Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
carolyn.gullery@cdhb.health.nz

23 September 2019

9(2)(a) [redacted]

[redacted]

[redacted]

RE Official Information Act request CDHB 10175

I refer to your email dated 27 August 2019 requesting the following information under the Official Information Act from Canterbury DHB, to be used as part of a report by the New Zealand Herald into Aged Care rest homes and residential care.

- **Copies of complaints received by the DHB since January 1 2019 about residential care, and copies of any related investigations and findings.**

There have been 14 complaints during this period. One is still in the process of being investigated. I have attached documentation as **Appendix 1.**

We have redacted information under section 9(2)(a) of the Official Information Act i.e. *"…to protect the privacy of natural persons including those deceased".*

I trust that this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

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

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Complaint 1
Maples Lifecare
12/02/2019

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted]	**Date Received:** 12.02.19
Received by: Alison Young	**Address:** Maples Lifecare
Email address:	**Phone Numbers** **Mobile:** 9(2)(a) [redacted]
ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)	
No	
DETAILS OF THE COMPLAINT	
Name of Facility: Maples Lifecare	
WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?	
Better meals, better communication, clarity of level of care.	
P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young **Date resolved**: 26.02.19	12.02.19 Received complaint 13.02.19 AY phoned to discuss 26.02.19 Phone call to discuss with owner.

File note:

15.02.19

I phoned [redacted] to discuss findings and plan for residents committee meeting. [redacted] is happy with this.

I explained that [redacted] level of care has always been rest home level [redacted] was unaware of this.

Happy that both concerns have been dealt with and doesn't want anything else done at this point.

I have told [redacted] is welcome to ring me if [redacted] feels meal improvement is not progressing as expected.

[redacted] is happy that this verbal discussion will be considered as the complaint closed.

26.02.19

[redacted] the owner rang me to discuss the meals. Some of the complaints from the committee have been problematic e.g. Too many frozen veges, when in fact all veges are fresh each day. Too much cheese but some people like cheese etc. He hope the regular resident meal committee meeting will help resolve some of these issues.

Alison Young

Complaint 2
Bloomfield Court
01/03/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) via HealthCERT	**Date Received:** 02.02.19 @ HealthCERT 01.03.19 to AY
Received by: Alison Young	**Address:**
Email address: 9(2)(a)	**Phone Numbers** Mobile: 9(2)(a)
ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)	
No	
DETAILS OF THE COMPLAINT	
Name of Facility: Bloomfield Court 9(2)(a) concerned about the late referral to GP about resident with chest infection nd then rest home decision to transfer to hospital.	
WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?	
P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young **Date resolved**: 19.03.19	08.03.19. Phoned complainant to discuss 15.03.19. Richard visited ARC to discuss. 19.03.19 Response sent to complainant

Details of Complaint received by HealthCERT

Date/time received: 20/02/2019

Complainant Name: 9(2)(a) [redacted]

Complainant Address: Click here to enter text.

Phone number: 9(2)(a) [redacted] Email Address: 9(2)(a) [redacted]

Complainant type: Other

If other, please state: 9(2)(a) [redacted] *works in local practice*

Anonymity required? Choose an item.

Is the complaint in regard to a specific resident/patient? No

Resident/Patient name: Click here to enter text.

Date of Birth: Click here to enter text. NHI: Click here to enter text.

Provider details:

Provider Name: Komal Holdings – Bloomfield Court Retirement Home

Contact: 9(2)(a) [redacted]

Contact details: [redacted]

Relates to Provider or Premises? Relates to provider

Services the complaint relates to: Rest Home

Complaint Details

Title of Complaint: Reporting and Management of Unwell Residents

Complaint area: Care (including medication and infection)

If other, please state: Click here to enter text.

Details: 9(2)(a) [redacted] contacted HealthCERT today re the late referral for a resident with a chest infection on 19 February. The resident had been unwell all day and GP contacted and visited at 3.00 pm yesterday. GP assessed the resident and thought that the resident could be cared for and the chest infection treated at the facility. The staff stated that they would not be able to manage the resident overnight as 9(2)(a) [redacted] was unsteady on 9(2)(a) [redacted] feet and want the resident referred to Christchurch Hospital.
The GP contacted the Registrar who also asked the question about the resident being treated at the facility however at that time the ambulance had arrived and transfer was made.

9(2)(a) [redacted] also commented that the facility often make referrals late in the day for GP assessment.

Suggests that the RN needs to assess the resident who is unwell earlier in the day and if appropriate requests a GP visit. Also wonders why the facility/ staff/RN are not able to care for residents who are unwell with an infection and not have to send them to the DHB.

Canterbury
District Health Board
Te Poari Hauora o Waitaha

19 March 2019

9(2)(a)

Dear 9(2)(a)

Re: Complaint about Bloomfield Court Aged Residential Care

Your complaint submitted to HealthCERT was forward on to me to reply to on behalf of the Canterbury DHB. You will recall that I phoned you on 8 March to get more clarity around the situation.

Your main issues were:

- Being called to visit a resident in the afternoon rather than the morning.
- Staff not being able to look after a resident at night.
- Frustration at non-urgent requests for documentation to be signed.

I asked Richard Scrase, the Nursing Director for Older People and Population Health, to follow up from a clinical and ARC perspective. Richard visited the facility on 15 March. In the case of this 9(2)(a) the general practice was contacted as soon as 9(2)(a) became unwell, (approximately 1.30pm). They asked for a visit at some time in the afternoon.

Rest homes are only required to have a Health Care Assistant at night, with a Registered Nurse on call, so the request for 9(2)(a) to go to hospital was reasonable. The fact that it took three people to move 9(2)(a) into the ambulance is an example of the challenge that the facility was going to have to care for 9(2)(a) especially during the night. They were aware that it would be unsafe practice to keep 9(2)(a) at the facility.

9(2)(a) remained in hospital for a number of days 9(2)(a) so the staff decision to have 9(2)(a) admitted proved to be a good clinical decision.

Richard did discuss with 9(2)(a) facility manager, the importance of reminding carers to take every opportunity to assess residents' skin integrity at times such as dressing, showering etc.

Regarding your frustrations at non-urgent requests for documentation. Both you, as the GP, and the ARC staff are busy people and have timeframes and priorities, so I recommend that you sit down with 9(2)(a) to consider ways to prioritise and streamline in a way that is going to meet both of your needs.

I hope Richard's input has given you confidence that we have investigated your complaint and provided suggestions for both parties to support the care and wellbeing of residents as well as staff.

Canterbury
District Health Board
Te Poari Hauora o Waitaha

I will now consider this complaint closed, but please feel free to contact me if there are any issues that you feel need further consideration.

Yours sincerely

Alison Young

Alison Young
Project Specialist

cc. 9(2)(a) @moh.govt.nz
9(2)(a) Bloomfield Court, 134 Rangiora-Woodend Road, Woodend 76110

BLOOMFIELD COURT
RETIREMENT HOME

9(2)(a)

22 February 2019

Good morning 9(2)(a)

I am writing with respect to the verbal complaint made to me late on the afternoon 19/2/2019 around your visit to the facility.

I again formally apologize on behalf of our nursing staff, both 9(2)(a) and myself, for the stress you experienced subsequent to that visit, it was certainly not our intention to cause any upset.

As I have already explained we do our best to request visits in a timely manner, escort patients to the surgery, or book for visits the next day when appropriate. On that day when a visit was requested there was no expectation for you to visit urgently, and as confirmed verbally by yourself and Practise Nurse 9(2)(a) it was agreed you would come some time, possibly after completing your arranged afternoon appointments. We understand that taking time out from your schedule impacted on the rest of your afternoon.

