Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner
(Case 20HDC01968)

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Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. The report discusses the care provided to Ms A by an alcohol and drug addiction treatment provider (the clinic).

2. The following issue was identified for investigation:

- *Whether the clinic provided Ms A with an appropriate standard of care.*

3. The parties directly involved in the investigation were:

The clinic	Alcohol and drug addiction treatment provider
Mr B	Complainant/Ms A's father
Mr C	Alcohol and other drug (AOD) clinician
Mr D	Clinic director
Mr E	Support worker
Ms F	Senior clinician

4. Mr G, a private counsellor, is also mentioned in the report.

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Background

5. The clinic is a private alcohol and drug treatment centre owned by Mr D. Mr D does not have clinical training and employed Ms F to manage the clinical care, with the support of AOD clinicians and support workers.

6. Ms A struggled with alcohol addiction and was enrolled in a programme at the clinic with the assistance of her parents. The programme covered four weeks of residential care followed by two years of ongoing support with recovery from alcohol addiction. Ms A's father, Mr B, complained to HDC that the clinic did not provide the level of support that was expected, and that a lack of support contributed to Ms A's deterioration and subsequent death from alcohol-related disease. My deepest sympathies go to Mr and Mrs B for the loss of their daughter.

Facts gathered during investigation

Residential care

7. Mr B contacted HDC to raise concerns about the care provided to his daughter, Ms A, who had entered the addiction recovery programme at the clinic on 23 Month1.[1] Ms A was in residential care at the clinic for a period of four weeks. Copies of email communication between Mr D and Mr B were provided as part of the complaint. The emails note that Mr B was satisfied with the first three weeks of the residential care component of the programme, and that during this time Ms A made progress with the support of AOD clinician Mr C.

8. Mr C was on leave during the final week of Ms A's residential care stay. Mr and Mrs B told the clinic in an email dated 15 Month9 that they felt that the last week was rushed, and that Ms A left residential care without a personalised plan, which they had expected from the service.

9. The clinic told HDC that during the week that Mr C was on leave, the programme was run 'entirely as planned', and there were 'no compromises'. The terms and conditions document provided by the clinic notes that an AOD counsellor will develop an after-care programme before graduation from residential care, and that a coach or counsellor will assist the resident with development of an exit plan for life after graduation.

10. Ms F told HDC that following graduation, Mr C was Ms A's main support person. HDC was not provided with any documentation to show that Mr C had developed an after-care programme. The clinical record was in the form of a daily summary of the residents as a group. Mr E, a clinic support worker, told HDC that writing this summary was part of his role.

11. Ms F said that she spent time with Ms A before she graduated, going through her relapse prevention plan and looking at short- and long-term goals. HDC was provided with a document that included a section titled 'Relapse Prevention Plan' and a section titled 'Safety Plan and Relapse Prevention'. This document was in the form of a blank template and

[1] Relevant months are referred to as Months 1–9 to protect privacy.

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appears to be a workbook for the residents to use and complete during the programme. HDC was not provided with a copy that had been filled in by Ms A. In response to my provisional decision, the clinic confirmed that it has no record of the aftercare plan that Ms F went through with Ms A and that the current process is to scan and attach the plans to the client file once completed.

12. The clinic told HDC that each client has at least weekly counselling with their assigned counsellor, who helps the client to develop a safety plan for life after residential care. The relapse prevention plan is shared in group sessions and added to as the client progresses through the programme.

13. In an email sent on 30 Month9, Mr and Mrs B told the clinic that they had understood that one-on-one counselling would be included in the course, and this did not occur. The terms and conditions document does not specifically outline the content of the package or what is included during residential care. However, information on the clinic's website provided a summary of what was included in the package.

14. Private one-on-one counselling packages are mentioned as an option on the clinic's website. This is listed as a separate package that is provided on a limited availability basis.

15. The clinic told HDC that Ms A was given 'ample opportunity' for private, one-on-one clinical meetings with a senior AOD[2] clinician, and that private space is available to clients to discuss issues they do not want to share with the group. The clinic also said that two senior AOD clinicians were onsite and available to meet with clients, apart from on 7 Month2, and that during residential care, clients are assigned a counsellor, with whom they have sessions at least weekly. The clinical record notes regular sessions with Mr C, which appear to be group work. There is no evidence of individual counselling sessions being scheduled with Ms A, or of Ms A requesting a private discussion.

