IDEA Services Limited

Community Support Worker, Ms C

Community Support Worker, Mr B

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC00085)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A, aged 15 years at the time of these events, had cerebral palsy, epilepsy, profound intellectual disability, and spastic quadriplegia. He was fully dependent for all cares.

2. IDEA Services Limited (IDEA Services) provided respite care for Mr A at a residential home (the Home) where up to six young people at a time received respite care.

3. Ms C and Mr B were community support workers at the Home. Mr B had been employed by IDEA Services since 2008, and Ms C had been employed since 2010. Both worked part time at the Home, usually one shift a fortnight.

4. In 2014, Ms C and Mr B were on an overnight shift together, caring for six high needs young people. Their shift began at 2.30pm. Their evening duties included signing in the service users for that evening and any medications they brought, making and serving afternoon tea and dinner, administering medications, bathing service users, and assisting them to bed.

5. The house had two bathrooms, each with a bath. There were instructions for bathing service users, which included, "Never leave the children unsupervised whilst they are in the bathroom area", "full supervision" and "always be present when a person is bathing". However, a practice had developed at the Home whereby community support workers would leave children/young people, including Mr A, alone in the bath for short periods of time. Mr A's personal support information included statements that Mr A must be "supervised at all times" and "cannot be left alone". Mr A was not funded for 1:1 care.

6. Ms C assisted Mr A into the bath in Bathroom A using the hoist at around 8.20pm or 8.30pm. Ms C assisted with the other service users, including running a bath in Bathroom B for another child. Ms C checked on Mr A every few minutes. Once the second bath was run, Ms C assisted Mr B to bring the other child inside and help him into the bath. Both community support workers then left the bathrooms to do other tasks.

7. At around 9pm Mr B checked on Mr A and discovered that Mr A's head was submerged in the water and he was not breathing. Mr B and Ms C removed Mr A from the bath. Mr B commenced CPR and Ms C telephoned 111.

8. An ambulance was despatched at 9.02pm and arrived at the Home at 9.14pm. Mr B continued CPR until paramedics took over. Mr A was taken to hospital, where he died at 11.58pm.

Findings

9. Mr A was a vulnerable young man with high needs, who relied on IDEA Services to provide him with services of an appropriate standard. IDEA Services failed to ensure that adequate policies and procedures were in place, and complied with, in order to support Mr A effectively and prevent him being left unsupervised in the bath. Accordingly, IDEA Services failed to 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]

10. There was a lack of clarity in IDEA Services' policies and procedures regarding bathing, and Ms C did not receive adequate training in caring for Mr A. However, Ms C was aware that previously Mr A had had a seizure while in the bath, and the Deputy Commissioner considered it was evident that it was an unsafe practice to leave Mr A unattended in the bath. By leaving Mr A unattended, Ms C did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

11. Mr B was aware that Mr A was left unsupervised. Despite the lack of clarity in IDEA Services' policies and procedures, the Deputy Commissioner considered it was evident that it was an unsafe practice to leave Mr A unattended in the bath. Accordingly, by allowing Mr A to remain unsupervised, Mr B failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Recommendations

12. IDEA Services has made substantial changes since this event. The Deputy Commissioner made the following additional recommendations to IDEA Services:

a) Commission an independent review of:

1. the changes made since this event;
2. the personal plans and risk management plans for each client at the Home to ensure that each contains clear instructions specific to that person; and
3. the manner in which important information is conveyed to staff to ensure that this accommodates the English reading skills of staff;

and report to HDC on the findings and any resulting action.

b) With the assistance of an independent reviewer, develop a methodology for allocating staffing levels commensurate to the needs of service users. Provide this information to HDC.

c) With the assistance of an independent reviewer, develop policies and provide training to ensure that community support workers are aware of their ability to access on-call staff at any time. Provide HDC with evidence of the completed policies and training.

13. IDEA Services, Ms C and Mr B were each asked to provide a written apology to Mr A's family.

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

Complaint and investigation

14. Ms A complained about the care provided to her son, Mr A (dec), by IDEA Services Limited.

15. An investigation was commenced, and the following issues were identified for investigation:

- *The appropriateness of the care provided by IDEA Services Limited to Mr A.*
- *The appropriateness of the care provided by Ms C to Mr A.*
- *The appropriateness of the care provided by Mr B to Mr A.*

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

17. The parties directly involved in the investigation were:

Ms A	Consumer's mother
Mr B	Provider/community support worker
Ms C	Provider/community support worker
IDEA Services Limited	Provider

18. Information was also reviewed from:

New Zealand Police	
WorkSafe New Zealand Limited	
Ms D	Provider/Regional Services Manager
Ms E	Provider/community support worker
Ms F	Provider/community support worker
Mr G	Provider/caregiver
Ms H	Provider/Family/Whānau Manager
Ms I	Provider/community support worker
Ms J	Provider/community support worker
Ms K	Provider/community support worker
Ms L	Provider/community support worker
Ms M	Provider/community support worker
Dr N	Clinical psychologist

19. Independent expert advice was obtained from Margaret Wyllie, a registered nurse and quality auditor/evaluator (**Appendix A**).

Information gathered during investigation

Introduction

20. Mr A, aged 15 years at the time of these events, had severe intellectual, physical, and developmental impairments, and was fully dependent for all cares. Mr A lived at home with his mother Ms A, who had assistance from a caregiver, Mr G, for two hours per day.

21. IDEA Services Limited (IDEA Services) provided respite care for Mr A at the Home, a house where up to six children/young people[2] at a time received respite care. Mr A usually stayed from Friday afternoon until Sunday afternoon.

22. Ms A's complaint to HDC was prompted by Mr A's death. Sadly, Mr A was found unconscious in the bath at the Home and, despite CPR being performed, subsequently he died.

Bathing at home

23. Mr G told the New Zealand Police (the Police) that he had assisted Ms A with caring for Mr A at home since January 2012. Mr G stated that his duties included bathing Mr A each night. Mr G said he would set up everything he required prior to commencing the bathing, and that while Mr A was in the bath he would be lying down almost flat on his back with his legs extended, and the water was at a level that had his chest, knees and head exposed. Mr G stated that he "never left the bathroom while [Mr A] was in the bath", and that if he needed anything he would call for someone to assist him.

24. Ms A told WorkSafe New Zealand (WorkSafe) that Mr A was unable to sit up in the bath if unsupported. She said that Mr A loved having baths, and that Mr G would allow him to remain in the bath for up to 10–15 minutes. She stated that neither she nor Mr G left Mr A alone in the bath.

25. Ms A said that Mr A had up to eight seizures per day, and these might be either grand mal (tonic clonic)[3] or petit mal seizures.[4] She stated: "He's had them numerously in the bath. Temperature change was one of the causes for seizures for him …"

26. Ms A stated that she did not know that Mr A was sometimes left alone when being bathed at the Home.

IDEA Services Limited

27. IDEA Services provides services within New Zealand to over 750 group homes and over 350 vocational day services, and delivers support to approximately 7,000 people. IDEA Services is principally funded through the Ministry of Health by way of a

[2] Please note that the six individuals receiving care on this day were aged between 11 and 20 years. For readability, they are referred to as children throughout this report.
[3] Grand mal or tonic clonic seizures feature a loss of consciousness and violent muscle contractions.
[4] Petit mal seizures normally feature a shorter period of unconsciousness than grand mal. They may be associated with small twitching but do not involve loss of posture.

service agreement. In the service agreement, under the heading "5.7 Key Inputs", is a requirement that the provider will be responsible for employing competent staff for adequate hours for the needs of the service user group to ensure 24-hour provision of services. The service agreement states:

> "The Provider will have sufficient experienced staff to provide a level of service relative to the service user's assessed needs such as risk management, dual diagnosis, physical disability, intellectual disability, high medical needs, personal cares and social functioning.
>
> …
>
> The Provider will recruit and orient staff to meet the core staff competence components but will also be responsible to ensure the particular needs of service users are also addressed in the orientation and ongoing training programmes."

28. The respite care section of the agreement requires that the provider will provide a safe environment for the service users.

Staff at the Home

29. Care is provided at the Home by community support workers (CSWs). IDEA Services told HDC that for each shift, the manager chooses a lead staff member, who has the overall responsibility to ensure that all essential duties are completed. The lead staff member must be at least a CSW Level 3, and the chosen lead CSW is identified on the roster.

30. Community support workers range from Level 1 to Level 4, and each step is associated with an increase in pay. IDEA Services said that at the time of this incident, a person would progress in level primarily based on length of service. However, the time it took to move from CSW Level 1 to CSW Level 2 could be reduced with the completion of a Level 2 National Certificate in Health, Disability and Aged Support.[5]

Policies/information for staff

31. IDEA Services' bathing and supervision policy and procedure was set out in the "Family/Whanau Respite Centre Manual" (December 2012) (the Manual). The 115-page Manual was located in the staffroom at the Home. It provides under the heading Bathing/Showering — "**Never leave the children unsupervised whilst they are in the bathroom area!**" (emphasis in original).

32. IDEA Services' Significant Hazards register (November 2006), located in the Health and Safety folder in the staffroom at the Home, stated under the hazard Hot Water:

> "**Bathing Policy** *(unless agreed and documented in the person's support plan, the following points must always be followed.)*

[5] Idea Services told HDC that toward the end of 2014 the classification system moved from being service based to qualifications based, and progression in level now requires completion of a New Zealand Certificate in Health and Wellbeing.

> - Always be present when a person is bathing. It is possible to afford the person some privacy by sitting just outside the bathroom with the door ajar so you always have him/her in sight.
>
> …
>
> - If the phone should go, or someone is at the door, do not leave the bathroom to answer, they will ring back.
>
> If it is important that you answer, pull the plug in the bath and support the person out." (Emphasis in original.)

33. In response to the provisional opinion, IDEA Services said that managerial staff attended the Home regularly prior to the incident, and that staff had the opportunity to query at fortnightly meetings whether they could leave users at the facility unattended while in the bath.

Notices

34. At the time of these events, the Home had two bathrooms. In Bathroom A there was a clawfoot bath, which was used when the child was bathed using a hoist. Bathroom A had a notice on the wall stating:

> "[RESPITE HOME].
> PROCEDURES FOR BATHING AND SHOWERING
>
> BATHING.
> ALL STAFF PERSONS TO READ THE CARE PLAN FOR ANY PERSON PRIOR TO ANY PERSONAL CARES BEING ATTENDED TO.
>
> STAFF TO COLLECT ALL CLOTHING, TOWELS, FLANNELS, INCONTINENT GEAR, TOILETRIES PRIOR TO PREPARING TO BATH OR SHOWER.
>
> PROCEED TO RUN THE BATH — RUN COLD WATER FIRST.
> ADD HOT WATER.
> CHECK TEMPERATURE OF WATER.
>
> ASSIST CHILD/YOUNG ADULT INTO BATH
>
> FOLLOW THE INDIVIDUAL CARE PLAN AS SET OUT FOR THE PERSON BEING BATHED OR SHOWERED.
>
> ASSIST PERSON FROM BATH. REMEMBER TO TAKE PLUG OUT OF BATH AT THIS POINT.
>
> ASSIST WITH DRYING AND DRESSING ACCORDING TO THE INDIVIDUAL'S CARE PLAN. WIPE INSIDE BATH WITH STERILISING AGENT.

SHOWERING — FULL SUPERVISION DURING SHOWERING IS REQUIRED …" (Emphasis in original.)

35. Bathroom B had the following printed instructions:

"ALL STAFF TO READ THE CARE PLAN FOR ANY PERSON PRIOR TO ANY PERSONAL CARE BEING CARRIED OUT.

BATHING — FULL SUPERVISION DURING BATHING IS REQUIRED.

FOLLOW THE INDIVIDUAL CARE PLAN AS SET OUT FOR THE PERSON BEING BATHED.

SHOWERING — FULL SUPERVISION DURING SHOWERING IS REQUIRED.

FOLLOW THE INDIVIDUAL CARE PLAN FOR THE PERSON BEING SHOWERED." (Emphasis in original.)

Performance reviews

36. The standard of practice set out in IDEA Services' Guidelines for Managing Performance IHC/IDEA Services December 2008 and HRP-24 Performance Management 2001 states that performance reviews are to occur within the first three weeks of employment, and at least once every 12 months.

37. IDEA Services stated that these are guidelines only, "and do not contain stipulated rules that performance must be reviewed to a rigid schedule. This would be unworkable in practice."

Mr A's personal support documents

38. IDEA Services had a number of personal support documents for Mr A that are detailed below, along with relevant sections of these documents:

a) Mr A's Personal Support Information (10 May 2013): Under Bathing/Personal Hygiene, it states: "I require full support with this." It further states: "[Mr A] needs CSW to wash and dry his body, as he cannot do this by himself." Under Taking Medications, it states: "I have medication three times daily", and under Seizure Management, it includes: "Ensure medication administrated — then control seizures … Often I need a sleep after."

b) Mr A's Care Plan: Mr A must be "supervised at all times".

c) Mr A's Alert and Crisis Response form (undated): "Unable to get self in and out of bath etc." Further down the form it states: "Cannot be left alone" and "Supervision required".

d) Mr A's Risk Assessment and Management Protocols (8 April 2013) identify that Mr A required a hospital bed to prevent falls, and required incontinence products 24/7. This document also notes, as an example only, that "having a seizure in the

bath" is a possible risk to physical health. However, the risk of seizure is not one that was then listed as a specific risk to Mr A.

e) Mr A's Support Needs Assessment was created by a needs assessment and service coordination agency on 13 January 2010): "[Mr A] requires full assistance with all his washing and drying needs."

f) Medication and Health Folder. The folder contains a dose pack chart which notes "may cause sleepiness" next to four of Mr A's five medications, and blister pack pages which have a pharmacist's warning highlighted in yellow: "This medication may make you sleepy and make it dangerous to drive or operate machinery. **Limit alcohol intake**" (emphasis in original). The folder also contains MIMS data sheets for Mr A's medications. These data sheets list sleepiness or drowsiness as a side effect of all of Mr A's medications.

39. IDEA Services told HDC that the instructions in Mr A's personal support information and the Alerts and Crisis Response form, which respectively state "bathing and personal hygiene — I require full support with this" and "supervision required — cannot be left alone", clearly indicate that Mr A was not to be left alone at any time, including in the bath.

40. Mr A was not funded for 1:1 care (provided when a care worker is with a client at all times).

41. In response to the provisional opinion, IDEA Services said that the requirement of full supervision was to ensure that if Mr A could not be supervised 1:1, he would be brought together with other service users.

Incident

42. Ms A said that she contacted IDEA Services and arranged to bring Mr A in for respite care for a few days. She said that this was Mr A's first day back at the Home for some time.

