their job description. From the start of Ms A's residence in 2006, employment records show that four registered nurses had resigned and that three of these had worked at the disability service for less than six months.

Mr D held fortnightly staff supervision meetings to discuss care issues and to resolve any problems between caregiving staff and registered nurses. There was also a monthly clinical meeting of duty leaders and key clinical staff to provide general discussion on day-to-day care of residents. No documentation was provided recording these meetings.

MOH issues-based audit

As noted earlier in this report, in May 2007 the MOH conducted an issues-based audit of the disability service. This was partly in response to the complaint concerning Ms A. The audit team were concerned at the lack of clear governance, with Mr D both the general manager of the disability service and a trustee. The auditors made the following comment on the business structure of the disability service:

> "There are no regular meetings, no minutes were able to be produced, no structure for service development, reporting risk management, complaints etc. There is no service user input into any governance arrangements".

The auditors noted that the MOH contract does not specify the client/nurse/caregiver ratio. Instead it promotes a collaborative work model (in partnership with the resident, across disciplines and with external services). However, this involved complex systems of operation and to succeed it required strong management. It also required staff to receive effective orientation, ongoing training and good supervision. Staff orientation and training registers were not provided.

The auditors noted that at the time of the audit, there were eight caregivers and one registered nurse available to cover the services provided by the disability service. The registered nurse was available four days a week, was relatively inexperienced in residential care work, and held a secondary employment position elsewhere. However, she was expected to work on call outside rostered hours. The audit document noted:

> "The contract calls for the Provider to employ competent staff for adequate hours for the needs of the service user group to ensure 24-hour service provision and that there will be sufficient experienced staff to provide a level of service relative to the service user's assessed needs. … When agency staff are engaged, service users have to provide instruction as to their personal care needs."

Residents' care
The MOH audit observed that:

> "Observations such as weight management, bowel management, and fluid intake and output have been haphazard … The care plans are too complex and the review is superficial if completed. … The involvement of allied health professionals was reported as being limited by professional staff we spoke with.
>
> Service user records are not complete and the electronic version is skimpy, poorly completed by some staff and do not provide a full picture regarding daily needs and progress.
>
> The ongoing assessment of functioning, abilities, well-being & support needs of service users is severely compromised by the lack of experienced registered nurses as there are considerable nursing procedures which require oversight and monitoring. … The system is currently that team leaders on each duty are accountable for staff management and ensuring processes are followed. The staff undertaking these roles are conscientious and do their best but often due to staff dynamics or shortages are put under pressure."

It was noted that there was a complaints process in place, which most residents and their families understood how to use this and were satisfied with how it operated. However, the audit team were unable to assess how many complaints were received as there was no complaints file or register on site. It was identified that they did not appear to monitor the documentation of complaints, or collect such information, as required, for auditing purposes.

Response to Provisional opinion

Comments from the parties have been reflected through amendments to the main text. The remaining comments are summarised below.

The disability service
Director Mr F provided a written apology to Ms A stating that the apology should have been given "prior to now and prior to any investigation".

Mr F advised that in July 2007, a nurse manager with considerable experience was employed to manage the disability service. The nurse manager formally reports to the director and trustees on the 15th and 30th of each month. The nurse manager is required to report on specific issues, which include residents' concerns arising from resident meetings, complaints, equipment requirements and staffing issues.

On 1 October 2008, an Issues Based Audit was conducted by the MOH and, as a result of the issues identified, immediate changes were implemented as follows:

- **Monitoring client weight**. In August 2007, a set of chair scales was purchased, and the policy revised to specify that all residents were to be weighed routinely each month and the weights charted for easy identification of any concerns. Residents causing concern are assessed by a dietitian, started on an appropriate diet and monitored. Each resident is seen by the the disability service general practitioner three monthly for a "warrant of fitness" check, which includes a review of the weight chart.

- **Dietitian review**. A registered dietitian now visits the disability service bi-annually and conducts a full review of the kitchen service and menus. The dietitian checks the menus for nutritional value, variety and availability, and the kitchen service for all-over quality.

- **Bowel care/monitoring**. The bowel care policy has been reviewed, and bowel charts developed to monitor every resident's bowel activity daily. Any required action is undertaken by senior staff. All residents now have a continence assessment carried out on admission and reviewed and updated every three months.

- **Staff training/feeding a client**. A feeding competency has been developed and staff are assessed and evaluated on this competency before they are expected to provide this aspect of care.

- **Complaints process**. A complete review of the the disability service complaint policy has been conducted and a new policy developed. All complaints are now acknowledged within three working days of receipt. A full and impartial investigation is carried out and a written response of actions taken provided to the complainant. Two resident surveys have been conducted in the last 18 months.

- **Educational session/advocacy services**. A Health and Disability advocate has conducted two education sessions for the disability service staff in the last 18 months on consumers' rights. The training is now a compulsory part of the the disability service training programme and will be held bi-annually.