Moving forward, I am making an undertaking that whenever possible I will liaise and facilitate any future visits you make to Bloomfield Court. I trust this is helpful, and look forward to your response as we seek to resolve this issue.

Yours faithfully

9(2)(a)

Bloomfield Court Retirement Home
134 Rangiora Woodend Road, Woodend
Ph. (03) 312 7088

Outcome / Resolution Decided Upon:	
Reasons for Outcome / Response from Complainant to outcome:	
Date outcome communicated to person making a complaint:	**Note Complainants response to outcome:**
Facility Manager's comments:	

Managers signature: **Date:**

Quality Improvement Co-ordinator signature: **Date:**

Complaint 3
Goldenage Healthcare
01/03/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a)	**Date Received:** 01.03.19 to AY
Received by: Alison Young	**Address:**
Email address: 9(2)(a)	**Phone Numbers** 9(2)(a)

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

9(2)(a)

DETAILS OF THE COMPLAINT

Name of Facility: Golden Age

Lack of 9(2)(a) commitment to supporting ARC staff when clinical issues occur

Commented on being asked to take 9(2)(a) to appointments ED etc.

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

More attention by GP and less expectations from staff for 9(2)(a) to manage 9(2)(a) care.

P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young **Date resolved**:14.03.19	07.03.19 Phoned complainant to discuss 07.03.19 Phoned Golden Age to discuss 14.03.19 Golden Age emailed with outcome of meeting with complainant 14.03.19 Letter written to complainant and complaint closed.

Canterbury
District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

Canterbury
District Health Board
Te Poari Hauora o Waitaha

14 March 2019

9(2)(a) [redacted]

Dear 9(2)(a) [redacted]

Thank you for spending time to chat with me on 7 March regarding some concerns you had about your 9(2)(a) [redacted] care at Golden Age Healthcare.

I suggested that we manage them as a compliant so that I could formally investigate each one. The main issues were:

- An expectation that you would provide transport for your 9(2)(a) [redacted] needed urgent or after hours care at the 224 Hour surgery or hospital.
- You had paid for doctor's consultation and ambulance.
- You feel as though the General Practitioner is not keeping you informed what is happening with your 9(2)(a) [redacted] care.

I phoned 9(2)(a) [redacted] the facility manager, of Golden Age and she was very understanding of your concerns. She was not aware that you had paid the account at the 24 Hour Surgery and ambulance. I understand she has made contact with you to refund these. She has reminded her staff to explain to any relatives who take a resident for a consultation that they are to ask for the account to be sent to Golden Health Care.

I reminded 9(2)(a) [redacted] that it is the responsibility of the facility to provide transport to appointments. If family choose to do this and feel confident to so, that is fine, but this needs to be their choice not the rest home's expectation.

9(2)(a) [redacted] has encouraged the General Practitioner to keep you up to date with your 9(2)(a) [redacted] care when you request this. I hope her discussion with him will improve his communication with you.

I have checked with the gerontology nurse specialist regarding your 9(2)(a) [redacted] level of care and she confirmed that 9(2)(a) [redacted] is definitely rest home level, so is in the right place.

I hope this has helped regain confidence in your 9(2)(a) [redacted] care.

I will close this complaint but please feel free to call me or talk to 9(2)(a) [redacted] if you feel there are still issues that haven't been resolved.

Yours sincerely

Alison Young

Alison Young
Project Specialist

Planning and Funding, Canterbury DHB, Ph 03 364 4163, PO Box 1600, Christchurch

Complaint 4
Elms Court Lifecare
06/05/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted]	**Date Received:** 06.05.19
Received by: Alison Young	**Address:** unknown
Email address: 9(2)(a) [redacted]	**Phone Numbers** **Mobile:** 9(2)(a) [redacted]

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

Yes, complaint by 9(2)(a) [redacted] on behalf of 9(2)(a) [redacted]

DETAILS OF THE COMPLAINT

Name of Facility: Elms Court Life Care

In relation to respite care from 6-22 April 2019:

- Failure to assist adequately with toileting and day to day care including showering, cleaning teeth, dressing and walking.
- Bell either not working or not being answered or unable to be reached resulting in 9(2)(a) [redacted] wetting or soiling himself on a number of occasions.
- Poor communication between staff at facility and other carers – Access carer topped up water and visited but did not complete 9(2)(a) [redacted] exercises, Access worker reported UTI and although 9(2)(a) [redacted] was seen by the Dr and had antibiotics prescribed, the prescription was not filled by the facility.
- Emotionally distressed as a result of the above.

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young **Date resolved**: 23.05.19	07.05.19 Rang 9(2)(a) [redacted] to discuss 15.05.19 Visited ARC to discuss 23.05.19 Response letter sent

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

20 May 2019

9(2)(a) [redacted]

Dear 9(2)(a) [redacted]

Re: Respite care at Elms Court Lifecare

9(2)(a) [redacted] Canterbury DHB social worker, passed your email with concerns about your 9(2)(a) [redacted] respite care while 9(2)(a) [redacted] was at Elms Court Lifecare while you were on holiday.

Your main issues were to do with 9(2)(a) [redacted] personal cares such as toileting, showering, teeth cleaning and correct equipment to enable 9(2)(a) [redacted] to sit comfortably. You also had concerns about accessibility of the bell and management of antibiotic medication on discharge.

Richard Scrase, Nursing Director for Health of Older People, and I met with 9(2)(a) [redacted] the owner, and 9(2)(a) [redacted] nurse manager, on Wednesday 15 May at Elms Court. 9(2)(a) [redacted] were very concerned that you were not happy with the standard of 9(2)(a) [redacted] care while 9(2)(a) [redacted] was at Elms Court. They expressed that it was certainly never their intention to leave either of you feeling disappointed with the service provided.

The clinical notes were reviewed during our visit, and although they don't go into the specific details laid out in your letter, they don't raise any specific issues. As regards the UTI, the facility appear to have managed this appropriately including the provision of their own stock of antibiotics in order to ensure that 9(2)(a) [redacted] received 9(2)(a) [redacted] prescribed medication in a timely manner. I can see that there was confusion for you when you needed to fill the prescription for the remaining antibiotics.

We discussed the importance of clarifying the responsibilities of the facility as well as expectations of clients and relatives, and then reporting on them often so that any challenges that may arise can be followed up and recorded at the time.

I am very sorry that this episode of respite care wasn't up to the standard you expected, because we see the provision of good quality respite care as an important and valuable form of support for people such as yourselves. I hope that next time you will both have a more positive experience.

Level 2, 32 Oxford Terrace, PO Box 1600, Christchurch.
Phone: (03) 364 4163, Facsimile: (03) 364 4165

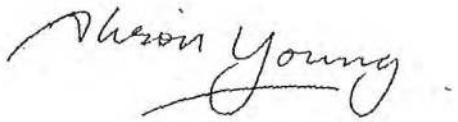
I consider this complaint now closed.

