Caregiver, Mr E

Manager, Ms D

Mary Moodie Family Trust Board (Incorporated)

A Report by the

Deputy Health and Disability Commissioner

(Case 10HDC00420)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. This report is about the failure of Mary Moodie Family Trust Board (Incorporated) (the Board), which operates a residential home for people with intellectual and physical impairments, to ensure safe systems were in place at the home. It is also about the actions of a caregiver at the home, Mr E, who used inappropriate force by dragging one of the residents, Ms A, across the floor by her legs and then by her arms, and the failure of the manager of the home, Ms D, to put in place adequate policies and provide caregiving staff with adequate disability support training.

2. At the time of the incident on 26 January 2010, Ms D was in a personal relationship with Mr E. Mr E had little training in the management of the residents and the policies in place were inadequate.

3. In response to the incident Ms D inspected Ms A's carpet burns, made a doctor's appointment, spoke with a staff witness, advised Mr E how to better manage such a situation in the future, and spoke to staff about the incident at a staff meeting. However, she failed to inform Ms A's parents or the Board about the incident.

Decision summary

4. The Deputy Health and Disability Commissioner (Deputy Commissioner) found that Mr E's actions were both unkind and disrespectful and that he breached Right 1(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code). In addition, Mr E did not provide services to Ms A with reasonable care and skill and so breached Right 4(1)[2] of the Code.

5. By failing to have adequate recruitment processes, orientation and staff training, Ms D put Ms A at risk of being harmed and, accordingly, Ms D breached Right 4(4)[3] of the Code.

6. By failing to notify the Board and Ms A's family of the incident involving Mr E, and by failing to ensure there was an appropriate management plan in place that provided staff with clear guidance on how to manage Ms A's challenging behaviour, Ms D failed to provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code.

7. Ms D also failed to take reasonable steps to reduce the use of restraint and to ensure that, when practised, restraint occurred in a safe and respectful manner. Accordingly, Ms D failed to comply with the Restraint Minimisation and Safe Practice Standard. This failure amounted to a breach of Right 4(2)[4] of the Code.

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

8. The Board failed to take reasonably practicable steps to ensure Ms A's behaviour management plan was appropriate. Accordingly, the Board is vicariously liable for Ms D's breach of Right 4(1) of the Code. The Board also failed to take reasonable steps to ensure Ms D complied with the Restraint Minimisation and Safe Practice Standard and so is vicariously liable for Ms D's breach of Right 4(2) of the Code. The Board's lack of supervision, guidance and monitoring of Ms D's performance, together with the lack of adequate policies, contributed to the unsafe system existing in the home and the failure to provide services of an appropriate standard to Ms A. Accordingly, the Board breached Right 4(1) of the Code.

Investigation process

9. On 10 April 2010, the Health and Disability Commissioner (HDC) received a complaint from Ms B[5] about the services provided by the Board to Ms A. An investigation was commenced on 30 June 2010. The following issue was identified for investigation:

- *The adequacy of the services provided by Ms D to Ms A in January and February 2010, and in particular, the adequacy of Ms D's actions in response to an alleged assault on Ms A on 26 January 2010.*

10. On 8 February 2011, the investigation was extended to include the following issues:

- *The appropriateness and adequacy of the care provided by the Mary Moodie Family Trust Board (Incorporated) to Ms A.*

- *The appropriateness and adequacy of the care provided by Mr E to Ms A on 26 January 2010.*

11. This report is the opinion of Tania Thomas, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

12. Information was reviewed from the following parties who were directly involved in the investigation:

Ms A	Consumer
Ms B	Complainant
Mary Moodie Family Trust Board (Incorporated)	Provider
Ms C	Chairperson of the Board[6]
Ms D	Provider/manager
Mr E	Provider/caregiver
Ms F	Provider/caregiver
Ms G	Provider/caregiver

Also mentioned in this report

[5] Ms B was employed by the Board as a caregiver at the time of the events.
[6] Ms C resigned from her role as Chairperson of the Board on 20 June 2011.

Ms H	Bureau caregiver
Dr I	General practitioner
Ms J	Caregiver
Ms K	Administration assistant
Ms L	Manager

13. Information was also reviewed from general practitioner (GP) Dr I.

14. Independent expert advice was obtained from nurse practitioner Bernadette Forde-Paus, and is attached as **Appendices A-D**.

Information gathered

Introduction

Mary Moodie Family Trust Board (Incorporated)

15. The Board governs a residential home for people with intellectual and/or physical impairments (the home). The fourteen residents who live in the home are aged from their late 20s to 50 years. The residents, who have lived together for a long time, were originally cared for by Mary Moodie. In 1991, when Mrs Moodie became unwell, the Board was formed so the residents could remain together as a family unit.

16. The governance structure of the Board is set out in a document entitled "Governance Policies". This document provides that "the Board will direct, control and inspire the organisation through the careful establishment of broad written policies reflecting the Board's values and perspectives". The Governance Policies describe the relationship between the Board and the manager of the home as follows: "the manager is the Board's only link to operational achievement and conduct, so that all authority and accountability of staff, as far as the Board is concerned, is considered the authority and accountability of the manager".

17. Policies on treatment of clients are required to be internally monitored on an annual basis. In order to monitor the manager's performance, the Board acquires data by way of internal reports, external reports and direct Board inspection.

18. The Governance Policies document states:

> "[I]n every case, the standard of compliance shall be *any reasonable manager interpretation* of the Board policy being monitored. The Board is final arbiter of reasonableness but will always judge with a 'reasonable person' test rather than with interpretations favoured by Board members or by the Board as a whole".

Ms A

19. Ms A has epilepsy and autism and is limited in her ability to communicate. She can say "yes" and "no" and conveys her needs by pointing or taking staff to what she wishes to do. When Ms A is agitated she can become aggressive and is very strong. Ms A likes routine and will indicate if she does not want to do something.

20. Ms A's father is her welfare guardian. He was appointed by the Family Court on 29 April 2009.

21. There was a documented management plan for staff to follow when providing services to Ms A (**Appendix E**). However, when asked about her knowledge of the "Afternoon Routine" plan, caregiver and team leader Ms G advised HDC "[W]hat is recorded as [Ms A's] 'Afternoon Routine' plan is not what was current at the time of the incident". However, she also stated "I do recall most of what is written in the document being in place if [Ms A] did not cooperate".

22. The Board advised HDC that at the time of these events "much information relating to management plans for individual residents was communicated informally between staff working on their shifts".

The incident

23. On the evening of 26 January 2010, Ms G was the team leader on duty. She advised that, at around 7.30pm, she asked a bureau caregiver, Ms H, to give Ms A a shower, but Ms A refused to cooperate. Ms G said that approximately 10-15 minutes later, she approached caregivers, Ms F and Mr E, who were in the lounge with two other residents, and asked if "one of them could help get [Ms A] to the bathroom". Ms G then returned to the bathroom to start showering another resident.

24. Ms F told HDC that Mr E agreed to take Ms A to the bathroom, and he went to get Ms A from her bedroom, where she had been for some time. Ms F told HDC that at this time she was in the lounge providing one-on-one care to a resident and watching music DVDs, which were quite loud. She said there is a wall separating the lounge from Ms A's bedroom and so she could not see anything that happened in the room and, because of the volume of the DVD, she did not hear anything either.

25. Ms F said she saw Mr E dragging Ms A out of her room by her feet. She said she yelled out "[Mr E], stop it". Ms F said that she knew Ms A had a mark on her back from when she had previously thrown herself onto the floor, and that this could be being aggravated. Ms F stated she told Mr E that Ms A's top was riding up and that "it could be aggravating a mark on [Ms A's] shoulder". She stated that she "reminded [Mr E] of this and told him to be careful." Ms F said that Mr E immediately stopped dragging Ms A and she thought "that was the end of it". However, "[Mr E] then turned [Ms A] around and pulled her by her arms instead". Ms F stated that, at that point, Ms A was "on her bottom/back and being pulled by her arms along the carpet". Ms F told HDC that she does not feel there is anything she could have done to have helped the situation and she did not have time to intervene as it happened too fast.

26. Ms F stated that Mr E put Ms A on the bean bag outside the bathroom and that Ms A was kicking out, pulling the couch next to her out and putting her finger near the power socket. Ms F said she then went over to assist Mr E and sat with Ms A for a period of time. She stated that, at 8pm, she left Ms A and went to put another resident to bed and write up that resident's daily notes.

27. The Board advised that the distance from Ms A's bedroom to the beanbag was approximately nine metres.

28. Ms A was showered by another caregiver. Ms G said she was called into the bathroom by the caregiver, who had noticed marks on Ms A's back. Ms G said the marks were "fresh and weeping". Mr E said that when it was brought to his attention that he had caused carpet burns to Ms A's back, he was very upset and rang Ms D that night and told her of the incident.

29. Mr E has provided HDC with a different account from that of Ms G and Ms F, of the events which immediately preceded the incident. Mr E stated that, earlier in the evening, Ms A had thrown a plate at another resident and that "just prior to the incident" Ms A had attacked another resident and he was asked by the team leader to take Ms A to her room to calm down. He said that Ms A ran to her room and started to throw her belongings around. Mr E said he stood in the doorway to ensure Ms A did not hurt herself, come out of the room and attack another resident or run away. Mr E stated:

> "[Ms A] then pulled out her drawer and threw it at the window. SHE PULLED OUT A SECOND drawer and went to throw it again at the window so I went into the room and held [Ms A] by her arms. It was my belief that if she smashed the window she would have jumped out of it causing great harm to herself. [Ms A] lifted her legs and we both went to ground. I stood up and by her arms pulled her from her room to get her away from any missiles. [Ms A] turned and kicked me in the ribs again sending me to the ground. I held [Ms A] by her legs and then pulled her out. Another staff member WHILE WATCHING TV rather than helping me pointed out that her top had rode up her back. I then stopped turned her around and took her to a bean bag to calm down where she was safe and there were no missiles for her to grab. I told [Ms A] to stay there and not move, in a firm voice, three times and after around twenty five mins with me sitting beside her she calmed down".

30. Ms F said that Mr E's account of being asked to intervene because Ms A had attacked another resident and was in her room throwing drawers was "completely false". She said that may have occurred earlier in the evening, but this was "certainly not" the reason Mr E went to Ms A's bedroom that evening.

31. Ms G could not recall whether Ms A had thrown a plate at another resident that evening but said "[Ms A] does do this sometimes". She said she had no recollection of Ms A attacking another resident that evening. Ms G recalls asking Ms F and Mr E if one of them could bring Ms A to the bathroom, but does not recall that she earlier asked Mr E to take Ms A to her bedroom.

32. Ms G stated that Ms F did not have the chance to tell her what had happened because, by the time Ms G had finished bathing the resident, Ms F had finished her shift. Ms G further stated that Ms H told her that "there had been a scuffle between [Mr E] and [Ms A]". Ms G also stated that she saw Ms A sitting on the bean bag looking stressed.

33. Ms G said when she spoke to Mr E about the incident, he told her that Ms A had got violent with him, but he did not say he had dragged Ms A. Ms G said she completed an incident form based on what Mr E had told her.

34. The Accident and Incident form completed by Ms G states "type of injury: carpet burn. Where: back. What happened before: [Ms A] was asked to go to the bath but refused and started kicking a staff member. Had to be restrained. What happened after: [the caregiver] noticed burn on back when bathing her".

The Community Team

35. The Community Team is a multidisciplinary team funded by the District Health Board, which provides clinical assessment services for people with an intellectual disability and challenging behaviours. The Community Team also provides education sessions for those involved with the care of people with an intellectual disability.

36. Ms A was initially referred to the Community Team in November 2005 due to changes in her presentation, such as her getting out of bed and refusing food and medications. On 30 January 2007, the Community Team sent the Board a detailed assessment of Ms A's behaviour and provided recommendations on how to manage Ms A, including proactive and reactive strategies. It suggested: "[the Board's] staff to develop precise documentation using prompts provided by [the Community Team]. The aim is to ensure recordings are objective, descriptive and reflect observations of [Ms A's] progress and behaviour. This is to include both seizure recordings and daily progress notes … ensure staff are provided access to and training on epilepsy and Autistic Spectrum Disorder (ASD)".

37. The Community Team also commented in its 2007 assessment that "in the past, MMT have used a lifting belt to physically remove [Ms A] out of an area where this has been required. This is not endorsed by [the Community Team]".

