Common errors in aged residential care settings contributing to statutory complaints: a review of cases investigated by the Health and Disability Commissioner in New Zealand

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ABSTRACT

AIM: Statutory agencies such as the Health and Disability Commissioner (HDC) of New Zealand and the Australian Aged Care Quality and Safety Commission investigate complaints when significant health and safety breaches are identified in aged residential care (ARC). This study aims to identify the human factors that lead to complaints to the HDC in New Zealand ARC. Complaint analysis can identify areas to prioritise to mitigate future complaints and improve quality of care.

METHOD: Yin's multiple-case study design was used to guide the research. Cross-case conclusions were drawn using Braun and Clarke's thematic analysis. Twenty-four HDC complaint cases from 2007 to 2021 were investigated using stratified randomised selection across three large ARC organisations.

RESULTS: The analysis showed four themes recurred most frequently in the 24 cases examined: 1) communication flaws; 2) documentation gaps; 3) policy-to-practice inconsistencies; and 4) staffing shortages and skill mix insufficiencies.

CONCLUSION: The analysis indicated commonly recurring problems. The investigative system could be more effectively managed by proactively investing in a human factors approach, such as the Systems Engineering Initiative for Patient Safety lens, rather than the current approach, which is more likely to apportion blame to individuals. This shift would mean that organisations could avert many harms by engaging experts to examine their complex system holistically and identify multiple parts of the system that contribute to events that currently come before the HDC.

With ageing, the number of people experiencing chronic diseases increases.[1] Consequently, they have a higher rate of disability that requires regular support.[2] If people cannot be supported in the community, they often end up living in aged residential care (ARC). In New Zealand the needs of older adults living in residential care are identified with an in-depth interRAI assessment every 6 months. According to the latest publicly available interRAI reports,[3] 33,060 people reside in ARC in New Zealand.

It is the right of all residents within ARC to receive high-quality care and to complain if this level of care is not provided.[4] With many vulnerable people residing in communal settings, the quality and safety of care must meet expected standards, necessitating continuous monitoring by agencies to assess the care residents receive.[5] Providing high-quality aged care is critical, and healthcare systems are designed to support older adults' increasing care needs, especially for those unable to live safely in the community.[2] To ensure quality, watchdog agencies in New Zealand monitor the services offered by ARC; in New Zealand, ARC is regulated by the Ministry of Health – Manatū Hauora (MoH), with all facilities currently required to be certified and audited to ensure they provide safe, appropriate care for their residents and meet the standards set out in the *Health and Disability Services (Safety) Act 2001*.[6]

Although regulations and policies are in place to monitor safe care, complaints occur frequently. In New Zealand, serious complaints are investigated by the Health and Disability Commissioner (HDC). For four consecutive years between 2020 and 2023, ARC facilities in New Zealand have

been the third most complained-about area scrutinised by the HDC, preceded by hospitals and medical/general practitioner (GP) care. By occupation, registered nurses (RNs) are the third most complained-about profession, following GPs and midwives.[7] These in-depth investigations involve interviews with those involved and analysis of clinical records, clinical notes and incident forms before deciding whether the provider breached the statutory Code of *Health and Disability Services Consumers' Rights* stipulated by the HDC legislation.[7] The HDC received 183 complaints regarding ARC during the 2022/2023 period.[7] Complaints investigated by the HDC are multifaceted, with common issues related to sector workforce challenges. Similarly, in Australia, there is a national aged care regulator whose goal is to protect and enhance older adults' health, wellbeing, quality of life and safety, called the Australian Aged Care Quality and Safety Commission (ACQSC). Table 1 combines and summarises the top 5 main complaints as categorised and reported by the HDC and the ACQSC.[8]

This study is part of a wider research project that focussed on the morbidity and mortality outcomes of complaints from 24 complainants.[9] All cases investigated centred around the deteriorating patient—this occurred in all the cases investigated (cases 1–24), and of these 75% (n=18/24) resulted in the resident's death.[9] These preliminary findings highlighted that within the rich narratives of the HDC complaints, many complainants blamed each other, i.e., organisational leaders blamed employees and employees blamed the workplace structures for the events. Besides our previous study,[9] only one other study has examined complaints from the HDC in New Zealand: Temelkovski et al.[10] investigated medical incidents in general, not specifically in aged care. This study aims to identify the human factors that underpin events at the HDC in ARC, so that analysis of learning and complaints can highlight priority areas.

