NZCommunity Living Ltd

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC02265)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a young woman at a residential care facility in 2019.

2. When the woman was accepted into the NZCommunity Living Limited facility, her parents provided the service with considerable information and guidance about her special needs. She required close monitoring in the event of illness, as her complex medical history increased her risk of complications.

3. Between 6 and 9 September 2019, the woman had diarrhoea and felt unwell, and on 10 September 2019, staff took her to see her GP. The GP advised staff to bring her back to the medical centre if her symptoms worsened or her condition did not improve over the next 48 hours, or if she showed further signs of illness, lethargy, or reduced fluid intake.

4. During telephone calls on the morning of 13 September 2019, the woman's mother noticed that her daughter was coughing frequently and sounded breathless. At around 5.30pm that day, the mother telephoned the facility and asked whether her daughter could see the doctor again, but was told that it was too late and that a home visit was too expensive. Later that evening, the mother advised staff that she would be picking up her daughter to take her to hospital.

5. The woman presented to hospital at approximately 7pm, and was admitted to the Critical Care Unit with a severe kidney and lung infection. She spent approximately two weeks in the Critical Care Unit and a further two weeks recovering in the hospital ward.

Findings

6. The Deputy Commissioner considered that NZCommunity Living Ltd had a responsibility to have in place adequate systems to ensure that the woman was provided with care of an appropriate standard. The Deputy Commissioner was critical of NZCommunity Living Ltd's management of the woman when she demonstrated a clear deterioration between 6 and 12 September 2019. There was a lack of monitoring and documentation of her food and fluid intake, and no short-term care plan was developed in response to a temporary change in health and support needs. In addition, her personal plan specifically noted that she was to be taken to hospital if she experienced both diarrhoea and vomiting, but this was not followed.

7. The Deputy Commissioner also criticised NZCommunity Living Ltd's error in administration of Augmentin to the woman and the delay in recognising her reaction to the medication; the lack of a sufficiently clear personal plan with adequate details to guide care workers to provide safe, effective care; and the failure to seek medical treatment within 48 hours of the GP consultation on 10 September 2019, as advised. The Deputy Commissioner found NZCommunity Living Ltd in breach of Right 4(1) of the Code.

8. The Deputy Commissioner was also concerned about the lack of staff training and induction on relevant policies and care and risk management. However, the Deputy Commissioner

was reassured by the changes made by NZCommunity Living Ltd in response to the concerns raised in this complaint, and considered that these omissions did not amount to a breach of the Code.

Recommendations

9. The Deputy Commissioner recommended that NZCommunity Living Ltd provide a formal written apology to the woman's family for the breach of the Code identified in this report; consider ways to use the findings of this report as a basis for staff training at all its facilities; schedule refresher education for staff on short-term care plans and the management of a deteriorating condition; and provide a progress report and key learnings following the use of "sticker alerts" on personal files, and on the implementation of MediMap.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs B about the services provided by NZCommunity Living Ltd to their daughter, Ms A. The following issue was identified for investigation:

- *Whether NZCommunity Living Ltd provided Ms A with an appropriate standard of care in August 2019 to October 2019 (inclusive).*

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

12. The parties directly involved in the investigation were:

Ms A	Consumer
Mr and Mrs B	Complainants
NZCommunity Living Limited	Group provider

13. Further information was received from Dr C, a general practitioner (GP).

14. Independent advice was obtained from Ms Margaret Wyllie (Appendix A).

Information gathered during investigation

Introduction

15. This report concerns the care provided to Ms A by NZCommunity Living Ltd while Ms A was a resident in a community-based care facility (the facility).

16. Mr and Mrs B's complaint concerns various aspects of their daughter's care, including delays in recognising Ms A's illness in September 2019, which resulted in a prolonged admission to hospital with severe sepsis and subsequent complications.

17. At the time of events, Ms A was in her thirties. Ms A's medical history includes Cohen's syndrome,[1] an intellectual impairment, a kidney transplant, scoliosis and multiple orthopaedic procedures.[2] Ms A's risk of complications in the event of illness and/or dehydration is increased because of her medical conditions.

18. Ms A was a resident at the facility from September 2018 until she was admitted to hospital on 13 September 2019 with a severe infection that affected her kidneys and lungs. Mr and Mrs B told HDC that following the events complained about, they lost confidence in NZCommunity Living Ltd's ability to care for their daughter, and she did not return to the facility as a resident following her discharge from hospital.

How matters arose

19. On 6 September 2019, staff reported that Ms A had some diarrhoea, and a health advisor was notified. Staff were advised to monitor and report any further episodes, ensure that extra fluids were given, and administer paracetamol as prescribed for stomach cramps, and to call back the following day if the diarrhoea continued. Night staff reported that Ms A had slept well and had had no diarrhoea. The incident report completed by staff on the same day states that Ms A had alerted staff that she had had diarrhoea for at least a couple of days.

20. On 7 September 2019, it is documented that Ms A had her breakfast as normal, and voiced that she felt unwell. She went to the toilet but did not report any diarrhoea. Staff noted that Ms A had a cough, and her temperature was taken (36.8°C). In the evening, Ms A had her dinner and was drinking water as normal. The night shift reported that she went to the toilet twice with no reports of diarrhoea, but that she was coughing on and off.

21. On 8 September 2019, there were no reports of diarrhoea, but Ms A told staff that she was "not feeling a hundred percent". Ms A ate her breakfast but did not feel like any lunch. She ate her dinner and drank electrolyte drinks. It was reported that Ms A had one episode of diarrhoea. The night shift documented that Ms A had an unsettled night and used the toilet three times, but did not report any diarrhoea.

22. On 9 September 2019, it was documented that Ms A had a cough, and that she ate breakfast and lunch. Ms A reported to staff that she had a small amount of diarrhoea. She ate and drank as normal, and the night shift reported that she went to the toilet and was coughing, but she slept well. There were no reports of diarrhoea.

[1] A genetic disorder characterised by diminished muscle tone, abnormalities of the head, face, hands and feet and eyes and an intellectual disability.
[2] A lateral curvature of the spine.

23. On 10 September 2019, it was reported that Ms A appeared unwell. The staff contacted the health advisor, who advised to take Ms A to see a doctor and to encourage plenty of fluids.

24. Ms A was seen by a GP, Dr C,[3] on the same day. NZCommunity Living Ltd told HDC that Ms A's health appeared to be improving until the afternoon of 12 September, when it was reported that Ms A had vomited.