38. It appears that the 2007 assessment and report were not retained on Ms A's file. On 1 April 2010, a Community Team registered nurse wrote to the Board including a copy of the 2007 assessment. She stated that she was "concerned that once again there is no record on [Ms A's] file as it was a combination of an extensive assessment process. It would be helpful for you to read this through and discuss the implications for [Ms A] and MMFT staff at the current time".

Restraint

39. Despite the Community Team's comment in 2007 that it did not endorse the use of the lifting belt to move Ms A, the documented management plan for Ms A included reference to the use of the lifting belt, and staff continued to be instructed to use the lifting belt.

40. On 19 September 2007, a "Restraint Consent Form" was signed by a GP (Dr I), a Board member, the restraint co-ordinator, and one of Ms A's parents. The consent form stated that a transfer belt[7] was to be used as Ms A "can place herself and others in clear dangerous position, this being a situation of high risk of injury/death/illness".

[7] It appears that the terms "transfer belt", "lap belt" and "lifting belt" are synonymous. The belt passes around the consumer's waist and is fastened with a buckle. It has a handle on each side.

41. Caregiver, Ms F, stated that they never used the lifting belt in the house and it was only used occasionally to get Ms A in and out of the van when she was refusing to cooperate. Ms G stated: "I remember the lifting belt was to be used in very rare circumstances; management advising staff it was to be used only for [Ms A's] personal safety and the safety of others".

42. There are records showing that the use of the lifting belt was reviewed on 26 March 2008, 22 October 2008 and 5 August 2009 by Dr I, the Board of Trustees and Ms D.

43. Ms D did not respond when asked if she had seen a copy of the Community Team's assessment of Ms A from 2007. However, on 24 August 2008, Ms D wrote to Ms A's parents asking them to sign a restraint approval form, which stated that the agencies involved with the development of the restraint programme were "[the Community Team], GP [Dr I], Board of Trustees and management". The copy of the form on the file has not been signed by Ms A's father, although the GP, Ms D, a Board member, Mr E (as Health and Safety Officer) and the Chair of the Board, Ms C, did sign an appendix to the form, on 5 August 2009. There is no signature from a Community Team representative.

44. On 22 October 2008, a "Restraint Use Assessment" form was completed by Ms D. This states that a lifting belt was to be used as Ms A has epilepsy and her behaviour can result in her throwing herself to the ground and refusing to move. It also states that Ms A had a history of placing herself in dangerous situations when offsite, which are unsafe to herself and others.

45. The form states that before using the lifting belt, staff were to follow Ms A's behaviour support plan guidelines. Staff were also to ensure that Ms A was safe by monitoring her closely and locking gates and doors or windows. Ms D documented "train staff" as a way to minimise the use of the lifting belt.

46. Ms D instructed staff to use a lifting belt when Ms A was taken out or at day base, if she refused to cooperate.[8] This instruction does not appear to have been documented in a management plan.[9] Ms D advised HDC that Ms A was known to kick and hit out at the staff while they were trying to use the lifting belt.

47. The use of the lifting belt by staff was recorded on a form "Restraint Recording". Between 8 September 2009 and 19 February 2010, it is recorded that the lifting belt had been used on Ms A 16 times. On one occasion (9 September 2009) the signature of the staff member using the lifting belt appears to be that of Mr E.

Ms D

48. Ms D commenced her role as manager at the home in June 2008. Prior to this she had worked in other managerial roles in the disability sector, as a house coordinator in the disability sector and as a counsellor. Ms D's curriculum vitae states that she has, inter alia, a leadership management certificate and has completed a supervisor's course, an advocacy course and Ministry of Health awareness, competence and responsiveness training.

[8] Day base is the workshop the residents attend during the day.
[9] The "[Ms A] –afternoon routine" document relates to Ms A's behaviour in the home.

49. Before being appointed, Ms D was interviewed by three Board members (including the Chair of the Board) and three referees were contacted, none of whom raised any concerns about Ms D. Following her appointment, she attended annual national residential intellectual disability conferences and the Board advised HDC that Ms D was encouraged to attend courses.

50. According to the manager's job description, Ms D's main function was to "ensure the smooth running of the Mary Moodie Family Trust Homes, that the policies of the Board of Trustees are adhered to and the rights of the residents are protected".

51. Ms D was responsible for the recruitment, orientation and training of new staff. She was also responsible for "planning a staff training programme which ensures that all staff have appropriate job training in all aspects of their duties". When asked about Ms D's performance evaluations, the Board advised HDC that "there is no evidence of any performance evaluation of Ms D in the file. There is very little information in the file". Ms D told HDC that there was a performance review in relation to her on file.

Appointment of Mr E

52. Mr E was initially employed as a maintenance worker on 16 March 2009 then, from 1 May 2009, as a caregiver. Ms D advised HDC that "[Mr E] was employed by the usual employment processes". Ms D said she was unable to make employment decisions independently without the Board's approval.

53. When asked about the appointment process, the Board Chair stated "a Board member is required to attend the formal interview of prospective employees. All Board members have been questioned and not one can remember attending [Mr E's] formal interview". Subsequently, the Board advised that it has no record of who was on the panel. Ms D has been asked who was on the interview panel, but she has not responded.

54. The interview form, dated 5 March 2008,[10] has a space for the names of the interview panel members but this has not been completed. In addition, the form is not signed and does not indicate whether the application was successful.

55. Mr E said that while he was employed in his maintenance role, he applied for a caregiving role to provide one-on-one care for a resident. He told HDC that he was interviewed by Board members for the position and "had to go through all the normal application processes to secure my position". On commencement of his new role he had two weeks of orientation and was buddied with another staff member for training.

56. Mr E had no formal training in, or experience with working with people with intellectual impairments. The interview form documented Mr E's response to questions asked during the interview. In response to the question "how would you describe an 'ordinary lifestyle' for someone with an intellectual disability?" Mr E responded, "a happy life. The best possible care — enjoyment of life within their capabilities".

[10] It is likely the year 2008 was an error. All other documents are dated 2009.

57. The Board had a policy on the recruitment of staff. Under the heading Interview Procedure there is a list of bullet points. Two of the bullet points are "Police check" and "Referee checks".

58. It appears that at the time of Mr E's appointment as a caregiver, reference checks were not carried out as, on the form "recruitment checklist" next to "referee checks completed", it states "N/A known". This form is not signed but the Board stated that Ms D completed it.[11] The Board and Ms D advised that a Police check was carried out. However, no documentation was provided to confirm this.

59. Mr E advised HDC that, after being in his caregiving role for eight months, in January 2010, he took on a Team Leader position on Wednesday nights. Ms C advised HDC that when the Board became aware of this in February 2010 it immediately removed Mr E from this shift.

Orientation

60. Ms D said that when Mr E commenced his role as a caregiver, he completed the standard orientation for this role. Mr E did not respond when asked about his orientation and training. Mr E's "orientation checklist" contains approximately 100 items in bullet point form covering the following areas: residents, duties, performance, and training/administration. Most of the items have been initialled as "achieved", however, ten have been left blank. Next to the initials is the date each item was achieved. All but three items were initialled on the same day, 27 May 2009.

61. The Board has advised that the initials refer to another caregiver, Ms J. However, the form provides that the items relating to "performance" were required to be completed by the manager and were to be scored out of ten. No score has been inserted and the initials appear to be the same as for the other items.

62. Ms J advised that the training was carried out weeks before the form was signed. Ms J said: "The Manager insisted I sign off all of the items on the date signed" and that, because of the pressure that she was under, she "signed off everything not realising that that section was Manager only".

63. At the end of the form, there are spaces to indicate that the employee has signed the employment contract and confidentiality agreement and that the orientation has been completed. These spaces are blank. There are also spaces for the employee and the manager to sign at the bottom of the orientation checklist. These have not been signed.

64. Ms D advised HDC that Mr E was given specific instructions regarding Ms A's care, including familiarisation with the "comprehensive behaviour support plan"[12] for Ms A, and that he attended a restraint minimisation meeting with a general practitioner, which provided him with a good understanding of restraint techniques and the use of the lap belt. However, the Board does not have any record of the training provided to Mr E other than the items listed in the orientation checklist. When asked whether he had specific instructions or training regarding providing care for Ms A, Mr E did not respond.

[11] Ms D was asked whether she carried out a reference check, but did not respond.
[12] The Board has not provided HDC with a comprehensive behaviour support plan for Ms A.

Mr E's relationship with Ms D

65. Ms D advised that she had known Mr E for approximately 28 years. After Mr E began working as a caregiver at the home, she and Mr E commenced a personal relationship. On 24 December 2009, Ms D informed Ms C that Ms D and Mr E were "intending to start a relationship". Ms D told HDC that Ms C responded that as long as the relationship remained on a professional level at work, she had no problem with it.

66. Ms C advised HDC that "There is no formal policy dealing with relationships between staff however governance policies in place at the time make it clear that the manager has an obligation to treat all staff fairly and that the manager, at all times, act professionally and not expose the organisation, the Board or staff to claims or endanger the credibility or reputation of the Trust". Ms C said that she made it clear to Ms D that it was essential that the relationship did not adversely impact on the professional standards required of both her, as the manager, and all staff.

The internal investigation

67. The Board has an "accident and incident reporting procedure". The procedure requires those present to ensure the resident is safe and report incidents and accidents to the manager. The staff member must fill out a "special incident/accident report form" in duplicate and place one copy on the client file and give one copy to the manager. The manager's duties are as follows:

> "Manager must ensure the appropriate actions have been taken.
>
> Manager takes steps to investigate (if required), write up the reporting and action taken sections on the form.
>
> Report to the Trust the nature of the incident. The Trust may review the actions taken by management to provide oversight. The family/guardian of the resident may be informed of the incident or accident depending upon the severity and nature.
>
> Analysis, trends and actions taken are communicated to service providers and family representatives.
>
> Close the incident/accident in the incident register."

68. On 27 January 2010, at around 8.15am, Ms D went to see Ms A. Ms D said that after examining Ms A, she made a doctor's appointment for her.

69. Ms D spoke to Mr E about the incident. Mr E told HDC that he was called into Ms D's office on the morning of 27 January 2010 and that he explained his actions to her. Mr E said that Ms D spent a long time going over the incident with him and advising a better way to deal with a similar incident in the future. Mr E said Ms D booked him on a training course for managing challenging behaviour and he was given a verbal warning.

70. Ms D advised HDC that when she spoke to Mr E about the incident he was "absolutely beside himself knowing he had hurt [Ms A] and that is the last thing that he would ever want". A record of Ms D's meeting with Mr E is documented on a form headed "individual staff meeting". The form is signed at the bottom by Mr E and Ms D and dated

2 February 2010. Ms D told HDC that this was the first available opportunity for them to meet to discuss the incident. However, Mr E told HDC that they first discussed the incident "at length" on 27 January 2010 (the day after the incident). The individual staff meeting form states:

> "Agenda items: [Ms A] – marks on her back. Observations by management indicated a struggle resulting in three welts between shoulder blades and four areas of carpet burn on right and left scapulars.
>
> Response to items: [Mr E] approached me about the situation explaining that [Ms A] refused to come out of her bedroom, started trashing it — throwing things etc. [Mr E] was kicked as he tried to get her to stop her hurting herself. [Ms A] dropped to the floor, it was then [Mr E] dragged her by her feet to the lounge + in the process inflicted carpet burn.
>
> Action required: I inspected [Ms A's] back the following day + made a doctor's appointment. I do not believe that all the marks on her back were inflicted during this struggle. [Mr E] instructed to use the lifting belt in the future or leave [Ms A] contained in her room."

71. Ms D stated that the Board's procedure was that she had to question Mr E about the incident. She stated that the questioning was thorough and in line with the practices set out by the Board.

72. Ms D advised HDC that, at this meeting, she suggested to Mr E that he undertake a course in managing challenging behaviour[13] and she advised him that once the investigation was complete it would be referred to the Board to decide what would happen next. She said Mr E was "well aware of the procedure and its consequences" and that, after the meeting, Mr E was issued with a verbal warning. Ms D has advised that she cannot recall where she documented the warning, but considers that the meeting notes would be sufficient to constitute a warning.

73. The Board advised HDC that verbal warnings would normally be recorded in the individual staff member's file, but it could find no record of a verbal warning having been given to Mr E.