43. There were two CSWs rostered on at the Home in the evening, Mr B and Ms C.

44. There were six high-needs children staying overnight on the day of this incident, including Mr A who had cerebral palsy,[6] epilepsy,[7] profound intellectual disability, and spastic quadriplegia.[8] He could not walk and was in a wheelchair, was non-verbal, incontinent and required full support with all care needs.

[6] 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.
[7] A neurological condition that manifests as recurring seizures.
[8] A subset of spastic cerebral palsy. Spastic quadriplegia affects the entire body. The term "spastic" refers to the muscle stiffness that accompanies the condition.

Mr B

45. Mr B commenced employment with IDEA Services in 2008, initially as a home support worker, and in 2009 he began working as a CSW at the Home. IDEA Services told HDC that Mr B completed orientation shifts with permanent staff including a Level 4 CSW, and that when staff are completing orientation shifts they are an extra staff person. IDEA Services said: "When the staff person is on orientation they read all of the personal support information of each individual."

46. Mr B told the Police that when he commenced his employment at the Home, there was an induction orientation to the Home. He said that he was not given a copy of the Manual, but was shown where it was. He stated that for his first few shifts he worked with a Level 4 CSW, Ms I. Ms I said that there would be only two staff members on duty even when one was going through orientation.

47. In 2009, Mr B completed 17 training courses, including Introduction to Intellectual Disability, Safety and Security, and Infection Control.[9] He attended courses on Medication Errors in 2011 and 2012, but undertook no further formal training thereafter except for completing a comprehensive First Aid course in 2013. IDEA Services told HDC that "[t]he record of learning is for core training and non-core formalised training and is not intended to record orientation or instruction changes with policy and procedure".

48. IDEA Services provided performance review documentation for Mr B for 2010 and 2011. In his 2010 review, Mr B was CSW Level 1. In his 2011 review, Mr B was CSW Level 2, and it is noted that he had not met the requirements to proceed to Level 3.

49. Mr B worked part time. He told WorkSafe that he worked for IDEA Services on a regular shift once a fortnight but, at times, he would have a month between shifts or, at other times, he worked several times a fortnight. He stated that he always worked at the Home, and that usually he worked every second week from 2.30pm Friday to 3pm Saturday. Mr B said that the CSWs would often get some sleep, but that "24 hours is a long time and you're sort of on duty the whole time. So if children were restless one night it could be quite tiring the next day."

50. Mr B told the Police that he remembers looking through some of the policies and manuals that were on site at the Home, and that the medication policy was explained to him. He said he was not given any copies of written policies or processes to keep. With regard to bathing, Mr B said he recalls being shown some information sheets that were in the bathrooms.

51. Mr B told the Police that he understood that full supervision was required when bathing children, and that full supervision meant being in the bathroom and able to support the child being bathed. He said he adhered to this policy for high needs children, but some children were able to bathe independently, for example, "an

[9] Six of the training courses were self-learning modules.

independent nearly 18 year old youth who it would not be fair to have someone in the bathroom with". Mr B further stated:

> "An overall blanket policy does not take into account the large variation of levels of care the children/youths need."

52. In response to the provisional opinion, Mr B said that "the occasions I had left children alone in the bath occurred whilst the hoist was still attached, thus making it highly improbable for the child to slip as they were supported by the hoist and sling".

53. Mr B said that the assessment as to who needed supervision and who did not was determined from talking to the parents and colleagues, and referring to the child's care plan. He told the Police: "[A]s far as I know other staff allowed the fully mobile children to bath themselves." Mr B stated that he was not aware of any policy or rules about one employee bathing two children at the same time with a child in each of the bathrooms.

54. Mr B told WorkSafe that he did not recall any training about what to do in the situation where he was bathing a child who needed full supervision and he was called away to help another employee or child. He stated that he had on occasions left a child alone in the bath, but just to "grab something like a second towel. So that would have been only a matter of seconds." He stated that he did not recall receiving any specific training on bathing or being trained as to how deep the bath should be.

55. Mr B stated that there was a team meeting every second Monday but, as usually he had class at that time, he was not able to attend all of them. He said that the minutes of the meetings were kept in the staff office at the Home and, if he missed the meeting, he would quickly flick through the minutes to check what was in them when he went back to work.

Ms C

56. Ms C commenced employment as a CSW with IDEA Services in 2010. Ms C stated that her induction to the Home was being told about the facilities at the Home and being shown how to do things. She said that she has dyslexia, so found reading policies and procedures difficult. She informed IDEA Services at her initial interview that she had dyslexia.[10]

57. In 2011, Ms C completed 21 training courses.[11] In 2012, Ms C attended a Medication Error course and completed family/whānau behaviour training. In 2013, Ms C completed the following courses: Workplace First Aid, Restraint Minimisation, Positive Behaviour Support, Pre-packaged Medication Level 2, and Advanced Moving People and Equipment.

58. Ms C told WorkSafe that although she had undergone medication training, the matters that were covered in the training were about the administration of medications, and

[10] This information is recorded in the interview notes and in the referee checks.
[11] Six of the training courses were self-learning modules.

she did not have any knowledge about the side effects of the medications administered. She said that she would know what the medications do "[o]nly by staff telling us and reading the information in the back of the medication folder. If it has actually been put in."

59. Ms C stated that there was supposed to be a staff meeting each fortnight, but from time to time meetings were cancelled. She said that at the staff meetings, children who were going to be attending that fortnight were discussed, and also hazards in the Home.

60. Ms C had performance reviews in 2012 and 2013. The overall assessment in the 2013 review is that Ms C had met the requirements to proceed to CSW Level 3. The document is signed by Ms C and the reviewer. IDEA Services told HDC:

> "Due to an administration error, [Ms C's] payroll record was not adjusted accordingly and no 'certified' record produced. The error was not raised by [Ms C] nor identified by her manager. Once the error became known, IDEA Services made adjustments in our Payroll which resulted in a back payment to [Ms C]."

61. Ms C stated that she worked at the Home on the first Friday/Saturday of each fortnight, and also provided weekly home support on Wednesdays, Thursdays and Sundays. She stated that her shift at the Home was from 2.30pm on Friday to 3.00pm on Saturday. Ms C said that she worked with Ms I on the Friday shift for around 18 months, until Ms I resigned.

62. Ms C said that if there were three or more children in the Home, there would be two support workers rostered on duty and, if less than three, only one. She said that, in addition to caring for the children, the CSWs were required to administer medication and do household tasks such as the cooking, cleaning and laundry. She stated that during the 24-hour shift she was at times able to have some sleep, but frequently children would be awake during the night.

Care of Mr A

63. Ms C stated that on the day of this incident she started work at the Home at 2.30pm and, at that time, there were a number of children there who had been attending a day-time holiday programme. She stated that between 2.30 and 3pm she was required to read the children's support plans for that day, and have a debrief with the other staff. She stated that because of the short period available, she would "skim" the support plan to see if there had been any changes. Ms C said that the children for the sleepover roster arrived between 3pm and 4pm.

64. Ms C stated that she believed that one of the children present that day had 1:1funding between 4 and 7pm, but there was no CSW rostered to provide the 1:1 care.

65. Ms C told WorkSafe that she and Mr B were on the same level, but she "took over a little bit on that shift because it was her regular shift" and not Mr B's. Ms C told HDC that she was CSW Level 2. In contrast, IDEA Services told HDC that Ms C was Level 3 and Mr B was Level 2, so Ms C was the lead CSW. IDEA Services said that, as the

only Level 3 CSW, Ms C was the lead CSW on shift, and this also meant that IDEA Services met its organisational requirements for at least one staff member to be CSW Level 3. The roster does not indicate that there was a lead CSW.

66. Ms A stated that she arrived at the Home with Mr A between 3.30pm and 4.00pm. She stated that she brought Mr A's medications with her and gave them to Mr B, and then left Mr A at the Home.

67. Ms C told WorkSafe that they were running late that day, and started dinner later than usual that evening. She said that she cooked dinner while Mr B looked after the children, and that dinner was served at around 6–6.30pm. The CSWs had to feed four of the six children.

Medication

68. Ms C stated that, following dinner, they administered the evening medications and began bathing the children. She said she gave Mr A his evening medications at 7.30pm because previously his mother had requested that he be given his medication at that time. Ms A told HDC that she did not instruct staff to give Mr A his medication at 7.30pm but had told staff on several occasions that Mr A should be given his bedtime medication about 20 minutes before bed because it sedated him.

69. Ms C said she gave Mr A his medication before his bath because they were running behind schedule. She stated: "[W]e have given [Mr A] medication before his bath before." Ms C said that she was not aware that any of his medications could make him sleepy, and did not know the side effects of any of his medications.

70. In response to the provisional opinion, IDEA Services said that the warnings were also "set out clearly, in bright yellow, on the very blister pack from which Ms C dispensed Mr A's medication on the evening the incident took place".

71. Mr A was prescribed the following medications:

a) Tegretol[12] syrup 100mg/5ml oral suspension 25mls — three times daily

b) Levetiracetam[13] 250mg tablet — one tablet twice daily

c) Clobazam[14] 10mg tablet — one at night

d) Quetiapine fumerate[15] 25mg tablet — two in the morning, two at night

e) Phenergan[16] 5mg/5ml oral elixir — 20mls at night

[12] Tegretol is a medication used primarily in the treatment of epilepsy and neuropathic pain. Common side effects include nausea and drowsiness.

[13] Levetiracetam is a medication used to treat epilepsy. It is used for partial onset, myoclonic, or tonic-clonic seizures. Somnolence is a common side effect.

[14] Clobazam is a benzodiazepine anticonvulsant used to treat epilepsy. Listed side effects include drowsiness. Clobazam was prescribed to Mr A alongside quetiapine fumerate and Phenergan to manage frequent night-time psychomotor agitation and sleep difficulty.

[15] Quetiapine fumarate is licensed for treatment of acute and chronic psychoses. Somnolence is a common side effect. Quetiapine fumarate was prescribed to Mr A alongside clobazam and Phenergan to manage frequent night-time psychomotor agitation and sleep difficulty.

f) Diazepam[17] 10mg/2.5ml rectal tubes — one rectally with seizure

Ms C's account

72. Ms C told WorkSafe that all six children present had high needs and, when one child was being bathed, the other CSW was responsible for five children. When asked whether she had been trained on what to do if she was called away when bathing a child who needed supervision, Ms C stated:

> "[W]ith [Mr A] my understanding was that … because we had the hoist and the sling that he was in that he was in a secured spot. So my understanding was that it was okay to leave him there for a few minutes just to go and check on other children, or assist if somebody needed to be assisted with."

73. Ms C told HDC that she thought it was safe to leave Mr A for short periods of time because she had him in the hoist and sling, which was a full body sling and also went between Mr A's legs. She said the sling was a U-shape that went under Mr A's bottom and up to his head so that he was secure. In response to the provisional opinion, IDEA Services told HDC that "[Ms C's] belief that the sling would prevent slipping was not known to IDEA Services and was at odds with the on the job bathing and hoist training she had received". It further said that there is no evidence that other staff shared this belief. As stated above, Mr B told HDC that he thought it was "highly improbable for the child to slip [if] they were supported by the hoist and sling". Ms C stated that it was a frequent practice for CSWs to leave a child unattended in the bath while they checked that the other children were safe. She said this would be for a few minutes at a time.

74. Mr A was bathed in bathroom A. Ms C stated to WorkSafe that the hoist she had been trained to use was not available that evening, and the hoist that was there was less comfortable for the clients. Ms C said that she had been shown how to use the hoist to put a child in the bath, but was never watched while she was doing so.

75. Ms C said that she was given no instructions as to how deep the water should be in the bath, or the correct temperature of the water, but she had been told to feel the water before putting the child in to make sure it was not too hot or cold. She stated that the depth of the water was so that it was in line with Mr A's ribcage while he was in the bath and that, while in the bath, he was still seated on the sling, which was attached to the hoist.

76. Ms C said that she had been told by Ms I and other staff to leave Mr A in the bath "for a little bit so that he can enjoy the water and enjoy a little bit of I guess the freedom of not being in his wheelchair". Ms C said that on most shifts she would leave children unsupervised in the bath for periods varying from a few seconds to around five

[16] Phenergan is an antihistamine that also has sedative effects. Phenergan was prescribed to Mr A alongside clobazam and quetiapine fumarate to manage frequent night-time psychomotor agitation and sleep difficulty.

[17] Diazepam is a sedative, muscle relaxant and anticonvulsant. It was prescribed for when Mr A had a seizure that lasted for longer than five minutes.

minutes. She said that it was her understanding that other staff also left Mr A in the bath unattended.

77. WorkSafe asked Ms C her understanding of the requirement "requires full support for bathing". She stated:

> "Full support is helping with cleaning. Supporting him in the bath. With [Mr A] it was making sure he was not going to slip down. Make sure that we secure him, that we do the whole personal cares …"

78. Ms C stated that she had bathed Mr A previously, and had never known him to slip in the bath. However, previously she had seen him have an epileptic seizure in the bath, during which he went stiff and developed shaking. She told HDC that he did not move from his spot during this seizure.

79. Ms C said that she assisted Mr A into the bath at around 8.20–8.30pm that evening. In an incident report she completed the following day, Ms C wrote that she gave Mr A a wash down and then let him relax in the bath, checking on him every few minutes. Ms C wrote that she went to help Mr B with the other service users, including running a bath for one of them.

80. Ms C stated that Mr A was "awake [and] happy in the bath" and she was "in and out of the bathroom" checking on the other children because one of the boys was in the kitchen.

81. Ms C said that she left Mr A again to assist Mr B with one of the other boys (Child A), who had been playing outside. She stated that Mr B had got Child A part way to the Home when he started "playing up", so she assisted Mr B to calm down Child A. She said that she had already run a bath in the other bathroom, and she put Child A into that bath tub. Ms C stated that she had never been instructed not to bath two children at the same time.

82. In her incident report, Ms C wrote: "Between 8.45[pm] and 9pm we had one of the service users a bit unsettled and getting out of the bath [so I] went and tried to calm him down."

83. Ms C stated:

> "And that was the time that, time flew by longer than I guess we both thought. And when I was calming Child A down, that's when [Mr B] said hey, I'll go and check on [Mr A] …"

84. When asked how long she had left Mr A unattended in the bath, she said:

> "[I]t felt like tops five minutes but I think it may have been longer because I just don't, I can't remember how long. I don't know how long a time went between me going and helping and it happening. It just, it didn't seem like a long time at all. It felt tops five minutes. It didn't feel longer than that."

85. Ms C stated that Mr B called to her to come to assist him with Mr A, and she helped Mr B to take Mr A out of the bath. Mr B commenced cardiopulmonary resuscitation (CPR) while she called 111 and also called the on-call supervisor, Ms H, who attended promptly.

Mr B's account

86. Mr B told the Police that he understood that Mr A needed full support in the bath. However, he added:

> "I don't believe it [was] unusual for staff to give [Mr A] personal time in the bath, I believe it was a general practice and all staff did this with [Mr A]. We would obviously still continually check him regularly, leaving him alone no more than a few minutes at a time."

