AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Waitemata
District Health Board
Best Care for Everyone

Disability Support Advisory Committee Meeting

Wednesday, 09 March 2016
1.30pm

Training Room
CCS Disability Action
14 Erson Avenue
Royal Oak, Auckland

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Published 02 March 2016

Agenda
Disability Support Advisory Committee
09 March 2016

Venue: Training Room, CCS Disability Action
14 Erson Avenue, Royal Oak

Time: 1.30pm

Committee Members
Sandra Coney (Chair)
Max Abbott
Jo Agnew (Deputy Chair)
Judith Bassett
Marie Hull-Brown
Dairne Kirton
Dr Lester Levy
Jan Moss
Robyn Northey
Russell Vickery
Shane WiJohn
Jade Farrar

Auckland DHB and Waitemata DHB Staff

Dr Dale Bramley	Chief Executive Officer Waitemata DHB
Ailsa Claire	Chief Executive Officer Auckland DHB
Samantha Dalwood	Disability Strategy Advisor WDHB
Aroha Haggie	Acting Māori Health Gain Manager
Dr Debbie Holdsworth	Director of Funding – Auckland & Waitemata DHB
Fiona Michel	Chief of People and Capability Auckland DHB
Kate Sladden	Funding and Development Manager, Health of Older People
Michelle Webb	Corporate Committee Administrator
Sue Waters	Chief Health Professions Officer
Tim Wood	Funding and Development Manager, Primary Care

(Other staff members who attend for a particular item are named at the start of the respective minute)

Apologies Members: Dairne Kirton.

Apologies Staff: Ailsa Claire, Dale Bramley, Debbie Holdsworth, Lester Levy.

Agenda

Please note that agenda times are estimates only

1.30pm **1.** **Attendance and Apologies**

1.35pm **2.** **Register and Conflicts of Interest**

Does any member have an interest they have not previously disclosed?

Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

1.40pm **3.** **Confirmation of Minutes 18 November 2015**

1.45pm **4.** **Action Points**

4.1 Support of High Needs Patients While in Hospital Update (verbal update)

1.50 4.2 Venues for Future Disability Support Advisory Committee Meetings

1.55pm **5.** **Chair's Report (Verbal)**

	6.	**Presentations**
2.05pm	6.1	Abuse of Older Adults and Vulnerable Adults E-learning Module (Delia McKenna, Professional and Clinical Leader Social Work)
	7.	**Improvement Activities**
2.25pm	7.1	Health of Older People Quarterly Report on Activities in Auckland and Waitemata District Health Boards
	7.2	Progress Update: Implementation of the NZ Disability Strategy in Auckland and Waitemata District Health Boards
	7.3	Facilities Development Projects and Accessibility at Auckland and Waitemata DHBs
	8.	**Papers**
3.05pm	8.1	Access to Bowel Screening and Cervical Screening Services for Disabled People – Barriers and Enablers
	8.2	National Maori Disability Action Plan
		8.2.1 Letter from Ministry of Health
	8.3	Health and Disability Commission Finding – Death of a Disabled Person in a Residential Care Home
3.45pm	**9.**	**For Information**
	9.1	Update on the Putting People First Implementation
3.50pm	**10.**	**General Business**

Next Meeting: Wednesday, 01 June 2016 at 1.30pm
New venue TBC once confirmed at this meeting

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Attendance at Disability Support Advisory Committee Meetings

Members	**12 Mar. 14**	**04 Jun. 14**	**27 Aug. 14**	**19 Nov. 14**	**11 Mar. 15**	**03 Jun. 15**	**26 Aug. 15**	**18 Nov. 15**
Sandra Coney (Chair)	1	1	1	c	1	1	1	1
Max Abbott	x	x	1	c	x	1	1	x
Jo Agnew (Deputy Chair)	1	1	1	c	1	1	1	x
Judith Bassett	1	1	x	c	1	1	1	1
Marie Hull-Brown	1	1	1	c	1	1	x	1
Dairne Kirton	1	1	1	c	1	1	1	x
Lester Levy	x	1	x	c	x	x	x	x
Jan Moss	1	1	1	c	1	1	x	x
Robyn Northey	1	1	1	c	1	1	1	1
Russell Vickery	1	1	1	c	1	1	1	1
Shayne WiJohn	n/a	n/a	n/a	n/a	n/a	1	x	1
Jade Farrar	n/a	n/a	n/a	n/a	n/a	1	x	1

Key: x = absent, # = leave of absence, c = meeting cancelled

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An “interest” can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction
- Having a financial interest in another party to a transaction
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction
- Being otherwise directly or indirectly interested in the transaction

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.

Ensure the full **nature** of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legisaltion.govt.nz) and “Managing Conflicts of Interest – Guidance for Public Entities” (www.oag.govt.nz).

Register of Interests – Disability Support Advisory Committee

Member	Interest	Latest Disclosure
Sandra CONEY (Chair)	Chair – Waitakere Ranges Local Board, Auckland Council	12.12.2013
Max ABBOTT	Pro Vice Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Board Member – Health Workforce New Zealand Board Member – AUT Millennium Ownership Trust Chair – Social Services Online Trust Board Member – The Rotary National Science and Technology Trust	28.09.2011
Jo AGNEW	Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Professional Teaching Fellow – School of Nursing, Auckland University Appointed Trustee – Starship Foundation Casual Staff Nurse – Auckland District Health Board	15.07.2015
Judith BASSETT	Fisher and Paykel Healthcare Westpac Banking Corporation Husband – Fletcher Building Husband is a shareholder of Westpac Banking Group Daughter is a shareholder of Westpac Banking Group	13.07.2015
Jade FARRAR	Disability Advisor for Te Pou National Leadership Group Member (Enabling Good Lives) Enabling Good Lives Christchurch "Local Area Group member" Cerebral Palsy Society Domestic Violence & Disability Group PHAB association (Auckland) Inc Auckland City Advisory Panel Member Director of Epic Studios Limited IT Support Consultant (community Connections Supported Living Trust) Owner/Webmaster of enablinggoodlives.co.nz	18.11.2015
Marie HULL-BROWN	Board Member – Age Concern Auckland Board Member – HOPE Foundation for Research on Ageing Advisory Committee Member – Selwyn Centre for Ageing and Spirituality	18.11.2015
Dairne KIRTON	Northern Regional Representative – CCS Disability Action National Board Grants Committee Member – Variety the Children's Charity Mentor – ImagineBetter – Raise Your Bar Project	26.08.2015
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman - Auckland Transport Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Lead Reviewer – State Services Commission, Performance Improvement Framework Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	09.02.2016

Jan MOSS	Coordinator of Complex Care Group Contractor to MoH, DS.S Board member YES Disability Centre, Albany Reference Group Member – MOH Disability Workforce NZ & Choices in Community Living	12.03.2014
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation Husband – Chair, Auckland District Council of Social Service	17.02.2016
Russell VICKERY	Wilson Home Management Committee Auckland Disability Law Chairman of Waitemata Community Law Life Member Auckland Branch of NZCCS Disability Action Cook Opie Hi Tech Trust Private Disability Consultant Australasian Rep for Inclusion Press	13.07.2015
Shayne WIJOHN	General Manager of Te Runanga o Ngati Whatua Ngati Whatua Representative – in affiliations to Te Rarava, Te Aupouri and Ngati Whatua	29.05.2015

Minutes
Disability Support Advisory Committee Meeting
18 November 2015

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 18 November 2015 in the Kauri Room, CCS Disability Action, 14 Erson Avenue, Royal Oak, Auckland commencing at 1.30pm

Committee Members present	**Auckland DHB and Waitemata DHB Staff present**	
Sandra Coney (Chair)	Samantha Dalwood	Disability Advisor
Judith Bassett	Kate Sladden	Funding and Development Manager, Health of Older People
Marie Hull-Brown		
Robyn Northey	Michelle Webb	Corporate Committee Administrator
Russell Vickery	Tim Wood	Funding and Development Manager, Primary Care
Jade Farrar	Dr Debbie Holdsworth	Director of Funding – Auckland & Waitemata DHBs
Shayne WiJohn		
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

Apologies were received from committee members Jo Agnew, Max Abbott, Dairne Kirton, Jan Moss and Lester Levy.

Apologies were received from senior staff members Dr Dale Bramley, Waitemata DHB Chief Executive, Ailsa Claire, Auckland DHB Chief Executive and Sue Waters, Auckland DHB Chief Health Professions Officer.

The apologies of Dr Debbie Holdsworth, Director of Funding ADHB/WDHB and Tim Wood Funding and Development Manager Primary Care for early departure were also received.

2. CONFLICTS OF INTEREST

Marie Hull-Brown advised that she had retired from the Mental Health Foundation. Jade Farrar advised that he was no longer Principle Advisor to the Director, The Cube.

3. CONFIRMATION OF MINUTES 26 August 2015 (Pages 8 to 13)

Resolution: Moved Robyn Northey / Seconded Russell Vickery

That the minutes of the Disability Support Advisory Committee meeting held on 26 August 2015 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Pages 14 to 16)

The majority of actions had been completed or were scheduled for future meetings. Updates were provided on the following items:

4.1 *Care of High Needs Young Patients While in Hospital*

Samantha Dalwood, Disability Advisor, Waitemata DHB spoke to the item on behalf of Jan Moss informing that discussion had occurred with the Ministry of Health. Ministry of Health Disability Support Services has agreed to discuss funding for individuals requiring support whilst in hospital on a case-by-case basis. There are positive examples where support has been funded. While the Ministry is not implementing an overarching policy, there has been a positive response that individual cases will be considered.

Members queried what the process was for seeking Ministry decision on these cases and how it ensured eligible people could access funding. It was advised that generally it was the role of the support person to activate this process. However this varied dependant on whether or not the patient was a recipient of Individualised Funding or funded through Taikura Trust.

The Committee considered how they could assist with ensuring access. It was suggested that Funding, Planning and Outcomes could prepare a briefing for the Ministry that proposed an automated process which incorporated tracking of cases. It was noted that collaboration with Taikura Trust and the NASC would be beneficial to support this.

The Committee requested a report back on the progress of this matter at an appropriate time.

Actions:

That a briefing be prepared for the Ministry of Health on a proposed process to ensure access to funding for support for individuals requiring complex care whilst in hospital

That discussions with Taikura Trust and Individualised Funding Services take place to determine who will track cases of individuals accessing funding for complex care whilst in hospital.

Resolution: Moved Judith Bassett / Seconded Robyn Northey

That a progress report be brought back to the Committee at its June 2016 meeting, with a view to reporting to the Ministry of Health how well the interim process for access to support funding for hospital patients requiring complex care is working.

Carried

Outstanding actions or those requiring further investigation were:

Census 2018 and the "Disability Data and Evidence Working Group"

It was noted that the item was complete. However, advice had been received that Statistics New Zealand have taken a decision to potentially cancel the 2018 Disability Survey. The Disability Survey would take place every ten tears and the next one would be in 2023.

DSAC Terms of Reference and Attendance at DiSAC

The Chair advised that this matter was still pending and that an update would be provided at the next DSAC meeting.

Draft DSAC Work Plan

Regarding Item 8.1.1 of 26 August 2015 the Chair advised that an update would be provided during consideration of Item 5 Chairs Report.

With respect to Item 8.1.2 of 26 August 2015 it was advised that joint meetings as per the DSAC workplan were being actively pursued. In particular the Committee were eager to progress joint meetings with the Auckland Council Disability Panel, the Seniors Panel and the Counties Manukau DSAC.

Jade Farrar informed that he was a representative on the Auckland Council Disability Panel. The Panel were currently considering Universal Design which was an area of joint interest for DSAC and presented opportunities for collaborative work. It was agreed that this topic would be useful to incorporate into the proposed joint meeting being planned for early 2016.

5. CHAIR'S REPORT

The Chair provided an update on her recent meeting with Auckland DHB Board Chair Lester Levy where the concerns of the Committee regarding the functioning of the DSAC and its request for direction as to how it can be more effective were discussed.

The Board Chair had noted that the Auckland DHB Board rely on DSAC to address matters relating to disability and provide it with advice on priorities and strategic matters. The Chair had asked that the Committee be reminded of its necessity and responsibilities relating to disability issues.

The next step is for the DSAC Committee Chair to meet with the Director of Funding Auckland DHB/Waitemata DHB to determine what critical issues are of priority for DSAC, and to incorporate these into a programme of work for future meetings.

Debbie Holdsworth advised that in light of this, the next DSAC meeting would have a significant focus on the strategies required to achieve the priorities identified in the revised work plan.

Actions:

That the Chair of the Disability Support Advisory Committee meets with the Director of Funding Auckland DHB/Waitemata DHB to identify and prioritise the critical disability issues for the Committee to focus on, and incorporate these into a programme of work for future meetings.

That a revised programme of work for the Disability Support Advisory Committee be reported back to the March 2016 DSAC meeting.

That the Chair's Report for November 2015 be received.

[Secretarial Note: Item 8.1 was considered next]

6. PRESENTATIONS (Pages 21 to 34)

6.1 Public Spaces Programme Update (Pages 21 to 28)

[Secretarial Note: this Item was considered after Item 8.1]

Malini Subramoney, Project Manager and Abbi-Harwood Tobin, Service Improvement Manager were in attendance for this item.

Tony O'Connor, Director Participation and Experience provided an explanation of his role and how it relates to the Public Spaces Programme projects highlighting:

- The composition of the associated Steering Group
- The roles of Malini Subramoney and Abbi-Harwood Tobin within the programme structure
- That the Public Spaces Programme was now known as the 'Healing Environments' Programme
- That the input and advice of DSAC relating this work was sought.

Tony, Malini, and Abbi then presented on the progress of the Programme (the presentation is attached as Item 6.1.1).

The following points were covered in discussion and in response to questions:

- Auckland and Waitemata DHBs each have their own programmes of work for Healing Environments. This is due to the need for each DHB to meet the specific requirements of their respective services and sites, and the volume of space that Auckland DHB sites contain. Waitemata DHB are developing principles of accessibility and inclusion that will apply to both DHBs to ensure consistency in application.
- The scope of the Healing Spaces Programme is currently limited to public spaces to create healing spaces for Auckland City Hospital visitors and families. Due to the size of work required expanding to clinical spaces will need to be considered at a later time.
- The Level 5 Layout and Services workstream is working on environmental accessibility, visual consistency and removing visual clutter, removing physical navigation hazards and ensuring retailers are required to make their spaces accessible. Members queried whether this would be enforced via contractual obligations for retail tenants and were advised it was being considered.
- The refurbished Muffin Break retail space was noted as an area that did not reflect the principles of a healing environment and this was acknowledged.
- The Level 8 Overbridge workstream is focusing on the Whanau Rooms and refuge spaces (or 'calm' areas) that meet the needs of all users. This work is being undertaken in collaboration with Design Labs. A prototype space has been created to test visual accessibility to ensure it works for people with cognitive and/or visual impairment conditions. It is supported by good feedback from users.
- The Wayfinding workstream is working on short term initiatives such as minimising visual noise, creating welcoming entrances and wheelchair bays. A long term strategy is being developed. The Committee acknowledged that the Wayfinding project was a significant piece of work and involved many components and areas.

Members considered that consistency in signage at both Waitemata and Auckland DHB's would be useful. They also queried the use of reverse contrast signage in blue and white. It was advised that Waitemata DHB had selected this based on the NHS standard.

It was agreed that it would be useful for Waitemata DHB to bring their Wayfind work to DSAC to consider where there may be opportunities for alignment between Auckland and Waitemata DHBs.

The Chair commented that it was pleasing to see that the Committee's recommendations following their site visit to North Shore Hospital had been implemented.

[Secretarial Note: Jade Farrar left the meeting at 3.13pm]

The project team advised that it intended to regularly report to DSAC on progress and to seek the Committees advice on ensuring accessibility and inclusiveness was incorporated throughout the Healing Environments programme.

Action:

That a report on the Waitemata DHB Wayfinding work and relevant design principles of accessibility and inclusion contained in the Waitemata DHB 2025 Programme be provided to the March DSAC meeting.

Resolution: Moved Robyn Northey / Seconded Marie Hull-Brown

That the presenters of the Public Spaces Update be formally thanked for their presentation.

Carried

7. IMPROVEMENT ACTIVITIES (Pages 17 to 28)

7.1 Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs (Pages 17 to 20)

Kate Sladden, Funding and Development Manager Health of Older People asked that the report be taken as read, highlighting the following:

- All DHBs continue to await the Director General's report on Home and Community Support Services. A memorandum from the Lead CE for Health of Older People has recommended DHBs roll over existing HCSS contracts until the full implications on future contracting are understood.
- For the 15/16 year a new clause has been included in the Aged Related Residential Care Agreement that requires all facilities to use interRAI as their primary assessment tool. It was noted that this assessment is to assess the change in a patient's level of need not level of care. Data collected for the first quarter of reporting against the new performance measure set by the Ministry of Health indicates this as 49% of Auckland DHB and 42% of Waitemata DHB residents have had an interRAI assessment within 230 days of their previous assessment. InterRAI has already been rolled out to all recipients of Home Based Support care.

Matters covered in discussion of the report and in response to questions included:

HOP Strategy Refresh

Submissions to the refreshed strategy are currently open and welcome. Age Concern recently hosted a community consultation meeting in conjunction with the Ministry of Health.

Demand for Home Based Support Services

Auckland and Waitemata DHBs have not stopped providing services to people whom only require housework. It was advised that there is means testing for people receiving housework only, which has always been standard process.

Interim Care Scheme

As requested by the Committee at its previous meeting, information was provided on the pathways utilised to provide interim care.

Kate spoke to the update highlighting the following:

- A recent Request for Proposals (RFP) for ICS has been undertaken; this was a joint RFP for Auckland and Waitemata DHBs, which is currently being finalised.
- Other objectives for interim care are to alleviate pressure on acute beds, enable the release of acute beds to patients with higher clinical need and reduce in length of stay in hospital.

There was no further discussion.

Resolution: Moved Judith Bassett / Seconded Robyn Northey

That the Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs for November 2015 be received.

Carried

7.2 Progress Update: Implementation of the NZ Disability Strategy in Auckland and Waitemata District Health Boards (Pages 21 to 28)

Due to time constraints there was no discussion of this report.

That the Progress Update: Implementation of the NZ Disability Strategy in Auckland and Waitemata District Health Boards report for November 2015 be received.

8. PAPERS (Pages 29 to 34)

8.1 A Standardised Approach to Health Literacy across Auckland and Waitemata District Health Boards (Pages 29 to 34)

[Secretarial Note: this item was considered before Item 6.1]

Leanne Kirton, Project Manager Primary Care Planning Funding & Outcomes - Auckland & Waitemata District Health Boards was in attendance for this item.

Tim Wood, Funding and Development Manager, Primary Care introduced the report highlighting the following:

- Currently there isn’t an organised and systematic approach to improving health literacy within Auckland and Waitemata DHBs. Implementing a standardised approach across Auckland and Waitemata DHBs would be aligned with the joint Auckland and Waitemata DHBs Disability Strategy Implementation Plan 2013-16.
- It is proposed that there be alignment with the Ministry of Health framework for health literacy
- The paper and recommendations enclosed in the agenda were presented to and endorsed by the Auckland and Waitemata Community Public Health Advisory Committee (CPHAC)

- Aspects that are yet to be developed are how we engage with the rest of the sector, what mechanisms and channels should be used for sharing of health information and the development of an evaluation process.

Tim Wood tabled a presentation (the presentation is attached as Item 8.1.1).

The following points were covered in discussion and in response to questions:

- Concerns were raised relating to the Ministry of Health definition of health literacy and the language used within the framework. Of particular concern was the language having the potential of seeming to promote impairment rather than capability, and of placing the onus on the consumer to increase their health literacy. It was acknowledged that traditional definitions of health literacy have focused on individual responsibility however the intent of the framework is to place greater responsibility on clinicians and the health sector. It was clarified that the intent and philosophy behind the framework is to achieve a health literate healthcare organisation that creates an environment that assists to develop health literacy skills with a focus on making it easier for people to navigate, understand and access information and services to take care of their health.
- The lack of reference to the relevant sections of the Health and Disability Code of Rights relating to effective communication and informed choice and consent was noted.
- There was shared concern that the use of the term 'literacy' has connotations of illiteracy. Advice was given that during sector engagement the intent of the framework was well understood.
- Whilst the word 'disability' isn't used in the proposed strategy language promoting inclusion has been used throughout. Management are confident that once approval to proceed with the strategic framework has been received disability will be included.

It was commented that the Auckland and Waitemata DHB websites seemed to have accessibility issues and therefore do not meet website accessibility standards. They also do not appear to cater for other languages.

Advice was given that the Blind Foundation had provided input and advice on accessibility during development of the websites. Samantha Dalwood undertook to seek advice from the Blind Foundation on the appropriate corrective action and to alert the DHB communications teams.

The Committee offered its observations and suggestions which included:

- When considering the culturally appropriate and accessible provision of health related information to Maori it is important to note that within Te Reo there are no existing translations for some health related words. Te Pou is currently undertaking work in this area and may be able to assist the DHBs.
- When ensuring that health literacy activities are culturally appropriate the cultural needs of our Asian population need to be considered as well those of Maori and Pacific.

The Committee expressed interest in the proposed Health Literacy Community Engagement forums and requested to be informed of the schedule for these to enable them the opportunity to attend where possible.

Tim advised that the Health Literacy Steering Group were eager to bring any key issues identified back to the DSAC for input and advice and this was welcomed by the Committee.

Further to earlier discussion regarding definitions and language used in the framework, members expressed disagreement with the CPHAC endorsement of Recommendation b) which proposes moving to the Ministry of Health definition of health literacy. DSAC held a differing view and considered that the definition as used by the Victorian Department of Health (Australia) more accurately reflected the intention of the framework.

In consideration of the recommendations of the report the Committee were supportive in principle of the implementation of a standardised framework subject to an amendment to Recommendation b) that reflects their view in relation to the definition of health literacy.

Resolution: Moved Judith Bassett / Seconded Russell Vickery

That the Disability Support Advisory Committee endorse:

a) **The proposed standardised approach to health literacy across the Auckland and Waitemata DHBs**
b) **The use of the New Zealand Ministry of Health definition and framework of health literacy but noting that the wider definition used by the Victorian Department of Health (Australia) more accurately defines the goal to which we should be aspiring to**
c) **The proposed next steps outlined in the "A Standardised Approach to Health Literacy across Auckland and Waitemata District Health Boards" paper**

Carried

[Secretarial Note: Tim Wood left the meeting at 2.36pm].

[Secretarial Note: Item 6.1 was considered next]

9. GENERAL BUSINESS

The Chair welcomed and introduced new Committee Secretary Michelle Webb to the committee and wished everyone a pleasant Christmas/New Year's holiday.

The meeting closed at 3.31pm.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 18 November 2015

Chair: ______________________ Date: __________
Sandra Coney

Action Points from Previous Disability Support Advisory Committee Meetings

As at Wednesday, 09 March 2016

Meeting and Item	Detail of Action	Designated to	Action by
Item 4 18 Nov 2015 And 3 Jun 2015	**Care of High Needs Young Patients While in Hospital** 1. That a briefing be prepared for the Ministry of Health on a proposed process to ensure access to funding for support for individuals requiring complex care whilst in hospital.	S Dalwood	9 March 2016 – verbal update to be provided at this meeting.
	2. That discussions with Taikura Trust and Individualised Funding Services take place to determine who will track cases of individuals accessing funding for complex care whilst in hospital.	S Dalwood	
	3. That a progress report be brought back to the Committee at its June 2016 meeting, with a view to reporting to the Ministry of Health how well the interim process for access to support funding for hospital patients requiring complex care is working.	S Dalwood	1 June 2016
18 Nov 2015 Item 5	**DSAC Programme of Future Work** 1. That the Chair of the Disability Support Advisory Committee meets with the Director of Funding Auckland DHB/Waitemata DHB to identify and prioritise the critical disability issues for the Committee to focus on, and incorporate these into a programme of work for future meetings.	S Coney D Holdsworth	9 March 2016 – Complete
	2. That a revised programme of work for the Disability Support Advisory Committee be reported back to the March 2016 DSAC meeting.		Verbal update to be provided at this meeting.
18 Nov 15 Item 6.1	**Public Spaces Programme Update** 1. That a report on the Waitemata DHB Wayfinding work and relevant design principles of accessibility and inclusion contained in the Waitemata DHB 2025 Programme be provided to the March DSAC meeting.	S Dalwood	9 March 2016 – Complete (see Item 7.2, page 31 of this agenda)

	2. That the presenters of the Public Spaces Update be formally thanked for their presentation.	M Webb	9 March 2016 - Complete
Item 7.1 11 Mar 2015	**Age Related Residential Care** All age related residential care providers will be using InterRAI by 2015. When baseline information becomes available from MoH a report is to be provided to the Committee, focusing on the impact InterRAI has had on outcomes in the community.	K Sladden	When information becomes available
Item 7.1 3 Jun 2015	**Health of Older People Quarterly Report on Activities** Schedule a presentation on the e-learning module for a future DSAC meeting and that this include reporting ability on compliance of training	M Webb/ S Dalwood	9 March 2016 – Complete (see Item 6.1 of this agenda)
Item 8.1 3 Jun 2015	**Disability Support Advisory Committees' Terms of Reference** 1. Advise the Minister of Health of the proposed amendments to the Committees' Terms of Reference. 2. Subject to the Minister of Health's agreement to the proposed amendments to the Committees' Terms of Reference, submit the draft paper to the Auckland and Waitemata District Health Board Boards.	Chair of Auckland and Waitamata Health Boards	In progress
Item 8.2 3 Jun 15	**Update on Collation of Statistic that Identify People with Impairments** That the Funder explore with both Auckland and Waitemata DHBs the implications of establishing a mechanism in future reporting systems that uses the definition of 'disability' and 2013 Census Questions 16 and 17 to capture functioning and disability information when reporting on serious adverse events.	D Holdsworth	Ongoing

Item 4 26 Aug 15 And Item 10 3 Jun 15	**Parking at the CCS Disability Action site** That the Secretary investigate the suitability of other accessible community venues for future DSAC Committee meetings *It was suggested that the Deaf Association rooms in Balmoral be considered and that the Corporate Business Manager check booking availability and price along with access, bathroom facilities and parking.*	M Webb	In progress – refer to Item 4.2. of this agenda
Item 8.1 26 Aug 15	**Draft Disability Support Advisory Committee Annual Work Plan** 1. That the Corporate Committee Administrator give priority to arranging the joint meetings specified in the work plan. *Commitments for local and central government determine the need to propose joint meetings be pursued for early 2016.*	M Webb	16 September 2015 In progress – verbal update to be provided at the meeting.

Venues for Future Disability Support Advisory Committee Meetings

Recommendation

That the Disability Support Advisory Committee:

1. **Receives the report.**
2. **Note the venue options for future Disability Support Advisory Committee meetings.**
3. **Agree which venue best meets the needs of the Disability Support Advisory Committee.**
4. **Endorse the Committee Secretary to make the required arrangements for Disability Support Advisory Committee meetings to take place at the preferred new venue as of June 2016.**

Prepared by: Michelle Webb (Committee Secretary)
Endorsed by: Sandra Coney (Committee Chair)

Glossary

DSAC	Disability Support Advisory Committee
ADHB	Auckland District Health Board
WDHB	Waitemata District Health Board

1. Executive Summary

At its meeting of 26 August 2015, the Committee requested that the Secretary investigate the suitability of other accessible community venues for future DSAC Committee meetings.

It was suggested that the Deaf Society rooms in Balmoral be considered and that the booking availability and price along with access, bathroom facilities and parking be checked. An assessment of potential venues has been undertaken and the options, including the merits and limitations of each site are now provided for the Committee's consideration.

This paper recommends that the Committee agree on a new venue for future DSAC meetings, and endorse the Committee Secretary to make the necessary arrangements for the meetings to take place at the preferred new venue as of 1 June 2016.

2. Analysis

A range of meeting venues within the Auckland CBD and in close travelling distance to Auckland City Hospital were investigated. A number of community facilities were included however many did not offer the required services, parking or accessibility. Four venues were shortlisted and site visits completed.

Those venues were:

- Auckland Deaf Society Building – Potters Park Events Centre
- Fickling Convention Centre
- Alexandra Park Conference Centre
- Best Western Newmarket Inn and Suites

A summary of each venue including accessibility features and costs is detailed below.

Option 1: Auckland Deaf Society Building (Potters Park Events Centre)

164 Balmoral Road, Balmoral, Auckland (drive time from ACH approximately 10 minutes)

Accessibility features: Fully accessible site. Disability toilet, full wheelchair access to all levels of the building, hearing loop throughout all meeting rooms, and 3 dedicated disability car parks at the front entrance.

Inclusions: Facilities provided include full kitchen, in room facilities for tea and coffee (beverages included in cost of room hire), ample free car parking and overflow car parking for 280 cars. Room set up and pack down provided by the venue.

Exclusions: Equipment hire (projector/data show, whiteboards etc.).

Other considerations: Car entry and exit to the site by right-hand approach only due to median strip.

Total cost per meeting: $210.00 plus gst.

Option 2: Fickling Convention Centre

546 Mt Albert Road, Three Kings Auckland (drive time from ACH approximately 15 minutes)

Accessibility features: Accessible site. Disability toilet one floor down from meeting rooms, wheelchair access to meeting room levels of the building, one dedicated disability car parks.

Inclusions: Room hire and tables and chairs, shared kitchen with fridge, hot water zip and oven. Limited free parking based on availability on arrival.

Exclusions: Room set up, tea and coffee, room pack down, equipment such as whiteboards, projectors/data shows etc.

Other considerations: Parking in retail car park on a first come first served basis.

Total cost per meeting: $137.20 plus gst.

Option 3: Alexandra Park

Main entrance, Greenlane West, Auckland (drive time from ACH approximately 10 minutes)

Accessibility features:

Moderately accessible site. Disability toilet, wheelchair access to meeting room levels of the building, 3 dedicated disability car parks at the front entrance

Inclusions: Free car parking on a first come first served basis. Room set up and pack down provided by the venue.

Exclusions: Tea and coffee, additional charges for use of equipment such as data show, whiteboards etc.

Other considerations: Only two options in size of meeting room, the first being too small and the second being too large.

Total cost per meeting: $385 plus gst for the smaller meeting room, $475 plus gst for the larger meeting room.

