Community Support Worker, Ms C
Disability Support Service

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC00439)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report discusses the care provided to Ms A, aged 49 years at the time of events, by a community support worker, Ms C, and a disability support provider (the disability service) on 17 February 2017.

2. On 17 February 2017, Ms A became heightened in mood, entered the office at the secure unit, and was removed from the office area by Ms C. The way in which Ms A was removed from the office area is disputed; however, the following facts are not disputed:

   - When Ms A's behaviour and mood became heightened, she entered the office, threw herself on the floor twice, and grabbed, pulled, and threw objects in the office. Ms C did not exit from the situation.

   - When Ms A refused to leave, Ms C removed Ms A from the office. She did this by coming into physical contact with Ms A in order to get her out of the office.

3. Ms A's support plans contain several references to how staff should respond to Ms A when she is in a heightened state. Ms A's Care and Rehabilitation Plan sets out specific de-escalation strategies such as giving her space, leaving the situation, and redirecting Ms A if she exhibits self-injurious behaviour.

4. Ms A's Personal Plan states that "staff are to remove themselves and others if she becomes violent". Her Safety Plan documents that one of Ms A's known triggers is being touched, and that staff should avoid physical touching where possible, especially when Ms A is unsettled, and ensure that she has enough personal space and remain at a safe distance if she becomes elevated.

Induction and training

5. Ms C was employed by the disability service in December 2016. The disability service and Ms C dispute the level of orientation Ms C received when she first began her role at the secure unit. However, it was found that even if it is accepted that Ms C received the training reported by the disability service, this was insufficient.

Incident reporting

6. Following the incident between Ms A and Ms C on 17 February 2017, Ms C did not complete an incident report. Furthermore, the disability service did not inform Ms A's welfare guardian of the incident until 25 days later, despite Ms A's welfare guardian having asked to be notified of serious incidents on the day they occurred. The disability service accepts that it did not inform Ms A's welfare guardian in a timely manner.

7. HDC was provided with evidence of a lack of clarity from staff about when to report incidents. In particular, staff reported being advised that in some instances, incident reporting was not required, or that there was a "threshold" for reporting incidents.

Findings

8. Adverse comment was made about Ms C for not exiting the room and coming into physical contact with Ms A when she was heightened in mood. However, it was accepted that Ms C could have been better supported in her role by a higher level of induction at the start of her employment. The Deputy Commissioner was also critical of Ms C for not completing an incident report.

9. The disability service was found to have departed from accepted standards on the issues of incident reporting and Ms C's orientation. The disability service has an organisational duty to ensure that its staff are supported appropriately in their role, and that incident reporting policies are well understood and implemented by all personnel. Accordingly, the Deputy Commissioner found that the disability service did not provide services to Ms A with reasonable skill and care, and breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

Recommendations

10. The Deputy Commissioner recommended that Ms C and the disability service provide a written letter of apology to Ms A, copied to her welfare guardian.

11. In response to the provisional decision, the disability service advised that it had implemented refresher training for staff, improved its incident reporting and management policy, as well as provided additional training for staff on incident reporting and following up incidents. As such, the recommendations made in the provisional decision have been met.

Complaint and investigation

12. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to Ms A by a community support worker, Ms C, and the disability service. The following issues were identified for investigation:

- *Whether Ms C provided Ms A with an appropriate standard of care in February 2017.*
- *Whether the disability service provided Ms A with an appropriate standard of care in 2017.*

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

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

14. The parties directly involved in the investigation were:

Ms B	Welfare guardian
Ms C	Community support worker
Disability service	Group provider

15. Further information was received from:

Ms D	Community support worker
Ministry of Health	

16. Independent expert advice was obtained from a registered nurse, Henrietta Trip, and is included as **Appendix A**.

Information gathered during investigation

Introduction

17. This report discusses the care provided to Ms A, aged 49 years at the time of events, by a community support worker, Ms C, and a disability support provider on 17 February 2017.

18. The focus of the disability support provider's programme (the programme) is on supporting people who have an intellectual disability and complex behaviour. The programme delivers Regional Intellectual Disability Supported Accommodation Services (RIDSAS).

19. The programme has been delivering services to Ms A at a secure unit since 2016. The secure unit is a service that was opened specifically for Ms A, and she is the sole person occupying this service. She receives 2:1 female staffing support. Ms A lives in her own flat and has access to the kitchen, living area, bedroom, lounge, bathroom, and laundry. All areas of the secure unit are open to Ms A except the office.

Ms A

20. In 2013, Ms A was made a Compulsory Care Recipient for 18 months pursuant to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR Act). There was an extension of Ms A's compulsory care order until late 2017.

21. Ms A has a well established intellectual disability, and has a long history of being verbally abusive, destructive, and violent, having perpetrated multiple assaults on family, friends, support staff, and people in the community.

Incident on 17 February 2017

22. At approximately 12am on 17 February 2017, Ms A awoke to go to the bathroom. Community support workers Ms C and Ms D were rostered on to support Ms A at this time. Ms A's daily notes record that she was "a bit hesitant to get up, lashing out at staff",

and that rather than using the toilet, she urinated on the floor. She was then redirected back to bed with no concerns, and went to sleep. At 4.33am, Ms A awoke again and had a shower.

23. The disability service provided HDC with another version of the daily notes, which it advised did not appear in its system until the following day (18 February 2017). Ms C submitted that she wrote this aspect of the daily notes but forgot to save the information from the template onto the daily recordings, and that this explains the delay in the daily recording appearing in the correct place.

24. Ms C's notes continued on from the information above. They state that after Ms A had had a shower, she hung up some paintings but was noted to be "getting bored". She then mopped her floor and cleaned her toilet. At approximately 5.30am, it is documented that Ms A ran out of her front door and had to be redirected back inside the unit. At this point, she became "highly elevated in moods and behaviour". Ms A's notes state that she began throwing the bucket of water she had used to mop the floors and then entered the office area and "threw herself on the floor twice".

25. It is documented that "despite a lot of gentle prompting and encouragement", Ms A refused to get up from the floor. Therefore, Ms C "proceeded to remove [Ms A] from floor in office", but at this point, Ms A got up and started grabbing, throwing, and pulling objects. The daily record notes that "staff intervened and … removed her from office". In response to the provisional decision, Ms C told HDC that she did not leave the office because she was concerned that Ms A would injure herself with the contents in the office. Ms C also believed that she could de-escalate the situation.

26. It is not disputed that Ms C removed Ms A from the office. However, the nature of the removal is disputed. According to the disability service, Ms A complained that Ms C removed her "by dragging her by her arm out of the office area". However, Ms C told HDC that she did not drag Ms A across the floor, and that she could not possibly have done so, as she is much smaller than Ms A, and she would never do this to a client. Ms C said:

> "[Ms A] was on the floor and she had calmed down a little. She made movements to get up off the floor. I leant down beside her and with my hands open and vertical I put them under her armpits so my wrists were supporting under her arms and I assisted her as she got up herself …
>
> Once [Ms A] was up, I kept my arms under her armpits and walked beside her and guided her gently out of the office. When we were outside the office, [Ms A] suddenly dropped herself to the floor outside the office."