87. Mr B told WorkSafe that he had bathed Mr A at least ten times, and Mr A had never had an epileptic event in the bath when he had bathed him.

88. The Police asked Mr B about his understanding of the meaning of "requires full support for activities such as bathing", and he replied that it meant that "they're not able to do that task on their own and they need support for all aspects of whatever task it says they needed that support for". He stated that he could not recall ever seeing a definition of what "support" meant.

89. Mr B said that there were signs about bathing and showering in each of the bathrooms at the Home, and that the signs said that all children required the same supervision.

90. When asked whether it was usual to give Mr A his bedtime medication before or after his bath, he stated that he was not sure and it would depend on the time. Mr B stated that he was not aware of any of the children present that night having 1:1 funding.

91. Mr B said to the Police that early on in the shift, he and Ms C discussed the tasks for the night, and Ms C said that she would bath Mr A. Mr B further said that Mr A's bathing was organised and supervised by Ms C. In response to the provisional opinion, Mr B said that Ms C "did not request additional help and support to do so, meaning I believed she felt confident to provide the care for that task".

92. Mr B told the Police that after dinner he carried out the normal tasks and went outside to clean up the sand from the sandpit. He said that at around 8.30pm he came inside and heard Ms C in the bathroom with Mr A. He recalls Ms C running another bath for Child A.

93. Mr B said he remembers that he assisted Ms C to get Child A inside, as Child A was very upset, and "once [Child A] was in the bath he was left as he is very independent and can be left alone". Mr B said that at that stage he went to do another task and, whilst working, he checked on Child A a few times.

94. In an interview with Worksafe several months after the incident, Mr B said that he remembers hearing the door open and shut a few times while Ms C was bathing Mr A,

but he was not aware whether she had left the bathroom or not. Mr B told Worksafe that Child A had got out of the bath while Mr B was in the lounge with the other children. He said Ms C heard Child A and came out, and then the two of them both got him quickly back into the bath. In response to the provisional opinion, Mr B said that he did not request or expect Ms C to leave Mr A to support the other children, and that doing this was Ms C's choice.

95. Mr B told the Police that at about 9pm he went to check the bedrooms by the bathroom Mr A used. He stated that the bathroom door was shut, so he opened the door to greet Mr A and check on him. In the incident report form that Mr B completed on the day after the incident, he wrote that "normally both staff will check in on children even if they are not the one bathing that child". In response to the provisional opinion, Mr B said that he intended this comment to mean checking in with the staff member bathing the child not as a replacement for the staff member. Mr B said that he expected to find Ms C in the room.

96. Mr B discovered that Mr A had vomited in the bath and was submerged in the water. Mr B noted that the water was deeper than he would have had it himself when he bathed Mr A. In response to the provisional opinion, Mr B said that the hoist sling straps were detached and in the water. Mr B had not previously told this to the Police or Worksafe. In his interview with Worksafe, Mr B said: "I remember the top 2 ones from the sling were attached. And possibly the side ones. But I can't remember exactly."

97. After Ms C and Mr B took Mr A out of the bath, Mr B commenced CPR. Mr B told Worksafe that he believes Mr A would have been left alone in the bathroom for less than a minute overall.

Ambulance service

98. According to the ambulance service patient report form, an ambulance was despatched at 9.02pm and arrived at the Home at 9.14pm. At 9.34pm Mr A was transferred by ambulance to the public hospital, arriving at 9.39pm.[18]

99. The attending paramedics told the Police that Mr B had said to them that Mr A would have been under the water for a maximum of five minutes.

Ms H

100. At the time of this incident, Ms H was employed by IDEA Services as a Family/Whānau Manager. She stated that she had been in the management role since 2013. Ms H told Worksafe that her role included recruiting new staff members as foster caregivers, supervising co-ordinators, staff meetings, caregiver meetings, monthly home visits with caregivers, data entry, and updating personal support information alerts and crisis support plans. She stated that she also managed the Home, which included completing the bookings for the children attending the Home,

[18] The times in this form were corrected by one of the paramedics. The original form recorded that the ambulance was despatched at 8.37pm, arrived at the Home at 8.41pm, left for the hospital at 9.33pm and arrived at 9.52pm.

and staff rosters for the overnight shift. Ms H suggested to Worksafe that the job was busy.

101. Ms H stated that on that day she went to the Home between 3.30pm and 4.30pm to collect a service user's property. Ms H said that on that afternoon the Home seemed normal and no more busy than usual. She said that no concerns were raised with her.

102. Ms H then left the Home but remained on call. Ms H stated that at 9.16pm she received a telephone call from Ms C saying that Mr A had drowned in the bath, and she went directly to the Home. Ms H stated that when she arrived there were two ambulances present, Mr A was on the floor, and Mr B told her he had been working on Mr A for 20 minutes doing CPR.

103. Ms H said she went into a bedroom where Ms C was with the other children. Ms H then rang the regional service manager for IDEA Services, Ms D, and gave her information about what had occurred and Ms A's telephone number and address. Ms D went to Ms A's home and drove her to the hospital.

104. Ms H said that she assessed the situation and gave instructions for the children to go to bed. Ms H then travelled in her own car to the hospital, and left Ms C and Mr B with the children. Mr B and Ms C remained on duty and finished their shift.

Mr A's death

105. Mr A was transferred to the intensive care unit. He did not regain consciousness and, sadly, died at approximately 11.58pm.

Subsequent events

106. Mr B and Ms C were placed on leave. Mr B was given a first written warning, which acknowledged that he was not directly responsible for the support provided in the bathroom, but stated: "However you were jointly responsible for the care and welfare of all the children on site and as such when you noted your colleague was not following policy you should have raised that with her." Mr B was advised that he was required to undertake a full reorientation prior to his next scheduled work time. Mr B resigned from IDEA Services.

107. Following an investigation, Ms C's employment was terminated.

Further information

IDEA Services Limited

108. IDEA Services told HDC that Ms C received advanced hoist training when she completed her Advanced Moving People and Equipment course in 2013, and that this training was relevant to Mr A's specific needs. IDEA Services noted that, for at least 12 months, Ms C received on-the-job training with a CSW Level 4, who showed her bathing procedures for children in the respite service.

109. IDEA Services stated that new employees received most of their training at the commencement of their employment, and training beyond that period may be for

refresher purposes or to meet some particular service user need, or for advancement towards a further qualification.

110. IDEA Services acknowledged that the day of Mr A's death was busy at the Home, but said it does not know why Ms C and Mr B did not call for assistance when it became clear they were running behind schedule. IDEA Services stated that it ran an "on-call" system for such an eventuality. IDEA Services further stated that an entry in Ms C's case notes previous to this incident demonstrates that Ms C had experience in calling in an additional CSW, and had recently been reminded by Ms H that she should do so if needed. Ms H's entry stated:

> "I phoned [Ms C] after reading an incident report regarding an incident at the Home this weekend where [Ms C] phoned [Ms L], asking her to come to [the Home], instead of contacting on-call. I asked why [Ms C] had phoned [Ms L] instead of on-call. [Ms C] said she rang [Ms L] because she lives just around the corner, and at the time, didn't think to ring on-call. I informed [Ms C] on-call would have responded straight away, and in the future, she was to contact on-call."

111. In response to the provisional opinion, IDEA Services said that Ms C had the choice not to bath Mr A that night and to wait until the next day.

Other staff

112. The Police and Worksafe interviewed a number of other staff at the Home about their training and practices when bathing children.

113. CSW Ms E stated that she knew there was a manual in the staff office, but had never read it. She stated that she knew she was not supposed to leave anyone by themselves, even if they were capable of looking after themselves. She said she did not receive any training during her orientation in relation to bathing a child, and the only training was on the job, with no formal assessment.

114. Ms E stated that she thought full supervision during showering meant that you would stay with the children and be visible all the time, but noted that people have a right to their privacy. She said that if they are capable of doing things themselves it is not necessary to stay with them. She stated: "I know there are a number of children who are left alone in the bath or shower not fully supervised. The senior staff knew the kids better than I did and I suppose they used their common sense." She said she had bathed Mr A but did not recall ever leaving him in the bathroom on his own.

115. CSW Ms F stated that the training she received on bathing was after induction, and was on-site informal training provided by the senior staff member present. She does not remember receiving a copy of the Manual, but knew there was one in the staff room at the Home, and said she had browsed through it as time allowed.

116. Ms F said that if she needed something from outside the bathroom when she was bathing Mr A, she would call from the door to the other staff member and would never leave Mr A unattended. She said: "I never saw anyone giving [Mr A] time in the bath alone but there were definitely other children at the facility that could bath or

shower themselves." She said that if a child was left alone the door was left open so they could be heard and easily checked.

117. CSW Ms M stated that she had read the Manual, including the Bathing Policy, and noted that the policy is very similar to, but not word for word the same as, the document on the wall in the bathroom. She said she understood that staff needed to be in the bathroom at all times, but that some of the older children liked to shower alone and their parents were happy for that to occur. She stated that there was no formal assessment in relation to bathing.

118. Ms M said that she used to stay with Mr A and bathe him the whole time except when she was preparing his bed with a shower curtain and a towel over it so that the bed would not get wet. Ms M said that when she left Mr A, she would hoist him out of the water so he was fully supported by the hoist. She said, "This would only have taken a second or two. On going back into the bathroom I would normally lower [Mr A] back into the water to get him warm and then take him back out and take him to his room and get him dressed."

119. CSW Ms J stated that she was required to read the Manual prior to working at the facility, and had read it during her orientation. However, she was not given a copy to keep. She cannot remember anything in the Manual about bathing, but thought that it mentioned to check each service user's individual care plan for bathing requirements. She said that during her first shift at the facility she was taken through bathing a child using the hoist, but she never underwent an assessment in relation to bathing a child.

120. When asked what she thought "full supervision during showering is required" meant, Ms J said it probably meant being in the room with the children for the whole time while they were being showered. She added:

> "This is quite a silly statement to have as there were children … who are teenagers and only have an intellectual disability. They were aware of their 'development' and were embarrassed and wouldn't shower if I tried to stay in the room with them. I have worked with other staff who I have seen leave [Mr A] in the bath alone for short periods; but they would always check him regularly."

121. CSW Ms L stated that she was shown some folders but never given the time to read the folders thoroughly, and she was "thrown into the job", which was "full on". She said she was given five policies, and is confident that none of them related to bathing children. She stated that she does not recall having seen the Respite Care Manual.

122. Ms L stated that she had, at times, left Mr A unattended in the bath "to attend issues with the children such as them hurting each other or breaking something, answering the door or to get something [she] had forgotten".

123. CSW Ms K stated that Ms I, who was CSW Level 4, orientated him to the hazards and all the procedures at the Home, and that this took about one hour.

124. Mr K said that he also received hoist training several times at IDEA Services. Mr K stated that he never left the children who needed the sling in the bath for any amount of time. He said that Mr A's legs and hands were not strong and so he was extremely careful when putting him in the bath, and he would remain in the sling the entire time. Mr K said that none of the staff he worked with left Mr A alone in the bath.

125. When asked what "requires full support for bathing" meant, Mr K said: "That means the person cannot do anything for himself and the IDEA Services policy is that you cannot leave a client in the bathroom or in the bath even in the shower … by themselves."

126. Former team leader Ms I stated that she conducted orientation training for new staff, which "normally lasted a couple of hours". Some training was conducted during the day when there were no children present, but training such as bathing was conducted with the children present. She said that there would still be only two staff members on duty even when one was going through orientation.

127. Ms I stated:

> "Part of this orientation was informing new staff about a number of relevant manuals they were required to read. These manuals included Health and Safety, Infection Control, Respite Facility and Hazard Control. Another manual included procedures and policies for IDEA Family/Whanau Services … Some of the manuals had a page in the front that the staff were required to sign once they had read them … These manuals were quite lengthy and it would have taken a couple of full days to get through them all. Once the staff member gained employment many would come in early prior to starting work to read some part of a manual and others read them at night once the children went to bed."

128. Ms I noted that there were some more capable children who could be left alone in the shower for up to five minutes at a time, and that these children would not shower unless they were left alone.

129. Ms I stated that when she bathed Mr A she filled the bath until the water came to the top of his chest when he was lying down, and she lowered him in using the hoist, and disconnected the sling while washing him. She added: "On the odd occasion he would slip slightly and I was able to pull him back up again." Ms I said that the last time she bathed Mr A, she left him for a few seconds in the bathroom with the door open to get his towel, as she had forgotten to take it into the bathroom. Ms I stated that her routine was to have one of the more able children in the shower in one bathroom and a second child in the bath in the other bathroom, but she never had two children in baths at the same time.

Steps taken following Mr A's death

130. After Mr A's death, IDEA Services took the following steps:

a) An experienced family/whānau manager temporarily managed the Home Respite Service for a six-week period.

b) It arranged for Ms D to carry out a management review of Mr A's death, which found that Ms C and Mr B may have become complacent about IDEA Services' policies and appeared to have made up their own rules.

c) It formulated an "Action Plan for the Home Respite Centre" as follows:

i. A memo was disseminated to all IDEA Services Respite to ensure that the Bath and Showering Policy was understood, displayed prominently and signage reviewed regularly by the family/whānau manager and level 4 CSWs.

ii. All support documentation for the Home Service users was reviewed by IDEA Services' family/whānau manager, in particular the Alert and Risk information.

iii. By two months after the incident, all the Home CSWs had been re-orientated with an emphasis on keeping children/young people safe.

iv. Additional training was provided to the Home staff regarding safe handling, hoist, bathing, medication and epilepsy.

v. Improvements were made to the roster system to ensure that staff held distinct responsibilities each shift and a lead CSW was designated. Roles and duties were reiterated at team meetings.

vi. The minute format to be used for staff meetings was updated to include a section for relevant training/discussion/updates on specific policies and procedures.

131. In addition, IDEA Services engaged Dr N (a clinical psychologist) to conduct an independent investigation into Mr A's death. IDEA Services formulated an action plan, based on Dr N's recommendations, which was completed as follows:

a) A process was set in place to ensure at least four-weekly visits to the Home by the family/whānau manager.

b) Service user medication folders were reviewed to ensure they were in line with policy and that side effects of sedation were highlighted as an alert. Medication side effects alerts were also updated on its electronic system.

c) Staff received dedicated training delivered by a pharmacist regarding side effects of medication. A laminated list of side effects for the medications in use at the Home was placed in a folder available to the staff.

d) The Home orientation process and content was reviewed by a service advisor to ensure it provided clear guidance for those staff responsible for orientation delivery.

e) The Sole Charge Competency Assessment was introduced as an assessment tool for all new and existing staff.

f) Staffing allocations at peak times were reviewed. Additional funding was obtained for one client.

g) The on-call role was reiterated to staff at a Respite Quality Forum held for staff.

h) A service review was undertaken to identify domestic tasks that could be performed while children were asleep rather than before bedtime.

i) Arrangements were made for the holiday programme to be relocated off site.

j) The maximum number of children at the Home overnight was reduced from six to five.

k) IDEA Services removed the second bath in Bathroom A at the Home so that it would be impossible for one staff member to bath two children at the same time.

l) A monthly newsletter was introduced as another form of communication with families.

m) A checklist was implemented for staff handover between shifts.

