Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Report by the Deputy Health and Disability Commissioner

(Case 20HDC01109)

Introduction

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

2. The report discusses the care provided to Mr A in 2018 by IDEA Services Limited (IDEA Services) and support workers Ms B and Ms C. In particular, the report considers the events surrounding an episode of Mr A choking on food, which ultimately led to his death. I express my sincere condolences to Mr A's family for their loss.

3. Mr A had cerebral palsy and an intellectual disability. He had received residential support from IDEA Services since July 2004. Mr A was a resident at a residential facility provided by IDEA Services. The facility is a large, single-storey house that accommodated residents with intellectual disabilities and varying support needs. The house provided 24-hour support, seven days per week, and typically had two staff present between 3pm and 8pm on weekdays, and a single staff member outside of these times.

4. Mr A's support plans identified him as being at risk of choking. He was one of three residents living at the house who had a known choking risk. Staff were aware of the risk, and IDEA Services said that the risk of choking was noted prominently on the house menu plan and on the front of the personal daily information books. Mr A's risk of choking was also noted in his

Names have been removed (except IDEA Services Limited and the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

medication folder, his personal support information (PSI), and Alerts & Crisis (A&C) information.

5. On the day of these events, Mr A left the table during dinner and, minutes later, Ms B found him unresponsive in another part of the house. Ms B called an ambulance and performed CPR[1] on Mr A. When paramedics arrived, they removed an item of food that was obstructing Mr A's airway, and they transported him to hospital.

6. Sadly, it was found that Mr A had suffered a fatal brain injury owing to a lack of oxygen. Mr A died two days later, shortly after being taken off life support. The Coroner determined that this was a preventable death and referred the case to HDC. Mr A's sister supported the referral from the Coroner.

7. The following issues were identified for investigation:

- *Whether IDEA Services Limited provided Mr A with an appropriate standard of care in 2018.*
- *Whether Ms B provided Mr A with an appropriate standard of care in 2018.*
- *Whether Ms C provided Mr A with an appropriate standard of care in 2018.*

8. The parties directly involved in the investigation were:

IDEA Services	Group provider
Mr A	Consumer
Ms B	Support worker
Ms C	Support worker

9. Information was received from the Coroner and an ambulance service.

10. Senior support worker Ms D is also mentioned in this report.

How the event arose

11. Ms B and Ms C were the two support workers scheduled to work from 3pm. Ms C was scheduled to finish her shift at 8pm, and Ms B was scheduled to finish at 10pm. Ms B was then scheduled for a sleep shift from 10pm–6am, and to work the next morning from 6am until 11am.

12. Ms C started her shift early, at 12.30pm, to support a service user with a planned activity. Ms C believed that she was required to complete a time-card training module[2] by the next day, or she would not be paid. She told HDC that Ms B and Ms D (a senior support worker and acting Service Manager at the time) both used the office at the house that afternoon to do their time-card training, but when it was her turn, the internet was not working. Ms C

[1] Cardiopulmonary resuscitation.
[2] Training on how to use a new time system to track time worked.

discussed with Ms B whether she could go home to finish the training. Ms B agreed, and Ms C left the house at 5.40pm.

13. Around 6pm, Ms B served a dinner of sausages and vegetables to the residents. Ms B noticed that Mr A left the table part-way through dinner. She was in the kitchen at the time, which adjoined the dining area. Ms B recalled that Mr A left the table around 6pm, although another service user at the table thought it was around 6.10pm.

14. Both Ms B and the other service user recalled that "a few minutes later", Ms B went to look for Mr A and found him unresponsive outside the bathroom at the far end of the house. Ms B said she then ran to get the house phone to call 111, and used her personal cell phone to call Ms D. The ambulance service confirmed that a call was received at 6.16pm, and Ms D confirmed that Ms B called her at 6.21pm.

15. Ms B told HDC that she left both phones on loudspeaker, and a 111 call-taker talked her through doing CPR. She maintained this until the paramedics arrived at the house and took over.

16. The ambulance care summary report states that when the paramedics arrived, they found Mr A lying face-up on the floor and Ms B was doing "very good [CPR]". The paramedics took over CPR and, during rhythm checks,[3] they rechecked Mr A's airway and found that a large piece of sausage had moved up his airway and could be removed with a laryngoscope.[4] The paramedics took Mr A to the public hospital at 7.20pm, where, sadly, he passed away two days later.

IDEA Services' investigation

17. IDEA Services completed an investigation into Mr A's death and produced an investigation report. The IDEA Services investigation concluded that "the available evidence indicates that Mr [A] died as a result of choking on a piece of sausage".

18. The investigation report made the following key findings:

- Ms B had not cut up Mr A's sausage but was aware of his choking risk and the expectations around meal preparation.
- Ms B did not attempt to clear Mr A's airway prior to commencing CPR despite having received appropriate training in this regard.
- If Ms C had not gone home early, she would have been there to assist with meal preparation and respond to the emergency situation.

19. The report determined that the key factors contributing to Mr A's death were that his sausages were not cut up, and that they were short-staffed owing to Ms C going home early.

[3] When the automated external defibrillator (AED) is checking the rhythm of the heart to determine whether or not a shock is recommended.
[4] An instrument used to examine the back of the throat.

20. The report also found that there was a discrepancy between Mr A's PSI and A&C information with regard to support required while eating. Because of his choking risk, both the PSI and A&C information stated that staff were to ensure that Mr A's food was cut into 1cm x 1cm sized pieces. The A&C information stated that staff were to be in the dining room while Mr A was having his meals, and the PSI stated that staff should always be at the table while Mr A was eating, and that he needed verbal reminders to slow down and chew thoroughly before swallowing. IDEA Services considers this to be a minor discrepancy with regard to requiring staff to be sitting at the dining table, or in the room. IDEA Services' internal investigator took the view that "this would make little difference in practice". The internal investigator also stated that the dining room and kitchen were "in effect one room". IDEA Services therefore does not believe this discrepancy had any impact or effect on staff understanding or practice, or the level of supervision that occurred in these circumstances.