27. The disability service told HDC that it considers that Ms C's actions caused injury to Ms A, including a sore back and a red mark on her lower back. At the time of events, several photographs were taken of Ms A's lower back. The photographs were provided to HDC, and do show a red mark. However, Ms C disputes that she caused these injuries.

Incident reporting

28. Two incident reports were provided to HDC by the disability service. The disability service told HDC that the initial incident report was completed by a community support worker when she started her shift after Ms C and Ms D finished theirs. The incident report stated:

> "Between 7 and 7.45am
>
> [Ms A] was upset on handover due to incidents that had happened on the shift before I came on.
>
> … [S]he was head banging and venting anger and frustration about a mark on her back. I checked and [Ms A] had a red mark on her lower back. [Ms A] accused [Ms C] of pulling her across the floor in the office and her skin was rubbing on the carpet."

29. The disability service told HDC that another incident report, submitted by Ms D, did not appear on its computer until the following day on 18 February. Ms C told HDC that she thought that Ms D had completed the incident report on the night of the incident. The description of events on the incident report appears to be a direct copy and paste of the information typed in Ms A's daily recordings (referred to above at paragraphs 24 and 25).

30. Both incident reports provided to HDC did not have an incident number. The disability service explained that at the time of the events, incidents were recorded on paper or electronic forms, which were then manually entered into a central incident system. When the report was entered into the system, a unique incident number would be generated.

31. Ms A's welfare guardian and cousin, Ms B, told HDC that she was not informed about the incident, but heard about it a few days later through a close friend, who had received a call from Ms A. Ms B added that it took the disability service 25 days to contact her about the incident, and that previously she had asked to be notified of serious incidents on the day they occurred. The disability service accepts that Ms A's welfare guardian was not informed of the incident in a timely manner.

Ms A's support plans

32. Ms A has several plans that document her needs and the way staff can support her in different situations. The main support plans discussed in this report are the Care and Rehabilitation Plan, the Personal Plan, and the Safety Plan.

33. The disability service told HDC that it expected Ms C to follow Ms A's Safety Plan and Personal Plan (discussed in more detail below). The disability service added:

> "In this situation, there was an expectation that the staff office door would be closed and locked so that [Ms A] could not enter, this was a requirement that staff were aware of and has been in place since the opening of the secure unit …

> In the event that [Ms A] did enter, [the disability service] would have expected [Ms C] to apply NVCI[2] training that was completed on 2 February 2017. This would have required her to exit from the situation arising."

34. Ms C reported that prior to these events she had never seen the Personal Plan or Safety Plan, and was shown these on 7 March 2017, after the incident. The disability service disputes this. (Discussed further below at paragraph 50.) In response to the provisional opinion, Ms C submitted that she was not aware that the office door was required to be closed. Ms C also added that she did not leave the office as she was concerned that Ms A would injure herself with the contents in the office. Ms C also believed that she could de-escalate the situation.

Care and Rehabilitation Plan (CARP)

35. This support plan contains five core sections. Of relevance is "Section 2: Managing Risks", which sets out strategies to minimise the risk to the health and safety of others, as well as to Ms A herself. Under "Endangering others", the plan notes that Ms A has a history of verbally abusing and threatening staff and damaging property. The plan states that to manage this, staff should engage in de-escalation strategies to prevent escalation of Ms A's behavior, and should utilise NVCI techniques as a last resort.

36. Under "Endangering Self", the plan sets out certain behaviours that are precursors to Ms A acting out and causing harm to herself, such as banging her head and body against walls and floors. Precursors included Ms A being reminded of boundaries or having her immediate goals thwarted, and feeling frustrated, anxious, distressed, or disappointed. The plan states that to manage this behaviour, staff are to de-escalate the situation, and that once the head banging has stopped, they are to re-engage interactions in a quiet and calm way to prevent re-escalation.

37. Specific de-escalation strategies referred to in the plan include to "give her space" and to "walk away from her to allow her time to calm down". The plan states: "[S]taff are to maintain safety at all times, removing yourself from area if at risk," and "intervention should occur to redirect [Ms A] away from head banging or self-injurious behaviour by offering a positive activity".

Personal Plan

38. This support plan documents specific information about Ms A's behavior, including support, risk management, and de-escalation and restraint strategies to be followed by staff. Of relevance, the Personal Plan states that "staff are to remove themselves and others if [Ms A] becomes violent". In terms of de-escalation and restraint, the plan states: "[I]f required to keep [Ms A] or others safe, utilise NVCI to mitigate a crisis situation as a last resort … no restraint may be used unless authorized by the care manager."

[2] Non-violent crisis intervention.

Safety Plan

39. This support plan addresses specific behaviours such as aggression, self-injurious behaviour such as banging of the head and body against a wall, and property damage. The plan notes:

> "Incidents of challenging behavior generally follow a predictable cycle. Anxiety or emotional stress increases in response to certain triggering events. Early warning signs can often be seen while the anxiety or stress rises. The stress reaches a peak and this is when the challenging behaviour is displayed. After a period of time, the stress is released and the person slowly calms."

40. Under the heading "Prevention", the plan lists one of Ms A's known triggers as being touched. It states:

> "
> - Where possible avoid physical touching especially when [Ms A] is unsettled.
> - Ensure [Ms A] has enough personal space.
> - Place yourself at a safe distance from her if she becomes elevated [in mood]."

41. Under the heading "Responding", the plan notes that when challenging behaviours are seen, often a person will move through different stages. In the context of Ms A, and of relevance, the plan provides:

1. Early warning signs	
What does it look like?	What can we do?
• Clenches her fist and bares her teeth • Pacing and bouncing on her toes in an aggressive manner • Becomes louder and more persistent • Refuses to listen or engage	• Calmly redirect using an activity that is known to increase calm and reduce agitation • Maintain safety by keeping a safe distance from [Ms A] — beyond her stretched arm length
2. Challenging behaviour	
What does it look like?	What can we do?
• Self-harm — banging head, fists on chest • Physically assaulting others • Throwing objects	• Maintain safety at all times, remove yourself from area

Supporting People who present with Challenging Behaviour guidelines

42. The disability service provided HDC with guidelines for Supporting People who present with Challenging Behaviour (Challenging Behaviour guidelines). The guidelines state that "[the disability service] is committed to supporting people in a non-aversive and proactive manner" and recognises that challenging behaviour is a way of communicating a need or concern.

43. The guidelines define "non-aversive practice" as working in a "non-punishing way". Some non-aversive strategies identified in the guidelines are:

- Avoiding triggers for distress, anxiety, and frustration, i.e., the precursor to challenging behaviour.
- Facilitating relaxation.
- Appropriate redirection away from a stressful situation.
- Giving the person sufficient space to process information and calm down.

Incident Reporting and Management policy

44. The disability service submitted to HDC an Incident Reporting and Management policy (Incident Reporting policy), which sets out processes that aim to ensure that all incidents and near misses related to clients and staff are reported to management and analysed in a consistent and supportive manner. The policy states that all staff are responsible for the timely and factual reporting of incidents that occur during the course of their work, or that are notified to them.