Wider organisational steps

132. IDEA Services has undertaken a comprehensive review to consider wider organisational lessons resulting from Mr A's death as follows:

a) IDEA Services undertook a review to consider the best quality dimensions of a respite service. A project manager was appointed to oversee the implementation of the clinical director's recommendations across respite services.

b) The Bathing Supervision Policy for Respite Services has been amended further.

c) New instructions have been issued to all respite service managers regarding how to describe supervision requirements in service users' support information.

d) Direct management support of all respite services has been increased with greater time allocated to actively monitor and coach staff.

e) Changes have been made to strengthen the booking and rostering arrangements managed by the service managers of each respite service.

133. IDEA Services said that it has met with, and provided regular updates to, the Ministry of Health, which commissioned the Standards and Monitoring Services Board to complete developmental evaluations of all facility based respite services operated by IDEA Services. The evaluations occurred during April–July 2015, and the evaluation of the Home was positive, with no requirements identified to meet contractual service specifications.

134. IDEA Services' senior officers have met with Ms A to apologise formally for Mr A's death and share with her the findings of the internal management review.

135. IDEA Services provided financial assistance to Ms A for funeral expenses and the cost of a headstone.

136. IDEA Services was prosecuted by WorkSafe New Zealand. The District Court ordered IDEA Services to pay $90,000 reparation and a fine of $63,500.

Further information — Ms C

137. Ms C told HDC: "What has happened to [Mr A] is mine and everyone's worse nightmare, I have to live with this every day." Ms C stated that she worked in this field because she enjoys helping and looking after people, and said she cared deeply for the children she looked after. She stated:

> "If I would have known then what I know now of course [Mr A] would still be with us. I did and followed what I was taught by senior staff and my intention was always to care for the children and keep them safe. However, that proved not to be so."

138. Ms C expressed a wish that these circumstances not happen to any other child or caregiver, and that the rules be made clearer.

Responses to provisional opinion

139. Responses to the provisional opinion were received from IDEA Services, Ms C and Mr B. Ms A provided a response to the "information gathered" section of the provisional report. Where appropriate, their comments have been incorporated into the "information gathered" section above.

140. In addition, IDEA Services told HDC that it considers that the policies and procedures for bathing Mr A were clear. IDEA Services said:

> "It is true that the prohibition on leaving [Mr A] alone is expressed in different ways across the documentation. But it must be acknowledged that different ways of expressing information can increase the understanding of such information to different individuals and can assist in making the overall message clear. Here, the different formulations in each of the documents above conveyed the same message: [Mr A] was not to be left alone, especially not in the bath."

141. IDEA Services said that it was not necessary to have specific instructions not to bath two children at the same time because there was clear instruction from IDEA Services that Mr A was not to be left unsupervised in the bath.

142. IDEA Services advised that "it was simply not foreseeable to IDEA Services management that one of its support workers would make such a radical departure from clear policy and from common sense in caring for someone with [Mr A's] degree of disability. To say that monitoring was inadequate is to speak with the benefit of hindsight".

143. Idea Services said "there does not appear to have been any confusion on the part of staff about supervision not being required when [Mr A] was asleep".

144. IDEA Services told HDC that it is sorry that Mr A died in such distressing circumstances and for the impact this has had on Mr A's family. It said that it has learnt from Mr A's tragic death and has made substantive improvements to strengthen its existing systems and processes.

145. Ms C provided an apology letter for forwarding to Mr A's family. She had no further comments to make in response to the provisional opinion.

Relevant standards

146. The New Zealand Health and Disability Sector (Core) Standards (NZS 8134.1:2008) 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 8134.1 requires the following:

> "a) Consumers receive safe services of an appropriate standard that complies 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."

147. NZS8134 provides (amongst other things) the following:

> "**Standard 2.8**
>
> **Consumers receive timely, appropriate, and safe service 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.**" (Emphasis in original.)

Opinion: Introduction

148. Mr A had severe intellectual, physical and developmental impairments, and was fully dependent for all cares. Mr A's mother arranged for him to receive respite care from IDEA Services for a few days in 2014. Mr A's mother trusted IDEA Services to care for Mr A and keep him safe. Mr A was found unconscious in the bath and, despite CPR being performed, subsequently he died.

149. 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.

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

Factual findings

151. The sequence of events is not entirely clear. Based on my review of the evidence, I consider that, on balance, the following occurred:

a) Ms C assisted Mr A into the bath in Bathroom A using the hoist at around 8.20pm or 8.30pm.

b) Between 8.30pm and 8.45pm Ms C assisted with the other service users, including running a bath for Child A in Bathroom B. Ms C checked on Mr A every few minutes. Once a bath was run for Child A, Ms C assisted Mr B to bring Child A inside and help him into the bath.

c) Once Child A was in the bath, both community support workers left him to do other tasks.

d) At some stage between 8.45pm and 9pm Child A got out of the bath. Both care support workers assisted him back into the bath.

e) At around 9pm Mr B checked on Mr A and discovered that Mr A's head was submerged in the water and he was not breathing. There was also vomit in the bath.

f) Mr B called out to Ms C for assistance.

g) Mr B and Ms C removed Mr A from the bath. Mr B commenced CPR and Ms C telephoned 111.

h) An ambulance was despatched at 9.02pm.

i) An ambulance arrived at the Home at 9.14pm and Mr B continued CPR until the paramedics took over.

j) Ms C telephoned Ms H at 9.16pm.

k) At 9.34pm Mr A was transferred to the public hospital and arrived at 9.39pm.

152. I am unable to make a finding as to the number of times that Mr A was left alone in the bath between 8.30pm and 9pm, and the duration of each period. I am also unable to make a finding on whether Mr B told Ms C that he would go to check on Mr A after assisting Child A back into the bath, or whether Mr B left to do other tasks and checked on Mr A on his way past the bathroom.

Opinion: IDEA Services Limited — Breach

Introduction

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

154. IDEA Services had a responsibility to ensure that Mr A received appropriate and safe services from suitably trained and experienced CSWs. I consider that there are several areas where the care provided to Mr A by IDEA Services fell short of the accepted standard. I have considered these below.

Care provided to Mr A

Care planning

155. Care plans are an essential tool for ensuring that consumers' care requirements are kept up to date and are communicated to all staff involved in that person's care. It is the proper documentation of this process that ensures continuity of care. NZS8134.1:2008 also requires that "[c]onsumers' service delivery plans are consumer focused, integrated and promote continuity of service delivery".[19]

156. The information available to the CSWs about the requirements when bathing Mr A could be found in a number of different documents. The Bathing Supervision Policy and Procedure was set out in the "Family/Whanau Respite Centre Manual", a 115-page document. It provides under the heading Bathing/Showering, "**Never leave the children unsupervised whilst they are in the bathroom area!**" (emphasis in original).

157. In addition, Mr A's personal support information under Bathing/Personal Hygiene provides, "I require full support with this", and, "[Mr A] needs CSW to wash and dry his body, as he cannot do this by himself."

158. Mr A's Risk Assessment and Management Protocols note as an example only that "having a seizure in the bath" is a possible risk to physical health. However, the risk of seizure is not then listed as a specific risk to Mr A, and therefore the potential triggers or management strategies were not assessed and recorded in this document. I note that Mr A experienced frequent seizures, including in the bath.

159. There were notices in each bathroom, containing differing information. The bathing/showering information in the manual does not include the same instructions as in the bathrooms. In particular, the notice in Bathroom A did not refer to a requirement for full assistance during bathing.

160. In my view, it was not good practice to have the instructions for bathing Mr A spread over a number of different documents containing different information. I consider that staff should have been able to access all relevant information easily to ensure that they had the information required to provide appropriate care.

[19] Standard 3.5.

161. Furthermore, I do not consider that the policies and plans provided were sufficiently clear that Mr A was never to be left alone in the bath. The instructions that Mr A was to be supervised at all times and could not be left alone were impractical, given that two staff members were caring for six high-needs children. As the staff were permitted to sleep overnight, it is clear that they were not expected to supervise Mr A at all times, for example, when he was in bed. I acknowledge IDEA Services' submission that there does not appear to have been any confusion on the part of staff about supervision not being required when Mr A was asleep. However, I remain of the view that multiple staff were of the view that they could leave children, including Mr A, alone in the bath for short periods of time.

162. I agree with my expert advisor, registered nurse and quality auditor/evaluator Margaret Wyllie's advice that the "documents in relation to [Mr A's] Personal Plan and risk management are not consistently clear with [bathing] instructions". Furthermore, it is evident from the interviews conducted with staff that most staff members believed it was acceptable to leave children (including Mr A) unattended in the bath for brief periods, and several commented that it was accepted that some children, who had lesser needs, could be allowed to shower unattended.

Medication

163. Mr A was prescribed a number of medications, some of which had a sedative effect. However, Ms C said that her medication training had focused on the administration of medications, not the medications themselves, so she did not know the side effects of any of Mr A's medications and was not aware that his medications might make him sleepy.

164. It was noted on several documents in Mr A's Medication and Health Folder that the medications may cause sleepiness or drowsiness. In addition, in response to the provisional opinion, IDEA Services advised that the warnings were also set out clearly, in bright yellow, on the blister packs. However, I remain of the view that these warnings were not sufficient to alert the CSWs that there could be a risk if Mr A's medication was administered prior to his bath. If this was a risk for Mr A, IDEA Services needed to ensure that the CSWs were aware of it. In my view, the warnings were not sufficiently relevant to Mr A's circumstances for the significance to be apparent to the CSWs.

Staff orientation and training

165. Mr B commenced employment with IDEA Services in 2008, and as a CSW at the Home in 2009. Although he underwent orientation, Ms Wyllie advised that the induction process documents were not completed accurately, and that it is unclear where the orientation occurred and whether it was specific to the Home. She noted that there were no follow-up notes. Ms C commenced employment in 2010 and she also underwent orientation and in-service training. Again the documentation is incomplete.

166. Ms I, who conducted the orientation and training for new staff, stated:

> "Part of this orientation was informing new staff about a number of relevant manuals they were required to read. These manuals included Health and Safety, Infection Control, Respite Facility and Hazard Control. Another manual included procedures and policies for IDEA Family/Whanau Services … Some of the manuals had a page in the front that the staff were required to sign once they had read them … These manuals were quite lengthy and it would have taken a couple of full days to get through them all. Once the staff member gained employment many would come in early prior to starting work to read some part of a manual and others read them at night once the children went to bed."

167. It is evident from the interviews with staff members conducted by the Police that many of the staff did not have a clear memory of having read the Manual. I am concerned that the Manual did not appear to have been read and used appropriately.

168. I note that Ms C has difficulty with reading as she suffers from dyslexia and, at the time of her appointment to her position, she informed IDEA Services of this issue. I am particularly concerned about the expectation that she would read a 115-page manual plus the support plans and other policies. However, I accept that Ms C had worked with an experienced CSW, Ms I, prior to these events and received on-the-job training from her.

169. With regard to ongoing training, Mr B completed the majority of his training between his start date and the end of 2009. Similarly, Ms C completed the majority of her training in the first year of her employment. However, there is no evidence that either CSW had specific training with regard to Mr A's needs other than the training Ms C received while working alongside Ms I. In addition, it appears that Ms C and Mr B believed that the hoist's sling prevented Mr A from slipping under the water. I am concerned by this, as it suggests that IDEA Services did not make it sufficiently clear that the sling would not prevent someone from slipping under the water.

170. I note that Ms I said she would leave more capable children alone to shower for up to five minutes at a time and had also left Mr A alone in the bath for a few seconds, with the bathroom door open, while she got a towel. Ms Wyllie stated: "There was no evidence of practical application or assessment of individuals with high/complex needs bathing or showering routines undertaken with staff."

171. Ms Wyllie further advised me that there did not appear to be a system for monitoring practices at the Home so that the more senior staff knew that the policies and processes set out in the Manual and other manuals were being followed, to ensure that an accepted standard of practice was occurring at all times. I am concerned that Ms C's and Mr B's orientation/induction documents were not completed, and neither of them appeared to have had specific training as to Mr A's needs, other than Ms C's time alongside Ms I. Furthermore, "on-the-job" training was insufficient in this case because the care plans were not sufficiently clear, staff practices had developed that were not in accord with the plans, and there was no robust system for monitoring the adequacy of the "on-the-job" training.

172. It is clear that a culture had developed at the Home whereby CSWs of all levels would leave children, including Mr A, alone in the bath for short periods of time. There is no value in a policy that is not followed by staff. In my view, staff should have been assessed while bathing/showering children, and also should have had regular refresher training to minimise the risk of practices diverging from IDEA Services' policies over time.

Performance reviews

173. Mr B had two performance reviews as a CSW, in 2010 and 2011. There are no performance review records for 2012/13, despite IDEA Service's guidelines for managing performance requiring that performance reviews occur at least every 12 months.

174. Ms C had one performance and development review, which is not dated, and two community support worker performance reviews, one dated 2012 and the other dated 2013. I note Ms Wyllie's advice that "[p]erformance reviews are an integral part of good employer/employee relationships and are pivotal to fostering these relationships". There appear to have been departures from IDEA Services' policy with regard to the performance reviews of both CSWs, and I am critical of this.

Staff-to-client ratio

175. No more than six children per night were permitted to stay overnight at the Home, and if there were six children present, two CSWs were rostered on duty.

176. On the evening that this incident occurred, six children were present at the Home, and each child had complex/high needs. During the afternoon there were a number of people arriving and leaving, as the children in the holiday programme were leaving and children were arriving for the overnight stay.

177. Ms Wyllie advised me that "[t]he configuration of the Home needed to be organised to meet the needs of the incoming children". In Ms Wyllie's opinion:

> "The staff to client ratio at [the Home] on [this day] appears to have been inadequate to meet the needs of these children in a safe way. Practices were compromised … There was a departure from the standards of care expected, especially when both CSWs were outside at one point encouraging the young person who was acting up to come inside …"

178. I endorse Ms Wyllie's advice. The six children at the Home that night had high needs that required a great deal of assistance from Ms C and Mr B. IDEA Services did not ensure that the staff-to-client ratio could meet the needs of the children in a safe way.

