Community Support Worker, Mr C

Community Support Worker, Ms D

NZCare Group Limited

A Report by the

Health and Disability Commissioner

(Case 11HDC00712)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. This report is about the care provided to Mr A (aged 21 years at the time) by a respite care facility owned and operated by NZCare Group Limited (NZCare) for young people with intellectual impairments.

2. Mr A was vulnerable because of his personal circumstances, which included his intellectual impairment and his difficulty in communicating effectively. Mr A required assistance with taking his medication, which included an anticonvulsant to prevent dangerous prolonged convulsions due to epilepsy.

3. On 16 May 2010, Community Support Worker (CSW) Mr C pushed Mr A's hand to his mouth because Mr A did not follow Mr C's instructions to cover his mouth when he coughed. Mr C told HDC that Mr A lashed out at him. Mr C then pulled Mr A out of his chair and pushed him to his room for time out. Mr A's Individual Support Plan provided some guidance on dealing with challenging behaviour. Mr C did not report the incident to management or complete a Reportable Events form, as required by NZCare policy. Another CSW, Ms E, was present when the incident occurred.

4. On 28 and 29 November 2010 and 24 June 2011, CSW Ms D did not administer Mr A's medication correctly, did not accurately document the incidents, and did not inform the on-call manager or Mr A's family, as required by NZCare policy.

5. NZCare was providing services to Mr A pursuant to a contract between NZCare and the Ministry of Health. The Ministry of Health audited a number of NZCare respite facilities in 2010.

Decision summary

Mr C — Breach

6. While there were deficiencies in Mr C's training, the Health and Disability Commissioner (the Commissioner) found that Mr C failed to provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code). The Commissioner also found that Mr C's actions were disrespectful, and therefore he breached Right 1(1)[2] of the Code.

Ms D — Breach

7. By failing to administer Mr A's medication correctly on two separate occasions, Ms D failed to minimise the risk of harm to Mr A and therefore breached Right 4(4)[3] of the Code. In addition, Ms D did not document her medication management errors or

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 1(1) of the Code states: "Every consumer has the right to be treated with respect."
[3] Right 4(4) of the Code states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

inform the appropriate individuals of these errors, and so breached Right 4(1) of the Code.

NZCare Group Limited — Breach

8. NZCare did not comply with its own staff training policies in respect of Mr C, or its own medication management policy in respect of Ms D. In addition, it did not take adequate steps to ensure that Ms D complied with its medication management policy following the first incident when Mr A's medication was not correctly administered, and failed to take adequate steps after the second incident. It was also noted that if NZCare became aware that it had insufficient information on any aspect of a client's care to support the client adequately, as claimed in Mr A's case, it had an obligation to obtain the necessary information. NZCare should not have taken on the responsibility of providing care to a client if it could not obtain the necessary information. Finally, NZCare failed to demonstrate that it had an adequate documentation system. Accordingly, the Commissioner found that NZCare was in breach of Right 4(1) of the Code.

NZCare Group Limited — Adverse comment

9. The Commissioner noted that the contractual evaluation audit undertaken on behalf of the Ministry of Health in early 2010 had made recommendations to support progress in some of NZCare's respite facilities. Some of the recommendations were made in respect of issues that were contributing factors to NZCare's failure to provide Mr A with an appropriate standard of care up to 18 months after the audit. The Commissioner considered that NZCare appeared not to have adequately addressed the issues raised in the audit.

Ms E — Adverse comment

10. Adverse comment was made about Ms E's inaction during the incident between Mr C and Mr A.

Complaint and investigation

11. The Commissioner received a complaint from Mrs B about the services provided by NZCare Group Limited to Mr A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by NZCare Group Limited between May 2010 and September 2011.*
- *The appropriateness of the care provided to Mr A by Mr C in May 2010.*

On 26 September 2012 the scope of the investigation was extended to include the following issue:

- *Whether Ms D provided Mr A with an appropriate standard of care between November 2010 and June 2011.*

12. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs B	Complainant
NZCare Group Limited	Provider
The facility	Respite facility
Mr C	Community Support Worker
Ms D	Community Support Worker
Ms E	Community Support Worker

Also mentioned in this report:

Ms F	Service Manager
Ms G	Area Manager

13. Information from the Ministry of Health and a paediatric neurologist was also reviewed.

14. Independent expert advice was obtained from a registered nurse, Bernadette Päus, and is attached as **Appendix A**.

Information gathered during investigation

Background

Mr A

15. Mr A, who was 21 years old at the time of these events, has severe refractory epilepsy[4] and global developmental delay.[5] His mother, Mrs B, describes him as having the understanding of a five-year-old. He does not have a welfare guardian.

16. Mr A normally lives with his family. In June 2008, he started spending approximately five nights per month at NZCare Group Limited's respite facility (the facility).[6]

17. NZCare advised that, at the time of these events, its normal practice was to draft Individual Support and Risk Management Plans for clients using an "Information Gathering Tool",[7] which families signed off.[8] Mr A's Individual Support Plan, dated

[4] Also referred to as severe intractable epilepsy, a type of epilepsy that involves seizures that are difficult to control with medication.
[5] This term refers to any lag in a person's physical, cognitive, behavioural, emotional or social development.
[6] Mr A was referred to the facility by a Needs Assessment Service Coordination (NASC) organisation.
[7] This is a generic form designed by NZCare and used to gather information about a client's needs from his or her family.
[8] At the time, NZCare did not receive a NASC assessment for each client referred by a NASC organisation; however, from January 2012 this became normal practice.

12 January 2010,[9] includes a behaviour support section which states, among other things:

> "Staff need to encourage [Mr A] to do things by making them appear fun and give a reward after.
>
> Staff to ignore stubborn behaviour at the time — divert [Mr A] and encourage him to do something another way or have someone else ask him."

18. Mr A's Risk Management Plan identifies a risk of injury due to seizure activity. To manage this risk, the plan instructs staff, amongst other things, to ensure that Mr A's medication is taken as prescribed. At the time of these events, Mr A required assistance to take blister-packed medication and felbamate, a liquid anticonvulsant medication that cannot be blister-packed. The felbamate was necessary to avoid Mr A suffering dangerous prolonged convulsions.

19. Mr A has a "Client Diary" which records activities, meals and any health issues that arise during his time at the facility. The diary entries are completed by NZCare staff at the end of each shift. The diary allows carbon copies of each entry to be provided to his school and family.

NZCare Group Limited

20. NZCare is contracted by the Ministry of Health to provide out-of-family respite care for young adults with an intellectual disability and/or Autism Spectrum Disorder. The relevant provisions of NZCare's contract with the Ministry of Health are attached as **Appendix B.**[10]

The Facility

21. The facility is operated by NZCare. It provides respite care for between four and five clients each night, with a total of up to 30 clients per month.

22. The facility is staffed by Community Service Workers (CSWs), a team leader, and a shift coordinator. The team leader and shift coordinator are senior CSWs who coordinate shifts and provide leadership to the team. Usually, two staff members work from 6am to 9pm (if necessary, a third staff member is also rostered on), and one staff member sleeps over. An on-call manager is rostered to be available from 5pm to 7am on week days and 24 hours over the weekend to provide advice and support as requested by staff. The facility is overseen by a service manager, who visits regularly. The service manager reports to an area manager.

Incident in May 2010

23. On 16 May 2010, Mr A was receiving respite care at the facility. CSWs Ms E and Mr C were on duty that day.

[9] This plan included 12 January 2011 as its "date for review", and was updated on 24 June 2011.
[10] These should be read in conjunction with Ms Bernadette Päus' independent expert advice.

24. According to Ms E, an incident occurred at approximately 2.40pm when she and Mr C were in the lounge with Mr A and four other clients. Mr A was sitting in a chair, coughing, as he had a cold.

25. Ms E wrote on a Reportable Events form[11] that:

> "[Mr C] asked [Mr A] to cover his mouth when he coughs. [Mr A] said 'he could not help it'. So [Mr C] got up from where he was sitting, walked up to [Mr A] and grabbed his arm and pulled it towards his face saying 'look it's easy, this is how you do it'. [Mr A] tried to free his hand from [Mr C] by pulling his hands away from [Mr C]. [Mr C] said 'that's it now you are going to time out'. So he pulled [Mr A] off the [recliner chair] and took him to the room, where he pushed him inside and closed the door of the room."

26. Ms E confirmed this account in an interview with HDC. She added, during the interview, that following the incident she went into Mr A's room to be with him because she knew the incident might trigger a seizure for Mr A.

27. Mr C did not report the incident to management or complete a Reportable Events form. He stated, during NZCare's internal investigation, that he did not do so because he made a decision at the time to "let it go" and because he was told that "some parents punished their kids when they got told of reportable events". NZCare stated that this was not true.

28. Mr C gave inconsistent accounts of the incident during NZCare's internal investigation and HDC interviews. However, overall he accepted that:

- he pushed Mr A's hand to his mouth (although he stated that this was a "game");
- he pulled Mr A off the recliner chair;
- he pushed Mr A on his shoulders or shoulder blades to "steer" him to his room and left him there;
- Mr A would have resisted and would not have been happy about going to his room;
- he told Ms E to leave Mr A in his room as Mr A needed time out; and
- Mr A remained in his room for half an hour or more.

29. Mr C recalled that he opened the door to check on Mr A while he was in his room. When Mr C did so, Mr A did not respond and so Mr C left him.

