HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Report by the Deputy Health and Disability Commissioner

(Case 23HDC00508)

Contents

Introduction

1. This report is the opinion of Ms 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 A by a disability services provider (Provider 1) and Ms A's residential transition to another disability services provider (Provider 2). During the investigation, concerns were raised about the adequacy of provider support through the transition by the local Needs Assessment and Coordination Service (NASC) provider. These concerns have been incorporated into the report.

3. The following issue was identified for investigation:

- *Whether [Provider 1] provided [Ms A] with an appropriate standard of care from January 2020 until 31 January 2023.*

4. The parties directly involved in the investigation were:

Ms B	Complainant
Ms C	Complainant
Disability services Provider 1	

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.

5. Further information was received from:

Disability services Provider 2	
Ms D	Interim Manager at Provider 1
Mr E	Lawyer representing Provider 1
Whaikaha|Ministry of Disabled People	Disability services funder

Information gathered during investigation

Introduction

Ms A

6. Ms A is aged in her fifties and has a history of developmental issues and severe intellectual disability. She is non-verbal but can express particular emotions such as happiness, frustration, and curiosity. Ms A resided at the Provider 1 whare[1] for approximately 25 years before transitioning/moving to Provider 2 on 31 January 2023.

Disability services Provider 2

7. Provider 2 is a kaupapa Māori residential disability service. Currently, it cares for three whānau.[2]

Disability services Provider 1

8. Provider 1 is a kaupapa Māori charitable trust. At the time of the complaint, Provider 1 was looking to end its journey as a residential care provider because of funding and logistics reasons. Mr E, the lawyer representing Provider 1, stated that Provider 1 had cared for Ms A since 1998, and Provider 1 had never held any formal guardianship or other court order for Ms A. Mr E said that Provider 1 had always sought the authority and advice of Ms A's eldest brother when making decisions regarding Ms A's care, until Ms B returned to New Zealand in 2021 and became her welfare guardian in 2023.

Complaints

Initial complaint

9. On 28 February 2023 HDC received a complaint from Ms C (on behalf of Provider 2) about the care provided to Ms A by Provider 1.

10. Ms C stated that in April 2022 Provider 2 was approached by Provider 1 enquiring whether Provider 2 would be able to take on the care of three whānau members who needed 24/7 residential care. Provider 2 agreed to the request. On 13 July 2022, Ms C met with the manager[3] of Provider 1, to express disappointment at the lack of progression and urgency regarding Ms A's transition and the subsequent gathering of information.

11. Ms B requested that Ms A be transitioned from Provider 1 to Provider 2 earlier than the other residents, and the move was actioned on 31 January 2023. According to Ms C, Ms A arrived at Provider 2 without any paperwork regarding her medical history, daily notes,

[1] Care home.
[2] Residents/consumers.
[3] Manager at the time of the transition.

doctor's information, specialist appointments, assessments, bank information, dietary requirements, and medical and allergy protocols. Ms C submitted email communications to HDC showing that she had requested the missing paperwork from Provider 1 on multiple occasions,[4] to no avail. The emails included responses from the manager at the time indicating that the information requested would be supplied. Ms C's requests included 'Current files/assessments' and 'Current medications, dates of annual reviews, medication reviews, OT[5] reviews, NASC reviews' for each whānau member. Ms C stated that because of the overall lack of documentation, they struggled with Ms A's transition to their whare, as they lacked knowledge about her history and behaviour.

12. Ms C said that Provider 2 did, however, 'receive expired medication and tins of unopened meal supplements which was of concern'. When Provider 2 requested the daily progress notes for Ms A, 'they were advised that this belonged to [Provider 1] and wasn't [Ms A's] property [and therefore] would not be handed over'.

13. Ms C also said that on the day of the move Ms A arrived with her sleeves tied, effectively to prevent her from using her hands, which made Ms C question Provider 1's restraint practices. Ms C provided HDC with two photos of Ms A. The first shows that Ms A's sleeves were tied,[6] and the second shows Ms A's hands covered with socks.[7]

14. Ms C told HDC that Ms A had only ever been examined by her GP in Provider 1's van, which she found to be inappropriate.

Second complaint

15. On 25 May 2023 HDC received a complaint from Ms B about the care provided to her sister, Ms A. In her complaint, Ms B stated that she transitioned her sister, Ms A, to Provider 2 earlier 'due to [her] concerns around the lack of care and support [Ms A] had received whilst at [Provider 1]'.

16. Ms B also raised concerns about a written complaint she made to Provider 1 in 2020. Allegedly, Provider 1 never provided Ms B with a formal acknowledgement or response to the complaint.

17. Ms B said that she supports Ms C's concerns that Ms A was restrained by tying together the ends of her clothing and covering her hands with socks. Ms B stated:

> 'I did question staff why this had been done and they said it was to keep her hands warm. On other occasions I have seen [Ms A's] hands restrained with socks and bound secure with sellotape. These types of restraint were constantly enforced on [Ms A] to stop her from pu[tt]ing her hands in her mouth.'

18. Ms B also raised concerns about how Provider 1 handled Ms A's funds. Ms B said that she did not receive any information about Ms A's financial position until she became the welfare

[4] On 7 August 2022, 14 November 2022, and 6 December 2022.
[5] Occupational therapy.
[6] This photo is dated 31 January 2023.
[7] This photo is undated.

guardian. Ms B queried withdrawals from the funds and asked who had the actual authority to withdraw funds. In particular, she noted that during 2021 and 2022, Provider 1 withdrew $8,000 but was not willing to account for the money spent.

