IDEA Services Limited

Area Manager, Ms C

Service A Manager, Ms D

Caregiver, Mrs B

Caregiver, Mr B

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC00597)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Master A has a number of complex medical conditions, including epilepsy, generalised brain dysfunction, and cerebral palsy, and has limited mobility. He is fully dependent for day-to-day care needs.

2. In 2004, when Master A was approximately 18 months old, he was placed in the care of IDEA Services Limited. Mr B and Mrs B were contracted by IDEA Services Limited to care for Master A, initially on a temporary basis, and from 2005 as full-time foster parents.

3. In November 2015, Master A's parents, Mr and Mrs A, raised concerns with IDEA Services about the care being provided to Master A by Mr and Mrs B. As a result of these concerns, Master A was uplifted from Mr and Mrs B's care on 10 December 2015.

4. The scope of this report as it relates to Mr and Mrs B is the care provided to Master A between 2012 and 2015, specifically in relation to medication management, provision of suitable food, methods of transferring Master A, and personal cares and hygiene. The scope of this report as it relates to IDEA Services includes only the oversight IDEA Services and its staff provided over the care provided to Master A by Mr and Mrs B between 2012 and 2015, and IDEA Services' investigation into the complaint laid by Mr and Mrs A in December 2015.

Medication management

5. Mr and Mrs A stated that on four occasions medication was found down the side of Master A's wheelchair or in his clothing, raising concern that Master A had not received that medication on those occasions. After Master A was uplifted from Mr and Mrs B, multiple blister packs of medication were found in his belongings, and Mr and Mrs A were concerned that Master A had not received medication on a number of occasions. They also noted their concern that between the evening of 10 December 2015 and 13 December 2015 (after Master A was uplifted) it is documented in Master A's Medication Administration Record that medication was administered to Master A by Mrs B on seven occasions.

Suitability of food

6. Mr and Mrs A were concerned that the food provided to Master A by Mr and Mrs B was not appropriate to his needs.

Method of transferring Master A

7. Mr and Mrs A were also concerned that Master A's equipment, hoist, and standing frame were not utilised by Mr and Mrs B for his safety. They stated that when the hoist was collected around a month after Master A was uplifted, it was missing its plug, and it had a flat battery.

Personal cares and hygiene

8. Mr and Mrs A told HDC that on a number of occasions Master A arrived at school unwell and not properly cleaned. Between 2013 and 2015, concerns in relation to the placement

of his equipment, the overuse of talcum powder, and that Master A 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 Master A to Mr and Mrs B on a daily basis. On 20 May 2015, the school also verbally notified the Ministry for Children of some concerns they had.

Oversight by IDEA Services

9. IDEA Services was required to undertake monthly caregiver home visits. Between December 2013 and December 2015, only 15 home visits were carried out in total.

10. IDEA Services was also required to engage with educational establishments. There is no documentation demonstrating contact between the school and IDEA Services staff.

IDEA Services investigation

11. On 9 December 2015, the local Needs Assessment and Service Co-ordinator (NASC) service asked IDEA Services to investigate concerns raised by Mr and Mrs A and to advise of the outcome. The Area Manager, Ms C, undertook an investigation and prepared an investigation report.

12. The report documented that Ms C had reviewed Master A's file and case notes, the caregiver home visit forms, Mr and Mrs B's files and case notes, Master A'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 by Ms C.

13. Ms C then provided her report to the General Manager, Ms E, on 16 December 2015. Ms E identified that there were no recommendations in the report, and Ms C amended the report to include recommendations. Ms E then changed the recommendations slightly. The finalised report by Ms C was four pages long, and listed seven recommendations, two of which related to the other service user in the care of Mr and Mrs B.

14. 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 Ms C meet with Mr and Mrs A to discuss the findings, and meet with Master A's school to agree on how to raise concerns in the future. Neither of these recommendations were included in the investigation report. The summary report was reviewed by Ms E and the Chief Operating Officer, Ms I (who was not provided with the investigation report). Ms C then provided the report to the NASC.

15. The summary report was also provided to Mr and Mrs A, but the recommendation to meet with them had been removed.

Findings

Mr and Mrs B

16. It was found that on four occasions, Master A 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 Mr and Mrs B were responsible for administering Master A's medication on a daily basis, and must take a degree of responsibility for the pills found in his wheelchair.

17. It was also apparent from the medication audit that Mr and Mrs B did not maintain Master A'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 Mr and Mrs B provided in relation to Master A's medication administration.

18. 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 Mrs B intentionally signed for dates where medication was not provided in order to mislead.

19. Criticism was made that Mrs B provided foods to Master A that were clearly at odds with the assessments that outlined the foods suitable for Master A.

IDEA Services

Oversight

20. It was noted that IDEA Services has accepted that its oversight of the care provided to Master A by Mr and Mrs B fell short of the expected standard. IDEA Services 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 IDEA Services provided services of an appropriate standard. IDEA Services failed to provide appropriate oversight and support of the care provided by Mr and Mrs B for a prolonged period of time in a number of areas, and also failed to engage with Master A's school.

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

Complaint management

22. It was found that the management of Mr and Mrs A's complaint did not comply with IDEA Services' complaints policy. The involvement of several senior management level staff in establishing a report that was not compliant with IDEA Services' complaints policy was reflective of a culture of non-compliance within IDEA Services' senior leadership team that allowed such behaviour and non-compliance with IDEA Services' policies to occur.

23. It was found that IDEA Services breached Right 4(2) of the Code, in not complying with its own standards when dealing with the complaint from Mr and Mrs A.

Disclosure

24. It is clear that there were issues with the care provided to Master A by IDEA Services, and these issues were identified during Ms C's investigation and the subsequent medication audit. These concerns were not conveyed to Mr and Mrs A.

25. Accordingly, IDEA Services failed to provide Master A with information that a reasonable consumer would expect to receive, and breached Right 6(1) of the Code.

Ms D

26. Criticism was made about the level of oversight Ms D carried out over the care provided to Master A by Mr and Mrs B.

Ms C

27. Criticism was made that Ms C did not discern that monthly home visits were not occurring from December 2014 to August 2015, and that she did not use the tools available to her to assist in providing oversight of Ms D's role and performance of the service.

28. While noting the shortfalls in Ms C's investigation report and the disclosure to Mr and Mrs A of the findings of the investigation and the medication audit, it was also acknowledged that Ms C had sent the report to managers at IDEA Services for their review and input, and had understood that they had approved the summary report for distribution. Criticism was made of Ms C for providing only the summary report to Mr and Mrs A 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 Master A had been receiving from Mr and Mrs B and IDEA Services.

Complaint and investigation

29. The Commissioner received a complaint from Mr and Mrs A about the services provided to their son, Master A, by IDEA Services Limited. The following issues were identified for investigation:

- *Whether IDEA Services Limited provided Master A with an appropriate standard of care. In particular:*
    a. *IDEA Services' oversight of the care provided by Mr and Mrs B; and*
    b. *IDEA Services' investigation into Mr and Mrs A's complaint.*
- *Whether Ms D provided Master A with an appropriate standard of care.*
- *Whether Ms C provided Master A with an appropriate standard of care.*
- *Whether Mrs B provided Master A with an appropriate standard of care. In particular:*
    a. *Medication management*
    b. *Provision of suitable food*
    c. *Method of transferring Master A*

   d. *Personal cares and hygiene*

- *Whether Mr B provided Master A with an appropriate standard of care. In particular:*

   a. *Medication management*
   b. *Provision of suitable food*
   c. *Method of transferring Master A*
   d. *Personal cares and hygiene*

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

31. The scope of this report as it relates to Mr and Mrs B is the care provided to Master A between 2012 and 2015, specifically in relation to medication management, provision of suitable food, methods of transferring Master A, and personal cares and hygiene. The scope of this report as it relates to IDEA Services includes only the oversight IDEA Services and its staff provided over the care provided to Master A by Mr and Mrs B between 2012 and 2015, and IDEA Services' investigation into the complaint laid by Mr and Mrs A in December 2015.

32. The parties directly involved in the investigation were:

Mr A	Complainant
Mrs A	Complainant
IDEA Services Limited	Provider, disability services
Mrs B	Caregiver/provider
Mr B	Caregiver/provider
Ms C	Provider, Area Manager IDEA Services
Ms D	Provider, Service A Manager, IDEA Services

Also mentioned in this report:

Ms E	General Manager
Mr F	Service A Co-ordinator
Ms G	Health advisor
Ms H	Holiday Programme Team Leader
Ms I	Chief Operating Officer
Ms J	Residential and day service Manager

33. Information from the school, the local Needs Assessment and Services Co-ordinator (NASC), the Ministry of Health (the provider of funding), and the department responsible for the well-being of children, Oranga Tamariki — Ministry for Children (previously Child Youth and Family) was also reviewed.

34. Independent expert advice was obtained from a registered nurse and lead quality auditor, Christine Howard-Brown (**Appendix A**). Independent expert advice was also obtained from a registered social worker, Nancy Jelavich (**Appendix B**), to obtain an indication of the

appropriateness of the care provided by Mr and Mrs B to Master A. It is acknowledged that both Mr and Mrs B are unregistered providers.

Information gathered during investigation

Background

Master A

35. Master A has tuberous sclerosis[1] and intractable epilepsy.[2] He has generalised brain dysfunction, which limits his mobility, and also has cerebral palsy,[3] which affects his left side in particular. Master A has limited use of his limbs, and his functional ability is around the age of an infant.[4] He is fully dependent for continence, bathing, and dressing, as well as all other day-to-day care needs. He is non-verbal and has poor eyesight. Master A receives a number of different medications and, of note, suffers from seizures and receives medication to minimise his risk of experiencing seizures. As detailed below, Master A has spent a significant proportion of his life under the care of IDEA Services. In 2004, Master A was placed into IDEA Services' care on a temporary basis with Mr and Mrs B. In 2005, this arrangement was changed to foster care. Master A lived with Mr and Mrs B in their family home from the age of approximately 18 months until he was uplifted on 10 December 2015 following concerns expressed by his parents, Mr and Mrs A. Following this uplift, IDEA Services carried out an investigation into the care provided to Master A. There was no record of the timeframe of the care IDEA Services was considering in the subsequent investigation report.

The role of IDEA Services/the section 141 agreement

36. In April 2005, an agreement pursuant to section 141 of the Oranga Tamariki Act 1989 (the Act) was created. Section 141 of the Act allows for the creation and establishment of agreements for extended care by external approved organisations for severely disabled children and young persons. Under this provision, a Needs Assessment and Service Co-ordination (NASC) service undertakes an initial needs assessment for the child.

37. At the time of events, IDEA Services was an organisation approved to provide care pursuant to section 141 of the Act, and it contracted individual caregivers to provide foster care in accordance with the Act. In accordance with the Act, once a referral has been received by IDEA Services from Oranga Tamariki — Ministry for Children, IDEA Services then reviews the needs of the individual, as identified by the NASC, and identifies a suitable caregiver.

[1] A genetic disorder characterised by the formation of abnormal tissue in multiple organs, most commonly the brain, skin, kidneys, retina, and heart. Effects of tuberous sclerosis include epilepsy that is resistant to treatment, and severe to profound impairment of global intellectual ability.

[2] A condition where the epilepsy activity itself may contribute to the severe neurological and cognitive impairment seen, over and above that which could be expected from the underlying pathology above.

[3] A condition marked by impaired muscle coordination (spastic paralysis) and/or other disabilities, typically caused by damage to the brain before or at birth.

[4] Report from a paediatrician, 12 April 2016.

38. In accordance with section 141 of the Act, the agreement between IDEA Services and Oranga Tamariki — Ministry for Children for Master A's care was created following a family group conference, which included input from Master A's family, the local NASC Service, and an Oranga Tamariki — Ministry for Children care and protection co-ordinator. The Oranga Tamariki — Ministry for Children care and protection co-ordinator certified that the agreement was an appropriate care option for Master A. IDEA Services was then contracted and funded by the Ministry of Health to provide care to Master A. IDEA Services contracted Mrs B as foster parent to provide care for Master A in a family setting. In foster care placements, the contracted caregiver is responsible for housing, caring for, and supporting the young person, including ensuring that the young person has access to emergency and regular medical or dental treatment. The section 141 agreement relating to the foster care arrangement was renewed on an annual basis until Master A ceased to be placed with Mr and Mrs B in December 2015, and the agreement lapsed on 14 December 2015.

39. Although Mr and Mrs A retained legal guardianship, the section 141 agreements outlined that IDEA Services had responsibility for Master A's "educational, social, cultural and religious needs". It stated: "While this Agreement operates, [Master A] will be cared for by IDEA Services in accordance with the Support Plan attached to this Agreement." The support plans outlined medication, support equipment, and nutritional requirements. Over the years, Master A's attached supports plans consistently identified that Master A was fully reliant on others for all aspects of personal cares, all nutrition needs, all medication needs, and all aspects of mobility. Master A's needs, which were documented in his support plans, remained consistent throughout the time he was under the care of IDEA Services.

Ministry of Health requirements

40. The Ministry of Health's "Disability Support Services Tier Two Specification — Foster Care" specifies requirements for foster care funded by Disability Support Services, and applied to Master A's placement with IDEA Services. Specification 6.3.2 requires the provider to advise the foster parents of any training opportunities, and ensure that the foster parents receive training commensurate with the needs of the person in their care. Specification 6.8, under the requirements of foster families, outlines what the provider (in this case, IDEA Services) is obliged to ensure that the foster family is capable of providing. Included in this list is: "Administer medication or assist the Person in taking medication in accordance with instructions from the prescribing doctor and the provider's medication standards and policy."

41. Specification 6.4 states: "The provider will … support and encourage the foster family, by way of a fortnightly contact and a monthly home visit." In addition, specification 6.5.1 states: "The provider will develop and maintain effective relationships with the following to ensure that the needs of the Person are met[:] … educational establishments."

IDEA Services' Service A

42. One of the functions of IDEA Services' Service A is to provide oversight over children who are placed with foster parents under section 141 agreements. The manual states that the

objective is to "support families/whānau so that they can stay together and so the child can remain at home". Standard 21, "Monitoring", in the manual states:

> "All [services] will be monitored and reviewed to ensure they continue to meet the needs of families and service users … Expectations of minimum supervision, contact and review levels are provided in the schedule below."

43. The schedule states that for individuals in a foster care arrangement, contact is to be made with the caregiver fortnightly by telephone or through a meeting, and that a home visit is to be undertaken on a monthly basis.

Service A Manager

44. The position description for the IDEA Services' Service A Manager stated that the main function of the role included ensuring that "the needs and aspirations of people with an intellectual disability and their family/whānau or primary caregivers are identified and supported by the [Service A] team", and "the day to day leadership of those staff employed by IDEA Services assigned to the [Service A Manager] under delegation from the Regional Service Manager". It also stated that the Service A Manager was responsible for "Employees and Caregivers who provide … foster care". Ms D held this role from 2014. In 2009, Ms D had been employed by IDEA Services as a co-ordinator for the region. Ms D stated that she provided support to Mr and Mrs B and Mr and Mrs A until 2013, and then again when she became the Service A Manager. The case notes show that Ms D carried out the role of communicating with Mr and Mrs B and was responsible for carrying out home visits at monthly intervals, with the exception of short periods of time where home visits were carried out by other IDEA Services staff members, throughout 2013, 2014, and 2015.

IDEA Services Area Manager

45. The position description for an IDEA Services Area Manager stated that the primary objective was to lead and manage the delivery of person-centred support services in a designated area in accordance with IDEA Services' Philosophy and Policy. It also stated that the Area Manager was to "[p]rovide leadership and direction to the Area Management Team consistent with IDEA Services' strategies and operational goals". Ms C was appointed as the Area Manager for the region in December 2014, and was responsible for the oversight of services in the area. Ms C told HDC:

> "One of these was [Service A] and my direct report in this service was [Ms D] … In my role, I provided support, advice and guidance to [Ms D] when required and formal oversight of [Ms D's] role and the performance of the service."

Mr and Mrs B

46. The contract caregiver agreements between IDEA Services and Mrs B between 2005 and 2015 list Mrs B as the sole caregiver. Mrs B was the only contracted foster care parent for Master A. However, Mr B and Mrs B lived together and both acted as caregivers and foster parents to Master A. It is clear that Mr and Mrs B were both acting as caregivers for Master A and another adult in their care, and that IDEA Services and Mr and Mrs A were aware of this.

47. Mrs B originally received training from IDEA Services during her orientation in 2003. Mrs B's orientation sign-off sheet confirmed that she had completed training on the medication policy, incident reports, and support plans. Mrs B last received medication handling and administration training in 2010. Mr B also acted as a caregiver for another service user who lived with Mr and Mrs B. Mr B also received training in 2012, which included core training relating to "[p]re-packaged medication … and moving people and equipment …". Mr B confirmed that he had read the 2011 "Medication policy" by signing the policy on 12 November 2012, and he completed a "Medication Competency Checklist" on 26 May 2012. IDEA Services implemented a new medication policy in October 2014, and a copy was provided to all caregivers. The Caregiver Orientation policy stated: "Your manager/coordinator will ensure that you sign the Medication Policy Sign-Off Form which indicates that you have reviewed the policy and understood the content." In relation to the amended policy in 2014, no "Medication Policy Sign-Off" forms were signed by Mr and Mrs B.

48. In April 2005, Master A commenced full-time foster care with Mr and Mrs B. The section 141 agreement setting up this arrangement was reviewed regularly by Master A's family, the local NASC Service, and an Oranga Tamariki — Ministry for Children care and protection co-ordinator, and renewed at least annually.

49. On 27 November 2015, Mr and Mrs A raised concerns with IDEA Services about the care being provided to Master A by Mr and Mrs B. Their concerns were reiterated on 30 November 2015 in an email to Ms D. Their concerns included the administration of medication and the use of Master A's hoist to move him. Mr and Mrs A requested that Master A be relocated to one of IDEA Services' residential facilities. Initially, IDEA Services perceived the purpose of the email to be a request for a change in placement, but when Mr and Mrs A raised their concerns with the NASC, IDEA Services carried out an investigation into Mr and Mrs A's concerns. The IDEA Services investigation considered aspects of the care provided by Mr and Mrs B, including medication management, the use of Master A's hoist by Mr and Mrs B, the adequacy of the food and nutrition provided to Master A, Mr and Mrs B's provision of respite care to another child, Mr and Mrs B not attending medical appointments, and Mr and Mrs B's maintenance of Master A's personal hygiene, and questioned whether Mr and Mrs B's relationship with each other affected the home environment.

50. Following Mr and Mrs A's complaint to HDC about the oversight and care IDEA Services provided to Master A and their concerns about the investigation carried out by IDEA Services, an investigation was commenced by HDC. Following review of all relevant information obtained during the investigation, the scope of this report as it relates to Mr and Mrs B is the care provided between January 2012 and 10 December 2015 only as it relates to medication management, provision of suitable food, methods of transferring Master A, and personal cares and hygiene. The scope of this report as it relates to IDEA Services is the oversight IDEA Services and its staff provided to Mr and Mrs B between January 2012 and 10 December 2015, and IDEA Services' investigation into the complaint laid by Mr and Mrs A in December 2015.

Medication management by Mr and Mrs B

Medication found

51. Mr and Mrs A stated that on four occasions (in November 2015) medication was found down the side of Master A's wheelchair or in his clothing, raising concern that Master A had not received that medication on those occasions. Mr and Mrs A state that on the first occasion (around November 2015), Mrs A found a pill down the side of Master A's wheelchair while visiting him at school. Mr and Mrs A stated that they did not raise the issue with Mr and Mrs B as they hoped that it was a "one off incident". However, approximately one week later Mrs A found another pill down the side of Master A's wheelchair. Another week later, Mrs A found another pill. According to Mr and Mrs A, on that occasion they raised their concerns with Mrs B directly, and Mrs B told Mr and Mrs A that she would be more careful. Mr and Mrs A told HDC that they reiterated "the importance of being vigilant because the medication is important in order to minimise [Master A's] seizures". There is no record of the dates on which the above pills were located in Master A's wheelchair. Mr and Mrs A state that two or three weeks later they again found medication down the side of Master A's wheelchair. On this occasion, Mr and Mrs A state that they raised the issue with IDEA Services. On 8 December 2015, following a family group conference, Mr and Mrs A also showed the last pill they had found in Master A's wheelchair to an employee of the NASC.

52. Mr and Mrs A stated that on 27 November 2015, they raised their concerns about medication management with Ms D from IDEA Services. On 30 November 2015, Mr and Mrs A also emailed Ms D expressing their concerns about Master A's medication administration and their belief that Mrs B was not using the correct equipment to move Master A. In this email, they also requested that IDEA Services move Master A from foster care with Mr and Mrs B to a residential facility. IDEA Services told HDC:

> "[Mr and Mrs A] have been advocating for residential placement for [Master A] since 2012 and have stated that they are unable and unwilling to support him at their family home."

53. This email was forwarded by Ms D to Ms C. IDEA Services stated that it did not consider the correspondence on 30 November 2015 to be a complaint but, rather, it was considered by management that Mr and Mrs A were raising these matters as a basis for their request for a change in Master A's residential placement to an adult residential facility.

54. Following the NASC communicating the concerns expressed by Mr and Mrs A to IDEA Services during the December 2015 family group conference, Master A's IDEA Services Holiday Programme Team Leader, Ms H, was interviewed by IDEA Services. Ms H stated to IDEA Services that staff had found an undissolved pill or a lolly on Master A's wheelchair and had shown it to her at some stage between 2014 and 2015. Ms H stated that she believed it to be a pill, and she verbally informed Ms D, who she recalls was present at the school programme on the day. However, Ms H accepts that staff should have written an incident report and filed it with the Service A Manager, but did not. No record of the date on which the pill was located is available. Ms D stated that she does not recall the matter being raised with her.

55. Mr and Mrs B told HDC that administering medication could be challenging, as at times Master A would physically resist taking his medication and fling his arms around.[5] Mrs B stated that on occasion when he did spit out a pill, they would re-administer the pill. Mr B stated: "[Master A] wore a protector as he dribbled a lot and if I saw a tablet dribble out then I would immediately re-administer it."

56. The Medication Policy stated:

> "Never administer dropped or spoilt medication. Use same day and times dose from another blister … pack. Put dropped or loose medication in the 'Return to Pharmacy container' … 'Notify … incoming staff to arrange for replacement dose to be obtained [and] notify your Service Manager or On-call Manager."

