

Information about complaints involving District Health Boards

1 June - 31 December 2007

Introduction

The following report presents data on complaints involving District Health Boards received by HDC over the six-month period 1 July to 31 December 2007, and those closed by HDC in the same time period. For incoming complaints, the report provides statistical information about the number of complaints categorized by Code right, for all 21 DHBs. For closed complaints, the report provides information about the way incoming complaints were resolved. Note that not all complaints received within one six-month period are closed within the same period; some (especially formal investigations) take longer than six months to resolve.

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

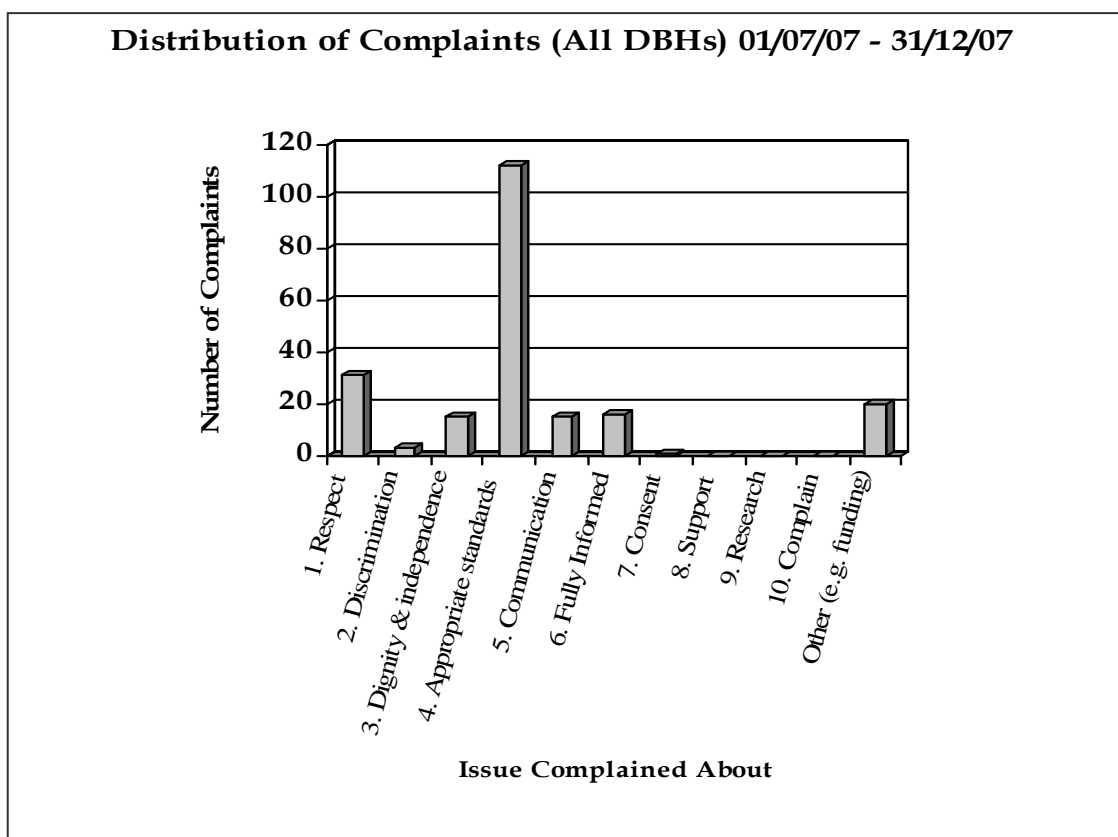
Frequency of complaints categorized by Code right

There were 213 new complaints involving DHBs for the period 01/07/07–31/12/07. Incoming complaints are categorised according to the Rights set out in the Code of Health and Disability Services Consumers' Rights. Some complaints raise issues of access or funding, or other issues outside the jurisdiction of HDC; these are identified as "Other issues". The Right most applicable to each complaint is listed in Table 1. The distribution of complaints with respect to rights involved is illustrated in the following graph. Complaints about the standard of care continue to predominate (52.6% of all complaints). (Figure 1).

Table 1: Subject of complaints

Right associated with complaint	Number of complaints
Right 1 Respect and privacy	31
Right 2 Fair treatment	3
Right 3 Dignity & independence	15
Right 4 Appropriate standards	112
Right 5 Effective communication	15
Right 6 Adequate and appropriate information	16
Right 7 Choice and consent	1
Right 8 Support	0
Right 9 Rights during teaching and research	0
Right 10 Having a complaint taken seriously	0
Other issues (eg, outside HDC's jurisdiction)	20
TOTAL	213

Figure 1: Distribution of Complaints



Outcomes of complaints

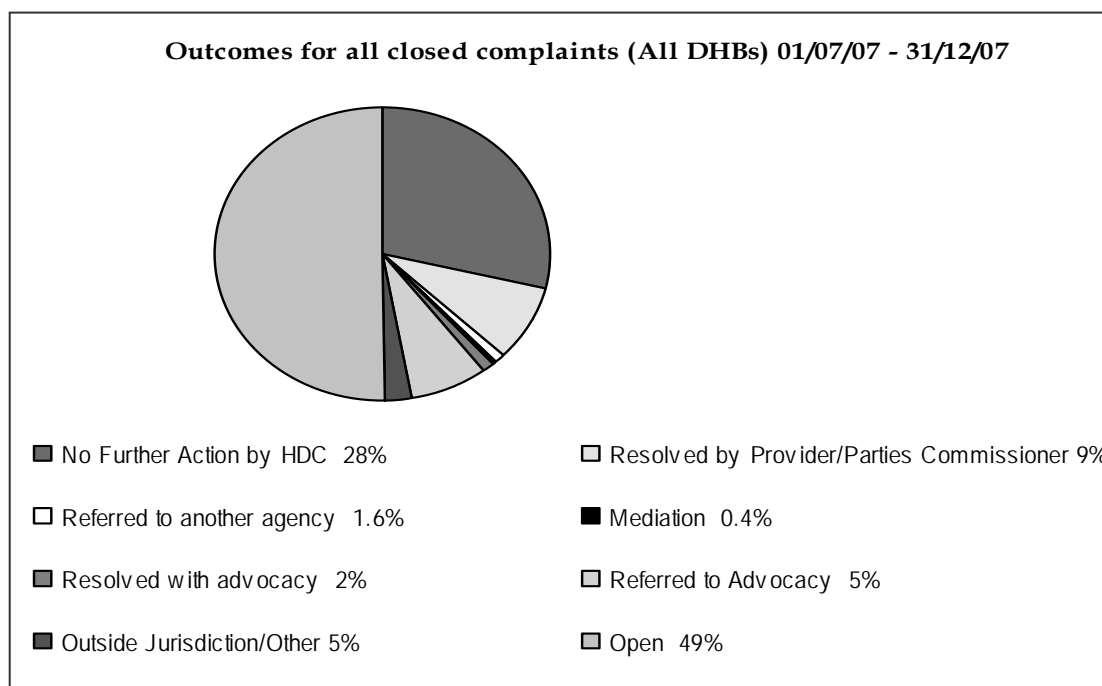
About half of the new complaints received involving DHBs between 1 July and 31 December 2007 were closed within this six-month period without formal investigation (213 new complaints received; 109 new complaints closed). Sixty of the 213 complaints received resulted in no further action being taken following assessment, although educational recommendations may have been made. Eighteen complaints were referred to Advocacy; of these, 2 have been resolved and 16 await resolution. A further 17 were resolved by the providers, the parties themselves or the Commissioner, and 2 were referred to another agency (eg, Privacy Commissioner). One hundred and four remain open; these include complaints currently in the assessment stages, or under investigation. Eleven complaints were found, following preliminary enquiries, to involve access to, or funding of, services, or other issues outside HDC’s jurisdiction. 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	60
Resolved by Provider/Parties/Commissioner	17
Referred to another agency	2
Referred to Mediation	1
Resolved with advocacy	2

Outcomes	Number of complaints
Referred to advocacy and awaiting resolution	16
Other issues (outside HDC's jurisdiction)	11
Open	104
TOTAL	213

Figure 2: Outcomes of complaints (percentages)



Learning from Complaints

1.0 Investigations and breach findings involving DHBs

In the period 1 July to 31 December 2007, 4 investigations involving DHBs were completed. In three cases an individual provider was found to be in breach of the Code (a surgical registrar, an obstetric registrar, and a psychiatrist) but the DHB was not found in breach. In the fourth case, the DHB was found directly liable for a breach of the Code. The four breach reports are summarised below.

1.1 Case 1: Delayed diagnosis of appendicitis and use of morphine

A young woman who presented to an Emergency Department three times over a six-hour period with symptoms of vomiting and severe abdominal pain was assessed on the latter two occasions by the surgical registrar. Surgery, performed more than 24 hours after her first presentation, revealed a ruptured appendix with free peritonitis in both upper quadrants. The patient suffered significant postoperative respiratory complications, thought to be largely a result of the peritonitis.

Although failure to make a correct diagnosis does not in itself amount to a breach of the Code, in this case the registrar misread a number of critical factors when assessing the patient (GP referral, physical observations and laboratory results on file), maintaining a diagnosis of gastroenteritis despite the patient's recurring severe pain, and deciding her condition did not

warrant after-hours surgery. In addition, his documentation was incomplete and unclear. The registrar was found in breach of Rights 4(1) and 4(2) of the Code.

At issue in the case was the administration of morphine before an abdominal examination had been carried out, and the roles of the ED nurse (in initial pain assessment), the ED house surgeon (in prescribing analgesics) and the surgical registrar. The DHB was not found to be in breach of the Code; however, the Commissioner recommended the DHB review the management of acute pain in its ED. (Opinion 06HDC08765, 9 October 2007, www.hdc.org.nz.)

1.2 Case 2: Failure to investigate fetal distress during labour

This case involved the delivery of a term baby following transfer from a rural maternity unit where an ARM at 10am revealed meconium-stained liquor and labour had failed to progress. Labour was assisted by an epidural and Syntocinon. At 6pm the CTG recorded areas of abnormality but this was not recognized by the registrar. After a Ventouse-assisted delivery at 9.20pm, complicated by the umbilical cord twice round the neck and a shoulder dystocia (both appropriately managed), the baby was born at 9.31pm with severe hypoxia consistent with global brain insult. The parents believed that the care provided by the registrar was compromised because he was too busy.

The registrar was found in breach of Right 4(1) of the Code for failing to investigate signs of fetal distress on the CTG by scalp blood gas analysis or discussion of birth plan with the consultant. Changes made by the DHB include introduction of 2 tiers of registrars and onsite SMO cover, weekly liaison meetings between neonatal and obstetric teams to discuss problems, clinical prioritization of all cases on the delivery suite, and communication workshops for registrars.

The complaint also highlighted a lack of information received by the parents, in particular about the risks and benefits of epidural anaesthesia. Although anaesthetists have an obligation to provide this information, LMCs can assist their clients by providing it at an earlier stage, before a woman is in established labour, as by then the environment is not conducive to an effective consent process. The DHB was not found to be in breach of the Code (Opinion 06HDC02099, 28 September 2007, www.hdc.org.nz.)

1.2 Case 3: Inadequate psychiatric assessment of a patient with a head injury

This complaint involved the care provided by a psychiatrist when a young man was admitted to a hospital's psychiatric unit for observation after being assessed in the ED with symptoms of anxiety. The locum MOSS (psychiatry) could find no evidence of mood or psychotic symptoms and, on the basis that the man's symptoms were consistent with a significant childhood head injury, he was discharged to a respite care facility, under the care of community mental health services (MHS). Two days later, the man left the respite facility, deliberately stepped into oncoming traffic, and was killed.

The psychiatrist was found in breach of the Right 4(1) of the Code. He failed to provide a thorough patient assessment, decisions about care and treatment were not properly considered, and provided no clear direction to the MHS team about their monitoring role. His documentation should have included a rationale for clinical decisions and a clear management plan, which should have been communicated within the mental health team. The DHB was not found to be in breach of the Code. (Opinion 05HDC13239, 11 September 2007, www.hdc.org.nz.)

1.2 Case 4: Inadequate communication about patient death after surgery

A young woman with a 3 day history of severe abdominal pain was admitted for exploratory laparoscopy. After surgery revealing bilateral salpingitis and tubo-ovarian abscesses with extensive abdominal pus, originating from the Fallopian tubes, symptoms of acute lung injury became evident; an overwhelming systemic infection was diagnosed. The woman suffered a cardiac arrest and died within 24 hours of admission. The family believed the death was the result of insufficient urgency, inappropriate antibiotic treatment, an inadequate diagnostic operation, and inadequate surgical and gynaecological management; however, no breaches of the Code were identified in relation to clinical care.

An important aspect of this complaint was the lack of effective communication with the patient's family, immediately before her death, and afterwards. Staff at the DHB failed to explain the seriousness of the woman's infection and the need for her to be in ICU after surgery, did not make contact when her condition deteriorated early the morning following the operation, and delayed telephoning when her condition further deteriorated. There should have been an early offer of a meeting with key staff in the days following the death, to explain what happened, and the outcome of the case review should have been promptly communicated to the family; however, despite several attempts, the family was not contacted until a month later. The DHB was found to have breached Right 5(1) of the Code. The case highlights the importance of appropriately and openly providing accurate information to family members, particularly in traumatic situations. (Opinion 06HDC08129, 17 September 2007, www.hdc.org.nz.)

2.0 Lessons from complaints not investigated by HDC

Lessons can be learned, not only from investigations, but also from complaints that are assessed but do not progress to investigations (technically resulting in a "no further action" outcome).

2.1 Case 5: Delayed rupture of Achilles tendon

A boy who sustained a laceration on the heel received a second injury 10 days after the first. At the initial examination tendon damage could not be assessed because of swelling and pain. Over the three weeks following, the boy was seen by two other GPs, a nurse who removed the sutures (and who had been directed to obtain a medical review, but didn't), the nurse at the A&M Centre who treated a second injury, and two final year physiotherapy students. None of these providers detected a defect or were alerted by the boy to any concerns about his Achilles tendon. Four weeks later, as the boy's movement remained abnormal, he received an ultrasound scan, confirming a rupture.

It was not clear when the tendon actually ruptured: it appeared that there had been a smaller or partial tear at the time of the first injury which had later resulted in a complete rupture, either by worsening over time, or as a consequence of the second injury. Care given was found to be reasonable in these circumstances.

However, improvements to practices have resulted: (i) the DHB has instituted a new policy to reinforce that nurses must consult with a doctor before deciding not to comply with a requested review; and (ii) final year physiotherapy students now review patients with supervisors on a daily basis, and are required to inform them if a patient's condition has worsened or is not improving.

2.2 Case 6: Suicide of a voluntary patient

A young woman whose history included episodes of self harm and attempted suicide received treatment as a voluntary patient in residential care where she was cooperative and compliant. Expression of suicidal thoughts later resulted in her admission to inpatient care. When

medical staff disagreed with her request to be discharged, she disappeared and, despite search of the grounds and surveillance of her room, was later found back at her residential care facility, having committed suicide.

The complainant was concerned that during the day patients were allowed unescorted access to an external outdoor area (for smoking cigarettes) that opened into the hospital grounds, and this provided the opportunity for the woman to leave the hospital. HDC's expert advisor commented on the difficulty of managing an at-risk patient on a non-secure ward, and advised that the care was, in the main, appropriate. The DHB reported changes made to its mental health service, including revision of assessment tools and the way patients are clinically observed; updating of the electronic health records system to make information available appropriate staff; recruitment of senior nurses and further qualified support workers; and construction of an external perimeter fence.

2.3 Case 7: Inadequate management of surgical patient

Following surgery an elderly woman was commenced on PCA. The next day the surgeon gave verbal direction for this to be discontinued but did not alter the medication chart and the morphine was continued. On the second postoperative day, the patient was found unresponsive and pale and diagnosed with fluid overload and morphine overdose, and later with acute renal failure.

There were inadequacies in documentation, communication, pain assessment, drug prescription, and administration of medication, oxygen and blood products, involving many staff across a number of departments. Although staff measured her critical observations regularly, they failed to respond to the woman's deteriorating condition; consistent and concerning trends were not acted upon until she suffered a critical event.

In response to a Reportable Event Form submitted by the surgeon, the hospital completed a serious event review report and undertook an action plan to address the deficiencies identified. No further action was taken on the complaint. The complaint highlights the need for staff not only to record information about patients, but to interpret it and act on it in a timely manner.

2.4 Case 8: Error in documentation of baby's weight

Incorrect doses of medication (including chloral hydrate and gentamicin) and nutrition were calculated, prescribed and administered to a baby with bronchitis for seven days on the basis of a wrongly recorded weight of 6.87kg. The correct weight was 3.7 kg. As the doses did not seem excessive, staff were not alerted to the possibility of a mistake. The gentamicin dose did not exceed the maximum for the baby's true weight, and audiology tests demonstrated no abnormality.

A DHB investigation resulted in changes including charting weights on percentile charts as a routine part of the admission process; a chart with average weights for age developed and displayed; the addition of nurses checking baby's weight against average weight chart when checking out prescribed medication; staff training for use of scales and weight charts. As HDC's expert identified no additional shortcomings in the care provided, and the parties were satisfied with the actions taken by the DHB, HDC took no further action on the complaint.

The case highlights the vulnerability of babies and small children, and the importance of medication safety in neonatal care. There is little margin for error. Checking procedures are essential to ensure any errors are promptly identified and addressed. (Opinion 07HDC05409 2 October 2007, www.hdc.org.nz.)

2.5 Case 9: Failure to document information supporting clinical decision

Following two weeks' bleeding, a woman whose pregnancy was 22 weeks and three days' gestation presented at the hospital with severe pain. She was reviewed by the obstetric registrar and on-call paediatrician who decided it was not appropriate to intervene. A spontaneous delivery occurred, and the inability of the baby to survive was confirmed. The woman complained that clinicians decided not to resuscitate her baby.

There are clear hospital guidelines pre-term labour; these include assessment of each case by medical and senior midwifery staff to determine chances of the baby's survival. In this case, the guidelines were followed; however the registrar's review is not recorded in the notes, nor is the advice of the paediatrician that intervention was not appropriate. This information formed part of the rationale for a decision not to intervene and so should have been formally documented. This complaint, and others to HDC — as well as concerns broached by clinicians — raise issues about the inconsistent approach among DHBs to information disclosure to parents about management of pregnancies and labour at borderline viability. In such cases parents need clear, honest and timely information.

3.0 Patient-centered care

While hospital environments and procedures may become routine for clinical providers, they are often not familiar for the patient. Patients have a right to be treated with respect and dignity, and to be provided with all the information they need, including what to expect during their admission and treatment. Several complaints concerned cases where care, while clinically acceptable, could have been improved by a more patient-centred approach.

3.1 Case 10: Consideration for elderly patients

An elderly woman who, having attended a city hospital Emergency Department for diagnosis of a suspected thrombosis, was sent home overnight (a distance of about 70km) and asked to return the following day for a scan. The DHB acknowledged that given the patient's age and distance to travel, admission overnight or a stay at the Accommodation Centre would have been appropriate. While guidelines are useful, in following them staff need to consider all circumstances when making such decisions and proactive questioning may be required. As a result of the complaint, the DHB has reviewed threshold for discharge home of elderly patients home requiring scans, and the current level of after hours radiology service.

3.2 Case 11: Failure to preserve dignity

An elderly man complained that his wife, in her last few days of life in an oncology ward, was left half naked on her bed without pillows or covers. The man described his wife as a former nurse who was caring and compassionate, and would never have treated her patients the way she was treated. He asked for more emphasis on the basics of compassion, care and gentleness, and for patients to be treated with dignity.

3.3 Case 12: Information about effects of treatment

A man who underwent a renal biopsy was not provided with adequate information about the risk of experiencing falls after undergoing the procedure, and the need to exercise caution when moving (he experienced falls); the changes to his anticoagulant treatment (which meant he would have to return to hospital for a second admission a few days after his biopsy to monitor his medication), and potential health risks associated with a CT scan. Lack of information may lead to uncertainty and confusion. Staff need to be clear what information needs to be communicated, when, and by whom.

3.4 Case 13: Reassurance about what to expect

A woman who was admitted to a gynaecology day ward for the induction of her stillborn baby was discharged without pain relief, and without any information about what to expect over the coming weeks. When admitted from ED several days later with pain and bleeding, was left in the ward “with no expectation of what was going to happen” regarding her dilation and curettage procedure. The woman’s distressing and tragic situation was exacerbated by the treatment she received. This case provides a good example of where a more caring, patient-focused approach may have assisted the woman in her physical and emotional recovery.

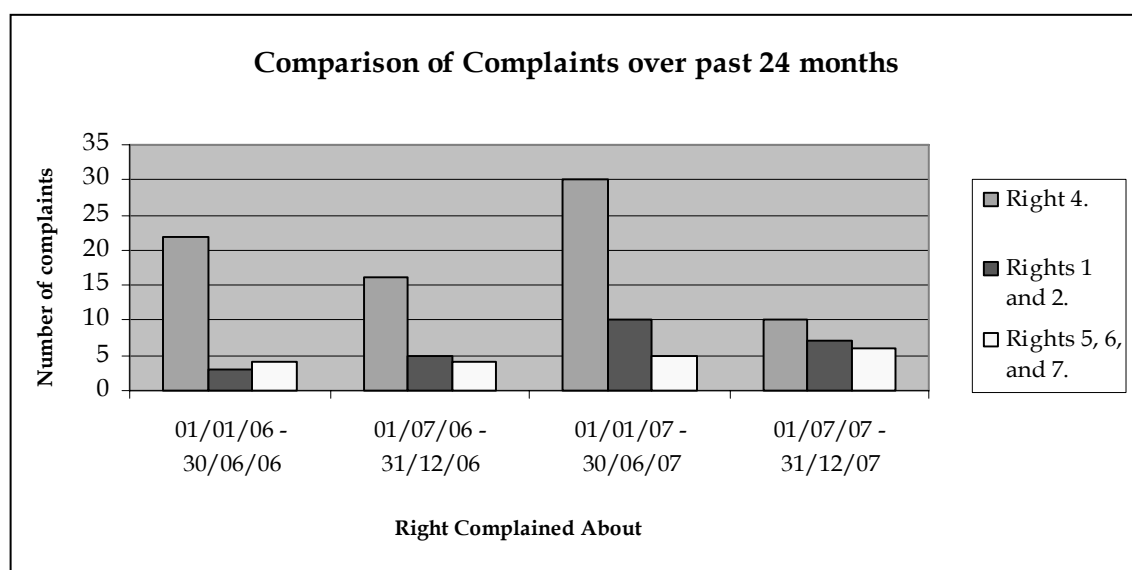
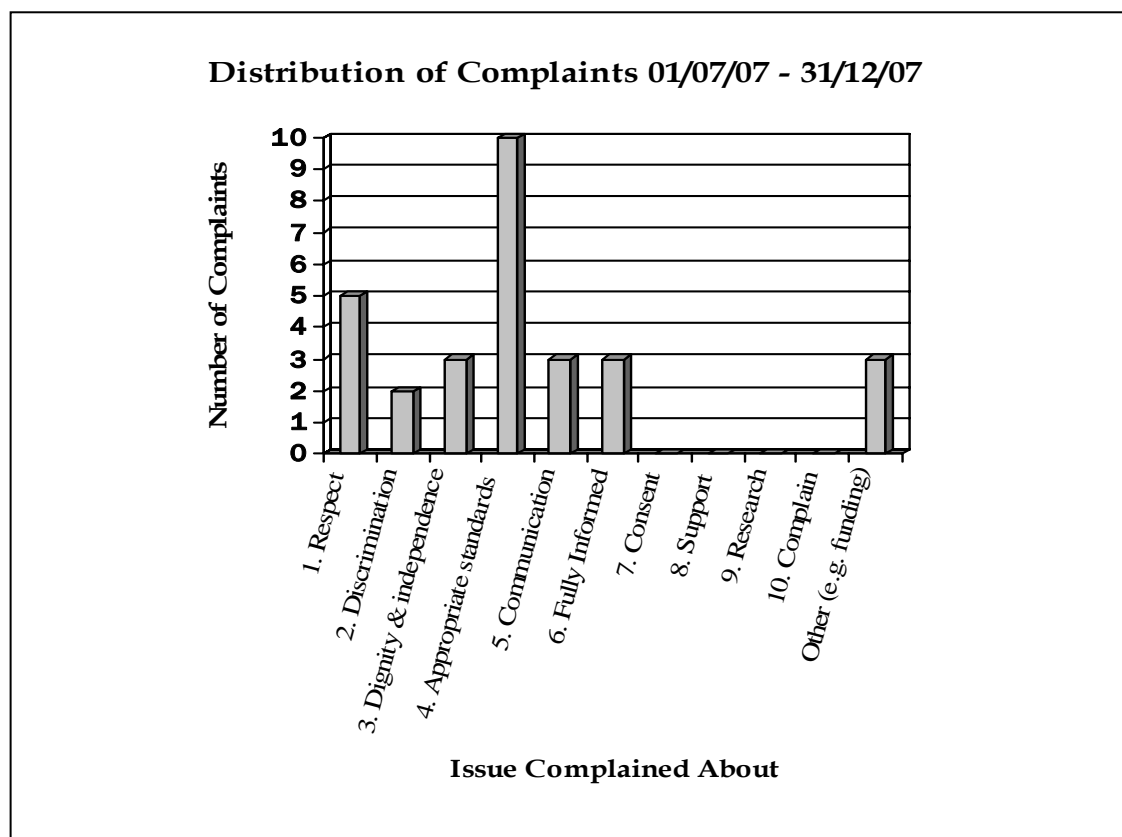
3.5 Case 14: Timely information

A woman who underwent an appendicitis operation complained that, despite the results of the CT scan being available for several hours, she was not informed about her diagnosis and did not know she was to proceed to surgery until the time she was taken to theatre. Afterwards, information that her appendix had perforated and that she would require ongoing intravenous antibiotics was provided only incidentally, and not until two days after surgery. Information about what has happened is important to a patient and, as a part of respectful care, this should have been provided at the first post-surgery ward round. The distress this patient experienced highlights the need for clinicians to communicate openly with their patients.

