IDEA Services Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 15HDC01145)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr B entered IDEA Services Limited's (IS's) residential service in July 2013. He has intellectual, physical, and developmental impairments and is dependent on others for his care.

2. Mr B's transition plan from school to the IS vocational and residential service, dated 29 April 2013, records: "[Mr B] is extremely vulnerable to any harm —physical, emotional occupational." The plan notes that Mr B needed full support while out in the community because of his blindness, and that he became lonely and could become "extremely frustrated" and lash out when frustrated.

3. In July 2013, Mr B entered an IS Residential Service care facility. He was assessed by a Needs Assessment and Service Coordination (NASC)[1] as requiring a "very high" level of support.

4. IS said that a safety plan/risk management plan (RMP) is put in place for significant risks to a person. IS provided HDC with an undated RMP for Mr B, which IS said was developed on 21 July 2013. This two-page document, containing three columns, records "current" risks (physical aggression and self-harm), risk triggers, and a management plan (prevention, intervention, crisis). The plan was not updated during the two years of Mr B's residency with IS. However, IS said that a safety plan was formulated on 29 January 2015 and updated on 6 May 2015. IS said that a safety plan is equivalent to a risk management plan. The RMP and safety plan do not refer to risks from other service users, and include only the risks of Mr B becoming physically aggressive and self-harming.

5. Mr B lived with another resident, Mr A, who is also intellectually disabled. IS told HDC that Mr A has ongoing issues with exposing himself to others and spitting and, less frequently, masturbating in front of others.

6. Between 2013 and January 2015, incidents involving Mr A exposing his genitals in front of Mr B, and incidents whereby Mr A had physically assaulted Mr B were recorded in incident reporting forms but were not followed up at the time. Following a physical assault on Mr B by Mr A in January 2015, Mr B went home for several weeks before being relocated to another IS place of residence.

7. In March 2015, Mr B became acutely unwell and was transferred to hospital by ambulance. He underwent a laparotomy, and a plastic surgical glove was located in his bowel. The plastic glove had caused an infection, and Mr B required a temporary loop colostomy. An independent review commissioned by IS could not determine who inserted the glove, or when or where it was inserted, but reached the conclusion that the glove was most likely inserted by a third party as a result of a sexual assault.

[1] The NASC organises Ministry of Health funded disability support services for people under 65 years of age who live in the region. It is responsible for assessing the level of support to be funded and provided to eligible users.

8. In July 2015, Mr B suffered burns as a result of spilling a staff member's hot drink, which had been left within his reach. Following this incident Mr B was removed from IS's care by his mother, and he now lives at home with her.

Findings

9. IDEA Services Limited failed to update Mr B's RMP plan, failed to identify risks sufficiently and put in place prevention strategies, failed to ensure that sufficient trained staff were on duty at all times, placed Mr B with another resident who exhibited inappropriate behaviour towards him, and moved him to an unfamiliar residence following another resident's violent behaviour. In addition, IS did not have in place policies and training to reinforce to staff that hot liquids should never be left in a manner that could put service users at risk, and IS staff did not manage incident reporting adequately. Noting the above, it was found that IS failed to provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code.

10. Criticism was made in relation to SW D's failure to recognise that it was unwise to leave a hot drink in a place where an intellectually impaired, blind client might be able to access it.

Recommendations

11. It was recommended that IS complete the following actions

a) Commission an independent review of:

i. the effectiveness of changes made to the service in light of the events highlighted in this report;
ii. the personal plans and risk management plans for each client in an IDEA Services Limited Residential Service care facility in the region to ensure that each has been reviewed and updated appropriately and contains clear information specific to that person. If the review identifies deficiencies, the review should extend to a random audit of clients in IDEA Services Limited Residential Service care facilities throughout New Zealand; and
iii. ongoing training needs of support workers, including in the area of first aid

and report back to HDC on the actions taken in response to this review.

b) Conduct an audit, over a three-month period, of compliance with incident reporting procedures and timelines.

c) Report on progress with the introduction of the electronic delivery system and evaluate the effectiveness of the system.

12. It was also recommended that IDEA Services Ltd provide Mr B and his family with a written apology for the failings identified in this report.

Complaint and investigation

13. The Commissioner received a complaint from Ms C about the services provided by IDEA Services Limited (IS) to her son, Mr B. The following issue was identified for investigation:

The appropriateness of the care provided by IDEA Services Limited to Mr B between December 2014 and July 2015.

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

15. The parties referred to in the report include:

Mr B	Consumer
Ms C	Complainant, mother of consumer
SW D	Provider/support worker
IDEA Services Limited	Provider
District Health Board	Provider

Also mentioned in this report:

Ms E	Service Manager
Ms F	Service Manager
Ms G	On-call manager
Ms H	Service Manager
SW I	Support worker
Dr J	Surgeon
Ms K	Clinical psychologist
Mr L	Service Manager

16. Information was also received from the Ministry of Health.

17. Independent expert advice was obtained from a registered nurse, Dr Frances Hughes (**Appendix A**).

Information gathered during investigation

Mr B

18. Mr B, aged 22 years at the time of these events, has Smith-Magenis syndrome[2] (SMS) and has complex support needs. He is blind and is partially deaf in one ear.

[2] SMS is a genetic disorder with features including intellectual disability, facial abnormalities, hearing and vision abnormities, difficulty sleeping, and numerous behavioural problems, such as self-harm. SMS is a rare condition that affects approximately 1 in 15,000–25,000 people.

19. Mr B also has attention deficit hyperactivity disorder (ADHD)[3] and sometimes has periods of challenging behaviour, including self-injury (head-banging and biting) and harm to others. His mother, Ms C, said that Mr B communicates using very short sentences, usually in question form, and his "understanding of verbal language is very basic but [he] is quite an intuitive young man when it comes to other people".

20. Until the age of 20 years, Mr B lived at home with his mother. As part of his transition from school, he attended a vocational service provided by IS.

IDEA Services Limited

21. IS provides services within New Zealand. In 2013–2015, IS had "around 5,500 staff working to support 7,000 people in [IS]".[4] IS is principally funded through the Ministry of Health by way of multiple service agreements. Under the heading "5.5 Support services", the service agreement requires the provider to be responsible for the ongoing assessment of the service user, and to be responsive to the service user's functioning, abilities, well-being, and support needs. Under the heading "5.7 Key Inputs", the provider is responsible for employing competent staff for adequate hours for the needs of the service user group to ensure 24-hour provision of services. The service agreement states:

> "The Provider will have sufficient experienced staff to provide a level of service relative to the service user's assessed needs such as risk management, dual diagnosis, physical disability, intellectual disability, high medical needs, personal cares and social functioning.
>
> …
>
> The Provider will recruit and orient staff to meet the core staff competence components but will also be responsible to ensure the particular needs of service users are also addressed in the orientation and ongoing training programmes."

Transition plan

22. Mr B's transition plan from school to the IS vocational and residential service, dated 29 April 2013, records: "[Mr B] is extremely vulnerable to any harm —physical, emotional occupational." The plan notes that Mr B needed full support while out in the community because of his blindness, and that he became lonely and could become "extremely frustrated" and lash out when frustrated. It also states that Mr B needed a suitable residential home where he would be safe and able to have a good life doing activities he enjoyed.

Residential care

23. In July 2013, Mr B entered the care facility. He was assessed by the NASC as requiring a "very high" level of support. Under the service agreement, he was to receive support for 24 hours a day seven days a week.

[3] Attention deficit hyperactivity disorder (ADHD) is a neurodevelopmental psychiatric disorder in which there are significant problems with neurologically based skills involving mental control and self-regulation.
[4] In accordance with information available on IS's website.

Mr A

24. Mr B initially lived at the care facility with another resident, Mr A, who is also intellectually disabled. IS told HDC that Mr A has ongoing issues with exposing himself to others and spitting and, less frequently, masturbating in front of others. IS said that neither it nor the experts who assessed Mr A's behaviour identified that he exhibited sexualised behaviour directed at Mr B.

25. IS stated:

> "[Mr A had] a history of serious aggressive behaviour and sexually inappropriate behaviour. However his aggression was primarily targeted at staff. His sexually inappropriate behaviour was primarily targeted at women."

26. IS told HDC that a number of agencies were involved in assessing, planning appropriate support, and contributing clinical expertise to Mr A's support and management. It said that it was actively working with these agencies to manage Mr A's inappropriate behaviour safely. IS stated that it had in place risk management and behaviour support plans for Mr A, to minimise the risk of harm.

Staffing arrangements

27. IS was funded by the Ministry of Health to provide Mr B with 24 hours a day seven days a week support and referral to specialist providers when required. Ms C alleged that "IS single staffed for two high needs young men", even though "[Mr B] was fully funded, one to one".

28. IS said that Mr B was funded by the Ministry of Health under a purchase unit called IHCINDR, which is used for residential services placements with IS where the person lives by him- or herself or with one other service user.

29. IS said that the NASC service authorisation specifies a daily funding rate, but does not specify how that funding is to be applied. It said that the usual support under such funding was to provide one-to-one support during the day.

30. The IHCINDR Community Residential Support Services Tier Two Service Specification (the Service Specification) provides: "This service provides 24-hour support at the level necessary for people to have a safe and satisfying home life." It states that people will be supported to live in a home of their choice (where a choice of home exists) and, as far as possible, with people with whom they are compatible. It states that the environment must safeguard residents from abuse and neglect, and ensure that their personal security and safety needs are met.

31. The Service Specification requires the provider to develop a documented personal plan within three months of entry to the service, and to review and amend the plan when circumstances change, or at least annually.

32. The Ministry of Health told HDC that, as the funder of the IHCINDR service, its expectations are that the provider provides a safe service, and that the service user's outcomes in his or her support plan are met. The Ministry stated that provided those

expectations are met, it may be appropriate to flex the hours across two service users, and there is no absolute requirement for 24-hour one-to-one care.

33. However, IS told HDC that there was a staff member present at the care facility 24 hours per day, including an awake shift at night. IS said: "For the period that [Mr B] lived with [Mr A], the home was double staffed during the day so the two support workers would work in with one another to cover short spells they needed to attend to their own personal hygiene."

34. IS also told HDC that on week days the second staff member worked from 3pm to 9pm. IS said that Mr B attended the vocational day base on week days from around 8am to 3pm, where he was supported one to one by a staff member from his residential team or a vocational staff person who was experienced in supporting him, and that on the weekends (when Mr B did not attend day base) there was a second staff member present from 8am to 3pm. This meant that Mr B and Mr A were rostered to be cared for by one staff member from 9pm until around 8am on week days, and from 3pm until 8am on weekends.

