

Complaints to HDC involving District Health Boards:

National Report - All DHBs

Report and Analysis for period 1 July – 31 December 2012

Introduction

This report provides aggregated DHB data and data specific to individual DHBs for the period 1 July – 31 December 2012. The data reflects only complaints to the Health and Disability Commissioner involving a DHB — it excludes those complaints made directly to a DHB that are not received by HDC.

Please also note that data reported captures only those complaints in which the DHB was identified as a provider by the complainant. Where a complaint is made about an individual practitioner at a DHB and the DHB is not identified, the complaint may not be included in these reports.

The report includes:

1. Data on complaints received:
 - (a) Current period:
 - how many
 - service type
 - key words (patient concerns or matters complained about)for national report: key words and primary issue
for individual reports: key words and classification of key words by service type
 - rate of complaints received
 - (b) Comparison over time (trend data):
 - number and rate of complaints received over current and previous six-month periods
2. Data on complaints closed:
 - (a) Current period:
 - how many
 - outcomes — how the matter was resolved
 - (b) Comparison over time (trend data):
 - rate of complaints investigated over current and previous six-month periods
3. Ranking
 - by rate of all complaints
 - by rate of complaints investigated

New material

For most tables, a column for percentage has also been added next to the number of complaints. Comparison tables for primary issue and key words (for national data and some individual DHBs) now show top five issues or key words for each reported period.

Please note: Discharge (denominator) data

Data for this report is provided by the Ministry of Health (MOH) and is provisional as at the date of extraction, **18 February 2013**. It excludes short stay discharges from emergency departments and patients attending outpatient units and clinics.

MOH discharge data is updated as figures come to hand from DHBs. Differences in data extracted at two dates six months apart can be considerable and are more apparent in larger DHBs. Rates for the immediate previous period have been recalculated according to the most recent data, and consequently frequency data for the previous period (Jan – Jun 2012) presented here may differ from that provided in the last report.

Classification of key words by service type

Feedback received in response to previous reports suggested that if the service associated with patient concerns were identified, those concerns could be more directly addressed through targeted service improvement. In this, and the previous report, this data was included for individual DHBs. Where any specific services are the subject of a complaint, the report shows correlations between those services and the substance of the complaints (key words) received about the care provided by those services.

The evaluation for the previous period specifically asked for feedback on this additional data. Nineteen out of twenty DHBs responded that they wish to continue to receive this data and hence it will be included in all reports from now on.

Other comment (as noted in previous reports)

(i) Timeliness

Respondents have suggested that having the reports available in a timelier manner may assist in the relevance and currency of the information. However, denominator data is obtained from the Ministry of Health and is not available before the end of the month following that in which DHBs provide it to the Ministry. The drafting, checking and the review of 20 reports is time consuming. We accept that the delay in their dissemination reduces their currency.

(ii) Ranking

The ranking system is based on rates of complaints; these rates are calculated using discharge numbers. To the extent that discharge numbers are a measure of DHB activity, this parameter appears to be a reasonable one to use for calculating rates and making comparisons across and within DHBs. It is accepted that discharge numbers are a limited indicator of DHB activity; that complexity is another factor, as are the numbers of patients that are not included in discharge data. Discharge data does not include short stay discharges from emergency departments and patients attending outpatient units and clinics, and yet these departments still generate complaints. Thus for DHBs where there are busy emergency departments and/or large numbers of patients attending clinics, the resulting rate of complaints may become inflated. Conversations with DHB staff have indicated that although the data has limitations, it is helpful.

We would appreciate further feedback on any other simple methods of representing this data.

National Data for all District Health Boards

1.0 Complaints received

In the period July—December 2012, HDC received a total of 292 complaints about care provided by all District Health Boards. Numbers of complaints in the previous four six-month periods from 1 July 2010 are 257, 268, 255 and 355; an average of 284 complaints received per six-month period. The total for the current period shows a 3% increase over the average number of complaints received for those previous periods.

1.1 Service type category

Complaints to HDC are shown by service type in Table 1.

Table 1 – Service types complained about

Service subject to complaint	Number of complaints	Percentage
Accident & Emergency	19	6.5%
Assessment for third party	2	0.7%
Counselling/therapy	2	0.7%
Dental	3	1.0%
General practice	4	1.4%
Inpatient mental health services	10	3.4%
Laboratory services	1	0.3%
Maternity ¹	11	3.8%
Medical	10	3.4%
Mental health services	37	12.7%
Methadone/drug & alcohol services	5	1.7%
Midwifery	5	1.7%
Multiple ²	37	12.7%
Non health or disability service	2	0.7%
Nursing	12	4.1%
Oncology	6	2.1%
Other	4	1.4%
Paediatric	4	1.4%
Physician care	5	1.7%
Physiotherapy	2	0.7%
Prison health	1	0.3%
Public hospital care ³	59	20.2%
Radiology	1	0.3%
Rehabilitation services	3	1.0%
Residential care services	2	0.7%
Rest home care	3	1.0%
Specialist care ⁴	6	2.1%
Surgery - public sector	33	11.3%
Vision care	3	1.0%
Total	292	

¹ Denotes care provided by any attending staff.