25. On 13 September, the afternoon staff reported that Ms A had started to cough, and this had caused her to vomit. In an incident report dated the same day, staff noted that Ms A had had diarrhoea for over a week, and vomiting for three days. Staff rated this incident as "severe".

26. NZCommunity Living Ltd told HDC:

> "[W]e advise that prior to her Doctor's visit on the 10th September 2019 [Ms A] presented with diarrhoea on the 6th, 8th and 9th September. Over this period, vomiting was first noted by staff on the 10th September 2019 which prompted escalation by our staff and [Ms A's] visit to the Doctor that same day."

27. Mr and Mrs B told HDC that on the morning of 13 September 2019, their daughter telephoned them and they noticed that she was coughing frequently. Mrs B said that she also noted Ms A's breathlessness. Ms A then rang her mother that same afternoon, again sounding breathless.

28. Mrs B told HDC that she rang the facility at 5.30pm on the same day and asked whether Ms A could see the doctor again, but was told that it was too late and that a home visit was too expensive. Later that same evening, out of concern for her daughter's health, Mrs B telephoned the facility and advised staff that she would be picking up her daughter to take her to hospital.

29. Ms A's hospital notes state that she presented at approximately 7pm and was admitted to the Critical Care Unit (CCU) with a severe kidney and lung infection. The medical notes document: "[O]verwhelming sepsis[4] in an immunosuppressed[5] patient." Ms A spent approximately two weeks in CCU and a further two weeks recovering in the hospital ward.

Ms A's personal plan

30. Mr and Mrs B told HDC that when their daughter was accepted into the NZCommunity Living service, they provided staff with a lot of information and guidance about her special needs, including reference to her transplanted kidney and the care needed to maintain her health.

[3] HDC undertook a separate assessment of Dr C's care and decided to take no further action.
[4] A potentially life-threatening condition that occurs when the body's overwhelming response to an infection damages its own tissues. Signs of sepsis may include fever, chills, rapid heart rate, breathlessness, fatigue, confusion, low blood pressure, and organ dysfunction.
[5] A state in which a person's immune system is not functioning as well as it should — this may be a result of medications given to reduce the risk of organ rejection following a transplant.

They said that they outlined that diarrhoea and vomiting meant that Ms A should go straight to hospital.

31. NZCommunity Living Ltd emphasised to HDC the importance of capturing the health information of individuals and of creating a personal plan that tailors the care to the needs and requirements of the person. NZCommunity Living Ltd stated:

> "The health and wellbeing section of a personal plan contains key information about a person's health condition and provides guidance to staff on how to manage this on a daily basis."

32. Ms A's personal plan noted that Ms A was to present to hospital if diarrhoea and vomiting developed. The plan also noted that staff were to inform Ms A's parents of any incidents involving Ms A, both minor and serious. NZCommunity Living Ltd said that personal plans identify who should be contacted "when something happens", or there are changes to an individual's health condition, and this is in line with its Residential Policy.

33. In response to Mr and Mrs B's concerns that their daughter was not taken to hospital when she became unwell with vomiting and diarrhoea — as was outlined in her personal plan — NZCommunity Living Ltd told HDC:

> "[W]e confirm that the support plan indicated the need for [Ms A] to present to [hospital] if diarrhoea and vomiting develop[ed]. We understand that this is specifically noted, as if [Ms A] were to present with both symptoms at the same time that this could lead to potential dehydration."

34. NZCommunity Living Ltd further stated:

> "When [Ms A] reported that she was feeling unwell on 10 September 2019, our staff contacted the on-call health advisor, a Registered Nurse (RN). The health advisor instructed to book an appointment with the GP, as the wait in ED would have been significantly longer and ED would have been unfamiliar with [Ms A's] medical history as opposed to her regular GP. We also believe that if [Ms A's] condition warranted admission to the ED, this would have been prompted by the GP, who specified her condition as non-urgent.
>
> While [Ms A's] personal plan and risk management plan would have prompted NZCommunity Living Ltd's staff to take [Ms A] to the emergency department, support staff at the house and the health advisor concluded that [Ms A] had vomited due to drinking fizzy drink and eating chocolate after which she reported to feel better … [The] level of effort that NZCommunity Living Ltd's staff completed into escalating the issue to the health advisor and actively monitoring and documenting [Ms A's] condition during this period was in line with our expectations."

Changes in health condition

35. In response to Mr and Mrs B's concerns that they were not notified of Ms A's change in condition, NZCommunity Living Ltd stated:

> "[O]n this occasion we acknowledge it did not occur to the standard we would expect [and that] following the first episode of diarrhoea on 6 September 2019, [Ms A's] parents were not notified about the change in health condition of their daughter until 10 September 2019 … The next contact with [Ms A's] parents occurred on 13 September 2019, when [Ms A] presented with a cough and vomiting. This is when [Ms A's] mother advised that she was coming to take her daughter to the emergency department."

Short-term plan

36. NZCommunity Living Ltd outlined its process for when people's health needs may require extra support and observations, which includes the development of short-term support plans. NZCommunity Living Ltd described short-term plans as particularly relevant when a person's health is deteriorating and may require support or assistance over and above their existing support plan.

37. NZCommunity Living Ltd's Residential Policy outlines the purpose of a short-term support plan, noting that each person will have a documented, dated and signed short-term support plan where there is a temporary change in support needs. NZCommunity Living Ltd also stated that the purpose of a short-term support plan is "to ensure that the care provided meets the person's requirements when there is a temporary change in their health condition".

38. Following a review meeting with the senior management team in response to this complaint, NZCommunity Living Ltd found that after Ms A's visit to the GP on 10 September 2019, a short-term support plan had not been created by the health advisor or the service delivery manager as per its Residential Policy.

Food and fluid intake

39. Mr and Mrs B raised concerns around their daughter's hydration levels and the need to monitor her fluid intake during her period of illness, to avoid dehydration.

40. On 6 September 2019, Ms A reported to a staff member that she had been experiencing diarrhoea for a couple of days, and the staff member called the on-call health advisor. The health advisor said to restrict Ms A's diet to "dry foods and water" and to ensure extra fluids. Ms A's progress notes show that from 2 September 2019 she had been off-colour, coughing, and had a sore bottom, and she had not been eating regular meals up until her visit to the GP on 10 September 2019.

41. NZCommunity Living Ltd told HDC:

> "Following the visit to the Doctor on the afternoon of the 10th September, NZCommunity Living Ltd's staff revisited [Ms A's] diet and placed a note in her diary listing the products she should not have … [N]o specific fluid and food balance sheet was maintained as such recording is not within the scope of our service."

