Decision 21HDC03014
24 November 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Multiple failings in woman's care by aged care facility

1. On 30 November 2021, the Health and Disability Commissioner (HDC) received a complaint from Ms A about the care provided to her aunt, Mrs B, by an aged care services provider (the provider) at one of its aged care facilities (the facility) in the North Island. Ms A raised concerns that, during Mrs B's stay at the facility, she experienced inadequate care, and staff were unprofessional in their interactions with Mrs B and her whānau.

Information gathered

2. Mrs B was severely sight impaired with a medical history that included type 2 diabetes, hypertension, and hyperlipidaemia.[1] She was also functionally incontinent,[2] wore incontinence products, and used the toilet six to seven times at night. Mrs B preferred to use furniture for support to help her when walking around at home rather than using a walking aid. However, this led to Mrs B falling over frequently, including in June 2021 when she fell and remained on the floor for approximately six hours. Due to Mrs B's high risk of falling and to ensure her mobility was closely supervised, she was admitted to an aged care facility at hospital-level care on 10 August 2021, which was during the COVID-19 pandemic. Mrs B was subsequently discharged to another provider on 2 November 2021.

3. Ms A said that Mrs B was concerned about '… how staff treat her, how they don't identify themselves when entering her room, they turn her bell off and she fears for her safety, they are aggressive and verbally short with her, and she doesn't feel valued or listened to'. Ms A said that Mrs B felt that she was being punished because of her incontinence;[3] felt neglected and abused; and was sometimes left cold at night when staff refused to put warm clothes or blankets on her. In addition, Ms A stated that the facility had put Mrs B on a two-hourly toileting regimen every night (due to issues of incontinence) but without her input or follow-up to see if it was working.

4. Ms A said that communication with management was confusing as they did not know who was in charge of the facility. Ms A said that she complained verbally about this on 26 and 28 October 2021 and asked interim manager, Ms C, to follow up on her complaints. However, Ms A said that Ms C advised that complaints would be acted on only if they were in writing. Ms A said that contacting management over the weekend for emergencies was 'impossible', and no one followed up with Mrs B or her whānau in response to their complaints. Ms A felt that concerns raised by the whānau were ignored by the facility.

[1] Abnormally high levels of lipids (fats) in the blood.
[2] Difficulty or inability to get to the toilet because of limitations such as mobility issues, cognitive decline, or environmental barriers but not due to problems with the bladder or bowel.
[3] The progress notes detail numerous occasions in August, September, and October 2021 when Mrs B required staff assistance with multiple toilet visits during the day and/or the night.

5. At a hui-ā-whānau[4] with HDC on 2 August 2024, Mrs B's whānau expressed their concern that the aged care service provider's actions breached her right to support, her ability to communicate effectively, her right to receive a reasonable standard of care, as well as her mana and wairua.

6. On 31 May 2022, the provider advised that, after reviewing Mrs B's clinical file, it acknowledged failings in communication, a lack of empathy and patience towards Mrs B, and a standard of care that did not meet its expectations.

7. The provider was unable to provide written evidence of pre-admission communication with Mrs B or her whānau and suggested that much of that communication would have been verbal. The provider noted that families would usually be given a 'Welcome Pack', which presumably happened in Mrs B's case. However, it was difficult to say what the 'Welcome Pack' would have consisted of in August 2021. The provider advised that it was unclear how pre-admission conversations were documented.

8. The provider produced nursing admission notes and an Initial Assessment and Care (IAC) plan, which included guidance on Mrs B's mobility and continence needs. However, the provider concedes that Mrs B's continence needs were not documented to the expected standard on the IAC or the continence assessment form.[5] The IAC also did not state what support Mrs B needed for her diabetes.

9. The provider also advised that Mrs B's file did not include blood glucose monitoring results, despite Mrs B having type 2 diabetes, or any short-term or long-term care plan. As a result, care home staff were not aware of the care Mrs B required.

10. The provider also noted that some staff had made unprofessional and personal statements about Mrs B in their progress notes. The provider said staff appeared to be unaware or uncaring about the fact that Mrs B was severely sight impaired, staying in an unfamiliar environment, and totally reliant on staff. The provider expressed its disappointment at Mrs B's two-hourly toilet regimen and suggested that investigating Mrs B's polyuria[6] would have been best practice.

