A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC02248)

Contents

Introduction

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

2. The report discusses the care provided to Ms B by a disability support service.

3. The following issue was identified for investigation:

   - *Whether [the disability support service] provided [Ms B] with an appropriate standard of care from 2016 to [Month5][1] 2020 (inclusive).*

4. The parties directly involved in the investigation were:

Ms A	Complainant/consumer's sister
Ms B	Consumer
Residential disability support service	

5. Further information was received from:

New Zealand Police
Whaikaha|Ministry of Disabled People

6. Also mentioned in this report:

[1] Relevant months are referred to as Month1–Month6 to protect privacy.

Names (except the advisor on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Needs assessment service coordination agency
ACC
Search and Rescue

7. Independent clinical advice was received from disability consultant Mrs Sandie Waddell (Appendix A).

Facts gathered

Introduction

8. Ms A complained to HDC about the care a residential disability support service (the support service) provided to her sister, Ms B. The complaint stemmed from a serious event that happened in Month5 2020 when Ms B wandered overnight from the support service residence. Ms A was concerned about the incident and the information she received from the support service over the period Ms B was missing, as well as the adequacy of the remedial measures the service provider took in response to the incident. Ms A also raised concerns about the provision of other information relating to her sister's care in the lead-up to this event and afterwards.

9. Ms A also complained to Whaikaha about these issues.

10. Following receipt of Ms A's complaint, HDC was advised that Ms B had passed away. I offer my sincere condolences to Ms A and her whānau.

Clinical history — background to serious event in 2020

11. At the time of the events, Ms B was 32 years old. She had an intellectual disability and was known to exhibit challenging behaviours, including verbal and physical aggression. In addition, Ms B had a history of psychosis,[2] visual impairment, and uncontrolled type 1 diabetes with insulin dependency and was at high risk of hypoglycaemia.[3]

12. In 2012, a personal order[4] was sought for Ms B to receive residential disability support services from the support service. The personal order was sought with the support of Ms B's mother, but it appears that Ms B's siblings were not informed about the order at the time.

13. Due to whānau conflict, Ms B's mother ceased contact with Ms B, and in 2016 Ms A became Ms B's next of kin. The support service told HDC that Ms A was interested in Ms B's welfare, and staff had noticed a 'significant uplift in [Ms B's] mood' when Ms A re-connected with her.

14. Ms B received residential support from the support service from 2011 to 2020 and shared the home with at least four other disabled people. The support service assisted Ms B with activities of daily living, diabetes care, and medication management. The support service developed a support plan (dated 24 November 2016), which noted that Ms B did not have

[2] A perception of reality that differs from other people and may involve hallucinations and unusual beliefs.
[3] Low blood-sugar levels. Severe hypoglycaemia can lead to seizures and a loss of consciousness.
[4] Under the Protection of Personal and Property Rights Act 1988.

the capacity to make significant decisions, but was able to express her preferences, and staff were to assist with maximum independence with personal care.

15. A needs assessment completed in 2016 by a needs assessment and service coordination agency noted that Ms B was able to express core needs, and that she had a 'highly problematic' sleeping pattern with the habit of getting up to wander in the middle of the night. Ms B was prescribed PRN[5] medications for her night-time agitation.

16. The needs assessment stated that Ms B required 24-hour supervision. The support service told HDC that Ms B was not funded for one-on-one support, although her care plan stated that staff needed to have 'line of sight' when she was awake.

17. The support service told HDC that Ms B had been known to have episodes of sleep disturbances overnight around the time of her disappearance, but a re-assessment of Ms B's needs was not sought by support service staff. Incident reports show that Ms B was awake and/or agitated during the nights of 12 Month2, 8 Month3, 28 Month3, 1 Month4, 27 Month4, 4 Month5 and 12 Month5 2020. In addition, the support service told the Police that Ms B had a habit of waking up at 9pm, and then again around 3–5am.

18. Ms B's risk management plan (dated 16 August 2017) states that she had a moderate risk for wandering when left unsupervised, particularly when she was upset and when she wanted to go home. Accordingly, the risk management plan instructed '[s]taff to keep [Ms B] in line of sight at all times'. However, as stated above, the support service told HDC that this was only during daytime hours. Police records show that in Month1 2020 Ms B had absconded during the day and was located nearby a few minutes later. Incident reports and Police records show no evidence of previous wandering during the night.

Facility staffing

19. The facility where Ms B resided was staffed 24 hours a day, 7 days a week. The support service told HDC that two support workers are always rostered on site during the day (6am till 10pm), with one support worker rostered for a 'sleepover shift' between 10pm and 6am. The support service told HDC that although it is referred to as a 'sleepover shift', staff are expected to respond to any potential disturbances during the night as required.

Expiry of personal order

20. The personal order initiated in 2012 was valid for three years and expired in October 2015. Upon expiry, further orders were not sought by the support service. The support service stated that this is not unusual in circumstances where support arrangements are working well and remain in the person's best interests, where the person is settled and not expressing concern or unhappiness about their living situation, or where there is no change in the person's clinical condition or capacity. The support service said that Ms B did not express or indicate any desire to leave her residence and had good relationships with her flatmates and staff.

[5] Medications taken as needed.

21. Ms A was in the process of seeking welfare guardianship[6] for Ms B, but the support service told HDC that it never received confirmation that the process had been completed.

22. Ms B's support plan recorded that she did not have a current welfare guardian or personal order, but that her whānau would support her with all major decision-making. The support service considered that after the expiry of the personal order, it could continue to provide services to Ms B that were in her best interests.

Ms B's disappearance

23. At 8.30am on Day 2 Month5 2020, Ms B was reported missing by support service staff.

Events leading up to incident

24. The support service told HDC that on Day 1[7] Month5 2020, on the eve of Ms B's birthday, Ms B had been excited about her birthday and was awake at night. She had planned to go out for lunch on her birthday and was expecting a letter.

25. An incident report noted that at 1.15pm on Day 1 Month5, Ms B had been 'shouting', '[raising] her voice', 'using rude language', and 'making loud noise'. Medication was administered and staff instructed Ms B to '[calm] down and rest in her room'.

26. The medication administration record shows that pericyazine[8] was administered at '11.30',[9] and clonazepam[10] was administered at '10.00'.[11] There is no record of medication administration around 1.15pm, although a subsequent incident report noted that medication was administered at this time.

27. Internal communication shows that at around 8pm on Day 1 Month5, Ms B was awake and in the kitchen. Her blood-sugar levels were checked and, as they were low, Ms B was given food and a drink to increase her blood sugar. She then slept on the couch.

28. The support service said that between 11.30pm and midnight, the sleepover support worker heard Ms B in the garage.[12] Ms B appeared to be searching for something and was distressed. The support service stated that staff were expected to keep Ms B in their line of sight and attempt to de-escalate if Ms B was displaying heightened behaviours. The support service told HDC that PRN medications were administered in line with Ms B's support plan, and the support worker directed Ms B to go to bed. As noted above, it is unclear which medications were administered at what time.

