Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Aged care provider breaches Code for care provided to resident before and after a fall

20HDC01252

In a report released today, Aged Care Commissioner, Carolyn Cooper, has found Tamahere Eventide Home and Retirement Village, an enrolled nurse and a registered nurse breached the Code of Health and Disabililty Services Consumers' Rights (the Code) for their care of a female resident in her nineties.

The resident had an unwitnessed fall, which resulted in a fractured hip and shoulder. She was admitted to hospital, where, unfortunately, she passed away.

Ms Cooper found Tamahere breached Right 4(1) of the Code for failing to provide services with reasonable care and skill.

The breach covered several failures across multiple areas – falls risk management, care provided prior to the fall, and the assessment and management following the fall.

Ms Cooper said together these, "demonstrate a pattern of suboptimal care and service failures at Tamahere."

Ms Cooper noted that the resident's care plan did not provide adequate support to manage her falls risk. In addition, CCTV footage showed her personal care needs were not met in a timely manner overnight, despite the hourly checklist being ticked to indicate this had been done.

"Although it is the carers' responsibility to undertake hourly checks, ultimately they work under the direction of registered nurses, and Tamahere should have had adequate systems in place to ensure hourly checks on residents were carried out by staff," Ms Cooper said.

Ms Cooper also found that the enrolled nurse on night duty breached Right 4(1) by failing to provide services with reasonable care and skill.

She noted that the enrolled nurse on night duty should have escalated the fall to the registered nurse so that a thorough head-to-toe assessment could have been undertaken before moving the woman.

The registered nurse also breached Right 4(1).

"As the senior staff nurse on the morning shift, the registered nurse had the responsibility to undertake a thorough head-to-toe assessment and to direct staff to

ensure the resident received safe, appropriate care until further assessment from the GP," Ms Cooper said.

"I am critical that a thorough assessment was not completed by either nurse who attended, and that the resident was assisted off the floor and required to walk to the bathroom when a fracture of her arm was suspected."

Ms Cooper offered her condolences to the family for the loss of their loved one.

Ms Cooper recommended that Tamahere undertake a number of actions to address the breach, including reviewing the education/training provided to staff in relation to falls management so that it aligns with accepted practice and guidelines, and providing evidence of education and training.

She noted that Tamahere had already provided an apology to the woman's family and recommended that the enrolled and registered nurses do the same.

30 January 2024

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.

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