

Information about Complaints

Report for District Health Boards 01/01/07 – 30/06/07

The following report presents data concerning complaints related to District Health Boards received by HDC over the six-month period 1 January — 30 June 2007, and those closed in the same time period. For incoming complaints, the report provides statistical information about the frequency of complaints involving specific Code rights relative to other Code rights, over all 21 DHBs. It also compares the frequency of incoming complaints for this period with that for two previous half-years. For closed complaints, the report provides information about the way incoming complaints were resolved. Please note that not all complaints received within one 6-month period are closed within the same period; some take longer than 6 months to resolve. Certainly this applies to cases that are resolved by investigation. Outcomes of complaints that are resolved by investigation are reported when the case is closed.

The case material is included to share lessons learned, to encourage reflection on systems and practices, and to identify where changes may be helpful in order to improve the quality and safety of health care.

Frequency of complaints classified by rights

There were 295 new complaints involving DHBs for the period 01/01/07 – 30/06/07. Incoming complaints are classified according to the Rights set out in the Code of Health and Disability Services Consumers' Rights. The Right most clearly associated with each complaint is recorded on initial assessment of each complaint. After preliminary enquires and investigations have been undertaken, a complaint may be found to involve more than one of the Rights. A complaint may also involve more than one provider, for example a physician and a DHB. Some complaints are associated with issues other than alleged breaches of Code rights, such as access to or funding of services, or issues outside the jurisdiction of HDC; these are identified as 'Other issues'. The subjects of the complaints are listed in Table 1 below and the distribution of complaints with respect to rights involved is illustrated in the following graph.

