# Auckland District Health Board

# Taikura Trust

# Aranui Home and Hospital Ltd

# (trading as Oak Park Dementia Unit)

**A Report by the**

**Deputy Health and Disability Commissioner**

**Case 08HDC20957**

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## Executive Summary

*Background*

1. Ms A complained that she was incarcerated in a secure rest home for more than a year without legal authority.

2. Ms A was a 43-year-old woman with a complex personal history, which included severe psychological trauma, depression and alcohol abuse. She was admitted to Auckland City Hospital in May 2007 in a confused state. She was assessed as not having the capacity to make decisions relating to her personal care and welfare and so she could not give informed consent. It was decided that an application should be made for a court order to place Ms A in an appropriate residential facility. The application was prepared but never filed with the Court.

3. In August 2007, Ms A was discharged from hospital and placed by Taikura Trust[1] at Oak Park, a secure rest home caring mostly for older people with dementia. Ms A understood that she was legally required to live there. She was assessed by Taikura Trust three times over the following ten months, and on each occasion she expressed her wish to leave Oak Park and to live somewhere more suitable.

4. Nearly a year after her admission to the rest home, Ms A was assessed as being too well to be in a secure unit, and as competent in relation to her personal care and welfare. The Community Alcohol and Drug Service (CADS) had become involved and, during its efforts to support Ms A and arrange access to a residential alcohol rehabilitation programme, CADS staff discovered that there was no court order and therefore no legal requirement for Ms A to remain at Oak Park if she did not wish to be there. Over the following two months, arrangements were made for Ms A's transition and she left Oak Park in October 2008.

*Findings*

5. This report finds multiple deficiencies in the care provided to Ms A. No one was legally appointed to act on her behalf, or informally available to advocate for her. She was effectively detained at Oak Park for periods of time, when there was no such legal requirement, and it was neither in accordance with her wishes nor always appropriate for her needs.

6. ADHB breached Rights 4(1)[2] and 4(5)[3] of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to have adequate systems in place to deal with the court order application, failing to take sufficient or appropriate action in

[1] Taikura Trust is a charitable trust providing needs assessment and service co-ordination for people under 65 years old with a physical, sensory or intellectual disability across greater Auckland. It is contracted by Disability Support Services (part of the Ministry of Health) to work with disabled people to help identify their needs and outline what disability support services are available. It allocates Ministry-funded support services and assists with accessing other supports.

[2] Right 4(1) — Every consumer has the right to have services provided with reasonable care and skill.

[3] Right 4(5) — Every consumer has the right to co-operation among providers to ensure quality and continuity of services.



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relation to Ms A's discharge, and for poor communication and co-operation between staff and with other providers.

7. Taikura Trust breached Rights 3,[4] 4(1) and 4(5) of the Code. It failed to verify Ms A's legal status or to ascertain, if Ms A was unable to consent to the placement, who could consent on her behalf and who it should consult and communicate with in relation to her placement. There was a lack of care and skill throughout the needs assessment/service co-ordination process, and there were deficiencies in communication and co-operation between staff, with Ms A, and with other service providers. Taikura Trust has been referred to the Director of Proceedings.

8. Aranui Home and Hospital Ltd trading as Oak Park Dementia Unit breached Right 4(1) of the Code. It failed to verify Ms A's legal status, or to ascertain who could make decisions on her behalf and who it should consult and communicate with in relation to her care. It did not take adequate steps to address the fact that she was inappropriately placed. Aranui Home and Hospital Ltd trading as Oak Park Dementia Unit has been referred to the Director of Proceedings.

## Complaint and investigation

9. On 18 December 2008 the Commissioner received a complaint from Ms A about the services provided by Auckland City Hospital, Oak Park, and general practitioner Dr J. The following issues were identified for investigation:

- *Whether Auckland District Health Board took adequate steps to ascertain and confirm the appropriate person to consent to Ms A's care and treatment between May and August 2007.*
- *Whether Auckland District Health Board consulted and communicated appropriately with Ms A and other relevant people in relation to her care and treatment, particularly her legal status.*
- *Whether Taikura Trust took adequate steps to ascertain Ms A's legal status in relation to informed choice and consent.*
- *Whether Taikura Trust took adequate steps to ascertain the appropriate person to give informed consent for Ms A's care and treatment.*
- *Whether Taikura Trust consulted and communicated appropriately with Ms A and other relevant people between 7 August 2007 and 20 October 2008, regarding Ms A's care.*
- *Whether Aranui Home and Hospital (trading as Oak Park Dementia Unit) treated and detained Ms A without lawful authority between 23 August 2007 and 20 October 2008.*

[4] Right 3 — Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.



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- *Whether Aranui Home and Hospital (trading as Oak Park Dementia Unit) provided Ms A with an appropriate standard of care between 23 August 2007 and 20 October 2008.*

10. An investigation was commenced on 18 June 2009.

11. The parties directly involved in the investigation were:

| | |
|---|---|
| Ms A | Consumer/Complainant |
| Ms B | Social Worker (Auckland District Health Board) |
| Dr C | Consultant Psychiatrist (ADHB) |
| Mr D | Lawyer (ADHB) |
| Ms E | Consumer's mother |
| Ms F | Social Work Team Leader (ADHB) |
| Dr H | Senior Medical Officer (ADHB) |
| Ms G | Chief Executive Officer (Taikura Trust) |
| Ms I | Team Leader (Taikura Trust) |
| Dr J | General Practitioner |
| Ms K | Needs Assessor (Taikura Trust) |
| Ms L | Service Co-ordinator (Taikura Trust) |
| Ms M | Supervisor (Oak Park) |
| Ms N | Registered Nurse (Oak Park) |
| Ms O | Service Co-ordinator (Taikura Trust) |
| Ms P | Alcohol and Drug Clinician (CADS) |
| Dr Q | Psychiatric Registrar (CADS) |

Also mentioned in this report:

| | |
|---|---|
| Dr R | Consultant physician |
| Ms S | ACH social worker |
| Ms T | Occupational therapist (Oak Park) |
| Dr U | Clinical leader, Mental health service (ADHB) |
| Mr V | Team Leader (Taikura Trust) |

Information was reviewed from: Ms A, ADHB, Taikura Trust, Oak Park Dementia Unit, Dr J, CADS, and the Ministry of Health.

12. Independent expert advice was obtained from physician Dr Geoffrey Robinson and is attached as **Appendix 1**.

13. This report is the opinion of Rae Lamb, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.



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## Information gathered during investigation

14. Ms A had a complex personal history which included severe psychological trauma, depression and alcohol addiction. She had multiple contacts with drug and alcohol services and made several unsuccessful attempts at detoxification and rehabilitation, but she remained vulnerable to relapse. Ms A had a transient lifestyle in recent years, with periods of homelessness.

*Admission to Auckland City Hospital*

15. On 11 May 2007, Ms A (then aged 43 years) was taken to Auckland City Hospital (ACH) by staff from a community centre, who were concerned about her physical and mental well-being. It was noted in her previous medical history that she had an alcoholic amnestic disorder.[5] She was admitted to a medical ward and her previous clinical records were requested from two other hospitals (Hospitals 1 and 2). Within a few days, Ms A was diagnosed with communicating hydrocephalus[6] and cryptococcal meningitis,[7] and treatment was commenced. She also had impaired mobility with a high risk of falling, and problems with urinary incontinence. Clinical records show that at this time Ms A's awareness of her whereabouts and the reason for her hospital admission fluctuated.

16. On 28 May, social worker Ms B met with Ms A. Ms B noted that Ms A gave her consent for social work input, but that she refused permission for Ms B to contact her friends.

17. On 29 May, an on-call house officer was asked to see Ms A after she expressed her wish to be discharged. The house officer spoke with her about her need for medical treatment for cryptococcal meningitis, and the risks of discharge with a central venous line (CVL).[8] Ms A was calm, returned to her bed and did not respond when asked if she would co-operate. The house officer noted that Ms A appeared to have temporarily accepted the need to stay in hospital, and outlined the actions to be taken in the event that Ms A became agitated, tried to remove the CVL, or tried to leave the hospital.

18. An entry in the clinical notes on 31 May indicates that Ms A was happy to remain in hospital. That day, Ms B contacted ADHB's legal service in relation to Ms A, seeking preliminary legal information and advice on the basis that she appeared to have some permanent mental incapacity.

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[5] Brain damage caused by alcohol-induced thiamine deficiency and characterised primarily by memory impairment (also known as Korsakoff Syndrome).

[6] A condition in which cerebrospinal fluid passes readily out of the brain into the spinal canal but is not absorbed.

[7] A fungal infection of the membranes covering the brain and spinal cord.

[8] A tube passed through a large vein in the neck, chest or groin. It has several uses including administration of medication, and is the preferred route for some medications.



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*Psychiatric assessments and application for an order*

19. On 31 May 2007, Ms A was assessed by consultant psychiatrist Dr C. Dr C is part of the liaison psychiatry team, which provides consultations to the hospital's medical and surgical teams. Dr C's impression was that Ms A had an alcohol amnestic disorder, that she was likely to have confusional overlay secondary to meningitis and hydrocephalus, and that this might take weeks to settle. He indicated that Ms A lacked capacity to make informed decisions and, accordingly, that an application for welfare guardianship would need to be made under the Protection of Personal and Property Rights Act 1988 (PPPR Act).[9] Dr C noted that Ms A needed to be assessed by an occupational therapist and have follow-up neuropsychological assessment in six months' time.

20. The same day, ADHB lawyer Mr D emailed templates and instructions to Ms B for applications under the PPPR Act, and stated that he would review the completed application. ADHB subsequently advised HDC that welfare guardianship was not an option without an appropriate person to take on this role.[10] The alternative was to apply for a personal order.

21. Ms B began seeking the background information necessary to complete the application for a personal order. On 6 June, Ms B contacted Ms A's mother, Ms E, who advised that no one currently had guardianship or had been appointed property manager for her daughter. Ms E explained that in view of the family's previous efforts to support their daughter, they were no longer able to help. She also said that her daughter might need to be sectioned to prevent her from leaving the building, and asked to be kept informed.[11] Ms A's parents live in another region and have guardianship of Ms A's daughter.

22. On 7 June, Ms B faxed a request for previous clinical records to Hospital 2, signed by Ms A. There are records in Ms A's ACH notes from Hospitals 1, 2, and 3, although it is not entirely clear which records were provided to ADHB by whom and when. Some information had previously been shared between these DHBs. In a letter dated 31

[9] The PPPR Act 1988 provides legal ways to assist people unable to manage their own affairs as a result of illness or disability. The Act emphasises the importance of making the least restrictive intervention possible in the life of a person subject to an order under the Act, of the person being enabled or encouraged to exercise and develop such capacity as he or she has to the greatest extent possible, and to make decisions to the extent that he or she is able.

[10] There are a number of differences between welfare guardianship and personal orders. In short, welfare guardians are appointed for people who are totally unable to communicate or understand decisions about their personal care and welfare. Personal orders are more limited and specific. A personal order may, for example, require a person to be provided with specific living arrangements.

[11] Being sectioned means legally detaining a person for the purposes of assessing that person's mental health and/or providing treatment.



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January 2007, from a Hospital 2 social worker to a Hospital 3 psychiatric consultant, it was noted that Ms A did not have a welfare guardian.[12]

23. On 27 June 2007, Ms B noted that following liaison with social work team leader Ms F and Mr D, she had been advised to apply for a personal order to place Ms A in a residential facility. Ms B requested medical statements from Dr C and senior medical officer Dr H to support this application. The same day, Ms F emailed one of the application documents to Mr D for him to review. He amended the document and returned it to Ms F.

*Assessment by Dr H*

24. Dr H's statement (written 27 June) noted that Ms A suffered from a significant cognitive impairment, likely due to alcohol-related memory deficits, possible normopressure hydrocephalus and, most recently, cryptococcal meningitis. He stated that despite treatment for the latter condition, her memory and judgement impairments had not improved. Dr H noted that she also suffered from significant gait instability and urinary incontinence. He stated that it was his professional belief that Ms A had irreversible marked impairments in both her short- and long-term memory, as well as in her judgement. He considered her prognosis to be quite poor, and that she was not likely to be able to make informed decisions regarding the care of her property or herself. To that end, he supported the appointment of a welfare and property guardian. He stated that Ms A also had significant need for permanent placement as prior to coming into hospital she had been chronically and intermittently homeless.

*Further assessment by Dr C*

25. On 16 July, Dr C reviewed Ms A. He found no change in her cognitive status when compared to her baseline assessment, despite resolution of her meningitis. On this basis, the assumption was that her condition was largely irreversible. Dr C confirmed that he would prepare a report in support of the PPPR Act application. He noted that placement would probably be in a rest home or private hospital, depending on the level of nursing care required.[13]

26. Dr C completed the medical report on 19 July. He noted that following Ms A's admission, the working diagnosis had been long-term alcohol abuse and dependence with secondary alcohol amnestic disorder. In addition, over the previous two years imaging studies suggested hydrocephalus and, during her last admission, a chronic

[12] Ms E recalls that she was asked to sign some documents when her daughter was admitted to a home in 2005. HDC has found no evidence that an enduring power of attorney for care and welfare existed then, or at any other time.

[13] People under 65 years with a physical, sensory or intellectual impairment who need residential care usually live in supported, community-based accommodation. Some people under 65 are accommodated in aged residential care facilities. There are four main types of aged care facilities: rest homes (Stage II) are for people who need a reasonable level of support but who do not require 24-hour access to qualified nursing care; private hospitals are for the long-term care of people who need ongoing nursing care; dementia rest homes (Stage III) are for those people whose confusion and behaviour is such that they require a secure (locked) environment; and specialist long-term care (or psychogeriatric) hospitals are for those people who require both regular nursing care and a secure environment.