29. The support service told HDC that following the medication administration, the support worker checked on Ms B and saw that she was asleep in her bed. Support service staff told

[6] Welfare guardianship is a legal arrangement in which a court-appointed guardian is responsible for making decisions on behalf of a person who is unable to make their own decisions due to a disability, illness, or injury.
[7] Relevant dates are referred to as Days 1–3 to protect privacy.
[8] A medication used to treat aggression, impulsiveness, and anxiety.
[9] It is not known whether this was AM or PM.
[10] Medication used for anxiety.
[11] It is not known whether this was AM or PM.
[12] The garage was in the basement of the house.

the Police that this check occurred at 2am, which is confirmed in subsequent internal email communications between support service staff.

30. Conversely, an incident report written retrospectively on Day 3 Month5 2020 refers to email correspondence from the sleepover support worker to the service delivery manager, which does not indicate what time the check occurred after the medication administration, and whether Ms B was asleep in her room when the check occurred. In addition, Police records show that occupants from two neighbouring properties[13] saw Ms B outside their houses at 1.30am on Day 2 Month5, with CCTV footage confirming this. This does not corroborate the support service's account to Police.

31. Police records also show that at 2.20am on Day 2 Month5 2020 Ms B was seen on CCTV footage around a neighbouring property, which was around 400m and a six-minute walk from Ms B's residence.

32. The support service stated that at some point during the night, the sleepover support worker left the facility to go to her car, but did not secure the top bolt on the front door of the facility on her return. The support service told HDC that the bolt on the front door was an environmental restraint for another resident, but staff formed a habit of locking all doors at night as a standard residential security measure to ensure the safety of the residents. The bolt could be unlocked from the inside by residents, but it locked behind the person exiting the front door. In response to the provisional opinion, Ms A expressed concern regarding the front door being unlocked.

33. At 6am on Day 2 Month5, the sleepover support worker completed handover to the two support workers on the morning shift. The support service's Shift Handover Policy (undated) stated that support workers must sight the consumer at the beginning and end of their shift. However, the support service told HDC that as Ms B had been up late and had been agitated and had not had enough sleep, a decision was made to allow Ms B to sleep, and neither the sleepover support worker nor the support workers beginning their morning shift completed a visual check.

34. Police records show that Ms A telephoned the facility around 8am to speak to Ms B but was informed that Ms B was asleep. In response to the provisional report, Ms A maintained that at this point, staff had told her that Ms B was asleep, rather than missing.

Incident

35. A visual check by support service staff was completed at 8.30am on Day 2 Month5, at which point Ms B was noted to be missing. This was escalated to senior staff and then reported to the Police at 9.13am on Day 2 Month5. The support service told HDC that the family was informed at 9.51am, and staff also informed the Ministry of Health and Ms B's general practitioner (GP).

36. The support service told HDC that an additional six staff were deployed to assist in locating Ms B, with an extensive search undertaken by staff, Police, and Search and Rescue teams.

[13] Around 200m and a three-minute walk from the residence.

Police records show that Ms B was located at 1.15pm on Day 3 Month5, around 800m (an 11-minute walk) from the residence. Ms B was found without any clothes, and she had a low body temperature, 'but otherwise [she was] OK'. Ms B was taken to hospital for treatment and observation.

Post-incident actions

37. The support service completed an investigation into the incident and found that Ms B had left the facility to check the letterbox, which was part of her normal routine. However, in the process, she had become disorientated and could not find her way back to the house. The support service was unable to determine the precise time at which Ms B wandered. In addition, the investigation found the following:

- Ms B's night-time sleep disturbances were not re-assessed formally;
- Support workers on the morning of Day 2 Month5 2020 did not follow routine handover procedures;
- The documentation for the use of the environmental restraint (for another resident) lapsed a month prior to the incident and was not in keeping with the support service's guidelines; and
- The incident report relating to Ms B's agitated state on the night of Day 1 Month5 did not include appropriate descriptors for her behaviour, times, the medication name and dose administered, or the contributing/possible causes for the incident. The support service told HDC that the incident report was not completed to an acceptable standard.

38. Ms A told HDC that she was not provided with a copy of the support service's investigation report or given an adequate explanation as to why Ms B went missing. The support service sincerely apologised to Ms B's whānau. The support service told HDC that updates regarding its investigations and findings were not provided to Ms A, even though its incident management system prompted engagement with whānau when the incident was reviewed by the manager.

39. On 27 Month5 2020, regional managers and service managers met with Ms B, Ms A, and whānau to discuss ongoing support arrangements. The meeting notes record that an 'extensive apology' was provided regarding the incident, and Ms A was informed that 'there was a review occurring', and that after completion, the review findings would be shared with her. The support service did not confirm when the review findings were communicated to Ms A.

40. The needs assessment service coordination agency informed the support service that following a meeting with Ms B's whānau on 20 Month5, a decision was made for Ms B to remain with her family, and a service exit date from the support service was confirmed for 16 Month6 2020.

Transfer of care to Ms B's whānau

41. Ms A and her whānau decided to take Ms B home after her discharge from hospital on 23 Month5 2020. Ms A said that this was because she did not 'get a clear picture that security

issues [within the support service's residence] had been remed[i]ed' and felt that no one took her sister's incident seriously. Whaikaha told Ms A that although the plan to implement alarms/locks on doors had not been implemented at this stage, additional staff had been placed on all shifts, to ensure the safety of residents.

42. The support service told HDC that Ms B was willing to go with Ms A to her home, and this was consistent with Ms B's support plan, which included goals to develop a stronger relationship with her sisters and spend time with them at their homes, and a longer-term goal to move to her sister's home. The support service said that Ms B had had overnight stays at Ms A's house, and these had been successful.

Information relating to support needs

43. Ms A told HDC that other than Ms B's medication prescription chart and 'a simple plan about [Ms B's] interests and hobbies', the support service did not provide her with information about how to support Ms B at home. Ms A said that the support service did not provide her with copies of previous medical records, including previous medication administration charts.

44. Ms A stated that she had requested a copy of Ms B's medical notes so that she could check whether Ms B had received regular checks by her GP and support service staff, including whether Ms B's diabetic condition had been monitored regularly. Ms A stated that she was concerned about Ms B's deterioration and diabetic control over the years.

45. The support service's exit form records that Ms A was provided with Ms B's 'specialist reports', support plans, general information, and her medication chart. The support service told HDC that it also provided the following:

- General care information and medication chart on 23 Month5 2020;
- Daily medication oversight and diabetes management support for several weeks (until Ms A had been trained in medication oversight by the GP), including onsite support for one hour a day and being available by phone;
- Arrangement of a needs re-assessment with the needs assessment service coordination agency;
- Funding of moving expenses, food vouchers, and financial assistance payments to assist with further expenses;
- Support with changing the signatories for Ms B's bank account;
- Training on insulin and diabetes management; and
- The option of accessing respite services through the support service if Ms A wished to, but this was declined.

