Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Failure to provide a resident with appropriate care after a fall

21HDC00191

A report released today by Aged Care Commissioner Carolyn Cooper has found Ranfurly Manor (Promisia Healthcare Ltd) breached the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide an appropriate standard of care to a female resident before and after her fall.

The resident, living in hospital-level care, was temporarily placed in an electric wheelchair but slid out. An initial check identified no injuries. However, over the following days, the woman complained of pain in her legs and feet. An X-ray, taken nine days after the fall, revealed a fracture in the woman's ankle.

Ms Cooper identified several failings in care at Ranfurly Manor, which collectively breached Right 4(1) of the Code, which gives consumers the right to services provided with reasonable care and skill.

The woman was placed in an electric wheelchair, despite the care plan noting this should not happen. "This raises concerns about staff adherence to care plans and the manner in which important information about residents' care [was] communicated between staff," Ms Cooper said.

Secondly, multiple staff failed to monitor, assess, and manage the woman's pain following the fall. This led to a delay in investigating and diagnosing the ankle fracture.

Thirdly, despite numerous expressions of pain recorded in the progress notes, staff failed to escalate the woman's care to the GP in a timely fashion. Ms Cooper said, "I am critical that over a nine-day period there were 20 documented expressions of pain from the woman, yet this was not escalated to the GP in an timely way after her fall."

Ms Cooper acknowledged that the policies in place at Ranfurly Manor to guide resident care were sound, however, the fact that multiple staff did not follow them consistently meant that service delivery was sub-optimal.

Sadly, the woman passed away during the course of the investigation. Ms Cooper offered her condolences to the whānau for the loss of their loved one and acknowledged the distress caused by the event.

Since the event Ranfurly Manor has made several changes, including moving to an electronic resident monitoring programme and conducting a daily review of adverse events and handover notes for registered nurses, team leaders and the Clinical Manager.

In addition, Ms Cooper recommended that Ranfurly Manor:

- Provide a written apology to the woman's family for the criticisms in this report.
- Provide an update on the changes made to the process for communication with family when an adverse event occurs for their family member.
- Provide an example of recent changes, including an audit of the registered nurse 24-hour review protocol, an audit of pain management to demonstrate evidence of use of the HCSL resident monitoring programme; random audits of staff compliance with the medication and falls policy; and the use of this report as a basis for staff training.

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

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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