Caregiver, Mr C

Creative Abilities and Associates Ltd

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC00007)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

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

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

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

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

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

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

Findings

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

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

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

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

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

Complaint and investigation

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

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

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

13. The parties directly involved in the investigation were:

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

Also mentioned in this report:

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

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

[2] Right 4(4) states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

Information gathered during investigation

Background

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

Mr A

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

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

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

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

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[3] The obstruction of the upper airway when sleeping.
[4] Cerebral palsy is a term used to describe a group of disabling conditions, which affect movement and posture. It is caused by a defect or lesion to one or more specific areas of the brain, usually occurring during fetal development before birth, but it can also occur as a result of hypoxia or injury during or after birth.
[5] Partial or total loss of the ability to articulate ideas or comprehend spoken or written language, resulting from damage to the brain caused by injury or disease.
[6] The Health Passport is a booklet produced by the Health and Disability Commissioner for consumers to record information that they want people to know about how to support and communicate with them.
[7] See paragraph 38 below.
[8] PEG feeding is used where patients cannot maintain adequate nutrition with oral intake.

Creative Abilities

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

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

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

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

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

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

Staff induction

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

[9] Supported living is a service that helps disabled people to live independently by providing support in those areas of their life where help is needed.
[10] Mr A received residential rehabilitation funding from ACC.
[11] The caregiver is required to remain awake and complete client and household duties during the shift. Creative Abilities also has sleepover shifts, where the caregiver sleeps at the residential home. This is for clients who do not require care during the night.

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

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

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

Communication book

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

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

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

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

Care plan documentation

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

All About Me

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

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

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

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

Care plans

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

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

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

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

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

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

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

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

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

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

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

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

Rehab Services information

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

Wheelchair straps

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

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

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

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

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

Creative Abilities' policies

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

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

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

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

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

Mr C

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

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

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

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

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

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

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

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

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

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

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

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

Other training — Mr C

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

House meetings

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

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

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

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

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

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

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

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

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

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

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

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

Performance appraisals

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

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

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

Supervision

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

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

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

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

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

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

Roster

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

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

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

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

[14] See above footnote 11

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

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

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

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

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

Previous occasion found sleeping on job

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

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

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

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

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

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

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

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

Evening shift – events leading to Mr A's death

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

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

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

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

[15] A Creative Abilities residential home.
[16] A Creative Abilities residential home.

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

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

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

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

Night shift

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[18] Dated 25 March 2014.
[19] In an interview with Creative Abilities, Mr C said that Mr A stopped breathing 4 to 5 minutes after he commenced CPR.
[20] HDC was provided with the digital file of Mr C's 111 call and had it transcribed.

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

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

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

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

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

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

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

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

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

Incident report form

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

Creative Abilities internal investigation

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

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

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

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

Changes made

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

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

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

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

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

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

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

g) Introduced parent approved training guides.

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

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

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

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

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

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

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

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

Police investigation

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

Further information provided by Creative Abilities

127. Creative Abilities advised that:

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

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

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

128. Creative Abilities also stated:

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

Responses to the first provisional opinion

Mr and Mrs B

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

Creative Abilities

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

Mr C

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

Responses to the second provisional opinion

Mr and Mrs B

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

Creative Abilities

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

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

Mr C

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

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

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

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

Relevant standards

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

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

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

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

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

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

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

Opinion: Introduction

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

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

Opinion: Mr C

Introduction

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

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

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

Factual findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Care provided – Breach

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

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

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

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

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

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

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

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

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

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

Conclusion

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

Opinion: Creative Abilities and Associates Limited

Introduction

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

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

Care provided — Breach

Care planning

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

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

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

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

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

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

[23] NZS 8134.1.2:2008 Standard 3.5.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Training

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

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

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

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

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

182. Ms Waddell advised:

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

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

Conclusion

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

Monitoring of hours worked by Mr C — Breach

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

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

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

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

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

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

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

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

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

192. Ms Waddell advised:

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

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

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

Monitoring of performance — Adverse comment

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

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

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

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

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

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

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

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

Recommendations in the first provisional opinion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

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

205. I recommend that Creative Abilities and Associates Limited:

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

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

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

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

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

Follow-up actions

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

Appendix A — Independent expert advice to the Commissioner

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

"I have been asked to provide an opinion to the Commissioner on case number C14HDC00007.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications and Experience Relevant to the Review:

I have a Post Graduate Diploma in Health Service Management and a Certificate in Quality Systems and Auditing Principles. I have worked in the Health and Disability sector for 25 years and have held senior management roles in both the Ministry of Health and ACC. I was the CEO of the New Zealand Disability Support Provider Network and am currently working as a lead auditor of Health and Disability Services nationwide. This includes auditing the development and implementation of policies, procedures and guidelines for compliance with the New Zealand Health and Disability Services Standards NZS 8134:2008 (the Standards).