74. After speaking to Mr E, Ms D called Ms F to her office and asked her what had happened. Ms F said she "relayed to her exactly what she had seen" and that Ms D told her that her version of the incident was the same as Mr E's and assured her that it would be dealt with in the right way, stating "just because they [Ms D and Mr E] were an item did not mean he would not be dealt with".

[13] Ms D told HDC that Mr E completed a three-day behavioural management course with the Community Team. However, there is no record of this in the documentation supplied to HDC by the Board.

75. The form documenting the meeting with Ms F is signed by both Ms F and Ms D and is dated 1 February 2010.[14] It states:

> "Agenda items: questioning of marks found on [Ms A's] back as [Ms F] was a witness to the incident.
>
> Response to items: the situation was explained which corresponded with the recollections voiced by [Mr E]. When asked if [Ms F] felt the action by [Mr E] was inappropriate [Ms F] stated that she felt it was.
>
> Action required: [Mr E] spoken to by management and instructed not to repeat the way in which the situation was managed. Advised to use the lifting belt or to contain [Ms A] in her room. All staff advised of this strategy.

76. Ms D stated that the subsequent procedure was that the incident would be tabled at the next Board meeting and the Board would take over the management of the incident. She stated "I was unable to make any decision involving disciplinary actions without the consent or involvement of the trustees".

77. Ms D stated that "obviously, this incident was complicated due to my relationship with [Mr E]. This is why my only involvement in the investigation was questioning [Mr E]. It was my intention that the incident be forwarded to the Board of Trustees as soon as possible so as they could handle the matter fairly without infringing on the credibility of the investigation".

78. Ms D initially advised HDC that she completed an accident and incident form in relation to the incident. She later advised HDC that she did not complete an accident and incident form, but Mr E did. However, the Board advised HDC that it has no record of an accident and incident form documented by Ms D or Mr E, but does have the incident form completed by Ms G. On the reverse of that form in the section headed "Management only" Ms D has added under "comments" the words "As per 2 previous reports" and under the section "Further action required" she has circled the word "no". She dated the form 1 February 2010.

Staff meeting

79. The monthly staff meeting was held on the morning of 27 January and Ms D explained to the staff what had occurred the evening before. Ms F recalls that Mr E was nearly in tears and said he would never hurt anyone intentionally.

Doctor's appointment

80. A caregiver took Ms A to see general practitioner, Dr I, on the afternoon of 27 January. Dr I prescribed some cream for Ms A's abrasions, which was to be applied morning and night.

81. A medical/dentist visit form was completed in relation to this appointment which states:

[14] It is not known why the form documenting the meeting with Ms F is dated earlier than the form documenting the meeting with Mr E.

"reason for visit: calcium to be re-charted and a check of her back marks/wounds.

Professional comments: 1. Calcium started … 2. Old abrasions on both scapular spines. Fresh abrasions over mid-thoracic spins – please check skin for any injuries after any violent incidents (and document).

Medication added/changed: [?] cream for abrasions"

Informing Ms A's parents

82. The Board's accident and incident policy states "depending on the severity and nature of the incident the family/guardian of a resident may be informed about it".

83. Ms D said that she did not contact Ms A's parents about the incident, but thought that she should have done so. She stated that she did not contact them because she was sick and was also preparing for an audit, and that it was not her intention to hide anything from them.

Outcome

84. Mr E said to HDC that he regretted the incident but "it just all happened so fast and I really thought I was doing the right thing". He said he apologised to Ms A at the time and she gave him a cuddle. He stated that he would deal with this differently if the situation arose again but, in saying that, he would take similar action rather than see someone harm themselves.

85. Mr E subsequently told HDC that since the incident he has researched websites and watched a DVD and now knows where he went wrong. Mr E told HDC: "never never would I deal with this in the same manner and still to this day [regret] my actions".

86. Ms D advised HDC that she was of the view that Mr E's actions were based on self-defence and that the injuries sustained by Ms A could have been a lot worse had Mr E not intervened.

Report to the Board

87. Ms F said that she contacted a Board member on 3 February 2010 and advised the Board member about the incident. She said the Board member responded that there was a Board meeting coming up and they would wait to hear about it then, in Ms D's report. Ms C has confirmed that on 3 February 2010, a Community Support Worker contacted a Board member about the incident. This was the first a member of the Board had heard of the incident.

88. The manager's job description requires that "a written monthly report is presented to the Board of Trustees detailing the care of the residents, incidents, staffing issues, financial accounts for payment, profit/loss statement, maintenance and general matters".

89. The Board's "Governance Policies" contain a section on the manager's communication with, and support of the Board. It states that "the manager will not permit the Board to be uninformed or unsupported in its work".

90. Ms D did not attend the monthly Board meeting on 10 February as she was sick that day. She advised HDC that she was suffering from pneumonia.

91. Ms C said that on the day of the Board meeting Ms D emailed her a copy of her report to the Board. The report did not mention the incident involving Mr E and Ms A or that Mr E had been given a verbal warning. The report did contain a bar graph of incidents/accidents, but it did not include the incident involving Mr E and Ms A because at that time there was no category for injuries caused to residents by staff.

92. When asked to comment on the failure to mention the incident involving Ms A in her report, Ms D advised that incident and accident reports are dealt with differently. Ms D said they are each collated and graphed and she would take a copy of a summary of each incident and accident report to the Board. She said that she would have presented her report to the Board verbally, if she had been there. It would then have been up to the Board to decide what step was to be taken next. Ms D also said she did not include the incident in her written report because it was "still under investigation".[15] However, on previous occasions Ms D had included details of staff performance issues that were still in the process of being investigated.[16]

93. Ms D advised that, in her absence, Administration Assistant, Ms K[17] gave the Board all the information that Ms K had access to. Ms D stated "my documentation and account of the incident were ready to present in my report". When asked why this documentation was not made available to Ms K to table at the Board meeting, she stated "[Ms K] was aware of the [Ms A] incident but the documentation relating to this was held in my office, and was not available to [Ms K]. It was not something [I] would expect [Ms K] to table for the Board".

94. When asked about the process for informing the Board about accidents and whether the graph alone was sufficient Ms C responded "all accidents and incidents were to be recorded on the graph. The Board would expect the manager to advise the Board if any of the accidents or incidents were of a more serious nature".

95. Ms C advised HDC that the Board had not spoken to Ms D about the incident, Ms D's investigation, or the outcome.

Resignation

96. Ms D did not return to work after taking sick leave from 10 February, and she resigned on 19 February 2010.

97. On 22 February 2010, Ms L was appointed to the position of temporary manager and she commenced the role on 25 February 2010. Ms L carried out a further investigation of the incident and reported to the Board on 14 February 2010 that Ms D had not followed the correct incident process in that:

[15] Ms D explained to HDC that "by still under investigation" she meant that she had completed her side of the investigation but it was up to the Board to decide if further steps needed to be taken.
[16] In Ms D's reports to the Board in September and October 2009 she detailed staff performance issues that were "still under investigation".
[17] Ms K is the estranged wife of Mr E.

- the police had not been notified;
- Ms A's parents had not been notified;
- no photograph of the injury could be found on the file;
- the investigation regarding Mr E had not been conducted correctly; and
- Ms D had not notified the Board of the incident.

Board records and policies

98. The Board has acknowledged that there was no documented restraint policy for Ms A apart from the "[Ms A] - afternoon routine" document and that the behavioural assessment written by the Community Team was not filed.

99. The Board stated "in the past, the Trust has not had detailed systems and procedures in place to record the provision of information and training to individual staff members other than the orientation checklist. As a result, the Board does not hold any specific record of the training received by [Mr E] with respect to [Ms A]".

100. The Board stated that although it had a professional boundary policy, governing relationships between residents and staff, there was no formal policy dealing with relationships between staff. The only relevant policy was the governance policy which stated that the manager has an obligation to treat all staff fairly and the manager must, at all times, act professionally and not expose the organisation, the Board or staff to claims or endanger the credibility or reputation of the Trust.

101. Since the incident, Ms L has undertaken a complete review of all policies and procedures operating within the Mary Moodie Family Trust. A number of new policies have been introduced and a new Policies and Procedures Manual has been developed. There is now a process for continuing review of all documentation used in conjunction with the operation of the Trust. There is a much greater emphasis on documentation and the structure of the management of the Trust.

102. Ms C advised HDC that they have not used the lifting belt in the home since March 2010 and that there were three staff training sessions with the Community Team in 2010, teaching staff how to deal with challenging behaviours. Ms A's behaviour was covered in detail during these sessions.

Response to provisional opinion – Ms D

103. In her response to the provisional decision, Ms D acknowledged that she would do things differently if a similar situation arose again. Ms D told HDC:

> "I sincerely regret what happened to [Ms A] … In hindsight my management of the situation was inadequate and if put in the same position again I would do things very differently. I take full responsibility for my actions. I would have informed the board sooner and stepped back from the situation to allow them to manage it. I would have also informed her family a lot earlier than I did.[18] Hindsight is a good thing and an opportunity to learn how to do things to ensure a more positive outcome.

[18] As stated, Ms D did not inform Ms A's parents about the incident.

…

I had been very open and honest with the board and staff of Mary Moodie in regards to the relationship I had with [Mr E] … You cannot help who you fall in love with but it would have been more professional if one of us had resigned earlier."

Relevant standards

104. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*[19]

Standards New Zealand has produced standards for the Health and Disability sector.[20] The foreword to the Standard states:

"The main intent of NZS 8134.2 is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. It is crucial that providers recognise which interventions constitute restraint and how to ensure that, when practiced, restraint occurs in a safe and respectful manner.

Restraint should be perceived in the wider context of risk management. Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself, but is one of a number of strategies used by service providers to limit or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others. All restraint policies, procedures, practices and training should be firmly grounded in this context."

The Standards are:

Restraint minimisation

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

Safe restraint practice

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

[19] NZS 8134.2:2008

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

Standard 2.3	Services use restraint safely.
Standard 2.4	Services evaluate all episodes of restraint.
Standard 2.5	Services demonstrate the monitoring and quality review of their use of restraint.

Safe seclusion use

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

Opinion: Breach — Mr E

105. Ms A was vulnerable because of her personal circumstances, which included her intellectual impairment and her inability to communicate effectively. She had the right to be treated with respect and to have services provided to her with reasonable care and skill. The issue in this case is whether Mr E's actions were necessary and reasonable in the circumstances, to protect Ms A or him from harm.

106. Mr E advised HDC that on the evening of 26 January 2010, Ms A had attacked another resident, and he had been asked by Ms G to take Ms A to her bedroom to calm her down. Mr E stated that Ms A ran to her bedroom and began to throw her belongings around. He said he initially stood at the door to ensure that she did not hurt herself, come out to attack another resident, or run away. Mr E stated that Ms A pulled out a drawer and threw it at the window then pulled out a second drawer and went to throw it at the window. Mr E said he then went into the room and held Ms A by her arms, because he believed that if she broke the window she could jump out and hurt herself.

107. Mr E claimed that while he was holding Ms A's arms, she lifted her legs, and they both fell to the ground. He said he stood up and pulled Ms A by her arms from her room to get her away from items she could throw. He alleged that Ms A then turned and kicked him in the ribs and they fell to the ground. He said he then held Ms A by her legs and dragged her along the floor, and, after a comment was made by another staff member, he turned Ms A around and pulled her by her arms to a bean bag.

108. Ms G has no recollection of Ms A attacking another resident that evening or that she asked Mr E to take Ms A to her bedroom to calm her down. Ms G stated that Ms A had refused to cooperate when Ms H had asked her to go to the bathroom, and that, later in the evening, Ms G asked Ms F and Mr E if one of them could bring Ms A to the bathroom.

109. Ms F told HDC that Mr E went to Ms A's bedroom. Ms F said Ms A had refused Ms H's request that she go to the bathroom and that she had been in her bedroom for "some time" when Ms G approached Mr E and her seeking their assistance. Ms F advised HDC that Mr

E's account of being asked to intervene because Ms A had attacked another resident and was in her room throwing drawers was "completely false", although it may have occurred earlier. She advised that this was "certainly not" the reason Mr E went to Ms A's bedroom that night.

110. Ms G advised that she did not see the incident but completed the incident form by recording Mr E's explanation to her of the events. The incident form written that night states: "What was happening before: [Ms A] was asked to go to the bath but refused and started kicking staff member. Had to be restrained."