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meningitis process was confirmed. He stated that his report was based on clinical assessments between the end of May and early July, and that information had been obtained from previous providers in three regions. He noted that in view of Ms A's nomadic lifestyle over the previous nine years, it was likely that the records were not complete.

27. Dr C summarised his findings:

> "Diagnostically she can be summarised as suffering from an Alcohol Amnestic Disorder that is characterised by severe inability to recall any newly presented information. In addition, she presents with moderate frontal system deficits mainly affecting arousal, attention and executive function. One also needs to consider the possible contributions hydrocephalus and chronic meningitis may have on her current cognitive difficulties and these, in part, are potentially reversible. During the assessment over the seven week period her cognitive status remained significantly impaired as was her ability and capacity to make informed decisions."

28. Dr C therefore supported the application for a personal order with a view to overseeing decisions about her person, including placement and health matters. He suggested it would be prudent to review the appropriateness of the order after nine to twelve months, in light of the possibility of improvements.

29. In relation to placement, Dr C noted:

> "[T]here is no evidence of severely challenging behaviour but by virtue of her profound amnesia, as well as disorientation and poor planning ability, she remains vulnerable. In addition, she is physically frail and has significant problems with gait, and therefore the risk of falls. Based on this, it seems reasonable for her to be managed in a rest home or private hospital facility where she can receive adequate support and monitoring of her healthcare needs."

30. Dr C subsequently advised HDC that at the time of his involvement with Ms A, the severity of her cognitive difficulties was such that there was no prospect of substance focused rehabilitation or abstinence-based support. Accordingly there was no recommendation for a referral to the Community Alcohol and Drug Service (CADS).

*Completing the PPPR Act application*

31. Dr C's report was emailed to legal services and social work services the same day. The following day, legal services emailed the draft documents back to social work services, and Ms B was asked to complete the affidavit and information sheet. On 24 July, Ms F emailed an electronic copy of the affidavit to legal services for finalising.

32. On 25 July, Ms B recorded in the clinical notes that the completed application had been sent to the ADHB lawyer. The hard copy of the application was not received by legal services. However, on 30 July, Mr D responded to Ms F's email with the



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electronic copy, asking that Ms B identify the authors of each annexure, complete the documentation and return it to him.

33. An unsigned copy of the application was provided to HDC, although it is not clear whether this was the final draft. The affidavit completed by Ms B includes information about Ms A's background and her admission to ACH. Ms B stated:

> "We are presently attempting to locate a facility with the capacity and capability to take [Ms A]. Beds come available at short notice and it may be necessary to have an order in place to take advantage of these placements, rather than seeking an order after a bed is identified."

34. And further:

> "[Ms A's] family has clearly expressed their wish not to be involved in her future care plan decisions."
>
> …
>
> "In my opinion placement in a residential care facility is in [Ms A's] best interest and is the least restrictive intervention in her circumstance."

*Referrals for residential care funding*

35. Ms B also noted in her entry on 25 July that funding for Ms A's placement had been declined verbally by Taikura Trust, and that she would apply for funding from mental health services.

36. On 30 July, Ms B took Ms A for a cup of coffee after she had expressed a wish to discharge herself. Ms A struggled physically to make it back to the ward, and appeared happy to go back to bed.

37. On 6 August, Ms B noted that mental health services had declined funding. Consultant physician Dr R wrote: "This is disappointing, [Ms A] is frustrated, as are we. We wait…?"

38. The next day, Ms B faxed an application to Taikura Trust for placement funding through the "Interim Funding Pool". She included the letters from Dr C and Dr H, and two pages from the clinical notes recording an occupational therapy kitchen assessment completed on 1 June.

*Interim Funding Pool*

39. The Interim Funding Pool (IFP) was set up by the Ministry of Health (MOH) to fund long-term support services for people with chronic health conditions who did not meet the access criteria for MOH Disability Support Services or DHB-funded support services. The interim system was put in place in November 2006 to administer funding while policy work was underway to allocate ongoing funding responsibility.



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40. The *Guide to Operating the Interim Funding Pool for Long-term Support Services* states: “Wherever appropriate, the IFP uses existing Ministry and NASC processes and procedures.” It explains that to ensure consistency, NASC agencies are required to consult with the IFP National Reviewer before an IFP referral is accepted or declined.

41. The Guide also sets out expected response times when IFP referrals are received. First contact should be made within two days of receiving a referral with sufficient information to determine eligibility. A facilitated needs assessment should be completed within 24 hours in a crisis when a person’s safety is at risk, within 24–48 hours for urgent referrals depending on the degree of urgency, and within five working days for all other eligible referrals. Service Co-ordination should be completed within five working days of a completed assessment for 80% of cases, and within 10 working days for the remaining 20% of cases.

42. It states also that needs assessments are undertaken using national assessment guidelines, and service co-ordination is in accordance with standard Ministry contracted NASC processes. Service packages are to be reviewed by service co-ordination staff six weeks after the start date to check services are being provided and are meeting the client’s needs and expected outcomes.

*Discharge from hospital*

43. Clinical notes over the next week show that Ms A had several periods of agitation and that she expressed her wish to go out. On 16 August, she left the hospital and was found several hours later, a short distance away. She was brought back to the ward by police. It was noted that she “appears comfortable with no concerns”.

44. On 20 August, the possibility of admitting Ms A to the psychiatric inpatient unit was considered, in light of the recent episode of wandering and episodic agitation. The consensus was that this was a placement issue and that Ms A did not meet the criteria for acute psychiatric admission. Dr C noted that funding and placement were to be pursued, with interim placement in a semi-secure unit if necessary.[14]

45. Ms B was due to go on leave, and noted on 21 August that in her absence, Taikura Trust would contact Ms F with a list of suitable private hospitals. Ms F emailed a private hospital about a possible placement, and copied this to other relevant staff, including Mr D. There was no mention of a personal order and, accordingly, Mr D understood that the application was no longer required. ADHB subsequently advised HDC that this happens “not infrequently”, for a range of reasons, such as when a discharge plan changes, if a patient becomes more competent, or if a family member applies for welfare guardianship.

[14] Semi-secure facilities are Stage II rest homes with additional measures in place (eg, keypads on main doors) to reduce the risk of residents wandering or leaving the premises without staff knowledge.



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46. On 21 August, Taikura Trust Chief Executive Officer Ms G emailed the referral for Ms A to the IFP National Reviewer, recommending that IFP funding be agreed. She noted:

> "I want to undertake a thorough assessment process involving mental health and given our experience over the last week or so this will take some time. We need to stabilise her in an environment where we can do that, hence my recommendation."

47. On 22 August, ACH social worker Ms S wrote in the clinical notes that she had been advised by Taikura Trust team leader Ms I that funding had been approved for a rest home (secure unit) through the IFP. Ms S wrote: "As pt [patient] would need funding for long term care [Ms I] has suggested that pt could be transferred to Aranui Home." Ms S contacted the clinical co-ordinator at Aranui, and was advised that they had a bed in their rest home (secure unit), and that they would be happy for her to be transferred the following day. Ms S informed Ms A's mother. There is no record that Ms A was informed.

48. An entry in the nursing notes later that evening states:

> "Pt looks sad — re — discharge thinks she is going to her mum."

49. And the next day:

> "Angry mood this morning. Not wanting to go now!!! Different stories about her destination.
>
> …
>
> Pt for discharge today. Phoned Aranui R/H, talked to SN [Ms N]. [Ms A] now going to Oak Park R/H (secure unit) ..."

50. Ms A was discharged to Oak Park Dementia Unit (Oak Park) that day. Staff at Oak Park recall that social workers and nurses from Auckland Hospital visited Oak Park before Ms A was placed there, but there is no record of this.

51. The discharge summary stated: "Placement for [Ms A] was problematic. [Dr R], consultant physician, and liaison psychiatry service both agreed that she was incompetent and would require [a] secure unit. Despite this, funding for her placement had been difficult leading to prolonged hospital stay. She was medically cleared for discharge at mid June. However, [an] interim placement was only found in late August." The outstanding issues were also noted:

"1. heavy drinking, please monitor
2. short term memory loss
3. urinary incontinence"



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52. Dr C subsequently advised HDC that at no time did he identify significant challenging behaviour that required placement at a higher level facility, and that this is reflected at various points in his notes. In his view, his recommendations were not implemented, and were misrepresented in the discharge summary.

53. In its response, ADHB advised HDC that it was for Taikura Trust to determine an appropriate facility for Ms A's needs, and to organise placement. It stated further:

> "It is not usual for Taikura Trust to consult with the referrer (ADHB, in this case) if the decision on placement is different to the recommendation made by the referring service. They do however consult with families on occasion, primarily around issues of location but ultimately they are the decision makers."

54. Taikura Trust advised that it was ADHB's decision to place Ms A at Oak Park.

*Role of Taikura Trust*

55. NASC services have the role of assessing need, prioritising and allocating resources for people with disabilities living in their area.

56. An IFP contract between the Ministry of Health and Oak Park set out the terms and conditions of Ms A's placement. This provided that the access to residential services should be arranged by way of an authorised referral from the Ministry of Health approved NASC service, following an individual needs assessment.

57. The NASC must ensure that:

- the individual is eligible (as assessed by a Ministry authorised specialised needs assessor/professional as recognised by the NASC, not the provider);
- the individual, and his or her family/whanau/advocate have been involved in the selection of the provider;
- any Māori service-user/whanau/family/guardian/advocate accepts the provider's cultural competence;
- the NASC service indicates that there is not a more appropriate residential facility available in the service user's region;
- a clear rationale is provided to the service user, his or her family/whanau/advocate (if appropriate) and the Ministry as to why placement in an aged care facility is being recommended.

58. The contract also shows that in the event of a disagreement in relation to a NASC agency's assessment of a person's need for the service, a review can be requested. If the review confirms the assessment, another NASC agency can be asked to carry out a further review.

*Admission to Oak Park*

59. Oak Park is a privately owned, 16-bed stage III dementia unit. It is part of the Aranui Home and Hospital Ltd, which also has a private hospital and stage II rest home. Oak Park has a contract with ADHB for the provision of age-related dementia care, and is also licensed to provide care to people under 65 years of age who require a secure



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environment. Most residents at Oak Park are aged over 65, with age-related dementia. At the time of Ms A's admission, there was only one other resident younger than 65.

60. Oak Park supervisor Ms M recalls that on 23 August, she was advised by a nurse from ACH that Ms A would be transferred by ambulance that day. Ms A arrived with some documentation from ACH, and there is reference in the home's progress notes that day to a discharge summary and medication chart.

61. Staff recall that Ms A required a lot of care and assistance at the time of her admission. On 27 August, she was assessed by Oak Park's occupational therapist, Ms T. Ms T noted that Ms A's goal was "to move to [the town where her parents live] to live an ordinary life". On 29 August, Ms A was seen for the first time by general practitioner Dr J. He also noted Ms A's wish to return to her parents' hometown.

*Needs Assessment*

62. A Needs Assessor from Taikura Trust, Ms K, also assessed Ms A on 29 August. Taikura Trust subsequently explained that in situations such as this, a customer support representative would usually liaise with the allocated needs assessor and the client or his or her representative, to arrange the assessment. Ms K was contracted by Taikura Trust on a fee-for-service basis. Her role was to complete an assessment to identify Ms A's support needs. It was then for a service co-ordinator to determine if those needs could be met and, if so, how and by whom.[15]

63. Ms K does not recall what information she was provided with prior to the assessment. She explained that when she arrived at Oak Park, she obtained information from written material on Ms A's file, from Registered Nurse (RN) Ms N, and from Ms A. Ms K initially spoke with RN N, who she recorded on the assessment as Ms A's legal representative. On the second page of the assessment, RN N signed the consent that authorised the collection, storage and use of information for identifying support needs and for service co-ordination. One page of the assessment records Ms K's discussion with Ms A, and this is signed by Ms A. Ms A subsequently advised that she had no recollection of this meeting.

64. The assessment indicated that Ms A communicated clearly and had no verbal issues, although she could be verbally aggressive when articulating her frustration. Ms K found that Ms A's memory was good, and rest home staff agreed. Ms K noted that Ms A had requested a psychiatric assessment to determine her current situation, and that RN N agreed this would be a good way to establish future goals and to be able to meet her needs appropriately.

65. Ms K noted three desired outcomes:

[15] The Policy, Procedure and Information Reporting Guidelines for NASC state that a needs assessment is undertaken in partnership with the disabled person and is a "…facilitated process of determining the current abilities, resources, goals and needs of a person with a disability and identifying which of those needs are the most important to the disabled person". Service co-ordination is the process of "setting up flexible and responsive solutions to meet the prioritised needs and goals of the disabled person, as identified in the needs assessment, in a manner that makes sense to them".



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- "For staff at Oak Park to be supported to have appropriate necessary assessments completed so as to formulate a care plan, so as to meet present needs, and to be able to inform [Ms A] of her situation.
- For staff at Oak Park to be supported to offer care at present level to meet needs around health and well-being until permanent care situation is established.
- For [Ms A] to be supported to have requests met around having assessments completed, and for her to have future living situation plan established so as to maximise her current well-being and health situation."

66. On 3 September, Ms T contacted Taikura Trust in relation to Ms A's request for a psychiatric assessment, and was advised that Taikura did not do psychiatric assessments. Ms T recommended that a referral should be made to the CADS.

