Complaints to HDC involving District Health Boards

Report and Analysis for period 1 July to 31 December 2017

Health and Disability Commissioner
Te Toihau Hauātanga

Feedback
We welcome your feedback on this report. Please contact Natasha Davidson at hdc@hdc.org.nz

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Commissioner's Foreword

I am pleased to present you with HDC's six-monthly DHB complaint report for July–December 2017. The report details the trends in complaints received by HDC about DHBs between 1 July and 31 December 2017.

The number of complaints received about DHBs in July–December 2017 is very similar to the average number of complaints received over the past four six-month periods. The trends detailed in the report also remain broadly consistent with the trends reported across previous six-month periods. The most commonly complained about service types continue to be surgical, mental health, and general medicine services. Issues complained about in relation to DHB services tend to fall into the categories of care/treatment, communication, consent/information and access/funding, with a failure to communicate effectively with the consumer being the most common issue in complaints.

In around a fifth of complaints about DHBs, complainants raised concerns regarding coordination of care. Additionally, inadequate coordination of care is a common finding on HDC's assessment of complaints about DHBs. Under Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code), every consumer has the right to co-operation among providers to ensure quality and continuity of services. Issues I see commonly around coordination of care in DHBs include deficiencies in handover between and within teams; inadequate escalation of care to senior staff; deficiencies in documentation hindering continuity of care; and a lack of clarity around roles and responsibilities. It is important that the system supports staff to work together effectively, allowing them to foster good working relationships and clear lines of communication.

I trust that this report will prove useful in continuing to promote learning and ongoing quality improvement.

Anthony Hill
Health and Disability Commissioner

National Data for all District Health Boards

1.0 Number of complaints received

1.1 Raw number of complaints received

In the period Jul–Dec 2017, HDC received a total of **439**[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

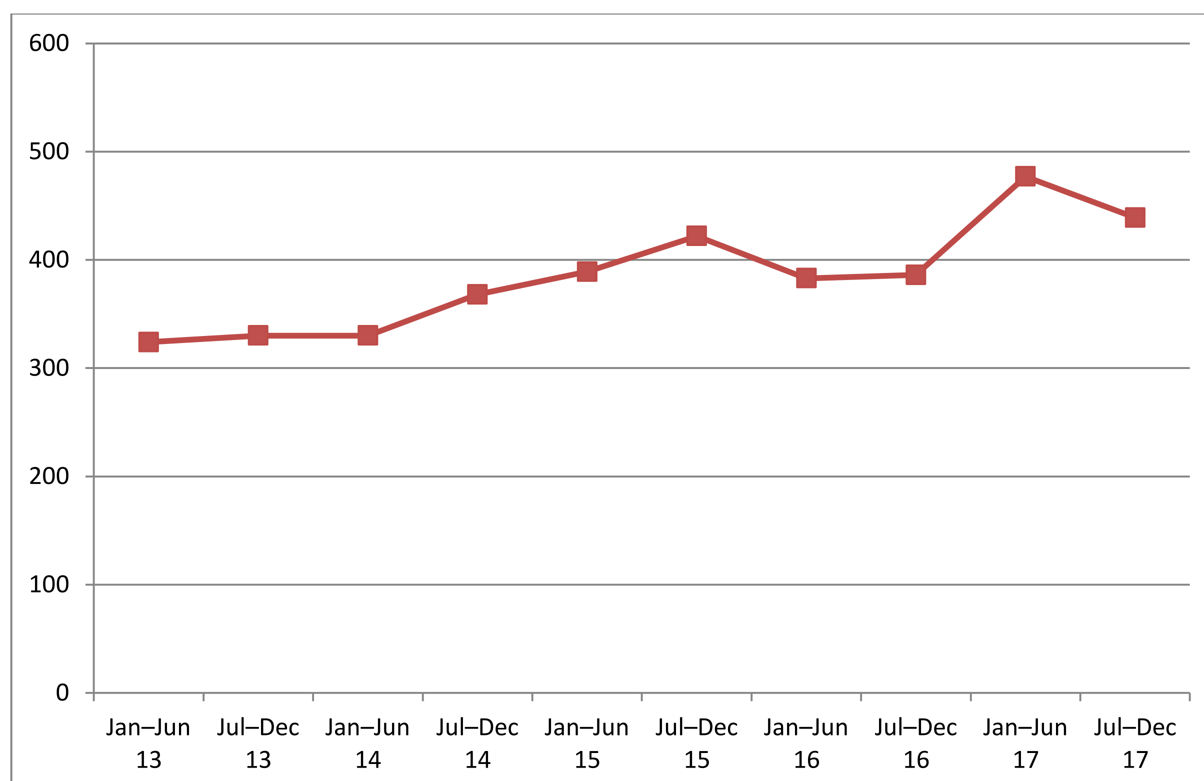
Table 1. Number of complaints received in the last five years

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Average of last 4 6-month periods	Jul–Dec 17
Number of complaints	324	330	330	368	389	422	383	386	477	**417**	**439**

The total number of complaints received in Jul–Dec 2017 (439) shows an increase of 5% over the average number of complaints received in the previous four periods, but a decrease of 8% over the number of complaints received in the previous six-month period.

The number of complaints received in Jul–Dec 2017 and previous six-month periods are also displayed below in Figure 1.

Figure 1. Number of complaints received



[1] Provisional as of date of extraction (19 January 2018).

