Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC00063)

Introduction

1. This report is the opinion of Carolyn Cooper, Aged Care Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Ms B at an Ultimate Care Group Limited care home.

3. During Ms B's residence at the care home, she suffered numerous unexplained injuries. Ms B's son raised concerns with Ultimate Care Group (UCG) but an internal investigation failed to identify the cause of the injuries and concluded that they may have been caused by self-harm. A subsequent independent investigation commissioned by the District Health Board (DHB)[1] identified that several of Ms B's injuries were highly likely to have been caused by physical assault by other residents and concluded that UCG did not respond to Ms B's injuries appropriately or take action to ensure her safety at the care home. It was also found that UCG's investigation of Mr A's complaint did not meet accepted standards of consumer complaint management.

4. The following issue was identified for investigation:

- *Whether Ultimate Care Group Limited provided Ms B with an appropriate standard of care from June 2018 to November 2019 (inclusive).*

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to the DHB now refer to Te Whatu Ora.

5. The parties directly involved in the investigation were:

Mr A	Complainant/son
Ultimate Care Group Limited	Care home provider

6. Further information was received from:

HealthCERT	Certification body
Te Whatu Ora	District health provider/funding authority

How matter arose

Background

7. Ms B, a woman in her seventies with advanced dementia, was a resident in the dementia unit at the care home from June 2018 to November 2019. On 1 November 2019 Ms B's son and legal representative, Mr A, made a formal complaint to UCG about unexplained and under-reported bruising on Ms B's body and face. UCG commenced an internal investigation.

8. UCG's investigation report dated 4 November 2019 concluded that there was 'little evidence that other residents [were] involved in any altercation'[2] and that Ms B was at high risk of falls, which increased the likelihood of bruising. The report also identified that on several occasions caregivers had reported bruising in Ms B's progress notes, but Mr A had not been notified of this because the registered nurse on duty had failed to enter this into UCG's electronic incident and accident system. No further concerns were identified. UCG put in place a healthcare plan, which noted that Ms B 'sustains bruises very easily just from constantly walking around'.

9. Mr A was not satisfied with UCG's response, and he arranged to move Ms B to another facility on 27 November 2019. Mr A made further complaints to UCG expressing concern that Ms B had been the subject of physical abuse at the care home. On 10 January 2020 UCG provided a final response to Mr A advising that '[UCG had] provided the best possible care for [Ms B]'.

10. On 2 December 2020 Mr A made a complaint to the DHB alleging that Ms B had been subject to abuse and/or neglect at the care home and that UCG had been untruthful in its response to Mr A's complaint. The DHB commissioned a shared service agency[3] to conduct an independent issues-based special audit of the care home in light of the concerns raised in Mr A's complaint.

[2] Except for one witnessed and documented instance when Ms B attempted to enter another resident's room and that resident tried to push Ms B out of the room, causing her to fall.
[3] An agency that provides a range of strategic, advisory, and programme management services to health sector organisations.

Special audit report

11. The scope of the audit was to review the care provided to the complainant's mother and to seek assurance that there were no systemic issues regarding the care provided at the care home.

12. The audit report noted two limitations faced by the audit team.

13. First, several key staff members who had cared for Ms B were no longer employed by UCG. This included a former senior manager, who coordinated the complaint response, the facility manager of the care home, the manager of clinical services at the care home, and most of the registered nurses who had been employed at the care home at the time. The audit team interviewed staff who had been employed by UCG both at the time of the audit and during Ms B's admission, including the sole remaining registered nurse who had been employed at the time of Ms B's admission. The audit team noted that Mr A's complaint to the DHB had asked that the nurses who had allegedly failed to enter information about Ms B's injuries into UCG's electronic incident and accident system be given an opportunity to review and respond to these allegations. However, the audit report concluded that this request was not appropriate, 'as all staff are employees of UCG, and as such, UCG is responsible to speak and act for its employees'.

14. Secondly, the audit report noted that several key records were not available for the audit team to review. These included part of Ms B's paper-based clinical record, which could not be found.

15. Despite these limitations, the audit team identified several issues in the care of Ms B and the management of Mr A's complaints.