Auckland District Health Board

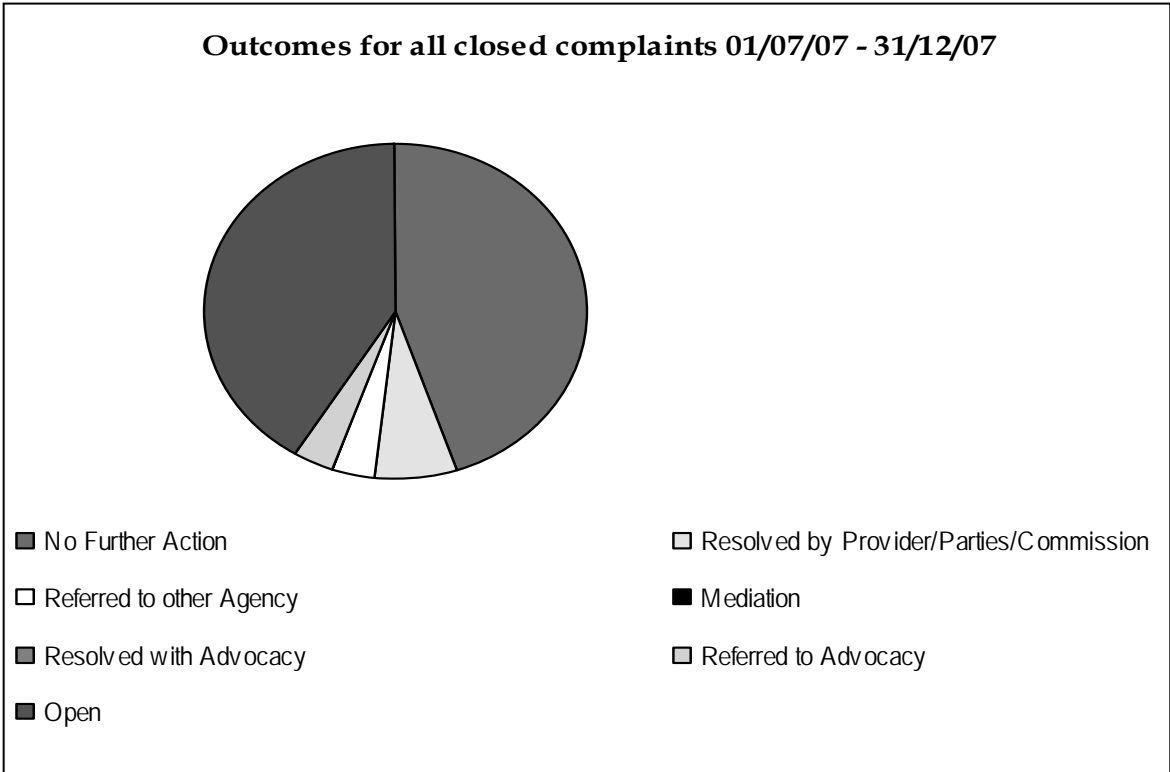
Complaints Information for period 01/07/07 – 31/12/07

The total number of complaints involving the Auckland District Health Board between 01/07/07 and 31/12/07 was 29 compared to 45 in the period of 01/01/07 and 30/06/07. This is equal to 13.2% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (10 complaints). There were five complaints related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy. Two complaints were related to Right 2 (discrimination) and three complaints related to Right 3, the right to dignity and independence. Three complaints were received relating to Right 5 (communication) and Right 6 (fully informed).



Outcomes of Closed Complaints

Of the 29 new complaints opened between 1/07/07 and 31/12/07, 17 complaints were closed in that period. Thirteen resulted in no action being taken; two were resolved by the provider, or the parties themselves, or the Commissioner. One was referred to Advocacy and one was resolved by Advocacy Services. One complaint fell into the category of “other”. Twelve complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect	1						4	5
Right 2	Discrimination			1				1	2
Right 3	Dignity/Independence	2	1						3
Right 4	Appropriate Standards	5						5	10
Right 5	Communication	2					1		3
Right 6	Fully Informed	2						1	3
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding	1	1					1	3
Total		13	2	1	0	0	1	12	29

Key

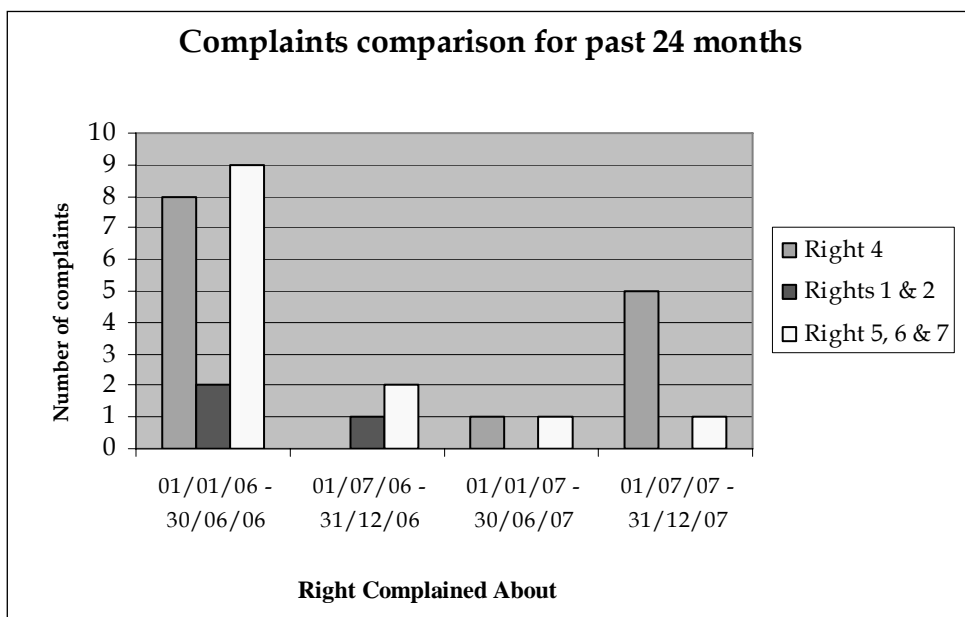
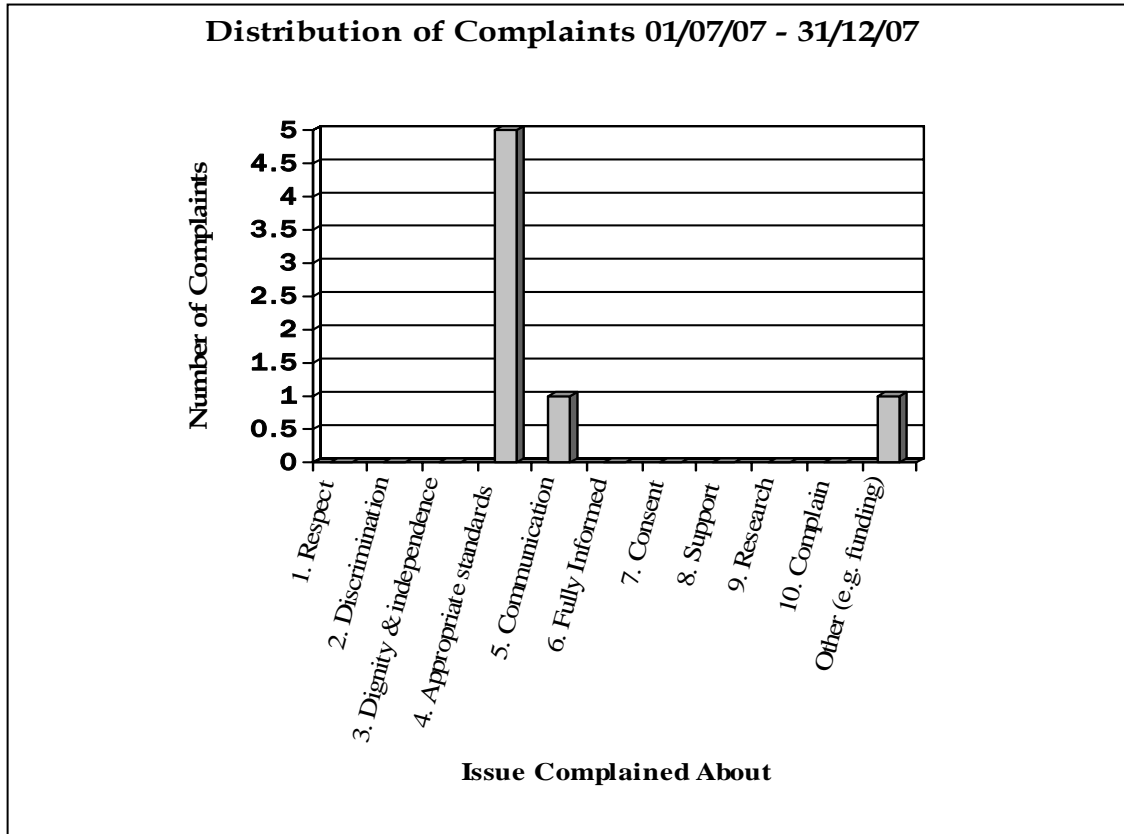
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|-----|-------------------------------------------|-------|------------------------|
| NA | No action | RA | Resolved with Advocacy |
| RP | Resolved by provider/parties/Commissioner | Ref A | Referred to Advocacy |
| Ref | Referred (eg District Inspector) | OJ | Outside Jurisdiction |
| Med | Mediation | | |

Bay of Plenty District Health Board

Complaints Information for period 01/07/07 – 31/12/07

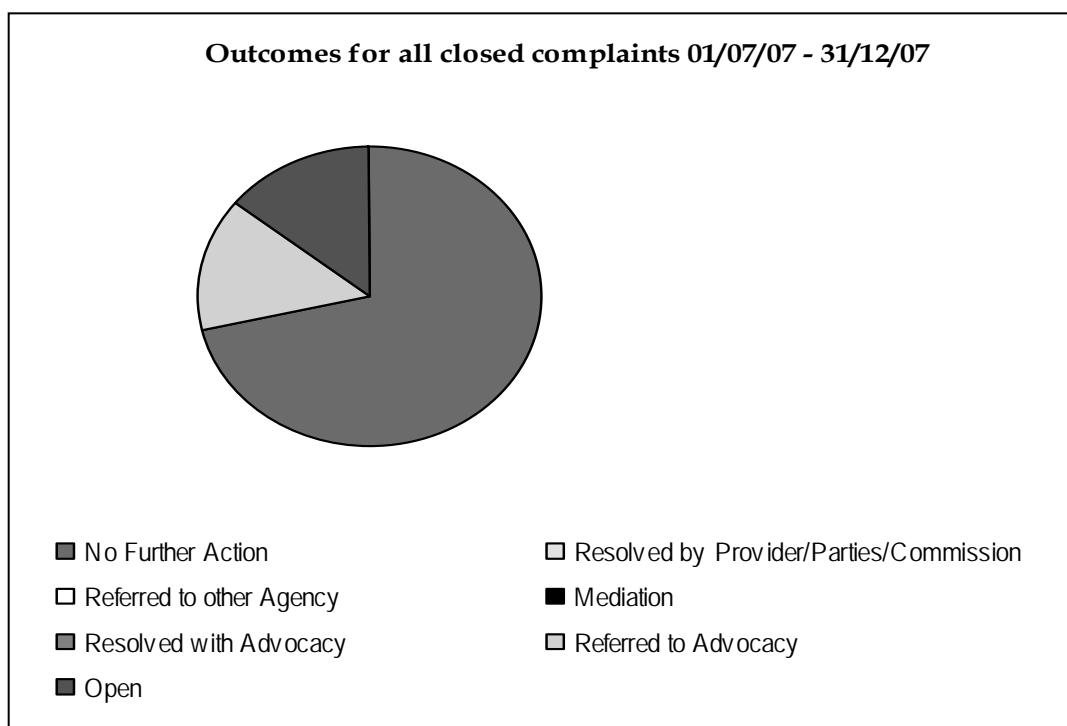
The total number of complaints involving the Bay of Plenty District Health Board between 01/07/07 and 31/12/07 was seven compared to three in the period of 01/01/07 and 30/06/07. This is equal to 3.28% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (five complaints). There was one complaint related to Right 5 (communication) and one complaint which was fell under the category 'Other'.

Total Number of Complaints: 7 (3.3% of all complaints)



Outcomes of Closed Complaints

Of the seven new complaints opened between 1/07/07 and 31/12/07, six complaints were closed in that period. Five resulted in no action being taken; one was referred to Advocacy Services and one complaint was found to be outside the jurisdiction of the Health & Disability Commissioner therefore no further action was taken. One complaint remains open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect								
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	3					1	1	5
Right 5	Communication	1							1
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding	1							1
Total		5	0	0	0	0	1	1	7

Key

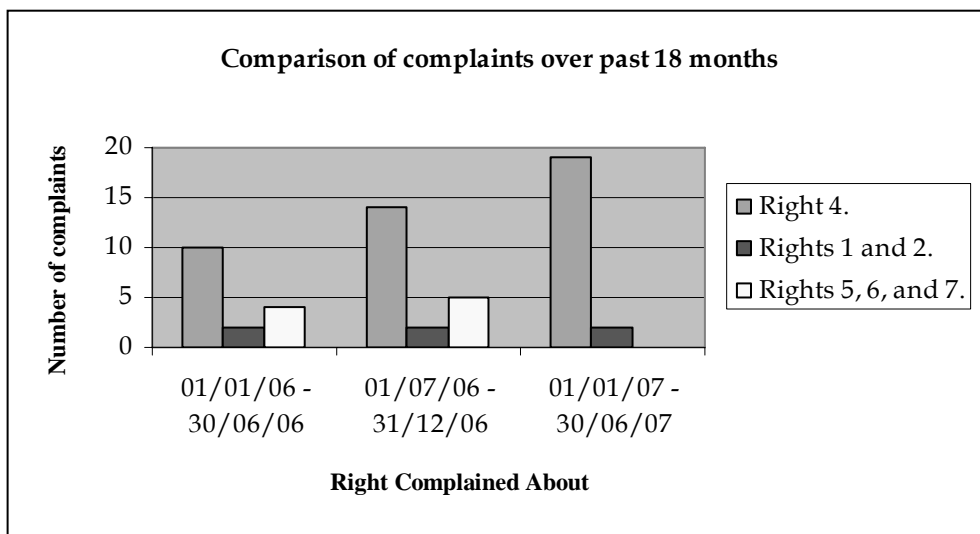
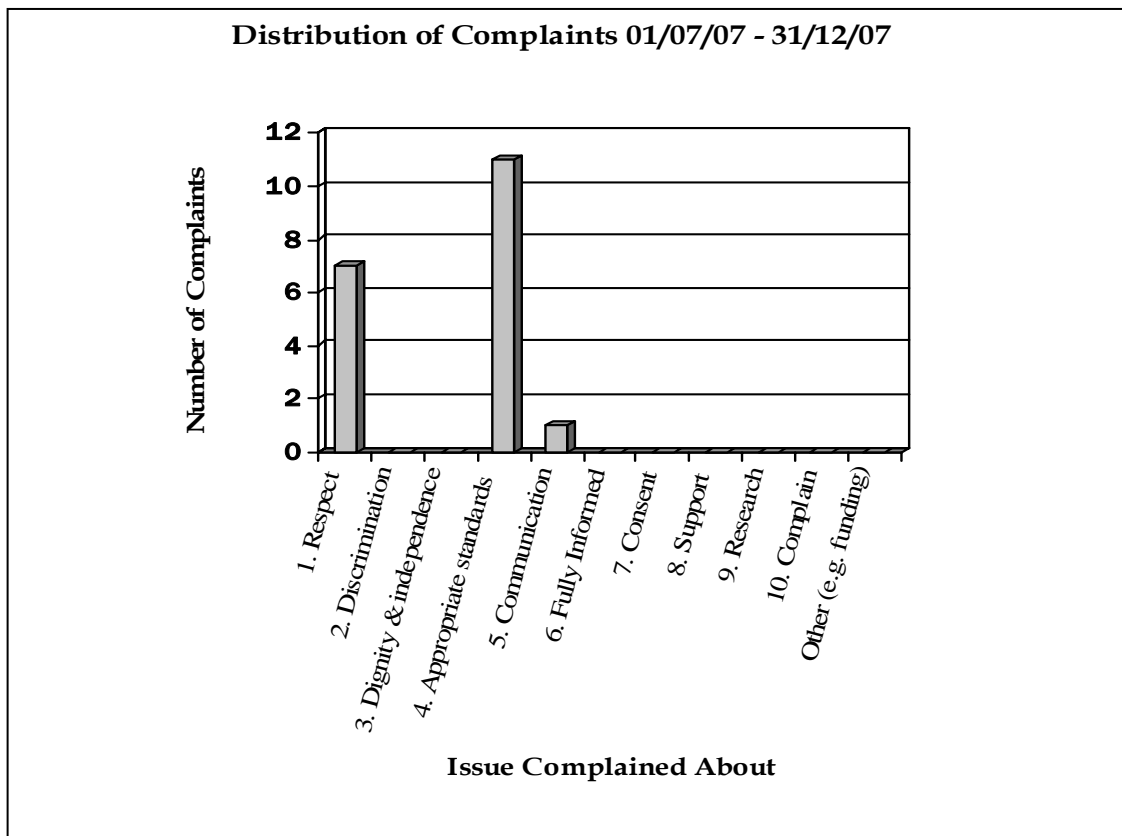
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Canterbury District Health Board

Complaints Information for period 01/07/07 – 31/12/07

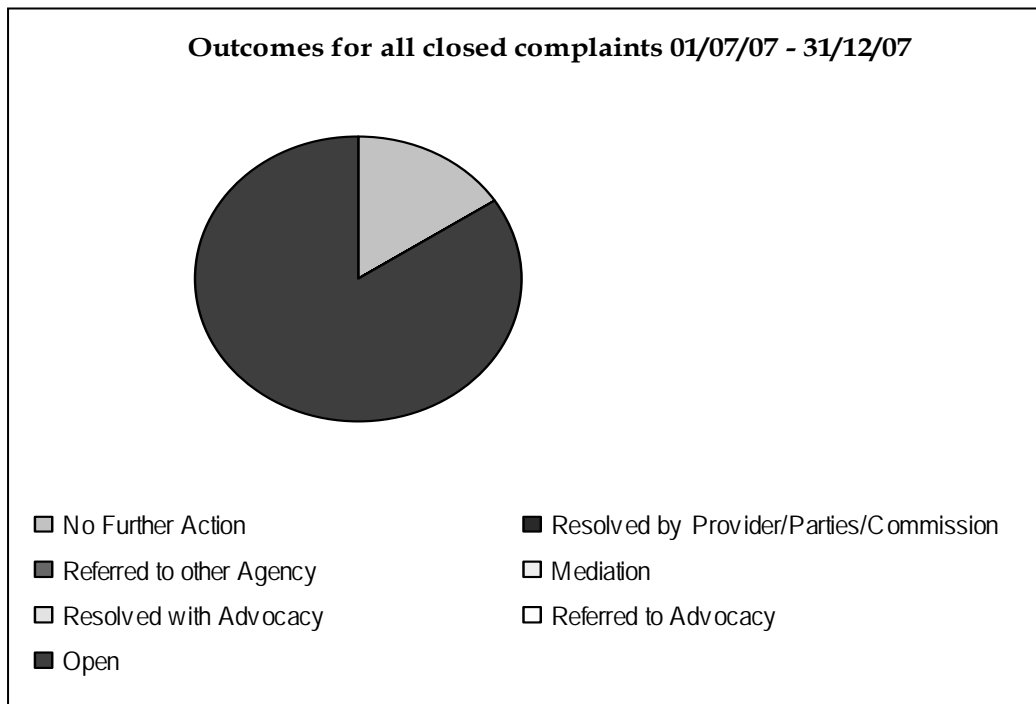
The total number of complaints involving the Canterbury District Health Board between 01/07/07 and 31/12/07 was 19 compared to nine in the period of 01/01/07 and 30/06/07. This is equal to 8.92% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (11 complaints). There were seven complaints related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy. One complaint was related to Right 5 (communication).