Option 4: Best Western Newmarket

112 Great South Road, Epsom, Auckland (drive time from ACH approximately 10 minutes)

Accessibility features: Not accessible. No wheelchair access. Two dedicated disability car parks at the site entrance.

Inclusions: Car parking on a first come first served basis. Room set up and pack down provided by the venue.

Exclusions: Tea and coffee, additional charges for use of equipment such as data show, whiteboards etc.

Other considerations: Limited car parking availability.

Total cost per meeting: $238 plus gst.

When considering costs, it should be noted that the total cost of non-community facilities includes the time of staff for room set up and pack down and tea and coffee consumables where community facilities do not.

3. Conclusion

Based on the information provided above, it is recommended that the Committee agree on a new venue for future DSAC meetings, and endorse the Committee Secretary to make the necessary arrangements for the meetings to take place at the new venue as of 1 June 2016.

Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs

Recommendation:

That Disability Support Advisory Committee receives the Health of Older People Quarterly Report on Activities in Auckland and Waitemata DHBs report.

Prepared by: Kate Sladden (Funding and Development Manager, Health of Older People)
Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

ARRC	Age Related Residential Care
DHB	District Health Board
HBSS	Home Based Support Services
HOP	Health of Older People
IBT	Inbetween Travel time
LTCF	Long Term Care Facility interRAI
MoH	Ministry of Health
PBF	Population Based Funding

1. Purpose

The purpose of this report is to provide an update to DiSAC on the progress and activities occurring across Auckland and Waitemata DHBs for Health Older People and areas of focus at a regional and national level. The report includes material common to both DHBs and where appropriate material specific to an individual DHB.

2. Home Based Support Services (HBSS)

2.1 Inbetween Travel Time (IBT)

In 2005/06 the Ministry of Health (MoH) and District Health Boards (DHBs) increased funding to Home and Based Support Service (HBSS) providers to reimburse support workers for travel costs (Fair Travel). This funding was rolled into contracts for HBSS. However, the amount of funding does not recognise the full mileage cost to workers or the cost of time taken by them to travel between clients.

In April 2014 under Cabinet authorisation, DHB and MoH representatives entered into negotiations with unions and employers to address issues associated with workers' travelling time and the reimbursement of travel costs. In September 2014 a settlement agreement was agreed by all parties and subsequently ratified. The legislation has just completed the Select Committee stage and it is expected it will be enacted prior to full settlement implementation on 1 March 2016.

Due to short timeframes to have systems in place for July 2015 an interim settlement was agreed where the MoH has been managing the funding centrally. From 29 February 2016 In-Between Travel (IBT) funding will be devolved to DHBs to manage.

In order to implement the settlement, Auckland and Waitemata DHBs have varied their HBSS contracts to:

- Remove fair travel funding (this funding will be retained to partially offset the costs of IBT)
- Add IBT components i.e. travel time, mileage and exceptional travel.

The MoH has provided the contract variation template for this purpose. The DHBs will also be receiving their PBF (65+) share of the IBT budget ($36.2M) that will be combined with the Fair Travel funding to cover IBT claims from providers.

Negotiating parties have agreed upon a one band model for travel up to 15km other than for the first client visit of the day. There will be two single standard payments for travel time and travel distance; $2.09 (8.5 minutes) and $1.85 (3.7km). Some visits will take more than 8.5 minutes and 3.7km and some less but for all travel under 15 km employees will receive the two standard amounts.

The parties have agreed an exceptional travel policy, which is paid on an actual basis and is only payable when travel exceeds 15km. Exceptional travel will be paid where no other home and community support employee is available who can meet the specific needs of the client.

The MoH's Audit and Compliance team will closely monitor and audit IBT claims.

An IBT Monitoring Working Group has been established to monitor operations of the Home and Community Support (Payment for Travel Between Clients) Settlement Act. The working Group will provide and indicative report on 1 June 2016 and a final report on 31 August 2016 with recommendations on any issues arising including proposed processes for resolution.

2.2 HBSS Models at Auckland and Waitemata DHBs

Work continues detailing the HBSS model at each DHB in readiness for procurement. However, this needs to be considered in light of the national notification to all DHBs to roll over their existing HBSS contracts for 12 months. This will allow for the IBT actions to be finalised and the implications of this and further recommendations from the Director General's report (yet to be released) on HBSS model components, future contracting and timelines to be fully understood.

2.3 interRAI – standardised clinical assessments

The table below reports on the MoH interRAI measure ie the proportion of clients receiving HBSS who have had an interRAI assessment (reported one quarter in arrears) for 2015/16.

	Q1	Q2
Auckland DHB	97.1%	97.5%
Waitemata DHB	88.6%	92.4%

3. Dementia Care Pathway

The Business Case to seek approval and secure resource from both Boards to rollout the *'living well with dementia model of care'* to all GPs across Waitemata and Auckland DHBs will soon commence the pre-approval steps before being submitted to the Boards. The Dementia eLearning resource for GPs and practice nurses is currently in development with the Goodfellow Unit at the University of Auckland. The resource will go live during March 2016 and will be an integral component of the new model of care. GPs and practice nurses will be credited with Royal New Zealand College of General Practitioners (RNZCGP) continuing professional education points on completion of the learning resource.

4. Aged Related Residential Care (ARRC)

4.1 interRAI – standardised clinical assessment (Action 7.1)

Previous reports to DiSAC have reported on the proportion of registered nurses in ARRC trained to undertake interRAI long term care facility (LTCF) assessments. The 2015/16 ARRC Agreement has a new clause that requires all facilities to use interRAI as their primary assessment tool. The table below shows performance against the MoH LTCF measure i.e. percentage of people in aged residential care who have a subsequent assessment completed within 230 days of their previous assessment.

	Quarter 1	Quarter 2
Auckland DHB	49%	62%
Waitemata DHB	42%	56%

4.2 Audits

Twenty five facilities were audited over quarter 2; the table below has a summary of the audit outcomes.

2015/16	**Auckland DHB**		**Waitemata DHB**	
	Q1	**Q2**	**Q1**	**Q2**
Number of audits	7	11	17	14
Av. no. of corrective actions per audit	3.6	1.8	2.5	1.7
No. of facilities with over 5 corrective actions	3	1	4	1
No. of facilities with a high risk corrective action	0	1	0	0
No. of facilities with no corrective actions from audit	1	3	5	1
No. of facilities achieving a continuous improvement	1	5	3	1
Number of complaints received	7	5	4	1

The gold standard attainment against an audit criterion is 'continuous improvement' (CI). CI is achieved when a criterion is fully attained and continuous improvements against the Health and Disability Sector Standards are demonstrated indicating quality improvement processes in place against service provision and consumer safety or satisfaction.

4.3 Pressure Injury Prevention and Management Programme

The MoH, ACC and the Health Quality and Safety Commission are working in partnership on a national Pressure Injury Prevention and Management Programme. As a result, pressure injuries graded stage 3 or 4 are now required to be reported to the MoH under section 31.

Starting in 2016 pressure injury prevention and management will be a focus of the ARRC audit process. We expect this will see an increase in both reporting and corrective actions relating to pressure injuries. At the same time it will provide an opportunity for the DHB Quality and Monitoring Managers to support to facilities to improve processes and protocols in this area of care.

4.4 Secure Dementia Unit Design

The evidence shows that the built environment impacts on the quality of life of people living in secure dementia units. The MoH has prepared a draft document *Care Guide for Secure Dementia Unit Design from a Person Centred Perspective,* which is soon to be released for consultation. This is important for Auckland and Waitemata DHBs as there are a number of ARRC new builds and reconfigurations incorporating secure dementia units underway and planned over the next 18 months.

Work is underway with clinicians in both DHBs to establish a process to support providers to achieve best practice in the design of dementia units and we have been liaising with HealthCERT MoH around the development of a local process to support their Guide.

5. Falls Prevention

A joint Auckland DHB, Waitemata DHB and ACC working group has been set up to implement a community fall prevention project. The working group is:

- Developing a clinical pathway including identification of target population, initial assessment, single point of entry and referral processes
- Assessment of current provision of group strength and balance providers including their effectiveness, safety, capacity and sustainability, and their inclusion in the clinical pathway
- Investigating falls prevention within HBSS provision.

A business case for the falls prevention project will be developed by 30 September 2016.

Waitemata District Health Board
Best Care for Everyone

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Waitemata DHB and Auckland DHB
Implementation of the New Zealand Disability Strategy 2013-2016
Current Status at 25 February 2016

Communication and Information Empowering people through knowledge and understanding
Current Status at 25 February 2016

What we will do… actions	**Where** we are now…current status
1. Accessible Communication guidelines developed.	**February 2016** – Since presenting at the November DSAC meeting the Health Literacy Steering Group have run two workshops with key stakeholders to inform further project development. The next phase has been identified as developing a project logic framework to support a planned approach to implementation.
2. Review of Web content and presentation.	**February 2016** – ongoing work. Changes will be made as part of the drive to be a 'Health Literate' organisation.
3. Increase formats of key documents, e.g. Strategic Plans.	**February 2016** – Since presenting at the November DSAC meeting the Health Literacy Steering Group have run two workshops with key stakeholders to inform further project development. The next phase has been identified as developing a project logic framework to support a planned approach to implementation.
4. Review the automated telephone system with regard to access for people with disabilities.	**February 2016 –** Funding has all been approved by both Auckland and Waitemata DHBs and we are awaiting implementation of phase one to push forward with the extra features which will see the introduction of email and text messaging. There have been some IT issues, which have delayed implementation, but these are being worked through.
5. Review the possibility of improved text communication to patients.	October 2015 – The new Contact Centre equipment has the capability to respond to text, emails and online enquiries and will be included as part of the second phase of Contact Centre development.
6. Continue the implementation of the Health Passport across both DHBs.	**February 2016** – Pauline Boyles, Capital and Coast DHB and Esther Woodbury from HDC are working on a content review with input from clinicians. They are also investigating an electronic platform for the Health Passport. Auckland DHB is now implementing the 'This is Me' booklet across Older Adult health wards and for anyone over 75. This has been adapted from the Alzheimer's UK booklet and is a communication tool for patients.
7. Work with the Deaf community to improve access to interpreters.	
8. Encourage the use of interpreters for non-English speaking families.	

Community and Engagement Working within a family and patient centred framework
Current Status at 25 February 2016

What we will do… actions	**Where** we are now…current status
9. Ensure a diverse range of disabled people are identified as stake-holders in all projects and service development.	October 2015 **–** One of the new consumer representatives on the Waitemata 2025 Programme Design Group identifies as having an Autistic Spectrum Disorder and brings this perspective to the group.
10. Engage regularly with the disability sector to develop their capacity to influence decision making and increase DHB responsiveness.	**February 2016 –** The Disability Advisor is working with Disabled Women's Forum to develop a well woman forum focused on screening and prevention. The disability social change agency Be.Accessible have joined Auckland DHB's Participation and Experience Steering Group. The Group is tasked with accelerating improvements in patient participation and experience, and is exploring the best way to structure a DHB-community collaboration to help do that. The Steering Group has identified a work-programme and is prioritising deliverables for the 2016 year.
11. Ensure the voice of people with learning/intellectual disabilities, particularly people with high/complex needs, is included in consumer reviews of service planning and development.	
12. Continue working with Health Links to increase health literacy through fully accessible patient information.	**February 2016** – Waitemata DHB and Health Links are running a forum for consumer representatives on 11 March, as part of Patient Experience Week.

Employment Opportunities Equal employment opportunities for people with impairments and carers
Current Status at 25 February 2016

What we will do… actions	**Where** we are now…current status
13. Encourage the use of supported employment agencies.	August 2015 – The Disability Advisor met with Waitemata DHB Director of Human Resources to discuss employment opportunities for disabled people, working with Hiring Managers and using supported employment agencies. The focus on Diversity in HR in 2016 will include this work.
14. Review all recruitment and employment policies and make recommendations to improve inclusion and employment opportunities for disabled people, as required.	August 2015 – Waitemata DHB HR Department are focusing on diversity in 2016. This will mean a focus on employment opportunities for Maori and Pacific people and people with impairments. Recruitment and employment policies will be reviewed and updated and there will be education for staff who are responsible for hiring and employing staff.
15. Collect data on the number of staff with disabilities (at the time of employment and/or when a disability is acquired).	August 2015 – HR to review the question asked to bring it into line with the NZ Census question and to look at data collection. Data also needs to be collected for staff who acquire an impairment during employment.
16. Work with Hiring Managers to increase disability awareness.	August 2015 – Waitemata DHB HR Department are focusing on diversity in 2016. This will mean a focus on employment opportunities for Maori and Pacific people and people with impairments.
17. Working with HR to look at how the DHBs support staff with Carer responsibilities.	August 2015 – The Waitemata DHB Good Employer policy is clear that it supports carers and allows for flexible working hours, where possible. The Diversity focus in 2016 will include carers.

Disability Responsiveness Educating staff and challenging stereotypes & assumptions

Current Status at 25 February 2016

What we will do… actions	**Where** we are now…current status
18. Work with Dieticians to improve the nutritional outcomes for disabled patients.	August 2015 - Nutrition and Hydration are embedded into the Patient Care Standards at Waitemata DHB. There are 'Nutrition Champions' in place across the nursing teams and great improvements have been made.
19. Develop 'Disability Champion' roles across the DHBs.	October 2015 – Auckland DHB Allied Health directors will take on the role of Disability Champions for the directorates at Auckland DHB
20. Promote the Disability Awareness e-learning module to all staff across the DHBs.	**February 2016** –The updated Disability Responsiveness e-learning module is nearly finished and ready for testing. The focus is on Communication (Ask the person) and Attitude (unconscious bias) and improving the patient experience. There is less focus on legislation and more on a practical response in a health setting. This will be available for both Waitemata and Auckland DHBs.
21. Provide a range of disability awareness training, targeting specific services.	
22. Develop tools to increase staff skills for working with people with communication difficulties.	**February 2016** –The updated Disability Responsiveness e-learning module is nearly finished and ready for testing. The focus is on Communication (Ask the person) and Attitude (unconscious bias) and improving the patient experience.
23. Ensure public waiting areas, wards and treatment areas meet the needs of a range of impairments, including people with autistic spectrum disorders.	**February 2016 -** Auckland DHB is in the midst of a RFP process for the retail spaces at Greenlane Clinical Centre and on level 5 of Auckland City Hospital. 'Accessible' is a principle that the RFP respondents have been asked to demonstrate in their service offering.

Physical Access Overcoming a disabling society
Current Status at 25 February 2016

What we will do… actions	**Where** we are now…current status
24. Encourage the use of symbols and pictograms in signage and way finding.	**February 2016 –** **Waitemata DHB** After rigorous tender process, a signage design and manufacturing company have been selected to improve the way finding and signage at North Shore and Waitakere Hospitals. The selected company will meet with Waitemata DHB Facilities Team on 18 February to discuss a timeline for the proposed programme of work. The DHB have requested that the work is fast tracked to address the need. Starting with North Shore Hospital, the selected company will review current signage, design improved signage and way finding and will implement the changes to external signage. Waitakere Hospital will follow and then internal signage for both hospitals. Work will also be done at the Mason Clinic. Very early consultation has been done with some community groups and hospital volunteers to get their views on way finding issues. This work will also impact on appointment letters and other patient information. **Auckland DHB** The following is underway for way finding at Auckland DHB: • developing terms of reference for a full way finding solution, which will be a multi-year programme of activity to bring together all the elements of way finding into a consistent, accessible and cohesive system • prototyping improvements to the welcome areas extending way finding pilot currently at level 1 • formally evaluating changes instituted in the Emergency Department to make entry and process clearer for patients. Commencement date TBC.
25. ADHB Disability Champions will complete the 2-day Barrier Free Training.	October 2015 – Auckland DHB is working with Waitemata DHB and Barrier Free Advisors for our public spaces work, including identifying issues for people with cognitive impairment.
26. An accredited Barrier Free Advisor will be involved in all new Facilities work.	October 2015 – Auckland DHB is working with Waitemata DHB and Barrier Free Advisors for our public spaces work, including identifying issues for people with cognitive impairment.
27. Adoption of Universal Design principles in all Facilities work.	**February 2016** - **Waitemata DHB Core Design Principles** While the wording has not yet been finalised, the Design Group has established the domains for core principles that should be applied across all Waitemata DHB design projects. These are: • Inclusive planning and universal design: designing with and for everyone using our services; person-centred design • Flexible and future-focused design: adaptability for future uses and new models of care while providing functional spaces for today's patients and staff; future models of care

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informed by evidence and inter/national best practice

- Enhanced patient and whanau experiences of our services: including welcoming environments
- Health promoting environments: including safe and secure (real and virtual) environments for all, and promoting independence in patients caring for themselves

As with everything else we do, facilities design is underpinned by Waitemata DHB’s core values: everyone matters; with compassion; connected; better, best, brilliant.

How might these principles be used?

The intention is that a core set of principles will be applied throughout the design process for all new building and re-design projects across Waitemata DHB. This will mean the consideration of the principles in the work up of all design briefs by the services and facilities, inclusion of the principles in design briefs given to architects/designers, requirements to include consideration of/responses to the principles in design documents from contracted designers/architects and others, and inclusion of consideration of the principles in all business cases including justification for how these principles have been addressed or not addressed as appropriate.

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<td>28. Building standards document developed in ADHB.</td>
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<td>29. A review of accessible toilets in ADHB buildings to be completed.</td>
<td>Ongoing – Upgrades to toilets will be done on an individual project basis when funding becomes available.</td>
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30. Work with Auckland Transport to improve accessible transport between hospital sites.	
31. Investigate the reported shortage of wheelchairs available - both numbers and sizes.	**February 2016 -** Auckland DHB has purchased a fleet of new wheelchairs and has replacement built into the wheelchairs budget for 2016-17. Wheelchair bays are being introduced at our main entrances on the Grafton site and a replenishment process has been agreed with our Orderly service.

Waitemata DHB and Auckland DHB Implementation of the Disability Strategy 2016-2019

Planning is underway for developing the next implementation plan for the Disability Strategy. The process for gaining input from the disability sector and community that has been used previously has been successful, particularly graphic facilitation and it is intended that this will be repeated at the consultation workshop.

It is acknowledged that the New Zealand Disability Strategy (2001) is being reviewed and an updated version will be available later this year. There are also a number of other strategies around disability that will need to be considered:

- Disability Action Plan 2014-2018; focuses on cross government priorities
- Un Convention on the rights of Persons with Disabilities
- Whaia Te Ao Marama: the Maori disability Action Plan 2012-2017.

Facility Project Stocktake for Auckland and Waitemata DHBs

Recommendation:

That the Disability Support Advisory Committee receives the Facility Project Stocktake – Auckland and Waitemata DHBs report.

Prepared by: Allan Johns (General Manager Facilities and Development)
Approved/Endorsed by: Dr Debbie Holdsworth (Director of Funding) and Sue Waters (Chief Allied Health Professions Officer – Auckland DHB)

Glossary

DHB	District Health Board
DSAC	Disability Support Advisory Committee

1. Introduction

The Disability Support Advisory Committee (DSAC) have asked for a more proactive active approach to the accessibility considerations of facility devlopments at both DHBs. A register of current facility projects is attached for both DHBs. This is to provide the Committee with full visibility of all projects either in the planning or implementation stages and to alert them to any projects that may be of interest.

New projects will be advised to the Committee as they are commenced.

PROJECTS REGISTER – Facilities & Development Auckland DHB

Campus	Project Name	Status of Project	Independent Accessibility Assessment?
Grafton Campus	Endoscopy Service Expansion - ACH Support Building	Plan	Minor Refurbishment only
Grafton Campus	Primary Birthing Unit Development - Level 10 A01	ON HOLD	
Grafton Campus	Acute Haemodialysis Unit - minor modifications	Plan	Minor Refurbishment only
Grafton Campus	ACH Bldg 7 Decant - SMO & Palliative Care	Plan	Office decant
Grafton Campus	Auckland Integrated Cancer Centre	Plan	Accessibility Assessment to be undertaken as part of design
Grafton Campus	Level 2 Adult Acute Care - ED,APU & Radiology Redevelopment	Plan	Accessibility Assessment to be undertaken as part of design
Grafton Campus	Haemodialysis Relocation from Grafton to Greenlane	Initiate	Accessibility Assessment to be undertaken as part of design
Grafton Campus	A08 L4 Brachytherapy Project - HDR Bunker	ON HOLD	
Grafton Campus	Security Monitoring Room - minor refurb	Execute	Minor Refurbishment only
Grafton Campus	AK Bathroom Audit - A32 - leaks behind walls - Wards, Staff WCs, & Public	Initiate	Maintenance
Grafton Campus	Main Entrance - External Paving - Level 4 & Level 5	Initiate	Maintenance
Grafton Campus	Echo Toilets	Initiate	Maintenance
Grafton Campus	Ward 97 Medication Room - RTC	Plan	Minor changes to medication room
Grafton Campus	Relocate wall in Sterile Supply Service Room	Initiate	Minor Refurbishment only
Grafton Campus	Oncology Building Toilet Upgrade	Plan	Minor Refurbishment only
Grafton Campus	MV 2 Linear Accelerator 15-16 - replacement	Initiate	Replacement like for like
Grafton Campus	Plain radiography room - Level 5, Grafton, x1	Plan	Replacement like for like
Grafton Campus	ACH A32 Main Hospital - theatre lift doors upgrade	Plan	Door upgrade only
Grafton Campus	ACH Bathroom upgrades / renewals	Plan	Maintenance
Grafton Campus	L4 Performance Improvement Team Fitout	Plan	Office refurbishment
Grafton Campus	L4 Facilities Offices Relocation	Plan	Office Refurbishment only
Grafton Campus	Paediatric Cath Lab Upgrade (Rm18.049) - Stage 2	Plan	Minor Refurbishment only

PROJECTS REGISTER – Facilities & Development Auckland DHB

Campus	Project Name	Status of Project	Independent Accessibility Assessment?
Grafton Campus	A08 - Replace carpet with vinyl in oncology.	ON HOLD	
Grafton Campus	A15 Fraser McDonald Unit Upgrade	Plan	Minor Refurbishment only
Grafton Campus	A15 Fraser McDonald Unit - Medication Room - RTC	Plan	Minor Refurbishment only
Grafton Campus	Lab Plus Shell Roof	Execute	Shell only no fitout
Grafton Campus	PC3 Laboratory - Fitout	Execute	Lab fitout
Grafton Campus	ACH Fluoroscopy Stage 2 Cath Lab 1 Rm no. 31.049	Plan	Replacement like for like
Grafton Campus	ACH Public Spaces - Level 5, L6, L7, L8, L9 bridges	Initiate	Managed through Performance Improvement Team
Grafton Campus	Environmental Improvement Mental Health services	Initiate	Minimisation of potential ligature points
Grafton Campus	RMO Lounge Refurbishment	Plan	Minor Refurbishment only
Greenlane Campus	Greenlane Bldg 17 Home Health - Ground and First Floor Refurb	ON Hold	
Greenlane Campus	Physiotherapy Outpatient Redevelopment - Greenlane	Initiate	Minor Refurbishment only
Greenlane Campus	Epsom Day Unit - Refurbishment - Building 7, Level 5	Plan	Accessability Assessment to be undertaken as part of design
Greenlane Campus	Endoscopy Service - long term expansion at Greenlane	Plan	Accessability Assessment to be undertaken as part of design
Greenlane Campus	Main Entrance - External Paving - Ground	Plan	Maintenance
Greenlane Campus	Radiology Reception Refurbishment	Initiate	No
Greenlane Campus	Car Park Redevelopment	Plan	Accessability Assessment to be undertaken as part of design
Greenlane Campus	Building 13 - Refurb to L3, L5, L6, L7 - kitchens, corridors, bath	Initiate	Minor Refurbishment only
Pt Chevalier	Rehab Plus Nurse Call Upgrade	Plan	Maintenance
218 Gt South Rd	218 Gt Sth Rd - YTP House Renovation	Plan	Minor Refurbishment only

Waitemata
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PROJECTS REGISTER – Facilities & Development and Waitemata 2025

PROJECT TITLE	END DATE	DISABILITY ADVISOR INVOLVED	DISABILITY ADVISOR (DA) COMMENTS AND/OR ISSUES
NORTH SHORE CAMPUS APPROVED/ IN PROGRESS			
Department of Medicine Office Suite – Level 3, Podium	Feb 16	No	
Bridge Link Elective Surgery Centre to Main Building	Jun 16	Yes	As beds will travel between ESC and main building there are no steps and it is wide enough hence accessible. The build will impact on some accessible parking spaces but Traffic is working with the DA to minimise disruption and to provide alternative accessible parking during the build period.
Community Building 5 - Relocation of Outpatients & Office refurbishment	Aug 16	Yes	Regular meetings with the DA to discuss access and facilities.
Ward 3 Refurbishment, Building 15, Tower	Apr 16	Yes	Ensured the provision of a fully accessible WC/Shower.
Site Master Plan – NSH & WTK / Procurement	Dec 16	No	
WDHB Medical Tower	2020	No	
Ground Floor Redevelopment • Antenatal • Cardiology	Oct 2017	Yes	Reviewed initial plans and preliminary design.
Ground Floor Redevelopment • Diagnostic Breast Service • SSW	Jul 2017	No	
Operating Theatre Refurbishment, Level 1, Main Building (1, 6, 7 & 8)	Aug 16	No	
Awhina Clinical and Learning Skills Centre, Lakeside (detailed design)	Mar 17	No	
Taharoto at NSH - Seismic Strengthening/ North Wing Refurb	tbc	No	
Store Room Kanban Modernisation, Inpatient wards, North Shore	tbc	No	
Gastroenterology Re-Processing Room Alterations, Level 1, Main Building	Nov 15	No	
WDHB Infrastructure Upgrade NSH & WTH	tbc	No	
NS Procedure Suite & Short Stay/Day Stay Wards	Jun 18	No	
Car park building, NSH		No	
Relocation of Child and Youth MHS and North Child Health Services- Pupuke Building		No	
NORTH SHORE CAMPUS / UNDER DEVELOPMENT			
SCBU (Special Care Baby Unit) Redevelopment, Level 2, Building 15 – NSH	Jun 16	No	
NSH office refurbishments • Surgical Pathology Office – Relocation and Refurbishment – NSH • 3 Mary Pointon • 15 Taharoto • 17 Taharoto • Telephonists Office	Sep 16	No	

PROJECTS REGISTER – Facilities & Development and Waitemata 2025

PROJECT TITLE	END DATE	DISABILITY ADVISOR INVOLVED	DISABILITY ADVISOR (DA) COMMENTS AND/OR ISSUES
- Level 8 offices			
Hyperbaric Oxygen Treatment Chamber – Feasibility Study – NSH - Feasibility report - Construction - Helipad feasibility report complete	Jul 15 2017/18	No	
Ambulatory & Outpatient Precinct including: Breast Care & Mammography Screening Ambulatory Module Oncology & Haematology Ambulatory Module	tbc tbc tbc	No	
Whanau Home Away from Home Accommodation, Lakeside – NSH	tbc	No	
Signage & Way finding – External	tbc	Yes	DA is a member of the Signage and Way Finding Steering Group.
WAITAKERE HOSPITAL CAMPUS APPROVED / IN PROGRESS			
Emergency Department Redevelopment	Aug 16	Yes	DA worked on preliminary design to identify access issues and improve waiting spaces for patients. Separate waiting area for people who find waiting difficult. Presentation to DiSAC June 2015.
Emergency Department Refurbishment	Apr 17	No	
Te Atarau Demolition and Establishment of On-Grade Car Park	Apr 16	No	
Dangerous Goods Store	Nov 15	No	
Seismic Strengthening - Snelgar & Health West	Jul 15	No	
Store Room Kanban Modernisation, inpatient wards, Waitakere Hospital	TBC	No	
Signage & Wayfinding - External	tbc	Yes	DA is a member of the Signage and Way Finding Steering Group.
CT & Waiting Area	tbc	No	
Waitakere Additional Beds	Jul 16	Yes	Regular meetings to review access issues for both patients and visitors.
WAITAKERE HOSPITAL CAMPUS / UNDER DEVELOPMENT			
WTH Redevelopment	tbc	No	
Waitakere Campus Staff Gymnasium	May 16	No	
Waitakere MRI	Mid 17	No	
MASON CLINIC APPROVED / IN PROGRESS / UNDER DEVELOPMENT			
Remedial Weather Tightness Works	2020	No	
15-Bed Medium Secure Inpatient Unit	Jan 17	No	
Campus Wide Security Review	Aug 15	No	
Additional Projects in Feasibility Phase	TBC	No	

PROJECTS REGISTER – Facilities & Development and Waitemata 2025

PROJECT TITLE	END DATE	DISABILITY ADVISOR INVOLVED	DISABILITY ADVISOR (DA) COMMENTS AND/OR ISSUES
COMMUNITY CAMPUS APPROVED/IN PROGRESS/ UNDER DEVELOPMENT			
Karaka St – barrier installation	Mar 16	No	
Hibiscus Coast Mental Health		No	
Pitman House Refurbishment		No	DA completed access audit in 2012. This report will still be relevant.
COMPLETED PROJECTS - MONITORING			
Podium Extension L3	Dec 15	Yes	
15 Bed Gynaecology Inpatient Unit – Level 2	Oct 15	Yes	
Loading Dock Safety Improvements, Lower GF, Main Building	Sep 15		
Front Of House Interior Refurbishment, Ground Floor, Main Building	Nov 15	Yes	
Histology (Surgical Pathology) Refurbishment – Level 1, Main Building	Aug 15		
Clinical Records Office Refurbishment – Lower GF, Main Building; Stage 2 completion	Jan 16		
Flagpole Erection	Dec 15		

Access to Bowel Screening and Cervical Screening Services for Disabled People: Barriers and Enablers

Recommendation:

That the Disability Support Advisory Committee receive the Access to Bowel Screening and Cervical Screening Services for Disabled People – Barriers and Enablers report.

Prepared by: Samantha Dalwood (Disability Advisor, Waitemata DHB)
Approved/Endorsed by: Dr Debbie Holdsworth (Director of Funding, Auckland and Waitemata DHBs)

Glossary

DHB	District Health Board
DSAC	Disability Support Advisory Committee

1. Introduction

The Disability Support Advisory Committee (DSAC) have asked for a series of deep dives into a number of DHB services starting with screening services. This is to inform the Committee on the barriers to disabled people accessing services and what is being done to reduce these barriers.

This paper looks at the Barriers and Enablers for disabled people accessing Bowel Screening and Cervical Screening services.