Care of Ms B

16. The audit team found that Ms B's bruises were likely to have been caused by a mix of probable unwitnessed physical assault by other residents,[4] possible unwitnessed rough handling by a staff member, and possible self-harm by banging into objects. Physical assault by other residents was believed to be the most likely cause of several of Ms B's bruises. The first instance of physical assault recorded in Ms B's progress notes was on 12 August 2018. Between April and November 2019 there were 14 documented instances of injuries, including bruising to Ms B's face and body, puncture wounds (such as from a fingernail), and possible 'grab mark' bruising. Many of these injuries were unexplained, and there were four instances of documented assault from other residents. The audit team concluded that it was not reasonable to assume that all of Ms B's bruises were caused by self-harm.

17. The audit team found that UCG did not respond to Ms B's injuries appropriately or take action to ensure her safety at the care home. The audit report noted that clear policy and associated procedures were in place that should have been followed by staff if they found or suspected that any resident was being harmed physically or was causing harm to other residents, and in this case, the policy was not followed. It was found that the documentation and staff responses over the time of Ms B's admission showed a culture of acceptance of

[4] The progress notes also document some instances of witnessed physical assault of Ms B by other residents.

bruising, a lack of documentation according to policy, a reluctance to consider all possibilities as to why Ms B sustained so many bruises, and acceptance of violence between residents in the dementia unit.

18. The audit team believed that Ms B had been passively neglected[5] in that UCG failed to provide her with safe care, which resulted in her being harmed on more than one occasion.

19. In addition to the concerns about the management of Ms B's bruising, the audit identified that Ms B had clearly lost weight steadily during her admission (approximately 8kg weight loss between June 2018 and September 2019). The report noted that this weight loss was not recognised in a care plan completed in November 2019. Because Ms B's clinical record could not be located, it was not known whether a graph or chart had been kept in her hard-copy record to show her monthly weight since admission. The audit report commented that such a chart would have clearly shown any clinician, including Ms B's GP, that Ms B was steadily losing weight and would have alerted clinicians to implement corrective actions and document these in her plan of care.

20. Further, the audit report noted that UCG's complaint response to Mr A stated that Ms B was 'unsteady on her feet and is a high risk of falls', but on her admission to the care home, Ms B had been assessed as having a low to no risk of falling,[6] and there was no evidence that her falls risk had been re-assessed subsequently. Despite this, a Lifestyle Plan completed for Ms B by a registered nurse and dated 22 May 2019 stated: 'Falls Risk — yes, need closely monitor.' This was negated by an interRAI assessment completed by a registered nurse on 1 October 2019, which stated that Ms B had not had a fall in the previous 180 days. Then, on 20 October 2019, an entry in the progress notes by a registered nurse stated: '[N]eed to monitor [Ms B] thoroughly as she has high risk for falls.'

21. The 'assessment and management of falls' policy in place at the time of Ms B's admission stated that where a falls risk was identified, the nurse was to complete a '5C1 Initial Nursing Assessment' for immediate management and interventions. Further, the policy required that monthly statistics and a separate record of falls be logged in the '6F5 Falls Summary' section of the resident's file, and the '6F5 Frequent Faller Clinical Assessment Tool' should be used at least three-monthly during quarterly GP reviews to assess residents who fall frequently to review the current interventions in place. The audit report noted: '[T]his documentation was not sighted.'

22. The audit report also stated:

> 'For [Ms B] to be assessed as a high risk of falling she would have needed a Coombes Falls Assessment score of 16 or more. To score 16 or more, there would need to be evidence of multiple falls in the previous six months, some degree of impaired mobility

[5] The Health and Disability Services Standard (HDSS) (NZS 8134:2008) defines passive neglect as 'refusal or failure by service workers, because of inadequate knowledge or disputing the value of the prescribed services, to provide basic necessities, resulting in harmful physical, psychological, material, and/or social effects'.
[6] On admission, Ms B scored 7 on the Coombes Falls Assessment form. The Coombes Falls Assessment is a tool for predicting falls risk: risk level 5–9 = low/no risk, 10–15 = medium risk, 16 or more = high risk.

> requiring the assistance of an aid or another person, some degree of cognitive impairment which showed a deterioration since admission, be on antipsychotic medication, have impaired sensory perception, and a degree of osteoporosis with a history of fractures.'

23. The audit report noted that there was no documented evidence sighted to support that Ms B fell frequently.

24. The audit team concluded that UCG did not provide Ms B with an appropriate standard of care.

Incident/accident reporting

25. The audit report identified deficiencies in the reporting of incidents/accidents at the care home. It was noted that staff did not have a practice of always informing guardians/family of incidents/accidents in a timely manner. In particular, the report stated that there was no record that family were informed when Ms B was verbally abused on 12 July 2018, or when she had a fall on 19 April 2019. Further, there was an 'unacceptable delay' in the family being informed that Ms B had been physically assaulted by another resident on 27 October 2019, as they were not informed until 30 October 2019.