Aftercare

16. Ms A's last day in residential care was 22 Month2. Mr B told HDC that part of the ongoing support included a life plan, counselling, and family involvement, and none of these were provided until after his email to the clinic on 15 Month9. Mr B said that by this time it was too late, as on 17 Month9 Ms A was admitted to the Intensive Care Unit (ICU) of a public hospital with alcoholic hepatitis and acute liver failure. Initially, Ms A made progress toward recovery, but then unfortunately she deteriorated and passed away.

17. In response to my provisional decision, the clinic told HDC that one-on-one counselling occurs at least once a week and continues as part of the after-care programme. However, this relies on the client taking up the offer of counselling. The clinic stated that aftercare is a two-way street that requires the client to engage, and often clients will continue to use alcohol or drugs, and, when this occurs, therapeutic interventions are not very effective unless the client is in a controlled environment.

[2] Alcohol and other drug.

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18. The terms and conditions for treatment at the clinic included a separate section for post-graduation aftercare support. This notes that ongoing support will continue via the clinic's graduates group for a period of two years; however, there is no detail on what this group is comprised of. The aftercare information sheet provided to clients outlines the following components included in aftercare:

- Assistance and advice for undertaking private counselling in their area to treat pre-existing, underlying issues;
- Follow-up calls from clinical support workers;
- Contact being a two-way street and phone numbers to call for support. Back-up contact via social media private chat;
- Senior clinician counselling and plan if issues are identified; and
- Reboot programme if necessary.

19. The terms and conditions also note that all that is required in most cases is a commitment to talk regularly with a support worker by phone. The support worker allocated to Ms A was Mr E. Mr E worked part time as a support worker providing overnight support two nights a week, and his duties involved follow-up phone calls to support graduates of the residential programme. Mr E told HDC that during the residential phase of the programme he discovered a family connection with Ms A. Mr E said that due to this connection, he developed a friendship with Ms A. He stated that he was assigned to provide support calls to Ms A following her graduation, and he contacted Ms A providing support regularly via phone, social media and text. However, Mr E told HDC that much of this contact was in the role of a friend, not a support worker representing the clinic.

20. Mr E recalls contacting Ms A by phone on an evening in Month3. He told HDC that this phone call was 'not in work time' and that Ms A sounded heavily intoxicated. Mr E contacted clinical staff and Ms A's mother, as he had concerns for Ms A's safety over the weekend. The clinic told HDC that on 6 Month3 confidentiality had to be broken due to safety concerns, and an intervention was put in place. This included access to Ms A's house for her mother to arrange support. On 9 Month3 Ms A was admitted to hospital with anxiety and alcohol withdrawal symptoms.

21. The terms and conditions include the following for situations where support phone calls are insufficient:

> 'If you feel in danger of lapsing or if you lapse, you may come back into the programme for a reboot. This is provided as an outpatient service half-day, five days a week. If there is an un-booked bed, then a residential reboot may be possible. Aftercare is subject to assessment and clients who continue to fail to follow exit plans, are dismissed for breaching registration terms or continue to use substances may not be assessed as suitable for reboot. In this situation private counselling may be offered.'

22. Following Ms A's lapse, she was offered three weeks' support via the outpatient programme, starting on 23 Month3. The clinic told HDC that outpatients do not have the

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same level of supervision as residential clients and also that after three days the programme was not able to continue due to the COVID-19 lockdown. The clinic told HDC that Ms A was contacted many times by a support worker during lockdown; however, Mr E maintains that although he did contact Ms A during lockdown, this was in the role of a friend. He was not in New Zealand at the time. By the time Mr E returned to work, Ms A had exited the programme and was under the care of her private counsellor, Mr G.

23. Mr C told HDC that during lockdown he was in contact with Ms A approximately three times per week, and he maintained open communication with Ms A's mother. In response to my provisional decision, Mr B confirmed that Mr C contacted Ms A on occasion over this time, but Mr B did not consider this contact to be frequent.

24. While lockdown was in place, Ms A was living with her mother. Ms A then returned to the outpatient programme. The clinic told HDC that this lasted only a short period as Ms A had begun drinking again. In Mr B's email to the clinic on 15 Month9 he explained that during the latter part of lockdown Ms A started spending weekends at her own home and relapsed.