2. Bowel Screening

2.1 Barriers to Screening

The following are seen as barriers to screening:

- Seen as embarrassing, especially posting the sample.
- Seen as not relevant as not feeling unwell.
- Fear/anxiety.
- Lack of understanding what the test is for or how to complete the test.
- Home address information incorrect, so test does not arrive.

2.2 Enablers to Screening

Waitemata DHB developed the resources for the screening programme so was able to ensure to process was accessible.

At the project planning stage, the Disability Advisor and Community Awareness Team Leader met with members of the disability sector to look at meeting specific needs.

A meeting with the Association of Blind Citizens (ABC) worked through the process for visually impaired people. If test is not responded to, then person will get a phone call. If they have a visual impairment, and no-one to support them with their mail, they may not have accessed the information that was posted to them. If test is not responded to, then person will get a phone call. This is an opportunity to explain to that the kit has been sent and to see if they need support to complete the sample. If necessary, a nurse will go out and support a blind/visually impaired person to complete the test kit.

The test kit instructions and supporting information is in plain English with pictures.

Information is available in different languages and in both written and video formats.

The video has subtitles for Deaf and hearing impaired people.

Under the ‘Getting Screened’ menu, there is a tab called ‘Disability Information’. Information here says “If you have any disability, illness or injury which may prevent you from doing the test or sending in your sample please contact us and we can discuss a solution with you.” This gives a really positive message of inclusion and support.

Because you are invited by letter to your home address, it is not dependant on an individual asking to join the screening.

Completion of the Bowel Screening process is free of charge.

3. Cervical Screening

3.1 Barriers to Screening

The following are seen as barriers to screening:

- Lack of awareness is the biggest barrier to cervical screening.
- Usually a GP will advise a woman that she should have cervical screening. This assumes that women are regularly seeing a primary care health professional.
- There is a cost to the person having the screening done. Some community or primary health organisations offer a free or low-cost service, but there is no consistent policy and the information is difficult to find.
- National Screening Unit website could be much more consumer friendly. Search ‘cervical screening’ and you go to the right page, but there is a huge amount of written information.
- There is a really inclusive approach to women with impairments made clear on the website, but this information is found under ‘where to have a smear test’ – difficult to find.
- No ‘easy read’ resources.

3.2 Enablers to Screening

- Free phone number to access information.
- Huge response to television adverts aimed at Pacific Island women. This advert was well responded to by other groups of women as well.

- Primary Care health professionals are good at reminding women to have cervical screening done every three years.
- Some community or primary health organisations offer a free or low-cost service.
- There are mobile screening vans to make the screening more accessible to the community. These may not be suitable for all physical impairments, but offer an alternative to the GP for women.

4. Next Steps

4.1 Bowel Screening

Elizabeth Buswell, Bowell Screening Community Awareness Team Leader, is reviewing all Bowel Screening project resources and public information in 2016.

4.2 Cervical Screening

The Disability Advisor met with Pauline Proud, Metro Auckland Regional Cervical Screening Project Manager and Jane Grant, Regional Cervical Screening Nurse Specialist to discuss barriers to screening for disabled women. The two areas of improvement that they will recommend on a national level are updating the website to be more consumer friendly and to create 'easy read' resources.

The Disability Advisor has spoken to Susan Sherrard, Chair of the Disabled Women's Forum, about working with them to set up a health information forum for disabled women and girls. This would cover more than cervical screening, but also contraception, breast screening, etc.

5. References

Waitemata DHB Bowel Screening website
http://www.bowelscreeningwaitemata.co.nz/GettingScreened/Disabilityinformation.aspx

National Screen Unit website
https://www.nsu.govt.nz/national-cervical-screening-programme/where-have-smear-test

Easy Health website – 'easy read' information
http://www.easyhealth.org.uk/listing/cervical-screening-(leaflets)

Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017 and the joint Waitemata and Auckland DHBs Disability Strategy Implementation Plan 2013-2016

Recommendation:

That the Disability Support Advisory Committee receives the Whāia Te Ao Mārama report.

Prepared by: Samantha Dalwood (Disability Advisor, Waitemata DHB)
Approved/Endorsed by: Dr Debbie Holdsworth (Director of Funding – Auckland and Waitemata DHBs)

Glossary

DHB	District Health Board

1. Executive Summary

This paper looks at the goals of Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017 and the New Zealand Disability Strategy (2001). The paper comments on how the work the two DHBs are doing to implement the New Zealand Disability Strategy aligns with the work that is being done through Whāia Te Ao Mārama.

2. Background

Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017 provides a strong foundation and a clear direction for providing the support that Māori disabled people and their whānau require. It also outlines key principles that people working in the disability sector need to acknowledge.

The New Zealand Disability Strategy was developed in 2001 and is being revised in 2016. The Disability Strategy was developed as a long-term plan for changing New Zealand into an inclusive society, one that values disabled people and continually enhances their participation. It is made up of 15 objectives, Objective 11 being Promote Participation of Disabled Māori.

Waitemata DHB and Auckland DHB, with input from the disability sector and disability community, developed a joint plan for the implementation of the New Zealand Disability Strategy. The most recent plan is from 2013-2016. Both DHBs will be developing the joint 2016-2019 plan over the next few months. It is important that the vision and goals of this work continue to align with Whāia Te Ao Mārama.

3. Vision

The Vision of Whāia Te Ao Mārama is that Māori disabled people and their whanau:

- Achieve a good quality of life and wellbeing
- Participate in and contribute to te ao Māori (defined as 'the Māori world')
- Participate in their communities, as other New Zealander's do

The Vision of the New Zealand Disability Strategy is for:

- A society that values our lives and continually enhances our full participation.

The Vision of the joint DHB Disability Strategy Implementation Plan is that"

- Waitemata DHB and Auckland DHB are fully inclusive.

4. Key Areas of the joint DHB Implementation Plan 2013-2016

4.1 Communication and Access to Information

The commitment of both DHBs to becoming 'Health Literate' organisations supports information being available in ways that all people can access and understand. This includes information available that meets cultural needs.

4.2 Physical Access

The Implementation Plan is focussed on making our public spaces fully accessible to all people.

4.3 Disability Responsiveness

Priority four, Responsive Services, and priority two, Better Support for Whānau of Whāia Te Ao Mārama focus on improving culturally responsive training and strengthening cultural competencies of workers. The DHBs offer disability responsiveness e-learning, as well as specific staff training on Māori tikanga and Māori pronunciation.

4.4 Consumer and Community Engagement

This is one of the guiding principles of Whāia Te Ao Mārama, improving the community engagement with Māori and to increase cultural responsiveness. The DHBs have been working to increase the community engagement with all disabled people, including Māori.

4.5 Employment Opportunities

The DHB Implementation Plan focusses on increasing the employment of all disabled people. Both DHBs have a focus on encouraging Māori students into healthcare and recruiting and retaining Māori staff. This reflects the Whāia Te Ao Mārama priorities of supporting the Māori workforce and offering better support for Whānau.

5. Conclusion

The work that both DHBs are doing aligns with both the New Zealand Disability Strategy (2001) and Whāia Te Ao Mārama. The new 2016-2019 Implementation Plan will continue to support the guiding principles and priorities of Whāia Te Ao Mārama and the revised New Zealand Disability Strategy (2016).

6. References

The New Zealand Disability Strategy (2001)
http://www.odi.govt.nz/resources/publications/new-zealand-disability-strategy.html

Whāia Te Ao Mārama: The Māori Disability Action Plan 2012-2017
http://www.health.govt.nz/publication/whaia-te-ao-marama-Māori-disability-action-plan-disability-support-services-2012-2017

National Maori Disability Action Plan

Recommendation

That the Disability Support Advisory Committee receives the information and letter from the Ministry of Health formally acknowledged by the Manawa Ora Committee Chair and referred to the Committee by the Waitemata DHB Board Secretary.

Prepared by: Michelle Webb (Corporate Committee Administrator)

1. Background

The attached information was considered at the Manawa Ora (Maori Health Gains Advisory) Committee at their meeting held on 10 February 2016 and was item 6.5 on the agenda (see pages 184 - 204).

It was received and agreed that this be referred to the Disability Support Advisory Committee, for its consideration.

The Committee will note that activities of the Te Ao Marama Group align with a specific topic on the draft DSAC Workplan; *"Specific activities related to addressing disability and whanau support issues as they relate to Maori"*.

The Manawa Ora Committee is agreeable to receiving comment from the Disability Support Advisory Committee via correspondence.

MINISTRY OF HEALTH
MANATŪ HAUORA

18 December 2015

PO Box 1026
Wellington 6140
New Zealand

Gwen Tepania-Palmer
Māori Health Gains Advisory Committee
North Shore Hospital
124 Shakespeare Rd
Westlake
Auckland 0622

Tena Koe Gwen Tepania-Palmer,

I am writing to provide your committee with an update on the work of the Ministry of Health Disability Support Services Te Ao Mārama Group. Te Ao Mārama Group is a group of external advisors that supports the implementation of Whāia Te Ao Mārama: The Māori Disability Action Plan and provides advice to the Ministry on issues that affect Māori disabled. The group includes Māori with disabilities and Māori that work within the sector. They are David Tamatea, Chair, Matthew Matamua, Trish Davies, Eric Matthews and Charmeyne Te Nana-Williams.

The purpose of Te Ao Mārama Group is to:

- support the implementation of the Whāia Te Ao Mārama: The Māori Disability Action Plan 2012–2017 (copy enclosed),
- monitor the implementation of the plan and provide advice to the Ministry regarding the effectiveness of the plan's implementation in improving the lives of disabled Māori and their whānau,
- provide advice and support to the Ministry of Health on issues relating to Māori disabled and their whānau.

The group meets 3 times a year. The first meeting in the new year is March 2016.

At the recent Te Ao Mārama meeting in November the group reviewed the detailed Ministry of Health Disability Support Services action plan, incorporating accountabilities, time frames and outcome measures. They also reviewed the 'Demographic Information on Clients Using the Ministry of Health's Disability Support Services', published April 2015 (www.health.govt.nz/publication/demographic-information-clients-using-ministry-healths-disability-support-services).

You may be interested in a couple of initiatives from the last year that have improved outcomes for Māori people with disabilities. They include:

- Enabling Good Lives Waikato, an innovative joint agency demonstration aimed at responding to the needs of Māori with disabilities who would like increased choice and control over their lives and their disability supports (www.enablinggoodlives.co.nz/),

- Individualised Funding (IF) where the disabled person can purchase supports using individualised funding. IF is proving popular in Northland for Māori disabled and their whānau. However, we have also found that many Māori disabled do not know IF is available nationally and do not know how to access it. If you are aware of people with a disability who are not sure how to access services, you can direct them to their local Needs Assessment Service Coordination (NASC) organisation who can provide help and advice.

During 2016 we will continue to keep you updated about the work of Te Ao Mārama. Meri Kirimete.

Naku iti noa na

Toni Atkinson
Group Manager
Disability Support Services

MINISTRY OF HEALTH
MANATŪ HAUORA

Māori disabled and their whānau

Vision for Māori disabled and their whānau

- To achieve a good quality of life and wellbeing
- To participate in and contribute to te ao Māori
- To participate in their communities as other New Zealanders do

Kaupapa

- Māori disabled will achieve a good quality of life through whānau support and high-quality disability support services

Guiding principles

Enabling Māori disabled

- Greater personal leadership, choice and control over disability supports accessed
- Acceptance of Māori diversity and disability experience
- Respect for Māori cultural values and preferences
- Māori disabled have roles within their whānau and their communities of choice

Valuing whānau

- Whānau as the principal source of support for many Māori disabled
- Whānau assisted to support disabled family members
- Socioeconomic solutions for Māori disabled

Respecting community

- Good partnerships with whānau, hapū, iwi, and Māori communities
- Full Māori participation in planning and delivering disability support services
- Change the attitudes of whānau, hapū, iwi and communities to support the vision for Māori disabled

Delivering high-quality, effective disability support services

- Culturally safe and trustworthy disability support services
- A high strategic priority placed on improving Māori disability outcomes
- Better Māori knowledge of and access to disability support services
- Equitable resource allocation for Māori-focused disability support services

Priority actions

Priority 1: Improved outcomes for Māori disabled

1.1 Require providers to ensure that personal plans to support Māori disabled are culturally appropriate and specifically identify and address the individual's cultural needs (2012–17)

1.2 Provide a range of new and innovative support options for supporting disabled people that offer Māori disabled and their whānau more personalised support arrangements and greater choice and control over the supports they use (2013–14)

Priority 2: Better support for whānau

2.1 Improve caregiver training to ensure whānau have access to culturally appropriate training to address the needs of Māori disabled (2013–17)

2.2 Develop the New Model for Supporting Disabled People to respond to whānau needs and priorities (2012–13)

Priority 3: Good partnerships with Māori

3.1 Improve the quality, reliability and comparability of national information about the demographics of, and disability supports provided to, Māori disabled (2012–17)

3.2 Improve the quality of the community engagement process with Māori, particularly with hapū, iwi, and community leaders and groups (2012–17)

Priority 4: Responsive disability services for Māori

4.1 Strengthen the cultural competencies of workers in the disability sector through the development and delivery of Māori cultural training (2012–17)

4.2 Support the Māori disability workforce to develop leadership skills and career pathways (2012–17)

Source: *Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services 2012 to 2017*

Whāia Te Ao Mārama:

The Māori Disability Action Plan for Disability Support Services

2012 to 2017

Citation: Ministry of Health. 2012.
Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services 2012 to 2017. Wellington: Ministry of Health.

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MINISTRY OF
HEALTH
MANATŪ HAUORA

Foreword

Whāia Te Ao Mārama literally translated means pursuing the world of enlightenment. It is an apt title for this document, which outlines a pathway towards supporting Māori with disabilities to achieve overall wellbeing, and bringing both them and our communities into a place of shared understanding and action.

Culture is an important component of our overall wellbeing, and providing culturally specific action plans such as this recognises the diverse contexts from which we all come, and the unique responses that are required to address the needs of the Māori disabled community.

One in five Māori are living with some sort of disability, and this represents a large proportion of our whānau, hapū and iwi. Each of these whānau will have different expectations and needs in terms of their health and wellbeing, although all tangata whenua have shared values and beliefs that underpin our respective aspirations.

This action plan provides a strong foundation and a clear direction for providing the support that Māori disabled people and their whānau require. It also outlines key principles that those of us working within the disability support sector need to acknowledge. In developing this action plan, we hope that we have created a resource which weaves us closer together as communities who are respectful and supportive of diversity.

This action plan was developed by Māori disabled people, their whānau, and those who work in the disability support sector; with support from the Ministry of Health. The collaborative approach used to bring this plan together outlines the importance that we place on bringing key stakeholders, particularly those who live with disabilities, into the process of developing shared solutions, and responses.

Helen Keller once said, 'No pessimist ever discovered the secret of the stars, or sailed to an uncharted land, or opened a new doorway for the human spirit.'

This Māori Disability Action Plan operates from an attitude of optimism – it is essentially encouraging us all to dare to be powerful, to operate from a position of strength. Our strength is inherent in our whakapapa; in whakawhanaungatanga; in our kaupapa, our tikanga.

Knowing our collective strength helps us to move us closer towards Te Ao Mārama and closer towards reaching a shared awareness about the needs of Māori disabled people.

Tikanga, after all, is about doing the right thing, at the right time for the right reason, and this is the essence that has been captured in this action plan.

Tēnā koutou katoa

Hon Tariana Turia
Associate Minister of Health

Acknowledgements

E kore e hekeheke he kakano rangatira

I will never be lost for I am the product of chiefs.

The development of this document was driven by the Associate Minister of Health Hon Tariana Turia, and led by the Māori Disability Leadership Group.

Over 200 Māori individuals who participated in hui, focus groups and interviews, and organisations such as Te Piringa, NASCA, NZFDIC and disability support services providers contributed to the content of this over an 18-month period.

The consultation process was supported by the New Zealand Federation of Disability Information Centres. The individual stories and art work for Te Tōrino were produced by Te Rau Matatini.

The development of this document was led by the Disability Support Services Group of the National Services Purchasing Unit within the National Health Board.

Thanks to all the staff who contributed to this work from across the Ministry of Health and Te Puni Kōkiri.

Māori Disability Leadership Group

Sylvia Ratahi
Rainus Baker
Karen Pointon
Maaka Tibble
Ruth Jones
David Tamatea

Contents

Introduction

8.2

Why an action plan?

A number of factors determine the outcomes for Māori disabled and their whānau. Some directly relate to how their needs are supported to participate in their own lives, communities and cultural worlds. This participation can shape their chances of attaining a quality of life that matches their aspirations.

The aim of *Whāia Te Ao Mārama: Māori Disability Action Plan 2012 to 2017* is to establish priority areas of action for achieving these aspirations, and to reduce barriers that may impede Māori disabled and their whānau from gaining better outcomes.

'Whāia te ao mārama' means to pursue and enable a good life that is self-determined, through enlightened supports. The tōrino double spiral diagram in the plan illustrates the four core elements needed for supports to be effective for Māori disabled:

- te ao Māori
- te ao hurihuri
- te rangatira
- tūhonohono.

Each element is interwoven and interdependent. Their purpose is to support Māori disabled to uphold their own mana and strong self-determination within their whānau, hapū, iwi and wider communities.

Māori disabled

Disability is a significant issue for Māori. One in five Māori report having a disability, and due to the youthfulness of Māori communities and the higher susceptibility of Māori to disabling health conditions as they age, the incidence of disability is expected to increase.

It is widely acknowledged that culture and health are closely linked, and that those services that fail to take account of the significance of culture in the assessment and support of Māori disabled have the potential to create a greater likelihood of poor outcomes and reduced health gains.

Māori aspirations

Māori disabled are clear about what will make a positive difference to their lives. They want:

- every opportunity to have leadership, choice and control over their lives (te rangatira)
- to be supported as both Māori and as disabled to thrive, flourish and live the life they want
- to be able to participate in te ao Māori (the Māori world)
- to have their whānau valued as their primary support system
- to be connected to natural support networks, including Māori and disability communities
- a holistic approach to their disability that also values the beneficial effects of Māori cultural views and practices on spiritual, mental, physical, emotional and whānau wellbeing.

Government priorities

The Ministry of Health's *Disability Support Services Strategic Plan 2010–2014* outlines the overall purchasing strategy and actions for providing disability support services to eligible New Zealanders. It continues the Ministry's move towards a needs- and outcomes-based approach to purchasing national disability services.

Whāia te Ao Mārama provides direction over the next five years for actions to address the needs and priorities of Māori disabled. It has been informed by community and stakeholder consultations with a Māori Disability Leadership Group comprising Māori disabled from across the disability sector, who provided leadership and peer review for the development of the plan.

Whāia te Ao Mārama is based on three principles from te Tiriti o Waitangi: Māori participation at all levels, partnership in service delivery, and protection and improvement of Māori wellbeing. *Whāia Te Ao Mārama* also reflects New Zealand's obligations as a signatory to the United Nations Convention on the Rights of Persons with Disabilities (2007), and as a nation that has stated its support for the United Nations Declaration on the Rights of Indigenous Peoples (2010).

The five-year action plan is aligned closely with:

- the New Zealand Disability Strategy (2001)
- Disability Support Services' new initiatives designed to supporting disabled people and their whānau
- cross-Ministry of Health initiatives such as the Uia Tonutia: Māori Disability Research Agenda
- intersectoral initiatives, particularly those related to the Government's Whānau Ora programme.

Reducing barriers

Māori disabled can experience discrimination and face significant barriers, both in everyday living and in accessing health, disability and other services. As a result of their disability experiences, Māori have reported feeling disconnected from their whānau, communities of choice and culture.

Reducing barriers to ensure Māori disabled and their whānau get disability information, resources and services is a key strategic challenge in supporting Māori disabled to achieve better outcomes.

Disability support services

Anecdotal evidence indicates that Māori whānau commonly take care of their disabled whānau members without accessing the supports by the Ministry of Health-funded disability support services. Effective disability services are seen as critical to achieving improved disability outcomes for Māori, and these services are expected to be responsive to Māori needs and priorities. A key strategic challenge is to achieve better Māori access to effective disability support services that are appropriate at both the population and individual levels of need.

Supporting New Zealanders with disabilities to receive better disability supports contributes to the Ministry's outcome to promote and protect the good health and independence of New Zealanders.

The Ministry is introducing new ways of supporting clients of disability support services. These initiatives recognise that disabled people and their whānau are the best people to determine how they want to live and develop goals that will meet their needs. The Ministry is developing initiatives to take account of the diverse needs and concerns of Māori, and will play an important role in supporting Māori clients to achieve good outcomes from disability support services. The shift to increasing disabled people's choice and control is consistent with what Māori communities have said they want from the Ministry's disability support services.

Māori data

Some of the following information has been sourced from the Ministry of Health's Disability Support Services database.

The 2006 New Zealand Household Disability Survey indicated that disability was a significant issue for Māori, with close to one in five Māori (approximately 96,700) reporting they had a disability.

Māori disabled make up approximately 5400 (16%) of people who access the Ministry of Health-funded disability support services. As a group, Māori disabled are predominantly youthful, with over a third (37.8%) under 15 years of age and 49% aged under 25 years. Maori disabled mainly have intellectual disability (50.9%) or physical disability (32.2%), and some Māori disabled have significant support needs, with 23% having very high levels of need.

Most live in the Auckland (26.4%), Waikato (12.3%) and Northland (10.6%) regions. Māori disabled predominantly live in urban areas (89%) rather than rural areas (11%). Those living in rural regions are mainly based in Northland (45.2%), Bay of Plenty (24.1%) and Gisborne (25.6%).

As at June 2011, almost two-thirds (64%) of disability support services funding from the Ministry of Health for Māori disabled was allocated to residential care, followed by home support (19.7%) and day programmes (5.2%).

Future changes to disability support services

After talking with disabled people, their families, providers and the wider disability sector, the Ministry of Health has developed, and is testing, a new model for supporting disabled people. The aim of the new model is for disabled people and their families to lead good everyday lives. It will increase people's control and choice, and the flexibility of their supports, as well as ensuring information and support are available in their local communities.

The new model incorporates work to enhance Individualised Funding and Choice in Community Living. The current support services model lends itself more to someone else making the decisions about what, and when, support is given.

Whāia Te Ao Mārama requires Māori disabled and their whānau to be fully involved in the planning and implementation of current and future development programmes to improve the disability support system.

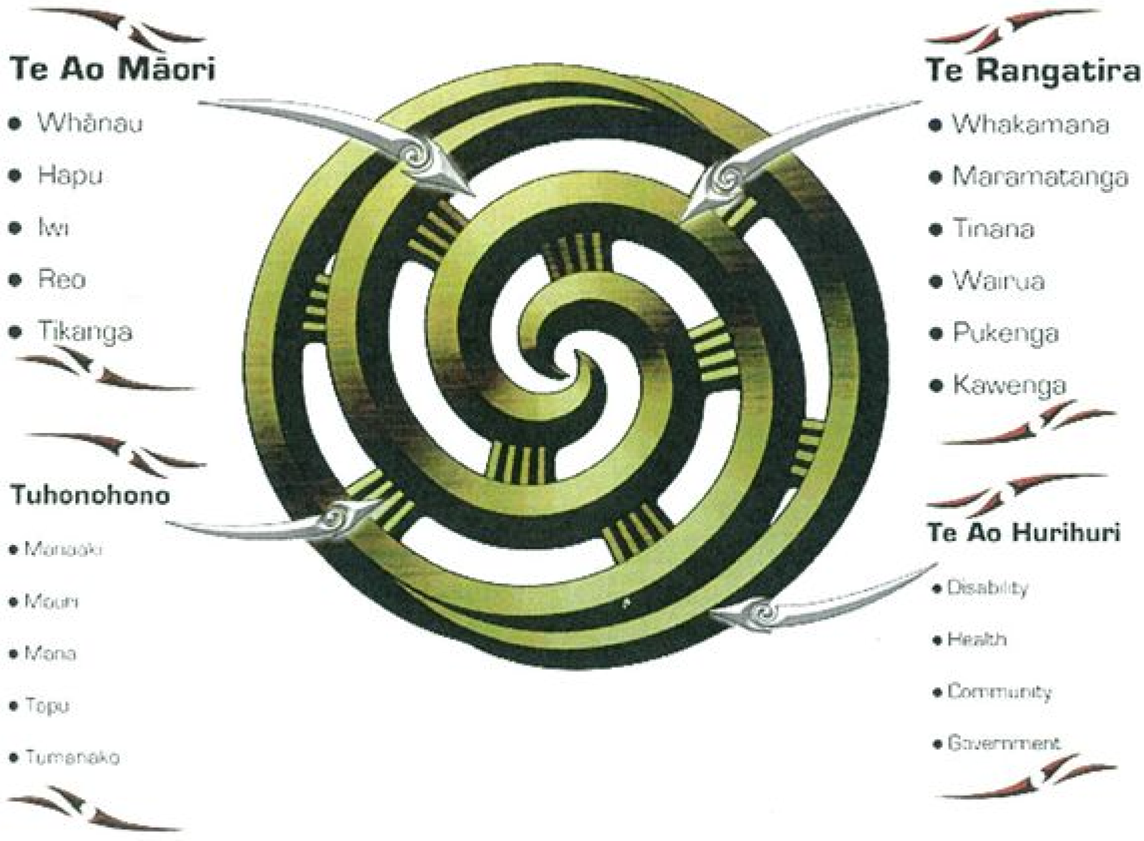
Strategic response

Whāia Te Ao Mārama responds to the wish expressed by Māori disabled and whānau for them to be able to live a good life, participate in te ao Māori and take part in their communities as other New Zealanders do.

There is no definitive word or description of disability in te reo Māori. Commonly te reo refers to a person's ability to flourish or function in relation to their ability to contribute to either their own, or others, wellbeing.

Whāia Te Ao Mārama's vision, kaupapa, guiding principles and priority areas have been developed in collaboration with Māori disabled, key stakeholders and the Māori Disability Leadership Group (see Table 1). It is a culturally anchored approach to supporting Māori disabled and their whānau through Ministry of Health-funded disability support services. The approach has been developed from a Māori world view which also recognises that Māori disabled know what works for them.

Figure 1: Whāia Te Ao Mārama: To pursue a good life with enlightened support



Whāia Te Ao Mārama reflects the four core elements needed for supports to be effective for Māori disabled. Close relationships with and between Māori disabled, their whānau, hapū, iwi and communities, and the Ministry are essential to make a positive difference for Māori disabled. Included alongside the core elements discussed below are excerpts from the stories of Māori disabled who have generously guided and blended their experiences into this action plan.

Te ao Māori

Te ao Māori (the Māori world) is represented by the space between the spirals, shown in Figure 1. This space represents a person's ability to participate in their own whānau, hapū and iwi, and as a Māori New Zealander. The person is included, and is able to draw on the support and opportunities, within whānau and the Māori community through te reo, whakapapa, whanaungatanga, manaaki and wairua.

> ‘For example, a taonga for Ngāti Kāpō might be the ability to make choices and the right to be Māori and access cultural resources. ‘It's the balance – active participation. Not even my mum and dad would have thought that I would become one of the leaders in health and disability services in Tairawhiti, or that I would have a major influence in terms of indigenous issues around the world!

> ‘I would have laughed at it myself, but it is about a vision. Ka pū te ruha, ka hao te rangatahi; mate atu he tetekura, ara ake he tētēkura – beautiful. So that's what our old people were thinking.’
>
> – Maaka, Ngāti Porou me Te Whānau ā Apanui)

Te rangatira

The te rangatira spiral represents Māori disabled as individuals living life and having the whakamana to take up their various roles as they have a right to do within their whānau, te ao Māori and society as a whole, and who are responsible for their own lives.

> ‘One of the concepts in Maoridom, which is so vitally important, is about applying tino rangatiratanga, which means that I can take control of my life and destination. We all want that – what's important to give you a good life is the foundation and the legacy that we leave for others. Self-advocacy is also important. It's that notion that talks about we can, ka taea mātau, ahakoa te aha, ka taea tonu e mātau. And then the other one is, mehemea kei kōrero koe mōku, māku anō au he kōrero, so if it's about us,

then don't talk about it without asking us. These are internally understood principles, which have been translated into Māori kupu.'

– Maaka, Ngāti Porou me Te Whānau ā Apanui)

Tuhonohono

This is the solid link between the spirals, which represents the points in a person's life where both the spirals and the space between them must connect to provide balance and harmony. These connecting points are important and represent personal milestones and relationships that Māori disabled have with their whānau, hapū, iwi and caregivers, who are in turn supported through Disability Support Services or other agencies.

> 'We're still using the same old institutions. Why can't we join the dots together to show that perhaps there is a different way to achieve the outcomes that we all needed to achieve? The imported system can't be working for our people, and there's some indigenous ways which could be working maybe a lot better.'
>
> – Gary, Ngāti Porou)

> 'Basically we go to people's houses that have ramps that we can access. Or we sit outside – we've sat outside in the rain with an umbrella, or if it's hot. So it really restricts you from doing the social things that you want to do with whānau. You sort of lose contact. And so of course contact with marae and wider whānau is also limited. We've had a lot of tangi and stuff. If I go, Tyler has to sit outside. So we can't do that, can't see the cuzzies or things . . . .'
>
> –Andrea and Tyler, Ngāti Mutunga me Moriori)

Te ao hurihuri

This is the spiral surrounding the disabled person. This spiral represents services, and the political, economic, social and environmental trends that support, influence and affect Māori disabled.

> 'Sometimes I do get labelled, and I don't like it. I look at myself as being treated like anyone else in the community. I don't have to go, "How come you're this handicapped fellow?" No, I'm a normal person just like you. I don't care if I've got a disability. I'm just a normal and loving person like you, and you should awhi it..'
>
> –Rainus, Ngāti Awa)

Sylvia says she has been able to express her needs to disability services and have her needs met. But she says some other disabled people are not so able to do so.

> 'They're not speaking up for what they want, 'cause some of them don't know how. Staff should also develop better skills in listening and speaking simple language to encourage disabled people to speak up. They've been shut up, like shut down or "shut out". Sometimes it's because they might bear a grudge against a person or a service, or vice a versa..'
>
> – Sylvia, Whakatōhea

A focus for action

Table one contains key features of the plan that have been developed through extensive consultation. These include:

- a **vision for Māori disabled and their whānau**
- the **kaupapa**
- **guiding principles** that underpin the vision
- the **priority actions** which state how these elements will be accomplished.