19. Ms B said that she was also concerned about Ms A's incontinence care. She stated:

> 'Most times I went to visit my sister she was soaking wet, and you could smell the urine and her [continence product] was visibly full. The [continence products] she had were ill fitting and appeared to be products you could purchase from a supermarket. The urine would also be soaked through to her clothing and often [Ms A's continence products] and clothing wasn't changed until I would ask the workers to change my sister. [Ms A] would often have had a bowel motion which had been left in her [continence product] again not being changed until I would ask that she be changed.'

20. Ms B also raised concerns that the staff did not manage another resident's sexualised behaviour appropriately. She stated:

> 'On more than one occasion there was inappropriate sexualized behaviour by another resident whilst [Ms A] and I were in the same area. The behaviour of the other resident would be exposing himself and self-soothing. Staff would be in the same area when this occurred but didn't feel the need to remove him from the common area where [Ms A] and I were. I observed that [Ms A] would sense something was not right when he was behaving in this manner and would protect herself by pushing him away from her or pulling his hair. I questioned staff why this behaviour would be allowed to occur in front of myself and in front of [Ms A]. The staff advised that this behaviour was usual, and they allowed the resident to behave this way in open common areas.'

21. Ms B did not specify any dates on which the above incidents regarding incontinence care and the management of the resident's behaviour occurred.

Responses

Concerns about transition

22. In response to the complaints about the transition, Ms D, Interim Manager[8] at Provider 1, stated that this is the first time that a matter of this nature has come to the attention of the office of the Health & Disability Commissioner, and she is disappointed about the nature of the complaint. Ms D stated:

> '[Provider 1] wishes to highlight that the placement at [Provider 2] was initiated by [Provider 1]. With that in mind, [Provider 1] has made significant efforts to facilitate and cooperate with the placement process and would not want to jeopardise nor self-sabotage any of that process.'

[8] At the time of the complaints.

23. Mr E stated:

> '[Provider 1] had not previously undergone a transition. This was therefore a new process which, with the benefit of hindsight, may have resulted in the miscommunication and other challenges that occurred during [Ms A's] transition.'

24. In response to HDC's questions about Whaikaha's knowledge of, and involvement with, the transition between Provider 2 and Provider 1, Whaikaha stated that it was aware of, and involved in, planning for the move of three whānau/whaiora[9] from Provider 1 to Provider 2. Communications involved both providers, the local NASC provider, and Whaikaha. Provider 2 required several changes and renovations to its property prior to the three whānau/whaiora moving into its whare. Whaikaha said that during the transition, Ms C raised concerns about limited documentation, including medical records, and that this lack of documentation contributed to a difficult transition for Ms A into the whare. Whaikaha acknowledged that '[Ms C] and her team worked hard throughout the transition of [Ms A] into their service and that they did not feel well informed prior to the move'.

25. Ms D noted that during the various forms of engagement, there had been information sharing/updates with both Provider 2 and Ms B around medical issues, behaviour/ habits, risk factors, nutrition, dietary/food intake, medications, daily routines, likes/dislikes, activities, COVID vaccinations, whakapapa,[10] welfare guardian status, history, whānau, job descriptions/contact details for kaimahi, [11] menu details, staff rosters and NASC assessments. Ms D did not specify exactly how this information was shared except through an example stated below, and no evidence was provided to HDC to show that this information was given to Provider 2.

26. Ms D stated that when Provider 2's kaimahi visited Ms A and the Provider 1 whare prior to the transfer, they were privy to daily progress notes, the lifestyle plan, and the 'folder' for Ms A. The folder held key information about Ms A, including her care plan, risk management plan, GP consultations, her profile, whānau information,[12] WINZ[13] information, hospital discharge summaries, and other documentation.

27. In response to my provisional opinion, Ms C clarified that visits to the whare occurred on only two occasions, and the second visit was to gauge interest from kaimahi, if they wanted to work for Provider 2.

28. Ms D said that on 18 January 2023 Provider 1 received an unexpected email from Provider 2 advising Provider 1 of Provider 2's plan to begin a transition of Ms A starting on 28 January 2023. On that date, Ms B also requested that Provider 1 hand over whānau photos, Ms A's medications and incontinence products, and everything belonging to Ms A, before Ms A's transition or on the day of the move. Ms B also asked that henceforth all information

[9] Residents.
[10] Genealogy.
[11] Provider 1 staff members supporting Ms A and the two other whaiora.
[12] Details of next of kin.
[13] Work and Income New Zealand.

and communications regarding Ms A and the transition should go through her. Ms D stated that normally, expired medications are given back to the local pharmacy, but because Ms B asked that everything belonging to Ms A be handed over, all medications (including expired medications) were handed over.

29. Ms D acknowledged that communication is imperative when working through a transition and exit process and was adamant that this is a two-way process. She believes there were some growth opportunities for both organisations, as it seemed evident that the 'expectations around transitioning were different from each of the organisations including the actions and follow up'. Ms D acknowledged that 'there were times [when] the transition process was met with delays and pauses which [were] not deliberate/intentional, but the delays were sometimes prompted by [Provider 2]'.