We also advise that Nationwide Advocacy act as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Telephone: 0800 555 050

Email: advocacy.services@xtra.co.nz

Yours sincerely



Alison Young

Project Specialist

Cc: 9(2)(a) [redacted]

Complaint 5
Avon Life Care Dementia Rest Home
15/05/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha
West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted] 9(2)(a) [redacted]	**Date Received:** 15.05.19
Received by: Alison Young and Karen Dennison	**Address:** c/o Older Persons Community Mental Health PMH
Email address: 9(2)(a) [redacted]	**Phone Numbers** **Mobile:** 9(2)(a) [redacted]
ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)	
Case Manager: 9(2)(a) [redacted]	
DETAILS OF THE COMPLAINT	
Name of Facility: Avon Lifecare Dementia Rest Home	
WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?	
That resident was able to remain in the facility	

P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young/Karen Dennison **Date resolved**: 22.05.19	15.05.19 Complaint received. 20.05.19 meeting with 9(2)(a) [redacted] 9(2)(a) [redacted] 21.05.19 meeting with 9(2)(a) [redacted] 9(2)(a) [redacted] 22.05.19 Letter to 9(2)(a) [redacted] closing complaint

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

21.05.2019

Dear 9(2)(a)

Re: Complaint: 9(2)(a)

Thank you for contacting us to outline you concerns about the care that 9(2)(a) has received at Avon Lifecare and in particular your concern that 9(2)(a) was being discriminated against because of 9(2)(a)

Your main issue was that having raised concerns about 9(2)(a) care that the facility had said they could not care for 9(2)(a) safely and on 16.05.19 you received an (undated) letter from the manager requesting that you 'transfer 9(2)(a) to a more appropriate environment'.

On 21.05.19 Richard Scrase, Alison Young and I met with 9(2)(a) 9(2)(a) at Avon Lifecare.

9(2)(a) were adamant that they were not asking 9(2)(a) to leave because of 9(2)(a) 9(2)(a) rather because they felt they were perceived as being unable to provide an adequate standard of care. They were able to outline various procedures they have in place to ensure 9(2)(a) safety in the facility, this included alarming the fire doors, instituting hourly checks and ensuring that wherever possible 9(2)(a) is cared for and accompanied by females. Furthermore, the males on the wing are grouped at one end of the facility and 9(2)(a) is in the room farthest from the men at the other end. We felt that the measures to mitigate risk were reasonable and discussed yours and our view that 9(2)(a) was appropriately cared for in their facility. 9(2)(a) readily changed their stance to evict 9(2)(a) and agreed that they would be happy to have 9(2)(a) remain in this facility with support from 9(2)(a) services.

It was clear that staff felt out of their depth and nervous in caring for someone with 9(2)(a) 9(2)(a) rather than dementia 9(2)(a) advised that they would like the staff to have more education about 9(2)(a) and about medication management including 9(2)(a) Richard offered to talk with 9(2)(a) about arranging this and will, I understand, work with both you and 9(2)(a) to make arrangements for further support for the staff at the facility.

With regard to the specific issue that 9(2)(a) may have made an allegation that 9(2)(a) 9(2)(a) which was not appropriately handled. 9(2)(a) advised that this matter had been investigated and that it was one of the support staff who used this terminology and was not in fact what 9(2)(a) had said. We did not take the matter further but Richard used the opportunity to outline the procedure that would need to take place in the event of such an allegation arising.

We consider this complaint now closed.

We also advise that the Nationwide Advocacy as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Level 2, 32 Oxford Terrace, PO Box 1600, Christchurch.

Phone: (03) 364 4163, Facsimile: (03) 364 4165

Telephone 0800 555 050

Email: advocacy.services@xtra.co.

Yours sincerely

Karen Dennison

Project Manager

Health of Older Persons

Complaint 6
Palm Grove Rest Home and Village
19/06/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha
West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER: 9(2)(a) [redacted]

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted] via HDC Re: 9(2)(a) [redacted] 9(2)(a) [redacted]	**Date Received:** 01 June 2019 to HDC 19 June to P&F
Received by: Karen Dennison via Alison Young/David Meates	**Address:** Palm Grove Rest Home and Village
Email address: 9(2)(a) [redacted]	**Phone Numbers** **Landline:** 9(2)(a) [redacted] **Mobile:** 9(2)(a) [redacted]

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

Yes, 9(2)(a) [redacted] complaining on behalf of 9(2)(a) [redacted]

DETAILS OF THE COMPLAINT

Name of Facility: Palm Grove Rest Home and Village

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

To have the complaint looked into – maybe more cleaners?

P&F STAFF MEMBER NAME	**DATES:**
Name: Karen Dennison **Date resolved**: 04.07.19	01.06.09 complaint made to HDC 19.06.10 complaint forwarded to P&F 20.06.19 email to 9(2)(a) [redacted] and phone call 27.06.19 visited Palm Grove 04.07.19 letter to 9(2)(a) [redacted] and complaint closed

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

18 June 2019

9(2)(a)

Tēnā koe 9(2)(a)

Complaint: **Palm Grove Rest Home and Village**
Our ref: 9(2)(a)

I write further to 9(2)(a) letter of 7 June 2019.

On 4 June 2019 you wrote to this Office raising concerns about the quality of the services provided to your 9(2)(a) at Palm Grove Rest Home and Village. You advise that on multiple occasions, you raised concerns with staff at Palm Grove Rest Home about the cleanliness of your 9(2)(a) room. You also state that when you and 9(2)(a) were cleaning 9(2)(a) room 9(2)(a) 9(2)(a) you discovered that the room was filthy.

In some instances, this Office may refer a matter to another agency if it is considered that it would be more appropriately dealt with by that agency. Having reviewed your complaint, I consider that HealthCERT and Canterbury DHB are the most appropriate agencies to consider your concerns. HealthCERT is the division of the Ministry of Health responsible for ensuring certain facilities, including hospitals and rest homes, provide services which reach the appropriate standard in accordance with their certification. Canterbury DHB funds the services provided at Palm Grove Rest Home.

For this reason, I have made a decision, in accordance with section 38(1) of the Health and Disability Commissioner Act 1994, to take no action on this matter but instead to forward copies of the complaint and relevant correspondence to Canterbury DHB and HealthCERT. HealthCERT can ask the service provider's designated auditing agency to review standards related to this complaint at the time of the next audit of the facility.

PO Box 1791 Auckland 1140; Level 10, Tower Centre, 45 Queen Street, Auckland 1010, New Zealand
Ph: 64 9 373 1060, Fax: 64 9 373 1061, Toll Free Ph: 0800 11 22 33, www.hdc.org.nz

Thank you for bringing your concerns to my attention.

Nāku iti noa, nā

9(2)(a) [redacted]

Deputy Health and Disability Commissioner

cc Palm Grove Rest Home and Village

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

04.07.19

9(2)(a) [redacted]

Dear 9(2)(a) [redacted]

Re: Palm Grove Rest Home and Village

Thank you for outlining your concerns, relayed to us by the Health and Disability Commissioners Office, regarding the quality of the services provided to your 9(2)(a) [redacted] *a resident at Palm Grove Rest Home and Village. Thank you also for providing me with copies of the correspondence relating to your complaint from* 9(2)(a) [redacted] *Business and Care Manager Palm Grove Oceania Healthcare. Your concerns specifically related to the cleanliness of your* 9(2)(a) [redacted] *room.*

I have looked at the most recent audit report, visited the facility, looked at the cleaning regime and spoken with 9(2)(a) [redacted] *clinical manager, at Palm Court.*

The audit report from September 2017 did not identify any issues with cleaning or infection control. A further 'surveillance audit' will be conducted sometime between September 2019 and January 2020

I met with 9(2)(a) [redacted] *clinical manager, at Palm Grove on 27 June 2019.* 9(2)(a) [redacted] *acknowledged your complaint and were sorry they had not been aware of it in order to investigate your concerns at the time. As a consequence of your complaint they carried out an internal cleaning audit on 12 April 2019. The internal audit found dust on skirting boards and ornaments but was otherwise unremarkable.*

Palm Court is divided into three sections and each of these sections has a dedicated cleaning team. Cleaning is carried out seven days a week and each resident's room is given a full clean on a weekly basis. There is a chart on the cleaning trolley that records when each room is cleaned to ensure that none of the rooms is missed.