Table 1: Māori disabled and their whānau

Vision for Māori disabled and their whānau

- To achieve a good quality of life and wellbeing
- To participate in and contribute to te ao Māori
- To participate in their communities as other New Zealanders do

Kaupapa

Māori disabled will achieve a good quality of life through whānau support and high-quality disability support services

Guiding principles

Enabling Māori disabled

- Greater personal leadership, choice and control over disability supports accessed
- Acceptance of Māori diversity and disability experience
- Respect for Māori cultural values and preferences
- Māori disabled have roles within their whānau and their communities of choice

Valuing whānau

- Whānau as the principal source of support for many Māori disabled
- Whānau assisted to support disabled family members
- Socioeconomic solutions for Māori disabled

Respecting community

- Good partnerships with whānau, hapū, iwi, and Māori communities
- Full Māori participation in planning and delivering disability support services
- Change the attitudes of whānau, hapū, iwi and communities to support the vision for Māori disabled

Delivering high-quality, effective disability support services

- Culturally safe and trustworthy disability support services
- A high strategic priority placed on improving Māori disability outcomes
- Better Māori knowledge of and access to disability support services
- Equitable resource allocation for Māori-focused disability support services

Priority actions

1.1	Require providers to ensure that personal plans to support Māori disabled are culturally appropriate and specifically identify and address the individual's cultural needs (2012–17)	**1.2**	Provide a range of new and innovative support options for supporting disabled people that offer Māori disabled and their whānau more personalised support arrangements and greater choice and control over the supports they use (2013–14)
2.1	Improve caregiver training to ensure whānau have access to culturally appropriate training to address the needs of Māori disabled (2013–17)	**2.2**	Develop the New Model for Supporting Disabled People to respond to whānau needs and priorities (2012–13)
3.1	Improve the quality, reliability and comparability of national information about the demographics of, and disability supports provided to, Māori disabled (2012–17)	**3.2**	Improve the quality of the community engagement process with Māori, particularly with hapū, iwi, and community leaders and groups (2012–17)
4.1	Strengthen the cultural competencies of workers in the disability sector through the development and delivery of Māori cultural training (2012–17)	**4.2**	Support the Māori disability workforce to develop leadership skills and career pathways (2012–17)

The action plan

Priorities for *Whāia Te Ao Mārama* have been informed by:

- available Māori disability and needs data
- feedback from Māori consumers and whānau hui
- guidance from the Māori Disabled Leadership Group
- consultation with Te Piringa, the Māori Disability Provider Network
- special focus groups and Māori disability experience-gathering exercises in 2011
- the current difficult economic climate, which will mean that all actions will be resourced within existing funding.

Priority 1:
Improved outcomes for Māori disabled

1.1 Require providers to ensure that personal plans to support Māori disabled are culturally appropriate and specifically identify and address the individual's cultural needs (2012–17)

1.2 Provide a range of new and innovative support options for supporting disabled people that offer Māori disabled and their whānau more personalised support arrangements and greater choice and control over the supports they use (2013–14)

Priority 2:
Better support for whānau

2.1 Improve caregiver training to ensure whānau have access to culturally appropriate training to address the needs of Māori disabled (2013–17)

2.2 Develop the New Model for Supporting Disabled People to respond to whānau needs and priorities (2012–13)

Priority 3:
Good partnerships with Māori

3.1 Improve the quality, reliability and comparability of national information about the demographics of, and disability supports provided to, Māori disabled (2012–17)

3.2 Improve the quality of the community engagement process with Māori, particularly with hapū, iwi, and community leaders and groups (2012–17)

Priority 4:
Responsive disability services for Māori

4.1 Strengthen the cultural competencies of workers in the disability sector through the development and delivery of Māori cultural training (2012–17)

4.2 Support the Māori disability workforce to develop leadership skills and career pathways (2012–17)

Monitoring and reporting on the implementation of *Whāia Te Ao Mārama*

The high-level actions in *Whāia Te Ao Mārama* are supported by a detailed Ministry of Health Disability Support Services action plan, incorporating accountabilities, time frames and outcome measures.

Internal monitoring and reporting of the implementation of *Whāia Te Ao Mārama* will occur on a quarterly basis, alongside Disability Support Services' quarterly reporting on achievement of its annual service plan.

The Whāia Te Ao Mārama Monitoring and Advisory Group – a new external group of Māori disabled – will meet six-monthly to review implementation progress and provide advice to the Ministry.

Appendix 1: Additional actions for future reference

The following actions were identified by the Māori Disability Leadership Group but were not included in Whāia Te Ao Mārama. These may inform future service planning for Maori disabled.

Priority 1: **Improved outcomes for Māori disabled**	› Develop learning and leadership training and development opportunities for Māori disabled, including tamariki (children) and taiohi (young people)
Priority 2: **Better support for whānau**	› Develop indicators to measure whānau outcomes › Support parents with disabled children, particularly in the areas of behaviour support and whānau-centred respite care › Ensure whānau are involved in the funding, planning and delivery of disability services, including the development of service specifications › Improve Māori provider capacity and capability to participate in Whānau Ora through Te Piringa
Priority 3: **Good partnerships with Māori**	› Additional actions have been identified to enable Maori participation and inclusion in disability service prioritisation, specification and engagement › whānau, hapū and iwi relationships are established to better engage disability awareness and supports through iwi health plans and whānau support options on marae
Priority 4: **Responsive disability services for Māori**	› Review the Quality Assurance Outcomes Framework for Māori disabled to guide the approach for Māori receiving disability supports › Use Māori disability research to inform service development for Māori disabled, including from Uia Tonutia: Māori Disability Research Agenda

Appendix 2: Glossary

Hapū	Māori sub-tribe, clan or kinship group
Iwi	Māori tribe or clan
Mana	Spiritual power, authority, integrity, prestige or group
Manaaki	To support
Marae	Central area of a village and its buildings
Māramatanga	Understanding
Pūkenga	Skills
Rangatira	Leadership
Rangatiratanga	Influence and control over life
Taiohi	Adolescent
Tamariki	Child
Tangata Whenua	Maori as indigenous people to this land
Te ao hurihuri	Contemporary society, including Disability Support Services and other services and factors that affect the individual
Te ao Māori	The Māori world in which the individual has a role within whānau and hapū, and is able to draw on the support and opportunities of whānau and also take up their role within whānau
Te rangatira	Disabled individual Māori living life and taking up their various roles within whānau, te ao Māori, and society as a whole
Te reo	Māori language
Tikanga	Customs, practices and protocols that reflect Māori knowledge and traditions
Tinana	Physical; bodily
Tūhonohono	Connectedness and relationships that Māori disabled have with their whānau, hapū, iwi and caregivers which provide balance and harmony in their lives
Wairua	Spirituality or spiritual health, which encompasses dignity and respect, cultural identity, personal contentment, and non-physical spirituality

Health and Disability Commission Finding - Death of a Disabled Person in a Residential Care Home

Recommendation:

That the Disability Support Advisory Committee receives the Death of a Disabled Person in a Residential Care Home report.

Prepared by: Samantha Dalwood, Disability Advisor, Waitemata DHB
Approved/Endorsed by: Dr Debbie Holdsworth, Director of Funding – Auckland and Waitemata DHBs

Glossary

DHB	District Health Board
DSAC	Disability Support Advisory Committee
HDC	Health and Disability Commission
HOD	Head of Department

1. Executive Summary

A caregiver and the residential care home where he worked have been found to have breached the rights of a disabled man who died in their care.

A report by the Deputy Health and Disability Commissioner, Rose Wall, dated 4 December 2015, was released stating that Creative Abilities and the caregiver, known only as Mr C, failed to provide the appropriate standard of services to the man. The report (appended) is summarised in this paper.

The provider is not contracted by either Auckland or Waitemata DHB however the recommendations in the HDC report are relevant to the DHBs in managing their contracted residential care providers. The case will be reviewed by the Planning and Funding Quality and Monitoring Managers to reduce the likelihood of similar events occurring in a DHB facility.

2. Background

Mr A (aged 20 years at the time of events) had complex needs and required 24-hour care. He was diagnosed with acute obstructive sleep apnoea, cerebral palsy and epilepsy. He was unable to walk and used a wheelchair.

In late 2012, Mr A became a Creative Abilities and Associates Limited (Creative Abilities) residential client and lived three nights per week at the Creative Abilities residential home (the House) with three other Creative Abilities clients. He lived at home with his parents on the other four nights of the week.

Mr C was a qualified caregiver and had been employed by Creative Abilities for several years. Mr C was the sole caregiver on duty on the "awake" night shift on the night of these events in late 2013. He was to remain awake during the night, and complete client and household duties during the shift. He was required to look after four clients with complex needs that night, including Mr A.

Mr C's shift started at 11.00pm and at approximately 11.10pm he transferred Mr A to his bed. Mr A's night-time care plan contained information about his medication regimen and sleep system. Mr C was required to check Mr A frequently and record on an Hourly Client Checklist that he had done so.

At approximately 3.00am, Mr A woke up. Mr C left Mr A on his back in bed for 10 to 25 minutes before transferring him to his wheelchair. At approximately 5.00am, Mr C transferred Mr A from his wheelchair back to bed, with the bed raised at the head end, in order to perform his personal cares. Mr C said that he went to the en-suite bathroom to wet the flannel; when he came back Mr A had moved so that he was diagonal on the bed and he was struggling to breathe. Mr C said that he tried to move Mr A back into position (lying straight on the bed) but Mr A's breathing became more difficult and he stopped breathing.

At 5.21am, Mr C called 111 and spoke to a call handler. The call handler was advised that a 19-year-old male was unconscious and not breathing. Under the guidance of the call handler, Mr C performed CPR until the two ambulances arrived at 5.33am. Mr A was taken to hospital where he died at 8.00am.

3. HDC Findings

Mr C failed to comply with Mr A's night-time care plan. He did not attach Mr A's shoulder harness after he transferred Mr A into his wheelchair or place a pillow under his head and shoulders after he transferred Mr A back to his bed to perform his personal cares. For these reasons, Mr C did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Creative Abilities did not provide services to Mr A with reasonable care and skill. The care planning for Mr A did not meet the accepted standard. Creative Abilities also did not have in place an adequate system to verify whether Mr C had accessed or received the information and training provided at the house meetings he had missed. For these reasons, Creative Abilities breached Right 4(1) of the Code.

In addition, the hours Mr C was allowed to work following a disciplinary process put at risk the clients he cared for, including Mr A. Accordingly, Creative Abilities failed to minimise the potential harm to Mr A and breached Right 4(4) of the Code.

Adverse comment is made about Creative Abilities' monitoring of Mr C's performance.

4. HDC Recommendations

Rose Wall, the Deputy Health and Disability Commissioner, recommended that the caregiver and Creative Abilities apologise to the man's family and that the care home conduct an internal audit of its patient plans and reviews the adequacy of its staff training programme.

Creative Abilities are to report back to HDC within four months of the date of the report (4 December 2015).

5. Applying the HDC Recommendations

The HDC report highlights the importance of documentation, care planning and staff training. Specific recommendations to be considered by the Planning and Funding Quality and Monitoring managers when supporting residential care are:

- All forms must be dated and signed with time of completion recorded
- Communication books and handover notes must contain all the information that needs to be communicated at handover. It is not acceptable to give some written information and additional verbal information
- Clear, unambiguous instructions – i.e. Not 'check the resident frequently', but 'check the resident every 2 hours'
- Identify when providers need documentation training
- Resident information should be stored in as few places as possible and must be consistent across all documents
- Information on equipment and how and when equipment is used must be written down and must be consistent across all documents
- Staff should sign to confirm that they are confident to use the equipment
- There must be an adequate system to verify if staff members have received information provided at meetings they have missed. Also, to check that staff are confident to carry out relevant tasks after receiving this information
- Adequate staff numbers so that staff members are not working double shifts or an excessive number of hours each week
- Issues raised in annual performance reviews are followed up in regular supervision meetings with staff members.

7. References

http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2016/14hdc00007

http://www.stuff.co.nz/auckland/76456039/carer-and-rest-home-criticised-after-death-of-disabled-man

http://www.radionz.co.nz/news/national/295479/caregiver-and-employer-faulted-after-death

http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11582960

Caregiver, Mr C

Creative Abilities and Associates Ltd

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC00007)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

Background

1. Mr A (aged 20 years at the time of events) had complex needs and required 24-hour care. He was diagnosed with acute obstructive sleep apnoea, cerebral palsy and epilepsy. He was unable to walk and used a wheelchair.

2. In late 2012, Mr A became a Creative Abilities and Associates Limited (Creative Abilities) residential client, and lived three nights per week at the Creative Abilities residential home (the House) with three other Creative Abilities clients. He lived at home with his parents on the other four nights of the week.

3. Mr C was a qualified caregiver, and had been employed by Creative Abilities for several years. Mr C was the sole caregiver on duty on the "awake" night shift on the night of these events in late 2013. He was to remain awake during the night, and complete client and household duties during the shift. He was required to look after four clients with complex needs that night, including Mr A.

4. Mr C's shift started at 11pm and, at approximately 11.10pm, he transferred Mr A to his bed. Mr A's night-time care plan contained information about his medication regimen and sleep system. Mr C was required to check Mr A frequently, and record on an Hourly Client Checklist that he had done so.

5. At approximately 3am, Mr A woke up. Mr C left Mr A on his back in bed for 10–25 minutes before transferring him to his wheelchair. At approximately 5am, Mr C transferred Mr A from his wheelchair back to bed, with the bed raised at the head end, in order to perform his personal cares. Mr C said that he went to the ensuite bathroom to wet the flannel and, when he came back, Mr A had moved so that he was diagonal on the bed, and he was struggling to breathe. Mr C said that he tried to move Mr A back into position (lying straight on the bed), but Mr A's breathing became more difficult, and he stopped breathing.

6. At 5.21am, Mr C called 111 and spoke to a call handler. The call handler was advised that a 19-year-old male was unconscious and not breathing. Under the guidance of the call handler, Mr C performed CPR until the two ambulances arrived at 5.33am. Mr A was taken to hospital, where he died at 8am.

Findings

7. Mr C failed to comply with Mr A's night-time care plan, in that he did not attach Mr A's shoulder harness after he transferred Mr A into his wheelchair, or place a pillow under his head and shoulders after he transferred Mr A back to his bed to perform his personal cares. For these reasons, Mr C did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

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

8. Creative Abilities did not provide services to Mr A with reasonable care and skill, as its care planning for Mr A did not meet the accepted standard. Creative Abilities also did not have in place an adequate system to verify whether Mr C had accessed or received the information and training provided at the house meetings he had missed. For these reasons, Creative Abilities breached Right 4(1) of the Code.

9. In addition, the hours Mr C was allowed to work following a disciplinary process put at risk the clients he cared for, including Mr A. Accordingly, Creative Abilities failed to minimise the potential harm to Mr A and breached Right 4(4) of the Code.[2]

10. Adverse comment is made about Creative Abilities' monitoring of Mr C's performance.

Complaint and investigation

11. The Commissioner received a complaint from Mr B about the services provided to his son, Mr A. An investigation was commenced on 6 March 2014. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Creative Abilities and Associates Ltd.*
- *The appropriateness of the care provided to Mr A by Mr C.*

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

13. The parties directly involved in the investigation were:

Mr B	Complainant/consumer's father
Mrs B	Consumer's mother
Creative Abilities and Associates Ltd	Provider
Mr C	Provider

Also mentioned in this report:

Ms E	Training Manager
Ms D	Residential Team Manager
Mr F	Team Leader
Ms G	Caregiver
RN H	Registered Nurse

14. Independent expert advice was obtained from a disability services advisor, Ms Sandie Waddell (**Appendix A**).

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[2] Right 4(4) states: "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."

Information gathered during investigation

Background

15. Sadly, Mr A (aged 20 years) died in late 2013. His father, Mr B, is concerned about the care provided to Mr A by Mr C, a caregiver employed by Creative Abilities and Associates Ltd (Creative Abilities).

Mr A

16. Mr A had complex needs and required 24-hour care. He was diagnosed with acute obstructive sleep apnoea,[3] cerebral palsy,[4] and epilepsy. Mr B said that Mr A had "little motor control, no head control, good eyesight and hearing". Mr A was unable to walk, and used a wheelchair. He would spend time in a standing frame, and a hoist was used for transfers. He also had aphasia[5] and was incontinent.

17. Mr A's parents told HDC that Mr A's epilepsy was well managed with medication. His parents stated that his epilepsy was always triggered by very high temperatures, but he had experienced only "minor turns" in the 11 years prior to his death. Mr A's "Health Passport"[6] also records: "[S]ometimes [he] has epileptic seizures." A Creative Abilities incident report form dated mid 2013 records that Mr A had a seizure, and states: "His face turned pale, whole body stiffened, eyes wide opened, lips were purple, not breathing and mouth was opened as well." This was also recorded on a "Seizure Record Form". This was the latest seizure recorded in Mr A's records. In response to the "information gathered" section of the first provisional opinion, Mr A's parents said that they were not advised of that incident, and had "no knowledge or recall of the report of a seizure … dated a few months before his death". They stated: "As far as we are concerned [Mr A] had not had a significant seizure since pre-puberty."

18. Mr A's parents advised that when Mr A's head was tilted backwards he was unable to pull his head forward again because of his cerebral palsy, and this could lead to obstructive apnoea. This also meant that Mr A was at risk of having difficulty breathing when lying down, and a sleep system was developed which enabled Mr A to sleep safely in the recovery position.[7]

19. Mr A was fed through a percutaneous endoscopic gastrostomy (PEG) feeding tube,[8] as he had a compromised swallowing reflex, which increased his risk of aspiration.

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[3] The obstruction of the upper airway when sleeping.

[4] Cerebral palsy is a term used to describe a group of disabling conditions, which affect movement and posture. It is caused by a defect or lesion to one or more specific areas of the brain, usually occurring during fetal development before birth, but it can also occur as a result of hypoxia or injury during or after birth.

[5] Partial or total loss of the ability to articulate ideas or comprehend spoken or written language, resulting from damage to the brain caused by injury or disease.

[6] The Health Passport is a booklet produced by the Health and Disability Commissioner for consumers to record information that they want people to know about how to support and communicate with them.

[7] See paragraph 38 below.

[8] PEG feeding is used where patients cannot maintain adequate nutrition with oral intake.

Creative Abilities

20. Creative Abilities is an organisation that supports people with physical and other needs to participate in community life. It provides a day service (the Centre). The Centre provides a number of activities for social rehabilitation and participation in the community. The services at the Centre include a leisure centre, gym, massage centre, community outings, an art centre, and work projects. Creative Abilities also provides supported living[9] at 14 residential homes, which are staffed by caregivers who are supported by registered nurses. Creative Abilities told HDC that it is audited and certified to the following standards: NZ8134:2008 Health & Disability Service Standards; NZ8158:2012 Home & Community Support Service Sector Standards; AS/NZ ISO9001:2008 Quality Management System; SAMS Standards and Monitoring Services; and ACC WSMP Workplace Safety Management Practices.

21. In mid 2011, Mr A began attending the Centre. Mr A's mother, Mrs B, attended the Centre to show the Training Manager, Ms E, how to assist Mr A with his activities, his feeding, bathroom and communication needs, and how to transfer him from his wheelchair safely.

22. Mr A attended the Centre during the day, four days per week (Monday, Tuesday, Wednesday and Friday). He participated in activities such as scrapbooking, baking, movies, music, art therapy, and community outings.

23. Later in 2012, Mr A became a Creative Abilities residential client, and stayed three nights per week at the Creative Abilities residential home (the House) with three other Creative Abilities clients.[10] He lived at home with his parents on the other four nights of the week.

24. When Mr A was at the House between 7am and 11pm, two caregivers were always rostered on. Between 11pm and 7am, one caregiver was rostered on. The night-time shift was an "awake" shift.[11] However, for the first few weeks that Mr A stayed overnight at the House, ACC provided additional funding to have two caregivers on the night shift.

25. Mr A also lived full time with Creative Abilities for three weeks in late 2013 while his parents were overseas.

Staff induction

26. Ms D, Residential Team Manager at Creative Abilities, told HDC that when Mr A started attending the Centre, Ms E did a lot of support work with him to familiarise herself with his needs. Ms D said that a number of staff did buddy shifts with Ms E at

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[9] Supported living is a service that helps disabled people to live independently by providing support in those areas of their life where help is needed.

[10] Mr A received residential rehabilitation funding from ACC.

[11] The caregiver is required to remain awake and complete client and household duties during the shift. Creative Abilities also has sleepover shifts, where the caregiver sleeps at the residential home. This is for clients who do not require care during the night.

the Centre, and they were shown how to support Mr A with his medication regimen, changing his clothes, and showering.

27. Ms D told HDC that before any staff worked with Mr A, they had to go through his care plan. They were also given specific notes about Mr A and his care requirements. Ms D said that the most difficult part of Mr A's care was changing him, as he would become agitated very quickly if he was out of his wheelchair.

28. Ms D said that Mr F, Team Leader at the House, had a number of buddy shifts with Ms E to learn how to support Mr A, and was responsible for inducting staff members into the night shift at the House.

Communication book

29. A parent communication book (the communication book) travelled with Mr A from the House to his home and back again. It recorded instructions and messages between Mr A's parents and Creative Abilities staff (usually Mr F) about the use of Mr A's wheelchair and other equipment, his feeding requirements, changes to his personal care needs, and any other concerns. Creative Abilities also had a separate staff communication book.

30. In response to the provisional opinions, Creative Abilities advised that the reason it did not transfer all communications between Mrs B and staff into the formal care plan was that Mr A spent 60% of his time at home, and because it would not have been practicable, as there were "copious" notes and communications. Creative Abilities noted that the communication book was kept at Mr A's residence, and staff read the communication book during each shift, often commenting and writing in it themselves. Creative Abilities stated:

> "Whilst all staff are aware of the requirement to read the communication book, in hindsight, we should not have relied solely on staff reading and following the communication book when it came to important instructions impacting upon ongoing care."

31. Creative Abilities stated that it has now introduced a system whereby staff need to sign to demonstrate that they have read the communication book and that all critical information has been transferred into the care plans.

Care plan documentation

32. Creative Abilities stated that Mr A's care plan included a document entitled "All About Me" and separate day-time and night-time care plans. It also stated that Mr A's "Health Passport" (see paragraph 17 above) was added to the "All About Me" document. In response to my second provisional opinion, Creative Abilities said: "[A]lthough our Care Plans are made up of separate documents, they are all kept in the single client file for ease of access …" Creative Abilities further advised that the approach to care planning had been audited previously under Standard NZS 8134.1.2:2008 and had always been deemed to be sufficient.

All About Me

33. The "All About Me" document contains relevant information about each client's needs. It includes sections (amongst other things) for dietary needs, daily living, equipment, medication, and risk management. In addition, the document contains basic information about Mr A's specific needs, including communication, personal care needs and how he slept.

34. Mr A's "All About Me" document was last updated 14 months prior to his death. In response to the first provisional opinion, Creative Abilities said that this document was due for update two months prior to Mr A's death, but it had not been updated because the staff member who had been responsible for the reviews had resigned.

35. In relation to Mr A's wheelchair, the "All About Me" document states that he needed to have his seatbelt on and neck brace in place when travelling. The head strap was not to be worn when travelling.

36. The key risks listed for Mr A were seizures, boredom/challenging behaviour, his PEG feeding tube coming out, and pressure areas developing.

Care plans

37. Mr A's morning care plan (undated) details his day-time medication regimen and PEG feeding schedule. It also records that in the morning, Mr A was to be placed on the toilet for 10–15 minutes before being dressed and his PEG set up and his teeth brushed. The care plan has handwritten changes, eg, the times and rate of feeding, and does not contain any other information about Mr A's personal care needs, including how and when he was to be showered, his toileting needs for the rest of the day, or how his skin integrity was to be maintained.

38. Mr A's night-time care plan (undated) details his night-time medication regimen and sleep system. The sleep system is illustrated by two photographs. In response to the "information gathered" section of my first provisional opinion, Mr B told HDC that the night-time care plan was supplied by him prior to Mr A moving into the House. Mr B said: "We had expressed our concerns about the importance of his night care and [I] offered to put the plan in writing. [I] wrote it, [and] took appropriate photos to show how [Mr A] should be positioned." Mr B said that when Mr A first moved in to the House, he placed a copy of the night-time care plan on the wall of Mr A's room. Creative Abilities advised that Mr A's night-time care plan and sleep system were clearly illustrated with photographs on the wall in his bedroom.

39. Mr A's occupational therapists developed a sleep system for Mr A. The night-time care plan states: "[Mr A] has difficulties with breathing when he is lying down and needs to sleep in the recovery position." The night-time care plan notes that Mr A would usually wake up between 2am and 3am (sometimes earlier), and required that Mr A be transferred to his wheelchair when awake. Mr B told HDC that if this did not happen, "he would wiggle onto his back and obstructive apnoea would kick in and he wouldn't be able to breathe". There was a baby monitor in Mr A's room and in the lounge, but the night-time care plan does not mention how and when the monitor should be used at night.

40. The night-time care plan also required that when Mr A was in his wheelchair, his feet needed to be strapped to the footplate, and his shoulder harness also needed to be on.

41. The night-time care plan details that half an hour before getting Mr A up for the day (approximately 5am), he was to be transferred back to his bed with the bed raised to 30–40 degrees at the head end with a pillow under his head and shoulders. The night-time care plan states: "He will be OK in this position but if he moves around he may have to be repositioned. He needs to be checked frequently." The night-time care plan does not explain what "frequently" means, and this is not noted anywhere else.

42. During the night, the caregiver was required to check high-needs clients, and sign on an "Hourly Client Checklist" to confirm that this had been done. The checklist has space underneath each hour (11pm, 12am, 1am, 2am, 3am, 4am, 5am, and 6am) for the caregiver to sign to confirm that a client has been checked. In response to the first provisional opinion, Creative Abilities said that it was communicated at team meetings that the hourly checks meant "more than just the hourly 'signed checks' especially when [Mr A] was awake and transferred to his wheelchair at night". In response to my second provisional opinion, Creative Abilities stated: "The hourly recording process we had in place was for the sole purpose of monitoring of our night time staff. It was not in any way the expected level of monitoring required for [Mr A]. All night time staff at [the House] were very aware that [Mr A] needed to be checked more frequently than the hourly checks and this was noted in the care plan documents."

43. There was also a "Sleep Record" form, on which to record Mr A's sleep pattern. Each night, the caregiver was required to record how long Mr A slept in his bed and in his wheelchair.

44. Creative Abilities had a separate form entitled "TFM Sheet for [Mr A]", which was used to record his daily food and medication requirements as administered throughout the day, and a "High Needs Client Care Sheet" which was used to record his bowel and urine output, drinks and food administered, and any seizure activity or skin integrity concerns. Creative Abilities also provided a separate "Skin Integrity Assessment Monitoring Form" which was used by staff to record any concerns about Mr A's skin integrity.

45. Short-term care plans were also used for short-term medical issues, eg, wounds or rashes, and medication, eg, antibiotics. In response to the first provisional opinion, Creative Abilities submitted that Mr A's care plan contained up-to-date information, as four short-term care plans were completed during the 14 months Mr A was in residential care. Creative Abilities also had an "Emergency Procedure if Feeding Tube Falls Out", a "Seizure Prococol for [Mr A]", and a "Support Information Record", which contained his basic health information should he need an emergency admission to hospital. The care plan folder also included information sheets on sleep apnoea and PEG feeding.

46. In response to the first provisional opinion, Creative Abilities submitted that Mr A had a detailed care plan that had input from Mr and Mrs B. Creative Abilities accepts

Names have been removed (except Creative Abilities and Associates Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

that Mr A's care plan did not contain detailed information about how to shower Mr A, but it stated that this was discussed at house meetings and in the communication book. Creative Abilities said that all staff were in the habit of reading the communication book each shift, but it acknowledged that the staff did not always sign to say they had done so (see paragraphs 30 and 31 above).

47. Creative Abilities also submitted that a number of their caregivers have English as their second language, and that it "continuously emphasised all crucial information regarding [Mr A's] cares verbally during house meetings …".

Rehab Services information

48. This section of Mr A's care plan contained further information about PEG feeding, illustrated instructions for giving him thickened drinks and tastes of food, aspiration management, and communication.

Wheelchair straps

49. In the care plan documentation, no document records in one place how Mr A should have been strapped into his wheelchair. In response to the first provisional opinion, Creative Abilities submitted that there was full information about the use of Mr A's wheelchair in appropriate places in his care plans. The "All About Me" form states that his seatbelt and neck brace were to be worn when travelling. His night-time care plan records that his feet and shoulders were to be strapped after he was transferred out of bed and into his chair. However, the day-time care plan does not specify whether wheelchair straps were to be worn during the day.

50. Mrs B said that on a number of occasions Mr A's head had become stuck behind his wheelchair headrest, so they had put a note in the parent communication book instructing staff to put the neck brace[12] on Mr A when he was in his wheelchair. Mr B said that this was a mandatory requirement, and that they also informed Mr F of this. There were three entries in the communication book by Mrs B in relation to the neck brace, with the last entry written about a week prior to Mr A's death. Mrs B wrote that the neck brace should be used when Mr A's head was floppy or when nobody was around to watch him. She did not record that the neck brace had to be put on at all times when Mr A was in the wheelchair.

51. Creative Abilities interviewed its staff about the neck brace. No caregiver understood that using the neck brace was a mandatory requirement as suggested by Mrs B. Mr F knew that the neck brace was to be used for transporting Mr A, and for when Mr A was unsettled, but he said that he was not aware that Mr and Mrs B had asked that Mr A always have it on when in his wheelchair.

52. In response to the second provisional opinion, Mr C said that in his view the documentation in the care plan regarding how Mr A should have been strapped into his wheelchair was not clear.

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[12] Also referred to in the communication book as the "neck collar" or "collar".

Creative Abilities' policies

53. The "Values and Expectations" manual (undated) provides (amongst other things) the following:

> "1.12 House and Company Meetings
>
> On the last Friday of each month there is a Company Meeting held … Attendance at this meeting is compulsory unless you have been directed to cover client care in a house. These meetings are very important as they also incorporate training and information sharing that is vital for your role.
>
> Once a month each house holds a House Meeting … if you hold a permanent shift in a house you must attend that House Meeting …
>
> …
>
> 1.19 Performance Assessment and Feedback
>
> Creative Abilities are committed to providing you with feedback regarding your performance … You will receive feedback on your performance during One-on-One and Supervision meetings, as required during the course of your employment, and through the annual Performance Appraisal process."