45. Under the heading "Open Disclosure", the policy requires that clients and their family/whānau or other support persons are to have the circumstances of the incident fully explained to them in an open and transparent manner.

46. There is evidence in team meeting minutes dated 10 March 2017 of a lack of clarity around incident reporting. Staff members are quoted to be raising the following concerns:

- "A staff member noted that when she started, she wrote incident reports when staff were assaulted. As time has gone on, she had asked herself whether many of the issues warranted an incident report, and she felt the majority of them did, but that staff were being told not to write them up. This has made it hard to know whether or not to record an incident or not."
- "Staff noted that the writing of the report is up to the individual person, but that if they were being told not to … this makes it very confusing …"
- "Staff noted that if the assault and subsequent injury sustained did not hurt, then it was not an incident report. The issue of pain inflicted appears to be the threshold."
- "One staff member was told, after having had her hair pulled and writing up an incident report, that this was '[Ms A's] normal', and this doesn't get reported."

47. At this meeting, it was clarified that all incidents should be reported and followed up.

Ms C — induction, training, and job description

48. Ms C was employed in 2016. Her curriculum vitae states that she has qualifications in social work and mental health support work. She has worked in both an administrative role for a rehabilitation and intellectual disability service, as well as a mental health support worker for the crisis and assessment treatment team.

49. During her interview for the community support worker role, it is documented in her interview notes that when asked what to do when confronted with a difficult situation such as yelling, damage of property, and aggression, Ms C replied: "[R]emove self from situation."

Induction and training

50. The disability service told HDC that Ms C completed two orientation shifts on 28 and 20 December 2016, with an additional staff member "buddying" her (a total of 16 hours). The disability service provided HDC with a copy of its roster for these dates, which shows Ms C being scheduled to work on these dates, and a note stating "orientation". The disability service said that Ms C was also given time to become familiar with Ms A's Personal Plan and Safety Plan. However, Ms C disputes this, and submitted that she had never seen Ms A's Personal Plan or Safety Plans. Ms C stated:

> "I see that [the disability service] says it has a record that I attended 16 hours of training. This is not correct. I am certain I was given only half a day's training.
>
> When I was given the job I attended a one-hour staff meeting and that was when I first met [Ms A]. She was outside the meeting room. The day I started, I was given half a day's training."

51. It is not disputed that on 2 February 2017, Ms C participated in an NVCI training class.

Job description

52. The disability service provided HDC with a job description signed by Ms C when she commenced employment. The relevant principal accountabilities and expectations for this role are documented as follows:

> "
> - Deliver quality support, as outlined in the relevant individual support plans.
> - Ensure that the support provided is in line with and enables individual goals, risk factors and strategies to minimise risk and the holistic needs of the individual and with respect for their dignity.
> - Ensure that support meets the required standards and reflects the appropriate support plans.
> - Ensure quality of practice meets contractual requirements, legal obligations and company policy and procedures.
> - Work within the supervision of multidisciplinary teams to ensure that any clinical care or care management needs are identified and plans put in place to manage these."

53. Under the heading "Health and Safety", Ms C's job description provided:

> "
> - Become familiar with all policies and procedures as they affect their working environment.

- Ensure that safe working procedures are practiced and no one is endangered through their actions or inactions.
- Report all incidents."

Further information

Disability service

54. The disability service told HDC that the training Ms C received was consistent with an existing service but differed from the specialised induction for the opening of a new service.

55. The disability service stated that since the incident, it has introduced a service-specific checklist to ensure that staff are familiarised with specific aspects of each individual person's plan and the arrangements at the specific service where they will be working. This includes orientation to the CARP, Personal Plan, Safety Plan, Behaviour Management Plan, and Personal protocols.

56. The disability service stated that in June 2017, a comprehensive orientation schedule was developed by its learning and development team. The process includes an induction session on Day 1 (led by the managers) and eLearning topics and skills training that familiarise new support workers with the disability service. There is also a service-specific component to orientation, where new support workers become familiar with the personal and safety plans of people who are supported in the service. NVCI training is also provided when support workers are working in services where this may be needed, such as with Ms A.

Responses to provisional decision

Ms B

57. Ms B was given an opportunity to comment on the "information gathered" section of the provisional opinion. She did not provide a response.

Disability service

58. The disability service was given an opportunity to respond to the provisional decision. It advised that it acknowledged and accepted HDC's findings as they relate to Ms A with respect to incident reporting and orientation. However, it reiterated that Ms C had significant qualifications and experience in supporting people with mental health and intellectual disabilities prior to her employment with the disability service.

Ms C

59. Ms C was given an opportunity to respond to the relevant section of the provisional decision, as it relates to her. Where relevant, Ms C's response has been incorporated into this report.

Opinion: Ms C — adverse comment

Incident on 17 February 2017

60. On 17 February 2017, Ms A became heightened in mood, entered the office at the secure unit, and was removed from the office area by Ms C. The way in which Ms A was removed from the office area is disputed. For the purposes of this opinion, it is not necessary for me to make a factual finding on whether Ms A was "dragged" or "assisted" out of the office.

61. The following facts are not disputed:

- When Ms A's behaviour and mood became heightened, she entered the office, threw herself on the floor twice, and grabbed, pulled, and threw objects in the office. Ms C did not exit from the situation.

- When Ms A refused to leave, Ms C removed Ms A from the office. Ms C did this by coming into physical contact with Ms A in order to get her out of the office.

62. There are several references in a number of Ms A's support plans as to how staff should respond to her when she is in a heightened state. Ms A's CARP sets out specific de-escalation strategies such as giving her space, leaving the situation, and redirecting Ms A if she exhibits self-injurious behaviour.

63. Ms A's Personal Plan states that "staff are to remove themselves and others if she becomes violent". Her Safety Plan documents that one of Ms A's known triggers is being touched, and that staff should avoid physical touching where possible, especially when Ms A is unsettled, and ensure that she has enough personal space and remain at a safe distance if she becomes elevated. Ms A's Safety Plan also notes that if Ms A begins to throw objects, staff should maintain safety at all times and remove themselves from the area.

64. The disability service stated that, as outlined in its Challenging Behaviour guidelines, it is committed to supporting people in a non-aversive and proactive manner that involves avoiding a person's triggers for distress, facilitating relaxation, providing appropriate redirection away from a stressful situation, and giving the person sufficient space to calm down.

65. My expert advisor, RN Henrietta Trip, referred to the Australasian Code of Ethics for Direct Support Professionals, which states that support workers should utilise the "least restrictive alternatives when implementing support strategies and secure for clients the dignity associated with taking reasonable risks in supportive environments while exercising their duty of care".

66. RN Trip advised that "the standard of care expected in this instance would indicate that staff should have removed themselves" when Ms A entered the office. RN Trip also noted that Ms C's actions did not appear to be in keeping with the non-aversive practice outlined in the Challenging Behaviour guidelines. RN Trip concluded that Ms C's actions were

"inappropriate" and would be considered a moderate departure from the accepted standard of care.

