Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Failures in hospital level care for woman with Parkinson's disease

20HDC00708

Aged Care Commissioner Carolyn Cooper today issued a report finding Remuera Rise Ltd (trading as Remuera Rise Care Home) breached the Code of Health and Disability Services Consumers' Rights (the Code) for their care of woman in her sixties living with Parkinson's Disease.

The woman was admitted to Remuera Rise for hospital level care. Her husband complained that she passed away prematurely due to failures in her care – including monitoring of her food and fluid intake, medication management and clinical issues.

He also alleged that during COVID-19 lockdowns, when family were not allowed to visit and supplement her care, the woman deteriorated more rapidly.

While acknowledging the unknown and changing situation staff faced in the context of COVID-19 lockdowns, Ms Cooper found Remuera Rise breached Right 4(1) of the Code, which gives consumers the right to services provided with reasonable care and skill.

The breach covered several failures in care, although Ms Cooper noted that the clinical issues in this case are all connected and would have impacted on each other to varying degrees.

There was a lack of documentation and planning to indicate that staff were taking a holistic approach to the woman's care. Also, there did not appear to be any documented, agreed, over-arching care plan in place, to ensure mutual and agreed understanding of what care could and should be provided by the facility, and when hospital admission was appropriate.

"This disconnect between the understood goals of the woman and her family and care staff was particularly evident towards the end of her life," Ms Cooper said.

In addition, Remuera Rise should have ensured there was agreed understanding of the most clinically appropriate and respectful approach to the care provided, and documented these discussions clearly.

Ms Cooper also made an adverse comment about the contracted GP who treated the woman. She raised concerns about the lack of clear documentation and considered that it would have been helpful for the GP to have made clear notes to show the woman's family were adequately informed when making significant decisions about her care.

Ms Cooper expressed her sincere condolences to the family for their loss.

In addition to recommending that Remuera Rise provide a formal apology to the woman's family, Ms Cooper made a number of other recommendations, including that they provide an update on the implementation of new documentation software and documentation training for all staff. She also recommended they provide training to staff around short-term care plans and use anonymised version of this report as a case study for staff to encourage reflection and discussion on caring for and supporting residents with Parkinson's disease.

Ms Cooper recommended the GP provide a formal apology to the woman's family and provide evidence that he has attended training sessions run by Remuera Rise in response to the recommendations regarding documentation.

In addition to planned changes, Remuera Rise has made a number of changes to its service as a result of these events, including:

- Implementing a communication form to be used by registered nurses with the GP when referring acute conditions.
- Training to refamiliarize nurses with medication administration policy.
- Training to refamiliarize nurses and healthcare assistants on clinical documentation, pain assessment and management guidelines, nutrition and hydration guidelines, communication policy and guidelines, delirium guidelines, challenging behaviours or behaviours of concern management policy, last days of life guidelines.
- Testing new software aimed to improve documentation.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

13 November 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 recommendation.Learn more: Education