Total Number of Complaints: **19 (8.9% of all complaints)**



Outcomes of Closed Complaints

Of the 19 new complaints opened between 1/07/07 and 31/12/07, one complaint was closed in that period. Three resulted in no action being taken. Sixteen complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect	2						5	7
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards							11	11
Right 5	Communication	1							1
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		3	0	0	0	0	0	16	19

Key

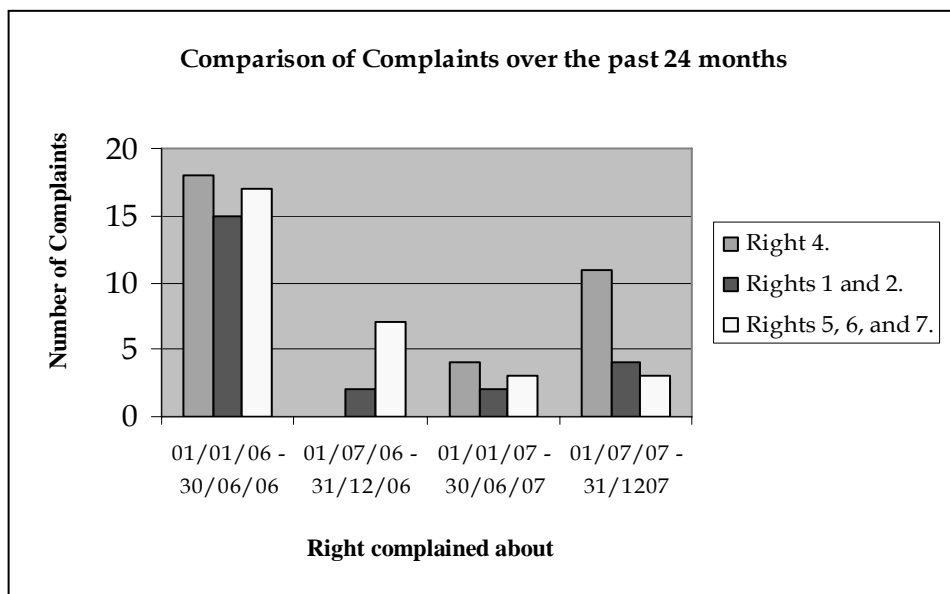
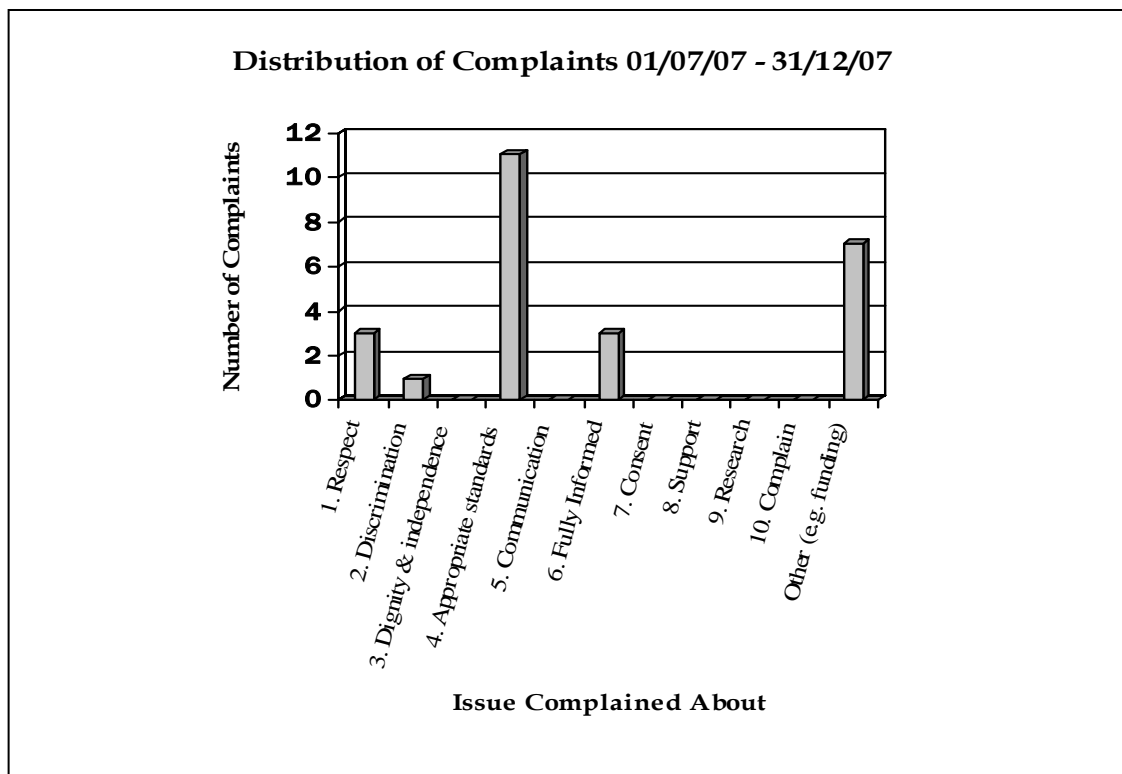
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Capital and Coast District Health Board

Complaints Information for period 01/07/07 – 31/12/07

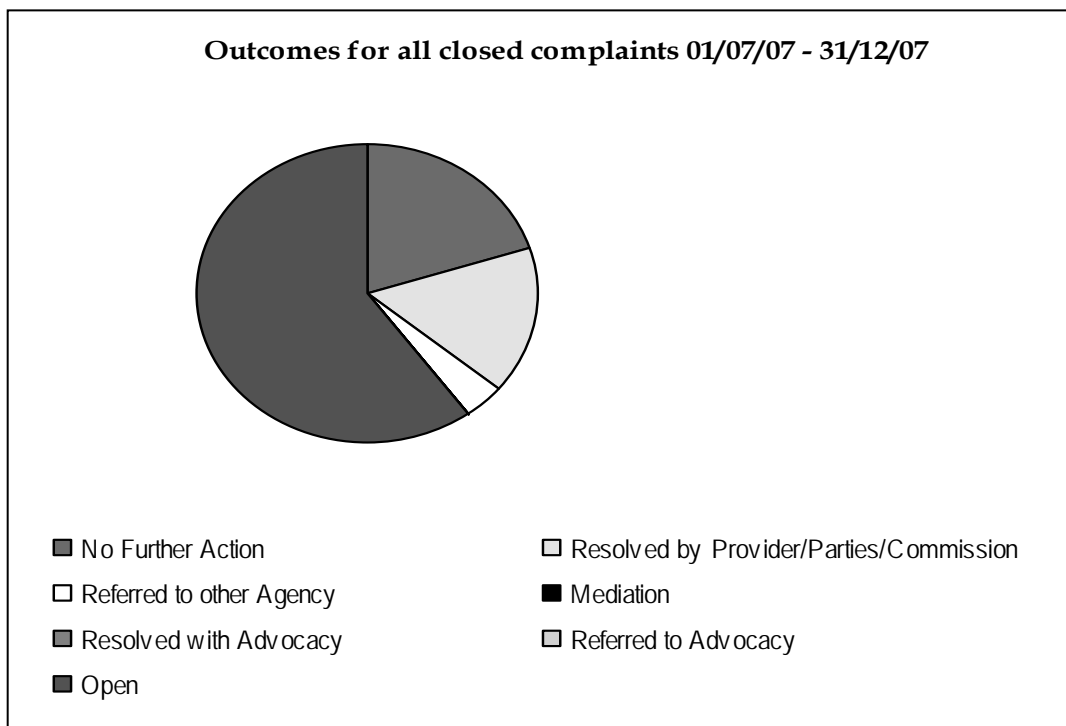
The total number of complaints involving the Capital and Coast District Health Board between 01/07/07 and 31/12/07 was 25 compared to nine in the period of 01/01/07 and 30/06/07. This is equal to 11.73% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (11 complaints). There were three complaints related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy. One complaint was related to Right 2 (Discrimination) and three complaints related to Right 6 (fully informed). Seven complaints fell under the category “Other”.

Total Number of Complaints: **25 (11.7% of all complaints)**



Outcomes of Closed Complaints

Of the 25 new complaints opened between 1/07/07 and 31/12/07, 17 complaints were closed in that period. Five resulted in no action being taken; four were resolved by the provider, or the parties themselves, or the Commissioner. One was referred to Advocacy. Fifteen complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect	2						1	3
Right 2	Discrimination							1	1
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	2						9	11
Right 5	Communication								
Right 6	Fully Informed	1						2	3
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding		4	1				2	7
Total		5	4	1				15	25

Key

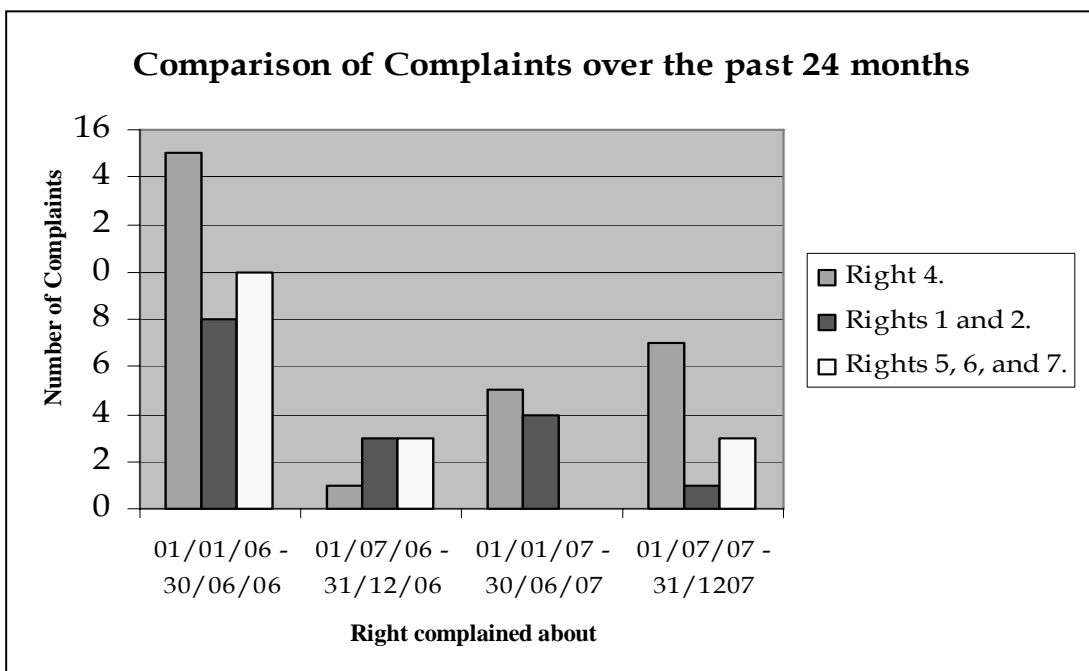
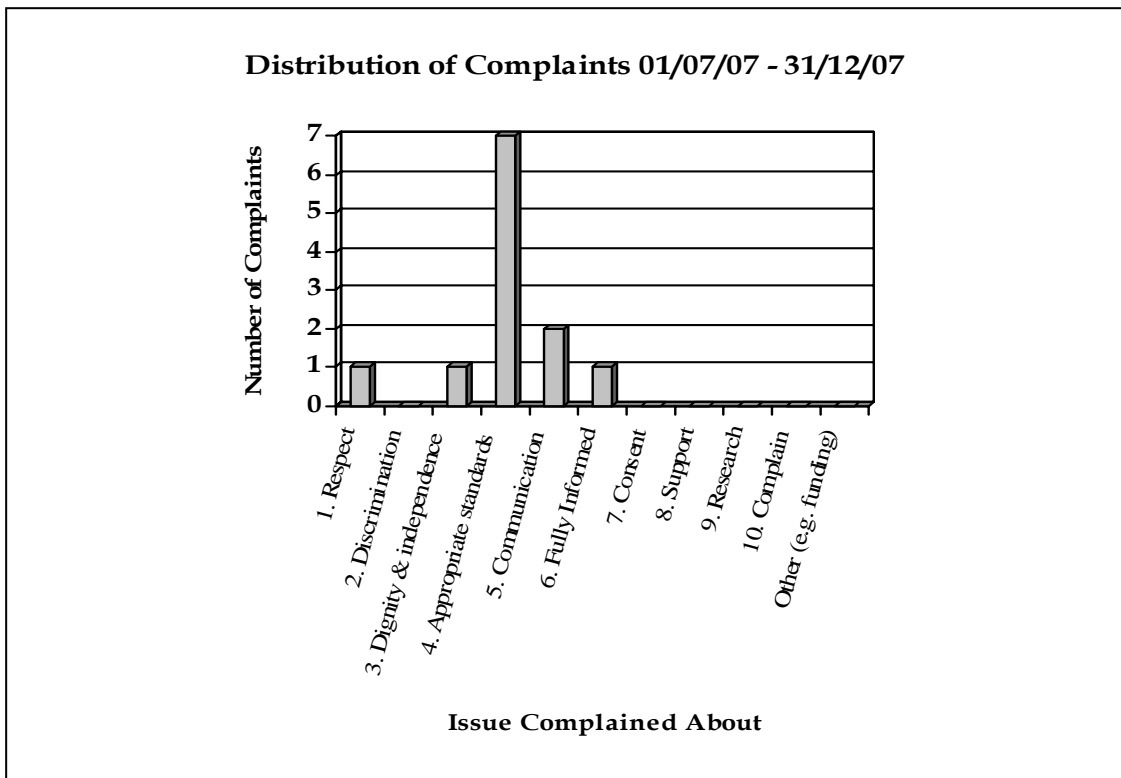
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Counties Manukau District Health Board

Complaints Information for period 01/07/07 – 31/12/07

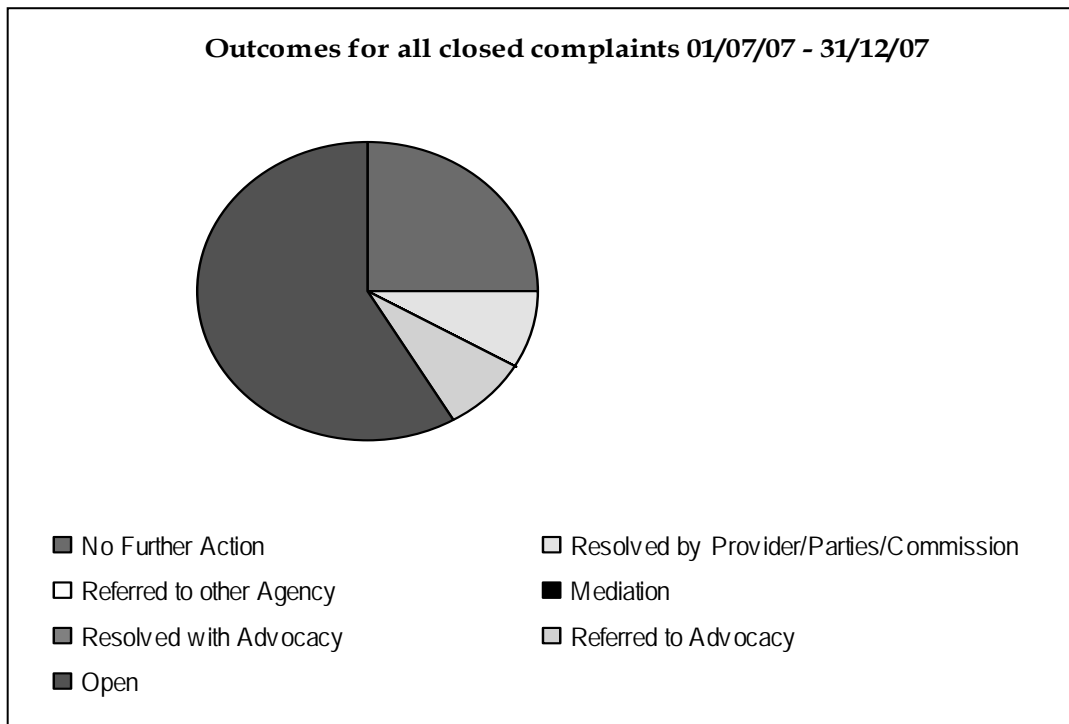
The total number of complaints involving the Counties Manukau District Health Board between 01/07/07 and 31/12/07 was 12 compared to nine in the period of 01/01/07 and 30/06/07. This is equal to 5.63% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (seven complaints). There was one complaint related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy. One complaint related to Right 3, the right to dignity and independence. Two complaints were received relating to Right 5 (communication) and one complaint related to Right 6 (fully informed).

Total Number of Complaints: **12 (5.6% of all complaints)**



Outcomes for Closed Complaints

Of the 12 new complaints opened between 1/07/07 and 31/12/07, five complaints were closed in that period. Three resulted in no action being taken; one was resolved by the provider, or the parties themselves, or the Commissioner. One was referred to Advocacy. Seven complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect							1	1
Right 2	Discrimination								
Right 3	Dignity/Independence		1						1
Right 4	Appropriate Standards	3					1	3	7
Right 5	Communication							2	2
Right 6	Fully Informed							1	1
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		3	1				1	7	12

Key

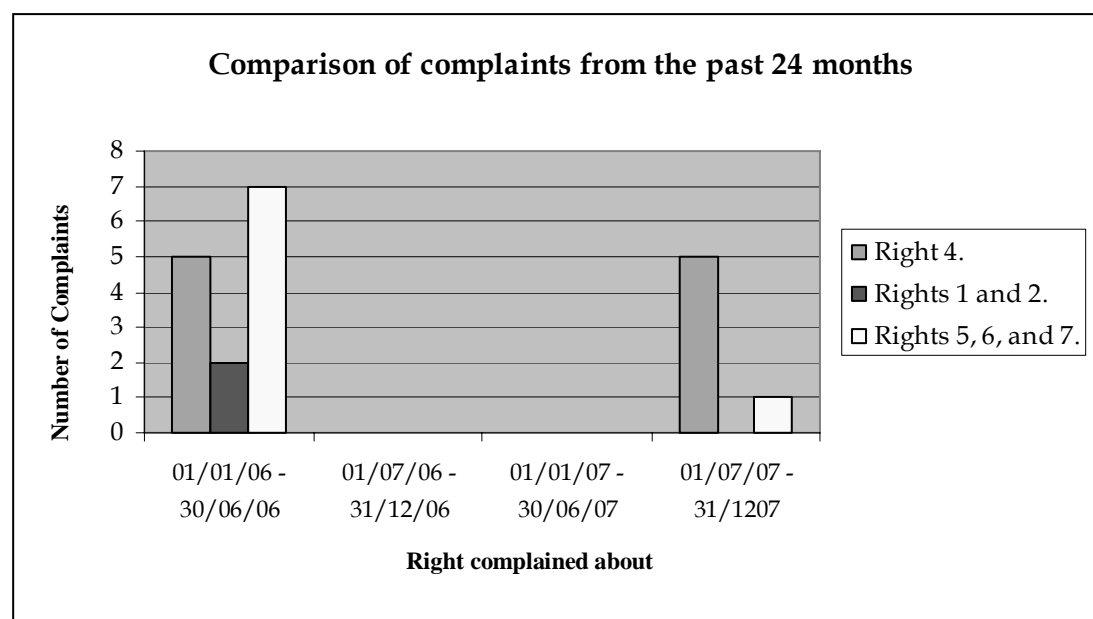
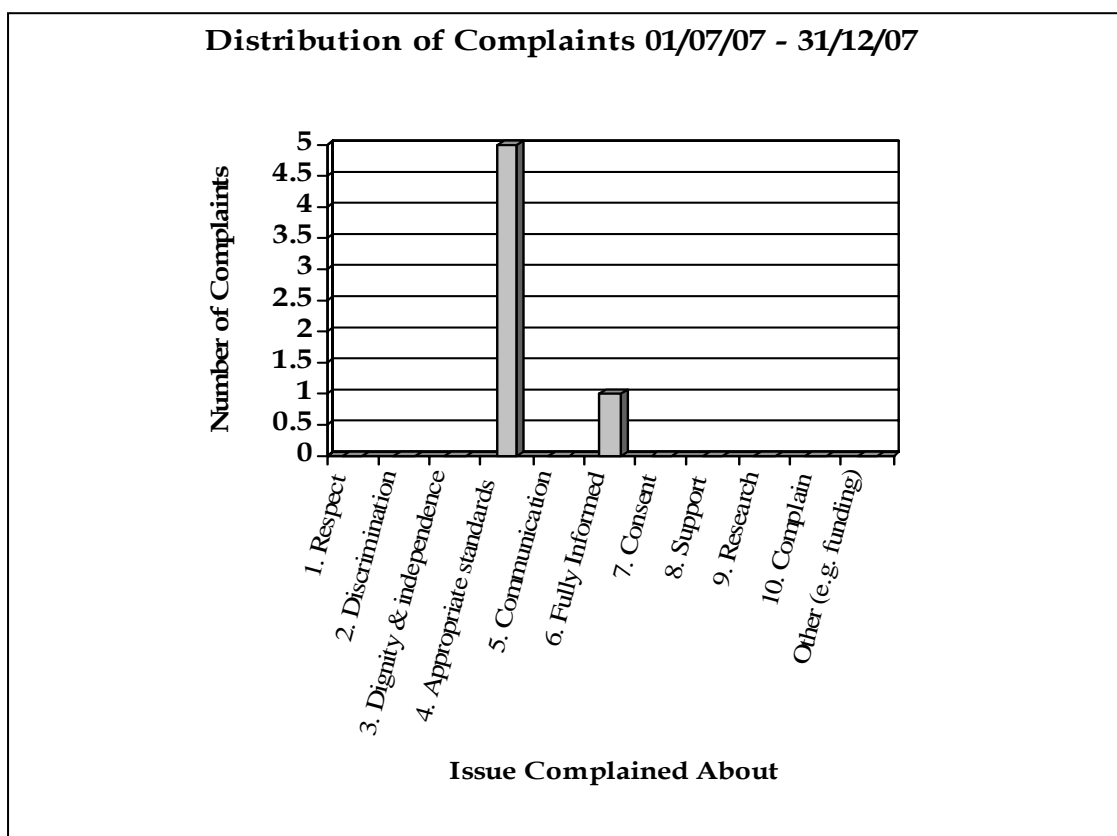
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Hawkes Bay District Health Board

Complaints Information for period 01/07/07 – 31/12/07

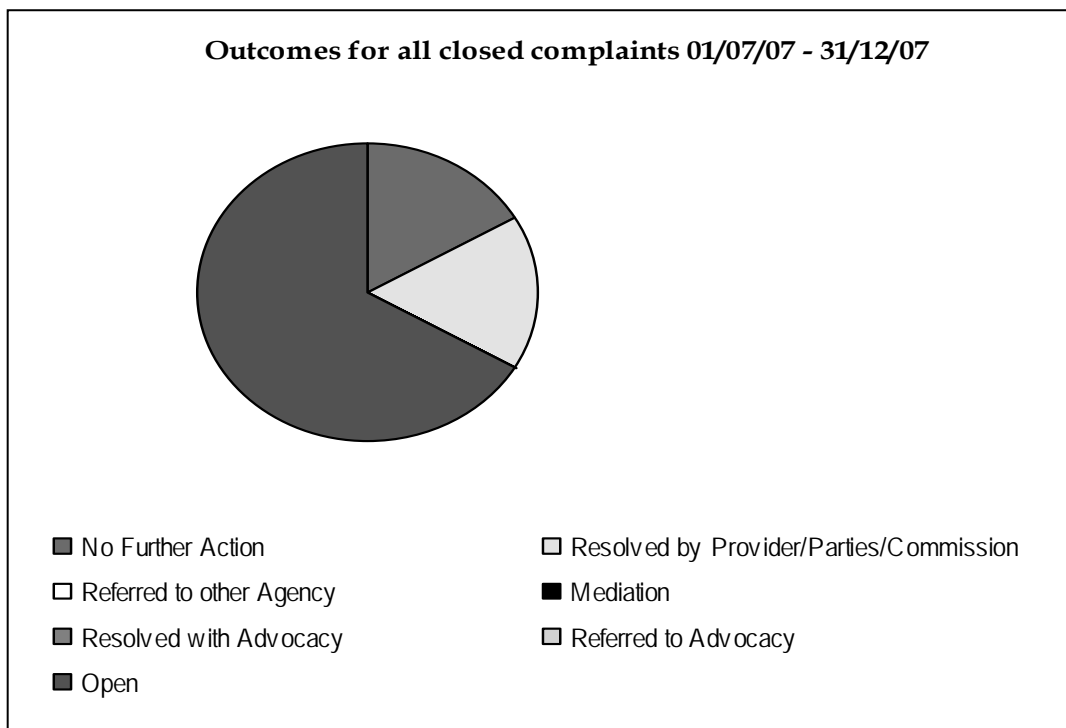
The total number of complaints involving the Hawkes Bay District Health Board between 01/07/07 and 31/12/07 was 6 compared to nil in the period of 01/01/07 and 30/06/07. This is equal to 2.8% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (two complaints). One complaint was received that related to Right 6 (fully informed).

