Disability Service
Community Support Worker, Ms B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00931)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the home-support care provided to a consumer by a home healthcare provider and a community support worker. The consumer fell from the sling of a ceiling hoist while the support worker was assisting him to transfer from his bed to his wheelchair. Following this, the support worker picked up the consumer and returned him to the bed without first calling for assistance or assessing him for injury. When asked by the consumer's mother what had occurred, the support worker was initially untruthful and denied the accident.

2. The report highlights the importance of support workers exercising due care and skill when undertaking manual handling of consumers, and of responding to accidents in a timely and safe manner.

Findings

3. The Deputy Commissioner found that Ms B failed to provide services to Master A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

4. The Deputy Commissioner did not find the disability service in breach of the Code. However, the Deputy Commissioner was critical that the disability service did not report the incident to the Health Quality and Safety Commission as its policies required.

Recommendations

5. The Deputy Commissioner recommended that Ms B undertake further training in moving and handling, hoist use, and first aid.

6. The Deputy Commissioner recommended that the disability service report the accident to the Health Quality and Safety Commission, and that the disability service provide HDC with confirmation and evidence of the steps for improvement it identified in response to the accident.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her son, Master A, by Ms B and a home healthcare provider (the disability service). The following issues were identified for investigation:

- *Whether Ms B provided Master A with an appropriate standard of care in 2020.*
- *Whether the disability service provided Master A with an appropriate standard of care in 2020.*

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

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

9. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer's mother
Ms B	Provider/community support worker
Disability service	Group provider

10. Further information was received from the district health board.

Events leading up to complaint

Background

11. This report concerns the care provided to Master A by community support worker Ms B, and the disability service, on 25 May 2020. On this date, Master A fell from the sling of a ceiling hoist while Ms B was transferring him from his bed to his powerchair.

Master A

12. Master A (in his early teens) has complex disability, including physical and cognitive impairment, epilepsy, and brittle bones. Master A uses minimal verbal communication but is able to verbalise pain and nausea. He is unable to weight bear through his legs and requires full assistance for mobility, including full hoist transfers in and out of his power wheelchair, commode, and bed.

13. Master A lives at his home with his parents and two younger siblings.

The disability service

14. The disability service provides services across New Zealand to consumers with complex health needs. It has been delivering services to Master A in his home since July 2017. The funder of these services is the Ministry of Health. In the time leading up to the events, the disability service was providing Master A with 30 hours of support per week, including morning shifts on school days to provide morning cares and prepare Master A for school, as well as afternoon shifts to assist Master A with meals, provide hygiene cares, and prepare him for bed.

Ms B

15. Ms B commenced employment as a community support worker with the disability service in 2019. She had completed a postgraduate diploma in Health Science in 2019. At the time of events, Ms B had been caring for Master A for approximately 11 months, providing 12 hours of regular support per week with additional hours when required.

Accident on 25 May 2020

16. At 8.15am on 25 May 2020, Ms B arrived at Master A's home to provide morning cares and prepare him for school. Her tasks that morning included providing hygiene cares, getting Master A dressed, and assisting him to transfer from his bed to his wheelchair using a ceiling hoist.

17. Mr and Mrs A were both working from home that day, in another part of the house. In an email to the disability service dated 27 May 2020, Mrs A described that at approximately 8.30am Master A's siblings told her that Master A was crying, and she went into Master A's room and saw that he was on his bed and appeared upset. Mrs A asked Ms B what had happened. Ms B advised that nothing had happened and that she had been rolling Master A over and Master A had thought that she had dropped him. Mrs A joked with Master A and reassured him that nothing had happened and she left the room.

18. Mrs A told the disability service that she returned to Master A's bedroom a few minutes later as Master A continued to cry and was saying that he "fell down". Mrs A reassured Master A again but he continued to cry. At this point, Ms B told Mrs A that Master A had fallen from the sling of the hoist during transfer from the bed to his wheelchair. In the Accident, Incident or Near Miss Report Form dated 25 May 2020 (the accident report) Ms B stated:

> "[Mrs A] came [into] the room & I just got scared & told her that he was just scared that I will make him fall. [B]ut after a while I thought to tell her the truth so I told her the whole story that he had a fall from the sling."

