Care provided to disabled boy in foster care
16HDC00597, 12 October 2018

Disability service provider ~ Foster parents ~ Medication administration ~ Appropriate care ~Monitoring ~ Rights 4(1), 4(2), 6(1)

This case relates to a boy who has a number of complex medical conditions, including epilepsy, generalised brain dysfunction, cerebral palsy, and limited mobility, and who is fully dependent for day-to-day care needs. When the boy was approximately 18 months old, he was placed in the care of the disability service. Foster parents were contracted by the disability service to care for the boy, initially on a temporary basis, and then as full-time foster parents. When the boy was in his early teens, his parents raised concerns with the disability service about the care being provided to the boy by the foster parents. As a result of these concerns, the boy was uplifted from their care.

HDC's investigation considered the care provided to the boy by the foster parents over a period of three years, specifically in relation to medication management, provision of suitable food, methods of transferring the boy, and personal cares and hygiene. The investigation also considered the oversight provided by the disability service and its staff over the care provided to the boy by the foster parents over the three-year period, and the disability service's investigation into the complaint laid by the parents.

Medication management

The boy's parents stated that on four occasions medication was found down the side of the boy's wheelchair or in his clothing, raising concern that the boy had not received that medication on those occasions. After the boy was uplifted from the foster parents, multiple blister packs of medication were found in his belongings, and the boy's parents were concerned that the boy had not received medication on a number of occasions. They also noted their concern that seven occasions of medication administration had been documented for the three days after the boy had left the foster parents' care.

The boy's parents were concerned that the food provided to the boy by the foster parents was not appropriate to his needs. They were also concerned that the boy's hoist and standing frame were not utilised by the foster parents for his safety. They stated that when the hoist was collected around a month after the boy was uplifted, it was missing its plug, and it had a flat battery.

The boy's parents told HDC that on a number of occasions the boy arrived at school unwell and not properly cleaned. Concerns in relation to the placement of his equipment, the overuse of talcum powder, and that the boy had been unwell with a runny nose or coughs on arrival at school, were documented in the school's communication book, which was sent home with the boy to the foster parents on a daily basis. The school had also verbally notified the Ministry for Children of some concerns.

The disability service was required to undertake monthly caregiver home visits. Over a period of two years, only 15 home visits were carried out in total. The disability service was also required to engage with educational establishments. There is no documentation demonstrating contact between the school and the disability service staff.

The Needs Assessment and Service Co-ordination (NASC) service asked the disability service to investigate concerns raised by the parents and to advise of the outcome. An investigation was undertaken and a report was prepared.

The report documented that there was a review of the boy's file and case notes, the caregiver home visit forms, the foster parents' files and case notes, the boy's medication file, the "running record" of concerns and seizure recordings from the school, the notification to the Ministry for Children, and the incident reports. No record is made of the timeframe of the information and documentation that was reviewed. The finalised report was four pages long, and listed seven recommendations, two of which related to the other service user in the care of the foster parents.

A summary report was also prepared. That report was one page long and included a selection of findings from the investigation report, but did not state the methodology used, and included only two recommendations — that the disability service meet with the boy's parents to discuss the findings, and meet with the boy's school to agree on how to raise concerns in the future. The two recommendations in the summary report were not in the finalised four-page report. The summary report was reviewed by senior management. The summary report was provided to the NASC and the boy's parents, but the recommendation to meet with them had been removed.

Findings

It was found that on four occasions the boy did not swallow his medication, as the pills were located in his wheelchair by other individuals and were not re-administered. It was held that the foster parents were responsible for administering the boy's medication on a daily basis, and must take a degree of responsibility for the pills found in his wheelchair.

It was also apparent from the medication audit that the foster parents did not maintain the boy's medication folder in line with the Medication Policy and, accordingly, did not maintain his medication folder to an appropriate standard. Criticism was made in relation to the level of care the foster parents provided in relation to the boy's medication administration.

In relation to the signing of the medication administration sheets for the incorrect dates, it was accepted that the medication was signed for in error, and there is no evidence to establish that the foster mother intentionally signed for dates where medication was not provided in order to mislead.

Criticism was made that the foster mother provided foods to the boy that were clearly at odds with the assessments that outlined the foods suitable for the boy.

It was noted that the disability service accepted that its oversight of the care provided to the boy by the foster parents fell short of the expected standard. The disability service had a responsibility to ensure that its staff were trained and therefore well equipped to carry out their duties to an appropriate standard, and that staff complied with all relevant requirements and policies to ensure that the service provided services of an appropriate standard. The disability service failed to provide appropriate oversight and support of the care provided by the foster parents for a prolonged period of time in a number of areas, and also failed to engage with the boy's school.

It was noted that the boy is a highly vulnerable individual who requires a significant amount of support, and has extensive daily care needs. He is non-verbal and is unable to express concerns about the care he receives. It was vital that the disability service provide

appropriate oversight and support to the boy's foster parents and caregivers to ensure that appropriate care was being provided. It was found that the service failed to do so, and, accordingly, did not provide services with reasonable care and skill, in breach of Right 4(1).

Complaint management
It was found that the management of the boy's parents' complaint did not comply with the disability service's complaints policy. The involvement of several senior management level staff in establishing a report that was not compliant with the complaints policy was reflective of a culture of non-compliance within the senior leadership team that allowed such behaviour and non-compliance with the policies to occur. It was found that the disability service breached Right 4(2) in not complying with its own standards when dealing with the complaint from the parents.

Disclosure
It is clear that there were issues with the care provided to the boy by the disability service, and these issues were identified during the investigation and the subsequent medication audit. These concerns were not conveyed to the boy's parents on the boy's behalf as his legal guardians. Accordingly, the disability service failed to provide the boy with information that a reasonable consumer would expect to receive, and breached Right 6(1).

Criticism was made about the level of oversight carried out over the care provided to the boy by the foster parents. Criticism was also made that the disability service did not discern that monthly home visits were not occurring, and that tools available to assist in providing oversight of the manager's role and performance of the service were not used.

While noting the shortfalls in the investigation report and the disclosure to the boy's parents of the findings of the investigation and the medication audit, it was also acknowledged that the report had been sent to managers at the disability service for their review and input, and it was understood that they had approved the summary report for distribution. Criticism was made that only the summary report was provided to the boy's parents rather than the full investigation report, as it was apparent that the summary report did not include all the information that was relevant to the care the boy had been receiving from the foster parents and the disability service.

The disability service was referred to the Director of Proceedings, who decided not to issue proceedings.