Also as part of the audit process I am also involved in service planning, assessment and delivery and the evaluation of effectiveness of outcomes for clients.

The Commissioner has asked that I:

Provide independent expert advice about the appropriateness of care provided to [Mr A] by the following parties: [Mr C], Creative Abilities.

Background:

[Mr A] (aged 20 years) was receiving respite care at [a Creative Abilities home] three nights per week. He was dependent on carers and required 24 hour care. He had his own room with an ensuite.

[Mr A] had cerebral palsy. His father said that [Mr A] had 'little motor control, had no speech, no head control good eyesight and hearing'. He also noted that [Mr A] had a 'huge backward thrust using his legs, which often made managing him difficult.'

[Mr A] had epilepsy. When he was small he had some major epileptic events, always triggered by very high temperatures. But for the eleven years before he died his parents had only witnessed 'minor turns' that lasted for a few seconds. [Mr A] was given Tegretol to help control his epilepsy.

He also suffered from acute obstructive apnoea, when his head was tilted backwards. He was unable to pull his head forward himself to recover from this.

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

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

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

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

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

The incident

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

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

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

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

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

Monitoring

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

Creative Abilities:

Creative Abilities has provided supported living day services to clients with physical and intellectual disabilities for 17 years. Five of the 15 homes are

considered high needs homes. Night shift staff in high needs homes are required to be awake during their shift.

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

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

The following Documents were provided to inform the review:

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

Tab 2: Information from [Mr C]:

1. Response to notification, 25 March 2014

Tab 3: Information from Ministry of Health:

2. Letter from Ministry of Health, 12 March 2014

Tab 4: Information from Creative Abilities:

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

Tab 5: Information from [the ambulance service]

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

Tab 6: Information from ACC

22. Letter from ACC 28 April 2014

Also provided electronically were:

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

PART 1:

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

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

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

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

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

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

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

In my opinion it is unacceptable practice for any care giver to ignore the instructions in a care plan which has been developed to set out the required support and/or interventions for individuals. I believe this is a departure from the required standard of care. This departure is, in my view and I believe would also

be that of my peers, significant in this case. Given the high needs level of [Mr A] and the requirement to ensure he is properly positioned and supported adequately in his wheelchair to ensure his safety, any lack of adherence to these instructions would pose a risk to his safety. The provision of safe care is required for all clients under the Health and Disability Service Standards (NZS 8134:2008).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART 2:

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

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

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

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

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

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

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

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

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

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

The fact that [Mr C] felt he was not trained sufficiently to care for [Mr A] is of concern. The fact that he was not able to assist the ambulance staff with clear recall and understanding of what [Mr A's] medical and disability needs were indicates, in my opinion, there were some issues with the standard and level of training provided to [Mr C]. This is especially around specific training to meet [Mr A's] care needs. In addition the fact that his first aid certificate had expired

may have contributed to [Mr C] not being in a position to administer CPR effectively without the instructions of the [ambulance service] call centre. This may have not been the case if he had kept current his first aid training. In my experience organisations generally support caregivers who are working with clients who have high care needs, to maintain current first aid certificates and in fact for the majority this is a requirement.

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

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

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

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

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

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

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

over the day shifts is usual at a house classified as high needs where one on one care is not required and would typically be accepted practice.

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

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

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

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

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

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

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

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

The specific duties checklist (again generic) for the house was clear.

In my opinion, the set of policy documents provided are appropriate for organisations delivering the type of services Creative Abilities are involved in.

e) Was the night shift monitoring of clients adequate?

The monitoring requirements for any clients would normally be indicated in their needs assessments and be included as a part of their care plan. Any variations to what was provided would typically be indicated here.