42. NZCommunity Living Ltd's Health and Wellbeing policy identifies the need for "good observation and documentation". The policy highlights that information needs to be "specific and accurate". The Residential Policy states:

> "We need to be aware of changes that can occur when people are unwell to ensure they receive the treatment they need which may prevent serious illness. This involves good observation, documentation, and communication between all employees."

GP consultation

43. Dr C told HDC that on 10 September 2019:

> "[Ms A] presented to the consultation accompanied by a caregiver from [the facility] … [S]he was reporting feeling nauseous. I did not note any sign of dehydration, anaemia[6] or respiratory distress. Her temperature was normal and she was haemodynamically[7] stable.
>
> … [Ms A] had signs and symptoms consistent with a viral infection ... I noted that she was euvolemic[8] in the context of [Ms A] presenting with episodes of diarrhoea … I suggested symptomatic treatment prescribing ondansetron[9] tablets for nausea and pimafucort ointment for fungal infection and inflammation of the skin in the perianal region.
>
> I also advised that [Ms A] should be brought back to [the medical centre] if there was a worsening of symptoms, or if there was no improvement in her condition despite treatment over the next 48 hours, or if she showed further signs of illness, lethargy or reduced fluid intake."

44. NZCommunity Living Ltd told HDC that following the GP visit, staff informed Mrs B of the outcome of the visit.

45. Mrs B told HDC that she was notified ahead of time that her daughter was going to see a doctor, but was not told of her diarrhoea. Mrs B was then briefed after the visit to explain that the doctor had diagnosed a virus and therefore Ms A would be isolating for a further three days, and would be visited by the doctor again if still unwell 48 hours later. Mrs B said that staff had assured her that her daughter was drinking and she had access to a water bottle in her room.

Administration of Augmentin

46. Mr and Mrs B raised concerns about Ms A being administered Augmentin on 21 August 2019 to treat a urinary tract infection.

[6] A condition in which the blood is deficient in red blood cells, in haemoglobin, or in total volume.
[7] Relating to blood circulation.
[8] A normal volume of blood in the body.
[9] A medication used to prevent nausea and vomiting.

47. Augmentin had been listed in Ms A's notes as an antibiotic to which Ms A is "allergic". This is noted in the "Allergies and Reactions" section of Ms A's personal plan, which states that Ms A has a reaction to Augmentin and it causes diarrhoea.

48. On 21 August 2019, Ms A was commenced on Augmentin for a urinary tract Infection, and it was not until a handover on 28 August 2019 that a staff member checked Ms A's personal plan regarding Augmentin. The staff member stated:

> "I vaguely remember seeing in her personal plan that she has a reaction to Augmentin. I came on iplanit,[10] checked her plan and sure enough, she has a reaction to Augmentin."

49. NZCommunity Living Ltd told HDC that on 21 August, staff were notified by Ms A's medical centre that Ms A's test results had shown a urinary tract infection, and that there was a prescription for Augmentin at the pharmacy. Staff from the facility picked up the Augmentin, signed it in, and administered Ms A six doses before the error was identified. NZCommunity Living Ltd stated:

> "Our investigation found the Doctor prescribed Augmentin despite it being listed as an allergy in [Ms A's] medical centre notes. This was dispensed by the Pharmacy and NZCommunity Living Ltd administered the medication. We unreservedly apologise that six doses were administered in error."

50. HDC requested information from Te Whatu Ora Disability Directorate and HearthCert about the certification, audits, and evaluation they hold about NZCommunity Living Ltd. The most recent certification audit undertaken in May 2021 for the facility identified shortfalls that included medication management.

51. NZCommunity Living Ltd acknowledged that medication management was an area for improvement. NZCommunity Living Ltd said that it now utilises "the allergy stickers" on people's medication files, and currently it is in the process of implementing the medication management system MediMap.

Responses to provisional opinion

Mr and Mrs B

52. Mr and Mrs B were given an opportunity to respond to the "information gathered" section of the provisional opinion. Where appropriate, changes have been made in response to their comments. Mr and Mrs B reiterated their concerns that NZCommunity Living Ltd had information about Ms A's needs and what actions to take, but did not keep the family updated with changes in her health, did not go back to the doctor, and did not follow guidelines in her plan to go to hospital.

[10] A case management platform.

NZCommunity Living Ltd

53. NZCommunity Living Ltd was given an opportunity to respond to the provisional opinion. NZCommunity Living Ltd said that it had no further comments, and is progressing with the Deputy Commissioner's recommendations.

Opinion: NZCommunity Living Limited — breach

Introduction

54. On 13 September 2019, Ms A was admitted to the CCU at the public hospital with serious medical issues, including a severe infection and "overwhelming sepsis". Ms A required a period of approximately four weeks as an inpatient to recover from her significant illness.

55. NZCommunity Living Ltd had an organisational duty to provide Ms A services with reasonable care and skill, and to have in place adequate systems to ensure that the care delivered to Ms A complied with the Code of Health and Disability Services Consumers' Rights (the Code). In considering the information gathered, the timeline of events leading up to Ms A's hospital admission on 13 September 2019, and advice from my independent advisor, RN Margaret Wyllie, I have identified a number of deficiencies in the care provided to Ms A by NZCommunity Living Ltd.

56. I discuss three key areas of concern. First, the care provided to Ms A in the lead-up to her hospital admission; secondly, the inadequacies in her care planning; and lastly, staff adherence to policies and procedures. Cumulatively, I consider that NZCommunity Living Ltd holds primary responsibility for these issues at an organisational level.

Care provided leading up to hospital admission

57. RN Wyllie noted that Ms A's progress notes outline the need for her to have plenty of water to drink, but there is no supportive documentation about her fluid intake. RN Wyllie advised that in light of Ms A's medical history, including Cohen's syndrome, an intellectual impairment, a renal transplant and immunosuppression, she would have expected Ms A's fluid and food intake to have been monitored and observations taken to assess her health and alert staff to any further deterioration. RN Wyllie considered that the lack of monitoring was a severe departure from accepted practice.

58. I accept this advice and find it concerning that effective planning and monitoring of Ms A's fluid and food intake was not initiated when she first became unwell. NZCommunity Living Ltd told HDC that it used a diary note to list products that Ms A should not have. However, I consider that this monitoring was neither adequate nor in line with NZCommunity Living Ltd's Residential Policy, which outlines the need for good observation and documentation.