26. The audit team said that UCG's open disclosure policy and incident/accident policy in use at the time of Ms B's care provided clear guidance for staff. The open disclosure policy stated:

> '[M]anagement shall actively promote a transparent consistent approach to full and open disclosure during the course of any aspect of resident service provision and where there is an instance of actual or potential adverse effect and/or harm to the resident … Any adverse, unplanned or untoward event shall be reported to the resident and/or their family/whānau or legal representative as soon as practically possible and within 24 hours of an event occurring.'

27. Further, the incident/accident management policy stated:

> 'Workers must report any incidents/accidents relating to residents … Completed forms are passed onto the [manager of the facility] and/or [the manager for clinical services] for review and risk assessment … Any risks rated "High or Extreme" must be logged in the H7S Management System (1Place) as soon as possible, for medium, low and negligible ratings please log in 1Place as soon as practicable.'

28. The incident/accident management policy also required staff to report incidents to the Ministry of Health using a Section 31 notice.[7] However, the audit report noted that completion of a Section 31 notice was not a required field in the incident/accident software in use by UCG, and there was no documentation in the incident/accident system that

[7] Section 31(5) of the Health and Disability Services (Safety) Act 2001 requires certified providers to notify the Director-General of Health about any health and safety risk to residents or a situation that puts (or could potentially put) the health and safety of people at risk, which includes assault of any kind.

showed that a Section 31 notice was completed and sent to the Ministry of Health as required. The Ministry of Health had not been contacted in relation to this matter.

29. The audit report concluded that UCG's policies were not complied with fully by management at the care home.

Complaints management

30. The audit team found that the investigation of Mr A's original complaint did not meet accepted standards of consumer complaint management, and it did not meet accepted business practice for records and risk management.

31. The audit team also concluded that Mr A's concern that he was not told the truth by senior members of UCG management team regarding the care of Ms B was justified. The audit team considered that the evidence showed that some communications between UCG and Mr A were not factual. For example, some communications gave conflicting and confusing accounts and did not always fully answer Mr A's concerns.

32. The audit report noted that the limited amount of documentation reviewed as part of UCG's internal investigation was of a poor standard and omitted the full facts when describing events. Further, it was found that the investigation of the initial complaint did not appear to fully investigate the question of whether there was any evidence to show that Ms B had been harmed by others. The complaint response contained only a vague reference to unwitnessed harm by other residents as being a likely reason to explain Ms B's bruising. The audit team concluded that the quality of the complaint correspondence provided in response to Mr A's complaint was poor.

33. UCG advised the audit team that a complaints register is held at facility level and another at head office level. However, there was no record at the facility or head office of any complaints received from Ms B's family during the period of her admission.

34. The audit team found that the system in place at UCG for recording consumer complaints at both the facility and the corporate level was not robust and failed to comply with UCG's internal complaints policy in the following ways:

- There was no evidence that Mr A's two informal verbal complaints (both made on 31 October 2019) were documented.
- The manager of the facility was not advised of Mr A's complaints immediately. Consequently, the complaints were not risk rated and logged into the complaints register.
- Mr A's formal complaints were not handled by the manager of the facility but rather by the former senior manager, and the manager for audit and compliance was not notified.
- A clear and accurate record of the complaint, subsequent action, and opportunities for improvement did not occur, as the investigation was not completed thoroughly.
- As a satisfactory outcome was not achieved, referral to an independent third party/ advocate for mediation/arbitration should have been made, but this did not occur.

- There is no evidence that Mr A was provided with a pamphlet or other information outlining the complaints process at the point the complaint was made.

35. The audit report noted that Mr A's complaint was acknowledged within five working days and further communication (advising of the results of the internal investigation) was made within 10 working days.

36. The audit team concluded:

- The acknowledgement process did not inform Mr A of his rights when making a complaint.
- The investigation of the complaint did not clearly inform Mr A of which components of his complaint were found to be justified or not justified following the investigation or were unable to be determined based on the evidence.
- The final response did not inform Mr A of any appeal process by UCG or how he could convey his satisfaction or dissatisfaction with the investigation.