Mr F advised that the disability service now has a clinical focus led by a registered nurse with relevant clinical experience. Individual resident care plans and assessments have been developed to ensure that the care provided is holistic and individually focused and includes such matters as continence, fall risk, pain and nutrition. Resident advocates and family members have input into these assessments and plans. Each resident is seen by his or her general practitioner within a week of admission. The residents are also now seen by a physiotherapist, who assesses their mobility, transfer plan and equipment needs.

A staff competency scheme covering 10 skill competencies has been developed. Staff are assessed for their competence in assigned tasks against these skills.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) are applicable to this complaint:

RIGHT 4:

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

RIGHT 10:

Right to Complain

(3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

Opinion: Breach — Mr D

In considering this complaint I am mindful of Ms A's impairment and her slight build. Losing significant weight over a short period of time, because of inadequate feeding, would have caused her considerable distress. Ms A was not able to communicate this directly to her caregivers. Rather she was dependent on them to provide her with appropriate care. In my opinion, Mr D did not ensure that Ms A was provided with reasonable treatment and care. My reasons for this conclusion are as follows:

Key issues:

Management of care
Although Mr D has stated that he had no clinical responsibility for residents, as general manager he was responsible for putting in place systems to safeguard the care of residents. This included ensuring that there was sufficient documentation to monitor and measure the progress of the residents and that there were systems in place to identify problems in a timely manner and to initiate appropriate intervention and resolution.

I acknowledge that Ms A was reviewed at a public hospital on 24 February and 30 March 2007, and she was not weighed in hospital, nor was action taken by clinicians to identify the causes of her weight loss. Further to this, Dr E also reviewed Ms A on

16 and 28 March and, although concerned by Ms A's deterioration in health, it was not until 20 April that Dr E referred her to hospital.

Mr D said that Ms A did not receive care "suitable for her needs". In explanation he said that "a cascade of systemic issues contributed to this situation and, while all involved did as they were able, there were gaps in the provision of services". He said that this occurred through circumstances outside of his control, such as staff shortages and the lack of resources and support available to him.

I do not accept Mr D's reasoning. Mr D understood that Ms A was highly dependent on the skills and experience of her caregivers and even asked that Mrs B provide training to the disability service staff in relation to her daughter's care. Mr D was clearly aware of the problems the disability service was having in providing Ms A with adequate care, and that from January 2007 Ms A's physical and emotional health was deteriorating and she was continuing to lose weight.

Mr D has said that it was the responsibility of the registered nurses to ensure Ms A received appropriate care. However, it is evident that there was a high turnover of registered nursing staff and an increasing dependency on agency staff. My expert advisor, Ms Sharon Brandford, noted that it is likely that a high turnover of staff, and clinical staff in particular, would have unsettled Ms A. Ms Brandford said that unfamiliar people providing daily care, and intimate care in particular, can lead the person being cared for to experience the care as occurring outside of their control. This can lead to a loss of dignity and the person closing down in order to cope with what is occurring. Ms Brandford observed that Ms A's 2007 progress notes identify episodes where this reaction occurred. From January 2007, Ms A's progress notes clearly track her decline in health and identify concerns regarding her weight loss and general demeanour. Ms Brandford advised that it is critical that the systems for documenting care are completed correctly, contain clear, updated information, and are systematically reviewed.

Ms Brandford said that the responsibility for ensuring Ms A received adequate clinical care rested with Mr D. I agree with this view. In my opinion there is no evidence that Mr D took any steps to correct the situation that was contributing to Ms A's deterioration, which included the provision of suitably trained staff and purchasing or accessing equipment required to provide appropriate care for Ms A.

Ms Brandford noted that it is reasonable to expect a facility such as the disability service to have weighing apparatus suitable for people with physical disabilities. In Ms A's case, her weight should have been routinely checked as her body base weight was already low. Ms Brandford commented that for someone who was already health compromised and slight, losing a third of her body weight in less than a year would have had profound consequences. Ms A took anticonvulsant medication, and this can have a different effect depending on body weight. It took three months after the disability service was alerted to Ms A's increasing weight loss for it to take action and weigh Ms A. Mr D relied on Ms A to be taken to a neighbouring rest home to be

weighed. In my opinion, this delay in initiating action was unacceptable and likely due to not having the appropriate weighing equipment on site for staff to use.

Complaints management
Mr D was responsible for ensuring that the complaints he received concerning the care of Ms A at the disability service were managed efficiently and that the parties making the complaint had their complaints acknowledged and were updated regularly on progress. The MOH contract stipulated that a complaints register be kept and be available for auditing purposes. The MOH audit team did not find a complaints register at the disability service in May 2007.