35. In addition, IS said that although "the service had double staffing for most shifts during the day" there were times when the care facility was single-staffed because of staff shortages and sickness. As the staff at the care facility needed to be skilled at re-direction and de-escalating behaviour, and be experienced in working with the residents, IS decided that at times of staff shortage it was safer to operate with one experienced staff member supporting the two residents than to introduce an untrained second staff member. IS said that the Service Manager and on-call managers monitored the service when there was single-staffing.

36. IS provided HDC with information about its core learning and development programme, which must be completed by support workers within the first 18 months of their employment. IS said that some components, such as first aid and personal safety, are refreshed on an ongoing basis. IS stated that it strongly supports staff to undertake the New Zealand Certificate in Health & Wellbeing. Level 2 has been compulsory since 2010, and level 3 is encouraged.

37. IS told HDC that a small group of key staff regularly supported Mr B, and that seven of the ten staff working with him had completed the Level 2 or higher National Qualification certificates. It also stated that the majority of staff had completed either positive behaviour support training or personal safety training.

Personal plan

38. As stated, IS was required to develop a documented personal plan[5] for Mr B within three months of entry to the service, and to review and amend the plan at least annually. However, despite IS being asked for Mr B's records, it has not provided HDC with his personal plans prior to 2015.

[5] A plan outlining personal support information regarding communication, personal care, activities and routines at home, health and medical needs, accessing the community, social activities, skills development, education, protection, and behavioural support.

Risk management plan

39. IS said that a safety plan/risk management plan (RMP) is put in place for significant risks to a person. IS provided HDC with an undated RMP for Mr B, which IS said was developed on 21 July 2013. This two-page document, containing three columns, records "current" risks (physical aggression and self-harm), risk triggers, and a management plan (prevention, intervention, crisis). The plan was not updated during the two years of Mr B's residency with IS. However, IS said that a safety plan was formulated on 29 January 2015 and updated on 6 May 2015. IS said that a safety plan is equivalent to a risk management plan.

40. The RMP for Mr B includes under "crisis": "[C]ontinue to monitor your tone of voice; keep calm; use the breakaway techniques; sometimes the fade in fade out strategy works well …" Mr B's RMP and safety plan do not refer to risks from other service users, and include only the risks of Mr B becoming physically aggressive and self-harming. In response to the provisional opinion, IS provided HDC with copies of its regional and its national Significant Hazard Registers for the time periods. IS advised that these outline common risks for all service users, "including risks in relation to living with other service users (and specifically, 'physical aggression')".

Incident Reporting and Response System Policy

41. IS provided HDC with a copy of its Incident Reporting and Response System Policy (no. 12207 December 2014), which was updated in March 2015. Both the original and amended policies provide that all accidents and incidents must be reported by staff within 24 hours of the incident occurring, and that all incidents must be recorded on an incident report form.

42. Section 4 of the 2014 policy requires the description of the incident to be "as accurate, factual and complete as possible". Section 2.1 of the 2015 policy states: "Write all information clearly [in the incident report] and be factual/accurate. This means describing the order of events, and what you observed and/or heard."

43. The 2014 policy requires the incident form to be forwarded to the Manager within 72 hours of the incident, and that the Manager/reporting officer or delegate is to investigate all incidents. It states that it is expected that most incidents will be investigated within 10 working days of being reported, and that the aim of the action to be taken is to prevent further incidents or reduce the frequency and seriousness of future incidents. It states that it is the responsibility of the person who identified the incident to ensure that any urgent actions needed to ensure the safety of those directly involved are taken. The policy states that there are no set criteria to determine whether a visit to the facility or staff member is appropriate, and that the evaluation of each situation will determine the immediate actions taken.

44. Section 2.4 of the 2015 policy states: "Any 'critical' event must be reported to the General Manager as soon as possible but no later than 12 hours after the event has occurred." A "critical event" is defined as including:

- An event that is dangerous and the service user's safety is at risk;
- An incident/service issue having serious impact on the service user's well-being;

- Any suspected abuse or neglect of a service user; and
- Abuse/assault of a staff member.

45. Section 3 of the 2015 policy states that Service Managers are responsible for the follow-up action required when they are informed of an incident or near miss, and they must "[i]mmediately assess the situation and provide support or advice that puts people's safety first". Where harm has occurred as a result of an incident, the Service Manager or on-call manager must attend the site of the incident. The policy states that Service Managers must check that the front of the incident report form records all "relevant and necessary information". Service Managers must complete an incident investigation and enter follow-up actions on the reverse of the incident report form when the investigation into the incident or near miss is complete.

46. Section 4.1 of the 2015 policy states that investigations should be completed as soon as practicable, and no later than 28 days after the incident.

47. Section 4.3 of the 2015 policy states that Service Managers must sign off all incident reports, and Senior Managers must co-sign all medium and high impact incident reports. The policy also states that, before co-signing a medium or high impact incident report, the Senior Manager must "ensure there is no further information required of the investigating manager prior to closing the incident investigation".

48. Appendix 1 of the 2015 policy sets out classification codes for different types of incidents such as verbal aggression; physical aggression; service user health; critical; and other behaviour. Descriptors of how incidents manifest (e.g., self-harm; disturbed sleep; slip/trip/fall) are listed under each incident classification type. There is space in the incident form for classifying an incident/near miss in this way.

July 2013–December 2014

49. Ms C said that, during Mr B's first 15 months at the care facility, there were a number of incidents that caused some concern, but they did not lead his parents to think he was unsafe.

50. On 23 October 2013, support worker SW D completed an incident report stating that Mr A had entered Mr B's room while naked, and that Mr A was spitting and stroking his (Mr A's) genitals. Another SW reported a similar incident on 8 November 2013 when Mr A entered Mr B's room twice while naked and was again spitting and rubbing his (Mr A's) genitals.

51. IS said that a lock was placed on Mr B's door on 11 November 2013 because Mr A had interfered with Mr B's privacy. IS told HDC that the lock automatically locked Mr B's bedroom door when the door shut. The staff had a key to open the door from the outside, and the lock would disengage when opening the door from inside the bedroom. IS said that, during the day, Mr B's and Mr A's bedroom doors were usually open.

52. On 14 November 2013, a psychiatrist reviewed Mr B and reported to Mr B's usual general practitioner:

> "[Mr B] is currently very settled and there are no real problems that require any additional intervention. His medication seems to be settled, currently risperidone[6] 0.5mg [twice per day], and there are no indications to change this.
>
> [Mr B] tends to be very tactile with staff he is familiar with and I understand that when he encounters new people he usually tries to assault them at least once. … This seems to be the only real ongoing problem and is unlikely to be managed with changes to his medication."

53. A SW completed an incident form stating that, on 14 December 2014, Mr A came into the lounge wearing only a bathrobe, and sat with his genitals exposed on the couch beside Mr B. The SW recorded that Mr A ignored requests to cover himself, so she took Mr B by the hand and redirected him away from Mr A. The incident form remained unprocessed with no follow-up or investigation until April 2015, after Service Manager Ms E resigned. It was signed off by the Area Manager on 27 April 2015, with no investigation findings or follow-up actions.

54. SW D completed an incident form on 17 December 2014, which states that she found Mr B crying in the toilet, and Mr B said, "[Mr A] hit me," and, when SW D asked Mr A whether he had hit Mr B, Mr A said that Mr B was "scum", and that Mr A did not want Mr B there. Again, the incident form remained unprocessed until after Ms E resigned. It was signed off by Service Manager Ms F[7] in April 2015.The follow-up actions were "Caregiver/Staff/SU follow up", and again no investigation findings are recorded other than "Incident report found following the Service Manager leaving".

Incident 16 January 2015

55. SW D completed an incident form dated 16 January 2015, which deals with two incidents — one at 8.30pm and the other at 11.06pm. The report states that Mr B had just been put to bed when the staff heard "a thumping type sound" and went to investigate. The form states that Mr B "had blood on his hand, & it appears he has picked a scab on his head, on inspection no open wounds or abnormalities found just skin condition near right eye sighted". The report notes that Mr B was shielding his face in a defensive way and his hands were trembling. SW D recorded that at 11.06pm Mr B shielded his face when he heard Mr A's name. She documented that these were possible signs of Mr B feeling unsafe. Again, the incident form remained unprocessed until it was signed off by Ms F in April 2015. There are no follow-up actions recorded, and again no investigation findings are recorded other than "Incident report found following the Service Manager leaving".

[6] An antipsychotic medication used to help reduce disruptive behaviour.
[7] Service Manager Ms F was not directly responsible for the service that supported Mr B, but carried out on-call duties at times.

Alleged assault

56. At 10pm on 19 January 2015, SW D notified the on-call manager, Ms G,[8] that Mr A had struck Mr B. Ms G completed an on-call report on the basis of information given to her by SW D. Ms G recorded:

> "[Mr B] came out of the toilet and [Mr A] came out of his bedroom and hit [Mr B], several times, then went back to his room … [SW D] checked for signs of injury, but didn't visibly notice anything, but said could possibly be bruising on-call asked if he needed to be checked out immediately. [SW D] said [Mr B] seemed his normal self & that she felt [that a] GP visit [tomorrow] morning could be made …"

57. Ms G recorded that SW D would remain on duty with Mr B so she could take him to the GP if needed and the awake overnight staff member, would be asked to come in early to provide additional support. Ms G recorded that later she called SW D back and was told that all was quiet and Mr A had settled down after the incident.

58. SW D told HDC that she took Mr B into his room, locked the door, and told him not to unlock the door from the inside.

59. SW D told HDC that Mr B was bleeding from his head and that, when she rang Ms G, she (Ms G) said that an ambulance should be called or Mr B should see a doctor the next day. SW D stated that she asked Ms G to come in, but Ms G replied that it sounded as though SW D had everything under control. SW D told HDC that she is pretty sure she did not say that Mr B was his "normal self". She also stated that Ms G was "notorious" for not attending houses when requested.

