

Complaints to HDC involving District Health Boards

Report and Analysis for period 1 July to 31 December 2020



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Feedback

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

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Citation: The Health and Disability Commissioner. 2021. *Complaints to the Health and Disability Commissioner involving District Health Boards: Report and Analysis for the period 1 July to 31 December 2020*

Published in June 2021
by the Health and Disability Commissioner
PO Box 1791, Auckland 1140

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This report is available on our website at www.hdc.org.nz

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Commissioner's Foreword

Tēnā koutou

I am pleased to present my Office's latest complaint trend report for DHBs. This report details the trends in complaints HDC received about DHBs between 1 July and 31 December 2020.

While the trends in this report are broadly consistent with previous reports, complaints about surgical services were notably the lowest we have reported. This resulted in mental health services becoming the most commonly complained about service type for the first time.

HDC is continuing to closely monitor the trends in complaints involving COVID-19-related issues, and we have included an outline of these complaints for DHBs on page 14. We continue to receive around 15 complaints per month related to COVID-19 issues. As would be expected, as restrictions have eased, complaints about COVID-19-related issues have decreased.

Strengthening HDC's approach to equity and enhancing our contribution to an equitable health and disability system is one of my current priorities as Health and Disability Commissioner. Accordingly, we are working to strengthen our data collection, analysis, monitoring, and reporting of matters relating to equity. This has enabled us to introduce a new section in this report — an analysis of consumer ethnicity. We will include this section in all complaint trend reports from now on.

Ethnicity data will become increasingly useful over time, as aggregated data will be analysed with other aspects of our complaints data, such as issues complained about, by ethnicity. Alongside this, we have implemented a system to collect demographic information from complainants who do not complete our online complaint form. For example, those consumers who are referred to HDC by other agencies or make complaints to HDC via the phone or email. Going forward, this will enhance the quality of data we can provide.

HDC provides an important platform for equity issues to be raised and addressed — both locally and system-wide. A number of our complaints point to consumers' concerns about discriminatory attitudes and approaches, and failures by people and services to act in a culturally safe way.

People's complaints to us also highlight that the way our health system is organised does not work well for those with complex needs. The system needs to be designed to meet the needs of consumers, rather than the needs of a system under pressure. I am pleased to see that making the system more consumer-centred is a central part of the vision of the recently announced health reforms. It is crucial that we maintain a focus on the needs of consumers during this period of significant transformation.

I trust that these reports continue to be of assistance in understanding complaint patterns for your DHB and nationally, with a view to improving the quality and safety of services.

He aha te kai a te rangatira? He kōrero, he kōrero, he kōrero.

Morag McDowell
Health and Disability Commissioner

National Data for all District Health Boards

1. How many complaints were received?

1.1 Number of complaints received

In the period Jul–Dec 2020, HDC received **464**¹ complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

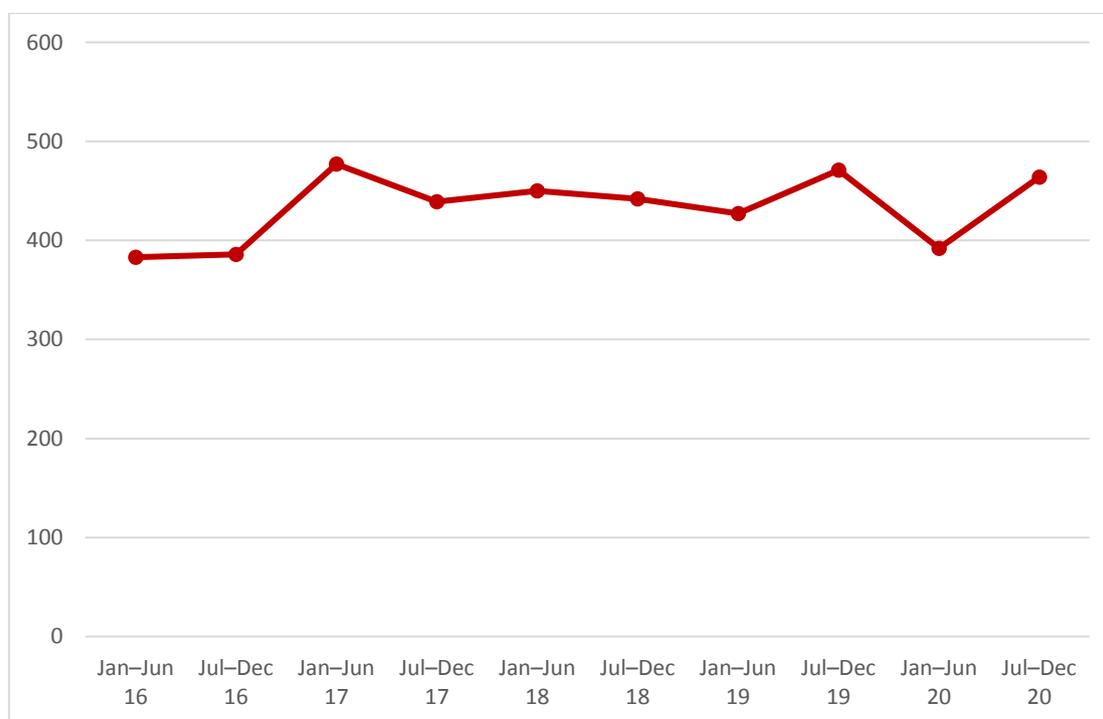
Table 1. Number of complaints received in the last five years

	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Average of last 4 6-month periods	Jul–Dec 20
Number of complaints	383	386	477	439	450	442	427	471	392	433	464

The total number of complaints received in Jul–Dec 2020 (464) shows a 7% increase over the average number of complaints received in the previous four periods.

The number of complaints received in Jul–Dec 2020 and previous six-month periods is also displayed below in Figure 1.

Figure 1. Number of complaints received over the last five years



¹ Provisional as of date of extraction (1 February 2021).

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.