Additional information

21. Ms C and Ms B are both extremely remorseful. Currently neither are working as support workers. Ms B told HDC that she is uncertain whether she will work as a support worker again because of the impact this event has had on her. Ms C told HDC that she has had a career change.

22. IDEA Services stated:

> "[O]n behalf of IDEA Services, I wish to state again how sorry we are for what occurred in relation to [Mr A's] death in [2018]. We consider client safety and support with the utmost priority in all services we provide. We have high expectations of all staff in this regard and it is very disappointing when we do not deliver on those expectations such as what occurred in this case.
>
> All staff who were involved in supporting [Mr A] were deeply affected by his death, and both staff and his fellow housemates all miss him greatly.
>
> As an organisation, we are committed to learning from cases such as this and we can assure you, and [Mr A's] family, that we will ensure that we learn from his death."

Response to provisional opinion

23. Mr A's sister was given an opportunity to comment on the sections of the provisional report relating to how the event arose, and the changes made since the events.

24. IDEA Services was given an opportunity to comment on the provisional opinion, and made the following submissions:

- IDEA Services does not accept that it had a culture of complacency with regard to risk management and does not accept that the discrepancy between Mr A's PSI and A&C information created a level of uncertainty or "complacency". It is IDEA Services' view that "if a wider range of support staff had been interviewed, they would likely not have made the same comments that have been made in this case by the support worker who made the error".

- IDEA Services stated that the view held by Ms B and Ms C at the time of events that it was appropriate for Ms C to leave her shift early, before dinner, was not acceptable and did not align with what the organisation required of them. IDEA Services does not believe that this view was held by the wider support staff workforce at the time, and certainly does not believe that it would be the case today.
- IDEA Services has not previously introduced a policy setting out expectations for staff when they wish to make changes or go home early from a shift because it does not wish to encourage this, and it considers that in any event this should only ever be considered in exceptional circumstances.
- IDEA Services does not accept that it had a lax approach to staff education and training and stated that it is committed to ensuring that its staff receive the highest levels of training, support and guidance, especially in relation to service user safety.

25. Where appropriate, IDEA Services' comments have been incorporated into this report.

26. Ms B was given the opportunity to comment on the relevant parts of the provisional opinion and had no further comments.

27. Ms C was given the opportunity to comment on the relevant parts of the provisional opinion. Where appropriate, her comments have been incorporated into this report. She confirmed that to her recollection the findings are accurate.

Opinion: IDEA Services — breach

Introduction

28. I have undertaken a thorough assessment of the information gathered in light of this complaint, and the relevant standards.

29. As a provider of disability support services, IDEA Services is responsible for delivering services to its clients in accordance with the Code of Health and Disability Services Consumers' Rights (the Code), and also the Health and Disability Services (Core) Standards (the Services Standards).[5]

30. In my view, the clients receiving residential support at the facility were particularly vulnerable as they had a combination of intellectual and physical disabilities that placed them at added risk of harm, and they were reliant on others to intervene if they were experiencing difficulties. This meant it was essential that all staff were vigilant and upheld a consistently high standard of care, and, as unfortunately this case demonstrates, it also required staff to be accessible and equipped to respond to serious situations. It was vital that staff followed the instructions in place in the support plans, at all times. The nature of the risks concerned meant there was simply no room for a lax approach or complacency.

[5] Health and Disability Services (Core) Standards: 2008 NZS 8134.1.

31. I consider that IDEA Services did not provide services to Mr A with reasonable care and skill, and therefore breached Rights 4(1) and 4(3) of the Code. The reasons for my decision are set out below.

32. I accept that it has been five years since this tragic event transpired, and that IDEA Services has instigated a number of changes in the meantime. At the end of this report, I make several recommendations for improvements and follow-up actions that could prevent similar events occurring in the future.

Staff adherence to support plans

33. Staff were aware of Mr A's choking risk, and support plans to manage this were documented in his PSI and A&C information. IDEA Services' investigation identified a discrepancy between Mr A's PSI and A&C information. His A&C information stated that staff were to be in the dining room while Mr A was having his meals, while the PSI stated that staff were always to be at the table while Mr A was eating, and that he needed verbal reminders to slow down and chew thoroughly before swallowing. However, both of these documents required a staff member to be present (whether at the table or in the dining room generally) while Mr A ate, and both stated that Mr A required his food to be cut into 1cm x 1cm sized pieces.

34. In addition, on 2 August 2012 and 10 April 2014 staff were sent a memorandum that highlighted the significance of choking risks and the size of food pieces to be given to people with choking risks, and in January 2016 a safety risk alert was issued to staff on the risks of cooking and serving whole sausages.

35. Despite the above, staff did not follow the support plans in the following ways:

- Ms B did not cut up Mr A's sausages. She stated that this was because of complacency and a belief that because the sausages were braised and therefore soft, Mr A could cut them himself.
- During dinner, Ms B was in the kitchen, which adjoined the dining room. She was not in the dining room or at the table while Mr A was having his meal, as required by Mr A's PSI and A&C information. Ms B stated that the dining table seated six adults, and it was unusual for a support worker to sit at the table during dinner. IDEA Services considered that the kitchen and the dining room were in effect one room.
- Ms B has not commented on whether or not she gave Mr A verbal prompts to slow down and chew properly. However, she stated that in practice, often staff did not give Mr A verbal prompts to slow down and chew properly.