67. On 12 September, Taikura Trust service co-ordinator Ms L phoned Oak Park, and was told that Ms A was settling in well. She wrote to Ms A, confirming that on the basis of the goals identified during the recent assessment, funding for Ms A's placement at Oak Park had been confirmed.

68. On 21 September, RN N requested information from Ms A's ACH records. Clinical summaries from 1996 onwards and Dr C's report were faxed to Oak Park a few days later.

*Reassessment*

69. On 1 November, Dr J contacted Taikura Trust, advising that Ms A was very unhappy at Oak Park and that she would like to move to a more suitable facility. On 14 November, Ms L acknowledged the referral with a phone call to the manager of Oak Park and noted that a reassessment was to be scheduled.

70. Dr J subsequently advised HDC that from the outset he was concerned that Oak Park was not a suitable long-term placement for Ms A — as a 43-year-old in a facility where most of the other residents were over 70 years old. Dr J recalled being advised on further enquiry to Taikura Trust that it was "unable to find an alternative placement for someone in her category (young, considered still incapable of self care and with alcohol issues)". Dr J considered that while Ms A gradually showed some improvement in her cognitive ability, she continued to need secure supportive care.

71. On 14 December, Ms A bought alcohol while out shopping with another resident and a staff member. This was the second time Ms A had obtained alcohol on a shopping trip, and staff decided she was not to be taken shopping again.

72. On 22 January 2008, Ms A was reassessed by Ms K. On this occasion Ms A signed the assessment herself. The outcomes identified were:

- "For [Ms A] to be supported to address her concerns around the present living situation.
- For [Ms A] to be supported to live in [the region where her parents live]."



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73. On 14 February a Taikura Trust team leader faxed an inter-NASC transfer request to another centre.[16] On 18 February, it was noted by Taikura Trust that the transfer request had been declined as they did not have an appropriate placement for her at that time and transfer was not supported by Ms A's family. It is not clear how or when this decision was communicated to Ms A.

74. On 26 March, RN N contacted Taikura Trust at Ms A's request. The service co-ordinator, Ms O, advised that another appointment would be made for Ms A.

75. The following day, Ms M noted that Ms A went out with a member of staff to buy a lotto ticket, and that she was "very happy that we allowed her out".

76. On 7 April, Ms M noted that Ms A phoned the Health and Disability Service, and that she was advised to stay at Oak Park until she had been assessed by the Care team.[17] The call was documented by an advocate from the Health and Disability Advocacy Service. The advocate recorded that Ms A said she wanted to leave the rest home but had been told she could not. The advocate noted that she spoke with the manager, who advised that someone from hospital was coming to review Ms A's situation and if things went all right in the review she would be removed from the rest home.

77. On 16 April, Ms A's situation was reviewed by the multi-disciplinary team at Oak Park. Dr J noted: "Consensus is that she is inappropriately placed among older demented patients. She needs secure placement — has sourced alcohol on several occasions when opportunity arose."[18] RN N recorded in the clinical notes that they were "[s]till waiting for Taikura Trust".

78. On 1 May, Ms M recorded that Ms A asked that arrangements be made for her to go out and live in the community, and that she was not happy to stay at Oak Park. On 9 May, RN N assisted Ms A to contact Taikura Trust again. Clinical notes indicate RN N made further efforts to contact Taikura Trust on 21 May, 23 May and 4 June. On 6 June, Ms M noted that RN N had arranged for Taikura Trust to meet with Ms A.

*Further assessments*

79. On 6 June, Dr J contacted the clinical leader of ADHB's mental health service, Dr U, about Ms A's situation. Dr U agreed to follow up.

80. On 14 June, Ms A again managed to leave the premises and obtain alcohol, but this was found by staff before she had the opportunity to drink it.

81. On 17 June, Ms A was reassessed by a Taikura Trust needs assessor, who stated: "[Ms A] has been at Oak Park for the last 10 months. She is too young for this facility. She is bored, frustrated and not happy. Neither [Ms A] nor staff at Oak Park think she has

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[16] An inter-NASC transfer is the process by which responsibility for meeting identified needs is transferred from one NASC agency to another, when a person moves to another area.

[17] The Care team is ADHB's community mental health service for older people.

[18] On 28 March, Ms A had again obtained alcohol when she managed to leave the premises.



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Korsakoff's." The outcomes identified were for support to attend a computer course, support to access counselling with CADS, and support to attend a relapse prevention programme. There is no record of any service co-ordination activity following this reassessment. Ms O subsequently advised HDC that the identified needs were not able to be met by Taikura Trust.

82. On 20 June, Dr U emailed Dr J to advise that he was still trying to get hold of past records. On 24 June, Dr J emailed Dr U to update him, noting that Ms A was becoming increasingly depressed. He wrote: "I would agree with her perspective that where she is is worse than prison."

83. Dr U assessed Ms A on 15 July. In his letter to Dr J, he noted that over the past year Ms A had physically improved and that she now seemed "much too well cognitively to be in a level 3 dementia unit". He stated: "My impression is that the reason she is in this unit is partly because [of] her previous cognitive problems and partly because of the ongoing risk of her abusing alcohol which would have worsened her mental and physical state." Dr U considered that in the short to medium term, Ms A should be in an addiction rehabilitation programme or an age-appropriate residential placement. There was reference also to Ms A being under the PPPR Act, and to Ms A's mother having power of attorney.

*CADS involvement*

84. On 2 July, Dr J had referred Ms A to CADS, noting Dr U's involvement and that Ms A wished to try to address her alcohol problems. Ms A was seen at CADS on 16 July by alcohol and drug clinician Ms P. Ms P wrote that the outcome of their meeting was that she would continue to support Ms A on a one-to-one basis, that she would request a psychiatric assessment from a CADS psychiatrist, and that she would refer Ms A to a rehabilitation programme for assessment.

85. On 21 July, CADS registrar Dr Q emailed Taikura Trust, seeking information about the outcome of their reassessment of Ms A, so that this could be co-ordinated with CADS input. She did not receive a response and, on 29 July, she sent a further email. In the meantime, Ms P followed up on options for rehabilitation, and supported Ms A to become involved in a relapse prevention group at CADS. She also began meeting with Ms A each week, often taking her out for coffee. Ms P subsequently explained to HDC that this would not usually be part of her role, but Ms A appeared to be inappropriately placed, had few opportunities to get out, and had no other support.

86. By 5 August, Dr Q had still not received a response from Taikura Trust. She phoned a customer services representative who said they had received the emails and that she would get back to Dr Q after she had spoken with Ms O. Dr Q contacted Oak Park, Dr J and liaison psychiatry nurses at ACH, seeking further information, particularly in relation to Ms A's legal situation.

87. On 6 August, Ms O emailed Dr Q, agreeing that it would be helpful to meet to discuss the way forward. She stated that Taikura Trust were not able to fund or assist with the desired outcomes identified in the most recent needs assessment, and that if Ms A's current placement was not appropriate they did not have any appropriate contracted



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providers. She stated that if Ms A moved into the community, Taikura Trust would be able to assist with personal care and household management support.

88. On 8 August, Dr Q replied to Ms O's email and explained that they were working on rehabilitation options for Ms A. Dr Q also noted that in view of possible residential rehabilitation, they needed to clarify Ms A's legal situation and determine what action was required for her to be able to leave the rest home. Ms O replied: "Under the 3PR Act (which we do not have a copy of) the EPOA named in the document is the person who needs to be making all of the decisions for [Ms A]. We do not have a copy of that document and we are also unaware of who the EPOA is."

89. After seeking advice from Waitemata DHB's legal service, Dr Q began arranging for the documentation necessary to apply for a change to the court order.[19]

90. The same day, Ms A slipped and fell at Oak Park, and sustained an undisplaced fracture of the pubic ramis. She was taken to Auckland City Hospital and discharged back to Oak Park on 12 August.

91. On 13 August, Dr J wrote to Dr Q. He stated that he was surprised about Ms A's placement from the outset, particularly in relation to the age difference between her and other residents. He noted also that as her primary problem appeared to be related to alcohol addiction (with significant psychosocial stresses), the lack of any sort of facilities at Oak Park to deal with her primary problem was a "striking deficiency". Dr J stated that he had attempted to point out to Taikura Trust on several occasions that her placement needed review, but that no practical solutions had been forthcoming. He concluded that in his view, Ms A's primary requirements were "custodial (at least while her clinical progress with her problems was monitored) and rehabilitative, within an age-appropriate environment".

92. On 19 August, Dr Q completed a cognitive assessment with Ms A. Dr Q concluded that Ms A was competent in relation to her personal welfare and placement, and that she needed to leave the rest home and be released from the PPPR Act order. Dr Q noted that this was difficult with CADS being the only service involved, that CADS was not equipped for this, and that it was not CADS' role.

93. Following the assessment, Dr Q and Ms P met with Ms O. Ms O agreed that Ms A was inappropriately placed, and that there needed to be a plan to transition Ms A to the more independent living situation she was seeking. It was agreed that Ms O would look at options for Ms A to move to a stage II rest home. The plan from there for moving on to some form of supported accommodation (as opposed to residential care) would depend on whether or not she was accepted by a residential rehabilitation programme. Ms O also agreed to look into funding for non-rest home supported accommodation funding. Dr Q undertook to liaise with Dr U in relation to Ms A's legal status and the PPPR Act order.

[19] CADS sits within Waitemata District Health Board but provides services throughout the greater Auckland area.



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*No PPPR Act order*

94. On 26 August, in Dr Q's absence, a psychiatrist emailed Dr U, advising him that following a call to the Family Court, she had confirmed that there was no PPPR Act order. The psychiatrist stated that Ms A was therefore free to leave Oak Park, but noted that telling her this immediately would have its problems and that this was something of an ethical dilemma. The email was forwarded to Ms O on 28 August. Ms P left telephone messages for Ms O on 28 and 29 August.

*September 2008*

95. Throughout September, CADS staff continued their efforts to access a rehabilitation programme for Ms A, and to co-ordinate this with a plan for Ms A's transfer to a more suitable residential facility or supported accommodation.[20] Ms P continued to provide support for Ms A in the meantime, although it was clear that Ms A was becoming increasingly frustrated with her situation.

96. Ms P left further messages for Ms O on 1 and 2 September. The psychiatrist emailed Ms O on 2 September, stating that she thought it was imperative that Ms A move to a Stage II rest home as soon as possible, that she was not certain what was holding up this process, and that Ms P had been trying to make contact since the previous Thursday. Ms P then spoke with a colleague of Ms O's at Taikura Trust, and was advised that Ms O was on leave. She explained that they had been looking at the possibility of Ms A being placed at a rest home. She asked Ms P if she could phone the rest home in Ms O's absence, or take Ms A to visit the home. Ms P suggested that this might be Taikura Trust's role, but was advised that Taikura Trust did not provide transport. Ms P spoke to her supervisor, noting her frustration with the "… lack of support from other areas for [Ms A]".

97. On 4 September, Ms P spoke to a service co-ordinator at Taikura Trust, who advised that Taikura Trust's role was only to provide funding for clients, and that there was nothing in place from their service to assist with transport to a new residential facility or ongoing support.

98. Ms P and a CADS team leader discussed a possible plan for Ms A's transition — an inpatient admission to withdraw from diazepam, medication to assist with alcohol abstinence, and a period of residential rehabilitation. Ms P visited Ms A that afternoon and discussed the plan. Ms P also informed Ms A that the PPPR Act documentation had not been located. Ms A surmised that there had never been a court order. Ms P noted that Ms A was naturally very upset, but she agreed with the plan Ms P outlined, which meant staying at Oak Park while transition arrangements were confirmed. Ms P also spoke with a Health and Disability advocate, who agreed to visit Ms A the following week.

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[20] The process of accessing a rehabilitation programme was not straightforward. Ms P and Dr Q explored a number of options. One rehabilitation programme was concerned about Ms A coming straight from a rest home and considered she needed to live in the community first. Two other rehabilitation programmes could not accommodate Ms A while she was taking benzodiazepine medication. (Ms A had been prescribed diazepam.) A detoxification programme in an inpatient unit was therefore necessary in the first instance.



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99. On 5 September, Ms P referred Ms A for an inpatient detox.[21] Ms P also spoke with RN N and Ms A. Ms A was reported to be very unwell emotionally, owing to the ongoing stressful situation in relation to her living conditions and the lack of PPPR Act documentation. She was assessed as having a greater risk of harm to herself or others than had been the case previously. Ms P gave Ms A contact details for the Mental Health Crisis Service in the event that she needed assistance over the weekend, and she informed the service about Ms A.

100. The following week, Ms A was reported to be more settled, and the level of risk was identified as low.

101. On 15 September, Dr Q outlined the situation to the CADS clinical director. The clinical director noted that CADS had done more than fulfil its role, and that it was not CADS' role to sort out the legal status/placement if residential rehabilitation did not work out. The clinical director indicated that this would need to be handed back to the GP. Dr Q discussed this with Dr J and followed up with a letter, in which she updated Dr J on CADS' recent input and intended future involvement. Dr Q asked Dr J to liaise with the advocate and whether he could access social work support to assist with placement issues. On 23 September, Dr J contacted a social worker and was advised to contact the Health and Disability Advocacy Service if Ms A had a complaint about the way in which she had been treated.

102. On 16 September, Ms A went to a CADS group meeting. After returning to Oak Park, a half-empty bottle of vodka was found in Ms A's room, and staff noted that she had been verbally aggressive.