Method

This multiple-case analysis study aimed to identify the issues thematically that led to complaints in ARC. Yin's multiple-case study methodology was chosen because it is an empirical approach that investigates a contemporary phenomenon in-depth within its real-world context.[11] We used the following keyword search within the HDC website: "decisions/search decisions/rest home/all occupations/all rights". A total of 114 potential cases were assessed over a 14-year period between 2007 and 2021. A stratified randomised selection of 24 HDC cases was used for analysis (eight each from three large New Zealand ARC companies). Each provider is a large supplier of aged healthcare and owns over 26 facilities, with a mix of hospital-level care beds throughout New Zealand. Each company had a similar number of publicly reported HDC complaints. Three large providers were identified on the HDC website; however, the individual patients and staff are de-identified. We then randomly chose eight cases from three large organisations to ensure that no single organisation could be identified. This was an added layer of anonymity to the complaints, which are publicly available on the HDC website, as it was not our intention to indicate that issues lay with a particular provider.

Data analysis using Braun and Clarke's[12] thematic analysis followed six steps: becoming familiar with the data; generating codes; constructing themes; reviewing themes; defining and naming themes; and reporting themes. Thematic analysis enables social and psychological

Table 1: Identified major complaints reported by the New Zealand Health and Disability Commissioner and Aged Care Quality and Safety Commission.

Aged care health and disability complaints[7]	The Australian Aged Care Quality and Safety Commission[8]
Capacity constraints/workforce challenges	Medication administration and management
Poor communication	Personal care and oral hygiene
Failure to escalate care	Personnel number sufficiency
Inadequate pain management	Consultation and communication representative/family
Poor care co-ordination	Healthcare falls prevention and post-fall management

interpretations of data, providing the researcher with a deeper understanding of the phenomenon[11] (see Table 2). Initially, all data were read and re-read to become familiar with the content. Reports were read in their entirety to identify codes for each case. After tentative conclusions were drawn for each case, the analysis examined whether these conclusions were replicated across the 24 case studies. The cross-case comparisons were then checked for literal and theoretical replications.[11] A structured list of codes was developed and then used to identify the themes (see Table 2). Braun and Clarke's recursive coding steps were followed: data familiarisation; generating initial codes; generating themes; reviewing themes; further defining and naming themes; and writing up. Authors one and three coded separately and then collaborated. Inductive analysis drove the thematic analysis.

Following Yin's multiple-case analysis, each case (complaint) was analysed discretely and then similarities were determined across the whole dataset. To strengthen the validity of the findings, a second researcher rechecked the themes to help reduce bias. Ethical approval was sought but not required, as HDC complaints are de-identified and publicly accessible. Each case presented in the public forum contained detailed reports, and no additional notes or information were used beyond the complaints found online. However, all providers' names have been removed to further de-identify the cases.

Results

The resident demographics from this study showed that 58% were in their 80s, 17% were in their 90s, 13% were in their 70s, 8% had no age given and 4% were under 60. Of the 24 cases, 58% were female, and 42% were male. Although this study is a small sample of people living in ARC, it is similar to findings from a recent epidemiological study based on interRAI data, which found that 60% of those in ARC are female and 48% are in their 80s.[13] As seen in Table 2, problematic communication occurred at all levels: between staff, doctors and facility managers, and between management staff. Documentation was generally incomplete or missing, and staffing, either shortages or poor skill mix, was mentioned in many of the complaints chosen. Policy was not adhered to in all the cases, or was not followed in relation to documentation, or patient management or assessment was not performed according to policy.