54. Creative Abilities' Recruitment, Selection and Rostering Policy provides:

> "An employee can only work in a house after receiving a house/client specific induction and after completing a training shift with the House Team Leader or other experienced team member."

55. The "House Manual" includes (amongst other things) policy statements on house duties, administration of medication, the emergency procedure for a feeding tube, guidelines for first-time seizure, and aspiration management.

Mr C

56. Mr C is a qualified caregiver, having obtained Level 3 Community Services Support from Careerforce.[13]

57. Mr C was employed by Creative Abilites for several years. He told HDC that he has worked in the healthcare sector since 2002.

58. Mr C advised HDC that, in his view, clients like Mr A with such complex medical conditions need a nurse or doctor to look after them, and he did not think he was qualified enough to do so. Mr C stated: "I personally had little understanding about [Mr A's] conditions. All I knew and that was emphasized in every house meeting that

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[13] Careerforce is New Zealand's Health and Community Support Services Industry Training Organisation. Careerforce qualifications are designed specifically for trainees who are working or volunteering in health, aged support, mental health, disability, social services, youth work, cleaning and urban pest management.

we had every month at the Centre was the ‘Apnoea’ condition.” Mr C said that he received very little training from Creative Abilities on working with Mr A.

59. In relation to his training, Mr C stated:

a) He had one night’s induction before working with Mr A on the night shift at the House.

b) He had training at the Centre on how to put Mr A in a standing frame and how to use the PEG feeding tube.

60. Creative Abilities kept a “Training Timetable”, which recorded what training was provided to each staff member about Mr A’s care. The Training Timetable records that on four occasions, Mr C received training on Mr A’s care at the Centre by the Centre Training Coordinator. The Training Timetable records that shortly after Mr A’s admission, Mr C was inducted into the night shift (how to care for Mr A at night) by Mr F.

61. In response to the first provisional opinion, Creative Abilities said that part of the four days of training Mr C received at the Centre included how to care for Mr A overnight. Creative Abilities told HDC that Mr C never told it that he was not comfortable caring for Mr A.

62. In an interview with Creative Abilities following Mr A’s death, Mr C said that the most recent training he had about caring for Mr A was around six weeks prior to Mr A’s death. Mr C said that topics included using the hoist and standing frame, and PEG feeding. Mr C was asked in that interview whether he felt knowledgable about what he was required to do as a night shift worker at the House. Mr C said: “I think in general I was [and] I was feeling confident there.” He said that he felt well supported by the Team Leader (Mr F).

63. However, in response to the second provisional opinion, Mr C said that he did not receive an adequate level of training “proximate to and specific to the needs of [Mr A]”. Mr C stated that not long before the incident he had advised his employer that he did not feel confident enough working at the House, and asked to work less shifts. He said: “These requests were not taken on board by the employer.”

Other training — Mr C

64. Creative Abilities’ training record for Mr C shows that he attended between one and three training modules each month during his employment. The training sessions covered a range of topics, and included vital signs, abuse and neglect, safe administration of medication, manual handling, and pump feeding. Creative Abilities advised that most recently, about two weeks prior to Mr A’s death, Mr C had been shown a PowerPoint presentation on vital signs. Mr C had also completed a first aid course in mid 2012, which was valid for two years.

House meetings

65. In accordance with the Values and Expectations Manual, house meetings were held once a month at the House. All caregivers with permanent shifts were required to attend unless they were working a shift at the time of the meeting.

66. The following is a list of meetings at which Mr A was discussed and Mr C was present:

a) In late 2012, Mr C attended a house meeting where Mr A's care was discussed. The Training Timetable recorded: "[Mr F] stated that [Mr A] is very happy; he is always laughing and giggling." There was a discussion about how to shower Mr A. It is also recorded that Mr F checked with staff whether or not they were confident operating Mr A's feeding pump.

b) In early 2013, Mr C attended a house meeting. The Training Timetable recorded that Mr F checked with staff if anybody wanted to be shown how to clean Mr A's wound (at the PEG insertion site). They also discussed cleaning Mr A's wheelchair, and how to position him in his standing frame. Training was provided on PEG insertion.

c) In mid-2013, Mr C attended a house meeting. Issues with Mr A's PEG feeding were discussed, and training was provided on Creative Abilities' new After Hours Support Policy.

d) In late 2013, Mr C attended a house meeting where Mr A's care was discussed. The training topic was "Zero Tolerance to Abuse and Neglect".

e) About two weeks prior to Mr A's death, Mr C attended a house meeting. Training was provided on vital signs. It was recorded in the Training Timetable that "[Mr A's] mum thanked the team for taking good care of [Mr A] while she was away".

67. There were seven other house meetings where Mr A's care was discussed that Mr C did not attend. For example, in mid-2013, details about Mr A's skin integrity and the arrival of new equipment/care aids was discussed. The training record from this meeting notes: "Night shift please before changing [Mr A] allow [Mr A] to be on this [the new shower chair] to encourage his bowels to move and to get in to a routine … [Mr A's] mum has asked for the team not to tilt the chair forward … [Mr A's] mum has acknowledged that the [neck] collar can be left on even when in bed or on the floor when left on at night use [neck] collar if head down."

68. Ms D told HDC that if a staff member was not present at a house meeting, that person could complete the training provided at another house meeting or at the Centre. She said that each staff member was provided with a copy of the meeting minutes, and they signed the minutes to confirm their understanding of what was discussed. If they did not understand, additional training would be provided at the relevant house or the Centre. Where a particular client was discussed at a house meeting, this was also recorded in the Training Timetable for that client.

69. In response to the first provisional opinion, Creative Abilities said that every team member who missed a house meeting was expected to obtain the electronic copy of the meeting minutes and read them. It stated that this is its company policy, and that this is explained to staff during their induction. However, in response to the second provisional opinion, Creative Abilities stated that it "provide[d] any relevant information [Mr C] may have missed at house meetings in his one-on-one monthly meetings with his supervisor … [a]s well as during regular staff interactions during the course of his working day".

70. There are no written records of these discussions, or that the information discussed at the house meetings Mr C missed was provided or obtained by him, or whether or not he received the training provided at a later date.

71. In response to the second provisional opinion, Mr C said that generally he worked only one night a week in the House. He stated: "It is not accepted that the level of passing on of information and specific requests involving the care of [Mr A] was passed on to [him] in the manner described by the Team Leader."

Performance appraisals

72. In response to the first provisional opinion, Creative Abilities stated that Mr C received a formal performance appraisal each year since commencing his employment. HDC was provided with copies of four of Mr C's performance appraisals. Creative Abilities was unable to locate three of Mr C's performance appraisals. From the date entries in one of the documents, it appears that some concerns were raised in Mr C's two most recent performance appraisals regarding Mr C's timekeeping, documentation, and communication. Creative Abilities told HDC that "if there are specific performance issues that have been identified through the appraisal process, positive or negative, then a goals sheet is put together …".

73. Only one goal sheet was provided to HDC. The goal sheet is undated but records that the three items listed were achieved by early 2013.

74. The performance appraisals are not signed or dated except for an "Appraisal form" dated late 2010 and a "2013 Performance Appraisal Summary" form that is dated late 2013.

Supervision

75. In response to the first provisional opinion, Creative Abilities provided HDC with documentation relating to Mr C's supervision.

76. Creative Abilities told HDC that Mr C had monthly one-on-one supervision meetings, and that he never raised any confidence issues about caring for Mr A during the meetings. Creative Abilities provided meeting notes from Mr C's supervision meetings for the period mid 2011 to late 2013.

77. There are four sections in the meeting notes: "Follow ups from previous One2One/Action points/KPI's", "Client related issues", "Training opportunities requested/offered" and "Any other issues". Follow-up actions are recorded as

"Leadership training", and "Careerforce level 4" (on four occasions), otherwise "all good" or "none" is recorded. Under "Client related issues" either the box is left blank or "no issues" or "none" is recorded. The one exception is mid 2013, where Mr F recorded that Mr C would like to ensure proper handover from staff. "Leadership training" and "Careerforce level 4" are also recorded on five occasions in the "Training Opportunities" section. Four meeting notes record that Mr C is happy to work or that he loves his job. No other issues were recorded. Each meeting note was signed by Mr F and Mr C.

78. On one occasion in mid 2013, the meeting note contains a detailed record of a one-on-one meeting between Mr C and Ms D. In the "Any other issues" section, Ms D recorded: "Hours — working a lot — permanent 5 night shift. Very good on picking up extra. Wants to go on holidays. Why working extra hours." However, the meeting note is unsigned.

79. The meeting notes do not record whether or not the concerns raised in Mr C's performance appraisals about his timekeeping, documentation, and communication, were discussed at any of his monthly supervision meetings.

Roster

80. Ms D told HDC that the maximum number of hours a caregiver could work was 55 hours a week, including sleepover shifts.[14] In response to the first provisional opinion, Creative Abilities said that "staff do not work additional hours to their base rosters except during times of very short notice absences". It stated that its policy is that vacant shifts can be picked up only by staff who have been fully trained and inducted into care for specific clients. However, in response to the second provisional opinion, Creative Abilities said that the 55 hours per week limit was introduced only after Mr A's death, and was not part of its roster requirement prior to 2014.

81. Creative Abilities told HDC that effective roster management for high needs clients is a sector-wide issue. It stated: "Finding appropriate staff at short notice becomes particularly difficult when the clients needing support have high and complex needs. These shifts cannot be filled by casual staff or other staff who do not have client specific training …"

82. Creative Abilities told HDC that Mr C's permanent roster was five "awake" night shifts per week, and that occasionally he picked up vacant shifts. Mr C often worked double shifts, ie, from 11pm to 7am followed by 7am to 3pm.

83. The number of hours worked by Mr C for the six weeks prior to Mr A's death are listed in the table below:

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[14] See above footnote 11

Names have been removed (except Creative Abilities and Associates Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Hours worked by Mr C			
Dates	**Base roster**	**Additional**	**Total hours worked**
Week 1	51	24	**75**
Week 2	42	0	42
Week 3	41	8	49
Week 4	42	17	**59**
Week 5	34	31	**65**
Week 6	42	16	**58**

84. In the six weeks prior to Mr A's death, Mr C exceeded 55 hours for four out of the six weeks. In response to the first provisional opinion, Creative Abilities accepted that the hours worked by Mr C were excessive.

85. Creative Abilities submitted that Mr C had "sufficient sleep opportunity in the days prior to [Mr A's] death" due to the timing of his shift. Creative Abilities said that as Mr C finished his shift at 7am and did not commence his next shift until 11pm the following day, he had "more than adequate opportunity to be well rested when he began his shift on the night of [Mr A's] death".

86. Creative Abilities also submitted that during this period it experienced an abnormally high number of short notice absences, and that it "had no option but to refer those additional shifts to [Mr C]". Creative Abilities stated that "there was no one with the specific training for the individual houses, [and] it is Creative Abilities' policy that only staff that have been inducted into a specific house can pick up additional shifts to make sure they are proficient in the needs of the clients in the house".

87. Creative Abilities further advised that although it has a small pool of casual staff who are trained and available to step in at short notice, it struggled to have more than one casual trained with its very high needs clients, and had tried utilising nursing bureau skilled staff, but considered that that had not brought about best practice.

Previous occasion found sleeping on job

88. During a spot audit in late 2013, Mr C was found asleep at the House at 3.15am. Mr B told HDC that Mr A was staying at the House that night and he (Mr B) was not informed about this incident until after Mr A's death.

89. In a letter to Creative Abilities, Mr C stated:

> "In the night of [date], Auditors came to carry out the usual routine inspection and they knocked on the front door but because I was in the far end room, I was unable to hear them. During the night I felt sick and very exhausted … Unfortunately I fell asleep and when the inspectors came I was unable to hear them … I would like

> to apologise for what took place at that night … This could have put clients in danger. I will make sure that I always ring the after hours and emergency number in the future shall a similar situation happen again.”

90. The meeting notes from Mr C’s monthly supervision meetings on two occasions in late 2013 do not reference any follow-up action plan regarding this incident or whether or not the issue was discussed at these meetings. Similarly, Mr C’s performance appraisal for 2013 does not mention the issue. However, Creative Abilities states that “[t]he incident was not included in his appraisal because it happened after the company-wide appraisal programme took place, [and] it would have been included in 2014 if [Mr C] had remained with Creative Abilities”.

91. Creative Abilities said that Mr C was given a final written warning following the audit incident, and he was told that he was unable to pick up any additional shifts. However, Ms D told HDC that Mr C was not stopped from picking up additional shifts, although he was stopped from picking up double shifts (eg, 11pm to 7am followed by 7am to 3pm). Ms D said: “[T]o my knowledge we monitored [Mr C] to make sure that he wasn’t doing too many shifts but we made sure that he wasn’t doing the sync shifts, the same double shifts.” However, Mr C’s roster shows that on two occasions in the approximately two weeks prior to Mr A’s death, Mr C worked double shifts on the following days:

a) From 11pm to 7am (House 2)[15] and then from 9.30am to 3.30pm; and

b) From 7am to 3pm (House 2) and then from 10pm to 3pm (two shifts at House 3),[16] followed by another shift from 11pm to 7am (House 2).

Evening shift – events leading to Mr A’s death

92. The evening shift is from 3pm to 11pm. Mr F and Ms G, caregiver, were rostered on at the House that evening.

93. Ms G told HDC that there were always two caregivers rostered on the evening shift at the House. She said that the two caregivers would always attend to Mr A’s personal care needs. Ms G also stated that when Mr A was being showered by the two caregivers on the shift, “We had to rush, be very quick and one would hold him and one will do the cleaning …”

94. Mr F stated: “You needed to be like very keen and observant with his care.” He emphasised in his interview with HDC that someone needed to be with Mr A when he woke up as he would become very agitated. Mr F stated that when Mr A was agitated he would perspire a lot.

95. In an interview with HDC, Ms G stated that she observed nothing unusual with Mr A that evening shift except for the amount of saliva he was dribbling. She said that they had to change his t-shirt and the flannel on his chest (which was soaking up the

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[15] A Creative Abilities residential home.

[16] A Creative Abilities residential home.

saliva), and both were very wet. However, she also said that it was normal for Mr A to dribble saliva.

96. In the timeline included as part of Creative Abilities' internal investigation report, it records at 9.30pm: "[Ms G] sees that [Mr A] is getting agitated. He is sweating above the waist and he has a lot of saliva, and his shirt is wet. She points it out to [Mr F]. [Mr F] and [Ms G] change [Mr A's] shirt. [Ms G] opens the lounge door to cool [Mr A] down. [Mr A] relaxes after this is done."

97. Mr F told HDC that the only thing that was unusual from the evening shift was that Mr A was perspiring a lot. However, Mr F also noted that it was quite normal for Mr A to perspire.

98. Ms G said that at handover to the "awake" night shift, the only thing she informed Mr C about was the amount of saliva that Mr A had been dribbling.

Night shift

99. Mr C was the sole caregiver on duty on the "awake" night shift. He was required to look after four complex clients, including Mr A. The night shift is from 11pm to 7am, and the duties include:

a) Read and sign the House Diary (staff communication book).
b) Handover with the team member(s) going off duty.
c) Read the care plan for each client.
d) Carry out a complete security check.
e) Complete hourly checks and sign immediately that this has been done.
f) Attend to all client needs.
g) Prepare food for the next day.
h) Clean all wheelchairs thoroughly.
i) All equipment to be put on charge (eg, wheelchair batteries).
j) Ironing.
k) Complete all other area specific duties (eg, cleaning windows/blinds).
l) Any medication administered to be signed and dated on relevant documentation.
m) Complete all required paperwork.
n) Handover with team member(s) coming on duty.

100. Mr C said that at the House he also had to put out the rubbish bins, change the clients' incontinence pads twice (or as required), sweep and rearrange the garage, clean all the windows, and dust the living room area.

101. Mr C stated that he started his shift at 11pm, and Ms G handed over from the evening shift.

102. At approximately 11.10pm, Mr C transferred Mr A to his bed. Mr C told Creative Abilities that at approximately 11.30pm, he read Mr A's care plan.

103. As noted above, an Hourly Client Checklist is required to be completed for each client with complex needs (including Mr A). Mr C signed on the checklist that he checked

Mr A every hour. However, in his interviews with Creative Abilities, he gave different times that he checked Mr A. They are as follows:

a) In one interview following Mr A's death, he said that he checked Mr A at 4.15am and 4.45am, and also followed the Hourly Client Checklist, although he filled in the last part of the checklist after 7am because of the subsequent events.

b) In his next interview, he said that he checked Mr A at 11pm, 11.10pm, 2am, 2.30am, 3.40am, 4.30am, and 5.03am. He said that he did not check Mr A between 11.10pm and 2am. During this interview, Mr C stated: "Yes I do stick to the routine of one hourly check but sometimes you may even go there not on top of the hour …" Mr C explained that he would often have to assist clients at various times during the night, which meant that sometimes he could not check each client on the hour.

104. In response to the second provisional opinion, Mr C stated that he completed the Hourly Client Checklist to show that he checked on Mr A during the night. He said that the checklist did not provide the ability to note the actual times of the check and referred only to the hour. He said the training he received from Creative Abilities was merely to indicate whether the client was asleep with the notation ASL or awake. Mr C said that he filled in the entries for 11–4am prior to Mr A having breathing difficulties and the incident that led to the ambulance being called.

105. Mr C's lawyer further submitted with regard to the differences in Mr C's accounts:

> "The manner of the questioning of [Mr C] in separate interviews by his employer concerning check times and the checklist timesheet accounts for evidence of conflicting times. It is understood [Mr C] was not shown the checklist during the interviews when questioned on this subject matter.
>
> It is submitted that the questioning of [Mr C] in relation to timing is not done in an orderly fashion and is confusing. It is further submitted it would be difficult for any person to remember times exactly when there is no provision in the checklist to record the actual times, and they are not shown the checklist during the interview process."

106. Mr C told Creative Abilities that Mr A was awake at around 3.15am/3.30am, and that he left him in bed for a little while. Mr C said that at this time Mr A's breathing was a bit noisy on his back, he was sweating a lot, and he was having saliva secretions (which Mr C said was not unusual). Mr C then transferred Mr A into his wheelchair. Mr C stated that he did not put on Mr A's shoulder harness when he put Mr A into his wheelchair,[17] and did not put on Mr A's neck brace, as he understood that this was for travelling only.

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[17] As noted above, Mr A's care plan required that his shoulder straps be put on when he was in his wheelchair at night.

107. Mr C said that he went into Mr A’s room just after 5am to prepare his personal cares. He moved Mr A from his wheelchair back to his bed, and positioned him on the bed, with his head elevated at the top of the bed. When asked whether Mr A’s head was on the pillow, Mr C replied, “No, the pillow was not there.” Mr C told Creative Abilities that the pillow was with the duvet, which was further down the bed. He said that Mr A was not covered by the duvet.

108. Mr C also said that it was normal for Mr A to have a lot of saliva, but that on this morning, he had “unusual saliva secretions. Thicker than normal and a bit foaming.”

109. In his written response to HDC,[18] Mr C stated that Mr A’s breathing difficulties started while he was on his bed, and not in his chair. Mr C said that he went to the ensuite bathroom to wet the flannel and, when he came back, Mr A had moved so that he was diagonal on the bed, and he was struggling to breathe.

110. Mr C said that he tried to move Mr A back into position (lying straight on the bed), but Mr A’s breathing difficulties worsened, and he stopped breathing.[19] Mr C said in an interview with Creative Abilities: “He was like rolling the eyes and his face was like pinkish, reddish with a lot of sweating … He had the thick saliva, having difficulty to breathe.” In another interview with Creative Abilities, Mr C said that Mr A was “shaking”, and he used the word “seizure” to describe how Mr A was acting.

111. Mr C called 111 and spoke to a call handler. The ambulance service told HDC that a call was received by the communication centre at 5.21am. The call handler was advised that a 19-year-old male was unconscious and not breathing. Below is an excerpt of Mr C’s 111 call transcript:[20]

Call handler	OK, tell me exactly what has happened?
Mr C	The client was in bed and I was about to get him ready and give him a wash and get him up.
Call handler	Yes.
Mr C	You know he’s got apnoea and just like a stopped breathing. You know the way they choking and just like stopped breathing.
… **Call handler**	… Is he awake?

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[18] Dated 25 March 2014.

[19] In an interview with Creative Abilities, Mr C said that Mr A stopped breathing 4 to 5 minutes after he commenced CPR.

[20] HDC was provided with the digital file of Mr C’s 111 call and had it transcribed.

Mr C	No — no, no. He is not responding at all.
Call handler	Is he breathing?
Mr C	No.

112. Two ambulances were dispatched at 5.23am. The call handler told Mr C to take Mr A off the bed and to put him on the ground. Under the guidance of the call handler, Mr C performed CPR until the ambulances arrived at 5.33am. The ambulance service told HDC: "On arriving at [Mr A's] room the crew found [Mr A] lying on the floor with a caregiver performing CPR on him. The crew report that the caregiver had been preparing a shower for [Mr A] and on returning to the room found [Mr A] in his chair not breathing."[21]

113. In the staff communication book, Mr C wrote: "[Mr A] was sweating and having excess saliva secretions overnight. At 5am while about to start his personal cares, he stopped breathing and became unconscious. I rang the ambulance and the person on the call instructed me to give CPR until the ambulance arrived. They took over and took him to hospital around 6.15am."

114. Mr C stated that the paramedics were searching for basic information about Mr A, but they could not locate the information in Mr A's folder. Creative Abilities told HDC that all of Mr A's information was at the House.

115. A statement written by registered nurse (RN) H from Creative Abilities said that at 5.44am he received a call from Mr C saying that Mr A "was breathing weak and seemed dying". RN H said that Mr C called again at 6.08am to ask Mr A's weight, and again at 6.17am to say that Mr A was on his way to hospital. RN H stated that Mr C said that Mr A had been revived but that his pulse and breathing were very weak. RN H then made several attempts to contact Mrs B, and advised her to go to hospital immediately.

116. At 6.30am, RN H arrived at the hospital. He contacted Mr F and asked him to come to the hospital. RN H tried to call Mrs B again, but she did not answer, so he assumed she was driving. RN H then called Mr B, who happened to be an inpatient at the hospital at the time.

117. At 7.20am, Mr F arrived at the hospital. At 7.40am, Mrs B arrived. Mrs B thought that Mr A had gone to hospital because his PEG had come off. RN H stated that he did not give Mrs B the details of Mr A's condition when he called her because he was uncertain, as the information he had received was very unclear.

118. At 8am, the tube assisting Mr A to breathe was removed, and he died a short time later.

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[21] However, as noted above, Mr C told the 111 call handler that Mr A went into breathing difficulties on the bed and not in his chair.

Incident report form

119. Mr C completed an incident report form on the morning of the incident. He recorded that the incident occurred at 5.05am. He wrote: "[Mr A] was sweating and having excessive saliva secretions overnight. At 5am while I was about to start his personal cares, he stopped breathing and became unconscious …"

Creative Abilities internal investigation

120. Following Mr A's death, Creative Abilities undertook an internal investigation. Mr C was interviewed by Creative Abilities seven times in less than five weeks. Two of the seven interviews were rescheduled shortly after commencing, and do not include substantive information about the events.

121. Creative Abilities identified a number of concerns in relation to the actions by Mr C on the night of these events. These included not adhering to the Hourly Client Checklist, entering incorrect information into the Hourly Client Checklist, and not putting on Mr A's shoulder strap. Following a formal disciplinary process, Mr C resigned.

122. The investigation report identified a number of inaccuracies and/or inconsistencies in Mr C's accounts. However, the report concludes that Mr A may have been more susceptible than usual to a compromised airway (as Ms G had noted a high volume of saliva secretions during the afternoon shift), and may possibly have aspirated and choked suddenly.

123. Ten days after Mr A's death, a manager at Creative Abilities visited Mr and Mrs B to update them on Creative Abilities' internal investigation. Later, Creative Abilities leadership personally delivered a copy of the internal investigation report to Mr and Mrs B.

Changes made

124. Following this incident, Creative Abilities made the following changes to its service:

a) Introduced a thumb print recognition system (Zambion) to enable its staff to clock in every hour during an "awake" night shift. It will also alert the Residential Team Manager to any staff attempting to pick up a double shift.

b) Changed its incident reporting procedure so that initially the forms go to the Social Services Manager for review before the Operations & Quality Manager.

c) Removed the "What Happened Today" forms and replaced them with client journals to encourage one-on-one time between the caregiver and client.

d) Amended its After Hours Manual from being a number of written paragraphs to a series of flow charts.

e) Introduced a new handover process, which includes a requirement to report any incidents to the Centre Manager during the day.

f) Made Level 3 Careerforce compulsory for all Team Leaders.

g) Introduced parent approved training guides.

125. The investigation report also made a number of recommendations, including:

a) Further training to staff about clients' care plans, use of the communication books, and filling in client forms.

b) Clear information sheets to be developed by the registered nurse for all clients with complex needs, and by the TM for all other clients.

c) Immediate baseline competence assessments to be conducted on all staff.

d) A "real time observation review" of all early morning shifts (5am–8am) at each residential home to identify any training needs.

e) Parents to be informed that all changes to care plans must be referred directly to the clinical team, not to house staff or office staff, to ensure that staff can be trained promptly and care plans updated.

f) Team Leaders to be provided with additional leadership training.

g) The CEO to develop a serious incident procedure manual.

Police investigation

126. The Police are considering Mr C's involvement in Mr A's death.

Further information provided by Creative Abilities

127. Creative Abilities advised that:

a) It is extensively audited by four separate external agencies, and all reports demonstrate that it has passed and does provide timely, appropriate and safe services from suitably qualified/skilled and/or experienced service providers.

b) Mr C had been providing night-time care to Mr A successfully for a period of over a year after his initial training regarding Mr A, so Creative Abilities considered that the events that took place could not be due to the level of initial training received by Mr C.

c) It does not accept that Mr C did not have sufficient understanding of Mr A's medical conditions other than his apnoea. Creative Abilities said that Mr C was provided with adequate one-to-one training, and received a full induction to caring for Mr A.

128. Creative Abilities also stated:

> "We, the management and staff of [Creative Abilities] were very disturbed by [Mr A's] tragic death. He was a lively member of not only [the House] but the entire Creative [Abilities] family and was loved by all. At the time of [Mr A's] death we apologised to the family and offered our support. This was again repeated when […] over 12 of [Mr A's] staff from [Creative Abilities] attended his funeral."

Responses to the first provisional opinion

Mr and Mrs B

129. A response to the "information gathered" section of the first provisional opinion was received from Mr and Mrs B. Where appropriate, that response has been incorporated into my report.

Creative Abilities

130. A response to the first provisional opinion was received from Creative Abilities. Where appropriate, that response has been incorporated into my report.

Mr C

131. Mr C did not respond to the first provisional opinion.

Responses to the second provisional opinion

Mr and Mrs B

132. A response to the "information gathered" section of the second provisional opinion was received from Mr and Mrs B. Where appropriate, that response has been incorporated into my report.

Creative Abilities

133. A response to the second provisional opinion was received from Creative Abilities. Where appropriate, that response has been incorporated into my report.

134. In addition, Creative Abilities advised that it has been audited regularly.

Mr C

135. A response to the second provisional opinion was received from Mr C. Where appropriate, that response has been incorporated into my report. In addition, Mr C submitted the following:

a) He "disputes the finding that he failed to place a pillow under [Mr A's] head and shoulders when he transferred [Mr A] back to his bed to perform his personal cares".

b) The interviews with Creative Abilities were affected by the nature of the questioning, the interview process, and his level of understanding (not being a native English speaker).

c) He was asked during his interviews about the positioning of the pillow at the time Mr A was in the bed, and it is unsafe to make a finding of fact that this equates to his not putting the pillow under Mr A's head and shoulders when he was moved into the bed.

Relevant standards

136. The New Zealand Health and Disability Sector (Core) Standards (NZS 8134.1.2:2008) published by the Ministry of Health state that the standards are to enable consumers to be clear about their rights, and providers to be clear about their responsibilities, for safe outcomes. NZS 8134 requires the following:

a) Consumers receive safe services of an appropriate standard that comply with consumer rights legislation.

b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner.

c) Services are managed in a safe, efficient, and effective manner which complies with legislation.

d) Services are provided in a clear, safe environment which is appropriate for the needs of the consumer.

137. NZS 8134 provides (amongst other things) the following:

"Standard 2.8	Consumers receive timely, appropriate, and safe services from suitably qualified/skilled and/or experienced service providers.
…	
Standard 3.5	Consumers' service delivery plans are consumer focused, integrated and promote continuity of service delivery."

Opinion: Introduction

138. At the outset, it is important to note that my role does not extend to determining the cause of Mr A's death. My role is to assess the quality of care provided to Mr A, and whether that care was provided in accordance with the Code. It is not my role to make findings of causation. Accordingly, the breach findings against Mr C and Creative Abilities should not be interpreted as having any implication as to the cause of Mr A's death.

139. Mr A had a right to have services provided to him with reasonable care and skill, and that minimised the harm to him. My concerns about the care provided to Mr A are set out below.

Opinion: Mr C

Introduction

140. Mr C was a qualified caregiver, having obtained Level 3 Community Services Support from Careerforce. At the time of events, Mr C had more than 10 years' experience in the health sector in New Zealand, and had been employed by Creative Abilities for several years. Mr C is no longer working as a caregiver.

141. Mr A stayed three nights per week at the House. Mr C was often the sole caregiver rostered on for the "awake" night shift when Mr A was staying overnight. Mr C was

solely responsible for Mr A and three other clients with complex needs during the night shift when Mr A died.

Factual findings

142. There are no other witnesses to corrobrate the exact sequence of events that occurred during Mr C's shift. Therefore, I must rely on the contemporaneous documentation and statements made by Mr C to establish what occurred. The evidence available to me is as follows:

a) The transcript of Mr C's 111 call at 5.21am.

b) Mr C's entry in the staff communication book on the morning of Mr A's death.

c) The incident report form completed by Mr C on the morning of Mr A's death.

d) Mr C's seven interview transcripts from the interviews conducted by Creative Abilities in the five weeks following the incident.

e) Mr C's written response to HDC dated 25 March 2014 and his response to the second provisional opinion dated 28 October 2015.

143. I note that there are a number of inconsistencies in the above evidence, including the times Mr C checked Mr A, what night-time duties he did, and when and how Mr A developed breathing difficulty.