Systemic issues

37. The audit team identified three systemic issues at UCG in relation to 1) records management, 2) quality and risk management documentation, and 3) the UCG management system.

Records management

38. When the audit team requested Ms B's clinical record for the purposes of the audit, UCG was unable to find her full paper-based clinical record. UCG's clinical records management policy required that paper-based clinical records be kept onsite at the care home, unless requested by the police via the coroner's office. This included archived records of discharged residents. It was unclear precisely how part of Ms B's file had been lost, but it was noted that the former senior manager took the file offsite during the investigation of Mr A's original complaint.

39. The audit team concluded that the inability to locate part of Ms B's paper-based clinical records was a breach of the Health (Retention of Health Information) Regulations 1996,[8] a breach of the Aged-Related Residential Care Services (ARRC) agreement,[9] which requires providers to comply with relevant legislation, and a potential breach of privacy legislation if confidential information was not stored securely.

40. Further, at the time of the onsite audit, UCG was unable to locate a complete set of its historical policies, procedures, and forms that were in use during the time of Ms B's

[8] The Health (Retention of Health Information) Regulations 1996 require providers to retain an individual's health records for a minimum of 10 years, beginning on the day after the date on which the provider last provided services to the individual.
[9] The ARRC agreement is a national contract between health funders and providers of residential care services.

admission.[10] It was identified that UCG did not have a policy on archiving of documents, including policies.

41. The audit team concluded that this was a breach of section 4A of the ARRC agreement, which requires providers to comply with all relevant legislation. This includes the Health and Disability Services Standards (HDSS).[11] At the time of Ms B's admission, the HDSS required that providers have a document control system to manage their policies and procedures to ensure that documents are 'approved, up to date, available to service providers and managed to preclude the use of obsolete documents'.[12] The audit report also noted that the HDSS required providers to provide the DHB with a copy of relevant documents on request.[13]

42. UCG was also unable to access electronic records of correspondence from its back-up systems.

Quality and risk management documentation

43. As noted previously, key policies and associated procedures reviewed as part of the audit were found not to have been followed by staff and management.

Management system

44. The audit noted that UCG is a large provider, and the care provided at facility level is overseen by multiple layers of management.[14] The report highlighted that the management controls in place at the time of Ms B's admission were not operating effectively, as evidenced by the fact that multiple staff and management did not follow UCG's policies.

Recommendations

45. The audit report recommended that the DHB consider requiring UCG to:

(1) Review its consumer complaints management policy and associated procedures and implement an ongoing audit system to ensure compliance.

[10] A hard copy file of these policies was located some weeks post the onsite audit. The audit team noted that UCG had a set of policies and associated procedures and forms in place to guide staff on the rules they must follow when carrying out their employment. The audit team found that on several occasions these had not been followed by UCG staff and management.

[11] NZS 8134:2008. In February 2022 NZS 8134:2008 was replaced by the Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021).

[12] As per criteria 2.3.4 of Standard 2.3 of the HDSS. Standard 2.3 requires: 'The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.'

[13] Section 10 of NZS 8134.0:2008. An audit of compliance with NZS 8134 is required to determine a service's level of attainment for relevant Standards. The audit framework sets out that to achieve an attainment level of 'fully attained', the service must be able to 'clearly demonstrate implementation (such as practice evidence, training, records, visual evidence) of the process, systems, or structures in order to meet the required outcome of the criterion'.

[14] Each facility has a clinical services manager, who reports to a facility manager, who reports to a regional manager, who reports to a regional operations manager, who reports to a general manager, who reports to a CEO.

(2) Review its records management practices to ensure that it complies with the ARRC agreement.

(3) Locate Ms B's missing clinical record or report this as a breach of privacy.

(4) Review its IT policies and procedures to ensure that in future it is better able to manage its business risk.

(5) Review and ensure that its management controls are effective and enable compliance with the ARRC agreement.

46. The audit report also suggested that the DHB could ask HealthCERT to follow up any of the above recommendations during the care home's next certification audit, which was due to occur before 6 August 2022.

47. On 3 December 2021, the DHB advised UCG that it was required to undertake several actions. These included that UCG acknowledge the failings identified in the special audit report, as well as complete recommendations 1, 2, 4 and 5. Regarding the issue of Ms B's missing clinical record as noted in recommendation 3, UCG was required to advise the DHB of the outcome of the Privacy Commissioner's findings of any outstanding matters relating to the lost records of Ms B. The DHB noted that its priority was ensuring that UCG was fulfilling its obligations for delivery of quality and safe services to protect the health and safety of current and future residents, and that the AARC agreement does not provide for financial recompense to residents or their families in such circumstances.