² A complaint where several services are involved.

³ A complaint about the overall level of care, where no individual practitioners are specifically mentioned, or practitioners are mentioned in a general way.

⁴ A complaint where a specific senior clinician has been named in the complaint.

The identifiable services where the numbers of complaints were greatest are mental health services - 12.7% (this ratio goes up to 16.1% if inpatient mental health services are also included), public sector surgery - 11.3%, and accident and emergency - 6.5%.

It may be noted that multiple services, where no individual service type is identifiable, is the second highest service type complained about alongside mental health services (12.7%). A failure to provide seamless care between providers is often at the heart of these complaints about multiple services.

1.2 Key words (Patient concerns)

The substance of each complaint to HDC is identified by a broad primary issue, and further by the key words patients and their families tend to use to describe their concerns more specifically. The frequently used key words in these 292 complaints to HDC in this period are listed in Table 2. As each complaint may contain more than one key word, and not all key words are included, the totals in Table 2 do not add up to 100%.

The top five key word data for the current year and previous three periods are shown for comparison.

Table 2 – Top five complaint key words in complaints received over last two years

Top five complaint key words (%)								
	Jan–Jun 11 n=268		Jul–Dec 11 n=255		Jan–Jun 12 n=355		Jul–Dec 12 n=292	
1	Inadequate treatment	43%	Inadequate treatment	35%	Inadequate treatment	33%	Inadequate treatment	22%
2	Attitude/manner	22%	Attitude/manner	19%	Diagnosis	21%	Inadequate care	16%
3	Diagnosis	17%	Diagnosis	18%	Inadequate care	18%	Coordination of treatment	14%
4	Communication with family	15%	Communication with family	12%	Attitude/manner	17%	Diagnosis	12%
5	Inadequate care	14%	Inadequate care	12%	Communication with family	10%	Attitude/Manner	11%

- The most frequently occurring key word in all periods reported remains *inadequate treatment*; however, the percentage of complaints where each of these appears is reducing. This period, in particular, showed a significant reduction.
- Complaints citing concerns about *attitude and manner* continue to reduce over consecutive periods.
- The percentage of complaints citing concerns with *diagnosis* has also reduced significantly for this period.
- Complaints citing concerns about *coordination of treatment* did not feature in the top five concerns for the previous periods but is the third highest reported concern in the current period.

Please note: *inadequate care* differs from *inadequate treatment* in that ‘care’ refers to supporting activities (eg, a nurse fails to take observations) whereas ‘treatment’ describes more active intervention where a standard of practice is relevant.

1.3 Service type and key words (concerns raised in complaints)

For each service type, the concerns raised in complaints received about the care provided by that service can be identified through an analysis of key words. The reports for individual DHBs list the services in that DHB that were subject to complaint, and the concerns associated with these services.

1.4 Primary issues

For each complaint received by HDC, one primary issue is identified. The primary issues identified in complaints from the period July to December 2012 are listed in Table 3. The table shows that

treatment is the most common primary concern, occurring in 176 (60.3%) of the complaints received by DHBs in this period.

Table 3 – Primary issues complained about

Primary issue in complaints	Number of complaints about this issue	Percentage
Access and funding	18	6.2%
Communication	33	11.3%
Consent/information	21	7.2%
Disability/Other issues	5	1.7%
Discharge & transfer arrangements	9	3.1%
Fees and costs	1	0.3%
Grievance/complaints process	1	0.3%
Management of facilities	6	2.1%
Medical records/reports	6	2.1%
Medication	7	2.4%
Privacy/confidentiality	1	0.3%
Professional conduct	8	2.7%
Treatment	176	60.3%
Total	292	

Table 4 shows a comparison over time for the top five primary issues complained about.