30. Ms D noted that once a transition date had been identified by Provider 2, everything moved very quickly, and the levels of urgency given to the timing around the placement were such that kaimahi were informed of the actual transition date prior to Provider 1. The final stages of the process happened so quickly that Provider 1 did not have the opportunity to assist with hands-on integration into Provider 2 following the move.

31. Ms D stated that Provider 1 sought input from the local NASC provider team, but minimal guidance and support was given around the transition process. She recalled a conversation held with the local NASC provider, Ms F, on 20 December 2022 advising Provider 1 not to 'releas[e] any information to [Provider 2] about [Ms A] or the other whānau until a transfer document [had been] provided'. Allegedly, Ms F said: 'We don't have to, nor are we obligated to provide any information about the clients to [Ms C] until then.' In response to the provisional opinion, the local NASC provider said that Ms F does not recall this conversation and noted that she was working to constructively navigate what was a difficult process, and no information was withheld from Ms C.

32. The local NASC provider stated that it was made aware of the impending closure of Provider 1 on 28 April 2022, via Whaikaha's portfolio manager. The provider said that partway into the transition in July 2022, Ms C raised concerns with Whaikaha about what she perceived to be a lack of information and a transition plan, and Whaikaha in turn notified the provider. The provider said that it supported both Ms C and Whaikaha with information during the transition process. In contrast with Ms D's recollection (referred to above), the provider also confirmed that no specific transfer document is required regarding the movements of clients between providers.

33. Whaikaha stated that its understanding is that Provider 2 was in receipt of available medical records and relevant documentation for Ms A at the time of her move from Provider 1. Whaikaha stated that in the weeks following the move, Provider 1 assured Whaikaha that it did not hold further documentation.

Concerns about hand restraints

34. In response to allegations about inappropriate restraints, Ms D stated:

> 'Hearing about an allegation of sleeves having been tied is certainly not a practice that is endorsed by [Provider 1] … [Ms A] has had a longstanding issue with sucking, licking, gnawing, hitting her mouth, and pushing her fist down her mouth to the extent where she would gag and sometimes choke. Skin integrity has often been compromised … [Ms A] also has very little insight and has historically been known to eat leaves, gloves, hair clips, debris on the ground.'

35. Ms D said that 'whilst attending GP visits for other medical matters regarding [Ms A], [Provider 1] sought advice about [Ms A] and this behaviour'. Ms D stated:

> 'From recollection, the GP explained that [Ms A] needed to keep her hands dry. [Provider 1] asked for resources/suggestions about anything that can be used to prevent this behaviour. The GP reiterated to just keep the hands dry.
>
> …
>
> [Ms A's] sister [Ms B] enquired about [Ms A's] behaviour with her hands and her mouth by asking (something along the lines of) "How come her hands aren't covered". Our staff recollects that an explanation was given that [Ms A's] hands could not be covered as [Ms A] may eat anything covering her hands. Despite the explanation, [Ms A's] sister is recalled by staff as having said something along the lines of "I don't care — just cover her hands".'[14]

36. The GP practice stated:

> 'Based on patient notes 13 [February] 2023, Carers enquired about what to do regarding patient putting her hands in her mouth. The GP (who is no longer here) noted "soft, wet skin, mostly inside the left hand, with no signs of infection." However, there is no further documentation on the advice given. Sorbolene moisturizer cream was also prescribed on this day, though the reason for this prescription is not noted.'

37. In response to my provisional opinion, Ms C stated that she and Ms B were present at Ms A's visit to the GP on 13 February 2023.

38. Ms D concluded:

> 'While not the most ideal of options, any efforts to use socks have been out of a concern for the safety for [Ms A] in a manner that best respects freedom to maneuv[er] and manipulate her movements as she pleased whilst minimising risk to her around hand hygiene, skin integrity, and swallowing any bandages.'

[14] Ms B was given an opportunity to comment on both statements by Provider 1 but chose not to.

39. Mr E reiterated that '[Disability services provider 1] has never endorsed the practice of covering [Ms A] (or any person)'s hands.' He said that when Ms B returned to New Zealand, she began to visit Ms A. Mr E stated:

> 'Initially, she engaged positively with [Disability services provider 1's] care for [Ms A], however in due course, began questioning all aspects of the care provided, including why [Ms A's] hands were weak and fragile, and how this could be avoided.
>
> …
>
> Over time, [Ms B] encouraged and prompted staff to keep [Ms A's] hands dry by whatever means. For this reason, [Ms A's] hands were covered only when [Ms B] was present, at her request. [Ms B] did not take issue with this practice until the transition process was complete, and it was highlighted as a form of restraint in the complaint of [Ms C].'

40. Ms B did not confirm to HDC whether she requested her sister's hands be covered at the time.

41. In response to the question whether Provider 1 had ever sought behaviour support from NASC or Whaikaha for Ms A, Mr E stated:

> '[The local NASC provider] and Whaikaha/Ministry of Health have observed [Ms A's] behaviours over the years via NASC assessments. [Provider 1] had been advised to seek guidance from a General Practitioner but has not been offered any further support or guidance.'

42. Whaikaha stated that following the move, Ms C also raised the issue of unauthorised restraint while Ms A lived at Provider 1, which Whaikaha discussed with the provider. Whaikaha said that Provider 1 explained that Ms A regularly placed her hands into her mouth, which led to a choking risk and breakdown of skin integrity on her hands, and Provider 1 sought assistance and advice from the GP. Provider 1 acknowledged to Whaikaha that placing socks over Ms A's hands was an inappropriate use of restraint.