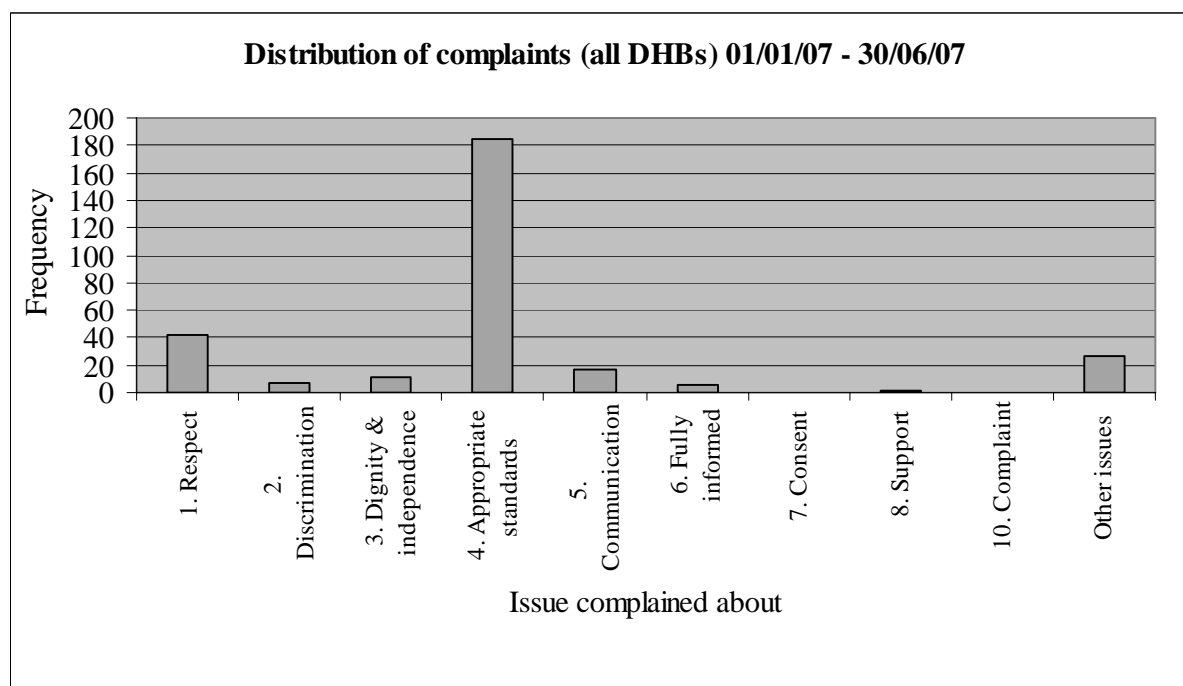
Table 1: Subject of complaints

Right associated with complaint	Number of complaints
Right 1 Respect and privacy	42
Right 2 Fair treatment	7
Right 3 Dignity & independence	11
Right 4 Appropriate standards	184
Right 5 Effective communication	17
Right 6 Adequate and appropriate information	6
Right 7 Choice and consent	0
Right 8 Support	2
Right 9 Rights during teaching and research	0
Right 10 Having a complaint taken seriously	0
Other issues (e.g. outside the Commissioner's jurisdiction)	26

TOTAL

295

Figure 1: Distribution of Complaints



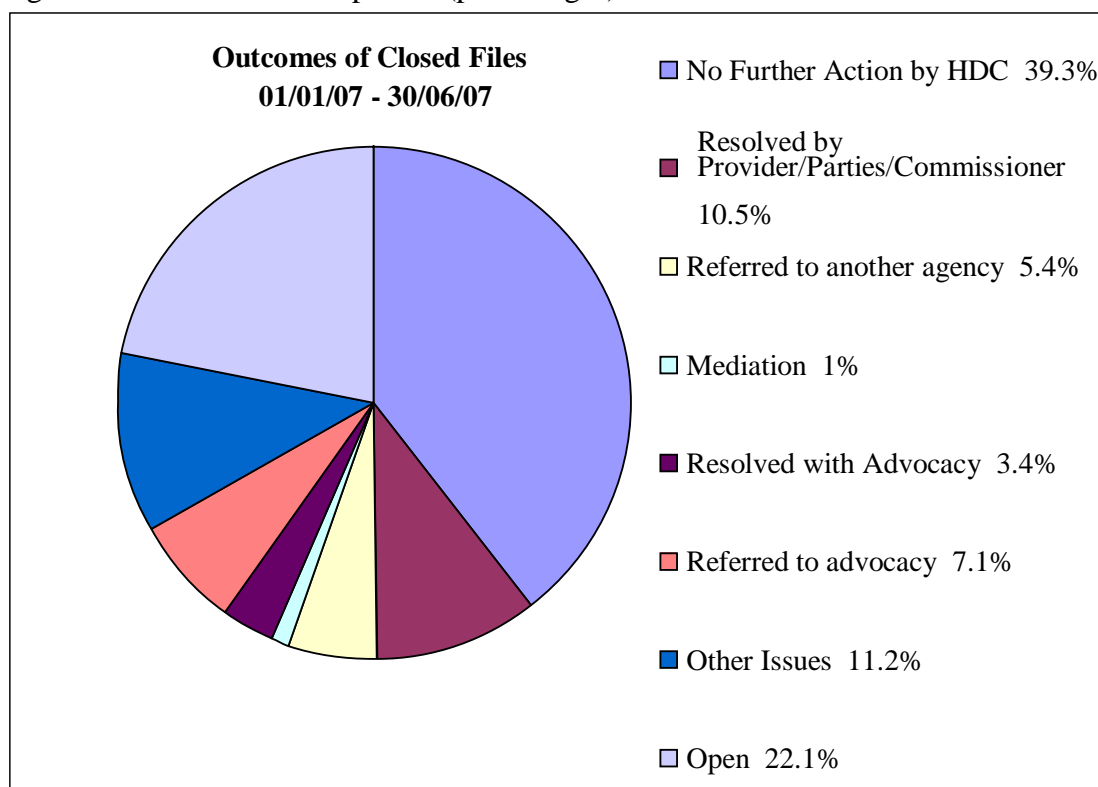
Outcomes of complaints

A large majority (80%) of the new complaints received involving DHBs between 1 January and 30 June 2007 were closed within this six month period without formal investigation (295 new complaints received; 220 new complaints closed). A large proportion (39.3%) of the 295 complaints received resulted in no further action being taken. Thirty-one complaints were referred to Advocacy; of these, 10 have been resolved and 21 await resolution. A further 31 were resolved by the providers, the parties themselves or the Commissioner. Sixty-five remain open; these include complaints currently in the assessment stages, or under investigation. Thirty-three complaints were found, following preliminary enquiries, to concern be outside the Commissioner's jurisdiction, or to involve issues such as access to services, funding and resources, and are designated as 'Other issues'. The outcomes are listed in Table 2 below and illustrated in the following graph (Figure 2).