25. In response to my provisional report, the clinic told HDC that COVID-19 had a profound impact on relapse rates in alcohol and drug addiction. Social isolation, increased anxiety, and disruptions to routine support systems like group meetings and therapy created a perfect storm for those in recovery.

26. A meeting was arranged with Ms A and her family for 29 Month5. The meeting was attended by Ms F, Mr C, Ms A, and her parents. During the meeting, a plan was developed and agreed to. HDC has not received minutes of this meeting or formal documentation of the plan. HDC received recollections of the meeting from Mr B, the clinic, Mr C, and Ms F. The recollections do not dispute that the following points were agreed:

- Ms A would not continue with the outpatient day programme. She would instead take a break and have private counselling for two sessions per week with Mr G for the next two months.
- Authorisation would be arranged to allow for Mr C and Mr G to communicate on Ms A's progress.
- A review would occur after two months to determine whether further time at the clinic, either day sessions or residential care, would be beneficial.

27. In addition, Mr B was under the impression that support worker contact would continue with Mr E, and that Ms F would provide Ms A with a timetable covering self-esteem, dealing with stress, and cognitive behavioural therapy. In response to my provisional decision, Mr B told HDC that no plan was documented, and no minutes of the meeting were taken. In addition, the suggested review did not occur, and Ms A did not receive a timetable or the support she expected.

28. Mr E told HDC that he 'took a step back' from providing support when, on his first shift back at work following his return to the country, he was advised that Ms A had exited the outpatient day programme and was under the care of her private counsellor.

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29. The clinic told HDC that Mr C had exited Ms A out of the programme. In contrast, Ms F told HDC that Ms A was never exited from the programme or formally discharged. Mr C told HDC that it was agreed that a support worker would continue working with Ms A alongside Mr G. In response to my provisional decision, Mr B stated that at no point did Ms A exit the programme, and he concurs with Ms F.

30. The authorisation for sharing of information between Mr C and Mr G was delayed. The clinical record for 3 Month6 provided by Mr G notes: 'Disclose form! (Mr C at [the clinic]).' Mr C told HDC that the clinic received the document but failed to pass this on to him until Ms A's mother contacted the clinic at the end of Month6. The clinic told HDC that it received the authorisation on 23 Month6, and Ms A's mother sent a text reminder to Mr C on 7 Month7 to advise that the form had been sent. It was then signed by Mr C and returned. Ms F told HDC that the form had gone missing.

31. Mr C's contract with the clinic was terminated two weeks later, on 22 Month7. Mr C told HDC that the clinic had instructed him not to continue communicating with clients and that no formal handover had been completed. Ms F told HDC that Ms A sent a text to her work phone on 5 Month8 asking about Mr C and why he was no longer at the clinic.

Family complaint to clinic

32. Mr B wrote in his email to the clinic on 15 Month9 that Ms A's mother contacted Ms F on 13 Month8 questioning why there had been no contact between the clinic and Mr G. Ms F and Mrs B reached an agreement that Mr E would be the liaison person between the clinic and Mr G now that Mr C was no longer a staff member.

33. Mr B also raised concerns that there had been no contact between the clinic and Mr G and said that he was not aware of any progress on revising authorisation for information to be shared with Mr E. Mr B informed the clinic that Mr E last spoke to Ms A in mid-Month8. HDC has not been provided with any information or evidence that Mr E was instructed to re-engage as a support worker or liaise with Mr G on behalf of the clinic.

34. On 18 Month9, the clinic responded to Mr B offering to meet with Ms A and her family; however, this was not possible, as Ms A had been admitted to ICU the previous day. Mr and Mrs B reflected on the care provided by the clinic while Ms A was in ICU and sent an email to the clinic outlining their experience, expressing dissatisfaction and requesting a refund.

35. The clinic told HDC that it does not accept any responsibility for Ms A's outcome and feels that it has done nothing wrong. The clinic said that the terms and conditions note that the clinic cannot guarantee any outcomes, and ultimately successful recovery is dependent on the actions and choices of the client. The clinic offered to make a donation to a charity of Ms A's family's choosing as a gesture of goodwill and acknowledgement of the family's loss.