Mr A's response to special audit

48. Mr A told HDC that he considered that the special audit report was thorough. However, he said that he did not agree with the conclusion that it was not appropriate to allow the registered nurses who had allegedly failed to enter information about Ms B's injuries into UCG's electronic incident and accident system the opportunity to review and respond to these allegations.

UCG response to special audit and the DHB

49. In a letter to the DHB dated 22 February 2022, UCG acknowledged and apologised for the flaws in the management of Ms B's care, for the mistakes in how Mr A's complaints and queries were handled, and for the undue stress and concern caused to Ms B and to Mr A and family. Regarding the care of Ms B, UCG said:

> 'We acknowledge that our care should have been safer and better executed. We apologise for the aspects of our care where we have failed to intervene effectively in the injuries and distress caused to [Ms B] and [Mr A] and family.'

50. Regarding the internal investigation and complaints management, UCG said:

> 'We acknowledge that former staff's investigative and communication efforts resulted in the failure to detect and to seek to explain what was happening to [Ms B] to [Mr A] and to our management. This led to a failure to trigger most of the processes that we would usually employ when there is a problem with a service/resident care. There was

> also a lack of accurate, robust advice to our management which unfortunately led to misunderstandings when [Mr A] escalated his concerns to our Head Office.'

51. In its letter to the DHB, UCG outlined changes that had been made since events, and it committed to several action items to prevent and mitigate the risk of any future failure to detect, take seriously, escalate, and act effectively where a resident is at risk of any kind of harm, and to continue to make improvements to the care of its residents. The changes made are detailed later in this report.

52. In response to HDC's provisional decision, Mr A said that it was untrue that there was 'a lack of accurate, robust advice' to management. Mr A said that he emailed the Chief Executive Officer (CEO) of UCG about his concerns and provided his complaint and photographic evidence of Ms B's injuries. Mr A stated:

> 'Despite the seriousness of the issues, [the CEO] chose to do nothing but put complete faith in the managers and staff I was complaining about. He could have at least emailed me, phoned me, or written to me or asked for a meeting to explore the evidence further. He did none of these things.'

UCG response to HDC

53. UCG agreed to HDC relying on the findings of the shared service agency's special audit report to assist in forming an opinion as to whether there had been a breach of the Code with respect to the care provided to Ms B.

54. UCG acknowledged that the quality of its internal investigation process and report did not meet UCG's expectations. UCG said that the investigation process and report did not achieve an accurate snapshot of what had been happening to Ms B and therefore proved to be misleading as to the actions that were needed.

55. UCG told HDC: '[T]he team dynamics that led to [Ms B's] and [Mr A's] experiences were idiosyncratic to [the care home] during that time and were, in our view, unusual in [UCG].' UCG stated:

> 'Our assessment is that one former senior manager was trusted, as they had been many times before, to drive the investigation and complaints responses with facility management. They decided upon and conveyed the internal and external messaging which was relied upon by more senior management. These communications resulted in the misunderstanding in Head Office that there was no evidence of abuse and that [Mr A's] approach was at times somewhat unreasonable. This, combined with the then use of paper-based systems (e.g., no online visibility of the photos of bruising shared by [Mr A]) meant that resident information … could not be seen by other UCG senior or support staff inside or outside of the care home.'

56. UCG said that it regretted this deeply and apologised[15] for all undue pain, stress, and concern caused to Ms B, Mr A, and other family.

57. In response to HDC's provisional decision, Mr A said that it cannot be that the issues in Ms B's care were 'unusual', given that UCG's former senior manager (who coordinated the response to Mr A's initial complaint) had done this work 'many times before'. Mr A said:

> 'I am unclear how UCG can have any idea about how wide spread any issues are given the poor quality of investigative work performed by [UCG's former senior manager], their poor systems and processes and [the CEO's] refusal to explore the evidence even when serious problems are brought to his attention.'

58. UCG told HDC:

> 'This experience has been invaluable for our understanding of what happened and for assessing the risk of a current or future similar occurrence of not being able to detect, intervene and provide support where staff performance/behaviour is not as expected. Sadly, the timing of the audit process has not provided an opportunity for reflection and learning with the former staff who directly led [Ms B's] care or who dealt with the original concerns and complaints from [Mr A], but we are committed to better outcomes and communications now and in future.'