Total Number of Complaints: **6 (2.8% of all complaints)**



Outcomes for Closed Complaints

Of the 6 new complaints opened between 1/07/07 and 31/12/07, two complaints were closed in that period. One complaint was resolved by the provider, or the parties themselves, or the Commissioner. One was found to be outside of the jurisdiction of the Health & Disability Commissioner and therefore no further action was taken. Four complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect								
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	1						4	5
Right 5	Communication								
Right 6	Fully Informed		1						1
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		1	1					4	6

Key

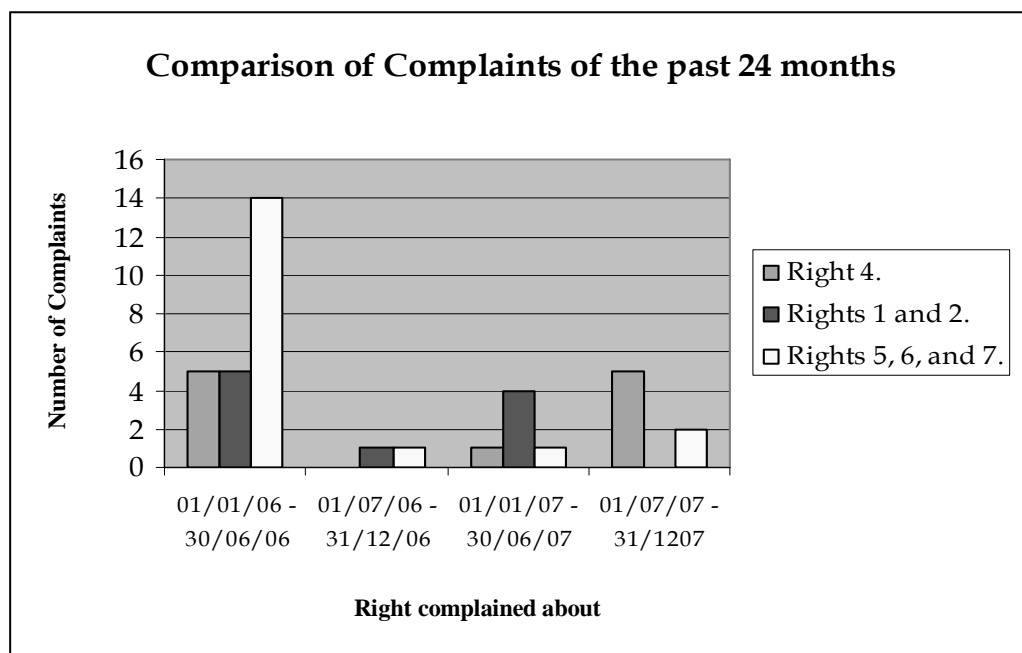
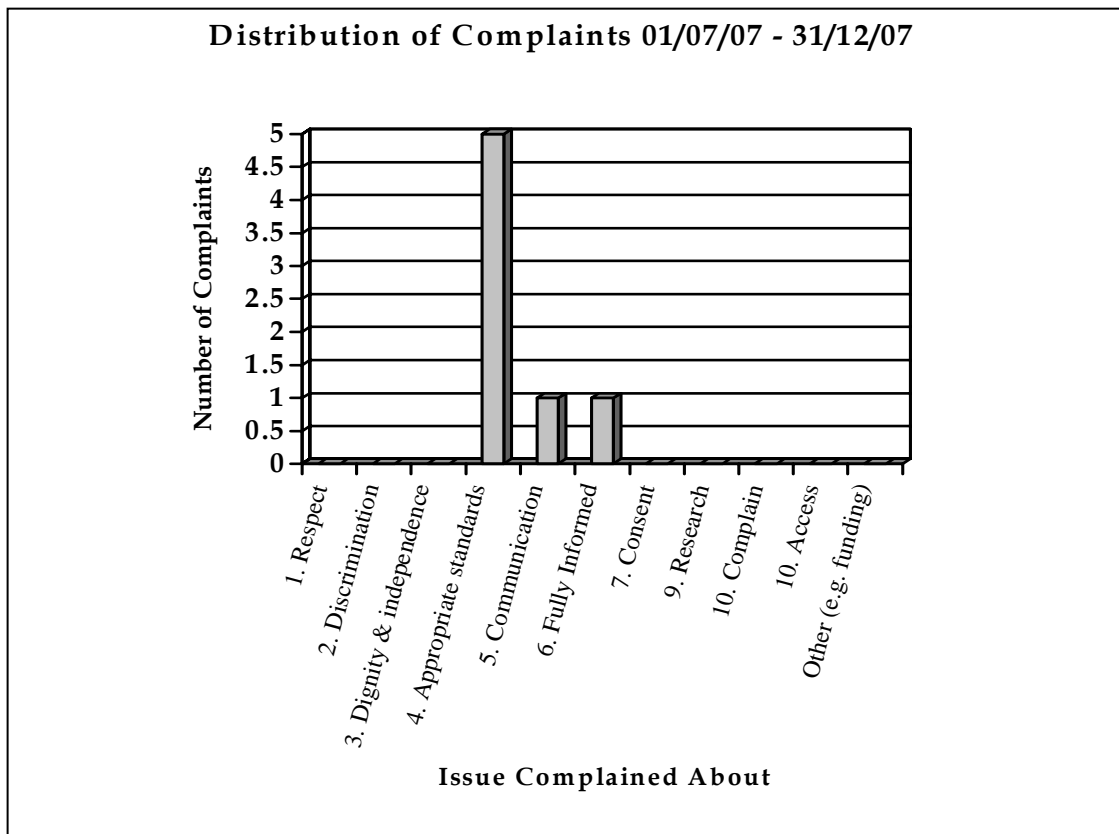
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Hutt Valley District Health Board

Complaints Information for period 01/07/07 – 31/12/07

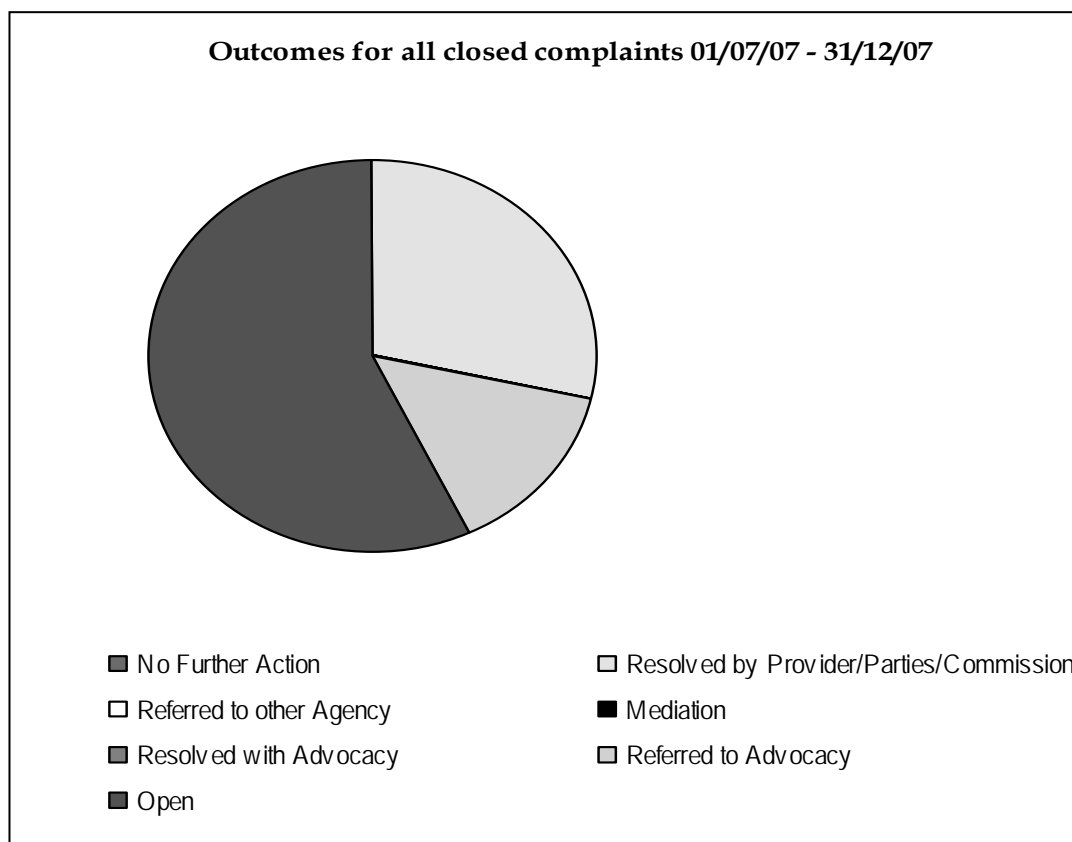
The total number of complaints involving the Hutt Valley District Health Board between 01/07/07 and 31/12/07 was seven compared to six in the period of 01/01/07 and 30/06/07. This is equal to 3.28% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (five complaints). There was one complaint related to Right 5 (communication) and one complaint relating to Right 6 (fully informed).

Total Number of Complaints: **7 (3.3% of all complaints)**



Outcomes for Closed Complaints

Of the seven new complaints opened between 1/07/07 and 31/12/07, three complaints were closed in that period. Two complaints were resolved by the provider, or the parties themselves, or the Commissioner. One was referred to Advocacy Services. Four complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect								
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards		1				1	3	5
Right 5	Communication							1	1
Right 6	Fully Informed		1						1
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total			2				1	4	7

Key

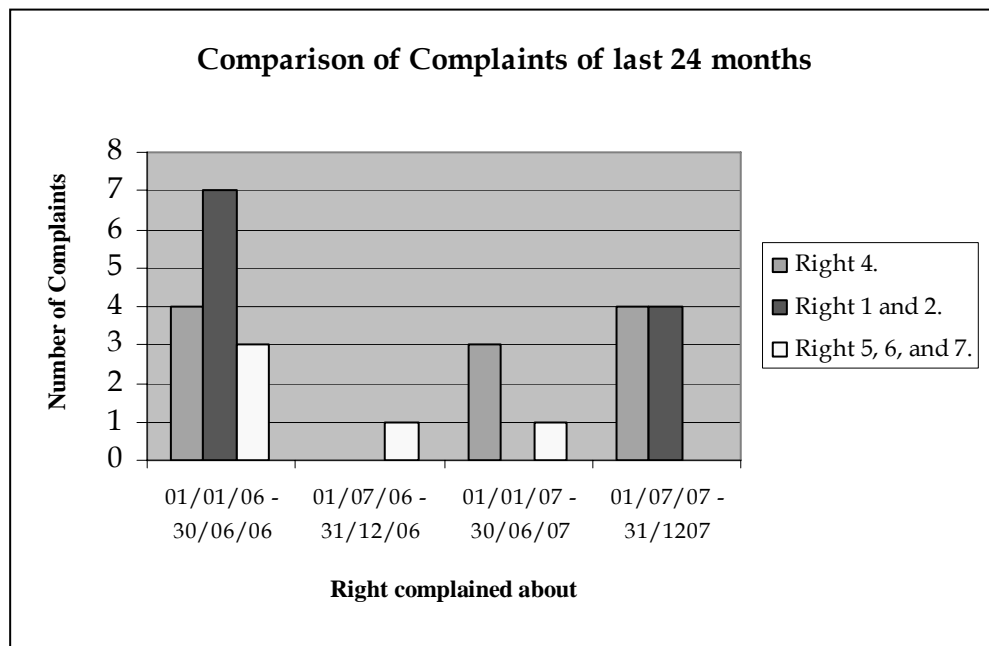
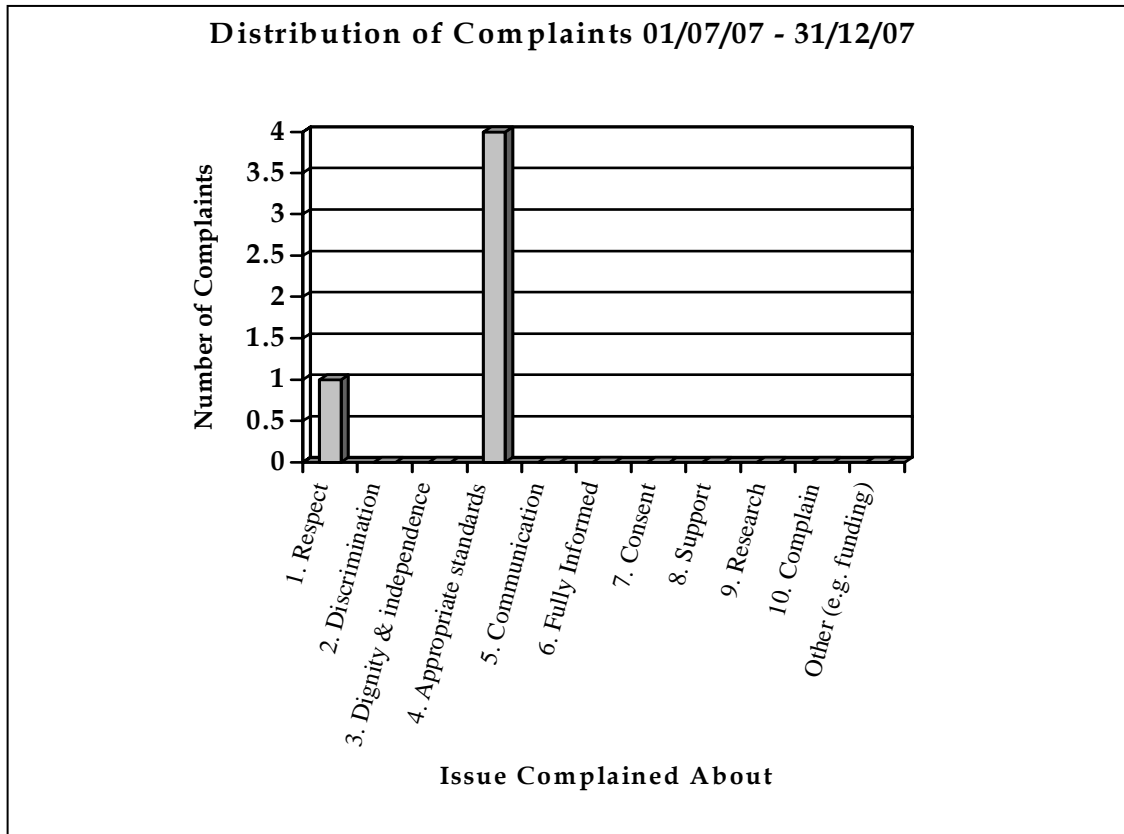
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Lakes District Health Board

Complaints Information for period 01/07/07 – 31/12/07

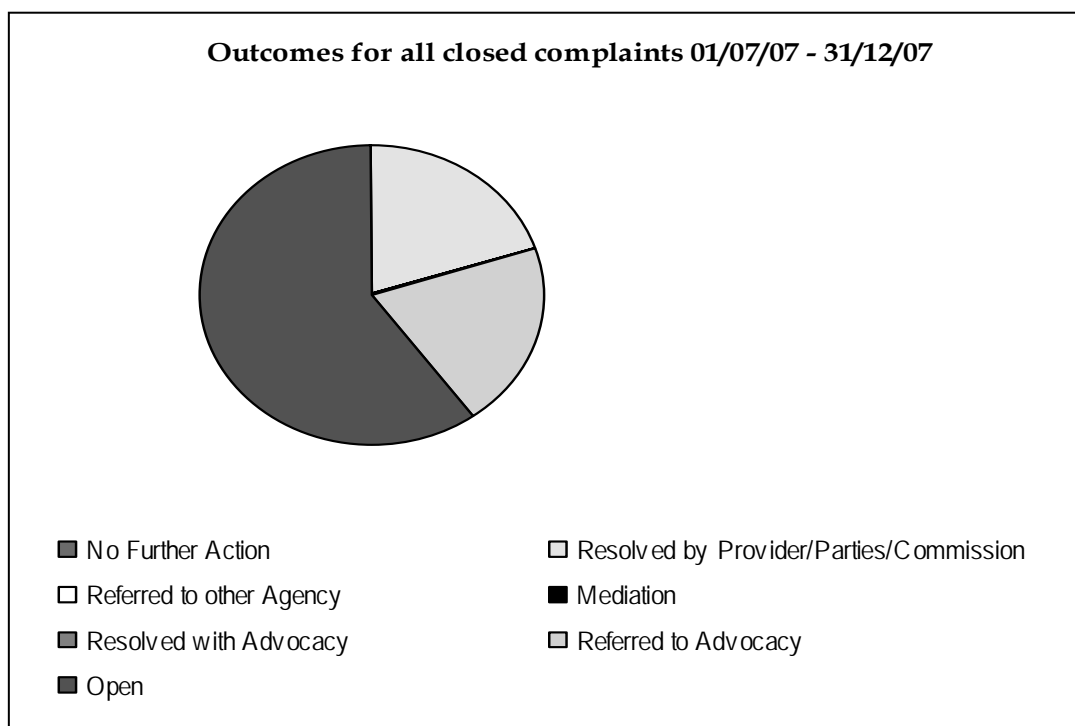
The total number of complaints involving the Lakes District Health Board between 01/07/07 and 31/12/07 was five compared to four in the period of 01/01/07 and 30/06/07. This is equal to 2.34% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (four complaints). One complaint was related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy.

Total Number of Complaints: **5 (2.3% of all complaints)**



Outcomes for Closed Complaints

Of the five new complaints opened between 1/07/07 and 31/12/07, two complaints were closed in that period. One was resolved by the provider, or the parties themselves, or the Commissioner. One was referred to Advocacy Services. Three complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect							1	1
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards		1				1	2	4
Right 5	Communication								
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total			1				1	3	5

Key

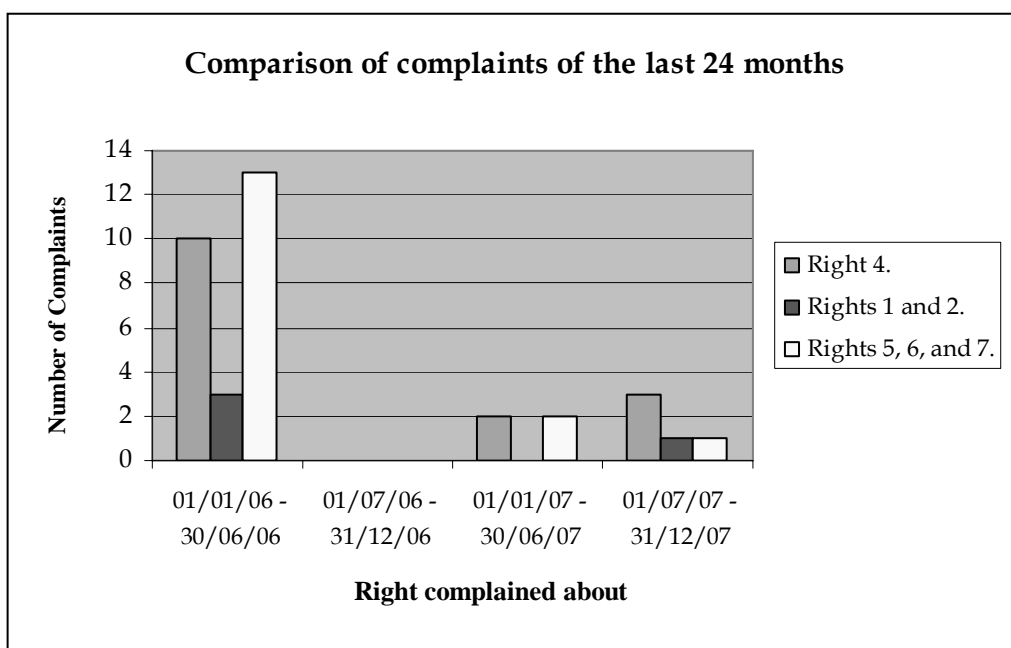
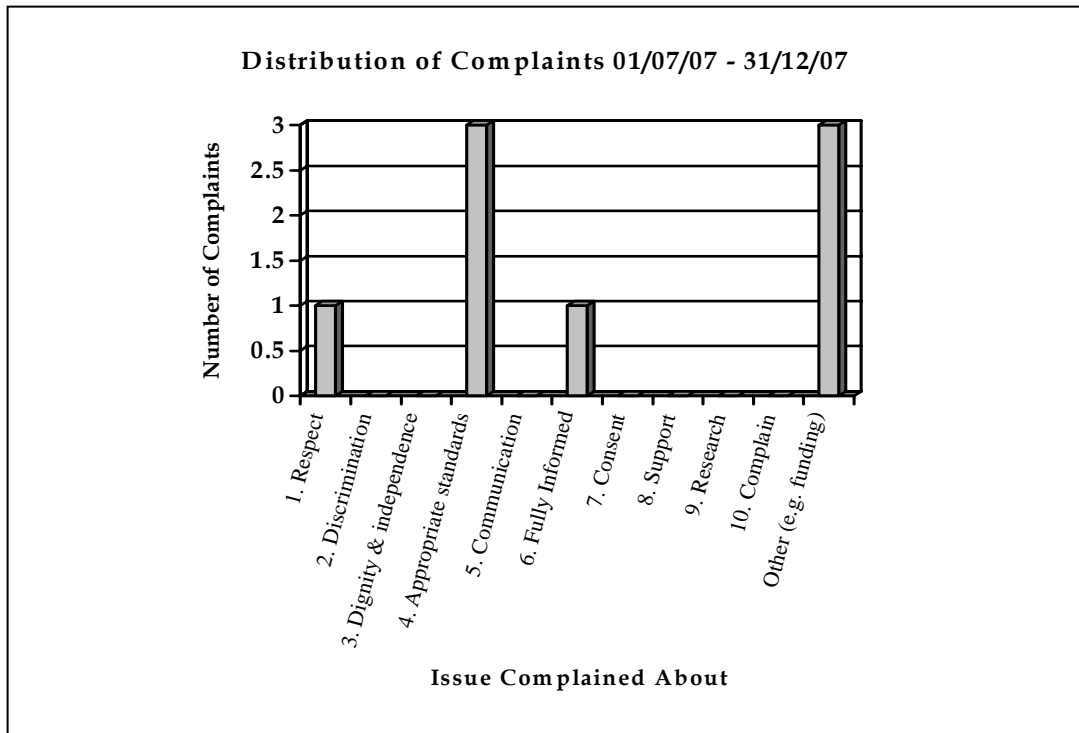
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Mid Central District Health Board

Complaints Information for period 01/07/07 – 31/12/07

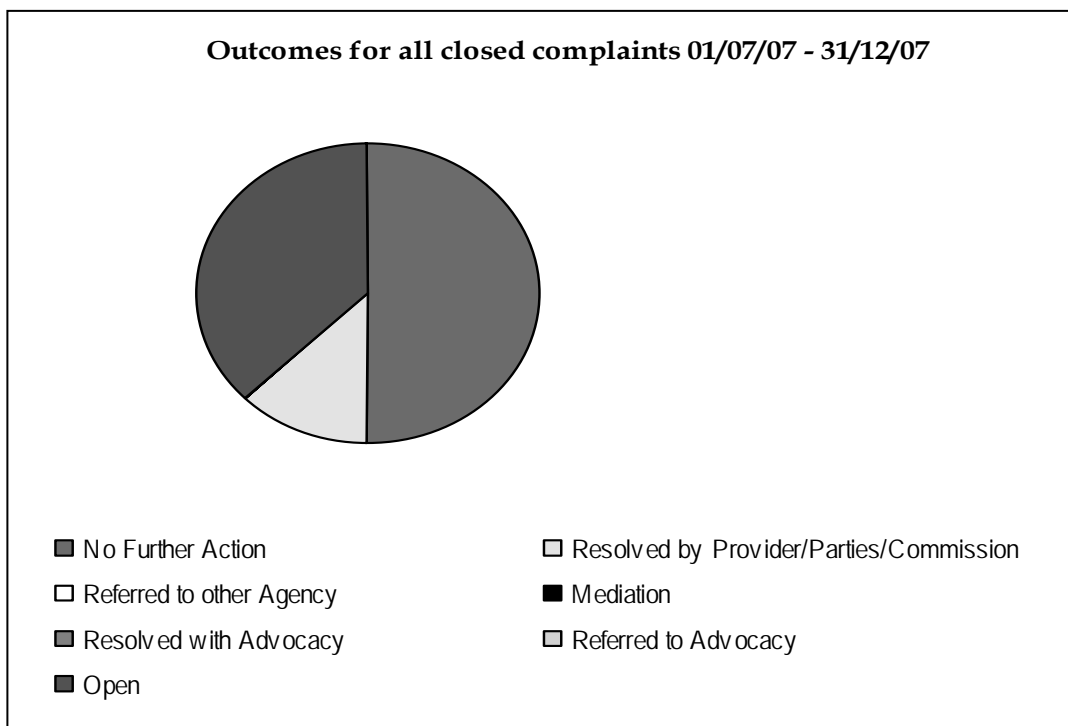
The total number of complaints involving the Mid Central District Health Board between 01/07/07 and 31/12/07 was eight compared to four in the period of 01/01/07 and 30/06/07. This is equal to 3.75% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (three complaints). There was one complaint related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy. One complaint related to Right 6 (fully informed) while three complaints fell under the category “Other”.

