Disability Service

Team Leader, Mr C

A Report by the

Deputy Health and Disability Commissioner

(Case 20HDC01226)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by a disability service provider and a team leader to a woman in 2020. The disability service provides community residential services and community-based rehabilitation support. The woman has a traumatic brain injury (TBI) and a complex mental health history and was a resident at the disability service at the time of events.

2. When the woman's behaviour deteriorated, her ACC-funded psychiatrist assessed her as presenting "with a manic relapse of her bipolar mood disorder". The psychiatrist started an application for compulsory treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act). The woman was then taken to a mental health service for assessment, but it was determined that she did not meet the criteria to be admitted or placed under a compulsory treatment order.

3. On 3 July 2020 the team leader took the woman to the emergency department (ED) at a hospital which was a considerable distance away from her residence. No handover was provided, and the woman did not have her medication with her. When the woman was assessed, she was not admitted to the hospital and, technically, was left homeless in the days following.

4. The disability service documented the following morning that the woman had been "[d]ischarged from Service to Mental Health".

Findings

5. The Deputy Commissioner found that the disability service did not provide services to the woman in a manner consistent with her needs, or in line with Sector Standard 2.5, and, as such, breached Rights 4(2) and 4(3) of the Code. The Deputy Commissioner was critical of the decision to take her to the ED as the situation was not an emergency, and therefore required better planning and coordination. The Deputy Commissioner considered that the decision focused on the disability service meeting its own needs and did not provide the woman with services consistent with *her* needs. The Deputy Commissioner was also critical of the disability service's "exit" of the woman as the disability service did not contact the ED in advance to advise staff that the woman would be coming for assessment, she did not have her medication with her, and there was no contingency in place for what would occur if the hospital decided not to admit her, which was a foreseeable outcome given the earlier mental health service assessment. Further, the woman's mother was the legal guardian[1] at the time of events and was not aware that her daughter had been discharged from the disability service. The Deputy Commissioner considered that the "exit" amounted to abandonment.

[1] Due to active orders under the Protection of Personal and Property Rights Act 1988.

6. The Deputy Commissioner made adverse comment about how the team leader left the woman at the ED. However, she accepted that he did not have decision-making power in this situation and was following direct instructions.

Recommendations

7. The Deputy Commissioner recommended that the disability service provide a written apology to the woman and her mother; provide HDC with a copy of the policy on behavioural management, outlining the process for staff when managing residents with challenging behaviours, and the escalation process; provide HDC with a copy of the policy for discharging residents from the disability service's care involuntarily, clearly outlining the safe exit and transfer of care process; review the ACC and Te Whatu Ora Service Standard Specifications as part of contract agreements and provide HDC with its escalation policy and protocol for transfer of care when a service is no longer appropriate for a resident's placement; and provide HDC with a copy of the training framework for managing challenging behaviours, clearly outlining how often the training is delivered and how it ensures that all staff have completed the training.

8. The Deputy Commissioner also recommended that the disability service, ACC, and Te Whatu Ora reflect on the deficiencies identified in this report and provide HDC with information on what further steps are occurring to improve co-ordination and co-operation between rehabilitation and mental health services to prevent a recurrence of such an incident.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from a nurse about the services provided by a disability service to Ms A. The role of complainant was later transferred to the consumer's mother. The following issues were identified for investigation:

- *Whether the disability service provided Ms A with an appropriate standard of care on 3 July 2020.*
- *Whether Mr C provided Ms A with an appropriate standard of care on 3 July 2020.*

10. This report is the opinion of Deputy Health and Disability Commissioner Vanessa Caldwell and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Ms A	Consumer
Ms B	Complainant/legal guardian
Disability service	Group provider
Mr C	Individual provider/team leader

12. Further information was received from:

RN D	Initial complainant/duly authorised officer[2]
Dr E	Psychiatrist
Te Whatu Ora 1 (formerly DHB1)[3]	Group provider
Te Whatu Ora 2 (formerly DHB2)	Group provider

13. Psychiatrist Dr F is also mentioned in this report.

Information gathered during investigation

Background

14. This report discusses the care provided to Ms A on 3 July 2020 by a disability service and Mr C (Team Leader).

15. The disability service provides community residential services and community-based rehabilitation support.

16. Ms A has a TBI, which she sustained in 2016. Dr E stated that Ms A has a "complex history", with significant mental health contact since 2007 and a diagnosis of bipolar mood disorder. Her mother, Ms B, was Ms A's legal guardian at the time of events.