Complaint rate calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (30 March 2021) 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

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
464	504,371	92.00

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jul–Dec 2020 and previous six-month periods.

Table 3. Rate of complaints received in the last five years

	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20²	Average of last 4 6-month periods	Jul–Dec 20
Rate per 100,000 discharges	81.44	78.79	99.08	88.23	93.80	88.47	87.97	92.92	90.35	89.93	92.00

The rate of complaints received during Jul–Dec 2020 (92.00) is very similar to the average rate of complaints received for the previous four periods.

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

² The rate for Jan–Jun 2020 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 2020

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	82	61,034	134.35
Bay of Plenty	20	29,436	67.94
Canterbury	50	57,474	87.00
Capital and Coast	41	29,752	137.81
Counties Manukau	31	49,129	63.10
Hauora Tairāwhiti	7	5,486	127.60
Hawke's Bay	16	19,098	83.78
Hutt Valley	11	17,661	62.28
Lakes	11	13,099	83.98
MidCentral	13	16,259	79.96
Nelson Marlborough	14	13,412	104.38
Northland	14	22,383	62.55
South Canterbury	7	6,048	115.74
Southern	31	27,698	111.92
Taranaki	12	14,449	83.05
Waikato	44	52,259	84.20
Wairarapa	4	4,473	89.43
Waitematā	56	55,006	101.81
West Coast	5	3,256	153.56
Whanganui	7	6,989	100.16

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. Further, 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 the number 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 services provided by a particular DHB. 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. Who complained?

2.1 Consumer ethnicity

The ethnicity of consumers who complained to HDC about DHB services in Jul–Dec 2020 is detailed below.

We have introduced this new section to the report and will include it in all complaint trend reports from now on. This data will become increasingly useful over time, as aggregated data will be analysed with other aspects of our complaints data, such as issues complained about, by ethnicity.

Alongside this, we have implemented a system to collect demographic information from complainants who do not complete our online complaint form. For example, consumers who are referred by other agencies or make complaints to HDC via the phone or email. Going forward, this will enhance the quality of the ethnicity data we can provide.

Table 5. Consumer ethnicity

Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	60	12.9%
Pacific	10	2.2%
Middle Eastern/African/Latin American	14	3.0%
Asian	20	4.3%
Other European	20	4.3%
New Zealand European	183	39.4%
Unknown/did not wish to answer	157	33.8%

3. Which DHB services were complained about?

3.1 DHB service types complained about

Please note that some complaints involve more than one DHB and/or more than one service or hospital; therefore, although there were 464 complaints about DHBs, 486 services were complained about. Figure 2 below shows the most commonly complained about service types in Jul–Dec 2020. A more nuanced picture of service types complained about, including individual surgical and medicine service categories, is provided in Table 6.

Mental health (24%) and surgical (23%) services received the greatest number of complaints in Jul–Dec 2020, with general surgery (6%) and gynaecology (6%) being the surgical specialties most commonly complained about.

This is the lowest proportion of complaints ever received about surgical services, with complaints about these services decreasing from 30% of all services complained about in previous periods to 23% in Jul–Dec 2020. This meant that mental health services became the most commonly complained about service type for DHBs for the first time in Jul–Dec 2020.

Other commonly complained about services included medicine (19%), and emergency department (15%) services.