19. Mrs A told the disability service that she asked Ms B from what height Master A had fallen and how he had landed. Mrs A stated that Ms B indicated that Master A had fallen from a height of approximately half a metre from the ground, and said that Master A had landed sitting down. Mrs A questioned the latter as Master A is not able to sit unsupported, and Ms B then told her that Master A had landed on his back. In the accident report, Ms B described that she "[p]ut on the sling & while transferring him from bed to powerchair somehow he had a fall on the floor on his back".

20. Mrs A told the disability service that she then asked Ms B how Master A came to be on the bed, and that Ms B advised that she had picked Master A up from the floor and placed him on the bed. In the accident report, Ms B describes "[m]anual lifting done by me" after Master A had fallen from the sling on to the floor.

21. Mrs A then called Mr A into the room and he checked Master A's neck, shoulders, and hands and found that Master A's elbow was "crackling". Mrs A called emergency services while Mr A asked Ms B for details of the fall. Mr A told HDC:

> "I asked [Ms B] exactly what happened and she said [that] she [could not] remember exactly what [or] how it happened but she only said [Master A] fell off the hoist sling and [Ms B] quickly picked him up and put him back on [the] bed."

22. Ms B called the disability service to notify it of the accident while the family waited for the ambulance service to arrive. An ambulance arrived and ambulance personnel assessed Master A. He was alert and appeared well and comfortable with normal breathing, and he "[d]id not hit his head, no LOC,[1] nil seizure activity".

[1] Loss of consciousness.

23. The ambulance took Master A to hospital, where he was assessed and examined. Master A was found to be alert and interactive with no external evidence of head injury. He was diagnosed with a broken left elbow and underwent surgery on 27 May 2020.

24. During his hospital admission, Master A experienced increased seizure activity and intermittent vomiting, which were thought to be because of his increased pain levels. By 30 May 2020, Master A's vomiting seemed to have stopped, and he was discharged home that day.

Disability service internal review following accident

Interviews

25. Following the accident on 25 May 2020, the disability service held three interviews with Ms B to determine the cause of the accident. The interviews were held on 26 May 2020, 30 June 2020, and 22 July 2020.

26. The interview notes from the initial interview on 26 May 2020 record:

> "[Ms B] said she dress[ed] [Master A] up and put the sling o[n]. She cross[ed] the sling as [she] was told and put the Blue on top and Gray on the bottom of the sling to the hoist, she said it looked okay and she lifted [Master A] holding his legs and suddenly [Master A] fell on the floor from the hole where his buttocks [were].
>
> She said she got scared and picked [Master A] up on the bed when [Mrs A] came on first instance she didn't inform her but she said when she came second time she felt guilty and inform the mum what happened.
>
> She also mentioned that the sling was not very appropriate with [Master A] as Mum has mentioned this."

27. The interview notes continue:

> "Feedback [from Client Services Manager]
>
> Its seems … that [Ms B] could have lifted [Master A's] leg [a] bit too high and he might have [slid] into the hole, it could be also the clothes he was wearing could be very slippery.
>
> Also potentially it seems that [the] sling was placed on [a] sitting position which might be not very suitable for [Master A]."

28. The interview notes from the second interview on 30 June 2020 record that Ms B reported that she had put the sling on Master A, connected the hooks onto the sling, and hoisted Master A above the bed. Ms B reported that she then held Master A by his legs to guide him toward his wheelchair, at which point he "just fell down". She believes that the straps of the sling were not loose, as Master A had not fallen when he was hoisted above the bed initially. The interview notes further record that Ms B acknowledged that she did not tell Master A's parents about the accident initially "for 2–3 seconds then told the truth as was wrong not

to". When asked whether she would have done anything differently in hindsight, Ms B indicated that she would not lie again and regretted that she had broken Mrs A's trust.

29. The interview notes from the third interview on 22 July 2020 record that prior to the interview, the disability service had consulted a "[p]hysiotherapist and other specialists of the hoist", and had been advised that if the sling is used correctly it is not possible for a hoist user to fall from the hoist. The disability service told HDC that these consultations were carried out over the telephone, and there is no written record of the conversations. The interview notes also record that following the accident, healthcare equipment suppliers inspected the sling and ceiling hoist in Master A's home and reported that the equipment was in good working order with no faults. The disability service told HDC that this communication was also carried out over the telephone.