11. The provider's internal review identified numerous shortcomings in the care it had provided to Mrs B relevant to this investigation, including:

    - Staff had not appropriately used Behaviour Recording Charts and did not appear to have prepared a long-term care plan for Mrs B.

    - There was no evidence that the facility's General Manager at the time had followed the complaints process.

[4] A culturally based meeting facilitated by HDC to help resolve complaints using Māori methods and protocols and to reach a better, more collaborative resolution for whānau (families) and consumers.
[5] A specific form used to assess the continence care needs of a person entering residential care.
[6] The excessive production and excretion of urine, typically defined as more than three litres per day in adults.

12. I also note that, on 6 January 2022, the facility's General Manager sent a letter to Mrs B via the Health Consumer Service Trust.[7] The letter apologised for any of the facility's actions that may have contributed to the distress experienced by Mrs B or her whānau and outlined changes and improvements that had been made.

Responses to provisional opinion

13. Ms A was given the opportunity to comment on the 'Information gathered' section of the provisional opinion. Her comments have been addressed in separate correspondence.

14. The provider was given the opportunity to respond to the provisional decision. In its response, the provider set out further changes it has made to address the issues raised in this complaint (which have been outlined in this report where relevant). The provider also stated its agreement that an anonymised copy of this report should be published so that the provider and other aged care service providers can utilise it as a learning tool.

Opinion: Aged care services provider – breach

15. In-house clinical advice was obtained from registered nurse (RN) and Aged Care Advisor, Jane Ferreira (**Appendix A**), on the care provided to Mrs B between August and November 2021. I have relied on this advice, and I have taken careful note of the shortcomings in care the provider had identified through its own review process, in forming my decision on the appropriateness of the care provided to Mrs B.

16. Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) provides that every consumer has the right to have services provided that comply with professional standards.

17. The Ngā Paerewa Health and Disability Services Standard[8] (the Standard) sets out the minimum standards necessary to provide fair and equitable health and disability services in New Zealand. Clause 3.1.1 of the Standard provides that, during the initial engagement prior to service entry, service providers shall ensure there is accurate information about the service available in a variety of accessible formats. Clause 3.2.1 provides that service providers shall engage with people receiving services to assess and develop their individual care or support in a timely manner. Clause 3.2.2 provides that care or support plans shall be developed within service providers' model of care.

18. I accept RN Ferreira's advice that there is limited evidence of communication with Mrs B and her whānau in the preadmission phase to discuss her admission or any specific requirements or goals for her care. RN Ferreira also advised that there is no evidence of:

- nursing admission assessments, reference to any handover information, or commencement of short-term care plans to support Mrs B's care and safety across shifts during the settling in phase
- a care summary to outline Mrs B's daily requirements

[7] The Trust had assisted the whānau in making a complaint to the aged care facility.
[8] NZS 8134:2021.

- a transfer plan to provide guidance to staff about Mrs B's range of mobility, or her required level of support to reposition given her identified high care needs.

19. RN Ferreria advised that this represents a moderate to significant departure from accepted practice. I accept this advice and am critical of this aspect of the care provided by the facility.

20. I accept RN Ferreira's advice that there is no evidence that an RN completed a continence assessment to identify Mrs B's toileting needs or that an agreed care plan for her toileting was put in place while she was at the facility.

21. I accept RN Ferreira's advice that there is limited evidence that Mrs B's frequent toileting requests were escalated to an RN or medical practitioner for further assessment or intervention.

22. I also accept RN Ferreira's advice that overall, the care provided to Mrs B represents a moderate to significant departure from accepted practice. Therefore, cumulatively, I find the provider in breach of Right 4(2) of the Code.

Opinion: Aged care services provider – adverse comment

23. Ms A raised concerns that the facility did not act appropriately on the concerns raised by the whānau. RN Ferreira notes that there are eight entries in the records of staff interactions with Mrs B's whānau. However, there is no record of meeting minutes between the facility's leadership team and Mrs B and her whānau in relation to concerns raised by the whānau. RN Ferreira also noted that there were no internal policies to outline the process for managing feedback and complaints. RN Ferreira advised that the standard of communication with Mrs B and her whānau, and the facility's complaints management, met the lowest level of acceptable professional standards. I accept this advice.