57. There is no record of Mrs B requesting replacement medication for Master A on any occasion.

58. Mrs B also told HDC:

> "We don't believe we gave medication inappropriately, always gave it to him at specific times. However we are not perfect. If I made the occasional error over the many years, I would hope someone told me so I could correct it. I do recall being told once by [Master A's] mum that a pill was found down the side of his wheel chair [on one occasion]. I contacted [Mr F] at [IDEA Services] and reported it."

59. IDEA Services told HDC that there is no record or recollection of Mrs B reporting to IDEA Services staff that any pills had been found down Master A's wheelchair. Mrs B told HDC that she did not write an incident report on that occasion, as she believed that this would be done by the school, which is where Master A was at the time the medication was found. Mrs B stated that she was not notified of any further incidents in which medication was allegedly found. Mrs B noted that initially it was reported to her by Mr and Mrs A that one pill had been found, and the first time she and Mr B were made aware that apparently four pills had been found was during HDC's assessment of Mr and Mrs A's complaint.

60. IDEA Services stated that it does not hold any record of any incident reports documenting that Mrs B informed IDEA Services of a tablet being found down the side of Master A's wheelchair. IDEA Services stated:

> "As the medication errors referred to were identified in the school setting, then [Mrs B] could not be expected to report these. In these circumstances, the foster caregiver is only expected to report incidents occurring during times when they are responsible and required to be providing support."

Storage of medication

61. IDEA Services' Medication Policy 2014 required caregivers to store medication in a secured and locked cupboard. IDEA Services stated that the medication folder for Master A was

[5] Refer to Addendum added 29 July 2019.

stored in a locked cupboard in Mr and Mrs B's kitchen, which was consistent with organisational expectations. It also stated:

> "Where service staff are responsible for medication they must return medication that is … discontinued … unused … **to the dispensing** [emphasis in original] Pharmacist for disposal."

62. After Master A was uplifted from Mr and Mrs B, multiple blister packs of medication were found in his belongings, raising concern that Master A had not received medication on a number of occasions. Mr and Mrs B originally stated that they were unaware of any medication in Master A's drawer. Subsequently, Mrs B told HDC that the blister packs found in Master A's drawer after he and his belongings were uplifted from her home were no longer prescribed, and had been discontinued by his paediatrician. She stated: "I regret keeping old stock of medication but [Mrs A] and [Ms D] [IDEA Services] both knew they were there. I asked [IDEA Services] for medication training and received it in 2016" (after Master A was uplifted from Mr and Mrs B's care). Mrs A and Ms D both stated that prior to Master A being uplifted, they were unaware of the blister packs being stored in Master A's drawer.

63. Mr and Mrs A state that they were not discontinued medications. They told HDC that the blister packs found in Master A's drawer contained types of medications that were never discontinued and, in addition, that the medication for random days were missing from the packs while other days were still in the packs. These blister packs were returned to Mr and Mrs A and subsequently disposed of in early 2016.

Documentation

64. Mr and Mrs A noted their concern that between the evening of 10 December 2015 and 13 December 2015 it is documented in Master A's Medication Administration Record that medication was administered to Master A by Mr and Mrs B on seven occasions. However, Master A was uplifted from Mr and Mrs B on the morning of 10 December 2015.

65. IDEA Services stated that when Master A was uplifted from Mr and Mrs B's care, it found that Mr and Mrs B had not signed for Master A's morning medication. According to IDEA Services, Ms D instructed Mrs B to sign the Medication Administration Records following the uplift of Master A, which Mrs B misunderstood and mistakenly signed for the rest of the week. With regard to the Medication Administration records being completed after Master A was uplifted, Mrs B stated:

> "When [IDEA Services] uplifted [Master A] his medication and clothing etc were taken. By mistake his medication signing sheets were left behind by [IDEA Services]. When [Master A] was taken away I was very upset and stressed and by mistake I signed 2½ days in advance when he was not in our care. I apologise for doing this."

66. Ms D told HDC:

> "Upon collection during uplift of [Master A], the medication file was in disarray. During my visits to the home the medication file had been organised with the required paperwork."

67. Ms D stated that the medication folder contained very minimal documentation at the time that Master A was uplifted, but that this had not always been the case during organised home visits, and that when it was viewed it was not in the state of disarray found when Master A was uplifted.

68. Ms D stated that on arrival at the new residential facility where Master A was placed temporarily, she and Mr F discovered that there were issues with the folder. Ms D accepted that Master A's signed medication signing sheets had not been collected for a year prior to his uplift.

69. Ms J managed residential homes and day services for people with multiple severe disabilities. Master A was moved to one of the residential homes under her care following his uplift from the care of Mr and Mrs B. She stated:

> "When we opened up [Master A's] medication folder on the day he arrived … I noticed that there was very little information in it. The [doctor's] chart was blank, it did not even have his name on it, therefore we did not know if the chemist chart that was in the folder was correct. There was no photo of [Master A] as is required, the signing sheets in the folder were blank, no health recording sheets were completed. There appeared to be a lot of old forms and blank sheets in the folder. Most alarmingly was the fact that the Midazolam dosage information was confusing and the recording sheet non-existent. Midazolam is a restricted drug which is required to be counted each day … The state of [Master A's] medication folder sent alarm bells ringing for me because this was a huge safety issue …"

70. Prior to the completion of the investigation, IDEA Services asked its Health Advisor, Ms G, to undertake an internal medication audit of Master A's medication folder, which contained documentation dated between 2011 and 2015. The audit was completed on 21 December 2015 and sent to Ms C. At the time, the medication audit report was not shared with Mr and Mrs A or the NASC. Ms G recorded:

> "Health Advisor Comments
>
> - Risk Management to organisation is huge
> - Poor documentation in Medication file
> - Medication file not complete
> - Consultants, specialists and allied services documentation is missing from 2014 onwards
> - No documentation of any PRN[6] [medication] administration
>
> Health Advisor Recommendations
>
> - Medication folders standardised to IDEA policy

[6] To be given as required.

- All contract board families have a medication competency and follow our medication process.
- More specific line of reporting to the manager of any health visits and any letters/incidents/appointments
- A clearer picture of health appointments which can be placed in Running record data base on shared file
- Health advisor be involved in up-skilling and ensuring competencies are completed for all families."

71. Following the medication audit undertaken in December 2015, Ms E wrote to Mr A in April 2016 and stated:

> "We acknowledge there were breakdowns in the medication procedures being applied to [Master A's] medication management. I apologise for these procedures not being followed."

Suitability of food

72. On 9 March 2012, during a routine medical appointment to determine Master A's needs, a speech language therapist reviewed Master A and documented:

> "[Master A] enjoys eating and has distinct likes and dislikes, which he communicates by either accepting the spoon or keeping his mouth closed … Smoother, runnier food such as yoghurt was harder for him to control and tended to leak out from his lips.
>
> …
>
> [Master A] is quite capable to meet his nutritional requirements well orally. He is able to eat a range of foods but finds foods that are soft and moist easier to manage. Dry, hard foods are difficult to manage as he does not chew effectively and mixed textures are problematic as once [Master A] has swallowed the liquid part he cannot safely chew and swallow the remaining harder lumps. Lumpy foods need to be dissolvable to reduce the risk of remaining food residue which is a choking hazard."

73. The speech language therapist's report was provided directly to Mr and Mrs B. In response to the provisional opinion, IDEA Services provided the Complex Needs Clinic review letter dated 14 May 2012 that was forwarded to Mr and Mrs B. The letter states:

> "At school [Master A] eats mushy and moistened food. He copes with this texture well and after having had a period when he was choking on the large lumps in food he is doing much better on this texture. We recognise that he manages other textures when he is home with [his foster parents] and as long as he is managing these without any coughing or spluttering, it is fine for [his foster parents] to continue to feed him with these textures, however the school team need to carry on with the mushy and moistened food."

74. IDEA Services states that this letter acknowledges and is permissive of Mr and Mrs B offering Master A food with different textures.

75. The support plans that accompanied the section 141 agreements for Master A in 2012, 2013, 2014, and 2015 all state:

> "Eating — likes sweet foods and puddings, cannot eat hard foods, all foods need to be cut small enjoys muffins and bananas. Chews food and swallows. Reliant on others to feed. Supplements are available. Good appetite."

76. Mr and Mrs A told HDC that the food provided for Master A by Mr and Mrs B was "unhealthy and inappropriate as it was not of the right consistency". In an email to IDEA Services dated 12 April 2012, Mr and Mrs A noted: "… [Master A's] lunches consist of heat and eat meals and [Mrs A] has started [sending] homemade meals to school 'on the sly'."

77. According to Mr and Mrs A, staff at the school commented to Mrs A about the "poor quality of food that was coming to school, both in terms of nutrition and choking hazard. e.g. supermarket frozen pizza, supermarket muffins". Mr and Mrs A stated that Mrs A made "batches of home cooked food" to be kept at the school for Master A. These concerns remained confidential to IDEA Services as requested by Mr and Mrs A. However, it is documented that during the 11 May 2012 home visit to Mrs B carried out by Ms D, they discussed healthy eating in great detail and discussed what a daily eating routine would look like for Master A. Ms D documented that Mrs B showed her Master A's school lunch for the following day, which included meat and vegetables. At this visit, Ms D also emphasised the importance of communication with others involved in Master A's life and care.

78. There is no record of further concerns being raised with IDEA Services by Mr and Mrs A in relation to Master A's food until 2015. In addition, following the 9 March 2012 speech language therapist report, no further medical reviews considered the consistency of Master A's food until 2016, when he was no longer in the care of Mr and Mrs B.

79. The school keeps a record of communication between its staff and Master A's caregivers in a "communication book". No concerns about Master A's food were documented in the communication book that was sent home with Master A to Mr and Mrs B. However, issues relating to the type, consistency, and texture of his food were documented in his activities book in February 2015, which was not sent to Mr and Mrs B.

80. Following Master A's uplift from the care of Mr and Mrs B, Master A's holiday programme support worker told IDEA Services that Master A's lunches were "[m]ainly canned food and frozen meals, some leftovers, more often its processed food. Fruit, yoghurt, bought muffins, jelly and juice." In addition, Master A's holiday programme Team Leader, Ms H, told IDEA Services that [Master A] had "[f]rozen meals, sometimes [Ensure][7] (pre-mixed) but never mixed properly".

[7] A nutritional dietary supplement.

81. Regarding concerns about the food provided for Master A, Mr and Mrs B stated:

> "[Master A] was provided with the same foods he ate at home. [Master A] can chew and eat food as long as it was cut up small for him. Leftovers comprised of extra food cooked the night before, that being vegetables and meat.
>
> [Master A] was also provided with yoghurt, bananas, muffin bake bars, custard etc. He also took along tinned food such as creamed rice in case he was hungry or so he had options should he not want the lunch provided. The tin was unopened, as it was not necessarily going to be eaten that day. It was assumed that as [Master A] cannot feed himself but can chew his food, the person feeding [Master A] would ensure that the food was given to him in small enough pieces appropriate for him.
>
> … Neither [the school] nor [Mr and Mrs A] have ever advised [us] they had concerns."

82. Mr and Mrs B further noted that Master A never choked on any of the food given to him by them, and therefore they considered that the food they were providing to him was appropriate. Mr and Mrs B stated:

> "[Master A] needed full assistance with eating and drinking. He always enjoyed his nutritional meals and puddings at night. He was given a good breakfast with V8 juice. A well prepared lunch was always sent to school with him. Had good comments about his lunch when he attended [school]. I [Mrs B] asked his mum if there was anything else he needed for lunch, and she said 'It was all good'.
>
> …
>
> [Master A's] lunchbox included a range of food, including some pre-packaged foods so he had options at school. The lunch box would include items such as some home made food along with fruit, yoghurt, muffin, fruit bars, custard and a v8 [juice] drink. [Master A] needed food to be cut up into small pieces for him so he was able to chew and eat the food."

83. IDEA Services told HDC that it first became aware of the school's concerns about the types of food being provided for Master A's lunch on 27 November 2015, after Mrs A informed them. IDEA Services stated that prior to this date it had no concerns about the types of food being provided to Master A.

Method of transferring Master A

84. Mr and Mrs A consider that Master A's equipment, hoist, and standing frame were not utilised by Mr and Mrs B for his safety. Mr and Mrs A stated that following the uplifting of Master A, Master A's hoist was missing its plug, and it had a flat battery.

85. Mr and Mrs B stated: "The allegation about us not using the hoist is not true." They said that the hoist was used on a daily basis, "mainly to get [Master A] in and out of bed, to change his undergarments/toileting/attending hygiene needs, to assist with putting him

into his wheelchair, and to lower [Master A] onto the floor for activities". Mr and Mrs B stated:

> "[T]he allegation we did not use the hoist makes no sense to [us] as it was needed to move [Master A] safely and not to cause harm such as skin tears or bruising to him or any fall and to also protect our safety."

86. Mr and Mrs B said that they are not aware of Master A having any bruising or skin tears during the time they supported him.

87. Mr and Mrs B stated that Master A had a hoist for approximately seven years, and were told by IDEA Services that a two-person lift was acceptable, but that they were to use the hoist for single person lifting. They said that at times they used a two-person lift, which was permitted by Master A's Personal Support Information.

88. On 25 November 2015, Mr F carried out a home visit, as detailed further below, which identified that Mrs B required training on how to use the hoist and how to lift Master A.

89. Another service user's mother, who visited Mr and Mrs B's house in 2015, told IDEA Services that she had visited approximately six times in the previous year, and had observed Mr and Mrs B using the hoist to move Master A on two to three occasions.

90. Regarding the battery being flat when the hoist was picked up, Mr and Mrs B stated that usually the hoist was charged overnight, and if not recharged regularly the battery would flatten very quickly. Mr and Mrs B consider it likely that the battery would have run out of charge between Master A's uplift and IDEA Services' collection of Master A's belongings on 6 January 2016. Mr and Mrs B stated that no one from IDEA Services reported that the plug was missing when it was picked up.

91. Mr and Mrs B told HDC that they were first made aware of the allegation that the plug was missing during HDC's assessment of Mr and Mrs A's complaint, and it is their belief that at the time of collection they had placed all of Master A's equipment together for IDEA Services.

Personal cares and hygiene

92. Mr and Mrs A told HDC that on a number of occasions Master A arrived at school unwell and not properly cleaned.

93. In this respect, between 2013 and 2015 concerns were documented in the school's communication book, which was sent home with Master A to Mr and Mrs B on a daily basis. Between 2013 and 2015, on approximately six occasions the school staff documented concerns about the placement of Master A's equipment, on one occasion they documented the overuse of talcum powder, and on one occasion they documented that his lunch was still frozen at lunch time. On one occasion, Mrs B recorded that Master A had spilt cocoa on his sleeve just prior to the taxi picking him up, and that she had tried to wipe it off. Issues about the suitability of Master A's equipment were identified by staff and physiotherapists who visited Master A at school, and, accordingly, his equipment was

changed. Other concerns included the incorrect positioning of Master A's support equipment, and that Master A had been unwell with a runny nose or coughs on arrival at school. On one occasion in July 2015, it was identified that Master A had a rash on his stomach, and on one occasion in September 2015 it was identified that he had a blister from his ankle support equipment. Occasions on which Master A had been incontinent during school hours and his pants replaced were also recorded and communicated to Mrs B.

94. Staff at the school also recorded their observations of Master A in the school notes for 2015. Of note, staff documented concerns about the incorrect positioning of his support equipment and clothing, that he was unwell on occasion, and that he had chafing marks on his leg. These notes were not available to Mr and Mrs B. On 20 May 2015, the school also verbally notified Oranga Tamariki — Ministry for Children of their concerns. The school principal told HDC:

> "[Master A] had been sent to school unwell, he was not positioned properly in his wheelchair, and his clothing had been pulled down leaving his bare skin in contact with the wheelchair. I can also confirm that the school reported that we had found dried faeces on his bottom and in his groin, along with leg chaffing and a red bottom."

95. The school staff completed an incident report and documented a file note, which stated:

> "Staff report care has always been 'shoddy' — staff have questioned selves in past whether they are making judgments due to their own personal standards — however, things have recently got worse."

96. Oranga Tamariki — Ministry for Children was unable to locate this notification.

97. The school principal advised HDC:

> "General hygiene was poor, including food stained clothes and filthy food encrusted wheelchair which staff and [Master A's] mother would clean. There had been ongoing concerns regarding the level of care provided up until the date of notification. Staff did on numerous occasions attempt to address this with the caregiver. Things would improve for a short while and then regress."

98. With regard to Master A's personal care and hygiene, Mr and Mrs B submitted the following:

> "Neither the school nor IDEA Services ever advised there [were] any concerns regarding [Master A's] care.
>
> …
>
> [Oranga Tamariki — Ministry for Children] have never approached [us] regarding [Master A's] care nor did they uplift him."

99. Mr and Mrs B further stated that Master A could "soil or wet himself" at home, at school, or in the taxi between home and school. Mrs B stated that he was showered every night after tea, and additionally if required. Mr and Mrs B maintain that Master A was always clean and dry when he left their home, and that the school never reported any concerns to them regarding his personal hygiene. Mrs B stated:

> "[Master A] may have had on some occasion, in the 7 years he went to school, the possibility of having some bowel movement on his way to school. [Master A] generally arrived home from school with very wet garments from urinary incontinence."

100. Mrs B further stated:

> "I deny ever sending [Master A] to school unwell and unsure when [that] would have happened. If this had happened it would not have been done intentionally. If he was unwell in the morning I would ring the taxi as they come at 7.25am, then notify the school. There was one time I recall I was going to keep him home, but his mum said to send him to school as she was going to pop in to school later. Between home and getting to school [Master A] was transported in [a] taxi. I am proud that he always left the house well dressed and covered. I cannot comment on any actions in the taxi but know another child would sometimes niggle him.
>
> … I positioned him in his wheelchair to the best of my ability and for his comfort and dignity. [Master A] was in nappies and required regular changing. He did not indicate desire for [the] toilet or discomfort if he was incontinent. Sometimes his urine was particularly strong and he could get skin irritation."

101. Mrs B provided a statement from the taxi driver who, from May 2013, regularly collected and drove Master A and other children to the school. The driver stated:

> "[Master A was always] clean, tidy, with clean clothes and clean hair every time. [Master A] always smelt so nice and I often made a comment to [Mrs B] in regard to this, I should know because we had to make sure the wheelchairs were well secured … [Mrs B] always took wonderful care …"

102. Mrs B told HDC:

> "I tried my best over the many years and believe it is to be expected that very occasionally there were lapses, I am sorry. They were rare, not usual, or a sign of neglect …
>
> [Master A] was regarded as a member of our family and our children also contributed to his care and support as would be expected of older siblings. We included [Master A] on family activities such as camping trips, going to the speedway and attending other local events … [Master A] had complex support needs. For example his night time care required me to wake up and turn him 3 hourly to change his position. There were times I would also check on him throughout the night and clearly I would do so if he was distressed or crying.

…

[Mr B] and I provided foster care for [Master A] to the best of our ability and I believe to an appropriate level. [Master A] was treated as a member of our family. [Master A] celebrated and spent most of every Christmas day and similarly his birthdays with our family … We built a new family home particularly to meet his support needs. In doing so this committed us to a larger mortgage. [Master A] had complex support needs and I and our family treated these as a priority. We provided care and support to [Master A] over a long period of time through his early development and also during periods of him being unwell and through hospitalisation and post surgery. While I do not believe there is any substantive or significant issues that I should apologise for, I am saddened [Mr and Mrs A] feel the way they do and our support for [Master A] and them have ended this way. I apologise if I contributed in any part to the way [Mr and Mrs A] feel."

IDEA Services' response

103. IDEA Services stated that it first became aware of concerns held by the school, such as Master A's positioning in his wheelchair and issues with personal hygiene, when these were brought to its attention by Mrs A in "late November 2015".

104. IDEA Services further stated:

> "[IDEA Services does] not accept there was a departure to meet [Master A's] personal hygiene needs [by Mr and Mrs B]. It is unreasonable to expect a child's health would not change from the time of leaving home to getting to school and it appears there was one occasion the school found faecal matter on his bottom."

IDEA Services' oversight of care provided to Master A

105. In respect of the Ministry of Health Service Specifications, and the section 141 contract with Oranga Tamariki — Ministry for Children, as outlined above, IDEA Services told HDC that its monitoring of foster placements includes:

1. Caregiver home visits (monthly);
2. Effective communication amongst the key parties (family, caregiver, school, health services, NASC and IDEA Services);
3. Regular (ideally monthly) supervision of the Service A Co-ordinator/Manager by their Reporting Officer; and
4. Review of the section 141 agreement through family group conferences.

Caregiver home/site visits

106. As stated above, the home visits were in place to provide support to, and to "foster engagement" with, the foster caregivers within Service A who were caring for children contracted with IDEA Services, and were required to be undertaken on a monthly basis. Standard 21, "Monitoring", in the Service A Manual states:

> "All [services] will be monitored and reviewed to ensure they continue to meet the needs of families and service users … Expectations of minimum supervision, contact and review levels are provided in the schedule below."

107. The schedule states that for individuals in a foster care arrangement, contact is to be made with the caregiver fortnightly by telephone or through a meeting, and that a home visit is to be undertaken on a monthly basis.

108. The IDEA Services Service A Manager or Co-ordinator tasked with the home visit was required to complete a home visit form. The purpose of the form was to provide a brief summary of any "key issues", progress on support plan goals, any health, medical and medication management issues and needs, therapy, educational, vocational or safety issues, any family or home visits, and any caregiver issues, needs, and actions required.

109. Between December 2013 and December 2015, only 15 home visits were carried out in total, and the visits rarely considered any aspect of Master A's medication management or his medication folder. It is apparent that Ms D, as a Co-ordinator and, subsequently, a Service A Manager, was involved in Master A's care and had contact with Mr and Mrs B throughout this period. No concerns were noted other than Mrs B requiring items such as gloves and additional timesheets, and changes to respite cover. Of note, in November 2015 Mr F documented on the final home visit form that Mr and Mrs B needed further information and training on elements such as the use of Master A's hoist, and training on his seizure medication.

110. In relation to the home visits not always being carried out on a monthly basis, Ms D, who previously had been a co-ordinator with IDEA Services, told HDC that there were changes in staff and insufficient resources to be able to carry out these visits, and that these concerns were reported and discussed with multiple senior managers. Ms D stated that she raised her concerns about her caseload with the Acting [Service A] Manager (who was located outside of the region), and was advised to "maintain contact as much as possible and to visit those caregivers that required a higher level of support".

111. Ms D was appointed as the Service A Manager for the region in 2014. Ms D told HDC that until 2015, she was responsible for "all services", and that for "much of these months [she] worked alone as [she] had to advertise for a new coordinator". Area Manager Ms C and IDEA Services state that in 2015 they were aware that Ms D was facing a number of personal issues, which they believe may have contributed to the gaps in expected monitoring and the oversight process.