30. The interview notes from 22 July 2020 record that the disability service advised Ms B of the information received from the physiotherapist and the hoist specialists and asked Ms B for comment as to how Master A may have fallen off the sling. Ms B responded:

> "[I] just don't know, [Master A] just fell down. Everything, hooks were on over bed. He was in a [seated] position over bed in the sling. Pulling him to wheelchair and fell from sling. He fell on his back, didn't check how and I picked [Master A] up … If the hooks were not done properly he would [have] slipped on bed only."

31. Ms B advised that she did not have any further information to add.

32. In a letter dated 2 July 2020, the disability service advised Mrs A that the outcome from its initial investigation was that her complaint was upheld and Ms B had been removed from Master A's service. The disability service further advised that Ms B had been interviewed and had been unable to give a full account about how the accident happened. The disability service noted that it had sought advice about whether the equipment may have been used incorrectly, and had been told that if the loops were not attached to the bar correctly, a fall may occur. The disability service was unable to determine whether that had happened in this case. Ultimately, the disability service was unable to determine the cause of the accident.

33. Following the final interview with Ms B, the disability service confirmed the above outcome in a letter to Mrs A dated 24 July 2020.

Training and competencies

34. As part of the disability service's internal investigation into the accident, Ms B's competencies were reviewed and found to be current.

35. The disability service provided HDC with copies of Ms B's induction and training records. These show that Ms B completed the disability service's pre-induction learning on 19 June 2019, and completed a one-day induction on 25 June 2019. The "[Disability service] Induction Programme Checklist" dated 25 June 2019 records that as part of her induction, Ms B received training on several topics, including the Code of Conduct, Complaints and

Incidents, and Client Rights. She also completed an example Accident, Incident or Near Miss Report Form.

36. The training records also show that Ms B's training and competency assessment for moving and handling was current at the time of the accident on 25 May 2020, having been completed on 9 July 2019. This training is to be refreshed every two years.[2]

37. The disability service provided HDC with a copy of its training materials for moving and handling. These include a section on "Management of a client who has fallen", which sets out that staff should take the following action when faced with a client who has fallen:

> "• Check the area for anything that may present a hazard.
>
> • Ask the person if he or she is having any trouble breathing or if anything hurts.
>
> • If the person appears to be unwell or injured, call for medical assistance.
>
> …
>
> • Make the person as comfortable as possible, keep them warm, and stay with them to wait for medical assistance to arrive. Follow any instructions given by the emergency services."

38. The training materials for moving and handling also contain a hyperlink to the St John first aid video library,[3] which contains instructional first aid videos for home-based carers. The video titled "Assisting with a patient who has fallen" states that if the person who has fallen cannot get up on their own, carers should help the person to be as comfortable as possible where they are and should not hesitate to call for assistance.

39. The moving and handling competency assessment form dated 9 July 2019 records that as part of this assessment, Ms B "[d]emonstrated safe and correct transfer of client using hoist" and "[d]iscussed processes for incident reporting [and] [e]quipment maintenance and safety".

40. The disability service told HDC that the ceiling hoist that was used on 25 May 2020 had been newly installed on 11 May 2020, although it is apparent from Master A's service plan that he had been having full hoist transfers since at least January 2019. As Master A's service plan provided for him to have one support worker per shift, it appears that these hoist transfers were being performed by one worker alone. The disability service was unable to comment on the reason for the new hoist, and advised that the assessment, trial, and application for the new hoist was carried out by an occupational therapist from the district health board. The disability service advised that Ms B had received specific training in the use of the new hoist at Master A's home on 11 May 2020, and had been assessed as competent in its use. Ms B confirmed to HDC that she had undertaken this training, and stated that afterwards she had felt confident in performing transfers using the hoist.

[2] As specified in the disability service's Moving and Handling policy.
[3] https://www.stjohn.org.nz/first-aid/first-aid-library/carers-nz-video-library/

Incident reporting

41. The disability service provided HDC with a copy of its Client Accident, Incident and Near Miss Management policy (Incident Management policy), which provides the processes and procedures required following an accident, incident, or near miss. The Incident Management policy sets out the Severity Assessment Code (SAC) ratings in Figure 1 (see Appendix A). A SAC is a numerical rating that defines the severity of an adverse event and, as a consequence, the required level of reporting and investigation to be undertaken for the event.