103. On 23 September, the rest home manager went to meet Ms A at Oak Park, but Ms A did not know she was coming and had gone to a meeting at CADS.

*30 September–1 October*

104. On 30 September, Ms M found Ms A in her room with two-thirds of a bottle of vodka. Later that evening, a staff member reported that Ms A had been physically aggressive towards her, pulling her hair, pulling her uniform and pushing her. Ms A denied this.

105. The following morning, RN N left a message for Ms P advising that they were no longer able to accommodate Ms A. RN N also contacted Ms O, who advised that the rest home had accepted Ms A and that staff would be coming to pick her up the following day. However, later that morning, Ms N was advised by the rest home that it was not able to accept Ms A as it did not consider it would be able to meet her needs.

106. Ms P contacted the Community Home Detox Service to ask about a possible inpatient admission. She then spoke with the Oak Park general manager who stated that in view

[21] This is an inpatient unit with 24-hour medical supervision for people who need a safe place to stop drinking or using drugs.



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of the safety issues for staff and clients, Ms A would need to leave Oak Park, and that the door would be open for her at 3pm that day. Ms P advised the Oak Park general manager to contact Ms O, who then agreed to follow up other rest home possibilities. Ms P also contacted Dr J, who by then had already spoken with RN N.

107. Later that afternoon, CADS confirmed that Ms A had a definite date for an inpatient detox admission on 20 October. RN N agreed that Ms A could stay until then, on the understanding that she maintained appropriate behaviour and did not go out. Ms A agreed.

*Subsequent events*

108. On 20 October, Ms A was admitted to the inpatient detox centre. Her belongings were transferred to another rest home which had agreed to accommodate Ms A after her discharge from the detox centre. Ms A was admitted on 10 November.

109. On 9 December, Ms A and an advocate met with Ms O and Taikura Trust team leader Mr V, to discuss some of the concerns Ms A had about the service she had received from Taikura Trust. Mr V apologised for the delays Ms A had had in addressing concerns with Taikura Trust in the past, and provided additional staff contact details to ensure she was able to contact staff more easily. Mr V assured Ms A that funding for her placement at the rest home was confirmed for the foreseeable future. Ms O undertook to provide Ms A with copies of her previous needs assessment reports. Mr V subsequently advised Ms A in writing that he had followed up on her concerns about comments made in her first needs assessment and her involvement in this process.

110. On 18 December 2008, Ms A submitted a complaint to HDC.

111. Ms A remained at the rest home until early 2009. She moved into independent accommodation in Auckland, but was not in contact with Taikura Trust or CADS.

112. Sadly, Ms A died later in 2009.[22]

**Further information from ADHB**

113. In its initial response to this complaint, the Board advised that Ms A worked co-operatively with the team whose care she was under, and that "where a patient is willing to be discharged to a care facility an order is not necessary". It stated further: "To the extent that a patient lacks capacity to make decisions care services can be provided by a private hospital under Right 7(4) of the Code."

114. ADHB advised that the social worker was proactive in supporting Ms A throughout her admission, and that this "included working with the MDT and communicating information about Ms A's care plan and discharge to Ms A and her family".

[22] Ms A was interviewed by HDC staff the week before she died. In light of the significant issues raised by her complaint, the decision was made to continue this investigation after her death. Ms A's mother supported this decision.



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115. It was also stated that ADHB could "… not comment on Ms A's impression that she was discharged to Oak Park Private Hospital under a court order as upon Ms A's discharge it would have been clear to ADHB staff that there was no order in place as Ms A had not been served with an order and there was no court documentation to support such an order under the PPPR Act".

116. However, ADHB subsequently acknowledged that it appeared that discharge proceedings had progressed in the belief that the PPPR Act application had been filed. It apologises to Ms A for the breakdown in this process and the fact that she was not advised that the application had not been lodged.[23]

117. ADHB noted in response to my provisional opinion that it is important to distinguish between discharge and discharge planning, in relation to consent. While preparation for discharge, and subsequent care in a rest home, are provision of services requiring the consent of the patient or his or her representative, the decision to discharge a patient is made by the hospital, and consent is not required.

118. ADHB has noted the learning that has resulted from these events:

- There need to be checks to ensure important documentation such as PPPR Act applications meet their destination.
- That placement arrangements need to be carefully documented in discharge arrangements.
- That the PPPR Act application process can be a lengthy affair which may not be completed before a patient is discharged. As such, ADHB's responsibilities for co-ordination may not stop when a patient leaves hospital.

119. ADHB also advised that further training for social workers by legal services had been initiated, and provided HDC with a protocol developed to guide staff with court orders under the PPPR Act.

120. ADHB undertook its own adverse event investigation, issuing its final report in November 2009. The purpose of the investigation was to identify factors that led to the failure to ensure appropriate legal authority was obtained to transfer Ms A to a [residential facility]. ADHB identified the primary cause as:

121. "The lack of an individual or a multidisciplinary team to coordinate and be accountable for:

- Identifying appropriate legal authority to treat and transfer [Ms A]
- The lodgement of the PPPR Act application for [Ms A]."

122. A number of contributory factors were outlined. Several recommendations were made for the development of processes for PPPR Act applications. The person or team responsible, and the timeframes were not specified.

[23] This apology was contained in correspondence submitted to HDC before Ms A died.



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123. In response to my provisional opinion, ADHB noted the following further changes:

- The ADHB "PPPR Act Staff Guide" is now published on the intranet. ADHB notes that situations where it is considered appropriate to seek a court order are exceptional, and cannot be managed in a prescriptive fashion, but that the "Staff Guide ensures that all staff have access to a resource for understanding and managing these issues safely and consistently".
- Two training sessions on the "PPPR Act Staff Guide" to be held in August 2010.
- Two training sessions on Right 7(1) to be delivered to ADHB social workers by the Nationwide Health and Disability Advocacy Service in August 2010.
- A guideline is being developed in relation to discharge planning practice and the specific role of social work, for patients identified as complex.
- Further training is planned in relation to Right 7(2).
- ADHB's legal guide on "Caring for Patients with Diminished Competence" is to be circulated to all social work staff.
- All new clinical staff are now required to complete an online training session covering the Code of Health and Disability Services Consumers' Rights, with ongoing in-service training to be managed by individual services.
- "Rapid rounds" have been introduced within the general medical service, to improve communication between staff and disciplines, and to indicate clearly the staff responsible for designated tasks. The overarching principle of "Rapid rounds" is to "plan for the day and plan for the stay" of every inpatient.
- A document has been developed to support the transfer of care from one health setting to another. This contains key clinical and social information, and contact details for the clinician responsible for completing the transfer so that that person can be contacted if more information is required.

*Additional information from Dr C and Dr R*

124. ADHB was asked to share my provisional findings with staff mentioned in the report. Individual responses were received from Dr C and Dr R. While both acknowledge that there were shortcomings in the service provided to Ms A by ADHB, they also raise concerns about wider systemic issues which they consider impacted on the care she received, and which have the potential to continue to be problematic.

125. Additional information from Dr C specifically in relation to Ms A's care has been incorporated earlier in this report. He also notes the lack of a specialised residential unit in Auckland for younger patients with severe cognitive impairment who are not able to be managed in supported community settings. Dr C comments on the arbitrary distinction between chronic health conditions and disability — "with different structures assuming responsibility for different poles of the spectrum but much debate about the interface between disability and health" — which is not helpful, can create barriers to care, and can result in a lack of clear clinical and co-ordination responsibility.

126. Dr R notes his concern about the resourcing of social workers at ADHB, specifically within general medicine. He also discusses the implications of Ms A's extended



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admission to ACH in the context of a hospital that often runs at 95–99% capacity, particularly in winter. He submits that this pressure on beds impacts on the management and safety of patients such as Ms A.

127. Dr R comments on the resistance commonly encountered in obtaining long-term care for patients such as Ms A. He describes how "extraordinary delays" become ordinary, contributing to a "learned helplessness".

128. These issues, Dr R states, relate to organisational motivation, structure and resourcing. He also notes his concern that greater fidelity to the checks and balances related to PPPR Act applications will prevent errors, but may also introduce delays and an excessively conservative approach to PPPR Act applications.

**Taikura Trust**

129. Taikura Trust did not respond to my provisional findings, but subsequently responded to the recommendations outlined in my provisional report.

130. Chief Executive Ms G apologised to Ms A's family for Taikura Trust's failure to provide Ms A with the service it promises its clients, and for breaching Ms A's rights under the Code. Ms G offered to meet with Ms A's family if they wished to do so.

131. Ms G advised that:

- Two practice advisors are developing a training programme and guide in relation to the PPPR Act and the HDC Code of Rights, to be delivered to staff through a series of workshops in October and November 2010.
- Taikura Trust has been drawing on recent experience with other clients subject to personal orders under the PPPR Act. Its goal is to lift the overall knowledge and capability of its employees generally, and to establish experts in the Act and its requirements who can act as mentors to their colleagues and establish networks with other relevant organisations.
- Taikura Trust has been working to improve the interface with mental health services across Auckland, so that clients with dual needs receive a more consistent service and access to appropriate supports. It began engaging with mental health teams from the three local district health boards over 18 months ago, in an effort to improve information sharing, establish key contacts and agree pathways. A pathway document was signed with ADHB's mental health service in June 2010.
- In September 2010, a hospital "in reach" position was established. The role was designed in conjunction with ADHB, and involves a staff member based at ACH to undertake eligibility screening, needs assessment and initial service co-ordination. This is currently being tested in the medical and rehabilitation wards, with the intention of extending it to the mental health service, Starship Hospital, and across the other two local DHBs.
- A Practice Development Leader was employed in February 2010, to help address gaps in areas of clinical competence. Under her leadership, a team of



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practice advisors with clinical experience has been established, to train and support new employees and to upskill and support existing staff. Their programme includes practice audits of documents and face-to-face meetings.

- Work has been initiated to better match the particular competencies of employees with the needs of clients, and to recruit new employees with specific expertise to fill gaps in the service's overall knowledge.
- A "Documentation Standard" is being developed for implementation in October 2010, to ensure employees are aware of what they need to document and how this must occur. This will be followed up with an audit to measure progress.

**Further information from Oak Park**

132. The General Manager at Oak Park stated that on the basis of the information they had at the time, it was understood that Ms A was legally required to reside there. The General Manager believes staff made every effort to meet Ms A's needs, and to arrange for her to be reassessed through Taikura Trust. RN N noted that she made repeated efforts to get Taikura Trust to reassess Ms A, at one point contacting them every second week.

133. In response to my provisional findings, Oak Park submitted that the assessment and placement of Ms A was explicitly outside the scope of the agreement it had with the Ministry of Health. The agreement states that it is the responsibility of the NASC agency to ensure the criteria for access to a facility have been met.

134. Oak Park notes that at the time of Ms A's admission, its staff, and ACH, understood that Oak Park was to be an interim placement only. This was reiterated in the first needs assessment. It states that staff made every endeavour to have Ms A reassessed, particularly as her condition improved. In the meantime, it provided her with a secure environment, and assisted her to move towards self-management of personal cares and with the management of ongoing back pain.

135. Oak Park submits that under the circumstances, it was entitled to act in accordance with Right 7(4) of the Code, and that it did so. It consulted with Ms A's mother because she had been appointed as the attorney under an enduring power of attorney.

136. In addition, Oak Park submits that the common law doctrine of necessity applied because it was necessary to act in the best interests of Ms A's life or physical or mental health, it was not practicable to communicate with her, and the actions taken were reasonable in the circumstances.

137. Ms M also responded to my provisional findings, stating that in her view, Oak Park provided Ms A with a good service. She describes the actions she and other staff took to support and care for Ms A, including efforts to arrange a reassessment, to facilitate telephone contact with her daughter, to provide emotional support, and to accommodate her specific needs and wishes.



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*Changes made*

138. Oak Park advises that it now has systems in place to ensure that:

- Residents are recorded as "competent" or "not competent" with respect to their personal welfare;
- Copies of PPPR Act orders, or EPOA documentation are held on residents' files;
- The files of residents who are deemed "not competent" are clearly marked;
- The expiry date of any PPPR Act order is diarised for action by staff;
- In the event that a PPPR Act order for welfare guardianship is issued, any existing EPOA is annotated to indicate that it has been superceded.

139. In response to recommendations outlined in my provisional report, Oak Park provided HDC with a copy of its policy and procedure in relation to residents admitted under a compulsory court order, and an updated checklist to be used for all new admissions. It also confirmed that training sessions had been held with staff in 2009–10, in relation to the Code of Health and Disability Services Consumers' Rights, and the Health and Disability Advocacy Service.

**PPPR Act applications**

140. The New Zealand Bill of Rights Act 1990 provides that everyone lawfully in New Zealand has the right to freedom of movement and residence and everyone has the right not to be arbitrarily arrested or detained. The PPPR Act provides for the making of a personal order with regard to a person who lacks competence. Section 6 provides that a person lacks capacity if he or she lacks, wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; or wholly lack the capacity to communicate decisions in respect of such matters. The PPPR Act provides protections for the subject person and sets out the process to be followed before a personal order is made. These include a requirement that the application and accompanying documents be served on the person concerned.[24] Section 74(1) requires the subject person to be present at the hearing unless there are exceptional circumstances. If a person is ordered to enter an institution, the institution must be specified in the order.[25] There is also a more flexible provision, for an order to specify living arrangements of a certain kind.[26] Following the hearing, if an order is made, it would have to be served on the subject person. The order may specify a review date and, if so, who is to apply for the review.[27] It will expire on the date in the order, or after 12 months, whichever is the earlier.[28]

[24] Section 63 of the PPPR Act.