46. The support service stated that it provided copies of documents that were relevant to Ms B's care. The support service said that it was cautious about releasing additional information (beyond the information required for day-to-day cares) without a clear basis for the release, particularly given the complex family dynamics and history.

47. The support service told HDC that it had informed Ms A that it would release additional information once she had been appointed as the welfare guardian. As noted above, Ms A did not confirm to HDC or the support service whether this occurred.

Communication regarding assault allegations

48. Ms A told HDC that allegedly Ms B had been assaulted by support service staff members. Ms A said that the findings from the investigation of these events was not communicated to her, and she felt that 'information was covered up'. She is unclear about the timelines relating to the assault allegations.

49. Ms A asked the support service and Whaikaha to provide her with copies of the incident reports and investigations relating to the alleged assaults. However, the support service's incident register shows no incidents relating to assault allegations, and neither agency provided Ms A with this information.

50. The support service told HDC that it did not provide incident forms and the Police investigation report to Ms A, as Ms B could not consent to the disclosure. The needs assessment service coordination agency also advised Whaikaha that there may have been concerns about Ms B's capacity to provide informed consent as she may not have understood what she was consenting to. The support service planned to provide this information once Ms A had confirmed welfare guardianship.

51. Ms A was given inconsistent information as to whether she was eligible to receive copies of the investigation and incident reports. A meeting with support service staff and Ms A in Month5 2020, an email from Whaikaha dated 28 Month11, and a phone call with support service staff on 9 Month18 indicated that Ms A would be provided with a copy of the investigation findings. Conversely, meeting minutes from Month12, and further emails from Whaikaha to Ms A on 27 Month19, 6 Month20, and 27 Month20 advised Ms A that this information could be provided only following welfare guardianship.

Further information

52. Ms A told Whaikaha that she would like to see improved communication with families, particularly around incidents and learnings from this incident, to ensure that such incidents do not happen again in the house or to other services.

53. Ms A also told HDC that she was not made aware of Ms B's COVID-19 diagnosis in Month2 2020. In response to this, the support service told HDC that it attempted to contact Ms A twice by phone, but staff were unable to reach her. However, the support service acknowledged that documentation is lacking in respect of this.

54. The support service told HDC that at times it had trouble reaching Ms A, which was complicated by her changing phone numbers. The support service did not provide evidence of the contact attempts made.

Internal policies

55. The support service's policy titled 'Privacy Policy and Guidelines' (undated) states that if the service user is not competent, Rule 11(2) of the Health Information Privacy Code 2020 must apply. Rule 11(2) allows for disclosure in cases where it is to the principal caregiver of the service user, it is not contrary to the express request of the service user, and it is necessary to prevent or lessen a serious threat to the life or health of the individual or another individual.

56. In addition, the policy notes that caregivers can use section 22F of the Health Act 1956 to obtain health information, and that the privacy officer should always be consulted prior to deciding. Refusal of the request can occur if the disclosure would be contrary to the service user's interests or if the service user does not want the information to be disclosed to the caregiver.

57. The policy states that if disclosure would not be in the service user's best interests, the person should be advised that the decision not to disclose has been made on clinical grounds.

Standards

58. The Health and Disability Services (Core) Standards (NZS) 8134.1:2008 at the time of the events states the following:

- Standard 3.3.4: 'The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach.'
- Standard 3.6.1: 'The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.'
- Standard 3.3: 'Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.'
- Standard 3.3.2: 'Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate.'
- Standard 3.8: 'Consumer[s] service delivery plans are evaluated in a comprehensive and timely manner.'

Responses to provisional opinion

Ms A

59. Ms A was provided with a copy of the 'information gathered' section of the provisional report and given the opportunity to provide comments. Ms A is concerned that the timeline of events as reported by support service staff in relation to Ms B's disappearance '[were] not adding up'. Other comments have been integrated elsewhere in this report where relevant.

Support service

60. The support service was provided with a full copy of the provisional report and given the opportunity to provide comments. The support service stated that broadly it accepts the provisional opinion and the proposed course of action. Other comments have been integrated elsewhere in this report where relevant.

Opinion: Support service — breach

Introduction

61. Ms B had an intellectual disability and was known to exhibit challenging behaviours. She also had a complex medical history. Ms B lived in the residential disability support service between 2011 and 2020. At 8.30am on Day 2 Month5 2020, Ms B was reported missing by support service staff. She was found approximately 30 hours later. After the incident, Ms B went to live with her whānau and was cared for by her sister, Ms A. Ms A complained to HDC about the care her sister received from the support service.

62. As a healthcare provider, the support service had a duty to provide care that was consistent with the Code of Health and Disability Services Consumers' Rights (the Code). I have carefully reviewed all the information gathered over the course of this investigation, including the responses received from the support service, Ms A, and other relevant parties. I obtained independent clinical advice from a disability consultant, Mrs Sandie Waddell. Mrs Waddell has worked in a range of senior management positions in the health and disability sector and is well placed to comment on the circumstances of this case.

63. I commend Ms A for advocating on her sister's behalf. Ms B's disappearance and the assault allegations were clearly unsettling for Ms A and, in the circumstances, it is understandable that she would seek further explanation. I am also conscious from remarks Ms A made to Whaikaha that she wanted learnings to be taken from the incident to ensure that this does not happen to others, and for there to be improved communication with families, particularly around incidents.

64. In reviewing this case, and importantly with reference to the concerns Ms A has raised, I have determined that aspects of Ms B's care was acceptable and of an appropriate standard. I note that as soon as Ms B was reported missing, the incident was escalated and managed promptly. I also consider that appropriate support was provided to Ms A in relation to Ms B's immediate care needs when she went to live with her whānau. I have also determined that the assault allegations that occurred between 2017 and 2020 were acted upon and managed promptly.

65. However, in my opinion, other aspects of Ms B's care were not up to the required standard, and I am critical of these shortcomings, as outlined below.

Failure to follow handover policy — breach

66. At 6am on Day 2 Month5 2020, the sleepover support worker at the support service completed a handover of residents to the incoming morning shift support workers, as part of the usual process. A handover involves the transfer of responsibility from one person to

another. The support service's Shift Handover policy states that support workers must sight each consumer at the beginning and end of the shift. However, neither the sleepover support worker nor the two incoming morning support workers completed this task during the handover, as subsequently identified by the support service's internal investigation.

67. Further to this, the NZS Standard 3.3.4 states that '[t]he service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach'.

68. The support service stated that this lapse in process was because staff had noted Ms B's agitation over the night of Day 1/Day 2 Month5 2020 and they wanted to allow Ms B to sleep in without disturbance. This delayed staff's recognition of Ms B's disappearance. The support service acknowledged that this omission fell below its expectations.

69. The policy in place was clear but was not followed by three support workers. As such, the support service not only failed to implement its internal policy but also failed to promote a service that ensured continuity of care, as per NZS Standard 3.3.4.

