Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Care provided to a young woman with complex needs by a residential care facility

19HDC02265

The Deputy Health and Disability Commissioner has found a residential care facility breached the Code of Health and Disability Service Consumers' Rights (the Code) in its care of a resident.

Ms Rose Wall found NZCommunity Living breached Right 4(1) of the Code – the right to services of an appropriate standard, provided with reasonable care and skill.

Ms Wall has recommended the facility provide a written apology to the woman and her family, use the findings of her report as a basis for staff training, provide the HDC with a progress update on improvements within three months of her report, and schedule refresher and ongoing training on short term care plans and management of a deteriorating condition.

These recommendations result from earlier failings by the service in their management of a young woman with complex health needs. Her medical history included a transplanted kidney and an allergy to the antibiotic Augmentin. The young woman's complex medical history meant she required close monitoring of any illness, particularly those that could result in her becoming dehydrated, due to her increased her risk of complications. Detailed information about the young woman's special needs, and the support she required, had been provided by her parents when she was accepted into the facility.

The woman had developed diarrhoea and felt unwell. About four days later staff took her to the GP who advised she return should symptoms worsen, or not improve, after 48 hours.

The woman's mother became increasingly concerned and requested another GP visit three days later. The facility declined, stating the expense of an in-home visit. The mother took her daughter to the emergency department later that evening.

The woman was admitted to the Critical Care Unit (CCU) with a severe kidney and lung infection. She spent around two weeks in CCU and another two weeks recovering in a general ward.

Ms Wall was critical of the facility's management of the woman when she demonstrated a clear deterioration over a brief four day period. The failings occurred in three key areas; the care provided prior to the woman's CCU admission, inadequacies in care planning and staff adherence to policies and procedures. The woman had also been administered Augmentin six times before the error was picked up.

"Ms A's complex medical history meant she required careful monitoring and management. This did not happen. Overall I consider the failures of staff demonstrate a pattern of suboptimal care."

Ms Wall said the report will be supplied to the Health Quality Safety Commission, Whaikaha/Ministry of Disabled People and HealthCert (Manatū Hauora).

NZCommunity Living has since strengthened the managment of indivuals' personal and risk management plans to ensure they are living documents, and included personal plan verifications to ensure staff become more familiar with residents' individual needs.

3 April 2023

Editor's notes

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

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

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

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

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

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