Figure 2. Service types complained about

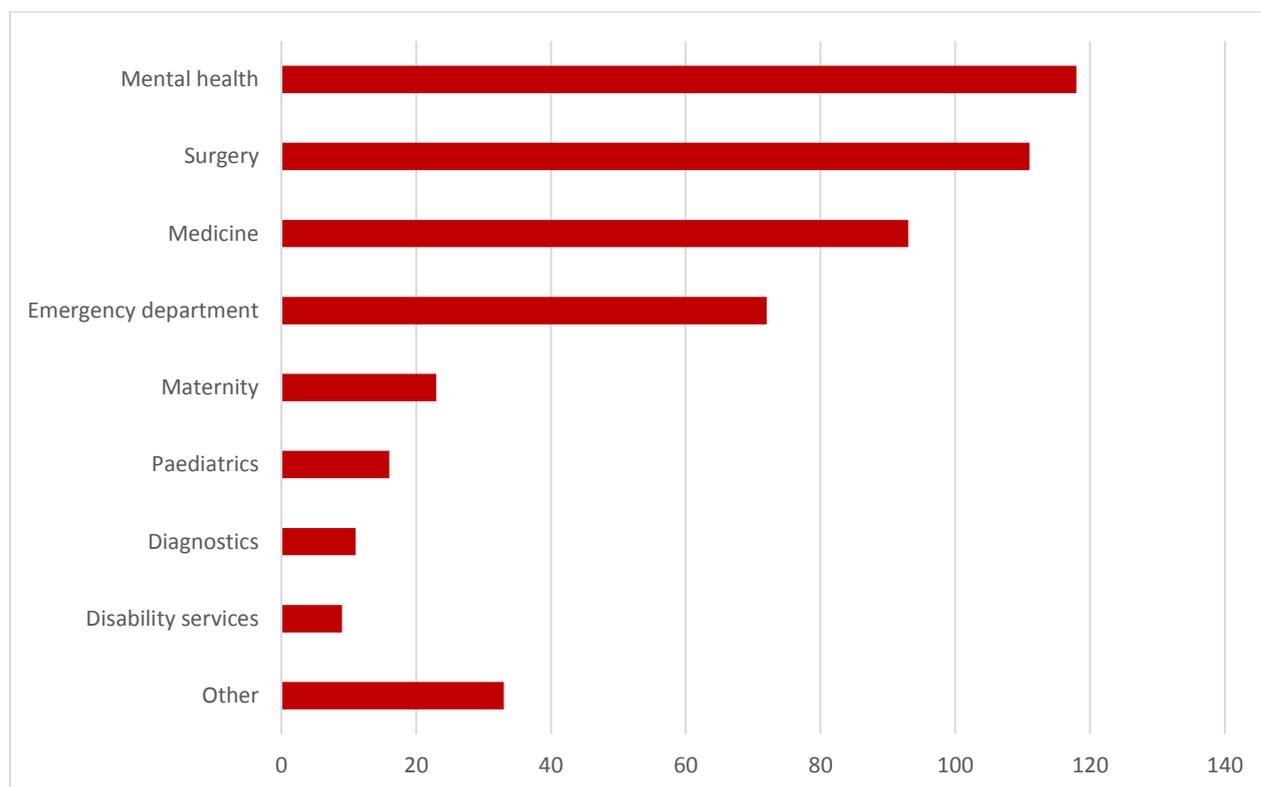


Table 6. Service types complained about

Service type	Number of complaints	Percentage
Alcohol and drug	5	1.0%
Anaesthetics/pain medicine	3	0.6%
Dental	2	0.4%
Diagnostics	11	2.3%
Disability services	9	1.9%
District nursing	4	0.8%
Emergency department	72	14.8%
Intensive care/critical care	5	1.0%
Maternity	23	4.7%
Medicine	93	19.1%
General medicine	15	3.1%
Cardiology	7	1.4%
Dermatology	1	0.2%
Endocrinology	3	0.6%
Gastroenterology	11	2.3%
Geriatric medicine	15	3.1%
Haematology	6	1.2%
Neurology	17	3.5%
Oncology	4	0.8%
Palliative care	1	0.2%
Renal/nephrology	5	1.0%
Respiratory	1	0.2%
Rheumatology	2	0.4%
Other/unspecified	5	1.0%
Mental health	118	24.3%
Paediatrics (not surgical)	16	3.3%
Physiotherapy	3	0.6%
Surgery	111	22.8%
Cardiothoracic	4	0.8%
General	30	6.2%
Gynaecology	27	5.6%
Neurosurgery	1	0.2%
Ophthalmology	3	0.6%
Orthopaedics	22	4.5%
Otolaryngology	5	1.0%
Plastic and Reconstructive	1	0.2%
Urology	12	2.5%
Vascular	5	1.0%
Other/unknown	1	0.2%
Other/unknown health service	11	2.3%
TOTAL	486	

Table 7 below shows a comparison of the proportion of complaints received over time for the most commonly complained about service types. As can be seen from this table, complaints about surgical services decreased for the first time in Jul–Dec 2020. There was also a small increase in complaints about emergency department services in Jul–Dec 2020.

Table 7. Comparison of the proportion of complaints received about the most commonly complained about service types

Service type	Jul–Dec 2018	Jan–Jun 2019	Jul–Dec 2019	Jan–Jun 2020	Jul–Dec 2020
Surgery	30%	31%	31%	31%	23%
Mental health	25%	22%	25%	22%	24%
General medicine	15%	18%	16%	18%	19%
Emergency department	12%	12%	11%	11%	15%
Maternity	3%	6%	5%	7%	5%

4. What did people complain about?

4.1 Primary issues identified in complaints

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jul–Dec 2020 are listed below in Table 8. 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 provide a valuable insight into the consumer’s experience of the services provided and the issues they care about most.

The most common primary issue categories were:

- Care/treatment (46%)
- Access/funding (16%)
- Consent/information (11%)
- Communication (7%)

The most common specific primary issues complained about were:

- Missed/incorrect/delayed diagnosis (13%)
- Lack of access to services (8%)
- Unexpected treatment outcome (7%)
- Waiting list/prioritisation issue (7%)
- Inadequate/inappropriate treatment (6%)

Table 8. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
<i>Access/Funding</i>	73	15.7%
Lack of access to services	39	8.4%
Lack of access to subsidies/funding	4	0.9%
Waiting list/prioritisation issue	30	6.5%
<i>Boundary violation</i>	2	0.4%
<i>Care/Treatment</i>	211	45.5%
Delay in treatment	19	4.1%
Delayed/inadequate/inappropriate referral	2	0.4%
Inadequate coordination of care/treatment	7	1.5%
Inadequate/inappropriate clinical treatment	26	5.6%
Inadequate/inappropriate examination/assessment	14	3.0%
Inadequate/inappropriate follow-up	8	1.7%
Inadequate/inappropriate monitoring	8	1.7%
Inadequate/inappropriate non-clinical care	4	0.9%
Inadequate/inappropriate testing	2	0.4%
Inappropriate admission/failure to admit	1	0.2%
Inappropriate/delayed discharge/transfer	15	3.2%
Inappropriate withdrawal of treatment	1	0.2%
Missed/incorrect/delayed diagnosis	62	13.4%
Personal privacy not respected	1	0.2%
Refusal to assist/attend	3	0.6%
Refusal to treat	1	0.2%
Rough/painful care or treatment	3	0.6%
Unexpected treatment outcome	33	7.1%
Unnecessary treatment	1	0.2%
<i>Communication</i>	31	6.7%
Disrespectful manner/attitude	11	2.4%
Failure to accommodate cultural/language needs	1	0.2%
Failure to communicate openly/honestly/effectively with consumer	8	1.7%
Failure to communicate openly/honestly/effectively with family	11	2.4%
<i>Complaints process</i>	2	0.4%
Inadequate response to complaint	2	0.4%
<i>Consent/Information</i>	52	11.2%
Consent not obtained/adequate	19	4.1%
Inadequate information provided regarding adverse event	1	0.2%
Inadequate information provided regarding condition	3	0.6%
Inadequate information provided regarding provider	1	0.2%
Inadequate information provided regarding results	7	1.5%
Inadequate information provided regarding treatment	4	0.9%
Issues regarding consent when consumer not competent	3	0.6%
Issues with involuntary admission/treatment	14	3.0%
<i>Documentation</i>	10	2.2%
Inadequate/inaccurate documentation	8	1.7%
Other	2	0.4%

Primary issue in complaints	Number of complaints	Percentage
Facility issues	23	5.0%
Accreditation/statutory obligations not met	2	0.4%
General safety issue for consumer in facility	13	2.8%
Inadequate/inappropriate policies/procedures	8	1.7%
Medication	23	5.0%
Administration error	6	1.3%
Dispensing error	1	0.2%
Inappropriate administration	3	0.6%
Inappropriate prescribing	11	2.4%
Refusal to prescribe/dispense/supply	2	0.4%
Reports/certificates	5	1.1%
Inaccurate report/certificate	5	1.1%
Professional conduct issues	25	5.4%
Assault	2	0.4%
Disrespectful behaviour	7	1.5%
Inappropriate collection/use/disclosure of information	13	2.8%
Other	3	0.6%
Disability-related issues	3	0.6%
Other	4	0.9%
TOTAL	464	

Table 9 shows a comparison over time for the top five primary issues complained about.

