Care of intellectually disabled man
(11HDC00712, 6 September 2013)

Disability services provider ~ Respite care ~ Community support worker ~ Intellectual impairment ~ Medication administration ~ Medication management ~ Incident reporting ~ Respect ~ Staff training ~ Rights 1(1), 4(1), 4(4)

A woman complained about the care provided to her 21-year-old son by a respite care facility for young people with intellectual impairments. The young man had difficulty in communicating effectively. He required assistance with taking his medication, which included an anticonvulsant to prevent dangerous prolonged convulsions due to epilepsy.

On one occasion, a Community Support Worker (CSW1) pushed the young man's hand to his mouth because he did not follow instructions to cover his mouth when he coughed. CSW1 then pulled the young man out of his chair and pushed him to his room for time out. CSW1 did not report the incident or complete a Reportable Events form, as required by policy. Another CSW was present when the incident occurred.

On two occasions, another CSW (CSW2) did not administer the young man's medication correctly, did not accurately document the incidents, and did not inform the on-call manager or the young man's family, as required by policy.

While there were deficiencies in CSW1's training, it was held that he failed to provide services with reasonable care and skill, and therefore breached Right 4(1). His actions were also disrespectful and a breach of Right 1(1). Adverse comment was made about the other CSW's inaction during the incident between CSW1 and the young man.

By failing to administer the young man's medication correctly on two separate occasions, CSW2 failed to minimise the potential harm to the young man, and she therefore breached Right 4(4). In addition, she did not document her medication management errors or inform the appropriate individuals of these errors, and so breached Right 4(1).

The respite care facility did not comply with its own staff training policies in respect of CSW1, or its own medication management policy in respect of CSW2. In addition, it did not take adequate steps to ensure that CSW2 complied with its medication management policy following the first incident when medication was not correctly administered, and failed to take adequate steps after the second incident. The facility failed to ensure it had sufficient information to be able to provide the young man with an appropriate standard of care, and failed to demonstrate that it had an adequate documentation system. Accordingly, the facility was found in breach of Right 4(1).

It was noted that a contractual evaluation audit undertaken on behalf of the Ministry of Health made recommendations to support progress in some of the disability services provider's respite facilities. Some of the recommendations were made in respect of issues that were contributing factors to the failure to provide the man with an appropriate standard of care up to 18 months after the audit. The disability services provider appeared not to have adequately addressed the recommendations made following the audit.