[25] Section 10(1)(d) of the PPPR Act.

[26] Section 10(1)(e) of the PPPR Act.

[27] Section 10(3) of the PPPR Act.

[28] Section 17(1) of the PPPR Act.



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# Opinion

### Introduction

141. When Ms A was admitted to Auckland City Hospital in May 2007, she was 43 years old. She had a complex and troubled history, and there were significant concerns in relation to her physical, mental and emotional well-being. She was homeless, she had limited social support, and she had struggled with alcohol abuse for many years. In many respects Ms A would not have been easy to help. However, the challenges she faced made her particularly vulnerable. Those working with her needed to pay careful attention to her needs and to observing and protecting her rights. This did not occur and, in my view, she was seriously let down by health and disability services.

142. At the time she was discharged from hospital, Ms A was assessed as not having the capacity to make decisions in respect of matters relating to her personal care and welfare, and so she could not give informed consent. No one was legally appointed to act on her behalf, or informally available to advocate for her. She was discharged to a secure rest home, caring mostly for older people with dementia. She was told she was legally required to remain there despite her wish to leave. She was effectively detained at Oak Park for periods of time, when there was no such legal requirement, and it was neither in accordance with her wishes nor always appropriate for her needs.

143. Protection of a person's liberty is a fundamental freedom in the Bill of Rights. Its importance is recognised by the protections built into legislation which allows the curtailment of freedom, such as the PPPR Act, the Mental Health (Compulsory Treatment and Assessment) Act 1992 and the Alcohol and Drug Addiction Act 1966. What happened to Ms A should be a salutary lesson to all health and disability providers to be cognisant of the legal basis for providing services, and the associated responsibilities.

144. Ms A was an extremely vulnerable consumer, at times homeless and living on the margins of the community. Although Ms A died nearly a year after leaving Oak Park, and her death was not directly related to these events, it is a tragedy that she did not live to see her rights recognised.

## Breach — Auckland District Health Board

145. The focus of this investigation in relation to ADHB has been on the steps taken by staff to protect Ms A's rights and interests, in the context of the assessment that she did not have the capacity to make informed choices and give informed consent.

146. ADHB staff clearly intended to apply for an order under the PPPR Act, but the application process was not completed. This fact was not known to Ms A, ADHB staff or other health and disability providers, and she was discharged to a secure residential care facility on the understanding that she was legally required to reside there pursuant to a court order. I do not consider ADHB took sufficient or appropriate action in relation to Ms A's discharge planning. This was exacerbated by a lack of co-



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operation between staff and with other providers, particularly Taikura Trust and Oak Park (discussed later).

147. Accordingly, I find that ADHB breached Rights 4(1) and 4(5) of the Code.[29]

**Informed consent**

*Inpatient care and treatment prior to 31 May 2007*

148. Ms A was admitted to ACH on 11 May 2007. She was diagnosed within a week with cryptococcal meningitis and communicating hydrocephalus, and commenced treatment. The extent to which these conditions were causing or contributing to her impaired mental functioning was not known. At times she was confused and disoriented, while at other times she was lucid, knew that she was in Auckland Hospital, and knew the reason for her admission. She was sometimes resistant to, or declined treatment, but for the most part she appeared to accept the need for admission and medical care.

149. Under Right 7(2) of the Code the presumption is that consumers are competent to make an informed choice and give informed consent, unless there are reasonable grounds to think otherwise.[30] The possibility that Ms A was not competent to make an informed choice and give informed consent was flagged early in her admission, when the question of welfare guardianship was raised on 15 May. A formal assessment of her competence was requested a fortnight later. It would appear that, initially, Ms A was presumed competent and able to give consent on her own behalf. There were no documented attempts to contact her family at this time, and Ms A's refusal of permission to contact her friends was respected.

*Inpatient care and treatment after 31 May 2007*

150. Dr C assessed Ms A on 31 May. He recorded that she lacked the capacity to make informed decisions, and suggested an application for welfare guardianship under the PPPR Act would be needed.

151. This indicates that Dr C considered Ms A lacked capacity in accordance with the definition set out in the PPPR Act, which states that the person "lacks, wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of his or her personal care and welfare".[31]

152. Having assessed Ms A as lacking capacity to make informed decisions, the basis for continuing to provide her with services becomes more complex, and ADHB needed to pay attention to who could make decisions about Ms A's care and welfare.

[29] See footnotes 2 and 3.

[30] Right 7(2) — Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

[31] Protection of Personal and Property Rights Act 1994 Part 1, 6(1)(a).



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153. Its first responsibility was to determine whether there was any other person available who was entitled to consent on behalf of Ms A. On 6 June, Ms B contacted Ms A's mother, Ms E, and was advised that there was no current welfare guardian or property manager. Ms E also explained that in view of previous events and current circumstances, her family could no longer help Ms A.

154. Efforts were made to obtain previous records from other DHBs. Nothing in these records indicated that there was anyone else with legal authority to consent on Ms A's behalf.[32]

155. Having established that there was no other person legally entitled to consent on Ms A's behalf, staff then needed to consider whether the provision of services was in her best interests, and whether it was able to ascertain her views — if so, staff needed to take account of those views and, if not, they needed to take account of the views of other suitable persons.[33]

156. In relation to Ms A's continued inpatient care and treatment, it seems that this was in her best interests. She was clearly very unwell, and she required inpatient treatment (including IV antibiotics) with careful monitoring. She was not able to care for herself, and there would have been serious risks in discharging her at this time.

157. There are some references in the clinical notes to Ms A's views on admission and treatment. Some staff, including Ms B, documented Ms A's consent to their input. On at least three occasions Ms A indicated her wish to leave hospital. However, on 29 May and 30 July, it appears she then accepted the advice of staff that she continued to need care and treatment. On 16 August, she left the hospital and was returned by police. It appears she was subsequently content to remain on the ward until she was

[32] I note that on 7 June, Ms B requested clinical records from another DHB with Ms A's signed consent. In light of Dr C's assessment, the basis for considering her competent to consent to this is not clear. Under Right 7(3) of the Code, a person with diminished competence retains the right to make informed choices and give informed consent, "to the extent appropriate to his or her level of competence", but there is no record of any discussion as to whether Ms A was sufficiently competent to consent to release of information. I also note that this information could reasonably have been requested without Ms A's consent, in accordance with section 22F of the Health Act and Rule 11 of the Health Information Privacy Code 1994.

[33] Right 7(4) — Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where —

a) It is in the best interests of the consumer; and
b) Reasonable steps have been taken to ascertain the views of the consumer; and
c) Either, —
   (i) If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
   (ii) If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.



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discharged the following week. Overall, I consider Ms A's views on her admission were discernable through her actions.

158. In summary, I accept that inpatient care and treatment were in Ms A's best interests, that her views were ascertained, and that there were reasonable grounds for believing that the provision of services was consistent with the informed choice she would have made if she were competent. On this basis, in relation to the provision of inpatient care and treatment, ADHB provided services in accordance with Right 7(4).

**PPPR Act application**

159. The focus of this investigation is not on the decision to apply for an order, or whether the PPPR Act was the necessary pathway. My concern is with what happened once the decision to apply for a personal order had been made.

160. The social worker, Ms B, first sought legal advice in relation to Ms A on 31 May 2007, and began collecting the information required for a personal order application. There was further communication between the social work and legal teams over the next two months as different sections of the application were completed and checked. On 25 July, Ms B noted in Ms A's clinical records that the completed application had been sent to the ADHB lawyer. The application was apparently not received by the legal service, although the reason for this is not known.

161. There was no follow-up process in place. Ms B assumed the application had been received and actioned, while Mr D assumed plans had changed and the application was no longer required. This was a serious breakdown in an important process, and it had significant and unacceptable consequences for Ms A.

162. It is evident that information provided by ADHB led Ms A and the providers involved in her post-discharge care to believe that a personal order was in place. I will say more later about the obligations of Taikura Trust and Oak Park to verify this information, but it is certainly the case that information provided by ADHB regarding Ms A's legal status was, albeit unintentionally, false and misleading.

163. It is not for me to determine whether the personal order application would have been granted by the Court, although I believe it is quite possible that it would. However, when a personal order is made there are certain important legal safeguards. Orders are not usually indefinite; if no end date is specified, the order expires after 12 months or when the effect of the order is spent.[34] In addition, the Court has the authority to attach conditions. It may specify a review date and, if so, the person or people responsible for applying for the review. It may also "make other such orders and give such directions as may be necessary or expedient to give effect, or better effect, to the personal order".[35] In this way, provision can be made for appropriate follow-up. I note that Dr C had acknowledged the possibility that Ms A's cognition might improve —

[34] Protection of Personal and Property Rights Act 1994 Part 1, section 17.

[35] Protection of Personal and Property Rights Act 1994 Part 1, section 10(4).



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as indeed it did — and that it "would therefore seem prudent to review the appropriateness of the order after a nine to twelve month period". This is precisely the sort of information the Court would consider in determining the conditions attached to any order granted.

164. ADHB acknowledged a breakdown in its processes, although initially also stated that staff would have been clear about the absence of a personal order as no order had been served and there was no court documentation. It identified a number of factors that contributed to the breakdown, including the lack of a formal process to deal with PPPR Act applications, poor communication between staff/teams, and the fact that no individual or team was co-ordinating and accountable for the application. It is unfortunate that the DHB's first response was to challenge and call into question Ms A's view of her discharge arrangements, when further scrutiny confirmed it.

165. This was a particularly difficult situation. While healthcare providers often deal with patients unable to give informed consent, most have legal representatives, such as an enduring power of attorney or welfare guardian, and/or some level of active family/caregiver involvement. When dealing with vulnerable consumers like Ms A the stakes are high. ADHB should have had a better system in place for dealing with PPPR Act applications; it failed both Ms A and its staff.

166. This represented a failure to provide services with reasonable care and skill and, accordingly, a breach of Right 4(1) of the Code.

**Discharge planning**

167. I am also dissatisfied with the adequacy of the arrangements made when planning for Ms A's discharge. Discharge planning is an important part of providing good hospital care. For some patients, this is a reasonably straightforward process: they return home, previous care and support arrangements, if any, resume and medical care is transferred back to the GP. For other patients it is more complicated, and hospital staff need to ensure appropriate arrangements are made for follow-up medical treatment, and for formal or informal support services. For a few patients, discharge planning is particularly complex. Ms A was clearly one such patient.

168. For most of her admission, Ms A was on a general medical ward and under the care of a multidisciplinary team. She clearly had complex needs; co-operation between hospital staff and with other providers was essential.

169. It is accepted that there was a greater level of consultation and discussion between ACH staff than was recorded. My expert advisor, Dr Robinson, notes the lack of clear documentation in relation to the discussions that would have occurred at multidisciplinary team meetings, and the associated clinical reasoning leading to decision-making. Clear, accurate written records are essential for effective communication between staff and for teamwork in the hospital environment. This was particularly important for Ms A, given the number of staff working with her, the length of her admission, and the complexity of her situation.



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170. Dr Robinson states: "Consultation with medical specialists including neurology, infectious diseases and psychiatric liaison in the early stages of admission was at a high standard in attempting to deal with complex issues." This is to the credit of ADHB and its staff. However, Dr Robinson also notes the absence of a "meaningful overarching plan commonly understood by all involved", and consequences of the poor communication between the social work and legal teams in relation to the PPPR Act application have already been noted.

171. By the end of July, Ms A's condition was relatively stable, and the main reason for her continued admission appeared to be less about medical treatment and more about the fact that she needed an appropriate place to be discharged to. However, it is accepted that at this time Ms A was not able to look after herself. She needed assistance and supervision with many activities of daily living and, by all accounts, she required 24-hour care.

172. Dr Robinson states:

> "My impression from the case notes is that for the last month of the patient's three month admission the overarching strategy and thus the discharge planning situation became stuck and somewhat lost. Aside from the unfortunate situation of the PPPR Act application becoming lost, seemingly forgotten and not filed, there were multiple case note comments that the treatment plan was "awaiting placement". There appears a lack of sustained direction to secure such placement. I saw no documented evidence of any case conference with relevant clinicians or multidisciplinary team conclusions on what should have been best provided in this patient's ongoing care interests. I acknowledge the protracted difficulties associated with accessing any funding, and the uncertainty as to which sort of institution may be appropriate or available."

173. I agree with Dr Robinson. I note that ADHB's own Discharge Planning policy requires that complex discharges are actively planned within multi-disciplinary meetings, with one of the goals of the policy being to identify, document and minimise risks associated with each consumer's transfer. That did not happen here.

174. Once Ms B had completed the PPPR Act application, she began efforts to secure funding for Ms A's placement. She initially contacted Taikura Trust but the referral was verbally declined. She referred Ms A to the mental health service, but was advised a fortnight later that funding had been declined. She then went back to Taikura Trust, and funding was approved two weeks later. The day after funding was approved, Ms A was discharged. Given the complexity of Ms A's needs and the fact that she would clearly continue to require a high level of care and support on discharge, I am surprised that there was not some form of case conference or discharge planning meeting. Had this taken place after Taikura Trust had accepted the referral, its staff also could have participated. This would have been an opportunity to discuss Ms A's ongoing care and support needs, including whether there were any other services that might usefully be involved, and what the arrangements were for Ms A to be reviewed 9 to 12 months later in accordance with Dr C's recommendation.