144. Mr C was interviewed by Creative Abilities seven times in less than five weeks following the incident.[22] I consider that the frequency of interviews conducted by Creative Abilities may have contributed to the inconsistent reporting of the event by Mr C. I note that he has submitted that the interviews were affected by the nature of the questioning, the interview process, and his level of understanding (not being a native English speaker).

145. The evidence on which I place most reliance is the contemporanous records written by Mr C, and the information he provided to the 111 call handler at the time of the incident.

146. Therefore, based on my review of the evidence, I consider that, on balance, the following occurred:

a) Mr C transferred Mr A from his wheelchair to his bed at approximately 11.10pm.

b) At approximately 3.15am/3.30am, Mr A awoke and Mr C transferred him from his bed to his wheelchair. Mr C did not put on Mr A's shoulder harness.

c) At approximately 5am, Mr C went into Mr A's room to start preparing his personal cares, and transferred Mr A from his wheelchair to his bed.

d) Sometime between 5am (when Mr C entered Mr A's room to transfer Mr A from his wheelchair back to bed) and 5.21am (when the ambulance was called), Mr A experienced breathing difficulty.

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[22] Two of the interviews were terminated shortly after commencing.

e) At 5.21am, Mr C called 111 and spoke to a call handler. Mr C told the call handler that Mr A had apnoea and had stopped breathing. Mr C commenced CPR under the instructions of the call handler.

147. In the circumstances, due to Mr C's inconsistent accounts, and the absence of any witnesses who are able substantiate the events, I am unable to make a finding as to the exact times Mr C checked Mr A during the night, and the night-time duties that Mr C completed and when he completed those duties. I am also unable to make a finding as to whether or not Mr A sweated more than usual, and whether or not his saliva secretions were thicker and in a greater volume than normal.

Care provided – Breach

148. As stated below, I consider that Mr C did not receive adequate training about caring for Mr A. Despite this factor, I am of the view that Mr C is also responsible for failing to provide services to Mr A of an appropriate standard.

149. Mr C was aware of Mr A's care plan information. He told Creative Abilities that after putting Mr A to bed, he read Mr A's care plan. Mr A's night-time care plan stated that when he woke, he was to be transferred to his wheelchair because, if left on his back, he could experience breathing difficulties. Mr A's night-time care plan also recorded that his feet were to be strapped to the footplate and his shoulder harness put on when he was in his wheelchair.

150. When Mr C transferred Mr A to his wheelchair from his bed, he did not attach Mr A's shoulder harness. My expert, Ms Sandie Waddell, advised me that it was unacceptable practice for any caregiver to ignore the instructions in the care plan, and that this was a significant departure from accepted standards. I agree that this was unacceptable. Ms Waddell said further:

> "Given the high needs level of [Mr A] and the requirement to ensure he [was] properly positioned and supported adequately in his wheelchair to ensure his safety, any lack of adherence to these instructions would [have] pose[d] a risk to his safety."

151. Mr C said that at approximately 5am he transferred Mr A from his wheelchair back to bed, with the bed raised at the head, in order to perform his personal cares. When asked whether Mr A's head was on the pillow, Mr C replied, "No, the pillow was not there." Mr C told Creative Abilities that the pillow was with the duvet, which was further down the bed. He said that Mr A was not covered by the duvet.

152. In response to my second provisional opinion, Mr C submitted that he was asked during his interviews about the positioning of the pillow at the time Mr A was in the bed, which does not equate to his not putting the pillow under Mr A's head and shoulders when he was moved into the bed, and Mr C "disputes the finding that he failed to place a pillow under [Mr A's] head and shoulders when he transferred [Mr A] back to his bed to perform his personal cares".

153. I do not agree. In an interview with Creative Abilities, Mr C clearly asserts that, when Mr A was lying on the bed after 5am, the pillow was with the duvet, which was not covering Mr A. Mr C has never asserted that he placed the pillow under Mr A's head and shoulders as stipulated in the night-time care plan. On balance, I remain of the view that he did not place the pillow in this manner and am critical that this was not done.

154. Mr C said that he went to the ensuite bathroom to wet a flannel and, when he returned, Mr A had moved so that he was diagonal on the bed, and he was struggling to breathe. Ms Waddell advised:

> "What is clear from all the information reviewed is that any time [Mr A] was left on his back, there was the potential for breathing difficulties to occur. Given this, it is my view that [Mr A] should not have been left unattended **at all** during this time in the morning when he was having his personal cares attended to. All necessary equipment and supplies needed to have been prepared prior to his being transferred onto the bed from his wheelchair."

155. I agree with Ms Waddell that Mr C should have prepared all of the items he needed prior to transferring Mr A back to his bed to perform his personal cares. However, I note that Mr A's night-time care plan did not state that he could not be left unattended in this position, but rather that he should be checked "frequently".

Conclusion

156. Mr C failed to comply with Mr A's night-time care plan in that he did not attach Mr A's shoulder harness when he transferred Mr A into his wheelchair, and did not place a pillow under his head and shoulders after he transferred Mr A back to his bed to perform his personal cares. In my view, for these reasons, Mr C did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Creative Abilities and Associates Limited

Introduction

157. Creative Abilities and Associates Ltd (Creative Abilities), as a provider of disability support services, is responsible for providing services to its clients in accordance with the Code. In addition, Creative Abilities is certified to the New Zealand Health and Disability Sector (Core) Standards (NZS 8134.1.2:2008) and is also required to provide services that comply with those standards.

158. In my view, Creative Abilities had a responsibility to ensure that Mr A received appropriate and safe services from suitably skilled and experienced support workers. I note that Ms Waddell considered that Creative Abilities' policy documents were comprehensive, and its staffing levels were acceptable. However, I consider that there are several areas where the care provided to Mr A by Creative Abilities fell short of the accepted standard. I have set out those areas below.

Care provided — Breach

Care planning

159. Care plans are an essential tool for ensuring that clients' care requirements are kept up to date and are communicated to all staff involved in that client's care. It is the proper documentation of this process that ensures continuity of care. NZS 8134.1.2:2008 also requires that "[c]onsumers' service delivery plans are consumer focused, integrated and promote continuity of service delivery".[23]

160. Mr A's care plan was made up of separate day- and night-time care plans, a document entitled "All About Me", and his "Health Passport", which was added to the "All About Me" document in late 2013. In addition to these four documents, Rehab Services' documents contained further information about Mr A's PEG feeding, illustrated instructions for giving him thickened drinks and tastes of food, aspiration management, and communication.

161. Mr A's "All About Me" document included sections (amongst other things) for dietary needs, daily living, equipment, medication, and risk management. In addition to these sections, the document contained basic information about Mr A's specific needs, including communication, personal care needs and how he slept.

162. Mr A's day-time care plan contained details of his medication regimen and his PEG feeding schedule. The only mention of his personal care needs in this document was that Mr A should be placed on the toilet for 10–15 minutes before being dressed, his PEG set up, and his teeth brushed.

163. Mr A's night-time care plan (provided to Creative Abilities by Mr B) provided information about his sleep system and how he should be positioned, and his medication regimen. There was a baby monitor in Mr A's room and in the lounge, but the care plan does not mention how and when the monitor should be used at night. The night-time care plan stated that Mr A "need[ed] to be checked frequently", but it is not detailed in the care plan how frequently Mr A needed to be checked. Ms Waddell advised: "The use of a template to sign off hourly checks was not in my opinion, adequate for the level of monitoring required specifically for [Mr A] by night staff … given the information contained in the care plan … this is a significant departure from what would be viewed as an adequate standard of care." I agree with Ms Waddell that hourly checks were insufficient for Mr A, particularly in the early hours of the morning when he would wake up and would need transferring to his wheelchair. In response to my second provisional opinion, Creative Abilities also acknowledged that Mr A needed to be checked more frequently than hourly, and advised that the hourly recording process was in place for the sole purpose of monitoring the night-time staff.

164. Ms Waddell advised that the sleep system was explained clearly using photographic images, and that Mr A's PEG feeding information was also clear. However, there was little information in either the day-time or night-time care plans in relation to his

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[23] NZS 8134.1.2:2008 Standard 3.5.

personal care needs. Creative Abilities accepts that Mr A's care plan did not contain detailed information about how to shower Mr A.

165. In all the care plan documentation, there is not full information in one place regarding how Mr A was to be strapped into his wheelchair. In the "All About Me" document it is stated that Mr A's seatbelt and neck brace were to be worn when travelling. In his night-time care plan it is recorded that his feet and shoulder harnesses were to be strapped after he was transferred out of bed and into his wheelchair. In response to the first provisional opinion, Creative Abilities submitted that there was full information about the use of Mr A's wheelchair in appropriate places of his care plans. However, I note that Mr A's day-time care plan did not specify what straps were to be used during the day.

166. There was also little information about Mr A's medical needs. While I note that Mr C stated that at every monthly house meeting, Mr A's apnoea condition was emphasised, Ms Waddell stated that it was a significant concern that there was a lack of prominent alerts to identify Mr A's apnoea. She advised:

> "There was no information prominently displayed in an easy to understand format about his obstructive apnoea condition or what to do if he did have difficulty with his breathing. The only information about the condition is a generic fact sheet which would have been difficult to understand for anyone with no medical knowledge and extremely challenging to read for staff for whom English is a second language or who have any literacy challenges."

167. In response to my second provisional opinion, Creative Abilities said that its approach to care planning had been audited previously under Standard NZS 8134.1.2:2008 and had always been deemed to be sufficient. However, Ms Waddell advised me that it is not good practice to have the care plan spread over a number of different documents. She stated:

> "Staff should be able to access all relevant information in the care plan easily to ensure they have all information required to provide appropriate care. If a number of documents are used to make up that care plan — all relevant information should be transferred into a single care plan if it forms a part of the required information when caring for a client.
>
> … The most effective and efficient way to ensure appropriate care is provided is to ensure **all** information is included in the one care plan, including any short term plans in place for specific issues and any references to recent/relevant incidents or complaints. The care plan needs to be a living document that is easily accessed by all staff.
>
> A care plan provides guidance for staff in their daily activity with a client. If it is not easily accessed and in one place there will be the risk of gaps occurring in the information for those providing care. The care plan is the overarching document that coordinates and gives all relevant and timely information for each individual client."

168. I agree with Ms Waddell's advice and remain of the view that in relation to Mr A, having a number of separate documents for Mr A's care plan increased the risk of key information being missed by staff. I accept that it was appropriate to have separate day- and night-time care plans for Mr A due to his complex sleep arrangements. However, in relation to his day-time needs, I remain concerned that there were at least four documents (his day-time care plan, the "All About Me" document, his "Health Passport", and Rehab Services' information) that staff had to refer to in order to obtain full information about Mr A's needs.

169. As Mr A had complex needs, it was also important that his care plans contained up-to-date and detailed information for Creative Abilities staff to refer to. This was particularly important, as several different caregivers provided care to Mr A, at times in isolation with sole responsibility for his care.

170. In response to the first provisional opinion, Creative Abilities submitted that Mr A's care plan did contain up-to-date information, as four short-term care plans were completed during the 14 months that Mr A was in residential care. However, I note that short-term care plans have a different purpose from the care plan. Ms Waddell stated that a short-term care plan is commonly used to address a particular issue or consequence from an event, and will be used only specific to that event or issue, eg, the administration of antibiotics or wound management. However, the care plan is used to describe:

> "… the supports and/or interventions that are planned to achieve desired outcomes as identified in an ongoing assessment process which includes both long and short term goals over a longer period of time. This will also incorporate all relevant information if more than one agency, or as in this instance, family members are involved in providing supports to the client."

171. The parent communication book often contained instructions to staff about the use of Mr A's wheelchair and his other equipment, his feeding requirements, changes to his personal care needs, and any other concerns. However, Creative Abilities did not add any of these changes to Mr A's care plan. Ms Waddell stated:

> "In my experience, the use of the communication book is generally seen as a very important part of the communication between a parent and an organisation caring for a family member. It would be seen as especially important in this instance where [Mr A] was not full time at the house and spent a number of nights at home with his family. It usually becomes an important written link to keep both the family and the organisation aware of any changes in the needs of a client and to ensure all information is current.
>
> It appears the use of the communication book was not used in this way and much of the communication took place verbally. It is my view that the written communications in the book by the parents were not seen as important enough to be shared with all staff and no information about the use of the neck cushion had been noted in the care plan. The fact that nothing had been added into the care plan after these written communications, even if they were shared with staff, is not

> reflective of good practice and would not be viewed as such in the wider sector. The response by Creative Abilities would be seen in my view as a significant departure from accepted practice, given the safety aspect of the communications that were entered into the book. It demonstrates a lack of effective communication systems in place at the time."

172. In response to my provisional opinions, Creative Abilities stated that the reason it did not transfer all communications between Mrs B and staff into the formal care plan was the fact that it was not practicable, as there were copious notes and communications, and because Mr A spent 60% of his time at home. However, Creative Abilities noted:

> "Whilst all staff are aware of the requirement to read the communication book, in hindsight, we should not have relied solely on staff reading and following the communication book when it came to important instructions impacting upon ongoing care. To enforce reading the communication book in the future we will ensure it is mandatory for all staff to sign the communication book during each shift. We would also ensure that any important communication that is vital to ongoing care of a client, gets formally included in the care plan with parent consent."

173. Ms Waddell stated that because Mr A spent only 40% of his time with Creative Abilities, in her view this made the information from Mrs B even more important to be used as an integral part of the care plan to ensure the care Mr A received was consistent. I agree.

174. Therefore, in my view, Mr A's day- and night-time care plans were not kept up to date. In addition, Mr A's "All About Me" document was last updated 14 months prior to his death. In response to the first provisional opinion, Creative Abilities said that this document was due to be updated two months prior to Mr A's death, but it had not happened owing to the resignation of the staff member responsible for the reviews. In my view, staffing issues should not impact on whether or not care planning information is kept up to date.

175. In my view, the lack of formality when informing staff about new instructions written by Mrs B in the parent communication book created room for confusion. I consider that verbally updating staff was insufficient, and that Creative Abilities also should have updated Mr A's care plan in collaboration with Mr and Mrs B, to ensure that the correct instructions were understood by both parties, and that they were clearly documented for all staff. As noted above, this was further complicated by having Mr A's care plan spread over several documents. Ms Waddell advised: "If all relevant information, including information from the parents relating to care, had been collated into one service plan which was then used to provide care for [Mr A] over the times when he was in the service, it would be described as up to date." As discussed above, this was not the case. I note that Creative Abilities has advised that a system has been introduced whereby staff need to sign to demonstrate that they have read the communication book, and that all critical information has been transferred into the care plans.

176. I acknowledge that aspects of Mr A's care plan were appropriate. In particular, Mr A had separate day- and night-time care plans, and the description of his sleep system was detailed. However, I agree with Ms Waddell's advice that it is not good practice to have a care plan spread over several documents, and that care plans must be kept up to date. I also agree with Ms Waddell that hourly checks for Mr A were insufficient, and that his care plan should have specified how frequently Mr A should be checked. I consider that, overall, Mr A's care plans were below the accepted standard.

Training

177. Creative Abilities' training record for Mr C shows that he attended between one and three training modules each month during his employment. The training sessions covered a range of topics and included vital signs, abuse and neglect, safe administration of medication, manual handling, and pump feeding. He obtained a first aid certificate in mid 2012, which was valid for two years. In my view, the general training provided to Mr C was appropriate. However, I have some concerns about the adequacy of the training provided to Mr C specifically about Mr A's care.

178. In relation to specific training on caring for Mr A, Creative Abilities kept a "Training Timetable", which recorded the training provided to each staff member. The Training Timetable recorded that on four occasions in 2012, Mr C received training on Mr A's care at the Centre. The Training Timetable recorded that Mr C was inducted into the night shift (how to care for Mr A at night) by Mr F.

179. In an interview with Creative Abilities, Mr C said that the most recent training he had with Mr A was around six weeks prior to Mr A's death. Mr C said that topics included using the hoist and standing frame, and PEG feeding. In this interview, he said that generally he felt confident working the night shifts at the House. However, he told HDC that he did not think he was qualified enough to work with Mr A, and had "little understanding about [Mr A's] conditions". Mr C stated: "All I knew and that was emphasized in every house meeting that we had every month at the Centre was the 'Apnoea' condition."

180. Mr C attended only five out of 12 house meetings where Mr A's care was discussed. Ms D advised that if a staff member was not present, that person could complete the training provided at another house meeting or at the Centre. She said that each staff member was provided with a copy of the meeting minutes, and they signed the minutes to confirm their understanding of what was discussed. In response to the first provisional opinion, Creative Abilities told HDC that it is the responsibility of the team member who misses a house meeting to obtain the electronic copy of the meeting minutes and read them. However, in response to the second provisional opinion, Creative Abilities stated that it "provide[d] any relevant information [Mr C] may have missed at house meetings in his one-on-one monthly meetings with his supervisor … [a]s well as during regular staff interactions during the course of his working day".

181. There are no written records of these discussions, or that the information discussed at the house meetings that Mr C missed was provided or obtained by him, or whether or not he received the training provided at a later date.

182. Ms Waddell advised:

> "[M]any of the regular updates that were specific around the care needed for [Mr A], including the use of the shoulder straps and the neck collar for [Mr A], were covered at the monthly meetings. There is no evidence that this training/ information was repeated for [Mr C] at any time following those meetings. Given that he was to have sole responsibility over night shifts and his subsequent lack of ability to assist ambulance staff during the event [with clear recall and understanding of what [Mr A's] medical and disability needs were], my view remains that there were some issues with the level and standard of client specific training for the care of [Mr A]."

183. I agree with Ms Waddell's advice. In my view, it was Creative Abilities' responsibility to have an effective system in place to ensure that any information or training missed at the monthly house meetings by staff was provided to them at a subsequent date. Creative Abilities has not been able to verify that the information discussed at the house meetings that Mr C missed was either specifically provided to him, or that he accessed a copy of the minutes, or whether or not he received the training he missed at a later date.

Conclusion

184. In my view, Creative Abilities did not provide services to Mr A with reasonable care and skill, as its care planning for Mr A did not meet the accepted standard. I am also critical that Creative Abilities did not have in place an adequate system to be able to verify whether Mr C accessed or received the information and training provided at the house meetings he missed. For these reasons, Creative Abilities breached Right 4(1) of the Code.

Monitoring of hours worked by Mr C — Breach

185. Ms D told HDC that the maximum number of hours a caregiver could work was 55 hours a week. However, in response to the second provisional opinion, Creative Abilities stated that the policy was not in force at the time of these events.

186. Creative Abilities told HDC that Mr C's permanent roster was five "awake" night shifts per week, and that occasionally he picked up vacant shifts. When Mr C picked up additional shifts, often he worked double shifts, ie, from 11pm to 7am followed by 7am to 3pm.

187. Following a spot audit when Mr C was found asleep on an "awake" night shift, Creative Abilities said that Mr C was given a final written warning and told that he was unable to pick up any additional shifts. Ms D told HDC that Mr C was not stopped from picking up additional shifts, although he was stopped from picking up double shifts. Ms D said: "[T]o my knowledge we monitored [Mr C] to make sure that he wasn't doing too many shifts but we made sure that he wasn't doing the sync shifts, the same double shifts."

188. However, Mr C's roster shows that on two occasions in the approximately two weeks prior to Mr A's death, he worked:

a) from 11pm to 7am (House 2) and then from 9.30am to 3.30pm (the House); and

b) from 7am to 3pm (House 2) and then from 10pm to 3pm (two shifts at House 3), followed by another shift from 11pm to 7am (House 2).

189. In relation to the additional hours that Mr C was allowed to work following the disciplinary action taken, Ms Waddell stated: "This in my view, demonstrates a complete disregard on the part of Creative Abilities of the provisions put in place for [Mr C], to guard against further incidents." She stated that this would be regarded across the sector as a significant departure from accepted good practice.

190. I am unable to make a finding when the requirement to work a maximum of 55 hours per week was instituted, as Creative Abilities has provided differing information. However, it is clear that in the six weeks prior to Mr A's death, Mr C exceeded 55 hours for four out of those six weeks. Ms Waddell stated that the hours worked by Mr C during that time period were excessive. In her view, such hours expose employees to a real risk of stress and fatigue issues. I agree.

191. In response to the first provisional opinion, Creative Abilities accepted that the hours worked by Mr C were excessive. Creative Abilities submitted that during this period, it experienced an abnormally high number of short notice absences. Creative Abilities said that it "had no option but to refer those additional shifts to [Mr C]", and that "there was no one with the specific training for the individual houses, [and] it is Creative Abilities' policy that only staff that have been inducted into a specific house can pick up additional shifts to make sure they are proficient in the needs of the clients in the house".

192. Ms Waddell advised:

> "It is a real challenge for residential services who provide support for high needs clients to get appropriate cover when there are staff absences and particularly when it is short notice. I agree with [Creative Abilities] that these shifts are not easily filled by casual staff and other staff who have not had client specific training. Some services have developed a pool of casual staff who are trained and are available to step in at short notice. Contingency planning is essential in such services where staff absences are not easily covered. What is relevant in this particular investigation is the fact that [Mr C] was on a regime of not being allowed to do extra shifts due to a performance issue. The fact that this was not enforced is, in my opinion, unacceptable given the nature of the performance concern."

193. I am very concerned that following the spot audit where Mr C was found asleep during an "awake" night shift, and the subsequent disciplinary process where a block on Mr C picking up double shifts was meant to be imposed, there appears to have been a lack of monitoring by Creative Abilities to ensure that this was the case. Creative Abilities continued to allow Mr C to pick up additional shifts, and he was able to work several weeks in excess of 55 hours per week. I remain of the view that the hours Mr C was allowed to work following the disciplinary process put at risk the

clients he cared for, including Mr A. Accordingly, Creative Abilities failed to minimise the potential harm to Mr A and breached Right 4(4) of the Code.

Monitoring of performance — Adverse comment

194. Creative Abilities had in place a performance assessment process, which included annual performance appraisals and monthly one-on-one supervision meetings.

195. Creative Abilities stated that Mr C had received a formal performance appraisal each year since commencing his employment. HDC was provided with copies of Mr C's performance appraisals for four years. Creative Abilities was unable to locate Mr C's performance appraisals for three years. From the electronic date entries in one of the documents, it appears that some concerns were raised in Mr C's two most recent performance appraisals regarding Mr C's timekeeping, communication and documentation. The performance appraisals are not signed or dated, except for an "Appraisal form" dated late 2010 and the "2013 Performance Appraisal Summary" form, which is dated.

196. Creative Abilities told HDC that "if there are specific performance issues that have been identified through the appraisal process, positive or negative, then a goals sheet is put together …" The only goal sheet provided to HDC was one for 2012. The goal sheet is undated but records that the three items listed were achieved by mid 2013.

197. Creative Abilities told HDC that Mr C also had monthly one-on-one supervision meetings with the Team Leader. Creative Abilities provided meeting notes from Mr C's supervision meetings between mid 2011 and late 2013 (a number of months were missing).

198. There was very little information recorded on each meeting note (except for one meeting note dated early 2013). The only follow-up action recorded is "Leadership training" and "Careerforce level 4" (on four occasions); otherwise, "all good" or "none" is recorded. The meeting note contains a detailed record of a one-on-one meeting between Mr C and Ms D. However, the meeting note is unsigned. In relation to the quality of the supervision meeting notes, Ms Waddell advised:

> "The [meeting note] clearly dated [mid] 2013 is comprehensive and covers each client with evidence of a good process having been followed. The remainder do not appear to have been done following a similar process and are, in my view, not reflective of good practice that would gain insight to an employee's progress or provide appropriate support for staff."

199. In addition, the meeting notes from two of Mr C's monthly supervision meetings in late 2013 do not reference any follow-up action plan regarding the night shift audit when he was found asleep. Similarly, Mr C's performance appraisal for 2013 does not mention this issue. However, Creative Abilities states that "[t]he incident was not included in his appraisal because it happened after the company wide appraisal programme took place". This comment by Creative Abilities is difficult to reconcile with the date of Mr C's 2013 performance appraisal summary sheet, which is dated a month after the incident. In my view, even if Mr C's performance appraisal had taken

place prior, this incident should have been followed up in his monthly supervision meetings that followed. In my view, Creative Abilities did not monitor Mr C's performance issues adequately.

Recommendations in the first provisional opinion

200. In my first provisional opinion, I proposed the following recommendations in relation to Creative Abilities:

a) Provide an update on the implementation of the recommendations detailed in its Investigation Report dated early 2014, and provide a report on the effectiveness of those recommendations.

b) Review its care planning process to ensure that all changes to its clients' care are also updated in their care plans, and that regular care plan reviews are conducted in collaboration with clients' families and other relevant health professionals.

c) Implement robust procedures to monitor the hours worked by its employees.

201. In response to the first provisional opinion, Creative Abilities provided a report on the effectiveness of its Investigation Report recommendations. It advised in relation to recommendation a):

a) All Creative Abilities clients have regular house visits from its registered nurses in addition to quarterly house operation audits. A report is completed following each audit and contains any action points and completion dates.

b) The Zambion thumb print scan is now in operation in each house and is checked regularly by the Human Resources Department and Residential Team Manager. Bi-monthly audits are conducted by the Residential Team Manager and the General Manager.

c) It has introduced three Area Team Supervisors (a new position) to help monitor and support the rostered staff at each house.

d) New personal care sheets have been implemented for each client.

e) Compliance and correct usage of the Care Plan is monitored by the registered nurses, Residential Team Manager and the Area Team Supervisors.

f) The registered nurses complete a yearly competency review for all staff.

g) Quarterly family forums are now held by the General Manager. It also proposes to introduce house meetings with family members.

h) It has introduced a new training group made up of the administrative team and company trainer.

i) It has introduced a "crossover shift" from 8pm to 4am to offer support and mentoring to the current night shift.

202. In response to the first provisional opinion, Creative Abilities advised in relation to recommendation b) that it has this process in place and will implement a new process whereby all staff are required to sign that they have read/checked for new information in the parent communication book during every shift. It also intends putting in place a formal process to ensure that all instructions that impact on the ongoing care of a client are also transferred into the care plan.

203. In response to the first provisional opinion, Creative Abilities advised in relation to recommendation c) that the Zambion thumb print system alerts and prevents staff from picking up additional shifts once they have reached the maximum number of hours allowed. The system also triggers any attempt by a staff member to request a double shift.

Recommendations

204. I recommend that Mr C and Creative Abilities and Associates Limited each separately provide written apologies to Mr A's family. The apologies are to be sent to HDC within three weeks of the date of this report being issued, for forwarding to Mr A's family.

205. I recommend that Creative Abilities and Associates Limited:

a) Provide a further update on its care planning process and the effectiveness of the changes already implemented and the new changes proposed. The update is to include examples of new documentation used.

b) Conduct an internal audit of its clients' care plans to ensure that all key information has been transferred from the parent communication book and other relevant documents into each client's care plan.

c) Review the responsibilities of the "awake" night shift staff in each residential home in light of the complexity of the clients.

d) Seek external expertise to review the adequacy of its staff training programme.

206. I recommend that Creative Abilities and Associates Limited report back to HDC, within four months of the date of this report being issued, on the steps taken with regard to these recommendations.

Follow-up actions

207.
- A copy of this report will be sent to the New Zealand Police, the Coroner, and ACC.
- A copy of this report with details identifying the parties removed, except Creative Abilities and Associates Limited and the expert who advised on this case, will be sent to the district health board, and it will be advised of Mr C's name.
- A copy of this report with details identifying the parties removed, except Creative Abilities and Associates Limited and the expert who advised on this case, will be sent to the Ministry of Health and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from health and disability services advisor Sandie Waddell:

> "I have been asked to provide an opinion to the Commissioner on case number C14HDC00007.
>
> I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> **Qualifications and Experience Relevant to the Review**:
>
> I have a Post Graduate Diploma in Health Service Management and a Certificate in Quality Systems and Auditing Principles. I have worked in the Health and Disability sector for 25 years and have held senior management roles in both the Ministry of Health and ACC. I was the CEO of the New Zealand Disability Support Provider Network and am currently working as a lead auditor of Health and Disability Services nationwide. This includes auditing the development and implementation of policies, procedures and guidelines for compliance with the New Zealand Health and Disability Services Standards NZS 8134:2008 (the Standards).
>
> Also as part of the audit process I am also involved in service planning, assessment and delivery and the evaluation of effectiveness of outcomes for clients.
>
> The Commissioner has asked that I:
>
> *Provide independent expert advice about the appropriateness of care provided to [Mr A] by the following parties: [Mr C], Creative Abilities.*
>
> **Background:**
>
> [Mr A] (aged 20 years) was receiving respite care at [a Creative Abilities home] three nights per week. He was dependent on carers and required 24 hour care. He had his own room with an ensuite.
>
> [Mr A] had cerebral palsy. His father said that [Mr A] had 'little motor control, had no speech, no head control good eyesight and hearing'. He also noted that [Mr A] had a 'huge backward thrust using his legs, which often made managing him difficult.'
>
> [Mr A] had epilepsy. When he was small he had some major epileptic events, always triggered by very high temperatures. But for the eleven years before he died his parents had only witnessed 'minor turns' that lasted for a few seconds. [Mr A] was given Tegretol to help control his epilepsy.
>
> He also suffered from acute obstructive apnoea, when his head was tilted backwards. He was unable to pull his head forward himself to recover from this.

[Mr A] had a compromised swallowing reflex which increased his risk of aspiration. He was fed via a PEG tube.

[Mr A] had a night time care plan (developed by [Mr A's occupational therapists]) which included a sleep system which enabled him to sleep safely in the recovery position. The care plan noted he would wake up 'usually between 2am and 3am but sometimes earlier'. The care plan required him to be transferred to his wheelchair when awake. [Mr B] advised HDC that if this did not happen 'he would wiggle onto his back and obstructive apnoea would kick in and he wouldn't be able to breathe.'

The care plan also required that, while in the wheelchair, his feet were strapped to the footplate and that he had the shoulder harness on.

The care plan also detailed that half an hour before getting [Mr A] up for the day he should be put back on the bed with the head end up 30–40 degrees with a pillow under his head and shoulders. The plan stated 'He will be OK in this position but if he moves around he may have to be repositioned. He needs to be checked frequently.'

It appears that [Mr A's] head had got stuck behind his wheelchair headrest on a number of occasions. In response to this, [Mr A's] parents had put a note in the communication book instructing staff to use a collar on [Mr A] when he was unattended in his wheelchair. They also informed the house manager.