Concerns about Provider 1's management of Ms A's finances

43. In response to the allegations of mismanagement of Ms A's funds, Ms D stated:

> '[Provider 1] maintains that it has managed [Ms A's] finances in a responsible manner. During the period that [Ms A] was in [Provider 1's] care, [Ms B] was not [Ms A's] property manager and it would have been inappropriate for the [provider] to disclose [Ms A's] financial information to [her].'

44. Mr E stated:

> '[Provider 1] has always been reluctant to claim back any expenditure regarding [Ms A's] care because she has been regarded as whānau. The [provider] therefore paid for all personal expenses incurred in respect of [Ms A's] care … during the 25 years that she was in [Provider 1's] care. Only after guidance from Whaikaha/Ministry of Health, from 2021, the [provider] began to draw upon [Ms A's] funds to finance her doctor's

> appointments, prescriptions, and other personal items or appointments. The expenditure was accounted for and reconciled via a Microsoft Excel spreadsheet and by retaining the associated receipts.'

45. The spreadsheets and receipts have been provided to HDC, Ms C, and Ms B.[15]

Management of previous complaint

46. In response to Ms B's concerns about a complaint made in 2020, Mr E submitted Provider 1's complaints policy and procedures. Mr E stated: '[Provider 1] is not aware of any complaint submitted by [Ms B] in 2020.' He said that Provider 1 has no record of such a complaint, and although the interim manager during that period is no longer a part of the organisation, efforts were made to contact the former interim manager, to no avail.

GP visits

47. In response to Ms C's concerns about Ms A being seen by the GP in the van, Ms D stated:

> '[This was a practice Provider 1] implemented to eliminate the risks to [Ms A's] safety where [Ms A], even with supports, was at risk of eating harmful items that were reachable in the Medical Centre — this included sterigels; gloves; food (even if others were eating their own food — [Ms A] was at risk of snatching it from them); people who smelled of cigarettes or food; access to small objects such as pens/erasers/ keys/toys/colourful objects.'

48. Ms D said that Provider 1 sought to protect [Ms A's] dignity and privacy, and, over the years, GP staff recommended that [Ms A] be seen in a comfortable environment, including in the van, which was heavily tinted to maximise her privacy.

49. The GP practice stated:

> 'Based on the patient notes, it appears that the GPs were indeed aware, and the patient was seen by different GPs for some of her consultations, in the van on multiple occasions however, there is no mention anywhere on file as to who recommended this process.'

50. In response to my provisional opinion, Ms C advised that since Ms A has been in Provider 2's care, she has always visited her doctor inside the clinic and there have been no issues of eating harmful items.

Incontinence management and sexualised behaviour management

51. In response to Ms B's concerns related to perceived neglect, Ms D stated that Provider 1 vehemently rejects the statements around the perceived neglect of Ms A.

[15] On 29 May 2023 Provider 1 received a letter from a law firm who represented Ms B, requesting the funds and cash to be forwarded to its office with the appropriate financial record accounting for the cash, including explanations for Provider 1's spending from May 2021 to September 2022. This request was completed by 28 June 2023.

52. In response to Ms B's concern about inadequate incontinence management, Mr E stated:

> '[Provider 1] does not have a written Incontinence Care Policy. Daily input and output are documented in clients' diaries … [The provider] does not accept that there were issues with the management of [Ms A's] incontinence … The staff were aware of and actively managed her urinary incontinence and changed her regularly as necessary.'

53. Mr E said that Ms A wore an adult incontinence product during the day as a precaution. He stated:

> '[Ms A] has always been self-sufficient at toileting and would toilet herself by pulling down her product (hands unrestrained). She is aware of the need and the urge to use the restroom and will go towards it when she feels the need. Staff were always present to assist and to monitor output and aid with aftercare. [Ms A] did experience urinary incontinence, primarily at night, which was managed by using incontinence products in/on her bedding. While asleep, [Ms A] would occasionally urinate the bed, prompting staff to replace the blankets, linen, and then wipe and reclothe her. Depending on the time of night and extent of urination, staff may bathe and return her to bed.'

54. Regarding the allegations of another resident's inappropriate sexualised conduct, Mr E stated:

> '[Provider 1 is] aware that whānau at the facility have different and at times complex intellectual challenges that can extend to behaviours that appear sexualised. Some of them lack the capacity to know that exposing or touching themselves may be deemed sexually inappropriate by others. However, this is something staff are aware of and they have always been vigilant about these behaviours and address them immediately when they arise, in a safe and appropriate manner.'

Local NASC provider's response

55. The local NASC provider stated:

> '[The local NASC provider's] "normal practice and role" when clients supported within residential services are moving between providers would be for a discussion to be held with a potential provider (with client/Welfare Guardian/whānau consent) and then the most recent My Plan or other [support needs] assessment provided, along with any other relevant information. However, in the situation we are responding to, the initial contact was made directly by the existing provider to the potential provider, initially being advised to the, then MOH (now Whaikaha) who notified [the local NASC provider].'

56. The local NASC provider said that as there were numerous email, phone, and video-call conversations between the local NASC provider staff, the providers, and Whaikaha regarding Ms A's move, 'there seemed to be no need for a particular meeting to be held where particular roles and responsibilities would be outlined'.