Complaints primarily regarding a lack of access to services decreased from 12% of complaints in Jan–Jun 2020 to 8% of complaints in Jul–Dec 2020. It may be that the higher proportion of complaints about a lack of access to services in Jan–Jun 2020 was due to restricted access to many services during the COVID-19 emergency response.

Table 9. Top five primary issues in complaints received over the last four six-month periods

Top five primary issues in all complaints (%)							
Jan–Jun 19 n=427		Jul–Dec 19 n=472		Jan–Jun 20 n=392		Jul–Dec 20 n=464	
Misdiagnosis	16%	Misdiagnosis	14%	Lack of access to services	12%	Misdiagnosis	13%
Waiting list/ Prioritisation	12%	Unexpected treatment outcome	9%	Misdiagnosis	10%	Lack of access to services	8%
Unexpected treatment outcome	9%	Waiting list/ prioritisation	8%	Unexpected treatment outcome	8%	Unexpected treatment outcome	7%
Inadequate treatment	7%	Inadequate treatment	8%	Waiting list/ prioritisation	7%	Waiting list/ prioritisation	7%
Lack of access to services	6%	Lack of access to services	8%	Inadequate treatment	5%	Inadequate treatment	6%

4.2 All issues identified in complaints

As well as the primary complaint issue, up to six additional complaint issues are identified for each complaint received by HDC. Table 10 includes these additional complaint issues, as well as the primary complaint issues, to show all issues identified in complaints received.

Table 10. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	104	22.4%
Lack of access to services	61	13.1%
Lack of access to subsidies/funding	8	1.7%
Waiting list/prioritisation issue	41	8.8%
Boundary violation	6	1.3%
Care/Treatment	351	75.6%
Delay in treatment	104	22.4%
Delayed/inadequate/inappropriate referral	12	2.6%
Inadequate coordination of care/treatment	90	19.4%
Inadequate/inappropriate clinical treatment	125	26.9%
Inadequate/inappropriate examination/assessment	127	27.4%
Inadequate/inappropriate follow-up	52	11.2%
Inadequate/inappropriate monitoring	44	9.5%
Inadequate/inappropriate non-clinical care	36	7.8%
Inadequate/inappropriate testing	53	11.4%
Inappropriate admission/failure to admit	9	1.9%
Inappropriate/delayed discharge/transfer	48	10.3%
Inappropriate withdrawal of treatment	3	0.6%
Missed/incorrect/delayed diagnosis	92	19.8%
Personal privacy not respected	4	0.9%
Refusal to assist/attend	9	1.9%
Refusal to treat	5	1.1%
Rough/painful care or treatment	24	5.2%
Unexpected treatment outcome	56	12.1%
Unnecessary treatment	3	0.6%
Communication	326	70.3%
Disrespectful manner/attitude	75	16.2%
Failure to accommodate cultural/language needs	11	2.4%
Failure to communicate openly/honestly/effectively with consumer	173	37.3%
Failure to communicate openly/honestly/effectively with family	132	28.4%
Complaints process	83	17.9%
Inadequate information provided re complaints process	1	0.2%
Inadequate response to complaint	82	17.7%
Consent/Information	108	23.3%
Consent not obtained/adequate	33	7.1%
Inadequate information provided regarding adverse event	9	1.9%
Inadequate information provided regarding condition	11	2.4%
Inadequate information provided regarding options	10	2.2%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding provider	4	0.9%
Inadequate information provided regarding results	14	3.0%
Inadequate information provided regarding treatment	39	8.4%
Incorrect/misleading information provided	6	1.3%
Issues regarding consent when consumer not competent	7	1.5%
Issues with involuntary admission/treatment	17	3.7%
Documentation	32	6.9%
Delay/failure to disclose documentation	3	0.6%
Inadequate/inaccurate documentation	27	5.8%
Other	3	0.6%
Facility issues	76	16.4%
Accreditation/statutory obligations not met	5	1.1%
Cleanliness/hygiene issue	8	1.7%
Failure to follow policies/procedures	5	1.1%
General safety issue for consumer in facility	17	3.7%
Inadequate/inappropriate policies/procedures	34	7.3%
Issue with quality of aids/equipment	7	1.5%
Issue with sharing facility with other consumers	2	0.4%
Staffing/rostering/other HR issue	10	2.2%
Other	4	0.9%
Medication	51	11.0%
Administration error	6	1.3%
Dispensing error	2	0.4%
Inappropriate administration	5	1.1%
Inappropriate prescribing	31	6.7%
Prescribing error	1	0.2%
Refusal to prescribe/dispense/supply	7	1.5%
Reports/certificates	11	2.4%
Inaccurate report/certificate	11	2.4%
Teamwork/supervision	5	1.1%
Inadequate supervision	5	1.1%
Professional conduct issues	48	10.3%
Assault	6	1.3%
Disrespectful behaviour	13	2.8%
Inappropriate collection/use/disclosure of information	25	5.4%
Other	9	1.9%
Disability-related issues	6	
Other	16	

On analysis of all issues identified in complaints about DHBs, the most common complaint issue categories were:

- Care/treatment (present for 76% of all complaints)
- Communication (present for 70% of all complaints)
- Consent/information (present for 23% of all complaints)
- Access/funding (present for 22% of all complaints)

The most common *specific* issues were:

- Failure to communicate effectively with consumer (37%)
- Failure to communicate effectively with family (28%)
- Inadequate/inappropriate examination/assessment (27%)
- Inadequate/inappropriate clinical treatment (27%)
- Delay in treatment (22%)
- Missed/incorrect/delayed diagnosis (20%)
- Inadequate coordination of care/treatment (19%)
- Inadequate response to complaint (18%)
- Disrespectful manner/attitude (16%)
- Lack of access to services (13%)

This is broadly similar to what was seen in the last period. However, there was a small increase in complaints about communication issues.