As [Mr A's] parents were fully aware of the staffing at the facility and the process of hourly checks, I draw the conclusion that there was no particular need for increased monitoring for [Mr A] initially, once he [was] put in his sleeping position as was required in his sleep system.

However, as he normally woke anytime from 2am onwards, it would be assumed that increased monitoring would need to occur to identify when he actually woke up and would need to be transferred into his chair. The care plan and notes did not detail the specific monitoring requirements. What was included was the need for getting him up when he woke, frequent checking when he was in his wheelchair and not to leave him unattended when he was placed on his back in the bed prior to getting him up.

Without having additional specific details provided on individual client needs for night monitoring, I would regard hourly checks along with the use of audio monitoring devices would usually be adequate for most clients throughout the night if they did not have high medical needs. When [Mr A] was waking up, I would expect the monitoring to be more frequent until he had been put in his wheelchair correctly and then monitoring him more regularly for the remainder of the night.

The formal records only detail the requirement for hourly monitoring checks. The detail that is contained in the care plan indicates some need for more active involvement between checks. The transcripts of interviews with [Mr C] do confirm his understanding of what was required during the night time care for [Mr A].

In my opinion if the needs assessments required more frequent monitoring for clients in this house, this should be reflected clearly in their care plans. It would be insufficient in my view to have a standard hourly check list and subsequently only hourly checks for a client with the specific needs that [Mr A] had. The use of a template to sign off hourly checks was not in my opinion, adequate for the level of monitoring required specifically for [Mr A] by night staff. This would not be a generally accepted adequate standard of care practice and given the information contained in the care plan, which is further discussed in the following section, this is a significant departure from what would be viewed as an adequate standard of care.

f) Was [Mr A's] care plan adequate?

The care plan is the main documentation that is used to direct staff on the care needs and support required in any residential service. This should have all specific information related to the individual and their requirements over each 24 hour period with appropriate alerts. I would normally expect to see in a good care plan, a timetable for care needs documented with relevant details of interventions required to meet those needs. I would also expect to see any medical conditions that would compromise safety prominently noted at the beginning with relevant responses required should an episode occur. I would expect it to be written in a

format that was easy to understand and with clear directions to manage care as required during a 24 hour period.

The care plan that has been provided had information about his feeding requirements and medicine schedule for the morning and for the 3pm–3.30pm timeframe. It also had a section for his night time medication and his transfer into bed. It is documented here that he has 'severe obstructive Apnia' and he had 'extreme difficulty when on his back and should never be left in this position — especially unattended'. It then had a picture of his sleeping position and instructions to get him back into his wheelchair when he woke where he would then sleep on and off. Finally an instruction to put [Mr A] back into bed on his back for half an hour was detailed. Instructions to check him frequently and that he may need repositioning were also given. This was a contradiction to the earlier instruction that he should never be left unattended.

Included in the folder was an emergency procedure should the feeding tube fall out, his medication chart, short term care plans — the most recent dated [late 2013]. Also included were seizure protocols, a sleep apnoea fact sheet, a MRSA information sheet, a support information record to be taken to hospital at the time of emergency or admission. Rehabilitation services information on his sleeping system, feeding, communication, physiotherapy programme had been provided as a part of the information kept on site.

The care plan did not, in my view, provide all the information needed nor was it set out in a way that was easy to follow. There was insufficient reference made at all to his personal care needs (i.e. showering) and very little information for his toileting needs. The high needs client care sheet requires detailed information to be recorded including if toileting occurred on each shift, skin integrity and feeding. The sheets provided were only signed with little of the detail asked for at the top of each column on the form.

There is little information about [Mr A's] specific physical needs, his communication or his medical needs. The information that is in the care plan is in differing fonts, many quite small, and had handwritten changes made that were not easy to decipher. The description of the sleep system was clearly explained with photographic images to assist staff. The feeding information was also clear.

Of significant concern was the lack of prominent alerts to identify his severe obstructive apnoea — other than a short reference in the 'bedtime' section.

There was no information prominently displayed in an easy to understand format about his obstructive apnoea condition or what to do if he did have difficulty with his breathing. The only information about the condition is a generic fact sheet which would have been difficult to understand for anyone with no medical knowledge and extremely challenging to read for staff for whom English is a second language or who have any literacy challenges. Care giving staff in this sector, would often fall into one or both of these categories. It is clear from much of the information reviewed, that care staff at this facility could also find the

information presented in the care plan difficult as interview transcripts demonstrate a number of care staff were from outside New Zealand.