Policies and service specifications

Transition/exit from service

57. According to paragraph 7.10 of Whaikaha's tier one service specification[16] for residential providers:

> 'The Provider will collaborate with other services to ensure People access all necessary Services. When a Person is transferred or exits from services and accesses other appropriate services they will do so without avoidable delay or interruption. The Provider will have policies and procedures for planning discharge/exit/transfer from services.'

Provider 1's Entry and Exit Policy

58. The policy states:

> 'This policy mandates that all [Provider 1] staff shall work together towards a coordinated and effective service that recognises entry into and discharge from [Provider 1]. Entry and exit is viewed as a single process that enables staff to provide structured and continuous care. Accordingly, discharge planning commences at the point of entry and continues throughout the service user's engagement with our service.'

Complaints

59. According to paragraph 8.5 of Whaikaha's tier one service specification for residential providers:

> 'The Provider will enable People/families/whānau and other people to make complaints through a process for the identification and management of complaints. This process will meet the requirements of the Health and Disability Commissioner's Code of Rights …'

Provider 1's Complaints Policy (2019)

60. The policy states:

> '[Provider 1] acknowledges that staff/clients/others have the right to express their concerns either about the organisation, the services they have received, the workplace, and/or their employment.
>
> All parties have the right to be heard. Complaints can be taken through the [Provider 1] process. Any complaints about [Provider 1's] services can also be taken through the Health & Disability Commission (refer to the Health and Disability Code of Rights for other information) and/or through a Health & Disability Advocate.

[16] The tier one service specification and tier two service specification for residential providers submitted by Whaikaha and referred to in this report are dated 2023. However, Whaikaha told HDC that essentially the specifications were developed in 2015. Whaikaha stated: 'The service specifications provided in the HDC response are the same as the those that were in force prior to Jan 2023.'

> Complaints are to be handled impartially, fairly and sensitively with due consideration of cultural values. They will also be handled at the level appropriate to the complexity or gravity of the complaint. For example, if the matter is not serious, the complaint may be held internally. For anything more serious harm incident, other parties or independent assistance/involvement may be sought.'

Restraints

61. The Health and Disability Sector (Restraint Minimisation and Safe Practice) Standards 2021 (HDSS) define 'restraint' as '[t]he use of any intervention by a service provider that limits a person's normal freedom of movement'. In accordance with the HDSS, Provider 1 stated that it supports the least restrictive use of enabler/restraint *only* as deemed necessary for safety whilst still preserving the client's dignity and respect. The standards also state that the least restrictive practices should be used and alternative interventions and de-escalation practices should also be explored, and that restraints are a last resort. The use of enablers is based on community living assessments for whānau to aid them in maximising their functional independence and comfort, including that 'any action that may become necessary to prevent injury, accident, or self-abuse requires immediate notification (with explanation) to the CEO'.

Behaviour support

62. According to paragraph 9.3 of Whaikaha's tier two service specification for community residential service providers, when delivering behaviour support:

> '[The provider will] ensure implementation of Behaviour Support is consistent with relevant Ministry guidelines and policies [and] ensure that challenging behavior is identified early and a referral is initiated to the Specialist Behaviour Support Service where the Provider requires support to manage the behaviour effectively. The Specialist Behaviour Support Service may be consulted for advice outside of a formal referral.'

Financial management

63. In accordance with Whaikaha's tier two service specification paragraph 6.5.1, the provider will ensure that:

> 'Where the Person does not have a financial manager or a family/whānau/guardian/ advocate to manage their money, and is unable to control their own finances, as a matter of last resort the Provider may act on behalf of the Person regarding financial decisions. The Provider must inform the Provider's governance body of these circumstances.
>
> …
>
> Maintain documentation of financial matters for audit purposes by [Whaikaha's] evaluation agency when People do not control their own money. People should hold copies of the documentation of their finances when these are managed on their behalf.'

Responses to provisional opinion

64. Ms B, Ms C, Provider 2, Provider 1, and the local NASC provider were given the opportunity to respond to relevant parts of the provisional opinion.

65. Ms B and Ms C provided a combined response, which has been incorporated into this report where applicable.

66. The local NASC provider stated that it 'accepts the recommendation to create and implement a Transition Process Document'. The local NASC provider's other responses have been incorporated into this report where applicable.

67. Provider 1 stated that it accepts the findings made in the provisional report. In addition, Provider 1 apologised to Ms A and her whānau for the areas in which the care they provided was inadequate as it did not protect Ms A in the way it should have. This included the inappropriate use of hand coverings, deficiencies in the transition process, the lapse in care delivery regarding clinic visits, and other aspects of its care. Provider 1 concluded that it is grateful for the perseverance of Ms A's whānau in raising these issues and ensuring that they were addressed.

Opinion: Provider 1 — breach

Transition — adverse comment

68. This part of the opinion discusses the adequacy of the transition of Ms A from Provider 1 to Provider 2.

69. Ms C stated that Provider 2 struggled with Ms A's transition because of the lack of urgency, progress, and overall lack of documentation, which ultimately impeded Provider 2's understanding of Ms A's history and behaviour. Ms C said that on the day of the exit, Ms A arrived at Provider 2 without any paperwork regarding her medical history, daily notes, doctor's information, specialist appointments, assessments, bank information, dietary requirements, and medical and allergy protocols. Ms C said that on multiple occasions she requested the documentation from Provider 1, as shown by the records submitted, to no avail.