Four themes were identified: 1) communication flaws, 2) documentation gaps, 3) policy-to-practice inconsistencies, and 4) staffing shortages and skill mix insufficiencies (see Table 2). The Appendix (Appendix Table 1) provides detailed examples of the issues relevant to themes. For theme 1, communication is multifaceted and vital in delivering healthcare; failures impair healthcare quality. Interprofessional communication, as well as communication between staff and residents and staff and family, was impacted. Communication breakdowns also occurred between managers and patient-facing staff. Granular examples are broad, such as a patient being unable to reach a call bell or an RN failing to escalate a concern. For theme 2, documentation includes evidence of planning and delivering quality patient care, as well as recorded provider communication. Common examples were undocumented decisions, discussions and assessments. Other examples were checklist indications that tasks had been undertaken but not attended to. For theme 3, policy-to-practice inconsistencies related to instances where clear policy guidance had not been followed, such as when to escalate, when to undertake procedures such as taking swabs for infection and when to instigate nutritional and falls assessments and referral. For theme 4, staffing shortages and skill mix insufficiencies meant that care staff lacked sufficient knowledge or that high workloads affected attention to resident care. For example, a resident's deteriorating condition might be documented but not addressed and escalated. There may also be no senior staff for the care staff to consult with. Line managers may not be clinicians and therefore may not know when to escalate.

Discussion

A single incident of patient harm is usually the result of many inter-related contributory factors, rather than an isolated sentinel event.[14] This research identified four influencing factors that led to complaints to the HDC. These are communication flaws, documentation gaps, policy-to-practice inconsistencies, staffing shortages and skill mix insufficiencies. This study's findings align with those identified by the HDC[7] and the ACQSC,[8] particularly communication (see Table 1), and these gaps have beleaguered ARC for decades. The recurring nature of these handful of issues suggests that proactive national strategies should focus on these key areas.

Table 2: Cases, codes and themes.

Case	Communication flaws	Documentation gaps	Policy-to-practice inconsistencies	Staffing shortages and skill mix insufficiencies
1	Communication with district health board and patient	Inadequate/poor documentation	Assessment management	High workload, shortage of RNs
2	Communication with family	x	Assessment management documentation	High workload
3	Communication with doctor	Inadequate/poor documentation	Assessment management documentation	High workload, shortage of RNs
4	Communication between disciplines	Inadequate/poor documentation	Management	x
5	Communication between staff	x	Assessment management documentation	High workload, insufficient training
6	Communication between staff and care planning	Inadequate/poor documentation	Assessment management documentation	Shortage of RNs
7	No escalation	Inadequate/poor documentation	Management documentation	Lack of sufficient knowledge
8	Communication to caregiver between different hospital nurses	Inadequate/poor documentation	Assessment documentation	High workload, shortage of RNs
9	Family to staff, staff and manager	Inadequate/poor documentation	Management and documentation	High workload, shortage of RNs
10	Staff to doctor	Inadequate/poor documentation	Staffing policy	High workload, shortage of RNs
11	Among staff	Poor documentation	Assessment management documentation	High workload, lack of sufficient knowledge
12	Communication with doctor	Poor documentation	Documentation	x
13	x	Inadequate/poor documentation	Assessment management documentation	High workload
14	x	Inadequate/poor documentation	Assessment management documentation	Shortage of RNs, lack of sufficient knowledge
15	x	Inadequate/poor documentation	Management	Lack of management
16	Communication between staff	Inadequate/poor documentation	Management	Shortage of RNs

Table 2 (continued): Cases, codes and themes.