17. ACC first referred Ms A to the disability service on 21 October 2019 for respite care. The referral included copies of a Behaviour Support Service (BSS) referral and report, which had concluded in August 2019; a Support Needs Assessment from March 2019; and a neuropsychological assessment report dated 15 July 2019. These documents presented a history of behavioural issues, including absconding, verbal abuse, and a risk of hurting herself or others.

18. Following the referral, Ms A stayed at the disability service for respite care in November 2019 and January 2020, before returning to the disability service as a resident on 22 June 2020. The disability service told HDC that "[w]ithin hours of [Ms A] arriving [on 22 June 2020], it was evident that this young lady was presenting quite differently from the [Ms A] that we knew previously". A summary of incident reports provided by the disability service shows that Ms A's behaviour deteriorated between 22 June and 3 July 2020, prompting a mental health assessment at a mental health service on 25 June 2020, and a psychiatric review by Dr E and a further mental health assessment at the mental health service on 3 July 2020. A staff member from the disability service took Ms A to Te Whatu Ora 2 on 3 July

[2] A health practitioner authorised to perform certain functions under the Mental Health (Compulsory Assessment and Treatment) Act 1992, including mental health assessments.
[3] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand.

2020, and the disability service documented on the morning of 4 July 2020 that Ms A had been "[d]ischarged from Service to Mental Health".

19. Below is a summary of Ms A's exit from the disability service:

Date / Time	Event
3 July 2020	Semi-urgent home visit assessment of Ms A by Dr E, who concluded: "[Ms A] presents with a manic relapse of her bipolar mood disorder. I have made an application for formal mental health assessment. ... In the absence of assertive and intensive community support by mental health services … it is not safe or tenable for [Ms A] to remain at [the disability service]. From a psychiatric perspective the nature of her current presentation cannot be adequately or safely managed remotely or on an outpatient basis and require[s] involve[ment] from a team that can provide intensive community based or inpatient [mental health] support." Dr E started an application for a compulsory treatment order under the Act and offered to liaise with the Mental Health Service at Te Whatu Ora 1.
Approx. 2.30pm	A mental health assessment was completed by psychiatrist Dr F at the mental health service, who concluded that Ms A "did not present as mentally disordered". He stated: "I do not doubt that the staff at [the disability service] have been very concerned about the behaviours described in numerous notes. Given that affective illnesses and psychoses cannot be turned on and off as such, I conclude that her behaviour over the past fortnight must be influenced by personality traits, substance intoxication, or both." Dr F recommended that Ms A continue her current medication regimen and encouraged the disability service to establish boundaries with Ms A, including reasonable consequences such as calling the Police or charging her if she committed an offence. He stopped the application for a compulsory treatment order under the Act.
2.43pm	Dr E emailed the ACC Recovery Partner/Kaihāpai and the ACC Service Development Manager at the disability service to advise that he was still waiting to hear from the mental health service, and that from his perspective it was "not a definite admission … but if not admitted [Ms A] [would] require assertive and intensive community support from [mental health services]".
3.14pm	In an email chain, the ACC Service Development Manager reported that Ms A was on her way to Te Whatu Ora 2.