179. Linked with this, IDEA Services had not given staff clear instruction not to bath two children at the same time, a practice that was unsafe in circumstances where there were only two support workers caring for six children. IDEA Services submitted that this was not necessary, due to the clear instruction that Mr A was not to be left unsupervised in the bath. I disagree and I remain of the view that IDEA Services did not provide clear instruction that Mr A should never be left alone in the bath. Having

said that, I accept that the CSWs had on-call assistance available, but note that they did not contact the on-call assistance when they found they were behind schedule.

Supervision

180. Both Mr B and Ms C worked only part-time at the Home, usually alternate overnight shifts on a Friday. As these were often alternate weeks, they had worked very few shifts together. In my view, it is of particular importance that staff who work infrequently have clear instructions and are supervised at a level appropriate to their knowledge and experience.

181. IDEA Services told HDC that it had a management practice whereby a lead CSW must be rostered on to each shift, and that this person must be a CSW Level 3 or above, and must be identified on the roster. Although IDEA Services states that Ms C had achieved a Level 3 Career Force status, I consider that Ms C's performance review record that states she met the requirements to proceed to CSW Level 3 is insufficient to confirm this. Ms C's own view was that she was CSW Level 2. Furthermore, Ms C was not identified on the roster as the lead support worker.

182. IDEA Services' management practice for supervision was not followed on the day of this incident, and, in my view, this contributed to a lack of clear divisions of roles and tasks.

Conclusions

183. Mr A was a vulnerable young man with high needs, who relied on IDEA Services to provide him with services of an appropriate standard. In my view, IDEA Services failed to meet that standard, and a range of factors contributed to that failure. These factors were as follows:

- IDEA Services' instructions with regard to bathing children were set out in a number of different places, and the information was not consistent.
- Mr A's care plan provided ambiguous instructions regarding bathing, and did not state unequivocally that he was never to be left unattended in the bath. The risk of Mr A having a seizure in the bath had not been assessed, and management strategies had not been recorded.
- The warnings noted in Mr A's Medication and Health Folder that medications may cause sleepiness or drowsiness were not sufficiently relevant to Mr A's circumstances to alert the CSWs to the potential risk of administering Mr A's medication prior to his bath.
- Ms C and Mr B lacked training specific to Mr A's needs.
- Staff were not assessed while bathing/showering children, and did not have regular refresher training to minimise the risk of practices diverging from IDEA Services' policies over time.
- A culture had developed at the Home whereby CSWs of all levels would allow more independent children to bath or shower unattended, and would leave children, including Mr A, in the bath for short periods of time.

- There was no robust system for monitoring the adequacy of the "on-the-job" training.
- IDEA Services did not ensure that the staff-to-client ratio could meet the needs of the children in a safe way.
- IDEA Services did not give staff clear instruction not to bath two children at the same time, a practice that was unsafe in circumstances where there were only two support workers caring for six children.
- The CSWs on duty worked part time at the Home, neither had been formally recognised as CSW Level 3, and no lead CSW was nominated in the roster. This contributed to a lack of clear divisions of roles and tasks.

184. Noting the above, I consider that IDEA Services failed to ensure that adequate policies and procedures were in place, and complied with, in order to support Mr A effectively and prevent him being left unsupervised in the bath. Accordingly, IDEA Services failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Ms C — Breach

185. Ms C was a qualified caregiver who, at the time of these events, had been working for IDEA Services for around three years. She worked at the Home on the overnight shift fortnightly on a Friday, and also provided weekly home support on Wednesdays, Thursdays and Sundays. Ms C's training at IDEA Services included courses on first aid, medication errors, pre-packaged medication, and moving people and equipment. Ms C also worked with Ms I, a CSW Level 4, for about 18 months, and had performance reviews in 2012 and 2013, and the assessments from both were positive.

186. On the evening of this incident, Ms C and Mr B were working together at caring for six high-needs children. Ms C began work at 2.30pm. Between 2.30 and 3.00pm, she was required to read the support plans of the children there that day and debrief with the staff ending their shift. She stated that because of the short time available, she would skim the support plans to see whether there had been any changes.

187. I note that Ms C has difficulty with reading as she suffers from dyslexia and, at the time of her appointment to her position, she informed IDEA Services of this issue. I am concerned about the expectation that she would read a 115-page manual plus the support plans and other policies. However, I accept that Ms C had worked with an experienced CSW, Ms I, prior to these events, and received on-the-job training from her.

188. Ms C's role that day is unclear. IDEA Services stated that Ms C was the team leader that day, because she was a CSW Level 3 and Mr B was a CSW Level 2. It referred to Ms C's 2013 performance review, which was signed by Ms C and notes that Ms C

had met the requirements to proceed to CSW Level 3. IDEA Services said that each level is accompanied by a different pay bracket but, in Ms C's case, an administration error meant that her payroll record was not adjusted accordingly and no certified record was produced.

189. However, IDEA Services did not identify on the roster that Ms C was the lead support worker that day. Furthermore, Ms C said that she and Mr B were both on the same level, CSW Level 2, but that she "took over a little bit on that shift because it was her regular shift". In my view, the lack of clear divisions of roles was unsatisfactory and may have impacted on Ms C's performance.

Bathing

190. Ms C assisted Mr A into the bath at around 8.20–8.30pm. She used the hoist with a sling attached to place him in the water, and left him seated in the sling while he was in the water.[20] Ms C said that she had been trained by Ms I and other staff to allow Mr A time to enjoy the water.

191. Ms C's understanding of the instruction that Mr A required full support for bathing was:

> "Full support is helping with cleaning. Supporting him in the bath. With [Mr A] it was making sure he was not going to slip down. Make sure that we secure him, that we do the whole personal cares …"

192. Ms C stated that she had bathed Mr A previously and had never known him to slip while in the bath. She told HDC that the sling was a U-shape that went under Mr A's bottom and up to his head, and also had a part that went between his legs. It appears that Ms C believed that the hoist's sling prevented Mr A from slipping under the water and, for this reason, she thought it was safe to leave Mr A for short periods of time. Mr A had had an epileptic seizure previously while Ms C was bathing him. Ms C said that during this, Mr A went stiff and developed shaking, but he did not move from his spot.

193. Ms C said that while Mr A was in the bath she was "in and out of the bathroom". She stated that it was her understanding that other staff also left Mr A in the bath unattended. Ms C said that, during most shifts, she would leave children unsupervised in the bath, for periods varying from a few seconds to five minutes.

194. During the time that Ms C was bathing Mr A, she left the bathroom to check on the other children, because one of the boys was in the kitchen. She said she left Mr A again to assist Mr B to calm down a boy who was "playing up". She said that she had already run the bath in the other bathroom, and she put that boy into the second bath tub and remained with him. Ms C said that she had never been instructed not to bath two clients at the same time.

[20] As noted above, the hoist Ms C used was not the one she had been trained on.

195. Ms C appears to have left Mr A multiple times over a period of approximately 30 minutes. Ms C was unclear about how long she left Mr A unattended in the bath on the final occasion. She said that it didn't feel longer than five minutes, but also acknowledged that it might have been longer.

196. It is evident from the interviews the Police conducted with a number of other CSWs that there was a common practice at the Home to leave children unattended in the bath for brief periods. However, all those interviewed were clear that if clients were to be left it should be for a very short period, such as to get a towel. In this case, by her own admission, the final occasion on which Ms C left Mr A was for a period of approximately five minutes.

197. Ms Wyllie advised that Mr A's safety was at risk when he was left unattended in the bath for periods of time whilst other children were being supported, and this was a significant departure from expected standards of care and accepted practice. I accept this advice.

198. I am of the view that Ms C failed to provide services to Mr A of an appropriate standard. There was a lack of clarity in IDEA Services policies and procedures regarding bathing, and I do not consider that Ms C received adequate training in caring for Mr A. However, Ms C was aware that previously Mr A had had a seizure while in the bath, and I consider that it was evident that it was an unsafe practice to leave Mr A unattended in the bath. Before Ms C took over caring for the other child, she should have arranged for Mr B to assume responsibility for Mr A.

199. I consider that Mr A should not have been left unattended at all while he was in the bath. By leaving Mr A unattended, Ms C did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Mr B — Breach

200. Mr B commenced employment at IDEA Services as a home support worker in 2008, and as a CSW at the Home in 2009. He was a CSW Level 2 who worked part time for IDEA Services. He stated that he worked on a regular shift once a fortnight but, at times, he would have a month between shifts and, at other times, he worked several times a fortnight.

201. Mr B told the Police that he understood that "full supervision" was required when bathing children, and that this meant being in the bathroom and able to support the child being bathed. He was aware of the signs in the bathrooms. However, Mr B had, on occasions, left children alone in the bath. He said that this was normally just to "grab something like a second towel … [and] would have been only a matter of seconds".

202. Mr B was familiar with Mr A's bathing requirements as he had bathed Mr A at least ten times. Regarding Mr A's bathing, he said:

> "I don't believe it [was] unusual for staff to give [Mr A] personal time in the bath, I believe it was a general practice and all staff did this with [Mr A]. We would obviously still continually check him regularly, leaving him alone no more than a few minutes at a time."

203. Mr B told the Police that early on in the shift, he and Ms C discussed the tasks for the night and Ms C said that she would bath Mr A. Mr B said that Mr A's bathing was organised and supervised by Ms C. In the incident report form that Mr B completed on the day after the incident, he wrote that "normally both staff will check in on children even if they are not the one bathing that child".

204. Ms Wyllie advised that Mr A's safety was at risk when he was left unattended in the bath for periods of time whilst other children were being supported, and this was a significant departure from expected standards of care and accepted practice. I accept this advice.

205. Given that Ms C and Mr B were working together, I consider that they had a joint responsibility to ensure that they provided Mr A with appropriate care. I acknowledge that Ms C was the one who assisted Mr A into the bath, and that Mr B considered that Ms C was organising and supervising Mr A's bathing. However, Mr B was aware that Mr A was being bathed in Bathroom A at the same time that Child A was being bathed in Bathroom B. Mr B acknowledged that both staff will check on children even if they are not bathing the child.

206. Although I acknowledge Mr B's statement that when he went to check on Mr A at around 9pm, he expected to find Ms C in there with Mr A, Mr B was aware that Mr A was left unattended in the bath. Despite the lack of clarity in IDEA Services policies and plans regarding bathing, which failed to make it sufficiently clear that Mr A was never to be left alone in the bath (discussed above), I consider that it was evident that it was an unsafe practice to leave Mr A unattended in the bath. Accordingly, by allowing Mr A to remain unsupervised, Mr B failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Other comment

207. I note that, on finding Mr A in the bath, Mr B acted swiftly and decisively in seeking Ms C's assistance to remove Mr A from the bath, and then performed CPR until the paramedics took over.

Recommendations

208. I recommend that IDEA Services Limited and Mr B each separately provide Mr A's family with a written apology for the failings identified in this opinion, to be sent to HDC within three weeks of the date of this report for forwarding to Ms A.

209. In my provisional opinion, I also recommended that Ms C provide a written apology. Ms C has sent a letter of apology to HDC and this has been forwarded.

210. I note the substantial changes that IDEA Services Limited has made prior to and following the WorkSafe investigation. Taking those into consideration, I recommend that IDEA Services complete the following actions within six months of the date of this opinion:

a) Commission an independent review of:

1. the changes made since this event;
2. the personal plans and risk management plans for each client at the Home to ensure that each contains clear instructions specific to that person; and
3. the manner in which important information is conveyed to staff to ensure that this accommodates the English reading skills of staff;

and report to HDC on the findings and any resulting action.

b) With the assistance of an independent reviewer, develop a methodology for allocating staffing levels commensurate to the needs of service users. Provide this information to HDC.

c) With the assistance of an independent reviewer, develop policies and provide training to ensure that CSWs are aware of their ability to access on-call staff at any time. Provide HDC with evidence of the completed policies and training.

Follow-up actions

211. A copy of this report will be sent to the Coroner.

212. A copy of this report with details identifying the parties removed, except the names of IDEA Services Limited and the expert who advised on this case, will be sent to the district health board, and it will be advised of the names of Ms C, Mr B, and the Home.

213. A copy of this report with details identifying the parties removed, except the names of IDEA Services Limited and the expert who advised on this case, will be sent to the Ministry of Health, and it will be advised of the name of the Home.

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

Appendix A: Independent advice to the Commissioner

The following expert advice was received from Margaret Wyllie, a registered nurse and quality auditor/evaluator:

"In general terms, I have been asked to provide an opinion to the Commissioner on Case No [16/00085] and I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

I am a New Zealand qualified Registered Nurse (081106) and contracted Quality Auditor/Evaluator and have been self-employed since 1996, working in a variety of areas within health and disability services. Specifically I have been asked to review documents and provide an opinion on the following issues:

IDEA Services Ltd (ISL)

1. *The appropriateness of the care provided by ISL to [Mr A]. Please include comment on the following:*
    a. *[Mr A's] care plan and risk assessment.*
    b. *[Mr B's] induction.*
    c. *[Ms C's] induction.*
    d. *The training provided to [Mr B] including specific training in relation to [Mr A] and his needs.*
    e. *The training provided to [Ms C] including specific training in relation to [Mr A] and his needs.*
    f. *The monitoring and supervision provided to [Mr B].*
    g. *The monitoring and supervision provided to [Ms C].*
    h. *The staff to client ratio at [the Home] on [date].*
    i. *[Mr B] and [Ms C's] workload on [date].*
    j. *The staff handover process and the way tasks are divided among staff each shift.*
    k. *ISL's policies and protocols including its house manual and bathing policy.*
    l. *ISL's response to the incident.*
    m. *The changes recommended and implemented by ISL as a result of the incident.*
    n. *Any other comments you would like to make.*

[Mr B]

A) *The appropriateness of the care provided by [Mr B] to [Mr A]. Please include comment on the following:*
    a. *His actions on [date].*
    b. *Any other comments you would like to make.*

[Ms C]

1. *The appropriateness of the care provided by [Ms C] to [Mr A]. Please include comment on the following:*

Names have been removed (except IDEA Services 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.

a. *Her actions on [date] including her decision to bath [Mr A] after his medication had been administered and to leave [Mr A] unattended in the bath for periods of up to five minutes.*
b. *Any other comments you would like to make.*

Relevant documents reviewed

Folder 1

- *Copy of complaint*
- *Ministry of Health Action Plan dated [2014].*
- *HDC notification letters dated [2014].*
- *[Mr B] response to notification dated [2014].*
- *[Ms C] response to notification dated [2014].*
- *ISL's response to notification of investigation dated [2014] and enclosed documents as listed:*
  1. *Documents relating to [Ms C].*
  2. *Documents relating to [Mr B].*
  3. *Statement from [Ms D] dated [2014].*
  4. *Details about the description of sleepover tasks.*
  5. *Details about the division of tasks during a sleepover.*
  6. *Details about the oversight/responsibility of tasks during a sleepover.*
  7. *Details about the process for bathing/showering.*
  8. *A description of each of the six clients staying at [the Home] on [date].*
  9. *No document.*
  10. *Policies.*
  11. *Sentinel Event Investigation Report.*
  12. *No document.*
  13. *Incident report summary.*
  14. *Additional information provided by ISL to the Ministry of Health and Worksafe.*
  15. *Action Plan dated [2014].*
  16. *List of actions undertaken since the incident.*
  17. *Action Plan based on [Dr N's] recommendations [2014].*

- *ISL's response dated [2014] and enclosed documents as listed:*
  1. *Excerpts from SER.*
  2. *Incident reports.*
  3. *Care plan information.*
  4. *NASC documentation.*
  5. *Communication diary [2013].*
  6. *Records of meetings with NASC and family.*
  7. *Action plan from Internal Management Review.*

Please note that there is some duplication of the documents provided by ISL and the Police.

