



Health and Disability Commissioner  
*Te Toihau Hauora, Hauātanga*

## **Multiple breaches of Code by aged care home in care of women with dementia**

**22HDC00063**

The Aged Care Commissioner has found that aged care service provider Ultimate Care Group (UCG) breached multiple rights of the Code of Health and Disability Services Consumers' Rights (the Code) in its care of a vulnerable resident with advanced dementia.

Carolyn Cooper found that UCG breached:

- Right 4(4) — the right to services of an appropriate standard provided in a manner that minimises harm and optimises quality of life
- Right 4(2) — the right to services that comply with legal, professional, ethical, and other relevant standards
- Right 10(3) — the right to the fair, simple, speedy, and efficient resolution of complaints
- Right 10(8) — the right to complain — and where, once a provider has accepted a complaint, the reasons for its decision are communicated clearly, as are its actions taken to address the complaint and the complainant's rights to appeal decisions

The breaches came to light following the woman's son complaining about the care of his mother over a period. He was concerned about the quality of an internal investigation into numerous unexplained injuries, which failed to find a cause and concluded that they could be the result of self-harm.

'I acknowledge the distress caused to Ms B and her family. Ms B was a vulnerable consumer who relied on the staff to keep her safe and to report and address any concerns about her safety and wellbeing. 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,' said Ms Cooper.

An independent investigation commissioned by Te Whatu Ora found that several of the woman's injuries were likely to have been caused by physical assault by other residents. The findings of the investigation report included that despite clear policies and procedures in place, UCG did not respond to the woman's injuries appropriately and failed to take action to ensure her safety. The report concluded that the woman had been passively neglected and that the facility had a culture of accepting behaviours of concern between residents that caused harm. It also found that UCG's

investigation into the son's complaint did not meet accepted standards for consumer complaint management.

Ms Cooper considered that the independent investigation had been thorough and she accepted the findings of the report. She was critical of UCG's failure to respond to the woman's injuries appropriately or take action to ensure her safety, including that her injuries were not documented, reported, or investigated appropriately. Ms Cooper was also critical that UCG failed to recognise that the woman was steadily losing weight and failed to undertake appropriate falls risk assessments. On this basis, Ms Cooper found that UCG did not provide the woman with services in a manner that minimised the potential harm to her and optimised her quality of life, in breach of Right 4(4).

Ms Cooper also found that UCG failed to provide the woman with services that complied with relevant policies and standards relating to open disclosure, incident and accident management, Ministry of Health reporting requirements, and retention of health information and records management. Ms Cooper therefore found that UCG breached Right 4(2).

Lastly, Ms Cooper was critical of several aspects of UCG's management of the woman's son's complaint. These included that he was not provided with information about internal or external complaints procedures and that UCG's internal investigation was not completed thoroughly, contained factual inaccuracies, and did not answer the son's concerns fully. Ms Cooper considered that these deficiencies breached Right 10(3). Further, Ms Cooper was critical that UCG's final response to the son's complaint did not inform him of any appeal process or how he could convey his dissatisfaction with the investigation, in breach of Right 10(8).

Ms Cooper acknowledged the changes made by UCG since the complaint was raised. She recommended that UCG provide a written apology to the woman and her family, report missing clinical records for the woman to the Privacy Commissioner and use this case as a basis for more staff training on complaints management and the detection and reporting of abuse. She has asked UCG to report on progress of these recommendations.

UCG has since implemented a new electronic resident records management system and reviewed its resident information-related IT policies and procedures. It has reviewed and updated its complaints education, policy, procedures and forms, and how complaints about abuse are managed. A new organisational structure has been put in place and new clinical roles have been created to focus on monitoring of resident e-files and giving real-time feedback to managers.

An independent audit has since found that UCG's care facility was compliant with its service provision contracts with Te Whatu Ora.

Health and disability service users can now access an [animated video](#) to help them understand their health and disability service rights under the Code.

***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 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 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendations.

Learn more: [Education](#)