70. In my opinion, it was particularly important to sight Ms B, given her increased agitation the previous night, her risk of wandering (as indicated by her risk management plan), and her habit of wandering at night (as had been identified during previous incident reports and accounts to the Police). Although staff had administered PRN medication on the night of Day 1/Day 2 Month5 2020 and had supported Ms B back to bed, it was still necessary for staff to follow the usual protocols, and I am critical that this did not occur.

71. I consider that the failure to follow the usual handover protocol reflects a lack of awareness by staff of the importance and value of handovers. It is widely recognised that high-quality handovers are essential for safe care delivery and consistency of care.[14] As part of this process, visual observation of the consumer helps to ensure that incoming staff can understand the consumer's current needs and spot potential discrepancies in care, helping to avoid miscommunication or missed details. Cumulatively, this contributes to improved continuity of care.

Inadequate incident reporting — breach

72. I have noted several issues with the quality of the incident reporting completed by support service staff.

73. First, there were discrepancies in the reporting and interpretation of the incident on Day 2 Month5 2020. An incident report was completed retrospectively by the service manager of the support service on Day 3 Month5 2020. The incident report noted that Ms B had received PRN medication for her sleep disturbance around midnight, after which the support worker had checked on Ms B, who was '[in] her room before [the support worker] went to bed'. The incident report does not state whether Ms B was asleep when the support worker checked on her.

[14] Safe handover | The BMJ.

74. Conversely, internal email correspondence with support service staff, and in the accounts provided to the Police, the support service stated that Ms B had been sighted as being asleep around 2am. However, CCTV footage showed that Ms B had been wandering around neighbouring properties between 1.30am and 2.20am. The CCTV footage, in conjunction with other witness accounts gathered by the Police, suggest that it is unlikely that Ms B was asleep in her bed at 2am.

75. In addition to the above inconsistencies, I note that there is limited description of the events that preceded Ms B's disappearance. An incident report completed at around 1.15pm on Day 1 Month5 2020 indicated disturbances in Ms B's behaviour. The support service's internal investigation also noted that the incident report completed on Day 1 Month5 2020 contained limited description of Ms B's behaviour and did not include the contributing/ possible causes for the incident or details of the medication given. In addition, I note the lack of clear and precise language used (such as 'around midnight'), the lack of objective reporting (such as 'she seemed satisfied by that'), the lack of detail of the effectiveness of the medication, and the lack of a timeline relating to the events (such as when Ms B was noted as being asleep).

76. I am critical of the quality of incident reporting in this instance. A robust incident report is crucial for understanding the nature and severity of the incident, helping identify all contributing factors, and helping prevent its recurrence. In my opinion, the inconsistencies in the incident reporting contributed to inaccurate information being communicated to the Police. In my opinion, the lack of quality reporting means that incidents, emerging trends, and latent risks go unidentified. More importantly, there is a lost opportunity for organisations to learn from adverse events, which in turn masks unsafe practices.

Conclusion

77. Mrs Waddell advised that the support service's failure to follow its Shift Handover policy and to complete an incident report to an adequate standard was a moderate to severe departure from the accepted standards of care. I agree and find that the support service breached Right 4(4)[15] of the Code.

Adequacy of information provision to whānau — adverse comment

78. After Ms B's disappearance, Ms A decided to take Ms B to their whānau home and became her caregiver. Ms A told HDC that she was not provided with enough information to manage Ms B's care and was not provided with copies of investigations relating to her wandering and assault allegations. In response to the provisional opinion, the support service stated that it disagrees that it failed to provide sufficient information on how to care for Ms B at home.

[15] Right 4(4) states: 'Every consumer had the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.'

79. Standard 3.3.2 of NZS states that '[e]ach stage of service provision (assessment, planning, provision, evaluation, review and exit) is developed with the consumer, and where appropriate their family/whānau of choice or other representatives as appropriate'.

80. Although Ms B did not have an active welfare guardianship, Ms A became Ms B's principal caregiver in Month6 2020. In addition, the support service told HDC that Ms A expressed interest in Ms B's wellbeing and took an active role in her care, and staff began to consult with Ms A in relation to Ms B's welfare from 2017 onwards. Ms B's support plan states that Ms B could not make major decisions but could express her preferences, and that her whānau would support her with all major decision-making.

81. Information provided by the support service indicates that Ms A was provided with Ms B's medication prescription chart, her support plan, and specialist and 'general care information', which the support service stated was 'pertinent to the delivery of daily care' to Ms B. In addition, the support service stated that staff provided ongoing daily on-site support and training on insulin and diabetes management, offered over-the-phone support, provided financial support, and offered access to respite services.

82. However, Ms A stated that the support service did not provide copies of previous medical records, including previous medication administration records, and she required this information so that she could check whether Ms B had received regular checks by her GP and support service staff, including whether her diabetic condition had been monitored regularly. In addition, Ms A requested copies of the incident investigations into the alleged assaults and Ms B's disappearance on Day 2 Month5 2024. In response to the provisional opinion, the support service acknowledged that there were difficulties in the transfer of investigation-related information to Ms A.

83. In a previous statement, the support service told HDC that it was cautious about releasing additional information (beyond that required for day-to-day care) without a clear basis for the release. The support service said that Ms B did not have the capacity to consent to disclosure of this information. A similar sentiment was expressed by the needs assessment service coordination agency to Whaikaha when it investigated Ms A's concerns. The support service told HDC that it planned to disclose this information once welfare guardianship had been confirmed, and that Ms A did not confirm whether this had occurred. I also note that the investigations relating to the assault allegations were sensitive in nature. In response to the provisional report, however, the support service stated that it was unaware of Ms A's request for all Ms B's medical records.

84. On balance, I note that as an interested party, Ms A would have benefitted from understanding what care had been provided to Ms B, particularly as Ms B moved to live with her permanently. I also note that while the investigations into the alleged assaults were sensitive in nature, they would not have revealed any new information that Ms B had not disclosed to her sister previously. Internal investigations undertaken by the support service showed that Ms A had been involved and was aware of the allegations. The support service's Privacy Policy and Guidelines stated that information could be disclosed to the principal caregiver of a service user who lacked capacity to consent if it was not contrary to the

express request of the service user or the best interests of the user. The support service did not indicate whether it consulted with its privacy officer, as required by its policy, whether Ms B refused disclosure of her health information, or why disclosure of such information would not have been in Ms B's best interests.

85. In addition to the above, it appears that inconsistent information was provided to Ms A as to whether she was eligible to receive copies of the investigations and incident reports. The meeting with support service staff and Ms A in Month5 2020, the email from Whaikaha dated 28 Month11, and a phone call with support service staff on 9 Month18 indicated that Ms A would be provided with a copy of the investigation findings. Conversely, in the Month12 meeting with support service staff and in emails from Whaikaha on 27 Month19, 6 Month20, and 27 Month20, Ms A was advised that this information could be provided only following the activation of welfare guardianship. As noted by Mrs Waddell, this was complicated further by the absence of detailed documentation about the communications between Ms A and the support service.