111. I accept that the incident occurred when Mr E was attempting to bring Ms A to the bathroom, as requested by Ms G.

112. Mr E has stated that Ms A was throwing objects when he went to the room and that she attacked him. The events in the bedroom were not observed by any other staff member. However, Ms F observed Mr E dragging Ms A by her legs across the lounge, then turning her around and pulling her by her arms. Ms F said that Ms A was on the ground on her bottom or her back while she was being pulled by her arms.

113. In my view, the issue in this case is whether, even if Mr E was acting to protect Ms A from hurting herself or to protect himself from an attack, it was appropriate to pull Ms A from her room by her arms, drag her by her legs into the lounge and then turn her around and again pull her across the floor by her arms (a total distance of approximately nine meters).

114. My nursing expert, Ms Bernadette Forde-Paus, stated:

> "Despite there being defects in [Mr E's] orientation and training and limited guidance by care plans, his action on 26th January 2010 when he was witnessed and admitted dragging [Ms A] from her bedroom firstly by her legs and then her arms through the living room was totally unacceptable."

115. In light of the lack of assistance provided by Ms F, his initial actions may have been reasonable, given his explanation of having acted to prevent risk of harm to Ms A. By his account, Mr E pulled Ms A by her arms from her room to get her away from items she could throw. This explanation is not able to be discounted by other witnesses. However, Mr E should have moved Ms A away from the immediate risk and then sought assistance. In my view, once Ms A was outside her bedroom there was no longer an imminent risk to her or to Mr E.

116. If, as Mr E stated, Ms A kicked him and they fell to the floor, Mr E should then have followed the Board's policy. This was to use the lifting belt with the assistance of another staff member to place Ms A in her room. If it was not safe to put her in her room he should have placed her in a safe place with the assistance of another staff member. It is clear that another staff member was available to assist Mr E, albeit she was watching television while providing one-on-one care to another resident.

117. In my view, Mr E should have requested Ms F's assistance and should not have dragged and then pulled Ms A once she was outside her bedroom and there was no immediate risk to her or to Mr E.

118. The next issue is whether Mr E's training and the information available to him were so deficient that these factors would mitigate this severe breach of standards. The management plan is not helpful in giving instructions as to how to deal with such a situation. The only advice it gives is "if she still refuses to move, ask another staff member to assist you to use the lap belt to put her in her room".

119. Ms D advised that Mr E had been trained in the use of the lifting belt and instructed to use it when Ms A resisted being moved. She said he had attended a restraint minimisation meeting. In September 2009, the restraint recording form appears to be initialled by Mr E, which suggests he had previously used the lifting belt.

120. Ms D also stated Mr E had been given specific instructions regarding Ms A's care, including familiarisation with a "comprehensive behaviour support plan". However, there is no evidence of this in the documentation provided to HDC.

121. I accept that Mr E's training and orientation could have been better, and that Ms A's afternoon routine care plan provided limited guidance on how to manage her behaviour. I also accept that Ms F did not assist Mr E. Nevertheless, Mr E did not react in a considered manner to the events as they occurred. It was unacceptable for Mr E to drag Ms A across the carpet by her legs and then pull her by her arms when there was no longer any immediate risk to her or to Mr E himself. I note my expert's advice that Mr E's actions were a severe and very serious departure from acceptable standards.

122. Ms A was entitled to be treated with respect and I consider Mr E's actions were both unkind and disrespectful. Accordingly, in my view, Mr E breached Right 1(1) of the Code. In addition, Mr E did not provide services to Ms A with reasonable care and skill and so breached Right 4(1) of the Code.

Opinion: Breach — Ms D

123. As the manager of the home, Ms D was responsible for its "smooth running", ensuring that the Board's policies were complied with, and protecting the rights of the residents. I have concerns about Ms D's recruitment, orientation and training of staff, the development of Ms A's care and lifestyle plans and the manner in which Ms D responded to the incident involving Mr E and Ms A.

Management of the incident

Actions required

124. Ms D was responsible for ensuring that the Board's policies were adhered to and the rights of the residents were protected. The process set out in the policy on accident and incident reporting procedures deals firstly with steps to be taken by the staff present at the time of an incident and then the steps to be taken by the manager (see paragraph 67).

125. With regard to the steps required to be taken at the time of the incident, Ms G checked that Ms A was safe and Mr E reported the incident to Ms D that night. Ms G also filled in an incident and accident report form that night.

Investigation

126. The following day (27 January 2010), Ms D checked Ms A's health by inspecting her back, and made a doctor's appointment for her. Ms D was then required to conduct any necessary investigation. Ms D interviewed Mr E on 2 February 2010 and instructed him to "use the lifting belt in the future or have [Ms A] contained in her room". Ms D also interviewed the witness to the incident, Ms F, on 1 February 2010. Ms D discussed the incident at a staff meeting on 27 January 2010 and reminded staff to use the lifting belt or contain Ms A in her room in such a situation.

127. Ms D was then required to write up the "report and actions taken" sections on the incident and accident report form. However, the information completed by Ms D on the form was minimal. Ms D has added under "comments" the words "As per 2 previous reports" and under the section "Further action required" she has circled the word "no". She dated the form 1 February 2010.

Report to Board

128. The next steps required in the policy are "report to the Trust the nature of the incident. The Trust may review the actions taken by management to provide oversight. The family/guardians of the resident may be informed of the incident or accident depending upon the severity and nature".

129. There is nothing explicit in the Board's policy directing the manager to inform the Board about serious incidents *immediately*. The response when Ms F told a Board member about the incident suggests that the Board expected to be notified of such incidents at the next Board meeting.

130. The policy required Ms D to report "the nature of the incident" to the Board. Ms D stated that the incident was included in the accident and incident graph presented to the Board. However, as there was no specific section for incidents with injuries by staff to residents, there was no specific record of this incident on the graph presented to the Board.

131. Ms D has indicated both that she intended to make a verbal report on the incident to the Board at the next meeting and also that she had prepared written documentation, but it was in her office and not accessible to be given to the Board by Ms K. Clearly there was written documentation available, such as the incident form and the interview records. I acknowledge that Ms D may have been reluctant to allow Ms K access to the information about Mr E's conduct as recorded in the reports, given that Ms K is Mr E's estranged partner.

132. Ms D was, by her account, suffering from pneumonia. However, she was able to email her report to the Board. I find it difficult to accept that she would not have been able to, at the very least, include in her email a brief explanation of the incident and alert the Board to her intention to report the matter more fully, either when she returned to work or at the next meeting.

133. Ms D advised HDC that she did not include the incident in her written report as it was "still under investigation". I find this explanation unconvincing, as on previous occasions Ms D included details of staff performance issues that were still in the process of being investigated. Furthermore, the policy required Ms D, after she had completed the incident form, to "Report to the Trust the nature of the incident. The Trust may review the actions taken by management to provide oversight".

Contact with family

134. The policy stated, "the family/guardian of the resident may be informed of the incident or accident depending upon the severity and nature". As this was a serious incident resulting in injury to Ms A, I consider the policy required Ms D to notify Ms A's family. Ms D has stated the reason she did not do so was because she was sick and preparing for an audit. I do not accept this explanation, as Ms D did not go on sick leave until two weeks after the incident took place, and preparing for an audit is not a sufficient explanation for overlooking a matter of such importance.

Personal relationship

135. Ms D initially asserted that her personal relationship with Mr E did not affect her management of the incident. In my view, this response demonstrates a lack of insight.

136. It was unwise of Ms D not to have sought guidance from the Board at the outset on how the investigation should proceed, in light of her personal relationship with Mr E. This was important to ensure that the investigation was conducted with independence and without the appearance of bias.

137. I agree with Ms Forde-Paus, that Ms D's failure to acknowledge that her management of this situation was inadequate with regard to her communication with Ms A's family and the Board and likely to be influenced by her personal relationship with Mr E, raises concerns about Ms D's judgement and management skills. In order to conduct a robust investigation of a serious incident it was necessary that Ms D step back and arrange for an independent person to conduct the investigation. It is noted that Ms D has since reflected on her management of the incident and now accepts that she should have informed Ms A's family and handed over management of the incident to the Board, given her conflict of interest.

138. In my view, Ms D's failure to inform Ms A's family about the incident was a breach of the accident and incident reporting procedures policy. Her failure to inform the Board about the incident contravened the Board's Governance Policies, in particular that the "manager will not permit the Board to be uninformed or unsupported in its work". She should also have advised the Board in order to ensure an independent assessment of the incident was conducted, given her obvious conflict of interest when carrying out an investigation into her partner's actions.

139. As stated, Ms A is a vulnerable consumer and both the Board and her family have roles to play to ensure she receives services of an appropriate standard. The incident should have been reported to the Board in order that steps could be taken to prevent a recurrence. Ms A's parents should also have been informed so they could reassure themselves about her well-being and be involved in her care planning.

Recruitment, orientation and training

140. As stated above, the Board's policies and Mr E's training were inadequate. Ms D was responsible for the recruitment and orientation of new staff. As she knew Mr E had no previous experience with, or training in, dealing with consumers with intellectual impairments, it was her responsibility to ensure Mr E received sufficient orientation to his role and ongoing training.

Appointment of Mr E

141. The Board's policy on the recruitment of staff is very brief, but it indicates that staff interviews should be with the manager and assistant manager. However, the Board advised HDC that a Board member is required to attend the formal interview of prospective employees.

142. The documentation completed during Mr E's interview and appointment processes is inadequate. It is unclear who attended the interview and the interview form is unsigned and incomplete.

143. The policy specifies that referee and Police checks are required but it does not specifically require any documentation that these matters have been completed. Despite this, Ms D should have documented that she had completed each of the items listed in the recruitment policy.

Orientation and training

144. The manager's job description states that the manager has responsibility for orientation and training of new staff and for the staff training programme. Ms Forde-Paus reviewed Mr E's documented interview for the position of community support worker and states that his responses indicate that he did not have a good understanding of the principles and values that underpin appropriate disability support. Although this may be relatively common when employing untrained caregivers, his lack of understanding emphasises that Ms D and the Board needed to ensure that Mr E underwent appropriate training.

145. Ms D advised that Mr E had received training because he attended a restraint minimisation meeting with a general practitioner. However, this training is not documented. As stated by Ms Forde-Paus, there is no evidence of staff training on professional relationships/behaviour, boundaries or advocacy. Ms Forde-Paus advised "the training on managing challenging behaviours appears inadequate". I agree with the advice of Ms Forde-Paus that there is little evidence of an adequate staff training programme.

Ms A's behaviour management plan

146. The intent of the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. Restraint should only be used in the context of ensuring, maintaining, or enhancing the safety of the consumer, service providers, or others.

147. Ms D's job description stated that she was "accountable for the residents' individual care and lifestyle plans in cooperation with the Residents Care Committee and any other advisors/consultants" and that she was responsible for updating the residents' care and

lifestyle plans "annually or as required". The Governance Policy 1.2 provides: "with respect to interactions with clients the manager will not cause or allow conditions, procedures, or decisions that are unsafe, undignified, and unnecessarily intrusive".

148. Ms A had a documented behaviour management plan in place at the time of these events.[21] It was headed "[Ms A] – afternoon routine" and set out a step-by-step process to "stop [Ms A's] behaviour outbursts and refusal to go to bed". This plan required staff to use the lifting belt if Ms A refused to cooperate. It is unclear when this plan was instigated, but it was in place in 2007, as it was referred to in the Community Team's assessment and recommendations. In addition, Ms D instructed staff to use a lifting belt when Ms A was taken out or at day base if she refused to cooperate. This instruction does not appear to have been documented in a management plan for Ms A.

149. Ms Forde-Paus advised that the management plan for Ms A was "inappropriate and unacceptable" noting that it encouraged "a punitive and controlling approach" and was "totally in conflict with modern philosophies and practices governing disability services". Ms Forde-Paus has advised that any behaviour management plan should be based on rewarding positive behaviour, and even when it is necessary to develop a "reactive" behaviour plan for safety reasons, it can be planned and worded in positive language that is motivating and encouraging and recognises the individual's autonomy.

150. Ms Forde-Paus also advised that a lifting belt should only be used to ensure a person's safety when there is imminent danger and that, in most situations, there are alternative, less intrusive approaches. I accept Ms Forde-Paus' advice that the behaviour management plan in place for Ms A was inappropriate.

Restraint minimisation and safe practice

151. Ms D had a responsibility to ensure that, when any form of restraint was used on the residents, it was actively minimised and used safely and respectfully. However, there is no record that Mr E received any training on restraint, despite Ms D's documentation that staff training was necessary to minimise the use of the lifting belt.