Mr D did not appear to record complaints, but instead said he generally relied on using an informal system of resolving complaints face-to-face. However, Ms A's parents stated that they provided Mr D with written and verbal complaints, to which he did not respond. As there is no record of Mr D responding to any of the matters raised by these parties, I have on the balance of probability accepted their version of events.

Summary

Mr D was responsible for setting up and monitoring the systems used by the disability service to deliver services to its residents and for ensuring the care provided was in line with the MOH contract requirements.

On the basis of information I have seen, I find that Mr D did not ensure that Ms A received an appropriate standard of care, or provide services that complied with the standards described in the MOH contract for residential care. Mr D did not recognise that Ms A required a higher level of care than staff at the disability service were able to provide. In my opinion, it would have been more appropriate for Mr D to have transferred Ms A to a facility that could have provided her with the necessary care, or to have taken steps to put such a plan into action. At the very least, Mr D should have discussed these matters with Mrs B, Ms A's enduring power of attorney, particularly once Mrs B had complained directly to him about her concerns regarding her daughter's welfare. Although Mr D was not a clinician, as a manager he had an obligation to use his professional judgement and take action to ensure Ms A received proper care and access to equipment.

Mr D needed to give clear direction to his clinical staff in order to ensure they provided Ms A with appropriate care. In my opinion, it is not acceptable for Mr D to claim he was not responsible for Ms A's clinical care when he was unable to engage registered nursing staff to ensure Ms A received the care and attention she needed, particularly as it appears Ms A was in a state of near starvation when she was admitted to the public hospital in April 2007. It is the responsibility of Mr D, as a provider, to show he took reasonable actions in the circumstances (Ms A's clinical needs and the provider's resource constraints) to give effect to Ms A's rights and to comply with the duties of providers outlined in the Code. The onus was on Mr D to prove that he took reasonable actions. I can find no evidence that any such reasonable actions were taken by Mr D.

I am satisfied that Mr D did not discharge his duty of care in this situation and accordingly, in my opinion, breached Right 4(1) of the Code. In not meeting the obligations in the MOH contract for residential services to work collaboratively with Mrs B he also breached Right 4(2) of the Code.

In not acknowledging the complaints he received and in not providing a fair, efficient and timely resolution of complaints, I find that Mr D breached Right 10(3) of the Code.

Opinion: Breach — The disability service

The disability service is contracted to provide 24-hour residential care to adults with physical disabilities that range from moderate to severe. The disability service accepted Ms A into the disability service as a resident knowing that she required full cares and a commitment by dedicated, trained staff to ensure she was properly looked after, was fed adequately, and had sufficient fluids to maintain her health.

General care

Prior to April 2006, the disability service had provided Ms A with short periods of respite care. It was generally understood that Ms A had a complex range of physical conditions and required dedicated full-time care. Her care plan was structured around the 15-page care plan developed by her mother, Mrs B, which described the support Ms A required on a day-to-day basis. This was full assistance with all needs, including personal hygiene, toileting, washing, eating and drinking. Ms A was reliant on her caregivers being trained to manage her complex needs and knowing her well enough to understand her methods of communication.

There was a high turnover of registered nursing staff over this time, and the reliance on agency caregivers may have contributed to the haphazard observations of Ms A's weight, bowel management and fluid intake. The care plans were complex and progress notes not adequately recorded. It is clear that from January 2007, Ms A's condition deteriorated dramatically, and the lack of adequate clinical recording and review led to a delay in this being identified.

Ms A did not, as required by the MOH contract, have an identified, designated key worker. In my view, the absence of this role meant that from the time clinical manager left in December 2006, Ms A's care ceased to be co-ordinated.

Weight loss

It is established that in July 2006, when Ms A attended school, she weighed 26kg. From January 2007, concerns were raised regarding Ms A's weight loss, by her parents, caregivers at the disability service and staff from the school. On 16 March 2007, Ms A's GP asked the disability service staff to weigh Ms A each week. Mr D said that the disability service did not have the equipment to weigh residents on site

and instead relied on using the equipment in the neighbouring rest home. Ms A was weighed on 14 April 2007 and was 17kg. On 23 April, Ms A was weighed following her admission to the public hospital and was 22kg. On the information provided by a dietitian, it is probable that Ms A gained between 2–4kg of weight during her first week in hospital. Although I am not persuaded that Ms A gained 5kg in just over one week, I am satisfied that on admission to hospital she had lost a lot of weight comparative to her body size, and that this posed a significant risk to her health and well-being.

Documentation
The documentation provided by the disability service for this investigation was limited and of variable quality. A lot of the documentation that was made available was undated and unsigned. The MOH audit noted that "progress records were skimpy, poorly completed … and do not provide a full picture regarding daily needs and progress". Ms Brandford noted that Ms A's bowel charts were sporadic and did not match the information in the daily progress notes, and that weight charts were not maintained. Ms Brandford also noted that due to the high turnover of staff, good, up-to-date documentation was critical to maintain continuity of care.