Induction and training

67. Ms C was employed by the disability service in December 2016. The disability service and Ms C dispute the level of orientation she received when she first began her role at the secure unit. The disability service told HDC that Ms C completed two orientation shifts with an additional staff member "buddying" her (a total of 16 hours). However, Ms C submitted that she attended a one-hour staff meeting and was given "half a day's training". It is not disputed that Ms C participated in an NVCI training class.

68. Even if it is accepted that Ms C received the training reported by the disability service, RN Trip also advised:

> "Given the complex history, presentation and support needs consistently identified for [Ms B], expected practice would necessitate all staff to have the same level of induction and orientation to the individual's specific support needs …
>
> [I]t is not only the service orientation and health and safety guidelines which need to be provided; the clinical adaptation, interpretation, application and implications specific and in relation to the person and their diagnoses (ID,[3] PTSD,[4] BPD,[5] EP,[6] medication and pain management [relating to arthritis] … must be provided … specialist education for staff is required for such a complex individual."

69. RN Trip concluded that "two shifts alongside a staff member and a 12 hour NVCI course would be considered insufficient".

Conclusion

70. I accept the advice of my expert that Ms C's actions were a moderate departure from accepted standards. I acknowledge that it is disputed that Ms C had seen Ms A's Personal Plan and Safety Plan. However, I note that during the disability service's recruitment process, in particular during her interview for the community support worker role, Ms C clearly articulated her knowledge of needing to remove herself from a situation where a client poses challenging behaviour. The Challenging Behaviour guidelines support this approach. Further, Ms C had attended an NVCI training class two weeks prior to the incident, and the disability service advised HDC that this training would have educated Ms C on exiting from situations such as the incident on 17 February 2017.

71. However, I also accept RN Trip's advice that Ms C's induction was insufficient. I am thoughtful of the very specialised service that is being provided to Ms A (such that she is the sole client), and would expect that training and support for all staff reflected this level of specialisation. I also acknowledge that Ms C was presented with a very challenging

[3] Intellectual disability.
[4] Post traumatic stress disorder.
[5] Borderline personality disorder.
[6] Epilepsy.

situation, and had been in her role with the disability service for less than two months when the incident occurred.

72. In conclusion, I am critical of Ms C for not exiting the room and coming into physical contact with Ms A when she was heightened in mood; however, I accept that Ms C could have been better supported in her role by a higher level of induction at the start of her employment.

Incident reporting — adverse comment

73. The Incident Reporting policy refers to the need for timely reporting of incidents. I am concerned that there was a delay in Ms C's notes about the incident appearing on the disability service's system, and I do not consider that incident reporting was completed in a timely manner. I also consider that Ms C should have written an incident report. I note that it appears that Ms D copied and pasted Ms C's daily notes into the incident report, and submitted this the following day. I do not consider this to be adequate, but accept that the systems the disability service had in place for incident reporting were unclear (discussed further below).

Opinion: Disability service — breach

74. As a provider of disability support services, the disability service is responsible for providing services to its clients in accordance with the Code.

Incident reporting

75. Following the incident between Ms A and Ms C on 17 February 2017, Ms A's welfare guardian was not informed of the incident, and told HDC that she heard about it a few days later through a close friend who had received a call from Ms A. Ms A's welfare guardian added that it took 25 days for the disability service to notify her of this incident, despite having previously asked to be notified of serious incidents on the day they occurred. The disability service accepts that it did not inform Ms A's welfare guardian in a timely manner.

76. The Incident Reporting and Management policy states that staff are responsible for the timely reporting of incidents that occur during the course of their work. The policy also requires that clients and their family/whānau are to have the circumstances of the incident fully explained to them in an open and transparent manner.

77. HDC has been provided with evidence of a lack of clarity from staff about when to report incidents. In particular, staff reported being advised that in some instances, incident reporting was not required, or that there was a "threshold" for reporting incidents.

78. My expert advisor, RN Trip, considers that the communication about incidents, both the lack of timely communication with Ms A's welfare guardian and the communication to

staff as to when an incident needs to be documented, was a moderate departure from accepted standards.

79. I agree. I am critical that there was significant delay in informing Ms A's welfare guardian of this incident, and that this is inconsistent with the disability service's incident reporting policy. Furthermore, the team meeting minutes of 10 March 2017 (after the incident) provided to HDC by the disability service show an alarming lack of clarity around incident reporting. This appears to be due to inaccurate or ineffective communication to staff around incident reporting.

Ms C's induction and training

80. The disability service and Ms C dispute the level of orientation she received when she first began her role at the secure unit. The disability service told HDC that Ms C completed two orientation shifts on 28 and 29 December 2016 with an additional staff member "buddying" her (a total of 16 hours). However, Ms C submitted that she attended a one-hour staff meeting and was given "half a day's training". It is not disputed that Ms C participated in an NVCI training class.

81. Even if it is accepted that Ms C received the training reported by the disability service, RN Trip advised:

> "Given the complex history, presentation and support needs consistently identified for [Ms A], expected practice would necessitate all staff to have the same level of induction and orientation to the individual's specific support needs …
>
> [I]t is not only the service orientation and health and safety guidelines which need to be provided; the clinical adaptation, interpretation, application and implications specific and in relation to the person and their diagnoses (ID,[7] PTSD,[8] BPD,[9] EP,[10] medication and pain management [relating to arthritis]) … must be provided … specialist education for staff is required for such a complex individual."

82. RN Trip concluded that "two shifts alongside a staff member and a 12 hour NVCI course would be considered insufficient", and found the level of induction and training provided to Ms C by the disability service to have been a moderate departure from accepted practice.

83. I accept RN Trip's advice. I acknowledge that the disability service recruited Ms C because of her significant experience in mental health and intellectual disability, and it has also drawn a distinction between the induction of new staff to an existing service, and the induction of staff to an entirely new service. However, as guided by RN Trip, I consider that Ms C should have received greater orientation at the start of her employment.

[7] Intellectual disability.
[8] Post traumatic stress disorder.
[9] Borderline personality disorder.
[10] Epilepsy.

84. I note that since June 2017, the disability service has implemented a comprehensive orientation schedule that appears to have greater detail than the induction Ms C received. Further, I am thoughtful of the very specialised service that is being provided to Ms A (such that she is the sole client), and would expect that training and support for all staff reflected this level of specialisation.

Conclusion

85. The disability service is ultimately responsible for the service delivered to Ms A.

86. I agree with my expert's comments that the disability service departed from accepted standards on the issues of incident reporting and its plan for Ms C's orientation. The disability service has an organisational duty to ensure that its staff are supported appropriately in their role, and that incident reporting policies are well understood and implemented by all personnel.

87. Accordingly, I find that the disability service did not provide services to Ms A with reasonable skill and care, and breached Right 4(1).

Recommendations

88. I recommend that Ms C provide a written letter of apology to Ms A, copied to her welfare guardian, Ms B. The apology should be provided within three weeks of the date of this report, for forwarding.

89. I recommend that the disability service provide a written letter of apology to Ms A, copied to her welfare guardian, for its breach of the Code. The apology should be provided within three weeks of the date of this report, for forwarding.

