DHB Office Braemar Campus



Private Bag 18 Nelson, New Zealand

2 July 2021
Via Email:

Thank you for your request for official information received 22 April 2021 by Nelson Marlborough Health (NMH)¹, followed by the necessary extension of time 21 May 2021 and notice of decision 21 June 2021, where you seek the following information:

Part 1

Dear

 Copies of all complaints received about aged care facilities/rest homes since January 1 2020, and all related correspondence, reports, documents and memoranda.

Part 2

Copies of any reports, documents, memoranda, correspondence, legal advice or emails, both internal
and external regarding how aged care facilities/rest homes and their residents fared during Covid-19
related restrictions (such as lockdowns but also ongoing visitor restrictions), including any concern about
the impact on residents, or staffing levels. This part of the request is not intended to capture usual or
normal correspondence with facilities, but more any documents etc that mention or outline how the
unprecedented events of 2020 affected facilities.

NMH response: Part 1 - Complaints received

NMH received nine complaints about age-related residential care services from 1 January 2020 to 7 May 2021. Due to the small size of a number of these residential care settings, level of detail in the communication and easily discoverable information in the file notes relating to residents, the family of the residents, and staff working with the resident, NMH finds it necessary to withhold the original complaints, and supporting investigation documents, to maintain the privacy of natural persons under section 9(2)(a) 'to protect the privacy of natural persons, including that of deceased natural persons'. In the circumstances, the withholding of that information is not outweighed by other considerations which render it desirable, in the public interest, to make that information available. At this time, we believe that withholding this level of information from public release, on these grounds is the only basis that ensures these documents and processes, intended to manage primary health care delivery can be meaningful, and assist NMH to perform its responsibilities, and maintain the effective conduct of its public affairs.

Further, we are withholding the original complaints under section 9(2)(b)(ii) 'to protect information where the making available of the information would be likely unreasonably to prejudice the commercial position' of aged residential care providers.

A summary of complaints and the related investigation findings are provided in Tables One to Seven below.

¹ Nelson Marlborough District Health Board

TABLE ONE

Complaint	Action by NMH	Comments / Timeline	Overall Finding
Unsafe work practices	Investigated by NMH Raised with <i>HealthCert</i> and investigating under auditing process	12 January 2021: Complaint received from <i>HealthCert</i> via email 13 January 2021: NMH commences investigation 13 May 2021: Awaiting outcomes from unannounced surveillance audit 29/06/2021: Based on findings from recent unannounced surveillance audit, HealthCert advised complaint closed due to concerns not substantiated. Unable to follow up with complainant directly for further information as anonymous.	Not substantiated

TABLE TWO

Complaint	Action by NMH	Comments / Timeline	Overall Finding
Staffing Personal cares	Investigated by NMH Discussion between NMH & family, and NMH and Facility	4 January 2021: Complaint received from family member via email 5 February 2021: NMH commences investigation 5 February 2021: Complainant advises NMH does not wish to pursue complaint 17 February 2021: Letter from Facility responding to complaint for review 23 February 2021: Complaint closed	Not substantiated

TABLE THREE

Complaint	Action by NMH	Comments / Timeline	Overall Finding
Personal Care Care Communication between families and management	members, staff and Facility	19 June 2020: Complaint received from family member via email 20 June 2020: NMH commences investigation 30 June 2020: Complaint responded to by Facility 25 September 2020: Investigation closed by NMH	Partially substantiated

TABLE FOUR

Complaint	Action by NMH	Comments / Timeline	Overall Finding
Facility Incident management process Employee escalation	Conversations held with Fac manager and complainants	lity 22 March 2021: Complaint received from employee 22 March 2021: NMH commences investigation and raises employee complaint with Facility 27 April 2021: Facility responds to NMH 6 May 2021: NMH reviewing response from facility. 11 June 2021: NMH email to facility to advise that is satisfied that the information provided addresses the concerns raised by a previous employee. 29 June 2021: Response to complainant regarding outcome of findings from documentation and discussion held with provider	

TABLE FIVE

Complaint	Action by NMH	Comments / Timeline	Overall Finding
Concerns relate to; meals, cleanliness, staff turnover	Conversations held with Facility manager and complainants	22 March 2021: Complaint received from family member 22 March 2021: NMH commences investigation and raises concerns with Facility 9 April 2021: Facility responds to NMH 13 April 2021: Response fed back to family. Further information requested by family 21 May 2021: further information received from provider. Information assessed. NMH satisfied that the information provided addresses the concerns raised. 28 June 2021: Complaint closed	Not substantiated

TABLE SIX

Complaint	Action by NMH	Comments / Timeline	Overall Finding
Care (change in level of care) Communication between families and management	Investigated by NMH Meetings/ discussions with family members, staff and Facility management and ownership	19 January 2021: Complaint received from family member via email 20 January 2021: NMH commences investigation 20 January 2021: 15 March 2021 – ongoing communication between NMH, family and Facility. 15 March 2021: Investigation by NMH resolved and closed	Partially substantiated
2. Lack of staff uniforms	Investigated by NMH Discussions with Facility and family member	30 June 2020: Complaint received from family member via email 6 August 2020: Investigation by NMH resolved and closed	Not substantiated

TABLE SEVEN

Complaint	Action by NMH	Comments / Timeline	Overall Finding
Communication between resident and management	Investigated by NMH Discussions with resident, and management	16 March 2021: Complaint received from resident via phone 16 March 2021: NMH commences investigation 30 March 2021: Investigation closed	Partially substantiated
Communication between employees and management Process and procedures	Investigated by NMH Meetings/ discussions with family members, staff and Facility management and ownership	15 March 2021: Complaint received via email 16 March 2021: Investigation commenced by NMH. External reviewer commissioned to undertake review. 29 June 2021: Findings made available by external reviewer and final report being reviewed by NMH. Areas for improvement will be drafted into actions for recommendation to involved parties	Substantiated

NMH response: Part 2 - COVID-19 impact

With older people one of the most vulnerable population to COVID-19, service delivery during Level 4 lockdown was reassessed and amended to ensure their safety. Most Age-Related Residential Care providers referred to Ministry of Health guidance, however many providers continued to adhere to Aged Care Association guidance resulting in barriers to bed access and isolation measures beyond recommended guidance. Continual change in lockdown levels and visitor restrictions can place undue stress for some families. For example, when Auckland moved to Level 3, many providers outside the district changed their restrictions.

It was not noted that staffing levels were negatively impacted by COVID-19.

NMH undertook a review of aged care capacity (completed at the beginning of 2020) that found, despite increasing demographic trends, with planned sector growth, no immediate concern regarding bed availability across the aged care sector, with note that consideration be given to availability of Dementia beds in the short to moderate term. Following the COVID-19 response that situation has changed. At the end of 2020, bed pressures in aged residential care were seen across the district as reduced social interaction and effective infection control meant that fewer elderly people died as a result of seasonal illness. This demand and limited supply of beds was a direct, unintended consequence of the effectiveness of the COVID-19 infection prevention response. There is some evidence that bed availability is starting to return to normal patterns, but it will take time to develop reliable bed capacity across all levels of care.

This response has been provided under the Official Information Act 1982. You have the right to seek an investigation by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or free phone 0800 802 602.

If you have any questions about this decision please feel free to email our OIA Coordinator OIArequest@nmdhb.govt.nz I trust that this information meets your requirements. NMH, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released. If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider.

Yours sincerely

Lexie O'Shea
Chief Executive