70. Mr E acknowledged that '[Provider 1] had not previously undergone a transition'. He stated:

> 'This was therefore a new process which, with the benefit of hindsight, may have resulted in the miscommunication and other challenges that occurred during [Ms A's] transition.'

71. Ms D stated that Provider 1 made significant efforts to facilitate and cooperate with the transfer of Ms A to the Provider 2 whare, and Provider 1 shared information and updates with both Provider 2 and Ms B. In addition, Provider 2's kaimahi had opportunities to access all information pivotal to understanding Ms A's history and behaviour when they visited Provider 1's whare.

72. I acknowledge the statement that Provider 2's kaimahi had access to Ms A's files when they visited the whare. However, this does not necessarily negate Provider 1's obligation to provide the documents Ms C requested multiple times.

73. Ms D acknowledged that at times the transition was delayed or paused. She said that this was not deliberate, and sometimes the delays were prompted by Provider 2. Ms D stated that it was evident to her that Provider 2's expectations of the transition process varied substantially from Provider 1's.

74. On 18 January 2023 Provider 1 received less than two weeks' notice of Ms A's move. Ms D acknowledged that due to the short notice, unfortunately Provider 1 did not have the opportunity to assist with hands-on integration to the Provider 2 whare.

75. I accept that Ms C considers that Provider 1 did not act with urgency or provide adequate documentation as requested, and I acknowledge her expectations, as discussed above. However, I also accept Ms D's statements that Provider 1 acted in good faith and provided some information and Ms A's possessions through various avenues, and that not all delays were due to Provider 1. However, Provider 1 providing access to documentation does not negate the need to send requested documentation and may have contributed to Ms C's struggles to understand Ms A's history and behaviour.

76. The local NASC provider stated that Ms C raised concerns with Whaikaha about what she perceived to be a lack of information, and in turn Whaikaha notified the local NASC provider. NASC stated that during the transition process, the local NASC provider supported both Ms C and Whaikaha with information. However, the local NASC provider also stated that no specific transfer document is required regarding the movement of clients between providers.

Findings

77. I consider that multiple factors contributed to the frustrations experienced by both providers during the transition process, including their own experience and expectations of the process, the limited involvement by the local NASC provider in coordinating the transition, and the alleged statement from Ms F that Provider 1 did not need to submit documents to Provider 2. Mr E acknowledged that challenges and miscommunication occurred because Provider 1 was new to transitions. However, I am concerned that before embarking on the transition, Provider 1 did not seek direct advice from the local NASC provider or Whaikaha about Provider 1's responsibilities and requirements, to ensure a smooth transition. The evidence provided shows that Provider 1 was not forthcoming with information that was requested multiple times, although I accept Ms D's statement that expectations of the transition varied.

78. In addition, Ms B's request that all communication regarding the transition and Ms A's possessions should go through her may have affected the communication between Provider 1 and Ms C. The shared confusion and frustration between Provider 2 and Provider 1 is clear, and likely was caused by Provider 1's inexperience in the transition processes, the different expectations, the limited coordination by the local NASC provider, and the alleged contradicting instructions from Ms F and Ms B. However, I consider that largely Provider 1

met Whaikaha's tier one service specification that providers will ensure that people transferring or exiting the service 'will do so without avoidable delay or interruption'. I note that there were no specific requirements for what information should be provided. Provider 1 also had an Entry and Exit Policy in place, and therefore met the tier one service specification requirement to have 'policies and procedures in place for planning discharge/exit/transfer from services'. Accordingly, I find that Provider 1 did not breach the Code of Health and Disability Services Consumers' Rights (the Code) in this matter. That said, it is disappointing that despite multiple requests from Ms C, Provider 1 did not provide the requested documentation or apparently discuss Ms C's information requests with her further and indicate what Provider 1 would be able to provide.

Hand restraints — breach

79. This part of the opinion discusses Ms C's and Ms B's concerns that Ms A's hands were restrained inappropriately.

80. Right 4(2) of the Code states that '[e]very consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards'.

81. The HDSS defines restraint as '[t]he use of any intervention by a service provider that limits a person's normal freedom of movement'. In my opinion, tying Ms A's sleeves and securing socks over her hands restricted her ability to use her hands in the normal way, and, accordingly, was a form of restraint. The HDSS further states that restraints should be used only as deemed necessary for safety whilst still preserving the client's dignity and respect, that restraints are a last resort, and that least-restrictive practices should be used and alternative interventions and de-escalation practices should also be explored.

82. Ms D stated that tying Ms A's sleeves was not a practice that had ever been endorsed by Provider 1. However, she said that the restraint was used because of concerns about Ms A's skin integrity, and because her GP had advised staff to keep her hands dry. Ms D acknowledged that socks had been used out of a concern for Ms A's safety.

83. Whaikaha stated that Provider 1 had acknowledged that placing socks over Ms A's hands was an inappropriate form of restraint.

84. Mr E stated that Provider 1 '[h]as never endorsed the practice of covering [Ms A] (or any person)'s hands' and said that this occurred only after discussions with [Ms B], and only when [Ms B] was visiting. [Ms B] stated that she had concerns about [Ms A's] hands being restrained. However, this strongly contradicts [Mr E's] statement. [Ms B] did not confirm to HDC whether she requested that her sister's hands be covered with socks at the time.