Folder 2

- *Police File Volume One*
  - *Witness statements.*
  - *Police notebook entries.*
  - *Life extinct certificates.*
  - *Statement of identification.*
  - *Property records sheets.*
  - *Scene diagrams.*
  - *Scene photographs.*
  - *Event chronology (constructed by Police).*
- *Police File Volume Two*
  - *Personal information ([Mr A]).*
  - *Service planning and delivery information.*
  - *File/case notes and correspondence.*

Folder 3

- *Police File Volume 3*
  - *Family/Whanau Respite Centre Manual.*
  - *Employee file — [Mr B].*
  - *Employee file — [Ms C].*
  - *Ambulance Communications.*
  - *Medications and health pack.*

Factual Summary

[Mr A], aged 15 at the time of the events, had complex needs including cerebral palsy. [In 2014], [Mr A's] stay at the respite care services at ISL's facility, [the Home], was intended to be for four days.

On [date], [Mr B] and [Ms C] were rostered on to care for six high needs children, including [Mr A], at [the Home]. At 7.30pm, [Mr A] was administered his night-time medication, which included a sedative. At 8.30pm, [Mr A] was put into a bath by [Ms C].

Bathing policy

[Mr A's] care plan, the bathing and showering policies, and notices on the bathroom walls state that full supervision of children in the bathroom is expected at all times and those children are never to be left alone in the bathroom.

[Ms C] told HDC that she did not receive formal training on bathing [Mr A] or how to use the hoist, however her Record of Learning identifies Moving Equipment & People L2 [in] 2011. The letter sent from ISL sent to the Health and Disability Commissioner dated 27 July 2015 included a Record of Learning current as at 13 July 2015 which identified Advanced Moving People & Equipment [in] 2013. [Ms C] does not recall being provided with information by ISL on the bathing policy but recalls seeing the notices in the bathroom. [Mr B]

said that he did not receive training in relation to [Mr A] outside of the usual induction training. [Mr B] understood there was a bathing policy and that all children should be supervised while in the bath or shower but said that there was an understanding among staff that some children were more independent (fully mobile) and could manage their own baths or showers.

Incident

[Ms C] said that she left [Mr A] unattended in the bath for periods of up to five minutes to attend to other clients and to give [Mr A] 'private time'. At around 9pm, [Mr B] said he went to mention something to [Ms C] and say hello to [Mr A]. However, [Ms C] was not in the bathroom and [Mr B] found [Mr A] submerged in the bath. An ambulance was called but sadly [Mr A] died.

A) [MR A'S] CARE PLAN AND RISK MANAGEMENT — Folder 1 Section 4 IDEA Correspondence

Personal Support Information dated 10 May 2013 states under Personal Care:

- bathing and personal hygiene — I require full support with this
- [Mr A] uses a hoist to get in and out of the bath. [Mr A] needs a Community Support Worker (CSW) to wash and dry his body, as he cannot do this by himself

Alerts and Crisis Response not dated …:

- Safe Handling — unable to get self in and out of bath etc
- Supervision required — cannot be left alone

IDEA Risk Assessment and Management Protocols (RAMP) dated 8 April 2013 under Risk Identification Checklist:

- [Challenging behaviours]
- Physical health — risks associated with health issues such as having seizures in the bath, mobility

These risks are then transferred to — Recording and assessing the level of risk

- Risk — physical health: requires a hospital bed to prevent falls — **impact minimal**
- Risk — physical health: requires incontinence products 24/7 — **impact minimal**
- Risk — harm to self: [Mr A] may bite or hit himself if he is upset — **impact minimal**

This leads into a Risk Management Plan dated 9 April 2013 (see below):

RISK MANAGEMENT PLAN

ASSESSMENT		MANAGEMENT	
RISK *Description of risk*	**TRIGGERS** *What increases likelihood of risk occurring*	**PROACTIVE** *Strategies to prevent*	**REACTIVE** *Response if risk occurs*
Physical Health: will fall out of a normal bed	will fall out of bed when the side rails are down or when is not in a hospital bed.	Use a hospital bed with side rails to prevent from falling out of Bed at all times	Reassure and check that he has not hurt himself. administer first aid if required. write an incident report.
Physical Health: Will u	If does not have incontinent products (dippers) then he will spoil himself	Make sure has clean dippers	Clean nd pot incontinent products
Harm to self: may bite or hit himself if he is up set	may do this as away to get attention, when he is board or when he is over excited.	Keep involved with the groups activities and keep a calm environment.	Reassure and redirect by playing a game or speaking to him.

Risk Assessment Management Protocol

Supports Needs Assessment undertaken by [Needs Assessor] dated 13 January 2010 and accepted by Mother signed and dated 16 January 2010 clearly states on page 8 under Supervision:

- Cannot be left alone, and on page 12 All Identified Support Needs states:
- [Mr A] needs 24 hour, 7 day a week care, support and assistance to ensure his health, safety and wellbeing are maintained
- Due to his age and disability [Mr A] needs full assistance with all household management and tasks

Opinion:

The instructions in [Mr A's] Personal Support information dated 10 May 2013 and the Alerts and Crisis Response form (not dated) do not clearly state that [Mr A] needs full assistance and cannot be left alone in the bath or bathroom.

IDEA Risk Assessment and Management Protocols (RAMP) dated 8 April 2013 has three processes: Risk Identification Checklist, Recording and Assessing Risk and Risk Assessment Plan (completed on 9 April 2013). The Risk Assessment Plan does not include full assistance with bathing using hoist, seizure management and/or safe practice with medication management (when it should be taken). All documents in relation to [Mr A's] Personal Plan and risk management are not consistently clear with these instructions, and there are typos (identified were dippers (diapers), spoil (soil) and board (bored) in the Risk Management Plan, which raises the question how well this was read and understood, as these errors were not picked up or corrected.

There appeared to be a departure from the Standards of Care documented in the Family Whanau Respite Care Manual (December 2012) and how well staff have been instructed or trained. This would be viewed in a similar manner by my peers, as [Mr A] should have had services provided to him that minimised the potential for harm.

B) [Mr B's] INDUCTION — Folder 1, Section 2

Employment commenced [in] 2008. Induction to IDEA Services Ltd:

- Orientation for prospective [Community Support Worker] document was not dated, not named, tick boxes were ticked, but there was no evidence of orientation provided by whom
- Orientation Checklist for Prospective Respite Community Support Worker identified the orientating staff person's assessment of [Mr B] in relation to his attributes for the position
- Abuse Guidelines signed off by [Mr B in] 2009
- IDEA Services Orientation Checklist [2009] document with [Mr B's] name in pen on front cover
- Staff Orientation Process:
- **Part 1** — Signing on New Staff 1.5 hours not dated or signed off by Manager
    - Content tick box — process no extra notes recorded and pages not named
- **Part 2** — Orientation to Key Policies and Procedures (2 hours office based)
    - Orientation completed by (not completed), Manager's name (not completed), Manager's signature and date (not completed)
    - Tick box process with no extra notes recorded and pages not named
- **Part 3** — Orientation to Residential and/or Vocational Processes (4 hours on site)
    - Service stream — not completed
    - Orientation completed by — not completed
    - Manager's name — not completed
    - Manager's signature — not completed
    - Date — incomplete
    - Orientation Facilitator — not completed
    - Tick box with no extra notes recorded, pages not named or dated and signed off on completion
- IDEA Services clarified in a letter to the HDC Commissioner dated 27 July 2015 that Part 3 is relevant for people working in residential and vocational settings, so would not be a compulsory area to be completed for a person working in a Respite Service or Home Support service.
- **Part 4** — Orientation to Additional Policies and Procedures (2 hours office based)
    - Service stream — not completed
    - Orientation completed by — not completed
    - Manager's name — not completed
    - Manager's signature — not completed
    - Date — not completed

- **Part 5** — Orientation — Site Specific to Service in Which Staff Will Work for First Time for New and Experienced Staff to be Completed on Site (1.5 hours)
    - Name of service/facility — not completed
    - Orientation completed by — not completed
    - Date — not completed
    - Tick box with no extra notes recorded, pages not named, dated or signed off on completion

Opinion as per the Guidelines for Independent Advisors:

The five part induction process documents were not completed accurately. It is unclear where this orientation occurred and whether it was specific to [the Home]. There were no follow-up notes. Site Specific Medication Orientation Checklist dated [2009] identified [the Home] as the service/facility.

The standard of practice demonstrated a departure from the ability to complete documents accurately and raises questions how well orientation/induction was managed, which would be viewed in a similar manner by my peers.

C) [MS C'S] INDUCTION — File 1, Section 1

Employment commenced [in] 2010:

- Orientation Checklist for Respite Centre Staff covered aspects in a tick box system
- 1 General Issues — all areas ticked
- 2 General Information About IHC Family/Whanau Services — all areas ticked
- 3 Information About the Respite Centre — all areas ticked
- 4 Information About Children and Young People — all areas ticked
- 5 Health and Safety
- 6 Inservice Training — Information has been given on: **(these areas were incomplete)**
    - Introductory Training
    - Medication Policy
    - IHC's Certificate in Supporting Families (5 modules)
    - Driver Training
    - Behaviour Support Training — Working With Challenging Behaviours
    - First Aid Course
    - Bicultural Training/Treaty of Waitangi
    - Lifting
    - Epilepsy Management
    - Care/Health Needs of Individual Children/Young People
- 7 Administration (all areas ticked)
- 8 IHC Documents discussed and supplied. **Areas not ticked**:
    - Complaints Policy
    - Transport Policy
    - Vehicle Operations Handbook
    - Driver's Orientation Form/Registration Form

- Medication Policy
- Respite Centre Manual

Signed off by Community Services Worker [in] 2010

Signed off by Reporting Officer [in] 2010

- Orientation Checklist for Home Support Workers covered aspects in a tick box system. **Areas not ticked:**
  - Complaints Form for Staff
  - Safe Handling Techniques for Lifting
  - Lift With Care
  - Well NZ Workplace Accidents
  - Incident Report Form and Information
  - Civil Defence and Emergency Management
  - Activity Risk Assessment and Management Form
  - Medication Policy
  - Home Support Timesheet
  - Individual Employment Agreement
  - Collective Employment Agreement
  - Employee In-service Policy
  - Library and Information Service

Signed off by Home Support Worker [in] 2011

Signed off by Reporting Officer on [in] 2011

IDEA Services clarified in a letter to the HDC Commissioner dated 27 July 2015 that the Orientation Checklist for Home Support is not relevant to the orientation [Ms C] received as a community support worker at the respite service.

Opinion as per the Guidelines for Independent Advisors:

In relation to these two Orientation Manuals, they were incomplete and there were no follow-up notes recorded. The Site Specific Medication Orientation Checklist [2011] identified [the Home] as the service/facility and was signed.

The standard of practice demonstrated a departure from completing documents accurately and raises questions of how well orientation and induction was managed, which would be viewed in a similar manner by my peers.

D) THE TRAINING PROVIDED TO [MR B] INCLUDING SPECIFIC TRAINING IN RELATION TO [MR A] AND HIS NEEDS — File 1, Section 2

- Record of Learning current as at 13 July 2015 provided to the HDC Commissioner on 27 July 2015 from ISL
- There were 17 learnings in 2009:

- […]Looking After Me L2, Introduction to Total Communication, Introduction Intellectual Disability
- […]Moving Equipment and People, Pre Packaged Medication, Infection Control, Safety and Security
- […]Quality of Life L2
- […]Understanding Your Role, Rights and Responsibilities, Support Plans
- 6 Self Directed Learning Modules[…]
- […]Health Matters 2010
- […]Team Based Learning (Medication Errors)
- […]First Aid
- […]Health Matters 2010
- […]Medication Errors (area based)

- Record of Learning current as at [2010]
- [Mr B] also had a current First Aid certificate [dated 2013] and a First Aid Refresher [in 2014].

Opinion as per the Guidelines for Independent Advisors:

The Record of Learning dated 13 July 2015 demonstrates that [Mr B] had completed the majority of learning following his start date [in] 2008 through to [December 2009], and then after that, Refresher First Aid and other specified training as noted above.

However, there is no evidence that there was any specific training in relation to [Mr A's] specific needs. Orientation/induction is not recorded on the Record of Learning or other site specific processes; only Medication Management.

E) THE TRAINING PROVIDED TO [MS C] INCLUDING SPECIFIC TRAINING IN RELATION TO [MR A] AND HIS NEEDS — File 1, Section 1

- Record of Learning current as at 13 July 2015 provided to the HDC Commissioner on 27 July 2015 from ISL
- There were 21 learnings in 2011:
  - […]Self Directed Learning Modules 1 Values and 2 Families and Whanau
  - […]Self Directed Learning Modules 3 Safety/Wellbeing, 4 Needs of Children and First Aid certificate
  - […]Team based learning — Medication Error
  - […]Self Directed Learning Module 5 Understanding Behaviour and Module 6 Positive Behaviour Support
  - […]Intro to Positive Behaviour Support
  - […]Health Matters 2010
  - […]Introduction Intellectual Disability, Looking After Me L2 and Introduction to Total Communication
  - […]Quality of Life L2 and Understanding Your Role
  - […]Support Plans L2, Pre Packaged Medication L2 and Rights and Responsibilities L2

  - […]Moving Equipment and People L2, Safety and Security L2 and Infection Control L2
  - […]Medication Error — area based
  - Level 2 Foundations [2012]
  - First Aid [2013]
  - Restraint Minimisation policy [2013]
  - Positive Behaviour Support F/W [2013]
  - Pre-packaged Medication L2 [2013]
  - Advanced Moving People and Equipment [2013]
- [Ms C] had completed her Community Support Services (Foundation Skills) Level 2 Career Force [in] 2012; supported to complete this through [an education provider …].

Opinion as per the Guidelines for Independent Advisors:

The Record of Learning dated 13 July 2015 demonstrates that [Ms C] had completed the majority of learning following [in 2011], and then after that, Refresher First Aid and other specified training as noted above.

However, there is no evidence that there was any specific training in relation to [Mr A's] specific needs. Orientation/induction is not recorded on the Record of Learning or any other site specific processes, other than Medication Management.