Table 4 – Top five primary issues in complaints received over last two years

Top five primary issues in all complaints (%)								
	Jan–Jun 11 n=268		Jul–Dec 11 n=255		Jan–Jun 12 n=355		Jul–Dec 12 n=292	
1	Treatment	60%	Treatment	66%	Treatment	60%	Treatment	60%
2	Communication	15%	Communication	10%	Communication	12%	Communication	11%
3	Consent/ information	6%	Consent/ information	6%	Access and funding	8%	Consent/ information	7%
4	Access and funding	5%	Access and funding	4%	Consent/ information	7%	Access and funding	6%
5	Management of facilities	5%	Medication	4%	Discharge & transfer arrangements	3%	Discharge & transfer arrangements	3%

The top five primary issues reported in this period are the same as those reported in the previous period and even their ratio is very similar to the previous period.

1.5 Overview of the content of complaints

Over the four periods reported:

- *Treatment* remains the over-riding concern. *Treatment* occurs as the primary issue in an average of 61.5% of complaints, and as a key word in average of 33% of complaints; and
- patients have consistently identified inadequacies in *communication*; this is noted as a primary issue and/or a key word in between 10% and 15% of complaints over the four periods reported.

1.6 Rate of complaints received – current period

When numbers of complaints to HDC are expressed as a rate per 100,000 discharges, comparisons can be made between DHBs, and within DHBs over time, enabling any trends to be observed.

Frequency calculations are made using discharge data provided by the Ministry of Health (provisional as at the date of extraction, **18 February 2013**).

Table 5 – Rate of complaints received per 100,000 discharges during July – Dec 2012

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
292	462,998 ⁵	63.07

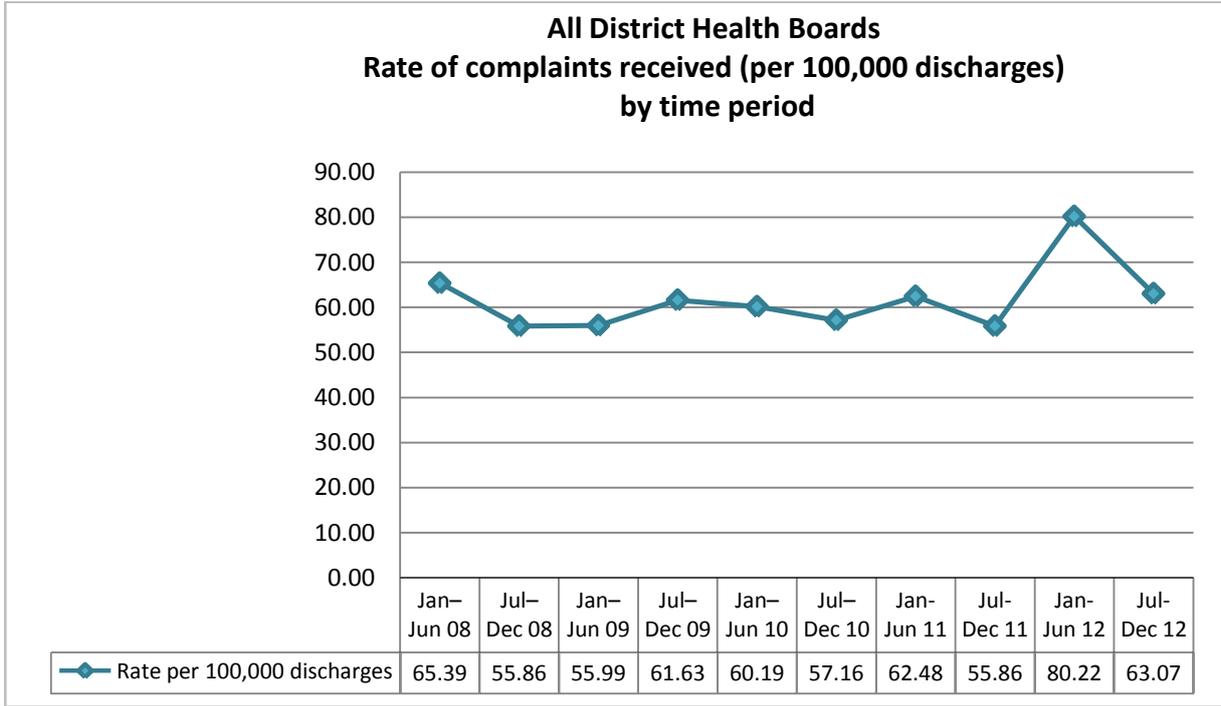
1.7 Rate of complaints received – comparison over time

Table 6 and Figure 1 show the rate of complaints received by HDC per 100,000 discharges⁶, for current and previous six-month periods.