Issues complained about in relation to COVID-19

HDC received 44 complaints about COVID-19-related issues at DHBs in Jul–Dec 2020. This represents 35% of all complaints about COVID-19 received by HDC during this time period, and is a small decrease on the 53 COVID-19-related complaints received in Jan–Jun 2020.

Similar to what was seen in the previous six-month period, the most common issues complained about for DHBs in regard to COVID-19 in Jul–Dec 2020 were:

- Lack of access to services/delayed treatment (43%)
- Policies regarding visitor restrictions/support people (18%)
- Inadequate/failure to follow infection control policies (7%)

4.3 Primary issues by service type

Table 11 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 previous periods.

Table 11. Three most common primary issues in complaints by service type

Mental health n=118		Surgery n=111		Medicine n=93		Emergency department n=72	
Issues with involuntary admission/treatment	13%	Unexpected treatment outcome	19%	Missed/incorrect/delayed diagnosis	17%	Missed/incorrect/delayed diagnosis	28%
Lack of access to services	12%	Lack of access to services & waiting list/prioritisation issue	14% each	Inadequate/inappropriate treatment	10%	Waiting list/prioritisation issue	14%
General safety issue for consumer in facility	8%	Consent not obtained/adequate	9%	Lack of access to services	6%	Inadequate/inappropriate examination/assessment	8%

5. What were the outcomes of the complaints closed?

HDC is focused on fair and early resolution of complaints. Each complaint received by HDC is assessed carefully and resolved in the most appropriate manner, bearing in mind the issues raised and the evidence available. The assessment process is thorough and can involve a number of steps, including obtaining a response from the provider/s, seeking clinical advice, and asking for information from the consumer or other people.

A number of options are available to the Commissioner for the resolution of complaints. These include referring the complaint to the Advocacy Service, to a professional body, or to another agency. HDC may also refer a complaint back to the provider to resolve directly. In line with their responsibilities under the Code, DHBs have increasingly developed good systems to address complaints in a timely and appropriate way. Where complaints are assessed as suitable for resolution between the parties, 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.

The Commissioner also 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; a more appropriate outcome can be achieved in a more flexible and timely way than by means of investigation; or the matters that are the subject of the complaint have been, are being, or will be, addressed appropriately by other means. Often a decision to take no further action will be accompanied by an educational comment or recommendations designed to assist the provider to improve services in future.

Where appropriate, the Commissioner may investigate a complaint, which may result in a DHB being found in breach of the Code. Notification of investigation generally indicates more serious issues.

5.1 Number of complaints closed

In the period Jul–Dec 2020, HDC closed **390**⁴ complaints involving DHBs. Table 12 shows the number of complaints closed in previous six-month periods.

Table 12. Number of complaints about DHBs closed in the last five years

	Jan– Jun 16	Jul– Dec 16	Jan– Jun 17	Jul– Dec 17	Jan– Jun 18	Jul– Dec 18	Jan– Jun 19	Jul– Dec 19	Jan– Jun 20	Average of last 4 6-month periods	Jul– Dec 20
Number of complaints closed	482	316	465	383	476	449	444	423	428	436	390

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.

5.2 Outcomes of complaints closed

In the Jul–Dec 2020 period, three DHBs had no investigations closed, nine DHBs had one investigation closed, four DHBs had two investigations closed, and four DHBs had three investigations closed.

The manner of resolution and outcomes of all complaints about DHBs closed in Jul–Dec 2020 is shown in Table 13.

Table 13. Outcome for DHBs of complaints closed by complaint type⁵

Outcome for DHBs	Number of complaints closed
<i>Investigation</i>	27
Breach finding — referred to Director of Proceedings	1
Breach finding	18
No breach finding — with adverse comment and recommendations	4
No breach finding with recommendations	3
No breach finding	1
<i>Other resolution following assessment</i>	361
No further action with recommendations or educational comment	35
Referred to Ministry of Health	2
Referred to District Inspector	16
Referred to other agency	2
Referred to DHB	97
Referred to Advocacy	70
No further action	132
Withdrawn	7
<i>Outside jurisdiction</i>	2
TOTAL	390

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.

5.3 Recommendations made to DHBs by HDC

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 14 shows the recommendations made to DHBs for complaints closed in Jul–Dec 2020. Please note that more than one recommendation may be made in relation to a single complaint.

Table 14. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	19
Audit	15
Evaluation of change	8
Meeting with consumer/complainant	1
Presentation/discussion of complaint with others	11
Provision of evidence of change to HDC	21
Review/implementation of policies/procedures	20
Training/professional development	22
TOTAL	117

The most common recommendations made to DHBs were that they conduct staff training (22 recommendations), provide evidence of change made in response to the complaint to HDC (21 recommendations), review or implement new policies and procedures (20 recommendations), apologise to the consumer/complainant (19 recommendations), and conduct an audit (15 recommendations). Recommendations for staff training were most often in regard to clinical issues identified in the complaint, followed by training on communication. Often HDC will ask the DHB to use an anonymised version of the complaint as the basis for the training.