86. Mrs Waddell advised that there were gaps in the information provided to the whānau over the period of the investigation and the subsequent remedial actions taken. She said that while there were face-to-face meetings during the transition, there was no formal transfer of the information requested in a timely way. Mrs Waddell advised that this was a mild departure from the accepted standard of care. I accept this advice.

87. While there was a risk of breaching Ms B's privacy, I am concerned that Ms A was not provided with all the relevant information. Ms A was interested in Ms B's welfare and became her permanent caregiver in Month6 2020, the support service had been consulting with Ms A since 2017, Ms B had disclosed the assaults to Ms A, and there is no evidence to suggest that Ms B did not want this information to be provided to Ms A. I am also concerned that the support service provided inconsistent communication to Ms A as to whether she needed welfare guardianship to access such information.

Adequacy of documentation — adverse comment

88. I have noted two areas of concern relating to documentation of Ms B's care.

89. First, as noted above, there was a lack of detailed documentation regarding the communication provided to Ms A about incidents between 2017 and 2020. In addition, Ms A expressed concern about a lack of communication regarding Ms B's COVID-19 diagnosis in 2020 and the medical interventions undertaken as a result of the diagnosis.

90. The support service told HDC that it attempted to contact Ms A twice by phone, and at times it had been difficult to get in touch with her because her phone number changed. However, the support service acknowledged that there was no documentation of its attempts to contact Ms A.

91. Mrs Waddell advised that it would have been appropriate to follow up the missed calls with a text message, which would have ensured that the next of kin was notified in a timely way.

Mrs Waddell considered that not doing so was a mild departure from an accepted standard of care. I accept this advice.

92. Secondly, the medication administration charts did not document 'PM' or 'AM' next to the times recorded, nor did staff utilise the 24-hour clock during documentation, making it unclear when Ms B's PRN medications were administered on Day 1 Month5 2020.

93. Documentation, including details of communication with families and times of medication administration, is essential for accountability of decisions and continuity of care amongst providers. In addition, poor clinical notes hamper later inquiry — thereby compromising the opportunity to address issues raised by or on behalf of a consumer, as well as quality improvement measures that may flow from such inquiry.

Overdue needs assessment — educational comment

94. My advisor and the support service noted that Ms B's needs assessment dated 14 June 2016 was a year overdue for its routine three-yearly review. Mrs Waddell advised that this was a mild departure from the accepted standard of care.

95. Standard 3.8 of NZS states that '[c]onsumer service delivery plans are evaluated in a comprehensive and timely manner'.

96. Mrs Waddell advised that the risk associated with an overdue assessment was mitigated by the support service's regular evaluation, incident documentation, risk assessments, and medical reviews. She also advised that Ms B's general support needs appear not to have changed enough to trigger a specific earlier assessment. The support service did not provide an explanation as to whether it attempted to obtain a timelier assessment from the needs assessment service coordination agency.

97. In response to the provisional opinion, the support service stated that the needs re-assessment lay with the needs assessment service coordination agency, and the support service was not authorised to undertake the assessment. In addition, the support service stated that the Whaikaha Service Specification for NASC services was updated in 2019, which means that it is acceptable to complete a re-assessment every five years,[16] and so a re-assessment for Ms B would not have been due until 2021. Further, the support service referred to guidelines from Health NZ that state that 'there is no time limit on the validity of your needs assessment'. The support service said that while Ms B's needs were complex, they were well established and consistent, and she had not wandered off the property previously. I acknowledge the support service's response and accept that a re-assessment may not have been due until 2021, given the change in the specification of NASC services. However, I note that the support service's internal investigation found that Ms B's night-time sleep disturbances had not been re-assessed formally, indicating that this could have mitigated the risk of her wandering on Day 2 Month5 2020.

[16] This is also stated in the service specification document: https://www.whaikaha.govt.nz/assets/Contract-and-Service-Specification-documents/Needs-Assessment-and-Service-Co-ordination.pdf

98. Although there is no evidence of previous disappearance during the night, incident reports from Month2 to Month5 2020 show that Ms B was waking at night and becoming agitated. In addition, the support service's account to the Police indicates that Ms B had a habit of waking up around 3–5am.

99. Mrs Waddell advised that while the night-time disturbances did not appear to be getting more frequent, a closer analysis of those sleep disturbances may have resulted in staff obtaining a timelier needs re-assessment. I agree and consider that this would have been helpful, given that Ms B was not funded for night-time support, and staff were doing 'sleepover' shifts. I consider that the support service should have sought a timelier assessment to ensure that it met Standard 3.8 of NZS. While the support service is not responsible for this assessment, it does have responsibility to flag the need for a re-assessment with the needs assessment service coordination agency. However, I accept that the risk was mitigated somewhat, as stated by my advisor.

Changes made since events

100. The support service told HDC that following the incident on Day 2 Month5, it made the following changes:

- It met with staff to address its expectations around handover protocol.
- It ensured that all needs assessments for service users were up to date.
- It implemented regular six-monthly reviews for service users to identify sleep patterns and disturbances, to ensure that appropriate resources were in place.
- It provided staff with spot training regarding restraints and enablers.
- It reviewed all household security arrangements, including door locks, to ensure compliance with its policy.
- Alarms were placed on its facility doors, which are activated if anyone leaves the house.
- It updated its documentation for the use of environmental restraint.
- As part of its referral and admission process, it now places a particular emphasis on clarifying details relating to welfare guardianship, personal orders, and, if relevant, enduring powers of attorney. This information is added to its internal client management system, with an expiry date set to alert the relevant service delivery manager of any necessary review.
- All referrals are triaged and discussed at an internal triage panel. The panel includes regional and service delivery mangers, team leaders, and quality, service and clinical leads to determine suitability of residential placements. If any concerns are raised, the individual/family are consulted before placement.
- It increased staffing on each shift, including the night shift. Door alarms were purchased to assist with the monitoring of the people it supports.

- It introduced client management software, which has facilitated a centralised, on-line record-keeping system that is outcomes based and person-centred. This has allowed for maintenance of more accessible records of contact with family, including emails and phone calls. As part of a support worker's induction and orientation at the support service, education and training are provided on how to document communications with family.
- It established a care and protection team.
- It instituted a STOP and WATCH programme to help staff identify any potential issues that are emerging as early as possible.
- It instituted 'keeping safe feeling safe' education for clients, to empower them to make complaints.
- It implemented 'dynamic risk assessments' training for staff, which is intended to support staff in making ongoing risk assessments, rather than relying solely on periodic risk assessment reviews.
- It implemented a monitoring process relating to monthly reviews of risk assessment plans.
- It surveyed clients to better understand their experience of the complaints process, which has allowed it to tailor the complaints response process to better meet client needs.