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It would also have been an opportunity to discuss any potential difficulties with placement, including the fact that there were few, if any, facilities specialising in care for people with the combination of needs Ms A had. Consideration could have been given to what else might be put in place to improve the chances for a successful placement, and possible rehabilitation.

175. ADHB has advised that its staff were not responsible for identifying a suitable residential care facility, although social work staff were quite involved in this process. I also understand that funding needs to be secured in the first instance. However, I am concerned that the result for Ms A was efforts over four weeks to secure placement funding, followed by less than two days to identify an appropriate placement.

176. It appears that as soon as funding approval was obtained, the pressure to discharge Ms A quickly took priority over the need to discharge her well. ADHB was advised that funding had been approved on 22 August, and it was noted that she was going to Aranui. Less than 24 hours later, she was discharged to Oak Park, admittedly part of the same organisation, but nonetheless a separate facility in a different part of town. It is hardly surprising that Ms A was angry, confused, and distressed about the different stories about her destination. While overall responsibility for placement was with Taikura Trust, ADHB had a key role in this process.

177. I accept that when hospitals are at or near capacity and there is a patient no longer requiring acute medical care, the impetus is to discharge without delay. However, due care must still be taken with regard to the circumstances of the discharge.

*Communication with Ms A*

178. It is important that patients are partners in the discharge planning process. I accept that Ms A's consent was not required when the decision was made to discharge her. However, I am concerned about the steps taken to discuss the discharge plan with Ms A. It is acknowledged that communication with Ms A was sometimes difficult, and there were clearly times when it would have been futile to attempt to talk to her about her future care needs. At other times, though, she was calm, lucid, oriented and co-operative. Dr Robinson notes that it seems likely her cognitive state would have precluded much in-depth discussion. Nevertheless, she should have been kept abreast of the care plans, and her views should have been sought, documented, and taken into account. If it were really not possible to establish her views at all, this should have been clearly recorded.

179. There is no evidence in the clinical records of attempts to discuss the discharge plan with Ms A. The extent to which she was aware of the plan for her to be admitted into residential care, let alone secure residential care, is not recorded in more than three months of progress notes. ADHB subsequently advised HDC that Ms A worked co-operatively with the team and that the social worker had communicated information about the care plan and discharge to Ms A. There is no evidence to verify this. These are important matters, and they should have been recorded.

**Communication and co-operation with other providers**



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180. I am also concerned about the level of co-operation between ADHB, Taikura Trust and Oak Park. Each of these organisations had its own obligations, but there was a shared responsibility to work together to ensure Ms A's care was transferred effectively. ADHB's failure to communicate effectively with Taikura Trust and Oak Park in relation to Ms A's legal status has already been discussed. The quality and quantity of information provided by ADHB was also lacking.

181. In relation to Ms A's placement, ADHB states that it was Taikura Trust's responsibility to identify an appropriate facility. It also states that Taikura Trust does not usually consult with the referrer if the decision on placement is different to the recommendation made by the referring service.

182. What recommendation on placement was made to Taikura Trust remains unclear. References in the clinical notes to the type of care Ms A required are inconsistent. Dr C states in his report for the PPPR Act application that "it seems reasonable for her to be managed in a rest home or private hospital facility". Ms B's referral to Taikura Trust on 7 August indicates that Ms A required private hospital placement. On 20 August, Dr C refers to a semi-secure unit. This appears to have followed an episode of agitation and wandering. The discharge summary, completed two days later, states that Dr R and the liaison psychiatry service had agreed Ms A needed to be admitted to a secure unit, although this is not documented in the progress notes.

183. I accept that overall responsibility for placing Ms A at Oak Park lay with Taikura Trust, and I will comment further on this later. Nevertheless, Ms A had been in hospital for more than three months and under the care of a multidisciplinary team. Hospital staff were well placed to provide Taikura Trust with information to assist with the decision on the most appropriate type of care.

184. As Dr Robinson states:

> "During the three month admission there would have been time to collate summaries from various disciplines including social work, physiotherapy, occupational therapy and psychiatry to give information and guidance to the receiving institution. […] I see no evidence of an integrated plan for ongoing care or treatment."

185. The information provided to Taikura Trust and Oak Park in relation to Ms A's care and support needs appears to have been minimal.

186. Although Dr Robinson notes that Ms A's clinical records do not show whether Ms A's discharge summary was sent to the home, Oak Park's records show that on the day of her admission they received the discharge summary and transfer form. The information in the discharge summary was brief and provided no guidance in relation to Ms A's care. The only actual instruction was "heavy drinking, please monitor". Information on the transfer form was minimal.



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187. Dr Robinson also notes that given Ms A's diagnosis and relatively young age, it would have been reasonable to consider the possibility of a neurological review, and that ideally the facility's GP should at least have been advised that this would be necessary in the event of worsening headaches or intellectual deterioration.

188. Nursing staff at ACH phoned Oak Park to confirm Ms A's transfer. Neither party documented the call so it is not known whether any other information was provided at this time. I am surprised that more written information was not provided. Ms A's own awareness of her support needs was clearly limited at this time, and ACH staff knew there was no active family involvement or other informal support. Little consideration seems to have been given to what information would be useful for those taking over Ms A's care. I note that the following month, Oak Park made a formal request for further information from ACH, including a copy of Dr C's report.

189. ADHB staff could and should have worked more closely with Ms A, one another, and with Taikura Trust and Oak Park, to facilitate Ms A's ongoing care. The failure to do so was a breach of Rights 4(1) and 4(5) of the Code.[36]

190. ADHB is to be commended on the steps subsequently taken to address the issues raised by these events, particularly in relation to staff education, and the measures to improve communication between its staff and with other agencies.

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## Breach — Taikura Trust

191. Taikura Trust was the agency responsible for assessing Ms A's support needs, prioritising and allocating resources and coordinating the services provided to meet her identified needs following her discharge from ACH. This included the selection of a suitable provider to meet her needs and determining the most appropriate residential facility. Taikura Trust was required to involve Ms A in the selection of the provider.

192. The front page of Taikura Trust's website states:

> "[W]e are totally focused on delivering support that removes the disabling effects of our community — support that empowers and results in positive change. Not the kind of change that works fine for a week or two, but effective change that is reliable, sustainable and liberating."[37]

193. This was not the service it provided to Ms A.

194. When Taikura Trust became involved with Ms A in August 2007, it had sufficient information to believe she was not, or might not be, competent to make an informed choice and give informed consent. However, it failed to verify Ms A's legal status, or

[36] See footnotes 2 and 3.

[37] http://www.taikura.org.nz



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to ascertain, if Ms A was unable to consent to the placement, who could consent on Ms A's behalf, and who it should consult and communicate with in relation to her placement. Subsequently, the information provided by Oak Park, together with the assessments carried out by Taikura Trust, should have raised concerns about the services provided to her, but again there was a failure to adequately address this.

195. The efforts made by Taikura Trust staff to inform Ms A about the options available and expected time frames for assessment and placement service provision were inadequate. There were deficiencies in communication, consultation and co-operation — with one another, with Ms A, and with other service providers.

196. Accordingly, Taikura Trust breached Rights 3, 4(1), and 4(5) of the Code.[38]

**Legal status**

197. When Ms A was referred to Taikura Trust, it received copies of the medical reports that supported the personal order application. It therefore had "reasonable grounds" for believing Ms A was not competent. In light of this, it had a responsibility to ascertain whether there was anyone else entitled to consent on her behalf and, if there was no such person, to ascertain the legal basis for providing her with services. Taikura Trust subsequently advised HDC that having received the initial referral and medical reports from ADHB, it expected to receive further information about the personal order in due course, and that as this was not forthcoming, it made "considerable efforts" to obtain the relevant documentation. This is not evident. Any efforts that were made were not until a year later, in August 2008, after CADS became involved.

198. Taikura Trust therefore provided services to Ms A for more than a year, assuming on the one hand that she was subject to a personal order under the PPPR Act and, at the same time, apparently giving no consideration to who had the legal authority to consent on her behalf, and who staff should be consulting and communicating with. This was unacceptable.

199. I am not suggesting that it was Taikura Trust's responsibility to check that ADHB had filed the application for a personal order. However, in order to establish the legal basis for it to provide services to Ms A, Taikura Trust needed to promptly obtain verification that a court order had been made and be aware of the conditions set out in the order. This could be done relatively simply by contacting the Family Court. A copy of the order needed to be on Ms A's file.

200. Following Ms A's admission to Oak Park, Taikura Trust conducted one needs assessment and two reassessments. These show clearly that Ms A's views were ascertained. These included her requests to be reassessed, to leave Oak Park to live somewhere more suitable, and to move nearer to her family. There were multiple staff members involved with Ms A, including customer support representatives, needs assessors, service co-ordinators, and supervisory and management staff. It has not

[38] See footnotes 2, 3, and 4.



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been possible to establish from the records provided to HDC who was involved with Ms A's referral between 7 and 29 August (when Ms K assessed Ms A), aside from Ms G and Ms I. The situation is complicated by the fact that arrangements were made to place her at Oak Park prior to assessment. While I have some concerns about the actions of individual staff, I consider overall responsibility for this matter lies with Taikura Trust as an organisation. There was a widespread and systemic failure to address the matter of her status at the outset of Taikura Trust's involvement with Ms A, and it was not picked up by any of the staff working with her subsequently. I note that in its initial response to HDC, Taikura Trust was *still* confused about Ms A's legal status, noting that her parents had legal power of attorney.

201. It is deeply disturbing that a provider of services for consumers where competence may be an issue, and its staff, should apparently have so little understanding of the legal requirements.

**Placement, 7–23 August 2007**

202. Ms A was referred to Taikura Trust by ADHB on 7 August 2007. Two weeks later, Ms G sought IFP approval and, the following day, Ms I contacted ACH social worker Ms S to confirm funding and discuss placement options.

203. Ms A's eligibility for Taikura Trust's service was through the IFP rather than the usual Disability Support Service (DSS). Nevertheless, the IFP guidelines state that wherever appropriate, existing MOH and NASC processes and procedures are used. It is expected that unless the guidelines state otherwise, clients whose services are funded through the IFP will be assessed and have services co-ordinated as they would if they were funded through DSS.

204. It is not known why there was a two-week delay between receiving the referral and applying for IFP funding, but this appears to be well outside the expected time frame. Given that funding approval for Ms A's placement was given prior to the needs assessment, it would appear the referral met the criteria for an urgent referral, meaning the assessment should have taken place within 24 to 48 hours. It is accepted that time frames are set for services throughout the health and disability sectors that, for one reason or another, cannot be met. In such situations, good interagency communication becomes all the more important. There is nothing in the information provided by Taikura Trust or ADHB to suggest any effort was made to inform staff at ACH about the progress of the referral or the reason for the delay.

205. It is usual practice to carry out a needs assessment before service co-ordination, for obvious reasons. In this case, the decision was made to fund services for Ms A and place her at Oak Park prior to the needs assessment. The rationale for this is not clear. Certainly there were several factors to be considered, including legal and policy requirements, Ms A's health needs, her apparent wish to be discharged, and the hospital's responsibility to facilitate timely discharge.

206. While I accept that there are circumstances when it may be appropriate for someone to be placed in care prior to an assessment, for example where there is an urgent need



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for a place of safety, that was not the case here as Ms A was in hospital. Moreover, Taikura Trust had sufficient information from the reports sent with the referral to know that Ms A's needs were not straightforward — legally, socially, and in terms of her health. In addition, she was being placed in a facility that cared primarily for older people with dementia and, as such, not an obvious fit for someone with Ms A's needs.

207. Taikura Trust states that the decision to place Ms A at Oak Park was made by ADHB. I do not accept this. Responsibility for Ms A's placement at Oak Park lay with Taikura Trust.

208. Ms S noted in the clinical records that Ms I had suggested Aranui. She had also confirmed funding approval for a secure rest home, so presumably her intention was the secure facility owned by Aranui (ie, Oak Park). Ms I does not recall the discussion with Ms S, but subsequently suggested that Aranui was the only facility Ms A could be admitted to at that time.

209. The picture that emerges from this, and from the actions taken by ACH staff at this time as outlined previously, is that as soon as funding for Ms A's placement was approved, she was placed at the first, or only, facility that accepted her. While the realities of finding suitable residential placements in a timely manner are acknowledged, I would be more understanding if there was some evidence that the potential risks and difficulties in placing Ms A at Oak Park had been discussed, and thought given to any action that might be taken to minimise and alleviate these and to how a more suitable facility might be found for her.

210. There was a lack of reasonable care and skill in the service provided to Ms A by Taikura Trust at this time and, accordingly a breach of Right 4(1) of the Code.

**Assessment and service co-ordination**

*August–September 2007*

211. Taikura Trust advise that when a referral is accepted, its usual process is for a customer support representative to liaise with the allocated needs assessor and the client or his or her representative to arrange the assessment. Ms K was contracted by Taikura Trust to carry out needs assessments, and she was asked to assess Ms A at Oak Park. She does not recall what information she was provided with prior to the assessment. There is nothing in the records to indicate she was told Ms A was, or may be, subject to a personal order. There is no evidence that she was provided with any specific instructions or guidance in relation to the assessment of Ms A, despite Ms G's intention that Ms A should be thoroughly assessed, with mental health service involvement.

212. When Ms K carried out the assessment, she recorded Oak Park's clinical co-ordinator, RN N, as Ms A's legal representative, and asked Ms N to sign the consent section of the needs assessment, which she did. It is clear that most of the information provided for the assessment came from RN N. There is one page at the back of the assessment, documenting Ms K's discussion with Ms A. This is signed by Ms A.