The short term care plans dated [late 2013] describe the use of creams and antibiotics to manage the inflammation around [Mr A's] peg site were signed as read by only four staff. Earlier ones had been signed by up to 9 staff. This illustrates not all staff were reading and signing off additions to the care plan.

In my opinion the care plan that was used to instruct and guide staff on the care required for [Mr A] is in the main, significantly below the acceptable standard for someone who had as significant a need level as [Mr A]. Parts of it I consider inadequate to provide appropriate guidance and information for staff to enable them to provide a good safe standard of care for [Mr A]. I believe it would be viewed as unacceptable across the sector as it lacked critical information presented in an easily accessible way to enable staff to provide safe care.

g) Please comment on the instruction [Mr A's] parents put in the communication book regarding the collar, and whether Creative Abilities took appropriate steps in response to this?

It is noted [in mid 2013] by [Mr A's] mother that when he couldn't hold up his head that the collar needed to be used. If he was alone at night she also stated it was a 'good idea' to use his collar. Again on [two subsequent occasions] his mother informed staff that [Mr A] needed to have his collar on when his neck was floppy as it had seemed to be happening a lot more often.

In response to these communications, the Team Leader said that he instructed night staff to put on the neck brace whenever [Mr A] became agitated.

The investigation report stated that none of the care givers knew that the parents intended the use of the collar to be used other than during transportation. Nor did they know it was to be used when he became agitated. They also did not know [Mr A] might have more difficulty breathing if his head was floppy and he was not wearing the collar.

The Team Leader stated he was not aware the collar was to be used when [Mr A] was unattended and was not aware this was a safety risk. One care giver interviewed during the investigation had no idea about the use of the collar apart from when he was in the taxi. He stated he had never seen it used in the house. The care giver was not aware of any communication from the parents and said they had actually never seen the communication book from the parents.

In my experience, the use of the communication book is generally seen as a very important part of the communication between a parent and an organisation caring for a family member. It would be seen as especially important in this instance where [Mr A] was not full time at the house and spent a number of nights at home with his family. It usually becomes an important written link to keep both the family and the organisation aware of any changes in the needs of a client and to ensure all information is current.

It appears the use of the communication book was not used in this way and much of the communication took place verbally. It is my view that the written communications in the book by the parents were not seen as important enough to be shared with all staff and no information about the use of the neck cushion had been noted in the care plan. This is not regarded, in my view, as an acceptable response by Creative Abilities. The fact that nothing had been added into the care plan after these written communications, even if they were shared with staff, is not reflective of good practice and would not be viewed as such in the wider sector. The response by Creative Abilities would be seen in my view as a significant departure from accepted practice, given the safety aspect of the communications that were entered into the book. It demonstrates a lack of effective communication systems in place at the time.

h) The ACC contract states: 'Clients receiving [Residential Support Services RS3] need 24-hour oversight supervision by clinical professionals, e.g. a registered nurse, physiotherapist or occupational therapist.' Was the supervision provided by Creative Abilities adequate?

There is evidence of a number of interventions and visits by clinical professionals with [Mr A] during the 2013 year. The Specialist Rehabilitation Service provided consistent oversight supervision for [Mr A] and records show they were on site regularly and provided good information to staff on sleeping, tube feeding, communication and seating systems. [Mr A] had been visited by an Occupational Therapist on the day before the event. The records also show the company registered nurse had been responsible for clinical oversight and had recently been involved in managing the issue with the inflammation around [Mr A's] peg site. He was also involved with liaising with the community health nursing service in the treatment of any abrasions, pressure concerns and medical interventions. These are all well documented and demonstrate in my opinion, that adequate clinical oversight and supervision was occurring.

i) Please comment on the recommendations in the ACC audit report and whether actions taken by Creative Abilities addressed these satisfactorily.

The review by ACC noted areas for improvement in the implementing of the Best Practise Change Programme, incident management, admission processes, document storage, and the role of the RN, increasing night shift reviews and clinical oversight with unscheduled home visits occurring.

Creative Abilities supplied information about reviews they have completed, changes already in progress and future recommendations.