60. SW D completed an incident report dated 19 January 2015, which states:

> "Approx[imately] 9.25 pm, [Mr B] exited his bedroom to use [the] toilet, I was there immediately, [Mr B] washed hands & was walking back to his room, when [Mr A] flung open his bedroom door & came running, lunging at [Mr B], assaulting, punching him over 30 times in head, neck, body, [Mr A] got [Mr B] in a headlock very hard, applying dangerous pressure to [Mr B's] neck, [Mr A] kicked [Mr B] about 20 times, saying I'm the man you fucking bitch. [Mr A] did not swing at me, but nearly hit me as I tried many times unsuccessfully to take [Mr B] outside to safety. [Mr B's] gash on head was dripping blood, firm pressure applied & reassurance given to [Mr B]. [Mr B] cried, hugged me & had trembling hands & shielded his face after being assaulted. … Later on at 10.50pm, [Mr A] came to lounge & did the fingers at [Mr B] with middle finger."

61. SW D wrote on the incident report: "On call has asked [that Mr B] be checked by doctor tomorrow please." The incident is recorded as being "high impact". Accompanying the incident form is a body map form completed by SW D, which records approximately 90 "X" marks indicating where Mr B had been punched, kicked, or placed in a headlock. The form also notes that Mr B was kneed and kicked

[8] Ms G was an IS Service Manager. She provided direct management to the service supporting Mr B for three months in 2015. Prior to this, she had on-call duties at times.

in the groin. The incident form remained unprocessed until 27 April 2015, after Ms E had resigned.

62. On the following day, 20 January 2015, Mr B was taken to a GP for a check-up. Mr B was examined physically, and the GP recorded: "[B]lows to [the] head, chest, abdomen and genitals and legs. No specific complaints or concerns. [Two] mild scalp abrasions cleaned with water. Is on [antibiotics] for 48 more hours [flucloxacillin] for skin infection …" The GP prescribed Betadine antiseptic for Mr B's scalp abrasions, and paracetamol for pain relief. He also completed an ACC injury claim form for Mr B having been "assaulted by fellow resident in home".

63. On 20 January 2015, IS informed Ms C of the incident. Ms C told HDC that Ms E suggested that Ms C take Mr B home for his own safety. Ms C said that her view was that Mr A should be moved from the care facility.

64. Ms C took Mr B home until 31 January 2015, during which time Mr B was supported by IS staff during the day. Ms C told HDC that Mr B had abrasions on his head and, a few days after 20 January, bruising appeared on his body. She said that he "displayed traumatised behaviour for about 5 nights, but not during the day" (emphasis in original). She stated that she was not aware of the full extent of the assault until SW D told her later, when Mr B was in hospital (after 3 March 2015). IS stated that it was not made aware of any trauma sustained by Mr B as a result of this incident.

65. IS told HDC that typically Police action is initiated at the time of such an incident to minimise harm to those affected. IS said that the Police were not involved on 19 January "as the staff member did not consider emergency services such as Police and Ambulance as necessary … The on-call manager acted according to the seriousness of the incident as conveyed to them." IS told HDC: "[The Area Manager] discussed with [Ms C] laying charges with the police and encouraged her and [Mr B's] father to visit the police on [Mr B's behalf]." Ms C told HDC that she filed a complaint with the Police about Mr A having assaulted Mr B.

66. SW D said that, for 18 months after the incident,[9] Mr B would say "no [Mr A]", and she believes that Mr B was traumatised by the assault. She said that, after the assault, Mr B would shield his face.

67. IS stated that the incident form was mislaid, delaying investigation of the incident. After the incident form was found, the area manager completed the "immediate actions to be taken" section of the incident report, stating that following the incident Ms E was to make a doctor's appointment for Mr B.

68. The area manager completed the "key findings of investigation" section with comments that Ms E contacted Mr B's mother, who took him home. The area manager also noted the subsequent events, including Mr B's move to another facility (Facility 2) (see below).

[9] SW D continued to care for Mr B after she was no longer employed by IS and he left IS's care.

69. IS told HDC that it did not raise with SW D the issue of the description of the incident as recorded in the incident form differing from the record Ms G completed.

70. On 27 April 2015, three months after the incident, IS completed an investigation into the event. IS told HDC that this occurred when senior management became aware of the incident. The one-page investigation report notes that the incident SW D reported to Ms G over the telephone was described as being a "minor incident", and that the incident report was found "unprocessed" in April 2015. IS stated that the delay in investigating the incident was a result of the incident report having been mislaid. IS said that the information provided to Ms G was different from that in the incident report, and Ms G acted according to the seriousness of the incident as conveyed to her. There were no follow-up actions in the report.

Change of residence

71. IS said that Ms C agreed that Mr B would move to another home. IS told HDC: "The option of change of residence was fully considered and acted upon which also aligned with [Ms C's] desired outcome for [Mr B]."

72. Ms C said that Ms E discussed with her alternative living arrangements for Mr B. Ms C told HDC that she requested that Mr A be moved. She said that Mr B's family had an issue with Mr B being moved, because "[Mr B] is blind and reliant on routine across the board to function well. Why move [Mr B] when it is [Mr A] that is unsafe? Family believes there was nowhere else to put [Mr A]." Ms C told HDC: "I never agreed to [Mr B] being moved to an alternative home, but I could not return [Mr B] to the care facility while [Mr A] was there."

73. IS decided that Mr B would live on his own at Facility 2 with continued one-to-one staffing. IS said:

> "The decision to move [Mr B] to [Facility 2] rather than moving [Mr A], was carefully considered weighing up a number of factors to achieve what was considered at that time to be the best outcome for both men."

74. IS said that the relevant factors included the physical environment of the houses, concern that Mr B might associate the care facility home with the assault, and that the neighbours at Facility 2 would be more accepting of Mr B than of Mr A.

75. IS told HDC that staff new to supporting Mr B had completed site-specific orientation at Facility 2 and a competency assessment. IS said that Ms C was involved in the selection of new staff and the orientation process.

76. On 31 January 2015, Mr B moved to Facility 2. The IS diary entry for the day records that Mr B was "happy and settled" and went to bed at 8.20pm. It is recorded that he requested that his bedroom door be open and was chatting to himself saying, "No [Mr A]."

Comments by Mr B

77. In an incident report dated 11 February 2015, SW D reported Mr B as saying: "[Mr A] don't hurt me please" and "nothing in the bum". In an incident report dated 2 March

2015, SW D reported Mr B as saying: "No [Mr A] — no dick in the bum" and "Leave my bum alone it hurts". The "key findings of investigation" sections on both incident reports, which were completed by the area manager on 9 March 2015, state that she became aware of the incident reports only on 4 March 2015, and that they would be followed up on 11 March 2015. No follow-up actions are recorded on either incident report.

IS initial investigation into allegations of sexual assault

78. On 11 March 2015, Service Manager Ms H[10] completed an investigation into the two incident reports. The investigation consisted of speaking with seven staff who were familiar with Mr B. The one-and-a-half page report states that all staff, other than SW D, "believe that [Mr B] would be unable to verbalise in this way". Ms H stated that she spoke to Mr B to gauge for herself his ability to verbalise information, and found that he was not able to verbalise more than two to three words. Ms H concluded:

> "[I]t is most unlikely that [Mr B] has said the statements that have been reported by the staff person. It is most probable that the infection[11] experienced by [Mr B] has caused him significant pain in the area of his 'bum', and may have contributed to any agitation he experienced."

79. The report does not refer to Ms H having sought advice about Mr B's ability to communicate from his mother or any clinician. The report contains no follow-up actions.

80. Ms C told HDC that although she believes that Mr B made some comments about Mr A, she does not believe that he made "these specific statements", as they are not characteristic of any statements he made before or after the surgical glove incident.

Surgical glove incident

81. IS told HDC that at 10.25pm on 2 March 2015, Mr B complained of a sore stomach. Staff called the on-call manager, who advised to give him paracetamol. At 10.42pm, he vomited twice, got up from the couch and walked to the hallway and banged his head on the door frame "with significant force" approximately 14 times. Mr B was lying on the floor groaning and saying "sore tummy", and staff noticed that he was bleeding from the corners of his eyes. An ambulance was called.

82. Mr B was taken by ambulance to the Emergency Department (ED) at the public hospital for "possible concussion having struck his head forcefully several times against a wall for about an hour from 10.30pm". At 2.20am on 3 March 2015, an ED registrar reviewed Mr B and recorded:

> "[Presenting complaint] Head injury … Patient complaining of abdominal pain after eating dinner this evening — had a large vomit (carers believed patient might have been over fed). Patient then proceeded to hit his head against the wall — not unusual activity. No [loss of consciousness] [or] seizure activity. One

[10] Ms H is an IS Service Manager. She provided direct management to the service supporting Mr B in April 2015. Prior to this, she had on-call duties at times.
[11] The infection referred to relates to Mr B's admission to hospital on 2 March 2015 with stomach pain.

> further vomit but otherwise back to normal … [Observations] stable afebrile. Patient following commands with eyes open. Speech normal for him. Head — small [laceration] to left upper occipital area. Skull not seen. Glue applied post clean. Attempted to examine patient but patient becoming agitated and unhappy. Carer [SW I] believes patient is normal. Impression: … no adverse features seen. Plan: Home, but head injury advice given."

83. Mr B was discharged from hospital around 3.30am on 3 March 2015 and returned to Facility 2. The discharge summary states that the abdominal pain and vomit were related to overfeeding, and there were no adverse features seen. The staff were given an information sheet to identify any signs of concussion. The incident was noted in the day diary for 3 March 2015:

> "[Mr B] very unsettled [at] hospital lashing out, uncooperative [with] nurses — hitting self, biting and spitting … discharged [at] 0330. [Mr B] had a Milo [and] went to bed by 4am — however [he was] up pacing [and] shouting has yet to sleep [at] 0630am."

84. IS told HDC that Mr B appeared unwell after returning to Facility 2 and that, at 6.30am on 3 March 2015, he began vomiting up dark brown vomit. The diary entry notes that Mr B vomited continuously until 11am. IS stated that the on-call manager was contacted and staff were advised that there was a stomach bug going around and to encourage fluids. IS said that Mr B was monitored by staff. He was given paracetamol at 10.30am.

85. IS told HDC that, at 3.20pm, staff reported a change in Mr B's vomit, which was now dark brown, grainy, and lumpy. An ambulance was called at 3.30pm.

86. Ambulance staff recorded: "… Abdo[men] distended painful to touch, umbilicus area, [nil] toileting today, limited food & fluid [intake] not normal for patient. … Mobilised but bent over on walking."

