Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Oceania Care Company Limited breaches Code for failures in care for respite resident 20HDC02116

Aged Care Commissioner Carolyn Cooper has found Oceania Care Company Limited breached the Code of Health and Disability Services Consumers' Rights for respite care provided to a resident.

The resident, a male in his eighties, had several medical conditions, including Parkinson's disease, heart failure, poor hearing, blindness in one eye and recurring TIAs (transient ischaemic attacks – mini strokes). While usually cared for at home, he entered respite care for a five day stay at Victoria Place Rest Home and Hospital (VPRH), owned by Oceania Care Company Limited.

On his first night, the man suffered an unwitnessed fall, however, no assessments were undertaken, and documentation was incomplete. In addition, his deteriorating condition post fall was not adequately responded to by VPRH employees.

On day three, an ambulance was called at the insistence of the man's whānau and the man was admitted to hospital where scans indicated new strokes. Unfortunately, his health continued to decline, and he passed away two weeks later.

Ms Cooper found Oceania breached Right 4 of the Code which gives consumers the right to appropriate standards | Tuatikanga.

Right 4(4) gives consumers the right to services provided in a manner that minimises potential harm and optimises their quality of life. Ms Cooper concluded that Oceania failed to comply with the Health and Disability (Core) Standards to minimise harm in several respects.

When the man entered respite care, no falls risk assessment was undertaken. Instead, it was indicated that he could walk with a mobility aid. Despite the man having stayed in respite care previously at VPRH, a new risk assessment should have been done.

"Given the likelihood of his condition deteriorating over time and the potential for workforce personnel changes, historic information was not sufficient," said Ms Cooper.

Following the man's fall and his subsequent breathlessness, Oceania failed to provide services with reasonable care and skill, which breached Right 4(1) of the Code.

Regardless of whether the fall was witnessed or not, a post-fall assessment should have been undertaken and neurological observations commenced. This did not occur and there was minimal follow-up monitoring in relation to the man's shortness of breath.

Oceania also breached Right 4(2) of the Code for record keeping. Ms Cooper said the documentation system at VPRH did not meet the Health and Disability Services (Core) standards which require that organisations ensure consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Oceania acknowledged that the man's clinical records did not meet its own standards of clinical practice.

Ms Cooper commented on a lack of respect shown to the man and his whānau by Oceania employees. This included being dismissive of injuries post fall, disregarding the letter from the GP presented by the man's wife and only calling an ambulance after the man's daughter-in-law threatened to drive him to hospital herself.

"Although some of these incidents are disputed, and, if they occurred, could be seen to be the actions of individual staff, my view is that management should set a positive culture with residents' wellbeing at the centre, and Oceania failed to do so," Ms Cooper said.

A registered nurse also breached Right 4(1) of the Code for failing to provide services with reasonable care and skill. Ms Cooper said the nurse needed to, "take responsibility for her failures and the failures of several of her staff to provide appropriate care to the man."

Ms Cooper also made adverse comments about two other registered nurses who provided care post fall.

Oceania has made several changes since the complaint, which are outlined in the report.

Ms Cooper made several recommendations for Oceania and the three registered nurses in her report, including that they provide formal apologies to the man's whānau for the failures in care.

22 April 2024

Editor's notes:

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

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 2022/23 HDC made 592 quality improvement recommendations to individual complaints, and we have a high compliance rate of around 96%.

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