1.2 Rate of complaints received

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.

Rate of complaints calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (25 May 2018) and is likely incomplete; it will be updated in the next six-monthly report. It should be noted that this discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges during Jul–Dec 2017

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
439	496,157	**88.48**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jul–Dec 2017 and previous six-month periods.

Table 3. Rate of complaints received in last five years

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17[2]	Average of last 4 6-month periods	Jul–Dec 17
Rate per 100,000 discharges	72.67	71.15	72.99	76.65	84.60	87.57	81.44	78.79	99.08	**86.72**	**88.48**

The rate of complaints received during Jul–Dec 2017 (88.48) shows a 2% increase over the average rate of complaints received for the previous four periods, but a decrease of 11% over the rate of complaints received in the previous six-month period.

Table 4 shows the number and rate of complaints received by HDC for each DHB.[3]

[2] The rate for Jan–Jun 2017 has been recalculated based on the most recent discharge data.

[3] Please note that some complaints will involve more than one DHB, and therefore the total number of complaints received for each DHB will be larger than the number of complaints received about care provided by DHBs.

Table 4. Number and rate of complaints received for each DHB in Jul-Dec 2017

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	67	62550	107.11
Bay of Plenty	17	26749	63.55
Canterbury	56	58748	95.32
Capital and Coast	31	30048	103.17
Counties Manukau	33	52490	62.87
Hawke's Bay	18	17346	103.77
Hutt Valley	19	16788	113.18
Lakes	6	12374	48.49
MidCentral	22	15892	138.43
Nelson Marlborough	14	12013	116.54
Northland	11	20781	52.93
South Canterbury	5	6244	80.08
Southern	44	27831	158.10
Tairāwhiti	2	5460	36.63
Taranaki	5	13321	37.53
Waikato	39	48543	80.34
Wairarapa	7	4735	147.84
Waitemata	43	54246	79.27
West Coast	4	3436	116.41
Whanganui	5	6562	76.20

Notes on DHB's number and rate of complaints

It should be noted that a DHB's number and rate of complaints can vary considerably from one six-month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six-month period. For smaller DHBs, a very small absolute increase or decrease in the number of complaints received can dramatically affect the rate of complaints. Accordingly, much of the value in this data lies in how it changes over time, as such analysis allows trends to emerge that may point to areas that require further attention.

It is also important to note that numbers of complaints received by HDC is not always a good proxy for quality of care provided, and may instead, for example, be an indicator of the effectiveness of a DHB's complaints system or features of the consumer population in a particular area. Additionally, complaints received within a single six-month period will sometimes relate to care provided within quite a different time period. From time to time, some DHBs may also be the subject of a number of complaints from a single complainant within one reporting period. This is important context that is taken into account by DHBs when considering their own complaint patterns.

2.0 Service types complained about

2.1 Service type category

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one hospital; therefore, although there were 439 complaints about DHBs, 451 services were complained about.

Surgical services (31.7%) received the greatest number of complaints in Jul–Dec 2017, with orthopaedics and urology (6.9% each) being the surgical specialties most commonly complained about. Other commonly complained about services included mental health (19.5%), general medicine (16.6%), emergency departments (12.0%), and maternity services (8.2%). This is broadly similar to what has been seen in previous periods.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Aged care	**2**	**0.4%**
Alcohol and drug	**4**	**0.9%**
Anaesthetics/pain medicine	**1**	**0.2%**
Dental	**1**	**0.2%**
Diagnostics	**6**	**1.3%**
Disability services	**8**	**1.8%**
District nursing	**2**	**0.4%**
Emergency department	**54**	**12.0%**
General medicine	**75**	**16.6%**
Cardiology	15	3.3%
Endocrinology	4	0.9%
Gastroenterology	7	1.6%
Geriatric medicine	10	2.2%
Haematology	2	0.4%
Infectious diseases	1	0.2%
Neurology	9	2.0%
Oncology	6	1.3%
Palliative care	1	0.2%
Renal/nephrology	1	0.2%
Respiratory	3	0.7%
Rheumatology	2	0.4%
Other/unspecified	14	3.1%
Hearing services	**1**	**0.2%**
Intensive care/critical care	**2**	**0.4%**
Maternity	**37**	**8.2%**
Mental health	**88**	**19.5%**
Occupational therapy	**1**	**0.2%**
Paediatrics (not surgical)	**15**	**3.3%**
Pharmacy	**1**	**0.2%**
Rehabilitation services	**1**	**0.2%**
Sexual health	**1**	**0.2%**
Surgery	**143**	**31.7%**
Cardiothoracic	5	1.1%
General	27	6.0%
Gynaecology	15	3.3%
Neurosurgery	5	1.1%
Ophthalmology	15	3.3%
Orthopaedics	31	6.9%
Otolaryngology	5	1.1%
Plastic and Reconstructive	5	1.1%
Urology	31	6.9%
Vascular	3	0.7%
Unknown	1	0.2%
Other/unknown health service	**8**	**1.8%**
TOTAL	**451**	