Total Number of Complaints: **8 (3.8% of all complaints)**



Outcomes for Closed Complaints

Of the eight new complaints opened between 1/07/07 and 31/12/07, five complaints were closed in that period. Four resulted in no action being taken; 1 complaint was resolved by the provider, or the parties themselves, or the Commissioner. Two were found to be outside the jurisdiction of the Health & Disability Commissioner and no action was taken. Three complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect	1							1
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards							3	3
Right 5	Communication								
Right 6	Fully Informed		1						1
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding	3							3
Total		4	1					3	8

Key

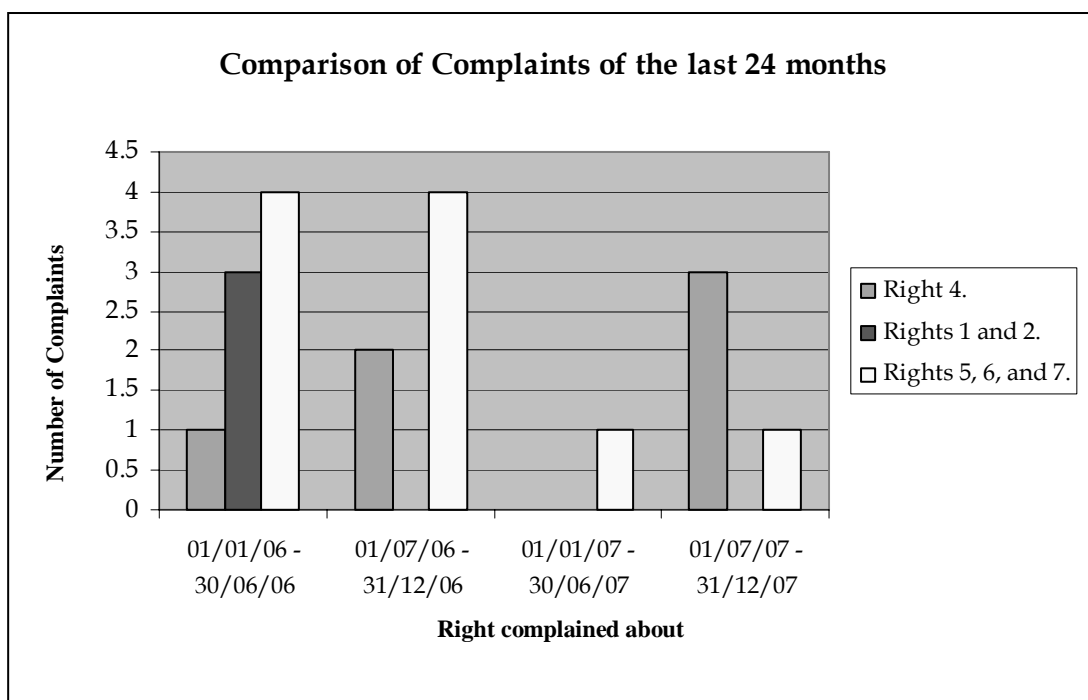
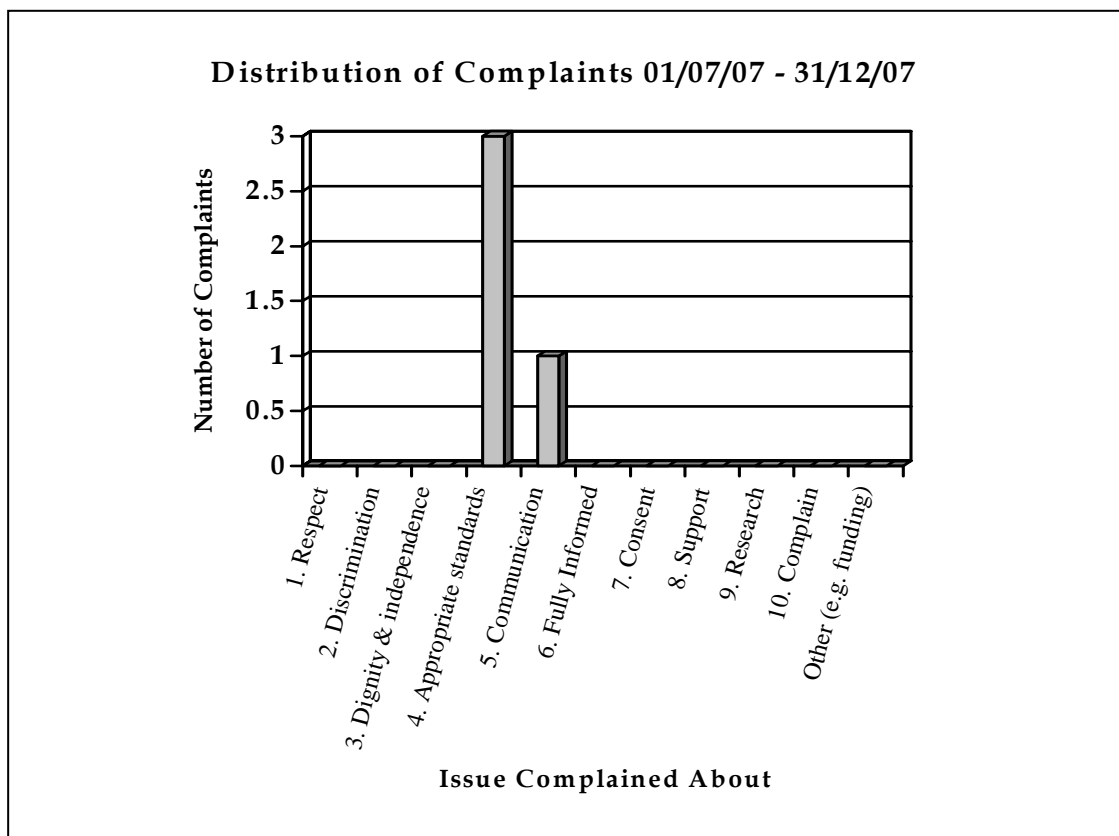
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Nelson District Health Board

Complaints Information for period 01/07/07 – 31/12/07

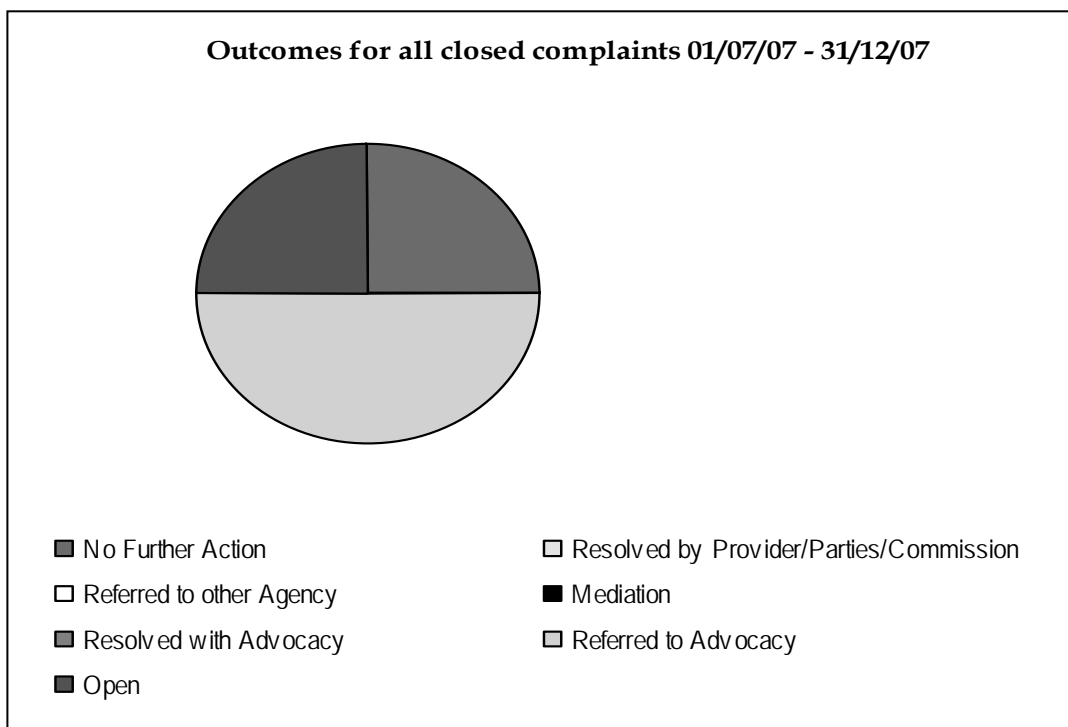
The total number of complaints involving the Nelson District Health Board between 01/07/07 and 31/12/07 was four compared to one in the period of 01/01/07 and 30/06/07. This is equal to 1.87% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (three complaints). One complaint was received relating to Right 5 (communication).

Total Number of Complaints: **4 (1.9% of all complaints)**



Outcomes for Closed Complaints

Of the four new complaints opened between 1/07/07 and 31/12/07, three complaints were closed in that period. One resulted in no action being taken and two were referred to Advocacy Services. One complaint remains open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect								
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	1					1	1	3
Right 5	Communication						1		1
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		1					2	1	4

Key

NA No action

RP Resolved by provider/parties/Commissioner

Ref Referred (eg District Inspector)

Med Mediation

RA Resolved with Advocacy

Ref A Referred to Advocacy

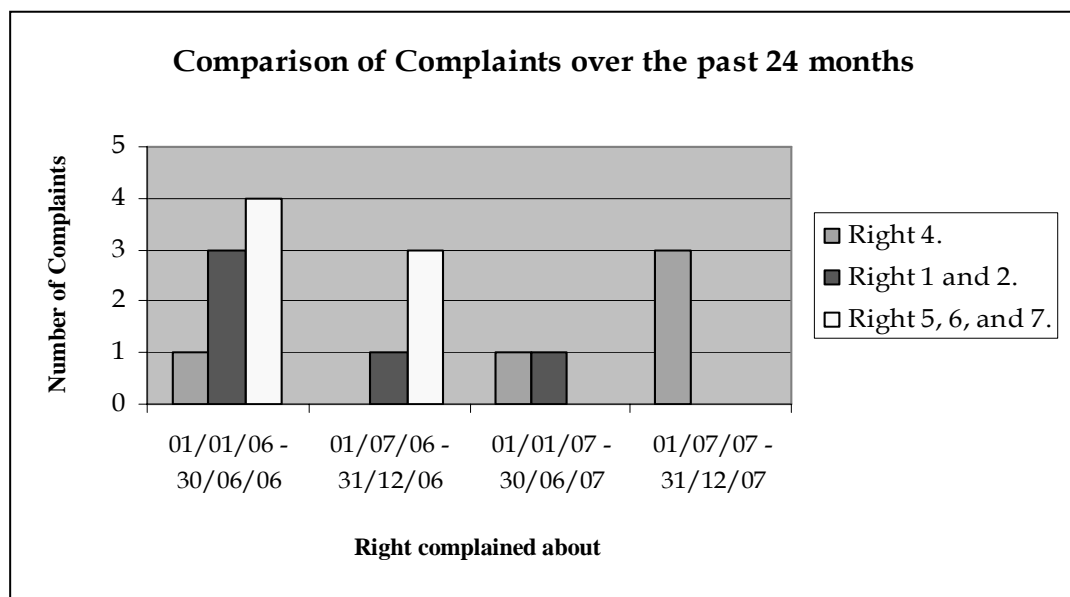
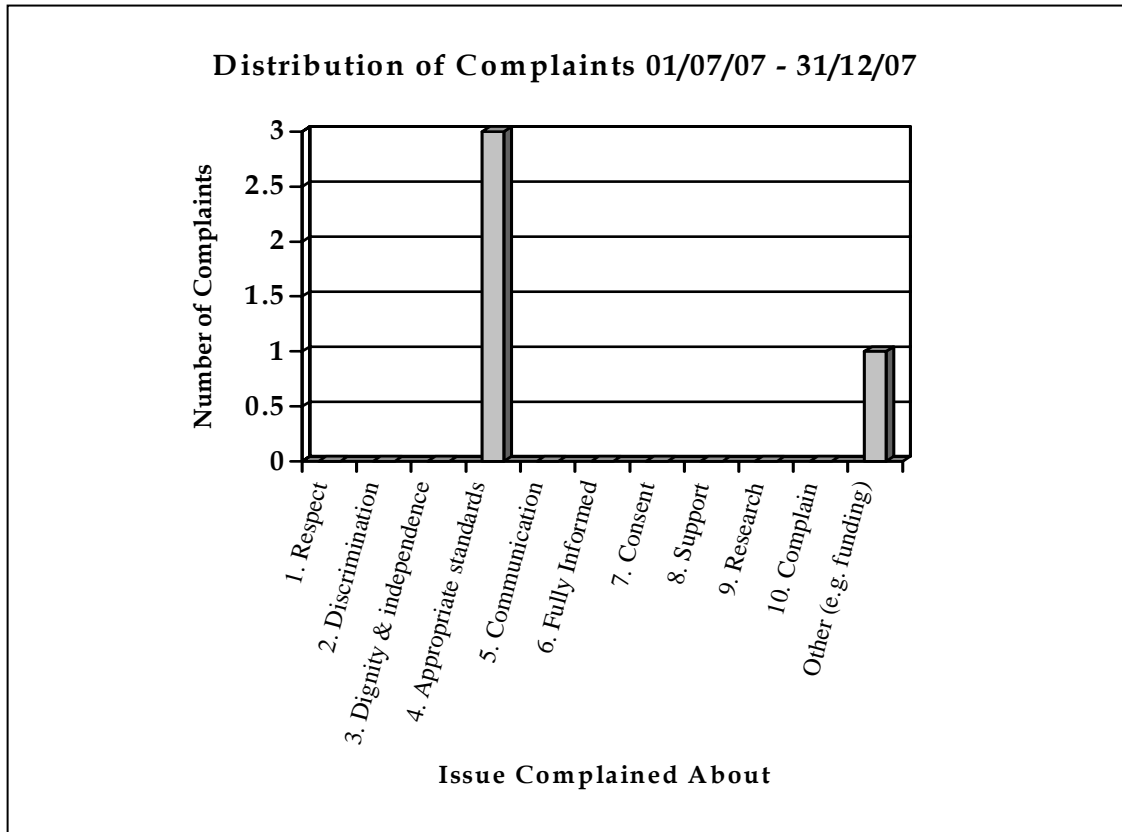
OJ Outside Jurisdiction

Northland District Health Board

Complaints Information for period 01/07/07 – 31/12/07

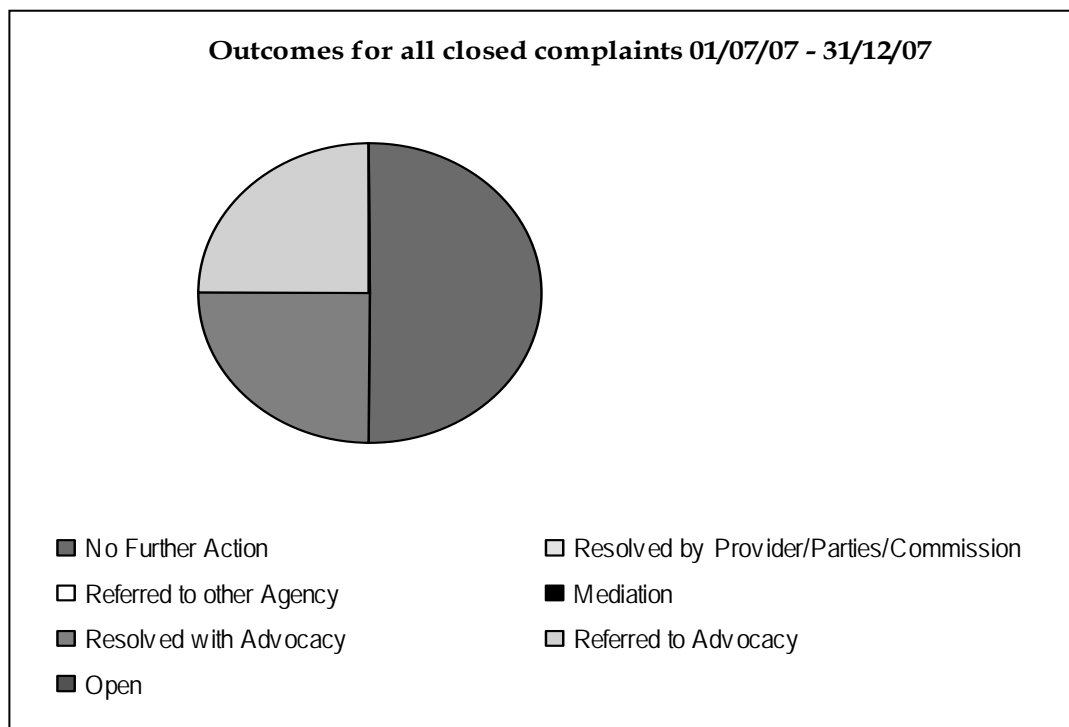
The total number of complaints involving the Northland District Health Board between 01/07/07 and 31/12/07 was four compared to two in the period of 01/01/07 and 30/06/07. This is equal to 1.87% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (three complaints). There was one complaint found to be within the category “other”.

Total Number of Complaints: **4 (1.9% of all complaints)**



Outcomes for Closed Complaints

Of the four new complaints opened between 1/07/07 and 31/12/07, all four were closed in that period. Two complaints resulted in no action being taken; one was resolved by Advocacy and one was referred to Advocacy Services. One complaint was found to be outside of the jurisdiction of the Health and Disability Commissioner and therefore no action was taken.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect								
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	1				1	1		3
Right 5	Communication								
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding	1							1
Total		2				1	1	0	4

Key

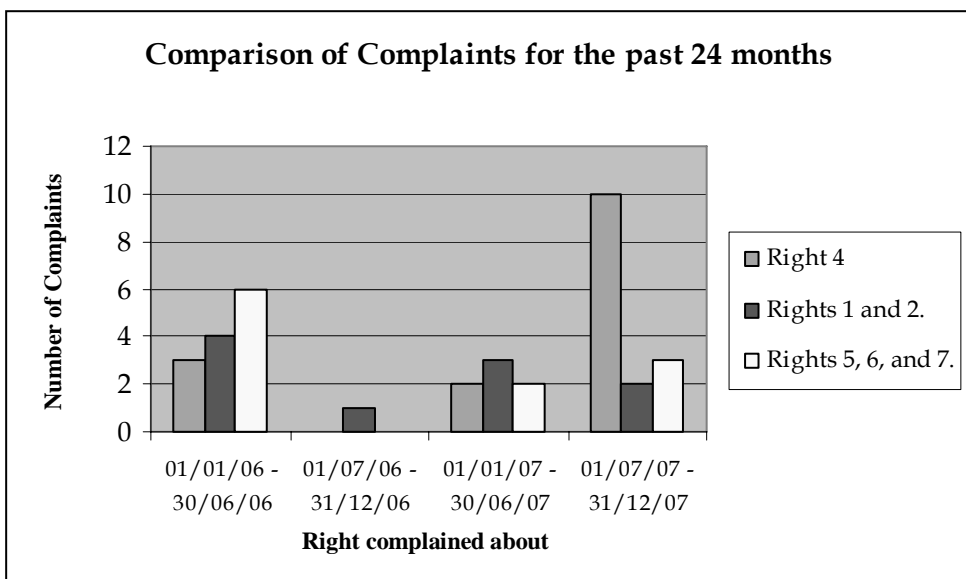
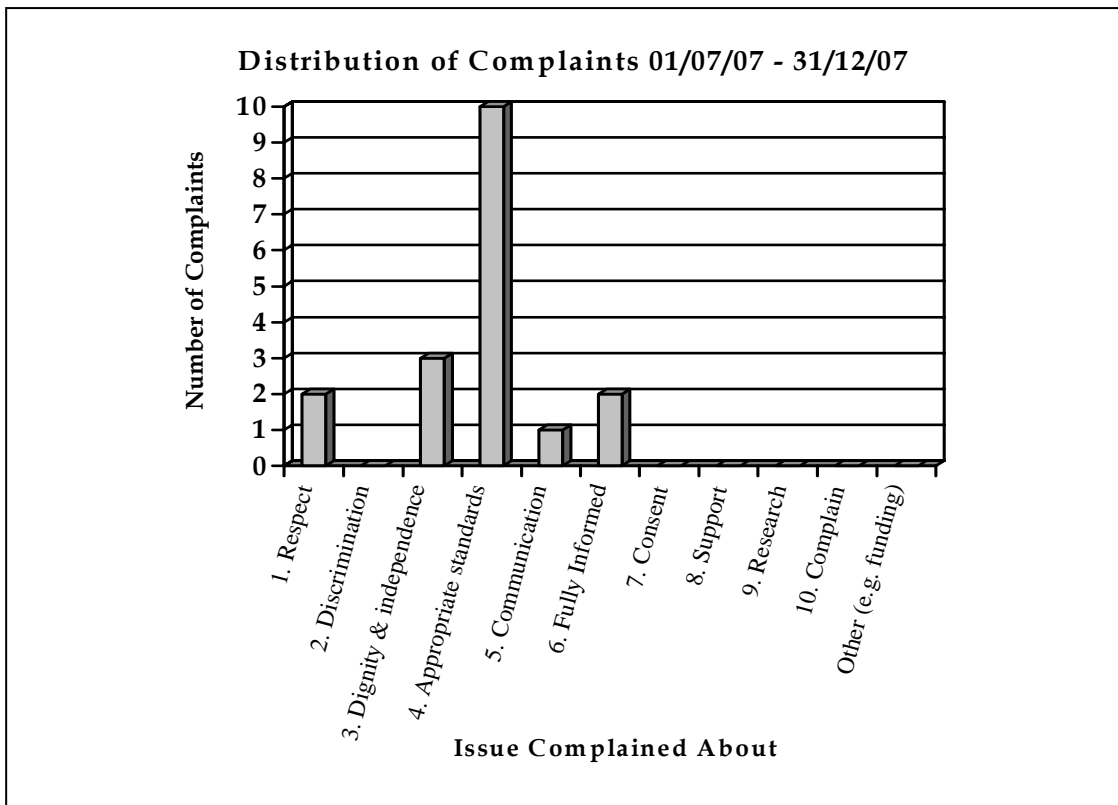
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Otago District Health Board

Complaints Information for period 01/07/07 – 31/12/07

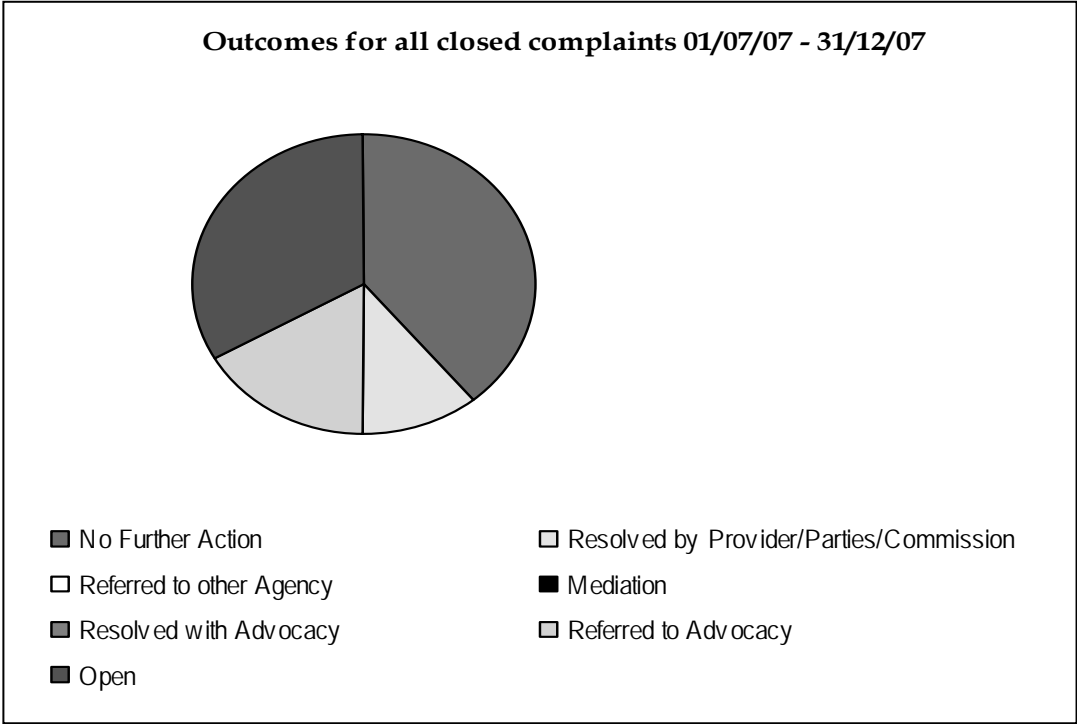
The total number of complaints involving the Otago District Health Board between 01/07/07 and 31/12/07 was 18 compared to seven in the period of 01/01/07 and 30/06/07. This is equal to 8.45% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (10 complaints). There were three complaints related to Right 3, the right to dignity and independence. One complaint was received relating to Right 5 (communication) two complaints related to Right 6 (fully informed). There were two complaints related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy.

