MIDCENTRAL HEALTH
A division of MidCentral District Health Board providing specialist health and disability services

7 October 2019

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Nicholas Jones
The New Zealand Herald
Palmerston North

Dear Nicholas

Complaint Investigation
Our Ref: Y19-2493

In reference to your official information request dated 27 August 2019 for copies of residential care complaints received by DHB since January 1 2019 and any associated investigations and findings.

MidCentral DHB has received complaints this year regarding aged residential care provided by seven of the 36 facilities which operate in our district. These are summarised below. We have not provided a copy of the complaint documents in order to protect the privacy of the residents involved and their families (Section 9 (2)(a) of the Official Information Act 1982). You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or Freephone 0800 802 602.

Summary of outcomes

MidCentral DHB complaints received 2019 pertaining to ARC facilities				
Date received	**From**	**Summary of Complaint**	**Outcome & Findings**	**Date closed out**
11/1/19	Family member	Concerned that the admission, planning and preparation processes for respite care were lacking, documentation was incomplete, and there was a failure to provide medical care when required.	Investigation undertaken by the organisation with DHB involvement. Concerns substantiated and a number of improvements recommended. These have been implemented.	5/3/19

23/1/19	NASC staff member	Concerns around observed lack of activities for residents and minimal staff engagement with residents.	Investigated by the organisation and explanation around why environment appears to have minimal stimulus aligned with organisations philosophy of care. Opportunity taken to review and improve service	12/4/19
20/2/19	Health of Older People Team Tararua	Concerns related care of residents around general assessment of resident deterioration, prevention of falls, management of pain and communication with medical team	Investigation undertaken by the DHB. Some care concerns were substantiated and a number of recommendations have been implemented including improved documentation for medical rounds, documenting if analgesia is declined, staff education and the importance of staff visibility in the facility.	23/5/19
15/5/19	NASC staff member	Resident told unable to receive rest home level care in apartment.	Investigation undertaken by DHB. Communication misunderstanding as resident is already receiving rest home level care in apartment.	4/6/19
17/5/19	Family member	Concerns around general care of husband including dehydration and general safety. Concerns also around correct use of skin creams to avoid excoriation.	Investigation undertaken by organisation. Some concerns substantiated and a number of improvements recommended. These have been implemented.	25/6/19
21/5/19	Family member	Concerned regarding quality of care provided to resident, and the ability to contact the facility by telephone. Communication skills of staff also a concern.	Investigation undertaken by the organisation with DHB involvement. Concerns regarding care were not substantiated and related to an increasing level of dementia. Opportunities for increased staff training around dementia education identified. A new telephone system is being installed, and	4/6/19

			new staffing arrangements put in place for answering phone calls after-hours.	
1/7/19	ElderHealth staff member	Concerns regarding an unexplained fracture of radius and the suggestion the injury occurred from a fall from a hoist.	Investigation undertaken by the DHB. No evidence that a fall from hoist occurred. Because of residents diagnoses the most likely cause of fracture was due to incorrect handling techniques. A number of recommendations have been implemented including staff update on safe transfers and manual handling.	16/9/19
17/7/19	Family member	Concerned the resident did not receive the appropriate level of palliative care in the last week of their life. Also concerned that staff were unwell, communication was poor, and the residents should have been transferred to hospital care.	Investigation undertaken by DHB. Level of care found to be appropriate, and that transfer to hospital not required. Concern around staff health unwarranted. A number of improvements to processes and communication identified. These are being implemented and the DHB will audit in 3 months.	3/10/19

Please note that this response, or an edited version of this response, may be published on the MidCentral DHB website ten working days after your receipt of this response.

If you wish to discuss any aspect of your request with us, including this decision, please feel free to contact me.

Yours sincerely

Andrew Nwosu
Operations Executive
Healthy Ageing and Rehabilitation