There appeared to be significant work in progress and also planned at the time the document was written. This was especially in the monitoring of staff working night shifts and communication systems. Training initiatives were also being implemented, including the requirement for all team leaders to have Level 3 Careerforce qualification and the introduction of parent approved training guides. Staff education about client care plans was to be implemented and staff

competence and compliance assessments were all initiatives planned towards improving the quality of client care in the service.

If these planned improvements are well developed and implemented they will, in my view, go a significant way toward addressing the shortfalls identified in the policies, procedures and practices of the organisation during the ACC review.

These will in my opinion directly impact on the improvement of client safety in an environment where vulnerable clients rely on their service providers to provide a safe and secure environment.

j) Did Creative Abilities take appropriate steps in response to finding [Mr C] asleep on duty on (date)?

[Mr C] was found asleep [during a night shift audit in late 2013].

A meeting was held with [Mr C] [following a letter (not supplied) sent to him]. It is assumed this letter was detailing the issue and requesting a formal meeting. This would generally reflect good process. A disciplinary investigation was carried out which resulted in a letter being sent to [Mr C]. It stated that serious misconduct had been proven and he was issued with a final written warning.

Detailed as the reasons for the serious misconduct finding were that [Mr C] had been found asleep, wrapped in a blanket on a mattress on the floor when the audit occurred. He had not signed off the hourly monitoring checklist and had not completed his duties as required for his shift.

As [Mr C] had had no previous incidents of this nature in the years he had been employed with Creative Abilities and had always been regarded as a responsible employee with no other relevant disciplinary issues, the written final warning was issued rather than a dismissal notice. As a part of the warning, a block was put on all extra shifts, with one exception made over [a holiday weekend].

In addition all staff were reminded that to be asleep on a night shift duty was a serious misconduct offence and could lead to summary dismissal.

This process followed by Creative Abilities demonstrates, in my view, a fair and just process and given all the relevant facts provided, I believe an appropriate decision was made. The process followed reflected their current policy and is one that would be representative of the sector and in line with current New Zealand Employment Law.

k) Please comment on the adequacy of the internal investigation carried out by Creative Abilities.

The internal investigation involved a series of interviews with staff involved in the care of [Mr A]. These being the care giver on duty at the time of the incident, the team leader, the registered nurse on call and two other caregivers who had looked after [Mr A]. In addition documents obtained from the house, clinical records

from the DHB, other relevant notes from his folder, communication books and specific house information was included. Training records and other HR information for [Mr C] were also a part of the review process.

In my opinion the available documentation reviewed was appropriate to inform the investigation. The quality of that documentation was also used and did inform the organisation as to where improvements could be made in the future.

The interviews held, while conducted with the relevant staff, were in my opinion poorly prepared for and lacked structure to enable the best possible evidence to be collated. They demonstrated a lack of a sound process in place to deal with incidents of this nature and were not as helpful to the investigation as they should have been.

In the absence of any apparent comprehensive procedures in carrying out this investigation, it is my view that the staff were not aware of how to actually structure interviews to ensure all information was gathered in a way that would assist in an investigative process. I don't believe the staff interviewed would have felt well supported.

There was a level of confusion in both the questioning and the lack of follow up where there were contradictions and lack of clarity of recall in the responses given. [Mr C] had a total of 7 interviews over a period of 5 weeks. I question the need for and the value gained from having all these interviews over that time frame. Although he had indicated he would like some personal support during the interviews, it appears this was never appropriately facilitated by Creative Abilities.

The fact that the conclusions drawn were in the main part, not conclusive would indicate some issues with the process in my view. It is acknowledged the investigation did have limitations due to the fact that [Mr C] was the only person to witness the events, until the arrival of the ambulance staff. The investigation had to be largely reliant on his recall of the facts to draw any conclusions as to the actual timeline of events that occurred. However it is my opinion, and I believe would be typically seen across the sector, it is sound practice that a clear documented policy and process is in place to guide investigations of this nature. This did not appear to have been the case during this investigation.

Are there any aspects of the care provided by Creative Abilities that you consider warrant additional comment?