59. In response to the provisional decision, Mr A said:

> 'It should not have taken the audit [commissioned by the DHB] to pick up the culture of violence, abuse and neglect. Even if it did, [the CEO] could have contacted his former staff members himself to talk about their many failings.'

60. Mr A also noted his concern that the staff involved with Ms B's care may now be employed in other areas of the health sector and that this posed a risk for other vulnerable consumers. Mr A asked that the individual nurses 'who tolerated violence, neglect and abuse' of Ms B be 'held to account'.

Responses to provisional decision

Mr A

61. Mr A was given the opportunity to respond to the 'How matter arose' and 'Changes made since events' sections of the provisional decision. His comments have been incorporated into this report where appropriate. Mr A also said:

> 'As a general comment, I am unimpressed with the assertions that UCG have improved because they have updated their systems and processes and policy documents. When I

[15] This apology was contained within UCG's response to HDC. In response to the provisional opinion, Mr A said that he had, to date, 'never received any type of apology or acknowledgement [from UCG] of failings identified in the audit report'.

> originally placed [Ms B] in the care of UCG I read all the audit reports which seemed fine and then I was terribly let down.
>
> I have never complained about UCG's policy documents. It is the application of the policies which is the issue.'

UCG

62. UCG was given the opportunity to respond to the provisional decision. UCG acknowledged the distress caused to Ms B and her family from their experiences in the care home and with several personnel from UCG. UCG stated:

> 'We are very disappointed by and accept that important aspects of our facility's performance and of the head office support offered to [the care home] reflected unexpected and unwanted departures from our own expectations and industry Standards.'

63. UCG also advised that the issue relating to the loss of part of Ms B's clinical record had not been reported to the Privacy Commissioner. It appears that the missing records have not been found. UCG said:

> 'We have pursued confirmation of how the file was handled and stored at the time when [Mr A] complained in 2019 and after, including asking the former senior manager, [care home] staff and others what they knew/know about the file and/or if they have it. We have also searched UCG premises including but not limited to [the care home].'

Opinion: Ultimate Care Group — breach

Introduction

64. I acknowledge the distress caused to Ms B and her family as a result of the events described in this complaint. Ms B was a vulnerable consumer who relied on the staff at the care home to keep her safe and to report and address any concerns about her safety and wellbeing appropriately. Unfortunately, it appears that this did not occur and, as a result, Ms B experienced repeated injuries over a prolonged period, which may have been preventable if appropriate and timely safeguards had been implemented. This is unacceptable in any residential care setting, and especially in those providing dementia care to consumers such as Ms B who are unable to report their experiences.

65. I commend Mr A for his commitment and perseverance to ensure that his concerns about the care of his mother were, eventually, investigated appropriately. I note that it is because of Mr A's persistence that significant changes have been made at UCG to improve its systems and services to minimise the risk of similar events recurring. I thank Mr A for bringing his concerns to this Office.

66. I have undertaken a thorough assessment of the information gathered. In light of the thorough independent investigation undertaken by the shared service agency at the request of the DHB, and UCG's acceptance of the findings of the special audit report, I do not consider it necessary to re-investigate the facts of this complaint. I note that Mr A agreed

that the special audit report was thorough (despite disagreeing with some of the conclusions). Further, given the significant passage of time and changes in staff at UCG since events, I am mindful that any further evidence gathered at this stage may be less reliable. For these reasons, I accept the findings of the independent special audit report commissioned by the DHB and have relied on these, in addition to UCG's response, as the basis of my decision.

Care of Ms B

67. I acknowledge Mr A's concern that most of the individual nurses who were involved in Ms B's care have not been provided the opportunity to comment on the issues raised during the course of this complaint and the special audit findings. While I consider it important to give individual providers the opportunity to respond to concerns raised about their care, in this case it is clear that multiple staff at different layers of the organisation failed repeatedly in their duty to provide appropriate care to Ms B. This demonstrates a concerning pattern of poor care for which ultimately UCG is responsible at a service level. As I am not inclined to hold the individual nurses to account for the deficiencies identified in this case, I do not consider it necessary to seek further comment from them.

68. UCG had an organisational responsibility to provide Ms B with services of an appropriate standard. I am critical that UCG failed to:

- Respond to Ms B's injuries appropriately or take action to ensure her safety at the care home, including that her injuries were not documented, reported, or investigated appropriately;
- Recognise that Ms B was steadily losing weight over the course of her admission and, as a result, UCG failed to implement corrective actions and document these in her plan of care; and
- Undertake appropriate falls risk assessments when a registered nurse noted in Ms B's progress notes in May and October 2019 that Ms B was at risk of falling.