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213. Although she was thought to be incompetent, Ms A was apparently willing to be assessed and able to clearly express that she did not want to be at Oak Park. Ms K clearly considered that the placement at Oak Park was temporary and that a permanent care situation should be arranged. Ms K spoke with Ms B the day after meeting with Ms A, and noted that Ms B was available to offer information for the purposes of service co-ordination. It is not known whether the assessment documentation was checked before it was passed to the service co-ordinator.

214. Service co-ordinator Ms L completed the administrative requirements for Ms A's placement, and noted that the placement was to be reviewed in one year's time. In light of the needs identified by Ms K, the service co-ordination is troubling. While the identified needs are somewhat confusing, the overall intent appears to be that Ms A needed further assessments, including a psychiatric assessment, to determine how her care and accommodation needs were to be met in the future (and that staff at Oak Park needed to be supported to meet Ms A's needs in the meantime).

215. A few days later, Oak Park's occupational therapist followed up Ms A's request for psychiatric assessment, and was advised that Taikura Trust did not do psychiatric assessments. Ms A then received a letter stating that based on the goals from the needs assessment, her placement at Oak Park had been confirmed. No explanation was given as to why no further action was planned in relation to the needs identified by Ms K, including psychiatric assessments and establishment of a future living situation plan to maximise her well-being and health situation.

*Reassessment, November 2007–June 2008*

216. Ms A was referred to Taikura Trust for a reassessment on 1 November 2007, by Dr J. The reassessment took place nearly 12 weeks later. While the time frames for assessment are expected rather than required, this seems excessive. Again, I would be more understanding of this if there had been some attempt to liaise with Dr J and staff at Oak Park in the meantime, to explain the reason for the delay and to check whether there was anything needed in the interim, but there is no evidence that this occurred.

217. The fit between the needs identified at the reassessment and the subsequent service co-ordination is again concerning. Ms A had expressed a wish to move nearer her family. Taikura Trust attempted to arrange an interNASC transfer but this was declined. There is no record that Ms A was informed of this, or of any other action taken to address the concerns she had expressed in relation to her living situation at this time. This is poor. It is not consistent with the aims of service co-ordination as outlined in the NASC guidelines, which refer to "flexible and responsive solutions to meet the prioritised needs and goals of the disabled person, as identified in the needs assessment, in a manner that makes sense to them".

218. I accept that there are many reasons why it may not have been possible to meet Ms A's identified goals and needs. Identifying a care facility that could meet her needs was never going to be easy, and the lack of appropriate residential care facilities for



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younger people with high and complex needs is known to be a problem nationally.[39] The need for a more diverse range of drug and alcohol treatment facilities throughout the country is highlighted in the recent Law Commission report on compulsory treatment for substance abuse.[40] What concerns me here is the lamentable failure to acknowledge the difficulty in any way, and respond accordingly. When Ms A's stated goal was identified as not viable, no consideration was given to an alternative, even though Ms K, Dr J, and Oak Park staff had also expressed their concerns about the unsuitability of her placement in a home caring mostly for older people with dementia.

219. Over the next three months, there is evidence that Ms A and staff at Oak Park made multiple attempts to seek further assistance from Taikura Trust. She was eventually reassessed on 17 June. Shortly after this, Dr U and CADS became involved, and steps were finally taken to address Ms A's inappropriate living situation. Taikura Trust should have responded to the requests and done more, significantly sooner than they did.

220. The service provided to Ms A throughout this period at this time was not consistent with NASC standards, it did not reflect the intention outlined by Ms G when she sought IFP funding approval, it was not supportive of staff at Oak Park, and it was not fair to Ms A. It was woefully inadequate and a breach of Right 4(1) of the Code.

**Documentation**

221. Taikura Trust's records in relation to Ms A are sparse. It would appear that much of the contact staff had with her, and with other providers, was simply not documented. Some of the gaps can be filled with reference to the records of other providers, including Oak Park, Dr J, and particularly CADS.

222. There is very little evidence of communication between Taikura Trust staff regarding Ms A, but it is not possible to establish the extent to which this was a lack of communication, or a failure to record it. Either way, this is a problem. Several staff members were involved in Ms A's service from Taikura Trust. Their involvement took place over an extended period of time, it included staff employed directly by Taikura Trust as well as contracted staff, and different people were responsible for different aspects of the service.

223. Irrespective of Taikura Trust's responsibility to ascertain who it should be communicating with on Ms A's behalf, it should also have been consulting with Ms A, to the extent appropriate to her competence. Ms O recalls that for a time, Taikura Trust received calls daily from Ms A, or Oak Park staff on her behalf. Mr V recalls

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[39] See, for example, the Social Services Committee report from the *Inquiry into the quality of care and service provision for people with disabilities (September 2008)*, available at http://www.parliament.nz/NR/rdonlyres/06259D2F-780B-40A0-9170-005C8C046E72/93089/DBSCH_SCR_4194_6219.pdf

[40] http://www.lawcom.govt.nz/sites/default/files/publications/2010/10/r118_compulsory_treatment_for_substance_dependence.pdf



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that for a period Ms A phoned him at least twice a week. Apparently *none* of these calls were recorded. This is not good enough.

**Co-operation**

224. It is also very clear that over the course of Taikura Trust's involvement with Ms A, there was a failure to work co-operatively with other providers, including ACH, Oak Park, Dr J, and CADS. This is evident in the delay in responding to referrals, the process of arranging Ms A's placement at Oak Park, the failure of staff to return telephone calls or respond to emails in a timely manner, and an apparent expectation that other services deal with matters that were clearly outside their remits. From November 2007, the impression is that Taikura Trust staff were more focused on what they could not do, rather than what they could do, to coordinate the services Ms A needed. Not surprisingly, Ms A was very unhappy.

225. For these reasons, I find that Taikura Trust breached Rights 4(1) and 4(5) of the Code.

**Dignity and independence**

226. As outlined above, the service provided to Ms A by Taikura Trust was deficient in several respects. In my view, the nature and extent of these deficiencies was inexcusable: she was treated more like a problem than a person.

227. There was a clear failure to ascertain Ms A's legal status, and to consider how decisions should be made on her behalf. Ms A's views were sought and then, it would appear, largely disregarded. Taikura Trust staff were repeatedly alerted to the fact that Ms A's placement at Oak Park was unsuitable. The response fell well short of acceptable.

228. Taikura Trust states that it endeavours to provide its clients with services that are empowering, reliable and liberating. These were sadly absent from the service provided to Ms A. On the contrary, I consider that there was a fundamental failure to respect Ms A's rights to dignity and independence and, accordingly a breach of Right 3 of the Code.

229. I am pleased to note the steps taken by Taikura Trust since these events and as a result of this investigation, to improve the service it provides. The actions taken to improve the knowledge and skills of staff in relation to the PPPR Act and the Code of Rights, to establish more effective working relationships with ADHB and other services, and to improve clinical competence, communication and documentation are noted. I note also that Taikura Trust has acknowledged that it failed to provide Ms A with the service it promises its clients, and accepts that it breached her rights under the Code.



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## Breach — Aranui Home and Hospital Ltd t/a Oak Park Dementia Unit

230. Ms A was admitted to Oak Park on 23 August 2007, and remained there until 20 October 2008. She made it clear on many occasions that she did not wish to be there. Oak Park initially had information that led it to believe she was required to stay there and was not competent to make decisions about her care. However, it failed to verify Ms A's legal status, or to ascertain who could make decisions on her behalf and who it should be consulting and communicating with in relation to her care. Once it became apparent that Ms A's competence was improving, it failed to take sufficient steps to have her situation reassessed and arrange for the removal of the order that it thought was in place.

231. Once again, I find it deeply disturbing that a facility of this nature should clearly fail to be aware of the legal process for the secure care of residents such as Ms A. In my view, Oak Park breached Right 4(1) of the Code.[41]

### Legal status

232. Staff at Oak Park had limited information about Ms A at the time of her admission but, like Taikura Trust, they had "reasonable grounds" for considering she was not competent to make informed decisions and give informed consent. This was indicated in the discharge summary that staff received on the day of her admission, and in Dr C's report obtained subsequently. Staff do not recall exactly what they had been told verbally about Ms A's legal status at the time of her admission, and there is nothing documented about this. It appears they believed there was a legal requirement for Ms A to be accommodated at Oak Park, but they thought that this matter had been addressed by ADHB and/or Taikura Trust and nothing further was required of them.

233. This is not acceptable. Oak Park too, had a responsibility to verify Ms A's legal status, and to be clear about the legal basis on which it was to provide services. While this is important for all health and disability service providers, the fact that Oak Park is a secure facility with the ability to physically detain people, and it routinely provides services to people with diminished capacity, means it should have been particularly vigilant. I note also that if, at the time of Ms A's admission, Oak Park provided services on the understanding that she was unable to give informed consent herself, insufficient consideration was again given to the implications of this. Surely, any provider in this situation would immediately ask: who can consent on this person's behalf and who should we therefore be communicating and consulting with? In other words, aside from its failure to verify Ms A's legal status, it failed to even begin to take the necessary action that would follow from an understanding that she was not competent to give informed consent. If, as they assumed, a personal order had been made, Oak Park staff should have obtained the order and determined from it whether it appointed a welfare guardian and/or provided that particular services were to be supplied to Ms A.

[41] See footnote 2.



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234. Oak Park staff should also have been mindful of the fact that had a personal order been granted as they believed, the Court's primary objectives are to make the least restrictive intervention possible in the life of the person, having regard to that person's incapacity, and that the person should be enabled and encouraged to exercise and develop such capacity as he or she has to the greatest extent possible.[42]

235. There was some contact between staff at Oak Park and Ms A's mother. It is not clear whether Ms A's views about this contact were sought. It is concerning that Oak Park's response to my provisional opinion asserts that it was proper to consult with Ms A's mother in her capacity as attorney, despite neither sighting an enduring power of attorney nor taking steps to have Ms A's competence reassessed as her condition improved.

236. In response to my provisional opinion, Ms M advised that "when [Ms A] tried to contact her daughter several times her mother disconnected the line". Ms M then contacted Ms A's mother to arrange for Ms A to have contact with her daughter. Although these efforts were commendable, it is clear that staff were aware that there were significant tensions in Ms A's relationship with her family.

237. Staff at Oak Park had ascertained Ms A's views about living at Oak Park, noting that Ms A made it clear on numerous occasions that she did not wish to be locked up in a dementia unit for older people. However, like Taikura Trust, Oak Park failed to respond adequately to these concerns.

238. As it became increasingly evident that Ms A's capacity to make informed decisions was improving, staff at Oak Park failed to act. Oak Park had a responsibility to request a reassessment of Ms A's competence by a medical practitioner and to take steps to have any personal order reviewed. This would have resulted in the earlier discovery that there was in fact no such order.

239. In its response to my provisional opinion, Oak Park argued that it was acting under the doctrine of necessity in order to preserve Ms A's life or health. I do not accept that a situation of emergency existed during the 14 months of Ms A's stay at Oak Park. At most, it may have been appropriate to treat her for the first few days after her admission while clarifying the position with regard to the Court order and/or the existence of an enduring power of attorney.

240. Oak Park also notes that Ms A did not immediately leave Oak Park when it became known that she had the legal right to do so. However, Ms A recognised that she needed support, and made a choice to stay there until alternative support was put in place. By this time, CADS was involved and Ms A could see that real efforts were being made to change her situation.

241. As stated previously, this investigation is not about the assessment of Ms A as not competent to make informed decisions. It is also not my role to speculate on what might have happened if Ms A had been allowed to leave Oak Park. Events following

[42] Protection of Personal and Property Rights Act 1994 Part 1, section 8.



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her discharge from Oak Park cannot be used to justify her inappropriate detention. The point is that in most circumstances, people retain the right to make their own decisions — irrespective of whether these decisions are in their best interests. Most people, most of the time, have the right to make bad decisions. There are situations in which denying people this right is justifiable, and that may well have been the case with Ms A because of her diminished capacity. However, doing so is a serious matter that challenges fundamental human rights. In such circumstances, it is critical that due care and attention is paid to ensure the protection of the person's rights and freedoms.

**Care provided**

242. Oak Park supervisor Ms M recalls staff from ACH visiting Oak Park a few days before Ms A's admission. This is unlikely: it is not usual practice, there is no evidence of such a visit in the records of Oak Park or ACH, and in fact Oak Park is not mentioned in ACH's records until the day of Ms A's discharge.

243. On 23 August 2007, Ms M was informed by phone that Ms A would be arriving by ambulance that day. Communication between staff at ACH, Taikura Trust, and Oak Park prior to, and on the day of admission is not well documented but appears to be limited. Ms A arrived with a discharge summary and transfer form. There was some discussion between Ms M and RN N in relation to Ms A's admission, but RN N recalls that it was not until she met Ms A later that day, that she became aware of her age.

244. The decision to accept a new resident should be made on the basis that the facility anticipates being able to provide care appropriate to that person's needs. I am concerned about the information — or lack of it — on which Oak Park staff based the decision to accept Ms A. While it is fortunate that there are residential facilities willing to admit people with impairments that other facilities may deem too difficult or challenging, careful consideration should still be given to the individual circumstances and needs of potential residents. Not doing so jeopardises the safety and well-being of the potential resident, current residents, and staff.