36. I sought independent advice from a quality auditor/evaluator, Ms Margaret Wyllie, who did not identify any departures from the accepted standard of care with regard to IDEA Services' policies and procedures. However, Ms Wyllie advised that "[p]olicy, guidelines, memos, Risk Plans and Support Plans appear to have been disregarded".

37. Ms Wyllie stated:

> "It appears to be both systemic because expected processes were not followed in relation to management of the service users in the dining room, and individual error, because [Ms C] left early."

38. Ms Wyllie considers that the departure from accepted standards was severe, as without Ms C on shift, the service users were left vulnerable, and a significant event occurred.

39. In my opinion, Ms B's presence in the kitchen rather than the adjoining dining area during dinner is a concerning failure, as this provided an opportunity to multitask. Ms B was not focused solely on the task at hand — being the direct supervision of residents while they were eating.

40. Criteria 3.6.1 of Standard 3.6[6] of the Services Standards sets out the requirement that "[t]he provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes".

41. In summary, I am concerned by the lack of adherence to Mr A's support plans, particularly given that during the time Ms B worked for IDEA Services, twice a memorandum was sent to staff to highlight the significance of choking risks, and a safety alert was issued to emphasise the importance of the support plans. I am further concerned by Ms B's statement that it was not common practice for staff to sit at the table or provide Mr A with verbal prompts during his meals. I consider that the discrepancy between Mr A's PSI and A&C information was unhelpful and would have led to variability in staff practice in managing Mr A's choking risk. I also accept that this may well have contributed to an element of complacency (as described above by Ms B) in the implementation of the support plans. The care plans were clear that Mr A was at risk of choking, and that consequently his meals needed to be cut up carefully, and he needed to be supervised appropriately. Ultimately, the services provided to Mr A were not consistent with his assessed needs.

Staffing levels

42. Ms C finished her shift early, around 5.40pm, to complete training at home that she had been unable to complete at work owing to internet issues. She had discussed this with Ms B, and Ms B had agreed, but Ms C did not inform or seek approval from her acting manager, Ms D.

43. Ms C left before the residents had their dinner, and IDEA Services considered this to have been a key factor that contributed to Mr A's death. IDEA Services stated:

> "If [Ms C] had not gone home early and remained at the house as rostered, she would have been there to assist with the meal preparation and to respond to an emergency situation at the dinner table. If she had sought her manager's approval for going home early, it is very likely that she would have been told to stay at work. It is considered likely

[6] Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

that this short-staffing contributed to [Mr A] not having the required assistance at the meal table and when he began to choke."

44. Ms Wyllie advised that it was a severe departure from the accepted standard of care and practice for Ms C to have left her shift early. This meant that there was only one support worker to supervise six residents, three of whom had known choking risks. It also meant that Ms B lacked support when she found Mr A unresponsive. In the immediate aftermath of this discovery, no staff member was available to supervise the other five residents while Ms B was busy with Mr A.

45. In response to the provisional opinion, IDEA Services stated that it was well known that this house required two support staff to be scheduled between 3–8pm, and one of the key reasons for this was to ensure that there was double staffing for the dinner period. IDEA Services said that it is its "strong view" that there was a "significantly high certainty" that any request to the manager to finish the shift early would have been declined, due to the known service user choking risks, and need for double staffing, especially at dinner time. IDEA Services also stated that it is an employment requirement for support staff to work the hours scheduled in their roster. This is outlined in Ms C's individual employment agreement, which states: "You shall agree to work rostered shifts, statutory days, sleepovers and weekend work."

46. I acknowledge that IDEA Services' expectation was for staff to seek a manager's approval to leave a shift early, and that support staff are contracted to work their scheduled hours. I also acknowledge that Ms C did not adhere to this expected process, and I have discussed this further below. However, it is not clear whether Ms C and Ms B were aware of the requirement to seek manager approval if they wished to leave a shift early, as there is no evidence that this expectation was communicated to them or understood. In response to the provisional opinion, IDEA Services stated that previously it had not introduced a policy setting out its expectations for staff when they wished to make changes to a shift or to go home early, because it did not wish to encourage this, and it considered that in any event, it should only ever be considered in exceptional circumstances.

47. I am concerned by the "disconnect" between organisational expectations and the beliefs, attitudes and actions of the IDEA Services' staff at the house. Both Ms C and Ms B considered it acceptable to leave a shift early without manager approval, and seemingly did not appreciate the ramifications of only one staff member working over the evening mealtime, when at least three of the six residents were particularly susceptible to harm.

48. IDEA Services had a responsibility to ensure that all staff were aware of organisational processes and requirements, and to ensure that the service was staffed adequately. I consider that IDEA Services must take responsibility at a service level for the failure of the staff at the house to follow the expected process if they needed to leave a shift early. Ultimately, this meant that there was a lack of adequate and appropriate supervision and support to maintain the safety of Mr A.

Staff training

Safer eating and drinking

49. Ms B had been working for IDEA Services for several years and Ms C for under two years.

50. Ms C and Ms B had partially completed Safer Eating and Drinking (SEAD) training prior to this event. IDEA Services stated in its investigation report:

> "According to staff meeting minutes, and [the service manager], Module one of the Safer Eating and Drinking programme had been delivered at the staff meeting on 20 July 2017. [Ms D, Ms B and Ms C] were all present at this meeting. Also attached to the meeting minutes were a memo regarding the side effects of medication and a risk alert regarding cutting up sausages. [Ms D, Ms B and Ms C] have signed as having been present at the meeting and read the meeting minutes."

51. The SEAD training at this time comprised 16 short modules, of which Ms B and Ms C had completed one. IDEA Services does not have a set timeframe within which this training should be completed (eg, within the first year of employment).

52. Ms B stated: "My training was basic First Aid. I had insufficient knowledge, experience and training to properly equip me for this work." She also stated that although she knew that Mr A had a risk of choking, she did not know that cerebral palsy had a known risk factor for swallowing difficulties.