85. Nonetheless, regardless of whether the restraints occurred as a request from Ms B or someone else, and even in the context of concerns about keeping her hands dry and keeping her safe, I consider that it was still an unacceptable practice and an inappropriate restraint. Restricting Ms A's freedom of movement in this way meant that she was unable to use her hands, and therefore unable to attend to her own needs (for example, using the toilet) in

her normal way. I consider that restraining her in this way did not preserve her dignity or respect. In addition, there is no evidence that Provider 1 considered or explored alternatives to the restraints used, as per the HDSS.

86. HDC asked Provider 1 whether it had ever sought behaviour support for Ms A. Provider 1 responded that the local NASC provider was aware of Ms A's behaviour, and Provider 1 had been advised to seek guidance from her GP. The tier two service specification is clear that it is the provider's responsibility to 'ensure that challenging behavior is identified early and a referral is initiated to the Specialist Behaviour Support Service … where the Provider requires support to manage the behaviour effectively'.

87. I am critical that such a referral was not initiated. This was a missed opportunity for Provider 1 to receive expert behaviour support and advice on how to manage Ms A's challenging behaviour.

Findings

88. I find that Provider 1 failed to adhere to the HDSS, which states that restraints should be used only as deemed necessary for safety whilst still preserving the client's dignity and respect, and that alternatives to restraint should be explored. By covering Ms A's hands with socks and tying her sleeves over her hands, Provider 1 did not adhere to the standards. In my view, this was an inappropriate restraint that did not preserve Ms A's dignity, and the perceived need for this type of restraint could have been avoided by seeking specialist behavioural support. Accordingly, I find that Provider 1 breached Right 4(2) of the Code.

Management of Ms A's finances — other comment

89. This part of the opinion discusses whether Provider 1 managed Ms A's finances adequately. Ms B raised concerns that Provider 1 did not disclose to her the details of Ms A's accounts and spending, in particular the $8,000 spent in 2021 to 2022.

90. The tier two service specifications state:

> '[A]s a matter of last resort the Provider may act on behalf of the Person regarding financial decisions. The Provider must inform the Provider's governance body of these circumstances.
>
> …
>
> Maintain documentation of financial matters for audit purposes.'

91. Provider 1 managed Ms A's funds for more than 25 years and, although it did not hold any formal order, it managed the funds on Ms A's behalf. Funds were not withdrawn from Ms A's accounts, Provider 1 considered Ms A to be whānau, and unfunded personal costs were paid by Provider 1 up until 2021. In 2021 Whaikaha advised Provider 1 to charge Ms A's accounts for costs that were not included in the Whaikaha-funded care package, such as medication, personal care items, clothing, and bedding. Provider 1 submitted a spreadsheet and the supporting receipts to HDC showing the auditable costs charged to Ms A's account

from 2021 to 2023. These appear to show that the purchases made for Ms A fitted the above criteria.

92. I accept Provider 1's statement that it began to charge Ms A's accounts for personal unfunded costs only in 2021, and that it managed Ms A's accounts appropriately, as evidenced by the records submitted. I also accept that charging a residential disability services consumer for such purchases is standard practice for many residential service providers.

93. Overall, I accept that Provider 1's intention was good, as it was paying out of its own pocket for Ms A's unfunded personal expenses prior to 2021. However, ideally this informal arrangement could have been formalised earlier, and a discussion held with Ms A and her whānau about how best to manage the personal expenses (and formal records kept) before 2021, to ensure full transparency. Arguably, Ms B's concerns about Ms A's finances could have been avoided if this had occurred.

94. When Ms B requested information about Ms A's accounts and Provider 1's spending, this was rejected by Provider 1 as its previous communication had always been with Ms A's brother and at the time of the request Ms B did not hold a welfare guardian order for Ms A. Once Ms B had been granted the welfare guardian order in 2023, Provider 1 submitted the details requested.

95. I consider that Provider 1 acted appropriately by not disclosing Ms A's financial details when Ms B did not hold a formal order. It appears that no wrongdoing or breaches of the service specification standards occurred in relation to Provider 1's handling and managing of Ms A's accounts. Accordingly, I find that Provider 1 did not breach the Code in this matter.

Management of previous complaint — no finding

96. This part of the opinion discusses Provider 1's management of Ms B's complaint in 2020.

97. Mr E submitted Provider 1's complaints policy and procedure from the time of the complaint and stated that Provider 1 is unaware of any such complaint having been recorded. Mr E said that Provider 1 contacted the previous manager to enquire about the complaint, to no avail. Provider 1 said that it could not respond to the allegations, due to the time lapsed and the lack of details provided by Ms B.

98. I accept Mr E's statement that Provider 1 has no record of this complaint having been lodged in 2020, and I acknowledge the difficulties in responding to allegations when so much time has lapsed and there is a lack of detail. I note that it appears that Ms B had not been following up on this matter, which occurred three years prior to this complaint. Due to the facts presented and the lack of further details, I am unable to ascertain whether this complaint was received and managed by Provider 1. I note that Provider 1 had a standard complaints policy and procedure in place at the time, which largely reflected Right 10 of the Code, including that '[e]very consumer has the right to complain about a provider in any form appropriate to the consumer'. The policy also met the contractual requirements of paragraph 8.5 of Whaikaha's tier one service specification about complaints. For these

reasons, I am unable to make a finding on this matter. However, I would be concerned if the complaint was received by Provider 1 and not acted upon appropriately at the time.