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jul–Dec 2017 are listed in Table 6. It should be noted that the issues included are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues can still provide a valuable insight into the consumer's experience of the services provided and the issues they care most about.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***73***	***16.6%***
Lack of access to services	26	5.9%
Lack of access to subsidies/funding	2	0.5%
Waiting list/prioritisation issue	45	10.2%
Boundary violation	***1***	***0.2%***
Care/Treatment	***208***	***47.4%***
Delay in treatment	14	3.2%
Delayed/inadequate/inappropriate referral	2	0.5%
Inadequate coordination of care/treatment	9	2.1%
Inadequate/inappropriate clinical treatment	29	6.6%
Inadequate/inappropriate examination/assessment	10	2.3%
Inadequate/inappropriate follow-up	4	0.9%
Inadequate/inappropriate monitoring	9	2.1%
Inadequate/inappropriate non-clinical care	11	2.5%
Inadequate/inappropriate testing	1	0.2%
Inappropriate/delayed discharge/transfer	14	3.2%
Inappropriate withdrawal of treatment	7	1.6%
Missed/incorrect/delayed diagnosis	54	12.3%
Personal privacy not respected	1	0.2%
Refusal to treat	5	1.1%
Rough/painful care or treatment	3	0.7%
Unexpected treatment outcome	35	8.0%
Communication	***35***	***8.0%***
Disrespectful manner/attitude	16	3.6%
Failure to communicate openly/honestly/effectively with consumer	8	1.8%
Failure to communicate openly/honestly/effectively with family	8	1.8%
Insensitive/inappropriate comments	3	0.7%
Complaints process	***2***	***0.5%***
Inadequate response to complaint	2	0.5%
Consent/Information	***55***	***12.5%***
Consent not obtained/adequate	9	2.1%
Inadequate information provided regarding condition	4	0.9%
Inadequate information provided regarding fees/costs	3	0.7%
Inadequate information provided regarding options	7	1.6%
Inadequate information provided regarding provider	1	0.2%
Inadequate information provided regarding results	2	0.5%
Inadequate information provided regarding treatment	9	2.1%

Primary issue in complaints	Number of complaints	Percentage
Incorrect/misleading information provided	1	0.2%
Issues with involuntary admission/treatment	19	4.3%
Documentation	***3***	***0.7%***
Inadequate/inaccurate documentation	2	0.5%
Other	1	0.2%
Facility issues	***26***	***5.9%***
Cleanliness/hygiene issue	2	0.5%
General safety issue for consumer in facility	14	3.2%
Inadequate/inappropriate policies/procedures	3	0.7%
Staffing/rostering/other HR issue	3	0.7%
Waiting times	3	0.7%
Other	1	0.2%
Medication	***19***	***4.3%***
Administration error	1	0.2%
Dispensing error	1	0.2%
Inappropriate administration	1	0.2%
Inappropriate prescribing	11	2.5%
Refusal to prescribe/dispense/supply	5	1.1%
Reports/Certificates	***3***	***0.7%***
Inaccurate report/certificate	3	0.7%
Other professional conduct issues	***10***	***2.3%***
Inappropriate collection/use/disclosure of information	7	1.6%
Other	3	0.7%
Disability-related issues	***4***	***0.9%***
TOTAL	**439**	

The most common primary issue categories concerned care/treatment (47.4%), access/funding (16.6%), consent/information (12.5%), and communication (8.0%). Among these, the most common specific primary issues in complaints about DHBs were “missed/incorrect/delayed diagnosis” (12.3%), “waiting list/prioritisation issue” (10.2%), “unexpected treatment outcome” (8.0%), “inadequate/inappropriate clinical treatment” (6.6%) and “lack of access to services” (5.9%). This is broadly similar to what was seen last period.

Table 7 shows a comparison over time for the top five primary issues complained about. The top five primary issues have remained broadly consistent over time.

Table 7. Top five primary issues in complaints received over the last four six-month periods

Top five primary issues in all complaints (%)							
Jan–Jun 16 n=381		**Jul–Dec 16 n=386**		**Jan–Jun 17 n=477**		**Jul–Dec 17 n=439**	
Misdiagnosis	16%	Misdiagnosis	15%	Misdiagnosis	15%	Misdiagnosis	12%
Inadequate treatment	9%	Unexpected treatment outcome	8%	Waiting list/ Prioritisation	10%	Waiting list/ prioritisation	10%
Unexpected treatment outcome	8%	Inadequate treatment	8%	Unexpected treatment outcome	9%	Unexpected treatment outcome	8%
Lack of access to services	6%	Lack of access to services	8%	Inadequate treatment	6%	Inadequate treatment	7%
Waiting list/ prioritisation	5%	Waiting list/ prioritisation	7%	Lack of access to services	6%	Lack of access to services	6%

3.2 All complaint issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Table 8 includes these additional complaint issues, as well as the primary complaint issues, to show all issues identified in complaints received.

On analysis of all issues identified in complaints about DHBs, the most common complaint issue categories were care/treatment (present for 77.9% of all complaints), communication (present for 57.6% of all complaints), consent/information (present for 26.0% of all complaints), and access/funding (present for 25.5% of all complaints).

The most common specific issues were "failure to communicate effectively with consumer" (37.6%), "inadequate/inappropriate clinical treatment" (33.5%), "inadequate/inappropriate examination/ assessment" (22.3%), "delay in treatment" (20.3%), "missed/incorrect/delayed diagnosis" (19.8%), "inadequate response to the consumer's complaint by the DHB" (17.5%), "failure to communicate effectively with family" (17.1%), "disrespectful manner/attitude" (17.1%), "inadequate coordination of care/treatment" (16.4%), and "unexpected treatment outcome" (15.0%). This is broadly similar to what was seen last period.