53. In response to the provisional opinion, IDEA Services said that Ms B had also received full support worker training, with ongoing refresher training on core modules throughout her time as a support worker. It is IDEA Services' view that she had received sufficient and appropriate training to prepare her for the required provision of support and to deal with this serious choking incident.

54. I am concerned that neither Ms B nor Ms C had received the full SEAD training by the time of these events, particularly as Ms B had been with IDEA Services for over five years.

First aid

55. The IDEA Services' significant hazards register that was in place lists "[o]bstruction of the airway causing choking" as the first identified hazard on the register. The control plan for this risk states that "[s]taff must undertake first aid training[7] and have a current first aid certificate".

56. Ms B completed first aid certification in 2012 and was re-certified in 2015. She had been booked for refresher[8] first aid training to renew her certification in 2017 but was recorded as absent. Ms B had not received refresher training at the time of these events, and so did not

[7] Which includes the management of choking.

[8] First aid certification is valid for two years with a three-month grace period from the expiry date. In order to maintain the certification, a refresher course must be completed within this timeframe.

have a valid first aid certificate. Ms C is recorded as not having completed first aid training while employed by IDEA Services.

57. Ms Wyllie advised that there is a three-month grace period from the date of certification expiry, during which time recertification must be completed to maintain a first aid certificate. I acknowledge that Ms B was within this grace period.

58. IDEA Services referred to this in its response to the provisional opinion. The training records provided by IDEA Services show a pattern of first aid certifications lapsing or being renewed at the very end of the grace period. Examples of this are a prior 11-month lapse in Ms B's certification before being re-certified in 2015, Ms D's re-certification within four days of the end of the grace period in 2016, and her 11-day lapse in certification in 2018.

59. In response to the provisional opinion, IDEA Services stated that it is common for there to be a delay of a few months before training can be completed, due to roster demands and individual preferences. IDEA Services said that this is common across the disability sector and is not unique to IDEA Services.

60. Ms Wyllie advised: "Whether [Ms B's] certificate was renewed or not, she still knew basic First Aid. The issue was not the First Aid certificate, but the absence of [Ms C]." I acknowledge this comment.

Summary

61. Ms Wyllie considered that the lack of compliance with policies, guidelines and plans was a systems issue as well as an individual issue, owing to a lack of training to ensure adherence. I agree. Ms B and Ms C were working in a home where there were three residents with a known choking risk. Had Ms C been present, she would not have had up-to-date first aid training to support Ms B. Overall, I consider that the training IDEA Services provided to Ms B and Ms C was insufficient. It is my view that if staff are working with residents who have choking risks, in order to provide services with reasonable care and skill, they need to receive timely and up-to-date training on safer eating and drinking, and first aid.

Conclusion

62. IDEA Services failed in its duty to manage Mr A's risks and keep him safe, and therefore failed to provide him with an appropriate standard of care. Although IDEA Services had a system in place within which risks and risk management plans were recorded, this did not translate into practice. The pattern of staff practices in a number of areas suggests that a lax attitude had developed, with a culture of complacency among staff at the house in relation to risk management at the time of events.

63. As stated at the outset of this report, unfortunately the risks to Mr A were such that there was simply no room for a lax approach or complacency with his care. Sadly, the consequences of staff deviating from Mr A's agreed management plan was that the risk became reality. I acknowledge the ongoing ramifications of Mr A's loss for his whānau, family and friends.

64. In summary, I consider that at a service level, IDEA Services failed to:

- Comply with its own significant hazards register;
- Have in place a consistent and unambiguous support plan for Mr A;
- Ensure that staff adhered to Mr A's support plans;
- Ensure that appropriate staffing levels were maintained; and
- Train staff sufficiently to ensure their competence as support workers.

65. I consider that IDEA Services failed to ensure that services were provided to Mr A with reasonable care and skill, and that the services were consistent with his needs. Therefore, I find that IDEA Services breached Rights 4(1)[9] and 4(3)[10] of the Code.

Opinion: Ms B — breach

Introduction

66. I have undertaken a thorough assessment of the information gathered in light of this complaint and have found that Ms B breached Right 4(1) of the Code. The reasons for my decision are set out below.

67. At the time of the incident, Ms B had been an employee of IDEA Services for over five years. She had been a support worker with Mr A for about two years. As such, it is fair to assume that she would have been familiar with the risks to which Mr A was susceptible, the significance of his management plans, and the importance of support staff adhering to the instructions in the plans.

68. Mr A left the table part-way through his dinner, between about 6pm and 6.10pm. At that time, Ms B was in the kitchen area that adjoined the dining room, and she noticed that he had left the table. Ms B went to look for Mr A sometime between 6pm and 6.16pm and found him unresponsive outside the bathroom at the far end of the house. She called 111 and Ms D and began CPR.

Adherence to support plans

69. Both Mr A's PSI and A&C information stated that he required his food to be cut into 1cm x 1cm sized pieces. His A&C information stated that staff were to be in the dining room while Mr A was having his meals, and his PSI stated that staff were to be at the table while Mr A was eating, and that he needed verbal reminders to slow down and chew thoroughly before swallowing.

[9] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[10] Right 4(3) states: "Every consumer has the right to have services provided in a manner consistent with his or her needs."

70. Ms B admitted that she did not cut up Mr A's sausages and could not give any explanation for this other than complacency and not seeing the risk. She said that the sausages were braised and therefore soft, and she thought that Mr A could cut the sausages himself.

71. Ms B stated that although she knew that Mr A had a risk of choking, she did not know that cerebral palsy had a known risk factor of swallowing difficulties.

