Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

IDEA Services and employee breach Code in care of resident
20HDC01109

The Deputy Health and Disability Commissioner has found IDEA Services, and a support worker, breached the Code of Health and Disability Services Consumers' Rights (the Code) in their care of a resident.

The breach involves severe departures in the standard of care provided to a long-term resident of an IDEA Services facility.

This case involved a resident who died following a choking incident. Tragically, it was a preventable death with support staff not following the man's support plans.

The man's support plans described his choking risk and how it was to be managed. Instructions included ensuring his food was cut into manageable-sized pieces and being present with him when he was eating. Staff were also meant to give him verbal prompts to chew his food properly before swallowing.

Rose Wall found IDEA Services breached Right 4 (1) and (3) of the Code – that is the right to services provided with reasonable care and skill, and the right to services provided in a way that minimises harm and optimises quality of life.

A support worker was also found to have breached Right 4(1). Ms Wall made an adverse comment about another support worker involved in the man's care, who had left her shift early, before the meal was served.

An internal investigation concluded the key factors contributing to the man's death were that his food was not cut up, and the house was short-staffed due to the other staff member leaving early that day. It also noted the support worker who found the resident unresponsive failed to first clear the man's airway before applying CPR.

Ms Wall said, "IDEA Services failed in its duty to manage the resident's risks, keep him safe and provide an appropriate standard of care. Although IDEA Services had a system in place for managing risk, this did not translate into practice. It is disappointing that a lax practice had been allowed to develop at the house, with a culture of complacency in relation to the management of risk".

She went on to say IDEA Services did not comply with its own significant hazards register or have a consistent and unambiguous support plan for the man. She noted IDEA Services' failure to make sure its staff adhered to the man's support plans, ensure staff training was up to date, and to have adequate staffing levels.

Of the support worker she said, "By not adhering to the resident's support plan to mitigate his risk of choking, and not attempting to clear his throat before

commencing CPR, [the support worker] did not provide services to the resident with reasonable care and skill."

While Ms Wall did make an adverse comment against the other support worker for leaving the shift early, she considered there were mitigating circumstances.

"I am concerned by the disconnect between organisational expectations and the beliefs, attitudes and actions of the IDEA Services' staff at the house," Ms Wall said.

Since the event, IDEA Services has formally apologised to the man's family, and ensured the incident is discussed at local and regional levels, with reminders to staff of the importance of adhering to individual support plans. It has also revised its Safer Eating and Drinking programme, and reviewed its First Aid training records to make sure its staff training is up to date.

It confirmed a number of organisational changes since the event. Ms Wall acknowledged both support workers involved were remorseful and had provided IDEA Services with written apologies to pass on to the man's family. She also noted the changes made by IDEA Services but has recommended it:

- Use this case to support staff training as a reminder of the significance of a choking risk and to highlight the importance of following individual support plans and the hazards register.
- Confirm there is a documented, and clearly communicate, expectation that staff must have the express permission of their manager to leave a shift early.
- Ensure these actions are confirmed to HDC within three months of its report being published.

17 July 2023

Editor's notes
The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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