Staff orientation and training records were not provided. This made it difficult to assess what training had been completed by staff, although I note that Mrs B provided some staff training on caring for her daughter.

Complaints procedures
The disability service prospectus outlined a complaints process. Ms A's family and the advocacy services made formal complaints to Mr D concerning Ms A's care and her weight loss, and said that they either received inadequate responses or no response to the concerns they raised. The MOH audit team recorded that although they did not find a complaints register, they were provided verbal information by residents that an informal hands-on complaints process was in place and was effective in achieving resolution. The MOH residential service contract requires material on complaints to be logged and used as part of the reporting mechanisms to ensure quality of care is occurring.

Summary

In my view, the disability service was obliged to have monitoring and reporting structures that would allow them to take action to manage identified problems. It was the responsibility of the trustees to ensure that these mechanisms were in place and working. It is not acceptable for Mr F to say that he relied solely on Mr D to provide him with information concerning the operation of the disability service. This is poor practice. It is evident that from January 2007, Ms A was not receiving adequate care. The disability service accepted funding to provide Ms A with care when it could not provide the level of care she required. In my opinion, Mr F and Mr D, as trustees, should have ensured that the reporting and governance systems used were robust enough to identify and correct the problems occurring at the disability service.

I accept that since the MOH audit in May 2007 the disability service has taken steps to address the problems of governance and management of the disability service. However, the Trust had a duty of care to Ms A, which it did not discharge, and therefore it breached Right 4(1) of the Code.

Opinion: Breach — Disability service company

The financial management of the disability service and the Trust is through a disability service company. The company employed the staff working at the disability service and provided the resources required by contract for its residents. In particular, the Company was responsible for employing Mr D, monitoring his performance, and ensuring that the disability service was meeting its MOH contractual requirements. I accept that the Company engaged Mr D to set up the Trust, manage the disability service and oversee the delivery of care. Mr D said that from 2006 onwards he advised the Company director Mr F that he was finding it difficult to provide care to high-needs residents on the resources available to him. Mr F denies this and said that he did not receive any documentation from Mr D that identified that the disability service was having difficulty retaining staff or providing residents with appropriate equipment and services.

I would have expected the Company to have in place a system to appraise Mr D's performance as general manager. It appears that this was compromised by Mr F relying on Mr D to set up and operate all the management systems (other than finances). This appears to have resulted in a conflict of interest in governance, with Mr D being both an employee of the Company and the only other trustee of the Trust.

In my opinion, Mr F should have been aware of what was occurring in the Company's core business, in particular regarding staff shortages, high staff turnover, inadequate staff training and orientation, the absence of a complaints register, the lack of resources such as scales, and that from January 2007, Mr D's management of the facility was failing. Accordingly I find the Company vicariously liable for not ensuring its employee, Mr D, was carrying out his duties appropriately, and therefore that it breached Right 4(1) of the Code.

Actions taken

In response to the recommendations made in the provisional opinion, the Company Director, Mr F, provided a written apology to Ms A and advised:

- A nurse manager has been appointed, who reports to the trustees bi-monthly.

- The disability service now has a clinical focus led by an experience registered nurse.
- There is now greater oversight of the resident care needs and staff competence.
- Resident weights are now routinely assessed and monitored with medical and dietitian input. A review of the kitchen service and menus has been undertaken and will be monitored bi-annually by a dietitian.
- The complaint policy has been revised to ensure appropriate follow-up of complaints.

Recommendation

I recommend that Mr D:

- Apologise for his breaches of the Code. A written apology should be addressed to Ms A and sent to this Office for forwarding to Mrs B by **15 December 2008**.

Follow-up actions

- A copy of this report will be sent to the Ministry of Health, HealthCERT and the District Health Board.
- A copy of this report, with details identifying parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1

Independent advice to Commissioner

The following expert advice was obtained from Ms Sharon Brandford, a registered clinical psychologist, and the national manager of IDEA Specialist Services. She has extensive experience in monitoring standards of care for people requiring comprehensive care. However, her area of speciality is in providing care for people with intellectual disabilities and significant communication needs.