36. The clinic's terms and conditions contain four paragraphs that outline behaviours and circumstances where no refund will be provided, including the following:

> 'Payment of the programme fee in full, is required prior to commencement of your programme. Your signed registration signifies acceptance and your commitment to the

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programme and the fee may be non-returnable (as noted in T&Cs) except under unforeseen circumstances (for example a family bereavement or accident, or circumstances beyond the client's control). These will be evaluated on a case by case basis with fairness and common sense applied.'

Documentation

37. There were no individual progress notes, assessments, treatment plans or recovery/relapse prevention plans relating to Ms A's care throughout the period Ms A was engaged with the clinic. Mr C was employed as a contractor, and the contractor agreement noted that he was responsible for writing case notes. However, HDC was not provided with any individual case notes pertaining to work with Ms A. In response to my provisional decision, Mr C stated that his notes were either emailed or dictated to Ms F and she would type them into her work computer. Mr C expressed concern that the clinic may not have retained a copy of the notes that were backed up on an external hard drive locked in the medical cabinet on the clinic's premises. In response to my provisional decision, the clinic confirmed that formal client notes were updated from initial clinical team emails or texts and that this system has since been upgraded.

38. Ms F told HDC that documentation consisted of a password-protected document on a computer that was used by clients. She said that she did not feel comfortable writing notes in this document, as there was no way to tell whether the notes had been edited or deleted, and she had concerns about confidentiality. Mr C told HDC that instead of documenting in the password-protected document, often information was sent between staff members via email and stored on the clinic's email server.

39. Ms F said that concerns about the inadequacy of the system were raised repeatedly. She said that on numerous occasions she had told the clinic about the lack of secure note-keeping and that a lack of policies and procedures was bad practice, and she wanted support in improving these processes. Ms F told HDC that she wrote draft policies and procedures to be reviewed and authorised by the founder; however, this did not happen, and she felt unsupported. In response to my provisional decision, the clinic Director disputed this. He stated that he repeatedly asked for policies to be developed but they did not eventuate.

40. Mr C told HDC that staff consistently expressed concerns about the documentation system and made suggestions for improvement. In response to my provisional decision, Mr C provided a list of requests made by staff to improve client care. The list included the following:

- A system for managing documentation;
- A secure private office space;
- An employee-only computer;
- A comprehensive policy and procedure manual;
- Employment contracts for staff;
- Minimising involvement of non-clinical or unqualified staff in client care;

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- A manual time-stamping system; and
- A board to oversee decisions and provide accountability.

41. The founder of the clinic told HDC that as he was not a clinician, he handed over full control of system management to qualified clinical personnel, and the clinical records were not at 'the standard [he] was promised'.

Relevant standards

Health and Disability Services (core) Standards

42. The NZS 8134.1:2008 Health and Disability Services (core) Standards include the following:

'Standard 2.9 Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Criteria The criteria required to achieve this outcome shall include the organisation ensuring:

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

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

2.9.3 Where the service is responsible for NHI[3] registration of consumers, the recording requirements specified by the NZHIS[4] are met.

2.9.4 Where the service is not required to meet the data requirements of the NZHIS adequate consumer detail is collected to safely manage consumer information.

2.9.5 The service keeps a record of past and present consumers.

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

Standard 3.4 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner …

3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning …

Standard 3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner …

[3] National health identification number.

[4] New Zealand Health Information Service.

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3.8.2 Evaluations are documented, consumer focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.'

Tikanga Matatika Dappaanz[5] Code of Ethics

43. The Tikanga Matatika Dappaanz Code of Ethics states:

'The Code sits alongside and is complementary to other related codes, standards and competency frameworks relevant to the addiction sector …

Professional competencies are a key pillar of safe and effective practice and sit alongside the Code. Dapaanz Registered Practitioners and dapaanz Endorsed Support Workers are required to demonstrate the competencies outlined in the Addiction Intervention Competency Framework …

6 Confidentiality and privacy

6.1 Upholds people's rights to confidentiality and privacy in accordance with relevant legislation and codes of practice. For example, ensures privacy in communications, the safe storage of information and vigilance about the disclosure of personal information that has been entrusted to them at work …

7 Conflict of interest

7.1 Declares and manages any actual perceived or potential conflicts of interest in a clear, open and timely manner.

7.2 Identifies and avoids compromising their professional responsibilities as outlined in these Code of Ethics when these conflict with organisational requirements …

11 Laws regulations standards codes and policies …

11.2 Applies legislation, regulations, standards, codes, and policies relevant to their work in a way that protects and enhances that mana of the people they serve, colleagues, the addiction sector and the public.