Also similar to the last six-month period, many complaints involved issues with a consumer's care/treatment, such as "inadequate/inappropriate follow-up" (10.0%), "inappropriate/delayed discharge/transfer" (9.8%), "inadequate/inappropriate monitoring" (8.2%), and "inadequate/ inappropriate testing" (7.7%).

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	***112***	***25.5%***
ACC compensation issue	1	0.2%
Lack of access to services	48	10.9%
Lack of access to subsidies/funding	8	1.8%
Waiting list/prioritisation issue	61	13.9%
Boundary violation	***2***	***0.5%***
Care/Treatment	***342***	***77.9%***
Delay in treatment	89	20.3%
Delayed/inadequate/inappropriate referral	22	5.0%
Inadequate coordination of care/treatment	72	16.4%
Inadequate/inappropriate clinical treatment	147	33.5%
Inadequate/inappropriate examination/assessment	98	22.3%
Inadequate/inappropriate follow-up	44	10.0%
Inadequate/inappropriate monitoring	36	8.2%
Inadequate/inappropriate non-clinical care	27	6.2%
Inadequate/inappropriate testing	34	7.7%
Inappropriate admission/failure to admit	11	2.5%
Inappropriate/delayed discharge/transfer	43	9.8%
Inappropriate withdrawal of treatment	8	1.8%
Missed/incorrect/delayed diagnosis	87	19.8%
Personal privacy not respected	5	1.1%
Refusal to assist/attend	11	2.5%
Refusal to treat	10	2.3%
Rough/painful care or treatment	20	4.6%
Unexpected treatment outcome	66	15.0%
Unnecessary treatment/over-servicing	5	1.1%
Communication	***253***	***57.6%***
Disrespectful manner/attitude	75	17.1%
Failure to accommodate cultural/language needs	2	0.5%
Failure to communicate openly/honestly/effectively with consumer	165	37.6%
Failure to communicate openly/honestly/effectively with family	75	17.1%
Insensitive/inappropriate comments	13	3.0%
Complaints process	***78***	***17.8%***
Inadequate response to complaint	77	17.5%
Retaliation/discrimination as a result of a complaint	1	0.2%
Consent/Information	***114***	***26.0%***
Consent not obtained/adequate	27	6.2%
Inadequate information provided regarding adverse event	5	1.1%
Inadequate information provided regarding condition	16	3.6%
Inadequate information provided regarding fees/costs	5	1.1%
Inadequate information provided regarding options	18	4.1%
Inadequate information provided regarding provider	3	0.7%
Inadequate information provided regarding results	6	1.4%
Inadequate information provided regarding treatment	36	8.2%
Incorrect/misleading information provided	11	2.5%

All issues in complaints	Number of complaints	Percentage
Issues with involuntary admission/treatment	20	4.6%
Other	3	0.7%
Documentation	***35***	***7.9%***
Delay/failure to disclose documentation	2	0.5%
Delay/failure to transfer documentation	2	0.5%
Inadequate/inaccurate documentation	29	6.6%
Intentionally misleading/altered documentation	3	0.7%
Facility issues	***75***	***17.1%***
Cleanliness/hygiene issue	7	1.6%
Failure to follow policies/procedures	5	1.1%
General safety issue for consumer in facility	25	5.7%
Inadequate/inappropriate policies/procedures	20	4.6%
Issue with sharing facility with other consumers	8	1.8%
Issue with quality of aids/equipment	7	1.6%
Staffing/rostering/other HR issue	9	2.1%
Waiting times	7	1.6%
Other	2	
Medication	***45***	***10.3%***
Administration error	5	1.1%
Inappropriate administration	6	1.4%
Inappropriate prescribing	23	5.2%
Refusal to prescribe/dispense/supply	11	2.5%
Other	2	
Reports/Certificates	***6***	***1.4%***
Inaccurate report/certificate	4	0.9%
Refusal to complete report/certificate	2	0.5%
Teamwork/supervision	***8***	***1.8%***
Inadequate supervision/oversight	8	1.8%
Other professional conduct issues	***26***	***5.9%***
Disrespectful behaviour	11	2.5%
Inappropriate collection/use/disclosure of information	12	2.7%
Threatening/bullying/harassing behaviour	4	0.9%
Other	4	
Disability-related issues	***7***	
Other issues	***13***	

3.3 Service type and primary issues

Table 9 shows the top three primary issues in complaints concerning the most commonly complained about service types. This is broadly similar to what was seen in the last six-month period. However, issues regarding safety in inpatient facilities became more prominent for mental health services and inadequate/inappropriate monitoring became more prominent for maternity services in Jul–Dec 2017.

Table 9. Three most common primary issues in complaints by service type

Surgery n=143		**Mental Health n=88**		**General medicine n=75**		**Emergency department n=54**		**Maternity n=37**	
Unexpected treatment outcome	19%	Issues with involuntary admission/ treatment	21%	Waiting list/ prioritisation issue	12%	Missed/ incorrect/ delayed diagnosis	37%	Inadequate/ inappropriate treatment	24%
Waiting list/ prioritisation issue	19%	General safety issue for consumer in facility	13%	Missed/ incorrect/ delayed diagnosis	11%	Disrespectful manner/ attitude	9%	Inadequate/ inappropriate monitoring	16%
Missed/ incorrect/ delayed diagnosis	9%	Failure to communicate effectively with consumer	7%	Inadequate/ inappropriate care	8%	Waiting list/ prioritisation issue	7%	Consent not obtained/ adequate	14%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **383**[4] complaints involving DHBs in the period Jul–Dec 2017. Table 10 shows the number of complaints closed in previous six-month periods.

