Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

**Care home in breach of Code after woman suffers several falls**
**20HDC01617**

A care home has been found in breach of the Code of Health and Disability Services Consumers' Rights (the Code) after a woman suffered several falls.

The woman, in her nineties at the time, was a resident at a care home owned and operated by Chatswood Lifecare Limited. She suffered several falls, including two in one day in 2020.

The care home's long-term care plan for the woman identified a history of falls and noted that she was able to take herself to the toilet, but staff were to ensure that a low walking frame was always within reach and respond to the sensor mat or call bell quickly.

On the day the woman had two falls, following the first fall a nurse created a short-term care plan, which noted that the woman should be supervised at all times when she was moving, her walking frame kept within reach, and her call bell responded to promptly. It is unclear whether the plan was handed over to the caregiver.

The second fall occurred when the woman was briefly left on the toilet by a caregiver while the caregiver resumed the medication round to other residents. The fall resulted in the woman being admitted to hospital with a fractured hip and wrist. She was placed on a palliative care pathway and, sadly, she died a few days later.

Aged Care Commissioner Carolyn Cooper found that Chatswood Lifecare Ltd failed to provide services to the woman with reasonable care and skill and breached Right 4(1) of the Code.

Ms Cooper considered that the care home did not ensure that the woman was reviewed sufficiently frequently given her frailty and deterioration, did not take adequate steps to ensure that the caregiver was made aware of the woman's short-term care plan, and did not provide compatible policies.

Ms Cooper was also critical that the caregiver did not note down important information about residents at handover, and that she did not assess the woman adequately before moving her after her last fall.

The caregiver apologised in writing to the woman's family for the criticisms identified in Ms Cooper's report.

Ms Cooper recommended that Chatswood Lifecare Limited also apologise in writing to the woman's family, review its process for handover to ensure that incoming staff

are adequately informed of key requirements and resident issues, and put in place a system to provide support for caregivers in the rest-home wing during medication rounds, which Chatswood Lifecare Limited have since completed. Ms Cooper also recommended that Chatswood Lifecare Limited establish a programme of regular in-service training for staff on the assessment of falls risk, monitoring, maintaining mobility in the elderly and the importance of exercise for balance and strength, and accurate documentation in regard to falls management; consider developing a flow chart of the process to manage a falls incident; and develop more comprehensive policies covering the review of falls risks and when the use of a hoist is required.

4 December 2023

***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 the 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 recommendations.

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