4pm	The ACC Service Development Manager called Ms A's mother and legal guardian, Ms B. Ms B told HDC that she understood that her daughter was being taken to Te Whatu Ora 2 and that she would be staying there.
7.30pm	After stopping twice along the way for refreshments, Mr C and Ms A arrived at the ED at Te Whatu Ora 2. There are differing accounts of what happened once Mr C and Ms A arrived at Te Whatu Ora 2. These are discussed further below. A triage note documented the following: "[Traumatic brain injury], bi polar, schizophrenia has been [discharged] from a facility in [Te Whatu Ora 1 region], she has family in [Te Whatu Ora 2 region] who don't want her so she has been dropped off at ED. Doesn't have any medications and is at risk of self-harm."
9pm	RN D began her assessment of Ms A.
11.10pm	RN D received a fax from Te Whatu Ora 1 with notes from Ms A's previous visits to the mental health service and information about Ms A's medications.
Before 12am	At some point in the night, Mr C presented to Ms B's home with Ms A's belongings. Ms B told HDC that no one had told her to expect him.
Approx. 12am	RN D and Mr C spoke on the phone about Ms A's exit from the disability service. The details of this conversation are disputed (discussed further below).
4 July, 1am	Ms A was discharged into the care of her stepmother.
10am	The disability service's diary notes for Ms A documented: "Discharged from Service to Mental Health."
5–7 July	Ms A's stepmother was able to keep Ms A for only one night, and Ms A was technically homeless for four days until she was admitted to the subacute unit at Te Whatu Ora 2.

Advice from Dr E regarding taking Ms A to Te Whatu Ora 2

22. In his assessment of Ms A on 3 July 2020, Dr E stated:

> "I appreciate that some of the difficulties may relate to a patient from [Te Whatu Ora 2 region] currently temporarily based in [Te Whatu Ora 1 region] and if admission is considered necessary, this may be better accommodated in [Te Whatu Ora 2 region]."

23. An email to the disability service from the ACC Recovery Partner/Kaihāpai at 12.57pm on 3 July 2020 states:

> "I just spoke to [Dr E] who is on his way back … from seeing [Ms A] … If we hit crisis point [Dr E] has suggested taking [Ms A] to the [District Health Board] and telling them that she is now homeless and trying to get an admission this way. But we hope that with [Dr E's] recommendation and his phone call and report that this will not be necessary."

24. In his response to HDC, Dr E clarified this advice, saying:

> "[Ms A's] placement was at risk of breaking down due to the relapse of her mood disorder and in my opinion the disability service lacked capacity to manage her without mental health support. My understanding was that her aunt with whom she had been living up to her transfer, declined to have her transferred back to [her home]. I meant to convey to [the ACC Recovery Partner/Kaihāpai] the message that if her placement was not supported by the [Mental Health] team, this would fail and she would technically become homeless."

Drop off at Te Whatu Ora 2 ED

25. There are differing accounts of what happened once Mr C and Ms A arrived at the ED at Te Whatu Ora 2.

26. In the complaint to HDC, RN D said she found that Ms A had no medications on her and nowhere to go, and that she was reportedly manic. During the assessment, Ms A advised RN D that a member of staff from the disability service had dropped her off and was going to take her belongings to her mother's house, and then drive back.

27. RN D spoke to ED staff to gather more information. The ED staff told her that they had not received any clinical handover or medications for Ms A. They had not realised that Mr C was a healthcare provider, and said that had they known this, they would not have let him leave ED without a handover. RN D said that ED staff told her that Mr C had refused to answer when asked who he was, and that he had left the ED so quickly that they had assumed he was a family member who was "dumping and running".

28. In response to this, the disability service provided the following statement from Mr C:

> "[Mr C] went to reception and informed the receptionist that he was from [the disability service]. He 'booked' [Ms A] in and advised that [Dr E] had recommended that [Ms A] be taken to ED as all her medical history is on file.
>
> The receptionist was advised that [Ms A's] Mother; [Ms B] holds the [P]PPR and had been notified, she did not want [Ms A] at her home. [Ms A's aunt] had been notified and she did not want [Ms A] at her home … [Mr C] advised the receptionist that he had just driven from [Te Whatu Ora 1 region] and had to go to drop off [Ms A's] belongings at her mother's home and then drive back to [Te Whatu Ora 1 region]. He asked if he could leave and was informed that it was alright to leave."

29. The disability service told HDC: "As [Ms A] had gone from [the mental health service] in [Te Whatu Ora 1 region] to [Te Whatu Ora 2 region], the medication had not been collected from the lock box at [the disability service]." The disability service also stated that the

receptionist at Te Whatu Ora 2 had been told this and had replied that "ED would sort this out".