112. Ms C told HDC that in response to workload concerns, she employed an additional co-ordinator, Mr F, in August 2015, to "strengthen [Service A's] operations" in the region.

113. Ms C stated that she met with Ms D monthly where possible for formal supervision, and they would discuss any issues Ms D had around the service users and caregivers for whom she was responsible.

114. During a home visit on 25 November 2015, Mr F identified that Mrs B required training on medication management and the use of the hoist.

115. IDEA Services told HDC:

> "In respect of management oversight, the case note functionality of IDEA Services' client information system provides a framework for the [Service A Manager] to see the frequency of required contact to effectively monitor and manage the service provided, and also for their respective manager to review through supervision of the [Service A Manager].
>
> …
>
> IDEA Services considers that appropriate processes are in place for regular home visit requirements. It is disappointing that these processes were not followed consistently by the relevant management in these circumstances, and over the relevant period of time.
>
> It is apparent that interpersonal communication differences between [Mrs B] and [Mr and Mrs A] have existed for some time. Despite this, in IDEA Services' view [Mrs B] provided compassionate and competent care for [Master A] since 2004, with oversight by IDEA Services. [Mr and Mrs B's] home has always been immaculate. Any allegation of neglect and sub-standard care of [Master A] is not accepted."

116. IDEA Services told HDC that it acknowledges that Master A's placement was not being monitored in accordance with organisational standards.

Medication management

117. IDEA Services told HDC that Master A's medication folder was to be checked at the home visits, which were required to be undertaken on a monthly basis. The monthly caregiver home visit form provides a record of a check of the medication folder. The form required the IDEA Services staff member carrying out the visit to "collect completed Medication Sign Off sheets, check and file, [and ask,] [H]ave there been any doctor's visits? Any changes to medication?" IDEA Services does not have any particular requirement for the signing sheets to be checked on receipt. However, IDEA Services stated that, in practice, the relevant manager for the service user usually checks these prior to arranging for the signing sheets to be filed. Following Master A's uplift, it was identified that all of his medication signing sheets from 2015, and some sheets from 2014, had not been collected by IDEA Services. Ms D stated that on previous years she had collected the sheets from Mr and Mrs B and had checked them before filing, and they were completed consistently.

118. The home visit form includes a tick box for co-ordinators and managers to note that they have sighted the medication folder. Ms C told HDC that following the identification of the lack of regular home visits, she found improvements that could be made in the medication file records and medication monitoring processes. She stated:

> "In essence [Ms D] had ticked the medication file as sighted but had not taken the further step of checking medication matched doctors prescribing sheet, protocols were up to date and signing sheets completed. [Ms D] received further training to clarify what was expected and how to achieve this."

119. In relation to the medication checking at home visits, Ms D stated that in 2014, "when the blue medication files were introduced to [Service A] there was little to no training as to what documents were required [to be included]".

120. IDEA Services stated:

> "Other procedures and processes for medication management also include medication audits, and a range of [audits] which may include [as a] criterion of the audit to [audit] medication management. IDEA Services policy is to apply these appropriately to ensure compliance."

121. Following its investigation into Mr and Mrs A's complaint to HDC, IDEA Services noted:

> "[I]t is acknowledged oversight of medication for [Master A] fell short of organisational expectations including the structure, organisation and contents of [Master A's] medication folder alongside other service management procedures. Home visits were also irregular and incomplete also during 2014–2015. There was minimal oversight or audit during that time by [Ms D] of [Master A's] medication so we cannot establish the practice of the caregiver in managing medication including management when there were changes to [Master A's] medication."

122. In addition, IDEA Services reported that an incident report form dated August 2013 was located in a previous manager's office (the manager had been on leave at the time, and no one had been reassigned to deal with the incident reports). The incident report raised concerns from a respite caregiver about Mr and Mrs B having sent Master A to respite care without his medication folder and PRN medication. It was unclear to the IDEA Services staff who located the incident report in 2014 as to what action had been taken at the time. It is documented that a Regional Services Manager (unnamed) discussed the incident report with Mrs B, but no evidence exists that it was discussed with Mr and Mrs A. Mr and Mrs A said that they were not informed of this incident report. IDEA Services asked the respite caregiver for further information, but she stated that she no longer recalls the specific details.

Communication with the school

123. While the Ministry of Health Service Specifications required IDEA Services to engage with educational establishments, with regard to the communication between IDEA Services and the school, IDEA Services told HDC that it did not have any contractual relationship or agreement with the school. It stated:

> "It was expected that the [Service A Manager] would liaise with any school [Master A] attended to establish a communication pathway to address both emergency and non-emergency support need[ed]. Although there was some limited contact in this

> manner, it would have been expected that more regular and formal processes were agreed and put in place."

124. There is no documentation demonstrating contact between the school and IDEA Services staff. All documented communication between 2014 and 2015 relates to contact between the school, Mr and Mrs A, and/or Mr and Mrs B. The school principal stated that she cannot recall IDEA Services professionals talking to the school. Mr and Mrs A stated that a previous manager maintained more contact with the school.

Concerns raised by Mr and Mrs A

125. On 26 April 2012, Mr and Mrs A emailed IDEA Services outlining their concerns that there had been a decline in their relationship with Mrs B, and that the care that Mrs B was providing to Master A was "not of an acceptable standard". Mr and Mrs A stated that the school also had expressed concerns to them about the care provided to Master A. In the email, Mr and Mrs A stated:

> "We would appreciate if IDEA Services could please provide alternative care arrangements for [Master A], preferably in a long term stable environment … our strong preference would be for [Master A] to be placed in one of IDEA Services Residential units …"

126. Mr and Mrs A understood that IDEA Services was aware of their concerns about Mr and Mrs B's care of Master A, and had been looking for an alternative placement for Master A for a number of years before he was uplifted in 2015. Mr and Mrs A stated that they requested that this email remain confidential to IDEA Services, and said that the email was not responded to. Mr and Mrs A's concerns remained confidential as requested, but, as outlined above, it is documented that during the 11 May 2012 home visit to Mr and Mrs B carried out by Ms D, Ms D discussed healthy eating with Mrs B, and the importance of communication with others involved in Master A's life and care was also emphasised at this visit.

127. IDEA Services told HDC that in its opinion the request from Mr and Mrs A for a transfer to residential services was due to relationship difficulties and communication issues they experienced with Mrs B, and not due to quality of care. IDEA Services stated that when concerns were raised about the communication breakdown in 2012, a meeting with Mr and Mrs A was held on 10 May 2012, and that following this, during the family group conference in October 2012, Mr and Mrs A made the decision to continue foster care placement with Mrs B.

128. Mr and Mrs A stated:

> "We knew that [Master A's] care had been less than ideal for at least five years and that the level of care had progressively deteriorated (also known to IDEA Services) and yet we maintained a position that we were unable and unwilling to have him live with us due to the profound level of his disabilities and the corresponding high level of care that he required."

129. Oranga Tamariki — Ministry for Children notes dated 12 October 2012 record that Master A's parents and IDEA Services both agreed to a new section 141 agreement. The notes state:

> "[T]here continues to be difficulties with the caregiver … however [the NASC has] advised [IDEA Services] this is really an issue they need to address, should not be part of FGC [family group conference].
>
> Outcome: FGC scheduled for 23 October — [The NASC representative] will liaise with [Ms D] from [IDEA Services] and advise that FGC will proceed to renew s141 agreement and they can address outstanding issues with caregiver outside of this process."

130. IDEA Services told HDC:

> "[Mr and Mrs A] initially requested IDEA Services provide residential care for [Master A] in May 2012. This was raised from time to time over the next few years … It is our understanding that the reason for [Mr and Mrs A's] request [in 2012] for residential placement was related to the communication issues, not related to quality of care."

131. IDEA Services further stated:

> "While IDEA Services at times actively recruited for an alternative foster caregiver for [Master A], finding a family who was willing and had the ability to meet [Master A's] support needs and appropriate physical environment in [the region] proved difficult."

132. In response to the provisional opinion, IDEA Services told HDC that according to its records, in response to Mr and Mrs A's request for residential placement made on 16 April 2012, in May 2012 Mr and Mrs A attended a meeting requested by IDEA Services, and that Mr and Mrs A's concerns were discussed at that time. IDEA Services also stated that its records show that in June and August 2012, IDEA Services had contact with the school Master A was attending at that time. IDEA Services said that the concerns raised in 2012 were resolved to the satisfaction of Master A's parents, and Mr and Mrs A made the decision to continue the section 141 agreement with IDEA Services and the foster care arrangement with Mr and Mrs B.

133. Mr and Mrs A told HDC that IDEA Services never responded to their 2012 email, and nor did IDEA Services make contact with the school in response to their concerns.

134. No further concerns regarding Master A's placement with Mr and Mrs B are recorded in the notes of the three family group conferences between 2013 and 2015.

IDEA Services' investigation into Mr and Mrs A's concerns

135. On 9 December 2015, the NASC emailed Area Manager Ms C and stated:

> "I have received a letter regarding concerns of the ongoing care for [Master A] whilst in the care of [Mr and Mrs B] dated 8 December 2015 from [Mr and Mrs A] … I do not

> have the information necessary to respond fully to [Mr and Mrs A's] concerns, therefore can you review and investigate and let me know the outcomes."

136. IDEA Services told HDC that it believes that the initial concerns from Mr and Mrs A were related to a request for a change in Master A's residential facility. IDEA Services stated:

> "When [Mr and Mrs A's concerns were] subsequently raised again with the NASC (the following week), IDEA Services then treated the matters as a complaint. It was identified quickly in consultation between the Area Manager and [the General Manager] that the matters raised were serious enough to warrant [Master A's] removal from [Mr and Mrs B's] home whilst an investigation was carried out. We do consider that the complaint was seen as serious at that time, and was treated as such from the initial stages."

137. Following receipt of Mr and Mrs A's concerns from the NASC, Ms C undertook an investigation into the care provided to Master A by Mr and Mrs B. Ms C began employment with IDEA Services in 2006, and had reviewed a copy of the Complaints Policy at that time as part of her induction. Since that time, the Complaints Policy has been amended — notably, a section on open disclosure was added in 2009. There is no record of Ms C having reviewed the amended policy. As Area Manager, Ms C was assigned the task of investigating Mr and Mrs A's complaint in December 2015.

Complaints Policy

138. The Complaints Policy stated:

> "Complaint: A complaint is any expression of dissatisfaction about any aspect of the service offered or provided and may be followed by an attempt to resolve the matter if the person is still dissatisfied. A complaint may be made orally or in writing.
>
> …
>
> Investigator: Investigator is the person to whom the Chief Executive/Chief Operating Officer/General Manager/National Manager may delegate authority to investigate and respond to a complaint.
>
> …
>
> Open disclosure: A timely and transparent approach to communicating with and supporting service users when things go wrong. This includes giving a factual explanation of what happened, an apology and actions taken to prevent any further recurrence of the event.
>
> …
>
> Service User: A service user is any user of services, or person legally entitled to give consent on behalf of a service user …"

139. The section "Establish investigation" states: "Within one week sort out who will investigate the complaint, who needs to be talked to and how the investigation will take place." The

section "Who is Responsible" states: "Community Services Manager/Area Manager/ Regional General Manager."

140. The section "Investigate complaint" states:

> "Review all related documentation. Interview staff involved and consult with other relevant staff. **Speak with the service user to hear their complaint and to ensure they understand the process and what will happen** … [emphasis in original]. Document on complaint form. Record findings on file noting any required action or action taken to address the issue and send to the manager responsible for managing the complaint."

141. The section "Respond to Complaint" states:

> "Provide a factual explanation of what happened and an apology if things have gone wrong. Also state what actions will be taken to prevent recurrence of the event … Draft response letter giving results of investigation and set out actions/response taken to address the issue … Get response reviewed as appropriate, e.g. by Service Advisor, General Manager, Area Manager/Regional Service or Operations Manager before sending final response letter."

142. The section "Close Complaint" states:

> "If the complainant wants a meeting to seek resolution, arrange meeting with complainant's manager and/or Area/Regional Service/Operations Manager as appropriate."

143. Appendix 1 of the Complaints Policy outlines what is to be included in the "Final Response Letter". Of note, point 6.1.3 outlines:

> "• … State who carried out the investigation and what was involved, i.e. 'staff concerned were interviewed', or 'person/name provided a report.'
>
> • If a number of issues have been raised, address each one of these individually in chronological order. It is helpful to use general headings to illustrate clearly to the person that each issue has been addressed.
>
> • At each stage, where applicable, state what should have occurred and apologise if it did not.
>
> …
>
> • State what corrective action will or has been taken as a consequence of this investigation.
>
> …
>
> • State that if they still have concerns, they can contact you again, and/or a meeting can be arranged if preferable."

Investigation

144. IDEA Services General Manager Ms E stated:

> "As part of the investigation process planning in December 2015, [Ms C] and I discussed what was to occur following the completion of her report, which included meeting with [Mr and Mrs A]."

145. There is no documentation in relation to this investigation planning process. During the investigation, Ms C and/or Ms D spoke to Mr and Mrs B, the principal of the school and the mother of another service user who was under the care of Mr and Mrs B, and with IDEA Services staff members, including an IDEA Services staff member for Master A's holiday programme, Ms H. Mr and Mrs A were not interviewed.

146. Ms D, on behalf of Ms C, interviewed the Holiday Programme Team Leader and Holiday Programme Support Worker. Of note, Ms H reported that Master A's wheelchair was unclean with food down the sides. The holiday programme support worker stated that his wheelchair would smell of urine and that Mrs B would drop him off at the programme.

147. Ms C stated:

> "I did not meet with [Mr and Mrs A] in a formal interview as I thought I had the information I needed about their concerns to enable me to carry out the investigation. I thought their complaint was quite clear and before and during the investigation [Mr A] was in communication with [Ms D] or me most days. In hindsight I can see that it would have been beneficial and would have made for a more robust investigation if I had formally interviewed [Mr and Mrs A]."

Investigation Report

148. Following her discussions with individuals and review of the material she had collated, Ms C completed her investigation report. The report documented that she had reviewed Master A's file and case notes, the caregiver home visit forms, Mr and Mrs B's files and case note, Master A's medication file, the "running record" of concerns and seizure recordings from the school, the notification to Oranga Tamariki — Ministry for Children, and the incident reports. No record is made of the timeframe of the information and documentation that was reviewed by Ms C.

149. Ms C also documented that she interviewed individuals, including the mother of the other service user, Mr and Mrs B, Mr and Mrs A, the principal of the school, and Ms D.

150. On 16 December 2015, Ms C sent the investigation report to Ms E. On 17 December 2015, Ms E sent an email to Ms C and identified that there were no recommendations documented. On the same day, Ms C sent through an amended investigation report that included recommendations. On 18 December 2015, Ms E emailed Ms C and stated: "I have changed recommendations slightly."

151. The report lists a review of findings in relation to medication, additional respite care being provided by Mr and Mrs B, meals, use of the hoist, Mr and Mrs B's relationship with one

another, and other miscellaneous issues. There are seven recommendations, two of which relate to another service user in the care of Mr and Mrs B. The investigation report is four pages long.

152. Ms C also requested and, on 21 December 2015, received a copy of the Health Advisor's medication audit of Master A's medication folders. Ms C cannot recall the date on which she requested that the audit be carried out, and stated that the audit was requested to review the oversight Ms D had been providing, and was not for the purpose of the investigation. As the medication audit was received after Ms C had finalised her investigation report, it was not included as part of the report.

Summary report

153. On 9 December 2015, the NASC raised with IDEA Services Mr and Mrs A's concerns about the care that was being provided to Master A. On the same day, the NASC asked Ms C to forward a copy of her findings once the investigation had been completed. Following this request, on 17 and 18 December 2015 Ms C and Ms E also corresponded in relation to producing a separate summary report for the NASC. The email heading stated: "[Ms C] investigation findings for NASC." On 18 December 2015, the summary report was also reviewed by Chief Operating Officer Ms I. Later that day, Ms C provided the summary report to the NASC.

154. Of note, the summary report was one page long and included only a selection of the findings that were included in the investigation report. The summary report did not state the methodology of the investigation, who had been involved, or who had been interviewed. It contained two recommendations — that the Area Manager meet with Mr and Mrs A to discuss the findings, and that the Area Manager meet with the school to agree on how to raise concerns in the future. Neither recommendation appeared in the report. There is no mention in the summary report of the report being a "summary" of the findings of IDEA Services' investigation.

155. Initially, Ms C told HDC through IDEA Services that she did not send the NASC or Mr and Mrs A the section of the report where she outlined her thoughts on what changes and improvements IDEA Services could consider learning from the event. Ms C stated that she thought that this was intended for an internal audience. However, later she told HDC that she believed that the summary report was the approved version of her original report for sending to the NASC and Mr and Mrs A. Ms C stated that she was under the impression that all seven of her proposed recommendations were removed by Ms E from the summary report as they had not been formally adopted by IDEA Services.

156. It is not apparent who removed the recommendations that were directed as service level improvements or quality assurance processes for IDEA Services as an organisation. However, the copy Ms E sent to Ms I included only one recommendation, which stated: "Area Manager to meet with [Mr and Mrs A] to discuss findings of the investigation." Ms I added the additional recommendation for Ms C to "[m]eet with the school to agree how concerns are raised in the future". Ms E told HDC:

> "On reviewing the report, it appeared to me that the concerns raised had been investigated. On subsequent review, and once I had received all relevant information, it did not meet the organisation's expectations."

157. Ms I stated that the purpose of the summary report was to respond to the NASC complaint, and said that she had not seen the report prior to her review of the summary report. Ms I stated: "I don't recall making any deletions to the report but did add an additional recommendation that a meeting should be held with [Mr and Mrs A]."

Disclosure of investigation findings to Mr and Mrs A

158. Ms C told HDC that on 18 December 2015 she and Ms D telephoned Mr A to arrange a meeting, but Mr A was out of town and unavailable. Ms C stated that she went over the key findings over the telephone, and Mr A seemed happy with this. She said that following the close-down period after Christmas, she "regrettably forgot all about contacting [Mr A] until he asked for the report via [Ms D]". IDEA Services' notes (author unrecorded) state: "1247: [Mr A] [out of town] for client not back until 8–9pm tonight. For record — not re IDEA Services. School really noticed the diff so much. Meet next week." There is no documentation that details the investigation report having been discussed with Mr and Mrs A.

159. Ms D told HDC that she recalled a telephone call to Mr A being made with Ms C. Ms D said that Mr A was out of town and that the investigation findings were discussed, but that she could not recall the specifics.

160. IDEA Services stated that the note of the telephone call was made by Ms D, as it was made in her work journal.

161. Mr A's telephone records show that one incoming call was received from Ms D's mobile telephone number at 12.47pm. Mr A told HDC that he cannot recall Ms C discussing the investigation, and he believes that the short telephone conversation he had with Ms D was in relation to Master A's placement at the residential facility.

162. Ms E told HDC that on 18 December 2015 Ms C informed her that she had met with Mr and Mrs A and that they were happy with the investigation report and findings. Ms E stated:

> "It was not until months later that [Ms C] informed me that she had only spoken to [Mr A] on the phone and not in person. Again, at that later point, she told me that she had discussed the investigation report with [Mr A] and he was happy with the report."

163. Ms C stated:

> "I returned to work on 5th January 2016 and regrettably forgot all about contacting [Mr A] until he asked for the report via [Ms D]. I admit that I should have contacted [Mr A] sooner but I didn't and I can only apologise."

164. Ms C sent Mr and Mrs A the same summary report sent to the NASC. However, Ms C removed the recommendation that she meet with Mr and Mrs A. Ms C told HDC that she

removed this because she "thought it was redundant as she had already met with them". Ms C subsequently recalled that she had not met with Mr and Mrs A, and stated that she apologises for this error. Ms C told HDC:

> "I did not send him the section of the report where I outlined my thoughts on what changes and improvements IDEA Services could consider learning from this event. This was not an attempt to hide my findings. I simply thought this was intended for an internal audience and would not have been relevant to [Mr and Mrs A's] concerns."

165. Ms E stated:

> "My expectations were that [Ms C] should have followed the organisation's complaint policy. If she had done that, she would have met with [Mr and Mrs A], and they would have had a chance to provide feedback into the process and eventual report."

166. Ms E told HDC that the summary report was not intended to be sent to Mr and Mrs A, as Ms C was to discuss her investigation report with them and then send a follow-up letter of the conversation. Ms E stated: "I apologise that I did not sight all of the investigation documentation before reviewing [Ms C's] report and ensuring that the complaints policy was followed correctly."

167. On 13 April 2016, Mr A sent an email to Ms E asking whether Master A's medication folder had been reviewed as part of the internal investigation. Ms E followed this up with Ms C via email and asked whether she had met with Mr and Mrs A.

168. On 20 April 2016, Ms C emailed Ms E and stated that she had spoken to Mr and Mrs A "in person" and had given them the report that the NASC had been provided.

169. IDEA Services told HDC that its practice is to provide a summary report focusing on the key findings, and the outcomes and actions taken or planned to take in response to the findings.

Concerns regarding investigation

170. On 22 January 2016, Mr and Mrs A sent an email to IDEA Services requesting a copy of the findings of Ms C's investigation. On 26 January 2016, the summary report was provided to Mr and Mrs A by Ms C. The summary report sent to Mr and Mrs A was the same as the one provided to the NASC except that the only recommendation included was: "Meet with school to agree how concerns are raised in the future." The recommendation that Ms C meet with Mr and Mrs A had been removed by Ms C. On the same day, Mr and Mrs A sent an email to Ms C expressing concerns about the care Master A had received and raising their concerns about the blister pack medication having been found in Master A's drawers. Ms C did not respond to this email.

171. On 10 April 2016, Mr and Mrs A wrote to Ms E and stated:

> "In our initial complaint back in early December to the NASC you will see that our number one concern was around [Master A] not being given his medication properly.

> Additionally our follow up email to IDEA Services investigation of our initial concerns stated the following: '… when we received [Master A's] belongings there were multiple blister packs of medication where adhoc days of medication appear to have been given.' … [C]an you please confirm what procedures were in place to audit that the medication folder was being completed when [Master A's] medication was given."

172. In the email, Mr A also expressed concerns about the involvement in the investigation of Ms D, who had direct oversight of Mr and Mrs B and therefore could not be impartial, and that the investigation did not cover all of the issues complained about, in relation to medication. Mr A also requested Master A's medication folder.