24. It is clear that the provider did not have policies in place to guide appropriate complaints management and did not respond appropriately to the concerns of the whānau, and I note that the provider has accepted these shortcomings. While I am critical of the provider in this respect, I also acknowledge the corrective steps it has since taken, and its apology to Mrs B's whānau. Regardless, I encourage the provider to reflect on my comments and those of RN Ferreira.

Changes made since the events

25. As noted above, the provider has advised on corrective steps it has taken since receiving this complaint. These include:

- The appointment of a new Clinical Nurse Leader, new administrator, new manager, and two new RNs; and
- The introduction of education sessions to ensure staff are aware of expectations and understand the anxieties that new residents can have and the complexities of their care. The sessions will cover communication, the Code of Rights, neglect and abuse, behaviours that challenge and how to complete the Behaviour Reporting Chart, person-centred care, incident reporting, short term care planning, correct documentation standards, the complaints process, and pain management and monitoring. The staff

education programme would include input from the Blind Foundation, the Deaf Association, the Parkinson's Society, and the Stroke Foundation.

26. In response to the provisional decision, the provider advised that it has reflected on the recommendations and feedback received in relation to this complaint. An anonymised version of this complaint will be shared within the organisation to ensure staff can learn from these events.

27. The provider also advised that it has recently formulated a 'Facilitator's Guide to Communication'. This resource is to be shared across the organisation. The provider has also organised an education session on cultural awareness.

Recommendations and follow-up actions

28. I accept RN Ferreira's recommendation that the provider undertake further education and training to all staff about effective communication and the delivery of culturally safe care. RN Ferreira notes that cultural safety is an outcome '… that enables safe service to be defined by those who receive the service'[9] and involves the principles of trust, open communication, and active listening, with a focus on two-way communication between the consumer and the healthcare provider to ensure safety, equity, and partnership in care. Evidence that this education and training has been conducted should be provided to HDC within six months of the date of this report.

29. A copy of the sections of this report that relate to the provider will be sent to HealthCert and the Ageing Well team at Health NZ.

30. An anonymised copy of this report, naming only my advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

[9] Guidelines for Cultural Safety, the Treaty of Waitangi, and Māori Health in Nursing Education and Practice, Nursing Council of New Zealand, 2011.

Appendix A: In-house clinical advice to the Commissioner

The following in-house advice was obtained from Jane Ferreira, Aged Care Advisor:

CONSUMER : [Mrs B]

PROVIDER : [Aged care facility – North Island]

FILE NUMBER : C21HDC03014

DATE : Thursday 27 October 2022

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1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the aged care facility]. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. **Documents reviewed**
   I have been provided with the following information to base my review on:

   - Provider response dated 31 May 2022
   - Clinical documentation, including incident reports, monitoring forms, resident progress, and medical notes
   - Consumer complaint

3. **Complaint**
   [Mrs B] was admitted to [the aged care facility] at hospital-level care from her home on 10 August 2021 and discharged to another provider on 2 November 2021. Whānau report that, during [Mrs B]'s stay, she experienced inadequate care and that staff were unprofessional in their interactions with [Mrs B] and with her whānau.

4. **Review of clinical records**
   For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

   In particular, comment on:

   a) Whether the nursing care was appropriate during [Mrs B]'s stay at the care home.
   A review of the submitted clinical documentation indicates there were missed opportunities to complete nursing assessments, care planning, and care delivery processes for the duration of [Mrs B]'s stay at the care home. As identified in the provider response, communication and documentation standards do not appear to meet the accepted professional practice requirements and timeframes for service providers under the Health and Disability Service Standards.