11.3 Acts to uphold the policies and contributes towards continuous improvement of quality of service in their work context.'

Health Information Security Framework

44. The Health Information Security Framework states:

'1.1 Purpose and background

A health and disability sector-wide Health Information Security Framework advises how health information is created, displayed, processed, transported, has persistence and is

[5] Drug and Alcohol Practitioners Association Aotearoa New Zealand.

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disposed of in a way that maintains the information's confidentiality, integrity and availability.

Confidentiality: Access to health and disability information is limited to authorised users for approved purposes.

Integrity: Data and information is accurate, consistent, authentic and complete. It has been properly created and has not been tampered with, damaged or subject to accidental or unauthorised changes. Information integrity applies to all information, including paper as well as electronic documents.

Availability: Authorised users ability to access defined information for authorised purposes at the time they need to do so …

1.2 Scope

The Health Information Security Framework is concerned with the security of health information wherever it may exist …

1.3 Health Information Security Framework Standard Application

The development and application of specific security policies and procedures to support the organisation is the responsibility of the organisation's management. However, compliance with the framework's Risk management section 1.4 is required from 1 July 2016 …

1.4 Risk management

Health care organisations must undertake the following three activities as a minimum to meet their responsibilities in managing health information.

1.4.1 Regularly undertake a (or review an existing) health information related risk assessment.

Look specifically at the areas listed in this document as a minimum. While documenting risk assessment processes is out of scope for this framework, the assessment must cover the following:

- probability of the risk event occurring
- impact if the risk event occurs
- available risk mitigation actions and counter-measures.

1.4.2 Develop and apply policies and procedures to address each of the identified risks …

1.4.3 Regularly monitor and report on the performance of the above policies/ procedures …

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1.5 Health care organisation category definition

The Health Information Security Framework records the minimum areas of policy (and associated procedures) to be developed and applied by all health and disability sector provider organisations.

The requirements for each individual security section have been grouped into three organisation compliance categories. Organisations are required to attain at least the Baseline level for each section.'

Responses to provisional report

Mr B

45. Mr B was provided with a copy of the 'facts gathered' section of my provisional report and given an opportunity to comment. Mr B's comments have been incorporated into this report where relevant.

Clinic

46. The clinic was provided with a copy of the provisional report and given an opportunity to comment. The clinic's comments have been incorporated into this report where relevant. The clinic also acknowledged the impact of a parent losing a child and passed on its condolences to the family. The clinic said that Ms A had higher level challenges but engaged well with the programme. She was open and honest with her struggles and had a full understanding of the possible impacts that could result from continuing to consume alcohol.

47. Mr D accepted my findings as related to policies and procedures and acknowledged that ultimate responsibility to monitor these systems falls to him. He outlined improvements in documentation that have occurred as a result of the purchase of a client management system for recording information that is designed for community and social care organisations.

48. The clinic maintained that any client contact that occurs within the two-year aftercare period is care provided in a professional capacity, and that aftercare work, by its very nature, can be outside working hours. The clinic stated that any conflict of interest is addressed and resolved with a commitment from staff to maintain appropriate and clear boundaries and said that staff were aware of the policies around professional boundaries and conflict of interest.

49. The clinic told HDC that all contractors and staff mentioned in this report (other than the founder) are no longer working for the clinic. The clinic is confident that its current policies and procedures align with industry standards, and it has committed to meeting the recommendations in this report.

Mr C

50. Mr C was provided with a copy of the provisional report and given an opportunity to comment. Mr C's comments have been incorporated into this report where relevant. Mr C stated that in his professional opinion, Ms A needed more care than the clinic was capable

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of providing, as primarily the clinic functions as a detox centre offering a one-month stay for individuals with mild to moderate addiction issues.

Opinion: Clinic — breach

Provision of care — breach

Introduction

51. Ms A sought help for alcohol addiction and entered a treatment programme with the clinic. She struggled to maintain sobriety following graduation from the residential care phase of the programme and was not able to complete a three-week outpatient reboot, as after three days the programme had to close while the COVID-19 Lockdown was in force. Ms A continued to struggle with sobriety and ultimately passed away eight months after graduating from residential care. I reiterate my condolences to the family for their loss and acknowledge the profound distress associated with the loss of a much-loved daughter.