30. Mr C told NZCare that while he was showing Mr A how to cover his mouth, Mr A lashed out and caught Mr C on the side of his head with his knuckles. Mr C later told HDC that Mr A punched him.

[11] The Reportable Events form is dated 16 May 2010, and was collected by the Service Manager on 12 June 2010. NZCare requires staff to complete a reportable events form after the occurrence of unusual or adverse events. This policy is discussed further below.

31. Mr C told HDC that the reason he took Mr A for time out was that he (Mr C) had previously looked after a child with "ADD-Asperger's" for whom time out was used when he became violent.[12] Mr C told NZCare, "[Mr A] was displaying disruptive behaviour that could influence the other clients and it upsets the other clients." Mr C also acknowledged to NZCare that he had read Mr A's Individual Support Plan and that it did not include time out as a method of restraint, but Mr C did so as a "spur of the moment" decision. Mr C stated that therefore he felt his actions were reasonable.

32. When HDC asked whether he would do anything differently with hindsight, Mr C said that he would "sit back and let [Ms E] deal with it". He also advised that he did not have a good relationship with Ms E and felt that she was not supportive.

33. Mr A told HDC that he did not like being pushed and shoved by Mr C. He said, "Didn't like it all. Pushing and shoving." When HDC asked Mr A where he was pushed, he replied, "On shoulders. Not good. Not good."

34. Ms E advised HDC that she verbally reported the event to Service Manager Ms F at 3.10pm or 3.15pm on 16 May 2010, after Mr C had gone home. Ms E said that she was advised to fill in a form, which she did, although she cannot remember the date on which she did so.

35. In contrast, NZCare advised HDC that Ms F was informed of the incident during a training day in May 2010 by another staff member who had heard about it second hand. Ms F followed this up with Ms E by asking her to complete a Reportable Events form.

36. The Reportable Events form is dated 16 May 2010. There is no notation on the form that it was completed retrospectively. However, in the section of the form headed "Managers Response", Ms F noted the following: "Please write up [reportable event]. [Reportable event] had to be requested again — received 12/6/10 to be actioned. Staff discussion."

37. Ms F did not advise Mr A's family of this incident. NZCare stated that Area Manager Ms G advised Ms F to inform Mr A's family of the incident. When Ms G realised this had not occurred, she telephoned Mrs B herself to apologise.

38. Mrs B stated that, following the incident, her son often mentioned Mr C's name and said that he did not want to return to the facility. Mrs B told HDC that, had she known about the incident, she would not have continued to take her son to the facility until an internal investigation had been completed.

39. NZCare told HDC that, as of 26 July 2010, Mr C was no longer employed by NZCare.

Relevant NZCare policies and procedure

40. NZCare's Code of Conduct, which employees must sign when they start working for NZCare, requires employees to maintain a high standard of conduct and performance.

[12] This was in a family, rather than professional, situation.

41. NZCare's Policy and Procedure Manual provides that "any event which results in an unsatisfactory outcome or level of service delivery" must be reported in writing on a Reportable Events form. The form must be completed as soon as possible and then sent or given to the relevant manager.

42. NZCare has a policy on supporting people who present with challenging behaviour. It states that strategies used by employees will be "non aversive and legal". It defines "non aversive" as "work[ing] in a non-punishing way" and includes proactive strategies to manage difficult behaviours.

43. NZCare also has a policy on the use of restraint, which is based heavily on the New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.[13] The policy defines restraint as "the use of any intervention by a Service Provider that limits a person's normal freedom of movement". It also states that restraint "must have been approved for use" and "only applied as a last resort". NZCare told HDC that it does not approve the use of time out.[14]

44. Orientation at NZCare includes an induction, a series of training sessions, the completion of workbooks and workplace verifications to meet the National Certificate in Community Support Services Foundation Skills Level 2. Orientation is usually completed within six to twelve months of appointment. The induction, which includes a separate workbook, is expected to be completed and signed off within one to three months of appointment.

45. NZCare also has an on-going training programme. Service managers do "spot checks", hold staff meetings, have staff discussions and deliver "spot topic" training to ensure that staff are complying with NZCare policies and procedures.

Mr C's orientation and training

46. In March 2010, NZCare employed Mr C as a CSW. Mr C had no prior caregiving experience. Mr C received two hours of induction training, according to NZCare records. NZCare advised that although incorrectly coded on his time sheet, Mr C also completed two "buddy up shifts"[15] that he was rostered to do as part of his induction. Mr C also completed a day-long Autism Spectrum Disorder training course as part of his training. The course did not endorse physical contact with people with autism.

47. Mr C said that during his first few days he was shown around the facility, given an overview of his duties and introduced to the clients.

48. NZCare was unable to provide HDC with a copy of Mr C's completed induction workbook. Mr C advised HDC that his induction and orientation "paperwork" was only partially completed. NZCare accepts that it did not comply with its own standards or national standards in this regard. In addition, Mr C's orientation was not

[13] NZS 8134.2:2008. These standards are reproduced below in the "Other relevant standards" section.
[14] Specifically, the induction workbook states that time out is "something we would normally try to avoid given the freedom to choose".
[15] These shifts involve working with other staff members in order to learn from them.

signed off. NZCare stated that this was because a disciplinary process in relation to Mr C had commenced during the orientation period.

49. Regarding Mr A specifically, Mr C told HDC that his understanding was that if Mr A was difficult, he was expected to walk away and "leave [Mr A] to it". Mr C also stated that he had not received restraint training, and his understanding was that restraint means "tying someone down".

50. In response to my provisional opinion, NZCare advised that its induction booklet includes a section on restraint, and that at the time of these events NZCare's restraint policy was available at the facility for any staff member to read.

Medication management

51. NZCare accepted that Mr A's medication was not correctly administered in late November 2010 and late June 2011. CSW Ms D was the employee responsible for administering Mr A's medication at the relevant times. She was initially employed by NZCare on 26 September 2010 as a shift coordinator, but was later promoted to the role of team leader. At the time of Ms D's employment, she had completed the National Certificate in Community Support Services Foundation Skills Level 2, which included a medication management component.

Incidents in November 2010

52. NZCare accepted that Mr A's medication was not administered correctly on two separate occasions between 28 and 29 November 2010.

53. Mr A required support to take his blister-packed medication (twice daily) and his felbamate.[16] For each stay at the facility, Mr A had his blister-packed medication and felbamate bottle with him on arrival, and he would take them with him on departure.

54. On 28 November 2010, when Ms D was shift coordinator, Mr A was given the blister-packed medication but not the felbamate. Ms D said that this may have been because the felbamate was not with the blister-packed medication, where it should have been kept.

55. NZCare requires staff to use medication checklists and medication administration signing sheets with clients who require assistance with medication. NZCare was unable to provide a copy of either of these documents for the relevant dates.

56. Ms D stated that a second staff member was involved in Mr A's medication management on 28 and 29 November. However, Mr A's Client Diary entries for "28 November 2010 (PM)" and "29 November 2010 (AM)" were completed by Ms D and record the "medication given" and "medication taken". Ms D stated that she wrote this because Mr A had been administered his blister-packed medication.

[16] The documentation provided by NZCare is not clear on the dose and frequency of felbamate Mr A required at that time. This is because some of the updates to the medication chart that Mrs B provided were undated.

57. Mrs B was not informed about Mr A missing his felbamate medication. When Mr A arrived home without the felbamate bottle, Mrs B rang the facility to find out what had happened. The staff told her that Mr A had not received his prescribed doses on the evening of 28 November 2010 or the following morning. Mrs B recalls that staff told her that this was because they could not find the key to access where the felbamate was kept. NZCare advised HDC that it was not aware that the staff could not find the key.

NZCare follow-up to November 2010 incident

58. On 29 November 2010, Mrs B complained to NZCare about this incident. In her email she stated:

> "So [Mr A] has missed not one but two doses of Felbamate medication. What is even more concerning is that I see on the client diary that he came home with that he was signed off as having his meds [sic]. As you know it is extremely dangerous for an epileptic to miss even one dose but for this to happen for two doses is unacceptable and has placed [Mr A] at considerable risk medically."

59. On 30 November 2010, NZCare Service Manager Ms F responded, "I must assure you that we take lapses in our duty of care very seriously, and we will investigate rigorously."

60. In response, Mrs B sent an email to Ms F and Ms G, dated 30 November 2010, which states:

> "… [W]e certainly don't want to see anyone lose their job or to know who the individual was that failed to administer the medication. All we want to be assured of is that our son whilst [he] is in your care … is medicated as per the charted medication dosage and times. … [W]e cannot emphasise enough the importance of [Mr A's] medication being given to him on time and as charted."

61. Subsequently, NZCare introduced a new policy requiring all medications to be signed off upon each client's arrival to, and departure from, the facility by two staff members. Ms F spoke with staff individually about the incident and asked a team leader to do Medication Support Competency[17] assessments with Ms D and another staff member. NZCare was unable to advise HDC who the other staff member was.

62. NZCare provided HDC with documentation to show that Ms D completed the required Medication Competency Assessment on 26 March 2011. However, NZCare could not provide documentation to show that Ms D had completed the Medication Competency Assessment prior to November 2010.

63. On 30 March 2011, Ms D completed NZCare's induction training. Ms D attended a medication management training course in May 2011.[18] Ms D advised HDC that

[17] This refers to part of NZCare's medication policy, which is described below under the heading "Relevant NZCare policies and procedures".
[18] In April 2012, Ms D's workbook for medication management training was yet to be signed off.

during her training, she learnt "to be very careful, give [medications at the] right time, right person".