It is difficult dealing with an issue of cleanliness in retrospect. Obviously I'm unable to make a comment on the state of your 9(2)(a) [redacted] *room at the time* 9(2)(a) [redacted] *although I accept that you did not consider it was up to standard. When I visited Palm Grove I did not identify any issues of concern however I will contact the auditors who will be conducting the audit between September 2019 and January 2020 to make them aware of your concerns and ask that they pay particular attention to cleanliness at that time.*

I consider this complaint now closed.

Level 2, 32 Oxford Tce, Christchurch, PO Box 1600, Christchurch 8140
Phone: (03) 364 4150, Facsimile: (03) 3644165

Yours sincerely

Karen Dennison

Project Manager

cc: 9(2)(a) [redacted]

Complaint 7
The Maples
23/07/2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER: 9(2)(a) [redacted]

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted] 9(2)(a) [redacted]	**Date Received:** 23.07.19
Received by: Alison Young and Karen Dennison	**Address:** 9(2)(a) [redacted]
Email address: 9(2)(a) [redacted]	**Phone Numbers** **Mobile:** 9(2)(a) [redacted]

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

9(2)(a) [redacted]

DETAILS OF THE COMPLAINT

Name of Facility: The Maples

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

That the facility has a clear process for escalating concerns when a resident is not doing well.

P&F STAFF MEMBER NAME	**DATES:**
Name: Karen Dennison **Date resolved**: 27.08.19	23.07.19 Complaint received. 26.07.19 p/c to 9(2)(a) [redacted] 30.07.19 p/c to the Maples, discussion with 9(2)(a) [redacted] facility manager, and meeting set up 02.08.19 to discuss complaint. Meeting date changed to 14.08.19 due to flu outbreak and unavailability of clinical manager. 14.08.19 meeting with facility and clinical managers – acknowledged issues- measures in place to counter. 27.08.19 Letter to 9(2)(a) [redacted] and complaint closed.

Maples
ARVIDA RETIREMENT & CARE

P 03 348 4362
E info@maples.co.nz

71 Middleton Road
Upper Riccarton
Christchurch 8041
maples.co.nz

26 August 2019

Karen Dennison & Richard Scarce
Canterbury District Health Board
Planning & Funding
Via email: karen.dennison@cdhb.health.nz

RE: Complaint 9(2)(a) [redacted]

Dear Karen and Richard

Concerns regarding the care provided to 9(2)(a) [redacted]

Thank you for meeting with 9(2)(a) [redacted] and I on 14th August to discuss the concerns raised by 9(2)(a) [redacted] regarding the care provided to 9(2)(a) [redacted] at Maples Retirement Village. As we discussed at that meeting, we accept that our staff response to requests for support and assistance was unacceptable and does not align with Arvida Maples' mission, vision and values. For this I would like to sincerely apologise. We consider all concerns raised with us are a gift which provide us with the opportunity to learn and improve the services we provide to our residents.

9(2)(a) [redacted] specific concerns relate to four issues:

- Food left lined up and not given/taken leading to weight loss and dehydration
- Failure to assist to toilet
- No pillows available
- Overall failure to provide appropriate care and intervene in a timely manner to address the deteriorating picture.

Background

9(2)(a) [redacted] stayed at Maples twice on respite admissions. 9(2)(a) [redacted] was assessed as requiring rest home level of care. The initial two-week stay was from 16th to 29th July 2018. During this stay the progress notes show an independent 9(2)(a) [redacted] who mobilised well with a walking frame, was social and content.

The second respite admission commenced on 7th June 2019, for 14 days, which was extended on 20th June for a further week, and again on 27th June. 9(2)(a) [redacted] came to Maples for respite this time as 9(2)(a) [redacted] 9(2)(a) [redacted] was going away on holiday. The family felt that 9(2)(a) [redacted] needed extra support as 9(2)(a) [redacted] had had multiple falls at home, was becoming increasingly confused, found it difficult to maintain 9(2)(a) [redacted] personal hygiene and there was a suspicion that 9(2)(a) [redacted] was taking 9(2)(a) [redacted] medication erratically.

At first 9(2)(a) [redacted] settled in well, enjoying the companionship of the other residents and remaining independent 9(2)(a) [redacted]

Mid-way through 9(2)(a) [redacted] stay 9(2)(a) [redacted] became increasingly angry and confused, declining to get out of bed, eat and accept help 9(2)(a) [redacted]. As is often the case when there is a change in behaviour it was suspected that 9(2)(a) [redacted] had a urinary tract infection. However, repeated dipstick tests did not confirm this, so we referred to 9(2)(a) [redacted] GP on the 28th July for further examination. 9(2)(a) [redacted] generally responded well to 9(2)(a) [redacted] grandson 9(2)(a) [redacted] visiting and 9(2)(a) [redacted] was often able to coax 9(2)(a) [redacted] to get up, eat something and accept help.

There was regular contact with family throughout 9(2)(a) [redacted] stay, especially 9(2)(a) [redacted] (grandson) while 9(2)(a) [redacted] was away 9(2)(a) [redacted] There was also regular contact with 9(2)(a) [redacted] GP, including visits,

blood tests, and referrals to Older People's Health and Geriatrician [redacted] (see attached progress notes).

On the 4th July [redacted] was assessed by Older Persons Health Geriatrician [redacted] Clinical Assessor [redacted] and nursing student [redacted] at Maples. [redacted] refused to engage in the assessment, denying any issues at home, no falls, no incontinence.

The assessment concluded that it was likely that [redacted] had an undiagnosed Alzheimers disease and would probably require secure dementia care to keep [redacted] safe. It was also agreed that [redacted] was no longer able to make decisions [redacted] and that it was appropriate for [redacted] Enduring Power of Attorney to be activated.

The plan was to extend [redacted] respite care stay by one week while Older Persons Health liaised with Older Persons [redacted] to find an appropriate placement in a dementia unit for [redacted] Geriatrician [redacted] advised Maples "not to worry about medications if [redacted] will not take them (digoxin and pain relief probably most important) and requested "dietitian input".

A Food and Fluids Chart was commenced on 5th July to determine [redacted] actual intake and recordings taken every day for three days. Maples' Registered Nurse [redacted] consulted with the Arvida dietitian [redacted] who made recommendations to boost [redacted] nutritional intake.

During [redacted] one-week respite extension, [redacted] continued to decline medications, resist support with personal care, and was not eating and drinking well despite staff encouragement and intervention. [redacted] also had two falls without injury. These were actively managed and followed up by registered nursing staff.

On July 10th, after discussions with [redacted] further consultation and review with the geriatrician [redacted] it was determined the best course of action was to transfer [redacted] to hospital.

Complaint

I set out below our response to the specific concerns raised.

Food not given/taken leading to weight loss and dehydration

I acknowledge the concerns that were raised in relation to food not being given or eaten by [redacted] observation that we failed to keep proper records of [redacted] medication and fluids was not borne out by the factual situation. Our eCase records show that a Food and Fluids Record Chart was commenced on the 5th July (see attached Fluid & Food Chart and progress notes). We encouraged [redacted] to eat and drink as well as offer nutritional supplements as per dietitian's suggestion. I accept that this concern would have been perpetuated by my inability to access the electronic resident files on eCase when [redacted] visited. I started at Maples on 10 June 2019 and was in the process of learning how to navigate the system. I have since had more training on the use of Ecase. This is ongoing.