Table 2: Outcome of complaints

Outcomes	Number of complaints
No further action by HDC	116
Resolved by Provider/Parties/Commissioner	31
Referred to another agency	16
Referred to Mediation	3
Resolved with Advocacy	10
Referred to advocacy and awaiting resolution	21
Other issues (Outside HDC's jurisdiction, access to services)	33
Open	65

Figure 2: Outcomes of complaints (percentages)



Learning from Complaints

1.0 Investigations and Breach cases involving DHBs

In the period 1 January – 30 June 2007, 8 investigations involving DHBs were closed. In 5 of the complaints, the DHBs involved were found to be directly liable for breaches of the Code; in one instance, this was because of the delay in responding to the complaint. Seven providers involved were also found in breach of the Code: two clinicians, two nurses, and three midwives. The five DHB breach reports are summarized below.

1.1 Case 1: Communication and continuity of care

A woman with possible cardiac symptoms was referred to hospital by her GP three times over the course of eleven days. On all three occasions, the patient was discharged without handover to her GP; she died at home on the day after her final discharge. The case highlighted deficiencies in internal communication between clinicians, and in the way the hospital managed the interface between primary and secondary care. Systems for the receipt and documentation of referral information, and the management of discharge information, were inadequate, and meant that the patient did not receive appropriate continuity of care. In these circumstances the DHB breached Right 4(5) of the Code. In response to these events, the DHB, in consultation with regional GPs and hospital doctors, is reviewing current practice and procedure in relation to the management of acute referrals and discharge information for ED patients. The DHB has also reviewed the timeliness of its radiological services. (Opinion 05HDC14141, 28 February 2007, www.hdc.org.nz)

1.2 Case 2: Inadequate nursing and medical care

A man admitted to hospital was initially treated for acute asthma. Tests taken on admission were not reviewed until 30 hours later despite several visits by medical staff. Instigation of the

correct diagnosis and treatment was too late to prevent his deterioration and death within 48 hours. The DHB failed to respond adequately to legitimate queries from the patient's family.

The care provided by nursing and medical staff was inadequate with regard to communication, documentation, handover and monitoring of the patient's condition, resulting in breaches of Rights 4(1) and 4(5) of the Code by several individuals. Flaws in the hospital systems included failure of staff to monitor, record, communicate and review vital information; poor handover; staff shortages; and lack of supervision of staff. These failures compromised safety and continuity of care and constituted breaches of Rights 4(1) and 4(5) of the Code. In regard to the lack of respect and compassion exhibited by staff, the DHB breached Right 1(1).

Following this case the DHB made improvements including the introduction of an admission to discharge planner, the introduction of an electronic digital radiology service, increased medical staffing (especially registrars), and a formalized process to review deaths. The DHB has been asked to review the management of hospital patients who have a nicotine addiction, and to review its systems for physiologically unstable patients in light of the expert advice on the matter, and then to report actions taken to improve the quality of care to these patients.

In view of the systemic problems underlying the poor care delivered by the DHB, the need for accountability for systems failures, and the public interest, the DHB was referred to the Director of Proceedings. The case has now been settled. (Opinion 05HDC11908, 22 March 2007, www.hdc.org.nz)

1.3 Case 3: Communication and integration in mental health services

A 17-year-old woman who had been under the care of the local city Child and Adolescent Mental Health Service (CAMHS) was transferred to a Home in another town, even although she was younger than the Home's usual clients. The Home relied on the city CAMHS for psychiatric services, but the Home and DHB did not have an established working relationship where provider roles, relationships and expectations were clarified. There were delays in getting psychiatric assessments and the woman committed suicide.