Table 6 – Rate of complaints received in last five years

	Jan–Jun 08	Jul–Dec 08	Jan–Jun 09	Jul–Dec 09	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12
Complaints received	258	236	230	270	256	257	268	255	355	292
Rate per 100,000 discharges	65.39	55.86	55.99	61.63	60.19	57.16	62.48	55.86	80.22 ^a	63.07

Figure 1 – Rate of complaints received per 100,000 discharges



The rate has reduced significantly when compared with the (unusual high of) previous period but is still on a higher side when compared with other reported periods.

⁵ The number of total discharges excludes short stay emergency department discharges, and patients attending outpatient units and clinics.

⁶ The rate for Jan-Jun 2012 has been recalculated based on the most recent discharge data.

2.0 Complaints closed

HDC closed **254** complaints involving DHBs in the period July — December 2012. This compares with 302 in the previous period.

2.1 Outcomes of complaints closed

Complaints are classified into two groups according to the manner of their resolution: whether investigation or non-investigation. Within each classification, there is a variety of possible outcomes. Once HDC has notified a DHB that a complaint concerning that DHB is to be investigated, the complaint remains classified as an investigation, even though an alternative manner of resolution may subsequently be adopted. An investigation may also be discontinued. Notification of investigation generally indicates more serious or complex issues.

The manner of resolution and outcomes of complaints closed is shown in Table 7.

The data is also presented in Figure 2 where the number of complaints for each outcome type is shown as a percentage of all closed complaints (percentages rounded to one decimal place).

Table 7 – Outcome of complaints closed by complaint type

Outcome	Number of complaints closed	Percentage
<i>Investigation</i>		
Breach	5	2.0%
No breach	1	0.4%
Investigation discontinued s38(1) ⁷	2	0.8%
<i>Non-investigation</i>		
Referred to Advocacy	18	7.1%
No further action — s 38(1) ⁸	142	55.9%
Referred to DG of Health	1	0.4%
Referred to District Inspector	8	3.1%
Referred to Medical Council	3	1.2%
Referred to Midwifery Council	1	0.4%
Referred to Nursing Council	1	0.4%
Referred to Provider ⁹	47	18.5%
Resolved by Parties	3	1.2%
Withdrawn	13	5.1%
Outside jurisdiction	9	3.5%
Total	254	

⁷ The Commissioner has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of formal investigation, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. This may happen, for example, where a DHB has carefully reviewed the case itself and no further value would be added by HDC investigating, or where another agency is reviewing, or has carefully reviewed the matter (for example, the Coroner, the Director-General of Health, or the District Inspector).

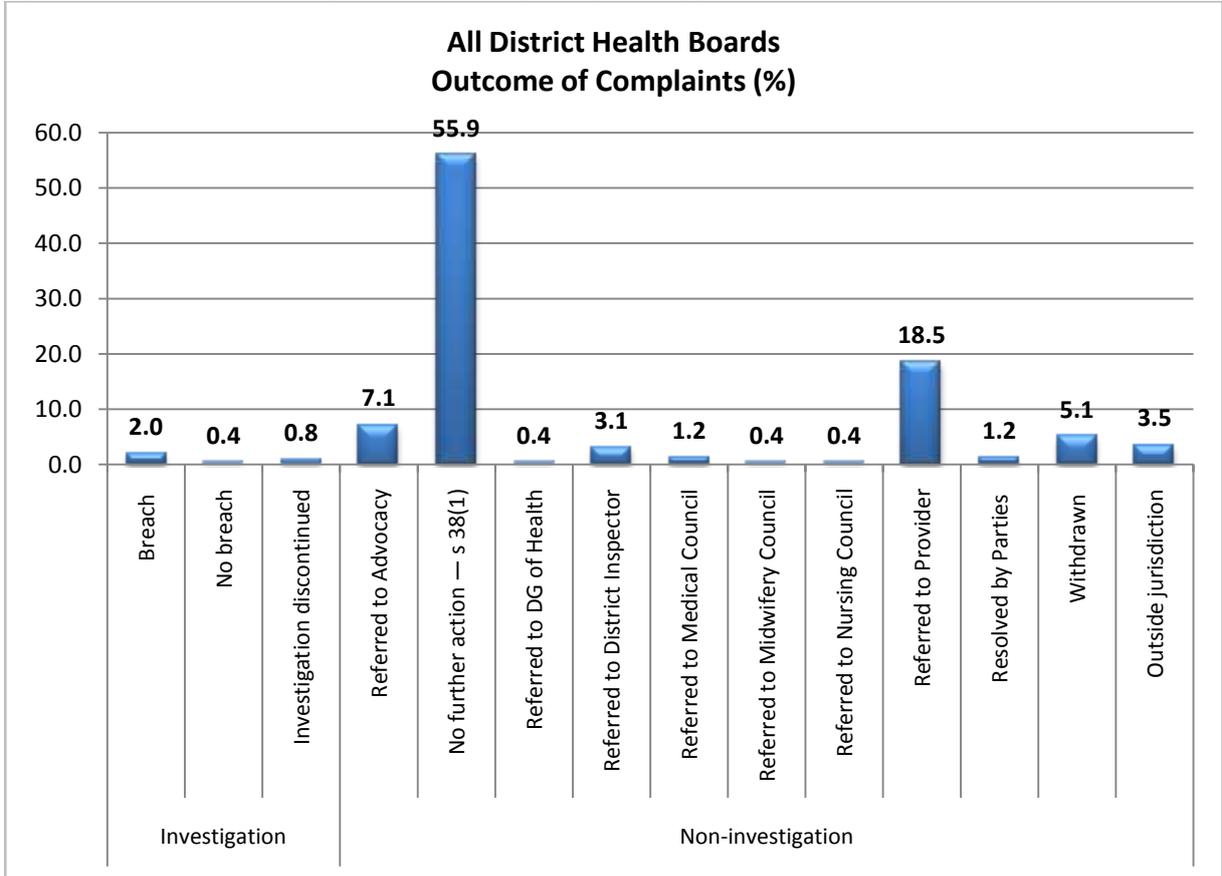
⁸ See previous footnote.