87. Mr B was taken to the public hospital and, at 7pm on 3 March 2015, a surgical registrar obtained his medical history from SW I and Ms C (who were in attendance). The surgical registrar conducted an abdominal examination with assistance from SW I and Ms C. The surgical registrar recorded her impression that Mr B could have appendicitis, an inflammation of the gall bladder, or a urinary tract infection. Later that evening Mr B underwent a scan under general anaesthetic, which revealed abnormal loops of thickened small bowel. Mr B remained in hospital under observation, and staff recorded that he was unwell and in pain.

88. On 4 March 2015, Mr B underwent a laparotomy[12] performed by surgeon Dr J. A surgical glove was discovered in Mr B's right paracolic gutter,[13] with free pus in his

[12] A laparotomy is a surgical incision through the abdominal wall to examine the abdominal organs and aid diagnosis.
[13] The space between the wall of the abdomen and the colon.

abdomen. A loop colostomy[14] was performed and a drain inserted. On 5 March, Mr B was transferred to the intensive care unit.

89. On 6 March 2015, Mr B was sedated for a colonoscopy. The clinical notes state: "[N]o obvious defects in rectal wall, evidence of old ? Scarring." From 6–9 March 2015, Mr B received wound care and medication for behaviour management due to periods of restlessness and self-harming. On 9 March 2015, Mr B was discharged from the intensive care unit to a ward.

90. On 13 March 2015, after discussion with Ms C, IS completed a restraint approval form and physical restraint protocol in order to dress Mr B in a body suit so that he would not interfere with his stoma bag once he was back in IS's care. Service Manager Ms H recorded the reasoning for the restraint, Ms C's agreement to it, and a new toileting protocol for Mr B (developed on 11 March 2015). The body suit was to be worn at all times for an expected period of three months.

91. After a difficult recovery, Mr B was discharged from hospital on 30 March 2015, following which he had ongoing oversight from district nurses for his wound care, stoma management, and follow-up. The hospital discharge summary states that Mr B's risperidone was to be increased to 1mg twice a day, and this dose was charted by Mr B's GP on 30 March 2015.

IS investigations into surgical glove incident

92. On 30 April 2015, a Quality Improvement Leader[15] completed an investigation into the events surrounding Mr B's hospitalisation on 3 March 2015. The investigation report found that medical assistance "should have been [sought] sooner on 3rd March [2015]" and that incident reports dated 11 February and 2 March 2015 were not investigated as should have occurred per IS's policy. The investigation report recommended that Mr B's support information be updated to reflect management of any existing/newly identified risks, such as storage of gloves. The Quality Improvement Leader recommended that a reflective practice session be held with staff to learn from the event and make appropriate changes.

93. IS said that when Mr B returned to the service post-hospitalisation, the location of the gloves was moved from the top of the water closet to a cupboard in the bathroom.

94. On 23 June 2015, Ms K, a clinical psychologist from Community Specialist Services,[16] completed an investigation to "gather and review evidence in relation to [the glove incident]" and report to IS with a clinical opinion as to the likely cause of the injury, and provide recommendations to prevent recurrence. Ms K did not interview Mr B or Mr A. IS told HDC that Ms K made a decision not to interview as Mr B and Mr A would potentially get stressed due to unfamiliar people, had limited verbal skills, and could become aggressive with strangers. However, Ms K noted that

[14] An opening formed by drawing a loop of colon through an incision in the abdominal wall and suturing it to the exterior of the body.
[15] She was not directly responsible for the service that supported Mr B.
[16] IDEA Services Community Specialist Services team provides services to children and families with intellectual disabilities and/or autism spectrum disorder.

it was "highly unlikely" that Mr B made the statements recorded by SW D in the incident reports (which appeared to implicate Mr A as the perpetrator), because Mr B's personal support information recorded that he had a limited vocabulary, and other IS staff thought it highly unlikely that he had made the statements.

95. Ms K concluded that it was unlikely that Mr B self-ingested the glove, because of the difficulty of swallowing a glove, and because Dr J considered it unlikely that it was swallowed because of the location where the glove was found in the bowel.

96. Ms K also concluded that it was unlikely that Mr B had inserted the glove into his own rectum, because he would not have had sufficient manual dexterity. Ms K stated that Dr J thought it would have taken something longer than a finger to insert the glove 3–4cm up through Mr B's rectum into his bowel, and that doing so would have caused Mr B pain.

97. The report states that, although the possibility that a third party inserted the glove was not discussed at interviews, IS staff who were interviewed did not think a staff member would have perpetrated an assault on Mr B.

98. As Dr J could not determine a timeframe within which the glove was inserted, the report considers whether Mr B had displayed trauma symptoms over the two years since he arrived in the service. It notes that it was thought that Mr B's fear-related behaviour (described as "shielding" by SW D and Ms F, and "cowering" by another SW):

> "… was related to an assault on [Mr B] by [Mr A] as this behaviour [by Mr B] had not occurred prior to [the incident on 19 January 2015] … With exception of this incident no other acute trauma symptoms were reported over the past two years."

99. Ms K's report found that it was not possible to determine a definitive cause or identify who was responsible for the insertion of the surgical glove. She said that Mr B "does not have the ability" to say what happened, there were no "clear indicators" as to who might be responsible, and "[f]rom the evidence available, it would appear unlikely that [Mr A] is the perpetrator". Ms K pointed to Mr A's lack of sexual interest in Mr B as evidence that supported that conclusion, as well as some staff having said that Mr A had a good relationship with Mr B and that Mr A was unlikely to have had the opportunity to assault Mr B without staff becoming aware of it.

100. IS then commissioned an independent review of the glove incident and the assault, which was undertaken by a quality improvement consultant.[17] In a report dated November 2015, the consultant stated that she could not determine who inserted the glove, or when or where it was inserted, but she reached the conclusion that the glove was most likely inserted by a third party as a result of a sexual assault. The consultant raised doubts about the veracity of SW D's report of the assault on 19 January 2015. The consultant concluded that there were doubts about the severity of the incident, given the absence of physical signs of injury to correspond to the incident form

[17] The consultant conducts independent investigations of incidents/accidents or complaints.

completed by SW D and the verbal description of the incident that SW D gave to Ms G at the time.

Further information — Ms C

101. Ms C said that, from early December 2015, Mr B had "been increasingly talking to himself about IS staff as he settle[d] down for the night". She said that some examples of Mr B's comments regarding Mr A are: "[N]aughty [Mr A], F**k off [Mr A], [Mr A] bad." Ms C stated that usually Mr B's statements about IS staff were positive.

102. Ms C said that the family have thought "long and hard" about who could have been responsible for inserting the glove into Mr B's rectum. She said that Mr B was with his family during the Christmas period and the two weeks between living at the care facility and moving to Facility 2. She said that, during those periods, Mr B was with her at all times apart from two nights when he stayed with another family member. Ms C said: "We have absolute certainty that the glove incident could not have occurred while with family. It could only have occurred while in IS care, either at the house, out and [a]bout or during a day program."

Care plans

103. IS provided HDC with documents entitled "Alerts & Crisis Response" (1 April 2015), "Personal Plan" (2 April 2015), and "Personal Support Information" (8 April 2015) for Mr B.[18] The Personal Support Information sets out the areas where support is required, and advice under the headings "What happens now?" and "What support is needed?".

Burn incident

104. SW D told HDC that on 3 July 2015, she made a hot drink and, before going to the toilet, placed the drink in a kitchen cupboard located just below waist-height. She told IS that she put the cup in the cupboard so that Mr B could not reach it.

105. SW D told HDC that, after she left the bathroom, she noticed that the venetian blind in the lounge area was wet and Mr B seemed damp. SW D stated that Mr B had had a cup of cold water earlier and she thought he must have thrown it. SW D said that Mr B hugged her and groaned, but could not articulate if anything was wrong. She said that Mr B had redness around his brow bone area and the top of his head.

106. IS provided HDC with a critical event report form dated 6 July 2015, which noted that SW D informed Ms F via telephone at 7.20pm on 3 July that Mr B was "scratching" and she requested approval for prn (as needed) cetirizine 10mg. Approval was given. At 7.30pm, SW D called Ms F again and reported that Mr B had been crying and scratching a "rash 3cm by 5cm on shoulder area and weepy". Paracetamol was approved and Ms F noted that she would check Mr B the following day.

107. IS said that Service Manager Mr L[19] visited Facility 2 at 7.40pm and was told by SW D that the existing rash on Mr B's body and head had become more irritated. Mr L

[18] IS did not provide any earlier versions of these documents.

[19] Mr L was an IS Service Manager and provided direct management to the service supporting Mr B from May to July 2015.

was concerned that the rash was "significantly inconsistent" with what he had observed earlier in the day, and informed Ms F, who said that she would attend Facility 2.

108. SW D told HDC that Ms F arrived at the house at 7.55pm and, at that point, SW D noted that the previously full cup that she had put in the cupboard was still in the cupboard but the cup was now empty. She also told IS that the cup was still in the cupboard when she discovered that it was empty.

109. Ms F thought that Mr B's injuries (fluid discharging from his forehead, right ear, right shoulder area, back of neck and upper back, with his skin peeled away) looked like burns, and attempted first aid. SW D told HDC that, although she had first aid training, she was only taught about minor burns, and did not know what a fresh burn looked like. She said that she did not see what Mr B did with the hot drink, and was not sure what to look for in a burn. SW D told HDC that she took advice from managers when something appeared wrong.

110. Mr L contacted Ms C to inform her of the incident. An on-call report completed by Ms F noted that she believed that hot tea had caused the burns.

111. An ambulance was called and Mr B was taken to the public hospital, arriving at 9.20pm. An ED registrar recorded:

> "Unattended [for a] few minutes. Accidently spilt hot cup of tea over himself. Thought to have burned lips then thrown cup over himself in anger. Burns to face [and] neck. Does not [complain of] pain. … [On examination] [second degree] burns [to] face [and] neck [approximately] 2% [of] body area. No oral/orbital movement. … [Impression] Minor burn."

112. Mr B was discharged back to IS's care at 1.30am. Ms C arrived at Facility 2 at 7am and decided to take Mr B home.

IS investigation into burn incident

113. IS told HDC that an investigation into the circumstances surrounding the incident was completed by a manager on 17 July 2015. Ms C told the manager that she had seen staff managing the risk by tipping drinks out, putting them in cupboards and on window sills, and keeping them out of Mr B's reach. The manager concluded that SW D was aware of the risk of hot water.