Case	Communication flaws	Documentation gaps	Policy-to-practice inconsistencies	Staffing shortages and skill mix insufficiencies
17	Communication between staff	Inadequate/poor documentation	Management	Lack of sufficient knowledge
18	x	Inadequate/poor documentation	Management	High workload, shortage of RNs, lack of sufficient knowledge
19	Communication with family	x	Culture of non-compliance	Lack of sufficient knowledge
20	x	Inadequate/poor documentation	Assessment management documentation	x
21	Communication with family	Inadequate/poor documentation	Management	High workload, shortage of RNs, lack of sufficient knowledge
22	Failure to escalate	Inadequate/poor documentation	Assessment management documentation	Lack of management
23	Communication with family	Inadequate/poor documentation	Assessment management documentation	x
24	x	Inadequate/poor documentation	Assessment management documentation	x

RN = registered nurse; x = not found.

Communication breakdown continues to be a leading factor contributing to complaints, patient injury and death.[15,16] In a United States of America (USA) study, Kusumoto et al.[17] retrospectively examined 21,101 claims from a medical professional liability provider between 2010 and 2019. Findings indicated that the most-observed issues involved communication between providers and patients, and between providers, documentation issues and care delays. Communication about expectations, inadequate informed consent and poor rapport were the primary reasons identified for communication issues between the patient/family and the provider. Providers' failure to communicate the severity of a patient's condition was the most common communication problem.

Documentation, a key form of communication,[18] was also a significant contributor to complaints in this study. Documental communication in clinical practice is vital as a record that documents the care received, and it enables high-quality care.[19]

The current research also found that staffing inadequacies contributed to complaints. Problematic areas were staff turnover, poor skill mix, workload and lack of managerial staff. Care facilities must have well-educated staff who have the time to observe and respond to deteriorating patients. In this context, a Swedish cross-sectional study[20] highlighted four themes that contributed to missed opportunities to provide safe care: lack of preparedness for unexpected situations; obstacles in a deficient work environment; unsatisfactory organisational planning; and individual shortcomings, such as fatigue or working when unwell. Henderson et al.[21] identified additional recurring issues: a lack of staff and an unexpected increase in patient volume or acuity. Inadequate staffing relative to required competencies was also noted.[22] Kusumoto's[17] review found that—in addition to communicative gaps—staffing, policy and protocol issues were identified as leading to liability complaints, and patient monitoring was also featured. Treatment delays are attributed to

the following key factors: poor skill mix, with staff lacking competency to recognise abnormal clinical signs; policies not being followed; and no or inadequate staff-to-staff communication during handovers or transitions of care.[16]

Ideally, clinicians should follow well-communicated protocols that guide patient care and communication.[23] Standardised evidence-based policies and procedures are fundamental to safe practice. Although policies are required to promote the integration of laws, regulations and sector standards, significant policy implementation gaps are common.[24,25] Hudson et al.[25] argue that there is a long-standing and inaccurate assumption that policy is a top-down, linear process, resulting in policy development prioritised over implementation. Policy development requires consultation at all levels to ensure that the "wicked problems" of healthcare are considered. This implementation gap is also attributed to inadequate resourcing, stakeholders not buying into the policy, communication issues and unclear guidelines. A data review by the Joint Commission,[16] a USA-based independent health accreditation organisation, found that a lack of consistency in policy adherence, communication failures and inadequate teamwork were leading causes of reported sentinel events.

In order to address these issues, good clinical governance in aged care ensures that safe, high-quality care is delivered through strong leadership, clear accountability and effective systems for monitoring and improvement. Overall, it shifts care from reactive responses to harm to proactive prevention, leading to safer, more consistent outcomes for residents.[26] In New Zealand, many agencies advocate for safe care in ARC. The MoH audits and certifies ARC agencies to ensure they meet the required standards. These audits occur every 1–4 years, depending on the outcome of the previous audit, and "spot audits" also occur unannounced. The MoH also publishes the *Age-Related Residential Care Services Agreement*,[27] which includes risk management clauses. One example is stipulating that care facilities must document and provide policies and procedures for identifying health and safety risks, prioritising care based on residents' vulnerability and the likelihood of recurrence, and minimising risk. The Office of the Aged Care Commissioner[28] is another agency that oversees the care provided to older people. This position is within the HDC's Office; it has an advocacy role focussed on the quality of care for older people and it makes statutory decisions in formal investigations. Therefore, if any of the aforementioned clauses in the ARC agreement are not met, this omission will be identified during an investigation. Although this rigour may appear laudable, there is a long-standing funding and staffing crisis in the ARC sector, which inevitably results in implementation gaps.