⁹ In line with their responsibilities under the Code, DHBs have increasingly developed good systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the provider to resolve, with a requirement that the provider report back to HDC on the outcome of its handling of the complaint.

In summary, Table 7 illustrates that:

- 74% of complaints were either closed with no action or no further action (55.9%), or referred to the provider for resolution (18.5%); and
- just 7.1% of complaints were referred to Advocacy in this period.

Figure 2 – Outcome of complaints closed by complaint type



2.2 Outcomes of complaints closed — comparison over time

The outcomes of closed complaints that are not closed following investigation are most commonly referred to advocacy, referred to provider or resolved with no further action. The distribution of these outcomes in the last four six-month periods is shown in Table 8.

Table 8 – Outcome of non-investigated complaints

Outcome of non-investigated complaints	Percentage of complaints			
	Jan—June 2011 (n=246)	Jul—Dec 2011 (n=217)	Jan—June 2012 (n=302)	Jul—Dec 2012 (n=254)
No further action — s38(1)	41.1%	48.8%	47.7%	55.9%
Referred to provider	28.9%	21.2%	22.9%	18.5%
Referred to Advocacy	16.4%	15.2%	8.3%	7.1%

Table 8 shows that:

- the percentage of complaints referred to advocacy, reduced considerably in the last period and has shown further reduction in this period;

- percentage of complaints with *no further action* has increased when compared to the previous periods; and
- the percentage of complaints *referred to provider* has shown significant reduction.

2.3 Rate of complaints closed following investigation during July – Dec 2012

Table 9 – Rate of complaints closed following investigation per 100,000 discharges

Number of complaints investigated	Total number of discharges	Rate per 100,000 discharges
8	462,998	1.73