64. NZCare explained to HDC that:

> "[t]he Service Manager made an error in judgment to not follow a disciplinary process. We take full responsibility and believe the Service Manager was influenced by [Mrs B's] insistence no one get in trouble for this incident."

Incident in June 2011

65. NZCare accepts that Mr A's medication was again not administered correctly on 24 June 2011.

66. Mr A was receiving respite care during the weekend of 24 and 27 June 2011. Ms D had been promoted to team leader and was working at the facility at that time.

67. At 7pm on 24 June 2011, Ms D gave Mr A his felbamate medication. However, she did not give him his blister-packed medication. Ms D told NZCare that this was because he had refused dinner and staff "usually give [the medication] after dinner". She thought she would be able to persuade him to take the blister-packed medication later. Ms D said she "didn't think to" note on the medication administration signing sheet that some of the medication had been refused, although she acknowledged that this had been covered in her training.

68. Mr A had dinner at around midnight but, by this time, Ms D "forgot all about [his blister-packed medication]" because "[her] mind was busy". Ms D did not complete a Reportable Events form that day and did not advise the on-call manager or Mr A's family.

69. The relevant medication administration signing sheet for Mr A shows that he was not given his blister-packed medication on the evening of 24 June 2011. However, the medication administration signing sheet should have been marked as "medication refused" under NZCare's medication policy (discussed below). All other medications are recorded as given that weekend. The medication checklist shows that only two evening doses of blister-packed medication were taken, whereas three should have been taken.

70. Mrs B said that, when Mr A arrived home, she noticed that he had not been given his blister-packed medication on one occasion over the weekend and telephoned the facility to find out what had happened.

71. At Ms F's request, Ms D completed a Reportable Events form on 28 June 2011 in relation to the incident.

NZCare follow-up to the June 2011 incident

72. On 28 June 2011, Mrs B sent an email to Ms F and Ms G, which stated:

> "… [T]his is now the second time that NZCare has failed to give medication to [Mr A] and frankly it is not only life threatening but totally unforgiveable.

Obviously [the] thorough investigation and new procedures [following November 2010] have failed …"

73. On 30 June 2011, as part of Ms F's investigation into the incident, Ms F had a discussion with Ms D. Ms D explained what had happened and stated that she knew the correct policy but did not follow it. The outcome of the discussion is documented as: "[Ms D] will follow procedure in future."

74. At the next staff meeting, staff were reminded about completing Reportable Events forms and informing their managers about reportable events. All staff were scheduled to complete training in medication administration by August 2011.

75. Ms D said that she is "so very sorry … and thankful that nothing happened to [Mr A]". She told HDC that in future:

- if she is not able to give medication for some reason, she will file a Reportable Events form, inform the client's family and the on-call manager immediately; and
- she will check that there is an up-to-date medication chart from each client's doctor.

Relevant NZCare policies and procedures

76. NZCare has a medication policy to ensure the safe management of medication. There are specific procedures to follow in the event of a medication being refused or accidentally omitted.[19] The policy provides:

"Responsibility for Medication:

[…]

- If medication is refused this must be noted on the [medication] administration sheet and the Manager informed;

- Record on the Medication Check Sheet that the medication has been administered and taken by signing in the space provided. The sheet also allows for the recording of withheld doses or extra doses given in the event of wastage;

[…]

Medication errors

If a medication is incorrectly given or accidentally omitted[:]

- The matter is to be discussed immediately with the client's clinical manager/[coordinator]. In the case of omission, consideration needs to be given to the timing of the next dose before any decision is made about giving

[19] The policy was revised in 2011 but not substantially changed.

the missed dose. The medical practitioner, prescriber or pharmacist may need to be consulted to assist in this decision making.

- The client must be informed and appropriate assessment/treatment undertaken.
- Every effort must be made to manage any adverse event resulting from the error/omission.
- A [NZCare] Incident Report is filled in.
- The person who incorrectly administered/accidentally omitted the medication writes a record of what occurred and what was done to manage it in the client's notes/files."

77. NZCare advised that, when a client arrives at the facility, staff record on a medication checklist the medications the client has brought with them. Upon the client's departure, staff record on the same checklist the medications the client is leaving with. Staff also sign individual medication administration signing sheets for clients when medication is given.

78. NZCare's medication policy states that CSWs "must be assessed as competent prior to assisting clients to take medication". The assessment is referred to as the Medication Support Competency and includes a Medication Competency Assessment and a Medication Competency Observation Checklist. Medication Support Competency must be reassessed on an annual basis.

79. The medication management policy in place in November 2010 stated: "Only one community support worker on duty should take responsibility for all Medication Support to all clients on each occasion." The policy required that person to note any medication refusal on the medication administration signing sheet and to inform the manager, and also required that person to record on a medication checklist that the medication had been administered and taken.

Mr A's medication

80. Mr A's neurologist wrote to NZCare on 28 June 2011, stating:

> "[I]t is of utmost importance that [Mr A] does receive his medication to avoid dangerous prolonged convulsions."

81. She told HDC:

> "I think that to miss a dose of his medication is quite a significant risk to [Mr A's] health … It placed [Mr A] at an increased risk of break through seizure."

82. NZCare submitted that, although Mr A's Risk Management Plan stated that his medications were to be taken as prescribed, Mr A's family did not adequately emphasise the risk to Mr A of a missed dose of his medication.

83. NZCare noted that it is the family's responsibility to provide an up-to-date medication chart for the client. NZCare provided HDC with the service agreements signed by Mr A's parents when he first started attending the facility, which state:

> "You must provide … up to date medical information including current medications and the level of support required. This should include written protocols from your GP regarding the safe management of any specific health issue, including epilepsy …"

84. NZCare received a medication chart from Mr A's family for Mr A dated 4 September 2009. Subsequently, Mrs B sent typed instructions whenever there were changes to Mr A's medication. These instructions were attached to the blister-packed medication Mr A took with him to the facility. Mrs B said that she expected staff to call their manager if they had any medication concerns and then call her.

85. NZCare said that the typed instructions Mrs B sent did not meet the standard required by NZCare because they were not approved by a doctor or pharmacist and lack sufficient detail. NZCare acknowledged that it should have obtained Mr A's updated medication chart and/or a letter from his doctor rather than continuing to support Mr A without the appropriate documentation.

86. In respect of Mr A specifically, Ms D told HDC that she knew that if he did not take the correct medication, he was at a higher risk of suffering a seizure.

87. Ms D left NZCare in September 2012.

Audit of NZCare's respite facilities

88. As stated above, NZCare is contracted by the Ministry of Health to provide out-of-family respite facility services. In March 2010, a routine contract evaluation report was issued by Standards and Monitoring Services (SAMS) for the Ministry of Health. The NZCare facilities evaluated in the report included this facility. The evaluation team conducting the audit found the services to be of an appropriate standard. However, the audit states, among other things, that:

- reviews of Individual Support Plans should occur as part of "service review[s]" with clients' families every six months and that this had not been occurring;
- some clients' Risk Management Plans "were very brief and did not appear to have been reviewed for some time" and that it is "anticipated this may occur at service review meetings"; and
- "We would encourage [NZCare] to schedule more specific disability training to meet the needs of the people [it supports]."

89. The Ministry of Health advised that these were recommendations only, made to assist NZCare in improving service delivery, and were optional. This is in contrast to requirements, which require follow-up action.

Changes made by NZCare

90. NZCare apologised to Mr A and his family for failing in its duty of care. Regarding improvement of respite service staff training, NZCare stated that it:

- has employed a training coordinator who monitors staff training;
- has implemented a new system to track, monitor and follow up all orientation workbooks from the time a new staff member is employed;
- now completes an annual audit of new staff files;
- has scheduled training with the service managers and team leaders to reiterate the importance of retaining medication administration signing sheets;
- has provided further training in medication management and reportable events;
- is developing an "individual learning and development programme" for respite services staff; and
- has secured funding for a two-day course for 32 respite services staff. The course will cover management of clients and strategies for clients, including managing Autism Spectrum Disorder, dual diagnosis, physical disabilities, epilepsy, challenging behaviours, and specialist health issues. A panel of service users and families will share their experiences as part of the course.

91. NZCare also advised that in regard to its policies generally:

- it is seeking advice from a clinical governance group about how best to engage with Needs Assessment and Service Coordination (NASC)[20] organisations to ensure that appropriate clinical documentation is provided;
- the clinical governance group has also been asked to review NZCare's procedures in relation to non-blister-packed medication;
- NZCare has appointed two additional Health Advisors (registered nurses);
- NZCare has implemented a "whistle-blower" (also known as a protected disclosures) policy to encourage reporting of incidents; and
- respite services staff can now email and scan documents directly from the facility to the service manager.

92. NZCare noted that since January 2012, a NASC organisation sends a needs assessment[21] for every client referred to respite care, with agreement from the family.

NZCare's response to expert advice

93. Independent advice from Registered Nurse Bernadette Päus identified that:

[20] NASC organisations work with disabled people to assess their needs and outline the services available to them, including Ministry of Health funded services. They can also make referrals for services.
[21] An assessment of an individual's abilities, goals, and needs.

> "… there appeared to be a lack of activity and stimulation, with [Mr A] appearing to spend a lot of time in his room and not going on the daily walks or community outings that his support plan indicates he enjoys (shopping trips)."

94. NZCare responded that the Client Diary entries initially provided to Ms Päus are specific to the days when the incidents complained about occurred. NZCare therefore provided HDC with additional Client Diary entries for Mr A, dated between June 2010 and May 2011, which record Mr A's participation in activities such as shopping trips, excursions and helping staff to cook.