Table 10. Number of complaints about DHBs closed in last five years

	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Average of last 4 6-month periods	Jul–Dec 17
Number of complaints closed	337	280	411	344	410	365	482	316	465	**407**	**383**

4.2 Outcomes of complaints closed

Complaints that are within HDC's jurisdiction are classified into two groups according to the manner of resolution — whether formal investigation or other resolution. 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. Notification of investigation generally indicates more serious or complex issues.

In the Jul–Dec 2017 period, **12** DHBs had no investigations closed, **3** DHBs had one investigation closed, **3** DHBs had two investigations closed, and **2** DHBs had three investigations closed by HDC.

The manner of resolution and outcomes of all complaints about DHBs closed in Jul–Dec 2017 is shown in Table 11.

[4] Note that complaints may be received in one six-month period and closed in another six-month period — therefore, the number of complaints received will not correlate with the number of complaints closed.

Table 11. Outcome for DHBs of complaints closed by complaint type[5]

Outcome for DHBs	Number of complaints closed
Investigation	***13***
Breach finding	4
No further action with follow-up or educational comment	6
No further action	1
No breach finding	2
Other resolution following assessment	***359***
No further action[6] with follow-up or educational comment	70
Referred to Ministry of Health	5
Referred to District Inspector	14
Referred to other agency	5
Referred to DHB[7]	81
Referred to Advocacy	65
No further action	108
Withdrawn	11
Outside jurisdiction	***11***
TOTAL	**383**

4.3 Recommendations made to DHBs following a complaint

Regardless of whether or not a complaint has been investigated, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted upon. Table 12 shows the recommendations made to DHBs in complaints closed in Jul–Dec 2017. Please note that more than one recommendation may be made in relation to a single complaint.

[5] Note that outcomes are displayed in descending order. If there is more than one outcome for a DHB upon resolution of a complaint then only the outcome that is listed highest in the table is included.

[6] 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 a District Inspector). Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice.

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

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	7
Audit	12
Presentation/discussion of complaint with others	7
Provision of evidence of change to HDC	31
Reflection	8
Review/implementation of policies/procedures	35
Training/professional development	18
Total	**118**

The most common recommendation made to DHBs was that they conduct a review of their policies/procedures or implement new policies/procedures (35 recommendations), followed by providing evidence to HDC of the changes they had made in response to the issues raised by the complaint (31 recommendations). Staff training was also often recommended (18 recommendations), and this was most commonly in relation to clinical issues. On some occasions, HDC also recommended that an anonymised version of the complaint be used as a training tool for staff.

5.0 Learning from complaints — HDC case reports

Incorrect dose of citalopram administered to elderly woman (16HDC00072)

Background
Mrs A, aged 88 years, was admitted to the orthopaedic ward at a public hospital following a fall at her rest home. Documentation from the rest home showed Mrs A's daily dose of an antidepressant (citalopram) as 10mg per day, half a 20mg tablet. An orthopaedic house officer, Dr D, prescribed Mrs A citalopram 10mg daily by writing on a paper medication chart. However, initially he wrote "20mg" and then immediately realised that the dose was half of a 20mg tablet, so changed the prescription to "10mg" by writing over the "2". Dr D did not re-write the prescription, as required by the DHB's policy.

The hospital ward pharmacist, Ms L, undertook a reconciliation for Mrs A's medication. Ms L documented the daily dose of citalopram as 10mg and annotated the paper medication chart by writing "½ x 20mg" underneath the prescription of citalopram. Throughout Mrs A's admission to hospital, no staff re-wrote Dr D's prescriptions of citalopram or asked him to do so.

Mrs A was transferred to another hospital. Another orthopaedic house officer, Dr E, completed the electronic discharge summary. Dr E misread the altered dose of citalopram on the paper medication chart as 40mg and listed Mrs A's dose of citalopram as 40mg on the discharge summary.

A geriatric medicine house officer, Dr G, admitted Mrs A to the second hospital. Dr G electronically prescribed Mrs A citalopram 40mg daily based on the discharge summary. Following Mrs A's admission, a ward pharmacist, Ms J, reviewed Mrs A's medication. Ms J compared the medication entry to the discharge summary from the previous hospital. Ms J thought that the dose of citalopram was high for an elderly person, but not unusual, so it was not a red flag for her.

Mrs A was given 40mg citalopram daily for over a week. During this time, she had periods of suspicion, paranoia, delusion, and confusion. None of the staff caring for Mrs A identified the citalopram dosage error. A nurse practitioner reviewed Mrs A for a mental health assessment, and identified the error. Mrs A's citalopram dose was immediately reduced to 10mg.