90. In response to the provisional decision, the disability service advised that it had implemented refresher training for staff, improved its incident reporting and management policy, as well as provided additional training for staff on incident reporting and following up incidents. As such, the recommendations made in the provisional decision have been met.

Follow-up actions

91. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Ministry of Health and the local district health board, and they will be advised of the name of the disability service.

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Henrietta Trip:

"**Opinion for Office of the Health and Disability Commissioner — Henrietta Trip**

I have been asked to provide an opinion to the Commissioner on **Case 17/00439**, and have read and agreed to the follow the Commissioner's Guidelines for Independent Advisors. I am a Registered Nurse (DipNS, BN, PGDipHealSc(Nursing), MHealSc(Nursing), PhD) with over 20 years clinical experience in working with individuals, family/whānau as well as health and disability service providers in the field of intellectual disability. Over this time I have held clinical, educational and auditing roles hence, I have an understanding of the standards required for Disability Support Services. Currently I work as a lecturer and researcher in a tertiary nursing education setting with a particular focus on health and long term conditions of populations considered vulnerable. I am involved in the local disability provider's network and nationally with health professionals working in the intellectual disability sector.

Referral Instructions from the Commissioner: Please review the enclosed documentation and advise whether you consider the care provided to [Ms A] by [Ms C] and [the disability service] was reasonable in the circumstances, and why. In particular, please comment on: The appropriateness of the support worker's actions on 17 February 2017. The adequacy of the training provided to [Ms C] by [the disability service] prior to commencing care for [Ms A]. Any other matters in this case that you consider warrant comment including the appropriateness of [the disability service's] policies and procedures. For each question, please advise: What is the standard of care/accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (Mild, Moderate or Severe)? How would it be reviewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

Sources of Information for Opinion: I received the following information: Complaint submission dated 17 March 2017 [the disability service's] response […] and attachments. [The disability service's] further response […] and relevant attachments. [Ms C's] response dated […] and further response [...] I sourced the following additional information:

Standards New Zealand (2008). NZS 8134.0:2008 *New Zealand standard health and disability services (General) standard.* Wellington: Standards New Zealand.

Health and Disability Commissioner (1994). *Code of health and disability services consumers' rights.* Wellington: HDC.

McVilly, K. & Newell, C. (Eds) (2007). *Australasian code of ethics for direct support professionals.* Melbourne: ASSID (Australasian Society for the Study of Intellectual Disability.

Hastings, R.P., Hatton, C., Taylor, J.L., & Maddison, C. (2004). Life events and psychiatric symptoms in adults with intellectual disabilities. *Journal of Intellectual Disability Research, 48*(1). doi: 10.1111/j.1365-2788.2044.00584.x

Keesler, J.M. (2014). A call for the integration of trauma-informed care among intellectual and developmental disability organizations. *Journal of Policy and Practice in Intellectual Disabilities, 11*(1), 34–42.

O'Brien, J. & Lyle, C. (1986). *Framework for accomplishments*. Decatur, GA: Responsive Syste[Ms A]ssociates.

Summary of Facts from HDC

Background

[Ms A], 49 years old at the time of this event, has an intellectual disability and was made a Supervised Care Recipient for 18 months [in 2013] under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 after being found unfit to stand trial for charges of assault and making a false statement. [Ms A's] volatile behaviour led to her being moved into a Secure Unit [in 2013]. Her care recipient status was changed from Supervised to Secure at that time. Her care order was renewed for another three years [in] 2014.

[Ms A] has a longstanding history of highly dysregulated behaviour throughout her lifetime. As a care recipient in hospital, she continued to become severely emotionally dysregulated which has led to head-banging and other self-harm, defecating and urinating in her residence and verbally and physically abusing staff. [Ms A's] level of risk has been assessed as high. Future victims of assault have been identified as those involved in her care when she is highly emotionally aroused and/or intent on getting her immediate needs met. [Ms A's] clinical file notes that her impulsivity, use of objects, high levels of emotional arousal, poor executive functioning and global cognitive impairment mean that serious harm could occur.

The Incident

On 17 February 2017, at approximately 4:30am to 5:00am, Community Support Worker, [Ms C] removed [Ms A] out of the staffroom. There are differing versions of events about *how* [Ms C] removed [Ms A] from the office area: The contemporaneous notes state that [Ms C] 'removed' [Ms A] from the office. A red mark was found on [Ms A's] back and a picture taken on the day of the incident (**enclosed**). [The disability service] believes that [Ms C] 'dragged' [Ms A] out of the office. [Ms C] denied dragging [Ms A]. She submitted that she 'assisted' [Ms A] out of the office. [Ms C] told HDC that 'I leant down beside her and with my hand open and vertical I put them under her armpits so my wrists were supporting under her arms and I assisted her as she got up herself'.

Other concerns

Both the complainant and [Ms C] raised concerns about inadequate training of staff. When the service commenced, three full weeks of training was provided to new staff. However, [Ms C] began working for the service a few months later and received a total

of 16 hours orientation and completed training on non-violence crisis intervention (12 hours). [The disability service] noted in their response that [Ms C] had 15 years' experience working in hospital level intellectual disability and mental health units.

The pertinent standards that apply to this case include:

Health and Disability Commissioner (1994). Code of health and disability services consumers' rights.

Right 1: Right to be Treated with Respect

Every consumer has the right to be treated with respect. Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.

Right 4: Right to Services of an Appropriate Standard

Every consumer has the right to have services provided with reasonable care and skill. Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards. Every consumer has the right to have services provided in a manner consistent with his or her needs. Every consumer has the right to have services provided in a manner that minimises the potential harm to and optimises the quality of life of that consumer. Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Right 5: Right to Effective Communication

Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Right 8: Right to Support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.

Right 10: Right to Complain (1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

Health and Disability Services (Core) Standards NZS 8134.1.1.:2008 Continuum of Service Delivery — Consumer Rights During Service Delivery

Standard 1.1 Consumers receive standards in accordance with consumer rights legislation

Standard 1.3 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy and independence

G.1.3.2 *(b) Specific training to prepare service providers to respond appropriately.*

Standard 1.8 Consumers receive services of an appropriate standard

1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.

Standard 1.13 The right of the consumer to make a complaint is understood, respected and upheld

NZS 8134.1.2.:2008 Continuum of Service Delivery — Organisational Management

Standard 2.2 The organisation ensures the day-to day operation for the services is managed in an efficient and effective manner which ensures the provision of timely, appropriate and safe services to consumers.

Criteria 2.2.2 Services are planned to meet the specific need of the consumer groups entering the service

Standard 2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

Standard 2.4 All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

NZS 8134.2.1.:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards — Restraint Minimisation

Opinion based on Referral Instructions from the Commissioner: The appropriateness of the support worker's actions on 17 February 2017.