152. In relation to Ms A's refusals to have a shower, her management plan "[Ms A] - afternoon routine" required the staff to use the lap belt to place Ms A in her room. She was to be left in her room for 15-20 minutes with the lights out. The plan did not include an instruction that restraint and seclusion were to only be used as a last resort or that they should be actively minimised. Accordingly, while there was documentation of the need to minimise the use of the lifting belt, no management plan had been developed to minimise the use of restraint on Ms A.

Conclusions

153. When providing care to vulnerable consumers such as Ms A, it is vital to recruit staff with the appropriate attributes and ensure that staff members are adequately trained, and are carrying out roles that are commensurate with their experience, knowledge and training. Ms D failed to ensure that Mr E's recruitment and orientation was robust and well documented. Furthermore, Ms D failed to develop an adequate staff training programme. I

[21] See **Appendix E**. Although not dated, the Board has confirmed that this was the plan that was in place at the time of the events.

conclude that the inadequate recruitment and orientation processes and inadequate staff training programme put Ms A at risk of being harmed. In my view, Ms D's failures amount to a breach of Right 4(4) of the Code.

154. Ms D failed to notify the Board and Ms A's family of the incident involving Mr E. As a result, the Board and the family were unable to work together to reduce the likelihood of a recurrence of such a situation. By failing to respond to the incident appropriately, Ms D did not provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code.

155. Ms D also failed to ensure that there was an appropriate management plan in place that provided staff with clear guidance on how to manage Ms A's challenging behaviour. As a result of her failure to develop an adequate management plan, Ms D did not provide services to Ms A with reasonable care and skill. In my view, Ms D's failures were a breach of Right 4(1) of the Code.

156. Ms D failed to reduce the use of restraint against Ms A and to ensure that, when practiced, restraint occurred in a safe and respectful manner. Accordingly, Ms D failed to comply with the Restraint Minimisation and Safe Practice Standard. In my view, this failure amounted to a breach of Right 4(2) of the Code.

Opinion: Breach — Mary Moodie Family Trust Board (Incorporated)

Vicarious liability

157. As the governing body of the home, the Board has overall responsibility for ensuring that its residents receive care that complies with the Code. In order to do so, the Board needs to provide its employees with adequate policies and procedures to guide their actions and ensure they receive adequate training. In addition, the Board needs to monitor compliance with the policies and procedures by its staff.

158. The Board was on notice that Ms A's behaviour management plan was inappropriate. The Community Team's assessment from 2007 provided detailed information, which should have formed the basis of an appropriate behaviour management plan for Ms A. The assessment also referred to the need for the Board to develop appropriate documentation and ensure the staff was provided with adequate training on epilepsy and ASD.

159. I am concerned that the Community Team's assessment and recommendations were not placed on Ms A's file to enable the manager to refer to them when updating Ms A's behaviour plan. In particular, Ms A's behaviour management plan advised staff to use the lifting belt to move Ms A to her bedroom. This is despite advice from the Community Team in 2007 that "in the past, MMT have used a lifting belt to physically remove [Ms A] out of an area where this has been required. This is not endorsed by [the Community Team]".

160. By not ensuring that the Community Team's assessment and recommendations were placed on Ms A's file, the Board contributed to Ms D's failure to ensure that Ms A's behaviour management plan was appropriate and consistent with modern philosophies

and practices. The Board should have taken steps to oversee and monitor Ms D's revision of Ms A's behaviour management plan to ensure the management plan and use of restraint were appropriate. The Board should also have ensured that, when undertaking these revisions, Ms D sought further support from external organisations, such as the Community Team. Accordingly, the Board failed to take reasonably practicable steps to ensure that Ms D provided services to Ms A with reasonable care and skill, and so, the Board is vicariously liable for Ms D's breach of Right 4(1) of the Code.

161. By failing to oversee and monitor Ms D's revision of Ms A's behaviour management plan, the Board also failed to take reasonably practicable steps to ensure Ms D was acting in compliance the Restraint Minimisation and Safe Practice Standard, and so is vicariously liable for Ms D's breach of Right 4(2) of the Code.

Direct liability

Communication and training

162. Information about individual residents was communicated informally between staff, while working their shifts. The Board did not ensure that a formal process was put in place for regularly disseminating information about residents' individual care plans to staff.

163. Ms Forde-Paus advised that there should be a forum facilitated by a suitably qualified person (either internal or external to the organisation) for staff to discuss residents' care/treatment plans and their progress and where staff can provide input and get feedback on managing challenging behaviour.

164. Ms D's job description provides that she was "responsible for planning a staff training programme which ensures that all staff have appropriate job training in all aspects on their duties". It has already been established that Mr E did not undergo appropriate training for his position and that there was no formal training programme in place. Of particular significance is the lack of formal disability support training in core areas such as human rights, advocacy, communication, de-escalation, risk minimisation and safe restraint.

165. Although it was the responsibility of Ms D to plan the training programme, the Board had a responsibility to ensure that an appropriate staff training programme had been implemented. The Board's failure to monitor the training provided to staff, or to recognise that the training that was being provided was inadequate, is not acceptable. I do not consider that it is unduly onerous to require a provider of health and disability support services to ensure that staff caring for vulnerable residents are properly trained and monitored.

Policies

166. The Board's policies were inadequate in many respects. Some policies were ambiguous or unclear. In relation to incident investigation, the Board did not have explicit policies in place for the lines of accountability between the manager and Board for serious events. In my view, the expectations of the Board should be clearly specified in a policy. For example, the circumstances in which the Board would wish to be notified of incidents between Board meetings should be set out.

167. Other examples of ambiguous or unclear policies included employment and recruitment processes, professional boundaries, and informing families about incidents. In addition, the behaviour management plan in place for Ms A was inappropriate and there was no adequate restraint minimisation plan.

168. As stated by Ms Forde-Paus "ultimate responsibility for organisation risk and standards of care lies with the Board and whilst there are clear issues with [Ms D's] performance including her recruitment, orientation and staff training duties, there also appears to be issues with the Board not being in touch with the operation of the home".

Conclusion

169. In my view, the Board's lack of supervision, guidance and monitoring of Ms D's performance, together with the lack of adequate policies, allowed unsafe practices to develop within the home and contributed to the failures to provide services to Ms A of an appropriate standard. Accordingly, I find the Board breached Right 4(1) of the Code.

Adverse comment — Ms F

170. The provision of care to consumers such as Ms A can be challenging and it is important that all staff work together in a collaborative fashion. Once it was evident that Mr E was having difficulties with Ms A, Ms F should have assisted him to manage Ms A. However, she remained sitting, watching television, while providing care to another resident, and did no more than tell Mr E to stop because his actions may have been aggravating an existing injury on Ms A's back.

171. I note that Ms F said she does not feel there is anything else she could have done to have helped the situation and that she did not have time to intervene. Despite this, I remain concerned at the mildness of Ms F's response. I am also concerned that Ms F did not do anything to assist Mr E in circumstances where assistance was clearly needed.

172. In my view, Ms F should reflect on her omissions and consider how they contributed to this situation.

173. However, it is acknowledged that, after reflecting on the incident, Ms F took the appropriate step of informing a Board member about it. This is to be commended.

Recommendations

174. I recommend that Ms D, Mr E and the Board each provide written apologies to Ms A and her family for their breaches of the Code. The apologies are to be sent to HDC by **17 January 2013**, to be forwarded to Ms A and her family.

175. I recommend that the Board:

- Work with Ms A's parents to develop the most appropriate process to discuss the contents of this report with Ms A.
- Ensure that an appropriate staff orientation and training programme is developed and implemented which includes core disability focussed training, such as managing challenging behaviour, human rights, advocacy, communication, de-escalation, risk minimisation and safe restraint.
- Ensure that a training programme includes annual refresher training on the elements included in the programme.
- Implement robust procedures to monitor the manager's performance and compliance with policies and procedures.
- Seek external expertise to assist with the review and audit of residents' individual care plans and its policies and procedures, to ensure they are consistent with best practice.
- Implement a formal process to enable staff to meet with an appropriately trained person on a regular basis to discuss and provide feedback on the residents individual behaviour plans.
- Take steps to recruit Board members with expertise in current standards and philosophies in the disability sector.
- Develop a clear and explicit policy on the manager's reporting responsibilities.
- Develop a policy on conflict of interests.
- Ensure all individual care and lifestyle plans clearly state the date they were implemented.

176. I recommend that the Board reports back to HDC by **1 February 2013** on the steps it has taken with regard to these recommendations.

Follow-up actions

- A copy of the final report will be sent to Ms A's parents.

- A copy of the final report with details identifying the parties removed, except the expert who advised on this case and Mary Moodie Family Trust Board (Incorporated) will be sent to the District Health Board and the Ministry of Health, and will be placed on the Health and Disability Commissioner website www.hdc.org.nz for educational purposes.

Appendix A — Independent advice to Commissioner

The following expert advice was obtained from nurse practitioner Bernadette Forde-Paus:

"**Introduction**
This report is being provided to the Commissioner following a request for independent expert advice on case number 10/00420 - complaint: against [Ms D].

I have read and agreed to follow the Commissioner's "Guidelines for Independent Advisors". There is no professional or personal conflict in relation to me providing this opinion and report.

I have read the documents provided and offer the following analysis.

Summary of Relevant Background Information
[At this point in her advice, Ms Forde-Paus outlines the background facts of the case. Some of this information has been omitted for the purpose of brevity.]
…

There is a policy *Accident and Incident Reporting Procedures* which states that 'Whenever an incident or an accident occurs between staff and or residents, no matter however severe or otherwise, an incident form must be completed.' The procedure states that these incidents must be reported to the Board and that the Board will assess the actions taken by management.

Within the Governance policies, Policy One 'Management Limitations' outlines *'1.9 Communication and Support to the Board: The manager will not permit the board to be uninformed or unsupported in its work …The Manager will not: Withhold, impede or confound information relevant to the board's informed accomplishment of its job….'*

The MMT position description for [Ms D's] management role states three '*Key Responsibilities'* at the start of the position description, firstly '*The Manager is accountable for ensuring that the physical, emotional, health … psychological needs of the residents are met at all times'*, secondly that, *'The philosophies of the MMT are maintained'*, and thirdly that, '*The families of the residents are fully informed on all aspects of their family member'*.

[Ms D's] CV indicates that she has had previous training which would have provided her with the knowledge of how to manage staff performance and misconduct. Her CV states she has a *Leadership Management Certificate* and that she had completed a *Supervisors Course* and *Advocacy Course* and *Ministry of Health Awareness, Competence and Responsiveness Training.*

Analysis and Conclusion
It is my opinion that in January 2010 [Ms D], in her role as manager of the Mary Moodie Family Trust, failed to appropriately investigate and respond to an incident of serious staff misconduct by [Mr E] and in doing so failed to provide [Ms A] with an adequate level of care. In considering the severity of the incident i.e. assault in which injury was sustained

against the investigatory and outcome action taken by [Ms D] i.e. meeting with the staff member and making recommendations on how he should manage similar situations in the future, with nil notification to the Board either immediately or in her monthly report, I consider was a severe departure from acceptable staff performance/management standards. I believe that [Ms D's] management of this incident would be considered with severe disapproval by her peers.

[Ms D]:

- Failed to fill out a special incident report as is necessary under the MMT policy.
- Failed to inform the family of the incident and failed to engage with the family in an appropriate way following a serious incident.
- Failed to inform the Board either at the time of the incident or at the next scheduled Board meeting. There was no mention of the incident in the Board report submitted by [Ms D] in her absence.
- I do not accept [Ms D's] explanation of intending to verbally report the incident to the Board at the next meeting as rationale for not incorporating it into her written report. In her mangers role [Ms D] would be aware of the necessity of documentation. Neither do I accept the explanation of being ill, there was plenty of time to inform the board and her illness does not appear to be of such severity that it would have prevented her from verbally informing at least one board member by phone or arranging for [Ms K] to table the necessary documentation at the board meeting.
- [Ms D] and the Board, in consultation with the family should have made a decision about informing the police of this incident.

Standards

Whilst neither of the staff members involved are registered health professionals, the incident (behaviour of the staff member) and investigation of the incident is not only in breach of the MMT philosophies of care and polices, but also inconsistent with:

- **Restraint Minimisation and Safe Practice Standards**, and
- **Health and Disability Sector Standards**
  - Part 1: Consumer Rights — Consumers receive safe & reasonable services in a manner that is respectful of their rights, minimises harm & acknowledges their cultural & individual values and beliefs.
    Part 2: Organisational Management — Consumers receive services that are managed in a safe, efficient and effective manner & that comply with legislation

Of course as part of this investigation you will make a judgement as to whether there is a breach of the **HDC Code of Rights** which all health sector employees must be aware of and have a working knowledge of.