173. On 13 April 2016, Mr A emailed Ms E and wrote:

> "[T]hanks for agreeing to supply a copy of [Master A's] medication folder contents. We would appreciate receiving a copy of these charts for the last 12 months that [Master A] was in foster care being the period 10 December 2014 to 10 December 2015. Given the improper medication dispensing was a key concern can you please advise if IDEA Services inspected [Master A's] medication folder as part of their internal investigation? If this was not inspected as part of the investigation can you please advise why not. If it was inspected can you please advise why no mention of it was made in the investigation report."

174. Initially, IDEA Services was unable to locate the requested medication signing sheets. However, it was later identified that Mr and Mrs B still had the signing sheets, and these were collected. On 26 April 2016, Mr A collected the signing sheets from IDEA Services and noted one week in December where a blank sheet had been included in Master A's medication folder, but which had been signed in the sheets collected. In relation to blister pack medication, the pharmacist said that when blister packs and medication signing sheets are dispensed from the pharmacy, "often more than one copy is printed out and sometimes an error is made". Mr and Mrs B also stated that sometimes more than one sheet would come from the pharmacy, and new sheets would be issued if Master A's medication was changed.

175. Following receipt of the communication from Mr A whereby he expressed dissatisfaction with the investigation report he had received in April 2016, Ms E completed an additional IDEA Services review in relation to Mr and Mrs A's complaint in December 2015. Ms E referred to the medication audit and detailed how the medication audit had identified inconsistencies between the contents of Master A's medication folder and organisational standards. Ms E wrote:

> "We acknowledge there were breakdowns in the medication procedures being applied to [Master A's] medication management. I apologise for these procedures not being followed."

176. Subsequently, in April 2016 Mr and Mrs A complained to IDEA Services about the quality of IDEA Services' investigation, including the involvement in the investigation of Ms D, who had direct oversight of Mr and Mrs B and therefore could not be impartial, and that the

investigation did not cover all of the issues complained about, including issues with the medication folder, and the blister packs having been located in Master A's drawer.

177. On 30 May 2016, Mr and Mrs A obtained the four-page investigation report under a Privacy Act request to IDEA Services. On 30 September 2016, Mr and Mrs A received a copy of the Health Advisor's medication audit, and on 13 October 2016 Mr and Mrs A received information from the IDEA Services' investigation, which recorded that between late 2014 and 2015 a holiday programme staff member had identified a pill down the side of Master A's wheelchair.

IDEA Services' responses to HDC

178. After Mr and Mrs A complained to this Office, IDEA Services told HDC in its response letter dated 20 July 2016 that the Area Manager had investigated the issues raised by Mr and Mrs A, that the investigation had been supported by an audit undertaken by an IDEA Services Health Advisor, and that the information had been provided to Mr and Mrs A. IDEA Services concluded at this time that "the investigation was reasonable, robust and appropriate as part of responding to the complaint".

179. IDEA Services also stated that on 20 January 2017 it acknowledged to Mr and Mrs A that it had become aware of the full circumstances surrounding the investigation and related process in December 2015, and that it apologised to Mr and Mrs A. This correspondence was provided to HDC.

180. IDEA Services also informed HDC that at this stage it carried out an additional review into the unanswered concerns of Mr and Mrs A about the unused blister pack medication found in Master A's drawers. IDEA Services stated that it was unable to establish the type of medication contained in the blister packs. IDEA Services said that at this time it offered Mr and Mrs A an opportunity to be interviewed as part of its review, and that the offer was declined. Following the additional review, Mr and Mrs A were given a draft copy of the investigation report, and an opportunity to provide further input before the report was finalised. IDEA Services told HDC that Mr and Mrs A's comments were then taken into account prior to the report being finalised.

181. In a later response dated 20 February 2017, IDEA Services stated that it is incorrect that the medication audit was considered as part of its investigation, and that Mr and Mrs A had been informed of the findings of the investigation.

182. In a later response dated 12 April 2017, IDEA Services told HDC:

> "Since we provided our initial response to the HDC in July 2016, and an update in February 2017, we have undertaken a more comprehensive review into the various concerns raised by [Mr and Mrs A], and the process that IDEA Services has followed in this regard.
>
> As a result of this recent review, we have been made aware at senior management level that the steps taken by the Area Manager in carrying out the initial investigation

> and subsequent summary report provided to [Mr and Mrs A], were not robust or meeting the organisations expectations (as we had initially believed) …
>
> In hindsight, we certainly wish we had acted more proactively at General Manager Level and above, including becoming more aware of this escalating complaint in the earlier stages."

183. IDEA Services stated that in April 2017 it also sent a further apology to Mr and Mrs A acknowledging the identified errors and failings and seeking resolution. This correspondence was provided to HDC.

184. IDEA Services told HDC:

> "IDEA Services acknowledges the complaints being made by [Mr and Mrs A], and we accept that we have not responded adequately to those complaints at the critical times. [Mr and Mrs A's] initial concerns raised in November 2015 were not sufficiently investigated or responded to as required by company policy."

Changes made since these events

185. IDEA Services acknowledged that Master A's medication was not managed in line with IDEA Services' policies, and has apologised to Mr and Mrs A. IDEA Services implemented several steps to prevent this from occurring again, including:

- Master A's medication folder was standardised to IDEA Services policy.
- All contracted caregivers have undergone further medication competency assessment and have been re-familiarised with the medication procedures in the region.
- The medication process and required checks have been reiterated to Service Managers.

186. IDEA Services told HDC:

> "As a direct result of this complaint and subsequent escalation, IDEA Services commissioned an independent legal review of the overarching Complaints Management Framework earlier this year. This review looked at recent escalated complaints and identified recommendations for improvement in the overall complaints management framework. That review led to a senior specialist resource being recruited to assist with high level complaints and the overarching process across the organisation. The organisation has consequently introduced a national priority focus on complaints management for Services staff in the past six months."

187. IDEA Services also stated that it has since run targeted training for Service Managers and Area Managers, with a particular focus on Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code) and IDEA Services' expectations when handling complaints.

Responses to provisional opinion

188. Mr and Mrs A were provided an opportunity to respond to the "information gathered" section of the provisional opinion, and declined to do so.

189. IDEA Services, Ms C, Ms D, and Mr and Mrs B were provided with an opportunity to respond to the relevant sections of the provisional opinion. Ms C and Mr and Mrs B did not provide any comment. IDEA Services' and Ms D's responses have been incorporated into the "information gathered" section above or outlined below, as appropriate.

190. Ms D stated that there was a lack of communication with Master A's school. She said that on a couple of occasions she had called the school and was unable to obtain an update because of confidentiality, but that this was not followed up.

191. Ms D stated:

> "I am aware that the number of required home visits were not carried out as per policy, however I do maintain that this was extremely difficult given the lack of resources and the other clients that required emergency support during the two year period … Of course this is not the fault of [Master A], however I do not believe he was neglected in any way. He was regularly seen at the IDEA Services Holiday Programme, which I managed, by staff, coordinators and myself."

192. Ms D also added that as of March 2015 she was asked to make no further contact with Mrs B after an allegation was made against her by Mrs B.

193. IDEA Services submitted that its medication policy is described in sufficiently plain English, and it does not agree that a separate medication policy specifically for foster caregivers would be advantageous, given that all core procedures in medication management are applicable in foster care and in residential settings. While IDEA Services accepts that some tailoring could be done within the same policy, it considers the extent of such tailoring to be small. It also stated that it does not believe that the tailoring of the medication policy would have had any material impact on the events that occurred in relation to this complaint.

194. IDEA Services stated:

> "While IDEA Services acknowledges there were deficiencies in the oversight we provided to [Master A], we do not accept that this lack of oversight resulted in a departure from any personal hygiene support or suitable meals being provided to him. While [Master A] may not have received all his medication on [four] occasions over the 11.5 years [Mr and Mrs B] cared for him, given the difficulties in administering medication to him, we consider this was a low incidence of medication not being administered."

195. IDEA Services accepts that it should have had an "ongoing relationship with the school as part of the oversight of [Master A's] support".

196. IDEA Services accepts the criticism that it did not treat Mr A's email of 30 November 2015 as a complaint, but stated that it considers that "the way the complaint was lodged contributed to some misunderstanding of [Mr and Mrs A's] concerns being raised at the time". IDEA Services stated:

> "Factors influencing that misunderstanding included the email being titled 'placement request for residential care facility' and aspects of the email requesting us to provide a response within 2 weeks including a written explanation of why [Master A] could not be placed in a residential facility. Further, we note that [Mr A] himself noted at the end of the November 2015 email that he was generally happy with the support provided by IDEA Services. He also requested that the contents of the email be kept confidential within IDEA Services. [Ms D] emailed [Ms C] about it on 2 December 2015, noting that she had already spoken with [Mr and Mrs A] about the email and the concerns raised, and that it would not be discussed at the Family Group Conference scheduled the next day on 3 December 2015."

197. IDEA Services told HDC:

> "The General Manager and Chief Operating Officer were of the understanding that the summary report was to be provided to the NASC/funder only. We accept that the General Manager could have had closer oversight of the proposed response to [Mr and Mrs A] by the Area Manager, but she did rely on what the Area Manager told her at the time."

198. IDEA Services further told HDC: …

> "We accept that the investigation process and resulting report (and subsequent summary report) could have been managed better, and we are truly sorry for the confusion and grief this has caused since. We are committed to ensuring that we have a robust framework in place for addressing complaints in relation to other service users going forward. We believe we have already done a significant amount of work in this area in the last 18 months, and we will continue to ensure that this remains a key focus area for Services staff."

Opinion: Mrs B

199. While my advisor, social worker Ms Nancy Jelavich, has identified several departures from the standard of care, I note that Mrs B is not a professional nor a peer of Ms Jelavich. I have used Ms Jelavich's advice to obtain an indication of the appropriateness of the care provided to Master A by Mrs B.

Medication management — adverse comment

Medication administration

200. There have been five reports of medication having been found down the side of Master A's wheelchair. While I acknowledge that the holiday programme staff member said that at some stage between late 2014 and 2015 she found an item down the side of Master A's wheelchair that she believes was a pill, I also note that other staff members present consider that it could have been a lolly. As I am unable to determine whether the holiday programme instance was a pill or a lolly, I find that there were at least four occasions, as reported by Mr and Mrs A, when medication was found in Master A's wheelchair or in his clothing. While I cannot determine the type of medication, as the pills were disposed of, I acknowledge Mr and Mrs A's concerns that Master A not receiving his medication could have had severely detrimental effects on his health, and that a certain level of care was required. I note Mrs B's submission that it could be difficult to administer medication to Master A as he would sometimes resist his medication, and that if he spat out the pill she would re-administer it. I note that there is no record of Mrs B having requested additional medication for Master A because of spoiled pills. Accordingly, I find that on these occasions, the pills that Master A did not swallow were not re-administered, as they were located in his wheelchair by other individuals.

201. Ms Jelavich advised:

> "As part of [Master A's] personal support information it states that [Master A] is able to take medications and is totally reliant on his caregivers administering this. It does not state that [Master A] has a history of spitting out/dribbling out his medication — at the time of the plan being developed this may not have been known."

202. Mr and Mrs B were responsible for administering Master A's medication on a daily basis, and must take a degree of responsibility for the pills found in his wheelchair. However, I am conscious of the fact that neither had confirmed to IDEA Services that they had read the Medication Policy 2014, and nor had any competency checklist been completed and returned to IDEA Services.

203. Expert advice was also obtained from a registered nurse and lead quality auditor, Ms Christine Howard-Brown. Ms Howard-Brown advised:

> "Although the [medication] policy can be considered thorough, it could be improved by developing a policy specific to foster care using plain English. The requirements within the policy could also be strengthened in relation to:
>
> — adding information about medications spat out
> — ongoing monitoring of competence
> — requirements for competence when people other than the caregiver named in the Foster care Agreement are or intend administering medicines
> — management of medication and medication administration records related to respite care and school."

204. I note IDEA Services' submissions regarding whether the Medication Policy used sufficiently plain English and whether it should have been tailored to foster parents. However, I am guided by Ms Howard-Brown's advice and am of the opinion that there were deficiencies with the Medication Policy owing to the absence of the above requirements. Accordingly, I remain of the view that the policy provided to Mr and Mrs B did not support them appropriately.

205. I also accept that administering medication to Master A could be difficult, and I note that Master A had grown since Mr and Mrs B had received their training on medication administration, and I note their comments that he would fling his arms around and resist taking the medication.[8] I consider that ongoing training and a medication policy that took into account the setting where care was being provided to Master A would have been of benefit to Mr and Mrs B in supporting them to provide care to a growing child with high needs. In addition, while I acknowledge and agree that it is important for Master A to receive his medication, there is no evidence that the increase in seizures reported by Mr and Mrs A was caused by medication not being administered.

206. I am of the opinion that if monthly monitoring meetings had occurred, deficiencies could have been identified sooner and remedial actions taken by IDEA Services at an earlier time.

Medication folder

207. Following IDEA Services' uplifting of Master A, the medication folder was found to be in disarray, and a medication audit found that the medication folder was inconsistent with organisational requirements. The IDEA Services Health Advisor, Ms G, who carried out the medication audit, recorded that there were failures in the medication records, including poor documentation on the file, the file being incomplete, no documentation of any PRN administration, and missing documentation from 2014 onwards for consultants, specialists, and allied services. It is apparent from the medication audit that Mr and Mrs B did not maintain Master A's medication folder in line with the Medication Policy and, accordingly, did not maintain his medication folder to an appropriate standard. I am critical of the level of care Mrs B provided in relation to Master A's medication administration.

Storage of medication blister packs — adverse comment

208. After Master A was uplifted from Mr and Mrs B, multiple blister packs of medication were found in Master A's belongings, raising concern that Master A had not received medication on a number of occasions. Mr and Mrs B told HDC that this was discontinued medication. The blister packs were subsequently provided to Mr and Mrs A and disposed of. Mr and Mrs A state that the blister packs were not discontinued medications. IDEA Services has not been able to confirm the type of medication found stored in Master A's drawers. I am unable to determine what medication was stored in Master A's drawers and why. I note that on 22 December 2014 the Medication Policy was amended to include a definition of "secure storage", to state that "blistered packaged medication should be in 'locked'

[8] Refer to footnote 5.

storage". There is no evidence that the December 2014 amendment was provided to Mr and Mrs B.

Suitable food — adverse comment

209. On 9 March 2012, a speech language therapist documented:

> "[Master A] is quite capable to meet his nutritional requirements well orally. He is able to eat a range of foods but finds foods that are soft and moist easier to manage. Dry, hard foods are difficult to manage as he does not chew effectively and mixed textures are problematic as once [Master A] has swallowed the liquid part he cannot safely chew and swallow the remaining harder lumps. Lumpy foods need to be dissolvable to reduce the risk of remaining food residue which is a choking hazard."

210. This report was provided to Mr and Mrs B. Mrs B told HDC that often she would provide a range of foods for Master A's lunch, including some pre-packaged foods and items such as fruit, yoghurt, muffins, fruit bars, custard, and a vegetable-based drink. Mrs B stated: "[Master A] needed food to be cut up into small pieces for him so he was able to chew and eat the food."

211. Ms Jelavich advised:

> "It was recorded by the school that at times the foods provided by [Mrs B] were not of the consistency as outlined in the personal plan and reported frozen pizzas and sausages were being sent to school that did not meet this requirement."

212. In addition, I note that Mr and Mrs B stated that Master A's food often included yoghurt, which the speech language therapist specifically noted was harder for Master A to control, and "tended to leak out from his lips".

213. I note that IDEA Services states that the letter dated 18 May 2012 is permissive of Mr and Mrs B offering Master A food with different textures. However, the letter states that although it was fine for Mr and Mrs B to continue to feed Master A these textures, the school needed to carry on with mushy and moistened food. In addition, it made no retraction about Master A's ability to eat foods such as yoghurt.

214. While I note Mrs B's observations and opinions about what she felt was appropriate for Master A, and those of IDEA Services, I am aware that Master A had had specialist reviews in 2012 and subsequent NASC assessments that outlined the food that was suitable for him. I am critical that Mrs B provided foods to Master A that were clearly at odds with the assessments, but am mindful that Mrs B may not have been aware of the concerns held by the school and Mr and Mrs A, and that there were no reported incidences of any choking episodes.

Personal cares — other comment

215. While I note that on occasion during the period between 2013 and 2015 the school documented concerns about Master A's hygiene and the use of his wheelchair and equipment, as outlined above, I have also considered Mr and Mrs B's submission that he

was always well cared for, and that his condition could change during the period of transport. I also note that the taxi driver who took Master A to school has submitted a statement outlining that Master A was always clean when he picked him up from Mr and Mrs B's residence. Although I note that there were some lapses by Mr and Mrs B in relation to missing equipment and food identified down the sides of his wheelchair when Master A arrived at school, and I hold concerns as to why this occurred, I am unable to make a finding that the instances of Master A arriving at school having soiled or wet himself occurred prior to him leaving Mr and Mrs B's house in the morning.

Method of transferring Master A

216. When the hoist was collected from Mr and Mrs B's home a month after Master A's uplift, the battery was flat. Mr and Mrs A consider that this is evidence that the hoist was not being used by Mr and Mrs B to transfer Master A. I note that Mr and Mrs B have submitted that in line with Master A's support plan they used either the hoist or alternatively a two-person lift, which was permitted, and that the battery likely ran out of charge between Master A's uplift and when the battery was collected from Mr and Mrs B. Mr and Mrs B also stated:

> "[T]he allegation we did not use the hoist makes no sense to [us] as it was needed to move [Master A] safely and not to cause harm such as skin tears or bruising to him or any fall and to also protect our safety."

217. Mr and Mrs B said that they are not aware of Master A having had any bruising or skin tears during the time they supported him. I also note that the mother of the other service user who lived with them stated that she witnessed Mr and Mrs B using the hoist, and that IDEA Services also stated that Mr and Mrs B used the hoist. I find that on the basis of the evidence provided, it is more likely than not that Mr and Mrs B used the hoist or a two-person lift to move Master A, in accordance with Master A's support plan.

Medication Administration Records

218. Between the evening of 10 December 2015 and 13 December 2015, it is documented in Master A's Medication Administration Record that medication was administered to Master A by Mr and Mrs B on seven occasions. However, Master A was uplifted from Mr and Mrs B on the morning of 10 December, and Mrs B could not have administered medication on those occasions. Mr and Mrs A expressed concern that this raises questions about the "authenticity" of all of the Medication Administration Records.

219. IDEA Services stated that as a result of its investigation it found that when Master A was uplifted from Mr and Mrs B's care, Master A's morning medication had not been signed for. According to IDEA Services, Ms D instructed Mrs B to sign the Medication Administration Records, which Mrs B misunderstood and mistakenly signed for the rest of the week.

220. With regard to the Medication Administration Records being completed after Master A was uplifted, Mrs B stated:

> "When [IDEA Services] uplifted [Master A] his medication and clothing etc were taken. By mistake his medication signing sheets were left behind by [IDEA Services]. When [Master A] was taken away I was very upset and stressed and by mistake I signed 2½ days in advance when he was not in our care. I apologise for this."

221. While I understand Mr and Mrs A's concerns, I accept that the medication was signed for in error, and there is no evidence to establish that Mrs B intentionally signed for dates where medication was not provided in order to mislead.

Opinion: Mr B

222. While my advisor, social worker Ms Nancy Jelavich, has identified several departures from the standard of care, I note that Mr B is not a professional nor a peer of Ms Jelavich. I have used Ms Jelavich's advice to obtain an indication of the appropriateness of the care provided to Master A by Mr B.

Medication management — adverse comment

Medication administration

223. There have been five reports of medication having been found down the side of Master A's wheelchair. While I acknowledge that the holiday programme staff member said that at some stage between late 2014 and 2015 she found an item down the side of Master A's wheelchair that she believes was a pill, I also note that other staff members present consider that it could have been a lolly. As I am unable to determine whether the holiday programme instance was a pill or a lolly, I find that there were at least four occasions, as reported by Mr and Mrs A, when medication was found in Master A's wheelchair or in his clothing. While I cannot determine the type of medication, as the pills were disposed of, I acknowledge Mr and Mrs A's concerns that Master A not receiving his medication could have had severely detrimental effects on his health, and that a certain level of care was required. I note Mr B's submission that it could be difficult to administer medication to Master A as he would sometimes resist his medication, and that if he spat out the pill it would be re-administered. I note that there is no record of Mr B having requested additional medication for Master A because of spoiled pills. Accordingly, I find that on these occasions, the pills that Master A did not swallow were not re-administered, as they were located in his wheelchair by other individuals.

224. Ms Jelavich advised:

> "As part of [Master A's] personal support information it states that [Master A] is able to take medications and is totally reliant on his caregivers administering this. It does not state that [Master A] has a history of spitting out/dribbling out his medication — at the time of the plan being developed this may not have been known."

225. Mr and Mrs B were responsible for administering Master A's medication on a daily basis and must take a degree of responsibility for the pills found in his wheelchair. However, I

am conscious of the fact that neither had confirmed to IDEA Services that they had read the Medication Policy 2014, and nor had any competency checklist been completed and returned to IDEA Services.

226. Expert advice was also obtained from a registered nurse and lead quality auditor, Ms Christine Howard-Brown. Ms Howard-Brown advised:

> "Although the [medication] policy can be considered thorough, it could be improved by developing a policy specific to foster care using plain English. The requirements within the policy could also be strengthened in relation to:
>
> — adding information about medications spat out
> — ongoing monitoring of competence
> — requirements for competence when people other than the caregiver named in the Foster care Agreement are or intend administering medicines
> — management of medication and medication administration records related to respite care and school."

227. I note IDEA Services' submissions regarding whether the Medication Policy used sufficiently plain English and whether it should have been tailored to foster parents. However, I am guided by Ms Howard-Brown's advice and am of the opinion that there were deficiencies with the Medication Policy owing to the absence of the above requirements. Accordingly, I remain of the view that the policy provided to Mr and Mrs B did not support them appropriately.

228. I also accept that administering medication to Master A could be difficult, and I note that Master A had grown since Mr and Mrs B had received their training on medication administration, and I note their comments that he would fling his arms around and resist taking the medication[9]. I consider that ongoing training and a medication policy that took into account the setting where care was being provided to Master A would have been of benefit to Mr and Mrs B in supporting them to provide care to a growing child with high needs. In addition, while I acknowledge and agree that it is important for Master A to receive his medication, there is no evidence that the increase in seizures reported by Mr and Mrs A was caused by medication not being administered. I am of the opinion that if monthly monitoring meetings had occurred, deficiencies could have been identified sooner and remedial actions taken by IDEA Services at an earlier time.