Failure to assist to the toilet

It was of significant concern that I heard [redacted] experience of seeking help to toilet [redacted] The staff response on this occasion was completely unacceptable and I sincerely apologise for this. We have reminded all staff of the importance of supporting residents when they are needed. No other tasks take precedence over this. As set out below, we will focus on our mission, vision, values and our commitment to delivering resident focused quality care at our next staff meeting and have brought forward our Wellness team training on the Living Well model and look forward to that being shared across all staff.

No pillows available

It was extremely disappointing to hear that staff declined [redacted] request for extra pillows for [redacted] as there were ample pillows and tri pillows available in the linen cupboard just beside [redacted] room. At the end of June, I personally reviewed all linen stocks and their condition. At that time numerous pillows of varying condition and several tri-pillows were counted. An order to restock old soiled pillows was placed and delivered to Maples on 12 July 2019. To prevent a reoccurrence of this we have addressed this directly with staff and set up a system to ensure stock is replaced as required.

Early intervention

We recognize that we could and should have referred [redacted] back to the Geriatrician earlier after the initial reassessment on 4th July as [redacted] general deterioration escalated. While we had hoped we could manage [redacted] care at Maples, it became increasingly evident that this was not possible. With the benefit of hindsight, we would have referred back to the Geriatrician and back into hospital care more quickly for more active treatment of [redacted] escalating weight loss and dehydration.

The concerns raised by this complaint have highlighted the need to establish better communication channels between residents, their families and staff as well as all members of the allied health team and staff.

At our next staff meeting, we will focus on our mission, vision, values and our commitment to delivering resident focused quality care. We will re-visit Altura staff education modules around customer service, Code of Rights, documentation and report writing with the aim being to refresh staff knowledge, improve critical thinking skills and ensure [redacted] experience is never repeated.

We have also highlighted with staff the importance of our Attitude of Living Well and Household Implementation. This training focuses on our 5 pillars – Eating Well, Moving Well, Resting Well, Thinking Well and Engaging Well and how they help us to focus on our relationships with both residents and each other. On their return the Wellness Champions will be sharing their knowledge with the wider staff group as we transition to the Arvida Living Well Model of Care.

In addition, we have identified a need to re-visit education around Enduring Powers of Attorney (EPOA). Both I and my Clinical Manager, [redacted] attended an ARC Forum on 25th July 2019 entitled Legal matters; Protection of Personal Property Rights Act, Enduring Power of Attorney, and Advance Care Planning to assist us to better understand this process.

We are planning at an upcoming Resident's meeting to bring in an expert on legal matters. We are hoping to include not only residents, but also their families and Maples staff. Our aim is to create more awareness around what is involved in getting EPOA and what it means.

We thank you for sharing information about the importance of ensuring that vulnerable individuals in our community who can easily slip through the system. As a result, we have revised our Respite enquiry/admission form to capture as much relevant information as possible prior to admission, e.g. what's been happening at home, current medical status, medications and EPOA contacts, to enable us to have a better understanding of the person's needs and can effectively manage their health and wellbeing. This is especially relevant when it is a repeat stay.

Once again, thank you for raising these issues with us and for working with me to look for solutions to improve service delivery at Maples. It is only if we understand the experiences of our residents and their families that we can take positive steps to ensure the issues you have raised do not happen again.

Yours sincerely

[redacted]

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

27.08.19

9(2)(a)

Dear 9(2)(a)

Re: The Maples - Arvida

Thank you for outlining your concerns regarding the care your 9(2)(a) *received while having respite care at the Maples. Your concerns specifically related to the inter-relationship between the staff and a failure to pass information on to senior staff, specifically you didn't think that the staff were clear about what to do when your* 9(2)(a) *started to deteriorate and that they treated* 9(2)(a) *as 'difficult' when they should have had a process in place to ensure that* 9(2)(a) *received prompt medical assessment. You also had concerns about a failure to provide standard care such as the provision of pillows and assistance with meals and mobilisation.*

Richard Scrase, Nursing Director Older People Population Health, and I met with 9(2)(a) *facility manager, and* 9(2)(a) *clinical manager, at the Maples on 14 August 2019.* 9(2)(a) *and* 9(2)(a) *acknowledged your complaint and expressed their regret at what happened during your* 9(2)(a) *stay, they both agreed that the care* 9(2)(a) *received was not up to standard and that staff should have intervened earlier, when your* 9(2)(a) *was starting to show signs of a change in* 9(2)(a) *condition, and that the issues with the food trays, pillows and mobilisation were unacceptable. They expressed their unreserved apologies for what had happened.*

9(2)(a) *advised us that they were using the issues raised regarding your* 9(2)(a) *care as a way to improve their service for other residents in their facility. They have introduced some specific staff training and adopted a process where any changes in a resident's condition must be notified to a registered nurse.* 9(2)(a) *also advised that they were looking at prioritising the employment of more staff.*

On 26 August 2019 9(2)(a) *provided us with a written response outlining the specific changes they have made as a result of your complaint, a copy of that letter is attached and summarised as follows: Wellness Team Training, a restocking system , the establishment of better communication channels between residents, families and staff, working with staff to refresh their understanding of the Code of Health and Disability Rights, customer service, (documentation and report writing with the aim to improve critical thinking and ensure that a similar situation does not arise), updated training regarding Enduring Powers of Attorney as well as a revision of the Respite Admission Form.*

Richard and I were satisfied that 9(2)(a) *had taken your concerns seriously and are actively working to ensure that a situation similar to the one your* 9(2)(a) *experienced does not arise again. As well as the steps that* 9(2)(a) *has outlined, Richard has offered to arrange to provide staff training on critical thinking to ensure that when someone's presentation changes in the way your* 9(2)(a) *did, that staff are taking a wider view of what may be happening and looking at multiple*

Level 2, 32 Oxford Tce, Christchurch, PO Box 1600, Christchurch 8140
Phone: (03) 364 4150, Facsimile: (03) 3644165

interventions/actions rather than relying on a single method to analyse an issue. We have also provided the South Island Alliance booklet on Delirium Capability Reflection for Teams for the staff to utilise.

I consider that this complaint is now closed.

I also advise that the Nationwide Advocacy Service act as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Telephone 0800 555 050
Email: advocacy.services@xtra.co.nz

Yours sincerely

Karen Dennison

Project Manager

cc: Richard Scrase
9(2)(a) [redacted]

Complaint 8
Bloomfield Court
10/06/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha
West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

BRN1685

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted]	**Date Received:** 10 June 2019
Received by: Karen Dennison via CDHB Website Complaint	**Address:** Bloomfield Court 9(2)(a) [redacted]
Email address: 9(2)(a) [redacted]	**Phone Numbers** **Mobile:** 9(2)(a) [redacted]

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

Yes, 9(2)(a) [redacted] complaining on behalf of 9(2)(a) [redacted]

DETAILS OF THE COMPLAINT

Name of Facility: Bloomfield Court

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

An appropriate procedure to deal with similar issues in future.

P&F STAFF MEMBER NAME	**DATES:**
Name: Karen Dennison **Date resolved**:28.06.19	19.06.09 complaint made on CDHB website 19.06.10 complaint forwarded to self to process 19.06.10 P/c to complainant and facility 19.06.26 Meeting at Bloomfield – development of Policy agreed.. 19.06.28 Letter to 9(2)(a) [redacted] closing complaint.