A further agency in New Zealand committed to building strong partnerships that foster quality improvement and enhance capability for sustainable practices in the future for ARC is the Health Quality & Safety Commission (HQSC). Current supported initiatives include a Deterioration Early Warning System (DEWS) feasibility study designed to detect acute deterioration and facilitate timely escalation of care for aged care residents. Another initiative is ARC caregiver guides, which are point-of-care reference tools to support decision making for healthcare assistants in aged care settings. The HQSC also initiated the ARC Quality Leads Forum, which facilitates network meetings that bring together quality leads representatives from major ARC providers.[29]

Although these governing strategies are in place, our data indicate that this process does not appear to be addressing serious, recurring issues. Resources focussed on quality improvement, organisational culture and human factors would be advantageous.

Recommendations

The current analysis indicates that pre-emptive approaches are needed to address these perennial problems in ARC. When investigating complaints, the World Health Organization[14] recommends a systems approach to patient safety that assesses harm with the view that mistakes are not primarily the result of discrete practices by health workers but rather of system or process failures. A human factors approach is not about eliminating human error. It is about designing resilient systems for unanticipated events.[30] In an Australian study, Hibbert et al.[31] concur with these recommendations and argue that, rather than focussing on each safety risk in isolation, ARC would benefit from implementing overarching evidence-based strategies that simultaneously address clinical and systemic issues to improve the quality of care provided to residents.

The Systems Engineering Initiative for Patient Safety (SEIPS) model is one such pre-emptive approach.[32] This model considers the overall system's performance and investigates the work system, processes and outcomes by examining

key characteristics of how components affect one another and how these interactions produce desired or undesirable outcomes. The SEIPS human factors analyses five key components: "person" (the worker's physical, cognitive and educational attributes); "tasks" (the worker's activities, including complexity, the time required and error potential); "tools and technologies" (equipment, software, hardware and design features integral to care delivery); "organisation" (the bigger picture of organisational culture, procedures and policies); and "internal environment" (ergonomic factors such as workflow design, space and lighting).

However, we concur with Woods et al.[33] that national regulation and funding models for ARC, in tandem with a market ethos, reduce the likelihood that the ethics of care will take priority over profit, with implications for residents' safety. We recommend that these tensions around the for-profit orientation of much of ARC be part of any analysis, as they relate to the key issues identified in this study.

Strengths and weaknesses

A strength of this case study analysis of complaints from the HDC is the pooling of qualitative findings from large volumes of rich data to inform practice standards. This is novel, and it is the only study to investigate complaints through a human factors lens. Yin's multiple-case study methodology provides in-depth, context-rich insights through triangulation and cross-case comparison, thereby enhancing validity and supporting theory development. However, limitations are that it is resource intensive, analytically complex, potentially subject to researcher bias and offers limited statistical generalisability.

Future research

Future research should evaluate SEIPS-based interventions in ARC with particular focus on the key findings from this research: 1) communication flaws, 2) documentation gaps, 3) policy-to-practice inconsistencies, and 4) staffing shortages and skill mix insufficiencies. Longitudinal and cross-national studies, alongside research on technology integration and consumer perspectives, are needed to strengthen proactive, human factors–informed care.

Conclusion

This research, which used data from cases collected over a 14-year period (2007–2021), shows the perennial nature of recurring problems. The inductive analysis identified four inter-related themes—communication flaws, documentation gaps, policy-to-practice inconsistencies, staffing shortages and skill mix insufficiencies—that significantly contributed to events that led to complaints to the HDC. These identified areas provide ARC agencies with focus points for setting up expert consultations, education and monitoring. Strong national and international evidence of clusters of repeated system failures resulting in resident harm underscores the importance of national surveillance bodies and organisations in examining the workplace system and working with human factors experts to implement changes that may prevent future events. Sustained change requires direction from regulators (MoH), support from HQSC to develop safety systems and support from management (owners) to develop a safety culture and sustainable clinical governance. Adopting a recognised systems approach, such as the SEIPS, and applying it to future internal risk assessment and prevention may help prevent harm and reduce complaints. Such an approach means that those who implement care are consulted about policies and processes rather than having to work around impractical and unsafe systems. An ethic of care needs to inform ARC, and this focus may be compromised in the profit-driven context.