Medication folder

229. Following IDEA Services' uplifting of Master A, the medication folder was found to be in disarray, and a medication audit found that the medication folder was inconsistent with organisational requirements. The IDEA Services Health Advisor, Ms G, who carried out the medication audit, recorded that there were failures in the medication records, including poor documentation on the file, the file being incomplete, no documentation of any PRN administration, and missing documentation from 2014 onwards for consultants, specialists, and allied services. It is apparent from the medication audit that Mr and Mrs B

[9] Refer to footnote 5

did not maintain Master A's medication folder in line with the Medication Policy and, accordingly, did not maintain his medication folder to an appropriate standard. I am critical of the level of care Mr B provided in relation to Master A's medication administration.

Storage of medication blister packs — adverse comment

230. After Master A was uplifted from Mr and Mrs B, multiple blister packs of medication were found in Master A's belongings, raising concern that Master A had not received medication on a number of occasions. Mr and Mrs B told HDC that this was discontinued medication. The blister packs were subsequently provided to Mr and Mrs A and disposed of. Mr and Mrs A state that the blister packs were not discontinued medications. IDEA Services has not been able to confirm the type of medication found stored in Master A's drawers. I am unable to determine what medication was stored in Master A's drawers and why. I note that on 22 December 2014 the Medication Policy was amended to include a definition of "secure storage", to state that "blistered packaged medication should be in 'locked' storage". There is no evidence that the December 2014 amendment was provided to Mr and Mrs B.

Suitable food — other comment

231. During the course of the investigation it became apparent that Mrs B took on the role of providing Master A with his daily food for his lunches at school. Accordingly, I do not have comment to make about Mr B in this regard.

Personal cares — other comment

232. While I note that on occasion during the period between 2013 and 2015 the school documented concerns about Master A's hygiene and the use of his wheelchair and equipment, as outlined above, I have also considered Mr and Mrs B's submission that he was always well cared for, and that his condition could change during the period of transport. I also note that the taxi driver who took Master A to school has submitted a statement outlining that Master A was always clean when he picked him up from Mr and Mrs B's residence. Although I note that there were some lapses by Mr and Mrs B in relation to missing equipment and food identified down the sides of Master A's wheelchair when he arrived at school, and I hold concerns as to why this occurred, I am unable to make a finding that the instances of Master A arriving at school having soiled or wet himself occurred prior to him leaving Mr and Mrs B's house in the morning.

Method of transferring Master A

233. When the hoist was collected from Mr and Mrs B's home a month after Master A's uplift, the battery was flat. Mr and Mrs A consider that this is evidence that the hoist was not being used by Mr and Mrs B to transfer Master A. I note that Mr and Mrs B have submitted that in line with Master A's support plan they used either the hoist or alternatively a two-person lift, which was permitted, and that the battery likely ran out of charge between Master A's uplift and when the battery was collected from Mr and Mrs B. Mr and Mrs B also stated:

> "[T]he allegation we did not use the hoist makes no sense to [us] as it was needed to move [Master A] safely and not to cause harm such as skin tears or bruising to him or any fall and to also protect our safety."

234. Mr and Mrs B said that they are not aware of Master A having had any bruising or skin tears during the time they supported him. I also note that the mother of the other service user who lived with them stated that she witnessed Mr and Mrs B using the hoist, and that IDEA Services also stated that Mr and Mrs B used the hoist. I find that on the basis of the evidence provided, it is more likely than not that Mr and Mrs B used the hoist or a two-person lift to move Master A, in accordance with Master A's support plan.

Opinion: IDEA Services Limited — breach

Standard of care — oversight

Home visits

235. The Ministry of Health's "Disability Support Services Tier Two Specification — Foster Care" specifies requirements for foster care funded by Disability Support Services, and applied to Master A's placement with IDEA Services. Specification 6.4 states: "The provider will … support and encourage the foster family, by way of a fortnightly contact and a monthly home visit."

236. Standard 21, "Monitoring", in the IDEA Services manual provides that for individuals in foster care arrangements, contact is to be made with the caregiver fortnightly by telephone or through meetings, and that a home visit is to be undertaken on a monthly basis.

237. The Service A Manager and Area Manager were responsible for ensuring that regular home visits were occurring, that appropriate notes were being taken, and that actions were carried out where any need was identified.

238. IDEA Services was required to carry out monthly home visits with Mr and Mrs B and Master A to provide support and to identify any needs of Mr and Mrs B and/or Master A. During 2013, 2014, and 2015, only 15 home visits were carried out for Mr and Mrs B and Master A. The visits were carried out by Ms D, Mr F, and another IDEA Services staff member. It is apparent that during 2013, 2014, and 2015 several IDEA Services staff at a management level did not ensure that appropriate oversight was provided in this regard. This level of oversight was especially important, as Master A is a highly vulnerable individual who has extensive daily care needs and requires a significant amount of support.

Monitoring of medication folder

239. The IDEA Services Service A Manager or Co-ordinator tasked with the home visit was required to complete a home visit form. The purpose of the form was to provide a brief summary of any "key issues", progress on support plan goals, any health, medical, therapy,

educational, vocational or safety issues, any family or home visits, and any caregiver issues, needs, and actions required.

240. Master A's medication folder was to be checked at the monthly home visits. The monthly home visit form provides a record of a check of the medication folder. I note that while the home visit form required the IDEA Services Manager or Co-ordinator to "sight" the medication folder, it did not specify what documentation was to be checked, or how it was to be checked. Ms D told HDC that no training was provided by IDEA Services regarding what documentation was required.

241. The home visit form also required the IDEA Services staff member carrying out the visit to "collect completed Medication Sign Off sheets, check and file, [and check,] [H]ave there been any doctor's visits? Any changes to medication?". IDEA Services does not have any particular requirement for the signing sheets to be checked on collection. However, IDEA Services stated that, in practice, the relevant manager for the service user usually checks these prior to arranging for the signing sheets to be filed. Ms D accepted that signing sheets were not collected or checked in 2015. IDEA Services has not provided any information about whether the sheets were collected prior to 2015. Ms D stated that in previous years, she had collected the sheets from Mr and Mrs B and had checked them before filing, and that they had been completed consistently. While I note Ms D's submission that she collected sheets for previous years, it is apparent that Master A's signing sheets had not been collected for a year when Ms C collected them after Master A's uplift.

242. Following IDEA Services' uplift of Master A, the medication folder was found to be in disarray, and a subsequent medication audit found that the medication folder was inconsistent with organisational requirements. The IDEA Services Health Advisor, Ms G, who carried out the medication audit, recorded that there were failures in the medication records, including poor documentation on the file, the file being incomplete, no documentation of any PRN administration, and missing documentation from 2014 onwards for consultants, specialists, and allied services. The audit also identified that the contents of Master A's medication folder had not been checked.

243. Expert advice regarding the investigation was obtained from a lead quality auditor, Ms Christine Howard-Brown. Ms Howard-Brown also identified issues regarding absent medication signing sheets, an absence of PRN medication records, the failure to ensure that medication was stored in a secure locked cupboard, and infrequent review and consideration of the standard of Master A's medication folder at home visits.

244. It is apparent that Mr and Mrs B did not maintain Master A's medication folder in line with organisational requirements, and that between 2013 and 2015 several IDEA Services staff at a management level did not ensure that appropriate oversight was provided over Master A's medication management. I note that Ms D submitted that between 2013 and 2015 there were changes in staff and insufficient resources to carry out home visits. Ms D stated that this was reported and discussed with senior managers, and I note that Area Manager Ms C stated that she was aware of this in 2015, and had recruited as a result. Ms

C told HDC that in response to workload concerns she employed an additional co-ordinator, Mr F, in August 2015, to "strengthen [Service A's] operations".

245. I am particularly concerned that for a period of two years, IDEA Services staff were aware that the oversight was suboptimal, but took no action to manage the risk to Master A of not carrying out these visits, and also failed to take action to ensure that appropriate support and training was in place, as discussed below.

Training

246. The Ministry of Health's "Disability Support Services Tier Two Specification — Foster Care" specifies requirements for foster care funded by Disability Support Services, and applied to Master A's placement with IDEA Services. Specification 6.3.2 requires the provider to advise the foster parents of any training opportunities, and to ensure that the foster parents receive training commensurate with the needs of the person in the care of the foster parents. Specification 6.8, under the requirements of foster families, outlines what the provider (in this case, IDEA Services) is obliged to ensure that the foster family is capable of providing. The list includes:

> "Administer medication or assist the Person in taking medication in accordance with instructions from the prescribing doctor and the Provider's medication standards and policy."

247. The IDEA Services Caregiver Orientation policy stated:

> "Your manager/coordinator will ensure that you sign the Medication Policy Sign-Off Form which indicates that you have reviewed the policy and understood the content."

248. No courses in medication management, the use of Master A's hoist, good nutrition, or documentation were offered to Mr and Mrs B, and during the home visits, no needs relating to further training were documented until November 2015.

249. I further note that Ms Howard-Brown advised:

> "Where there is a couple acting as foster parents, and the agreement to provide foster care is with one rather than two parents, there needs to be clear expectations set for the support provided by the non-contracted foster parent. For example, whether they can administer medication and how their competence to administer medication is assessed and monitored."

250. In relation to Mr B, IDEA Services did not set clear expectations for Mr B's role in Master A's care, or how his competence was to be assessed and monitored.

Medication

251. Mr and Mrs B told HDC that administering medication to Master A could be challenging, as Master A would at times resist taking his medication by closing his mouth or moving his

arms.[10] On at least four occasions, medication was found in Master A's wheelchair or in his clothing, indicating that he did not receive that medication. Mrs B last received medication handling and administration training in 2010, and Mr B in 2012.

252. While IDEA Services implemented a new medication policy in October 2014, it did not ensure that it received confirmation from Mr and Mrs B that they had read the medication policy or that they had completed a "Medication Policy Sign-Off Form" confirming that they had read and understood the policy. In addition, training was not provided in relation to the new policy. It was not until 25 November 2015 that Mr F identified during a home visit that Mrs B required training on medication. I note that training was provided in 2016, after Master A had been uplifted from IDEA Services' care.

253. Furthermore, Ms Howard-Brown advised:

> "Although the policy can be considered thorough, it could be improved by developing a policy specific to foster care using plain English. The requirements within the policy could also be strengthened in relation to:
>
> — adding information about medications spat out
> — ongoing monitoring of competence
> — requirements for competence when people other than the caregiver named in the Foster care Agreement are or intend administering medicines
> — management of medication and medication administration records related to respite care and school."

254. I note IDEA Services' submissions regarding whether the Medication Policy used sufficiently plain English and whether it should have been tailored to foster parents. However, I am guided by Ms Howard-Brown's advice and remain of the opinion that there were deficiencies with the Medication Policy owing to the absence of the above requirements. I also note Ms Howard-Brown's comments:

> "Complacency can become an issue particularly if you have been caregiving for a number of years, the policies were signed off on only 2 occasions these dates were 2008 and 2010, and there had been no refresher training over a 6 year period."

255. I find that it was not appropriate for IDEA Services simply to provide a copy of the medication policy to Mr and Mrs B and expect them to read the policy without establishing whether they actually understood the policy and what was required of them. I hold the view that training should have occurred in these circumstances. Accordingly, I consider that the policy and the lack of refresher training provided to Mr and Mrs B did not support them appropriately.

256. I also accept that administering medication to Master A could be difficult. I note that Master A had grown since Mr and Mrs B had received their training on medication administration, and I note their comments that he would fling his arms around and resist

[10] Refer to footnote 5.

taking the medication.[11] I consider that ongoing training and a medication policy that took into account the setting where care was being provided to Master A would have been of benefit to Mr and Mrs B in supporting them to provide care to a growing child with high needs.

Medication folder

257. While I note that Mr and Mrs B were responsible for administering Master A's medication on a daily basis and updating his medication folder, I am conscious of the fact that neither had received training on the updated IDEA Services Medication Policy, which included changed expectations over medication management. I also note that the issues with the medication folders were not identified until after Master A was removed from Mr and Mrs B's care.

Storage of medication

258. After Master A was uplifted from Mr and Mrs B, multiple blister packs of medication were found in Master A's belongings, raising concern that Master A had not received medication on a number of occasions. Mr and Mrs B told HDC that this was discontinued medication. Subsequently the blister packs were provided to Mr and Mrs A, who disposed of them. Mr and Mrs A stated that they were not discontinued medications. IDEA Services was unable to provide any further information or confirmation on the nature or type of the medication found stored in Master A's drawers. I am unable to determine what medication was stored in Master A's drawers and why.

259. I also note that the updated Medication Policy was sent to Mr and Mrs B in October 2014, yet changes were made in December 2014 regarding the need for locked secure storage of medication. Accordingly, it is apparent that from 22 December 2014 the drawer in Master A's room was not an appropriate location in which to store medication. As stated above, Mrs B had not received training on the Medication Policy since 2010, and Mr B had not received training since 2012. There is also no record that the updated Medication Policy with the changed storage requirements was provided to Mr and Mrs B.

Engagement with the school

260. The Ministry of Health's "Disability Support Services Tier Two Specification — Foster Care" specifies requirements for foster care funded by Disability Support Services, and applied to Master A's placement with IDEA Services. Specification 6.5.1 states: "The Provider will develop and maintain effective relationships with the following to ensure that the needs of the Person are met … educational establishments." It is clear that between 2014 and 2015 the school had a number of concerns in relation to Master A's nutrition, personal care, and hygiene needs.

261. I note that IDEA Services has expressed that the school never raised these concerns with IDEA Services. However, the Ministry of Health contract required IDEA Services to engage with educational institutes, and this was not done for an extended period of time. I also note that the school's principal was entirely unaware that Mr and Mrs B were engaged by

[11] Refer to footnote 5.

IDEA Services to provide support to Master A. I am highly critical that, as part of its oversight of the care provided to Master A by Mr and Mrs B, IDEA Services failed to interact on an appropriate level with Master A's educational provider. Clear communication with the school would have allowed IDEA Services to identify and address any perceived issues in the care being provided by Mr and Mrs B.

Conclusion

262. Aspects of the services provided to Master A were unacceptable. I note that Mr and Mrs B were providing services in areas in which training had not been provided or was not up to date. Of note, I recognise that IDEA Services had not obtained confirmation from Mr and Mrs B that they had read the Medication Policy in 2014, Mr and Mrs B had not received the updated policy, which clarified that secure storage meant "locked", and Mr and Mrs B had not received any training on the updated medication administration policy until 2016, following receipt of the complaint.

263. IDEA Services had obligations under the section 141 agreements, the Ministry of Health Services specifications, and its own policies, which outlined the level of oversight required to be carried out for foster caregivers, including training and home visits, and what was to be reviewed at these visits. However, it is apparent that staff failed to comply with those obligations and policies consistently. In addition, the lack of oversight meant that the need for further training for Mr and Mrs B, and concerns noted by Mr and Mrs A and/or the school, were not identified by IDEA Services. I am of the opinion that had IDEA Services carried out appropriate and regular monthly home visits, where the competency needs of the foster caregivers were reviewed with regard to training needs, and had the medication folders been reviewed appropriately, the issues with the care Mr and Mrs B were providing would have been identified at an earlier time.

264. I note that IDEA Services has accepted that its oversight of the care provided to Master A by Mr and Mrs B fell short of the expected standard. IDEA Services 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 IDEA Services provided services of an appropriate standard. IDEA Services failed to provide appropriate oversight and support of the care provided by Mr and Mrs B for a prolonged period of time in the areas identified above, and also failed to engage with Master A's school.

265. Master A is a highly vulnerable individual who requires a significant amount of support and has extensive daily care needs. Master A is non-verbal and is unable to express concerns about the care he receives. It was vital that IDEA Services provide appropriate oversight and support to Master A's foster parents and caregivers to ensure that appropriate care was being provided. In my opinion, IDEA Services Limited failed to do so, and, accordingly, did not provide Master A services with reasonable care and skill, in breach of Right 4(1) of the Code.[12]

[12] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Complaint management — breach

266. IDEA Services told HDC that initially it did not treat the concerns expressed by Mr and Mrs A on 30 November 2015 as a complaint, as it viewed the concerns as a request for a transfer of residence. IDEA Services also stated that it considers that the way the complaint was lodged contributed to some misunderstanding about the concerns being raised at that time. IDEA Services also noted a comment at the end of the 30 November 2015 email that Mr A was generally happy with the support provided by IDEA services, and a request that the contents of the email be kept confidential within IDEA Services. However, I note that the IDEA Services policy in place at the time of Mr and Mrs A's complaint defined a complaint as "any expression of dissatisfaction about any aspect of the service offered or provided and may be followed by an attempt to resolve the matter if the person is still dissatisfied".

267. I am of the opinion that Mr and Mrs A's concerns expressed to IDEA Services on 27 November 2015 and 30 November 2015 about the administration of Master A's medication and the use of his equipment by Mr and Mrs B should have been recognised by IDEA Services as a complaint regarding Master A's care. I am critical that it took a further meeting with the NASC, which involved Mr and Mrs A raising these concerns again, for IDEA Services to treat the concerns as a complaint.

Investigation

268. IDEA Services has acknowledged that its investigation process and subsequent summary of the findings of Ms C's report sent to Mr and Mrs A did not meet its own expectations, and has communicated this to Mr and Mrs A and HDC. Ms C prepared an investigation report and a summary report. Only the summary report was distributed to the NASC and Mr and Mrs A.

269. Ms Howard-Brown reviewed both the investigation report and the summary report, and advised:

> "Appendix one of the Complaints Policy includes guidance for the completion of the final response letter. The [summary report] is almost entirely inconsistent with this guidance. The response to complainant letter is not dated. It does not outline the complaint or the investigation process but rather the findings. It refers to personal information about the foster carers that had not been substantiated (if the methodology section of the investigation report is accurate) and is inappropriately worded. The recommendations in the letter do not match the recommendations from the investigation report. The letter does not include an option to meet to discuss the investigation results or that the complainant has the right to refer their complaint to the Health and Disability Commissioner if they wish. The letter has spelling and grammar errors."

270. Based on the information available to review, it can be concluded that the full investigation was not completed in accordance with IDEA Services' policy expectations and is not of an acceptable standard that peers would expect. There remain elements of the original complaint that have not been adequately addressed.

271. As part of the investigation, Ms C and Ms D spoke with key parties, but did not interview Mr and Mrs A. Ms C stated that this was because she thought she had the information she needed about their concerns, the complaint was quite clear, and Mr A was in communication with her most days. However, she stated that in hindsight it would have made for a more robust investigation if she had interviewed Mr and Mrs A.

272. As well as interviewing key parties, Ms C documented that she reviewed Master A's file and case notes (although did not record the time frames of the documentation she reviewed), his caregiver home visit forms, Mr and Mrs B's files and case note, Master A's medication file, the "running record" of concerns and seizure recordings from the school, the notification to Oranga Tamariki — Ministry for Children, and the incident reports.

273. Ms C then provided her report to Ms E on 16 December 2015. Ms E identified that there were no recommendations in the report, and Ms C amended the report to include recommendations, and Ms E then changed the recommendations slightly.

274. The finalised report by Ms C was four pages long, and listed seven recommendations, two of which related to the other service user in the care of Mr and Mrs B.

275. 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 Ms C meet with Mr and Mrs A to discuss the findings, and meet with Master A's school to agree on how to raise concerns in the future. Neither of these recommendations were included in the four-page report. The summary report was reviewed by the General Manager, Ms E, and the Chief Operating Officer, Ms I (who was not provided with the four-page report). Ms I added the recommendation that Ms C meet with the school to discuss how concerns they held were to be raised in the future. Ms C then provided the summary report to the NASC.

276. The summary report was also provided to Mr and Mrs A, but the recommendation to meet with them had been removed.

277. Ms C states that she believed that the summary report was the approved version of her report for distribution to the NASC and Mr and Mrs A, and that all of the recommendations had been removed by Ms E as they had not been adopted by IDEA Services. IDEA Services also stated that its practice is to provide a summary report focusing on the key findings, outcomes, and actions taken or planned to take in response to the findings. Ms E stated that the summary report was not intended to be sent to Mr and Mrs A. While I note that IDEA Services has expressed its dissatisfaction to HDC about the manner in which Ms C carried out the investigation and drafted her report and subsequent response letter, it is apparent that the investigation report was reviewed and altered by the General Manager, and that most of the recommendations were removed for the purposes of the summary report. It is also apparent that the summary report was reviewed and amended by the Chief Operating Officer. I am aware that all the findings that were critical of the services and oversight provided by IDEA Services regarding Master A were removed prior to sending the summary report to the NASC and Mr and Mrs A. I am

of the opinion that this was all information relevant to the concerns about the care provided to Master A, and that there was no good reason for it to be withheld. I note that the information removed mostly relates to findings that suggest a lack of oversight on IDEA Services' behalf over the care provided by Mr and Mrs B to Master A. In addition, there is no identification of the report being a "summary" when it was provided to the NASC or Mr and Mrs A.

278. On the basis of the information received and reviewed, including the email chain between the senior managers outlined above, I find that at some stage during this process, information was deliberately removed from its report to minimise the significance of its findings. I can find no other reason, with the exception of the information relating to the other service user in the care of Mr and Mrs B, for IDEA Services staff to remove this information.

279. There are no notes of the investigation planning process meeting between the General Manager, Ms E, and Ms C. Further, while I note that the Complaints Policy stated, "Get response letter reviewed, as appropriate, e.g. by Service Advisor General Manager, Area Manager/Regional Service or Operations Manager before sending final response letter", the responsibilities of the managers who reviewed the investigation report are unclear, as is the documentation they should have reviewed, and whether anyone other than Ms C was responsible for signing off on the investigation report and/or response letter. However, it is clear from the emails between Ms C, Ms E, and Ms I that Ms C's senior managers held some involvement in the finalising of her report. Therefore, I accept that Ms C could have reasonably believed that her senior managers had not accepted her recommendations and had removed them.

280. IDEA Services has stated that in hindsight it would have been prudent to clarify the plan to share the investigation findings with Mr and Mrs A at the time those discussions were occurring in December 2015.

281. I note that despite the investigation report and summary report being reviewed by senior managers, IDEA Services did not identify shortcomings in the investigation of the complaint it received.

282. Mr and Mrs A expressed concerns about the complaints management process carried out by Ms C, and remained dissatisfied with IDEA Services' resolution of the complaint. The Complaints Policy states: "If complaint unresolved, it remains open and work continues to resolve the complaint." I am highly concerned that IDEA Services did not look into the correspondence of 26 January 2016 where Mr A raised concerns about partially used blister packs having been found in Master A's drawer, and the email on 10 April 2016 from Mr and Mrs A to Ms E where they expressed concern about the blister packs found in Master A's drawer and whether Master A's medication folder was reviewed by Ms C during her investigation.