59. I do not accept NZCommunity Living Ltd's position that fluid and food monitoring is not within its scope of service. In my view, when NZCommunity Living Ltd accepted Ms A into its care it then assumed responsibility for keeping her safe. It had an obligation to provide a

reasonable standard of care to Ms A, and this included a minimum standard of monitoring food and fluid intake to ensure that Ms A did not become dehydrated, especially in light of her medical history and the impact of dehydration on her health.

60. I also find it unacceptable that after approximately six days of Ms A being unwell, NZCommunity Living Ltd treated the episodes of diarrhoea and vomiting on 12 and 13 September as separate incidents. It is clear from the information obtained that further medical advice should have been sought when Ms A's condition did not improve within 48 hours of the GP visit on 10 September, as had been stipulated by Dr C. I am also concerned that it took a telephone call from Mrs B to her daughter on 13 September 2019 to recognise that Ms A needed urgent medical treatment.

Short-term care planning

61. On 10 September 2019, the GP advised that Ms A should be taken back to the medical centre if her symptoms worsened or there was no improvement in her condition over the next 48 hours, or if she showed further signs of illness, lethargy, or reduced fluid intake.

62. RN Wyllie noted that at no time was Ms A's personal plan updated or a short-term plan created to reflect the GP visit and his advice.

63. While there is some documentation of Ms A's health in the staff daily notes, this form of update was an insufficient response to support Ms A's health needs. NZCommunity Living Ltd needed to ensure that staff were briefed fully and guided by a short-term plan to manage Ms A's health consistently and, most importantly, to recognise and respond to any deterioration in her condition.

64. In my view, the lack of an appropriate short-term plan following Ms A's GP consultation on 10 September 2019 meant that the need for support over and above the existing support plan was not provided, and this contributed to Ms A's deterioration in health.

Ms A's personal plan

65. Mr and Mrs B told HDC that their daughter's complex health needs were communicated to staff, and staff were provided with information and guidance on her care needs.

66. NZCommunity Living Ltd told HDC that it recognised Ms A's complex care needs. NZCommunity Living Ltd stated: "As [Ms A] had a Renal Transplant, she was considered to have complex health needs …" NZCommunity Living Ltd emphasised the importance of an individual's plan and noted that its Residential Policy clearly outlines that an individual's support plan and a risk management plan are developed as part of the entry process into NZCommunity Living Ltd residential facilities.

67. RN Wyllie advised that Ms A's personal plan did not clearly define a "serious incident or accident" that required escalation to Ms A's parents and clinical staff, and there was no risk management plan with clear instructions to staff about Ms A's pre-existing conditions.

68. It appears that Ms A's condition deteriorated between 10 and 13 September 2019. I note that following the GP visit on 10 September, Ms A's parents were notified of concerns about

their daughter's health. However, I find it concerning that NZCommunity Living Ltd did not notify Ms A's parents — as outlined in Ms A's personal plan — when Ms A's condition deteriorated over the following two days. In my view, NZCommunity Living Ltd's plan of response during this period was inadequate to guide staff.

Administration of Augmentin

69. Ms A's personal plan recorded an "allergy" to Augmentin and noted that she should not be given this medication. Despite this, Ms A was administered six doses of Augmentin. The error was detected when a staff member "vaguely recalled" having read about the allergy in Ms A's plan.

70. RN Wyllie noted that there were no red flags for Ms A's reaction to Augmentin on the front page of her personal plan.

71. I am concerned that staff administered six doses of Augmentin to Ms A, and that detection of the error relied on staff arbitrarily recalling details of Ms A's personal plan. Ms A's reaction to Augmentin should have been more visible to all staff. This was a further deficiency in the personal plan. While I acknowledge NZCommunity Living Ltd's response and the implementation of new processes, including "allergy stickers", clearly this is an area that warrants ongoing attention, as identified by the certification audit undertaken at the facility in May 2021. In addition to any corrective actions resulting from the certification audit, I encourage NZCommunity Living Ltd to refresh staff training at the facility and re-test staff competencies, with a focus on allergies.

Conclusion

72. In my view, NZCommunity Living Ltd had a responsibility to have in place adequate systems to ensure that Ms A was provided with care of an appropriate standard. Ms A's complex medical history meant that she required careful monitoring and management. Overall, I consider that the failures of staff demonstrate a pattern of suboptimal care. In particular, I am critical of the following:

a) The lack of clear monitoring and documentation of Ms A's food and fluid intake.

b) The failure to seek medical treatment within 48 hours of Ms A's GP consultation on 10 September 2019, as advised, when Ms A's condition did not improve between 11 and 13 September 2019.

c) The failure to develop a short-term plan in response to Ms A's changing health needs when she demonstrated a clear deterioration between 6 and 12 September 2019.

d) The lack of a sufficiently clear personal plan containing adequate details to allow care workers to provide safe, effective care for Ms A.

e) The error in administration of Augmentin to Ms A and the delay in recognising her reaction to the medication.

73. For the reasons set out above, I consider that NZCommunity Living Ltd failed to provide services to Ms A with reasonable care and skill, in breach of Right 4(1) of the Code.[11]

Staff knowledge and training on plans and policies — adverse comment

74. As noted above, staff did not follow Ms A's personal plan for when she should be taken to hospital. Staff also lacked knowledge of Ms A's reaction to Augmentin.

75. RN Wyllie raised concerns around staff training and induction on relevant policies and Ms A's care and risk management plan. RN Wyllie also noted that a personal care plan is a living document, and adjustments in specific areas should be completed when change occurs before a full review.

76. I agree with RN Wyllie's advice. I am concerned by NZCommunity Living Ltd's disregard of Ms A's personal plan, which specifically noted that Ms A was to be taken to hospital if she experienced both diarrhoea and vomiting. However, I acknowledge and am reassured by the changes NZCommunity Living Ltd has made around staff training and induction processes for individual personal plans (outlined below) in response to the concerns raised in this complaint.

Changes made

77. As a result of this complaint, NZCommunity Living Ltd implemented the following changes to the management of individuals' personal and risk management plans:

a) The individual plan now combines the daily support requirements as well as the risk management plan to ensure that these aspects of a person's support and safety requirements are readily available for the support team. To ensure that the plan is a living document, NZCommunity Living Ltd policy now requires the risk section of the plan to be reviewed monthly, and the support aspects to be evaluated on a three-month cycle. Each person's plan is also discussed at regular team meetings, and is required to be reviewed fully on an annual basis.

b) NZCommunity Living Ltd recognises the importance of staff being familiar with people's individual requirements, and now includes the verification of a personal plan in the person's "onboarding" process into the service. When the personal plan is created, house staff will have two days to review the person's plan. The service manager will then verify that all support workers have read and signed the plan.

c) NZCommunity Living Ltd has also created an alert box in its client management system, iPlanit. The alert box appears on opening each person's profile. The purpose of the alert box is to list a person's allergies and temporary changes to the person's health condition.