The poor care was attributed to a lack of clear systems and well-functioning inter-service relationships. Both the Home and the DHB were found in breach of Rights 4(1) and 4(2) for failure to provide services with reasonable care and skill and in compliance with relevant standards, and Right 4(5) for failure to cooperate to provide continuity of care.

The DHB has responded by reviewing its practice and relationships with other mental health providers in the area, improving communication, integration, and responsiveness of clinical and support services across mental health and addiction services, introducing a bi-monthly newsletter, and increasing the frequency of, and attendance at, managers' meetings. (Opinion 05HDC05329, 24 May 2007, www.hdc.org.nz)

1.4 Case 4: Neonatal nursing care

Three hospital midwives failed to adequately detect and monitor neonatal hypoglycaemia in a baby who subsequently suffered neurological damage. Shortcomings included not recognising and responding to the change in the baby's feeding pattern, failing to fully document care provided (breaches of Rights 4(1) and 4(2) of the Code), and failing to document a care plan for the baby (a breach of Right 4(2)). As a result of these events the DHB reviewed its breastfeeding policy and introduced a policy for neonatal hypoglycaemia prevention and management; it has now been asked to review this policy in light of the expert comment regarding current practice. The DHB was also advised to undertake an audit of neonatal

breastfeeding recording, and staff awareness of policies regarding assessment and monitoring of the nutritional requirements of low weight/at risk infants. (Opinion 05HDC16723, 28 June 2007, www.hdc.org.nz)

1.5 Case 5: Team work between specialties

A woman was found at 21 weeks' gestation to have a significant redevelopment of previously treated congenital aortic stenosis. She was cared for by a number of providers from different specialties, both in her region and at the city hospital to which she was admitted with a view to prolonging pregnancy. At 29 weeks' gestation, her condition deteriorated and, despite emergency surgery, both mother and baby died.

The woman's care was adversely affected by the failure of the various clinical teams to work together effectively, and in a manner that minimised potential harm, highlighting shortcomings in the DHB systems for integration and coordination of care. The DHB breached Rights 4(4) and 4(5) of the Code.

The GP, midwife (LMC) and obstetrician received adverse comment because of their failure to discuss the all options available to the patient once the significance of her cardiac condition became known — including termination, which she had raised, and which all three were aware of — effectively depriving her of the opportunity to make informed choices about her care.

In response to this case, the cardiology and Materno-fetal Medicine Services have changed their processes to ensure that the all cardiology consultations with pregnant women are scheduled as urgent; that these women are seen by the Specialist cardiologist; and that there is now mandatory re-evaluation of all women considering pregnancy (at both the cardiology service and pre-pregnancy counselling clinic) by the materno-fetal medicine specialist. (Opinion 05HDC13401, 29 June 2007, www.hdc.org.nz)

2.0 Responding when things go wrong

In Case 2 above, the DHB failed to respond adequately to legitimate queries from the patient's family. The Commissioner noted that when a patient is harmed or dies unexpectedly during an admission, management and clinicians owe families a duty of candour — to openly discuss and honestly disclose what has happened and to apologise for any shortcomings in care.

In Case 4 above, the DHB failed to respond to requests from HDC for information related to this complaint for eight months, despite a total of 16 follow-up contacts. In failing to facilitate a speedy and efficient response to the complaint, the DHB breached right 10(3) of the Code. The DHB is to undertake two independent reviews of their complaints management system, one by the internal auditor, and the other by Barbara Crawford, Quality and Risk Manager for Waikato DHB.

3.0 Lessons from complaints not investigated by HDC

Lessons can be learned, not only from complaints where investigations have been carried out (which may or may not result in breach findings, and which are listed on the HDC website www.hdc.org.nz), but also from complaints that do not progress to investigations, and which result in a 'no further action' outcome.