30. Around midnight, RN D called Mr C as he was driving back. RN D and Mr C provided their recollections of that phone call:

- RN D recalls that Mr C told her that Ms A had been exited from the disability service. She asked Mr C what the plan was and who had accepted the referral. Mr C said there was no plan and no referral. She asked what Ms A's medications were, and where they were, and Mr C said that "[Ms A] had forgotten them". RN D asked Mr C to provide some form of handover, including Ms A's history, and he said that he could not do that until Monday (6 June 2020). RN D then told him that this was unacceptable, and Mr C hung up.
- Mr C recalls that RN D called him a bad clinician, and he clarified that he was a team leader, not a clinician. He also said that he was following recommendations that were made after an earlier assessment of Ms A. When asked about handover documentation, he told RN D that he had informed reception that the relevant documentation was at the mental health service and suggested that the information could be emailed or faxed to Te Whatu Ora 2.

31. Eventually, RN D was able to obtain enough information from Ms A and medical records to document a partial history for Ms A.

Subsequent events and information

32. The disability service stated that because Ms A was being taken to the ED at Te Whatu Ora 2, no call was made to advise that she would be arriving. The plan was that Ms A would present at ED and be assessed "as per ED protocol".

33. Ms B told HDC that she had understood that her daughter would be staying at Te Whatu Ora 2 until it was safe for her to return to the disability service. She said that she was not informed that her daughter had been exited from the disability service until "a day or two" after this occurred.

34. Currently Ms A is living at a residential rehabilitation facility, and her mother remains her legal guardian. Ms A is not receiving mental health support.

35. Mr C and the ACC Service Development Manager no longer work at the disability service.

Responses to provisional opinion

36. Ms B was given an opportunity to respond to the "information gathered" section of the provisional opinion and had no further comments.

37. The disability service was given an opportunity to respond to the provisional opinion and had no further comments.

38. Mr C was given an opportunity to respond to the relevant parts of the provisional opinion. Where appropriate, his comments have been incorporated into the report. Mr C also submitted the following:

- In his role as a team leader, he did not manage people and he had no power in the situation. He stated that he only acted following direct instructions from his superiors. He felt that if he had disagreed with or not followed the instructions to take Ms A to Te Whatu Ora 2 ED, his job may have been at risk.
- He ensured that Ms A had her evening medications on 3 July 2020, and he had been told that all Ms A's relevant documentation would be sent to the necessary people. Mr C stated that he relied on this information.
- He was told that Te Whatu Ora 2 had a facility to take care of Ms A, and he was under the impression that he was taking Ms A to Te Whatu Ora 2 to be cared for by an appropriate service. He did not question whether the hospital would admit her, as he believed that the correct arrangements had been made.

Introductory comment on coordination of care and expectations

39. The overlap between traumatic brain injury (TBI) and mental health issues is not uncommon, as people who have had a TBI frequently experience mental health problems. This report highlights the difficulty of coordination of care between mental health services, rehabilitation services, and ACC.

40. The difficulties between TBI and mental health services are well known in the health and disability sector. ACC's guideline on "Traumatic Brain Injury: Diagnosis, Acute Management and Rehabilitation" (2006) states:

> "The Guideline Development Team has found that a recurring message from health care practitioners working with people with TBI is the difficulty of adequate cohesion between mental health services, rehabilitation services and ACC. This is thought to partly reflect historical service divisions, different funding streams and uncertainty about what services are able and willing to offer."

41. The guideline states that rehabilitation services contracted to manage people with TBI and local mental health services "need to work together to specify and document policies for dealing with people with TBI who have mental health issues, whether they pre-date or follow the TBI". The guideline also states that ACC personnel need to be involved in these discussions and approve any local policies so that they can be included in existing and future contracts.

42. Ms A has a complex mental health history, and the TBI sustained in 2016 had a further impact on this. It is evident that there has been a fragmented approach to Ms A's care, and

that this has not encompassed adequate support needs for both her episodes of mental health concerns and the lifelong impact associated with living with a TBI.