Other considerations

[Ms D]

It is concerning that in [Ms D's] response to the HDC investigation she has not acknowledged that in hindsight her judgement and management of this situation was

inadequate and likely marred by her personal relationship with [Mr E]. In not acknowledging or believing this, it raises concerns about her management skills and abilities as it suggests she would do the same given the same circumstances and therefore wouldn't seek supervision, or immediate involvement of the Board or consider referring the management of the incident to someone independent, given her personal relationship with the employee being investigated. This raises concerns about her working with vulnerable people in the future.

Lines of Accountability between the Board and the Manager
It appears that there is a lack of explicit policy which dictates immediate reporting to the Board serious staff misconduct or serious events.

- Whilst the *Accident and Incident Reporting Procedure* states that '*whenever an incident … occurs between staff and or residents, no matter however severe or otherwise, an incident form must be completed … [and] that these incidents must be reported to the Board …[and] that the Board will assess the actions taken by management'* ; and
- Governance policy one states that the *'manager will not permit the Board to be uninformed or unsupported in its work …The Manger will not withhold, impede or confound information relevant to the Board's informed accomplishment of its job….'*
- I note in [Ms F's] statement to you that when she informed a Board member of her concerns about the incident not being reported to the Board, the Board member advised s/he would await to hear about it in [Ms D's] report to the Board.

There is not any policy (in the documents supplied to me) that explicitly directs the manager to inform the Board prior to the next Board meeting of serious incidents. Whilst there is a lack of explicit policy it appears that there was an implicit awareness of the need to inform the Board of important issues prior to meetings as [Ms D] had done so in December in relation to her relationship with [Mr E] and again in January in relation to concerns about staff performance and client care. Whilst there was an implicit understanding about contacting the Chair of the Board prior to the monthly meeting which [Ms D] clearly understood, it should be explicit in the policies. Ultimate responsibility for organisation risk and standards of care lies with the Board. It is therefore important that there is very explicit policy in place with makes it mandatory for the manager to contact the Chair of the Board immediately in response to situations of severe staff misconduct or serious events, as this type of incident generally requires quick decisions/responses and careful guidance to ensure that due process is occurring and organisation risk is minimised. Such decisions and responses require a particular set of knowledge and skills which a person managing a small residential home will often not have. Having mandatory immediate reporting to the Board for serious incidents allows the Board the opportunity to call an extra and urgent meeting or to ensure that the right support is given to the manager to ensure that due process is being followed, particularly in relation to the rights and responsibilities of the victim and also employment law issues in relation to the employee.

I recommend that the MMT:

- Reviews and updates their policies so that there are explicit lines of accountability between the manager and the Board in situations of serious staff misconduct and serious events which make it mandatory for the manager to report such incidents to the Board immediately.
- Has clear policy in the situation where the manager is in personal relationships with an employee, which ensures that should there be a staff performance issue someone independent manages the situation.

Whilst there was a failure of the Board to have explicit policies for serious events in relation to lines of accountability between the manager and the board, I believe it was an unintentional technical failure. There was less explicit policy and implicit practices, so whilst it needs immediate correction I would view it as a mild-moderate unintentional failure."

Appendix B — Further independent advice to Commissioner

On 21 December 2010, Ms Forde-Paus provided the following further advice:

"Please comment on the adequacy of [Ms D's] response to questions regarding her failure to inform the Board about the incident either verbally, or in her written report. A file note of the relevant part of the discussion is pasted below. I have also **attached** for your information:

A copy of the bar graph referred to by [Ms D].

Copies of [Ms D's] reports to the Board for the months of September 2009-December/January 2010 (for comparative purposes).

As stated above, I am interested in your views on the adequacy of [Ms D's] reasons for not reporting the incident to the Board (either verbally, or in her written report).

Telephone interview with [Ms D] on 11 October 2010:

I [Investigator] advised [Ms D] that I had a copy of her report that she emailed [Ms C] on 10 February, and noted that it does not include any mention of the [Ms A] incident. [Ms D] advised that incident and accident reports are dealt with differently. They are all collated and graphed and it was [Ms K's] job to graph the incident reports and then she ([Ms D]) would take a copy of a summary of each incident and accident report to the Board.

Ms Forde-Paus: *I don't really understand this answer, but refer to my previous comment that [Ms D] failed to complete a special incident report as per the policy and standard procedure under these circumstances.*

I asked [Ms D] to confirm then that she did not consider that her report to the Board was the correct forum to include information about the incident. [Ms D] confirmed this was correct - she advised that incidents and accidents were a separate process.

Ms Forde-Paus: *Again I don't understand this comment as it's contrary to what [Ms D] had formerly said that she intended to verbally report the incident to the Board at the next meeting, that being her justification and explanation for having failed to put it in the report – again a rationale that I do not accept. Anything that requires discussion, particularly of a serious nature (as this incident was) should at the very least be outlined in the report (as this is the legal document) with more detail being added verbally at the Board meeting.*

I asked [Ms D] to comment then on the fact that this was also a staff issue. Did she consider informing the Board about that aspect of it. She said that the Board would have been informed if she had been at the meeting ... I asked [Ms D] why was this aspect of the incident (staff performance issue) was not included in her report to the Board? [Ms D] responded that it was still under investigation and it would have been verbally presented to the Board at the meeting had she been there.

Ms Forde-Paus: *This explanation is completely at odds with the monthly reports which you have attached. In the September report dot points 8 and 9 both outline current staff performance issues, as do dot points 2, 3, 4 & 5 in the October report (in fact they form the majority of the report). Again the November report deals with current staff performance issues in dot points 4, 6 & 7 and again the December report in dot point 3.*

Current staff performance is a major feature of the monthly reports with staff performance being the main reporting factor in the October and December reports.

I asked [Ms D] why was it "still under investigation"? [Ms D] advised that she had only completed her side of the investigation. Once all the accidents and incidents are collated they are then taken to the Board and it is up to the Board to decide what step is to be taken next. She advised that it was out of her hands at that point.

Ms Forde-Paus: *As outlined above this answer doesn't make sense in terms of how [Ms D] had been reporting staff performance and given the serious nature of this particular incident.*

I then asked [Ms D] to confirm that she chose not to include the incident in her written report to the Board, but await collation of all the accidents and incidents forms and then report it to the Board. [Ms D] responded that that was the process that she followed with all accidents and incidents and there was no point whatsoever that she was not to disclose anything.

Ms Forde-Paus: *As discussed above.*

I asked [Ms D] to clarify that she had never raised an accident or issue to the Board in any other way except for this set process? [Ms D] responded that she could not say never, there was one time that an incident involved the chairperson's son and she did verbally ring the chairperson in regard to that incident but she could not recall any other incidents that she had rung the chairperson about.

Ms Forde-Paus: *As discussed above.*

I then asked [Ms D] why she had treated that incident differently? [Ms D] responded that it depends on the circumstances at the time, and she can not really answer that.

Ms Forde-Paus: *I accept that particular responses do depend on the circumstances, however, in this situation of a serious and out of the ordinary incident one would have expected the opposite response to [Ms D's] ie rather than responding in a less responsive way one expect a more immediate response and actions.*

I asked [Ms D] to confirm that in these circumstances, she did not see any reason to treat it differently? She confirmed that she had not. She further advised that she advocated for [Ms A] there was no way [Ms A] was in any danger."

Ms Forde-Paus: *There is nothing in this new information which changes my original opinion that in January 2010 [Ms D] in her role as manager of the Mary Moodie Trust failed to appropriately investigate and respond to an incident of serious staff misconduct by [Mr E] and in doing so failed to provide [Ms A] with an adequate level of care and protection. The severity of the incident (assault in which injury was sustained) against the investigation and actions taken by [Ms D] i.e. meeting with the staff member and making recommendations on how he should manage similar situations in the future, with no notification to the Board (either immediately or in her monthly report), in my opinion was a severe departure from acceptable staff performance/management standards. I believe that [Ms D's] management of this incident would be considered with severe disapproval by her peers.*

As well as failing to respond to the bad staff performance appropriately/reasonably [Ms D] more specifically:

- *Failed to fill out a special incident report as is necessary under the MMT policy*
- *Failed to inform the family of the incident and failed to engage with the family in an appropriate way following a serious incident.*
- *Failed to inform the Board either at the time of the incident or at the next scheduled Board meeting.*

I remain concerned (as I pointed out in the initial report) that [Ms D] has never changed her response throughout this investigation. There is no retrospective acknowledgment that her judgement and management of this situation was inadequate. This is of concern as it suggests that she would do the same in the same/similar circumstances. This raises concerns about her working with vulnerable people in the future.

A complete aside from what you have asked me to comment on I thought it necessary to make a comment about the unease I felt when reading through the "Managers Reports" the comments relating to staff recruitment and employment, for example dot point 3 in the November report seems to indicate a very casual, informal (?unprofessional) method/process around this. I acknowledge this may just be how it appears when reading these reports, but I thought it was worth flagging with you as it could be indicative of some dysfunction within the service generally."

Appendix C — Further independent advice to Commissioner

On 22 February 2011 Ms Forde-Paus provided the following further advice:

"This additional report is being provided to the Commissioner following a request for an additional response on case number 10/00420 [Ms D] & Mary Moodie Family Trust (MMFT). I have been asked to comment on the following:

1. The adequacy of MMFT's policies and procedures on recruitment, orientation, and training of caregivers.
2. The adequacy of the orientation and training provided to [Mr E], particularly in relation to dealing with difficult or challenging behaviour from a resident.
3. The adequacy of the changes made by MMFT since the incident to ensure its staff are adequately trained to handle difficult and challenging behaviour from a resident.
4. Any other comment you wish to make in relation to the recruitment, orientation, and training of caregivers at MMFT.

The adequacy of MMFT's policies and procedures on recruitment, orientation, and training of caregivers.

I raise the following concerns and issues, having read through the documents provided:

Recruitment Checklist

- There was no 'Referee Check' completed, apparently because [Mr E] was 'known', however, he was initially only employed to do maintenance work. I would have expected a reference check when he moved into a care-giving role.
- There is no evidence that a police check was completed. Whilst permission was sought in the interview it doesn't appear to have occurred. I believe this type of check is essential when working with venerable people and should be part of the recruitment requirements and checklist. The absence of this, in my opinion is firstly a deficiency in policy, followed by a deficit in recruitment practice.
- It is Board policy that a Board member must be present when interviewing and hiring new staff. This did not happen in the case of [Mr E's] employment.

Orientation Checklist

- Firstly the Recruitment and Orientation Checklist is not signed. This is unacceptable in itself, but also I do not know who the initials belong to – they don't appear to be [Ms D's].
- In my opinion the Orientation Checklist is inadequate in several places. Whilst it's fine to have certain parts of it in dot-point style, there are some sections that definitely require more information, for example the coverage of 'Health and Safety' and 'Policy' is inadequate. There doesn't appear to be an area checking familiarity with the MMFT mission statement and guiding values, rather there is just a general statement/checkbox about the policy manual. A service's guiding principles needs to be given more attention. I have attached in the appendix the

Health and Safety and Policy sections of MMFT and a local NGO as a comparison.

- The 'Performance' section of the Orientation Checklist is required to be filled out by the Manager and the person is given a graded score out of 10. This was not done in [Mr E's] case. It is simply dated as opposed to graded. This is unacceptable as this part of the orientation is clearly about assessing the person's ability to communicate and interact in an appropriate manner whilst predicting and meeting the individual needs of the residents. For this not to have been completed by the manager, or in this case where there is a conflict of interest, with a senior staff member is not acceptable.
- The pairing of new staff (and [Mr E] in this case) with a senior staff member for ten days is a good practice.