114. The report found the following:

- Service documentation, records, descriptions of routines, and Mr B's behaviour support plan are silent on the risks associated with hot drinks and the action required to manage associated potential harm;
- Strategies to manage the risk of burning from hot water/drinks had not been identified, agreed, implemented and monitored;
- Records of staff meetings are silent as to any discussion about the risk of hot drinks;

- Changes to more effective management support at [Facility 2] had not matured to a point where all risks had been identified;
- All those interviewed agreed that, due to his visual impairments, it would be unlikely that Mr B had accessed the cupboard as described by SW D, located the hot drink and removed it, and had the acuity to return it to the same place, particularly as it was likely that he burnt himself in the process;
- Staff took steps to understand and manage the risks associated with hot water but had done so inconsistently and not in response to an agreed plan or strategy.

115. IS said that, although it accepts that the risks posed by hot water/drinks were not included in Mr B's RMP, it was "not convinced" that, even if the RMP and Alerts and Crisis Response had mentioned such risks, SW D's actions "would have been different given she failed to report the injury or the need to urgently access medical treatment". IS stated: "However [Mr B's] Alerts and Crisis information included a more general provision regarding household hazards which included electrical appliances and the need for constant supervision."

116. IS told HDC that SW D had received burns training and provided two pages of the 2013 booklet for the "Basic First Aid and Recertification Manual" for the 2013 first aid course SW D completed. This stated:

> "**Deep burns**
>
> DIAL EMERGENCY
>
> Full skin thickness and / or deeper
>
> **Signs and symptoms**
>
> Relatively painless — may be pain around edges of burn
>
> White or charred skin — usually surrounded by superficial burn
>
> Shock
>
> Deep burns always require medical attention immediately — DIAL EMERGENCY."

Further information — Ms C

117. On 4 July 2015, Ms C removed Mr B from IS's residential care, but IS staff continued to support Mr B during week days until 25 July 2015. Ms C said: "[Mr B] now resides at his mother's home and will never be returned to IS care!"

118. Ms C said that, on 9 November 2015, Mr B had a stoma reversal operation with a successful outcome. She told HDC that Mr B is back to his old self and participating fully in family activities.

Further information — IDEA Services

119. IS said that it needed to strengthen its oversight of incident reporting and follow-up actions. IS stated that it has taken steps to strengthen and monitor practices at the local area level. The Area Management Team meet twice weekly to review incidents assessed as medium or higher seriousness to assist with management oversight and ensure that actions are put in place to minimise recurrence.

120. A copy of the service incident register for each service is attached to the staff team meeting minutes to allow a review by the senior manager for the area following each team meeting.

121. The incident report registers from services are reviewed at the area office to ensure that all incidents are processed in a timely manner.

122. Copies of final reports and investigation reports of all incidents classified as having high impact are submitted to the General Manager for review.

123. The Chief Operating Officer meets monthly with Quality and National Clinical Advisors to review critical events and tracking of progress and action.

124. IS is introducing an electronic delivery system that will allow for better monitoring of incidents, reporting, and follow-up.

125. IS stated that, in its view, there were appropriate staffing levels for Mr B at all times as required under the service agreement and NASC funding. IS stated: "[W]e do not accept that any service users were not safe or placed in a situation of unacceptable risk as a result."

126. IS also stated that there is no way of telling when the glove was inserted.

Response to provisional opinion

127. IS was provided with an opportunity to respond to the provisional opinion. IS stated:

> "Whilst we generally accept the HDC's finding in respect of staffing levels, we wish to note the challenge faced by the organisation when needing to find suitable trained support workers to assist service users such as [Mr B] and [Mr A] at short notice.
>
> As the draft report has quoted (at para 9), the service agreement specifications require 'sufficient experienced staff to provide a level of service relative to the service user's assessed needs.' It is not uncommon for disability support providers to operate with staff working alone at certain times, and we believe it is common practice to have on-call support from managers for staff, as what occurred in this situation. Sometimes it is considered safer to rely on a reduced staff ratio with the usual staff who service users are familiar with (and therefore behave better with), compared to the alternative of bringing someone new in temporarily who may cause disruption or unsafe behaviour amongst certain service users.

> In this case we acknowledge that there were times when the staffing levels were lower than would usually be expected, but we do not accept that any service users were not safe or placed in a situation of unacceptable risk as a result."

128. IS told HDC that it has since introduced a national focus on complaint management. IS stated:

> "The chief executive has commissioned a quality review to be carried out across [IS] with a specific focus on the key quality and safety mechanisms that are in place to provide safe, high quality services to service users."

129. IS also told HDC that it has launched an "intranet" to provide training and publications on topics to staff including supervision, incident reporting, abuse and safety, incidents involving multiple service users, and concerns raised by service users and family members.

130. IS told HDC:

> "IDEA Services is truly sorry for the events that [Mr B] has experienced in this case. We acknowledge that these events were distressing for both [Mr B] and his family. It is disappointing when we do not provide exceptional service and support as expected."

131. Ms C was provided with an opportunity to respond to the "information gathered" section of the provisional opinion, and her response has been incorporated where relevant.

132. SW D was provided with the relevant sections of the provisional opinion. SW D told HDC that, looking back on the incident with the hot drink, she will always regret placing the cup there, and has learned from the incident.

133. SW D stated that the first aid training she received spoke only of "superficial burns". She said that she was also told that an experienced staff member would "know what to do" and that she was told to always telephone the medically trained staff member who was on call.

Relevant standards

134. The New Zealand Health and Disabilities Sector (Core) Standards (NZS8134.1:2008) state that the standards are to enable consumers to be clear about their rights, and providers to be clear about their responsibilities for safe outcomes. NZS8134.1 requires the following:

> "(a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

(b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner;

(c) Services are managed in a safe, efficient, and effective manner which complies with legislation; and

(d) Services are provided in a clean, safe environment which is appropriate for the needs of the consumer."

135. NZS 8134 provides (amongst other things) the following:

"**Standard 2.8 Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.**

…

Standard 3.5 Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery." (Emphasis in original.)

Opinion: IDEA Services Limited — breach

Introduction

136. As a provider of disability support services, IS is responsible for providing services to its clients in accordance with the New Zealand Health and Disabilities Sector (Core) Standards and the Code of Health and Disability Services Consumers' Rights (the Code).

137. Mr B entered IS's residential service in July 2013. He has intellectual, physical, and developmental impairments and is dependent on others for his care. IS had a responsibility to ensure that he received services of an appropriate standard from suitably trained, supported, and experienced staff. IS also had a responsibility to protect him from being harmed by other clients.

138. I consider that a combination of inadequate care planning in relation to risk management, insufficient staffing, placement with a resident who exhibited inappropriate behaviour that sometimes escalated to violence, and poor management of incident reporting placed Mr B in a position of vulnerability, and the care provided to him fell short of the accepted standard.

Care planning and risk management

139. Care plans are an essential tool for ensuring that consumers' care requirements are kept up to date and are communicated to all staff involved in that person's care. It is the correct documentation of this process that ensures continuity of care. NZS

8134.1:2008 requires that "[c]onsumers' service delivery plans are consumer focused, integrated and promote continuity of service delivery".[20]

140. IS provided HDC with care plans dated 2015 but, despite being asked to supply all Mr B's records, it did not provide the earlier care plans. I am critical that Mr B's records were incomplete.

141. IS said that a safety plan/RMP is put in place for significant risks to a person. IS prepared an RMP for Mr B on 21 July 2013, but the RMP was not subsequently updated. The RMP records the current risks, risk triggers, and management plan. IS said that a safety plan was formulated on 29 January 2015, and that a safety plan is equivalent to a risk management plan.

142. On 6 May 2015, the safety plan for Mr B was updated, and contained "triggers to be aware of", and how to limit triggers and respond accordingly.

143. The RMP and Safety Plan do not refer to risks to Mr B from other people, and include only the risks of him becoming physically aggressive to others and self-harming. In response to the provisional opinion, IS provided HDC with copies of its regional and its national Significant Hazard Registers for the time periods. IS advised that these outline common risks for all service users, "including risks in relation to living with other service users (and specifically, 'physical aggression')".

144. My expert advisor, registered nurse Dr Frances Hughes, advised that the lack of an up-to-date RMP contributed to Mr B being placed in a position of vulnerability. Dr Hughes stated:

> "Intellectual disability support services are expected to have individualised comprehensive plans for their clients, to ensure clients' needs and risks are clearly understood by those providing support and mitigate any risks identified to prevent harm occurring."

145. Dr Hughes advised that Mr B's RMP was outdated, and it was unclear what staff were applying in relation to behaviour and risk management. She further advised that despite incident forms being completed, updates to Mr B's RMP did not occur.

146. In my view, the RMP should have been reviewed and updated regularly to ensure that the services provided to Mr B were appropriate and relevant to his needs. I am critical that this did not occur.

Staffing levels

147. Mr B lived at the care facility with Mr A. IS was funded by the Ministry of Health to provide Mr B with 24 hours a day seven days a week support.

148. IS told HDC that there was a staff member present at the care facility 24 hours per day, and that Mr B had one-to-one care while he was at day base. After day base there

[20] Standard 3.5.

was a second staff member on duty 3–9pm on week days. In addition there was an extra staff member from 8am–3pm on the weekend. One staff member worked an overnight awake shift.

149. IS said:

> "For the period that Mr B lived with [Mr A], the home was double staffed during the day so the two support workers would work in with one another to cover short spells they needed to attend to their own personal hygiene."

150. That is clearly incorrect. One staff member was responsible on the planned roster for both Mr B and Mr A from 9pm until Mr B left for day base during the week at around 8am, and from 3pm until 8am on the weekends. Furthermore, IS said that there were times when the service was single-staffed because of staff shortages and sickness, and it considered that it was safer to operate with one experienced staff member supporting both residents than to introduce an untrained second staff member. IS said that the Service Manager and on-call managers monitored the service when there was single staffing.

151. I am very critical that IS did not put processes in place to ensure that it had sufficient trained staff on duty at all times to provide Mr B with appropriate supervision. In my view, it was insufficient to have managers monitor the service, as they would not necessarily be immediately available in an emergency. Dr Hughes advised that, as the staffing of the houses was variable, at times Mr B was at risk. I agree.

Failure to provide a safe environment

Mr A's conduct

152. IS said that Mr A had a history of serious aggressive and sexually inappropriate behaviour, but noted that his aggression was primarily targeted at staff, and his sexually inappropriate behaviour was primarily targeted at women.