283. Ms C told HDC:

> "The purpose of my investigation in my mind was to identify areas for personnel, service and process improvement in my branch that may also inform wider IDEA Services Policy Development."

284. However, I note that the Complaints Policy required Ms C to undertake the following:

> "… State who carried out the investigation and what was involved, i.e. 'staff concerned were interviewed', or 'person/name provided a report.'
>
> If a number of issues have been raised, address each one of these individually in chronological order. It is helpful to use general headings to illustrate clearly to the person that each issue has been addressed.
>
> At each stage, where applicable, state what should have occurred and apologise if it did not.
>
> …
>
> State what corrective action will or has been taken as a consequence of this investigation.
>
> …
>
> State that if [the complainants] still have concerns, they can contact you again, and/or a meeting can be arranged if preferable."

Conclusion

285. It is apparent that the Complaints Policy required Ms C to consider all of the issues raised by Mr and Mrs A, and to focus on providing them with the outcomes and the corrective actions taken, and an opportunity to meet to discuss the matter further. Accordingly, I do not accept that it was appropriate for Ms C to focus solely on service level improvements.

286. Following Ms C's investigation into the complaint, the finalised report recommended that Ms C meet with Mr and Mrs A to discuss the findings of her investigation. I note that Ms C accepts that she was supposed to meet with Mr and Mrs A in person, and states that she forgot to do this, but thought that she had. Ms C stated that this is why she removed the recommendation that she meet with Mr and Mrs A from the summary report prior to sending it to Mr and Mrs A.

287. Ms C and Ms D recall telephoning Mr A on 18 December 2015 to discuss the key findings of the report and arrange a meeting. Ms D said that Mr A was out of town and that the investigation findings were discussed, but that she could not recall the specifics. Mr A stated that he cannot recall any discussion of the investigation occurring in December 2015, and the telephone note of this conversation does not mention the report or a discussion of the findings, or the arranging of a meeting. Due to the conflicting information, I am unable to make a finding as to whether the investigation findings were discussed with Mr A on 18 December 2015 and, if so, to what extent.

288. Although IDEA Services had systems in place to respond to complaints, in my opinion it did not take sufficient steps to ensure that Mr and Mrs A's complaint was responded to appropriately and in line with the Complaints Policy in place at the time of events. As outlined above, IDEA Services' managerial staff failed to identify that Ms C had not adhered to the Complaints Policy, and did not identify that the investigation report and summary report did not meet the expectations of the Complaints Policy.

289. It is my view that IDEA Services' response to the concerns raised by Mr and Mrs A did not reflect a fair or proper investigation of their concerns relating to Master A's medication, use of the hoist, food, and personal cares. Of note, Mr and Mrs A expressed that their main concern was the management of Master A's medication, and the investigation into the complaint was completed by Ms C, Ms E, and Ms I prior to the receipt of the medication audit by Ms G.

290. It is apparent that even after Mr and Mrs A complained to this Office, IDEA Services in its response letter dated 20 July 2016 did not appropriately review the investigation it had taken in relation to Mr and Mrs A's concerns. Of note, IDEA Services submitted that the Area Manager investigated the issues that had been raised by Mr and Mrs A, that the investigation had been supported by a review undertaken by an IDEA Services Health Advisor, and that the information had been provided to Mr and Mrs A. IDEA Services concluded at this time that "the investigation was reasonable, robust and appropriate as part of responding to the complaint".

291. IDEA Services stated that on 20 January 2017 it acknowledged to Mr and Mrs A that it had become aware of the full circumstances surrounding the investigation in December 2015 and the related process, and apologised to Mr and Mrs A.

292. In a later response dated 20 February 2017, IDEA Services stated that it is incorrect that the medication audit had been considered as part of the investigation, and that Mr and Mrs A had been informed of the findings of the investigation.

293. In a later response dated 12 April 2017, IDEA Services told HDC:

> "Since we provided our initial response to the HDC in July 2016, and an update in February 2017, we have undertaken a more comprehensive review into the various concerns raised by [Mr and Mrs A], and the process that IDEA Services has followed in this regard.
>
> As a result of this recent review, we have been made aware at senior management level that the steps taken by the Area Manager in carrying out the initial investigation and subsequent summary report provided to [Mr and Mrs A], were not robust or meeting the organisations expectations (as we had initially believed) …"

294. IDEA Services also informed HDC that at this stage it carried out an additional review into "[Mr and Mrs A's] additional concerns about unused blister pack medication found in [Master A's] drawers".

295. IDEA Services stated that in April 2017 it also sent a further apology to Mr and Mrs A acknowledging the identified errors and failings and seeking resolution.

296. It is apparent that initially Mr and Mrs A tried to manage their complaint with IDEA Services, and received responses that were at odds with what had happened in reality in terms of IDEA Services' management of their initial complaint. It is hardly surprising that Mr and Mrs A chose to pursue their complaint through HDC.

297. Dealing with complaints effectively and meaningfully is an essential part of providing a quality healthcare service. It is apparent that IDEA Services' position on its management of the concerns expressed by Mr and Mrs A has changed over the course of time. IDEA Services completed the report of its investigation into Mr and Mrs A's complaint in December 2015. It is unacceptable that the issues identified by IDEA Services in April 2017 were not recognised and accepted by IDEA Services at an earlier stage.

298. IDEA Services had a complaints policy in place to deal with complaints from consumers and their guardians. Ms Howard-Brown advised that the full investigation was not completed in accordance with IDEA Services' policy expectations, and was not of a standard that peers would expect.

299. I conclude that the involvement of several senior management level staff in establishing a report that was not compliant with IDEA Services' complaints policy is reflective of a culture of non-compliance within IDEA Services' senior leadership team, and allowed such behaviour and non-compliance with IDEA Services' policies to occur.

300. Right 4(2) of the Code states that every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards. I do not consider that IDEA Services complied with its own standards when dealing with the complaint from Mr and Mrs A. Accordingly, I find that IDEA Services breached Right 4(2) of the Code.

Disclosure — breach

301. It is apparent that information obtained as part of IDEA Services' investigation into Mr and Mrs A's complaint was information that a reasonable consumer would expect to receive. As a health consumer, Master A had the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. As stated in HDC's "Guidance on Open Disclosure Policies", it is seldom reasonable to withhold information about a consumer from that consumer.

302. Master A and his guardians, Mr and Mrs A, were entitled to know about the failures and issues identified in the care provided to him by IDEA Services, including the issues with his medication management, the issues with the provision of suitable food to Master A, the issues with his hygiene cares, the use of the hoist, the lack of IDEA Services' oversight of Mr and Mrs B, and the discovery of, and content of, the incident report that was provided by a respite carer to IDEA Services in 2013, which reported that Master A was sent by Mr

and Mrs B to respite care without his medication folder and PRN medication, as identified as part of Ms C's investigation.

303. In addition, a medication audit of Master A's medication folder was carried out by Ms G, and although Mr and Mrs A had expressed concerns about partially used blister packs having been located in Master A's drawers, it was not until April 2016, five months after the initial complaint was made, that Mr and Mrs A were made aware of the results of the medication audit. The audit was not provided to Mrs and Mrs A until 30 September 2016.

304. IDEA Services failed to comply with its own Complaints Policy by failing to provide the findings of the investigation to Mr and Mrs A until 26 January 2016, and by failing to share the results of the medication audit that had been requested as a result of Mr and Mrs A's concerns. It is apparent that three senior management-level staff were involved in the drafting and finalisation of the investigation report and summary report, which did not adhere to the Complaints Policy in place at IDEA Services. I am highly critical that findings and recommendations that related to issues identified with the care and oversight provided by IDEA Services were not included in the report sent to Mr and Mrs A and to the NASC.

305. IDEA Services' definition of "Open Disclosure" is clearly laid out in its Complaints Policy, and states:

> "A timely and transparent approach to communicating with and supporting service users when things go wrong. This includes giving a factual explanation of what happened, an apology, and actions taken to prevent any further recurrence of the event."

306. It is clear that there were issues with the care provided to Master A by IDEA Services, and these issues were identified during Ms C's investigation and the subsequent medication audit. These concerns, and the above incident reported in 2013, were not conveyed to Mr and Mrs A.

307. Accordingly, IDEA Services failed to provide Master A with information that a reasonable consumer would expect to receive, and breached Right 6(1) of the Code.[13]

Medication Administration Records — other comment

308. Between the evening of 10 December 2015 and 13 December 2015, it is documented in Master A's Medication Administration Record that medication was administered to Master A by Mr and Mrs B on seven occasions. However, Master A was uplifted from Mr and Mrs B on the morning of 10 December, and Mr and Mrs B could not have administered medication on those occasions. Mr and Mrs A expressed concern that this raises questions about the "authenticity" of all of the Medication Administration Records.

[13] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"

309. With regard to the Medication Administration Records being completed after Master A was uplifted, Mrs B stated:

> "When [IDEA Services] uplifted [Master A] his medication and clothing etc were taken. By mistake his medication signing sheets were left behind by [IDEA Services]. When [Master A] was taken away I was very upset and stressed and by mistake I signed 2½ days in advance when he was not in our care. I apologise for this."

310. IDEA Services stated that as a result of its investigation it found that when Master A was uplifted from Mr and Mrs B's care, Mr B had not signed for Master A's morning medication. According to IDEA Services, Ms D instructed Mr and Mrs B to sign the Medication Administration Records, which Mrs B misunderstood and mistakenly signed for the rest of the week.

311. While I understand Mr and Mrs A's concerns, I accept that the medication was signed for in error, and there is no evidence to establish that Mr and Mrs B intentionally signed for dates where medication was not provided in order to mislead.

Opinion: Ms D — adverse comment

Service A

312. One of the functions of the Service A division of IDEA Services is to provide oversight of children placed with foster caregivers under section 141 agreements. Standard 21, "Monitoring", in the manual states: "All [services] will be monitored and reviewed to ensure they continue to meet the needs of families and service users." The Manual also provides that for individuals in foster care arrangement, contact is to be made with the caregiver fortnightly by telephone or through meetings, and a home visit is to be undertaken on a monthly basis.

313. In 2009, Ms D was employed by IDEA Services as a Service A Co-ordinator for the region. Ms D stated that she provided support to Mr and Mrs B and Mr and Mrs A until February 2013. However, it is clear from the case notes that Ms D communicated with Mr and Mrs B, and carried out home visits with them, throughout 2013, 2014, and 2015. In May 2014, Ms D became the Service A Manager in the region. As Service A Manager, Ms D was required to provide oversight and leadership of the local Service A Team, and was responsible for the day-to-day leadership of those staff employed by IDEA Services assigned to the Service A Manager. Ms D was specifically responsible for caregivers who provide foster care, including being responsible for the oversight of the care Mr and Mrs B were providing to Master A between May 2014 and December 2015.

Home visits

314. The monthly home visits were to be carried out by Service A. Following her time as a Service A Co-ordinator, during the time that Ms D was Service A Manager, nine home visits were carried out by Ms D and Mr F in 19 months.

315. The home visit forms required the IDEA Services employee to consider any "[c]aregiver Issues/Needs/Actions agreed" during each home visit. Between May 2014 and October 2015, these remained largely blank in relation to Mr and Mrs B, with the exception of needs such as additional gloves, respite carer arrangements, and the need for timesheets. Mr and Mrs B were not offered courses in medication management or the use of Master A's hoist, and no needs relating to further training were documented until November 2015.

316. I note that Ms D submitted that there were changes in staff and insufficient resources to carry out monthly home visits. Ms D stated that this was reported and discussed with multiple senior managers, and I note that Ms C stated that she was aware of this in 2015, and had recruited another co-ordinator as a result. In response to my provisional opinion, Ms D also added that she was asked to make no further contact with Mrs B as of March 2015 after an allegation was made against her by Mrs B.

317. Co-ordinator Mr F was appointed in August 2015 and reported to Ms D. Mr F assisted with liaising with foster caregivers and carrying out home visits. Following Mr F's appointment, five home visits were carried out over five months, although there is no documented home visit form for one of the visits.

318. Following a home visit on 25 November 2015, Mr F identified that Mrs B required training on "lifting/hoisting/seizure, medication". It is documented that Mrs B raised concerns about a lack of training on this occasion. It is apparent from the documentation for the home visits carried out by Ms D that the need for further training for Mr and Mrs B in relation to the administration and documentation of medication went undocumented by Ms D until it was identified on 25 November 2015.

319. Mr and Mrs A stated that their concerns about medication were raised with Ms D at a meeting on 27 November 2015. On 30 November 2015, Mr and Mrs A also emailed Ms D expressing their concerns about Master A's medication administration and their belief that Mrs B was not using the correct equipment to move Master A.

320. The Ministry of Health's "Disability Support Services Tier Two Specification — Foster Care" specifies requirements for foster care funded by Disability Support Services, and applied to Master A's placement with IDEA Services. Specification 6.5.1 states: "The Provider will develop and maintain effective relationships with the following to ensure that the needs of the Person are met … educational establishments." It is clear that between 2014 and 2015 the school had a number of concerns in relation to Master A's nutrition, personal care, and hygiene needs.

321. I note that IDEA Services has expressed that the school never raised these concerns with IDEA Services. However, the Ministry of Health contract required IDEA Services to engage

with educational institutes, and this was not done for an extended period of time. I also note that the school's principal was entirely unaware that Mr and Mrs B were engaged by IDEA Services to provide support to Master A. In response to the provisional opinion, Ms D noted that there was a lack of communication with Master A's school. She said that on a couple of occasions she had called the school and was unable to obtain an update "due to confidentiality", but that this was not followed up. I am highly critical that, as part of her oversight of the care provided to Master A by Mr and Mrs B, Ms D failed to interact on an appropriate level with Master A's educational provider. Clear communication with the school would have allowed Ms D to identify and address any perceived issues in the care being provided by Mr and Mrs B.

Medication management

322. Following IDEA Services' uplift of Master A, the medication folder was found to be in disarray, and a medication audit carried out by IDEA Services found that the medication folder was inconsistent with organisational requirements.

323. Expert advice was obtained from lead quality auditor Ms Howard-Brown, who advised:

> "A record of training for [Mrs B] held by IDEA Services was provided for review. This includes 17 training courses (some as self-learning modules) completed between 2004 and 2016. Of these, there was an introduction to medication administration in 2008, pre-packaged medication in 2010, medication errors in 2016. A medication competency checklist was completed in September 2010. This included a written answer on how to respond to medication errors and medication refusals amongst other questions … A medication policy sign-off form was completed in response to an updated policy in 2011."

324. It is apparent from the medication audit that Mr and Mrs B did not maintain Master A's medication folder in line with organisational requirements. It is also apparent that Ms D did not carry out monthly home visits between 2014 and 2015 and, when visits were carried out, neither she nor her co-ordinator identified any issues with Master A's medication folder. I note Ms D's assertion that during home visits it was observed that the medication folder had been organised with the required paperwork and had not always contained minimal documentation, and that it was not in the state of disarray found when Master A was uplifted. However, I also note the comments arising out of the medication audit completed on 21 December 2015, which included that documentation from consultants, specialists, and allied services is missing from 2014 onwards.

325. In addition, Ms D stated that there was little to no training as to what documents were required in the medication folder. On the home visit forms there was a tick-box for co-ordinators and managers to note that they had sighted the folder. No other guidance was provided on the home visit forms to managers and co-ordinators as to what specific documentation they were required to check.

326. I also note that the updated Medication Policy was sent to Mr and Mrs B in October 2014, yet changes were made in December 2014 regarding the need for locked secure storage of

medication. While Ms D provided the October 2014 Medication Policy to Mr and Mrs B, there is no evidence that she provided the updated December 2014 policy, or communicated to Mr and Mrs B the changes that had been made.

327. I note that Ms D felt that there were limited resources available, but I remain critical of the level of oversight carried out by Ms D over the care provided to Master A by Mr and Mrs B. Ms D failed to ensure that monthly home visits were carried out, and despite the requirement to check the medication folder on these visits she did not identify issues with Master A's medication folder, and nor did she document any need for further training of Mr and Mrs B.

Opinion: Ms C — adverse comment

328. Ms C held the position of an Area Manager at IDEA Services, and accepts that from November 2014 she was tasked with the oversight of Ms D. Ms C was also responsible for carrying out the investigation into Mr and Mrs A's complaint.

Oversight of Ms D

329. IDEA Services told HDC that Master A's medication folder was checked at home visits. The monthly caregiver visit form provides a requirement for a check of the medication folder. Following its investigation into Mr and Mrs A's complaint in 2015, IDEA Services concluded that the oversight fell short of what was required — in particular that there were irregular home visits and there was a lack of medication management undertaken by Mr and Mrs B.

330. The position description for an IDEA Services Area Manager stated that the primary objective was to lead and manage the delivery of person-centred support services in a designated area in accordance with IDEA Services' Philosophy and Policy. It also stated that the Area Manager was to "[p]rovide leadership and direction to the Area Management Team consistent with IDEA Services' strategies and operational goals".

331. Ms C was appointed as Area Manager for the region in December 2014 and was responsible for the oversight of services in the area. Ms C stated:

> "One of these was [Service A] and my direct report in this service was [Ms D] … In my role, I provided support, advice and guidance to [Ms D] when required and formal oversight of [Ms D's] role and the performance of the service."

332. In relation to the oversight of Ms D by Ms C, IDEA Services told HDC:

> "In respect of management oversight, the case note functionality of IDEA Services' client information system provides a framework for the [Service A] Manager to see the frequency of required contact to effectively monitor and manage the service provided, and also for their respective manager to review through supervision of the [Service A] Manager.

> An annual file review is another means to identify any gaps in the regularity of oversight visits. The review done in May 2015 did identify such gaps, but the Area team did not then develop an action plan to address the identified shortcomings as would have been expected …"

333. Ms C stated that she felt that Ms D was an experienced manager and that Service A was brought under the management of Area Managers only in November 2014. I accept that Ms C believed that she was carrying out the oversight that was expected of her by having monthly supervision meetings, and by employing an additional employee to strengthen Service A in the region. However, I note that Ms C did not pick up on the fact that monthly home visits were not occurring from December 2014 to August 2015, and I am critical that she did not use the tools available to her to assist in providing oversight of Ms D's role and performance of the service.

Investigation

334. Area Manager Ms C carried out the investigation into the concerns held by Mr and Mrs A. As part of the investigation, Ms C and Ms D spoke with key parties, but did not interview Mr and Mrs A. Ms C stated that this was because she thought she had the information she needed about their concerns, the complaint was quite clear, and Mr A was in communication with her most days. She stated that in hindsight it would have made for a more robust investigation if she had interviewed Mr and Mrs A.

335. As well as interviewing key parties, Ms C reviewed Master A's file and case notes, caregiver home visit forms, Mr and Mrs B's files and case note, Master A's medication file, the "running record" of concerns and seizure recordings from the school, the notification to Oranga Tamariki — Ministry for Children, and the incident reports. Ms C also requested a medication audit of Master A's medication folder. However, this was not received prior to Ms C finalising her investigation findings. Ms C stated that she had requested the medication audit for internal purposes relating to monitoring the oversight Ms D had been carrying out.

336. Ms C then provided her report to Ms E on 16 December 2015. Ms E identified that there were no recommendations documented, and Ms C then amended the report to include recommendations. Ms E then changed the recommendations slightly.

337. The finalised report by Ms C listed seven recommendations, two of which related to the other service user in the care of Mr and Mrs B.

338. A summary report was also prepared for the NASC. The summary report was reviewed by General Manager Ms E and Chief Operating Officer Ms I (who was not provided with the longer report). Ms I added an additional recommendation that Ms C meet with the school to agree on how to raise concerns in the future. Ms C then provided the summary report to the NASC. The summary report was one page long and included a selection of findings from the investigation report, but did not state the methodology, what information had been reviewed, or who had been interviewed, and included only two recommendations —

that Ms C meet with Mr and Mrs A to discuss the findings, and that Ms C meet with the school to agree on how to raise concerns in the future.

339. Ms C states that she believed that the summary report was the approved version of her report for distribution, and that all of her recommendations had been removed by Ms E as they had not been adopted by IDEA Services.

340. Expert advice was obtained from lead quality auditor Ms Howard-Brown. Ms Howard-Brown advised:

> "Appendix one of the Complaints Policy includes guidance for the completion of the final response letter. The response letter is almost entirely inconsistent with this guidance. The response to complainant letter is not dated. It does not outline the complaint or the investigation process but rather the findings. It refers to personal information about the foster carers that had not been substantiated (if the methodology section of the investigation report is accurate) and is inappropriately worded. The recommendations in the letter do not match the recommendations from the investigation report. The letter does not include an option to meet to discuss the investigation results or that the complainant has the right to refer their complaint to the Health and Disability Commissioner if they wish. The letter has spelling and grammar errors.
>
> Based on the information available to review, it can be concluded that the full investigation was not completed in accordance with IDEA Services policy expectations and is not of an acceptable standard that peers would expect. There remain elements of the original complaint that have not been adequately addressed."

341. As noted by my expert, there were elements of Mr and Mrs A's complaint that were not addressed adequately. I note that Ms C told HDC that "the purpose of [her] investigation in [her] mind was to identify areas for personnel, service and process improvement in [her] branch that may also inform wider IDEA Services Policy Development", as Master A had already been removed from the care of Mr and Mrs B and was not at risk. However, I note that the Complaints Policy required her to respond to the complainant, and stated:

> "If a number of issues have been raised, address each one of these individually in chronological order. It is helpful to use general headings to illustrate clearly to the person that each issue has been addressed."

342. It is apparent that the Complaints Policy required Ms C to consider the issues raised by Mr and Mrs A, which were conveyed again by the NASC, provide them with the outcomes and the corrective actions taken, and provide them with an opportunity to meet to discuss the matter further. Accordingly, I do not accept that it was appropriate for Ms C to focus solely on service-level improvements. At the time of the investigation, and in the subsequent months, Master A was still cared for by IDEA Services.

343. Ms C accepts that she was supposed to meet with Mr and Mrs A to discuss the findings of her investigation in person, and states that she forgot to do this, but thought that she had.

Ms C stated that this is why she removed the recommendation that she meet with Mr and Mrs A. Ms C stated that she and Ms D telephoned Mr A in December 2015 to discuss the investigation report and findings. Ms D told HDC that she recalled a telephone call being made to Mr A with Ms C. She said that Mr A was out of town and that the investigation findings were discussed, but that she could not recall the specifics.