42. The disability service also provided HDC with a copy of the accident report that was completed by Ms B on 25 May 2020. The accident report records that the accident was rated with a SAC of 3 (moderate severity). Appendix 3 of the Incident Management policy contains the District Health Board and Ministry of Health Risk Assessment Guidelines and Process (see Appendix B), which sets out the reporting process required for each level of the SAC system. A SAC3 event requires the disability service to report the event to the DHB funder immediately only if there is potential media interest, and to include the event in the quarterly report to the DHB funder.

43. The disability service provided HDC with two Quality Assurance (QA) Detail reports, which set out the actions taken in the disability service's internal investigation into the 25 May 2020 accident. The first report records on 25 May 2020: "funder notified". A subsequent QA Detail report documents that the incident risk rating was raised from moderate severity (SAC3) to major severity (SAC2) on 24 June 2020, because the disability service had been advised that Master A had been re-admitted to hospital for ongoing concerns about his health[4] and escalation to the funder. Appendix 3 of the disability service's Incident Management policy provides that a SAC2 event requires the disability service to:

> "• Complete a Reportable Events Brief to be sent to the Health Quality and Safety Commission (HQSC) within 15 working days, and
>
> • Notify the DHB funder of the event within 3 working days or immediately if there is potential media interest."

44. The requirement to complete and send a Reportable Events Brief to HQSC is set out in the HQSC's National Adverse Events policy 2017.[5] This policy supports a national approach to reporting, review, and learning from adverse events and near misses for the purpose of contributing to improved quality, safety, and experience of health and disability services. The policy also sets out the SAC rating and triage tool described above and contained in Appendix A of this report.

[4] Master A's Client Notes record that he was re-admitted to hospital for concerns about continued vomiting and diarrhoea on 11 June 2020 and 30 June 2020.
[5] Available on the Health Quality and Safety Commission website at: https://www.hqsc.govt.nz/resources/resource-library/national-adverse-events-policy-2017/

45. In a letter from the disability service to Mrs A on 2 July 2020, the disability service explained that the NASC[6] was notified of the accident immediately after it occurred. The disability service noted on further review that due to the nature of Master A's injury, the notification also should have been sent to the Ministry of Health as the funder of Master A's services, and acknowledged that it was a mistake to record the notification to the NASC as notification to the funder. The disability service advised that its process has been reviewed, and that staff have been advised of the notification pathway to ensure that the Ministry of Health is consulted earlier.

46. The disability service provided HDC with a copy of its notification of the accident to the Ministry of Health dated 23 June 2020. The disability service told HDC that a Reportable Events Brief was not sent to HQSC as the accident was being investigated by the Ministry of Health.

Further information

Master A

47. Due to Master A's cognitive impairment and limited speech, HDC did not seek comment from him about the accident.

Mrs A

48. Mrs A told HDC that Master A suffered from ongoing vomiting for approximately six weeks following the accident, and she was concerned that Master A may have hit his head when he fell. She stated that clinicians could not determine the cause of Master A's vomiting, and that he continues to require medication for this issue. Mrs A also told HDC that unfortunately Master A has not regained the use of his left arm since the accident. She remains frustrated and disappointed that she still does not know how the accident occurred.

Ms B

49. Ms B told HDC that she considered making changes to her practice following the accident, but that this was difficult as she does not know how the accident happened. She reiterated her account of the accident, which was consistent with the information she provided to the disability service in her interviews on 30 June 2020 and 22 July 2020. Ms B also noted that as someone else took the sling off the hoist following the accident, she was not able to check whether the hooks of the sling had been attached properly. She told HDC: "My biggest mistake was that I picked up [Master A] from the floor and put him back on bed and did not tell [his] parents."

50. Ms B told HDC that she does not believe that Master A hit his head when he fell. She also expressed that she cared for Master A a great deal and thinks of him every time she uses a hoist with other consumers. Ms B asked HDC to tell Mrs A that she is very sorry about the accident.

