Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Retirement Village Care Centre in breach of Code for care of a woman near the end of her life

20HDC00651

Edmund Hillary Retirement Village (EHVR) has breached the Code of Health & Disability Services Consumer's Rights (the Code) over the care provided to an elderly woman near the end of her life.

Visiting hospice nurses identified that the woman was experiencing end-stage heart failure. A GP assessment also indicated that she was nearing the end of her life. However, the nursing team at EHRV did not start planning for the woman's end of life care.

When the woman's daughter visited, during COVID-19 restrictions (which allowed families to visit residents who were receiving palliative care or nearing the end of life), the Clinical Manager attempted to prevent the visit because she believed the woman was not nearing the end of life.

Aged Care Commissioner, Carolyn Cooper was critical of the failure to commence end of life care planning for the woman following the hospice assessment and GP assessment. She was also critical of the failure to update the woman's care plans when she experienced deterioration in the last days of her life, even as her needs changed significantly. She found that these failures meant that the woman did not receive services in a manner consistent with her needs, in breach of Right 4(3) of the Code

Ms Cooper found that EHRV breached Right 4(1) of the Code for failing to provide services with reasonable skill and care by not performing regular assessments for common symptoms during the woman's last days of life.

Ms Cooper also found that the communication from EHRV to the woman's family did not comply with relevant palliative care standards, a breach of Right 4(2) of the Code.

Ms Cooper said the Clinical Manager behaved poorly in her interactions with the woman's daughter and nursing staff did not feel comfortable questioning her judgement, which contributed to the failure to commence end-of-life planning.

"This report highlights the importance of timely end-of-life care planning, in partnership with family, and the importance of updating care plans in accordance with palliative and end-of-life needs, and ensuring an environment where staff feel comfortable questioning or correcting the views of those senior to them," Ms Cooper said.

EHRV shared with HDC a number of changes made since the events, including changes to improve recognition of the signs of early deterioration, and to involve the family/whānau at the earliest point possible.

The Aged Care Commissioner recommended that EHRV provide a written apology to the woman's family; complete an audit to confirm that residents are receiving appropriate planning for end-of-life care and that regular assessments for symptoms are carried out near the end of life; and use the report as a basis for staff training.

4 September 2023

ENDS

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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