43. Sadly, this case is not an isolated scenario, and it highlights the importance of robust systems and good communication between providers, to ensure coordinated care that is flexible in order to meet the changing needs of people with complex care needs. Community support services must have the back-up of specialist services, including behavioral specialists, to intervene appropriately and responsively when requested, to better support people who experience episodes of distress or challenges that require higher levels of intervention. I stress that it is entirely inappropriate for care facilities to utilise emergency departments as alternative accommodation solutions.

Opinion: Disability service — breach

Introduction

44. The disability service is responsible for providing services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code) and the New Zealand Home and Community Support Sector Standards[4] (the Sector Standards). In my view, this did not occur, and I have found the disability service in breach of Rights 4(3)[5] and 4(2)[6] of the Code. The reasons for my decision are set out below.

Failure to meet patient needs

45. Dr E's assessment of Ms A on the morning of 3 July 2018 was that she presented with a manic relapse of her bipolar mood disorder. Dr E began the application for a formal mental health assessment to be completed to determine whether Ms A should be placed under a compulsory treatment order.

46. However, when Dr F at the mental health service completed a formal mental health assessment of Ms A later that day, he concluded that Ms A did not present as mentally disordered and did not meet the requirements to be placed under a compulsory treatment order. Dr F discontinued the application for a compulsory treatment order and recommended that Ms A remain on her current medication, and that boundaries be established with Ms A, including reasonable consequences.

47. Following the assessment by Dr F, Ms A was driven by Mr C directly from the mental health service to the ED at Te Whatu Ora 2. Mr C made two stops along the four-hour drive for refreshments.

[4] NZS 8158:2012 was applicable at the time of events.
[5] Right 4(3) states: "Every consumer has the right to have services provided in a manner consistent with his or her needs."
[6] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

48. I am very concerned about how a decision was reached that it was appropriate to take Ms A to the ED at Te Whatu Ora 2. EDs are for emergency care, and I do not consider that this was an emergency situation for the following reasons:

- There was clear clinical advice that Ms A was not presenting as mentally disordered and did not meet the threshold for a compulsory treatment order; and
- Two stops were made on the way for refreshments, which suggests both a lack of urgency and a lack of psychiatric instability or significant risk that would normally be required to meet the threshold for a psychiatric emergency.

49. I acknowledge that Ms A's behaviour had reached a point where the disability service's staff felt that they could no longer manage her. However, even if I allow for the possibility that an exit from the disability service was necessary in these circumstances, the situation was not an emergency, and therefore required better planning and coordination. I consider that by failing to think critically about Ms A's situation and initiate the appropriate planning, and instead taking Ms A to hospital, the disability service focused on meeting its own needs and did not provide Ms A with services consistent with *her* needs, and therefore breached Right 4(3) of the Code.

50. I also have significant concerns about Ms A being left at Te Whatu Ora 2, which I discuss below.

Drop-off at Te Whatu Ora 2 — "Dump and Run"

51. Ms A was a vulnerable consumer, not only because of her TBI and complex history with significant mental health contact since 2007, but also because of the behaviour she was exhibiting at the time of the events, which placed her in situations that put her safety at risk. The disability service was aware that Ms A had limited support from her whānau and that they were not in a position to care for her. This meant that Ms A relied heavily on the services the disability service provided.

52. The disability service has addressed the leaving of Ms A at Te Whatu Ora 2 as an exit from the service. However, I do not consider this to have been an appropriate exit for the following reasons:

- The disability service did not contact Te Whatu Ora 2 in advance to advise staff that Ms A would be coming for assessment;
- There was no contingency in place for what would occur if Te Whatu Ora 2 decided not to admit Ms A, which was a foreseeable outcome given the earlier mental health service assessment;
- Ms A did not have her medication with her; and
- Ms A's mother/legal guardian was not informed that Ms A was being exited from the service.