1. Creative Abilities follow up to the disciplinary response to [the incident] when [Mr C] was found asleep on duty.

Although a block was put in place on [Mr C] doing additional shifts following [this incident], as a part of the disciplinary response, this was not adhered to by the organisation. Several weeks later following this incident, and in the days leading up to the death of [Mr A], [Mr C] completed a number of shifts that resulted in 33 hours on duty in a 48 hour period.

This is my view, demonstrates a complete disregard on the part of Creative Abilities of the provisions put in place for [Mr C], to guard against further incidents.

This would, in my view, be regarded across the sector as a significant departure from what would be accepted good practice following the disciplinary process and the subsequent actions that had been determined.

2. Registered nurse clinical leadership for care staff.

The apparent lack of training by the registered nurse for care staff who had no medical qualifications and knowledge was apparent in the interview transcripts. [Mr C's] stated concern about the lack of training in caring for [Mr A] in his letter to the organisation also reflects this. Clinical staff in any organisation have a responsibility to educate care staff in these areas, especially where there are specific medical and disability needs for individual clients. This did not appear to have occurred in the case of the needs of [Mr A].

Follow-up Questions:

1) In your view, would a child with [Mr A's] needs be able to be cared for by a caregiver (like [Mr C]) if proper training was provided?

The training required to support a child with similar needs to [Mr A] would certainly be able to be provided in a community service setting such as the one in which [Mr A] had been receiving care. In my view care givers would be able to provide adequate support if their training included sufficient specific information and training regarding any medical needs and the management of these, as well as training on how to provide care for all client specific physical impairment needs. I would expect a current first aid certificate to be held by a care giver if sole care or responsibility was required.

2) Creative Abilities told HDC that its staff were able to work a maximum of 55 hours per week (this includes any sleepover shifts). Please provide comment about whether this is reasonable.

Should staff be working 'sleepover shifts' it would be reasonable to allow them to work some additional hours. Usually a sleepover shift does allow a care giver to get some sleep as they are not required to be awake once clients are settled for the night. Sleepover staff are required for any emergencies that may occur during the night that clients would not be able to respond to themselves due to their level of impairment. If there had been no need for staff to be awake for any length of time for any reason during a sleepover shift, it is acceptable in my view, for additional hours to be worked during the working week as staff will have had sleep. If staff had had unsettled nights due to client needs, asking them to work additional hours would not be reasonable. Managing staff stress and fatigue is a clear responsibility of any employer and monitoring staff working hours and conditions is a crucial part of that process, particularly where staff are working with clients wholly dependent on their support.

The practice of giving overnight awake staff additional shifts would not be viewed as acceptable in the sector if it was more than 2–3 hours at the end of the occasional shift.

3) The last [six weeks] of [Mr C's] shift record shows that he worked the following hours:

— [Week 1]— 58 hours total (42 hours base roster, 16 hours not base).

— [Week 2]— 65 hours total (34 hours base roster, 31 hours not base).

— [Week 3] — 59 hours total (42 hours base roster, 17 hours not base).

— [Week 4]— 49 hours total (41 hours base roster, 8 hours not base).

— [Week 5] — 42 hours total (42 hours base roster, 0 hours not base).

— [Week 6] — 75 hours total (51 hours base roster, 24 hours not base).

Please provide your comments, if any, on [Mr C's] hours worked.

The hours provided that [Mr C] worked over the last two month period are, in my view, excessive. This opinion is based on the fact that his normal rostered hours were awake night shifts where he was required to be awake at all times in the houses. Any additional hours worked would appear to have been during the day immediately following a night shift when he would normally be expected to be getting some sleep or having some time off. This is very concerning given that following his disciplinary process from the [audit] incident, a block was put in place to ensure he did no additional hours other than his rostered shifts.

Any hours worked over the 55 hours that Creative Abilities apparently allowed, was not only against their reportedly accepted practice, but would also expose employees to real risk of stress and fatigue issues. Four of the six weeks in this period were over and above the 55 hours the organisation told the HDC they allowed. This would indicate to me that they were not actively monitoring workers' activity.

In my view, the hours worked as documented above by any staff member, would be deemed unacceptable by most in the sector and would certainly increase the risk to client safety. It would not generally be viewed as good employment practice. Discussions with colleagues in similar organisations confirm any hours worked by care giving staff over and above 100 hours in any fortnightly period would be of concern and immediately addressed.

4) Two staff members were needed to move [Mr A] into his wheelchair. There was one person rostered on overnight. Please provide your comments, if any, about this arrangement.