344. Mr A said that he cannot recall any discussion of the investigation occurring with Ms C in December 2015. The telephone note does not record any mention of the investigation findings having been discussed with Mr A. Due to the conflicting information, I am unable to make a finding as to whether the investigation findings were discussed with Mr A on 18 December 2015 and, if so, to what extent.

345. IDEA Services has expressed dissatisfaction to HDC about the manner in which Ms C carried out the investigation and drafted her report and subsequent response letter. However, it is apparent that two other IDEA Services managerial staff reviewed and altered Ms C's investigation report before it was finalised. In addition, Ms C told HDC that she "understood that the report she received back from [Ms E] was the approved IDEA Services version of her original report to be used for communicating with the NASC and Mr and Mrs A". I note that IDEA Services disputes this understanding. The report was received via email and had the title "[Ms C] Investigation findings for NASC". As discussed above, the responsibilities of the managers who reviewed the investigation report are unclear, as is the documentation they should have reviewed, and whether anyone other than Ms C was responsible for signing off on the investigation report and/or the response letter. While I note the shortfalls in Ms C's investigation report and the disclosure to Mr and Mrs A of the findings of her investigation and of the medication audit, I note that Ms C had sent the report to managers at IDEA Services for their review and input, and had understood that they had approved the summary report for distribution. I am, however, critical of Ms C for providing only the summary report to Mr and Mrs A rather than the full investigation report, as it is apparent that the summary report did not include all the information that was relevant to the care Master A had been receiving from Mr and Mrs B and IDEA Services.

Recommendations

346. I recommend that IDEA Services:

a) Provide a written apology to Master A and his family for its breaches of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Master A and his family.

b) Audit its compliance with its Complaints Policy and provide HDC with the outcome of that audit within three months of the date of this report.

c) Confirm the implementation of the changes to its medication management policies, conduct a review of the effectiveness of these policies, and report back to this Office within three months of the date of this report.

d) In light of this report, and Ms Howard-Brown's comments on what could be improved in its Complaints Policy, report back on any further changes made to the policy, within six months of the date of this report.

e) Implement a policy outlining the responsibilities of IDEA Services employees and contractors to engage with educational and other establishments (including NASCs and the Ministry for Children) on a regular basis, and report back within six months of the date of this report.

347. I recommend that Ms D provide a written apology to Master A and his family for the deficiencies identified in the care she provided to Master A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Master A and his family.

348. I recommend that Ms C provide a written apology to Master A and his family for the deficiencies identified in the investigation she carried out following Mr and Mrs A's complaint to IDEA Services. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Master A and his family.

349. I recommend that Mr and Mrs B provide a written apology to Master A and his family for the deficiencies identified in the care they provided Master A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Master A and his family.

350. Should IDEA Services resume providing care via foster care arrangements, I recommend that IDEA Services:

a) Implement a system that outlines how a foster caregiver's competency to administer medication, to use support equipment, and to provide food, personal cares, and other aspects of daily living, is to be assessed and monitored on a regular basis.

b) In light of this report, and Ms Howard-Brown's comments on what could be improved in its Orientation Manual for Foster Caregivers, consider making further changes to include information about re-orientation processes for longstanding foster caregivers.

c) Implement a system whereby home visit forms are reviewed as an annual internal audit process.

d) Implement a policy requirement for all home visit forms to have all sections of the form completed during every home visit carried out, and ensure that all staff who perform home visits are trained on this policy requirement.

e) Following the first 12-month period of resuming foster care arrangements, conduct an audit of all home visit forms and medication folders for consumers under any such arrangement, and report back to HDC within six months of this audit commencing.

f) In light of this report, and Ms Howard-Brown's comments on what could be improved in its medication management policies, in particular their relevance and application to non-health professionals supporting vulnerable consumers in a home/family care setting, review its medication management policy and report back on any further changes made.

351. Should Mr and Mrs B resume providing care via foster care arrangements, I recommend that they:

a) Undertake further training in the handling and administration of medications, including the documentation and disposal of medication.

b) Undertake further training on incident reporting procedures.

352. I recommend that the Ministry of Health consider how its contracts effectively protect and safeguard vulnerable consumers who are placed into care under section 141 agreements.

Follow-up actions

353. IDEA Services Limited will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

354. A copy of this report with details identifying the parties removed, except IDEA Services Limited and the experts who advised on this case, will be sent to the Ministry of Health and Oranga Tamariki — Ministry for Children.

355. A copy of this report with details identifying the parties removed, except IDEA Services Limited and the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

356. The Director of Proceedings decided not to issue proceedings.

Addendum added 29 July 2019

357. The following information was provided by Mr and Mrs A following the conclusion of this investigation. It has been included as an addendum to the decision at the request of the Privacy Commissioner:

1. Master A is unable to use the left side of his body, including his left arm, hence he could not "fling his arms" (plural).

2. Master A does have limited movement in his right arm. However, he is severely limited in terms of dexterity and coordination, to the point that he lacks the ability to fling his right arm around in order to avoid taking his medication.

3. Master A has never ever "physically resisted" taking his medication.

4. Master A lacks the ability to physically "spit out a pill", or indeed anything else such as food that he does not like.

5. Mr and Mrs A said that they fully accept that at times it can be challenging to administer Master A's medication or feed him, e.g., if he has recently had a seizure and is more unresponsive than usual. In those situations it is more a case of the pill not being swallowed properly and it would then "sit in his mouth" and he would dribble out a partially dissolved pill.

6. Master A regularly dribbles, and has to have his bandannas changed throughout the day. Sometimes the dribbling can be quite extensive, which helps to explain point five above.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Christine Howard-Brown, a registered nurse and lead quality auditor:

"Thank you for your request on behalf of the Commissioner to provide an opinion on the care provided by IDEA Services to [Master A]. I understand that the opinion requested is specific to the standard of care provided to [Master A] by IDEA Services in its capacity as the contract manager of foster care services.

I am a registered nurse, lead quality auditor and hold a Masters of Business Administration. I have worked in secondary and tertiary care hospitals including community services as a clinical nurse specialist, nursing advisor and duty manager before I commenced working as a quality auditor in health and disability services in 2003. Most of my experience in disability services relates to service reviews, service improvement initiatives, quality audits and serious event reviews. To the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have reviewed records and correspondence documented on file and the issues presented in the letter requesting an opinion. To support the opinion, I have also referred to the Ministry of Health publication 'Roles and Responsibilities for Supporting Children and Young People with Disabilities under the Children, Young Persons and Their Families Act 1989' (2010); the Health and Disability Commissioner's Code of Rights; Health and Disability Services Standards NZS8134:2008 and Home and Community Support Sector Standard NZ8158:2012.

Background
[Master A], a 14-year-old boy with multiple disabilities, was placed in foster care with [Mr and Mrs B] when he was 2½ years old. This was done under section 141 of the Children, Young Persons and their Families Act 1989. As IDEA Services is an approved cultural social service under this Act, it is funded to provide care by the Ministry of Health and it retains overall responsibility for the day-to-day care of [Master A]. [Mr and Mrs A] maintain legal guardianship of [Master A].

On 22 April 2016, [Mr A] first raised his concerns with [HDC] about the care provided to [Master A]. Since then his complaint has evolved and grown as he has collected more information via Official Information Act requests to IDEA Services. […]

On 20 May 2015, [the school] [Master A] attended, made a notification to Child, Youth and Family Services (CYFS) regarding the poor care [Master A] was receiving from [Mr and Mrs B]. As a result of this, [Master A] was uplifted from [Mr and Mrs B's] care and transferred to [a residential facility]. This event triggered [Mr and Mrs A] to make a complaint to IDEA Services.

[Mr and Mrs A] advised IDEA Services that prior to [Master A] being uplifted by CYFS, they already had concerns about the standard of care being provided to him. However, they had been unable to move [Master A] from [Mr and Mrs B's] care due to a lack of a suitable alternative.

While [Master A] was in [Mr and Mrs B's] care, [Mrs A], [Master A's] mother, had found one of [Master A's] pills down the side of his wheelchair. Thinking it was a one-off, she did not raise any concerns. However, a week later, [Mrs A] found another pill down the side of [Master A's] wheelchair. The same day, [Mrs A] advised [Mrs B] of her finding and [Mrs B] undertook to be more careful. Unfortunately, the next week, [Mrs A] found another pill in [Master A's] wheelchair. [Mr and Mrs A] visited [Mr and Mrs B] and explained the need for vigilance regarding medication administration as the medication was required to help control [Master A's] seizures. Two or three weeks later, [Mrs A] found another pill in [Master A's] wheelchair.

[Mr and Mrs A], along with the [school], were also concerned about the standard of food [Master A] brought for lunch. Both reported that [Master A] often was provided 'heat and eat' meals such as — pizza, frozen food, muffins and leftovers. They were concerned that the quantity of food was often for two people, lacked nutrition, and the consistency was inappropriate for [Master A]. [Mrs A] compensated for this by providing [the school] with fruit and vegetables to supplement the food [Master A] was given by [Mr and Mrs B].

Following [Master A] being uplifted by CYFS, more concerns came to light for [Mr and Mrs A].

[Mr and Mrs A] believe that [Mr and Mrs B] were not using the hoist provided to transfer [Master A]. When the hoist was returned to them, the batteries were dead and the plug was missing. They are unsure how [Mrs B] would have transferred [Master A] in the school holidays as [Mr B] would have been at work during the day.

When [Master A's] personal belongings were returned to [Mr and Mrs A], they were concerned to find partially used medication blister packs in his drawers and his clothes and bedding smelt of cat urine.

On 26 January 2016, [Ms C] wrote to [Mr and Mrs A] to provide her findings into the care provided to [Master A]. [Mr and Mrs A] were not satisfied with her investigation and pursued the matter further with IDEA Services and made a complaint to the HDC office.

Opinion on specific advice requested

1. Whether IDEA Services provided appropriate oversight of [Mr and Mrs B's] medication administration to [Master A]

An initial investigation by IDEA Services in December 2015 into [Mr and Mrs A's] complaint acknowledged some medication issues had occurred. The findings stated there had been four instances where medications were found down the side of

[Master A's] wheelchair but this was not notified to IDEA Services; the medication file was in disarray; protocols outdated; and there was no medication administration signing sheet.

IDEA Services undertook, at its own discretion, a subsequent investigation in March 2017 into the initial investigation related to medication management. Information contained within the IDEA Services investigation report demonstrates expected medication management processes consistent with IDEA Services policies and procedures were not always used by [Mr and Mrs A].

In this report, IDEA Services state '*oversight of medication for [Master A] fell short of organisational expectations including the structure, organisation and contents of [Master A's] medication folder alongside other service management procedures*'.

From a review of records provided to the Health and Disability Commissioner, there are multiple examples which indicates oversight by IDEA Services requires improvement. This includes:

- failing to adequately respond to an incident report completed in August 2013 by the respite caregiver that raised concerns about medication management by [Mr and Mrs B]
- regular medication signing sheets provided for the last year do not represent a continuous record for the year indicating there may be some missing signing sheets. There were some minor anomalies in the signing sheets (related to the signing register)
- signing sheets indicate [Mr B] had been administering medications but there were no records provided by IDEA Services related to any training or competence testing of him to administer medications
- an absence of PRN (as needed) medication records for review. From progress notes it is clear there was seizure activity at school that required PRN and a reference to PRN medicine in one home visit home report (June 2015). These factors along with PRN medication use following [Master A's] placement in alternative care indicates it was likely that at times there was some PRN medicine use or indication that PRN medicine may have been required
- medications were not stored as required by IDEA Services medication policy
- Monthly home visits did not include documentation that indicated the medication folder was reviewed. In one home visit record, concerns are raised about PRN medications for discussion at the following meeting (with no subsequent record in relation to this).
- An analysis of medication folder documentation completed by IDEA Services in December 2015 (following [Master A] moving from [Mr and Mrs B]) found multiple irregularities including an unsigned PRN protocol and school developed PRN protocol which had been amended without associated documentation to check the accuracy of the amendment.
- IDEA Services concluded from its recent review that there was poor medication documentation held on file, the medication file was incomplete and there was no

documentation of any PRN medicine administration. Recommendations were made for standardisation of information consistent with IDEA Services policy, improved documentation and up-skilling for all families.

In summary, IDEA Services has acknowledged short falls in its oversight of medication management. There is adequate evidence within records provided to the Commissioner that supports this conclusion. There has been a significant departure from accepted practice in the implementation of IDEA Services policies that provide guidance in the oversight required when monitoring medication administration.

The standard of care for medication management is adequately outlined in the IDEA Services policy. Making improvements to this policy, monitoring its implementation, along with completion of orientation and re-orientation requirements to demonstrate competence in medication management would help prevent a similar occurrence in the future.

2. Whether IDEA Services provided appropriate oversight over the standard of care [Mr and Mrs B] provided to [Master A]

The Foster Care Agreement outlines IDEA Services obligations along with that of the foster carers. IDEA Services is responsible for, but is not limited to, fortnightly phone contact and monthly visits to monitor the placement and terms of the Agreement; advising of upcoming training opportunities and facilitating attendance; setting up the Lifestyle/Support Plan; providing emergency accommodation and respite; and auditing [Master A's] personal finances.

A series of Monthly Home Visit reports were reviewed. Reports were brief and most were incomplete with little or no progress reported against the support plan, little or no mention of medications and no mention of the medication folder being sighted. Where onward actions were identified, these were not always carried forward to onward months. One report (June 2015) mentions seizure activity and PRN medication issues with no subsequent action.

No records of fortnightly phone contact were provided for review. One Monthly Home Visit report referenced upcoming training to include lifting, hoisting, seizure, medication (November 2015).

From correspondence provided, [Master A] received respite from time to time. Reference in records was also made that [Master A's] personal finances were not being managed by the foster carers.

A foster care file review report was completed by IDEA Services in August 2014 and May 2015. The 2014 review found requirements were mostly met except for the following areas:

- monitoring of foster care placements to organisation's standards (missing some monthly reports)
- file does not contain a property inventory

— caregiver performance review overdue.

An incomplete copy of the 2015 report was provided for HDC review. Partial information provided rated requirements as met noting some file variation and one criteria not met noting the annual performance review was overdue.

The standard required by IDEA Services for maintaining the standard of care delivered by foster carers is consistent with contemporary practice. Documentation reviewed supports a lack of attention to detail to meet standards expected by IDEA Services. This represents a moderate departure from IDEA Services requirements and accepted practice in the oversight over the standard of care. Peers would be likely to accept that where there are such long standing arrangements with the foster carers, involvement by the parents, special schooling arrangements and on-going medical care, that a level of informality may occur when completing routine monitoring. For this reason, having supervision and/or rotation of IDEA Services staff completing routine monitoring is useful along with regular internal audits.

When a couple act as foster parents, and the agreement to provide foster care is with one rather than both parents, there needs to be clear expectations set for the support provided by the non-contracted foster parent. For example, whether they can administer medication and how their competence to administer medication is assessed and monitored.

3. The adequacy of IDEA Services' investigation into [Mr and Mrs A's] complaint

[The NASC] received a complaint from [Mr and Mrs A] about [Master A's] care provided by [Mr and Mrs B]. [The NASC] requested IDEA Services investigate the complaint and provided a copy of the complaint to IDEA Services on the 9th December 2015.

The complaint by [Mr and Mrs A] included several aspects:

— concerns about non-administered medication,
— additional caregiving of other (children with special needs, pre-school children and an adult with special needs) by [Mr and Mrs B] being inappropriate,
— meals having inadequate nutritional value,
— equipment not being used creating a health and safety risk,
— [Mr and Mrs B] not attending medical appointments, and
— breach of [Master A's] human rights.

The Complaints policy used by IDEA Services sets out requirements for complaints management including investigations. The policy requires acknowledgement of the complaint in writing within five working days of receipt; that the complaint is entered into the complaints register and an investigation is established within one week of the complaint.

From records provided to HDC, there is no acknowledgement letter. This may be because [the NASC] may have notified [Mr and Mrs A] given the complaint was made

to them and then handed across to IDEA Services. Although not best practice, it would be reasonable that IDEA Services did not also acknowledge the complaint if IDEA Services had knowledge or receipt of an acknowledgement letter sent by [the NASC] to the complainant that outlined the complaint had been handed to IDEA Services for investigation. IDEA Services stated it verbally acknowledged receipt of the complaint and agreed to investigate it with [the NASC].

Given the nature of the complaint included an alleged breach of [Master A's] human rights, risk associated with other children being cared for in addition to [Master A] and non-administration of vital medication, this complaint could have been considered serious requiring escalation to senior management and arguably meets the definition of a serious complaint as per the Complaints Policy.

The complaint was added to the complaints register. The initial investigation was commenced and completed within timeframes as required by the Complaints Policy.

The investigation methodology is outlined in the investigation report dated 16 December 2015. This included the review of relevant documentation and several interviews. Notably, the methodology did not include observation of [Master A], an interview of the foster carers, the pharmacist or the inspection of available equipment. Although likely to be unintended, in not interviewing the foster carers, not only insufficient information was collected in the investigation process, it did not meet principles of a duty to act fairly in respect of the foster carers and may be perceived as not being impartial.

The investigation report summarises the complaint. The summary does not include all aspects of the complaint. This includes omitting reference to a breach of [Master A's] human rights and that the foster carers were not attending medical appointments with [Master A]. This is likely to mean critical elements of the investigation into the complaint may not have occurred, especially as the report does not include reference to either of these matters.

The investigation report is poorly written. It doesn't reference the complaint properly (as discussed above), it omits information such as the number of reports reviewed, time period for which they related to, whether the methodology included notes of interviews or transcription, how information collected was corroborated, what documentation was assessed against (e.g. the personal support information, plan, prescriptions etc.); uses bullet points, some which are disconnected and without sufficient context or reference making their relevance difficult to interpret. The findings include some potentially unsubstantiated information that warranted verification. The findings imply the foster carers had been interviewed or alternatively information gathered unrelated to the investigation process had been used to provide a viewpoint from the foster carers' perspective. There is no analysis of findings or conclusion that then leads to the recommendations. It is unknown whether the report was peer reviewed.

Appendix one of the Complaints Policy includes guidance for the completion of the final response letter. The response letter is almost entirely inconsistent with this guidance. The response to complainant letter is not dated. It does not outline the complaint or the investigation process but rather the findings. It refers to personal information about the foster carers that had not been substantiated (if the methodology section of the investigation report is accurate) and is inappropriately worded. The recommendations in the letter do not match the recommendations from the investigation report. The letter does not include an option to meet to discuss the investigation results or that the complainant has the right to refer their complaint to the Health and Disability Commissioner if they wish. The letter has spelling and grammar errors.

Documentation from IDEA Services does not indicate whether this letter had been reviewed by a senior manager as required by the Complaints policy. This may be because an Area Manager was the author of the letter. However, good practice would include having such a letter peer reviewed.

IDEA Services has acknowledged the summary of the investigation and process did not meet its expectations and have communicated this to [Mr and Mrs A]. IDEA Services also states in its response to the Health and Disability Commissioner that it did not adequately respond to complaints made by [Mr and Mrs A].

Based on the information available to review, it can be concluded that the full investigation was not completed in accordance with IDEA Services policy expectations and represents a significant (major) departure in the standard required and that which peers would expect. There remain elements of the original complaint that have not been adequately addressed.

4. The adequacy of IDEA Services policies and procedures, in particular, its medication policy, monthly caregiver home visit form, and complaints policy

IDEA Services has a suite of policies and procedures, not all were provided for review. Comment is made on the medication policy, monthly caregiver home visit form and complaints policy. All policies, procedures and forms reviewed would be considered to meet requirements of either the Health and Disability Services Standards or Home and Community Support Sector Standards. Therefore, there is no departure in accepted practice in the adequacy of policies and procedures.

<u>Medication Policy</u>

The orientation manual for foster parents requires caregivers to comply with the [IDEA Services Medication Policy]. All caregivers are required to hold a copy of the Policy and be familiar with it. The manager or coordinator is required to ensure the Medication Policy Sign-off form is completed.

The Medication Policy provided to HDC for review is titled Medication Policy. The scope of the policy applies to all contracted caregivers and [employees]. This makes

the scope broad covering caregiving in the home by foster parents and residential care services operated by IDEA Services. The following observations are made:

- Such a broad scope could make interpretation of policy requirements difficult for foster carers to understand as some sections of the policy are relevant to certain services (not foster care).
- The definition of medication incident doesn't explicitly include medication spat out or found not to have been administered. There are instructions for medications dropped or spoilt (of which medication spat out or found not to have been administered would apply).
- Use of terminology could be confusing as terms are used such as service user, service staff which are unlikely to represent plain English for a foster carer.
- The policy is thorough and includes management and administration of medication, medication errors and incidents, references to forms, quick reference information, requirements for the blue medication and health folder; and PRN protocol development. The policy also references competency assessment requirements and forms requiring completion for medication competency.

Although the policy can be considered thorough, it could be improved by developing a policy specific to foster care using plain English. The requirements within the policy could also be strengthened in relation to:

- adding information about medications spat out
- ongoing monitoring of competence
- requirements for competence when people other than the caregiver named in the Foster care Agreement are or intend administering medicines
- management of medication and medication administration records related to respite care and school.

Monthly caregiver home visit form

The Orientation Manual for Foster Parents sets out expectations for supervision, contact and review by managers/coordinators and includes monthly home visits. There is an IDEA Services document entitled Minimum Contact Standards for Foster Care. This includes a requirement for completion of the Monthly Home Visit form.

The form is self-explanatory and includes prompts for completion. If completed in full each month, the form would provide sufficient information to support monitoring by IDEA Services consistent with the Foster Care Agreement.

It was noted, in several monthly caregiver home visit forms reviewed in relation to [Master A], that they were incomplete.

The Minimum Contact Standards for Foster Care Service could be strengthened by adding a mandatory requirement for the Monthly Home Visit form to have all fields completed; and providing more information or referencing the responsibilities for what to specifically check in relation to medication management each month. If not

already undertaken, IDEA Services could include monitoring the completion of Monthly Home Visit forms to its internal audit process.

Complaints policy

There is a Complaints Policy. This is comprehensive and includes a policy statement, references to legislation, definitions, the complaints process, guidelines and associated pro-forma letters including plain English resources.

The policy is consistent with the Code of Rights. The Complaints policy is well written and could be considered a comparable example to other health and disability services.

There is an opportunity to update the Complaints policy or provide some supplementary information that includes further definitions (e.g. of a serious complaint in the definitions section) and provide more guidance as to collection and analysis of information collected as part of the investigation process.