Findings
The Commissioner considered that the following accumulation of apparently innocuous actions or inactions, none of which, taken individually, were a material lapse in care, added up to a failure on behalf of the DHB:

- The original prescription was amended rather than re-written in contravention of the DHB's policy;
- The prescription was then annotated by the pharmacist to clarify the required dose, but no action was taken to seek to have the prescription re-written;
- Numerous staff were involved in the administration of the medications, none of whom sought to have the prescription re-written;
- The house officer preparing the discharge summary made a transcribing error, having misinterpreted the corrected dose on the prescription;
- On admission to the second hospital the transcribing error became a prescribing error, as the 40mg dose was prescribed based on the discharge summary; and
- The pharmacist at the second hospital undertook the full medicine reconciliation on Mrs A's admission but, while she considered the dose to be high in an elderly patient, she did not investigate further, preferring to wait until Mrs A was stable rather than alert medical staff to her concerns.

In addition to these specific examples, the Commissioner considered there to have been numerous opportunities for the error in the dosage to be identified, or at the very least queried, at the second hospital — from the pharmacist who suspected that the dose was high, to the medical and nursing staff who were caring for Mrs A. None of these individuals took the opportunity to question the dose of 40mg, despite acknowledgement from various practitioners that it was a high dose for someone of Mrs A's age, and given the fact of Mrs A's deterioration. The Commissioner was concerned at the lack of critical thinking exhibited in this case.

The Commissioner held that the DHB failed to provide services with reasonable care and skill in relation to the prescribing and administration of citalopram, and breached Right 4(1) of the Code.

Recommendations
The Commissioner noted that the DHB had put in place a system by which a transfer reconciliation will be performed by a pharmacist at the receiving service using additional sources of information, and considered such action to be an appropriate step in light of the issues highlighted in this case.

The Commissioner recommended that the DHB:

- Use the case as an anonymised case study for the education of staff;
- Conduct a random audit of the transfer reconciliations performed by pharmacists at the receiving service over a three-month period, and report back to HDC on the effectiveness of the new process in identifying errors in discharge summaries; and
- Report to HDC on the implementation of electronic prescribing at the first hospital.

Assessment and management of orthopaedic patient (14HDC00134)

Background
Mr A, a 75-year-old man, was referred to a public hospital for knee surgery. Mr A had previously had a hip dislocation following which he suffered a large gastrointestinal (GI) bleed secondary to use of non-steroidal anti-inflammatory drugs (NSAIDs).

Mr A attended an outpatient appointment with an orthopaedic registrar and a pre-admission clinic where he was assessed by a house officer and a consultant anaesthetist. Neither the orthopaedic registrar, house officer, nor the anaesthetist reviewed the previous clinical records or documented the past history of the GI bleed.

Mr A underwent total knee joint replacement surgery at the hospital, undertaken by an orthopaedic surgeon who had previous knowledge of Mr A and his history. A surgical checklist and a surgical time-out protocol was completed but neither recorded the history of a GI bleed. The anaesthetist on the day of surgery (who was not the anaesthetist at the pre-admission clinic) was not made aware of the history of a GI bleed. Postoperatively, with the orthopaedic surgeon's knowledge, the anaesthetist charted pain relief that included ibuprofen, an NSAID.

The orthopaedic surgeon reviewed Mr A and expected him to be discharged home in four or five days' time. The orthopaedic surgeon went on leave, but the handover that took place was not documented. No other orthopaedic staff member was specified in Mr A's clinical record as being the responsible clinician for the leave period.

Mr A then showed signs of deterioration. An on-call house officer reviewed Mr A and queried a peptic ulcer. The house officer stopped the ibuprofen and diagnosed renal impairment. Another house officer reviewed Mr A and telephoned the on-call medical registrar. The medical registrar considered that Mr A required further fluid resuscitation and reassessment prior to any escalation of care.

The medical registrar was the first doctor in a role above house officer to review Mr A. No examination findings were recorded. The medical registrar concluded that Mr A had sepsis secondary to pneumonia and acute kidney injury. The medical registrar did not seek advice from a more senior clinician. No follow-up plans, further investigation, or recommendations to the orthopaedic team were documented.

A second medical registrar performed an examination and concluded that Mr A was acutely unwell with chest sepsis and renal injury. The medical registrar anticipated that Mr A might need higher care intervention and planned further review. Mr A deteriorated, and the second medical registrar escalated Mr A's case and contacted a consultant. A transfer to ICU was agreed. Sadly, Mr A died.

Findings

The Commissioner noted that Mr A's case serves as a salutary reminder of the importance of due consideration of a consumer's clinical record and past clinical history, and clear and accurate communication and documentation. The Commissioner commented: "Healthcare teams must consistently communicate well with one another, and ensure that there is accurate documentation. These functions form two of the layers of protection that aid the delivery of seamless care. When any one or more of those layers do not operate optimally, there is potential for the patient to be harmed."

The Commissioner was critical of the orthopaedic registrar, and the anaesthetist and house officer at the pre-admission clinic, for not reviewing Mr A's clinical record and recording the relevant patient history in the contemporaneous record.

The orthopaedic surgeon acknowledged that he was familiar with Mr A's clinical history and that he proceeded cognisant of that. However, he did not enter Mr A's history of a GI bleed into the contemporaneous record. Mr A was later prescribed NSAID medication with the orthopaedic surgeon's oversight, without the relevant past clinical history being documented. Additionally, Mr A's handover was not documented. The Commissioner considered that the orthopaedic surgeon failed to ensure quality and continuity of services, in breach of Right 4(5) of the Code.