51. Ms B told HDC that she continues to work as a support worker with a new employer, and has not received any further training on moving and handling or hoist use since the accident.

[6] Provides needs assessment and support coordination services. It is funded by the Ministry of Health.

Disability service response to accident

52. The disability service provided HDC with copies of emails between the disability service and the Ministry of Health from 21–27 July 2020. The emails outline several actions that the disability service had taken in response to the accident, including:

- Reviewing and improving processes and practices with regard to the use of hoists, and the appropriate action when dealing with an incident/accident;
- Strengthening training on hoist management for support workers; and
- Reviewing and updating the Incident Management policy with respect to the requirements and expectations of reporting incidents to the disability service's funders.

53. The disability service told HDC that as part of its response, the accident was also reported to the Health and Safety Committee, which was asked to:

- Review the understanding of support workers regarding the actions to be taken in any emergency, and in particular in the event of a fall;
- Communicate the key message to stop and assess before acting; and
- Gather feedback from staff about whether they require further training or process clarification.

Responses to provisional decision

Mrs A

54. Mrs A was given an opportunity to comment on the "Events leading up to complaint" section of the provisional report. Some of her comments have been addressed separately, and her remaining comment is summarised below.

55. Mrs A noted that the hoist training provided to Ms B by a DHB occupational therapist on 11 May 2020 (described in paragraph 40 of this report) was arranged by her, not by the disability service. Mrs A queried whether the disability service would have arranged appropriate training if she had not done so.

Ms B

56. Ms B was given an opportunity to comment on the provisional report. Some of her comments have been integrated into this report, and the remainder are summarised below.

57. Ms B denies that initially she told Mrs A that Master A had landed in a sitting position (as described in paragraph 19 of this report). Ms B told HDC that at all times, she told Mrs A and the disability service that Master A had landed on his back.

58. Ms B confirmed that the "crackling" of Master A's elbow was first heard when Mr A assessed Master A for injury after Ms B had placed him on the bed.

59. Ms B advised that currently she is on leave from work, and will not return until at least April 2023. Accordingly, she requested an extension of time in which to complete the recommendation set out in paragraph 8080 of this report.

Disability service

60. The disability service was given an opportunity to comment on the provisional report, and advised that it accepted the report and had no further comment to make.

Opinion: Ms B

Introduction

Facts unable to be resolved

61. I acknowledge that Master A and Mrs A have experienced ongoing challenges following Master A's fall and the loss of function in his left arm. The concern about his vomiting is also extremely distressing. I note that one of Mrs A's aims in submitting her complaint to HDC is to understand how the accident occurred and how Master A landed when he fell. This would inform Master A's family and carers about how to avoid a similar accident re-occurring, and may also inform Master A's clinicians as to a treatment plan for his ongoing vomiting. While Mrs A's desire for this information is entirely understandable, my role is limited to assessing the quality of care Master A received, and I am unable to comment on whether Master A's vomiting was caused by the fall.

62. Unfortunately, based on the evidence available, I am also unable to make a finding as to exactly how the accident occurred or whether Master A hit his head when he fell. While I appreciate that this will be disappointing for Mrs A, I note that both the disability service and HDC have given Ms B several opportunities to explain what happened, and I do not consider that further investigation will shed any more light on the matter.

63. Despite the above, I still have concerns about the care Ms B provided to Master A, which I discuss below.

Care and skill — breach

Transfer

64. I acknowledge that Ms B has consistently said that she used the hoist and sling as she was instructed, including that she hoisted Master A above the bed first to test that he was held by the sling securely. She maintains that Master A's fall was an unexplainable accident. However, the advice provided to the disability service from its hoist specialists is that it is not possible for a hoist user to fall from the sling if the equipment is used correctly. Given the purpose of hoists and the importance of user safety, I am inclined to accept this advice. The hoist had been newly installed two weeks prior to the accident. I note that the equipment suppliers checked the equipment after the accident and found it to be in working order. I am unable to accept the suggestions put forward by the Client Services Manager about how the accident happened, as they are too speculative.

65. Overall, the available evidence does not support Ms B's claim that Master A fell from the sling due to an unexplainable accident.