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

9(2)(a) [redacted]

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

28.06.19

9(2)(a) [redacted]

Dear 9(2)(a) [redacted]

Re: Bloomfield Court Complaint

Thank you for contacting us to outline your concerns regarding the care your 9(2)(a) [redacted] *received at Bloomfield Court, in particular that* 9(2)(a) [redacted] *was left on the floor from approximately 1.50am to 7am when she fell on 30 May 2019. You also felt that there had been a general slipping of standards at Bloomfield Court in the last couple of years.*

I reviewed the Certification Audit for Bloomfield Court dated 19 March 2019, this did not identify any concerns.

On 11 June 2019 9(2)(a) [redacted] *provided me with a copy of* 9(2)(a) [redacted] *letter to you regarding this matter and on 26 June 2019 Richard Scrase, Nursing Director Older Persons Population Health, and I met with* 9(2)(a) [redacted] *Bloomfield Court.*

It is difficult to assess a slipping of standards because this is a subjective question, however we were able to closely consider your concern about the 30 May incident. We agree that despite the care that was given and the fact that your 9(2)(a) [redacted] *was kept comfortable at the time and did not appear to suffer any ill effects as a consequence of this event, the response was inappropriate and the decision should not have been made to leave your* 9(2)(a) [redacted] *on the floor overnight. Considering this in retrospect,* 9(2)(a) [redacted] *agrees and has advised that she will work with Health Care Compliance Solutions to develop a Policy/Procedure for how to respond if a resident falls, particularly at night.* 9(2)(a) [redacted] *will provide Richard and me with a copy of the Policy once this has been developed and expects this to be available in four to six weeks. If you would like me to provide you with a copy of the Policy when I receive it please let me know and I will forward this to you.*

I'm pleased to hear that your 9(2)(a) [redacted] *is happy in* 9(2)(a) [redacted] *new premises. I hope that you* 9(2)(a) [redacted] *will feel satisfied with the knowledge that your complaint has resulted in a change to the Policy/Procedures to deal with any similar issues should they arise again at Bloomfield Court.*

We consider this complaint now closed.

We also advise that Nationwide Advocacy act as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Telephone: 0800 555 050

Level 2, 32 Oxford Tce, Christchurch, PO Box 1600, Christchurch 8140
Phone: (03) 364 4150, Facsimile: (03) 3644165

Email: *advocacy.services@xtra.co.nz*

Yours sincerely

Karen Dennison

Project Manager

cc: Richard Scrase
cc: 9(2)(a) [redacted]

Complaint 9
Elms Court Life Care
14/05/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted]	**Date Received:** 14.05.19
Received by: Alison Young	**Address:** **NA**
Email address: 9(2)(a) [redacted]	**Phone Numbers** Mobile: 9(2)(a) [redacted]

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

9(2)(a) [redacted]

DETAILS OF THE COMPLAINT

Name of Facility: Elms Court Lifecare

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

Withdrawal of premium room fee

P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young **Date resolved** 17.05.19	**14.05.19** Phone all from 9(2)(a) [redacted] with decision to make a formal complaint seeing no progress with owner. 15.05.19. Discussed with Greg Brogdon. Meeting with owner to discuss. 17.05.19 Owner wrote to family with drawing requirement

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

20 May 2019

9(2)(a) [redacted]

Dear 9(2)(a) [redacted]

Re: Premium room at Elms Court Lifecare

Thank you for bringing your concern regarding your 9(2)(a) [redacted] room being changed to a premium room.

In a situation where a rest home is sold, the new owner must take on the original Admission Agreement of each resident.

I discussed this issue with the owner 9(2)(a) [redacted] last week and I see he has emailed you retracting the need to pay the premium.

I will consider this complaint now closed, but please feel free to contact me if this issue does not settle.

The Nationwide Advocacy act as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Telephone: 0800 555 050
Email: advocacy.services@xtra.co.nz

Yours sincerely

Alison Young

Alison Young
Project Specialist

cc 9(2)(a) [redacted]

Complaint 10
Radius Hawthorne
27/03/2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a)	**Date Received:** 27.03.19
Received by: Alison Young via OPMH	**Address:** NA 9(2)(a)
Email address: 9(2)(a)	**Phone Numbers** Mobile: 9(2)(a)

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

9(2)(a)

DETAILS OF THE COMPLAINT

Name of Facility: Radius Hawthorne

- Dirty room
- Visit at lunch time Urine soaked bed and not cared for all morning
- Complained to clinical manager she said they have 93 other residents.
- Admitted to hospital with severe dehydration, delirium and pressure injury.

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young **Date resolved**: 10.04.19	07.04.19 Richard checked HCS. 02.04.19 Emailed 9(2)(a) to tell we will look into this. 03.04.19 RS & AY visited facility then RS reviewed notes 08.04.19 AY discussed with HealthCERT 10.04.19 AY drafted response letter RS checked 10.04.19 Response letter sent

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

10 April 2019

9(2)(a)

Dear 9(2)(a)

Re: Complaint 9(2)(a) care at Hawthorne Rest Home

Firstly, I have heard that your 9(2)(a) passed away 9(2)(a) My sympathy to you and your family. I can imagine that when there were areas of 9(2)(a) care at Hawthorne that you felt were not at the standard you expected this will have added to your distress at this time.

I am writing to explain our process for investigating your concerns, the results of our investigation and our plans to monitor improvements.

On 03 April, Richard Scrase, Nursing Director, Health of Older People, Canterbury DHB, and I met with the Facility Manager, the Clinical Nurse Manager and a Radius Operations Manager at the Hawthorne facility to understand your 9(2)(a) care while 9(2)(a) was there.

Following our meeting Richard reviewed Hawthorne's clinical notes in 9(2)(a) file as well as 9(2)(a) hospital file before and after 9(2)(a) stay at Hawthorne. There were some areas of your 9(2)(a) care while 9(2)(a) was at Hawthorne that Richard felt were not up to the standard we would expect. This included pressure area care, monitoring fluid intake, passing urine, bowel movements and documentation. Failure to manage these areas well can result in dehydration, delirium and pressure injuries.

While your 9(2)(a) did make providing some of 9(2)(a) care challenging at times, and 9(2)(a) could be resistive to cares; never the less, the facility is contracted to deliver fundamental cares to people with 9(2)(a)

Richard met with the facility and clinical managers again after his review to discuss your 9(2)(a) care. He also discussed the importance of careful assessment, documentation and follow up of anything that is outside the expected range. He discussed his expectation that the facility puts plans in place to ensure there is improvement.

We have asked one of our Gerontology Nurse Specialists to visit the facility on a regular basis to provide additional education to staff and assess progress being made toward improvement. If she identifies any other concerns, or lack of progress, we will return to the facility with a plan for management.

We have made a note for Hawthorne's next Ministry of Health's certification audit to ensure that these specific areas of assessment, follow up, monitoring and documentation are being maintained to the quality standard. This will enable us to keep a long term watch that improvements have been embedded.

Level 2, 32 Oxford Terrace, PO Box 1600, Christchurch.
Phone: (03) 364 4163, Facsimile: (03) 364 4165

We have told Hawthorne's Facility Manager that we would expect them to make contact with you regarding your 9(2)(a) care while 9(2)(a) was a resident there.