95. In response to Ms Päus' advice that highlighted flags or reminders should be placed on clients' medication charts at the facility, NZCare noted that this is outside the scope of its service. It stated that this would need to be indicated by the family or the pharmacist on the blister-packed medication. However, NZCare expressed a willingness to specifically request this from clients' families in the future.

96. Regarding Ms Päus' suggestion that NZCare staff members should contact clients' family members in the event that a client refuses his or her medication, NZCare advised that this is current practice, and that this can be included in clients' Individual Support Plans if it is indicated by clients' families.

97. Ms Päus also raised a concern that the behavioural guidelines for staff in Mr A's support plan were "nominal". NZCare responded that while it provides its staff with general behavioural support training, it is not funded to provide specialist nursing or behavioural support for each client, and therefore relies on instructions provided by clients' families. In response to my provisional opinion, NZCare advised that it intends to discuss funding for behaviour support with the Ministry of Health.

Service Manager Ms F

98. NZCare advised that Ms F no longer works for NZCare. NZCare was unable to provide a forwarding address, and best efforts on behalf of HDC to contact Ms F were unsuccessful.

Response to provisional opinion — NZCare Group Limited

99. NZCare advised that it accepts the findings made in this report and acknowledges that errors were made.

100. A full copy of NZCare's statement, including an update on changes it is implementing, is included as **Appendix C**.

Other relevant standards

New Zealand Health and Disability Services (Core) Standards[22]

101. Standards New Zealand has produced standards for the Health and Disability sector.[23]

> "Standard 1.3 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.
>
> […]
>
> Standard 1.8 Consumers receive services of an appropriate standard.
>
> […]
>
> Standard 2.2 The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.
>
> Standard 2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.
>
> […]
>
> Standard 2.8 Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.
>
> […]
>
> Standard 3.3 Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.
>
> […]
>
> Standard 3.12 Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines."

[22] NZS 8134.1:2008.

[23] Standards New Zealand explains standards on its website as follows: "Standards are agreed specifications for products, processes, services, or performance. New Zealand Standards are developed by expert committees using a consensus-based process that facilitates public input. New Zealand Standards are used by a diverse range of organisations to enhance their products and services, improve safety and quality, meet industry best practice, and support trade into existing and new markets."

New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards[24]

102. The foreword to the Standards states:

> "The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practiced, restraint occurs in a safe and respectful manner.
>
> Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices and training should be firmly grounded in this context."

103. It also provides:

> "Both enablers and restraint limit the normal freedom of movement of the consumer. It is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint but rather the intent of the intervention. Where the intent is to promote independence, comfort and safety, and the intervention is voluntary, this constitutes an enabler."

104. The Standards are:

Restraint minimisation

Standard 1	Services demonstrate that the use of restraint is actively minimised.

Safe restraint practice

Standard 2.1	Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint and ongoing education on restraint use and this process is made known to service providers and others.
Standard 2.2	Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.
Standard 2.3	Services use restraint safely.
Standard 2.4	Services evaluate all episodes of restraint.

[24] NZS 8134.2:2008

Standard 2.5	Services demonstrate the monitoring and quality review of their use of restraint.

Safe seclusion use

Standard 3.1	Services demonstrate that all use of seclusion is for safety reasons only.
Standard 3.2	Seclusion only occurs in an approved and designated seclusion room.

Opinion: Breach — Mr C

Introduction

105. Mr A was vulnerable because of his personal circumstances, which included his intellectual impairment and his difficulty in communicating effectively. As a disability services consumer, Mr A had the right to be treated with respect and to have services provided to him with reasonable care and skill.

Discussion

106. According to Mr C, he pushed Mr A's hand to his mouth because Mr A did not follow earlier instructions to cover his mouth when he coughed. Mr C stated that Mr A then "lashed out" at him, so Mr C pulled Mr A off the recliner chair, turned him around, and then pushed Mr A between his shoulder blades to "steer" him towards his room. Mr C stated that he left Mr A in his room for time out. Mr C said that time out was necessary because Mr A was "displaying disruptive behaviour that could influence the other clients and it upsets the other clients".

107. In contrast, Ms E stated that when Mr A said that he "could not help" coughing without covering his mouth, Mr C pulled Mr A's arm towards his face saying, "Look it's easy, this is how you do it." Ms E said that when Mr A tried to free his hand from Mr C, Mr C said, "That's it, now you are going for time out," then pulled Mr A off the recliner chair, pushed him into his room and closed the door.

108. Mr A said that he did not like being pushed and shoved by Mr C, "Didn't like it all. Pushing and shoving."

109. In my view, regardless of whether Mr A "lashed out", Mr C's conduct that day was unacceptable. Mr C advised NZCare that he had read Mr A's Individual Support Plan. The Support Plan states: "Staff to ignore stubborn behaviour at the time — divert [Mr A] and encourage him to do something another way or have someone else ask him." It also clearly states: "[Mr A] requires full supervision at all times and environments to remain safe … due to seizure activity." Mr C advised HDC that he understood that he was to walk away and leave Mr A alone if he was being difficult.

110. My expert nursing advisor, Ms Bernadette Päus, stated that while it would have been appropriate for Mr C to point out to Mr A, in a respectful and educative manner, that coughing without covering your mouth is undesirable, there was no need for Mr C to physically move Mr A's hand to his mouth. If Mr A became upset, Mr C should have left Mr A alone, even if Mr A did "lash out" at Mr C. Ms Päus advised that Mr C's conduct was a severe departure from accepted standards.

111. I agree with Ms Päus' advice. In my view, Mr C should have either demonstrated to Mr A how to cover his mouth, or asked Ms E for support, as outlined in the Individual Support Plan. Mr C's actions were also inconsistent with his own understanding that Mr A should be left alone if he was being difficult. Even if Mr A did lash out, it was not appropriate for Mr C to respond as he did. Mr A was seated and was not posing a significant or immediate threat to himself or those around him.

112. In addition, Mr C's actions were not in line with NZCare's policy on challenging behaviour, which states that clients should be supported using "non-aversive strategies". Furthermore, Mr C did not complete a Reportable Events form, as required.

113. Clause 3 of the Code states that a provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in the Code. "The circumstances" means "all relevant circumstances".[25] Therefore, Mr C's level of training is a relevant circumstance that I need to take into account.

114. I accept Ms Päus' advice that NZCare's policies relating to restraint minimisation and dealing with challenging behaviours appear to be robust and consistent with accepted standards. However, the limited evidence available suggests that Mr C was not adequately trained in these policies.

115. NZCare advised that Mr C received two hours of induction and completed two "buddy-up" shifts. Mr C also received a day-long Autism Spectrum Disorder training course where physical contact with autistic clients was discouraged. However, NZCare could not provide HDC with a copy of Mr C's induction workbook (completed or otherwise), and Mr C told HDC that he only partially completed the "paperwork" that he was given as part of his orientation. I also note that Mr C advised HDC that he had not received any restraint training and that he thought restraint meant "tying someone down". Furthermore, at the time of the incident, Mr C was in his second month of work and had no prior caregiving experience.

116. Ms Päus advised me that Mr C's induction and orientation fell short of NZCare's standards. NZCare accepted Ms Päus' advice, stating:

> "We accept that NZCare is unable to provide evidence of Mr C's completed induction workbook and agree we have not complied with our own standards and national standards in this instance, for which we apologise."

[25] Code of Health and Disability Services Consumers' Rights, Clause 3.

117. The level of training given to Mr C was inadequate, particularly given that he had no prior experience working as a caregiver of consumers with intellectual disabilities. These deficiencies somewhat mitigate Mr C's severe departure from expected standards. However, Mr C had read Mr A's Individual Support Plan. He was told what to do if Mr A's behaviour became challenging. Therefore Mr C, at the very least, knew what was expected of him when caring for Mr A. I note Ms Päus' view that while there were deficiencies in Mr C's training, he would have had sufficient understanding about appropriate and respectful care.

Conclusion

118. Taking into account all of the above, I consider that Mr C's conduct of pushing Mr A's hand over his mouth, pulling him from his chair and pushing him towards his room for time out was inappropriate. I also consider that it was unacceptable for Mr C not to complete a Reportable Events form. Such documentation is important for patient safety. Accordingly, I find that Mr C did not provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

119. I also find that Mr C breached Right 1(1) of the Code because he did not treat Mr A with respect. Mr C acknowledged that he pushed Mr A to his room. Mr A advised HDC that he did not like being pushed and shoved and he did not feel good about what had happened. Therefore, I consider that the overall manner in which Mr C treated Mr A was disrespectful.

Opinion: Breach — Ms D

120. On 28 and 29 November 2010 and 24 June 2011, Ms D failed to administer Mr A's medication correctly, and also failed to appropriately record the incidents on the relevant documentation.

121. Ms D was a CSW with prior caregiving experience. She was initially employed by NZCare as a shift coordinator and later promoted to the position of team leader. She had completed a National Certificate in Community Support Services Foundation Skills Level 2 training when she started at NZCare.

122. Prior to November 2010, Ms D did not undergo a Medication Competency Assessment, an NZCare policy requirement for CSWs before administering medication.

November 2010 incident

123. On 28 and 29 November 2010, Ms D did not correctly administer Mr A's medication. She believes that this occurred because the felbamate was not with the blister-pack medication, where it should have been. Mrs B recalls being told by staff over the telephone that the key to the cupboard where the felbamate was stored could not be found.