66. While I am unable to determine how the accident occurred, it remains that Ms B was responsible for moving and handling Master A with reasonable care and skill, which in this case involved transferring him from his bed to his wheelchair, and it is clear that this transfer was unsuccessful. I also note that one of the primary purposes for developing and using moving and handling care plans, including the use of hoists, is to reduce the risk of injury to workers and healthcare clients.[7] While I acknowledge that accidents can happen despite all safety protocols being followed, in this case I consider that the incidence of the fall itself demonstrates that Ms B did not exercise reasonable care and skill when she attempted to transfer Master A from his bed to the wheelchair on 25 May 2020.

Actions taken after accident

67. Ms B admits that she manually lifted Master A from the floor onto the bed after he fell from the sling, without first assessing him for injury. I find this very concerning, particularly in the context of Master A's brittle bones condition and Ms B's report that he fell onto his back. Ms B also acknowledges that she did not immediately disclose the accident or call for assistance following the fall, or disclose the accident when asked about the reasons for Master A's distress.

68. The moving and handling training that Ms B underwent states that appropriate management for a client who has had a fall is to first check the area for hazards, then assess whether the person is unwell or injured and, if so, call for medical assistance. The St John instructional video for "Assisting with a patient who has fallen" also outlines that if the person who has fallen cannot get up on their own, carers should not hesitate to call for assistance. I note that Master A is reported as having cried following the fall, which should have warned Ms B that Master A may have been in pain and needed to be checked for injury. Accordingly, I consider that following Master A's fall, Ms B should have called for assistance from Master A's parents immediately and assessed him for injury. Had this occurred, it would have been clear that he was injured (as became apparent when Mr A examined Master A), and that emergency services should be called for assistance and instruction before moving him. I am critical that this basic principle of first aid was not followed, and note that this delayed the call to emergency services and transfer to hospital. I acknowledge that Ms B has reflected on this aspect of her care and recognises that she should not have moved Master A after the fall.

Conclusion

69. In summary, I consider that Ms B failed to provide services to Master A with reasonable care and skill because:

- It is more likely than not that Ms B did not use the hoist correctly, resulting in Master A falling;

[7] https://www.worksafe.govt.nz/topic-and-industry/health-and-safety-in-healthcare/moving-and-handling-people-in-the-healthcare-industry/

- After the fall, Ms B manually lifted Master A from the floor to the bed without first assessing him for injury. This could have compromised any injuries sustained by Master A; and
- Ms B did not immediately disclose the accident to the family and/or call for assistance, which delayed the call to emergency services and transfer to hospital.

70. Accordingly, I find Ms B in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[8]

Communications with family — adverse comment

71. I note that Ms B's communications with Mrs A following the accident did not comply with the Incident Management policy, which states that clients and whānau are entitled to truthful and open communication at all times following an incident. Ms B acknowledged that initially she was untruthful when Mrs A first asked her what had happened, and explained that she was scared and panicked. I note that Mrs A has said that even after Ms B told her that Master A had fallen, Ms B provided inconsistent descriptions of how he landed. I acknowledge that in her response to my provisional decision, Ms B denied that initially she told Mrs A that Master A had landed in a sitting position, and maintains that at all times she told Mrs A and the disability service that Master A had landed on his back. I am unable to determine what Ms B initially told Mrs A about how Master A landed. However, it is clear that Ms B's initial untruthfulness led to a breakdown in trust and, in light of this, it is understandable that Mrs A would feel that Ms B may still not be providing a fulsome account about how the accident occurred or how Master A landed when he fell. While I am critical of this aspect of Ms B's care, I understand the reasons for her initial dishonesty and I am reassured that she did report the accident in the minutes afterwards.

Opinion: Disability service

Training and competency assessment — no breach

72. As a healthcare provider, the disability service is responsible for providing services in accordance with the Code. I am satisfied that the disability service met its obligations to provide Ms B with adequate training and assessment for moving and handling (including management of a client who has fallen and hoist use) and incident reporting. The disability service's records show that Ms B's training and competency for moving and handling was current at the time of the accident. It is also evident that Ms B had received training in the use of the ceiling hoist in Master A's home two weeks before the accident, and had been assessed as competent in its use. Ms B confirmed to HDC that she had received this training and had felt confident in transferring Master A using the hoist.