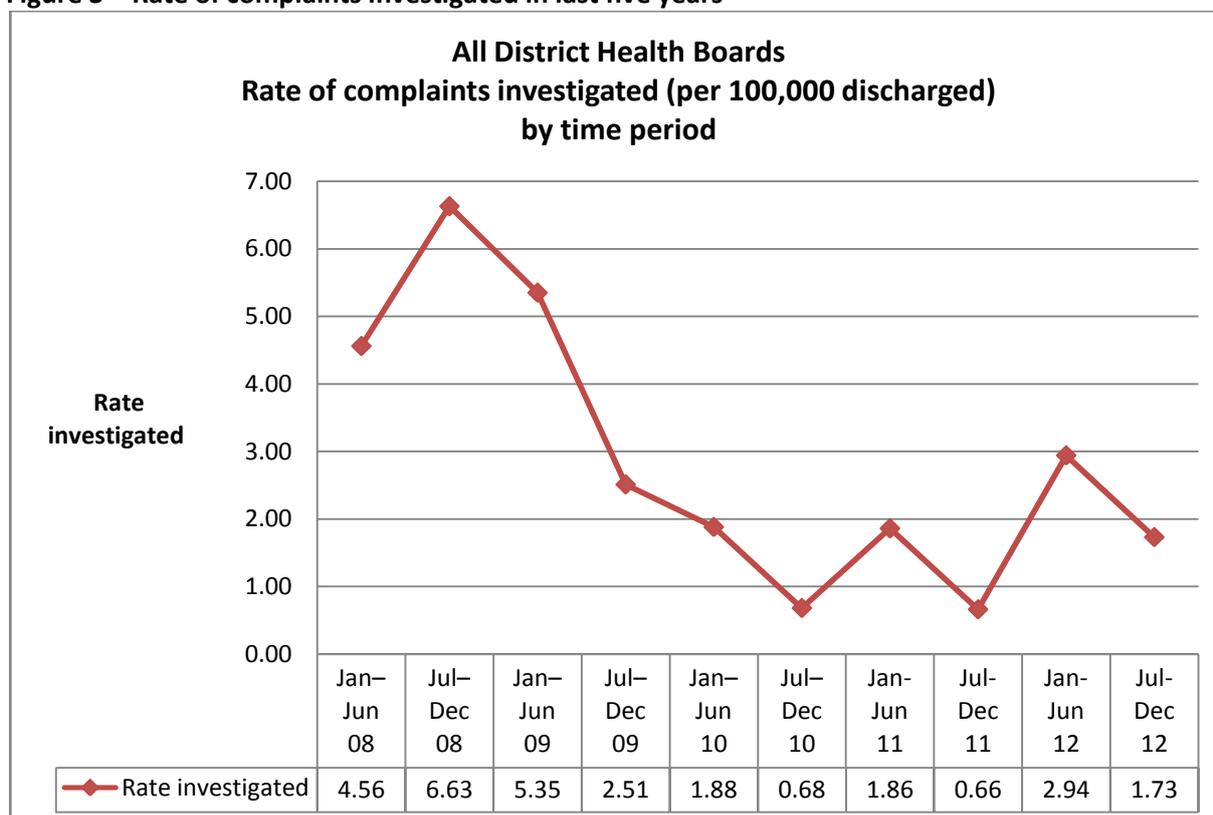
2.4 Rate of complaints closed following investigation – comparison over time

Table 10 and Figure 3 show the comparison of the rate of complaints closed following investigation in the last five years.

Table 10 – Rate of complaints investigated in last five years

	Jan–Jun 08	Jul–Dec 08	Jan–Jun 09	Jul–Dec 09	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12
Complaints closed	256	240	251	229	262	257	246	217	302	254
Investigations	18	28	22	11	8	3	8	3	13	8
Rate investigated per 100,000 discharges¹⁰	4.56	6.63	5.35	2.51	1.88	0.68	1.86	0.66	2.94	1.73

Figure 3 – Rate of complaints investigated in last five years



¹⁰ The rate for Jan-Jun 12 has been recalculated based on the most recent discharge data.

3.0 Ranking

Tables 11 and 12 show the rate of complaints about DHBs received by HDC (Table 11), and those investigated (Table 12), per 100,000 discharges for each DHB (ranked, not named¹¹) relative to other DHBs for this period.

Each DHB's ranking on the tables can be identified from its individual report.

All individual DHBs were subject to some complaints to HDC. The rate of complaints ranged from 25.96 complaints per 100,000 discharges to 213.68 complaints per 100,000 discharges — a greater than eight-fold increase in frequency across DHBs.

Table 11 – Rate of complaints received per 100,000 discharges

DHB ranking	Rate of complaints to HDC per 100,000 discharges	DHB ranking	Rate of complaints to HDC per 100,000 discharges
DHB 1	25.96	DHB 11	59.83
DHB 2	29.11	DHB 12	65.12
DHB 3	31.17	DHB 13	72.78
DHB 4	36.42	DHB 14	73.00
DHB 5	40.51	DHB 15	92.14
DHB 6	42.18	DHB 16	92.42
DHB 7	48.07	DHB 17	102.15
DHB 8	51.08	DHB 18	105.05
DHB 9	51.68	DHB 19	136.96
DHB 10	58.17	DHB 20	213.68
		All DHBs	63.07

For investigated complaints (Table 12), the data from all DHBs showed a rate of 1.73 investigated complaints per 100,000 discharges, and a range of 0 to 21.09 complaints per 100,000 discharges.

¹¹ Individual DHBs have not been named in this report given the small sample size and the short period covered (six months).

Table 12 – Rate of complaints investigated per 100,000 discharges

DHB ranking	Rate of investigated complaints per 100,000 discharges
DHB 1–14	No complaints investigated
DHB 15	1.85
DHB 16	4.27
DHB 17	4.47
DHB 18	8.10
DHB 19	8.65
DHB 20	21.09
All DHBs	1.73

4.0 Learning from complaints — HDC case reports

In the following cases, the complaint raised issues of concern, and action was taken to improve hospital systems and practices. The first complaint highlights the significance of CTG use in monitoring of maternal and fetal well-being; and the remaining three complaints highlight the importance of having a seamless service when multiple professionals are involved in patient care. The first three complaints were investigated — the full anonymised reports can be found on the HDC website.