COMPETING INTERESTS
Nil.

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URL
https://nzmj.org.nz/journal/vol-139-no-1642/common-errors-in-aged-residential-care-settings-contributing-to-statutory-complaints-a-review-of-cases-investigated-by-the-healt

CITATION
Mowat R, Dewar J, Chapman M, Cook C. Common errors in aged residential care settings contributing to statutory complaints: a review of cases investigated by the Health and Disability Commissioner in New Zealand. N Z Med J. 2026 Sep 25;139(1642):21-31. doi: 10.26635/6965.7455.

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Appendix

Appendix Table 1: Mapping out examples within each theme.

Communication flaws	Documentation gaps	Policy-to-practice inconsistencies	Staffing shortages and skill mix insufficiencies
Case 1: Mrs X needs the call bell to get attention. She has no other means of communicating that she needs something. The bell is found out of her reach many times. Consequently, she could not get to the toilet as often as she needed.	Case 3: Ms X's family requested she is to be seen by a GP on day 2—this was not documented in the clinical notes by the nurse who administered pain relief (RN X). Day 3—the GP came to the home and left without seeing Ms X. The GP filled a prescription requested for her earlier, which included an increased dose of laxative. There was no note in the GP notebook that the family requested a visit.	Case 6: Policies in place and implemented but not carried out correctly. Nursing staff failed to escalate to the GP for a review. There were several instances when the GP should have been informed or a review requested. There were several instances when wound swabs should have been taken and were not.	Case 3: RN X observed a wound on Ms X's lower leg and dressed it. It was 18 days since she'd last seen it herself. She documented in the progress notes it was "not improved nor significantly deteriorated". She did not update the wound evaluation form due to her workload.
Case 7: The registered nurse did not escalate to the on-call manager, and did not seek medical advice when management of Mr X's condition quickly became problematic.	Case 9: Misremembering conversations, when they took place, what was said, and to whom—e.g., three people involved in an interaction about the condition of Mr A and his new hospital room have three very different recollections, such as Mrs B recalling an interaction with RN F who wasn't on duty.	Case 5: There were policies in place for starting charts, but they were not implemented. In the case of nutrition, the admission checklist and policy were inconsistent. Mr A should have had a mini nutritional assessment within 48 hours but it took 1 week as per checklist. Not all aspects of care needs covered in care plans and assessments.	Case 5: While accepting four to six new residents per week, recruiting and orienting new staff, CM X states: "*I was working as a caregiver, RN and trying to learn a new* [clinical manager] *role, without the mentorship I was promised.*"
Case 8: A caregiver wrote in Mrs X's care notes that Mrs X was confused and not making sense. She documented that an RN was informed, verbally. None of the three RNs recall being given this information. No RN appears to have read the care notes. If they did, they took no action.	Case 6: Patient came in for respite/short-term care. The assessment care and discharge plan misses key information, e.g., no documented baseline observation, no management plan for pressure area risks or for maintaining skin integrity, poor care planning, details about wounds missing from wound care plan, notes in wrong place, missed from relevant care plans and reviews, ambiguous notation and lack of clarity over which wounds were being dressed when, with what and by whom. On two occasions there are notes of a worsening wound (not sure which wound) in which words like "necrotic" were crossed out.	Case 23: The pattern of non-compliance with the rest home's policies on falls and incident reporting by staff is also very concerning. Particular issues were inconsistency of filling out the forms and informing the family.	Case 21: The facility manager and clinical nurse manager were on leave for 8 days and 9 days respectively of Mr X's stay. The operator states neither had approval to be on leave during the holiday period. There was inadequate staffing and skillset over holidays when the client was in the rest home.