72. IDEA Services stated that module one of the SEAD programme had been delivered at a staff meeting in 2017, and Ms B had signed as having been present at the meeting and having read the minutes. Attached to the minutes from that meeting was a risk alert regarding cutting up sausages. In addition, memoranda sent to staff in 2012 and 2014 highlighted the significance of choking risks and the size of food pieces to be given to people with choking risks. Again in 2016, a safety risk alert was issued to staff on the risks of cooking and serving whole sausages.

73. During dinner, Ms B was in the kitchen rather than at the table or in the dining room. She has not commented on whether she gave Mr A verbal prompts to slow down and chew properly but noted that often staff did not give him these verbal prompts.

74. My independent advisor, Ms Wyllie, considered that "expected processes were not followed in relation to management of the service users in the dining room". She said that "[t]he standard of care was not accepted practice as there was departure from policy, processes and practice". Ms Wyllie quantified the departure as severe. IDEA Services stated in response to the provisional opinion that its internal investigator took the view that whether staff were at the dining table or in the room would make little difference in practice. IDEA Services considered that the kitchen and adjoining dining room were in effect one room.

75. I accept Ms Wyllie's advice. I am critical that Ms B did not follow expected processes in relation to Mr A's care in the dining room for the following reasons:

- Ms B did not cut up Mr A's sausages, despite this being a clear requirement in his support plans and despite Ms B having been made aware of his particular risk of choking.
- I consider it more likely than not that Ms B did not give Mr A verbal reminders to slow down and chew thoroughly, despite this being documented in his PSI.
- Ms B was in the kitchen area during dinner, rather than at the table or in the dining room, as required by Mr A's support plans. I acknowledge that IDEA Services considered the kitchen to be a part of the dining room. However, I disagree with IDEA Services' position on this matter, and note that this is not included in Mr A's support plans.

First aid response

76. Once Ms B found Mr A unresponsive and rang 111, she began CPR with the assistance of the 111 call-taker. Ms B maintained this until the paramedics arrived and took over. The ambulance care summary report stated that the paramedics found that Ms B was doing "very good [CPR]", and that during rhythm checks they rechecked Mr A's airway and found that a large piece of sausage had moved up and was able to be removed with a laryngoscope.

77. A key finding from IDEA Services' investigation was that Ms B did not attempt to clear Mr A's airway before commencing CPR, despite having received first aid training.

78. Ms B had completed first aid certification in 2012 and was re-certified in 2015. She was recorded as absent from refresher training in 2017, and her first aid certification lapsed, meaning that she did not have a valid first aid certificate at this time.

79. Ms B stated: "My training was basic First Aid. I had insufficient knowledge, experience and training to properly equip me for this work."

80. Ms Wyllie advised: "Whether [Ms B's] certificate was renewed or not, she still knew basic First Aid."

81. I accept Ms Wyllie's advice and I am therefore concerned that Ms B did not attempt to clear Mr A's throat before performing CPR.

Conclusion

82. I consider that by not adhering to Mr A's support plans to mitigate his risk of choking, and not attempting to clear Mr A's throat before commencing CPR, Ms B did not provide services to Mr A with reasonable care and skill, and therefore breached Right 4(1) of the Code.

Opinion: Ms C — adverse comment

83. I have undertaken a thorough assessment of the information gathered in light of this complaint and have some concerns about the care Ms C provided to Mr A.

84. Ms C was rostered to work 3pm to 8pm. However, she started her shift early (at 12.30pm) to support a service user with a planned activity, and she finished her shift early (at 5.40pm). Ms C left her shift early because she believed that she needed to complete a time-card training module by the next day or she would not be paid, and she was unable to do this at work because the internet had stopped working by the time she was able to use the office. Ms C had finished most of her tasks for the day, and the only task left was to serve dinner. She discussed with Ms B whether she could go home early to finish the training. Ms B agreed and confirmed that she could serve dinner on her own.

85. Ms C felt that because she had worked the number of hours she had been rostered for that day, and because Ms B had agreed that she could leave early, this was sufficient. Ms C considered Ms B to be her superior because she had more experience working for IDEA Services. Ms C also thought that she would not be paid if she did not complete the time-card training by the next day, because Ms D had written a note in the house diary that said: "Important — Time Card training should be finished by [date] (Thursday). Thank you. Otherwise we won't get paid …" Ms C said that Ms D had also advised her verbally at the start of her shift that if the training modules were not completed, she would not get paid. Ms C said that she followed Ms D's instruction because Ms D was the senior support worker, and the acting Service Manager at the time.

86. Ms C also stated in her response to the provisional opinion that she understands that she should not have gone home early, and regrets that decision. She said that she was put in a stressful situation that day because she was the sole income provider for her household and was concerned that her income would be affected if she did not complete the training in time.

87. IDEA Services stated:

> "[I]t would never be our practice to tell staff that they would not be paid in future if not completing training by a certain deadline. Instead, what we believe may have occurred here is that the support worker was told that she would not be paid for the time spent completing the training if she did not complete it by a certain date. Our practice is to pay support workers for time spent in training, however sometimes we may withdraw the offer to pay for the time in training if a support worker chooses to delay for an unreasonable period of time."

88. IDEA Services' investigation was critical of Ms C leaving her shift early without manager approval and considered it a contributing factor leading to Mr A's death. The report stated:

> "If [Ms C] had not gone home early and remained at the house as rostered, she would have been there to assist with the meal preparation and to respond to an emergency situation at the dinner table. If she had sought her manager's approval for going home early, it is very likely that she would have been told to stay at work. It is considered likely that this short-staffing contributed to [Mr A] not having the required assistance at the meal table and when he began to choke."

89. My independent advisor, Ms Wyllie, considered that there was insufficient staffing at the time of the incident. Ms Wyllie advised that not having two staff on shift at this time was a severe departure from the standard of care, and that Ms C's absence compromised the residents and Ms B.