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

Recommendations

78. I recommend that NZCommunity Living Ltd:

a) Provide a written apology to Ms A and her family for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Use the findings of this report as a basis for training staff at all NZCommunity Living Ltd's facilities, in a way that maintains the anonymity of all parties involved, and provide evidence of the training within three months of the date of this report.

c) Provide a progress report and key learnings following the use of "sticker alerts" on personal files, and on the implementation of MediMap. This information is to be provided to HDC within three months of the date of this report.

d) Schedule refresher education for all facility staff on short-term care plans and the management of a deteriorating condition, and schedule regular and ongoing education sessions on care planning (to be held at least every two years). In addition, outline how staff will be audited to show that they have completed the relevant training. Evidence of the scheduled training is to be provided to HDC within three months of the date of this report.

Follow-up actions

79. A copy of this report with details identifying the parties removed, except NZCommunity Living Ltd and the advisor on this case, will be sent to HealthCERT (Manatū Hauora), and it will be advised of the name of the facility.

80. A copy of this report with details identifying the parties removed, except NZCommunity Living Ltd and the advisor on this case, will be sent to the Health Quality & Safety Commission, Whaikaha|Ministry of Disabled People, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to Commissioner

The following expert advice was obtained from RN Margaret Wyllie (original report dated 6 April 2021):

> "I have been asked to provide an opinion to the Commissioner on Case Reference C19HDC02265. I have read and agreed to follow the Commissioner's Guidelines for Independent Providers.
>
> 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. Following [Ms A's] visit to the General Practitioner on 10 September 2019 what observations, checks and documentation would you expect to be kept by her care team? In light of your answer to the previous question, do you consider the care provided by [the] staff was in accordance with standard practice?
> 2. What level of detail and instruction would you expect to be included in a Care Plan for someone with [Ms A's] pre-existing medical conditions? Do you consider that [Ms A's] Care Plan was adequate to instruct her care workers in her care?
> 3. The adequacy of [the] Health and Wellbeing policies and procedures, particularly with regards to instructing care workers in making observations to determine the condition of residents' health.
> 4. Any other matters in this case that you consider warrant comment or that you consider amount to a departure from the standard of care or accepted practice.
>
> Information and documentation provided to undertake this review and advise whether the care provided to [Ms A] by [NZCommunity Living Limited] was reasonable in the circumstances and why?
>
> - Health and Disability Commissioner (complaint) 27 November 2019
> - Letter to complaints assessor … 1 December 2020
> - Letter to complaints assessor 10 December 2020
> - Letter to HDC … 28 January 2020
> - Health Visit form 13 September 2019
> - Health Visit form 10 September 2019
> - Consultation [Dr C] 10 September 2019
> - Health Visit forms 21 August 2019, 19 August 2019 and 13 July 2019
> - Progress notes 2 March–20 September 2019
> - On-call clinical notes
> - Health and Wellbeing notes
> - Outcome Goal notes
> - Contact Log
> - Incident forms from 23 March–14 September 2019

- Personal Plan start date 15 September 2018 — review date 15 September 2019
- Section 6 Health and Wellbeing policies — next review August 2018:
  - Assessing a Person's Health Condition
  - Nutrition and Hydration
  - Healthy Food Pyramid
  - Hydration Principles
  - Heart Healthy Dietary Pattern
  - Salt and Health
  - How to Keep Fat Intake Low
  - Food Safety
  - Daily Oral Care
  - Physical Activity
  - Sleep
  - Bowel and Bladder Management
  - Infection Prevention Overview
  - Hand Washing Technique
  - Personal Protection Equipment
  - Infection Prevention Outbreak Procedure
  - Stop the Spread of Germs

Comments

1. Following [Ms A's] visit to the General Practitioner on 10 September 2019, what observations, checks and documentation would you expect to be kept by her care team?

From progress notes between 10 September 2019 and 13 September 2019, it appears that [Ms A] was, for the most part, confined to her bedroom for the three days. On occasions when she ventured from her room, from progress notes, it appears that she was rude to staff. She was spoken to about making a noise when up to go to the toilet and waking up other people in the house. With an excoriated bottom she would have been in significant discomfort. Progress notes state that ointment was applied, no comment about pain relief (apart from Panadol once) or whether the redness had reduced. Progress notes state plenty of water to drink. There was no supportive documentation re how much fluid was consumed and/or exactly what food was eaten.

On-call clinical guidance — no notes recorded for 10 September 2019 on what staff were expected to do or any change made to Personal Plan or a short-term plan introduced.

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

[Ms A] has Cohen's syndrome, intellectual impairment, immunosuppression, renal transplant in 2008 and multiple orthopaedic procedures. One would expect fluid intake, food intake and observations assessing a person's health would have been recorded to ensure further deterioration did not occur.

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 was severe, as significant further deterioration occurred.

c. How would this 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.

2. What level of detail and instruction would you expect to be included in a Care Plan for someone with [Ms A's] pre-existing medical condition? Do you consider that [Ms A's] Care Plan was adequate to instruct her care workers in her care?

[Ms A's] Care Plan had a start date of 15 September 2018 and a review date of 15 September 2019. This plan had not been revised post-visit to the General Practitioner on 10 September 2019 or post onset of some diarrhoea and a cough. Progress notes from 2 September 2019 indicate that she has been off-colour, coughing and had a sore bottom, was not eating regular meals up until visit with General Practitioner on 10 September 2019. When her Personal Plan was due for review on 15 September 2019, [Ms A] was in hospital.

Advice

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

Accepted practice for a Personal Plan is that it would be compiled in conjunction with the person/family/advocate or guardian. On the front of the plan there is a place for ownership to be documented — this was blank. A Personal Care Plan is a living document and adjustments in specific areas should be completed when change occurs before a full review. Needs changes can be written in by hand and signed and dated. I believe that [Ms A's] Personal Plan is on a computer programme iplanit and is not difficult to adjust.

The Personal Care Plan lacked detail page 2/17.

When Something Happens, type Serious Incidents — staff to ring my parents and inform Service Manager. If after-hours to ring on-call health advisor, staff to complete incident form in daily notes in iplanit.