Appendix Table 1 (continued): Mapping out examples within each theme.

Communication flaws	Documentation gaps	Policy-to-practice inconsistencies	Staffing shortages and skill mix insufficiencies
Case 17: RN X was told by RN Y that they did not administer the once-a-day medication, clozapine, to Mrs X because they couldn't find it. After RN Y's shift finished, RN X found they had signed the medication chart confirming they did administer clozapine. RN X tried to call RN Y who was off-duty to clarify the situation. When they got no answer, they didn't want to risk giving a second dose.	Case 21: Mr B's medical regimen was not reviewed. There was a discrepancy at admission between what was written in his prescription and what was written on the medication. This was not clarified at the time. When Mr B's condition deteriorated (probably due to medication), a GP review was not requested (policy). When Mr B became unsteady and drowsy, medication was withheld. Documented in progress notes, not medication chart.	Case 24: interRAI assessment started, much of it not completed because Mrs X was in hospital. It was not completed within 3 weeks of admission, contrary to best practice. Nor was it completed after 3 days of observation by staff members as per policy.	Case 15: Rest home did not have a clinical manager or consistent on-site leadership or management support.
Case 9: Concerned about Mr X's weight loss, Ms X, the temporary manager, asked staff to weigh Mr X. They weighed him 2 days later: "*His wedding ring was literally falling off his finger*."	Case 12: RN L wrote in the hospital communication diary for staff on the morning of 23 March to contact Dr D and hospice nurse for directions on how to manage Mrs A's care. The entry was ticked off. However, there is no record Dr D and the hospice were contacted. RN C and Mrs B discussed Mrs A's condition and a doctor review. There is no documentation between staff and Mrs B on this day.	Case 11: Mrs A was not assessed upon admission as per policy. A care plan was not implemented upon admission as per policy. A care plan was not signed off by a RN. Between EN Ms I and CN M, Ms D, it appears no one formally assessed Mrs A (paragraph 42–43). Ms B describes the handling of her mother's move to hospital-level care as "very casual".	Case 14: RN X was on sick leave for a month and was not replaced. RN E took on her responsibilities. RN X's role as registered nurse wasn't filled. A senior staff member may have had more oversight of junior and casual staff and responded in a timelier fashion to clinical indicators.
Case 19: Staff–family—around lifestyle plan, move to dementia unit. Family and facility at odds. Family decisions affected the dementia unit's ability to manage Mrs A. Family members at odds with each other. Family getting involved in medication, and the frequency and dosage of medication. Ineffective medication made it harder to manage Mrs A's carers. Better communication with the family may have prevented some of the outcomes.	Case 18: Updates about Mrs B's condition and care were put in the wrong documents—i.e., "*handover sheets and communication books are not records of care*"—which led to omissions, lack of continuity of care, failure to monitor and evaluate: e.g., information in EN/RN comms book about Mrs B's food intake chart being commenced but doesn't say why started or what the concerns are (entry lacks specificity).	Case 1: Inadequate admission, unclear documentation from the outset to assist staff in their care of Mrs X, e.g., how to handle her given her fractured arm, how to keep her arm stable, failure to undertake baseline pain assessment, no multidisciplinary input, failure to conduct formal nursing assessment, failure to seek medical review for urinary tract infection.	Case 2: RN X, RN Y, RN Z refer to large workload and staff stretched to limits, shortage of RNs, RNs working shifts while maintaining own workload and responsibilities, expected to take work calls on days off, unable to complete tasks to best of ability or respond as quickly as they would like when attending to other residents. There had been a reduction in staff when operator took over. RN C states no support from line manager, who is not an RN.

GP = general practitioner; RN = registered nurse; EN = enrolled nurse; CN = charge nurse.
Names were transcribed verbatim from the Health and Disability Commissioner complaints.