Staff Education and Training

- I guess this is the most concerning part of [Mr E's] checklist in terms of credibility of the processes used to employ [Mr E]. Whilst the checklist outlines mandatory training these are all signed off on the same day. It is not possible to have undergone this extent of training in one day. This of course raises the credibility and reliability of the checklist and to a certain extent the whole process involving [Mr E's] recruitment and employment.
- It is clearly defined in the Manager's job description the responsibility of orientation and training of new staff (point 4) and having a staff training programme (section 5) and ensuring that staff are meeting this via a staff performance appraisal process (point 6).
- I do not see evidence of an adequate staff training programme. I have attached with this report a staff training programme for a local NGO, as introduced above. Whilst this is a large NGO which also provides mental health support along with disability support, it outlines the disability training programme within this. Whilst MMFT would have difficulty running an extensive staff training programme because of its relatively small size, other smaller NGOs manage this by aligning with larger NGOs for shared staff training.
- There does not appear to be any staff training on professional relationships/behaviour and boundaries. Neither does there appear to be any on advocacy. The training on managing challenging behaviours appears inadequate (expanded in the section below).
- Whilst it appears that there was inadequate staff training, this is something that the Board should have been reviewing and monitoring, typically by the presentation from the manager of a staff training programme for their approval and sign off.

[Mr E's] Interview Transcript

- [Mr E's] interview transcript is not indicative of someone who has a good understanding of the principles and values that underpin appropriate disability support. He clearly has no understanding of what 'an ordinary life'/normalisation means, nor what qualities are ideal in this type of support role. His responses are typically of a parental style and not appropriate for supporting people with an intellectual disability today.

- I do not understand why question 12 [Can you describe a situation where you have done something with a person rather than something for?] was marked 'not applicable'.
- There is no evidence of interviewing to elicit his ability to be a team player.

The adequacy of the orientation and training provided to [Mr E], particularly in relation to dealing with difficult or challenging behaviour from a resident.

- I believe the overall training given to [Mr E] was inadequate, but it would require further investigation to ascertain exactly what was undertaken in relation to the 'training' section of the orientation training package, for example, what did the 'Code of Rights and Advocacy' and the 'Disability' training consist of. Along with further investigation of the training outlined by [Ms D] in her response to the H&DC. In this response it would appear that [Mr E] did not do any training on managing challenging behaviour, as she states that [Mr E] was *'intending to attend a managing challenging behaviour course*'. She also states that he '*attended the restraint minimisation meeting*'.
- Firstly, training in challenging behaviour should have been mandatory and should have occurred within the orientation timeframe or very soon after. This type of training cannot occur by staff simply reading or talking to a co-worker, it needs to be presented by suitably qualified health professionals in a formal training package. Secondly I am concerned about the word 'meeting' when describing the restraint minimisation training. This type of training should not be conducted in a meeting but a formalised training package.
- Any staff dealing with people with disabilities, either intellectual or physical, who also have challenging behaviour; need to have training in managing challenging behaviour in an appropriate way and in accordance with up-to-date Ministerial guidelines. Core components of such training generally include human rights and advocacy; communication and de-escalation, risk minimisation and safe restraint.
- As raised above in the absence of training on professional behaviour and boundaries [Mr E's] reply to the HDC is indicative of inappropriate terminology, behaviour and boundaries, for example, *'[Ms A] responds well to males and they seem to be able to* ***control her outbursts****…..she would open the door and give me a cuddle…this continued after the incident.'*

Additional Points of Concern

- [Removed as comments do not relate to this investigation.]
- It is also concerning that a staff member was employed after [Ms D] was given a bad report from a referee — again this puts [Ms D's] recruitment and management skills into question.
- The ability of [Mr E] to be working as a team leader within [eight] months with no previous experience as a care-giver and an inadequate level of training is unacceptable. Is the manager expected to report to the Board those who are being delegated into team leader roles?

The adequacy of the changes made by MMFT since the incident to ensure its staff are adequately trained to handle difficult and challenging behaviour from a resident.

- Whilst the new manager has implemented some changes for staff training regarding the management of challenging behaviour, there is no description about what this involves.
- In my opinion having reading material available isn't the optimal training option for challenging behaviour education, as staff can simply sign the register without there being any evaluation ie did they understand what they read? Can they implement it?
- The response does not outline what is involved in the DHB training that the staff can now access. Did [the Community Team] do any staff training during their visits? Are they planning on regular visits? Involvement with the staff training programme?
- Evaluation and review of the patient management plans should occur at set intervals with clinical involvement not '*as required*'.
- There is no implementation of disability focused training or training around professional behaviour and boundaries.
- The movement from punishment based protocols to positive reinforcement programmes is positive.
- The involvement with family when discussing behaviour programmes is an improvement, however, families should be involved in all aspects of the person's management and care.

Conclusion

It is my opinion that the MMFT's polices and procedures on recruitment, orientation and training were less than adequate and were heavily reliant on the manager, in that the Board did not appear to be overseeing or monitoring these processes. The orientation and training of [Mr E] was inadequate in many areas, however the pairing up with a senior staff member for 10-days was consistent with good practice.

As discussed in my first opinion, ultimate responsibility for organisation risk and standards of care lies with the Board and whist there are clear issues with [Ms D's] performance, including her recruitment, orientation and staff training duties, there also appears to be issues with the Board not being in touch with the operation of the home. It would appear that the Board did not ask [Ms D] to present a staff training and education programme for their approval.

I would recommend reviewing the membership of the Board in order to ascertain that there is Board membership which has a solid understanding of disability residential support.

Whilst there are some clear failings in terms of [Ms D's] performance there is also clear failings in regard to the Board's role. I would also recommend consideration be given to some level of external review of MMFT."

Appendix D — Further independent advice to Commissioner

On 3 June 2011, Ms Forde-Paus provided the following further advice:

"This additional report is being provided to the Commissioner following a request for an additional response on case number 10/00420 regarding the Mary Moodie Family Trust (MMFT). I have been asked to comment on the following:

Mary Moodie Family Trust Incorporated:

1. Please advise what standards apply in this case.
2. Was there a departure from any of those standards by Mary Moodie Family Trust incorporated? If so, please provide details.
3. If not already included, comment on:
   - The adequacy of the management plan in place for [Ms A] at the time of the events
   - The adequacy of the MMFT's orientation and training processes
   - The adequacy of the MMFT's process for disseminating information to staff in relation to management plans for individual residents
   - The adequacy of the steps taken by the MMFT to ensure [Ms D] was suitably experienced and trained for her position
   - The lack of any formal policy dealing with relationships between staff members
   - The adequacy of the steps taken by the MMFT to ensure [Ms D] was complying with the MMFTs policies and procedures.

[Mr E]

1. Please advise what standards apply in this case.
2. Was there a departure from any of those standards by [Mr E]. If so, please provide details.

The adequacy of the management plan in place for [Ms A] at the time of the events
Having read the response from [Ms C] and the Behaviour Assessments from the [Community Team], I offer the following comments and opinion:

- The behaviour management plan titled '[Ms A] – Afternoon Routine' is inappropriate and unacceptable. It is encouraging a punitive and controlling approach and is totally in conflict with modern philosophies and practices governing disability services. Even when a 'reactive behaviour plan' has to be developed for safety reasons it can be planned and worded in a way that is not overtly controlling and punitive, for example, it can be written in positive language that is motivating and encouraging and recognises the individual's autonomy. Any behaviour management plan should be developed using the principles from 'positive behavioural intervention' and based on rewarding positive ('good') behaviour.
- Unfortunately the MMFT is a small service which I assume doesn't have its own clinical team or clinical advisor or behaviour support specialists. The MMFT staff appear to consist mainly of untrained staff.

- The [Community Team] has completed two very thorough assessments (with recommendations), one in 2007 and another in 2010.
- Many other bigger disability NGOs have staff with specialist behaviour support training or clinical qualifications who are able to take specialist reports and develop the information within them into a useable and functional support/care plan which staff can easily follow and implement.
- It would likely have been helpful/ideal if the [Community Team], who likely knew the limitations of the MMFT had developed their assessment and recommendations into a practical support plan and behaviour management plan for [Ms A] which gave clear 'step by step' advice to staff on how they should respond to/manage each of [Ms A's] difficult behavioural presentations.
- It appears that in conjunction with no clinical leadership in [Ms A's] residence, the [Community Team] assessments (whilst containing good information) have failed to transfer into something that was useable and functional to guide the direct-care staff to manage [Ms A].
- It would have been helpful if the [Community Team] had recommended a review process and provided a follow-up review, however, this may not be within their service specs.
- If the [Community Team] had been asked for input in developing the afternoon routine they would have been able to develop a plan that is more positive in focus, more clearly defined and one that is consistent with positive behaviour programming.
- The [Community Team] does not endorse the use of the lifting belt. In my opinion a lifting belt should only be used to ensure safety where there is imminent danger, for example, if a person was in the community and in immediate danger. In most situations there would be alternative approaches which could be used that would be less intrusive.
- It is positive to read that the lifting belt has not been used since the new manager has been in place.
- I was not provided with any more documentation regarding [Ms A's] care plan.

The adequacy of the Trust's orientation and training processes

I refer to my opinion in my third report to you where I raised problems with the operation of the orientation programme (as opposed to the checklist itself) for [Mr E]. I also noted that I did not see evidence of the MMFT providing an adequate training programme for him either. It is likely that the inadequacy of [Mr E's] training was a reflection of the overall training and education provided to staff by the MMFT at that time. Whilst I recall the orientation programme contained many of the core orientation training needs one would see in this type of service, for example, service overview and structure, policy and procedures, health and safety, infection control, job descriptions and role expectations etc, the more specific staff training programme to ensure staff are appropriately trained and have the right attitude for supporting people with an intellectual disability and also those with challenging behaviours was significantly lacking. I have again attached the outline of the staff orientation and training programme from a local NGO which can be used as a comparison. As previously discussed the outline does also include mental health training (which does not apply to the MMFT/this case). As previously discussed, whilst a small organisation like the MMFT would be unlikely to be able to provide an extensive in-house staff training programme like the example

provided, it could align with larger NGOs to ensure that staff are provided with the essential education and training for working with the population group within its two houses. Organisations like the [Community Team] are also available to provide specialist staff training as are other community agencies, like the epilepsy society for example. Listed below are what I would consider essential training and education requirements for staff working in the MMFT — such training needs to be provided by appropriately trained/specialist staff and cannot be gained by reading material:

- Understanding Intellectual Disability and the support role, including advocacy, values and philosophies for disability services
- Professional relationships/behaviour and boundaries
- Client support/management plans
- Appropriate note writing
- Positive Practices in Managing Challenging Behaviour, including de-escalation, risk minimisation and safe restraint.
- First Aid
- Autism
- Epilepsy
- Alternative and Augmentative Communication
- Anxiety and mental health symptoms in people with an intellectual disability
- Intimacy and relationships
- Grief and Loss
- Stress management

As discussed in my previous report the MMFT Board had a responsibility for monitoring and reviewing the adequacy of the staff orientation and training programme and ensuring the manager is implementing them satisfactorily.

Please note that I did not have information relating to the orientation and training programme when compiling this report. Whilst I had it for the last report it was not included in the bundles for this further opinion so I am going by memory and previous comments. Many of the general comments I made in the previous report relating to [Mr E] about the orientation and staff training programme are relevant and would apply to this opinion also.

The adequacy of the Trust's process for disseminating information to staff in relation to management plans for individual residents

According to the information provided by [Ms C] 'much information relating to management plans for individual residents was communicated informally between staff working on their shifts'.

- In my opinion this is unacceptable there should have been a 'formalised' process for disseminating information on a regular basis.
- There should have been some daily method of communication between staff and services which staff could communicate any concerns – even if this is a brief or simple system, for example, it is common for services use a note-book system between day programmes and residential houses to pass on any concerns. There

should be a system in place for staff to communicate between shifts – even if this is a brief handover with the more extensive clinical discussion happening in a weekly or monthly meeting.

- When providing a service for people with intellectual disability and challenging behaviour or complex needs it is important that there is ongoing and regular opportunity for team meetings (facilitated by the management and with specialist behaviour support involvement (eg either in-house or externally eg [the Community Team]) to discuss the individuals progress and support plan so that everyone is aware of the person's behaviours/difficulties and knows how to respond to them.
- It is important that direct care-staff working with people with challenging behaviour have the opportunity of meetings where they can ventilate their feelings and obtain support and feedback from their co-workers and management/behaviour support team. By sharing common experiences, or relating difficult experiences, staff can offload some of their feelings of frustration with each other. Additionally, staff can share any positive outcomes they have experienced. Such meetings serve to help staff cope with the demands placed on them of supporting people with challenging behaviours and may also facilitate the transfer of education and knowledge from one staff member to another.
- In relation to clinical information for new staff, I recall from the last opinion that this is covered off in the orientation check list which is appropriate, but how it occurs was not outlined.
- It should be expected that all new staff have the opportunity to read and familiarise themselves with the patients history, their current care plan, including a behaviour/risk management plan if they have one.
- After reading this they should have the opportunity to talk with a senior staff member to ask questions and gain any further information they require.
- The practice of pairing new staff (as was the case with [Mr E]) with a senior staff member for ten days is a good practice and in my opinion should be a part of orientation and training.