124. Ms D subsequently marked the relevant Client Diary entries with "medication given" (28 November 2010) and "medication taken" (29 November 2010). She stated that she did so because Mr A had taken his blister-packed medication, despite not being administered his felbamate. Ms D did not inform Mrs B or the manager of this incident.

125. Ms F discussed the incident with Ms D and, in March 2011, Ms D underwent a Medication Competency Assessment.

June 2011 incident

126. On 24 June 2011, Ms D again failed to administer Mr A's medication correctly. In this instance, she administered the felbamate but not the blister-packed medication. Ms D stated that this was because Mr A initially refused the blister-packed medication and, although she intended trying to give it to him later, she forgot to do so. Ms D did not mark the medication as refused, and she did not inform a manager or Mr A's family of the incident.

Discussion

127. Ms Päus advised that the above incidents were the result of an individual staff member neglecting to follow NZCare's policy. She stated:

> "Because [Ms D] was in both [shift coordinator] and [team leader] role[s] with considerable experience who had completed extensive training, including her 'Medication Competency Assessment'[26] her failure to administer medication in-line with organisation policy, including her failure to report medication refusal by a client to the on-call manager, is a severe departure from acceptable standards."

128. I accept my expert's view that Ms D's errors amounted to a severe departure from accepted standards. In relation to the November 2010 incident, I consider that Ms D should have sought the assistance of the on-call manager if she was unable to locate the felbamate or the key to the medication cupboard. Ms D's actions of marking the relevant Client Diary entries with "medication given" and "medication taken" did not comply with NZCare's medication policy, which states that if a medication is omitted, the staff member responsible should write a record of what occurred and what was done to manage the incident. The information that Ms D recorded was misleading and placed Mr A's safety at risk. Furthermore, Ms D did not inform Mrs B of the incident.

129. During my investigation and in response to my provisional opinion, Ms D stated that there was another staff member involved in Mr A's medication management on 28 and 29 November 2010, but declined to provide further information.

130. Regardless of whether another staff member was involved, Ms D told HDC that she was responsible for Mr A's medication on this occasion, and recorded erroneously in his Client Diary that the medication had been given. Therefore I remain of the view that Ms D failed to administer Mr A's medication correctly in November 2010 and subsequently failed to follow the correct NZCare policy.

[26] As noted above, Ms D did not undergo a Medication Competency Assessment prior to March 2011.

131. In June 2011, Ms D also failed to administer Mr A's medication correctly, and did not record the medication as refused and inform the on-call manager and Mrs B of the incident.

132. I am mindful that Ms D held senior roles at the time of the incidents. While Ms D had not undergone a Medication Competency Assessment in accordance with NZCare policy prior to March 2011, she had prior experience as a CSW and held relevant national qualifications. Furthermore, Ms D knew that Mr A could have seizures if he did not take the correct medication. Despite having such knowledge, she failed to administer Mr A his correct medication on two separate occasions.

133. In my view, Ms D's failure to administer Mr A's medication correctly endangered his health and well-being. Ms D failed to comply with NZCare policy following these incidents. I therefore consider that Ms D did not provide services in a manner that minimised the potential harm to Mr A and, accordingly, breached Right 4(4) of the Code. Furthermore, Ms D did not correctly record the medication errors on the relevant documentation, which was not only misleading but also placed Mr A's safety at risk, and she also failed to inform Mr A's family of the incidents. These failings amounted to a breach of Right 4(1) of the Code.

Opinion: Breach — NZCare Group Limited

Introduction

134. NZCare has overall responsibility for ensuring that its clients receive care that complies with the Code. In order to do so, NZCare needs to provide its employees with adequate policies and procedures to guide their actions and ensure they receive adequate training. In addition, NZCare needs to monitor staff compliance with those policies and procedures. While I have identified my concerns about the decision-making and actions of key individual staff, NZCare also had a responsibility to operate the facility in a manner that provided Mr A with services of an appropriate standard. This organisational duty of care includes providing a safe healthcare environment for its consumers, and ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It also includes responsibility for the actions and omissions of its staff.

Mr C

135. Ms Päus advised that NZCare's orientation programme is well structured and thorough. It includes an induction, training and workbooks. Importantly in this case, NZCare's comprehensive policy on restraint minimisation is among the topics addressed in the orientation programme.

136. Despite having policies regarding staff orientation, NZCare failed to follow those policies in respect of Mr C. Mr C had no prior caregiving experience, and this was known to NZCare. While Mr C did receive two hours of induction and, according to

NZCare, completed two "buddy-up" shifts, NZCare could not provide evidence of Mr C having completed his induction workbook. As noted above, Mr C advised HDC that he only "partially" completed the relevant "paperwork".

137. NZCare acknowledged that, in this instance, it failed to comply with its own policies and national standards; namely, the New Zealand Health and Disability Services (Core) Standards (Standards 2.8 and 3.3) and the New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (Standard 1), specified above.

138. The importance of providing an appropriate level of training to staff on how to manage challenging behaviour of consumers with intellectual disabilities cannot be overstated. Adequate training ensures not only the safety of the consumer and the staff member, but also that the management of such behaviour is respectful to the consumer. This point is also emphasised in Ms Päus' expert advice:

> "In my opinion it is imperative that staff who are going to be working with clients who have challenging/difficult behaviours, must be trained in behavioural management strategies in the induction period and the course must be provided by suitably qualified health professionals in a formal training package. NZCare in many ways can be commended for their staff training package, but again (as I have seen before) there is not a strong or immediate focus on staff training [regarding] dealing with difficult client presentations/challenging behaviours. This type of training cannot occur by staff simply reading policies or talking to a co-worker. If staff do not have appropriate training in this area they are likely to use their own personal techniques (as was demonstrated by [Mr C] in this incident), which are generally inappropriate."

139. While I acknowledge that Mr C's conduct on 16 May 2010 was a matter of individual responsibility, I consider that Mr C's inadequate training, particularly relating to the management of challenging behaviour, contributed to the poor standard of care Mr A received that day. This failure is the organisational responsibility of NZCare.

140. NZCare advised that it has initiated several changes to prevent similar occurrences in the future, such as employing a training coordinator, implementing a system to monitor orientation workbooks, and developing an "individual learning and development programme" for respite services staff.

Ms D

141. NZCare's medication policy provides that a CSW must be assessed as competent prior to administering medication to clients. This involves the CSW completing a Medication Competency Assessment. However, at the time of Ms D's employment, and prior to the November 2010 incident, NZCare did not ensure that Ms D undertook the Medication Competency Assessment.

142. While I note that Ms D had prior caregiving experience and held relevant qualifications, NZCare should have ensured that she was trained and competent pursuant to its own medication policy. This is particularly important given that Mr

A's Risk Management Plan clearly identifies that Mr A is at risk of injury due to seizure activity, and it specifically instructs staff to ensure that his medication is taken as prescribed. Therefore, I consider that NZCare's failure to comply with its own policy to assure itself of Ms D's competency contributed to Mr A not receiving an appropriate standard of care in November 2010.

143. Following the November 2010 incident, NZCare was on notice regarding the importance of the dosage and timing of Mr A's medication. In my view this was adequately communicated by Mrs B in her email of 30 November 2010. Mrs B stated: "[W]e cannot emphasise enough the importance of [Mr A's] medication being given to him on time and as charted."

144. I note that Ms F spoke with each staff member at the facility individually about Mr A's medication management following the November 2010 incident. I acknowledge that, as a result of the November 2010 incident, NZCare made an amendment to its medication policy requiring two staff members to sign medication off on medication checklists. In March 2011, Ms D was required to undertake the Medication Competency Assessment. Furthermore, since these events, NZCare requested a clinical governance group to review its policies in relation to non-blister-packed medication.

145. However, despite these changes, on 24 June 2011, Ms D made another medication error. I am therefore concerned that the actions taken following the November 2010 incident were insufficient in light of Ms D's repeated inability to administer Mr A's medication correctly. As this Office has previously stated, without staff compliance, policies become meaningless.[27] I consider that NZCare did not take adequate steps to ensure that Ms D complied with its policies and procedures, which placed Mr A at risk.

Care planning

146. NZCare was providing care to Mr A in accordance with its contract with the Ministry of Health (relevant parts attached as **Appendix B**). The relevant parts of the contract require NZCare to have an "individual plan/care plan" in place for each user of its out-of-family respite services. It also requires that these plans address users' medication requirements, and communication and behaviour support where appropriate.[28]

147. In relation to Mr A's medication management, NZCare stated that, according to the service agreement signed by Mr A's parents, more appropriately detailed updates and medication charts should have been provided to NZCare by Mr A's family. However, NZCare acknowledged that it should not have continued to provide medication support to Mr A without the required documentation.

148. Given that an adverse event occurred in relation to Mr A's medication management, and that managers at the facility had explicit notice of its importance, I do not

[27] Opinion 09HDC01974 (21 June 2012).
[28] Clause 5.1.1.

consider that it would have been beyond NZCare's responsibility to at least make a note of this on Mr A's medication chart following the incident in November 2010. In addition, at this point staff should have asked Mrs B to provide updated medication charts and instructions from Mr A's doctor.

149. I note Ms Päus' suggestion that highlighted flags be placed on the medication checklists of clients particularly at risk. NZCare stated that its staff are not qualified to do this in the absence of direct instruction from the consumer's healthcare practitioner. However, as NZCare provides assistance with medication as a service, it has a duty to take reasonable steps to ensure that staff have the correct information regarding a client's medication. In my view, this did not occur in Mr A's case; NZCare continued, over an extended period of time, to support Mr A to take his medication without up-to-date and sufficiently detailed documentation.