6. Learning from complaints

6.1 Discharge of woman at risk of stroke⁶

This case reflects a number of themes seen in HDC complaints in regard to discharge planning and anticoagulation management. It highlights the importance of clear decision-making and accurate documentation about medication at discharge, so that clear advice is provided to the consumer and their GP.

Background

An elderly woman presented to the Emergency Department (ED) of a public hospital with rectal bleeding. The woman was taking dabigatran (an anticoagulant) for stroke prevention. The woman was assessed in ED and her regular medication was noted. The ED clinician assessed her as having a diverticular bleed (gastrointestinal bleeding).

The woman was then admitted to the Acute Surgical Unit and reviewed by a consultant. A planned gastroscopy and colonoscopy were documented. The consultant also requested that the woman's dabigatran be withheld to prevent further bleeding during these investigations. Dabigatran was not given to the woman during her admission.

A colonoscopy showed diverticular disease (small bulges/sacs in the wall of the large intestine), as well as haemorrhoids. No active bleeding was found and no further investigation was recommended. A plan was made to discharge the woman. A house officer prepared the woman's discharge summary. The discharge summary did not state that dabigatran should be re-started or that it had been stopped on admission to hospital. Advice to the consumer's GP stated "no change to regular medications", and did not include any guidance regarding if and when to re-start dabigatran.

The woman sought clarification from a nurse at the hospital about recommencing her dabigatran. The nurse advised the woman that she would consult the medical team and get back to her. The nurse asked the woman to contact her GP if she had not heard back the following day. The nurse did not follow up with the woman. The woman then presented to her GP as instructed. The GP decided to withhold dabigatran for two weeks, and restart it if her haemoglobin remained stable.

Three days after discharge, and 12 days after her last dose of dabigatran, the woman had a stroke and was re-admitted to hospital.

Findings

HDC's clinical advisor found the treatment of the woman's rectal bleeding to be timely and appropriate. The focus of HDC's investigation was the DHB's failure to formulate and communicate instructions to the woman about recommencing dabigatran on discharge.

The Commissioner noted that the completion of an accurate discharge summary is a basic requirement that should have been met. In this case, the discharge summary lacked essential information, including an accurate record of the woman's medications, advice to the woman about re-starting dabigatran on discharge, and clear advice to her GP. Additionally, a nurse's inability to access information regarding the plan for dabigatran management, either from the discharge summary, the clinical notes, or by contacting the medical team, resulted in a lost opportunity to give the woman clear instructions on discharge. Lastly, the lack of information on the discharge summary meant there was insufficient guidance for the woman's GP.

⁶ Case 18HDC01085.

The Commissioner considered that these deficiencies indicated poor discharge planning processes, for which the DHB was responsible. Accordingly, she found that the DHB failed to provide services to the woman with reasonable care and skill, in breach of Right 4(1).

Recommendations

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

- Provide a written apology to the woman's family
- Use an anonymised version of this report as a case study to encourage reflection and discussion during education sessions for staff on the importance of communication of discharge plans
- Provide further education to house officers on the discharge summary, with emphasis on the importance of accuracy and the need to seek clarification if there are uncertainties
- Review the effectiveness of the new electronic medication reconciliation programme and the changes to its electronic discharge summary
- Consider developing a multi-disciplinary approach to anticoagulation management, particularly in clinical situations where management may not be clear
- Consider sharing its re-designed electronic discharge summary with other DHBs

6.2 Care of woman and her baby⁷

This case highlights the importance of the need for comprehensive management plans in complex cases, and the need for co-ordinated care planning led by an obstetrician and LMC in consultation with a multi-disciplinary team. Additionally, it raises issues around the importance of considering a woman's care holistically, including providing appropriate cultural support.

Background

A woman in her twenties, who was pregnant with her first child, engaged a self-employed registered midwife as her Lead Maternity Carer. At 23 weeks' gestation the woman was admitted to hospital and diagnosed with hyperemesis (severe nausea and vomiting in pregnancy). She then began to receive care from the Obstetrics team for her hyperemesis. The DHB stated that an obstetrician was responsible for her care, but there was no record of a formal transfer of the woman's care from her LMC to Obstetrics. It appears that at times her care was shared between Obstetrics and her LMC.

The woman experienced multiple hospital admissions and was treated for dehydration and malnutrition. The woman lost 7kg during her pregnancy and was seen by a dietician. Further follow-up appointments were made, but the woman did not attend. The woman also developed iron deficiency and megaloblastic anaemia, which was managed with iron supplements and blood transfusions. The obstetrician consulted General Medicine about the woman's anaemia, and was advised to replace any deficiencies until delivery and to undertake investigations at a later time. An ultrasound scan showed that the woman had gallstones, and the General Medicine team arranged for this to be managed following delivery of her baby. A formal multidisciplinary management plan was not developed in response to her complex presentation.

Scans showed that the woman's baby was very small for gestational age, and a plan was made to monitor the growth of the woman's baby closely, including weekly ultrasounds, twice-weekly monitoring of the baby's heart rate (CTGs), and an induction of labour at 38–39 weeks' gestation.

⁷ Case 18HDC00384.

At 39 weeks' gestation the woman's labour was induced. The baby was born in good condition but with a low birth weight. Due to her low birth weight, the baby's blood glucose level (BGL) was monitored. Her second BGL reading was low, and she was given dextrose gel and formula milk, which increased her third BGL reading. The paediatric team was not called in response to this low reading. The final BGL reading was taken seven hours after the low reading, despite DHB guidelines stating that BGL should be monitored for at least 12 hours after a low reading.

Four days after birth, the baby was noted to be floppy, difficult to rouse, and cold. The baby was transferred to the Specialist Baby Care Unit (SBCU), where she was treated for severe hypoglycaemia. The baby showed possible seizure activity and was given a higher dose of phenobarbitone than is recommended for a neonate.

Findings

The Deputy Commissioner noted that the woman was seen by at least five obstetricians during her pregnancy, as well as her GP, LMC, and other specialist teams, and that multiple locums were involved in providing care to her. The Deputy Commissioner commented that in this scenario, a formal management plan should have been developed to guide all providers in their care and ensure a seamless service. This should have included a clear record of the transfer to the Obstetrics team and the ongoing role of her LMC.