I want to thank you for bringing this concern to our attention. While I will consider this formal aspect of your complaint now closed, please be assured that we will continue monitoring until we are confident that there is improvement to an acceptable standard and that this is maintained.

We also advise that Nationwide Advocacy act as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Telephone: 0800 555 050

Email: advocacy.services@xtra.co.nz

Yours sincerely

Alison Young

Project Specialist

Complaint 11
Admatha
04/02/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted]	**Date Received:** 04.02.19
Received by: Alison Young	**Address:** 9(2)(a) [redacted]
Email address: 9(2)(a) [redacted]	**Phone Numbers** Mobile: 9(2)(a) [redacted]

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

EPOA for 9(2)(a) [redacted]

DETAILS OF THE COMPLAINT

Name of Facility: Admatha

- Respite care as transition to 'final admission'
- Returned home exhausted. Blister pack medication not given one day.
- Dirty ensuite
- Lost 4 Kg in 5 days
- Interview on arrival depersonalizing

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

DHB have long term respite beds

P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young **Date resolved**: 16.04.19	02.04.19 Complaint lodged 12.04.19 Discussed with Dementia Care NZ 15.04.19 Admartha sent report follow review of feedback from EPOA 16.04.19 Response letter sent

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

16 April 2019

9(2)(a) [redacted]

Dear 9(2)(a) [redacted]

9(2)(a) [redacted] customer service facilitator at Burwood Hospital, passed your website enquiry on to me, because I manage the contracts with Aged-related Residential Care providers in Canterbury.

Thank you for bringing your concerns to our attention. There were two main issues:

- Contradiction in advice
- 9(2)(a) [redacted] care during 9(2)(a) [redacted] respite care at Admartha.

I am unclear what you mean in your first comment 'Contradiction in advice when caring for a person with dementia at home and actual funded services provided'. Your suggested solution was to fund dedicated long term respite beds so the journey is patient centred.

Respite is never long term. It is to give the main carer a break and the maximum a person can have in a year is 28 days. Most people use this for short breaks, say one or two weeks at a time. Long term care is admission under the Age-related Residential Care Agreement. The DHB pays contracted providers a rate per day for each bed occupied. In Canterbury we have over 700 empty beds in Aged Residential Care across the four levels of care. The DHB does not get involved in how rest homes manage their booking system for respite. They need to do this in a way that gives them confidence that they will be able to provide the level of care required.

I spoke with the clinical manager at Admartha and then to 9(2)(a) [redacted] from Dementia Care NZ who own Admartha. They told me that they were reviewing the issues that you raised in your feedback following 9(2)(a) [redacted] stay. These were the same issues you submitted to the DHB via the website. I felt it was reasonable for them to complete this and report their findings to me before I stepped in to investigate.

I have now received their report. 9(2)(a) [redacted] has informed me that they will make contact with you to discuss it, as part of their process for quality improvement. For this reason I won't go into the details of each item you raised, but will comment that they found areas where they:

- accept they made a mistake, for example, the room not being up to standard for cleanliness.
- didn't follow their expected standards, such as the admission process.
- found opportunities for improvement. This includes having clearer guidelines for medication management between people at the facility under the Canterbury DHB's Aged-related Residential Care Agreement and the Respite Agreement. This is a grey area for all facilities, but they have decided that they will make a standard process to avoid confusion for staff, as well as relatives and partners.

Level 2, 32 Oxford Terrace, PO Box 1600, Christchurch.
Phone: (03) 364 4163, Facsimile: (03) 364 4165

I believe that Admartha has followed a good process in following up your feedback. I would encourage you to accept their invitation to discuss this, because they are keen to learn from your experience to improve their service.

I will consider this complaint closed, but if you feel that your meeting with Admartha and Dementia Care NZ staff doesn't meet your expectations then please feel free to contact me again and I can follow up.

The Nationwide Advocacy act as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Telephone: 0800 555 050

Email: advocacy.services@xtra.co.nz

Yours sincerely

Alison Young

Project Specialist

Cc 9(2)(a) Burwood Customer Service facilitator.

Admatha
CHRISTCHURCH

34 Averill Street
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Christchurch 8013
Ph: 03 385 1286
F: 03 386 3240
E: 9(2)(a)
W: www.admatha.co.nz

15th April 2019

Dear Alison,

Thank you for the complaint you lodged via an email to 9(2)(a) Dementia Care NZ (DCNZ) on the 10th of April 2019. The complaint was made to the CDHB by 9(2)(a) regarding the care of 9(2)(a) partner 9(2)(a) while 9(2)(a) respite care period at Admatha rest home from 4th of March 2019 till 9th March 2019.

We welcome every complaint as it provides us with an opportunity to improve the care we provide to our residents. This letter is to advise you that your complaint has been entered into our complaints register.

Any complaint we receive is taken extremely seriously. It is important to us that the issues raised are fully investigated and any findings satisfactorily addressed.

We follow a formal process for every complaint. Your complaint will be investigated by me 9(2)(a) 9(2)(a) (Clinical Quality Coordinator, Dementia Care NZ) alongside the Clinical Manager of Admatha Dementia Care 9(2)(a) will provide oversight and guide the investigation. The DCNZ Directors will be kept fully informed of our progress.

Following the investigation a meeting will be initiated to provide you with any relevant information and to discuss the outcomes from this complaint. At the conclusion of this process, you will receive a letter summarising the complaint, the findings and outcomes. If you have any concerns in the interim with the way your complaint is being processed you are most welcome to contact 9(2)(a)

We value our relationship with you and your team, Alison, and are most appreciative of your bringing these concerns to our attention.

Yours sincerely

9(2)(a)

DCNZ

Complaint 12
Admatha
10/04/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha
West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted]	**Date Received:** **10.04.19**
Received by: Alison Young	**Address:** 9(2)(a) [redacted]
Email address: NA	**Phone Numbers** 9(2)(a) [redacted]
ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)	
9(2)(a) [redacted]	
DETAILS OF THE COMPLAINT	
Name of Facility: Admatha	
WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?	
Better food, more staff.	
P&F STAFF MEMBER NAME	DATES:
Name: Alison Young **Date resolved**: 26.04.19	**10.04.19** Complainant called on phone 15.04.19 Information from Admatha re plan for investigation 18.04.19 Resport from investigation 26.04.19 Response letter sent

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

26 April 2019

9(2)(a)

Dear 9(2)(a)

You will recall that we spoke on the telephone on 10 April with concerns about your 9(2)(a) care at Admatha following. You had three main issues:

1. A resident pushed 9(2)(a) which resulted in 9(2)(a) falling and fracturing 9(2)(a) hip.
2. The meals were not up to expectation; especially 9(2)(a) gluten free meals 9(2)(a) 9(2)(a)
3. Staff off duty in the afternoons are always on their phones and doing kung foo in the lounge.

I have spoken to 9(2)(a) from Dementia Care NZ who own Admatha. She agreed to provide oversight of Admatha's investigating your complaint.

9(2)(a) told me that you submitted an official complaint to Admatha on 01 April with similar concerns. For this reason I have not investigated the details, but rather reviewed the investigation process that Admatha used to review the incident. While the staff work hard to provide a secure environment for all residents, it is unfortunate that sometimes things get out of control no matter how many staff are present. I understand that you have been invited to a meeting with the staff to provide you with an opportunity to give your perspective and share ideas that you think may support caring for 9(2)(a)

Your second complaint regarding the meals. The facility uses a dietician approved menu and 9(2)(a) diet needs to be adhered to. All the processes are in place for this to happen, so it is disappointing that it is overlooked some times. My suggestion is to alert the staff to this every time a meal with gluten in it is given to 9(2)(a) I would suggest you report it to the registered nurse on duty as well.