The reviewed clinical file documentation provides limited evidence of communication with [Mrs B] and her family/whānau in the preadmission phase to discuss her admission, any specific requirements, or her goals for care. There is no evidence of nursing admission assessments, reference to any handover information, or commencement of short-term care plans to support [Mrs B]'s care and safety needs across shifts during the settling in phase. There is no evidence of a care summary to outline [Mrs B]'s daily requirements, nor a transfer plan to provide guidance to staff about [Mrs B]'s range of mobility or required level of support to reposition given her identified high care needs.

The available preadmission information included a comprehensive assessment completed on 26 June 2021 by a Clinical Nurse Specialist (CNS) and an interRAI Home Care assessment completed on 14 July 2021 to support placement in aged residential care. The CNS report provides a thorough account of [Mrs B]'s health status, self-care abilities, and required levels of support. The report discusses [Mrs B]'s limited mobility, high falls risk, concerns with obesity, and challenges with all activities of daily living due to her profound visual impairment. Associated concerns relate to medication and continence management, personal care, and safety needs. The interRAI report concurs with the CNS report and provides supporting assessment comments relating to [Mrs B]'s level of functioning and ongoing care wishes.

Preadmission information provides detailed communication about a resident when transferring care responsibilities between service providers. Admission nursing assessments provide an opportunity to review the clinical handover data and inform care planning, as part of the nursing process. There appears to be no reference to any preadmission information by registered nurses to guide care staff about specific care and communication strategies to support [Mrs B] to orientate to her new home.

As identified in the provider response, there are identified opportunities for improvement in clinical documentation standards. Entries in reviewed progress notes describe care delivery occurring, with statements from care staff outlining daily activities and support provided to [Mrs B]. Several entries provide objective and subjective information with judgemental statements that show a lack respect for the consumer, and as discussed by the provider, are below accepted practice standards.

Behaviour monitoring forms were commenced on 3 September, which qualified and care staff completed over a period of weeks until 31 October 2021. There is a comment on page 1 which states '*capture any complaints please'*; however, the wider purpose for monitoring is unclear. There is no evidence of review by a registered nurse to identify themes of distress, triggers to behaviour events, or apparent analysis to inform corrective actions.

The preadmission information discusses [Mrs B]'s medical history of diabetes and hypertension with headaches; however, there is no evidence of monitoring of blood glucose levels, vital signs, or consideration of pain and the potential impacts to her wellness, mood, and behaviour. There was no evidence provided to address skin integrity, nutritional needs, weight, continence, and bowel management.

The incident report for the unwitnessed fall event on 3 September 2021 provides evidence of first aid measures, including recording of vital signs and neurological assessment prior to hospital transfer, which is in line with accepted practice. It is unclear if pain assessments were completed at the time of the fall or on a regular basis during her post-fall recovery. There is evidence of a review of [Mrs B]'s falls risk on 3 September 2021, with an update to the incident report on 4 September 2021; however, there is no evidence of registered nurse review of her care and safety needs, nor a GP [General Practitioner] review on her return from hospital in the clinical notes. [Mrs B] was assessed by a physiotherapist post-fall with a range of exercises to support the left ankle injury. There is noted improvement reported in physiotherapy notes; however, there is no evidence of a short-term care plan completed by a registered nurse to support professional nursing care responsibilities.

As outlined in the provider response, the care home team who were in post at the time of [Mrs B]'s admission did not appear to complete an interRAI assessment nor commence any related care planning for [Mrs B] during her stay at the care home. There is limited evidence of registered nurse input to her care, and the clinical oversight, direction, and delegation of care responsibilities is unclear in the hospital-level community. There is no evidence of care evaluation as part of the nursing process to support discharge planning and handover to [Mrs B]'s next care provider, which is the accepted standard of practice to ensure continuity of person-centred care between service providers.

The provider's response letter acknowledges there are departures from accepted care standards and service provider responsibilities. The response has provided discussion of corrective actions, including recruitment of new staff with an extensive list of proposed education sessions. Evidence of completion of these actions was not provided at the time of case review.