The Deputy Commissioner found a number of aspects of the care provided to the woman and her baby by the DHB to be suboptimal, including:

- There was a lack of clarity about when the woman's care was transferred to Obstetrics, and no documented discussions about the decision.
- There was no documented coordinated formal management plan to guide all providers in their care of the woman.
- The DHB's guidelines on the assessment and management of hyperemesis and malnutrition were inadequate.
- The BGL monitoring of the baby was not timely, and a paediatric review was not requested in accordance with the guidelines.
- The initial dose of phenobarbitone administered to the baby was higher than recommended and not consistent with the guidelines.

The Deputy Commissioner considered that cumulatively these deficiencies indicated a pattern of poor care, and found that the DHB failed to provide services to the woman and her baby with reasonable care and skill, in breach of Right 4(1).

The Deputy Commissioner was also critical that there was a missed opportunity to seek advice from a tertiary hospital regarding the woman's baby, who was significantly small for her gestational age.

The DHB reported that it had concerns about the woman's compliance with her plan of care, and had issues with contact. HDC's clinical advisor noted that a woman's quality of life can be adversely affected by hyperemesis, and sources of psychological support should be considered. The Deputy Commissioner noted that there was an opportunity to intervene and provide cultural support to the woman and her whānau to facilitate compliance with her plan of care. This may have supported her needs more holistically and provided significant benefit in terms of psychosocial issues she was experiencing. The Deputy Commissioner was critical of this missed opportunity to provide cultural support.

Recommendations

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

- Review compliance with the nausea and vomiting in pregnancy guidelines developed
- Consider developing guidelines for when concerns about babies who are significantly small for their gestational age or the severity of a woman's symptoms may require consultation with a multidisciplinary team to develop a plan
- Consider developing guidelines for when the management of a baby who is small for their gestational age may require a referral to a fetal medicine specialist or to a larger centre for tertiary subspecialist opinion
- Consider HDC's clinical advisor's comments regarding the need to provide appropriate cultural support in complex cases
- Arrange training for new staff on the use of the hypoglycaemia kit implemented since this complaint, and provide further training to current staff on the management of neonatal hypoglycaemia, with an emphasis on the indications for paediatric notification and the recommended duration of monitoring BGLs
- Review the guidelines for administering phenobarbitone, and ensure that all relevant staff are made aware of the guidelines.

6.3 Care of young man with sepsis⁸

This case reflects the coordination of care issues that are often seen by HDC in respect of patients awaiting review by different teams in an ED/medical assessment unit, and highlights the importance of having systems that optimise continuity of care.

Background

A man in his twenties, with a history of Crohn's disease, was transported by ambulance to the ED of a public hospital. He had been feeling increasingly unwell, and was experiencing rectal bleeding, an increased heart rate, and non-radiating chest pain.

The man was assessed and triaged. It was noted that he met the sepsis criteria, and this was communicated to the ED senior house officer. While in ED, the man's observations were taken on two occasions, but his Early Warning Score was not calculated. He was reviewed by an ED house officer, who sought a review by the General Surgery team. Despite meeting the sepsis criteria, IV antibiotics were not commenced in the ED, as it was decided to await the surgical review.

The man was then reviewed by a General Surgery consultant, who discussed his case with a gastroenterologist. No antibiotics were charted or commenced by the General Surgery team. Following General Surgery review, the man continued to be stationed in the ED area. ED, General Surgery, and Gastroenterology all had differing views as to who was responsible for the man's care.

The man was moved to MAPU (a medical assessment unit situated within the ED). The admission process to MAPU was not followed, and the medical registrar on duty at the time was not informed of the man's admission to MAPU.

The man's condition was monitored by nursing staff in MAPU and his condition deteriorated. However, he did not receive a medical review until nearly five hours later, when the man's concerned family contacted his gastroenterologist. On examination, the gastroenterologist noted that the man

⁸ Case 18HDC01768.

had obvious features of sepsis, and IV fluids and IV antibiotics were commenced. The man was then admitted to the General Medicine team.

Findings

In respect of this case, the Deputy Commissioner noted that when a patient is likely to be seen by multiple teams during the course of a hospital admission, it is essential that clear and effective communication occurs between all teams involved, and that DHBs have processes to optimise the continuity of care. She also commented that units such as MAPU serve as a boundary ward between different teams and, as such, the line as to who is responsible may be blurred or unclear. A clear written policy, effective communications, and ultimately agreement between teams is vital to ensure accountability and appropriate management of patients in such a unit.

In this situation there were issues with the communication between doctors in ED, General Surgery, and Gastroenterology, as well as between nursing staff and the medical registrar in MAPU. As a result, no team was responsible for the man's care. In this respect, the Deputy Commissioner considered that clinical staff at the DHB did not co-operate effectively, and the man was not provided with quality and continuity of services, in breach of Right 4(5) of the Code.

The Deputy Commissioner also considered that the DHB failed to provide care to the man with reasonable care and skill, in breach of Right 4(1) of the Code, for the following reasons:

- The sepsis policy was not followed, and the man was not administered IV antibiotics or IV fluids in a timely manner despite meeting the sepsis criteria.
- The man did not receive any medical review in MAPU until his gastroenterologist saw him.
- There was no written policy or protocol about MAPU at the time of this incident.
- The admission process to MAPU was not followed.
- There was poor documentation by MAPU and ED nursing staff, MAPU nursing staff did not use the Early Warning Score sticker as per policy, and on some occasions the Early Warning Score was not calculated and noted by ED nursing staff.

As a consequence of the above failings, the man was left in pain, with no specified person taking responsibility for his treatment, for a protracted period of time. It is fortunate for the man that his family took an active approach — otherwise he may have deteriorated further.