90. I accept Ms Wyllie's advice and am critical that Ms C felt it appropriate to finish her shift early without approval from a manager. I am concerned that although she had the support of her colleague, seemingly she did not appreciate the ramifications of leaving her to work unsupported during the evening mealtime, when at least three of the six residents were particularly susceptible to harm.

91. However, my criticism is mitigated for the following reasons:

- Ms C clearly felt pressured to complete her time-card training before the end of the day because she was under the impression that if she did not do so, she would not be paid. Although IDEA Services has since clarified that this was not correct, it is clear that Ms C had received verbal and written information from the acting Service Manager to this effect.
- There is no clear documentation of an organisational requirement for staff to obtain explicit approval from a manager before making any changes to their scheduled hours.

92. Accordingly, while I express my significant concern over this behaviour, I have not found Ms C in breach of the Code.

Changes made since events

IDEA Services

93. IDEA Services provided a verbal and written apology to Mr A's family, and made the following changes:

- Local area and regional teams discussed this case in meetings, and staff were reminded of the importance of following individual support plans and SEAD plans.
- First aid training records were reviewed, and any staff whose training period had expired were rostered for refresher training as soon as practicable. This continues to occur on a rolling basis following the implementation of a new learning management system in late 2018.
- In 2019, the SEAD programme was revised by a new national clinical team. The new introductory module of the programme includes a revision of first aid for choking events, and it is recommended that the Service Manager regularly discuss first aid responses for choking, including rehearsal of first aid response, at team meetings.
- A new SEAD policy and guidelines booklet for managers was developed in line with the new SEAD programme.
- A human resources process relating to staff conduct occurred after this incident.
- IDEA Services management considered the recommendation from its internal investigation to review and clarify the process in relation to acting area manager authority and responsibilities. IDEA Services management decided not to amend the process and practice because it believes it is sufficient as it is.
- IDEA Services management considered Ms Wyllie's suggestion to remove sausages from the menu for those who have identified choking risks, but its view remains that when managing choking risk, the best approach is "[i]t is not what you eat, but how you eat it".

94. Further, in response to the provisional opinion, IDEA Services stated that it has made significant organisation-level changes in the five and a half years since these events, which assist in guiding staff and minimising risks for service users. In particular, IDEA Services has established:

- A new client management system, "IHC MySupport";
- A new Service Manager model;
- A new national clinical support team (including nurses, clinical psychologists, speech and language therapists and a nutritionist); and
- A new national Health and Safety Manager and team structure.

95. IDEA Services also noted that in 2019, as part of the revised Safer Eating and Drinking framework rollout, it undertook a review of all service user support plans where there was an identified choking risk, to ensure that plans and related guidance to staff were appropriate. This was led by the new national clinical team. IDEA Services stated that this is now done on

an annual basis as part of the regular annual review of each person's support plan. Further, it is its practice that staff will seek further assistance, with the support of the national clinical team, where any changes occur for a service user in between annual review periods.

Ms B

96. Ms B provided IDEA Services with an apology to be passed on to Mr A's family.

97. Ms B no longer works for IDEA Services and stated that she is uncertain whether she will work as a support worker again because of the impact this incident has had on her. Ms B said that as a result of the incident she has been unemployed and has received many hours of counselling.

Ms C

98. Ms C provided IDEA Services with an apology to be passed on to Mr A's family. Ms C has since left IDEA Services and has had a career change.

Recommendations

99. Taking into consideration the apologies made, and the changes that IDEA Services Limited has made since the time of events, I recommend that IDEA Services:

a) Ensure that this case is referred to as a case study in staff training with local area and regional teams as a reminder of the significance of choking, as well as to highlight the importance of following individual support plans and the hazard register. Confirmation that this has been done is to be provided to HDC within three months of the date of this report.

b) Ensure that there is a documented and clearly communicated expectation that staff do not leave any shift early without the express permission of their manager. A copy of the documentation of this expectation, and a copy of any written communication to staff regarding this are to be provided to HDC within three months of the date of this report.

Follow-up actions

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

101. A copy of this report with details identifying the parties removed, except the names of IDEA Services Limited and the independent advisor on this case, will be sent to Whaikaha|Ministry of Disabled People, Te Tāhū Hauora Health Quality & Safety Commission, and WorkSafe, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

102. Section 59(4) of the Health and Disability Commissioner Act allows the Commissioner to bring a matter to the attention of any person or authority where it is considered necessary or desirable in the public interest. In accordance with section 59(4) of the Act, this complaint will be referred to WorkSafe.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from contracted Quality Auditor/Evaluator Ms Margaret Wyllie:

> "I have been asked to provide an opinion to the Commissioner on Care Reference 20HDC01109 and I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a contracted Quality Auditor/Evaluator and have been self-employed since 1996, working in a variety of areas within Health and Disability Services. Specifically I have been asked to review documents and provide an opinion on the following issues:
>
> 1. The adequacy of care provided to [Mr A] by IDEA Services and its staff on and around [the day of these events]
> 2. The adequacy of actions taken by staff after [Mr A] was found to be unresponsive
> 3. The adequacy of relevant policies, procedure and staff training at the time of these events
> 4. Any other factors that may have contributed to this incident or other matters that may warrant comment
>
> Information and documentation provided to undertake this review and advise whether the care provided to [Mr A] by IDEA Services was reasonable in the circumstances and why:
>
> - Certificate of Findings Section 94 Coroner's Act 2006
> - Service User cover sheet
> - Alerts and Crisis Response [2017]
> - Personal Support Information [2017]
> - Developmental and Social History
> - Bookmark 'I Am At Risk of Choking When I Eat'
> - Daily information 2018
> - Medication Alert, Medication Checking form
> - Medication Chart
> - PRN Protocol form, medication signing sheets
> - Medication Administration Record [2018]
> - Unichem Summary of Medication
> - Controlled Drug Stock Take form
> - Health History Running Record
> - Weight recording
> - Incident Report [2018]
> - Critical Incident Reporting form [2018]
> - Health Appointment/file note [2018]
> - Annual Health Check [2017]