Monitoring of maternal and fetal well-being during labour (10HDC00996)

Background

A woman was admitted to hospital for induction of labour. Her care was initially managed by the hospital's core midwifery staff and she was provided with routine care and monitoring in accordance with the district health board's (DHB) induction of labour guidelines.

Labour

The morning after labour was induced, the fetal heart rate increased and a cardiotocogram (CTG) was commenced. The on-call consultant obstetrician reviewed the CTG trace shortly after, and considered it showed normal fetal activity. That evening, the woman's waters broke and her lead maternity carer (LMC) was called to attend. The LMC assessed that woman was in early labour and the woman was given sedation to help her rest overnight.

The following morning, the woman requested an epidural. The LMC was not certified to administer epidurals and stated that she handed over the woman's care to the hospital midwives. The LMC left the hospital at 6am. The hospital midwife caring for the woman monitored the fetal heart rate by CTG, assessing it as "overall reassuring".

Around two hours later, a senior midwife noted that the CTG was monitoring the maternal heart rate and alerted the hospital midwife. However, when the senior midwife returned to the room approximately an hour later, she saw that the CTG was still monitoring the maternal heart rate. The senior midwife repositioned the CTG and saw that the fetal heart rate was abnormal. The woman's labour was expedited however, sadly, the baby died soon after birth.

Outcome

It was held that the LMC failed to appropriately monitor maternal and fetal well-being and breached Right 4(1). She also failed to take appropriate steps to arrange for an epidural or hand the woman's care over to the secondary care team, and breached Right 4(5).

The hospital midwife failed to use appropriate equipment, correctly read the CTG and request assistance when necessary and breached Right 4(1). Her failure to seek assistance impaired the woman's continuity of care and, accordingly, she breached Right 4(5).

The senior midwife failed to provide adequate supervision to the hospital midwife, and failed to take adequate steps to monitor the maternal and fetal well-being when she became aware that the CTG was monitoring the maternal heart rate instead of the fetal heart rate. The senior midwife breached Right 4(1). She also failed to call for assistance when she became aware that the baby was at risk and an emergency delivery was required, and breached Right 4(2).

The DHB failed to take reasonable steps to ensure that services of an appropriate standard were provided to the woman and breached Right 4(1). For failing to have systems in place to ensure that services of an appropriate quality and continuity were provided, the DHB also breached Right 4(5).

Delay in diagnosis of metastatic bone disease (10HDC00703)

Background

In 2002, a woman had a mastectomy for invasive breast cancer and was advised that she had an 80 percent risk of the cancer recurring within the next five years. She was an outpatient at the Oncology Clinic of a public hospital. She also had a history of chronic regional pain syndrome (CRPS) of the knees.

In 2007, the woman experienced a sudden onset of back pain without suffering any trauma. She was assessed at the Emergency Care Centre of a hospital and an x-ray was taken of her lumbar spine to exclude cancer. The x-ray showed "no bony lesions" and her spine was of normal alignment. As her condition did not improve, she was referred to the General Medical Team the following day.

The General Medical Team assessed the woman, taking into account her CRPS, breast cancer history and normal x-ray. It was determined that her condition was due to "muscle spasm" and she was reviewed by the Orthopaedic Team. Upon review, the orthopaedic registrar considered that she had mechanical back pain and advised analgesia and early mobilisation.

The woman was discharged, and sought ongoing treatment from her GP. She was subsequently seen at Outpatient Clinics by a breast surgeon and an oncologist. Both doctors noted that the woman was doing well but made no reference in the clinical record of her recent hospital admission or that she was experiencing severe back pain.

Three months later the woman was diagnosed with metastatic bone disease.

Outcome

It was held that there were failures on the part of the General Medical Team in ensuring that the woman's condition was adequately investigated. In particular, they failed to undertake an MRI or a bone scan in light of the woman's cancer history and poor response to analgesia. Furthermore, the General Medical Team did not directly communicate with the Oncology Clinic about the woman's admission.

It was also held that the failures of the General Medical Team were service failures and are directly attributable to the DHB as the service operator. Accordingly, the DHB was found to have breached Rights 4(1) and 4(5).

Care of patient by community mental health services (10HDC00805)

This case concerns the psychiatric care provided to a 45-year-old man with a severe personality disorder, by a DHB's Community Mental Health (CMH) service.