Recommendations

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

- Provide a written apology to the man
- In the event that MAPU is reinstated, randomly audit whether the new MAPU policy and admission process has been complied with
- Randomly audit whether the sepsis policy has been complied with within the ED and MAPU. Where the audit results do not show 100% compliance, advise what further steps will be taken to address this issue
- Provide evidence to HDC that further education about the sepsis pathway and documentation has been provided to nursing staff
- Report back to HDC on the outcome of the DHB's consideration in respect of patients awaiting review by primary teams, and the process of escalation of patients in the event of deterioration before formal handover of care, and whether any improvements have been made
- Use this report as a basis for staff training, and disseminate the learning and changes made following this case via the DHB's existing forums for nursing and medical teams.

6.4 Supervision and hospital transfer of man with severe depression⁹

This case highlights the importance of critical thinking, particularly in respect of escalating risk and ensuring that the overall picture, including the consumer's mental and physical health, is taken into account in any decision-making.

Background

A man with a history of severe depression and Type 1 diabetes was voluntarily admitted to a psychiatric hospital owing to a significant deterioration in mood and suicidal ideation. During his admission he was placed under the Mental Health Act owing to escalating risk to himself and others. Because of a concern that the man might absent himself from the open ward without leave, he was transferred to the locked High Care Area (HCA). The man was placed under HCA observations, which required him to be observed at 5–15 minute intervals with variable timing to avoid predictability.

A few days later, the man was observed by staff trying to stack furniture in the HCA courtyard in an attempt to abscond. He was advised to cease this behaviour. A few hours later, the man became agitated and upset after receiving a phone call informing him that a family member had had an accident and was at the hospital's ED. The man's requests to visit the ED and be with his family were denied because of the risk to both himself and others. That day, the man was being supervised by a registered nurse with the assistance of a healthcare assistant.

Whilst in a state of agitation, the man went to the HCA courtyard for a cigarette. He was observed from a distance by the healthcare assistant, while the registered nurse went to the office to make a phone call. The man wedged a chair into the courtyard fence and climbed onto the roof of the HCA. He then jumped from the roof and attempted to run away, but soon collapsed.

The man was immediately attended by a registered nurse and a healthcare assistant. The man was unable to mobilise unaided and reported unbearable pain with weight-bearing. He was assessed by a house surgeon who was working under the direction of senior Specialist Mental Health staff. The house surgeon arranged for the man to be seen by the Orthopaedics Department at a public hospital. He was administered codeine for pain management, but continued to complain of pain.

Owing to significant concerns about the man's suicidal ideations and the risk to his family, who were in the ED at the time, it was deemed not appropriate to transport the man to the hospital immediately. Additionally, after discussion with the orthopaedic registrar, it was determined that the acuity of the man's injury was such that he could remain at the psychiatric hospital until his family left the ED.

Later the night, the man, accompanied by a registered nurse, was transferred to the public hospital by taxi. The DHB stated that a taxi was used as it was thought that there would be a delay in an ambulance attending given the low acuity level of the man's injury. X-rays showed that the man had bilateral fractures on both ankles. He underwent a number of surgeries on his feet.

Findings

The Mental Health Commissioner was concerned that several staff at the psychiatric hospital demonstrated a lack of critical thinking in regard to the care the man received leading up to and after the incident where he injured himself. The overall picture of the man's condition was not taken into account in the decision-making of staff to ensure a safe physical environment and prompt action after the incident. In particular, the Mental Health Commissioner was concerned by the following deficiencies:

⁹ Case 18HDC02113.

- The level of observation assigned to the man before the incident did not allow for adequate observation of his behaviour or adequate time to react to his behaviour. The man had attempted to abscond that morning, there was concern about his suicidality, and he was becoming increasingly agitated about being detained. These factors elevated the existing risk, necessitating a higher level of observations.
- Given the clinical risks with which he was presenting, the man should not have been alone in the HCA courtyard, and should have been observed by staff in close physical proximity to him.
- The man's transfer to the hospital was unduly delayed for four and a half hours. HDC's clinical advisor noted that the man had severe injuries — he was unable to be mobilised and was in pain. Additionally, the man already had impaired function in his lower legs owing to complications from his diabetes, which would necessitate a timely transfer.
- Transporting the man to hospital by taxi was not appropriate. HDC's clinical advisor stated that the man should have been transported, urgently, by ambulance, as would have happened if his injuries had occurred at any other location. The position of the man's legs in a taxi would have contributed to pain and swelling, and his condition could not be monitored in a taxi as it would be in an ambulance.

As a result of the above deficiencies, the Mental Health Commissioner found that the DHB failed to provide services to the man in a manner that minimised potential harm to him, in breach of Right 4(4) of the Code.

Recommendations

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

- Provide an apology to the man
- Amend its observation policy to direct staff to maintain the assigned level of observation for a consumer whilst the consumer is smoking, including guidance on what to do if a situation is escalating
- Review local clinical documentation on how formal observations are recorded, implemented, handed over, and reviewed. Incident data should be used to track the number of occasions when an inability to maintain observations is reported by staff, and to identify themes, trends, and improvement opportunities. Any new systems and tools developed as a result of the review should be auditable
- Undertake an audit of hospital transfers to ensure that its updated Hospital Health Pathway (which requires consumers to be transferred in a suitable vehicle depending on their presentation) are being adhered to
- Report back to HDC on the outcome of its consideration of the following recommendations:
 - Have a registered nurse in the outdoor area of the HCA any time there is a consumer there, to ensure that the area is within continuous line of sight
 - Review the outdoor area of the HCA for risk of absconding, including the design of the fence and the furniture placed in the area
 - Remind staff that although the outdoor area of the HCA is used for smoking, supervision of smoking is not the only factor determining need for observation — risk of self-harm, harm to others, and absconding also need to be considered
 - Review existing policy on transfer to acute medical care, focusing on clearly distinguishing between a simple transfer from one setting to another and when an acute medical event should be treated as an emergency.