150. I also note the concern raised by Ms Päus that the level of detail in the behaviour section of Mr A's Individual Support Plan is not sufficient to assist staff adequately in dealing with Mr A's challenging behaviour. The behaviour support section in Mr A's Individual Support Plan states:

> "Staff need to encourage [Mr A] to do things by making them appear fun and give a reward after.
>
> Staff to ignore stubborn behaviour at the time — divert [Mr A] and encourage him to do something another way or have someone else ask him."

151. Ms Päus considered that

> "there was a lack of information to guide staff on how specifically to deal with the oppositional behaviours that [Mr A] is capable of engaging in, for example, refusing to shower, refusing medication, refusing to eat, hitting out".

152. Ms Päus suggested that a registered nurse or behavioural specialist be asked to include more detailed guidelines in Mr A's Individual Support Plan. In response to this concern, NZCare explained that it is not funded to provide specialist behaviour support to individual clients, but intends to discuss this with the Ministry of Health. NZCare said it relies on information provided by the family when detailing the individual behaviour support information in clients' Individual Support Plans.

153. In Mr A's case, I agree with Ms Päus that it would beneficial if the behaviour support guidelines in his Individual Support Plan were more detailed. I note that NZCare now receives a NASC assessment for each client, with agreement from the client's family. NASC assessments are generally comprehensive and multidisciplinary. This will go some way towards improving the lack of specific detail in Mr A's support plan, which was not based on a NASC assessment. I note that, in addition, NZCare has asked a clinical governance group to provide advice on how best to engage with NASC organisations.

154. Nonetheless, I am concerned by NZCare's inference that its care planning in regard to Mr A's medication and behaviour support was deficient as a result of inadequate information provided by Mr A's family.

155. Overall, I consider that if NZCare becomes aware that it has insufficient information on any aspect of a client's care to enable it to support the client adequately, the onus is on NZCare to obtain the necessary information. Otherwise, it should not take on the responsibility of providing care to that client. In accepting responsibility to provide care to a consumer, NZCare must ensure it has sufficient information to provide an appropriate standard of care.

Documentation

156. I am concerned that NZCare could not provide HDC with several documents relevant to this investigation. Specifically, it was unable to account for:

- Mr C's induction workbook;
- the relevant medication checklist and medication administration signing sheet for 28 and 29 November 2010;
- the Medication Competency Assessment for Ms D prior to March 2011 or any information as to whether this was completed; and
- any information about the second staff member who was to undergo a Medication Competency Assessment following the medication incident in November 2010.

157. In my view, NZCare's failure to account for these documents indicates a failure to ensure accurate records are completed and retained in the interests of patient safety. Having an appropriate system for managing documentation relating to important aspects of NZCare's service is integral to its ability to provide an appropriate standard of care to its consumers. An organisation that does not have adequate documentation systems cannot achieve that goal.

Conclusion

158. In conclusion, I consider that NZCare failed to:

- comply with its own policies in respect of its training of Mr C;
- satisfy itself of Ms D's competency to administer medication in accordance with its own policies prior to November 2010; take adequate steps to ensure that Ms D complied with NZCare's medication policy after the November 2010 incident, despite clear indication of the importance of ensuring that Mr A received the correct medication;
- ensure it had sufficient information to be able to provide Mr A with an appropriate standard of care; and
- demonstrate that it has an adequate documentation system.

159. Accordingly, I consider that NZCare failed to provide Mr A with services with reasonable care and skill and, therefore, breached Right 4(1) of the Code.

Opinion: Adverse comment — NZCare Group Limited

160. In early 2010 some of NZCare's respite facilities underwent a contract evaluation report by SAMS on behalf of the Ministry of Health.

161. I note that some of the problems identified above in relation to Mr A's care were areas commented on in the SAMS audit. Specifically, the audit recommended that Individual Support Plans and Risk Management Plans for clients needed to be reviewed more regularly. It also noted that some Risk Management Plans appeared not to include sufficient detail. In addition, NZCare was encouraged to schedule "more specific disability training to meet the needs of the people [it supports]".

162. I note that these comments support Ms Päus' advice that the behavioural guidelines in Mr A's Individual Support Plans should have been more detailed, and that additional training regarding managing challenging behaviour should be provided to staff.

163. I also note that, had Mr A's Individual Support Plan and Risk Management Plan been reviewed with Mr A's family every six months, as stated in the audit, this would have provided an opportunity for NZCare to request and obtain sufficiently detailed and up-to-date information regarding Mr A's medication management from his family. Mr A's Individual Support Plan and Risk Management Plan (both dated early 2010) were due to be reviewed in 12 months' time, but Mr A's Individual Support Plan was not reviewed for 18 months.[29]

164. I accept that, since Mrs B's complaint, NZCare has introduced new staff training measures and programmes, and receives more comprehensive NASC assessments on which to base its Individual Support Plans and Risk Management Plans.

165. However, the incidents complained of occurred over more than 12 months and, when Mr A missed his medication in June 2011, nearly 18 months had passed since the audit. It is of significant concern that issues raised in the audit appear not to have been adequately addressed by NZCare.

[29] HDC does not have information on whether Mr A's Risk Management Plan, dated 2010, was updated.

Opinion: Adverse comment — Ms E

166. The provision of care to disability services consumers can be challenging, and therefore it is important that staff work together in a collaborative fashion and assist each other in difficult situations.[30]

167. On 16 May 2010, Ms E saw that Mr C's conduct towards Mr A was inappropriate. However, Ms E did not intervene. If Mr A did lash out at Mr C, Ms E did not assist Mr C.

168. I am concerned at Ms E's omission to intervene. In my view, Ms E should reflect on her omission and consider how it contributed to this situation. I do note that Ms E felt intimidated by Mr C. NZCare has since introduced a "whistle-blower" policy, which may assist staff who find themselves in similar situations in the future.

Recommendations

Mr C and Ms D

169. I recommend that Mr C and Ms D provide written apologies to Mr A and his family. The apologies are to be sent to HDC by **20 September 2013**, for forwarding to Mr A and his family.

NZCare

170. As per the recommendation in my provisional opinion, NZCare has provided a written apology, which will be forwarded to Mr A and his family.

171. I recommend that NZCare:

- implement a policy to ensure that it regularly requests clients' families to provide information from the client's medical providers regarding the timing, dosage and importance of the client's medication, and support families to provide information in the correct format;
- review its criteria for accepting clients and consider declining to provide care if there is insufficient information provided to enable staff to support that client adequately;
- review its document management system with a view to ensuring that all required documentation pertaining to staff orientation and training, medication management, and other relevant matters, is appropriately completed and filed;
- complete an audit of its records relating to the facility in order to identify areas for improvement;
- review the newly introduced "whistle-blower" policy and its effectiveness; and

[30] Opinion 10HDC00420 (19 December 2012).

172. I recommend that NZCare report back to HDC, by **30 November 2013** on the steps it has taken with regard to the above recommendations.

173. In addition, I recommend that NZCare report to HDC, by **7 October 2013** on the advice of the clinical governance group referred to above, and any action it plans to take based on that advice, especially regarding effective engagement with NASC, and NZCare policies relating to blister-packed medication.

Follow-up actions

- A copy of this report with details identifying the parties removed, except for the expert who advised on this case and NZCare Group Limited, will be sent to the relevant District Health Boards. They will be advised of Mr C's and Ms D's names.

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

Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from Bernadette Päus, Nurse Practitioner:

"This report is being provided to the Commissioner following a request for independent expert advice on case number 11/00712 — regarding the standard of care provided by NZCare to [Mr A] and the care provided by [Mr C] to [Mr A]. I have read and agreed to follow the Commissioner's 'Guidelines for Independent Advisors'.

I am a Mental Health Nurse Practitioner with over 20 years experience in the subspecialty area of Intellectual Disability. Over this time I have held clinical, leadership, educator and advisory roles in the intellectual disability area. My role is closely aligned to NGOs providing disability support so I have a good understanding of the standards and principles on which the current service is based. At the time of writing this report I am employed as a Nurse Practitioner by the Southern DHB with 0.5 of my clinical role being within the Intellectual Disability mental health area.

I have read the documents provided and offer the following opinion on the questions requested in your letter dated 10/8/2012.

Advise what standards apply in this case

New Zealand Standards Health and Disability General and Core Services Standards

NZS8134.1.1: Consumers' Rights to be treated with respect and receive services in a manner that has regard for their dignity (.3); Consumers receive services of an appropriate standard of good practice (.8)

NZS8134.1.2: Organisation Management of services ensures that the day-to-day operation of the service is managed in a manner which ensures the provision of appropriate and safe services to consumers (.2); Are of appropriate quality (.3); Consumers receive appropriate and safe service from suitably qualified/skilled and/or experienced service providers (.8)

NZS 8134.1.3 Service Delivery: Consumers receive competent and appropriate services in order to meet their needs (.3); Medicine management — consumers receive medications in a safe and timely manner that complies with current legislative requirements and safe practice guidelines

Ministry of Health Service Specifications (DSS213A1) for 'Out of Family' Respite Services for Adults

To enable people with disabilities to enjoy a positive, meaningful and stimulating experience (2.1), with individualised and appropriate care plans (5.1.1)

That is of acceptable quality/standard (8.1)

With competently trained staff (5.3.1) including appropriate training in managing challenging behaviour (5.1.3) and,

Risk management (5.1.2) including safe medication management (8.4)

New Zealand Standards Health and Disability Services Restraint Minimisation and Safe Practice Standards which requires that physical restraint (holding a person/moving a person) and limiting their movement should only be used in the context of ensuring safety and applied via rigorous practice policies (including reporting requirements) and by staff with appropriate training.