73. In her response to my provisional report, Mrs A clarified that she had arranged the hoist training provided by the occupational therapist on 11 May 2020. I note that this is not in

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

dispute, and I am unable to speculate on what training the disability service may have arranged if Mrs A had not arranged this training. I consider that it was reasonable for the disability service to rely on the training that had been arranged by Mrs A to satisfy itself that Ms B and Master A's other support workers had received adequate training in the use of the new ceiling hoist.

74. Accordingly, I accept that the disability service had systems in place to ensure adequate training and competency assessments for those performing hoist transfers for Master A, and that in this case Master A's fall during the hoist transfer was caused by Ms B independently.

Risk assessment — no breach

75. I note that the disability service has advised that an occupational therapist carried out an assessment and application for the ceiling hoist that was installed on 11 May 2020. I consider that it was reasonable for the disability service to rely on this assessment to satisfy itself that it was appropriate for Master A to be transferred with the use of this hoist. Further to this, Master A's 2019 service plan indicates that he had been having full hoist transfers since at least January 2019, and that these transfers were being performed by one support worker at a time. I am satisfied that there is no indication that it was not appropriate for this to continue with the new hoist.

Report to Health Quality and Safety Commission — adverse comment

76. I am critical that the disability service did not complete and send a Reportable Events Brief to HQSC. The Incident Management policy is clear that an SAC2 event must be reported to the Ministry of Health and HQSC. The two entities perform separate functions and processes, and notification to one cannot be treated as notification to the other. In failing to send a Reportable Events Brief to HQSC, the disability service did not comply with its Incident Management policy and did not meet the requirements of HQSC's National Adverse Events Reporting policy.

77. HQSC's national adverse events reporting system plays an important role in enhancing consumer safety by learning from adverse events and near misses that occur in health and disability services. The system relies on providers of these services making accurate and timely reports of all adverse events and near misses to form a complete picture of the types and frequency of events and to facilitate national learning. I ask the disability service to bear this in mind and ensure that in future it meets its obligations under HQSC's National Adverse Events Reporting policy, including to notify HQSC of serious adverse events in a timely manner and provide HQSC with findings and recommendations from review of these events.

Report to Ministry of Health — educative comment

78. I am mildly critical that disability service staff do not appear to have understood the pathway for notification of the accident to the funder of services. The disability service admits that it recorded its notification to the NASC on 25 May 2020 as notification to the funder, due to an apparent misunderstanding that the NASC was the funding body of Master A's services. I am nevertheless reassured that the disability service identified this issue during the course

of its internal investigation and advised that consequently it took steps to review and clarify its process and advise staff of the notification pathway.

79. I do not consider there to have been a delay in the disability service's notification of the accident to the Ministry of Health. I note that initially the accident was rated as a SAC3 event, which did not require separate notification to the funder at that time. I note that the QA Detail report records that the SAC rating was elevated from SAC3 to SAC2[9] on 24 June 2020, and the disability service notified the Ministry of Health of the accident on 23 June 2020.

Recommendations

80. I recommend that Ms B undertake further training in moving and handling, hoist use, and first aid. She is to contact HDC by 30 April 2023 to confirm whether she has returned to work, and is to provide evidence of the recommended training to HDC within six months of the date of her return to work.

81. I recommend that the disability service provide HDC with an update and evidence of the following steps it advised the Ministry of Health and HDC that it had taken or intended to take after this accident:

a) A review of processes and practices with regard to the use of hoists and the appropriate action when dealing with an incident, and amendment as required to ensure that processes and practices align to current sector best practice.

b) A review of training on hoist management for support workers, and amendment as required to ensure that training aligns with current sector best practice.

c) A review and update of the Incident Management policy with respect to the requirements and expectations of reporting incidents to the disability service's funders.

d) A review of its support workers' understanding regarding the actions to be taken in an emergency, and in particular in the event of a fall, and communication of the key message to stop and assess before acting.

e) Gathering of feedback from staff about whether they require further training or process clarification, and any steps taken in response to that feedback.

This update and evidence is to be provided to HDC within six months of the date of this report.