A needs assessment by appropriately qualified professionals is used to determine the requirements for the safe transfer of any individual. This would typically include the method of transfer and the staff requirement to do so safely. Specific information from any specialist physiotherapy or occupational therapy

assessments was not provided in his care plan where it would normally be expected to be found. No information was provided to specify the number of staff needed to transfer [Mr A].

[Mr A] does say in his 'All about Me' booklet that he has his own hoist and sling. This would suggest that these were needed to be used to transfer him in and out of his wheelchair as required. It is considered best practice to have two people available to transfer anyone who requires hoist transfer, although this could be done with one person who has had adequate training. Colleagues confirm while this is not ideal, it is done within this sector where only one trained staff member is available. A care giver lifting a client would not be acceptable practice.

5) Pg 15. I would be grateful if you could explain what you mean by, 'Two care givers over the day shifts is usual at a house classified as high needs where one on one care is not required and would typically be accepted practice'.

Over a usual day shift, two care givers would generally be adequate to provide care and activities for similar clients in similar settings. There are some clients in community settings who have been assessed as requiring one on one support to ensure their safety and the safety of others. This is normally due to behavioural issues. The evidence provided suggests that this was not the case here.

6) Pg 16 (re ACC initial funding). Is it usual practice for a service user to have more care givers over an induction period?

It is, in my experience, usual practice for care givers in a training period to have shifts completed with a 'buddy' for however long is needed to ensure they are able to undertake duties competently by themselves. This is accepted practice right across the sector during any induction period for new staff whether the duties are of a general nature or working with specific clients. In this case it is assumed ACC made the decision to start with two care givers for a period of time initially, then made the decision that one person would then be able to manage to meet the needs of [Mr A] on their own."

In response to the first provisional opinion, new information was provided by Creative Abilities, and further expert advice was obtained from Ms Waddell on 15 June 2015:

"**REF: C14HDC00007**

I have been asked by the Deputy Health and Disability Commissioner to provide further expert advice in response to additional information that has been provided by Creative Abilities.

Following a review of that information I have the following comments to make:

1. Refer Part 2; P 13 of my original advice.

Given that [Mr C] had completed a First Aid Certificate in [mid] 2012 and this was valid for a period of two years, Paragraph 5 above should be deleted.

2. Refer Part 2; P14.

Paragraphs 2 and 3:

The fact that [Mr C] felt he was not trained sufficiently to care for [Mr A] is of concern. The fact that he was not able to assist the ambulance staff with clear recall and understanding of what [Mr A's] medical and disability needs were indicates, in my opinion, there were some issues with the standard and level of training provided to [Mr C].

However as mentioned on P13 of my advice, many of the regular updates that were specific around the care needed for [Mr A], including the use of the shoulder straps and the neck collar for [Mr A], were covered at the monthly meetings. There is no evidence that this training/information was repeated for [Mr C] at any time following those meetings. Given that he was to have sole responsibility over night shifts and his subsequent lack of ability to assist ambulance staff during the event, my view remains that there were some issues with the level and standard of client specific training for the care of [Mr A].

3. Additional comments following the review of the newly provided information:

a) One-on-one monthly supervision meetings/performance appraisals.

The information provided of the one-on-one supervision sessions show a variance in dates and many that are illegible so it is not clear if these were actually completed every month. The one [clearly dated] is comprehensive and covers each client with evidence of a good process having been followed.

The remainder do not appear to have been done following a similar process and are, in my view, not reflective of good practice that would gain insight to an employee's progress or provide appropriate support for staff.

b) The performance appraisal documents provided on the official sheets are not clearly dated but there are a number of comments referring to timeliness and issues with documentation not being completed. If, as would appear from editing dates, these are related back to 2012, then it would be expected that any such issues identified would be addressed in monthly supervision sessions. This does not appear to have occurred."

Further expert advice was obtained from Ms Waddell on 17 June 2015:

"**1) Creative Abilities submit that it has a detailed care plan. It submits that the care plan is made up of the 'All About Me' document, Health Passport, day-time care plan, night-time care plan, the short-term care plans and other documents including a skin integrity assessment. Could you please comment on:**

a) whether it is appropriate to have the care planning information spread over a number of documents;

It is generally not accepted good practice to have different parts of a care planning document spread over a number of different documents that may also be located in different locations. Staff should be able to access all relevant information in the care plan easily to ensure they have all information required to provide appropriate care. If a number of documents are used to make up that care plan — all relevant information should be transferred into a single care plan if it forms a part of the required information when caring for a client.