53. Sector Standard 2.5 provides that consumers' entry into, and exit from, services are facilitated in an equitable, timely and respectful manner. Specifically, Standard 2.5.2

requires there to be a planned exit in cooperation with the consumer, and for this to be documented, communicated, and implemented effectively. There is no evidence that Ms A's exit was planned with either Ms A or her mother (who needed to be informed as Ms A's legal guardian). Further, there is no documentation of an exit plan, and the exit was not implemented effectively, as demonstrated by the fact that Ms A ended up homeless for a few days after it occurred. Accordingly, I consider that the disability service did not provide services to Ms A that complied with sector standards, and therefore breached Right 4(2) of the Code.

Conclusion

54. I am very concerned about the care provided to Ms A by the disability service on 3 July 2020, and consider that the "exit" from the disability service amounted to abandonment of Ms A at Te Whatu Ora 2.

55. The disability service was responsible for providing services to Ms A in accordance with the Code and the Sector Standards. As detailed above, I consider that the disability service did not provide services to Ms A in a manner consistent with her needs, or in line with Sector Standard 2.5, and therefore I have found the disability service in breach of Rights 4(3) and 4(2) of the Code respectively.

Opinion: Mr C — adverse comment

Introduction

56. Mr C was a team leader at the disability service at the time of the events. I have undertaken a thorough assessment of the information gathered in light of concerns raised as part of this complaint, and I am concerned about Mr C's actions in relation to taking Ms A to Te Whatu Ora 2 and leaving her there.

Leaving Ms A at Te Whatu Ora 2

57. Mr C left Ms A at Te Whatu Ora 2 unsupported and without her being admitted as an inpatient. Mr C was aware that Ms A had been assessed by the mental health service as not meeting the requirements to be admitted as an inpatient, and that Ms A's whānau were not in a position to care for her.

58. It is my view that there was a lack of critical thinking on Mr C's part, and Ms A should not have been left at Te Whatu Ora 2 without first being admitted, as this left Ms A in a vulnerable position, particularly due to her lack of alternative care options.

59. My concerns are, however, mitigated by the fact that Mr C was under the impression that appropriate arrangements had been made and he was taking Ms A to Te Whatu Ora 2 to be cared for by an appropriate service. Mr C also stated that he acted only following directions from his superiors. In addition, although Mr C was a team leader, he was not responsible for

the decision to take Ms A to Te Whatu Ora 2, and there was no clear process to guide him in this situation, and therefore Mr C was not equipped sufficiently to know what to do.

Information provided to Te Whatu Ora 2 on arrival

60. Mr C stated that when he arrived at the ED at Te Whatu Ora 2, he informed the receptionist that he was from the disability service and that Dr E had recommended that Ms A be taken to Te Whatu Ora 2. Mr C also told the receptionist that Ms A's medical history was "on file".

61. I am concerned that the information Mr C provided was misleading, as there was no clear recommendation from Dr E that Ms A needed to be taken to the ED at Te Whatu Ora 2. I acknowledge that Dr E had advised that "if admission [was] considered necessary, this may be better accommodated in [Te Whatu Ora 2]". I also acknowledge that the ACC Recovery Partner/Kaihāpai had told the disability service that Dr E had suggested "taking [Ms A] to the [District Health Board] and telling them that she is now homeless and trying to get an admission this way", if they reached "crisis point". However, even if I accept that this is the information the disability service was working with, Ms A had been assessed as not in crisis by the mental health service, so this pathway remained inappropriate.

62. Further, I note that the information "on file" was not readily available to staff at Te Whatu Ora 2, and RN D was required to obtain Ms A's history from the mental health service, and information about her medications from Te Whatu Ora 1. Ultimately, RN D was able to obtain only a partial history for Ms A.

63. However, my concerns about Mr C's actions are mitigated by the fact that he was under the impression that relevant information would be sent to Te Whatu Ora 2 by the disability service, and that appropriate arrangements had been made for Ms A to be cared for at Te Whatu Ora 2. Taking this into consideration, and the fact that there was a four-hour drive to the Te Whatu Ora 2 region, I consider that it was reasonable for Mr C to assume that Ms A's information would have been sent to the appropriate service at Te Whatu Ora 2 by the time he arrived.