153. However, it is clear from the information available that on a number of occasions Mr A's behaviour impacted negatively on Mr B's privacy, safety, and well-being, before and after December 2014:

- On 23 October 2013, SW D completed an incident report stating that Mr A had entered Mr B's room while naked, and that Mr A was spitting and stroking his genitals.

- On 8 November 2013, a SW reported a similar incident when Mr A was said to have entered Mr B's room twice. In response to this incident and the incident in October, IS placed a lock on Mr B's door.

- On 14 December 2014, a SW reported that Mr A came into the lounge wearing only a bathrobe and sat on the couch beside Mr B with his genitals exposed.

- On 17 December 2014, SW D completed an incident form that reported that she had found Mr B crying in the toilet, and that he had said that Mr A had hit him.

When asked whether he had hit Mr B, Mr A said that Mr B was scum and he (Mr A) did not want Mr B there.

- On 16 January 2015, SW D completed an incident form that stated that Mr B was shielding his face in a defensive way and his hands were trembling. SW D recorded that Mr B later shielded his face when he heard Mr A's name. She documented that these were possible signs of Mr B feeling unsafe.

- On 19 January 2015, SW D notified the on-call manager, Ms G, and completed an incident form stating that Mr A had repeatedly struck Mr B.

154. In respect of the incident on 19 January 2015, there are a number of differences between what was recorded by the parties involved. The incident form completed by SW D reflects a serious assault. SW D recorded, among other things, that Mr B suffered blows to the body, as well as a cut on his head.

155. In contrast, Ms G recorded that SW D had told her that she (SW D) had checked Mr B for injuries and "didn't visibly notice anything". The information recorded by the GP, who saw Mr B the next day, indicates that abrasions were found on Mr B's scalp, and over the days following the incident Ms C observed that bruising appeared, and that Mr B displayed traumatised behaviour at night for about five nights.

156. On the information available, I am unable to make a finding as to what was said during SW D's and Ms G's conversation. However, taking into consideration the information available, including the records made by SW D, Ms G, and the GP who saw Mr B the next day, I find it more likely than not that Mr B was struck by Mr A a number of times and, as a result, sustained injuries including bruising and abrasions to his scalp.

157. In my view, there was a concerning pattern of Mr B being subjected to inappropriate behaviour by Mr A, which sometimes escalated to violence. I note that IS said that it was actively working with various services to manage Mr A's inappropriate behaviour, and had put in place plans to minimise harm. However, Mr B was particularly vulnerable to Mr A's behaviour, because at times there was insufficient staff to care for both residents at the care facility. In particular, I note that SW D was alone with Mr B and Mr A when the assault occurred on 19 January 2015.

158. I am concerned that IS responded inadequately to multiple incidents involving Mr A's behaviour, which at times escalated to violence. That, together with having one staff member caring for two high-needs residents at times each day, put Mr B at risk of suffering further harm.

159. I consider that the incident reports show that IS failed to provide Mr B with a safe environment. I am highly critical of this failure.

Change of residence

160. Following the incident on 19 January 2015 during which Mr B was assaulted, Mr B was taken home until 31 January 2015, when IS moved him to a different home

(Facility 2). IS said that the reason Mr B was the one who was moved was that Mr A needed a secure environment. Ms C said that Mr B's family had an issue with moving Mr B because he is blind and depends on routine to function well. She was concerned that Mr B was moved rather than Mr A.

161. IS said that the relevant factors in the decision to move Mr B included the physical environment of the houses, concern that Mr B might associate the home with the assault, and that the neighbours at Facility 2 would be more accepting of Mr B than of Mr A.

162. I accept that Mr A was difficult to manage and needed a secure environment. However, the decision to move Mr B rather than Mr A resulted in Mr B having to become familiar with new surroundings and staff.

Glove incident

163. On 2 March 2015, Mr B became unwell with stomach pain and vomiting. An ambulance was called and he was taken to the ED at the public hospital. He was discharged around 3.30am and returned to Facility 2.

164. On 3 March 2015, at 6.30am, Mr B began vomiting up dark brown vomit. He vomited continuously until 11am. However, it was not until 3.20pm, when his vomit changed to being dark brown, grainy and lumpy that an ambulance was called. A subsequent investigation report found that medical assistance should have been sought sooner, when the vomiting started. I agree. In my view, medical assistance for Mr B should have been sought shortly after 6.30am.

165. On 4 March 2015, Mr B underwent a laparotomy, which uncovered a surgical glove in his right paracolic gutter, and free pus in his abdomen. Following the surgery, Mr B had a stoma, which was difficult to manage in light of his disabilities.

166. Subsequently, IS arranged for three investigations to be conducted, but the reason for the glove being in Mr B's bowel could not be determined. The consultant considered it unlikely that Mr B had swallowed the glove or inserted the glove into his rectum himself, and concluded that it was likely to have been the result of a sexual assault by a third party. Ms K also thought it unlikely that Mr B had swallowed the glove or inserted the glove into his rectum himself, and concluded that Mr A was unlikely to have been the perpetrator.

167. I accept that it is unlikely that Mr B inserted the glove himself. I am unable to make a factual finding as to when or how the glove was inserted into Mr B's rectum.

Burn incident

168. SW D said that on 3 July 2015, she made a hot drink and, before going to the toilet, placed the drink in a kitchen cupboard located just below waist-height. Subsequently it was found that the cup was empty and Mr B had suffered burns to his face and neck.

169. I agree with IS's investigation conclusion that it appears unlikely that Mr B could have accessed the drink, burnt himself, then returned the cup to where he found it. However, there was no information in IS's service documentation, records,

descriptions of routines, or in Mr B's RMP about the risks associated with hot drinks and the actions required by staff to manage associated potential harm.

170. Dr Hughes noted that the risk of burning from hot water or hot drinks had not been formally identified, and advised that there was insufficient evidence of how IS applied preventative risk management in relation to products like hot drinks.

171. Although it could be seen as a matter of common sense that hot drinks should never be placed where an intellectually impaired, blind service user could access the hot liquid, IS should have had policies in place, and should have provided training, to reinforce to staff that hot drinks and other liquids should never be left in a manner that put service users at risk.

Adherence to IS incident reporting policy and follow-up

172. IS's Incident Reporting and Response System Policies (the incident reporting policies) provide, among other things, that Service Managers are responsible for follow-up action when they are informed of an incident, and must immediately assess the situation and provide support or advice that puts people's safety first. Service Managers must complete an incident investigation and enter follow-up actions on the reverse of the incident report form when the investigation into the incident or near miss is complete. The 2014 policy states that it is expected that most incidents will be investigated within 10 working days of being reported, whereas the 2015 policy states that investigations are to be completed no later than 28 days after the incident.

173. On a number of occasions there were delays in processing incident reports, resulting in delays in actioning follow-up as required by the incident reporting policy. In particular:

- Incident reports completed on 14 December 2014, 17 December 2014, 16 January 2015, and 19 January 2015 remained unprocessed for extended periods of time (up to four months) until they were discovered following the resignation of the service manager, resulting in delays in the follow-up actions required by the policy. This included a delay of approximately three months before an investigation was completed into the 19 January 2015 incident, in which Mr B suffered injuries after being struck a number of times by Mr A.
- An incident report dated 11 February 2015 completed by SW D reported that Mr B had said, "[Mr A] don't hurt me please" and "nothing in the bum", and on 2 March 2015, SW D reported Mr B as saying, "No [Mr A] — no dick in the bum" and "Leave my bum alone it hurts". The "key findings of investigation" sections on both incident reports, which were completed by [the area manager] on 9 March 2015, state that she became aware of the incident reports only on 4 March 2015, and that they would be followed up on 11 March 2015. No follow-up actions are recorded on either incident report.

174. On 11 March 2015, Service Manager Ms H completed an investigation into the alleged comments Mr B had made to SW D about Mr A in February/March 2015. Ms H spoke to seven staff familiar with Mr B. Her report states that no staff, other than SW D, believed that Mr B would be able to verbalise in that way. Ms H spoke to Mr

B to gauge for herself his ability to verbalise information, and found that he was not able to verbalise more than two to three words, but she did not contact any clinicians who had treated Mr B or speak to Ms C.

175. IS concluded that Mr B was not capable of verbalising the statements as reported by SW D. Ms C told HDC that although she believed Mr B made some comments about Mr A, she did not believe that he made the specific statements SW D reported, as they were not characteristic of any statements he made before or after the glove incident.

176. On 27 April 2015, IS completed an investigation into the incident of 19 January 2015 in which SW D reported that Mr B was struck by Mr A numerous times. The one-page investigation report notes that the incident SW D reported to Ms G over the telephone was described as a "minor incident" and the incident report was found "unprocessed" in April 2015. IS said that the information provided to Ms G was different from that in the incident report, and Ms G acted according to the seriousness of the incident as conveyed to her. There were no follow-up actions.

177. Dr Hughes advised that the incident reporting policy covers all key processes and procedures that one would expect to see in residential services. However, Dr Hughes said that she did not consider that staff followed the incident reporting policy. She also advised that it was unclear how lessons and learnings from incidents occurring from 14 December 2014 onwards were integrated into Mr B's RMP and updated management strategies. Dr Hughes further observed that this was compounded by the significant gaps in accuracy of events, time delays in incident reports being reviewed by senior managers, and, despite incidents of assault occurring, that it did not appear that considerations as outlined in policy were followed (including safeguards being instituted).

178. In my view, IS was responsible for managing and overseeing the Service Manager during her employment, including checking that she had processed incident forms. Furthermore, it should have taken action when she resigned, to check that all incident reports had been processed. It is concerning that it was some months before the failure to respond to incident reports was identified and remedied.

Conclusion

179. Mr B is a vulnerable man with high needs who relied on IS to provide him with safe services of an appropriate standard. In my view, IS did not meet that standard, and a number of factors contributed to this. These factors included:

- Mr B's RMP was prepared on 21 July 2013 and was not subsequently updated, despite the incidents described in this report.
- Risk planning was insufficient. Risks were not identified satisfactorily and adequate risk prevention strategies were not put in place.
- IS did not ensure that it had sufficient trained staff on duty at all times to provide Mr B with safe care.
- Mr B was placed with another resident who exhibited inappropriate behaviour towards him which at times escalated to violence.