52. Having considered the information in the clinic's terms and conditions, I find that the care provided to Ms A broadly met the aspects of the programme that were listed. Ms A received residential care for a period of four weeks. The clinic stated that at least weekly counselling occurred, and a relapse prevention strategy was put in place, although there is little documentation to evidence this. In addition, support worker phone calls were initiated following graduation, Ms A was enrolled in a reboot programme when she relapsed, and senior clinicians from the clinic met with Ms A and her family to plan a way forward when the reboot was unsuccessful. However, I am limited in my assessment because of the lack of clinical documentation available to HDC. Although broadly the terms and conditions have been met, I consider that systems issues contributed to confusion and misunderstanding.

Information provided to consumers

53. The terms and conditions and the clinic's website information lacked detail on the content of the programme and specific information on what was included in aftercare other than support worker contact and a reboot if necessary. There is mention of a graduates group with no information on how the group would function or membership composition. A lack of detailed information allows misunderstandings to occur between service providers and consumers, and confusion in what aftercare consists of may lead to an impression that more has been promised. This is shown in the multiple terms that are used by different parties for a plan of care, including 'aftercare programme', 'exit plan', 'relapse prevention plan', 'safety plan', and 'life plan'.

Conflict of interest

54. Although the care provided was consistent with the clinic's terms and conditions, I am critical of the clinic's decision to assign Ms A a family friend, Mr E, as her support worker. It is clear that Mr E contacted Ms A and provided support on multiple occasions. However, the professional role of the support worker and the role of a friend blurred. The majority of Mr E's contact with Ms A was after working hours and while he was overseas when New Zealand's border was closed due to the COVID-19 pandemic. Mr E was clear that he was not acting in his role of support worker when he phoned Ms A on 6 Month3 and had to contact Ms A's mother to ensure Ms A's safety.

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55. Providing care to friends or family compromises objectivity and continuity of care and creates an environment where misunderstandings can occur. There was no clear boundary between the support that Mr E was providing as a friend and the support provided as a staff member of the clinic. I consider that this a clear conflict of interest and inappropriate in the context of professional support work.

Failure to replace liaison person

56. The clinic had a responsibility to meet the agreement that was made with Ms A and her family on 29 Month5. It was agreed that Mr C would liaise with Ms A's private counsellor on her progress and whether she would benefit from further time at the clinic after a period of two months.

57. Following Mr C's departure from the clinic, no attempt was made to hand over the role of liaison to another staff member until Ms A's family contacted the clinic, three weeks later, to question why there had been no communication between Mr G and the clinic. A further verbal agreement was made to arrange for Mr E to be the liaison person. However, there is no evidence to support any action being taken to inform Mr E of this, or to replace the disclosure of information form. I am critical of the failure to assign a replacement liaison person when Mr C's contract was terminated.

Conclusion

58. In my view, no one individual is responsible for the deficits identified above. I consider that the lack of a clearly structured aftercare programme, the systems in place for handing over care, the absence of a secure system for clearly documenting consumer information, including plans, agreements, and meeting minutes, and the blurring of roles between friendship and employee contributed to differing expectations of service provision, confusion, and lack of continuity on the plan of care. For these reasons, I find that the clinic failed to provide services to Ms A with reasonable care and skill, and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[6]

Documentation — breach

59. The standard of documentation is extremely poor, almost non-existent. Information was communicated between clinicians by email and stored on the email server, not in a dedicated patient management system as required by the Health and Disability Services Standards. There was a single password-protected Word document recording the daily activity of the group of residents, and no uniquely identifiable individual records. This is far below the level expected of a healthcare provider.

60. In my view, the minimum expectation would be for interactions that involve therapeutic discussion or action, such as counselling, assessment of risk and progress, goal setting, and care planning, to be appropriately dated, signed, and documented in an individual file that is located in a system that meets the baseline requirements of the Health Information Security Framework.

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

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61. I note Ms F's and Mr C's comments that a lack of trust in the system in place at the clinic contributed to poor documentation, and the founder's response that he 'handed full control over to qualified person[ne]l to handle all systems', and that clinical records were 'not at the standard [he] was promised'. I do not accept that the director of the clinic can abdicate responsibility for setting up systems and processes to the clinicians. It is incumbent on owners and directors to ensure that the staff and contractors they employ have the tools and systems in place to provide the services for which the consumer has engaged them. I consider that clinician involvement in setting up appropriate systems is critical to make certain they are fit for purpose. However, ultimately it is the directors' responsibility to ensure that systems that comply with industry standards and expectations are in place.