Total Number of Complaints: **18 (8.5% of all complaints)**



Outcomes for Closed Complaints

Of the 18 new complaints opened between 1/07/07 and 31/12/07, 12 complaints were closed in that period. Seven resulted in no action being taken; two were resolved by the provider, or the parties themselves, or the Commissioner. Three were referred to Advocacy Services. One complaint fell into the category of “other” and one complaint was found to be out of the jurisdiction of the Health and Disability Commissioner and therefore no further action was taken. Six complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect		1				1		2
Right 2	Discrimination								
Right 3	Dignity/Independence	2						1	3
Right 4	Appropriate Standards	3					2	5	10
Right 5	Communication	1							1
Right 6	Fully Informed	1	1						2
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		7	2				3	6	18

Key

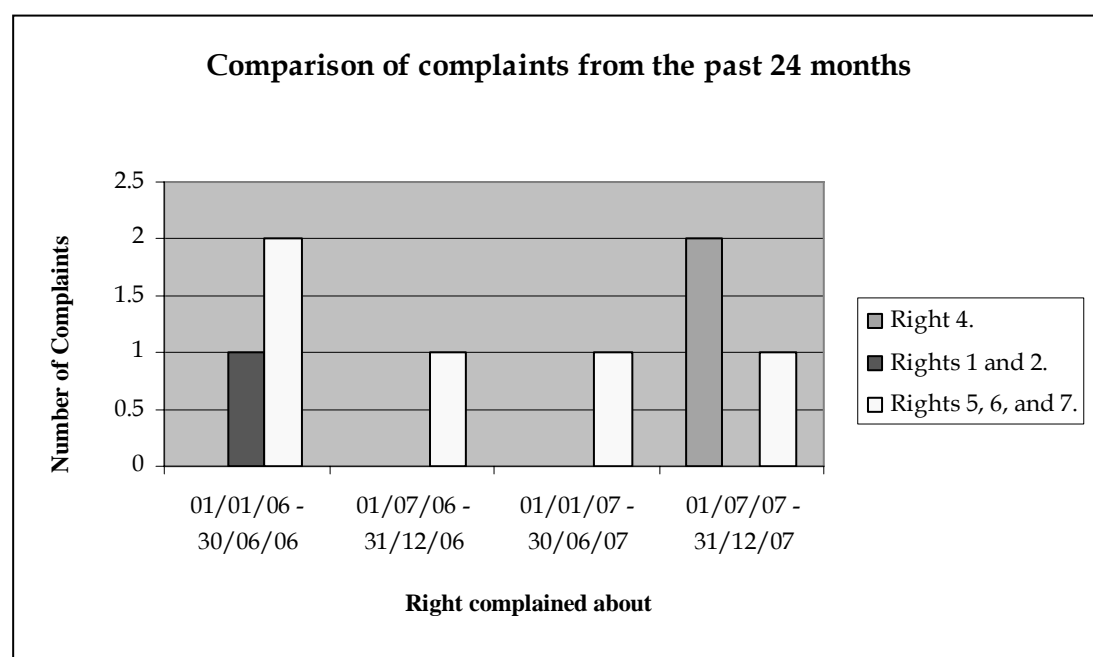
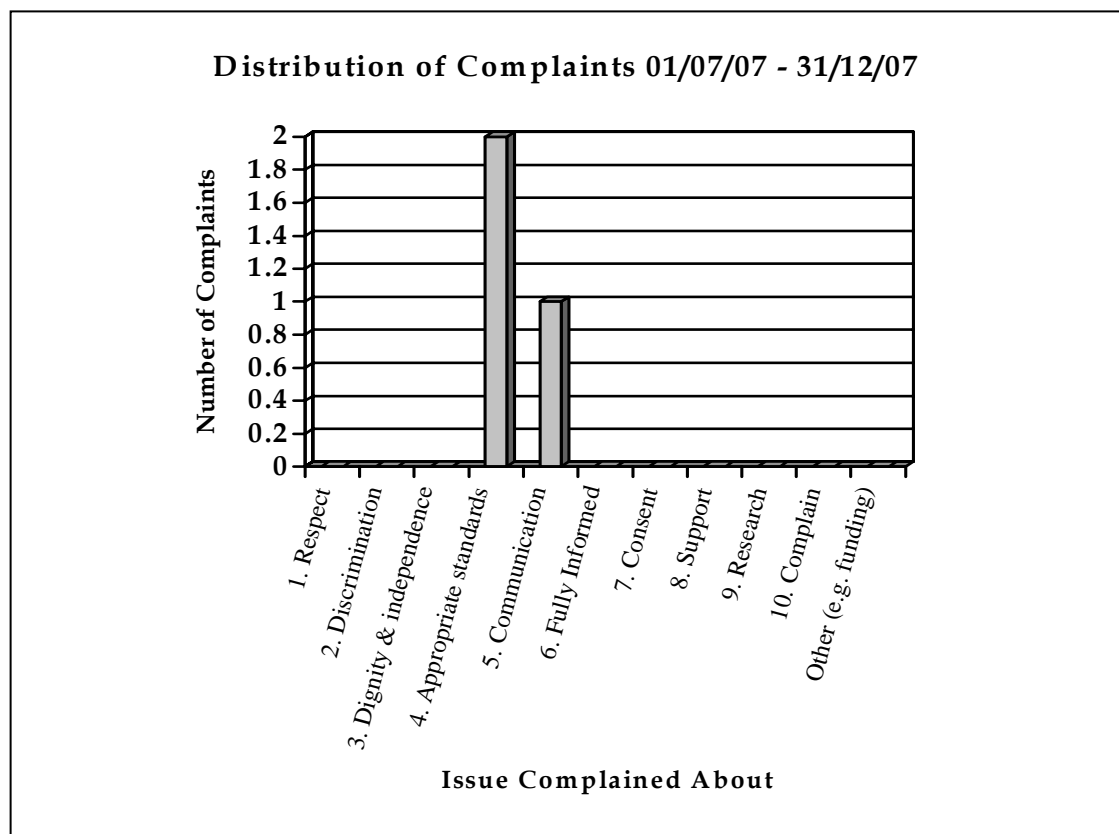
- NA No action
- RP Resolved by provider/parties/Commissioner
- Ref Referred (eg District Inspector)
- Med Mediation
- RA Resolved with Advocacy
- Ref A Referred to Advocacy
- OJ Outside Jurisdiction

South Canterbury District Health Board

Complaints Information for period 01/07/07 – 31/12/07

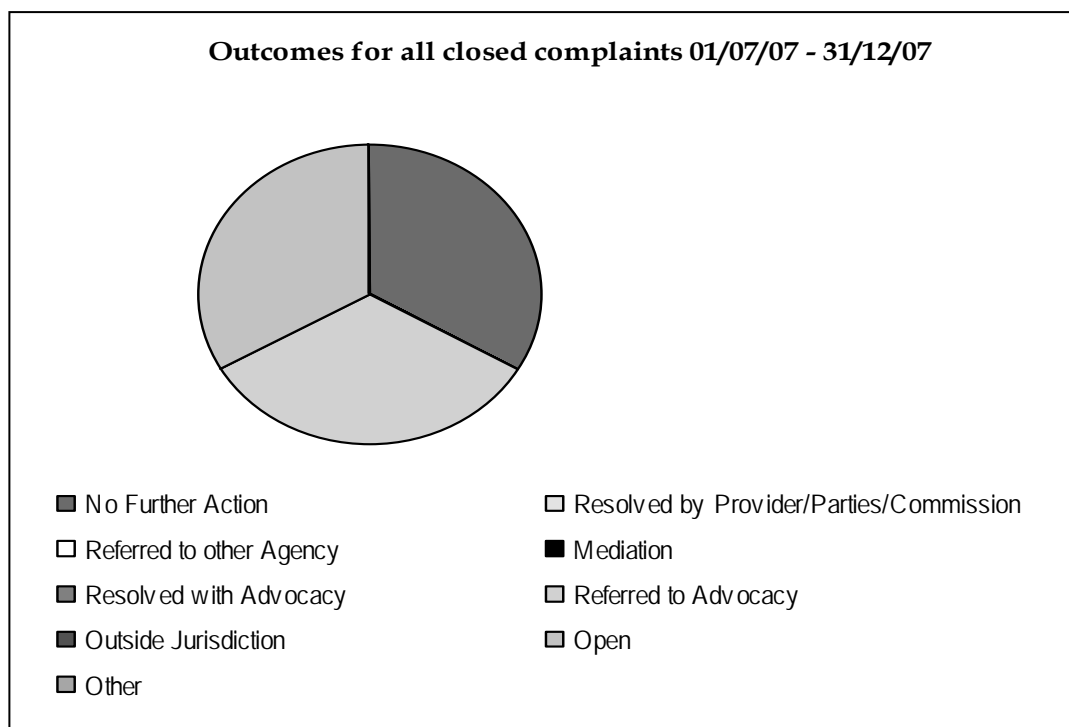
The total number of complaints involving the South Canterbury District Health Board between 01/07/07 and 31/12/07 was three compared to one in the period of 01/01/07 and 30/06/07. This is equal to 1.4% of all complaints received in the period of 31/07/07 – 31/12/07. Two complaints were related to Right 4, the right to services of an appropriate standard (10 complaints). One complaint related to Right 5 (communication).

Total Number of Complaints: **3 (1.4% of all complaints)**



Outcomes for Closed Complaints

Of the three new complaints opened between 1/07/07 and 31/12/07, two complaints were closed in that period. One resulted in no action being taken; 1 was referred to Advocacy Services and one complaint remains open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect								
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards						1	1	2
Right 5	Communication	1							1
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		1					1	1	3

Key

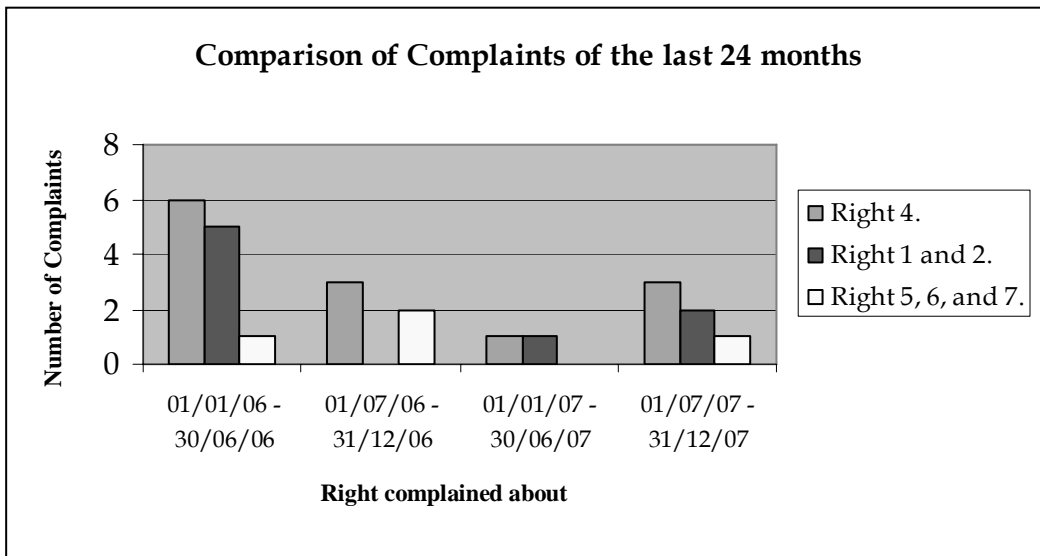
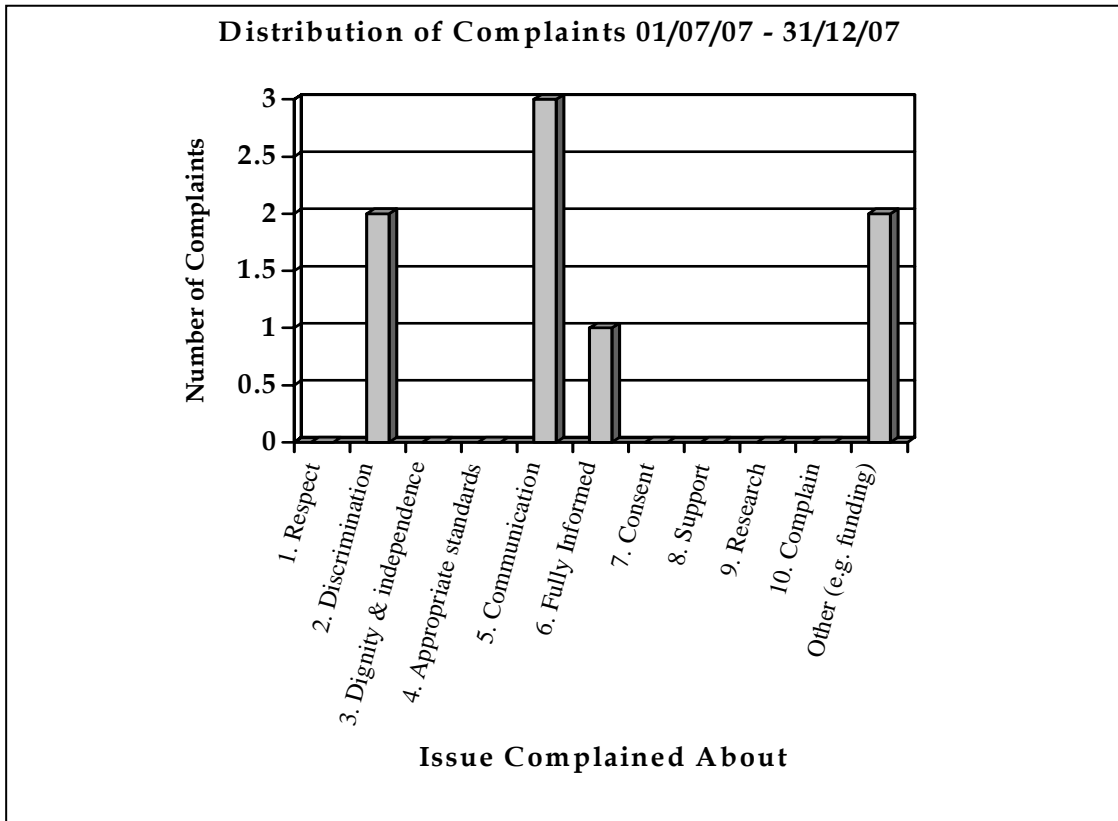
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Southland District Health Board

Complaints Information for period 01/07/07 – 31/12/07

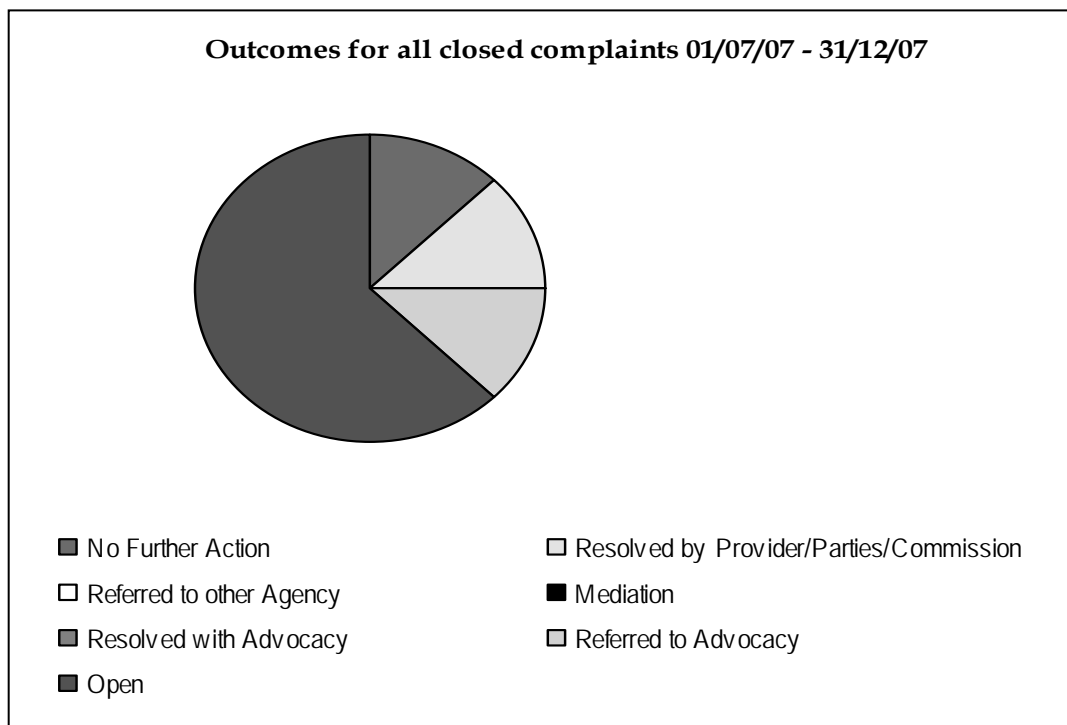
The total number of complaints involving the Southland District Health Board between 01/07/07 and 31/12/07 was eight compared to two in the period of 01/01/07 and 30/06/07. This is equal to 3.75% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (three complaints). There were two complaints related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy. One complaint related to Right 5 (communication) and two complaints were found to be within the category “other”.

Total Number of Complaints: **8 (3.8% of all complaints)**



Outcomes for Closed Complaints

Of the eight new complaints opened between 1/07/07 and 31/12/07, three complaints were closed in that period. One resulted in no action being taken; one was resolved by the provider, or the parties themselves, or the Commissioner. One was referred to Advocacy Services. One complaint fell into the category of “other”. Five complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect							2	2
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	1						2	3
Right 5	Communication							1	1
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding		1				1		2
Total		1	1				1	5	8

Key

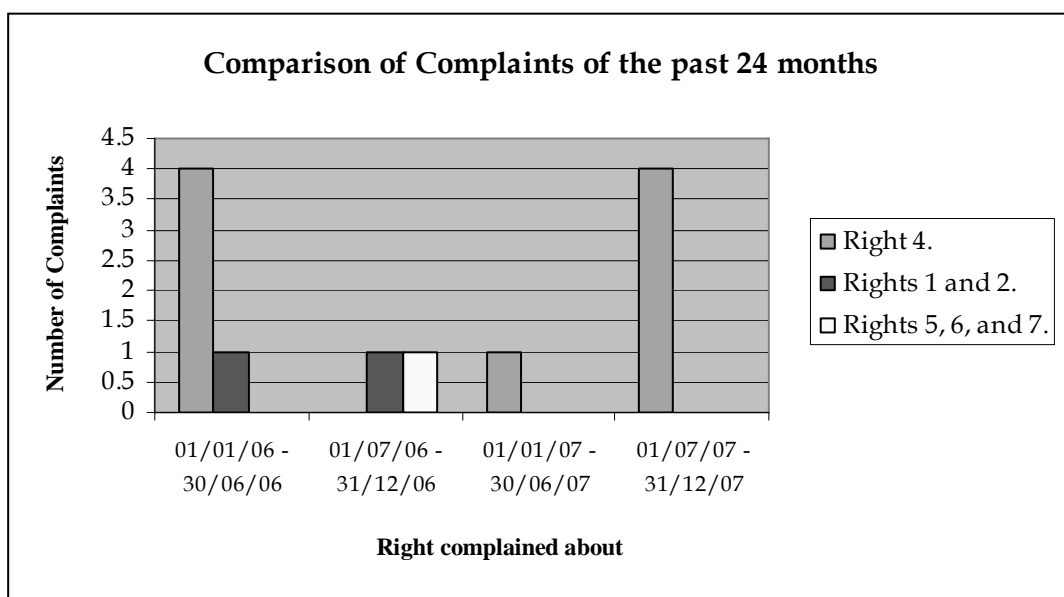
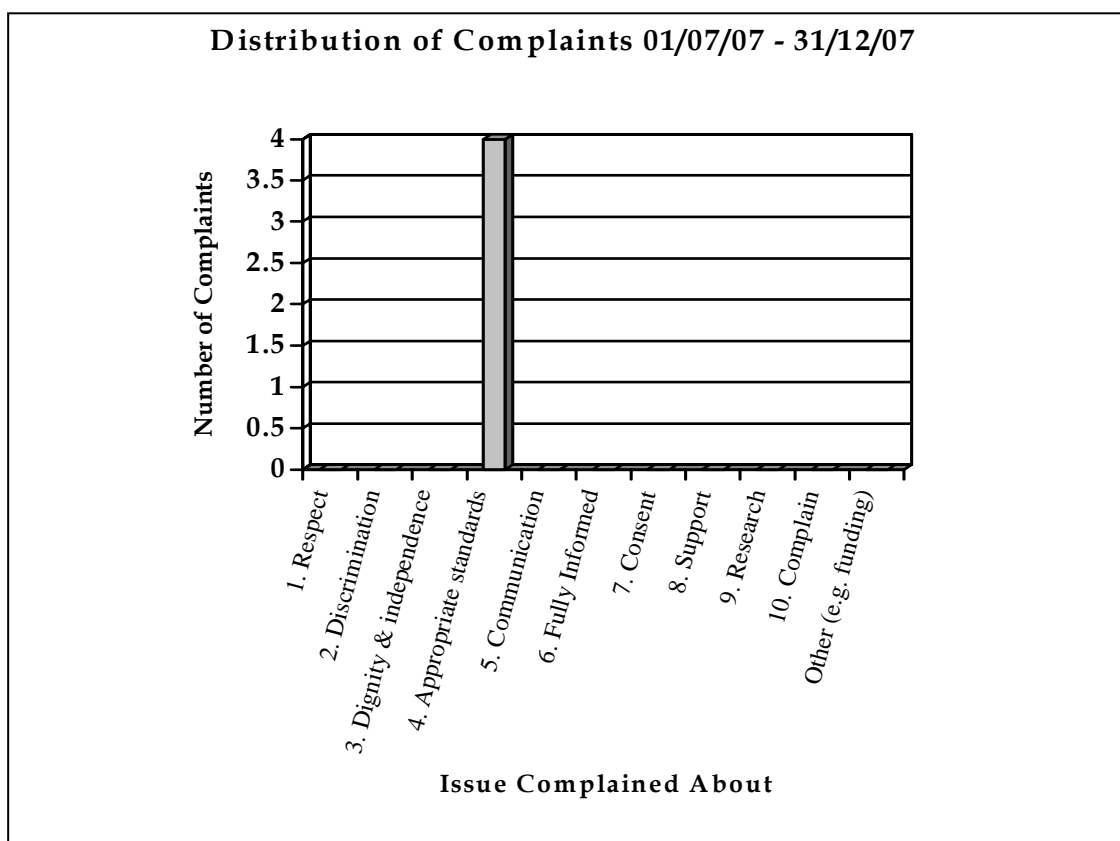
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Tairawhiti District Health Board

Complaints Information for period 01/07/07 – 31/12/07

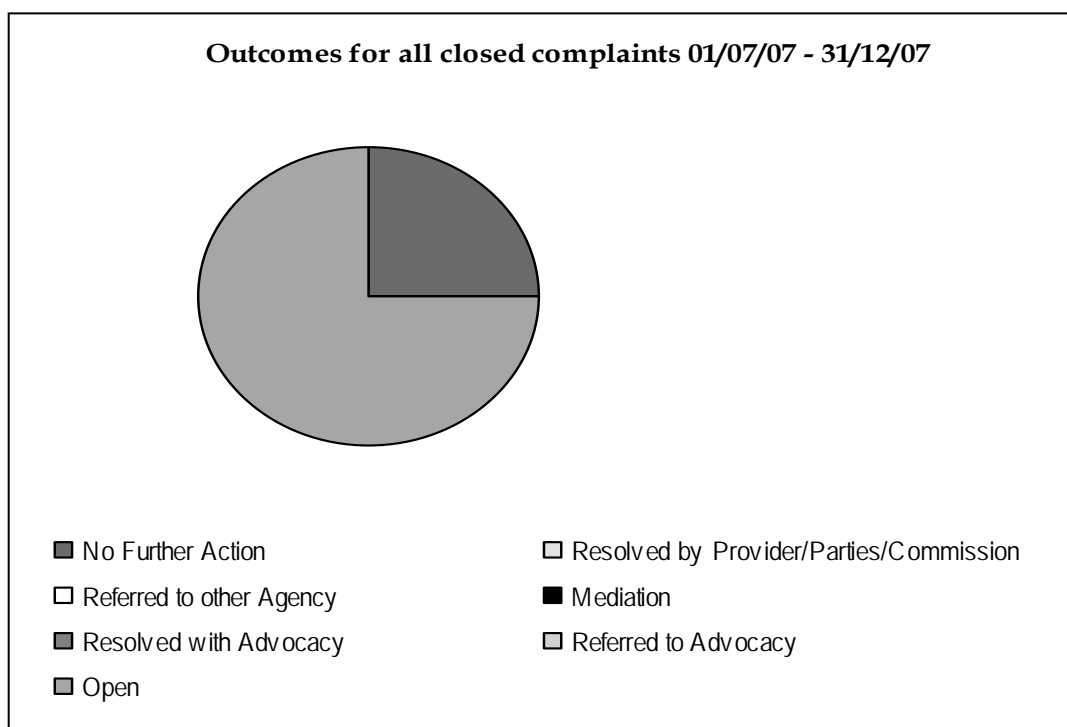
The total number of complaints involving the Tairawhiti District Health Board between 01/07/07 and 31/12/07 was four compared to one in the period of 01/01/07 and 30/06/07. This is equal to 1.87% of all complaints received in the period of 31/07/07 – 31/12/07. All four complaints related to Right 4, the right to services of an appropriate standard.