- Mr B was moved to an unfamiliar residence following the other resident's violent behaviour.
- IS did not have in place policies and training to reinforce to staff that hot liquids should never be left in a manner that put service users at risk.
- IS staff did not manage incident reporting adequately.

180. Noting the above, I consider that IS failed to provide services to Mr B with reasonable care and skill, and breached Right 4(1) of the Code.[21]

Opinion: SW D — adverse comment

181. SW D said that on 3 July 2015, she placed a hot drink in a kitchen cupboard located just below waist height, and then left Mr B alone in the room. When she returned, she noticed that the venetian blind in the lounge was wet and that Mr B seemed damp. She said that Mr B hugged her and groaned but could not articulate whether anything was wrong. He had redness around his brow bone area and the top of his head.

182. At 7.20pm, SW D informed Ms F that Mr B was "scratching" and she requested approval to administer cetirizine. At 7.30pm, SW D called Ms F again and reported that Mr B had been crying and scratching a "rash 3 cm by 5 cm on shoulder area and weepy". Service Manager Mr L visited the home at 7.40pm and was told by SW D that the existing rash on Mr B's body and head had become more irritated. SW D said that, although she had first aid training, she had been taught about only minor burns, and did not know what a fresh burn looked like.

183. After Ms F arrived at the house at 7.55pm, SW D noticed that the previously full cup in the cupboard was empty. Mr B was later found to have second degree burns to his face and neck covering two percent of his body area.

184. During the IS investigation into this incident it was noted that all the staff interviewed thought that it would be unlikely that Mr B had accessed the cupboard, located the hot drink, removed it and had the acuity to return it to the same place, particularly as it was likely that he burnt himself in the process.

185. Although I am unable to make a finding about the circumstances in which Mr B received the burn injury, I am highly critical that SW D did not recognise that it was unwise to leave a hot drink in a place where an intellectually impaired, blind client might be able to access it. However, I acknowledge that the risk identification and management strategies and other documentation was silent about the risk posed to Mr B from hot liquids, and no strategies to manage the risk of burning from hot water or drinks had been identified, agreed, implemented or monitored.

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

Recommendations

186. I recommend that IDEA Services Limited complete the following actions and report back to HDC within six months of the date of this opinion:

a) Commission an independent review of:

i. the effectiveness of changes made to the service in light of the events highlighted in this report;
ii. the personal plans and risk management plans for each client in an IDEA Services Limited Residential Service care facility in the region to ensure that each has been reviewed and updated appropriately and contains clear information specific to that person. If the review identifies deficiencies, the review should extend to a random audit of clients in IDEA Services Limited Residential Service care facilities throughout New Zealand; and
iii. ongoing training needs of support workers, including in the area of first aid

and report back to the HDC on actions taken in response to this review.

b) Conduct an audit, over a three-month period, of compliance with incident reporting procedures and timelines.

c) Report on progress with the introduction of the electronic delivery system and evaluate the effectiveness of the system.

187. I recommend that IDEA Services Ltd provide Mr B and his family with a written apology for the failings identified in this report, to be sent to HDC within three weeks of the date of this report, for forwarding to Mr B and Ms C.

Follow-up actions

188. A copy of this report with details identifying the parties removed, except the names of IDEA Services Limited and the expert who advised on this case, will be sent to the district health board and the Ministry of Health (HealthCERT).

189. A copy of this report with details identifying the parties removed, except the names of IDEA Services Limited and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Dr Frances Hughes:

"I Frances Anne Hughes have been asked to provide an opinion to the Health and Disability Commissioner (HDC) on case number 15/01145. I confirm I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualification and experience to undertake review

I am a registered nurse with a BA, MA and Doctorate in Nursing. I have over thirty years of experience in the New Zealand health system. I have clinical expertise working with clients in both mental health and intellectual disability. I am a Fellow of the College of Mental Health Nursing in New Zealand and Australia.

I have held senior executive positions in nursing and mental health in New Zealand and Australia, including chief nurse, principal consultant and acting deputy director of mental health for the New Zealand Ministry of Health. I was the Commandant Colonel for the Royal New Zealand Nursing Corp for seven years providing strategic nursing leadership to the New Zealand Army and held the first professional positon in nursing and mental health at Auckland University.

I have been recognised for my leadership and my work in nursing and mental health through the award of both a Harkness Fellowship in Health Care Policy from the Commonwealth Fund in New York and Senior Fulbright Scholarship. I received a distinguished Alumni Service Award from Massey University in New Zealand and the New Zealand Order of Merit in 2005 for Services to Mental Health.

I have experience in quality, patient and service audits in both non-government organisations ('NGOs') and public hospital settings. I owned and operated a mental health and intellectual disability service 'Hillcrest Lodge' in the Kapiti region for 12 years.

Methodology

I have reviewed the following:

- Complaint from [Ms C]
- Response from Idea Services (with 47 attachments)
- Letter from [the DHB] with comments from [Dr J] (surgeon)
- Risk Plan for [Mr B] (undated)
- Transition plan for [Mr B] (29 April 2013).

Disclaimer

The findings of this review are limited to the materials that have been reviewed (above).

Opinion on questions posed by Commissioner

1. The appropriateness of the care provided by Idea Services. Please comment on the adequacy of the:
   a. Incident reporting
   b. Investigation into the latex glove incident
   c. Supervision of [Mr B], and whether [Mr B] was suitably protected from other residents
   d. Indecent Reporting Policy (attachment 11)
2. The appropriateness of the care provided by the caregivers involved in [Mr B's] care
3. Do you have any concerns about the care provided by any individuals if so please discuss
4. Please comment on any other aspects of the care provided to [Mr B] you feel is necessary.

It would be helpful if you would advise, where applicable:

- What is the standard of care/accepted practice
- If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is; and
- How would it be viewed by your peers?

Chronology

Events of interest for this opinion occurred between December 2014 and July 2015.

12 January 2015	Returned from home leave (tab 4)
14 January 2015	Appointment with GP re sores on face — *Pityriasis Versicolor* diagnosed. *'Can't catch from someone else'* antifungal tables prescribed and shampoo (tab 6)
January 2015 (exact date unclear)	Mother raises issue of fungal infection on face
19 January 2015	IR [Incident Report] completed by [SW D] 9.25pm [Mr A] assaults [Mr B] (tab 9) 'over 30 times in head, groin and neck'
20 January 2015	GP appointment (tab 8), no concerns. Betadine

	antiseptic to scalp.
31 January 2015	[Mr B] settles into new home. (tab 10)
3 March 2015	File note (tab 12) night. [Mr B] 'admitted to hospital due to possible concussion due to constant head banging' — Discharged 0330 nil sign of concussion, cut on head. [Mr B] starts vomiting Ambulance called (exact time unclear) Admitted to hospital 21.07 (tab 14)
4 March 2015	Laparotomy surgical glove found in right paracolic gutter (tab 14)
30 March 2015	Discharged by [the DHB] Precise diagnosis was unclear on how latex glove got into bowel (tab 14)
7 April 2015	IR (tab 38) [SW D] picking and scratching previous scars
8 April 2015	Summary of personal goals from personal plan developed (tab 27)
24 April 2015	Meeting report (tab 34) — [Mr B's] family, [initials] and [Ms H] (IS) — concerns raised re [Mr B's] safety, behavioural management, behaviour support plan still in development, issues regarding new staff, current status quo unacceptable to family, mystery regarding how glove got in situ. To meet again in 3 weeks, to review and evaluate
26 April 2015	IR (tab 36) [IS staff member] [Mr B] removed stoma bag, unsettled need PRN Diazepam
28 April 2015	GP apt (tab 31) aggressive and defiant smearing faeces — increase in Risperidone 1mg TID, discuss with psychiatrist
29 April 2015	IR (tab 37) [SW D] loud noise — [Mr B] rocking, stomping, holding staff jacket
30 April 2015	Investigation report [IS staff member] on [Mr B] 3/3/2015 (tab 17) *Findings:*

	'medical assistance should have been sorted sooner on 3/3 when vomiting started' 'two incident reports 11/2 & 2/3 abuse of flatmate not investigated' *Recommendations:* Meeting with staff (sic) Independent SS review of two incidents not reported (sic) Support information to reflect management of any existing/newly identified risks.
3 June 2015	IR [Mr I] (tab 43) [Mr B's] MP3 player in insinkerator when turned on 'waste disposal is not supposed to be used it was turned off and there was a sign on this'
2 July 2015	[Ambulance service] report (tab 45) called pain in leg and appointment made to [see] GP IR [Mr I] (tab 46) [Mr B] complained of sore foot ambulance called
3 July 2015	IR and CER form (tabs 19 and 23) GP visit regarding sore feet — *PRN oral meds for rash* Ambulance called 7.55 in regard to injuries
4 July 2015	IR and CER form (tabs 19 and 23) 1.30am — [Mr B] released from hospital "assessed and treated by medical professionals for burns"
4 July 2015	IR and CER form (tabs 19 and 23) [Ms C] takes [Mr B] home and subsequently removes him from services
6 July 2015	Critical event report (CER) on [Mr B] event date 3/7/2015
17 July 2015	Investigation report [manager] (tab 23) *Findings:* • Further exploration regarding hot drinks (staff

	employment) (sic) • Risk of burning from hot water/hot drinks has not been formally identified … strategies not been addressed • Changes have occurred at [the second facility] but management support has not matured to a point where all risks have been identified • Unlikely due to visual impairment that [Mr B] able to access cupboard as described by [SW D] (sic) • No guidance in support information for staff about managing supervision when staff are indisposed. *Recommendations:* • Comprehensive assessments to ensure all risks and sources of harm are identified • Support information is updated to reflect this • Supervision requirements are clearly articulated when indisposed. • An employment investigation is undertaken in relation to this incident.

Professional opinion on specific questions

1. The appropriateness of the care provided by Idea Services. Please comment on the adequacy of the:

a. Incident reporting:

Idea Services incident reporting policy pages 7, 8, 11, 12, 14, 15 and 16 clearly outline the responsibilities for reporting attendance on site and follow up actions. The following areas are of particular relevance for this case:

For incidents where harm has occurred the Service Manager/on call Manager must attend the site of the incident.

All reported incidents and near misses must be investigated by the Service Manager.