69. On this basis, I consider that UCG failed to provide Ms B with services in a manner that minimised the potential harm to her and optimised her quality of life. Accordingly, I find that UCG breached Right 4(4) of the Code of Health and Disability Services Consumers' Rights (the Code).[16]

Compliance with relevant standards

70. Under Right 4(2) of the Code providers must provide services that comply with legal, professional, ethical, and other relevant standards. I am critical that:

- UCG staff did not have a practice of informing family of incidents and accidents in a timely manner and failed to comply with UCG's open disclosure and incident/accident management policies;

[16] Right 4(4) states: 'Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.'

- UCG did not notify the Ministry of Health of incidences of assault against Ms B, as required under section 31 of the Health and Disability Services (Safety) Act 2001;
- UCG was unable to locate Ms B's full paper-based clinical records, in breach of the Health (Retention of Health Information) Regulations 1996; and
- UCG was unable to locate a complete set of its policies, procedures, and forms that were in use during the time of Ms B's admission, as required under the HDSS.

71. On this basis, I consider that UCG breached Right 4(2) of the Code.

Complaint management

72. Right 10(3) of the Code states that providers must facilitate the fair, simple, speedy, and efficient resolution of complaints. I am critical of several aspects of the way in which UCG managed Mr A's complaints, including the following:

- The two verbal complaints made by Mr A on 31 October 2019 do not appear to have been documented, and Mr A's informal and formal complaints were not logged into UCG's complaint registers.
- There is no evidence that Mr A was provided information about internal or external complaints procedures, including the availability of the Nationwide Health and Disability Advocacy Service or HDC.
- The internal investigation into Mr A's concerns was not completed thoroughly and, as a result, failed to identify the likely cause of Ms B's injuries that were the subject of Mr A's concerns.
- The complaint response contained factual inaccuracies and conflicting and confusing accounts and did not answer Mr A's concerns fully.

73. On review of the above deficiencies, I consider that UCG did not facilitate a fair resolution of Mr A's complaint and, accordingly, breached Right 10(3) of the Code.

74. Right 10(8) of the Code provides that as soon as practicable after a provider decides whether it accepts that a complaint is justified, the provider must inform the consumer of: (a) the reasons for the decision; (b) any actions the provider proposes to take; and (c) any appeal procedure the provider has in place. As found by the special audit report, at the conclusion of the internal investigation, UCG failed to inform Mr A clearly of which components of his complaint were found to be justified or not justified, or were unable to be determined based on the evidence. Further, UCG's final response did not inform Mr A of any appeal process by UCG or how he could convey his dissatisfaction with the investigation. Accordingly, I find that UCG breached Right 10(8) of the Code.

Changes made since events

75. I acknowledge that since these events UCG has made several changes to minimise the risk of similar events occurring.

Records management

76. In 2019 UCG replaced the paper-based resident records management system used during Ms B's residence in the care home with an electronic platform, e-Case. UCG said that e-Case has greater information security and transparency, better and more timely access to detailed resident information, and improved visibility for all supporting managers whether based at a facility or remotely.

77. UCG noted that while the implementation of e-Case was not driven by this complaint or any individual situation, the special audit report reinforced the benefits of an electronic system.

78. As part of the implementation of e-Case, UCG also reviewed its resident information-related IT policies and procedures.

Complaints management

79. UCG reviewed and updated its complaints education, policy, procedures, and forms and enhanced its internal transparency of complaints and feedback through the implementation of e-Case.

80. UCG said that it has revisited how complaints about abuse are handled. It said that while these complaints have been rare, the staff who worked on the special audit process and who now support UCG Regional and Facility Management have directly applied lessons from this situation when coaching regional and facility staff on complaints and concerns.

Organisational structure

81. UCG advised:

> 'We have implemented a new Organisational Structure with new expertise and capacity for ensuring better attention to and escalation of complaints. We have new clinical roles dedicated to monitoring resident e-files and giving real-time feedback to all of our Clinical Services Managers, Regional Managers and Facility Managers.'

82. UCG said that its national team structure now provides checks and balances to prevent, detect and disrupt the kind of team dynamics that thwarted more agile, appropriate approaches to Ms B's care and Mr A's concerns.