Total Number of Complaints: **4 (1.9% of all complaints)**



Outcomes for Closed Complaints

Of the four new complaints opened between 1/07/07 and 31/12/07, one complaint was closed in that period. One resulted in no action being taken; three complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect								
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	1						3	4
Right 5	Communication								
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		1						3	4

Key

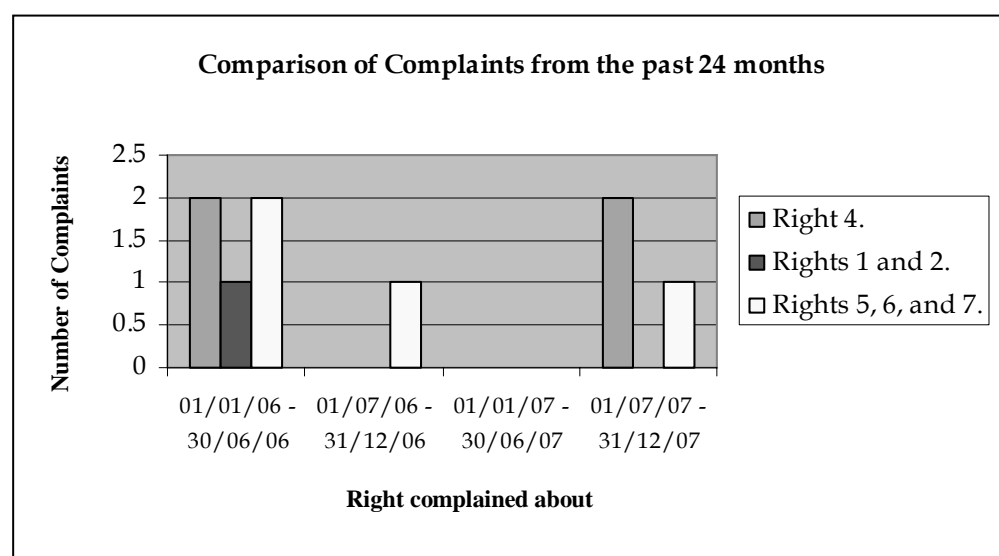
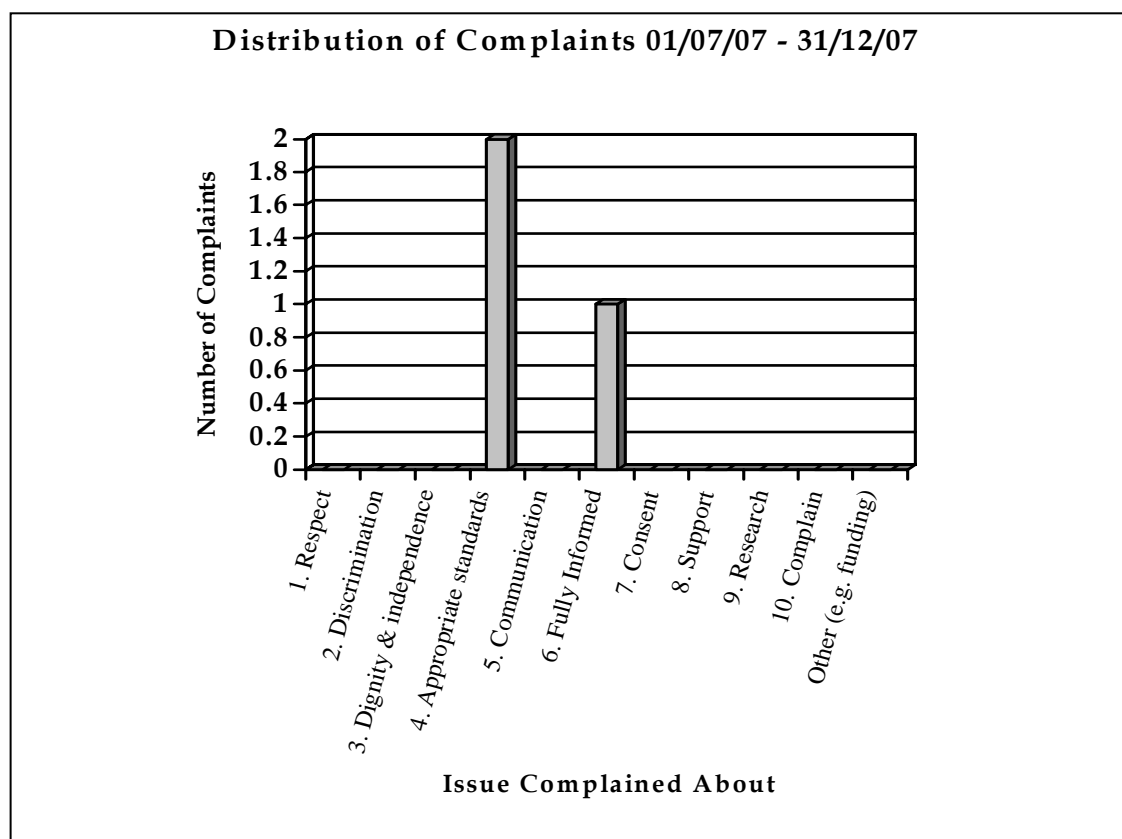
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Taranaki District Health Board

Complaints Information for period 01/07/07 – 31/12/07

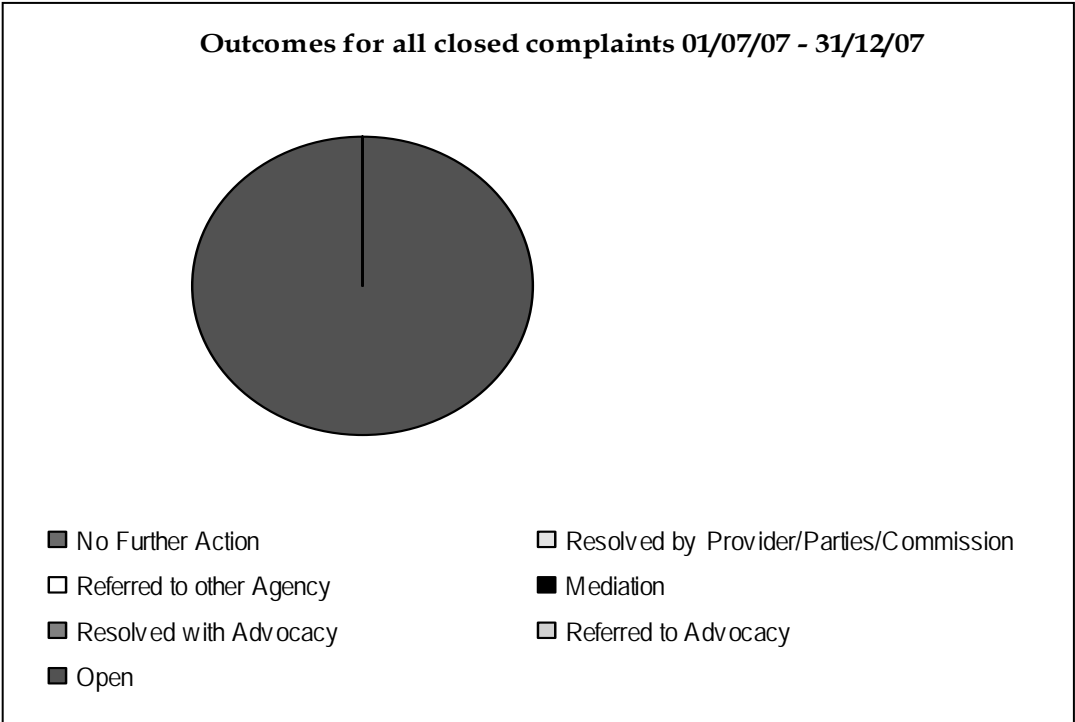
The total number of complaints involving the Taranaki District Health Board between 01/07/07 and 31/12/07 was three compared to nil in the period of 01/01/07 and 30/06/07. This is equal to 1.4% of all complaints received in the period of 31/07/07 – 31/12/07. Two complaints related to Right 4, the right to services of an appropriate standard. One complaint related to Right 6 (fully informed).

Total Number of Complaints: **3 (1.4% of all complaints)**



Outcomes for Closed Complaints (no closed complaints for Taranaki)

All three complaints remain open at this stage.

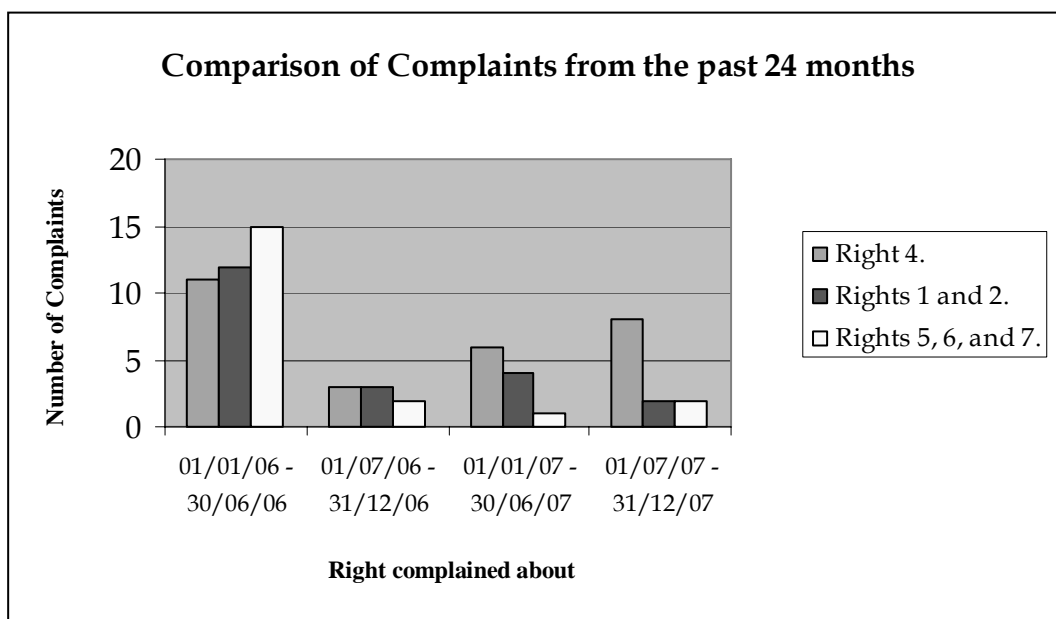
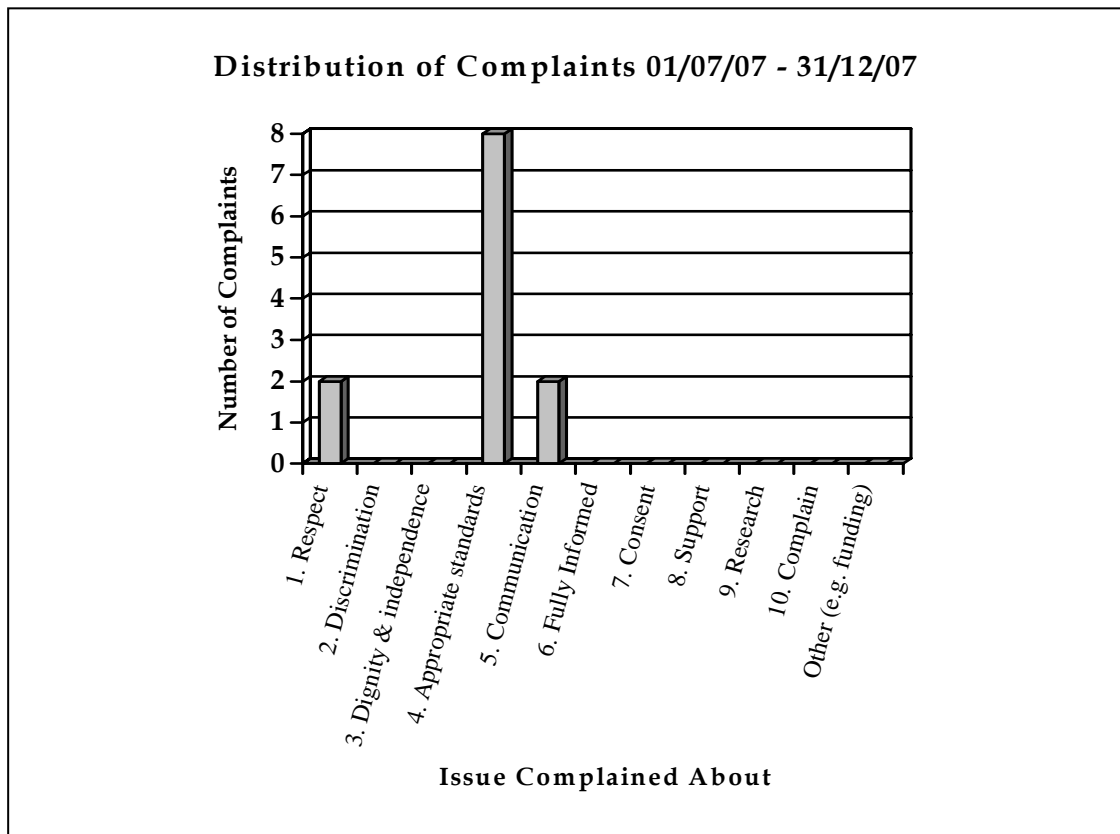


Waikato District Health Board

Complaints Information for period 01/07/07 – 31/12/07

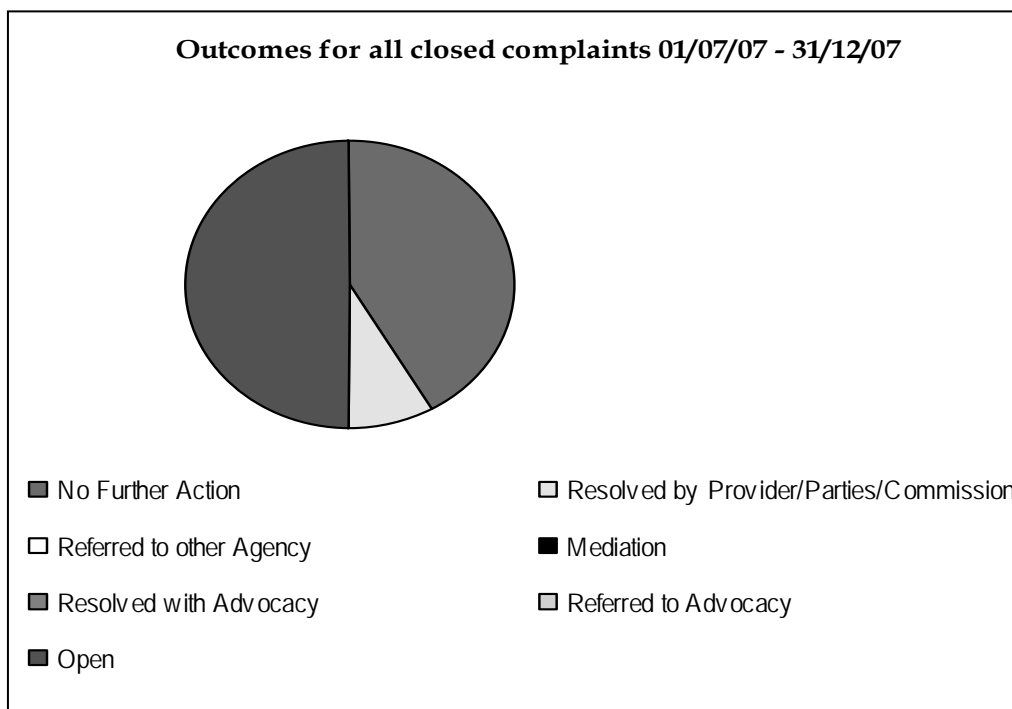
The total number of complaints involving the Waikato District Health Board between 01/07/07 and 31/12/07 was 12 compared to 11 in the period of 01/01/07 and 30/06/07. This is equal to 5.63% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (eight complaints). There were two complaints related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy. Two complaints were related to Right 2 (discrimination) and two complaints related to Right 5 (communication).

Total Number of Complaints: **12 (5.6% of all complaints)**



Outcomes for Closed Complaints

Of the 12 new complaints opened between 1/07/07 and 31/12/07, six complaints were closed in that period. Five resulted in no action being taken and one was resolved by the provider, or the parties themselves, or the Commissioner. Six complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect	1	1						2
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	3						5	8
Right 5	Communication	1						1	2
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		5	1					6	12

Key

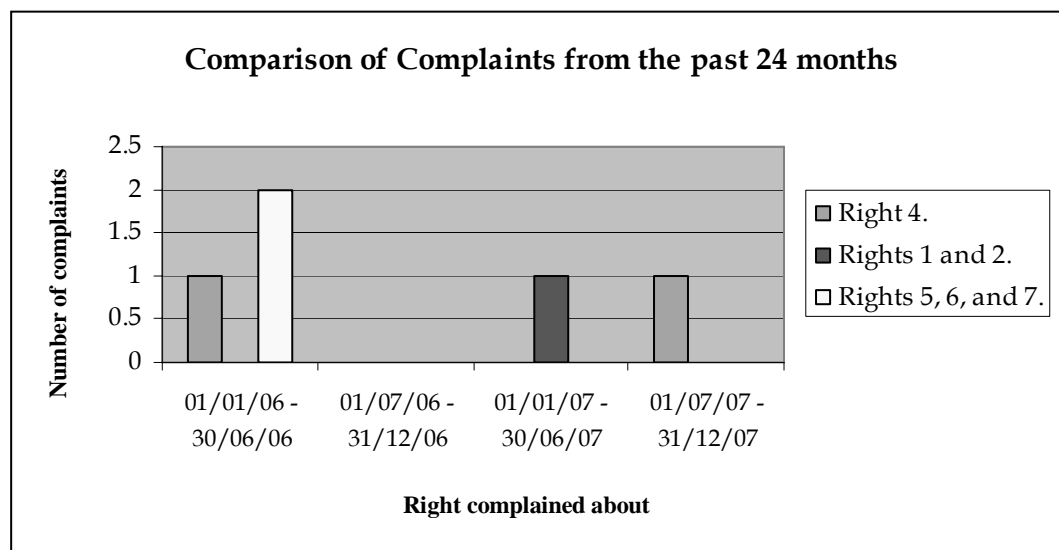
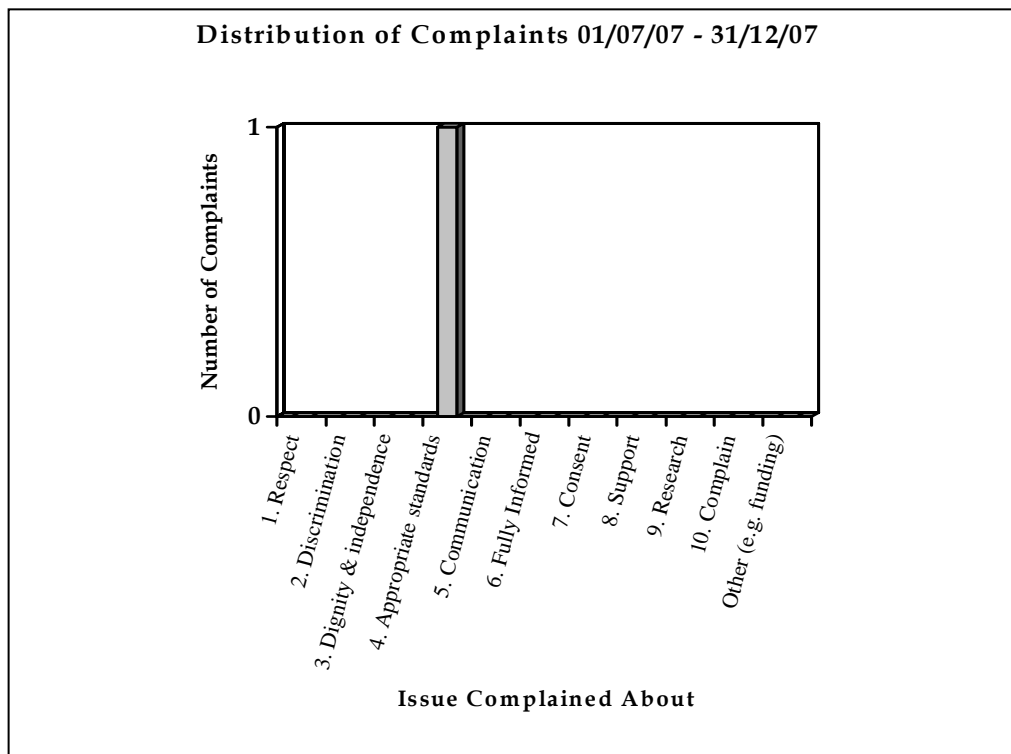
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Wairarapa District Health Board

Complaints Information for period 01/07/07 – 31/12/07

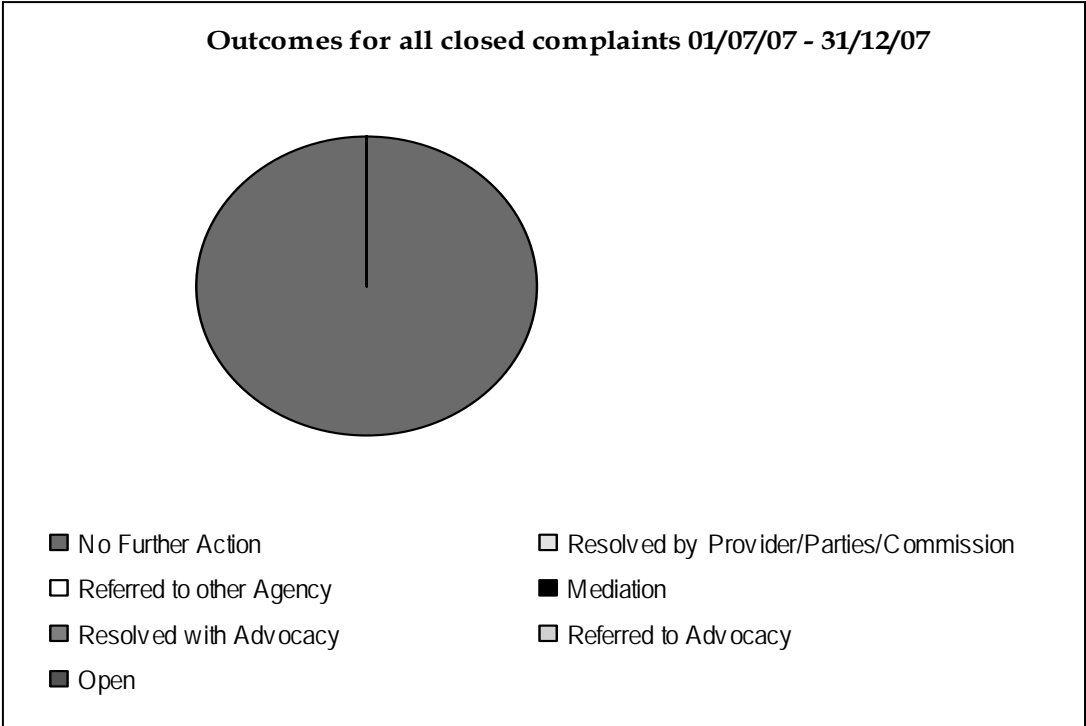
The total number of complaints involving the Wairarapa District Health Board between 01/07/07 and 31/12/07 was one compared to one in the period of 01/01/07 and 30/06/07. This is equal to 0.46% of all complaints received in the period of 31/07/07 – 31/12/07. This complaint related to Right 4, the right to services of an appropriate standard.

Total Number of Complaints: **1 (0.5% of all complaints)**



Outcomes for Closed Complaints

The one new complaint opened between 1/07/07 and 31/12/07 resulted in no action being taken. There are no complaints remaining open.