The incident

On the night of [these events], [Mr C] was the caregiver on duty. He was caring for four clients.

[Mr C] said that when he transferred [Mr A] to his wheelchair that night he did not put [Mr A's] shoulder straps on (and said that he only did this while feeding [Mr A]).

[Mr C] said that he transferred [Mr A] to the bed at about 5am.

It is unclear at what time [Mr C] discovered [Mr A] having breathing difficulties. However, [the ambulance service] received a call from [Mr C] at [5.21am]. He was told to commence CPR, which he did. Resuscitation attempts were unsuccessful.

The ambulance transferred [Mr A] to [hospital]. [Mr A] passed away at 8.25am [that morning].

Monitoring

[Mr C] filled in a number of entries on the hourly checklist at 7am that morning, rather than at the time of each check. He said this was 'because of everything that was going on'.

Creative Abilities:

Creative Abilities has provided supported living day services to clients with physical and intellectual disabilities for 17 years. Five of the 15 homes are considered high needs homes. Night shift staff in high needs homes are required to be awake during their shift.

Creative Abilities noted that they requested additional funding from ACC to provide two staff on night shift to care for [Mr A]. ACC provided additional funding (in order to provide two staff members on night shift) only for [a period of two weeks in late 2012].

[RN H] was holding the on-call after-hours phone [at the time of these events].

The following Documents were provided to inform the review:

Tab 1:1–20. Correspondence from [Mr B]

Tab 2: Information from [Mr C]:

1. Response to notification, 25 March 2014

Tab 3: Information from Ministry of Health:

2. Letter from Ministry of Health, 12 March 2014

Tab 4: Information from Creative Abilities:

3. Letter from Creative Abilities (3 February 2014), enclosing their Investigation Report and enclosures
4. Training timeline
5. Individual staff training record for [Ms E]
6. Training records
7. Values and expectations document
8. List of duties
9. Individual staff training record for [Mr C]
10. Night shift auditing
11. After hours phone record by [RN H]
12. Incident report for [the date of Mr A’s death]
13. Disciplinary action prior to [Mr A’s death]
14. Shifts for [Mr C]
15. Hourly client checklists
16. Incident reporting
17. Notes from meeting to discuss trial at Creative Abilities house
18. Letter from ACC to Creative Abilities
19. Interview transcripts with handwritten amendments from interviewees

Tab 5: Information from [the ambulance service]

20. Letter from [the ambulance service]
21. Transcript of ambulance call

Tab 6: Information from ACC

22. Letter from ACC 28 April 2014

Names have been removed (except Creative Abilities and Associates Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

Also provided electronically were:

23. Two emails from CA explaining the additional documentation.
24. CA House Manual.
25. CA Health and Safety Manual.
26. CA Quality Manual.
27. A copy of CA’s training calendar for 2013/2014.
28. CA’s Recruitment Selection Policy.
29. CA’s Safeguarding and Challenging Behaviour Policy.
30. CA’s Values and Expectations Booklet.
31. Three audit results from 2013 conducted by Health Audit NZ for the NZS 8134 and 8135 standards and also CA’s ISO9001 audit conducted by Telarc.

PART 1:

The appropriateness of the care provided to [Mr A] By [Mr C].

a) Please comment on [Mr C’s] failure to use the shoulder straps (as required by the care plan) when [Mr A] was sleeping in the wheelchair.

The care plan stated that when [Mr A] was put into his wheelchair after he woke during the night that his feet were strapped to the footplate and the shoulder harness ‘should be put on as well.’ His Health Passport document also stated he needed full support when seated in his wheelchair.

This documentation was kept on site at the house. The father also reported guidelines for night time care were also up on the wall in the bedroom.

It is usual practice that all caregivers will be familiar with what is contained in each person’s care plan, along with other relevant information, and follow all instructions and guidelines in the management of their care.

In the third interview transcript [between Creative Abilities and Mr C], [Mr C] states he did not put on the shoulder straps when he put [Mr A] in his wheelchair on the night of the incident. When asked if knew he was supposed to put them on and that this was in the care plan, he chose not to answer. In [the next interview conducted with Mr C], he again confirmed he did not put the shoulder straps on and this was something he only did ‘sometimes’ and other times he didn’t.

The Team Leader, [in an interview], confirms he passed on all information and specific requests to all team members involved in the care of [Mr A] following any discussions with [Mr A’s] mother. He reports all staff were aware of the need to use the harness at all times when [Mr A] was seated in his wheelchair and also that the collar was to be used if he got agitated.

In my opinion it is unacceptable practice for any care giver to ignore the instructions in a care plan which has been developed to set out the required support and/or interventions for individuals. I believe this is a departure from the required standard of care. This departure is, in my view and I believe would also be that of my peers, significant in this case. Given the high needs level of [Mr A] and the requirement to ensure he is properly positioned and supported adequately in his wheelchair to ensure his safety, any lack of adherence to these instructions would pose a risk to his safety. The provision of safe care is required for all clients under the Health and Disability Service Standards (NZS 8134:2008).

b) What would you consider an adequate check during the night on a client like [Mr A]? Would observing him for 10 seconds from outside the bedroom be sufficient?

The required frequency of checks during the night was not noted in his care plan. The hourly checklist used in [the House] requires that all clients are checked on the hour between 11pm and 7am. No definitional information is given about what a 'check' should involve.

In [Mr A's] situation, where he was unable to manage positioning himself, it is clear that when he woke after the effects of his sleeping tablet wore off that he did tend to wriggle about and was in danger of moving onto his back. It is well documented that he could then have difficulty breathing due to his involuntary obstructive apnoea medical condition.

His parents, who according to their information provided, spent a lot of time working with the staff at Creative Abilities to ensure his needs would be met adequately. They told staff he would make a lot of noise if he was struggling to breathe. These noises would indicate that he had moved onto his back and was having some difficulty. They reported that this could occur any time after 2am when he awoke. In the care plan there were clear instructions to move him into his wheelchair when he did wake up and he would then sleep on and off until morning.

In my opinion if [Mr A] was correctly positioned as per the instructions in the sleep system provided by the specialist rehabilitation service, an hourly check, supported by the monitor in his bedroom would be sufficient for the first three hours (11pm–2am). The monitor would pick up any noises [Mr A] made if he did wake up any earlier which did not normally occur.

Due to his need to be repositioned at any time after 2am, I would have expected more frequent checks would be required to ensure when he woke up he was able to be moved into his chair. This needed to occur before he managed to wriggle onto his back and then subsequently be at risk of developing breathing difficulties. [Mr A] had complex needs and the requirement for awake staff overnight was due to his physical and medical conditions rather than any behavioural concerns. Consequently in my view, the level and frequency of observations would be higher than would be normally considered adequate for other high needs clients who did not have chronic health conditions that would compromise safety, and could in fact could be life threatening. His care plan stated that he needed to be 'checked frequently' following that transfer into his chair as again he could have positioning problems if he got agitated.

The need to be 'checked frequently' would, in my opinion require more than hourly checks. I would also expect that a thorough assessment by qualified health professionals would have detailed the frequency of those checks more clearly. None of this information was in the care plan or other instructions provided during the review.

An observation from outside the bedroom would not, in my opinion, be sufficient for [Mr A], given his diagnosed medical condition that could have compromised his breathing. I believe that would not be an acceptable check and I would normally expect a care giver to go to the side of the bed to check that [Mr A] was sleeping without any problems. This would be generally accepted practice in the monitoring of a resident with a similar diagnosis.

I believe this view would be supported by health professionals and other service providers caring for similar groups of clients.

c) Please comment on the appropriateness of [Mr C's] monitoring of [Mr A] in each of the following scenarios:

i) If he did not check [Mr A] between 11.10pm and 2am (while [Mr A] was in bed).

The required practice was to do an hourly check on all clients in the house and that this was then recorded as having been completed.

If this was not done, I would consider this a failure to carry out the required duties of the shift and it would be regarded as a performance issue. [Mr A] was a high needs client and had been assessed as needing awake staff on the night shift, therefore it would be expected those regular checks would occur. This would be considered a moderate departure from an acceptable level of care for [Mr A] as the information provided supports the fact that he had been positioned correctly in his required sleep system. He had also been given his sleeping medication.

ii) If he did not check [Mr A] between 3.40am and 5am (while [Mr A] was in his wheelchair).

The care plan stated once [Mr A] was in his wheelchair he needed to be 'checked regularly' as he moved around and may have needed repositioning. At least one incident had been reported to Creative Abilities by the parents where [Mr A] had got himself stuck between the headrest and the top of the wheelchair when he moved about. His mother also reported in the communication book that at home with [Mr A], he had been having issues with holding his head up while he was in the wheelchair. As recently as [a week prior] she wrote in the communication book that these issues were still continuing and he needed to have the collar on when he was in his chair. Given these concerns and communications between the parents and the Team Leader with subsequent discussions with staff, it would have been necessary to ensure there was frequent checking of [Mr A] when he was in his chair.

In my view there would need to be an increased level of monitoring from the required hourly checks when he was asleep. If [Mr C] failed to check [Mr A] during the timeframe of 3.40am to 5am, this would be an unacceptable and in my opinion would be a significant departure from what would be typically seen as an acceptable level of care provision in the sector.

iii) If he did not complete the hourly checks but later filled in the sheet to indicate they were done.

If in fact [Mr C] did not complete the hourly checks, then later filled in the sheets to say they were done, [this] would again be a performance issue of a significant level. As per the policies of Creative Abilities detailed in the 'Values and Expectations' booklet, the act of falsifying records would be deemed serious misconduct. The failure to carry out the required duties of a shift which could subsequently risk client safety would also be seen as a failure to comply with procedures. Again this would be deemed misconduct or in this case serious misconduct and be a completely inappropriate monitoring process. Any level of dishonesty in the area of documenting care is typically regarded in the sector as significant where the client group is one that is particularly vulnerable.

In my experience, disciplinary action would certainly be indicated if this was the case.

iv) If he did complete the hourly checks but filled the check sheet in later, at 7am.

If [Mr C] did in fact complete the hourly checks as required but filled in the check sheet later, this would be of a lesser concern as the monitoring had actually occurred.

However, it is my opinion that this practice is not an acceptable one. It could lead to errors being made with the risk of confusion about when checks had actually occurred.

I would consider this a moderate departure from acceptable standards as it would still have potential to increase levels of risk to clients.

v) If he did not transfer [Mr A] from his bed to his wheelchair when he woke up.

Given the regularly documented communications between staff, parents and the information in the care plan, the need to transfer [Mr A] from the bed to his wheelchair when he awoke after the effects of the sleeping pill wore off is very clear. The Team Leader reported this information was clearly understood by team members on night shifts both in his interview and the records of training given. [Mr C] also reflected in his interviews following the incident that he knew and understood the procedure when [Mr A] woke was to transfer him into his wheelchair.

In my opinion, if the transfer into his wheelchair was not done in a timely way, it would be a significant departure from what was required to provide safe care for [Mr A] as required under the Health and Disability Service Standards. The risk factors were well documented and in my view, failure to follow the required procedure would increase the levels of risk to [Mr A] significantly.

vi) If he did not use the audio monitor in [Mr A's] room.

The use of the audio monitor was not documented as a part of the care plan for [Mr A]. The only references made to the use of the monitor in the information given were comments in [two] interview transcripts with [Mr C]. In the [first] interview, [a manager] asked if the monitor was on and [Mr C] replied 'Yes I think so, the light was on the speaker in the lounge.' In the [second] interview with the CEO, [Mr C] was asked again if the monitor was on. He replied he did not check the monitor when he came on, he knows the monitor is there and always on. However in earlier interviews he made no reference to it being there as a monitoring device or that it had alerted him to any issues on the night of [these events].

The use of the monitor can be assumed to have been an assistive device in the monitoring of [Mr A] and in my opinion this would be of value as a part of that process. However there is little evidence in the information provided to show this was considered important in the subsequent investigation or that in fact it was used regularly and was required to be on.

Information given by the parents confirms that [Mr A] made a considerable noise when he was awake and moving onto his back into an unsafe position.

It appears from the information provided that [Mr C] was not aware of any irregularities with the monitor and there is no evidence to suggest [Mr A] was having any difficulties with breathing that would have registered on the monitor. Again this is not explored well in the interviews with [Mr C] which is surprising and makes informed comment difficult.

There is insufficient information and documentation to give a clear view on the use of, or lack of use of, the monitor on the night of the event other than to observe that it could be an important support in the monitoring of anyone with sleep apnoea.

How often it was used is not clear nor requirements for its use in assisting monitoring.

d) Did [Mr C] act appropriately in leaving [Mr A] in bed between 2.30am and 3.40am when he observed that [Mr A] was partly awake but then went back to sleep?

It is well documented that the sleeping pattern of [Mr A] was not always the same every night and that he woke anywhere from 2am onwards at which time he needed to be transferred into his chair.

[Mr C] said he checked on [Mr A] at around 2.30am and saw that he was sleeping lying on his side. Then he said he was partly awake and then went back to sleep. He then reported he got him up over an hour later at 3.40am. There is considerable confusion in the actual times given across all the interviews and in fact if [Mr A] was actually awake at any time over that period. As the time check records had apparently not been kept accurately, it is very difficult to get a clear picture of what actually happened during this time period.

It does seem to be on record that [Mr A] was not checked between 2.30 and 3.40 am, although he had apparently woken up for a short time. If this was the case, it is my opinion that [Mr A] should have been checked more frequently during this time. Given his pattern of wriggling onto his back once he woke, he would then be susceptible to experiencing breathing difficulties. It would then be necessary to make more frequent checks to ensure [Mr A] was still asleep. This time period in question, is also within the normal timeframe that [Mr A] normally woke and needed to be transferred into his wheelchair.

The length of time he was left unchecked would, in my opinion, be outside the realms of best practice and significant given the specific needs [Mr A] had. I believe sufficient information had been given by the parents to the organisation to indicate the procedure required to ensure [Mr A] was cared for safely. If [Mr A] was left unchecked for this period of time, at this particular time of the night, it is my opinion it would not be regarded in the sector as safe and appropriate practice.

e) If he transferred [Mr A] to the bed once he woke up, what would be a reasonable period to leave him unattended on the bed?

The care plan stated that [Mr A] needed to be put back on his bed about 30 minutes before it was time to get up. This appears to be for the purpose of, though not specifically documented in the care plan, to have some personal cares done. The head of the bed was to be put up at around 30–40 degrees and a pillow placed under his head and shoulders. The plan stated he will be ‘OK in this position but he may move around … he needs to be checked frequently’. Unfortunately ‘frequently’ had no clarification attached to further assist anyone to define exactly how often that would need to be. This clarification appears to have been left up to training and induction programmes given by the organisation to its caregivers and their discretionary judgment. The night time instruction sheet, according to the investigation report, stated that [Mr A] should not have been left unattended while on his back. It stated also in that report that the time [Mr A] was left on his back must be kept to a minimum. Given that the night time sheet instruction sheet and the care plan do not have the same information contained in them, there was room for some confusion. According to the transcripts, on this occasion [Mr A] was only left unattended on the bed when [Mr C] went to wet the flannel, and when he returned [Mr A] had begun to have breathing difficulties. It is noted here that [there] are a number of discrepancies in the timeframes surrounding the incident and exactly what happened, when and where.

What is clear from all the information reviewed is that any time [Mr A] was left on his back, there was the potential for breathing difficulties to occur. Given this, it is my view that [Mr A] should not have been left unattended **at all** during this time in the morning when he was having his personal cares attended to. All necessary equipment and supplies needed to have been prepared prior to his being transferred onto the bed from his wheelchair. The information provided is unclear and does not enable any conclusion to be made as to actually what did occur during this period of time.

f) Please comment on the timeliness of [Mr C's] call to the ambulance at 5.21am after having observed breathing difficulties.

There are again a significant number of discrepancies in [Mr C's] account of the times that events actually occurred on that morning and when [Mr A] actually began to have breathing difficulties. In the incident report completed later that morning, [Mr C] states that [Mr A] stopped breathing at 5.05am. In the final investigation report it is concluded by the organisation that it was at 5.15am that [Mr A] suddenly began having breathing difficulties. The communication book on site records he stopped breathing at 5am.

What can be verified was the ambulance service received a call at 5.21am and two ambulances were dispatched at 5.25am arriving at 5.33am.

The times [Mr C] has given are so varied, as are the reports of what his condition was and whether or not he was or was not breathing at what times. It appears when he was speaking with the ambulance service that breathing had already stopped which was why they instructed him to begin CPR. This is verified by the transcript of that call which recorded that, when asked, [Mr C] said [Mr A] was not breathing at all. According to the interviews conducted with [Mr C] these times vary with each interview as does the condition of [Mr A] and when the ambulance was actually called.

It does appear that there were no other factors apparent during the night that indicated [Mr A] was having any issues prior to being laid on his back on the bed in the morning to have his personal cares done.

Given the inability to verify a significant part of what actually occurred prior to the ambulance being called and the lack of reliable evidence, I don't find it possible to offer a sound opinion on the timeliness of the call.

PART 2:

Please comment generally on the appropriateness of the care provided to Mr A by Creative Abilities and Associates Ltd (Creative Abilities).

a) Was [Mr C] given appropriate orientation and training?

[Mr C] had gained a Level 3 Community Support Services (Core Competencies) qualification…

Much of his training since then seems to have been provided through attendance at house and group meetings. Records given report he had attended [recent training in Manual Handling, Food safety and Vital Signs]. He had attended a Flocare training programme…and had a specific induction to [the House prior to Mr A] becoming a respite resident. He had an induction to the night shift at [the House] and the Team Leader reports that he passes other information over to the teams on the night shift as needed.

The staff are expected to attend house meetings monthly and company meetings on the last Friday of every month. If staff do not attend, they are expected [to] read the minutes and sign off this has been done. In 2013 [Mr C] attended only four of these team meetings. It is at these meetings more specific training is done around the individual needs of the clients at the house. It is unclear whether the Team Leader followed up with [Mr C] from the meetings he missed to go over the specific training from those sessions. There are no records of any specific training done for the night shift. Information provided did confirm [Mr C] attended some training sessions at the Centre overseen by the Training Centre Coordinator where specific sessions around [Mr A's] care were held.

[Mr C] also inducted a new staff member into the night shift in [late] 2013.

[Mr C] completed training for a first aid certificate [mid] 2012. This was not revalidated and was therefore expired.

In [Mr C's] letter to [HDC on 25 March 2014] he stated he personally had little understanding of [Mr A's] condition and felt he had had little training on working with him provided by Creative Abilities. He stated he didn't feel qualified enough to work with someone with such high needs as [Mr A].

The training records are not easy to follow and an undated email to [Mr C] asks him to remember a date for a course he reportedly attended so they could issue a certificate of attendance. This suggests training records were not well kept. This was also noted as an area that was identified for improvement in the certification audit conducted in [mid] 2013.

The Health and Disability Services Core Standards (2008) require organisations have a 'system to identify, plan, and record on-going education for service providers to provide safe and effective services to consumers'. While the training programme for the year has a number of individual and organisational sessions recorded as being held in a range of areas, it is not evident as to who actually attended which ones, and the records appeared disorganised.

The fact that [Mr C] felt he was not trained sufficiently to care for [Mr A] is of concern. The fact that he was not able to assist the ambulance staff with clear recall and understanding of what [Mr A's] medical and disability needs were indicates, in my opinion, there were some issues with the standard and level of training provided to [Mr C]. This is especially around specific training to meet [Mr A's] care needs. In addition the fact that his first aid certificate had expired may have contributed to [Mr C] not being in a position to administer CPR effectively without the instructions of the [ambulance service] call centre. This may have not been the case if he had kept current his first aid training. In my experience organisations generally support caregivers who are working with clients who have high care needs, to maintain current first aid certificates and in fact for the majority this is a requirement.

Based on the information reviewed, it is my view the training programme for [Mr C] was insufficient to ensure he was able to provide the level of care required for clients with such complex needs as [Mr A]. Regular and on-going training programmes for care givers are required as part of contractual arrangements by funders. Where clients have high needs it is crucial, in my view, that regular training include current first aid certification and resident specific training, particularly when a care giver has sole responsibility on night shifts.

b) Please comment whether the number of shifts [Mr C] was rostered on for and the lengths of these shifts was reasonable.

[Mr C] was regularly rostered on for three night shifts (11pm–7am) at [the House] and two night shifts at the other two high needs houses. This was a total of 5 night shifts per week. He had no second job and the organisation reports he did the occasional day shift at [the Centre] to enable him to attend training sessions and company meetings.

These rostered shifts are in my opinion, a reasonable number of shifts and it is common practice across sector to work permanent rostered night shifts. I believe this is representative of the sector where organisations are involved in providing 24 hour staffing for residential houses. The length of the shifts is also in my opinion reasonable and again generally accepted practice.

c) Please comment on the adequacy of the staffing at this facility.

The staffing at this facility is reported by the organisation as having two caregivers covering the morning and afternoon shifts with a one hour cross over at the change of those shifts. One care giver is on duty for the night shift. The service also has a Team Leader who appears, from the information provided, to work at the house during some shifts with an oversight role, provide training and also to act as a liaison with families and other health professionals involved with the clients. The Team Leader in this role at the time of the incident had nursing qualifications…, a Business Management degree… and was currently completing a Careerforce qualification.

The staffing levels at any facility are determined by the assessed needs of the clients. If anyone is assessed as needing 1:1 care then staffing would need to be provided at that level. The assessments of all the clients at the House were not provided but from the information that is given, it appears that apart from [Mr A], the remaining clients did not need significant supervision over the night shift period. The fact that the house did have awake staff indicated the clients needed to have some regular monitoring and assistance during the night. Two care givers over the day shifts is usual at a house classified as high needs where one on one care is not required and would typically be accepted practice.

From my experience the staffing levels seem to be acceptable as no clients were reported to be ventilator dependent or have behavioural concerns which would then have triggered a need for higher staffing levels. Without having more specific information as to all the individual assessments, it would appear from the available information that the staffing levels during the day would have been adequate. The level of staffing overnight also appears to be adequate however, without full individual assessment information this can only be given as a general view.

It is noted that the ACC were asked to fund two overnight care givers for [Mr A] but this was only approved for a short period. It must be assumed ACC felt that [Mr A] could be adequately managed by one awake staff from then on.

d) Please comment on the appropriateness of the policies and procedures in place in [late] 2013.

A number of policy and procedure documents were reviewed. The Health and Disability Services (Core) Standards require regular review of all policies and procedures to ensure they are aligned with current good practice and service delivery.

The policies and procedures in place were comprehensive. The quality and health and safety manuals document policies and procedures have all met the requirements as evidenced in their [mid] 2013 audit report.

A management system assessment report against the AS/NZS ISO 9001:2008 standard found no areas of non-compliance were found.

The ‘Values and Expectations’ manual had good information for staff about the code of conduct and what expectations the organisation had for its staff. This included relevant human resources (HR) processes and procedures. The duties checklist was clear.

The Clients Health and Wellbeing After Hours document provided had good clear flow charts and explanations of how to deal with a range of health and personal cares issues on a generic basis.

The specific duties checklist (again generic) for the house was clear.

In my opinion, the set of policy documents provided are appropriate for organisations delivering the type of services Creative Abilities are involved in.

e) Was the night shift monitoring of clients adequate?

The monitoring requirements for any clients would normally be indicated in their needs assessments and be included as a part of their care plan. Any variations to what was provided would typically be indicated here.

As [Mr A's] parents were fully aware of the staffing at the facility and the process of hourly checks, I draw the conclusion that there was no particular need for increased monitoring for [Mr A] initially, once he [was] put in his sleeping position as was required in his sleep system.

However, as he normally woke anytime from 2am onwards, it would be assumed that increased monitoring would need to occur to identify when he actually woke up and would need to be transferred into his chair. The care plan and notes did not detail the specific monitoring requirements. What was included was the need for getting him up when he woke, frequent checking when he was in his wheelchair and not to leave him unattended when he was placed on his back in the bed prior to getting him up.

Without having additional specific details provided on individual client needs for night monitoring, I would regard hourly checks along with the use of audio monitoring devices would usually be adequate for most clients throughout the night if they did not have high medical needs. When [Mr A] was waking up, I would expect the monitoring to be more frequent until he had been put in his wheelchair correctly and then monitoring him more regularly for the remainder of the night.

The formal records only detail the requirement for hourly monitoring checks. The detail that is contained in the care plan indicates some need for more active involvement between checks. The transcripts of interviews with [Mr C] do confirm his understanding of what was required during the night time care for [Mr A].

In my opinion if the needs assessments required more frequent monitoring for clients in this house, this should be reflected clearly in their care plans. It would be insufficient in my view to have a standard hourly check list and subsequently only hourly checks for a client with the specific needs that [Mr A] had. The use of a template to sign off hourly checks was not in my opinion, adequate for the level of monitoring required specifically for [Mr A] by night staff. This would not be a generally accepted adequate standard of care practice and given the information contained in the care plan, which is further discussed in the following section, this is a significant departure from what would be viewed as an adequate standard of care.

f) Was [Mr A's] care plan adequate?

The care plan is the main documentation that is used to direct staff on the care needs and support required in any residential service. This should have all specific information related to the individual and their requirements over each 24 hour period with appropriate alerts. I would normally expect to see in a good care plan, a timetable for care needs documented with relevant details of interventions required to meet those needs. I would also expect to see any medical conditions that would compromise safety prominently noted at the beginning with relevant responses required should an episode occur. I would expect it to be written in a format that was easy to understand and with clear directions to manage care as required during a 24 hour period.

The care plan that has been provided had information about his feeding requirements and medicine schedule for the morning and for the 3pm–3.30pm timeframe. It also had a section for his night time medication and his transfer into bed. It is documented here that he has 'severe obstructive Apnia' and he had 'extreme difficulty when on his back and should never be left in this position — especially unattended'. It then had a picture of his sleeping position and instructions to get him back into his wheelchair when he woke where he would then sleep on and off. Finally an instruction to put [Mr A] back into bed on his back for half an hour was detailed. Instructions to check him frequently and that he may need repositioning were also given. This was a contradiction to the earlier instruction that he should never be left unattended.

Included in the folder was an emergency procedure should the feeding tube fall out, his medication chart, short term care plans — the most recent dated [late 2013]. Also included were seizure protocols, a sleep apnoea fact sheet, a MRSA information sheet, a support information record to be taken to hospital at the time of emergency or admission. Rehabilitation services information on his sleeping system, feeding, communication, physiotherapy programme had been provided as a part of the information kept on site.

The care plan did not, in my view, provide all the information needed nor was it set out in a way that was easy to follow. There was insufficient reference made at all to his personal care needs (i.e. showering) and very little information for his toileting needs. The high needs client care sheet requires detailed information to be recorded including if toileting occurred on each shift, skin integrity and feeding. The sheets provided were only signed with little of the detail asked for at the top of each column on the form.

There is little information about [Mr A's] specific physical needs, his communication or his medical needs. The information that is in the care plan is in differing fonts, many quite small, and had handwritten changes made that were not easy to decipher. The description of the sleep system was clearly explained with photographic images to assist staff. The feeding information was also clear.

Of significant concern was the lack of prominent alerts to identify his severe obstructive apnoea — other than a short reference in the 'bedtime' section.

There was no information prominently displayed in an easy to understand format about his obstructive apnoea condition or what to do if he did have difficulty with his breathing. The only information about the condition is a generic fact sheet which would have been difficult to understand for anyone with no medical knowledge and extremely challenging to read for staff for whom English is a second language or who have any literacy challenges. Care giving staff in this sector, would often fall into one or both of these categories. It is clear from much of the information reviewed, that care staff at this facility could also find the information presented in the care plan difficult as interview transcripts demonstrate a number of care staff were from outside New Zealand.

The short term care plans dated [late 2013] describe the use of creams and antibiotics to manage the inflammation around [Mr A's] peg site were signed as read by only four staff. Earlier ones had been signed by up to 9 staff. This illustrates not all staff were reading and signing off additions to the care plan.

In my opinion the care plan that was used to instruct and guide staff on the care required for [Mr A] is in the main, significantly below the acceptable standard for someone who had as significant a need level as [Mr A]. Parts of it I consider inadequate to provide appropriate guidance and information for staff to enable them to provide a good safe standard of care for [Mr A]. I believe it would be viewed as unacceptable across the sector as it lacked critical information presented in an easily accessible way to enable staff to provide safe care.

g) Please comment on the instruction [Mr A's] parents put in the communication book regarding the collar, and whether Creative Abilities took appropriate steps in response to this?

It is noted [in mid 2013] by [Mr A's] mother that when he couldn't hold up his head that the collar needed to be used. If he was alone at night she also stated it was a 'good idea' to use his collar. Again on [two subsequent occasions] his mother informed staff that [Mr A] needed to have his collar on when his neck was floppy as it had seemed to be happening a lot more often.

In response to these communications, the Team Leader said that he instructed night staff to put on the neck brace whenever [Mr A] became agitated.

The investigation report stated that none of the care givers knew that the parents intended the use of the collar to be used other than during transportation. Nor did they know it was to be used when he became agitated. They also did not know [Mr A] might have more difficulty breathing if his head was floppy and he was not wearing the collar.

The Team Leader stated he was not aware the collar was to be used when [Mr A] was unattended and was not aware this was a safety risk. One care giver interviewed during the investigation had no idea about the use of the collar apart from when he was in the taxi. He stated he had never seen it used in the house. The care giver was not aware of any communication from the parents and said they had actually never seen the communication book from the parents.

In my experience, the use of the communication book is generally seen as a very important part of the communication between a parent and an organisation caring for a family member. It would be seen as especially important in this instance where [Mr A] was not full time at the house and spent a number of nights at home with his family. It usually becomes an important written link to keep both the family and the organisation aware of any changes in the needs of a client and to ensure all information is current.

It appears the use of the communication book was not used in this way and much of the communication took place verbally. It is my view that the written communications in the book by the parents were not seen as important enough to be shared with all staff and no information about the use of the neck cushion had been noted in the care plan. This is not regarded, in my view, as an acceptable response by Creative Abilities. The fact that nothing had been added into the care plan after these written communications, even if they were shared with staff, is not reflective of good practice and would not be viewed as such in the wider sector. The response by Creative Abilities would be seen in my view as a significant departure from accepted practice, given the safety aspect of the communications that were entered into the book. It demonstrates a lack of effective communication systems in place at the time.

h) The ACC contract states: 'Clients receiving [Residential Support Services RS3] need 24-hour oversight supervision by clinical professionals, e.g. a registered nurse, physiotherapist or occupational therapist.' Was the supervision provided by Creative Abilities adequate?