F) THE MONITORING AND SUPERVISION PROVIDED TO [Mr B] — File 1 Section 2 and Police File 2/2, Section 2

Employed from [2008] and as CSW Level 1 from [2009], it appears that [Mr B] was a casual part time staff member who undertook one shift per fortnight at [the Home]; usually a sleepover shift from 2.30pm to 3pm the next day.

In place:

- Case Note Records for Caregivers and Home Support Worker (HSW) where dialogue was recorded of conversations had between [Mr B] and various IDEA Services (ISL) staff
- Performance Record Community Support Worker (after 12 months employment) dated [2010], page 5 of 6. This performance record included learning and development activities agreed for next period to [2011] which were:
  - [Mr B] will learn more about medication being used at [the Home] and the impacts and contraindications etc. Target date — ongoing
  - [Mr B] will complete the Learning and Development of Children With Disability paper at Massey University[…]
- Review of Performance for period to [2010], page 2 of 6 identified:
  - Orientation to be completed by (not signed)
  - Basic Learning and Development Modules have been completed [2009]. These included Health and Safety, Principles of Safe Handling, Infection Control, Medication, Introduction to Intellectual Disability and Bicultural Training

Additional learning for Residential Vocational staff [in 2009]:

- Introduction to Total Communication[…]
- Introduction to Positive Behaviour Support[…]
- Introduction to Personal Planning[…]
- Role of the Support Worker — Module 1[…]
- Role of the Support Worker — Module 2[…]

- Other specified learning and development completed so far:
  - Autism ([Dr N])
  - Hoist training
  - Epilepsy

  } These do not appear on [Mr B's] Record of Learning

Performance record was signed off by the employee on [date] 2010 and the Manager on [date] 2010.

- Performance Record Community Support Worker (Level 2 or Level 3) — Review of Performance for period from [date] 2011 to [date] 2012. This performance record included learning and development activities agreed for next period, page 7 of 9 (not dated):
  - NCCSS (National Certificate Community Support Services). Target date […] 2011
- Review of Performance for period [date] 2011 to [date] 2012, page 2 of 9
  - Basic Learning and Development Modules have been completed [date]
  - Progress against other learning and development objectives set at last review:
    - General knowledge around medication — [2010]
    - Massey University paper in Learning and Development of Children With an ID (Intellectual Disability) — [2010].

  Performance record was signed by the employee on [date] 2011 and Manager on [date] 2011.

Case Note Records for Caregivers (HSW) Home Support Worker

Name on this form [Mr B]

There were over 60 documented contacts from [date] 2010 to [date] 2013. A sample of contacts in relation to monitoring and supervision which relate to performance:

Meeting	[2010]	[Mr B] was unable to attend the staff meeting at [the Home] tonight	F/W Co-ordinator [Ms H]
Meeting	[2010]	[Mr B] attended [the Home] staff meeting	F/W Co-ordinator [Ms H]
Meeting	[2010]	[Mr B] attended [the Home] staff meeting	F/W Co-ordinator [Ms H]
Training	[2011]	Attended Medication training	F/W Co-ordinator

			[Ms H]
In Person	[2011]	[Mr B] came in to see me — wanted to swap sleepover	F/W Co-ordinator [name]
Telephone	[2012]	Medication error — called [Mr B] about medication error. [Mr B] advised that he would try not to make a mistake again. I advised that it is very important that we get medication right	F/W Co-ordinator [name]
In person	[2012]	Saw [Mr B] at [the Home], seemed in good spirits, showed him menu and recreation plans for [the Home] for August	F/W Co-ordinator [name]
Email x 6	[2012]	Several incidents re medication, trying to set up a meeting time	F/W Co-ordinator [name]
Meeting	[2012]	Please explain meeting with myself and […]. [Mr B] turned up 15 minutes late with no explanation. Asked [Mr B] about the medication incidents. [Mr B] said he takes responsibility for not checking things properly; felt a little out of routine as Friday is the busiest, and some children overlapped with ASP (After School Programme) and [the Home]. Also [Mr B] was rostered on with [a] new staff member. This was [her] first sleepover. […] has decided no further action will be taken for [Mr B] and that will look at putting on extra staff member on Fridays for two hours to sign medication in	F/W Co-ordinator [name]
Meeting	[2013]	[Mr B] unable to attend Restraint Minimisation Did not attend [the Home] staff meeting (no apology). TXT reminder [sent before] meeting […]	F/W Co-ordinator [Ms H]
Training	[2013]	Did not attend the Positive Behaviour Support training. TXT reminder sent day before[…]	F/W Co-ordinator [Ms H]
Meeting	[2013]	Did not attend [the Home] staff meeting (no apology) TXT reminder about [the Home] staff meeting sent [several days earlier]	F/W Co-ordinator [Ms H]
Telephone	[2013]	Phoned [Mr B] about Medication training on [Monday]. [Mr B] advised	F/W Co-ordinator

		he couldn't get time off from his second job	[name]
Meeting	[2013]	Did not attend [the Home] staff meeting — apologies	F/W Co-ordinator [Ms H]
In Person	[2013]	[Mr B] visited the office — said passed driver's test and completed his First Aid on Saturday with [education provider]	F/W Co-ordinator [Ms H]

The majority of other calls were in relation to roster change requests or extra shifts from both parties, and a level of difficulty in being able to reach [Mr B] on occasions due to him having 'phone troubles'.

Opinion as per the Guidelines for Independent Advisors:

[Mr B] had two performance reviews; one dated to [date] 2010 and the other to [date] 2012. In both, there was expressed positive comments in relation to [Mr B's] abilities. There was no further performance records for 2012–2013 or 2013–2014. The standard of practice set out in the Guidelines for Managing Performance IHC/IDEA Services December 2008 and HRP-24 Performance Management 2001 states *within the first 3 weeks of employment and at least once every 12 months.*

Performance reviews are an integral part of good employer/employee relationships and are pivotal to fostering these relationships. There appears to be a departure from IDEA/IHC policy. There were no recorded Case Note Records for Caregivers HSW after [the start of the holiday period] 2013. The letter to the HDC dated 27 July 2015 from ISL stated that [the Home] was closed [over the holiday period], however the roster provided dated […] indicates that there were staff rostered on from [a few days before Mr A's arrival].

G) THE MONITORING AND SUPERVISION PROVIDED TO MS C — File 1, Section 1 and Police File 2/2, Section 1

Employed from [2010] — worked for Family Whanau Services since [2011]. It appears that [Ms C] is on a casual contract and had worked pretty much full time since starting. The only shift that [Ms C] works at the Respite house is a sleepover shift, which runs from 2.30pm on a Friday to 3pm on a Saturday once a fortnight.

- Performance and Development Review for Home Support Workers (not dated or period of review identified). Action to be taken, page 5 of 5:
  - First Aid training [2013]
  - Autism training[2013]

Signed off by Home Support worker[…]and Reporting Officer [in 2013]

- Performance Record Community Support Worker (CSW) (Level 2 or Level 3). Date of review [in 2013] — CSW Level 2, page 2 of 7

Review of performance for (unidentified) period

1. Basic Learning and Development Modules have been completed:

- Health and Safety [2011]
- Principles of Safe Handling [2011]
- Infection Control [2011]
- Medication [2011]
- Introduction to Intellectual Disability [2011]
- First Aid [2011]

Additional learning for residential/vocational staff:

- Introduction to Total Communication [2011]
- Introduction to Positive Behaviour Support [2011]
- Role of the Support Worker Module 1 [2011]
- Role of the Support Worker Module 2 [2011]

Additional learning and development attended during current period:

- Medication error [2012]

Objectives for next period — not dated — incomplete, page 6 of 7:

- Level 3 certificate
- [Ms C] requires training to be a competent Level 3, page 6 of 7

Signed off by employee and Manager's signature [2013]

- Performance record Community Support Worker (Level 2 or Level 3)

CSW Level 2 — date of review [2012]

Review of performance for period from [2010] to [2012]:

- 1. Basic Learning and Development Modules completed, page 2 of 7 as above

Objectives for next period to [2013], page 6 of 7:

- More training — look at Level 3 certificate, Autism training.
- Learning and development activities agreed for next period to [date] 2013, page 6 of 7
- Level 3 — to be organised by Manager
- Autism — to be organised by Manager

Performance record signed off by employee and Manager [2012]

Both performance reviews had positive comments from the reviewer.

Case Note Records for Caregivers (HSW) Home Support Worker

Name on this form [Ms C]

There were over 120 documented contacts from [2011 to 2013]. A sample of contacts in relation to monitoring and supervision which relate to performance:

Training	[2011]	Attended Medication Training	F/W Co-ordinator [Ms H]
Meeting	[2011]	Attended the HSW (Home Support Worker) meeting	F/W Co-ordinator [Ms H]
Telephone	[2011]	Phoned [Ms C] to come in to office to sign timesheet	F/W Co-ordinator [Ms H]
Training	[2012]	Attended Sexuality Workshop at [external education provider]	F/W Co-ordinator [name]
Telephone	[2012]	Asked [Ms C] if she had a copy of her Training Agreement Level 2	F/W Co-ordinator [name]
Letter	[2012]	Posted out Level 2 Training Agreement to be completed	F/W Co-ordinator [name]
Meeting	[2012]	Attended morning HSW meeting	F/W Co-ordinator [name]
Telephone	[2013]	Asked if [Ms C] able to work at [the Home] today (unable to)	F/W Co-ordinator [Ms H]
Telephone	[2013]	Asked if [Ms C] able to work at [the Home] ASAP today or tomorrow (unable to)	F/W Co-ordinator [name]
Telephone	[2013]	[Ms C] doing First Aid training on [date]. Checked she was doing 80 hours a fortnight or less	F/W Co-ordinator [name]
Training	[2013]	Attended First Aid training	F/W Co-ordinator [Ms H]
Meeting	[2013]	Did not attend [the Home] Support meeting (no apology)	F/W Co-ordinator [Ms H]
Meeting	[2013]	Attended [the Home] staff meeting	F/W Co-ordinator [Ms H]
In person	[2013]	[…]	F/W Co-ordinator [Ms H]
Training	[2013]	Attended Positive Behaviour	F/W Co-ordinator

		Support training	[Ms H]
Meeting	[2013]	Attended [the Home] staff meeting	F/W Co-ordinator [Ms H]
Telephone	[2013]	Phoned [Ms C] and asked if she could go to [the Home] to pick up [the Home's] bank statement on her way to the office today. [Ms C] said that was fine, as she has to go to [the Home] to pick the shopping list up.	F/W Co-ordinator [Ms H]
Meeting	[2013]	Did not attend [the Home] staff meeting — no apology	F/W Co-ordinator [Ms H]
Memo	[2013]	Thank you for attending the Medication training on [date]. Please follow the Medication policy as discussed in training. Please complete the Medication policy sign off form and Medication Competency Checklist and [date] at the Safe Handling training. Due to the number of medication errors, the Site Specific Medication Orientation and Competency assessment will need to be completed again for all staff.	F/W Co-ordinator [Ms H] F/W Co-ordinator [name]
Meeting	[2013]	[Ms C] attended [the Home] Support meeting	F/W Co-ordinator [name]
Telephone	[2013]	I phoned [Ms C] after reading an incident report regarding an incident at [the Home] this weekend where [Ms C] phoned Ms L, asking her to come to [the Home], instead of contacting on-call. I asked why [Ms C] had phoned Ms L instead of on-call. [Ms C] said she rang Ms L because she lives just around the corner, and at the time, didn't think to ring on-call. I informed [Ms C] on-call would have responded straight away, and in the future, she was to contact on-call.	F/W Co-ordinator [Ms H]

The majority of other calls were in relation to persons that [Ms C] supported in the community and providing their monthly reports, [Ms C's] leave requests and sickness absences.

Opinion as per the Guidelines for Independent Advisors:

[Ms C] had one Performance and Development Review (not dated) and two Performance Record Community Support Worker (Level 2 and Level 3) forms — one dated [2013] and other on [2012]. The one dated [2012] stated 'date to review process [2013]'. In both performance records for the period [2012] to [2013] there were positive comments recorded in relation to [Ms C's] progress. The standard of practice set out in the Guidelines for Managing Performance IHC/IDEA Services December 2008 and HRP-24 Performance Management 2001 states *within the first 3 weeks of employment and at least once every 12 months.*

Performance reviews are an integral part of good employer/employee relationships and are pivotal to fostering these relationships. There appears to be a departure from IDEA/IHC policy. There were no recorded Case Note Records for Caregivers HSW after [date]. The letter to the HDC Commission dated 27 July 2015 from ISL stated that [the Home] was closed [over the holiday period], however the roster provided dated […] indicates that there were staff rostered on from [a few days before Mr A's arrival].

H) THE STAFF TO CLIENT RATIO AT [THE HOUSE] ON [THE DAY OF THIS INCIDENT] — Folder 1, Section 4, 5, 6, 7, 8 and Folder 2, Section 14

It is stated that the maximum number of children at [the Home] was six and for that number there were two carers, which equates to a 1:3 ratio, except when one CSW is bathing a person unable to be left alone in the bath. The people booked in to receive services at [the Home] on the evening of [date] were six (Section 8, Folder 1), each with complex/high needs, although [Mr A] appears to be the most complex, being unable to sit upright unaided and requiring full support with his personal cares, eating, drinking and bathing. He was doubly incontinent and wears products. Four of the other people were also incontinent and wore products to manage their incontinence. Two had environmental restraints in place due to their ability to abscond and behavioural needs. All six people had no clear verbal communication and used a variety of ways to make their needs known.

On the afternoon of Friday [date] it appears there was significant activity at [the Home]; children in the holiday programme, children from the previous night's stay leaving and other children arriving. The configuration of [the Home] needed to be organised to meet the needs of the incoming children; four of the incoming children (noted that being ideal for them to have their own room). [The Home] has four bedrooms, so prioritising who had what room was important. File 2, Section 23 identifies [Mr A's] bedroom as closest to Bathroom A.

Letter to [Mr B] dated [2012] — *following medication incidents — there will be no further action taken regards to medication issues. We have come to the conclusion there is a need for a third staff member to be on shift at [the Home] respite on a Friday afternoon during the peak time of 3–5pm to support staff to complete their role to the best of their ability and to prevent any further medication errors at sign-in,* signed by [Family Whanau Co-ordinator].

It would appear on this particular Friday afternoon [of the incident] no additional support was available to the two CSWs ([Ms C] and [Mr B]), it did not appear that the two CSWs had decided on a clear division of roles, tasks and accountabilities and who was clearly taking the lead. Folder 1, Section 6 states a lead staff member is chosen for each shift, staff member chosen to lead a shift is identified on the roster. To be eligible the staff member must be at least a Community Support Worker Level 3 and above. Both CSWs were at Level 2. [Ms C] completed Level 2 Foundation [in 2012] as recorded on her Record of Learning current at 13 July 2015. The information provided did not identify that [Ms C] had achieved a Level 3 Career Force status. If the Career Force Level 3 status is confirmed, there is still the issue that [Ms C] was not identified on the roster as the lead Support Worker on duty on [date].