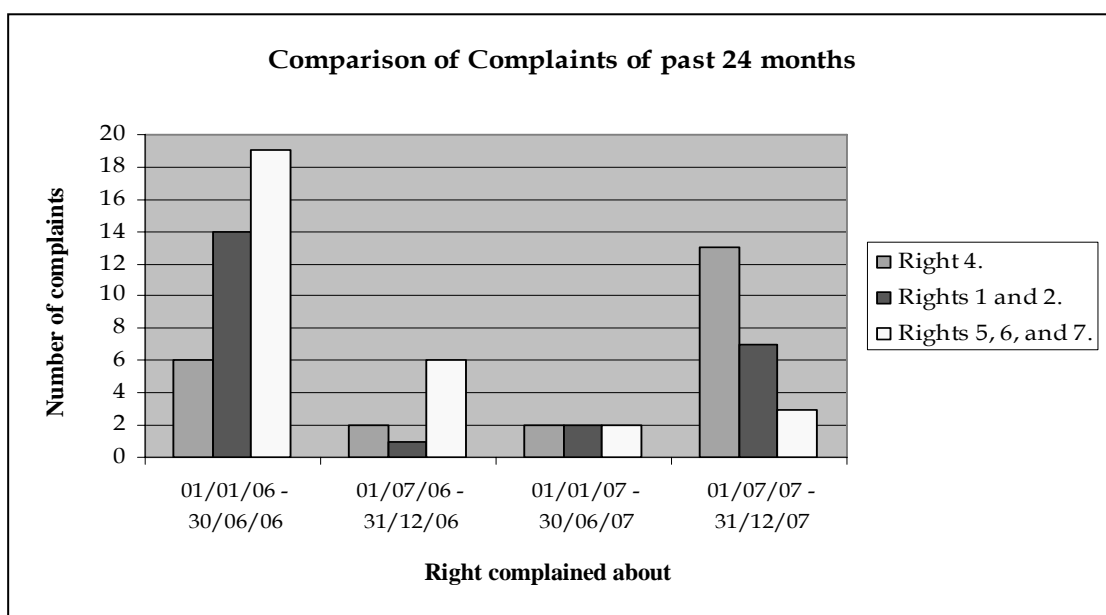
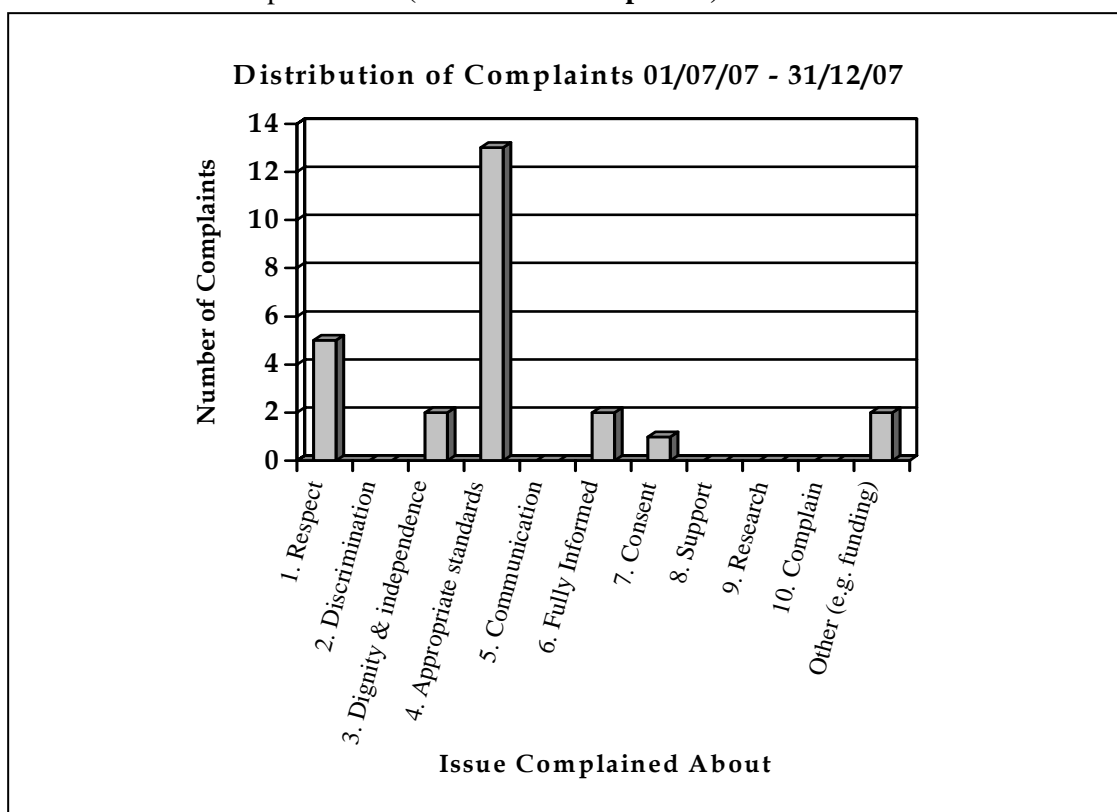


Waitemata District Health Board

Complaints Information for period 01/07/07 – 31/12/07

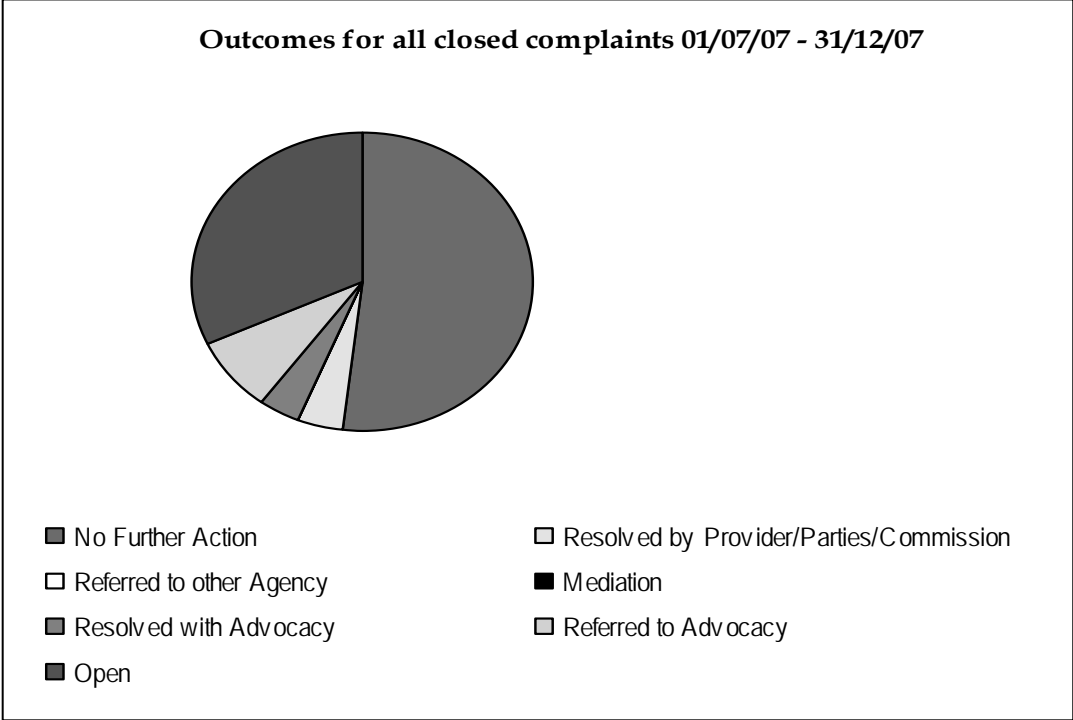
The total number of complaints involving the Waitemata District Health Board between 01/07/07 and 31/12/07 was 25 compared to six in the period of 01/01/07 and 30/06/07. This is equal to 11.73% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaint was related to Right 4, the right to services of an appropriate standard (13 complaints). There were five complaints related to Right 1, the right to be treated with respect regarding values, beliefs, culture and religion, including the right to personal privacy. Two complaints were related to Right 3, the right to dignity and independence. Two complaints were received relating to Right 5 (communication) and one related to Right 6 (fully informed). There were two complaints found to be within the category “other”.

Total Number of Complaints: **25 (11.7% of all complaints)**



Outcomes for Closed Complaints

Of the 25 new complaints opened between 1/07/07 and 31/12/07, 17 complaints were closed in that period. Thirteen resulted in no action being taken; one was resolved by the provider, or the parties themselves, or the Commissioner. One was resolved with Advocacy and two were referred to Advocacy Services. One complaint was found to be outside of the jurisdiction of the Health and Disability Commissioner and therefore no action was taken and two complaints fell into the category of "other". Eight complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect	3						2	5
Right 2	Discrimination								
Right 3	Dignity/Independence						1	1	2
Right 4	Appropriate Standards	6	1				1	5	13
Right 5	Communication								
Right 6	Fully Informed	1				1			2
Right 7	Consent	1							1
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding	2							2
Total		13	1			1	2	8	25

Key

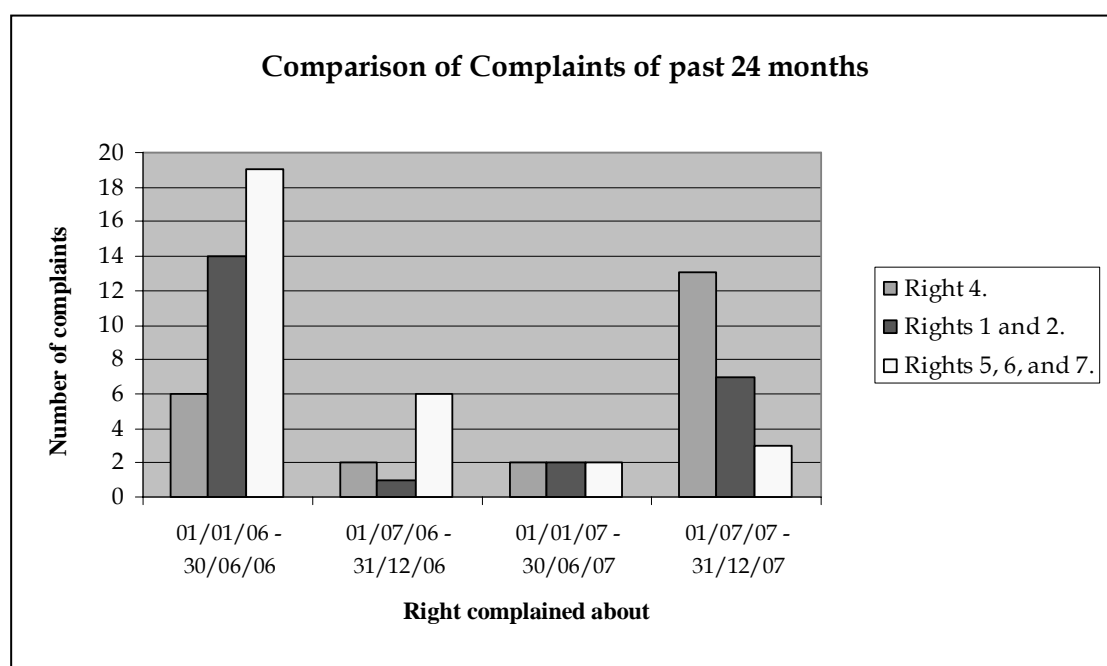
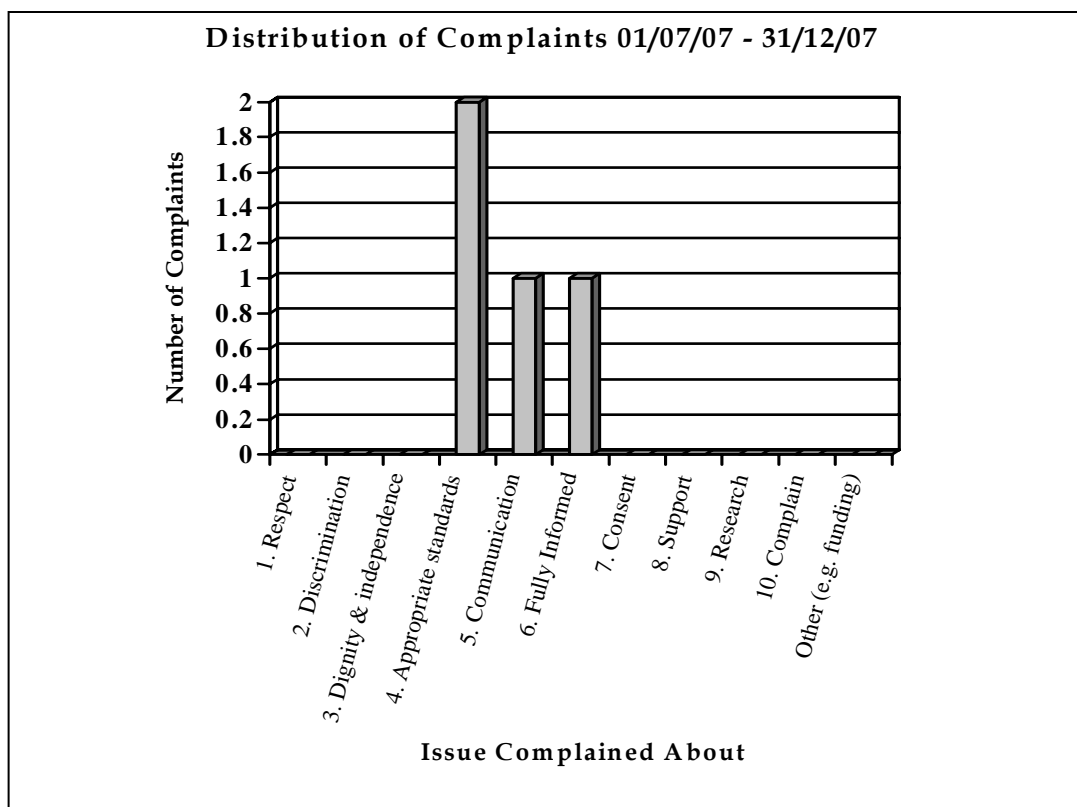
- NA No action
- RP Resolved by provider/parties/Commissioner
- Ref Referred (eg District Inspector)
- Med Mediation
- RA Resolved with Advocacy
- Ref A Referred to Advocacy
- OJ Outside Jurisdiction

West Coast District Health Board

Complaints Information for period 01/07/07 – 31/12/07

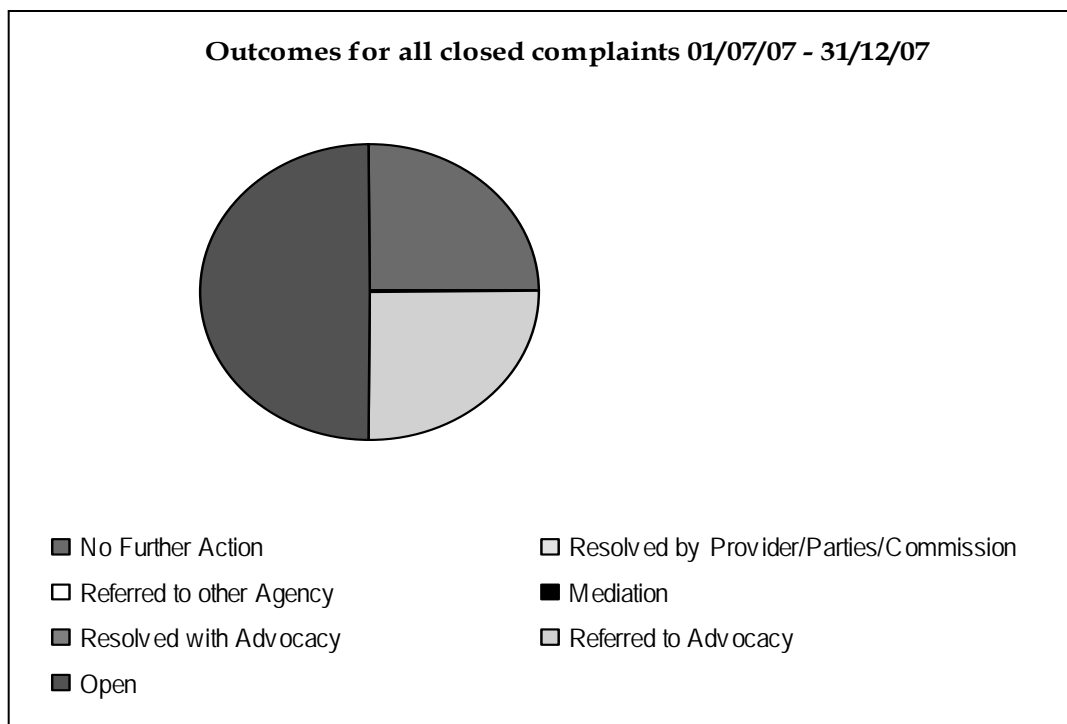
The total number of complaints involving the West Coast District Health Board between 01/07/07 and 31/12/07 was four compared to six in the period of 01/01/07 and 30/06/07. This is equal to 1.87% of all complaints received in the period of 31/07/07 – 31/12/07. Two complaints were related to Right 4, the right to services of an appropriate standard (10 complaints). One complaint was received relating to Right 5 (communication) and one related to Right 6 (fully informed).

Total Number of Complaints: **4 (1.9% of all complaints)**



Outcomes for Closed Complaints

Of the four new complaints opened between 1/07/07 and 31/12/07, two complaints were closed in that period. One complaint resulted in no action being taken; and one was referred to Advocacy Services.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect								
Right 2	Discrimination								
Right 3	Dignity/Independence								
Right 4	Appropriate Standards	1					1		2
Right 5	Communication							1	1
Right 6	Fully Informed							1	1
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding								
Total		1					1	2	4

Key

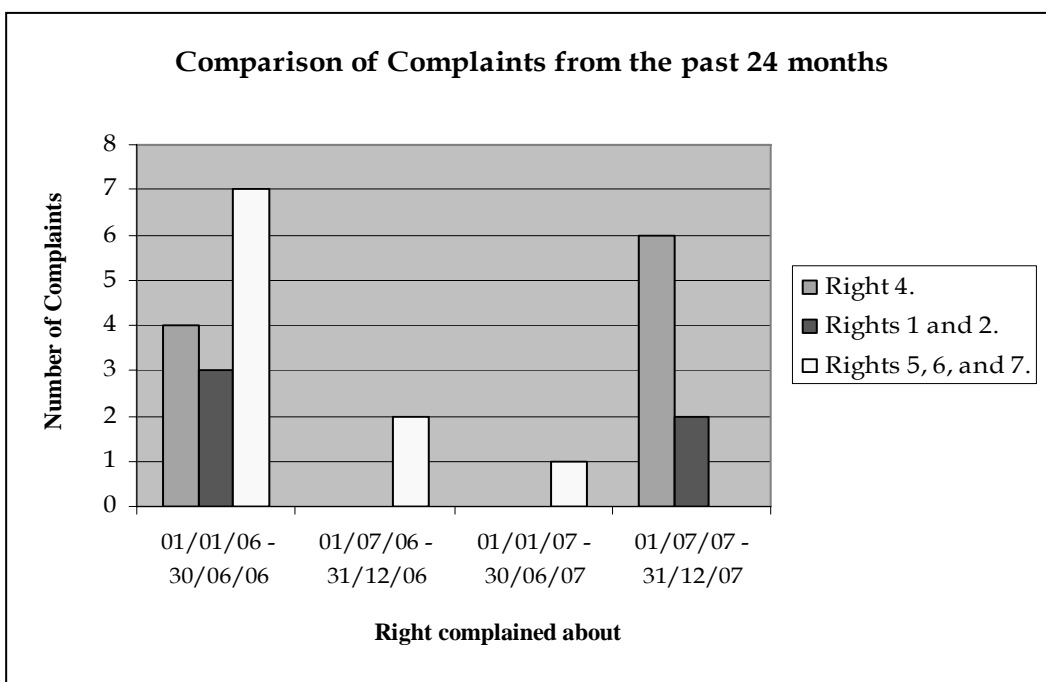
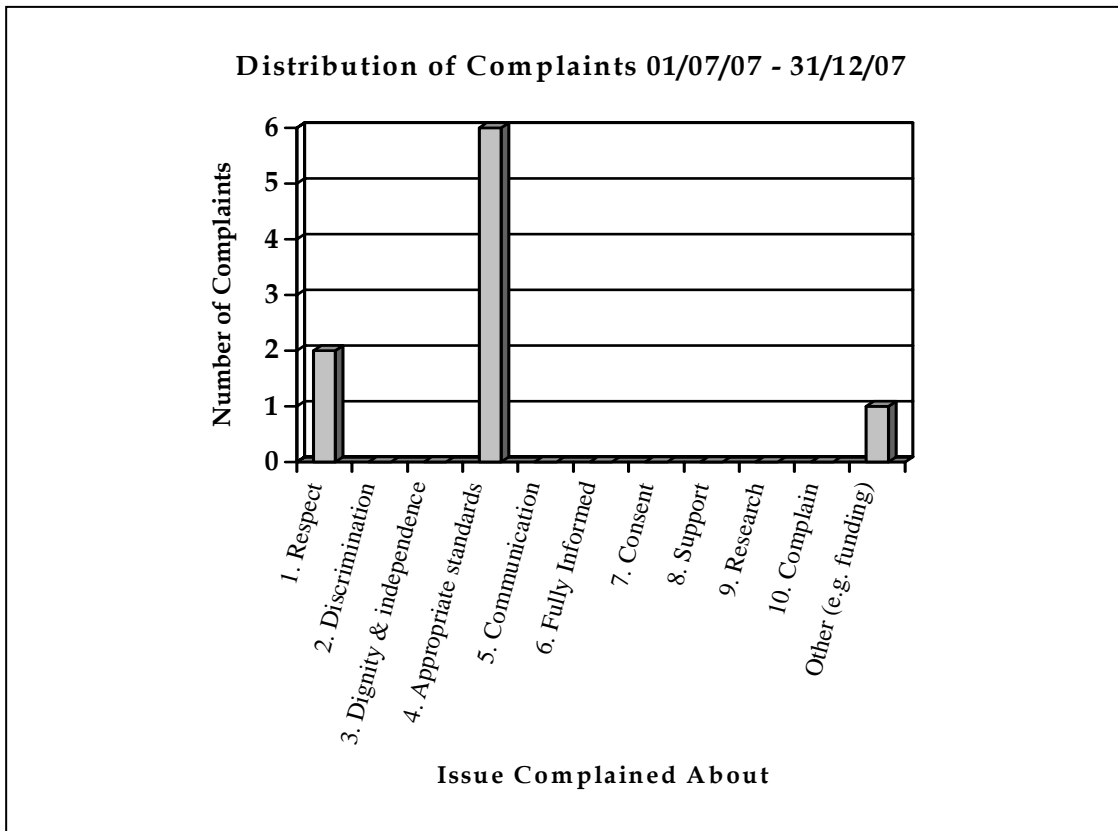
NA	No action	RA	Resolved with Advocacy
RP	Resolved by provider/parties/Commissioner	Ref A	Referred to Advocacy
Ref	Referred (eg District Inspector)	OJ	Outside Jurisdiction
Med	Mediation		

Whanganui District Health Board

Complaints Information for period 01/07/07 – 31/12/07

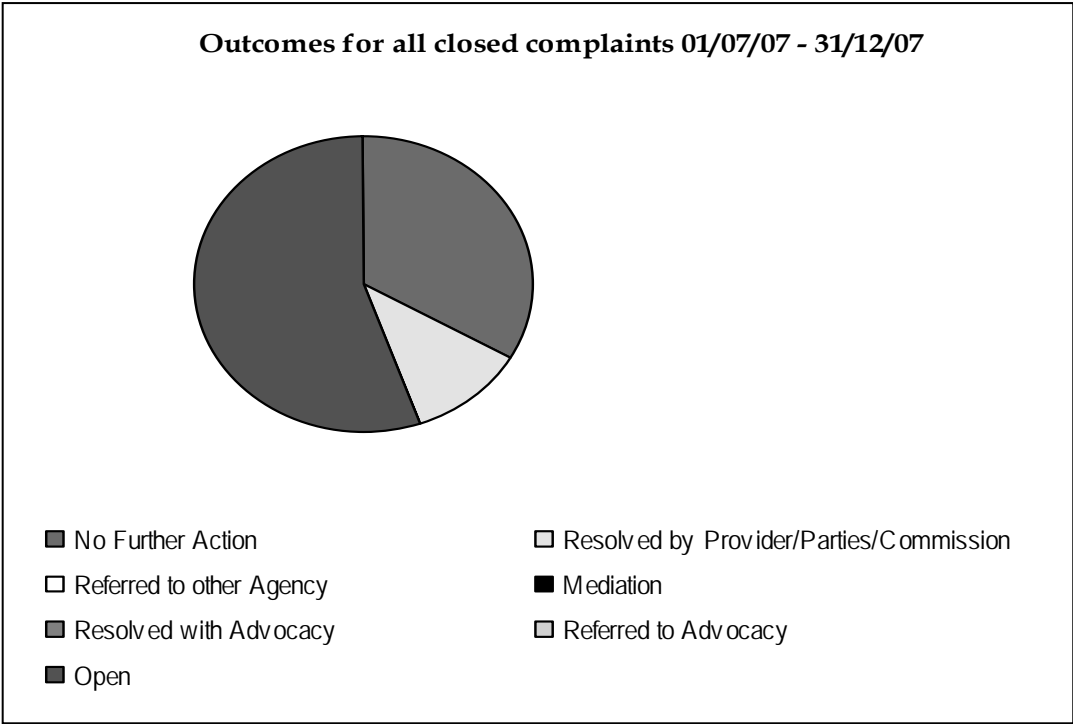
The total number of complaints involving the Whanganui District Health Board between 01/07/07 and 31/12/07 was nine compared to one in the period of 01/01/07 and 30/06/07. This is equal to 4.22% of all complaints received in the period of 31/07/07 – 31/12/07. The most frequent complaints were related to Right 4, the right to services of an appropriate standard (eight complaints). There was one complaint found to be within the category “other”.

Total Number of Complaints: **9 (4.2% of all complaints)**



Outcomes for Closed Complaints

Of the nine new complaints opened between 1/07/07 and 31/12/07, four complaints were closed in that period. Three resulted in no action being taken; one was resolved by the provider, or the parties themselves, or the Commissioner. One complaint was found to be outside of the jurisdiction of the Health and Disability Commissioner and therefore no action was taken. Five complaints remain open.



Subject of Complaint		Outcome of Closed Complaint						Open	Total
		NA	RP	Ref	Med	RA	Ref A		
Right 1	Respect		1					1	2
Right 2	Discrimination								
Right 3	Dignity/Independence	2						4	6
Right 4	Appropriate Standards								
Right 5	Communication								
Right 6	Fully Informed								
Right 7	Consent								
Right 8	Support								
Right 9	Research								
Right 10	Complain								
Other	e.g. access, funding	1							1
Total		3						5	8

Key

- NA No action
- RP Resolved by provider/parties/Commissioner
- Ref Referred (eg District Inspector)
- Med Mediation
- RA Resolved with Advocacy
- Ref A Referred to Advocacy
- OJ Outside Jurisdiction