Type — Serious Accident — staff to ring parents and inform Service Manager or if after-hours, to ring on-call health advisor. Staff to also ring 111 Ambulance for urgent medical assistance and complete incident form and document in daily notes in iplanit.

This does not clearly specify what is a serious incident or what is a serious accident. Incident forms — reviewed.

- Incident No 37046 28 August 2019 — severity Moderate. Staff member came on duty and at handover it was mentioned that [Ms A] was on Augmentin for her UTI. Staff member states 'I vaguely remember seeing in her Personal Plan that she has a

reaction to Augmentin. I came on iplanit, checked her plan and sure enough, she has a reaction to Augmentin. Called Manager. Told her what I had found and asked what I should do, followed her advice, called doctor and arranged to have [Ms A's] medication changed'.

Contributing Factors: Doctor did not see note about [Ms A] having a reaction to Augmentin. Staff did not check Personal Plan or Allergy and Reactions part in passport.

Health Visit form dated 21 August 2019 as of 19 August 2019 [Ms A] had routine bloods and urine done. Results back and [Ms A] has a UTI and has been put on antibiotics (Augmentin) for 15 days. (Stopped on 28 August 2019, possibly had taken them for six days).

The Health Visit form dated 21 August 2019 shows short-term support plan required Yes/No. Yes was circled, but plan not available with the documentation sent.

- Incident No 37966 6 September 2019 — severity Moderate. [Ms A] went to bathroom before dinner. She came and told staff that she had had an accident in her underwear. Checked her underwear and she had diarrhoea. [Ms A] indicated that she had had this for at least a couple of days. Called on-call. On-call said to restrict her diet to dry foods and water. If she has more diarrhoea tomorrow, then call on-call again and possibly take [Ms A] to doctors. Cream applied to [Ms A's] buttocks, as it was quite sore.

- Incident No 38383 13 September 2019 — severity Severe. When afternoon staff came on, [Ms A] was sitting in lounge with a bucket on her lap. She was coughing and started vomiting into the bucket. Afternoon staff thought it best that [Ms A] be removed from the communal area, so as to not share her bugs/germs that she has. [Ms A] has had diarrhoea for over a week and vomiting for three days. She was taken to the doctor on 10 September 2019 and the doctor did say that she should be taken back if no improvement within three days. Staff discussed calling [Ms A's] mother to discuss what was happening to her health. After receiving a phone call from [Ms A], her mother called staff and said she and her husband would come and take [Ms A] to the Emergency Department at [the public hospital].

Contributing Factors: Diarrhoea and vomiting for past three days. Staff were supposed to take her back to the doctors if she had not improved after three days.

- Incident No [#] — severity Moderate. [Ms A's] mother rang to say that [Ms A] was admitted to ICU. She is septic, dehydrated and her kidney function is lower.

- Incident Nos [#], Medication Management, [#] Health and Wellbeing and [#] Health and Wellbeing were all notified by the same staff member.

- Incident No [#] Health and Wellbeing notified by another staff member.

My Personal Care within Personal Plan page 6/17. *[Ms A's] bowels can move several times a day and sometimes during the night. This is normal for [Ms A]. Staff to monitor and report any concerns to health advisor or Service Manager or if after-hours, ring on-call health advisor.*

My Health and Wellbeing within Personal Plan page 8/17. *If [Ms A] gets diarrhoea and vomiting she is to be taken to ED at the public hospital.* There is mixed messaging within [Ms A's] Personal Plan and instruction to staff is not clear.

Allergies and Reactions within Personal Plan page 9/17. *[Ms A] also has a reaction to Augmentin. This causes diarrhoea.* It was advised that this is noted in the Allergy section of her Doctor's Prescribing Chart (not sighted).

What Makes Me Unhappy page 12/17 within Personal Plan.
Information description — *[Ms A] can become anxious at time (sic) and may repeat herself often.*

Help Me Manage My Behaviour
Information description — *Staff to ensure that they inform [Ms A] of any changes this will reduce her anxiety.* There was no evidence of what triggers to look out for that precipitates anxiety and how to reduce anxiety.

There was no Risk Management Plan that provided clear messages about the numerous risks in relation to [Ms A's] pre-existing medical conditions if certain processes were not adhered to. There were no red flags for the reaction to Augmentin and/or Cyclizine on the front page of her Personal Plan.

At the end of [Ms A's] Personal Plan page 17/17 there was no evidence to support that all staff who were to support [Ms A] with her cares had read her plan and understood her needs.

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 considered to be severe.

Considering facts:

That [Ms A] was prescribed Augmentin on 21 August 2019 (which she has a reaction to). The Short-term Support Plan required was not ? completed or provided. This was not picked up until 28 August 2019 by staff member coming on duty, stating *'I vaguely remember seeing in her Personal Plan that she has a reaction to Augmentin'.*

That the Personal Care Plan for [Ms A] lacked by ownership by herself or her parents/guardian or who scribed the plan and whether she had a key worker appointed or not.

That within the Personal Plan there are several ambiguous statements.

That there were no clear instructions to manage risks associated with [Ms A's] pre-existing medical conditions in a format that was easily accessible, as well as reactions to medications.

That there was no evidence that all staff who support [Ms A] had read her Personal Care Plan. If they had, she would not have been left until the afternoon shift to have another visit to her General Practitioner, or should the instructions under My Health and Wellbeing have been followed? ie *If [Ms A] gets diarrhoea and vomiting she is to be taken to ED at the public hospital.*

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.

3. The adequacy of [the] Health and Wellbeing policies and procedures, particularly with regards to instructing care workers in making observations to determine the conditions of residents' health.

Section 6 Health and Wellbeing policies next review due August 2018. Whilst this section is overdue for review, the Assessing a Person's Health Condition (page 49/77) has a sound base, but there was no supportive evidence provided that the staff supporting [Ms A] have read and understood policy/protocol/procedure expectations. There was no supportive evidence of training provided in managing a person's wellbeing.

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

Policy/procedure and protocol reviews vary throughout organisations. Most organisations have a two or three yearly review, not annual. In this instance it would be more useful to understand if all staff supporting [Ms A] had read these protocols.

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 would be moderate; more importantly would be the need for staff to record more accurately fluid and food intake for someone who was off-colour/unwell from approximately 2 September to 13 September 2019, taking into consideration her significant pre-existing medical conditions.

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.