- … 'My Assessment'
- … Service Authorisation [2017]
- [Ms B] Basic First Aid [2015]
- Learning and Development Attendance Register form [2017]
- First Aid Training records
- Staff Schedule (undated)
- Menu sheet [2018]
- Healthcare policy [2017]:
  - Appendix 1 Vital Signs Guide
  - Appendix 2 Drinking Water
  - Appendix 3 Suicide Paper
- Safety Risk Alert [2016] subject — Preparation of Sausages for Cooking
- National Memorandum
- … DHB Soft Diet Recommendation Memorandum [2012]
- Regurgitation and Choking Minimisation
- IDEA Services Significant Hazards Register 2016
- Resource Folder [2017]
  - 2.6 Hospitalisation of a Person
  - Safer Eating and Drinking policy August 2019 (published)
  - Safer Eating and Drinking policy Guidelines
- Internal investigation into the death of [Mr A] service user
- Response letter from Chief Executive dated 6 August 2020

Comments

1. The adequacy of care provided to [Mr A] by IDEA Services and its staff [in] 2018

- According to the internal investigation into the death of [Mr A] (service user) under heading Events of Incident, SW1 ([Ms B]) was supporting the residents of [the facility] to prepare and eat dinner [on this date]. She was working alone at this time because the other rostered support worker SW2 ([Ms C]) had gone home early. The staff schedule for [the facility] (undated) identifies two rostered staff; SW1 3pm–10pm and SW2 3pm–8pm.

- SW2 left early before the meal was served, putting the service users and SW1 in a compromised situation.

- According to the menu dated … 2018 there were six people in this … bed home that had to have food cut up into 1cm x 1cm pieces to prevent choking. Sausages, spuds and vege was the menu for that evening. If the other people had similar alerts and crisis responses under the heading Other Choking as [Mr A's] dated [2017] which states '[Mr A] is at risk of choking. Staff to ensure that food is cut up into 1cm x 1cm sized pieces. Staff to be in the dining room while [Mr A] is having his meals', then there were insufficient staff present in this home at the time of the incident. [Mr A] was a Band 4 Very High SPA level according to the Service Authorisation form dated [2017].

- The information provided indicates that SW2 left work early without signoff (permission) from management. Within the internal investigation notes there was no clarification as to why SW2 left approximately three hours before her shift ended.
- Personal support information dated [2017] Summary of Personal Goals from Personal Plan [2017] under Personal Care — Eating drinking/having the right food/adequate fluids/feeding assistance — [Mr A] is at risk of choking. Ensure healthy food options are available. Verbal reminders to slow down, chew thoroughly before swallowing. Staff to cut food into 1cm x 1cm pieces. Staff to always be at the table while [Mr A] is eating. [Mr A] is on the IDEA Services Choking Risk Register. All food is to be cut into small portions. Staff to sit with him and provide prompts to slow down and chew properly.
- From staff training records SW1 undertook training in Safer Eating and Drinking for Support Workers on … 2018 and SW2 on … 2018. The Safer Eating and Drinking policy 2019 (published) has been in place since the death of [Mr A].

Advice

a. What was the standard of care/accepted practice?

- The accepted practice of two staff on shift from 3pm to 8pm was not adhered to.
- The absence of SW2 compromised the service users and SW1.

b. If there has been a departure from the standard of care, how significant a departure do you consider this to be? (mild/moderate/severe)

The departure was severe; as without SW2 on shift the service users were open to vulnerability and a significant event occurred.

c. How would it be viewed by your peers?

As this is a confidential matter, this has not been discussed with peers. I would estimate however, their view to be similar.

d. If there has been a departure from the standard of care or accepted practice, do you attribute it to systemic factors, individual error or both?

This question provides for some level of conjecture, as it is unclear who gave SW2 permission to leave her scheduled shift. Why wasn't management notified and a replacement sought? It appears to be both systemic because expected processes were not followed in relation to management of the service users in the dining room and individual error, because SW2 left early.

2. The adequacy of actions taken by staff after [Mr A] was found to be unresponsive

- SW1 was in the adjoining kitchen at the time [Mr A] left the dining room table. Timelines are varied in the internal investigation into the death of [Mr A], service user document:

Events of Incident:

- 21 states [Mr A] left the table around 6pm.

- 22 states [another] service user stated there were five residents at the table. [This service user] thought that [Mr A] left the table at about 6.10pm.
- 23 states subsequently found by SW1 collapsed on the floor outside the bathroom at the end of the house a few minutes later when she went to check where he was. This happened between 6pm and 6.20pm.
- 25 states SW1 ran to get the house phone and called 111 and used her personal cell phone to call [Senior Support Worker (SSW)] ([Ms D]).
- 26 SSW confirmed SW1 called at 6.21pm. This event would have been traumatic for SW1 without the immediate support of SW2.
- 29 SSW stated that she informed SW1 that she would come to [the facility] as soon as possible. According to her phone records SSW then called SM3 [On Call Manager] as she knew she could get there sooner. SM3 confirmed that she received the call from SSW at approximately 6.25pm and immediately set off to [the facility], arriving at 6.35pm. According to Appendix A timeline ambulance arrived at 6.24pm.
- 29 the ambulance had already arrived and was attending to [Mr A].
- 30 SM3 saw plates on the bench with pieces of sausage on them, confirming sausages for the meal.
- 31 SSW arrived at [the facility] at 6.50pm. SM3 and SSW had a brief conversation, during which it was agreed that SM3 would continue to support SW1 and the service users and SSW would contact [Mr A's] sister.
- 32 SW2 also arrived shortly before 7pm, having been informed by SSW of the incident at approximately 6.25pm. SSW had contacted SW2 by telephone, expecting her to be at [the facility]. SW2 was at home, but decided she should go back to [the facility] when she heard what had happened.
- Certificate of Findings from the Coroner states *'around 6.50pm on … 2018 [Mr A] finished dinner and walked to the toilet, he collapsed in the hallway and was found unresponsive by a support worker. [Mr A] had choked on a piece of sausage while eating dinner. He was revived by ambulance staff and transported to [the public hospital]. He unfortunately suffered a brain injury and he died [two days later].* The Incident Report No … records Date of Incident … 2018 and Time of Incident 6pm completed by SW1 states *'I went to see where [Mr A] was a few minutes after he left the dining room table and found [Mr A] lying on the hallway floor unresponsive. I called ambulance and started CPR. The ambulance arrived and took over'.*