3.1 The circumstances of a 'no further action' outcome may vary. For example, preliminary information received from the provider(s) involved, and/or an appropriate HDC

independent expert and/or the Commissioner's clinical advisor Dr Stuart Tiller, may indicate that the care complained about was appropriate, and there was no apparent breach of the Code. Or, the steps taken by a DHB on receipt of a complaint may pre-empt the need for HDC action. Where a DHB has adequately dealt with the complaint, completing (if necessary) a thorough investigation into the episode of care complained about, and taking appropriate steps to rectify any evident shortcomings, there may be nothing further to be achieved by instigating an HDC investigation.

In other circumstances a patient may have complained directly to the DHB and, having received no response, or a response they considered unsatisfactory, have forwarded the complaint to the Commissioner, who may then address any issues of concern.

4.0 Changes to systems and processes

In the cases summarized below, DHBs have responded to complaints by making changes in their systems and processes to improve the quality and safety of care.

4.1 MRSA protocol

Following surgery for the removal of a foreign body from her hand, a 4-year-old child developed necrotizing fasciitis, resulting in amputation of her finger. The DHB's internal investigation revealed that its policy had not been effective in identifying the patient's MRSA status and prompting re-screening. It has subsequently reinforced its procedures for screening for MRSA, and has improved Clinical Records procedures to ensure that a Chart Tracking Summary (including any Medical Alert Warnings) is included in the new patient file, even where there are no previous in- or out-patient records, and that admissions data is included.

4.2 Patient identification

A patient who had attended the gastroenterology day unit was found on discharge to be wearing another patient's identification bracelet. The DHB confirmed that the patient had received the right procedure and the correct medications; however their investigation revealed both human error and systems issues. A range of systems improvements have been made. These include: issue and first check of ID bracelet by nurse admitting the patient; second check by a nurse and clinician by checking the bracelet with the patient (if possible) and against the medical record before consent and before administration of drugs; revised outpatient/inpatient Assessment and Procedure forms which require a recorded action (tick box) by each nurse; the Procedure Record also requires a signature confirming identification. In addition, the new policy for patient identification has been extended into bronchoscopy suite, and a formal "Team Time Out" policy (checking patient identification, site and procedure) has been rolled out hospital-wide.

4.3 Pressure sore management

A complaint regarding care provided to a tetraplegic patient during a 5-day hospital stay had been largely addressed by the DHB, however, the Commissioner remained concerned regarding the failure of the DHB to provide the patient, who had been assessed as being at risk of developing pressure sores, with a pressure relief mattress, despite his requests. As a result of the complaint, the DHB has introduced the "Waterlow Score" tool for assessing and managing pressure area risk and guiding mattress selection. (Re-evaluation using the tool confirmed that patient care had fallen below the required standard in this case.) The DHB reported that this issue is also being reviewed across the district in an effort to standardize the approach and to improve the continuity of care between multiple providers (hospital, respite carers, rest homes etc).

4.4 Specialist referrals

A patient complained directly to the DHB regarding difficulty securing a specialist appointment. The process, over 7 months, involved three written GP referrals and 8 phone conversations, in addition to 4 calls not returned as promised. The DHB response was that the second letter was 'misfiled or misplaced' and promised to review the referral, booking and notification processes. The matter was subsequently brought to the attention of the Commissioner, who asked for feedback from the DHB. Changes made to reduce the likelihood of delays include: (i) the frequency of prioritization of referrals by an orthopaedic consultant had been increased from weekly to twice-weekly, so patients and GPs get earlier notification of the outcome of the referral; and (ii) the filing system for referral letters has been changed and is now based on stage in the process, making them easier to locate.

4.5 Information, communication and consent regarding procedures

Two complaints concerned the provision of adequate information to patients about to undergo procedures. In one case, a patient who suffered a perforation as a complication of an oesophageal dilatation complained that he had not been informed of this complication and its implications. Subsequently, the DHB has undertaken to develop an explanatory pamphlet to be sent out to all patients being booked for this procedure (giving them the opportunity to read information before the day of the appointment), and risks specific to this procedure will be detailed on the consent form in language that can be easily understood by the patient. The need to discuss possible complications, and their possible implications (eg increased length of stay), has been reinforced.