> "I have been asked to provide an opinion to the Commissioner on case Number 07HDC07675, as to whether the standard of care provided to [Ms A] by [the] Trust was appropriate. I agree to follow the Guidelines for Independent advisers supplied by your office.
>
> I am a registered Clinical Psychologist. I have had extensive experience in the development and monitoring of standards of care for people with a range of intellectual disabilities in New Zealand throughout the past 26 years.
>
> I completed my academic and clinical training from University of Canterbury in 1981, and have worked in the field of community-based supports for people with intellectual disability for almost all of the period since.
>
> I worked as a Regional Service Adviser for IHC Southern Region for 4 years till 1989, then as a Service Adviser for Standards and Monitoring Services for 6 years. I was self-employed from 1995 till 2001, supporting a range of community-based projects. Since 2000, I have been employed in various clinical leadership roles with Timata House and IHC Behaviour Support Services. I am currently employed by IDEA Services as National Manager of its Specialist Services. I have held this position since December 2006, and have responsibility for specialist advisory services for people with challenging behaviour, Autistic Spectrum Disorders, and significant communication needs. I believe I am well qualified to comment on the standards and expectations reasonably expected of community-based services available to people with a range of disability support needs.
>
> I have been instructed to provide an opinion as follows by the Commissioner in the matter of [Ms A]'s care from [the] Trust. [Ms Brandford has outlined the questions asked of her and lists the information provided by this Office. The questions are repeated in her advice, and the documentation is identified earlier in this report, and have therefore been omitted for the sake of brevity.]

I address the Commissioner's questions in order:

1. Was the care provided by [the] Trust to [Ms A], in relation to her nutrition and weight, appropriate?

I make the following comments with the proviso that I am not qualified to comment on appropriateness of the content and volume of her food and fluid intake. My comments are limited to matters related to the significant support needs [Ms A] has to eat and drink, and the role of the disability service staff to provide this support and monitor her nutritional intake and weight.

I believe the care she received was inadequate, by virtue of:

1. The minimal monitoring of her weight, and
2. The apparent absence of action by the General Manager to the clinical risks related to feeding due to staff inexperience and turnover.
3. The apparent absence of effective remediation systems to address staff and family concerns about [Ms A]'s food and fluid intake, and subsequent weight loss.

Her dietary preferences were reported well by her mother and recorded in entry documentation. I noted evidence this information was appropriately transferred to the disability service documentation systems for kitchen staff and initial health assessments, and those involved in food purchasing. A Feeding Assessment was most recently completed through her school in November 2006, though its findings in relation to staff support methods do not appear to have been transferred into the disability service records. It is not possible to see from material provided how such information is conveyed to staff.

[Ms A] is reported to need patient assistance when eating and drinking. Notes show a very inconsistent pattern of eating and drinking, rather than any trend or obvious pattern. There were many recorded instances of mealtimes where she was assisted to eat large volumes (e.g. 1½ meals) with no reported difficulty. Instances of reluctance to eat were reported as well, often associated with physical unwellness or seizure episodes. There were numerous entries in the notes where there is no reference to food or fluid intake. [Mrs B] was informed on 10 February 2007, that [Ms A] was refusing to open her mouth for drink, but found [Ms A] drank heartily, as if thirsty.

For weight records in the period of interest (April 2006–April 2007) there are only three recorded weights in the disability service records:

1 September 2006	28kg
6 April 2007	17kg
26 April 2007	22kg

The latter two recordings occurred after a review by her GP on 16 March 2007, consequent on a complaint by [Mrs B]. An entry by the RN after this GP visit requested weekly checks. The first occurred after three weeks April — 17kg but I found no indication this was recorded in the disability service files. In combination, these observations suggest a poor appreciation of the importance of dietary and fluid management for [Ms A]. She experienced a 40% reduction in body weight over seven months. Such a profound change in someone whose health status was already compromised should have triggered more assertive response by the disability service.

If not, what else should have been done?

It is reasonable to have expected that [Ms A]'s weight would have been routinely checked, regardless of any specific health concerns.

1. Her base weight was very low, and therefore she was vulnerable to minor fluctuations

2. She had a history of occasional bowel difficulties

3. She had occasional ingestion difficulties (food and drink)

4. She took anticonvulsant medication which can have different effect depending on body weight

It is reasonable to have expected [the] Trust to have appropriate weighing apparatus to suit people with physical disabilities. This would have made it much easier for staff and [Ms A] to have routine checks.

It is reasonable to have expected the registered nursing staff would have communicated to [Ms A]'s mother their observations about [Ms A]'s well-being. This appears to have occurred, albeit informally. [Mrs B] was informed of her daughter's 17kg recording on 20 April, 14 days after it was first noted by [the disability service] staff. This only appears to have occurred in the context of a visit, rather than assertive reporting of a health concern to a parent and legal guardian.

It is reasonable to have expected [the disability service] staff to have acted on [Ms A]'s weight reduction themselves. It appears a medical review occurred only at [Mrs B]'s request.

It is reasonable to have expected that nurses would have reported their limited capacity to manage [Ms A]'s weight changes to the General Manager if they believed this was due to factors related to staffing levels, skills, retention or daily practice matters. I do not know if this occurred. Reports from [Mrs B] suggest that staff were clearly concerned about [Ms A].

It is reasonable to have expected the General Manager to have adopted alternative strategies to mitigate the clinical risks inherent with unstable staffing, and to have secured resources to address this systemic issue.