Your third complaint about staff on their cell phones and doing kung foo in the lounge is unclear. The staff deny this occurring. Again, if you see it happening the best way to manage it is to report it at the time to the registered nurse on duty.

I have reviewed the investigation process that Admatha use and feel that they have investigated your complaints appropriately.

Level 2, 32 Oxford Terrace, PO Box 1600, Christchurch.
Phone: (03) 364 4163, Facsimile: (03) 364 4165

I hope [redacted] continues to improve [redacted] It is a challenging time for you and I can understand you wanting to spend time together and comfort each other under these difficult circumstances.

We consider this complaint now closed.

There is a Nationwide Advocacy act as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Telephone: 0800 555 050

Email: advocacy.services@xtra.co.nz

Yours sincerely

Alison Young

Project Specialist

Complaint 13
Windsor House
11/04/2019

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER:

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted]	**Date Received:** 11.04.19
Received by: Alison Young	**Address:** 9(2)(a) [redacted]
Email address: NA	**Phone Numbers** 9(2)(a) [redacted]

ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)

9(2)(a) [redacted]

DETAILS OF THE COMPLAINT

Name of Facility: Windsor House

Slowness in responding to 9(2)(a) [redacted] declining condition.

Not happy with Facility Manger's response to 9(2)(a) [redacted] complaint.

WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?

Improved response to acute events.

P&F STAFF MEMBER NAME	**DATES:**
Name: Alison Young **Date resolved**: 01.03.19	10.04.19 Called 9(2)(a) [redacted] to discuss 15.04.19 RS collected clinical notes to review 23.04.19 RS review completed 26.04.19 Draft letter sent to RS to review 24.04.19 Letter sent to complainant and complaint closed 01.05.19 Visit to facility

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Planning and Funding

26 April 2019

Dear 9(2)(a)

You will recall that I spoke to you on the telephone on 11 April due to concern about 9(2)(a) 9(2)(a) care at Windsor House. There were two main issues:

- Lack of response by staff when you alerted them to 9(2)(a) 'scrambled' speech and 9(2)(a) limp left arm.
- The Facility Manager's 9(2)(a) letter to you was long and filled with detail. This resulted in you feeling that you were being fobbed off.

I asked Richard Scrase, Nursing Direction Older People - Population Health, to review 9(2)(a) 9(2)(a) clinical notes to understand what happened, and whether 9(2)(a) care was at the standard that we expect.

Richard has now completed his investigation of notes from both Windsor and the hospital. The hospital notes confirm that 9(2)(a) did have a type of stroke.

The rest home's notes show that the actions by the staff following the first observation were not appropriate for a suspected stroke. The change in 9(2)(a) condition should have been escalated urgently to 9(2)(a) general practitioner by telephone and an ambulance called.

Your second concern regarding 9(2)(a) letter. I have read this, and I agree that it is too long and not written in a manner that is helpful to you. There is also some incorrect clinical information about 9(2)(a) stroke.

Richard and I intend to meet with 9(2)(a) Clinical Manager, and 9(2)(a) to discuss his report. We will also provide 9(2)(a) with some feedback from his letter and direct him to information that will help him with writing responses to concerns from residents and relatives in the future.

I understand that the Community Stroke Team is still visiting 9(2)(a) at the rest home to provide a programme of physiotherapy based rehabilitation. I hope 9(2)(a) is making a steady improvement.

I will consider this complaint now closed.

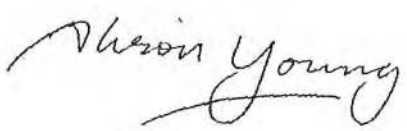
Level 2, 32 Oxford Terrace, PO Box 1600, Christchurch.
Phone: (03) 364 4163, Facsimile: (03) 364 4165

There is a Nationwide Advocacy act as agent to the Health and Disability Commission should you wish to take this complaint further. Their contact details are:

Telephone: 0800 555 050

Email: advocacy.services@xtra.co.nz

Yours sincerely



Alison Young

Project Specialist

Health of Older People

Complaint 14
Pacific Haven
31/07/2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER: 9(2)(a) [redacted]

PLANNING AND FUNDING COMPLAINTS FORM

Name of Complainant: 9(2)(a) [redacted]	**Date Received:** 31 July 2019
Received by: Karen Dennison via 9(2)(a) [redacted] Health Cert	**Address:** Pacific Haven
Email address: 9(2)(a) [redacted]	**Phone Numbers** 9(2)(a) [redacted]
ANY RELATIONSHIPS (EG FAMILY MEMBER COMPLAINING ON BEHALF OF ANOTHER FAMILY MEMBER)	
Yes, 9(2)(a) [redacted] complaining on behalf of 9(2)(a) [redacted]	
DETAILS OF THE COMPLAINT	
Name of Facility: Pacific Haven	
WHAT WOULD BE AN ACCEPTABLE OUTCOME FOR THE COMPLAINANT?	
P&F STAFF MEMBER NAME	**DATES:**
Name: Karen Dennison **Date resolved:**	19.07.31 Complaint forwarded from health cert 19.08.01 P/C to 9(2)(a) [redacted] discussed complaint, agreed to my obtaining 9(2)(a) [redacted] letter of complaint from 9(2)(a) [redacted] social worker. Further p/c to advise I would wait for PH's response before looking in to this. 19.08.02 p/c to 9(2)(a) [redacted] 9(2)(a) [redacted]

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

REFERENCE NUMBER: 9(2)(a) [redacted]

	19.08.19 p/c from 9(2)(a) [redacted] have response from PH, unhappy, talking with a lawyer and will come back to me 19.08.19 p/c from 9(2)(a) [redacted] has response from PH, unhappy, seeing a lawyer and will then come back to me.

Complaint re 9(2)(a) [redacted]

31/07/19 Complaint via 9(2)(a) [redacted] from Health cert who was contacted by 9(2)(a) [redacted] concerned about 9(2)(a) [redacted] care at Pacific Haven. 9(2)(a) [redacted]

1.08.19 P/c to 9(2)(a) [redacted] discussed 9(2)(a) [redacted] concerns and agreed to my obtaining a copy of 9(2)(a) [redacted] letter of complaint from the social worker. I spoke with the 9(2)(a) [redacted] social worker, 9(2)(a) [redacted] who provided me with a copy of 9(2)(a) [redacted] complaint. Complaint dated 27 July and asked for a response by the end of August. In interests of clear and fair process advised 9(2)(a) [redacted] that we would wait for Pacific Haven's response before investigating. Agreed that 9(2)(a) [redacted] will re-contact me once 9(2)(a) [redacted] has received the response and decide what 9(2)(a) [redacted] wishes to do from there.

2.08.19 P/C to 9(2)(a) [redacted] outlined role and advised would wait for PH response. 9(2)(a) [redacted] will contact me when 9(2)(a) [redacted] hears back from PH.

19.08.19 p/c 9(2)(a) [redacted] Has response from Pacific Haven -appalled and seeing a lawyer about this. Also reiterated issue about other resident taking 9(2)(a) [redacted] computer – unhappy that police are not charging 9(2)(a) [redacted]

We agreed that I would wait to hear back from 9(2)(a) [redacted] once 9(2)(a) [redacted] and 9(2)(a) [redacted] have spoken with the lawyer and decided what they want to do . 9(2)(a) [redacted] will provide me with a copy of PH's letter of response.