Advice

a. What was the standard of care/accepted practice?

The standard of care was not accepted practice as there was departure from policy, processes and practice. Timeframes vary; the Certificate of Findings from the Coroner states around 6.50pm.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? (mild/moderate/severe)

The departure from standard of care or accepted practice would be severe — SW1 found [Mr A] unresponsive; time is very important when an unconscious person is not

breathing. Permanent brain damage begins after only four minutes without oxygen, dependent on the area of the brain that was affected by lack of oxygen.

c. How would it be viewed by your peers?
As this is a confidential matter, this has not been discussed with peers. I would estimate however, their view to be similar.

d. If there has been a departure from the standard of care or accepted practice, do you attribute it to systemic factors, individual error or both?
From the Events of Incident Report … SSW confirmed that SW1 called her at 6.21pm and described her manner as distressed and hysterical. This, under the circumstances, would not have been an unexpected state for SW1 to be in, considering she was left to manage alone until the ambulance arrived at 6.24pm. SW2, shortly before 7pm, decided to return from her home to [the facility]. Why did she leave in the first place?

It is considered that this departure from this standard of care is attributed to both systemic factors where processes were not followed and individual error — SW2 not notifying management of leaving early and deciding she should go back to [the facility] when she heard what had happened, no immediate support for SW1 from IDEA Services staff until 6.35pm; a frightening situation to be in with responsibility for four other service users, as well as dealing with the crisis.

3. The adequacy of relevant policies, procedures and staff training at IDEA Services at the time of these events

Training

- SW1 Basic First Aid certificate dated [2015]
- Learning and Development Attendance Register form First Aid [2017] — SW1 absent
- SW1 Safer Eating and Drinking [2018]
- SW2 no completion of First Aid recorded
- SW2 Safer Eating and Drinking [2018]
- SSW First Aid complete [2018]
- Safer Eating and Drinking — discussion session [2020]
- Safer Eating and Drinking and Induction [2019]
- Safer Eating and Drinking for Support Workers [2018]
- Safer Eating and Drinking Classroom [2017]

Resource Folder IDEA Services 2017 in Appendix 7 IHC Policies and Procedures Safer Eating and Drinking policy published August 2019

SW1 and SW2 both completed training after the critical incident with [Mr A].

Appendix 5 IDEA Services Significant Hazards Register 2016 identifies Obstruction of the Airways Causing Choking as the first identified hazard on the register. There is also an individualised hazard bookmarked for [Mr A].

Two memorandums dated 10 April 2014 and 2 August 2012 and a Safety Risk Alert January 2016 subject Preparation of Sausages for Cooking.

Within the Safer Eating and Drinking Guidelines, there are clear instructions re the Risks of Choking and Swallowing Difficulties, which states:

- People with intellectual disabilities have an increased risk of both choking and having eating, drinking and swallowing difficulties

Advice

a. What was the standard of care/accepted practice?

- IDEA Services offers training that is there to support the role of a support worker in all aspects of specific care needs of the service users.
- Whilst SW1 had not attended the [2017] First Aid course, she had a First Aid certificate dated [2015]. Certificates are valid for two years and there is a 3 month grace period from the date of your certificate expiry, during which time you must complete your recertification course to maintain your certificate. SW1 was within the three month grace period. Whether her certificate was renewed or not, she still knew basic First Aid. The issue was not the First Aid certificate, but the absence of the other rostered SW2.
- It is also noted that both SW1 and SW2 had both completed training in relation to Safer Eating and Drinking after the critical incident with [Mr A] had taken place.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? (mild/moderate/severe)

The departure from the standard of care and accepted practice was severe when the SW2 left before the meal was eaten and the significance of having three people with the risk of choking left unsupervised at the table. Policy, guidelines, memos, Risk Plans and Support Plans appear to have been disregarded.

c. How would it be viewed by your peers?

As this is a confidential matter, this has not been discussed with peers. I would estimate however, their view to be similar.

d. If there has been a departure from the standard of care or accepted practice, do you attribute it to systemic factors, individual error or both?

Both, training and individual error.

4. Any other factors that may have contributed to this incident or other matters you consider warrant comment?

From the staffing schedule for this home, it was clear that double-staffing at meal times to provide support to the service user was an expectation.

Recommendations

- That no staff leave the premises of any facility before their shift ends without the express permission of management.
- Staff adhere to the expectation in relation to the support needs of the people, especially those with significant evidence of the possibility of choking as spelt out in the Safer Eating and Drinking Guidelines *'people with intellectual disabilities have an increased risk of both choking and having eating, drinking and swallowing difficulties'*.
- Staff should follow repeated instructions in relation to the Hazard Register, memos provided and take on board the significance of choking.
- That sausages be removed from the menu for those people who have identified significant choking risks.

Margaret Wyllie"