What standards are applicable in this case? Please advise on the disability service's care of [Ms A] with reference to those standards.

Applicable standards include the Health and Disability Sector Standards, but these have been the focus of an issues-based audit from the Ministry of Health recently, so are not specifically referred to here.

Applicable standards are those listed in the Code of Health and Disability Services Consumers' Rights:

Right 3 – to being treated with dignity
Right 4 – services of an appropriate standard
Right 6 – to be fully informed
Right 10 – to complain

Right 3. [Ms A] required intimate care on a daily basis. In the absence of records showing what training staff received on [Ms A]'s support needs, it is hard to be assured that [Ms A] was afforded her dignity with staff inexperienced in her intimate care needs. While her toileting needs are most obvious, staff inexperienced in assisting her to eat or drink could easily distress her through clumsy or intrusive approaches, and cause her to resist eating. Such behaviour from [Ms A] was reported.

Right 4. This has been addressed in response to question 1, relating to the inadequacy of supports to eat and drink adequately, the slowness to respond to weight loss, and inaction to maintain adequate health.

Right 6. I note that there is an expectation at the disability service that residents will be 'consulted about all matters affecting them'. Key amongst these is the selection of one's support staff. It may be pertinent to check with the ex-Manager how this right was exercised in the face of intense staff shortages. It is likely that [Ms A] was distressed by frequent changes in her support staff, and the loss of control inherent in being fully dependent on unfamiliar people to provide daily care. I make this comment because it is a well researched and oft-reported observation from people with significant physical support needs.

Right 10. See response to Questions 4 and 5 below. [Ms A's father] reported that he received no response to his complaint in 2006. [Ms A's mother] received insufficient response to her complaint about [Ms A]'s weight loss. Furthermore, it is inappropriate that her letter of complaint was circulated to all staff. Both parents raised concerns in appropriate ways on matters that were perfectly reasonable. Of equal concern is the absence of evidence to suggest

the complaints were seen as opportunities for learning, and continual quality improvement.

I believe that the General Manager's conduct related to complaints received was inadequate, and would meet with severe disapproval by his peers.

What measures should have been put in place when [Mrs B] raised her concerns about [Ms A]'s weight loss in January 2007? Please comment.

It would be reasonable to have expected a formal acknowledgement from the General Manager of her concerns, including:

1. An action plan to increase her weight.
2. An undertaking to much more frequent weight checks, review of these and reporting to [Mrs B] and/or the GP on these results.
3. A staff education plan to ensure her weight and fluid support needs were fully understood and appreciated by staff, and a refresher cycle to ensure this knowledge was shared with new staff.
4. Advice and guidance sought from health professionals such as GP, dietitian, speech language therapists to maximise safe swallowing.

It would be reasonable to expect the complaint was logged in a register, and documentation maintained as to actions related to resolution. This would then have been made available to [Mrs B] and to the Commissioner for this investigation.

Please comment on the disability service's documentation of [Ms A]'s care.

My advice to the Commissioner in this report regarding [Ms A]'s care has been significantly constrained by the paucity of documentation available from the disability service.

- A current Care Plan was seen by me (completed 1 September 2006, and due for review 1 March 2007). It is of an acceptable standard. It lacks detail relevant to her recently changed status from school pupil to adult. A morning and afternoon and evening checklist was also provided, presumably to give staff day-to-day guidance. However it is undated, and outdated, and not on the disability service standard documentation format, so its status and availability to staff is not known.
- The Resource Folder states a log is maintained of Complaints and resolution. I did not see this.
- Bowel records were sporadically maintained and not congruent with detail in daily notes.
- Weight charts were not maintained. Occasional weight checks were recorded in an embedded way in daily notes, so subtle changes difficult to observe. This is not good documentation practice.

- There are no staff training records sighted, to review the frequency of training for staff on specifics of [Ms A]'s care plan, or sign-offs of competencies achieved for new staff. This is a common practice for staff I would have expected to see.
- Notes indicate that new staff sometimes had hands-on coaching on how to support [Ms A], but I am not confident (in the absence of Staff training material) that this occurred adequately for all. There are references to some daily care activities not occurring due to staff shortages. Paired coaching is also likely to have been constrained in such instances.
- Policies related to documentation standards could not be found by the new manager. Such standards should stipulate basics such as citing sources, authors, review dates, mechanisms for archiving, and ensuring they are in a form that maximises their ease of use by direct care staff.
- The documentation had a distinct medical and care bias. This is clearly of critical importance. Disability providers are however charged with providing holistic support and development. [Ms A] finished schooling in December 2006, yet plans I sighted had few details about her day activities since graduation. Leaving school is a watershed event heralding adulthood, yet there was little acknowledgement or planning on a wider perspective in documentation provided.

In the absence of these organisation standards, I comment that those sighted by me were of variable quality. There was substantial material that was undated and unsigned.