The adequacy of the steps taken by the Trust to ensure [Ms D] was suitably experienced and trained for her position

- Whilst the information in the response from [Ms C] in relation to the employment of [Ms D] fails to outline [Ms D's] previous experience, other than this it appears to indicate an adequate recruitment process - four people were interviewed, [Ms D] 'stood out' amongst the other applicants, three reference checks were done which didn't raise any concerns and the Chairperson of the Board accompanied [Ms D] to the homes for a visit and to assess her appropriateness for the position.
- It would be important to ensure that at least one of the referees was a previous manager and that the referees were appropriate people – this information was not supplied.
- I note from [Ms D's] response to you, that she claims to have eighteen years experience in the 'Health and Disability field' from 'hands-on roles to management positions'.

- If one of the referees was a former manager and [Ms D's] description of her previous experience was correct then it is my opinion that the process was adequate, it could, however, have been improved by having someone external to Board members on the interview panel, for example, someone with disability management experience (for example from another NGO) or a clinician from a specialist service or maybe a consumer representative.
- Ms C's reply indicates that the Board made available to [Ms D] adequate training opportunities and that she attended an annual conference and different courses. I do not know if she attended a local disability provider forums – if not this would have been helpful and appropriate.

The lack of any formal policy dealing with relationships between staff members

I don't think it would be common for NGOs to have a policy dealing specifically with intimate relationships between staff members. Normally this is dealt with broadly in overarching policies, for example code of conduct policies. Relationships like this are inevitable at times and there is nothing in law which prohibits this type of relationship. [Ms D] appropriately told the Board about her relationship with [Mr E]. Whilst the chairperson of the Board made it clear to [Ms D] that it was essential that "*the relation did not adversely impact on the professional standards required of either her as the manger and the staff*" it did not appear to put any process in place to assist or monitor her with this. Ideally they would have provided her with some managerial support and/or supervision to ensure that appropriate boundaries were being maintained in the workplace and that there was ongoing transparency and review of this issue, given that we all know it is easy to lose perspective when romantically involved with a person.

The adequacy of the steps taken by the MMFT to ensure [Ms D] was complying with the MMFT's policies and procedures

As [Ms C] outlines [Ms D] was required to submit a monthly report to the Board meeting which would have provided some indication of compliance with the Trusts policies and procedures. According to her job description she had mandatory reporting items (care of residents, out of the ordinary incidents, staffing issues, various financial reports, maintenance, audit reports). It would then be the responsibility of the Board to ensure compliance with policies and procedures, including ensuring appropriate client care and service provision. This type of monthly reporting system is reliant on the managers accurate self-reporting. In a small service like the MMFT where there is only one manager there is no capacity for peer review/checking – this is a risk. In such a situation the risk of poor managerial practice could be minimised by ensuring there is a process for managerial assistance or supervision and review in conjunction with disability expertise within the Board membership.

Comment on the adequacy of the changes the MMFT has made since this incident and recommendations/points to consider.

- A complete review of the MMFT policies and procedures is positive, but there needs to be some assurance that the new policies and procedures are consistent with best-practice policies and procedures.

- What or who has [Ms L] used to support her to develop these? ie what checks are in place to ensure that the new policies and procedures are adequate and appropriate?
- In my last report I said it was my opinion that whilst there were some clear failings in terms of [Ms D's] performance, there was also clear failings in regard to the Board's role. At the time I recommended consideration be given to some level of external review of MMFT. In the absence of this occurring I recommend (if it is not already happening) that some collaborative assistance is sought from an NGO which has been assessed/audited as providing quality services, to support [Ms L] as she attempts to rectify the gaps in service provision at the MMFT residences.
- Recruitment of new Board members with a variety of skills is positive if this includes members with expertise and a good understanding of up-to-date standards and philosophies for disability service provision (as outlined in my last report). If this is not the case I would strongly recommend that people with these qualifications and experience/expertise are sought.
- The initiation of training with the [Community Team] since the incident has been an appropriate and positive step. It appears the staff have undergone general training for managing challenging behaviour along with more specifically targeted training in relation to [Ms A].
- It is important that the MMFT ensure that all staff attend Behavioural Training and have annual refreshers/updates.
- Along with training for managing challenging behaviour, has an appropriate staff orientation and training programme been developed and implanted which includes core disability focused training as outlined above? If not I would strongly recommend that this happens.
- Has a process been implemented, as described above, where the team get opportunities to meet (facilitated by suitable qualified staff) to discuss residents care/treatment plans and their progress and where they can provide input and get feedback on managing challenging behaviour. If not I would recommend that such a process is implemented.
- As discussed above I didn't view [Ms A's] care plan I would recommend that the care plans of the residents at the MMFT are reviewed/audited.

Conclusion

The standards that apply to this case and which I have based my opinion and recommendations on are:

- Health and Disability Sector Standards NZS8134:2001
- The New Zealand Disability Strategy: Making a world of difference
- Restraint Minimisation and Safe Practice Standard NZS 8141:2001
- Standards within the Health and Disability Code of Rights (1994)

In relation to the Mary Moodie Family Trust

It is my opinion that the MMFT departed from acceptable standards in that they:

- Failed to provide adequate managerial support and/or supervision and monitoring to the manger who was in a sole manager role.

- This led to a failure to provide:
  - An adequate staff orientation and training programme.
  - An adequate care/behavioural management plan for [Ms A] to guide direct-care staff.

These failures culminated in an inadequate level of care provided to [Ms A].

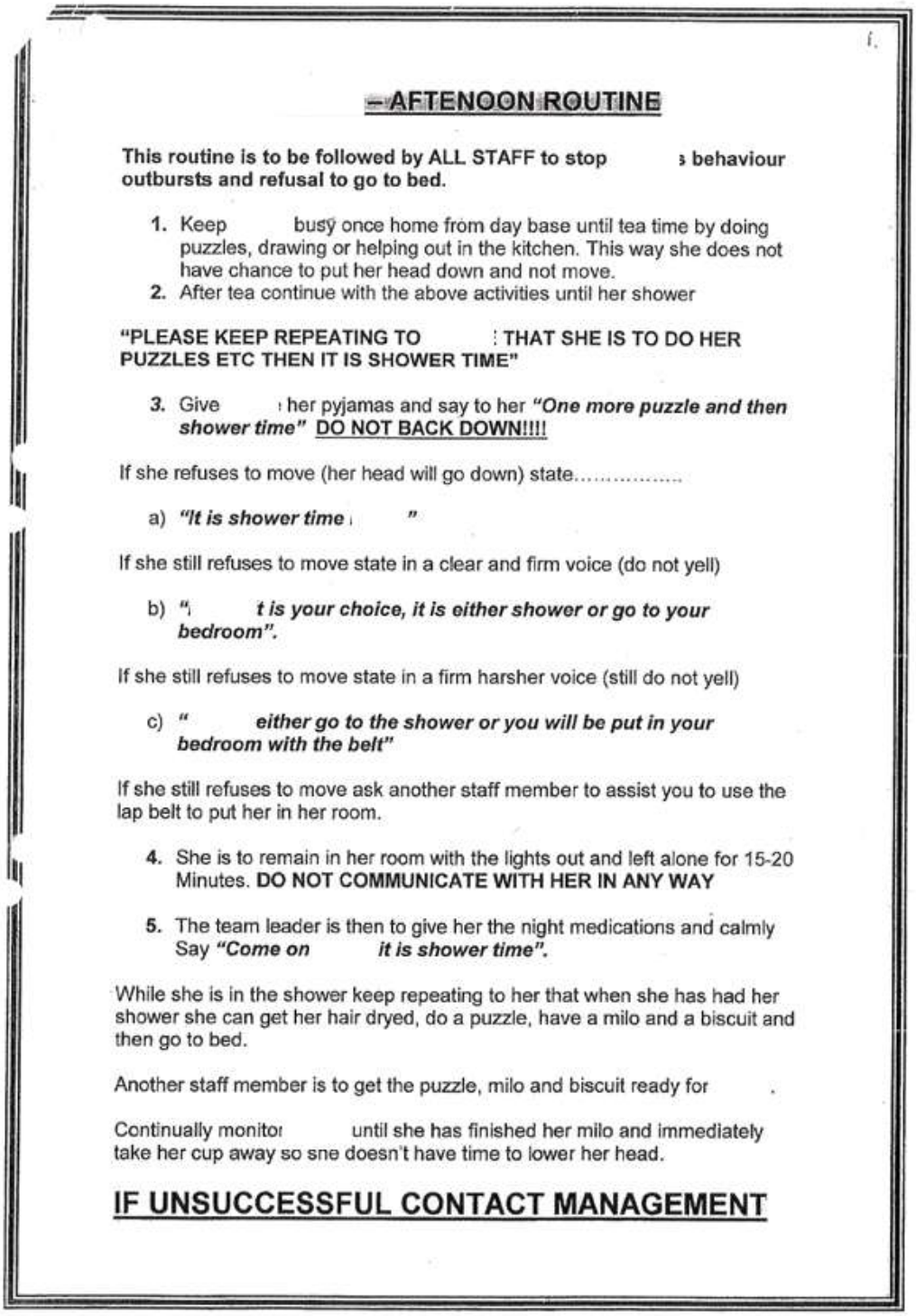
The MMFT is a small NGO. I believe that this case highlights a problem to the actual "contractors" in that it is probably good practice not to have small NGOs providing services to people with intellectual disabilities who have complex presentations who are not closely aligned with another NGO. Maybe people with complex presentations should go to well established larger NGOs with good infrastructure, policies procedures and proven practices. However, in saying this it is the responsibility of the Board to be aware of what it is they are taking on/providing a service for, they need to be aware of their shortcomings/limitations and have a plan in place for dealing with this/meeting these gaps. Each Board member has a responsibility to know what their mandate is; it is therefore my opinion that the severity of the departure from acceptable standards in this case falls within the moderate range.

[Mr E]
The above named standards are the same standards that apply to [Mr E].

Despite there being deficits in [Mr E] orientation and training and limited guidance via care plans his action on the 26th of January 2010 when he was witnessed and admitted to dragging [Ms A] from her bedroom firstly by her legs and then her arms through the living room was totally unacceptable. It was not supported in her care-plan (which outlined the use of a lifting belt in these circumstances) and in my opinion was no less than common assault.

[Mr E's] actions on this day, in my opinion were a severe and very serious departure from acceptable standards."

Appendix E — Afternoon routine



AFTENOON ROUTINE

This routine is to be followed by ALL STAFF to stop s behaviour outbursts and refusal to go to bed.

1. Keep busy once home from day base until tea time by doing puzzles, drawing or helping out in the kitchen. This way she does not have chance to put her head down and not move.
2. After tea continue with the above activities until her shower

"PLEASE KEEP REPEATING TO : THAT SHE IS TO DO HER PUZZLES ETC THEN IT IS SHOWER TIME"

3. Give her pyjamas and say to her ***"One more puzzle and then shower time"*** **DO NOT BACK DOWN!!!!**

If she refuses to move (her head will go down) state.....

a) ***"It is shower time "***

If she still refuses to move state in a clear and firm voice (do not yell)

b) ***" t is your choice, it is either shower or go to your bedroom".***

If she still refuses to move state in a firm harsher voice (still do not yell)

c) ***" either go to the shower or you will be put in your bedroom with the belt"***

If she still refuses to move ask another staff member to assist you to use the lap belt to put her in her room.

4. She is to remain in her room with the lights out and left alone for 15-20 Minutes. **DO NOT COMMUNICATE WITH HER IN ANY WAY**

5. The team leader is then to give her the night medications and calmly Say ***"Come on it is shower time".***

While she is in the shower keep repeating to her that when she has had her shower she can get her hair dryed, do a puzzle, have a milo and a biscuit and then go to bed.

Another staff member is to get the puzzle, milo and biscuit ready for .

Continually monitor until she has finished her milo and immediately take her cup away so she doesn't have time to lower her head.

IF UNSUCCESSFUL CONTACT MANAGEMENT