The second concerned a gastroscopy, when the patient was physically restrained by two staff members. The patient complained that as she had not been provided with the information that the procedure involved such restraint, and that the procedure had been conducted without her informed and voluntary consent. Although she had been advised she could at any time change her mind about the procedure (and elect the use of a light anaesthetic), she was unable to signal her wish due to the restraint to her hands and the tubing in her mouth. The Commissioner highlighted the need for effective, thorough and transparent communication between health professionals and patients, before, during and after procedures. He noted that this patient was provided with information about the procedures on the day of her appointment, and recommended that the information may be more useful if mailed to patients along with the appointment letter, to enable them to digest it and be better prepared for the procedure. As a result of the complaint, the DHB has initiated agreed hand signals to indicate the need for staff to halt their procedure so patient needs can be met, made changes to the consent process, and provides IV cannulation for all patients to facilitate sedation if the procedure performed without sedation becomes distressful.

4.6 Delay in diagnosis and treatment

Following gynaecological surgery, a patient experienced a 3 month delay in receiving pathology results which showed Grade 3 cancer of the fallopian tube. The service involved a provincial DHB and treatment providers from another regional (base) DHB running clinics (outreach clinics) from the provincial hospital, and relied on the accurate and efficient flow of information between the DHBs. Information provided to HDC indicated that the provincial DHB had clear processes in place for managing referrals, but that their efficiency depended upon visiting clinicians having all the required documentation and information available. In this case, systems for referrals at the base DHB failed to identify and manage delays. The base DHB has proposed improvements to the referral pathway which include: pathologists' correspondence being opened in their absence; the registering of slides into a computerized tracking system; the development of Terms of Reference by the gynaecology pathology team to clarify roles and responsibilities and identify patients who are experiencing delays; and

outpatient nurses from both DHBs working together to define and document roles and responsibilities when organizing clinics.

4.7 DNR orders

A complaint raised issues regarding the confusing and contradictory information provided to the consumer's family about the basis for a DNR order, and the way in which the order was completed and communicated. The Commissioner's response to the DHB noted that the fact that resuscitation is medically contraindicated is a valid basis for a DNR order; that although consent under Right 7 of the Code may not therefore be an issue, under Right 6 a patient has the right to the information that a reasonable consumer in that consumer's circumstances would expect to receive and that the decision should have been discussed with the consumer. DNR policies need to provide clear guidance to staff as to the basis of the order and the level of care to be provided following the order; and staff need to be aware of, and follow, a DNR policy. The Commissioner commented that DNR orders involve difficult judgement calls for providers and are a very emotive issue for consumers and their families, and that these factors only increase the need for clear guidance and communication.

4.8 Need for clear standardized information about clotting risks

A complaint from a woman who was treated for a metatarsal fracture of her foot and later developed a deep vein thrombosis in her leg reflects concerns being raised more frequently in complaints to HDC, and highlights important issues regarding the diagnosis and treatment of patients with suspected pulmonary embolism (PE) or deep vein thrombosis (DVT), particularly when patients are immobilized after surgery. Currently there is a lack of awareness about, and clear, standardised advice regarding the risks of, and treatment options for, DVT, PE and other clotting issues. One of HDC's independent experts has advised that there is good evidence that any patient immobilized for significant time should have prophylactic medication (eg Clexane) to prevent DVT, but this is not done enough, and that an information pamphlet for patients would be helpful. The Commissioner has recommended that the DHB consult with both group and individual providers about their approach to patients at risk of PE and DVT and use this information for the development and implementation of a policy. The Commissioner will make relevant information available to other providers when it comes to hand.

5.0 More learning from complaints

Reports of most complaints that have been resolved by investigation are placed in an anonymised form on the HDC website (www.hdc.org.nz) as an information and learning resource. Reports are classified according to provider groups, and can also be accessed using key words, such as the Code rights, procedures, or diagnoses relevant to the case. Many of these reports include information about changes made to systems or practices to improve the safety and quality of health care.