Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

**Shortcomings in hospital-level care by aged care provider**

**21HDC00401**

Aged Care Commissioner Carolyn Cooper has released a report today finding Calvary Hospital Southland Limited (Calvary) breached the Code of Health and Disability Services Consumers' Rights for hospital-level care provided to a resident.

The female resident had multiple comorbidities and had experienced a decline in mobility in the years prior to the event. The physiotherapist's plan outlined alternative mobility requirements instead of walking, which was found to be too fatiguing.

The woman suffered a fall, while being assisted with walking to the toilet by staff, which was contrary to the physiotherapists advice. She was later admitted to hospital. Following x-rays, which revealed two fractures, the woman was referred to palliative care, where she passed away a short while later. The case was referred to HDC by the Coroner, who had concerns about the care the woman received at Calvary.

Ms Cooper found Calvary breached the Code for failing to provide services with reasonable care and skill (Right 4(1)). This covered several shortcomings in care.

Coordination of care between staff in relation to the woman's mobility was inadequate. On several occassions, staff failed to follow the physiotherapist's instructions when mobilising the woman. Finally, there was a lack of post-fall assessment and a poor standard of documentation.

"The physiotherapist documented the woman's mobility requirements appropriately and in a timely manner in the clinical records, but I am critical that the oncoming staff did not review the clinical records to identify any changes in the woman's care plan," Ms Cooper said.

"In my view, the overall coordination of the woman's care between staff members at Calvary in relation to her mobility was inadequate."

Ms Cooper expressed concerns about the failure by several staff members to appropriately document the care provided. She noted that previous reports by this Office have stressed the importance of providers keeping full and accurate clinical records.

"Calvary has a responsibility to provide oversight of its staff in relation to the standard of documentation. In my view, these deficiencies indicate a pattern of poor documentation at Calvary, which I find concerning," she said.

Ms Cooper expressed her sincere condolences to the woman's family for their loss and acknowledged their distress in the days prior to her passing.

Since the events outlined in the report, Calvary has undertaken an internal investigation and identified a number of areas for improvement, including implementing a traffic light system to ensure patient mobilisation and handling requirements are explained clearly on the boards above patients' beds.

Considering these changes, Ms Cooper's recommendations for Calvary included for that they provide a formal apology to the woman's family and provide education/training to its staff on handover/coordination of care.

26 February 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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