Recommendations

101. I acknowledge the extensive changes made by the support service. In addition, I recommend that the support service:

a) Provide a written apology to Ms A for the breach of the Code found in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Provide further training to staff on the following topics:

   i. incident reporting;

   ii. roles and responsibilities of support workers;

   iii. documentation standards; and

   iv. reporting changes in behavioural patterns, including changes in sleep, using the STOP and WATCH tool.

   The support service is to provide evidence of the training to HDC in the form of training material and staff attendance records, within nine months of the date of this report.

Follow-up actions

102. A copy of this report with details identifying the parties removed, except the independent advisor on this case, will be sent to the Ministry of Social Development, Whaikaha|Ministry

of Disabled People, and the needs assessment service coordination agency and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Mrs Sandie Waddell, a disability consultant:

'I have been asked to provide clinical advice to HDC on case number 20HDC02248. I have read and agree to follow HDC's Guidelines for Independent Advisors. I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint. I am aware that my report should use simple and clear language and explain complex or technical medical terms.

I have a Post Graduate Diploma in Health Service Management and a Certificate in Quality Systems and Auditing Principles. I have worked in the Health and Disability sector for over 30 years and have held senior management roles in community organisations, the Ministry of Health and ACC. I was the CEO of the New Zealand Disability Support Provider Network and worked as a lead auditor of Health and Disability Services nationwide from 2021–2022. This included auditing the development and implementation of policies, procedures and guidelines for compliance with the New Zealand Health and Disability Services Standards NZS 8134:2008 (the Standards). As a part of the audit process, I was involved in reviewing organisational policies and procedures, service planning, assessment and delivery and the evaluation of effectiveness of outcomes for clients.

I have conducted assessments of business and community organisations' responsiveness to accessibility and the needs of people with impairment and provided advice on how this can be improved. I am currently a trustee on a Board of Trustees for a disability organisation that provides a range of support services to people with disability (tangata whaikaha) in my region.

Brief description of events
Following an event in [Month5], [Ms A] made a complaint to the HDC regarding a number of issues she was unhappy about concerning the care of her sister [Ms B].

These included a failure to inform her of [Ms B's] Covid-19 diagnosis, information not being provided following an investigation into the event when her sister absconded overnight from her home with [the support service] and the inadequacy of information concerning investigations, medical care, during the period [Ms B] was reported missing and other general information relating to her sister's care.

[The support service] provided a number of responses and documents relating to the issues raised. They also reported changes that were subsequently made to the service in response to those concerns. They also provided more context to the specific complaints, a copy of the internal investigations, relevant documentation and detail around their actions during and after the events.

[Ms B] was a 32-year-old woman who had been receiving residential support from [the service provider] from 2011–2020.

[Ms B's] primary diagnosis was Intellectual Disability including visual impairment due to [Ms B] losing her sight at the age of approximately fifteen because of poor diabetes management. She could only make out shadows and bright colours.

[Ms B] was diagnosed with Diabetes Mellitus Type1 and was insulin dependent. She was administered regular Humulin R injections in the morning and at lunch time, and her blood sugar levels (BSL) checked pre meals. [Ms B] was supported by staff with her insulin by dialling the pen to get the right dose for each injection. [Ms B] had PRN Novorapid for BSL. She was prone to hypoglycaemia. Staff referred to PRN Protocol for treating her hypoglycaemia and or hyperglycaemia.

[Ms B] could exhibit verbally aggressive behaviour such as yelling, swearing and demanding things when she was not able to see or talk to her family, or when she was not aware of what was happening or which staff were on duty. [Ms B] could also become verbally aggressive with unfamiliar staff, a noisy or busy environment, and when other flatmates made comments to upset her. [Ms B] enjoyed having visitors especially when her family visited.

Question 1: The accepted standard of reviewing and updating needs assessments (including the need for overnight care) and whether this occurred in [Ms B's] case.	
List any sources of information reviewed other than the documents provided by HDC:	NZS:8143:2008 Health and Disability Services Standards (Continuum of Service Delivery)
Advisor's opinion:	The last comprehensive needs assessment done by [the needs assessment service coordination agency] (the MoH contracted Needs Assessment Agency) prior to the incident, was completed on 14/06/2016. It was due for a three yearly review in 2019 but there was no evidence provided to confirm this happened. However, there was adequate documentation provided to show an updated risk assessment was recently completed, medical reviews that were done regularly and a detailed support plan was in place detailing the supports required by [Ms B]. In her initial needs assessment, there was no requirement for awake staff at night or additional restraints needed for her. It was detailed in her plan that staff needed to have "line of sight" oversight for her during her awake hours. This requirement had not been changed since that assessment.
What was the standard of care/accepted practice at	As per the required Health and Disability Services Standards 3.3–3.6 regular assessments, service

the time of events? Please refer to relevant standards/material.	planning and service delivery and 3.8 evaluations were generally undertaken regularly. The exception was a new assessment by [the needs assessment service coordination agency] which was one year overdue. Her general support needs did not appear to have changed enough to trigger a specific earlier assessment. This would have been expected to have been completed in 2019.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	I would see this as a mild departure as there was evidence to show that regular evaluation, incident documentation, risk assessments and medical reviews had been carried out by [the support service] internally and changes made where required.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I believe my colleagues in the sector would concur with this departure as mild.
Please outline any factors that may limit your assessment of the events.	My knowledge of wait times and availability of assessors at that time is limited and this may affect my assessment. However, there is no evidence a new assessment had been requested or followed up by [the needs assessment service coordination agency].
Recommendations for improvement that may help to prevent a similar occurrence in future.	1. Ensure [the needs assessment service coordination agency] have a system to flag when a review assessment is due. 2. Follow up is undertaken by [the support service] to ensure these are up to date for their residents. I note this was also recommended following the internal investigation by the organisation.
Question 2: Whether [Ms B's] needs assessment accurately identified her needs and the level of support she required at the time she went missing was sufficient.	
List any sources of information reviewed other than the documents provided by HDC:	NZS:8143:2008 Health and Disability Services Standards (Continuum of Service Delivery)

Advisor's opinion:	Having reviewed the information provided, including all events recorded, it is my opinion that while [Ms B] had complex needs and behaviours, these were being generally managed well by staff according to her identified needs and the strategies implemented to manage these. Staff had developed relevant de-escalation techniques to assist [Ms B] to participate in life in her community and at her residence. She was assessed as needing closer supervision while out in the community but she had developed skills to manage in her home with line of sight supervision, including being able to go to the letterbox and get the mail independently. The organisation was not funded for 1:1 support for her or for awake staff overnight. There was evidence she had periods of being unsettled during the night but the overnight staff appear to have managed these in line with the responses required — that of settling her down and administering PRNs as required. Staff have documented these incidents as they have occurred, with their actions noted. She had never previously attempted to leave the premises or abscond at night. The overnight staff regularly reported they would need to assist her to settle. It is this area where it could be argued that a closer analysis of those sleep disturbances may have resulted in a reassessment being requested, however from the incidents recorded they did not appear to be getting more frequent. Her medical needs, including her diabetes management, were regularly reviewed with insulin monitored and PRNs administered as and when required, especially when she was having unsettled sleep episodes. Changes were made in her medication needs as required. Documentation was regular and there had been no evidence of any significant changes in her support needs from her 2016 assessment.
What was the standard of care/accepted practice at the time of events? Please	I am of the view that the needs assessment had sufficient detail to reflect her needs and levels of support required at the time she went missing.

refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was therefore no departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I believe the opinions above would be supported by my peers and my colleagues in the health and disability sector.
Please outline any factors that may limit your assessment of the events.	Nil
Recommendations for improvement that may help to prevent a similar occurrence in future.	Nil
Question 3: Whether risk management strategies and safeguards were appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	NZS:8143:2008 Health and Disability Services Standards (Quality and Risk Management Systems)
Advisor's opinion:	[Ms B] had a comprehensive risk management plan in place with modifications that showed regular review and updating annually from 2016–2019. These included identified risks, with actions to mitigate and manage, detailed around her safety, mobility, medical concerns, sexuality and behaviours. She had a risk identified labelled "*wander, abscond I can wander off the property when left unsupervised. I also try to abscond or runaway when I become upset and wants to go home. Staff to keep me in line of sight at all times*

	and talk to me nicely when I am upset to come back inside." It was labelled a moderate risk which would indicate this has not been something which has been identified as a high risk and was able to be managed by the staff on duty. There was no indication and/or documentation that [Ms B] was at risk at any time previously during the overnight periods. A previous resident had required a bolt at the top of the outside door which had not been removed once the client left the service. This was left open on the night of the event, but it is reported that staff and residents all knew how to unbolt the door if required as the house was not one where current residents needed to be locked in, rather it was used as an additional security measure. There had been no previous indication additional overnight security would be required for [Ms B's] safety. Whether this would have been enough to stop [Ms B] leaving on the night of the event is not clear.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	My opinion here is that the comprehensive risk assessment was appropriate for [Ms B] with the resulting safeguards in place at the time. Given there were no previous incidents of her leaving the premises at night and her support needs assessment required only sleepover staff.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was therefore no departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Given the evidence provided, I am confident my peers would confirm this opinion.

Please outline any factors that may limit your assessment of the events.	Nil
Recommendations for improvement that may help to prevent a similar occurrence in future.	I note the organisation has now required that all environmental restraints are now to be reviewed and kept current as needed.
Question 4: Whether the care (including checks) provided to [Ms B] on the night and morning she went missing was reasonable; and if not what further action you would have expected.	
List any sources of information reviewed other than the documents provided by HDC:	NZS:8143:2008 Health and Disability Services Standards (Continuum of Service Delivery)
Advisor's opinion:	From the reviewed documentation, it does indicate there were some issues with the care provided to [Ms B] on the night she went missing. The notes written by the overnight staff have some discrepancies with the internal investigation notes. The support worker, in her notes, details that [Ms B] was heard in the garage at around midnight. She was found to be in an agitated state, given a PRN and taken back to her room. It is not clear from the notes whether she was sighted asleep or only in her room again. The particular PRN given was also not recorded. The internal report into the incident states she was sighted asleep on the lounge couch at 8pm then following the disturbance in the garage, the investigation reports she was sighted asleep which is at odds with the incident report. As noted in the investigation, in my view the reporting was not to an acceptable standard and lacked relevant details from the overnight staff. The job description and procedural documents require staff to *"find out where and how people are and sight them"* at changeover of shifts. This did not occur at the changeover of shifts, by either shift, when the morning shift arrived. Subsequently her absence was not noted until a couple of hours later. This delay may

	have resulted in a different outcome, depending on the time she left the premises.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The lack of detail and variations in event notes and the investigation, as well as the failure to sight [Ms B] at the shift handover are not of an acceptable standard as required in the delivery of services in line with the Health and Disability Sector Standards in place at the time.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This departure would, in my view, be seen as a moderate to severe departure from an accepted standard of care.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I am of the view that my peers would also see this departure in a similar light.
Please outline any factors that may limit your assessment of the events.	Nil
Recommendations for improvement that may help to prevent a similar occurrence in future.	Some of the recommendations made in the internal investigations for this question reflect the recommendations I would have made to prevent a similar occurrence in the future. Specifically: 1. Training around improved incident report writing. 2. Sleep pattern reporting and analysis when indicated following incidences of disturbed sleep as needed. 3. A review of security arrangements in place at residences be implemented on a planned and regular basis. 4. Refresher courses on responsibilities and requirements for roles for all staff, including shift changes.

Question 5: Whether the actions taken after [Ms B] was identified as missing were reasonable; and if not what further action you would have expected.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	According to the policy in place at the time of the incident, all the required actions were undertaken in a timely way. [Ms A] did include in her complaint that staff were unaware that [Ms B] was missing when she first called and this is addressed in the previous question. Once she was discovered to be missing, staff did contact her.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The Missing Persons policy reviewed, was appropriate for this type of organisation and responsibilities clearly defined.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was no departure from accepted practice in this area.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The policy and subsequent actions would be viewed as acceptable and appropriate.
Please outline any factors that may limit your assessment of the events.	Nil
Recommendations for improvement that may help to prevent a similar occurrence in future.	Nil

Question 6: Whether communications with [Ms B's] next of kin regarding the COVID test result, and the missing person notification, were appropriate and timely.	
List any sources of information reviewed other than the documents provided by HDC:	Information reviewed as per *Branch process when notified of positive COVID-19 test.*
Advisor's opinion:	[Ms B] returned a positive test for Covid in [Month2] 2020. The staff who were living on site during the lockdowns reported she was asymptomatic and appropriate precautions were taken re PPE for staff, isolation and other members of the household informed. It is reported, though not recorded but witnessed by staff, that they tried on two occasions to contact [Ms B's] sister [Ms A] on her mobile phone but were not able to contact her. This had also been an issue at other times with contact not always easy as she had previously changed her phone number. Although [Ms A] would have had missed calls recorded, unfortunately they did not leave a message or send a text which would have been more likely to have ensured that the next of kin were notified in a timely way. In this instance that would, in my view, have been a more appropriate response given the difficulties with the initial calls and avoided the family finding out much later that they hadn't been informed. The contact following the missing person event appears also to have been delayed as, according to the complainant, the police were already out looking for her sister.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Communication with whānau is an important factor in the services provided to residents. Given the uniqueness of the Covid-19 period there was no "standard" to be followed but the expectation would be families would be informed of any health issue in a timely way.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This departure would be seen as mild given the fact [Ms B] was asymptomatic and not unwell. In addition, the country was in a lockdown situation … However, this would have expected to have been followed up sooner than the fact that the information was only made available sometime later during the missing person event. The complainant was obviously surprised to learn of the Covid test some 3 months later. The delay with informing the complainant of the missing person is only a mild departure as it appears from the complaint that this delay was around an hour.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I am of the view that my peers would also see this departure as mild.
Please outline any factors that may limit your assessment of the events.	No specific times were documented for the calls made to [Ms A], however she did state it was an hour after her first call.
Recommendations for improvement that may help to prevent a similar occurrence in future.	1. If issues occur with communication to family members it would be recommended to leave a voicemail and/or a text if appropriate. 2. A discussion with the family member on the best way to communicate would be indicated if concerns had been raised. This has apparently now been implemented across the organisation and an apology made.
Question 7: Whether the changes made to [Ms B's] care for her return to the community house were appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	NZS:8143:2008 Health and Disability Services Standards (Restraint minimisation standards)
Advisor's opinion:	A team meeting was held on 23 [Month5] 2020 to look at what needed to occur following [Ms B's]