For this question, I believe the care delivered to [Mrs B] was of the minimum and/or lowest level of acceptable professional standards. There is limited evidence of nursing assessment, care planning, and documentation to safely support her care needs. This is a moderate to significant deviation from accepted practice, and it would be viewed similarly by my peers.

b) Was the approach to [Mrs B]'s continence management appropriate?
According to the CNS report, [Mrs B] experienced '*functional urinary incontinence and visits the toilet very often to keep her dry*' and reportedly visited the toilet six to seven times at night. Due to her visual impairment, she slept intermittently day and night, preferring to remain in her room in a familiar environment. This information is also reflected in the interRAI assessment completed in July 2021.

The complaint information outlines concerns expressed by [Mrs B]'s whānau that the care home put [Mrs B] on a two-hourly toileting schedule every night, without her input. [Mrs B] reportedly expressed distress with the '*toileting rule*' to her whānau, who advised it was causing her unnecessary stress, and impacting her mental health and wellbeing.

On review, there is no evidence within the clinical records that a continence assessment was completed by a registered nurse to identify [Mrs B]'s toileting needs, or an agreed plan of care implemented to support her toileting requirements while she resided at the care home. Progress note entries discuss regular interactions between [Mrs B] and care staff regarding call bell activity for frequent toileting requests; however, there is limited evidence of escalation of concerns to a registered nurse or medical practitioner for further assessment or intervention.

The preadmission information described [Mrs B] as '*determined*' with a desire to maintain a level of choice and independence. The ARRC Services Agreement and Health and Disability Service Standards require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. Care decisions are made in partnership with the resident, their nominated representative, and registered nurses at the care home. Evidence of these interactions, including health education and informed consent, is required to be documented in the resident's family contact record, care plan, progress notes, and meeting minutes.

For this question, I believe the care delivered to [Mrs B] was of the minimum and/or lowest level of acceptable professional standards. There is no evidence of specific nursing assessment or a personalised plan of care developed in partnership with [Mrs B], or her nominated representative, to support her continence requirements. Progress note entries reflect a lack of clinical leadership by qualified staff and understanding, support, and respect by some members of the care team, which provides an opportunity for further education and training on professional documentation standards. This is a moderate to significant deviation from accepted practice, and it would be viewed similarly by my peers.

c) Whether communication between [Mrs B], her family/whānau, and the care home team was appropriate during [Mrs B]'s admission.

The consumer complaint discussed visiting difficulties during [Mrs B]'s admission to the care home and related communication issues. I acknowledge the distress experienced by [Mrs B] and her whānau during the COVID-19 pandemic. The pandemic was a challenging time for all residents, family/whānau, and care home teams in Aotearoa New Zealand, with frequent changes to health guidance and care home visiting criteria. The provider has submitted copies of local documents that were sent to nominated resident representatives that outlined preferred approaches to the management of COVID-19, which appear to be within accepted practice standards at the time.

The consumer complaint also refers to a lack of acknowledgement and feedback in response to their concerns. The family/whānau record provides eight entries of interaction with [Mrs B]'s whānau during her admission, but there is no evidence provided of meeting minutes between the care home leadership team, [Mrs B], or her whānau, regarding expressions of care or conduct concerns. Company policies were not included in the evidence bundle to outline the care home process for managing feedback and complaints; however, the provider response has acknowledged identified gaps with communication and documentation standards and discussed steps for corrective

actions. As outlined in the provider response, a formal apology was sent to [Mrs B] and her whānau on 31 December 2021, which they accepted as evidenced.

Open and respectful communication with a resident and their nominated representative is a significant part of service provider responsibilities and a fundamental part of providing culturally safe healthcare. For this question, I believe the standard of communication with [Mrs B] and her whānau, and the process of complaint management, is of the minimum and/or lowest level of acceptable professional standards and would be viewed similarly by my peers.

5. Cultural advice

Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice (Nursing Council of New Zealand, 2011) states: 'Cultural safety is an outcome of nursing education [and nursing practice] that enables **safe service to be defined by those who receive the service**.'

The principles of cultural safety involve trust, open communication, and active listening, with a focus on two-way communication between the consumer and healthcare provider to ensure safety, equity, and partnership in care.

In addition to the provider's list of corrective actions, a recommendation from this clinical review would be the provision of further education and training to all staff about effective communication and the delivery of culturally safe care.

Jane Ferreira, RN, PGDipHC
Aged Care Advisor