The reported information and relevant documentation pertains to an incident which focuses on the manner in which [Ms C] removed [Ms A] from the office of [the disability service] on 17 February 2017 at approximately 4.30–5.00am. At the time of the incident, [Ms A] was 49 years of age. The information contained in the *Specialist Assessor's Review* [...], *Needs Assessment* […], *Care and Rehabilitation Plan* [CARP] […] informs of [Ms A's] extensive and complex personal, social, physical and mental health history. She has accessed a range of community based supports, caregiving situations (including independent living) and inpatient admissions throughout her adult life. She has a history of being assaulted and can present with a range of dysregulated behaviours for example impulsivity, high levels of emotional arousal, poor executive function. The *CARP* identifies that [Ms A] was *'assessed as having a Mild to Moderate Intellectual Disability'*, and *'working diagnoses'* of *'Complex PTSD and Borderline Personality Disorder'*. It is also documented that [Ms A] has epilepsy (tonic-clonic): Another document provided states that [Ms A's] epilepsy is *'predominantly absence seizures well controlled by medication.'* The above documents discuss the complexity

of [Ms A's] history and explain the implications of the diagnoses for her in terms of; presentation, interpretation of, and response to, her environment(s) and, appear to have informed [Ms A's] *Personal Plan* (RIDSAS […]) and *Safety Plan* […]. The latter lists a number of *'Triggers to be aware of'* with corresponding recommendations '*What you can do to reduce or avoid triggers.'* One of the former is identified as *'Being touched'* and the recommended response in regard to the latter is '*Where possible avoid physical touching especially when [Ms A] is unsettled. Ensure [Ms A] has enough personal space. Place yourself at a safe distance from her if she becomes elevated.'* 17.02.2017: In the *[Service] Daily Recording* it was documented that [Ms A] had been *'mopping the floor in her flat'*, and ran out the front door to a neighbouring unit. On redirection *'she became highly elevated … when writer took the bucket of water out of the flat … and [Ms A] threw it on the floor… and bucket is broken. Removed bucket and it is in the office [Ms A] came into the office and threw herself on to the floor twice. Despite a lot of gentle prompting and encouragement, [Ms A] refused to get up from the floor. Writer proceeded to remove [Ms A] from floor in office, that when [Ms A] got up and started throwing and grabbing the tray and stuff that were on the bench including staff glasses, and trying to pull the land line phone off the wall. Staff intervened and writer removed her from office. [Ms A] accused staff of scratching her lower back.'*

17.02.2017: Incident form completed by [a community support worker] stated that at 0700 [Ms A] *'was head banging and venting anger and frustration about a mark on her back. I checked and [Ms A] had a red mark on her lower back, [Ms A] accused staff [Ms C] of pulling her across the floor in the office and her skin was rubbing on the carpet, I gave [Ms A] some cream to put on it and advised Residential Manager [the residential manager] about this, [Ms A] also advised that she would like to make a complaint about it.'* [Ms A] had stated that [Ms C] *'dragged her out of the staffroom by her arm'.* 17.02.2017: File note — Complaint from [Ms A]. Statement taken and documented by [the residential manager]. [Ms A] was asked '*if she was telling the truth as she had previously made allegations against [the residential manager] which were not true. [Ms A] told [the residential manager] she was telling the truth … [Ms C] scrapped my back/bum by pulling me out of the office on the carpet and it hurt my back … [I] was naughty this morning because she burst into the office and threw stuff off the desk in the office and layed on the floor. I got up the first time as [Ms D] told me to get up, but the second time was when [Ms C] dragged me. I showed [Ms C] the mark but she said it was not her that did that … she did not want [Ms C] coming on shift because she hurt me.' [Ms D] then admitted that [Ms C] had physically removed [Ms A] from the office. She asked what are we supposed to do in situations like that's? … [The area manager] informed [Ms D] that she needed to remove herself from the situation as property can be repaired, and again she has the option of ringing on call … utilise the strategies taught at NVCI …'*

18.02.2017: Incident form completed by [Ms D]. 07.03.2017: Letter *Re: Outcome of Investigation — Proposed Decision to Dismiss* from [area manager] identifies that the [Service's] review of documentation (progress notes and the incident report) in relation to the events — were not sufficiently completed by [Ms C]. 15.03.2017: Letter

Re: Outcome of Investigation — Proposed Decision to Dismiss from [Ms C] […] states that *'[Ms C] has denied the allegations that she dragged [Ms A] out of the office and this has been confirmed by* [Ms H — who was on shift] … [Ms C] *would physically be unable to do what has been alleged against her.'* 20.03.2017: Letter *Re: Outcome of Investigation — Dismissal Without Notice*, from [area manager] responds to concerns raised by [Ms C] as part of the investigation into the incident and subsequent disciplinary process. Specifically '4. *Whether [Ms C] was physically able to drag [Ms A]. [Ms C's] evidence [was] that she placed her hands under [Ms A's] arms to lift her and remove from the office …'*

The photograph provided of the 'red mark' dated 17.02.2017 appears to resemble that of a carpet burn. The Code of Conduct for [Service], signed by [Ms C] under section 1.2 Personal Behaviour states: *Any behaviour endangering the life or security of people in our care is strictly prohibited, Physically assaulting or threatening, or grossly neglecting any person in our care is grounds for summary dismissal.*

What is the standard of care/accepted practice?

The information in the progress notes provided, does not identify the immediate risk of personal harm to either [Ms A] herself or others — at the point at which she was removed from her position on the office floor. It is also not clear in this progress note who the writer is, who 'removed' [Ms A] from the office nor how this was undertaken. The information in [Ms A's] *Safety Plan* clearly identifies 'Being touched' as a trigger. Accepted evidence-based practice indicates that 'behaviour' is a form of communication and therefore a function which may indicate an unmet need (this includes possible triggers): A person with a mild–moderate intellectual disability who experiences significant life events due to adverse personal, social and mental health history, may have additional needs related to trauma informed care and for whom this may be heightened (Hastings, Hatton, Taylor & Maddison, 2004; Keesler, 2014) such that which is evident in the information provided about [Ms A].

The Australasian Code of Ethics for Direct Support Professionals [DSPs] (McVilly & Newell, 2007, p.10) states that DSPs *'acknowledge that the way they behave directly influences the quality of life of clients they support and the reputation of the services in which they work. They are committed to conducting themselves in ways that demonstrate respect for clients and those with whom they work.'* This is evidenced in the manner in which DSPs *'utilise least restrictive alternatives when implementing support strategies and secure for clients the dignity associated with taking reasonable risks in supportive environments while exercising their duty of care to all.'* Accountability is also explained as taking *'responsibility … for what they do and for what they write … maintain accurate documentation …'*

Based on *NZS 8134.2.1.:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards — Restraint Minimisation,* [Ms A's] *Safety Plan*, and the findings from [the Area Manager] […], the standard of care expected in this instance would indicate that staff should remove themselves when *'[Ms A] was in the office.'* The actions taken by [Ms C] do not appear to be in keeping with the [Service's] policy:

Section 2.3 — Serious Misconduct (Irresponsible conduct that could result in the injury of a client or fellow employee). Section 2.4 — Misconduct (Failure to report an accident or incident affecting a client or an employee. Supporting People who Present with Challenging Behaviour Guidelines in regard to Aversive Practice. Following an incident, it would be expected that the staff involved would document in detail both in the progress notes and complete the organisation's Incident Form. *The Incident Reporting and Management* policy of the [Service] expects *'All staff are responsible for the timely and factual reporting of incidents that occur during the course of their work, or that are notified to them.'* The following *The Health and Disability Commissioner (1994) Code of health and disability services consumers' rights* are relevant:

Right 1: Right to be treated with respect

Right 4: Right to service of an appropriate standard

Right 5: Right to effective communication

Right 8: Right to support

Right 10: Right to complain

The above are in keeping with *Health and Disability Services (Core) Standards NZS 8134.1.1.:2008 Continuum of Service Delivery — Consumer Rights During Service Delivery.*

In my opinion, the reported actions, as documented, in regard the support worker on 17.02.2017 were inappropriate.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

In my opinion, [Ms C's] practice was a moderate departure from the expected standard of care or accepted practice.