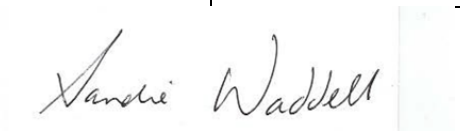
	discharge from hospital following the event of [Day 2] [Month5] 2020. Agreed at that meeting was: 1. To install restraints/alarms on the main door 2. To monitor her behaviour closely especially on outings 3. To have a belated birthday celebration 4. Make contact with her sister on a weekly basis 5. Monitor her food and fluid intakes. Staffing was increased on each shift including a wake over on the night shift to ensure the increased monitoring and supervision was able to occur. [Ms A] returned with [Ms B] to the house following her discharge and apparently she had arranged to meet the manager there. There was no record of this arrangement. She also said she had had a discussion with the manager who had assured her that door alarms were to be installed. When these were not present on her arrival, she took [Ms B] home with her. Staff reported they were unaware of any meeting scheduled and also they were unaware [Ms A] was unhappy when she was onsite. It appears the manager has now left the organisation and none of these details are able to be confirmed and the organisation was unaware of these issues until a meeting held around 6 months later. The immediate changes agreed along with increased staffing were, in my view, appropriate and would have increased the security and monitoring for [Ms B]. However, as [Ms A] took her sister home from the facility there is no further update on whether these would have been sufficient. As there is a process to be followed to install relevant alarms and restraints it is unlikely these would have already been in place given the short timeframe for

	her discharge, being only notified that morning and the meeting having only just taken place. My view is the actions agreed were appropriate, but what actually took place in the time from the discharge to the residence and then when [Ms B] left with [Ms A] was not clear from the documentation provided.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The changes that were to be made at the facility and the interim addition of awake staff made would be an appropriate response to ensure [Ms B's] safety.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	In my opinion, there was no departure from accepted practice in those agreed actions.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would, in my opinion, agree with the proposed and interim changes as being sufficient at the time.
Please outline any factors that may limit your assessment of the events.	Given the lack of documentation with much of the discussion not able to be verified for either party, it is not possible to make a further comment or assessment. Unfortunately the manager was unable to confirm what arrangement/meetings had occurred or been arranged as she no longer works for the organisation.
Recommendations for improvement that may help to prevent a similar occurrence in future.	1. Review overnight security at all the community facilities to ensure residents are not able to wander outside at night. 2. Update training for all staff in documentation to ensure it is detailed and provides adequate information to assist in identifying any changes in need and to ensure the safety of all residents.

Question 8: Whether [Ms B's] transition to living with whānau, including assessment, communication and information sharing with her next of kin was timely and appropriate.	
List any sources of information reviewed other than the documents provided by HDC:	N/A
Advisor's opinion:	In relation to the transition for [Ms B] back to her whānau, the exit process from the service was implemented as per the organisational policy. [The support service] funded all moving expenses, set up a weekly payment during the transition and contacted [the needs assessment service coordination agency] re an updated assessment to take into account her new situation. They also provided staff daily to provide [Ms B's] medication oversight until [Ms A] was trained by the GP. They facilitated meetings with a GP and the bank and offered respite should it be needed. There were issues with disclosure of all information requested by [Ms A] that she raised at a meeting in [Month12]. Due to the fact that welfare guardianship was yet to be set up, the decision was made to give all immediate information required to provide care and that once guardianship was confirmed, all other information would be forwarded. This included all the police investigation information as well as event documentation. The organisation acknowledge they did not provide timely information in a number of areas, including updates following their internal investigation and information following incidents that are reviewed by a manager. In my opinion there were gaps in the information provided to the whānau over the period of the investigation and the subsequent remedial actions. While there were face to face meetings during the transition, there was no formal transfer of the information requested in a timely way. It was

	obviously a difficult time for [Ms A] and this was exacerbated by the time delays in the provision of the information.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The communication issues were obviously challenging for [Ms A] and would be less than acceptable at the time of the event. There are always issues with privacy and disclosure of information, but given [Ms B] was now resident with [Ms A], it would have been acceptable to provide information requested, especially the information following the disappearance.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This would be a mild departure. The transition was managed according to required policy procedures and additional support was also provided. Essential information was shared, however issues around legal guardianship presented some concerns around privacy and conflicting reports about what was provided.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I believe colleagues would also view this as a mild departure from accepted practice.
Please outline any factors that may limit your assessment of the events.	Lack of detailed documentation about the communications between the parties surrounding the events and subsequent recollections from those involved impacts assessments here.
Recommendations for improvement that may help to prevent a similar occurrence in future.	That documentation is completed for **all** interactions with whānau, especially following significant events and where formal investigations are undertaken.
Question 9: Adequacy of the policies and training in place at [the support service] at the time of the events.	
List any sources of information reviewed other than the documents provided by HDC:	NZS:8143:2008 Health and Disability Services Standards (Organisational Management)

Advisor's opinion:	Following review of all the relevant policy documents provided, the organisation has comprehensive policies in place as per the requirements under the Standards. The adverse event procedure was not provided, but it would seem that staff training needs to be on a more regular basis to ensure adequate and thorough documentation is completed in the case of events such as [Ms B's] disappearance, by staff on duty at the time. As discussed in a previous response this was inadequate. The policy documents provided are adequate to guide staff in the houses as to responses required for this set of events. All staff had relevant qualifications in the area of service provision they were engaged in. The individual training plans were not provided but in order to obtain certification these must be in place and are checked during the audit process.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The policies provided were of a standard that would be accepted in the sector. The training programme was not available for review.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	There was no departure from an acceptable standard of practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	N/A
Please outline any factors that may limit your assessment of the events.	The lack of relevant training records limited my view on the adequacy of their training programme but it is referred to in a number of the communications from

	the organisation. These reflect an on-going commitment to training and ensuring refreshers are a part of staff meeting processes.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Information provided by the CEO on the new policies and training being implemented following the event are encouraging. The management of incidents and complaints now being overseen at a national level will strengthen the process and reflects a commitment from the organisation to learn and develop further.
Question 10: Any other matters in this case that you consider warrant comment.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	There are no outstanding issues that I think need further comment as the advice in the previous responses is comprehensive and addresses the issues raised.
Signature:  Date of Advice: 5 October 2024'	