Recommendations

- It is important that personal planning be completed in conjunction with the person, parents/guardian with documented evidence that this has been completed (it is an expectation now that people have choice and ownership of their plans).
- That a key staff support person is appointed; this is also best practice
- That where a person has significant pre-existing medical conditions, a Risk Management Plan forms part of the Personal Plan and is signed off as read by all staff who are providing support
- That when support staff take a person to the General Practitioner, they are fully aware of what drugs a person may have a reaction/allergy to
- That where there appears to be a breakdown in positive relationships between family and providers, more regular face to face meetings be held to avoid further deterioration
- That where a person presents with forms of challenging behaviour, a more specific plan be put in place to address how they are to be managed
- That a red flag or sticker with reactions/allergies be placed on the Health Visit form, as well as prescriptions and Risk Management Plans

[Margaret Wyllie]"

The following further advice was obtained from RN Wyllie (amended report dated 6 October 2021):

"I have been asked to provide an opinion to the Commissioner on Case Reference C19HDC02265. I have read and agreed to follow the Commissioner's Guidelines for Independent Providers.

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. Following [Ms A's] visit to the General Practitioner on 10 September 2019 what observations, checks and documentation would you expect to be kept by her care team? In light of your answer to the previous question, do you consider the care provided by [the] staff was in accordance with standard practice?
2. What level of detail and instruction would you expect to be included in a Care Plan for someone with [Ms A's] pre-existing medical conditions? Do you consider that [Ms A's] Care Plan was adequate to instruct her care workers in her care?
3. The adequacy of [the] Health and Wellbeing policies and procedures, particularly with regards to instructing care workers in making observations to determine the condition of residents' health.

4. Any other matters in this case that you consider warrant comment or that you consider amount to a departure from the standard of care or accepted practice.

Information and documentation provided to undertake this review and advise whether the care provided to [Ms A] by [NZCommunity Living Limited] was reasonable in the circumstances and why?

- Health and Disability Commissioner (complaint) 27 November 2019
- Letter to complaints assessor … 1 December 2020
- Letter to complaints assessor 10 December 2020
- Letter to HDC … 28 January 2020
- Health Visit form 13 September 2019
- Health Visit form 10 September 2019
- Consultation [Dr C] 10 September 2019
- Health Visit forms 21 August 2019, 19 August 2019 and 13 July 2019
- Progress notes 2 March–20 September 2019
- On-call clinical notes
- Health and Wellbeing notes
- Outcome Goal notes
- Contact Log
- Incident forms from 23 March–14 September 2019
- Personal Plan start date 15 September 2018 — review date 15 September 2019
- Section 6 Health and Wellbeing policies — next review August 2018:
    - Assessing a Person's Health Condition
    - Nutrition and Hydration
    - Healthy Food Pyramid
    - Hydration Principles
    - Heart Healthy Dietary Pattern
    - Salt and Health
    - How to Keep Fat Intake Low
    - Food Safety
    - Daily Oral Care
    - Physical Activity
    - Sleep
    - Bowel and Bladder Management
    - Infection Prevention Overview
    - Hand Washing Technique
    - Personal Protection Equipment
    - Infection Prevention Outbreak Procedure
    - Stop the Spread of Germs

<u>Additional Information provided by HDC dated 1 October 2021</u>

- Letter to HDC from [NZCommunity Living Limited] dated 29 April 2021
    - Short-term Support Plan dated 21 August 2019

- Risk Management Plan last modified on 15 February 2019
- Training record for support worked (undated)
- Team Meeting Minutes dated 16 February 2017
- Training record for video — Stop and Watch training for 2020 and 2021
- Entry to Services Sign Off form dated 24 September 2018
- My Goals and Dreams form dated 4 February 2018
- Orientation Check Sheet for … 22–26 January 2017

Comments

1. Following [Ms A's] visit to the General Practitioner on 10 September 2019, what observations, checks and documentation would you expect to be kept by her care team?

From progress notes between 10 September 2019 and 13 September 2019, it appears that [Ms A] was, for the most part, confined to her bedroom for the three days. On occasions when she ventured from her room, from progress notes, it appears that she was rude to staff. She was spoken to about making a noise when up to go to the toilet and waking up other people in the house. With an excoriated bottom she would have been in significant discomfort. Progress notes state that ointment was applied, no comment about pain relief (apart from Panadol once) or whether the redness had reduced. Progress notes state plenty of water to drink. There was no supportive documentation re how much fluid was consumed and/or exactly what food was eaten.

On-call clinical guidance — no notes recorded for 10 September 2019 on what staff were expected to do or any change made to Personal Plan or a short-term plan introduced.

The Short Term Support Plan provided with a date completed of 21 August 2019, with a date ceased of 29 August 2019 has no relevance to this event, as it was prior to the event taking place.

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

[Ms A] has Cohen's syndrome, intellectual impairment, immunosuppression, renal transplant in 2008 and multiple orthopaedic procedures. One would expect fluid intake, food intake and observations assessing a person's health would have been recorded to ensure further deterioration did not occur.

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 was severe, as significant further deterioration occurred.

c. How would this 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.

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[Ms A's] Care Plan had a start date of 15 September 2018 and a review date of 15 September 2019. This plan had not been revised post-visit to the General Practitioner on 10 September 2019 or post onset of some diarrhoea and a cough. Progress notes from 2 September 2019 indicate that she has been off-colour, coughing and had a sore bottom, was not eating regular meals up until visit with General Practitioner on 10 September 2019. When her Personal Plan was due for review on 15 September 2019, [Ms A] was in hospital.

Advice

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

Accepted practice for a Personal Plan is that it would be compiled in conjunction with the person/family/advocate or guardian. On the front of the plan there is a place for ownership to be documented — this was blank. A Personal Care Plan is a living document and adjustments in specific areas should be completed when change occurs before a full review. Needs changes can be written in by hand and signed and dated. I believe that [Ms A's] Personal Plan is on a computer programme iplanit and is not difficult to adjust.

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Type — Serious Accident — staff to ring parents and inform Service Manager or if after-hours, to ring on-call health advisor. Staff to also ring 111 Ambulance for urgent medical assistance and complete incident form and document in daily notes in iplanit.

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Contributing Factors: Doctor did not see note about [Ms A] having a reaction to Augmentin. Staff did not check Personal Plan or Allergy and Reactions part in passport.

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The Health Visit form dated 21 August 2019 shows short-term support plan required Yes/No. Yes was circled, but plan not available with the original documentation sent.

The Short Term Support Plan date completed 21 August 2019 and date ceased 29 August 2019 identifies [Ms A] has a UTI. Nurse called and script is at [the] Pharmacy. ~~Augmentin~~. Cefalexin 1 capsule 3 times a day.