How would it be reviewed by your peers?

This would be deemed by my peers as a moderate departure of care or accepted practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.

This opinion is based on the information provided. There is some conflicting information surrounding the events. Key recommendations include: Staff take responsibility for their actions and ensure timely reporting of incidents. The organisation ascertains the competence of staff employed into identified roles. Ensure that all staff have been provided consistent orientation and ongoing training that is adapted and specific to the needs of the person(s) they are employed to support. This includes; understanding their roles and responsibilities in the assessment of, and responses to situations that may escalate, the integration of diagnostic implications into the care of a person and how these are to be managed in the context

of promoting respect, choice, community presence, participation and skill acquisition (O'Brien & Lyle, 1986) for persons with intellectual disability who require secure care in the community.

The adequacy of the training provided to [Ms C] by [the disability service] prior to commencing care for [Ms A].

The *Request for Service Provision* […] by NIDCA (National Intellectual Disability Care Agency), under a *Secure Order for* community residential support pursuant to the ID(CC&R) Act (Intellectual Disability Compulsory Care & Rehabilitation Act, 2003), was *'To provide a residential and lifeskills service for [Ms A] at [the disability service].'*

[Ms C's] Resume states that she has [qualifications] in Social Work [and] Mental Health Support Work. […] From this document, it appears her work experience was primarily as a mental health support worker both in the community and in a secure mental health care setting. In regard to the latter, it is likely, [Ms C] would have been working under the direction and delegation of registered health professionals on a daily basis.

The *Role Description* for a *Community Support Worker* includes accountabilities and expectations in regard to providing support '*for managing challenging behaviour to protect the client, themselves and others'* as well as protecting the safety of clients '*from harm, injury …'.* Health and Safety requirements within this role also require the employee to *'Ensure that safe working procedures are practices and no one is endangered through their actions … Report all incidents …'*

It is not clear from the information available whether the mental health secure setting in which [Ms C] had previously worked was for people with a dual diagnosis […]. It is noted that the work undertaken within the intellectual disability service over this period of time was primarily administrative. The responses documented as part of the interview process clearly indicate that [Ms C] was able to articulate key skills including the need to *'remove self from situation'* to ensure all parties are safe within a given environment.

Working with a person with both intellectual disability and complex mental health needs in a secure community setting, in my opinion, requires that staff receive specific, initial and ongoing training and education in terms of the respective diagnoses, their presentation and the specific support therefore required for the individual. In the *Formal Investigation Meeting Minutes* (23.02.2017) provided, [Ms C] made the following statements not only in reference to herself, but in consideration of staff that may come through in time to come, particularly those for whom English is not their first language: *'… if [Ms A] gets really really heightened. That's what would be really, really helpful … we need to be properly orientated into um how we manage the care with [Ms A] … I've had experience in mental health, but that's totally different … we work as a group … under the guidance of a nurse and, they're always on the floor … that's not happening to us.'*

The concerns included incident reporting: *'How can we write proper incident report? … daily notes? And they said they were going to get back to us. We haven't heard anything.'* [The area manager] stated that working with people who have personality disorder '*is probably [what] people are unprepared for … the original staff group had a very detailed sort of ah coaching and how to script and using the right sort of phrasing and … behaviour management stuff that would actually work with [Ms A].'*

Section one of this opinion provided a context as to [Ms A's] extensive support needs and is relevant as it pertains to the adequacy of training provided to [Ms C]. In regard to training: The *Appointment Letter — Casual Support Worker* (21.12.2016) states that *'[Service] expects all our works are fully trained in all aspects of the role and to achieve this provides full training for staff. As part of your induction/orientation into the organisation you will be required to undertake relevant training for the role and attend regular ongoing training. This may include on-the-job training, relevant national qualifications and/or attendance at appropriate courses.'*

The information available in the documents provided indicate that [Ms C] received two on-the-job shifts and NVCI training. Concerns were raised about the orientation that had been provided as well as workplace safety by [Ms C] shortly after commencing work at [the disability service]. [The disability service] sought a review from [the] Health and Safety Manager, who was asked to *'provide a high level overview of H&S practices in place at [the disability service].'*

09.03.2017: Report by [the] Health and Safety Manager regarding *'concerns raised in December 2016* [emphasis added] *around the safety of staff at the site'.* He found '*mixed levels of awareness of basic Health and Safety practices …* [linked to] *orientation and induction* [emphasis added]*. There is evidence that staff have received training (such as NVCI) and basic H & S induction but understanding of this and how to apply it appears inconsistent.'* There was also reference to issues of consistency about when a behaviour constituted a reportable incident and how it was managed. His conclusions were that whilst there *'is an awareness of compliance requirements'* it was recommended that *'there must be a plan and commitment to ensure staff safety and awareness of the basic H&S standards and processes is in place for this residence … [and that] a training matrix for all staff is required.'*

30.12.2016: Team Meeting Minutes (p.7) include documented reference to the following and an expectation that *'all staff are to be familiar with Hazards and Identified Control Forms.'* This meeting was attended by [Ms C]. Service Specific Hazards: Challenging and unpredictable behaviours; Verbal & Physical Assaults on Staff Generic Hazards: Violence; Lifting Handling; Non Reporting; Training for all staff in identifying hazards.

02.02.2017: Documentation from the Certified Instructor with [the disability service] verifies that [Ms C] completed a 12 hour Nonviolent Crisis Intervention — NCI — Units 1–10 Training Class.

10.02.2017: Team Meeting Minutes: [Ms C] *'raised concerns about health and safety (i.e her and [another worker] not be orientated and feeling unsafe).'*

14.03.2017: In HDC Website Complaint Submission [Ms A's] welfare guardian noted that she had '*expressed [her] concerns to [disability service] staff prior to this care arrangement about the insufficient trained care worker staff. I had also voiced them at [Ms A's] official reviews where my concerned were documented.'*

20.03.2017: The letter *Re: Outcome of Investigation — Dismissal Without Notice*, from [the area manager] responds to concerns raised by [Ms C] as part of the investigation into the incident and subsequent disciplinary process. Specifically *'6. [Ms C's] orientation. I am happy to clarify that [Ms C] began working at [the disability service] [in] 2016. She received two orientation shifts (one 'day shift' and one 'afternoon shift')* [in 2016] *where she was buddied with a more experienced staff so she could observe. As part of her orientation, [Ms C] was given time to read and familiarise with all the relevant information, such as the Emergency Service Folder, and [Ms A's] folder with her Personal Plan and Safety Plan.'*

What is the standard of care/accepted practice?