Are there any aspects of the care provided by [the] Trust that you consider warrant additional comment?

Staff Instability
[Ms A] was in the care of a service which employed a number of staff. It has been reported that [the] Trust experienced high staff turnover and shortages for both its direct care staff as well as its registered nurses. This issue appears to have been of some duration. I note this has been a common feature of community-based service delivery in NZ for the past three to five years as a result of high employment rates.

For [Ms A] this meant that across a week or month, many individual staff had responsibility for supporting her particular needs and wishes. This is of relevance to the perceived slippage in management of her diet and fluid intake, as well as monitoring. There are several instances noted where her parents provided this scrutiny and alert.

For [the disability service], staffing instability meant they were vulnerable to erosion of standards, loss of intimate knowledge, and clinical staff feeling over-exposed and responsible for more than is within their employment frame. Resignations are common when clinical staff feel unsafe in their practice.

There was insufficient material provided to the Office to determine if this featured at the disability service.

In response to staff instability, I would expect to see evidence of strategies to mitigate risks, such as:

- Increasing reliance on documentation and procedures for monitoring, to minimise the risks of information loss and rigour present when there is a more consistent support network.
- Specific adaptation of models of delivery, personnel support and training, to accommodate higher staff turnover, and the lower experience base that arises from this.
- Assertive recruitment and retention strategies to encourage new staff and to provide a supportive framework for current staff.
- Supplementary resource allocation to increase monitoring and quality control.

I saw no evidence to suggest any such variations in practice occurred. There is no policy describing procedures for review of documentation, or for quality control of the service provided. It is therefore not possible to compare the current circumstance against the Trust's own expectations.

Clinical Accountability
I am left with the impression that rostered nursing staff were left with responsibility for oversight of all resident cares. With a rostered team however, one person must be held accountable for core clinical services in a disability support service with such a demand on personal and health supports. This appears to have been the General Manager, who held full responsibility for the standard of care and for ensuring the service had systems to maximise standards of care.

Records provided give no indication of his actions in this regard. His position description makes cursory reference to his responsibility for maintaining standards of care provided by registered and direct support staff. Indeed, clinical safety is not specifically listed as a Key Duty Area; rather, it is assumed under Quality management. I believe this role definition is inadequate.

It is reasonable to expect [the disability service] to have organisational structures that addressed clinical oversight, given its stated commitment to quality of care for people with significant physical dependency. It would be expected that [the disability service] had policies that clearly delineated his responsibilities from those of registered nursing staff."

Appendix 2

Executive Summary: from the Ministry of Health Audit of the disability service in May 2007:

Introduction / Background / General Observations

The service has a number of issues:

- Staff capacity (both in numbers and qualifications).
- Absence of police checks for staff.
- Medication systems.
- Responsiveness to personal care needs.
- Complaints procedures.
- Capacity to provide day activities.
- Responsiveness to phone calls.
- On call arrangements.
- Implementation of audit and quality programme.
- Availability of equipment.
- Risk management system implementation.
- Responsiveness to call system.
- Management and observation of weight and fluid intake.
- The governance structure.

Rostered Staffing Pattern
Six Caregivers are on duty from 6.45 am to 11.15 pm and there are two awake caregivers from 10.45pm to 7.15am. One registered nurse works 32 hours per week (four days per week) and at the date of the audit a second registered nurse had just commenced employment. Both registered nurses are relatively inexperienced and have other positions, one in a rest home, and the other in theatre at a private hospital. While there is supposed to be an on-call arrangement in place it was unclear as to how this worked in practice and the longer serving registered nurse indicated that there were no clear guidelines but she was called two to three times per week.

Specific issues raised during the audit were:

- Service users being left in bed due to limited equipment being available.
- Response to call system being variable from five minutes to two hours, one service user informed us that they had to intervene on behalf of the person in the next room who could not attract the attention of staff. A family member indicated that her family member had to wait five hours one night for someone to attend to her.
- A family member also indicated they have had to pick a service user up off a chair at least three times because staff were not available.

- The level of support does not meet social, spiritual, emotional and recreational needs on a consistent basis.
- When agency staff are engaged service users have to provide instruction as to their personal care needs.

Risk Management
The risk management system are not robust and while there are technically policies and procedures they are not implemented. An incident and accident reporting system was noted. Review of documentation showed that the Incident Register was not up to date and the incidents are not analysed for trends. In the auditors' opinion the response from management to managing incidents fall woefully short of what is expected in response to what are some serious lapses in processes.

Examples are listed below:

- Insufficient equipment to undertake catheterisation (22/3/07) requiring hospitalisation of service user.
- Staffing issues on 16/17 March 2007 of severe magnitude and note that one staff member had done a double shift.
- Noted that a service user had finger mark bruising on upper leg (31/3/07).
- Staff abandoning duties and deliberately disobeying orders (31/3/07) this led to poor care.
- Morphine not accounted for according to policy (18/19 March 2007).
- Antibiotics not given as prescribed (14/3/07).

