

Oceania Care breaches Code in care of vulnerable resident 20HDC02394

Oceania Care Centres have breached the Code of Health and Disability Services Consumers' Rights (the Code) by not providing an appropriate standard of care to a female resident.

The Aged Care Commissioner found both Otumarama and Whareama care centres breached Right 4 of the Code – tautikanga – the right to an appropriate standard of care. Whareama also breached Right 4(4) for failing to provide services that minimised harm and optimised quality of life. Sadly, the woman died while in the care of Whareama Care Centre.

The woman, who was in her 90s, had complex co-morbidities, was assessed as at a high risk of falling and had issues sustaining her weight. She was admitted to Otumarama Care Centre after a stay in hospital.

While she was there, she fell, which resulted in a bruise on her head and elbow. She was monitored in Otumarama for two days and progress notes mentioned it appeared that she was in pain and drowsier than usual. During this time the woman's daughter asked that her mother see a GP and have an x-ray. The clinical manager at the time recommended continued neurological observations as her's were still in normal range.

After two days however, the woman was admitted to hospital for further investigation. The hospital diagnosed delirium, and a superficial head injury, but noted that the woman had experienced significant weight loss, weighing just 44kg.

Carolyn Cooper said, "... several entries in the progress notes indicated that Mrs A had pain in her head and was deteriorating. However, her care was not escalated to hospital until two days later. ...For this reason I consider that Oceania Care did not provide an appropriate standard of care."

The woman's daughter asked for her to be moved to Whareama Care Centre where she was put on a nutrition management plan which included eating in the dining room so she could be monitored. The woman was also on oral medication to prevent an Addisonian crisis — a life threatening condition requiring oral hydrocortisone or, if that isn't possible, intravenous hydrocortisone. Her care notes emphasised the necessity of an immediate medical review with intravenous hydrocortisone being provided if the woman was unable to take her oral hydrocortisone.

On the day of her death, the woman's family found her in her room. Progress notes on that day report the woman's daughter was very worried that her mother may

have vomited up her morning dose of hydrocortisone. The woman was moved into the lounge, where she deteriorated and sadly passed away.

Carolyn Cooper was critical of Whareama Care Centre for not completing falls risk assessment plans, not undertaking nutrition assessments or performing enough weight loss monitoring, not having a personalised care plan and leaving the woman unsupervised while eating.

Additionally, Ms Cooper was critical that on suspicion of the woman not ingesting her oral hydrocortisone tablet, staff did not escalate her care to the hospital where the woman could have been given intravenous hydrocortisone.

Carolyn Cooper has recommended Oceania Care provide a written apology to the woman's family and use an anonymised copy of her decision for staff training. Both care centres are now closed.

15 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 '<u>Latest</u> <u>Decisions</u>'.

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 <u>Code of Health and Disability Services Consumers' Rights</u> (the Code).

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

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