82. I recommend that the disability service complete a Reportable Events Brief for the 25 May 2020 accident and send this to the Health Quality and Safety Commission within 15 days of

[9] An SAC2 event requires notification to the funder within three business days of the event being reported to the provider.

the date of this report. Evidence of this is to be provided to HDC within six months of the date of this report.

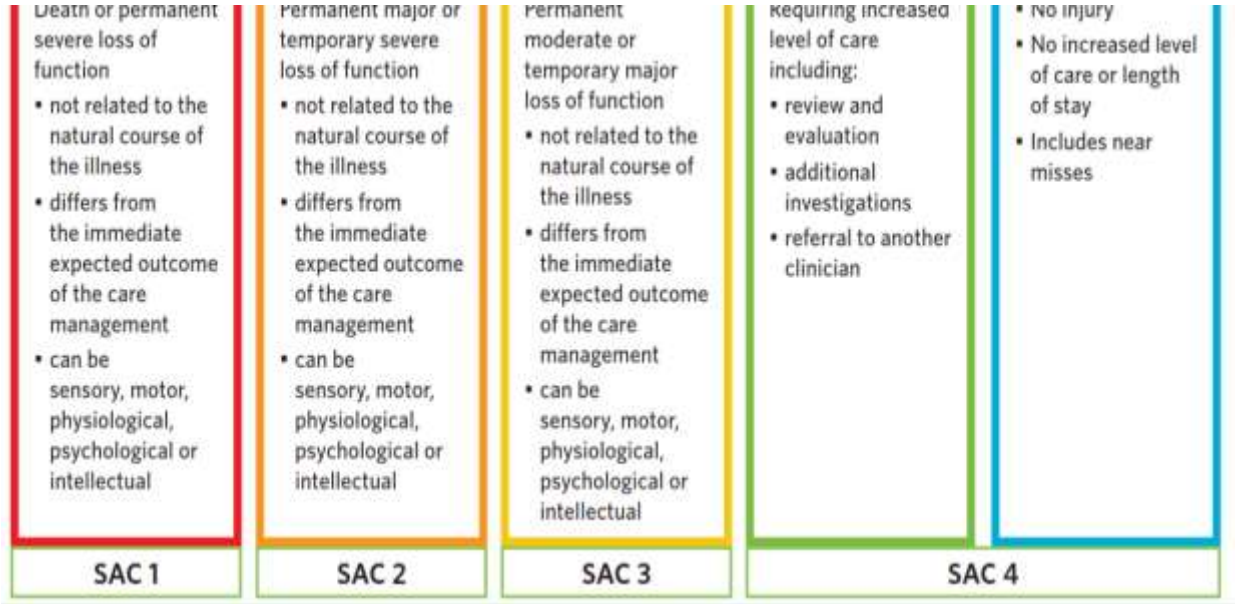
Follow-up actions

83. A copy of this report with details identifying the parties removed will be sent to the Ministry of Health.

84. A copy of this report with details identifying the parties removed will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Incident Management policy (Severity Assessment Code)

Figure 1 of the disability service's Client Accident, Incident and Near Miss Management policy sets out the Severity Assessment Code (SAC) scores for accidents, incidents or near misses:



Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: District Health Board and Ministry of Health Risk Assessment Guidelines and Process

Appendix 3 of the disability service's Client Accident, Incident and Near Miss Management policy sets out the reporting requirements for events by Severity Assessment Code (SAC):

Severity Assessment Coding (SAC) and Reporting Process	
SAC4	Low Risk • Action required as per your organisational policy • May include in report to funder if considered relevant e.g. health sector issue or learning
SAC3	Medium Risk • Action required as per your organisational policy • Report to DHB funder if there is potential media interest immediately • Report in quarterly report to DHB funder
SAC2	High Risk • Action required as per your organisational policy • Complete Reportable Events Brief (REB) Part 1 and send to HQSC within **15 working days** • Notify DHB funder by phone or email within **3 working days** or report immediately to DHB funder if there is a potential media interest • Report in quarterly report to DHB funder
SAC1	Extreme Risk • Immediate action required as per your organisational policy • Complete Reportable Events Brief (REB) Part 1 and send to HQSC within **15 working days** • Notify DHB funder by phone or email within **24 hours** or report immediately to DHB funder if there is a potential media interest • Record in quarterly report to DHB funder