Orientation Manual

The orientation manual reviewed is comprehensive. It could be strengthened by adding information about re-orientation or maintaining competence where there are long-standing agreements with foster carers.

5. Whether IDEA Services were sufficiently clear with [Mr and Mrs B] with respect to their role and scope of responsibilities

A Foster Care Agreement held between IDEA Services and [Mrs B] dated May 2015 includes responsibilities of the caregiver ([Mrs B]) and IDEA Services. The Board Payment is in respect of both [Mr and Mrs B]. Responsibilities include references to several policies and procedures including that the caregivers will provide services in accordance with IDEA Services transport policy, incident reporting policy, philosophy of IDEA Services; medication standards and policies. Reference is also explicitly made to the caregivers attending relevant training and meetings.

A previous Foster Care Agreement was provided for review dated March 2014 which includes equivalent content as the 2015 agreement, but was an agreement between IDEA Services and both [Mr and Mrs B]. IDEA Services stated it no longer held more historic orientation information. IDEA Services also states in its response to the Health and Disability Commissioner that the agreement to deliver foster care was with [Mrs B] (i.e. didn't include [Mr B]).

The May 2014 IDEA Services caregiver orientation manual was provided for review. This is a comprehensive manual which includes, but is not limited to, information about IDEA services philosophy, types of caregiving, roles and responsibilities of a caregiver, respite, training, support and supervision, meetings, performance reviews, complaints management, Code of Rights, other legal provisions under legislation, finances, health and safety, emergency procedures, family contact, incident and accident reporting and medication requirements. It references policies and

procedures and competence requirements relevant to the caregiving role. There is an orientation checklist requiring sign-off by the caregiver and manager included.

A copy of a completed orientation checklist specific to [Mrs B] was provided dated 20 May 2010. This references a July 2001 orientation manual (so a prior version to the May 2014 version provided for review but likely to be very similar based on a comparison of the checklists).

A record of training for [Mrs B] held by IDEA Services was provided for review. This includes 17 training courses (some as self-learning modules) completed between 2004 and 2016. Of these, there was an introduction to medication administration in 2008, pre-packaged medication in 2010, medication errors in 2016. A medication competency checklist was completed in September 2010. This included a written answer on how to respond to medication errors and medication refusals amongst other questions.

A medication policy sign-off form was completed in response to an updated policy in 2011. Although the training record includes First Aid having expired in 2014, there was a training certificate dated 11 October 2014 so it was likely valid at the time of the complaint. Safe handling had not been undertaken in the period for which the training record covers.

All records pertain only to [Mrs B] and not [Mr B]. However, there are medication administration records signed by [Mr B] in 2015 and references within documentation reviewed which indicated [Mr B] took an active carer role.

No annual performance reviews were provided for review.

[Master A's] personal support information is dated December 2013 (created in 2009 and updated in 2013) with the next review date of June 2014. Page one of five of a second personal support information from the personal support information was provided dated 5 December 2014. Although, not recently updated, the information is comprehensive, strengths based and person centred. There was no [Service A] support plan provided for review.

A Health and Safety Feedback sheet completed August 2015 was reviewed. It noted upcoming expiry of a First Aid Certificate. It didn't include a check of the medication prescribing sheet, signing sheet and match to blister packaging. It included medications signed for correctly. The sheet was not signed by the caregiver, but was signed by the service coordinator.

It can be concluded that the role and scope of responsibilities for [Mrs B] are clearly documented in a signed agreement held with IDEA Services. Regular monitoring was occurring by IDEA Services but appears to have lacked sufficient focus and proactive checking of medications and documentation consistent with IDEA Services policies and expectations. It appears annual performance reviews were overdue, however regular training opportunities were being provided to [Mrs B]. Peers would be likely to

consider that [Mrs B] was familiar with the scope of her role and responsibilities and that this had been clearly communicated to her, notwithstanding a potential level of informality in monitoring of these responsibilities by IDEA Services. Monitoring by IDEA Services which contributes to setting ongoing expectations represents a moderate departure from accepted practice. Policies, procedures and documents established by IDEA Services are consistent with accepted practice.

The role and scope of responsibilities for [Mr B] is not clear as there is no IDEA Services documentation pertaining to his role and responsibilities, yet he was taking an active carer role and had previously been in a contracted role. There could also be some confusion as the Board Agreement which forms part of the Foster Care Agreement pertains to both [Mr and Mrs B]. Based on the information available, it is not possible to determine the extent of the departure from accepted practice.

6. Any other matters

From school progress notes provided for review, it is clear there were concerns being identified by [the school] related to incorrect positioning of [Master A] and occasions where [Master A] has been sent to school unwell. Where seizure activity is noted, it sometimes includes notification to either [Mrs A] and/or [Mrs B]. One incident form from [the school] was provided which indicated poor positioning causing pressure injuries and concern about [Master A's] condition on arrival to school that was notified to CYF.

IDEA Services in its response to the Commissioner acknowledges that regular contact with [the school] to ensure IDEA Services is aware of any issues or concerns would be useful. I would fully support a more integrated approach to monitoring and communication between [the school] and IDEA Services as this is likely to improve [Master A's] management and quality of life.

Yours sincerely

Christine Howard-Brown"

Appendix B: Independent advice to the Commissioner

The following expert advice was received from a social worker, Nancy Jelavich:

"**Health and Disability Commission Review**

Tuesday 23 May 2017

Complaint: [Master A]/[Mr and Mrs B]

Ref# C16HDC00597

As an independent advisor to the Health and Disability Commissioner I have read and agree to follow the guidelines as set out on the HDC website in relation to providing my professional opinion on this matter.

I am a fully registered social worker who has been practising post qualification for 14 years in the field of working with vulnerable children and their families across health, education and welfare. In addition to my Bachelor of Social Work I hold a post-graduate certificate in professional supervision, and a diploma in child protection. I have been the Service Manager for Barnardos Foster Care for the past 3 years and previously was the Residential Services Team Leader for Stand Children's Services, my role at the children's residence included managing the medical clinic held on site. I have been Chairperson for the board of trustees for Lifekidz trust which is an after school and school holiday programme for children and young people with special needs for the past 5 years.

Background:

[Master A]:
[Master A] is a 14 year old boy and the son of the complainants, [Mr and Mrs A]. He is diagnosed with:

- Tuberous Sclerosis (severe)
- Epileptic encephalopathy (with tonic, myoclonic and generalized tonic clonic seizures).
- Profound developmental delay
- Cerebal Palsy with left hemiplegia
- Visual impairment

Foster Parent relationship:
[Master A] was placed with [Mr and Mrs B] when he was [18 months] old. This was done under s141 of the Children, Young Persons and their Families Act 1989. As IDEA services is an approved cultural social service under this Act it is funded to provide care by the Ministry of Health and it retains overall responsibility for the day to day care of [Master A]. [Mr and Mrs A] maintain legal guardianship of [Master A].

Complaint:
On 20 May 2015, [the school] [Master A] attended, made a notification to Child Youth and Family Services (CYFS) regarding the poor care [Master A] was receiving from [Mr and Mrs B]. As a result of this, [Master A] was uplifted from [Mr and Mrs B's] care and transferred to [a residential facility]. This event triggered [Mr and Mrs A] to make a complaint to IDEA Services.[14]

[Mr and Mrs A] advised IDEA Services that prior to [Master A] being uplifted, they already had concerns about the standard of care being provided to him. However they had been unable to move [Master A] from [Mr and Mrs B's] care due to a lack of a suitable alternative.

While [Master A] was in [Mr and Mrs B's] care, [Mrs A], [Master A's] Mother, had found one of [Master A's] pills down the side of his wheelchair. Thinking it was a one-off, she did not raise any concerns. However, a week later, [Mrs A] found another pill down the side of [Master A's] wheelchair. The same day, [Mrs A] advised [Mrs B] of her finding and [Mrs B] undertook to be more careful. Unfortunately, the next week, [Mrs A] found another pill in [Master A's] wheelchair. [Mr and Mrs A] visited [Mr and Mrs B] and explained the need for vigilance regarding medication administration as the medication was required to help control [Master A's] seizures. Two or three weeks later [Mrs A] found another pill in [Master A's] wheelchair.

[Mr and Mrs A], along with [the school], were also concerned about the standard of food [Master A] brought for lunch. Both reported that [Master A] was often provided heat and eat meals such as pizza, frozen food, muffins and leftovers. They were concerned that the quantity of food was often for two people, lacked nutrition, and the consistency was inappropriate for [Master A]. [Mrs A] compensated for this by providing [the school] with fruit and vegetables to supplement the food that [Master A] was given by [Mr and Mrs B].

Following [Master A] being uplifted, more concerns came to light for [Mr and Mrs A].

[Mr and Mrs A] believe that [Mr and Mrs B] were not using the hoist provided to transfer [Master A]. When the hoist was returned to them, the batteries were dead and the plug was missing. They are unsure how [Mrs B] would have transferred [Master A] in [the school] holidays as [Mr B] would have been at work during the day.

When [Master A's] personal belongings were returned to [Mr and Mrs A], they were concerned to find partially used medication blister packs in his drawers and his clothes and bedding smelt of cat urine.

[14] On 22 September 2017, HDC clarified with Ms Jelavich that Master A was not uplifted in response to a notification to CYFS but as a result of a complaint received from Mr and Mrs A that had been made to the NASC. On 22 September 2017, Nancy Jelavich wrote: "The correction of information by the complainant about the way in which [Master A] was uplifted and what prompted the making of the complaint does not alter my advice as written in the report."

On 26 January 2017, [Ms C] wrote to [Mr and Mrs A] to provide her findings into the care provided to [Master A]. [Mr and Mrs A] were not satisfied with her investigation and pursued the matter further with IDEA Services and involved the Health and Disability Commissioner's Office.

Information that has been provided to me for the purpose of the review were:

- Report from [a paediatrician] regarding [Master A] dated 12 April 2016.
- Undated (but sent in an email dated 26 January 2016) Investigation Report from [Ms C].
- Mr A's email response to [Ms C's] Investigation dated 22 April 2016.
- Information from [the school] dated 16 February 2017.
- Response to complaint from [Mr and Mrs B].
- [Mr A's] email response regarding medication administration dated 2 April 2017.
- Information from IDEA Services including:
  - Draft (to be finalised after [Mr and Mrs A] have had input) investigation report headed 'Investigation Report into Three Aspects of Medication Management'.
  - [Master A's] personal support information
  - Medication signing sheets for [Master A].
  - Analysis of Medication Folder
  - Foster Care agreements for 2014 and 2015
  - Caregiver home visit forms
  - [Mrs B's] record of learning.
  - Caregiver orientation manual
  - Minimum contact standards for foster care service.

I have been instructed by the Commissioner to comment on the following areas:

1. The appropriateness of the medication administration and retention of blister pack medications.
2. The provision of suitable food for [Master A's] needs.
3. The methods of transferring [Master A] and the appropriateness of this for his needs.
4. Whether [Mr and Mrs B] met [Master A's] personal hygiene needs.
5. The lack of incident forms received by IDEA services from [Mr and Mrs B] for 2015 regarding [Master A].
6. Any other matters you consider warrant comment.

For each question I have been asked to advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? (e.g. mild, moderate or severe).
c. How would it be viewed by my peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

1. The appropriateness of the medication administration and retention of blister pack medications.

The standard of care/accepted practice for the handling of medication is set out in the Caregiver Orientation manual [which] states that you must keep all medication in your house locked (12.3 Medication p45). Complete pharmacy sign-off sheets. Read and sign Medication policy.

As part of [Master A's] personal support information it states that [Master A] is able to take medications and is totally reliant on his caregivers administering this. It does not state that [Master A] has a history of spitting out/dribbling out his medication — at the time of the plan being developed this may not have been known.

There were alleged to be 4 incidents (not recorded) of finding medication down the side of [Master A's] wheelchair; if [Mr and Mrs B] were aware that the medication was not swallowed and re-administered the medication (as stated in [Mr and Mrs B's] response received 6 March 2017) then there is a departure to the standard practice as this is not noted on the medication charts. I would view this as a moderate departure of the practice as the consequences for such actions would not result in harm to [Master A] as he still received his medication to manage his Epilepsy.

However, if the situation was as [the school] reported, that the medication was found and [Mrs B] was unaware that the medication had not been swallowed then this is deemed as a medication error defined under incident reporting. The lack of reporting on such instances would be a departure from the standard practice of Incident Reporting and considered severe with the likelihood of harm to [Master A] not receiving his medication as high.

In both of the above mentioned scenarios there is a departure to the recording of medication administration/incident reporting as outlined in the medication policy. IDEA Services acknowledged that there has not been an adherence to the medication policy in their 'Investigation report into three aspects of medication management ([region])'.

It is unknown as to what the medication was in the blister packs so we are unable to ascertain whether it was Scenario A) a discontinued prescription or Scenario B) surplus/un-administered stock. If it was scenario A) then retention of the blister packs only becomes a departure to the policy as it was not stored in the locked storage and was found in the drawers; this departure would be considered mild. If it was scenario B then there is a departure to the policy of how medication should be administered and disposed of and that would be considered severe given the health impacts that could result.

The Health Advisor's audit of the medication folder on 21/12/15 for [Master A] noted that there was poor documentation in the Medication file, that it was not complete, consultants, specialists and allied services documentation is missing from 2014 onwards and no documentation of any PRN administration.

The lack of documentation and the retention of the blister packs in an unlocked storage would be viewed by my peers as a departure from standard practice which is consistent with the Health Advisor's audit.

Recommendations for improvement that may prevent future occurrences happening were already set out in the medication folder review. It recommended that [Mr and Mrs B] undertake training for handling and administering medications which include the documentation and disposal of medications. I understand that [Mr and Mrs B] had training in 2008, 2010 and most recently in April 2016 which was subsequent to the medication folder review. My recommendations are consistent with the recommendations set out from that review.

I also consider that a controlled drugs register may be of benefit in these instances which even for those that are not controlled drugs you may have a count system in place to track the numbers of tablets, and can clearly document when you have had to use one extra due to [Master A] spitting it out and have another person counter-sign. The IDEA services worker who is monitoring the placement can be responsible for counter-signing with the number of tablets that should be remaining. If an old medication is discontinued then it is signed off and the medication returned to the chemist asap, in the interim the unused medication should still be stored in the locked storage.

Complacency can become an issue particularly if you have been caregiving for a number of years, the policies were signed off on only 2 occasions these dates were 2008 and 2010, and there had been no refresher training over a 6 year period.

2. The provision of suitable food for [Master A] to eat.

The standard of care that is required in relation to providing suitable food is set out in the Foster Care agreement that was signed off by [Mr and Mrs B]; it states that they agree to meet [Master A's] needs as set out in his personal plan. The most recent agreement was signed off in 2015, the support plan is dated 5 Dec 2015 which outlines 'Eating and drinking/having the right food/adequate fluids/ feeding assistance'; it was outlined:

> *[Master A] requires total support with all of this and 'I love food and like to try different flavors. I need my food to be very soft and in small bits so I can manage them'.*

The paediatric report outlines clearly what [Master A's] needs are in relation to his diet and it was clear that foods should be soft and of a consistency easy for him to swallow; the paediatrician advised that chunky foods would not be suitable. This report was dated from 2016. It was unclear as to what earlier paediatric reports had stated in relation to this as they were not available as part of this review; however [the school] and [Mrs A] held concerns [about] the types of food that were being provided so [Mrs A] chose to supplement this.

[Master A] was provided with enough food so as not to consider neglect in this instance, concerns were also about the large amount that [Master A] was given and one should consider that if it was known he can spit out his food then it [was] prudent to send more than needed in case of such instances. Peers would not view this as a concern and would be concerned if there was not enough food being provided. However the appropriateness of the food's consistency warrants some examination.

It was recorded by [the school] that at times the foods provided by [Mrs B] were not of the consistency as outlined in the personal plan and reported frozen pizzas and sausages were being sent to school that did not meet this requirement. I believe this is a departure of the expected standard and would be deemed as moderate. The impact that this has on [Master A] was minimal because [Mrs A] chose to supplement the food and although this was addressed with [Mrs B] at the time, there was only short-term change observed in the consistency of foods being sent to school. In instances such as these where there are low level concerns identified regarding care it would be expected that these be addressed with the caregiver to allow for change to occur which appears to have been undertaken by both [the school] and [Mrs A]. It appears from the visiting child forms that I reviewed that these concerns were not noted; this may be [because] the person conducting the home visit has not been made aware of the concerns by either [Mrs B], [Mr and Mrs A] or School.

Peers would view this departure as mild; however it must be noted that it was an on-going concern despite intervention therefore increasing the significance to moderate.

Recommendations to prevent future occurrences is for [Mr and Mrs B] to adhere to the requirements set out in the personal information plan. Ensuring feedback avenues occur between school, [Mr and Mrs A] and IDEA Services with [Mr and Mrs B] would be integral to ensure the care of [Master A] is upheld to the standards required.

3. The methods of transferring [Master A] and the appropriateness of this for his needs.

The expected standard of practice for moving [Master A] has been set out in the caregiver orientation manual; it is identified that safe handling is a training requirement before starting caregiving. [Mrs B's] training records indicate that she completed 'Moving Equipment and People L2' in 2010. Other aspects of safe handling may have been covered as part of the induction training; however it is not explicit in the records. [Mrs B] states in her letter of response that she was never given training on how to safely lift [Master A]. This in itself is a departure to the expected standard which should be noted in the review of IDEA Services' oversight of this placement and not an area for which I am charged with responding to.

The standard of care is also set out in [Master A's] personal plan which states 'I have a hoist at home which can be used when needed. If being lifted I need two people to lift me as I am growing pretty big'. In this instance (Scenario A) if only one person was lifting [Master A] this would have been against the required standard of ensuring a 2 person lift. This would be a moderate departure of the standards and reviewed by

peers as well as under Health and Safety as a significant risk not only to [Master A] but to the person undertaking the lift.

[Mrs B] denies the allegation that [Master A] was ever lifted by only one person. If [Mrs B] had only used the hoist and a 2 person lift (Scenario B) then there would be no departure from the standards expected, however given the lack of response explaining why the plug was missing and the batteries were flat it is unclear as to what the actual practice for moving [Master A] was.

Peers would view Scenario A's departure of the expected standards as moderate as this allows for significant risk to all parties. Peers would view Scenario B as the expected standard of practice.

Recommendations to prevent future occurrences include training on manual handling, the use of hoists and back care. Re-visiting these may assist where complacency may become an issue.

The staff removing [Master A's] belongings should have checked all the equipment prior to moving it/taken an inventory etc. This would have highlighted that the plug was missing and an explanation ascertained at the time could have been obtained.

5. The lack of incident forms received by IDEA services from [Mr and Mrs B] for 2015 regarding [Master A].

The expected standard of practice is outlined below.

The incident reporting policy states that 'the initial report may be verbal but a written record is required as soon as possible, within 24 hours of the incident and to be received no later than 72 hours following the incident. The incident will be recorded on a standard form, be based on observations, be accurate, factual and complete and uses non-judgmental, non-aversive language (section six Operation guidelines Policies relating to all services, p111)'. Medication errors are listed on pg. 112 to be one of the incident categories that must be reported against.

[Mrs B] states in her account of events that she called IDEA services on one occasion to report the incident. [Mrs B] has not supplied a copy of the incident report for the purpose of this review and it is unclear as to whether there was one completed within the 24 hour time frame. This is a departure to the expected standard and I would consider this departure to be moderate. Peers would view this also as a moderate departure given the impact the incidents of medication errors could have.

Given that there was an alleged phone call to IDEA services detailing the incident then responsibility should also fall on IDEA services to ensure that they follow up for receipt of the incident.

Peers would view this departure as moderate as Incident reporting is required under Health and Safety regulations, the incident reports allows for tracking care,

understanding patterns and behaviours and most importantly a significant role in the prevention of future incidents occurrence.

Recommendations to ensure incident reports are documented and followed up would require re-training of [Mr and Mrs B] in the incident reporting procedures. Ensuring a closer monitoring system is in place and the IDEA Services worker connecting directly with [the school] and [Mrs A] to also obtain incident reports from them.

4. Whether [Mr and Mrs B] met [Master A's] personal hygiene needs.

The standard of care that is expected for [Master A's] personal hygiene needs are: 'I need total support with all aspects of hygiene. At home I have huge shower/wet room where I am showered, washed and then dried.' In relation to bowel/bladder management 'I use continence products and like to have them changed regularly. My caregivers tend to leave 2 spaces when fastening my nappy, this is comfortable for me'. For care in general the standards that are expected is that any caregiver will meet the basic hygiene, health and care needs for any child in their care; this includes: ensuring children are appropriately clothed, have their health needs met and hygiene needs responded to. It is deemed a care and protection concern where there is failure to meet these needs and on-going occurrences of this can be detrimental to a child's development.

The school reported on one occasion they noted [Master A] to have faecal matter stuck to his bottom. This was not a concern that [the school] held in isolation hence their subsequent notification to CYF based on the evidence recorded on their daily observation sheets for [Master A]. These were supplied to me for the purpose of this review. In the absence of CYF's reports around their follow up actions and whether they conducted an investigation under s17 of the CYPF Act 1989 it is difficult to say whether there was any evidence of neglect. However, given that [the school] held concerns over a period of time I would say that there has been an oversight on those occasions to meet [Master A's] personal hygiene needs. This is a departure from the expected standard of care and in my view is a moderate departure. The impact of such a departure has been mild in relation to associated health impacts.

[Mrs B] makes comments of how she worked hard to keep on top of the level of care [Master A] required and did not recall ever sending him to school unwell despite [the school] observations indicating on a few occasions that this did occur.

Peers would consider [Mrs B's] care of [Master A's] personal hygiene needs as well as his basic health needs to be a departure from the expected standard of care and would also view the basic care needs not in isolation but holistically and recognise that the departure from the standards has occurred over a period of time not just as an isolated incident.

It is unclear as to whether [CYPF] conducted a care and protection investigation and upheld the complaint of neglect. On that basis it is difficult for me to make specific

recommendations to prevent recurrence in respect of the caregivers. It is also unclear whether a s396 investigation was undertaken with IDEA Services.

In conclusion, the other matters that I consider warranting comment are that I understand that the aspect of IDEA's oversight of the placement has been reviewed by another party and should be considered in conjunction with this review. The investigation report into three aspects of medication management that was undertaken by IDEA Services held recommendations for [Mr and Mrs B] to re-visit the incident reporting guidelines as well as the administration and returning of medicines to the pharmacy in a timely manner. I believe these are appropriate remedial actions to be taken alongside a review of IDEA's Medication policy.

Nancy Jelavich
Service Manager — Foster Care, Barnardos"