83. In response to the provisional decision, Mr A said: '[T]his is untrue in my experience.' He noted that following the audit report he sent a complaint letter to UCG requesting a refund of Ms B's fees. Mr A said that he received a response from UCG's new National Relationship Manager advising that they would respond to his concerns, but he never received a further response.

June 2022 certification audit

84. In June 2022 the shared service agency conducted a certification audit at the care home. The audit was conducted against the Health and Disability Services Standards Nga Paerewa[17] and the service contracts with the DHB. The audit process included a review of policies and

[17] NZS8134:2021.

procedures and resident and staff files, and observations and interviews with family, residents, management, staff, and a nurse practitioner.

85. Key findings of the certification audit, as they relate to this investigation, included:

- **The Code**: The service has implemented policies and procedures to ensure that services are provided in a manner that upholds patient rights and complies with the Code. Staff receive education on the Code, and there is evidence that the Code is implemented in everyday practice. Residents receive services in a manner that considers their dignity, privacy, and independence and facilitates their informed choice and consent.

- **Protection from abuse**: Policies are implemented to support residents' rights, communication, complaints management, and protection from abuse. Staff receive orientation and mandatory annual training on abuse and neglect. Staff interviews confirmed staff awareness of their obligations to report any incidences of suspected abuse or neglect. Staff and family/whānau interviews confirmed that there was no evidence of abuse or neglect.

- **Complaints management**: The service has a culture of open disclosure and a complaints policy and process that is in line with Right 10 of the Code. Complaints processes are implemented. Interview with the facility manager and a review of complaints in the complaints register indicated that complaints are investigated promptly, and issues are resolved in a timely manner. Interviews with the facility manager, staff, and residents confirmed that residents are able to raise any concerns and provide feedback on service. Residents and family/whānau stated that they had been able to raise any issues directly with the facility manager and clinical services manager.

- **Incident/accident reporting**: There is a policy requiring that family/whānau are advised within 24 hours of an event occurring. Review of documentation and staff and resident family/whānau interviews confirmed that timeframes are being met regarding informing a resident's family/whānau of events that have occurred.

- **Risk management**: Quality and risk management systems are in place. Meetings are held that include reporting on various clinical indicators, and quality and risk issues, and there is review of identified trends. The facility follows the UCG national adverse event reporting policy for external and internal reporting (where required) to reduce preventable harm by supporting system learnings. Notifications to HealthCERT under Section 31[18] were reviewed and had been completed for the appointment of the facility manager and clinical services manager.

- **Records management**: Systems are in place to ensure the secure management of resident and staff data. Resident care and support information can be accessed in a timely manner and is protected from unauthorised access.

[18] Health and Disability Services (Safety) Act 2001.

- **Care planning**: The individualised long-term care plans (LTCPs) are developed within three weeks of a resident's admission to the facility. Short-term care plans are developed for acute problems, for example infections and weight loss. The nursing progress notes are recorded and maintained. Monthly observations such as weight and blood pressure were completed and are up to date.

86. The certification audit identified one corrective action that was not directly related to this complaint.

87. On 21 November 2022 Te Whatu Ora wrote to UCG acknowledging the changes that had been made in UCG's information systems and management team structures. Te Whatu Ora noted that the June 2022 certification audit had confirmed that the care home had demonstrated that it met requirements in relation to management controls and compliance with the ARRC agreement, including the complaints policy and processes. Te Whatu Ora confirmed that it considered Mr A's complaint closed.

Recommendations

88. In light of the changes already made and the findings of the June 2022 certification audit, I recommend that UCG:

a) Provide a written apology to Ms B and her family for the breaches of the Code found in this investigation. The written apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

b) Report the matter relating to the loss of part of Ms B's clinical records to the Privacy Commissioner. Confirmation of this is to be provided to HDC within three weeks of the date of this report.

c) Use this case as a basis for further developing the existing education/training for staff on:

(i) Detection and reporting of abuse and neglect; and
(ii) Complaints management.

Evidence confirming the content of the education/training (for example, training material) and delivery (for example, attendance records) is to be provided to HDC within three months of the date of this report.

Follow-up actions

89. A copy of this report with details identifying the parties removed, except Ultimate Care Group Limited, will be sent to Te Whatu Ora, HealthCERT, the Nursing Council of New Zealand, the New Zealand Aged Care Association, Age Concern New Zealand, and Grey Power New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.