Also in place was a checklist-type document which stated:

All staff are to write their name, the date and sign each column to indicate that they have read and become familiar with the information as listed below on client's file.

File Name — [Mr A]

Staff Name, Alerts and Crisis, Revised Support Info, Medication Info, Support Plans, Behaviour Support Info, Risk Management Plans and Other.

[Date of incident] signed by one staff member — not both CSWs on duty. Name not clear, but it appears to be [Ms C's] signature.

On the Friday evening of [the incident] both CSWs have stated that dinner and other processes were running late, one of the children was acting up and it was at this point, had they called for assistance, they may not have compromised their practices because of running late.

The Family/Whanau Manager was at [the Home] at around 2.30pm to 3pm on the afternoon of [the incident], was it possible at this point to predict a busy evening?

Opinion as per the Guidelines for Independent Advisors:

The staff to client ratio at [the Home] on Friday [date] appears to have been inadequate to meet the needs of these children in a safe way. Practices were compromised. Was there a reluctance to call for assistance? This is not clear. It is clear however, that a full orientation to the clients' needs with a practical assessment re bathing procedures was not given. The roster provided for [this period] did not identify who was to lead the shift. There was a departure from the standards of care expected, especially when both CSWs were outside at one point encouraging the young person who was acting up to come inside. This would be viewed in a similar manner by my peers.

I) [Mr B] AND [MS C'S] WORKLOAD ON [THE DAY OF THE INCIDENT]

The work practices of the night of Friday [date] were compromised. In Folder 1, Section 4 a description of the usual tasks required on sleepover shift with headings Shift Beginning, Before Shift End, Service User Support, Household Activities, Administration Activities and further to these tasks it was stated staff will support children arriving and leaving the Respite Centre. Clearly, the workload for these two CSWs was to be busy with six children of various high and complex needs being settled in.

When their routines started running late and [Mr A's] bath time (which was usually around 7pm and then given his medication) on this particular Friday [Mr A] was given his Nocte medication at 7.30pm, then bathed at 8.30pm (medical file with Police and it is unclear what medication was given) and was being left unattended for short periods, safe practice was compromised. It is unclear why these two CSWs did not call the on-call person to come in to provide support and assistance.

It would appear that there was no identified leader on duty or a CSW taking the lead on duty and checking each other when a departure from expected routines occurred. The shift is recorded to have been running two hours late in their routines. A phone call to the Family Whanau Manager was made at 9.16pm to alert her of the incident in the bathroom with [Mr A].

Opinion as per the Guidelines for Independent Advisors:

Due to the high and complex needs of the six children accessing services at [the Home] on [the date of the incident], it is clear that there was to be a busy night ahead; what discussion and planning took place between [Mr B] and [Ms C] about how the evening was going to be worked was not clear. The roster provided for [this period] did not identify who was to lead the shift. It is also unclear why the Family Whanau Manager who visited in the afternoon did not detect that the mix of children warranted some additional support in the busy hours.

The standard of care and accepted practices, as set out in the Family Whanau Respite Care Manual (December 2012) were compromised, which resulted in a significant departure from best practice when [Mr A] was left in the bath unattended.

J) THE STAFF HANDOVER PROCESS AND THE WAY TASKS ARE DIVIDED AMONG STAFF EACH SHIFT — Folder 1, Section 5, Section 6 Statements

<u>Section 5</u>

The two staff members discuss and agree the tasks to be completed at the beginning of the shift. The lead staff ensures the tasks allocated is equitable and is completed. The lead staff member is selected to manage the shift and has overall responsibility for the Respite Centre.

Section 6

A lead staff member is chosen for each shift and has overall responsibility/oversight to ensure all essential duties are completed. The staff member chosen to lead a shift is identified on the roster. The staff's competency level, orientation and training received will determine if a staff member is selected to lead a shift. To be eligible the staff member must be at least a Community Support Worker Level 3 and above.

As noted in [Dr N's] Report 5) Folder 1, Section 11

The two on duty staff seemed not to be well organised or well co-ordinated on the evening of [date]. There seemed to be poor assignment of roles and tasks.

Opinion as per the Guidelines for Independent Advisors:

The Residential Roster provided from [this period] identified [Mr B] and [Ms C] covering the shift on [date of the incident], but it was not recorded which of these two CSWs had been chosen to lead the shift. Neither of these CSW were Level 3 and above. This was a departure from IDEA Services' expected practice, as set out in Section 5 and 6 above.

K) ISL'S POLICIES AND PROTOCOLS INCLUDING ITS HOUSE MANUAL AND BATHING POLICY — Folder 3, Section 1

The Policy and Protocols within the Family Whanau Respite Centre Manual provide guidance as to ISL's expectations of their staff work standards of practice. However, it is not clear at what point staff read this manual or refer to it to ensure best practice. This Family Whanau Respite Centre Manual is paramount to the staff having an understanding of how to practice. Staff statements indicated that staff did not have a clear memory of having read this manual.

Staff were paid whilst on orientation, which normally lasted a couple of hours, longer if the driving orientation was included.

[Ms I], as Level 4 from [2009] to [2013] stated 'I conducted all of the orientation/training for new staff. Part of this orientation was informing new staff about a number of relevant manuals they were required to read. These manuals included Health and Safety, Infection Control, Respite Facility and Hazard Control. Another manual included Procedures and Policies for IDEA Family Whanau Services. These manuals were quite lengthy and it would have taken a couple of full days to get through them all. Some of the manuals had a page in the front that staff were required to sign once they had read them. Once a staff member gained employment many would come early prior to starting work to read some part of a manual and others read them at night once the children went to bed'.

Within the Family Whanau Respite Centre Manual dated December 2012 on page 19–6 Bathing and Showering states:

Never leave the children unsupervised whilst they are in the bathroom area

From the information provided there were two bathrooms; one where there was a claw bath which was the bathroom used for the hoist, which was the bathroom [Mr A] was bathed in (Bathroom A). This bathroom has a notice on the wall:

[The Home's] procedure for bathing and showering **(Section 23, Folder 2)**

- ***Bathing — all staff persons to read the Care Plan for any person prior to any personal cares being attended to***
- ***Staff to collect all clothing, towels, flannels, incontinence gear, toiletries prior to preparing the bath or shower***
- ***Proceed to run the bath — run cold water first and add hot water***
- ***Check temperature***
- ***Assist child/young adult in to bath***
- ***Follow individual Care Plan as set out for the person being bathed or showered***
- ***Assist person from bath, remember to take plug out of bath at this point***
- ***Assist drying and dressing according to the individual's Care Plan. Wipe inside bath with sterilizing agent***

Bathroom B — Folder 1, Section 11, [Dr N's] Report

Printed instructions in second bathroom:

- ***All staff to read the Care Plan for any person prior to any personal care being carried out***
- ***Bathing — full supervision during bathing required***
- ***Follow the individual Care Plan as set out for the person being bathed***
- ***Showering — full supervision during showering required***
- ***Follow the individual Care Plan as set out for the person being showered***

The Family Whanau Respite Centre Manual also identifies 32 Activity Risk Assessment and Management Policy Guidelines page 57:

- ***All children must be supervised when near or in water***

Opinion as per the Guidelines for Independent Advisors:

The Family Whanau Respite Centre Manual (December 2012) does not appear to [have] been read and used appropriately. There was no evidence of practical application or assessment of individuals with high/complex needs bathing or showering routines undertaken with staff.

6 The Bathing/Showering page 19 does not include the same instructions as in the bathrooms, and the notice in Bathroom A did not have anything about full assistance. [Mr A's] Care Plan, needs assessment also stipulated full assistance. There has been a departure from the accepted standard of practice which resulted in a significant loss.

There does not appear to be a system for monitoring practices in the respite house so that the more senior staff know that the policies and processes within the

Family Whanau Respite Centre Manual and other manuals are being followed to ensure at all times an accepted standard of practice is occurring, and this would be viewed in a similar manner by my peers.

L) ISL'S RESPONSE TO THE INCIDENT — Section 14, Folder 1

It appears that ISL undertook a full investigation and developed an Action Plan based on recommendations from [Dr N] and their own investigation. Both [Mr B] and [Ms C] who were on duty were given compassionate leave of two weeks with extensions while formal investigations took place. The Ministry of Health was kept informed.

Opinion as per the Guidelines for Independent Advisors:

IDEA Services Ltd appears to have been co-operative and provided information requested.

M) THE CHANGES RECOMMENDED AND IMPLEMENTED BY ISL AS A RESULT OF THE INCIDENT — Section 14, Folder 1 and Section 15 Folder 1

The Action Plan based on recommendations from [Dr N] dated [2014] have been addressed and action taken to meet these recommendations with timelines. The Action Plan [the Home] — Management Review updated [2014] provides further confirmation of what has been completed. [Ms C's] employment was terminated and [Mr B] did not return to work at the Respite Centre and it was confirmed [in] 2014 that he had resigned. Signs have been replaced in wet areas and ensure they align with policy. Training of risk assessment and management was undertaken [in] 2014. Support information to be discussed at fortnightly facility meetings. Clear roles have been defined with the introduction of a key worker as lead on shift. A training component has been introduced to staff meetings monthly.

Opinion as per the Guidelines for Independent Advisors:

IDEA Services Ltd needs to have a monitoring and review system in place to ensure the practical application of personal care needs for the people utilising [the Home] Respite Centre. Personal Plans and Risk Management Plans for each person need to contain clear instructions specific to that person. Community Support Workers need to be able to access on-call staff without fear of reprisal.

[Mr B]

1 The appropriateness of the care provided by [Mr B] to [Mr A]

A His actions on [date], Folder 2, Section 3

From the documentation provided it seemed that the two staff on duty did not appear to have been well organised and there appeared to be no clear leader and a poor assignment of tasks. Neither staff, once they were running late, thought to call for assistance, so mistakes were made; compromising practices.

[Mr B's] statement to Police states 'I understood that [Mr A] needed full support to use the bath, he needed full support to undress and get in and out of the bath, as well as being bathed. There was an understanding that provided the sling was supporting [Mr A], you could quickly duck out to grab a towel or something nearby, but not engage in any other tasks'. [Mr B] may or may not have known [Ms C] had left [Mr A] in the bath to help him outside with a child who was acting up.

[Mr B] went on to state 'I don't believe it is unusual for staff to give [Mr A] personal time in the bath, I believe it was a general practice and all staff did this with [Mr A]'. Also [Mr B] stated on [date] '[Ms C] and I discussed the taskings for the night. [Ms C] had said she would bath [Mr A], which is why I carried on with other tasks. I am not aware of what she ([Ms C]) was doing, as I was engaged in other tasks, but I am aware she wasn't with [Mr A] 100% of the time.'

It appears a lot of information about each person is passed on from one Community Support Worker to another, and when a divergence from a Personal Plan occurs, no one is monitoring practice or there has been no changes to a person's Personal Plan which allows these divergences to occur.

On [date], whilst there may have been a discussion about taskings, there was no specific CSW appointed to lead the shift. [Mr B] stated that he worked the sleepover shift at [the Home] once a fortnight. When [Mr B] found [Mr A] submerged in the bath, his First Aid knowledge and skills were used, and he reacted quickly.

Opinion as per the Guidelines for Independent Advisors:

On the night of [the incident] routines were running late and the standards of care/accepted practice as set out in [Mr A's] Personal Plan, Risk Management Plan, the Family Whanau Respite Manual (December 2012) and [Mr A's] mother's expectations of being fully supervised at all times, were compromised. [Mr A's] safety was at risk when he was left unattended for periods of time whilst other children were being supported. Clearly, there was a significant departure from standards of care and accepted practice. There has been a systems failure in relation to inconsistent practice across the service, not reading and following instructions, inconsistent instructions within documentation, no process for monitoring personal care practices in accordance with policy and some complacency within work practices, which resulted in a serious incident. This would be viewed in a similar manner by my peers.

[Ms C]

1 The appropriateness of the care provided by [Ms C] to [Mr A]

A Her actions on [date], Folder 2, Section 2

From the documentation provided it seemed that the two staff on duty did not appear to have been well organised and there appeared to be no clear leader and a poor assignment of tasks. Neither staff, once they were running late, thought to

call for assistance, so mistakes were made; compromising practices. It appeared that there were six high needs children/young adults in the service that evening. [Ms C] was obviously trying to meet the mother's request for the medication to be given at 7.30pm, with little knowledge of the consequences of giving this medication and not bathing [Mr A] until 8.30pm.

In [Ms C's] statement to Police she states 'I believe there was a general consensus between staff that [Mr A] could be left unattended for short periods to soak in the bath as long as he was regularly checked'.

Personal support information — [Mr A] 10 May 2013

Personal Care	What Happens Now?	What Support is Needed
Bathing/personal hygiene	I require full support with this	[Mr A] needs to have his incontinence products checked [Mr A] uses a hoist to get in and out of the bath [Mr A] needs CSW to wash and dry his body

The Personal Plan information is not clear that [Mr A] is to be assisted at all times when in the bath. In his Personal Plan under heading Sleep/Night Support for [Mr A] it states 'I normally go to bed at 8pm. I have my evening medication half an hour before bed'. Clearly, the staff were running late on [the night of the incident].

[Ms C] stated 'that there is not a lot of time to read manuals whilst working at [the Home]. I am not the type of person who can unwind after all of the stress with the children and read a manual. I also have dyslexia and find I have to read things over and over to understand them'. [Ms C] also worked the sleepover shift at [the Home] from 2.30pm Friday until 3pm Saturday once a fortnight — her fortnight often coincided with [Mr A's] booking. There did not appear within any of [Ms C's] training in relation to [the Home] to be any one on one training to Personal Plans, personal cares or personal assessment to ensure [Ms C] understood clearly what each person's needs and abilities were to support her learning deficit, or the risk that she took leaving [Mr A] unattended to help [Mr B] outside when another person was acting up.

Opinion as per the Guidelines for Independent Advisors:

On the night of [the incident] routines were running late and the standards of care/accepted practice as set out in [Mr A's] Personal Plan, Risk Management Plan, the Family Whanau Respite Manual (December 2012) and [Mr A's] mother's expectations of being fully supervised at all times, were compromised.

[Mr A's] safety was at risk when he was left unattended for periods of time whilst other children were being supported. Clearly, there was a significant departure from standards of care and accepted practice. There has been a systems failure in relation to inconsistent practice across the service, not reading and following instructions, inconsistent instructions within documentation, no process for monitoring personal care practices in accordance with policy and some complacency within work practices, which resulted in a serious incident. This would be viewed in a similar manner by my peers.

Report prepared by Margaret Wyllie"