Background

In 2010, the man attempted suicide, precipitated by relationship stress and eviction from his partner's house. The Psychiatric Acute Community Team (PACT) staff arranged respite accommodation while he waited for a CMH psychiatric assessment. During the assessment, the man attempted to self harm. He was transferred to the Intensive Care Unit (ICU). Two days later, he was discharged from the mental health service by a psychologist on the psychiatric liaison team and sent to his partner's home without CMH follow-up. There was no communication with the man's partner about his discharge and his GP received conflicting information about psychiatric follow-up arrangements from the ICU medical team and the liaison team psychologist.

Several weeks later, a psychiatrist and CMH nurse saw the man. The psychiatrist understood that the nurse was assigned as the man's case manager. However, the nurse believed he was attending the assessment merely as a "second observer", and that a case manager would be assigned if, on completion of the assessment, the man was considered to be suitable for CMH care. Unfortunately, the assessment could not be completed in the allocated time slot, so a second appointment was made for a month's time, when the psychiatrist returned from leave. The psychiatrist placed his handwritten notes on the man's paper file before going on leave, but he did not communicate with the man's GP or partner. No interim contact was planned, but a crisis plan was made, in which the CMH nurse was to be the man's first point of contact with the service should he go into crisis. This crisis plan was not documented anywhere in his clinical notes or his electronic file. There was also no record of the nurse being present at the assessment or in what capacity.

Crisis

The man went into crisis within two weeks of the assessment. His partner approached the PACT three times over three days, advising she had asked the man to leave her home and he was threatening suicide. PACT staff were unaware that the man had been seen recently by the psychiatrist or that there was a crisis plan involving the CMH nurse as point of first contact. Despite recognising that the man's relationship breakdown and eviction were risk factors, no arrangement was made to review the man by PACT or CMH staff. The man was found dead from suicide a few days later.

Outcome

It was held that the psychiatrist's handwritten notes of the assessment were inadequate to inform care and this substandard documentation breached Right 4(2). He failed to communicate with the man's GP and partner, and did not take adequate steps to ensure that the crisis plan was documented on the man's clinical record, which compromised his continuity of care. These failures amounted to a breach of Right 4(5).

It was also held that the failure of the DHB's CMH service to contact and assess the man when informed by his partner of his known risk factors breached Right 4(1). The DHB's failure to take appropriate steps to involve the man's partner in the discharge planning breached Right 4(2), while system failures around role clarity and responsibilities, and in the flow of information and communication between CMH, PACT and the GP impaired the man's continuity of care, and was a breach of Right 4(5).

Care of patient during the birth of her baby; delay in treatment; response to complaint; referral from private to public funded treatment

Background

This case concerns a woman who had a history of difficult, slow-to-progress labours leading to traumatic deliveries of large babies. When she became pregnant for the third time, her Lead Maternity Carer (LMC) was aware of her anxieties in light of her previous experiences during childbirth.

When she arrived at hospital in labour, she immediately passed meconium, which caused alarm. She asked for a Caesarean section, but soon after, the baby was born. The woman suffered extensive tearing from the birth and required follow-up surgery.

The woman complained that the midwife denied her a Caesarean section, compromised the safety of the baby by leaving the woman unattended to write notes when the baby's head had crowned, did not protect her perineum at the time of birth and did not perform an episiotomy, given her past history.

Following the birth, the woman experienced ongoing pain, stress incontinence and faecal incontinence. She was advised by a bowel specialist that she had sustained a fourth-degree perineal tear requiring further surgery. This surgery was not performed until a year later as a result of deficiencies in the care provided by the DHB particularly in relation to its communication with the woman and other providers, and the process for approval of inter-DHB funding for surgery.

Outcome

The Commissioner's expert advised that the midwifery care provided was thorough and comprehensive, and consistent with expected standards and that even if an episiotomy had been intended, there was insufficient time to do so. Furthermore, at this stage, there was no indication an episiotomy was necessary. It was also held that the actual clinical management provided by the DHB was consistent with expected standards, although it seems the surgery was unduly delayed.

Follow-up actions

As a result of this complaint, the Commissioner asked the DHB to:

- meet with the woman to apologise for the distress the delays in accessing surgery caused, and for its failure to communicate with her;
- undertake an audit of the colorectal surgeon's referral documentation;
- undertake an audit of the Antenatal Clinic records to ensure that discharge summaries are completed and a copy sent to GPs when patients are transferred from secondary maternity care;
- undertake an audit to ensure staff compliance with its updated referral protocol for patients requiring elective surgery;
- review the record-keeping processes within the customer services department with a view to improving processes to ensure enquiries are appropriately resolved within the accepted timeframe.