There is evidence of a number of interventions and visits by clinical professionals with [Mr A] during the 2013 year. The Specialist Rehabilitation Service provided consistent oversight supervision for [Mr A] and records show they were on site regularly and provided good information to staff on sleeping, tube feeding, communication and seating systems. [Mr A] had been visited by an Occupational Therapist on the day before the event. The records also show the company registered nurse had been responsible for clinical oversight and had recently been involved in managing the issue with the inflammation around [Mr A's] peg site. He was also involved with liaising with the community health nursing service in the treatment of any abrasions, pressure concerns and medical interventions. These are all well documented and demonstrate in my opinion, that adequate clinical oversight and supervision was occurring.

i) Please comment on the recommendations in the ACC audit report and whether actions taken by Creative Abilities addressed these satisfactorily.

The review by ACC noted areas for improvement in the implementing of the Best Practise Change Programme, incident management, admission processes, document storage, and the role of the RN, increasing night shift reviews and clinical oversight with unscheduled home visits occurring.

Creative Abilities supplied information about reviews they have completed, changes already in progress and future recommendations.

There appeared to be significant work in progress and also planned at the time the document was written. This was especially in the monitoring of staff working night shifts and communication systems. Training initiatives were also being implemented, including the requirement for all team leaders to have Level 3 Careerforce qualification and the introduction of parent approved training guides. Staff education about client care plans was to be implemented and staff competence and compliance assessments were all initiatives planned towards improving the quality of client care in the service.

If these planned improvements are well developed and implemented they will, in my view, go a significant way toward addressing the shortfalls identified in the policies, procedures and practices of the organisation during the ACC review.

These will in my opinion directly impact on the improvement of client safety in an environment where vulnerable clients rely on their service providers to provide a safe and secure environment.

j) Did Creative Abilities take appropriate steps in response to finding [Mr C] asleep on duty on (date)?

[Mr C] was found asleep [during a night shift audit in late 2013].

A meeting was held with [Mr C] [following a letter (not supplied) sent to him]. It is assumed this letter was detailing the issue and requesting a formal meeting. This would generally reflect good process. A disciplinary investigation was carried out which resulted in a letter being sent to [Mr C]. It stated that serious misconduct had been proven and he was issued with a final written warning.

Detailed as the reasons for the serious misconduct finding were that [Mr C] had been found asleep, wrapped in a blanket on a mattress on the floor when the audit occurred. He had not signed off the hourly monitoring checklist and had not completed his duties as required for his shift.

As [Mr C] had had no previous incidents of this nature in the years he had been employed with Creative Abilities and had always been regarded as a responsible employee with no other relevant disciplinary issues, the written final warning was issued rather than a dismissal notice. As a part of the warning, a block was put on all extra shifts, with one exception made over [a holiday weekend].

In addition all staff were reminded that to be asleep on a night shift duty was a serious misconduct offence and could lead to summary dismissal.

This process followed by Creative Abilities demonstrates, in my view, a fair and just process and given all the relevant facts provided, I believe an appropriate decision was made. The process followed reflected their current policy and is one that would be representative of the sector and in line with current New Zealand Employment Law.

k) Please comment on the adequacy of the internal investigation carried out by Creative Abilities.

The internal investigation involved a series of interviews with staff involved in the care of [Mr A]. These being the care giver on duty at the time of the incident, the team leader, the registered nurse on call and two other caregivers who had looked after [Mr A]. In addition documents obtained from the house, clinical records from the DHB, other relevant notes from his folder, communication books and specific house information was included. Training records and other HR information for [Mr C] were also a part of the review process.

In my opinion the available documentation reviewed was appropriate to inform the investigation. The quality of that documentation was also used and did inform the organisation as to where improvements could be made in the future.

The interviews held, while conducted with the relevant staff, were in my opinion poorly prepared for and lacked structure to enable the best possible evidence to be collated. They demonstrated a lack of a sound process in place to deal with incidents of this nature and were not as helpful to the investigation as they should have been.

In the absence of any apparent comprehensive procedures in carrying out this investigation, it is my view that the staff were not aware of how to actually structure interviews to ensure all information was gathered in a way that would assist in an investigative process. I don’t believe the staff interviewed would have felt well supported.

There was a level of confusion in both the questioning and the lack of follow up where there were contradictions and lack of clarity of recall in the responses given. [Mr C] had a total of 7 interviews over a period of 5 weeks. I question the need for and the value gained from having all these interviews over that time frame. Although he had indicated he would like some personal support during the interviews, it appears this was never appropriately facilitated by Creative Abilities.

The fact that the conclusions drawn were in the main part, not conclusive would indicate some issues with the process in my view. It is acknowledged the investigation did have limitations due to the fact that [Mr C] was the only person to witness the events, until the arrival of the ambulance staff. The investigation had to be largely reliant on his recall of the facts to draw any conclusions as to the actual timeline of events that occurred. However it is my opinion, and I believe would be typically seen across the sector, it is sound practice that a clear documented policy and process is in place to guide investigations of this nature. This did not appear to have been the case during this investigation.

Are there any aspects of the care provided by Creative Abilities that you consider warrant additional comment?

1. Creative Abilities follow up to the disciplinary response to [the incident] when [Mr C] was found asleep on duty.

Although a block was put in place on [Mr C] doing additional shifts following [this incident], as a part of the disciplinary response, this was not adhered to by the organisation. Several weeks later following this incident, and in the days leading up to the death of [Mr A], [Mr C] completed a number of shifts that resulted in 33 hours on duty in a 48 hour period.

This is my view, demonstrates a complete disregard on the part of Creative Abilities of the provisions put in place for [Mr C], to guard against further incidents.

This would, in my view, be regarded across the sector as a significant departure from what would be accepted good practice following the disciplinary process and the subsequent actions that had been determined.

2. Registered nurse clinical leadership for care staff.

The apparent lack of training by the registered nurse for care staff who had no medical qualifications and knowledge was apparent in the interview transcripts. [Mr C's] stated concern about the lack of training in caring for [Mr A] in his letter to the organisation also reflects this. Clinical staff in any organisation have a responsibility to educate care staff in these areas, especially where there are specific medical and disability needs for individual clients. This did not appear to have occurred in the case of the needs of [Mr A].

Follow-up Questions:

1) In your view, would a child with [Mr A's] needs be able to be cared for by a caregiver (like [Mr C]) if proper training was provided?

The training required to support a child with similar needs to [Mr A] would certainly be able to be provided in a community service setting such as the one in which [Mr A] had been receiving care. In my view care givers would be able to provide adequate support if their training included sufficient specific information and training regarding any medical needs and the management of these, as well as training on how to provide care for all client specific physical impairment needs. I would expect a current first aid certificate to be held by a care giver if sole care or responsibility was required.

2) Creative Abilities told HDC that its staff were able to work a maximum of 55 hours per week (this includes any sleepover shifts). Please provide comment about whether this is reasonable.

Should staff be working 'sleepover shifts' it would be reasonable to allow them to work some additional hours. Usually a sleepover shift does allow a care giver to get some sleep as they are not required to be awake once clients are settled for the night. Sleepover staff are required for any emergencies that may occur during the night that clients would not be able to respond to themselves due to their level of impairment. If there had been no need for staff to be awake for any length of time for any reason during a sleepover shift, it is acceptable in my view, for additional hours to be worked during the working week as staff will have had sleep. If staff had had unsettled nights due to client needs, asking them to work additional hours would not be reasonable. Managing staff stress and fatigue is a clear responsibility of any employer and monitoring staff working hours and conditions is a crucial part of that process, particularly where staff are working with clients wholly dependent on their support.

The practice of giving overnight awake staff additional shifts would not be viewed as acceptable in the sector if it was more than 2–3 hours at the end of the occasional shift.

3) The last [six weeks] of [Mr C's] shift record shows that he worked the following hours:

— [Week 1]— 58 hours total (42 hours base roster, 16 hours not base).

— [Week 2]— 65 hours total (34 hours base roster, 31 hours not base).

— [Week 3] — 59 hours total (42 hours base roster, 17 hours not base).

— [Week 4]— 49 hours total (41 hours base roster, 8 hours not base).

— [Week 5] — 42 hours total (42 hours base roster, 0 hours not base).

— [Week 6] — 75 hours total (51 hours base roster, 24 hours not base).

Please provide your comments, if any, on [Mr C's] hours worked.

The hours provided that [Mr C] worked over the last two month period are, in my view, excessive. This opinion is based on the fact that his normal rostered hours were awake night shifts where he was required to be awake at all times in the houses. Any additional hours worked would appear to have been during the day immediately following a night shift when he would normally be expected to be getting some sleep or having some time off. This is very concerning given that following his disciplinary process from the [audit] incident, a block was put in place to ensure he did no additional hours other than his rostered shifts.

Any hours worked over the 55 hours that Creative Abilities apparently allowed, was not only against their reportedly accepted practice, but would also expose employees to real risk of stress and fatigue issues. Four of the six weeks in this period were over and above the 55 hours the organisation told the HDC they allowed. This would indicate to me that they were not actively monitoring workers' activity.

In my view, the hours worked as documented above by any staff member, would be deemed unacceptable by most in the sector and would certainly increase the risk to client safety. It would not generally be viewed as good employment practice. Discussions with colleagues in similar organisations confirm any hours worked by care giving staff over and above 100 hours in any fortnightly period would be of concern and immediately addressed.

4) Two staff members were needed to move [Mr A] into his wheelchair. There was one person rostered on overnight. Please provide your comments, if any, about this arrangement.

A needs assessment by appropriately qualified professionals is used to determine the requirements for the safe transfer of any individual. This would typically include the method of transfer and the staff requirement to do so safely. Specific information from any specialist physiotherapy or occupational therapy assessments was not provided in his care plan where it would normally be expected to be found. No information was provided to specify the number of staff needed to transfer [Mr A].

[Mr A] does say in his 'All about Me' booklet that he has his own hoist and sling. This would suggest that these were needed to be used to transfer him in and out of his wheelchair as required. It is considered best practice to have two people available to transfer anyone who requires hoist transfer, although this could be done with one person who has had adequate training. Colleagues confirm while this is not ideal, it is done within this sector where only one trained staff member is available. A care giver lifting a client would not be acceptable practice.

5) Pg 15. I would be grateful if you could explain what you mean by, 'Two care givers over the day shifts is usual at a house classified as high needs where one on one care is not required and would typically be accepted practice'.

Over a usual day shift, two care givers would generally be adequate to provide care and activities for similar clients in similar settings. There are some clients in community settings who have been assessed as requiring one on one support to ensure their safety and the safety of others. This is normally due to behavioural issues. The evidence provided suggests that this was not the case here.

6) Pg 16 (re ACC initial funding). Is it usual practice for a service user to have more care givers over an induction period?

It is, in my experience, usual practice for care givers in a training period to have shifts completed with a 'buddy' for however long is needed to ensure they are able to undertake duties competently by themselves. This is accepted practice right across the sector during any induction period for new staff whether the duties are of a general nature or working with specific clients. In this case it is assumed ACC made the decision to start with two care givers for a period of time initially, then made the decision that one person would then be able to manage to meet the needs of [Mr A] on their own."

In response to the first provisional opinion, new information was provided by Creative Abilities, and further expert advice was obtained from Ms Waddell on 15 June 2015:

"**REF: C14HDC00007**

I have been asked by the Deputy Health and Disability Commissioner to provide further expert advice in response to additional information that has been provided by Creative Abilities.

Following a review of that information I have the following comments to make:

1. Refer Part 2; P 13 of my original advice.

Given that [Mr C] had completed a First Aid Certificate in [mid] 2012 and this was valid for a period of two years, Paragraph 5 above should be deleted.

2. Refer Part 2; P14.

Paragraphs 2 and 3:

The fact that [Mr C] felt he was not trained sufficiently to care for [Mr A] is of concern. The fact that he was not able to assist the ambulance staff with clear recall and understanding of what [Mr A's] medical and disability needs were indicates, in my opinion, there were some issues with the standard and level of training provided to [Mr C].

However as mentioned on P13 of my advice, many of the regular updates that were specific around the care needed for [Mr A], including the use of the shoulder straps and the neck collar for [Mr A], were covered at the monthly meetings. There is no evidence that this training/information was repeated for [Mr C] at any time following those meetings. Given that he was to have sole responsibility over night shifts and his subsequent lack of ability to assist ambulance staff during the event, my view remains that there were some issues with the level and standard of client specific training for the care of [Mr A].

3. Additional comments following the review of the newly provided information:

a) One-on-one monthly supervision meetings/performance appraisals.

The information provided of the one-on-one supervision sessions show a variance in dates and many that are illegible so it is not clear if these were actually completed every month. The one [clearly dated] is comprehensive and covers each client with evidence of a good process having been followed.

The remainder do not appear to have been done following a similar process and are, in my view, not reflective of good practice that would gain insight to an employee's progress or provide appropriate support for staff.

b) The performance appraisal documents provided on the official sheets are not clearly dated but there are a number of comments referring to timeliness and issues with documentation not being completed. If, as would appear from editing dates, these are related back to 2012, then it would be expected that any such issues identified would be addressed in monthly supervision sessions. This does not appear to have occurred."

Further expert advice was obtained from Ms Waddell on 17 June 2015:

"**1) Creative Abilities submit that it has a detailed care plan. It submits that the care plan is made up of the 'All About Me' document, Health Passport, day-time care plan, night-time care plan, the short-term care plans and other documents including a skin integrity assessment. Could you please comment on:**

a) whether it is appropriate to have the care planning information spread over a number of documents;

It is generally not accepted good practice to have different parts of a care planning document spread over a number of different documents that may also be located in different locations. Staff should be able to access all relevant information in the care plan easily to ensure they have all information required to provide appropriate care. If a number of documents are used to make up that care plan — all relevant information should be transferred into a single care plan if it forms a part of the required information when caring for a client.

My opinion would be that it is a significant departure if all the care plans were not able to be accessed easily by all care staff. If all information relevant to day to day care planning, including information, alerts and specific instructions and responses needed should any health or disability event occur was not contained in the one plan, it would be considered only a moderate departure. In essence if non-essential information such as historical information or detailed assessments was located in other parts of the organisation that would not constitute a significant departure. I believe this view would be shared by my peers.

b) whether there should be one formal care plan containing all relevant information;

The most effective and efficient way to ensure appropriate care is provided is to ensure all information is included in the one care plan, including any short term plans in place for specific issues and any references to recent/relevant incidents or complaints. The care plan needs to be a living document that is easily accessed by all staff.

c) whether or not there are any risks/advantages in having the care plan as described in a) or b).

A care plan provides guidance for staff in their daily activity with a client. If it is not easily accessed and in one place there will be the risk of gaps occurring in the information for those providing care. The care plan is the overarching document that coordinates and gives all relevant and timely information for each individual client.

2) Creative Abilities submit that [Mr A's] care plan contained up-to-date information because in the 18 months [Mr A] was in their care, it completed four short term care plans. Please comment on:

a) the different purpose of a care plan and a short term care plan;

A short term plan is commonly used to address a particular issue or consequence from an event that will only be used specific to that event or issue. Examples of these would be the administration of antibiotics, wound management or any other specific intervention designed to be used in the short term. A care plan describes the supports and/or interventions that are planned to achieve desired outcomes as identified in an ongoing assessment process which includes both long and short term goals over a longer period of time. This will also incorporate all relevant information if more than one agency, or as in this instance, family members are involved in providing supports to the client.

b) whether you agree with Creative Abilities that this meant [Mr A's] care plan was up-to-date.

If all relevant information, including information from the parents relating to care, had been collated into one service plan which was then used to provide care for [Mr A] over the times when he was in the service, it would be described as up to date. My recollection is that this was not the case.

3) Creative Abilities say that the reason why [Mr A's] 'All About me' document had not been updated in 14 months (the review was 2 months overdue at the time of [Mr A's] death) was due to the staff member responsible resigning and had not yet recruited a replacement. Do you have any comments on this?

All information that is needed as a part of a care plan needs to be kept current. Staffing issues should not impact on whether or not care plans were kept up to date.

4) Creative Abilities stated that the reason it did not transfer all communications between [Mrs B] and staff into the formal care plan was due to the fact that [Mr A] spent 60% of his time at home. Do you have any comments on this?

See response to 2. In addition, my view is that because [Mr A] only spent 40% of his time with [Creative Abilities], this would make information from [Mrs B] even more important to be used as an integral part of the care plan to ensure care was consistent and based on what was happening at the time for [Mr A] when he came into the service for support.

5) Creative Abilities submit that [Mr C's] induction into caring for [Mr A] included four day-time training shifts and one night-time buddy shift/induction. Please comment on:

a) whether you consider this to be sufficient induction training for caring for [Mr A];

The amount of induction time needed to ensure a caregiver was ready to take full responsibility for a client would depend on a number of things. The skill levels, the previous experience and what existing knowledge the person had about a particular client and their care needs. The service, probably in this case the team leader, would need to make that judgement call based on their observations and the skills and experience of the individual. Not having seen evidence of exactly what training was included in the day and night shifts I don't feel able to comment more specifically.

b) whether you consider this to be sufficient induction training for caring for [Mr A] as a solo carer on the night time shift.

See above response. Again this would need to be a judgement call on the part of the service depending on what they observed during training.

6) Creative Abilities submit that the reason some of its staff work excessive hours is due to short notice absences by staff. It stated that 'Finding appropriate staff at short notice becomes particularly difficult when the clients needing support have high and complex needs. These shifts cannot be filled by casual staff or other staff who do not have client specific training'. Do you have any comments on this?

It is a real challenge for residential services who provide support for high needs clients to get appropriate cover when there are staff absences and particularly when it is short notice.

I agree with [Creative Abilities] that these shifts are not easily filled by casual staff and other staff who have not had client specific training. Some services have developed a pool of casual staff who are trained and are available to step in at short notice. Contingency planning is essential in such services where staff absences are not easily covered. What is relevant in this particular investigation is the fact that [Mr C] was on a regime of not being allowed to do extra shifts due to a performance issue. The fact that this was not enforced is, in my opinion, unacceptable given the nature of the performance concern."

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Putting people first

Recommendations

March 2015

www.health.govt.nz

These recommendations were taken from the Putting People First quality review

1. Embrace good performance and actively promote this, by:
   - Clearly defining and communicating what constitutes good performance and expected outcomes – and monitor against these
   - Supporting and encouraging best practice – and how this can be achieved
   - Show-casing great examples – including how these were achieved.

2. Revitalise the culture of DSS, with the aim of re-focusing people's roles on the substance of the tasks they are there to complete. Ensure staff have the time and resources to enhance the systems and processes that safeguard the well-being of disabled people.

3. Restructure the roles of CRMs around regional responsibilities, with all general CRMs given regional oversight of residential and community-based disability services, including service access through the NASCs.

   Retain specialist roles in areas where senior or specialist skills are required.

4. Review the role of CRMs to:

   i) assess how they spend their time, with the aim of streamlining the role and re-focusing it on building and maintaining provider relationships, and

   ii) ensure they are adequately resourced.

5. Encourage new providers of both residential services and other support options to enter the disability sector.

6. Support good practice by encouraging and supporting providers to take part in peer reviews and communities of practice – particularly where providers are isolated.

7. Do not award new contracts to providers who are in breach of their contract or who do not otherwise hold themselves accountable for achieving high standards of safety and performance.

8. Only contract with residential providers who support those with high and complex needs, if they have staff with the requisite skills and experience.

9. Support the development of more flexible support options to better meet the needs of disabled people with high and complex needs.

10. Attract, recruit, and retain appropriately skilled disabled people, and others with a high level of experience of disability and disability issues.

11. Identify what drives exceptional performance and design organisational and personal KPIs around this to support positive behaviours and outcomes.

12. Create a new support role, a group of people who build strong and trusted relationships with disabled people, and support them to stay safe and speak out when needed. These people may themselves be disabled, and the design and oversight of this role could be by a disabled people's organisation.

13. The Ministry of Health adopts a policy of having no tolerance for the abuse that is inflicted on disabled people.

14. Ensure those who cannot speak themselves – and their families – are fairly represented at forums that result in decisions affecting their future care needs and the future of the sector.

15 Ensure disabled people are safe after laying a complaint, by:

i) removing the alleged perpetrator from contact with the disabled person if there is potential for that person to be re-harmed in any significant way, and
ii) provide supports that will enable them to overcome the effects of being abused.

16 Set up a Panel of Experts to provide expert advice and support to the Ministry. Membership on the panel should be based on the fit between the individual's specialist knowledge and expertise and the range of skills needed to respond to the serious incidents, complaints and issues that occur in the sector.

17 Conduct a timely, independent investigation into all serious complaints in a manner that is fair and equitable to all concerned. Those members of the Expert Panel who have the most appropriate skills undertake the investigation and report back to the Ministry.

18 Ensure the findings of the Panel are binding, so the Ministry has the power to effect change and hold providers to account for implementing the changes needed.

19 That the Ministry of Health work with the Ministry of Justice to ensure the legislation covering disabled people provides the necessary protection to keep disabled people safe from serious harm.

20 The Ministry of Health work with Police to ensure there are sufficient police officers with the requisite skills and knowledge to capture all of the evidence needed to prosecute valid cases of abuse.

21 Enhance current memorandums of understanding between the Ministries and agencies involved in providing supports to the disability sector. Ensure these include formal protocols and clear roles and responsibilities around sharing information, making joint decisions, and designing the processes to be followed when working jointly on a case.

22 Providers must report all significant risks and serious incidents to the Ministry within 24 hours of becoming aware such an issue exists.

23 Develop clear definitions of significant risks, issues, and critical incidents, and a clear pathway for reporting these to protect the safety of service users.

24 Include a clear escalation path in future contracts that allows for a staged approach to managing poor performance or non-compliance against contract.

25 Replace existing PMRs with a report that focuses on quality of life outcomes, as well as challenges experienced, and improvements being put in place by service providers.

26 Replace the current Certification audit and developmental evaluation with an enhanced developmental evaluation, which assesses all residences on average once every three years. This needs to be supplemented by the safety requirements in the Standards that relate to disabled people, including:

- Safe medication practices and procedures
- Quality food and nutrition
- Waste disposal and infection control
- Safe facilities and environment
- Emergency Planning
- Restraint minimisation.

This also needs to be supplemented by:

- An assessment of the extent to which the house provides a warm and homely environment.

27 The Ministry contract for the use of the best developmental evaluation tool and process available in the market place. It is recommended that this cover:

- Identity and autonomy
- Choice and control
- Relationship and partnership
- Belonging and personal networks
- Competence and support to contribute
- Customised supports
- Safety and respect.

28 Require evaluation agencies to demonstrate the quality and consistency of their evaluators and report outcomes – with agency choice based on the achievement of consistently high outcomes.

29 Conduct no-notice issues-based audits whenever there is sufficient concern that the safety or well-being of a disabled person is at risk.

30 Design and implement a complaints and issues resolution process, which is based on:

- clearly defined levels of risk
- key thresholds and escalation points
- who does what when, i.e., clear roles and responsibilities
- effective case management methodology.

31 Provide CRMs with training to equip them with best practice knowledge and skills relating to managing disability-related crises.

32 The Panel of Experts provides specialist knowledge, expertise and advice to support CRMs to resolve challenging or complex complaints and issues.

33 Implement a single electronic management system that brings together all information relating to providers and the disability sector – with urgency. The design must allow Ministry staff to gain a clear picture of providers over time, as well as risks, patterns and trends relating to providers in the sector.

34 The Ministry must act on the knowledge it has – and make the hard decisions including terminating provider contracts, where appropriate, in a timely way.

35 Ensure the role NASCs play supports the well-being of disabled people. In particular, ensure there is transparency and consistency in information and decision making, and disabled people are supported to choose those services or provider(s) that best meets their needs, personal goals and preferences.

36 Ensure providers offer a consistently high standard of care and support.

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HP6125 March 2015

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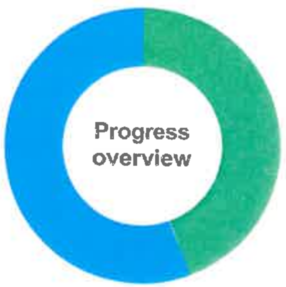
Hearing the voice of disabled people



56%
Completed or ongoing

44%
In progress

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HP6144 January 2016

Integrate the work of the Quality Improvement Panel with the Ministry's Quality team on complaint and incident management

REC 16 17 18 30 32

Ensure those who can't speak for themselves, and their families, are represented at the Consumer Consortium

REC 14

Work with the sector to identify how a support role could help people stay safe and speak out when needed

REC 12

Develop an agreement between the Ministry and the Police outlining processes to be used when a complaint of abuse is lodged

REC 19

Ensure those who can't speak for themselves, and/ or their families are involved in the residential service specification review

REC 14

Support the use of disability responsiveness tools and training materials for organisations that support disabled people

REC 12

Incorporate advice from the Police into the detailed processes for services on managing abuse

REC 19

Work with the sector on ways to involve people who can't speak for themselves in decisions affecting their lives

REC 14

Provide clear communication to the disability sector about the Ministry's position of zero tolerance to abuse

REC 13 15

Support the Police to use disability responsiveness training materials to enhance their skills when working with disabled people

REC 20

Incorporate into contracts and service specifications detailed processes for how to manage incidents of abuse

REC 15

Review and update policies relating to abuse prevention

REC 13

Review the agreement between the Ministry and Child, Youth and Family Services about working together

REC 21

Establish a Quality Improvement Panel to review and provide advice on complaints and issues

REC 16 17 18 30 32

Develop guidelines for services to proactively prevent abuse and processes for reporting when abuse does occur

REC 5

Develop an agreement with the Health and Disability Commissioner outlining processes when a complaint of abuse is lodged

REC 21

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Improving performance management

58%
Completed or ongoing

42%
In progress

Contract specialist investigator(s) to manage and carry out complaint investigations

REC 30

Review feedback on the performance of contracted evaluation agencies

REC 28

Introduce a new incident reporting form for all providers

REC 22 23

Assess other Ministry electronic provider databases for potential use by Disability Support Services

REC 33 34

Tender for evaluation services

REC 28

Develop guidance for service providers on what is a 'significant incident' and how to use the new reporting form

REC 22 23

Develop a database to improve Disability Support Services' management of service provider data and performance

REC 33 34

Publish and maintain a list of evaluation agencies on the Ministry's website that links to their websites and reports

REC 28

Investigate the development of a sector-wide tool for reporting, storing and analysing incidents and risks

REC 22 23

Present bi-monthly quality reports to inform Disability Support Services' decisions about provider performance

REC 33 34

Review the criteria the Ministry uses for deciding when to carry out issues-based audits

REC 29

Review service provider performance reporting tools

REC 24

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Improving performance management

58%
Completed or ongoing

42%
In progress

Ensure NASCs have available information on all support options so disabled people can make informed decisions

REC 35

Commission issues-based audits when and as required

REC 29

Work with the sector to ensure expectations of provider performance are clear

REC 24

NASCs provide information in a manner appropriate to the individual

REC 35

Improve processes for monitoring action plans resulting from issues-based audits

REC 29

Investigate a new evaluation tool that covers service quality and quality of life measures

REC 25 26 27

Support NASCs to adapt processes to allow a disabled person sufficient time to make informed decisions

REC 35

Review and improve the existing complaints management system

REC 30

Establish a working group to co-design proposals for changes to safety regulations in disability supports

REC 26 27

Support NASCs to use an escalation process when unsure about appropriate support options

REC 35

Provide training to Disability Support Services staff on the improved complaints management system

REC 30

Develop options to change regulation so disabled people can live ordinary lives free from harm, in the same way as others

REC 26 27

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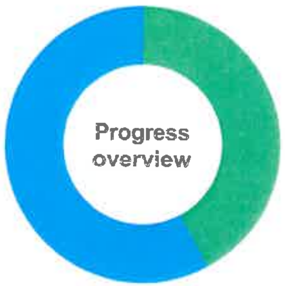
Supporting providers



42%
Completed or ongoing

58%
In progress

Encourage peak bodies to share best practice across sector

REC 6 36

Develop a comprehensive document outlining the Ministry's performance expectations of service providers

REC 1 11

Require peak bodies to routinely share information about good practice and service delivery

REC 6 36

Provide ongoing training to Disability Support Services staff on good contract management practice

REC 2 3 4 31

Review service specifications for accuracy, flexibility and a person-centred focus, to include outcome measures

REC 1 11

Ensure organisations have the knowledge and skills to implement quality governance procedures

REC 6 36

Increase requirements of providers to strengthen their focus on quality outcomes for disabled people

REC 1 11

Follow procurement guidelines and don't award new contracts to providers not meeting performance and safety standards

REC 7

Investigate reorganising Contract Relationship Manager roles around regions and specialist functions

REC 2 3 4 31

Promote good performance through Provider Forums

REC 1 11

Review process for deciding whether to issue new contracts to providers and use agreed tools to ensure consistency

REC 7

Develop a procurement strategy that increases choice, control and flexibility for disabled people

REC 5 9

Establish a recognition programme for providers who do high quality work

REC 1 11

Identify the skills needed to support people with high and complex needs in the residential service specification

REC 8

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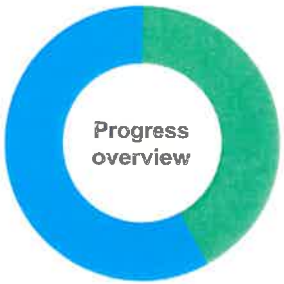
Supporting providers



42% Completed or ongoing

58% In progress

Encourage good providers to extend geographic boundaries

REC 5 9

Replace the Ministry's contract management system to reduce administration and increase the focus on relationship management

REC 2 3 4 31

Require providers to undertake police checks prior to hiring staff

REC 8

Develop alternative residential support options

REC 5 9

Streamline provider contracts to improve reporting and audit processes

REC 2 3 4 31

Establish a two-year project to provide paid internship opportunities for young disabled people

REC 10

Identify gaps in residential service delivery and engage providers to meet those needs

REC 5 9

Undertake a stocktake of Contract Relationship Manager roles to identify how they can be more efficient and effective

REC 2 3 4 31

Investigate the establishment of a two-year Mainstream supported employment placement for a disabled graduate

REC 10

Implement new payment structure to ensure nationally consistent and fair pricing

REC 5 9

Implement a risk management tool to improve performance management

REC 2 3 4 31

Actively ensure the employment of disabled people is promoted and supported within the Ministry

REC 10

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