Staff are to complete and record within 24 hours and fax to 'your manager'

Service Managers must be responsible for the follow-up action required when they are informed of an incident

Review [RMP] and update management strategies to eliminate or minimise risk

For service users who have been exposed to violence or harm consider whether the person causing harm needs to be removed

Incidents of violence towards others must be coded Medium or High

This was evidenced in the investigations findings:

- 17 December 2014 (tab2) incident report found post Service Manager leaving
- 16 January 2015 (tab2) incident report found post Service Manager leaving
- 19 January 2015 (tab 9) incident report — reported to on call as minor incident, incident found unprocessed in April. [Report] (tab 2) (undated unsigned) states the following 5.6 information on the incident report was inconsistent. Other incidents of staff member misreporting
- 11 February 2015 (tab 2) only became aware of IR on 4 March 2015.
- 2 March 2015 (tab 2) only became aware of this 4 March 2015
- Report completed by [SW D] on [Mr B] 3/3/2015 (tab 17), two incident reports 11/2 & 2/3 abuse of flatmate not investigated
- Investigation report on 3/3 (tab 23) completed by [a service manager]. On call [manager] was not informed of any calls from [SW D] re [Mr B] suffering burns
- IR [Mr I] (tab 43) [Mr B's] MP3 player in insinkerator when turned on *'waste disposal is not supposed to be used it was turned off and there was a sign on this'*. No mention of an IR of policy breach or actions to prevent this occurring again
- 4 July IR and CER (tab19 and 23). Despite [Mr B] having been in service for length of time. Risk of burning from hot water/hot drinks has not been formally identified … strategies not been addressed.

In relation to the above events I do not consider that staff followed their own incident reporting policy. It is unclear how lessons and learnings from incidents occurring from 14 December 2014 onwards have been integrated into [RMP] and updated management strategies. This is compounded by the significant gaps in accuracy of events, time delays in IR being reported and subsequently reviewed by senior managers. Despite incidents of assault occurring it does not appear considerations as outlined in policy were followed including removal of the client, option of police being involved or safeguards instituted. IS acknowledge its own undated/unsigned [report]. IHC incident policies and procedures policy 12207 (page 15) states *'Ensure actions are focused on prevention or minimising harm occurring again'.*

b. Investigation into the latex glove incident

The following evidence was reviewed:

- Idea Services [report] (unsigned and undated) (tab2 p4) states that two investigations were carried out.
- Investigation report [IS staff member] on [Mr B] 3/3/2015 (tab 17)
- Investigation of 3/3/15 by [Ms K] 23/6/15 (tab18)
- Visiting Surgeon report [Dr J] 11 September 2015.

In reviewing the reason for the glove being in situ in [Mr B's] bowel, a cause could not be determined. The incident was investigated by IS both at the local service level and also involved Specialist Services (SS) within Idea Services.

The report written on 23/6 by [Ms K] clinical psychologist from SS provides the most comprehensive overview of the context surrounding this event. There are limitations with these reports and investigations, including:

- None address the issue of prevention for the future at a level that would provide reassurance for safety going forward.
- It is unclear from all the investigations what risk strategies have been put in place to prevent products like gloves being left in places where they could be either inserted or ingested.

IHC incident policies and procedures policy 12207 (page 15) states *'Ensure actions are focused on prevention or minimising harm occurring again'*. I conclude that whilst comprehensive in nature, investigations occurred totally internally within Idea Services and did not provide detail on preventive and future harm minimisation.

c. Supervision of [Mr B], and whether [Mr B] was suitably protected from other residents:

The following evidence was reviewed in [relation to] the above:

- 19 January 2015 (tab 9) IR by [SW D] 9.25. [Mr A] assaults [Mr B]
- February 2015 (tab 2) [Mr A] don't hurt me please
- 2 March 2015 (tab 2) no [Mr A], [Mr A] gone
- Investigation of 3/3/2015 by [Ms K] 23/6/15 (tab 18). The flatmate has a history of serious aggressive behaviour and sexually inappropriate behaviour
- Idea Services report to [the care facility] (unsigned and undated) (tab 2, p1) funding for [Mr B] and his flatmate one staff on shift per 24 hours — times of shortage single staff did occur monitored by SM and on call. Competence issue of level 5 staff person

- 7 April 2015 IR (tab 38) [SW D] picking and scratching previous scars … Another example of query stereotypical behaviour
- 24 April 2015 — Meeting report (tab 34) — previous assault that occurred in the care facility is currently before the courts … acknowledged that [Service Manager] level 5 is not doing his job. Behaviour support plan in draft
- Risk management plan for [Mr B] (undated and unsigned) appears to be 2013
- 13 June 2015 IR [Mr I] (tab 43) [Mr B's] MP3 player in insinkerator when turned on
- 3 July 2015 — IR and CER form (tab 19 and 23) — burns
- 17 July 2015 Investigation report [by a manager] (tab 23).

In reviewing the above it was clear that [Mr B] was affected by the behaviour of his flatmate, who *had a history of serious aggressive behaviour and sexually inappropriate behaviour*. The context of [Mr B's] care is such that staffing of houses he was located in was variable, meaning that at times he was at risk. His [RMP] was outdated and it is unclear what staff were applying in relation to behaviour and risk management between December 2014 through to July 2015.

Despite incident forms being completed, updates did not occur to his plans. Investigator reports outline 'risk of burning from hot water/hot drinks has not been formally identified … strategies not been addressed. Changes at [Facility 2] but management support has not matured to a point where all risks have been identified. Unlikely due to visual impairment that [Mr B] able to access cupboard as described by [SW D] (sic). No guidance in support information for staff about managing supervision … when staff indisposed.'

Incidents were occurring on a regular basis and indeed becoming more serious in nature over the time period in question. [Mr B] was assaulted, hospitalised with a latex glove in bowel and suffered scalding from a hot drink. From the evidence I have reviewed there is a lack of up-to-date [RMP], lack of compliance with incident reporting and house procedures and senior management oversight — outlined in IS own investigations. I conclude that [Mr B] did not receive the appropriate skilled staffing, staff did not comply with internal policies and management supervision. In my professional opinion, I do not believe that [Mr B] received the duty of care nor was he adequately protected.

d. Incident Reporting Policy (attachment 11):
The above policy was reviewed against the service specification (tab 46). The policy covers all the key processes and procedures that one would expect to see in residential services. One area that could be strengthened is the area of oversight of compliance with reporting and actions, due to delays and non-compliance with processes by staff and the Service Manager as evidenced in this review. IS should investigate how they can have a greater overview in future. With critical and serious incidents it also would be advisable to involve external personnel including consumer/family in reviews.

Summary

Intellectual disability support services are expected to have individualised comprehensive plans for their clients, to ensure clients' needs and risks are clearly understood by those providing support and mitigate any risks identified to prevent harm occurring.

Between December 2014 and July 2015, events occurred which placed [Mr B] in a position of vulnerability. The [RMP] was outdated and he was placed in a house with a client who had a serious history of assault. [Mr B] was described as talking about [Mr A] and was assaulted on more than one occasion.

While an Incident Report Policy was in place, it was not adhered to by staff and there were time delays in reporting events and inconsistencies in documentation of incidents. Staff did not appear to provide accurate information on events. Idea Services itself identified that there had been changes in-house and that *'management support has not matured to a point where all risks have been identified'*. Subsequently, there is no clarity regarding what risk strategies may have been put into place.

Care provided to [Mr B] was variable and he was not adequately protected as evidenced by the nature of his injuries which included assault, scalding, and a latex glove in bowel for which no cause could be established. There was no determination in relation to 'how a latex glove was found in [Mr B's] bowel', but there was also insufficient evidence of how the service applied preventative risk management in relation to products like this and also hot drinks in house.

A lack of compliance with incident reporting policies, lack of up-to-date [RMP], inadequate compliance with house procedures, changes and a lack of staffing issues have all created a risk for [Mr B].

All of the above is a departure from the standard of care expected, not only in contractual arrangements but in National Service Specifications."

Further expert advice was obtained on 7 December 2015:

"[The departure] was very serious, client was funded a[t] a high level, service was expected to provide level of service and have appropriate internal systems to deliver on this."

Further expert advice was obtained on 27 September 2016:

"In response to your letter 7 September 2016, I provide the following response

Advice Requested

1. IDEA Services Response — causes you to alter your advice in any way

Response

The report I wrote dated the 2 December 2015 was based on the information provided and recorded in the methodology section. I accept that IDEA services may have access to wider contextual information but apart from the response supplied no new factual information has been supplied to me to consider. I stand by this report and do not wish to alter it.

2. Consumer Protection — evidence provided if this was accepted by the Deputy Commissioner, what steps would you consider IDEA service should have taken (if any) ? If so what.

Response
If the Deputy Commissioner accepts this evidence, IDEA services house, risk policies and client [Mr A] [RMP] should have identified this behaviour. These would then identify clear processes to assist staff to manage in a house environment where client lived with others ie. where do staff get their guidance from and how do other clients know what is OK and not in regards to client privacy from others. Are there rights reflected in the operational processes of house management?

Apart from staff training, regular meetings with staff re what is occurring in house. I would expect IDEA to ensure: 1. Greater supervision requirements of client [Mr B] by staff; and 2. Location or modification of his bedroom arrangements in house that reduced the ease of access to other client bedrooms and processes whereby clients can safely lock their rooms if they wish and deemed appropriate.

I would also expect to see in the [RMP] and Individual plan specific behaviours detailed and outlined with strategies to mitigate effects on other clients due to [Mr A] behaviour such as fondling himself, flicking saliva etc.

3. Staff Training — Please advise whether you consider [SW D's] training was adequate

Response
I have reviewed the training records from IDEA services. The training appears to be comprehensive in nature and appropriate for the role that [SW D] was undertaking.

The issue that arises from review is the recency and need for refreshment of some areas.

The majority of the training occurred in late 2008 and [SW D] only had three training programmes in 2015 — first aid, CPI short version and code of rights.

The CPI programme outlined in attachment 2, clearly covers identifying behaviours and how to intervene appropriately. This should have been adequate to assist [SW D] to work with clients she was working with.

What would be helpful is to have reviewed the IDEA training cycle (plan) for their support workers. This would provide greater clarity of what occurs on an ongoing basis. It would also be useful to know if [SW D] had a personal development plan and annual assessment re what was the plan for her future development — other certificate courses etc. If [SW D] felt that her training was not adequate to meet her work requirements between herself and her immediate supervisor this should have been identified.

I cannot make any further comment on staff training with the information I have reviewed. If any further information is provided I am happy to review."