The *Orientation Schedule Monday 3 August–Friday 7 August* outlined the topics that had been identified as needed for the incoming staff for [Ms A] at [the disability service]. Aside from orientation to the service itself, roles and responsibilities, Promapp training, Environmental and Medication management, Personal and Safety Plans were also on the timetable. Given the complex history, presentation and support needs consistently identified for [Ms A], expected practice would necessitate all staff to have the same level of induction and orientation to the individual's specific support needs.

As identified above, it is not only the service orientation and health and safety guidelines which need to be provided; the clinical adaptation, interpretation, application and implications specific and in relation to the person and their diagnoses (ID, PTSD, BPD, EP, medication and pain management — has *'early signs of arthritis to hip areas'*) must be provided: Independently, these each have clinical considerations, and in combination, specialist education for staff is required for such a complex individual.

In my opinion, two shifts alongside a staff member and a 12 hour NVCI course would be considered insufficient. As would be expected and, in my opinion, is in keeping with the level of clinical support required for direct care staff working with someone with complex needs such as [Ms A], the [disability service] consistently states that *'clinical supervision is provided to all staff at [the disability service] every fortnight*' and is provided by a registered nurse with mental health experience and who had worked with [Ms A] in the *'hospital level*' setting prior to the current [disability service]. It is not clear from the information provided whether this was available to [Ms C] individually or as a group process.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

In my opinion, there was a moderate departure from the expected standard of care or accepted practice: What was provided to the staff team initially, does not appear to be congruent or to the same level as what was offered to [Ms C].

How would it be reviewed by your peers?

This would be deemed by my peers as a moderate departure of care or accepted practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.

According to the *Specialist Assessor Review Report* (11.05.2017), as a result of the alleged incident in question '*changes in practice have occurred … staff room door always being locked … staff member involved was dismissed … [Service identified] as training issue and [the area manager] explained that retraining in respect to procedures to maintain [Ms A's] safety were undertaken … NVCI was identified … and courses were delivered to staff requiring that refresher … [Welfare Guardian] expressed persisting concern about the qualifications and training of [staff] …'* Comprehensive training updates need to be scheduled undertaken at regular intervals for all existing staff and the same level of education and training is to be provided for each incoming staff member before they are on rostered numbers. Ensure that all plans related to the specific care of [Ms A] are current. Ensure there is documentation in keeping with the *Restraint Minimisation and Safe Practice Standards* (Standards New Zealand, 2008) in regard to the rationale of a locked staff office door in the context of a person's home.

Any other matters in this case that you consider warrant comment including the appropriateness of [the disability service's] policies and procedures.

According to the Incident Form dated 17 Feb 2017 by [a community support worker] the following actions (listed below) were taken in response to [Ms A's] complaint *'about being dragged on the carpet in the office'.* [The community support worker] contacted [the residential manager] who completed the list of actions below. This action was corroborated by a written statement by [staff] on 14.09.2017 and 13.09.2017 respectively.

17.02.2017: [The residential manager] viewed the red mark on [Ms A's] back with [the community support worker] present [the area manager] notified at approximately 8.30am that morning when she visited the service, and … also sighted the mark on [Ms A's] back. [Managers] agreed mark was consistent with carpet burn. Photo taken of [Ms A's] mark on her back and [Ms A] informed that her complaint will be followed up on immediately. Follow up with staff [Ms C] & [Ms D] occurred and decision made to proceed with formal investigation. Due to safety reasons [Ms C] stood down from her evening shift scheduled 17.02.2017.

[Ms C] was stood down immediately. The information provided in regard to the timeliness of the response of the service to [Ms A's] complaint indicates that it was taken seriously from the outset (Incident Report by [community support worker] 17.02.2017; Letter by [the residential manager] to the HDC 12.09.2017). [Ms A's] Welfare Guardian was *'not informed of the incident by [disability service] staff but heard about it a few days later through a close friend who had received a call from [a manager] … It took [the area manager] 25 days to contact me about this incident. At [Ms A's] previous review it was stated that I would be notified of serious incidents on the day they occurred. This did not happen.'*

10.03.2017: Minutes of the [disability service] Team Meeting which was facilitated by [the area manager] identified that staff continued to be uncertain it is appropriate to write an incident report '*but that staff were being told not to write them up.'* Staff expressed concern about the lack of follow up by the Residential Manager when an incident report had been filed. Several of the documents provided refer to the fact that [Ms A] has epilepsy and, as indicated above, it has been identified as tonic clonic and/or absence. From the information provided, there is no information about how epilepsy presents in [Ms A].

What is the standard of care/accepted practice? [Ms A's] Right to Complain was upheld. Of note, there is no number on the Incident Form which, in my opinion, is not in keeping with reporting procedures. An incident number allows tracking, monitoring and auditing of all incidents and provides key information in quality reporting and management. According to the [service's] *Incident Reporting and Management* requires that *'clients, their family/whanau … are to have the circumstances of the incident fully explained to them in an open and transparent manner.'* From the documentation reviewed, including *Incident Reporting and Management* there is an expectation that all incidents, hazards, including near misses are to be reported. If a person has epilepsy, expected practice would require that there be information within a person's *Personal Plan* and *Safety Plan* about; i/ what it is ii/ how it presents for the individual and iii/ recommended support and response. It is known that epilepsy, may for some people, indicate a behavioural phenotype meaning, that there are clear explanations that may be understood by presentation of this neurological condition in relation to the individual.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? In my opinion, the documentation and communication of [the disability service] was a moderate departure from the expected standard of care or accepted practice. Please note, reference to communication is in regard to timely communication with [Ms A's] Welfare Guardian and the messages received by staff as to when an incident needs to be documented.

How would it be reviewed by your peers?

This would be deemed by my peers as a moderate departure of care or accepted practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.

Opinion based on the information provided and in keeping with *Health and Disability (Core) Standards: NZS 8134.1.2.:2008 Continuum of Service Delivery — Organisational Management.* Review [Ms A's] epilepsy status: Ensure there is clear documentation within her *Personal Plan* and *Safety Plan* in regard to; i/ what staff need to look out for, ii/ how to support [Ms A], iii/ how this presents separate to or within the context of other presentations deemed challenging. Determine the *Incident Reporting and Management* policy timeframes within which the family/whānau, welfare guardian or significant other of a client is notified of an incident. Staff and management (including Team Leader, Residential and Area Manager) attend specific, person-centred orientation, health and safety and NVCI training together: This is to ensure there is consistency in the understanding about the systems that are in place, hazard and incident reporting, and the expectations about targeted, specialist service delivery for individuals such as [Ms A] who has complex support needs which are specific to her as a person and in regard to her pre-existing, acquired mental health and intellectual disability."