The first medical registrar did not provide appropriate advice or perform an adequate initial assessment of Mr A in a timely manner, and failed to seek advice from a senior colleague when Mr A's condition warranted it. The Commissioner considered, therefore, that the medical registrar did not provide Mr A with services with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner was critical of the second medical registrar for not making contact with a senior colleague earlier.

The Commissioner considered that Mr A's case highlighted the following DHB systems issues, which contributed to his suboptimal care:

- The DHB's primarily paper-based records system did not assist staff to facilitate effective review of patient history, and there was no alert process or system for significant patient co-morbidities.
- The wording and nature of several of the questions on the DHB pre-assessment patient questionnaire may have been subject to misinterpretation.
- There was a lack of clarity about the person to whom oversight of Mr A's care had passed, particularly once the orthopaedic surgeon went on leave, and the orthopaedic department did not, at that time, have a policy relating to the handover of patients.
- Many staff in this case did not adhere to Early Warning Score (EWS) protocols appropriately.
- Escalation to more senior staff did not occur appropriately when Mr A deteriorated.

For these reasons, the Commissioner considered that the DHB did not provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code.

In respect of the DHB's failings in this case, HDC's expert advisor noted: "Direct clinical oversight particularly over weekends and nightshifts will always be a challenge with senior staff relying on the judgement of junior staff on when it is appropriate to seek guidance. Factors such as organisational culture, perceived approachability of senior staff and junior staff awareness of any delegated authority policy can all be influencing factors. Safety 'check points' such as the EWS which allow for a protocol driven backup outside of individuals' judgement should be well understood by clinical staff using such tools and not circumvented."

Recommendations
The Commissioner recommended that the orthopaedic surgeon provide details on the steps taken to formalise handover of his own surgical inpatients to orthopaedic colleagues in the event of taking leave; provide an update on his active participation in the changes made to the surgical safety checklist and procedures following this complaint; and provide an update on the changes made to the mechanisms of handover between consultants, and the documentation of patient management instructions. It was recommended that the first medical registrar provide evidence to HDC of undergoing further education on the application of the EWS, the deteriorating patient, and the escalation of care to senior colleagues in the event of patient deterioration.

The Commissioner made a number of recommendations to the DHB, including that it:

- Prepare or modify a policy or guidelines to clarify roles and responsibilities of staff, and outline precisely when in the patient surgical pathway, and by whom, the patient's clinical history and records are to be reviewed and significant issues communicated;
- Provide a detailed update in relation to its development of electronic patient records;
- Implement an electronic alert process or system in the patient record for clear flagging of significant patient co-morbidities and clinical history;
- Provide a copy of its critically appraised and modified preoperative screening questionnaire form;
- Provide details of the steps taken to allow treating clinicians to re-check all patient hard copy records, electronic records, and medications immediately prior to surgery;
- Provide details of the mechanisms being pursued to ensure an appropriate medical response to an EWS trigger, and to ensure that DHB junior doctors are confident and supported to escalate concerns about deteriorating patients to senior colleagues; and
- Detail changes made to increase the robustness of transfer of care within the orthopaedic service, including extra medical and elder health support for orthopaedic patients.

Inadequate coordination of mental health care (14HDC01343)

Background
Mrs A, aged in her sixties, experienced a decline in her mental health following an accident in which she suffered physical injuries.

Mrs A self-referred to Mental Health Services (MHS) at a DHB, where she was reviewed by a consultant psychiatrist, Dr B, who diagnosed a major depressive episode and prescribed antidepressants and sleeping medication. Dr B was Mrs A's lead clinician, and a nurse, RN C, was Mrs A's key worker. Following this review, Mrs A received regular input from MHS. She was also being seen by her GP and by a medical team for the injuries sustained in her accident.

Two months later, Mrs A self-harmed and was taken to the emergency department. Subsequently, she was admitted to an inpatient mental health service (the inpatient service). Mrs A refused regular antidepressant medication and denied suicidal intent. She was discharged six days later. Mrs A was

readmitted to the inpatient service the following day after a further incident of self-harm. She denied thoughts of self-harm, and about a week later she was discharged with key worker follow-up.

A few weeks later, Mrs A was reviewed by RN C, and then the following day reviewed by Dr B and RN C. The plan was for daily key worker contact following the review, but this did not occur. There was confusion about the key worker arrangements for Mrs A. RN C worked three days a week, and told HDC that she shared the key worker role for Mrs A with another nurse, RN D. RN D stated that she was not asked by anyone at any time to be part of the delivery of clinical services to Mrs A. There is no documented record that RN D was asked to share the role with RN C.

Mrs A died a few days later.

Findings
The Mental Health Commissioner considered that, overall, the treatment planning for Mrs A was lacking, and there was a lack of evidence to show that Mrs A's particular risks were considered adequately in order to form treatment plans to guide all staff and support persons involved in Mrs A's care.

In respect of the confusion around the key worker arrangements for Mrs A, HDC's expert advisor stated: "Clarity of role is an important component of care. Failure to be explicit and ensure that all parties are aware of their roles and subsequent responsibilities and duties can cause treatment plans to not be enacted which may have serious consequences … As more staff age and plan for retirement by reducing working hours this will become a more common occurrence and needs explicit direction rather than relying on less formal practices of colleagues covering days off." The Mental Health Commissioner considered that the coordination of Mrs A's key worker care in this situation was inadequate, and that it was the DHB's responsibility to have clear processes in place to ensure that Mrs A received appropriate continuity of care.