GP visits — adverse comment

99. This part of the opinion discusses the concerns about the appropriateness of Ms A being seen by her GP in the Provider 1 van.

100. Ms D stated that the practice of Ms A being seen in the van by the GP was implemented to eliminate the risks associated with eating harmful items, as had occurred in the past. Ms D said that the practice was endorsed by GP staff and was aimed at protecting Ms A's dignity and privacy.

101. The GP practice responded that it was aware of the practice of seeing Ms A in the van, and that Ms A was seen on multiple occasions. However, the practice notes do not specify who recommended the process.

102. I acknowledge that GP staff did not raise concerns about this practice, and that the intention behind it was to minimise risks to Ms A. However, I note that Ms A was exhibiting challenging behaviour, and I am concerned that this was a missed opportunity for Provider 1 to seek specialised behaviour support in collaboration with the local NASC provider, to find alternative options for Ms A. Nonetheless, despite this, I find that Provider 1 did not breach the Code on this matter.

Incontinence management — no finding

103. This part of the opinion discusses the concerns raised about Provider 1's management of Ms A's incontinence.

104. Ms D vehemently rejected the statements around the perceived neglect of Ms A.

105. Ms B stated that most times when she visited Ms A, she was soaking wet, and she could smell the urine as it had soaked through to Ms A's clothing. Ms B said that often incontinence products and clothing were not changed until she asked the staff to do so. Ms B did not provide any specific dates on which these incidents occurred.

106. Mr E does not accept that there were any issues regarding Provider 1's management of Ms A's incontinence. He stated that Ms A wore an adult incontinence product as a precaution, but that she was self-sufficient at toileting and staff were always present to assist.

107. Due to the differing statements and lack of further information, I am unable to make a finding on this matter. However, I would be critical if Ms A was left in wet incontinence products on multiple occasions, as alleged by Ms B.

Sexualised behaviour management — no finding

108. This part of the opinion discusses the concerns raised about how Provider 1 managed the sexualised behaviour by another resident.

109. Ms B stated that on more than one occasion she witnessed that another resident would be exposing himself and self-soothing, but staff did not feel the need to remove him from the common area. Ms B did not specify any dates on which these incidents occurred.

110. Regarding inappropriate sexualised behaviour by another resident, Mr E said that some of the residents have complex intellectual challenges, but staff were aware of these and addressed such behaviour when they arose, in a safe and appropriate manner.

111. I acknowledge Ms B's concerns about another resident's sexualised behaviour and the potential impact this had on Ms A. However, I also acknowledge that sexualised behaviour can occur alongside complex intellectual disabilities, and that often it is not possible to prevent the behaviour from starting. What is important is that such behaviour, if it occurs, is managed appropriately and in a way that respects and upholds the rights of all consumers involved. Provider 1 stated that it was aware of this behaviour and managed it actively, although Provider 1 did not provide specific details of the management strategies used by staff.

112. Due to the differing statements and lack of further information, I am unable to make a finding on this matter.

Opinion: Local NASC provider — adverse comment

113. This part of the opinion discusses the support provided to Provider 1 and Provider 2 by the local NASC provider during Ms A's transition.

114. The local NASC provider stated that it did not follow the normal transition/referral process, as the initial contact was made by Provider 1 asking Provider 2 whether it would be able to care for three of its whānau. The local NASC provider said that Whaikaha notified it about the transition only once it had been agreed. Partway through the transition, Ms C raised concerns to the local NASC provider that Provider 1 did not provide enough information or a transition plan.

115. I accept that this transition process was not the norm for the local NASC provider and that it was not aware of both providers' limited experience of the transition process. In addition, the local NASC provider was unaware of the different expectations of both providers. However, I suggest that in future, asking the providers some simple questions could easily ascertain their experience levels and expectations for the transition process.

116. Notwithstanding the local NASC provider's response to the provisional opinion disputing that information was withheld, I remain critical that when concerns were raised by Ms C, the local NASC provider did not become involved to coordinate and manage the transition effectively. Had this occurred, the processes and responsibilities could have been explained in detail to the providers, including what paperwork needed to be completed and handed over. The local NASC provider would also have been able to answer the questions that arose during the process and guide the providers accordingly.

117. I would be concerned if Provider 1 was led to understand that it did not need to supply Provider 2 with documentation until a 'transfer document was provided' when this was not the case.

118. I trust that this complaint will guide the local NASC provider in future referral and transition matters.

Recommendations

119. In the provisional opinion, I recommended that Provider 1 provide an individual formal written apology to Ms B on behalf of Ms A for Provider 1's breach of the Code and the other issues identified in the report. The apology has been sent to HDC and passed on to Ms B.

120. As noted above, Provider 1 no longer provides residential care. As such, notwithstanding my finding that Provider 1 breached Right 4(2) of the Code with respect to its restraint of Ms A, I have not recommended any specific learning and development training courses regarding restraints.

121. I recommend that the local NASC provider develop a written transition process document outlining the transition process and key actions, responsibilities, and documentation that needs to be completed prior to the transition. The document can be used to guide providers and whānau in the transition process. However, I note that the document should not be used instead of a face-to-face meeting. The local NASC provider should provide HDC with evidence of a transition process document within six months of the date of this report.

Follow-up actions

122. A copy of this report with details identifying the parties removed will be sent to Whaikaha|Ministry of Disabled People and the Ministry of Social Development.

123. A copy of this report with details identifying the parties removed will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.