NZCare's Organisational Policies and Procedures, including Code of Conduct

H&DC Code of Rights: As part of this investigation you will make a judgement as to whether there is a breach of the H&DC Code of Rights which all health sector employees must be aware of and have a working knowledge of.

Was there a departure from any of those standards by NZCare? If so please provide details

Policies and procedures relating to medication management
The organisation has policies and procedures around medication management which give clear guidelines and instructions to staff about their responsibilities. In my opinion these policies are consistent with expected standards.

The organisation also has an education package '*Medication Management Trainee'* (that is aligned with their medication policy) which staff complete via a workbook which is comprehensive and of a good standard and which is in line with current good practice.

The policies and training outline a process for managing situations of client refusal to take medication which involves notifying the coordinator and the on-call duty manager.

The NZCare Induction/Orientation and ongoing training programme includes an '*Induction Assessment Workbook'* which requires new staff to demonstrate evidence of their understanding of the organisation's policies and procedures (which includes medication management). The employee has to demonstrate their knowledge to the manager and team-leader who are charged with providing them with feedback, coaching and sign off of competency. Once their workbook and orientation forms are complete they are placed on the employee's personal file as evidence of their orientation training and that they have attained the required knowledge and skills to competently provide safe and person-centred support.

If there is evidence on employees' files (via completed workbooks) that all staff working in this NZCare facility have completed their orientation training, induction workbook and medication workbook then I would not consider there to be a departure from organisational standards. However, if this is unable to be

demonstrated i.e. workbooks and forms not completed, as appears to be the case with [Mr C] then I would consider that the organisation has failed to comply with its own standards and in doing so has failed to comply with the national standards outlined above.

Policies and procedures relating to restraint

The NZCare Induction Package covers 'Working in a Non Aversive Way', which clearly defines aversive and non-aversive practise and also proactive strategies to manage difficult behaviours. It also explains that 'reactive' strategies can only be used to maintain safety. It also outlines the definitions of restraint i.e. placing hands on a person to make them move and restricting their movement/freedom. It also covers abuse and neglect including psychological abuse (i.e. being unkind or unnecessarily rough with a client). These policies give clear guidelines to staff on their responsibilities.

The training via the induction programme relating to restraint ensures that the employees demonstrate a thorough understanding and working knowledge of policies and practices relating to restraint. They have to indicate how they would respond in certain situations via case scenarios. The policies and procedures relating to restraint are consistent with expected standards.

As above, if there is evidence on employees' files that all staff working in this NZCare facility have completed their orientation training and induction workbooks and have demonstrated a working understanding of restraint and how it applies to their role, I do not consider there to be a departure from organisational standards. However, if this is unable to be demonstrated i.e. uncompleted workbooks or orientation forms, as appears to be the case with [Mr C] then I would consider that the organisation has failed to comply with its own standards and in doing so has failed to comply with the external national standards outlined above.

Other procedures relevant to this complaint

There was a failure by the service manager ([Ms F]) at the time of the incident with [Mr C] to inform [Mr A's] parents. [Ms F] had been asked by her area manager to inform the family but failed to do so, therefore NZCare was let down by her initial failure to follow organisational policy in regards to involving families and again when she failed to comply with a specific instruction from her manager. It appears that this was client specific as [Ms F] appears to have appropriately involved families when dealing with other situations of concern.

In general, staff have access to all policies and procedures which will provide them with clear guidelines when unsure of the appropriate action to take in a specific situation. Overall the policies and staff training appear to be robust and certainly consistent with expected standards, with the exception of training around managing challenging behaviour, which I will discuss in the last section of this report.

There is evidence of regular review of policies and procedures, including spot checks at staff meetings.

Staff can access the on-call duty manager if they require support.

Management of [Mr A's] medication

The NZCare medication management policy appears robust and is consistent with expected standards. The staff training package is comprehensive and reinforces adherence to the policy.

In both of these medication incidents the organisation was let down by individual staff who neglected to follow organisational policy:

Failure by a staff member to: administer medications as per the policy — failure to administer doses; records being signed off prior to medication being given, medications not given simultaneously as required, failure to report client refusal to take medications to the on-call duty manager.

Failure by the service manager to respond to the first medication error in the manner required (disciplinary action); however, she did conduct an investigation and endeavour to take corrective actions and provide a solution (implement two-person medication management). Also [the] (on-call service manager) was very quick to respond to [Mrs B's] concerns.

Please comment of the appropriateness of [Ms D's] care of [Mr A]

As outlined above [Ms D] failed on two occasions (Nov 2010 & June 2011) in her responsibility to follow organisational policy in regard to [Mr A's] medication management.

Because [Ms D] was in both coordinator and team-leader role with considerable experience who had completed extensive training, including her 'Medication Competency Assessment' her failure to administer medication in-line with organisation policy, including her failure to report medication refusal by a client to the on-call manager, is a severe departure from acceptable standards.

Orientation and training relating to working with people with disabilities, restraint and medication management; in particular of [Mr C]

The Induction/Orientation programme appears to be of a high standard and well within acceptable standards. It outlines: good levels of mentoring, coaching and supervision (from the house manager and team-leader) for the induction period; ongoing buddying with an experienced staff member; assessing the uptake of knowledge and information via workbooks and spot checks; an established 'ongoing training programme' and thorough policies and procedures which provide staff with clear guidelines. In addition there is evidence of training opportunities in addition to the in-house programme, which demonstrates a commitment to ongoing relevant training, for example the autism training workshop that [Mr C] attended.

However, the information I was given regarding [Mr C's] induction and orientation fell short of the organisation's standards. The information provided indicated [Mr C] had two days of induction training and one day of Autism specialised training, but there is no evidence that he completed his induction training booklet. [Mr C] himself indicated he partially completed it.

Care planning for [Mr A]

Meaningful Activity: In reading through [Mr A's] Individual Support Plan, [Mr A] appears to be someone who does not like to be overstimulated, enjoys having time on his own watching his DVDs/listening to music. I get the impression that he has autistic features and therefore most likely enjoys observing what is happening in the environment from the periphery and engaging in activities where there is not an intensive focus on him. However, reading the daily notes there appeared to be a lack of activity and stimulation, with [Mr A] appearing to spend a lot of time in his room and not going on the daily walks or community outings that his support plan indicates he enjoys (shopping trips).

Behavioural Guidelines: I also thought there was a lack of information to guide staff on how to specifically deal with the oppositional behaviours that [Mr A] is capable of engaging in, for example, refusing to shower, refusing medication, refusing to eat, hitting out. There were nominal instructions to guide staff on how they should manage and these were written in a somewhat basic way. It would be worth considering having the RN Health advisor or a behavioural specialist complete more detailed behavioural guidelines which would provide clear guidance to staff as to how to deal with specific difficult/behavioural presentations.

Change in Presentation: [Mr A] had a noticeable change in attitude about attending the respite care facility with related behaviour changes. These were a flag that something was not right. There didn't appear to be attention paid to the message he was signalling. It would have been appropriate for this to be discussed at a team meeting.

Please comment on the appropriateness of [Mr C's] care of [Mr A] in May 2010. Please provide your advice in the alternative here:

(a) If you were to believe [Mr C's] statement in relation to this incident
In relation to the incident on the 16th May 2010, it is my opinion [Mr C's] conduct towards [Mr A] was not consistent with an acceptable level of care — it was disrespectful, inappropriate and was technically assaultive in nature. It was not consistent with the organisation's policy and practices.

It was appropriate for [Mr C] to point out to [Mr A] in a respectful and educative manner that sneezing without covering your mouth is undesirable. If [Mr A] was receptive (given that he had a tendency to be unreceptive this would have to be carefully assessed) [Mr C] could have gone on to demonstrate how to do this — using his own hand and mouth for demonstration purposes. There was no need for [Mr C] to take [Mr A's] hand and physically move it to his face and to do so was

antagonistic and not surprisingly appeared to result in unsettling [Mr A]. This first failure of appropriate care was followed by a second failure — once [Mr C] saw that he had upset [Mr A] he should have backed off (the first step in de-escalation in such circumstances), even in the event of [Mr A] hitting him (with it being unclear from the discrepancies in [Mr C's] statements whether this happened or not). Pulling him from his lazy boy chair and pushing him from behind by his shoulders was unnecessary, contrary to restraint policy/guidelines (i.e. there was no safety issue) and constituted assault.

Even though there were deficiencies in [Mr C's] induction training (he stated he had only 'partially' completed his paper work), it would be reasonable to expect that between his two day orientation training (during which time new staff have to 'sign acknowledgment of the Code of Conduct and Duty of Care policy'), partial completion of the workbook, and the time he was employed (and therefore time to read over organisational policies) he would have gained sufficient knowledge and understanding in regards to appropriate and respectful care and the restraint policy.

I therefore do not believe that [Mr C's] conduct towards [Mr A] can be wholly explained through inadequate/partial completion of his orientation training.

In conclusion: Whilst [Mr C] failed to follow organisational policy in relation to expected standards of care in his interactions with [Mr A], it appears that NZCare also departed from their own policies and standards (and therefore from expected external standards as outlined above) regarding [Mr C's] induction and orientation training.