Medication left behind

64. Ms A did not have any of her usual medication with her when she was assessed by RN D at Te Whatu Ora 2. Mr C stated that he ensured that Ms A had her evening medication with her before leaving and said that he had been told that Ms A's relevant information would be sent to the necessary people. Mr C understood this to include information on Ms A's medications. Mr C told HDC that he relied on this information.

65. The disability service stated that "[a]s Ms A had gone from the mental health service in [the Te Whatu Ora 1 region to the Te Whatu Ora 2 region], the medication had not been collected from the lock box at [the disability service]". However, given that the disability service and the mental health service are a short drive from each other, I am at a loss to understand why this would have been a barrier to collecting Ms A's medication, particularly when it is something essential to Ms A's wellbeing.

66. In the context of advice from the mental health service that day — ie, that Ms A should remain on her current medication — and given that the disability service's plan appeared to be to exit Ms A from the service (and therefore Ms A would be unable to return to retrieve her medication), I am concerned that Mr C did not ensure that Ms A had her medication with her, other than what she needed for that evening.

67. However, again my concern is mitigated by the fact that Mr C understood that Ms A's medications and relevant information would be sent to Te Whatu Ora 2, and he relied on this information.

Conclusion

68. In summary, I am concerned by the following aspects of Mr C's actions on 3 July:

- Leaving Ms A unsupported at Te Whatu Ora 2 before she was admitted as an inpatient;
- Providing misleading and insufficient information to Te Whatu Ora 2 on arrival; and
- Not collecting Ms A's medications from the disability service prior to leaving.

69. However, I accept Mr C's submissions that in his role as team leader he did not have decision-making power in this situation, and he was following direct instructions to take Ms A to Te Whatu Ora 2. Further, I accept that he was under the impression that arrangements had been made for Ms A to be cared for by an appropriate service at Te Whatu Ora 2, and that he understood that Ms A's relevant information would be sent to Te Whatu Ora 2.

Recommendations

70. I recommend that the disability service:

a) Provide a written apology to Ms A and Ms B. This should be sent to HDC, for forwarding to Ms B, within three weeks of the date of this report.

b) Provide HDC with a copy of the disability service's policy on behavioural management, outlining the process for staff when managing residents with challenging behaviours, and the escalation process. This is to be provided to HDC within three months of the date of this report.

c) Provide HDC with a copy of the disability service's policy for discharging residents from the disability service's care involuntarily, clearly outlining the safe exit and transfer of care process. This is to be provided to HDC within three months of the date of this report.

d) Review the ACC and Te Whatu Ora Service Standard Specifications as part of the disability service's contract agreements. The disability service is to provide HDC with its escalation policy and protocol for transfer of care when a service is no longer appropriate for a resident's placement. This is to be provided to HDC within six months of the date of this report.

e) Provide HDC with a copy of the disability service's training framework for managing challenging behaviours, clearly outlining how often the training is delivered and how it ensures that all staff have completed the training. This is to be provided to HDC within three months of the date of this report.

71. I recommend that the disability service, ACC, and Te Whatu Ora reflect on the deficiencies identified in HDC's report and provide HDC with information on what further steps are occurring to improve co-ordination and co-operation between rehabilitation and mental health services to prevent a recurrence of such an incident.

Follow-up actions

72. I will ask Whaikaha|Ministry of Disabled People to consider a direction to residential services that are funded to provide care, to ensure that they understand their responsibilities and duty of care when the service feels ill-equipped to support a client adequately.

73. I will also ask Whaikaha|Ministry of Disabled People and Te Whatu Ora to consider working together to develop protocols to improve coordination of care, to better meet the needs of people who have complex and challenging needs and to avoid the use of hospitals as an alternative housing solution, as occurred in this case.

74. A copy of this report with details identifying the parties removed, other than the disability service, will be sent to ACC, Te Whatu Ora|Health New Zealand, Whaikaha|Ministry of Disabled People, and the Ministry of Health's Director of Mental Health and Addiction Services.

75. A copy of this report with details identifying the parties removed[7] will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[7] In accordance with HDC's naming policy, the decision not to name the provider publicly has been made in order to protect the identity of individuals.