245. Oak Park submits that it was Taikura Trust's responsibility to ensure Ms A's placement met the access criteria set out in the placement agreement. It states that it acted on the instructions of Taikura Trust, and suggests that it had little or no say in the decision to admit Ms A. I disagree. Oak Park not only had a say, it had a responsibility to consider whether it would be able to provide an appropriate service and, indeed, meet the requirements set out in the placement agreement with regard to her ongoing care. In HDC's experience, it is not uncommon for facilities to decline admission if they they do not anticipate being able to meet a person's assessed needs, or to seek a person's transfer if they subsequently find that they cannot do so.

246. Additional information was later obtained from Taikura Trust following the NASC assessment on 29 August, and from ACH following RN N's request on 21 September.

247. Staff at Oak Park consider that they did their best to provide an appropriate service to Ms A while she was resident there. While I accept that there were some improvements



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in Ms A's health and well-being while she was at Oak Park, and that staff attempted to contact Taikura Trust on Ms A's behalf, I consider that staff should have done more, sooner, to address the concerns about her situation.

248. Ms A expressed concerns about the placement within days of arriving at Oak Park. She was formally referred back to Taikura Trust by Dr J on 1 November 2007, little more than two months after admission. Oak Park advises that its staff made every effort to arrange for Ms A to be reassessed by Taikura Trust. It is evident from the records that staff indeed phoned Taikura Trust on several occasions, to follow-up on the referrals for reassessment and the assessment outcomes.

249. However, as it became increasingly clear that Ms A did not wish to stay at Oak Park and that it was not a suitable placement for her, staff should have been more assertive. As well as assisting Ms A to contact the needs assessor or service co-ordinator, Oak Park had a responsibility to inform Taikura Trust explicitly if it was not able to provide an appropriate service to Ms A. While Oak Park is not responsible for the failures of Taikura Trust outlined in the previous section, it should have been apparent that phoning and leaving messages on Ms A's behalf was not sufficient. One option would have been a written referral or letter to a manager or to the chief executive, clearly outlining staff concerns and the inadequate response received to date. Furthermore, Oak Park's contract for the provision of services to Ms A specified action that could be taken in the event that Oak Park disagreed with a NASC assessment. These steps were not taken.

250. There was a lack of reasonable care and skill in the service provided to Ms A and, accordingly a breach of Right 4(1).

### Additional comment — CADS

251. The Community Alcohol and Drug Service that became involved with Ms A was not the subject of this investigation. Nevertheless, it has become apparent that to a significant extent, CADS staff effectively picked up the ball that other services had dropped. While Ms A's continued placement at Oak Park had been clearly identified as unsatisfactory, it was the persistence of CADS staff in particular that led to clarification of Ms A's legal status, which in turn enabled her to leave Oak Park — as she wished to do, and had every right to do. The comprehensive records kept by CADS staff are also noted.

252. Staff at CADS are to be commended for their diligent and compassionate efforts to support Ms A at a time when others seemed ready to overlook her rights.

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## Recommendations

253. I recommend that Auckland District Health Board provide to HDC:



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- A written apology to Ms A's family for breaching the Code and failing to protect and uphold Ms A's rights, by **30 November 2010**.
- Evidence that training has been provided to staff regarding the PPPR Act, the "PPPR Act Staff Guide", by **30 November 2010**.
- Evidence that training has been provided to social work staff regarding Right 7(1), and that the legal guide on "Caring for Patients with Diminished Competence" has been circulated to all social work staff, by **30 November 2010**.
- An update on the arrangements with Taikura Trust for patients referred from Auckland City Hospital to that service, by **31 January 2011**.
- A copy of the guidelines being developed in relation to discharge planning, and the role of social work, for complex patients, by **31 January 2011**.

254. I recommend that Taikura Trust provide to HDC by **31 January 2011**:

- Evidence of the training provided to staff in relation to the PPPR Act and the HDC Code of Rights, and a copy of the staff guide;
- An update on the arrangements with ADHB for clients referred to Taikura Trust from Auckland City Hospital, including feedback on the testing of the hospital "in reach" position, how it has worked, and whether it will be rolled out further.
- A review of the requirements for staff to keep clients, their representatives and other key people informed in relation to time frames, and the outcomes of assessments/reassessments.
- A copy of the "Documentation Standard" currently being developed, and confirmation of the proposed audit process/schedule.

255. I recommend that Aranui Home and Hospital Ltd t/a Oak Park Dementia Unit provide to HDC by **30 November 2010**:

- A written apology to Ms A's family for breaching the Code and failing to protect and uphold Ms A's rights.
- A review of its policies and procedures for residents subject to a compulsory court order.
- Evidence of further training provided to staff specifically in relation to informed consent and the requirements of the PPPR Act.



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## Follow-up actions

- Taikura Trust will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- Aranui Home and Hospital Ltd t/a Oak Park Dementia Unit will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Minister of Health, the Director-General of Health, and the Coroner.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, Auckland District Health Board, Taikura Trust, and Aranui Home and Hospital Ltd t/a Oak Park Dementia Unit, will be sent to all district health boards, the Health Quality and Safety Commission, and the NZ Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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## Addendum

The Director of Proceedings decided to take proceedings before the HRRT against Taikura Trust and Aranui Home and Hospital Ltd. Proceedings are pending.



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## Appendix 1 — Advice from Dr Geoffrey Robinson

Thank you for seeking my opinion on aspects of this case.

I have read and agreed to follow the Commissioner's guidelines for independent advisors.

**Qualifications and relevant experience:**

MB.ChB Otago 1972

Fellow of the Royal Australasian College of Physicians (FRACP) 1979

Foundation Fellow of the Australasian Chapter of Addiction Medicine FAChAM 2002

My Physician training was in general internal medicine. In 1978–1979 I undertook a two year residency training programme in Addiction Medicine at the Addiction Research Foundation, Clinical Institute Toronto Canada. This was affiliated to the University of Toronto.

On returning to New Zealand in December 1980 I was the medical director of the Alcohol and Drug Services for Wellington Hospital Board (now Capital & Coast DHB) for 22 years. This was half of my clinical time. The other half was as a general physician at Kenepuru Hospital, which included being responsible for a four-bed medical detoxification unit. I ceased being an acute general physician in 2005 when I became the Chief Medical Officer for CCDHB. I continue to be responsible for the medical detoxification unit. In this role I am familiar with patients with alcoholism who from time to time require supervised accommodation because of intellectual impairment, or other disabilities.

Since 2008 I have been the New Zealand President of the Royal Australasian College of Physicians.

*[Summary of request and documentation provided omitted for brevity]*

In summary, the case was a 43-year-old woman admitted to general medicine at Auckland Hospital 12/05/07, having been brought to the Emergency Dept by [staff from a community centre].

She was homeless and was known to be an alcoholic who had previously been to various alcohol rehabilitation programmes, without apparent sustained abstinence upon discharge.

During the admission she was considered to have:

- An alcohol-related organic brain syndrome with intellectual impairment and memory disorder



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- Hydrocephalus on a CT scan, previously found at [Hospital 1]
- Cryptococcal meningitis treated with antifungal drugs.

Throughout the admission there were problems with continuing cognitive impairment, behavioural disorder (e.g. uncooperative at times and wandering), mobility disturbance and falls, and urinary incontinence.

Application was made by clinicians for an order under the Protection of Personal and Property Rights Act 1989, but this was never filed. She was discharged 23/08/07 to Oak Park Rest Home which is a secure unit mostly caring for older patients with dementia.

My comments are based entirely on the documentation provided by the HDC as listed previously. It is difficult to appreciate the discussions that would have occurred at the Multi-disciplinary team meetings and the associated clinical reasoning leading to the decision making which occurred, as I found that these were not clearly documented as such.

I advise that the clinical situation such as developed in this case is not infrequently complicated by many of the issues encountered, e.g.

- Considerations of the necessity for the PPPR Act being invoked.
- Lack of funding of residential care post-discharge, as this type of patient falls outside the boundaries of Mental Health Services or Care for the Elderly providers.
- The lack of tailored suitable residential services for these younger patients.
- Often a lack of clarity as to which services provide ownership for the care of these patients, and acute medical services are frequently required to attempt to cope with these complex situations.

Specific advice sought:

**"The standard of communication and consultation between hospital staff, Ms A and other relevant people, in relation to the care provided while she was an inpatient".**

Consultation with medical specialists including neurology, infectious diseases and psychiatric liaison in the early stages of the admission were at a high standard in attempting to deal with the complex issues. I note the mid July consultation to neurosurgery with the patient's assessments prior to and following lumbar puncture. It is possible these later medical endeavours distracted or delayed discharge planning to an institution. I note that CADS were not seemingly consulted during the admission, but her alcohol withdrawal was appropriately assessed and treated. It is unlikely given her clinical status that the patient would have been a candidate for traditional residential alcohol and drug services and it is noted there had been limited benefit achieved in the past. I note no involvement of rehabilitation services but am unsure if ADHB has either access to or provides such for younger patients of this type.



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I thought that good efforts were made to obtain the patient's medical records from past providers and also there were reasonable efforts to contact the (estranged) family and keep them informed.

It is difficult to discern the interactions of staff with the patient from the case notes. The main preoccupation seemed to be around day to day management of the clinical situation and it seems likely that her cognitive state would have precluded much in depth discussion. I note also the Allied Health involvements including Social Work, Physiotherapy and Occupational therapy. As stated earlier it is hard to establish from the documentation available to me how this was integrated into a meaningful overarching plan commonly understood by all involved.

**"The adequacy of ADHB's discharge planning".**

My impression from the case notes is that for the last month of the patient's three months admission the overarching strategy and thus the discharge planning situation became stuck and somewhat lost. Aside from the unfortunate situation of the PPPR Act application becoming lost, seemingly forgotten and not filed, there were multiple case note comments that the treatment plan was "awaiting placement". There appears a lack of sustained direction to secure such placement. I saw no documented evidence of any case conference with relevant clinicians or multi-disciplinary teams conclusions on what should have been best provided in this patient's ongoing care interests. I acknowledge the protracted difficulties associated with accessing any funding, and the uncertainty as to which sort of institution may be appropriate or available.

**"The appropriateness of the patient's discharge plan"**

During the three month admission there would have been time to collate summaries from various disciplines including social work, physiotherapy, occupational therapy and psychiatry to give information and guidance to the receiving institution. I am not aware that any of this was prepared and forwarded to Oak Park Rest Home. I see no evidence of an integrated plan for ongoing care or treatment.

In stating this, I believe that such ideals are often underachieved outside of what I have seen from multi-disciplinary discharge information from the CCDHB Rehabilitation Unit here. There needs to be strong case ownership by either a case coordinator or case manager who leads the decision making and coordinates the various clinical goals and strategies into an integrated plan.

I note a comment from an RN, on the day before discharge 22/08/07 to please start the "tx" letter which is probably a transfer of care document. The medical discharge summary was done at 3.10 p.m. on the day before discharge. Also there was a RN (unsigned) final comment on discharge 23/08/07 of a verbal handover to [a registered nurse] at Aranui Oak Park, but the content of this handover was not documented.



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I have read the worthy document "ADHB Discharge Planning Policy", and see that this case comes up short on some of these ideals (standards) in particular around "complex discharges are actively planned in the MDT (Page 3);" and in the principle stating that "information relating to aggressive behaviours is conveyed clearing to receiving services.

**"Standard of Discharge Documentation"**

I note on Page 38 of the Clinical Notes that the discharge check list to be documented 24 hours prior, and on the morning of discharge was not completed. The clinical summary (medical) is noted and briefly addressed most issues. This was sent to [a general practitioner]. It is hoped a copy accompanied the patient to the discharge institution, regrettably not named in this summary. There is no documentation to support this hope.

**"The adequacy of the arrangements made by Auckland DHB for the patient's follow up care after discharge"**

No follow up arrangements were noted in the discharge summary or in the clinical notes. This may be acceptable but it would be reasonable to have considered the possibility of a neurological review given this relatively young patient's meningitis and hydrocephalus. Ideally at least advice to the GP at the Institution that this would be necessary if headaches worsened or there was intellectual deterioration (in the absence of ongoing drinking as presumed in a "secure unit").

It is clear this patient required residential supervised care. However it is possible she could have some potential for improvement in cognitive or physical function, and ideally the receiving institution should have the capability to be resourced to identify, assess and facilitate rehabilitation potential. As the patient was discharged to a secure dementia facility it would seem ideal that a "needs assessment review" would have been considered in discharge planning "directions".

**"Any aspects of the care and treatment provided by ADHB needing additional comment"**

This case illustrates various challenges in management including general medicine being required to coordinate alcohol, neurological, infectious disease, psychiatry and medicolegal interfaces. In addition there were difficulties with mobility, falls, incontinence and likely episodes of uncooperative behaviour. Allied health disciplines were also much involved.

My impression (from the case notes) was of the lack of a clear sense of leadership, integration, coordination and direction, and later in the admission any sense of urgency in resolving "awaiting placement", and for example what happened to the PPPR situation. I would like to see the multi-disciplinary meeting outcomes and plans clearly documented in the case notes, which is probably a challenge across many services and departments in all hospitals but essential to effective discharge.



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As I have indicated, I believe that with regard to discharge planning and discharge documentation that there were areas that were suboptimal, as I have attempted to highlight.

You have asked what view peer-providers might have about this situation and it may be that General Medical Units in New Zealand who are faced with similarly complex situations with the intellectually impaired younger patient and all the difficulties around placement would be sympathetic, and thus that they may regard ADHB's performance as acceptable or at least not much below the required level. My experience suggests to me that this situation required dedicated care coordination and thus a better result for this patient could have been achieved

Yours sincerely

**G M Robinson FRACP**

**CONSULTANT PHYSICIAN**



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