My opinion would be that it is a significant departure if all the care plans were not able to be accessed easily by all care staff. If all information relevant to day to day care planning, including information, alerts and specific instructions and responses needed should any health or disability event occur was not contained in the one plan, it would be considered only a moderate departure. In essence if non-essential information such as historical information or detailed assessments was located in other parts of the organisation that would not constitute a significant departure. I believe this view would be shared by my peers.

b) whether there should be one formal care plan containing all relevant information;

The most effective and efficient way to ensure appropriate care is provided is to ensure all information is included in the one care plan, including any short term plans in place for specific issues and any references to recent/relevant incidents or complaints. The care plan needs to be a living document that is easily accessed by all staff.

c) whether or not there are any risks/advantages in having the care plan as described in a) or b).

A care plan provides guidance for staff in their daily activity with a client. If it is not easily accessed and in one place there will be the risk of gaps occurring in the information for those providing care. The care plan is the overarching document that coordinates and gives all relevant and timely information for each individual client.

2) Creative Abilities submit that [Mr A's] care plan contained up-to-date information because in the 18 months [Mr A] was in their care, it completed four short term care plans. Please comment on:

a) the different purpose of a care plan and a short term care plan;

A short term plan is commonly used to address a particular issue or consequence from an event that will only be used specific to that event or issue. Examples of these would be the administration of antibiotics, wound management or any other specific intervention designed to be used in the short term. A care plan describes the supports and/or interventions that are planned to achieve desired outcomes as identified in an ongoing assessment process which includes both long and short term goals over a longer period of time. This will also incorporate all relevant

information if more than one agency, or as in this instance, family members are involved in providing supports to the client.

b) whether you agree with Creative Abilities that this meant [Mr A's] care plan was up-to-date.

If all relevant information, including information from the parents relating to care, had been collated into one service plan which was then used to provide care for [Mr A] over the times when he was in the service, it would be described as up to date. My recollection is that this was not the case.

3) Creative Abilities say that the reason why [Mr A's] 'All About me' document had not been updated in 14 months (the review was 2 months overdue at the time of [Mr A's] death) was due to the staff member responsible resigning and had not yet recruited a replacement. Do you have any comments on this?

All information that is needed as a part of a care plan needs to be kept current. Staffing issues should not impact on whether or not care plans were kept up to date.

4) Creative Abilities stated that the reason it did not transfer all communications between [Mrs B] and staff into the formal care plan was due to the fact that [Mr A] spent 60% of his time at home. Do you have any comments on this?

See response to 2. In addition, my view is that because [Mr A] only spent 40% of his time with [Creative Abilities], this would make information from [Mrs B] even more important to be used as an integral part of the care plan to ensure care was consistent and based on what was happening at the time for [Mr A] when he came into the service for support.

5) Creative Abilities submit that [Mr C's] induction into caring for [Mr A] included four day-time training shifts and one night-time buddy shift/induction. Please comment on:

a) whether you consider this to be sufficient induction training for caring for [Mr A];

The amount of induction time needed to ensure a caregiver was ready to take full responsibility for a client would depend on a number of things. The skill levels, the previous experience and what existing knowledge the person had about a particular client and their care needs. The service, probably in this case the team leader, would need to make that judgement call based on their observations and the skills and experience of the individual. Not having seen evidence of exactly what training was included in the day and night shifts I don't feel able to comment more specifically.

b) whether you consider this to be sufficient induction training for caring for [Mr A] as a solo carer on the night time shift.

See above response. Again this would need to be a judgement call on the part of the service depending on what they observed during training.

6) Creative Abilities submit that the reason some of its staff work excessive hours is due to short notice absences by staff. It stated that 'Finding appropriate staff at short notice becomes particularly difficult when the clients needing support have high and complex needs. These shifts cannot be filled by casual staff or other staff who do not have client specific training'. Do you have any comments on this?

It is a real challenge for residential services who provide support for high needs clients to get appropriate cover when there are staff absences and particularly when it is short notice.

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