The Mental Health Commissioner noted that between Mrs A's first and last engagements with the MHS, there were a number of inadequacies in the coordination of her care, which were attributable to the DHB — most notably, the failures in treatment planning and the poor coordination of key worker care. Therefore, the DHB was found in breach of Right 4(5) for not ensuring continuity of care for Mrs A.

The Mental Health Commissioner considered that numerous aspects of Mrs A's care by Dr B were inadequate, and that Dr B failed to provide services of an appropriate standard to Mrs A, in breach of Right 4(1) of the Code. In particular, the Mental Health Commissioner considered that the decision to discharge Mrs A from the inpatient service the second time was inappropriate, there was an inadequate risk assessment during Dr B's last clinical review of Mrs A and the documentation for this was poor, and there was a lack of documentation regarding Dr B's decision not to use Mental Health (Compulsory Assessment and Treatment) Act 1992 provisions to treat Mrs A.

The Mental Health Commissioner was critical of RN C's communication of her expectations to RN D, and of her documentation.

Recommendations
The Mental Health Commissioner recommended that the DHB develop clear protocols for circumstances where key worker care may be shared in relation to a mental health consumer, including a clear method of documenting the care arrangement and the role of each key worker in the circumstances. He also recommended that the DHB use this case as an anonymised case study for education of its key worker and psychiatrist staff, including in relation to their respective roles.

The Mental Health Commissioner recommended that should Dr B return to practise medicine, the Medical Council of New Zealand should consider whether a review of her competence is warranted.

He also recommended that should RN C return to practise nursing, she should undertake a course on documentation.

Inadequate care provided to baby in hospital (15HDC01330)

Background

At seven days old, Baby A was admitted to a public hospital with 11% weight loss since birth, jaundice, and reduced feeding. She was treated with phototherapy on the children's ward.

Baby A's temperature spiked the following day. The consultant paediatrician ordered investigations to try to determine the cause, and decided to commence intravenous (IV) fluids and antibiotics. A junior paediatric registrar prescribed the antibiotics and IV fluids. The registrar prescribed IV fluids at a rate of 180ml/kg/day, which was higher than the amount recommended by the DHB's policy and other national guidelines.

A registered nurse, RN B, cared for Baby A on the following evening shift. During this shift, RN B administered Baby A's antibiotics, and then recommenced the IV fluids. At about 8.30pm the IV monitor began to flash, indicating that there was a "downward occlusion". RN B and a senior nurse investigated the line and the IV site, but did not find any obvious issues. RN B did not clearly document the issues she had with the IV line during the shift, nor did she hand these over to the following shift.

Another registered nurse, RN C, took over Baby A's care at 11.15pm for the night shift, but she did not review Baby A for nearly two hours. At around 2.30am, Baby A was due for her next antibiotics. RN C said that there were no signs of phlebitis or tissue infiltration when she commenced the first IV antibiotic. During the administration of the antibiotic, Baby A's mother noted a blister forming on Baby A's arm, and the arm swelled immediately. RN C stopped the antibiotic infusion and called for assistance. Baby A was reviewed by a senior house officer and treated for an extravasation injury.

The paediatric fluid balance charts from throughout Baby A's hospital admission were not filled in regularly by staff in accordance with the DHB's policy.

Findings

The Deputy Commissioner found a number of failings in the care provided to Baby A by the DHB, including:

- The DHB did not have a clear consensus on which IV fluid guidelines were to take priority;
- The registrar's orientation to the IV fluid guidelines was inadequate;
- Multiple staff reviewed Baby A, but did not recognise that her IV fluid prescription was too high; and
- Multiple staff did not fill in Baby A's fluid balance chart in accordance with policy requirements.

The Deputy Commissioner considered that, cumulatively, these factors painted a picture of poor care and, accordingly, the DHB failed to ensure that services were provided to Baby A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner considered that by failing to comply with the DHB's policy regarding hourly IV site monitoring and documentation; not documenting an accurate description of the issues she encountered or the actions she took in response to the IV pump alarm; and not handing over the issues she had with the IV pump to the following shift, RN B did not provide services to Baby A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner also considered that by failing to review the baby's IV site for two hours at the start of her shift, and by failing to document the phlebitis and infiltration scores in accordance

with the DHB's policy, RN C did not provide services to Baby A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner was critical of the registrar for prescribing a rate of IV fluids that was higher than the amount recommended by guidelines.

Recommendations
The Deputy Commissioner made a number of recommendations to the DHB, including that it:

- Establish a clear consensus on which guidelines are to be followed when prescribing IV fluid to neonates, and ensure that this is documented clearly in existing policy or in a new policy document;
- Provide HDC with the results of its six most recent monthly audits of IV access;
- Use the case as an anonymised case study during induction of nursing and medical staff to the children's ward and neonatal unit; and
- Provide HDC with confirmation that the actions taken to meet the recommendations made in the DHB's internal investigation are continuing.

The Deputy Commissioner recommended that RN B undertake an audit of her compliance with fluid balance recording standards. The Deputy Commissioner also recommended that in the event that RN C hold a nursing position in which she is responsible for administering IV fluids to her patients, she undertake a self-audit of the standard of her fluid balance chart documentation.