Evaluation and review — [Ms A] is feeling no discomfort when going to the toilet (Team Leader).

- Incident No [#] 6 September 2019 — severity Moderate. [Ms A] went to bathroom before dinner. She came and told staff that she had had an accident in her underwear. Checked her underwear and she had diarrhoea. [Ms A] indicated that she had had this for at least a couple of days. Called on-call. On-call said to restrict her diet to dry foods and water. If she has more diarrhoea tomorrow, then call on-call again and possibly take [Ms A] to doctors. Cream applied to [Ms A's] buttocks, as it was quite sore.
- Incident No [#] 13 September 2019 — severity Severe. When afternoon staff came on, [Ms A] was sitting in lounge with a bucket on her lap. She was coughing and started vomiting into the bucket. Afternoon staff thought it best that [Ms A] be removed from the communal area, so as to not share her bugs/germs that she has. [Ms A] has had diarrhoea for over a week and vomiting for three days. She was taken to the doctor on 10 September 2019 and the doctor did say that she should be taken back if no improvement within three days. Staff discussed calling [Ms A's] mother to discuss what was happening to her health. After receiving a phone call from [Ms A], her mother called staff and said she and her husband would come and take [Ms A] to the Emergency Department at [the public hospital].

<u>Contributing Factors:</u> Diarrhoea and vomiting for past three days. Staff were supposed to take her back to the doctors if she had not improved after three days.

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<u>My Personal Care</u> within Personal Plan page 6/17. *[Ms A's] bowels can move several times a day and sometimes during the night. This is normal for [Ms A]. Staff to monitor*

and report any concerns to health advisor or Service Manager or if after-hours, ring on-call health advisor.

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Information description — *[Ms A] can become anxious at time (sic) and may repeat herself often.*

Help Me Manage My Behaviour

Information description — *Staff to ensure that they inform [Ms A] of any changes this will reduce her anxiety.* There was no evidence of what triggers to look out for that precipitates anxiety and how to reduce anxiety.

There was no Risk Management Plan that provided clear messages about the numerous risks in relation to [Ms A's] pre-existing medical conditions if certain processes were not adhered to. There were no red flags for the reaction to Augmentin and/or Cyclizine on the front page of her Personal Plan.

The Risk Management Plan for [Ms A's] Active Plan(s) provided had entries regarding her pre-existing risks on 23 September 2018, 24 September 2018 and 15 February 2019. There was no evidence that this plan had been read by the support staff involved in her care.

At the end of [Ms A's] Personal Plan page 17/17 there was no evidence to support that all staff who were to support [Ms A] with her cares had read her plan and understood her needs.

The Orientation Check Sheet provided for … states:

- Key documents: clients files
  - Personal information
  - Risk management
  - Support plans
  - Lifestyle plans
  - Health-related documents

These were signed and dated on 26 January 2017, when [Ms A] had not been admitted to this service.

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 considered to be severe.

Considering facts:

That [Ms A] was prescribed Augmentin on 21 August 2019 (which she has a reaction to). The Short-term Support Plan has since been provided. This was not picked up until 28 August 2019 by staff member coming on duty, stating *'I vaguely remember seeing in her Personal Plan that she has a reaction to Augmentin'.*

The Short Term Support Plan date completed 21 August 2019 and date ceased 29 August 2019 identifies [Ms A] has a UTI. Nurse called and script is at [the] Pharmacy. ~~Augmentin~~. Cefalexin 1 capsule 3 times a day.

Evaluation and review — [Ms A] is feeling no discomfort when going to the toilet (Team Leader).

Augmentin was crossed out, but was not initialled by whoever made the change.

That the Personal Care Plan for [Ms A] lacked ownership by herself or her parents/guardian or who scribed the plan and whether she had a key worker appointed or not.

The My Goals and Dreams information-gathering tool provided for [Ms A] identified her Primary Support Worker as … It also identifies People Involved as Mum, [Ms A], [primary support worker] and …, however there is no evidence to support that they were invited and/or attended ie signature and date.

That within the Personal Plan there are several ambiguous statements.

The Risk Management Plan for [Ms A's] Active Plan(s) provided had entries regarding her pre-existing risks on 23 September 2018, 24 September 2018 and 15 February 2019, but there was no risk identified in relation to her reaction to Augmentin. There was no evidence that this plan had been read by the support staff involved in her care.

That there was no evidence that all staff who support [Ms A] had read her Personal Care Plan. If they had, she would not have been left until the afternoon shift to have another visit to her General Practitioner, or should the instructions under My Health and Wellbeing have been followed? ie *If [Ms A] gets diarrhoea and vomiting she is to be taken to ED at the public hospital.*

The Orientation Check Sheet provided for … identified that her orientation was completed in January 2017. There was no evidence that she had read information specific to [Ms A].

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.

3. The adequacy of [the] Health and Wellbeing policies and procedures, particularly with regards to instructing care workers in making observations to determine the conditions of residents' health.

Section 6 Health and Wellbeing policies next review due August 2018. Whilst this section is overdue for review, the Assessing a Person's Health Condition (page 49/77) has a sound base, but there was no supportive evidence provided that the staff supporting [Ms A] have read and understood policy/protocol/procedure expectations. There was no supportive evidence of training provided in managing a person's wellbeing.

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

Policy/procedure and protocol reviews vary throughout organisations. Most organisations have a two or three yearly review, not annual. In this instance it would be more useful to understand if all staff supporting [Ms A] had read these protocols.

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 would be moderate; more importantly would be the need for staff to record more accurately fluid and food intake for someone who was off-colour/unwell from approximately 2 September to 13 September 2019, taking into consideration her significant pre-existing medical conditions.

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.

Recommendations

- It is important that personal planning be completed in conjunction with the person, parents/guardian with documented evidence that this has been completed (it is an expectation now that people have choice and ownership of their plans and there would be signatures and dates to signify that they had been involved).
- That where a person has significant pre-existing medical conditions, a Risk Management Plan forms part of the Personal Plan and is signed off as read by all staff who are providing support
- That when support staff take a person to the General Practitioner, they are fully aware of what drugs a person may have a reaction/allergy to
- That where there appears to be a breakdown in positive relationships between family and providers, more regular face to face meetings be held to avoid further deterioration

- That where a person presents with forms of challenging behaviour, a more specific plan be put in place to address how they are to be managed
- That a red flag or sticker with reactions/allergies be placed on the Health Visit form, as well as prescriptions and Risk Management Plans

[RN Wyllie]

Original report dated 6 April 2021

Amended report dated 6 October 2021”