Ongoing assessment & being responsive, Registered Nurse support to work with clients who have high medical needs
The ongoing assessment of functioning, abilities, well-being and support needs of service users is severely compromised by the lack of experienced registered nurses as there are considerable nursing procedures which require oversight and monitoring. The organisation had a "Care Manager" who was described as very effective but that person has not been replaced. At the very least there needs to be an experienced registered nurse on morning and afternoon shift daily to ensure support workers have oversight and are supported in what are sometimes complex care procedures. The system is currently that team leaders on each duty are accountable for staff management and ensuring processes are followed. The staff undertaking these roles are conscientious and do their best but often due to staff dynamics or shortages are put under pressure.

Personal care
Observations such as weight management, bowel management, and fluid intake and output have been haphazard and in 2 cases have led to hospitalisation. The care plans are too complex and the review is superficial if completed. There are a number of service users with pressure sores. The involvement of allied health professionals was

reported as being limited by professional staff we spoke with (this is not the case for ACC funded service users).

Accommodation & Household Support Services
All cleaning, laundry and meal preparation is done by the home. The meals are prepared by a chef and described by all we spoke to as well as observed as being tasty and of a good variety. Given that one of the concerns raised that led to this audit was regarding two service users' nutritional status (one extreme weight loss and one extreme weight gain) the auditors were keen to ensure that there is access to dietitian advice. There are individual dietary plans but the Chef has had no contact with the dietitian and he is keen to develop a direct liaison. The auditors spoke with the person who has gained weight and the person was not of the opinion that weight is an issue. [The disability service] has worked hard to provide a relevant diet for this person but as people can access takeaway food by phone and supplement with high fat and low nutritional status food staff are unable to manage this situation. There are no legal orders to prevent access to this takeaway food yet staff have to manage the outcome. The person's weight gain recently led to the hoist being broken. The woman who lost considerable weight is no longer at the home but the lack of observation and staff attention to food intake appear to be a primary cause in the matter.

Complaints resolution
There is a complaints process. All service users and families we spoke with understood and have used the process with the majority being satisfied with the outcome. The auditors were unable to ascertain how many complaints had been received and what degree of resolution has occurred as there are no Complaint Registers and no logging of all the complaints written or verbal on the register. Information is available regarding the H&D Commissioners Code of Rights and independent advocacy services. Given no Board or Governance structure there is no oversight of the complaints or trending by audit processes. One service user indicated that he would not feel comfortable complaining as there may be repercussions.

Staffing
The contract calls for the Provider to employ competent staff for adequate hours for the needs of the service user group to ensure 24-hour service provision and that there will be sufficient experienced staff to provide a level of service relative to the service user's assessed needs. Further[more] the staff are expected to work in a collaborative way to best meet the service user's ongoing needs.

There is insufficient staff to meet needs, oversight and supervision is limited and given the vulnerability of service users this does cause concern for the GPs, NASC staff and service users and families. All staff we spoke with noted staffing as a major issue. There is also need for strong management of staff to ensure that systems and processes are followed and that staff work together effectively. The auditors were informed of a few instances of staff refusing to undertake duties, and not respecting the senior people. There is a number of staff committed to provide effective support but due to the environment are frustrated.

Staff receive an orientation to the service but given reliance on agency staff this compromises effective care. Records made it difficult to assess what training has been completed. The registered nurse indicated that she had no orientation and there is no ongoing professional supervision. She also works at another facility which is where she receives her support and training.

There is a training programme; primarily in house and modelled on the mental health strengths based approach due to the GM's professional background (Psychology). This does not necessarily meet the specific needs of service users and the GM indicated that it was not wholly successful. Training records which were difficult to source indicate that a number of staff failed to attend training. Training has been given in lifting etc but due to staff turnover and agency staff involvement this is a vexed area. Staff do not undergo a police check prior to employment and no performance management systems are in place so staff performance is not reviewed regularly. Staff have group supervision and it is expected that they attend, the focus is on discussing service user's needs.

Quality Requirements
There is no audit programme so issues are not raised and little capacity to improve quality. A range of committees were in place but have been in abeyance. There is no disability specific training and the programme is primarily based on personal care and TV for those who do not have active family input. Service user records are not complete and the electronic version is skimpy, poorly completed by some staff and do not provide a full picture regarding daily needs and progress.

The structure of [the Company] is not conducive to clear governance and management separation with the GM (who has now left) sitting on a subsidiary [company] Trust with the owner. There are no regular meetings, no minutes were able to be produced, no structure for service development, reporting risk management, complaints etc. There is no service user input into any governance arrangements. The financial arrangements are managed by the owner.