[Mr C's] failure to comply with organisational standards and NZCare's departure from their own organisation's policies and standards for Induction and Orientation training in my opinion resulted in [Mr A] receiving inappropriate care.

In my opinion [Mr C's] departure [from] appropriate care was severe and consistent with misconduct […].

(b) If you were to believe witness Ms E's statements in relation to this incident (including her reportable event and interview with HDC)
If I was to accept Ms E's statement of the events it indicates a more severe level of inappropriate conduct — assaultive/rough handling of [Mr A] by [Mr C]; however, my conclusion would be the same — [Mr C's] conduct was a severe departure from acceptable standards. No client should be subjected to rough handling or assaultive (physical handling not in line with restraint policies) behaviour.

It would have been appropriate to consider a formal complaint of assault in this instance.

Summarised conclusion relating to both incidents
In my opinion, NZCare have good policies, staff induction and training and checks in place which ensure staff are aware of their responsibility. In regard to the

medication errors it was the actions of individual staff members who failed to comply with organisation policy which led to the events under investigation rather than the organisation itself. In regards to the incident with [Mr C] it appears to be a combination of his individual act to disregard organisation policy in conjunction with the organisation departing from its policy regarding his induction training.

Please comment on the adequacy of the changes made by NZCare since these incidents

NZCare have acknowledged their failure in their duty of care to [Mr A] in regard to these events and have apologised unreservedly for this. Their investigation of these complaints appears thorough and consistent with good standards […]. The remedial steps they have put in place (outlined below) are good:

Retraining of staff where there were identified competency issues;

Increasing the Health Advisory role (which is appropriately filled by a registered nurse) who is providing clinical support and advice to managers and CSWs, and reviewing client plans/level of support;

Ensure there is an up-to-date medication sheet signed by the GP for people accessing respite care;

Redevelopment of the education and training programme to ensure it is appropriate for staff working at the Respite Care facilities;

Attaining of [a training grant] which has secured funding for a two day course which covers specialist training appropriate to the area;

Development of the Whistle Blowing policy which is endeavouring to make the reporting of abuse by peers as easy as possible;

Further development of the Family Information booklet to help improve communication with families;

Enhanced IT systems which make communication between house staff and management easier and therefore more timely;

Review of the management team's processes for ensuring appropriate communication with families with changes to enhance.

Do you have any recommendations for improvement?

Medication: Consider putting highlighted flags/reminders on client medication sheets where there are 'risk' issues, for example, on [Mr A's] sheet there could be a highlighted (by way of bright sticker or highlighter pen) reminder that his medications must be given at the same time and at the times stated. This is similar to the highlighting system used on drug charts to show that a person is allergic to a particular medication. [Mr A's] requirement to take his medication at regular intervals and to take all his medications at the same time fall into a risk category that doesn't apply to most drugs.

Family Involvement: The suggestion that […] family members be contacted if a client refuses their medication is a good one. It may not be appropriate for all clients, but the ability to do this could be outlined in each person's individual care plan.

Workbooks: I note from the information provided that completed induction workbooks are placed on staff files. It would make more sense to photocopy these books and place one on the file (as evidence) and give the other one back to staff so they can refer to it as a refresher/reminder.

Staff Training: Review systems in place to monitor staff orientation/induction and training. Consider reporting of this to a high level of management if this is not already the case. This is particularly important when there is a high staff turnover as appears to be the case in these NZCare facilities.

Supporting People with Challenging Behaviour: Having provided opinions before relating to service provision to people with intellectual disability and challenging behaviour, this case once again shows the lack of weight given to training staff on how to manage challenging behaviour. In my opinion it is imperative that staff who are going to be working with clients who have challenging/difficult behaviours, must be trained in behavioural management strategies in the induction period and the course must be provided by suitably qualified health professionals in a formal training package. NZCare in many ways can be commended for their staff training package, but again (as I have seen before) there is not a strong or immediate focus on staff training re dealing with difficult client presentations/challenging behaviours. This type of training cannot occur by staff simply reading policies or talking to a co-worker. If staff do not have the appropriate training in this area they are likely to use their own personal techniques (as was demonstrated by [Mr C] in this incident), which are generally inappropriate. Many people believe that their own personal strategies for managing difficult behaviour in children is appropriate when working with people with an intellectual disability. Only as a result of formal training do they understand the philosophies driving disability services and the legislative requirements they are compelled to work within. Most providers in the Otago area offer a one or two day course on Managing Challenging Behaviour either in the induction period or early on in the staff member's employment. Until staff have done this type of training they should be rostered on with a staff member who has successfully completed the training. This is particularly important in the disability field as many of those applying for work in this area are looking for *any* employment where no qualifications are required. Often the choice to work with people with disabilities is not based on a personal desire to support people with disabilities to have a good quality of life, but rather it offers an employment opportunity that does not require any qualifications. The [training course] will go someway to rectifying this problem if it occurs early on in the staff members' employment.

[Mr A's] Individual Support Plan: As outlined above some further development of the Behaviour section of [Mr A's] care plan by a health professional/specialist would be appropriate.

Limitations
This opinion is based on information provided

Bernadette Päus *RCpN; BN; MHSc, PGDip***.**

Mental Heath & Intellectual Disability Nurse Practitioner"

Appendix B — Relevant provisions of NZCare's contract with Ministry of Health

Ministry of Health Service Specifications for "Out of Family" Respite Services for Adults

Clause 2.1 — Respite services have the following objectives …

To enable people with disabilities to enjoy a positive, meaningful and stimulating experience that replicates the "out of family" experiences of people who do not have disabilities.
…

Clause 5.1.1 — … The provider will have in place an individual plan/care plan for all service users using the service …[which] will cover:
…
- Medication
- Communication and Behaviour supports where appropriate

…

Clause 5.1.2 — The Provider's Risk Management Plan shall address matters such as:
- Staff recruitment and supervision that emphasise the safety of people with disabilities
  …
- Dealing with challenging behaviours — when and how to access support services and when to access NASC for reassessment/review
- Management of crises and incidents — incidents and crisis situations should be documented and reported to primary carers/family/whanau, welfare guardians and designated advocates

  …

Clause 5.1.3 — The Provider will:

- Ensure that communication and behavioural support is addressed in each service user's individual plan/care plan where appropriate
  …
- The Provider will incorporate strategies of individual behavioural support plans to form the basis of upskilling of all staff
- The home has and operates a non aversive policy for managing challenging behaviour which adopts the principle

that a person's freedom should be restricted only for safety reasons
- Restraint procedures will be based on the Standards New Zealand document "Restraint Minimisation and Safe Practice NZS8141: 2001"[31]

Clause 5.3.1

The Provider will be responsible for employing competent staff … The Provider will have sufficient experienced staff to provide a level of service relative to the service user's assessed needs which may include but is not limited to: communication requirements, behavioural support, risk management, intellectual disability, personal cares and social functioning.

Staff training where applicable, which may include but is not limited to:

- General training of caregivers, including, but not restricted to:
- Disability issues — including: values/attitudes; inclusion, empowerment

…

- Communication strategies
- Behaviour support
- Interactions that will enhance the service users self esteem and independence

Clause 8.1

The Provider is required to comply with the Ministry of Health General Contract Terms, the Ministry of Health Provider Quality Specifications and Health & Disability Sector Standards NZS8134: 2001.

In accordance with the Provider Quality Service Specifications other quality indicators will be incorporated as part of your internal evaluation and service development plan.

Clause 8.4

People with disabilities will be cared for in an environment that is safe for them, their primary carers/family/whanau and other people using facilities on the site.

The Provider will have documented policies/protocols for the following aspects of service delivery:

…

- Managing disruptive behaviour in the least restrictive way possible
- Medication administration

[31] These standards were updated in 2008.

Appendix C — Statement from NZCare

"NZCare accepts the findings of the Health and Disability Commissioner in this case. We are very sorry that this has occurred and acknowledge that errors were made. The safety and wellbeing of the people we support is paramount, and in this circumstance we did not deliver the standard of support the client or family should expect.

NZCare is committed to providing quality services to people with disabilities. We believe we have in place a robust policy and procedure framework to ensure that people at all levels of the organisation understand what is expected of them. It is very disappointing when we do not deliver against those standards. When this does happen, we try to put right the wrong if we can and then learn from it so as to continually improve.

We have taken the issues raised in this complaint very seriously and we believe we have taken immediate and appropriate action as required. This action has included … the development and implementation of the following:

- The Family Information Booklet has been developed and implemented throughout NZCare services to help increase communication with clients and families;
- A comprehensive Protected Disclosures policy has been developed and introduced to staff;
- A new Health Advisor (registered nurse) role has been created within [the area] to strengthen our clinical oversight and learning and development for staff. This role has been introduced at our discretion and is not required (or funded) by contractual requirements;
- A review of medication management with a particular focus on non-blister packed medication has been carried out by our clinical governance team, and new procedures implemented accordingly; and
- A comprehensive 2-day specific training has been developed for all staff employed in the Out of Family Respite services. This is compulsory for all new staff and must be repeated every 2 years.

NZCare has apologised to [Mr A] and his family. We take responsibility and are very sorry for any distress that he and his family experienced as a result of his visits with our respite service. Since [Mr A] ceased to access NZCare's service, we have regularly made contact with the local Needs Assessment Service Co-ordination agency to enquire whether there was anything further we could do to support the family or assist in the transition to another provider. We wish him the very best in future."