Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Care home fails to provide appropriate standard of respite care for palliative care resident

20HDC01432

The Health and Disability Commissioner has found a care home breached the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide an appropriate standard of care to a respite patient.

The man, in his seventies at the time, had a complex medical history. He had been discharged home following hospital treatment for urosepsis , delirium and treatment for spinal cord compression, and was admitted to the care home, MLC 2011 Limited, for palliative respite care as his support needs were increasing.

The man's family raised concerns in relation to the care he received during his week at the care home, including pressure injury and fluid intake management, as well as a medication error.

They also complained about the appropriateness of the meals, personal cares, responses to call-bell activation, and supervision of medication trolleys.

Aged Care Commissioner, Carolyn Cooper, noted that the man's pressure injury management should have been supported by adequate and appropriate documentation, and that there were concerns with his hydration management and monitoring.

A medication error had occurred, although this was managed appropriately. While the man was becoming increasingly frail, given the cumulative nature of the issues with his care, she found MLC 2011 Limited breached Right 4(1) of the Code, the right to appropriate standards | Tautikanga.

Ms Cooper acknowledged that other issues raised by the man's family were concerning and did not align with the family's expectations of care delivery.

After a week-long respite admission at the care home, the man returned home. He was then admitted to a hospice and sadly passed away a few days later. Ms Cooper offered her condolences to the family.

The care home had since made several changes to its communication and documentation, and undertaken staff training.

Ms Cooper recommended that MLC 2011 Limited provide an apology to the family for the deficiencies in care highlighted in this report. As the residential care facility has changed ownership since the time of events, several recommendations were made for the new owners. These are outlined in the report.

22 July 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

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 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Read our latest Annual Report 2023

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

For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 6709