62. This investigation identified areas where information was not handed over to relevant members of staff, documents were misplaced, there were insufficient policies, a lack of guidance for staff, and different opinions on whether Ms A was exited from the programme. There was no central point of reference for storing information or communicating plans of care for an individual client. I consider that this contributed to a general lack of consistency, coordination, and communication.

Conclusion

63. It is clear to me that the clinic failed to meet the minimum expected standard for recording and storage of clinical documentation as outlined in the Health and Disability Services Standards and the Health Information Security Framework. Therefore, I find that the clinic breached Right 4(2) of the Code.[7]

Opinion: Mr C — adverse comment

64. I acknowledge Mr C's comments on the inadequacy of the patient management system for documenting clinical notes. However, as an AOD clinician, Mr C has a responsibility to comply with the standards and competencies associated with his profession. This includes documenting clinical interactions as outlined in the Health and Disability Services Standards and contributing towards quality improvement. It is not sufficient to carry out assessments and document interactions with clients in an email rather than in a dedicated and secure individual file.

65. I am critical of the complete lack of individual clinical documentation provided to HDC related to Ms A's care. I note Mr C's response to my provisional decision, and, due to the paucity of information provided to HDC, I am unable to determine whether he in fact documented clinical interactions that were dictated or transcribed and stored as securely as possible in the absence of an appropriate patient management system. Nevertheless, I remind Mr C of his responsibility to comply with standards and maintain professional practice, as outlined in the dapaanz Code of Ethics.

[7] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

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Changes made since events

66. The clinic told HDC that a more robust recording and retrieval system for documentation has been implemented. The system includes the following:

- A record-keeping policy.
- Notes made each day for every client by the supervisor on shift. Notes are checked each morning by the manager, who also makes a daily note.
- Each clinician has a confidential folder to store clinical records, accessible by the clinician and manager only, on a shared drive. The manager checks weekly to ensure that regular notes are being made.
- Each client has at least weekly one-on-one counselling. Notes of these sessions are stored as above.
- A weekly staff meeting is held to discuss incoming clients, current clients, aftercare clients, progress, and concerns. Minutes are recorded, transcribed, and stored in the shared drive.

- In response to my provisional decision, the clinic stated that systems are now 'vastly different' with a completely new team in place, development of new policies and procedures, and the purchase of the system for documenting client information. The clinic is confident that all relevant standards are now adhered to, and that all staff are aware of recording standards for client information and understand their obligations to maintain service delivery and information management standards.
- The clinic informed HDC that at the time of these events the graduates group was an online resource, but it has now been upgraded to in-person contact for local clients and video-conference for clients outside the region. The clinic now provides weekly aftercare group sessions that are facilitated by an AOD clinician and an IBOC[8]certified trainee psychotherapist.

Recommendations

67. I acknowledge the changes made by the clinic. In addition, I recommend that the clinic:

a) Provide a formal written apology to Mr and Mrs B for the breaches of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mr B, within three weeks of receiving this report.

b) Provide HDC with a copy of the structured and measurable aftercare programme that was developed since the time of these events, and any consumer feedback received since implementation. This information is to be provided to HDC within six weeks of receiving this report.

c) Develop a consumer information brochure for each programme, clearly communicating what is included and how it will be delivered and update the information on its website

[8] International Board of Certification.

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accordingly. A copy of the information brochure is to be provided to HDC within three months of receiving this report.

d) Review its terms and conditions document for accuracy, clarity of the service provided, and consistency of terms. A copy of the reviewed document is to be provided to HDC within three months of receiving this report.

e) Audit its documentation system for compliance against the baseline category of the Health Information Security Framework standard and the Health and Disability Services standards and provide a report of the results and corrective action plan to HDC within three months of receiving this report.

f) Develop a policy on conflict of interest and provide HDC with a copy of this policy and evidence of communication of the policy to staff, within six weeks of receiving this report.

Follow-up actions

68. A copy of this report with details identifying the parties removed will be sent to the Addiction Practitioners Association Aotearoa New Zealand (dapaanz) and the Director of Addiction Services (Health New Zealand|Te Whatu Ora) and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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