Complaints to the Health and Disability Commissioner involving District Health Boards

Report and Analysis for period 1 July 2014 to 30 June 2015

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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COMMISSIONER'S FOREWORD

I am pleased to present HDC's second full year analysis of complaints involving district health boards (DHBs).

The consumer's voice for bringing change is a powerful one. New Zealand's health and disability sector is a sector of which we can be proud, and where, in the vast majority of cases, services are delivered with exceptional care and skill. However, as with any system, there is always room for improvement. Consumers' complaints provide a vital perspective on their experience of health care services and the issues they care most about. The analysis of complaint data strengthens our ability to identify systemic issues and can provide insights into aspects of care that are not caught by other systems of health and disability service monitoring. As such, consumers are invaluable partners in quality improvement.

Complaints management is an integral part of the quality improvement process. All healthcare organisations should have a complaints management system that welcomes complaints from both consumers and staff members. Although leaders are responsible for setting the culture of an organisation, staff members play a role in expressing culture. It is important that individual staff are encouraged to take personal responsibility for adopting a proactive and positive approach to dealing with and responding to complaints. Staff should also be encouraged to view complaints as a learning opportunity and be open to reviewing their own roles to identify any areas for improvement.

I note that in almost a quarter of complaints about DHB services to HDC in 2014/2015, the consumer had first complained directly to the DHB and then complained to HDC after they found the DHB's response to their complaint to be inadequate. In 2014/2015, HDC began to provide complaint resolution workshops for DHBs. These three-hour interactive workshops aim to develop DHB staff confidence and capability in resolving and learning from complaints. As complaint volumes continue to rise (both to my Office, and to complaints agencies internationally), I encourage all providers, but in particular DHBs, to consider how best to equip their staff to manage complaints well.

Every complaint is an opportunity to learn and improve the system. System improvement at a local level occurs in the majority of complaints that come to HDC, either in response to direct recommendations made by HDC, or through providers taking proactive steps in response to the issues raised. These changes result in safer, higher quality service delivery by stronger local systems. I trust that this report will serve to highlight the encouraging changes made in response to complaints about DHB services in 2014/2015, and continue to promote learning and ongoing quality improvement.

Anthony Hill
Health and Disability Commissioner

EXECUTIVE SUMMARY

In the 2014/2015 year, HDC received 757 complaints involving DHBs. This was an increase of 15% compared to the number received in the previous year. The significant year on year increase in complaints about DHB services is consistent with increasing overall complaint numbers to HDC each year.

The rate of complaints about DHB services is also increasing, with the 2014/2015 rate of 81 complaints per 100,000 discharges being the highest to date.

Complaints were received in relation to a wide variety of DHB service types, with the most commonly complained about service types being surgical and mental health services. The service types complained about are broadly consistent with what was seen in complaints about DHBs last year.

Also consistent with complaint trends seen in 2013/2014, doctors were the individual providers complained about most commonly within complaints about DHB services, with 78% of all complaints identifying them as responsible for at least some of the concerns identified.

Missed, incorrect or delayed diagnosis was the primary issue of concern raised by the complainant in 17% of complaints. When all issues raised in complaints were considered, we found that concerns about inadequate/inappropriate treatment were the most prevalent, followed by a failure to communicate effectively with the consumer. This is broadly consistent with complaint issue trends in 2013/2014, although there was an increase in the proportion of complaints involving an inadequate assessment, a failure to communicate effectively with the consumer, and an inadequate response to the consumer's complaint by the DHB.

The issues raised in complaints varied by the service type involved. Services with high diagnostic workloads, such as general medicine and emergency departments, commonly received more complaints regarding missed, incorrect or delayed diagnoses. Surgical services saw an increase in complaints regarding access/funding issues in 2014/2015, with 13% of complaints about surgical services being primarily in relation to a waiting list/prioritisation issue.

In the 2014/2015 year, HDC closed more complaints about DHBs than ever before. The 754 complaints closed this year was an increase of 9% over the number of complaints closed about DHBs in the previous year. This included the conclusion of 45 formal investigations. Around 19% of complaints were referred back to the DHB for resolution. In around 23% of cases, HDC recommended some kind of follow-up action or made educational comments designed to facilitate improvement in DHB services. The most common recommendation made by HDC to DHBs was that they review their policies/procedures, followed by the recommendation that the DHB conduct an audit, most often of policies/procedures and/or documentation.

BACKGROUND

1. The Health and Disability Commissioner

HDC is an independent crown entity established under the Health and Disability Commissioner Act 1994 to promote and protect the rights of health and disability services consumers. The rights of consumers are set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code places corresponding obligations on all providers of health and disability services, including individual providers and organisational providers such as district health boards.

HDC promotes and protects the rights of consumers of health and disability services by:

- resolving complaints;
- improving quality and safety within the sector; and
- appropriately holding providers to account.

As such, HDC fulfils the critical role of independent watchdog for consumer rights within the sector.

Rights under the Code

1. The right to be treated with respect.
2. The right to freedom from discrimination, coercion, harassment and exploitation.
3. The right to dignity and independence.
4. The right to services of an appropriate standard.
5. The right to effective communication.
6. The right to be fully informed.
7. The right to make an informed choice and give informed consent.
8. The right to support.
9. Rights in respect of teaching or research.
10. The right to complain.

Anyone may make a complaint to HDC about a health or disability service that has been provided to a consumer. It is not uncommon for HDC to receive complaints from third parties, such as family members, friends, or other providers involved in the consumer's care. The Commissioner may also commence an investigation at his own initiative, even without having received a complaint, if he considers it appropriate to do so.

For HDC to have jurisdiction to assess and/or investigate a complaint, there must have been the provision of a health or disability service to a consumer by a provider, and a possible infringement of the consumer's rights under the Code.

2. District Health Boards

There are 20 district health boards (DHBs) with responsibility for funding or providing a specified range of health and disability services on behalf of the government. Public hospitals, and other public health services, including various clinics and community-based services, are owned and funded by DHBs. Individual providers (for example, doctors and nurses) working in a DHB's facility are usually employed by that DHB.

3. This Report

This report describes the complaints HDC received and/or closed in relation to DHBs during the 2014/15 financial year.

Complaints about DHBs are of particular interest as DHBs are the largest organisational providers of health and disability services in this country. Approximately one third of complaints received by HDC each year relate, at least in part, to DHB services.

The complaints are described both in terms of overall numbers and characteristics, as well as by reference to case studies. In terms of complaints received, the issues included in the analysis 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. Case studies are included to encourage readers to consider their own service provision and to ask "could that happen at my place" and, if so, what changes can be made to prevent it.

This report provides some analysis of changes that have occurred in DHB complaints over time, but this is limited by the ability to extract the relevant data from HDC's complaints database. We expect that, over time, as we continue to analyse the data to the degree of specificity demonstrated in this report, additional time series analysis will become possible. We anticipate that this will be of significant additional usefulness.

COMPLAINTS RECEIVED

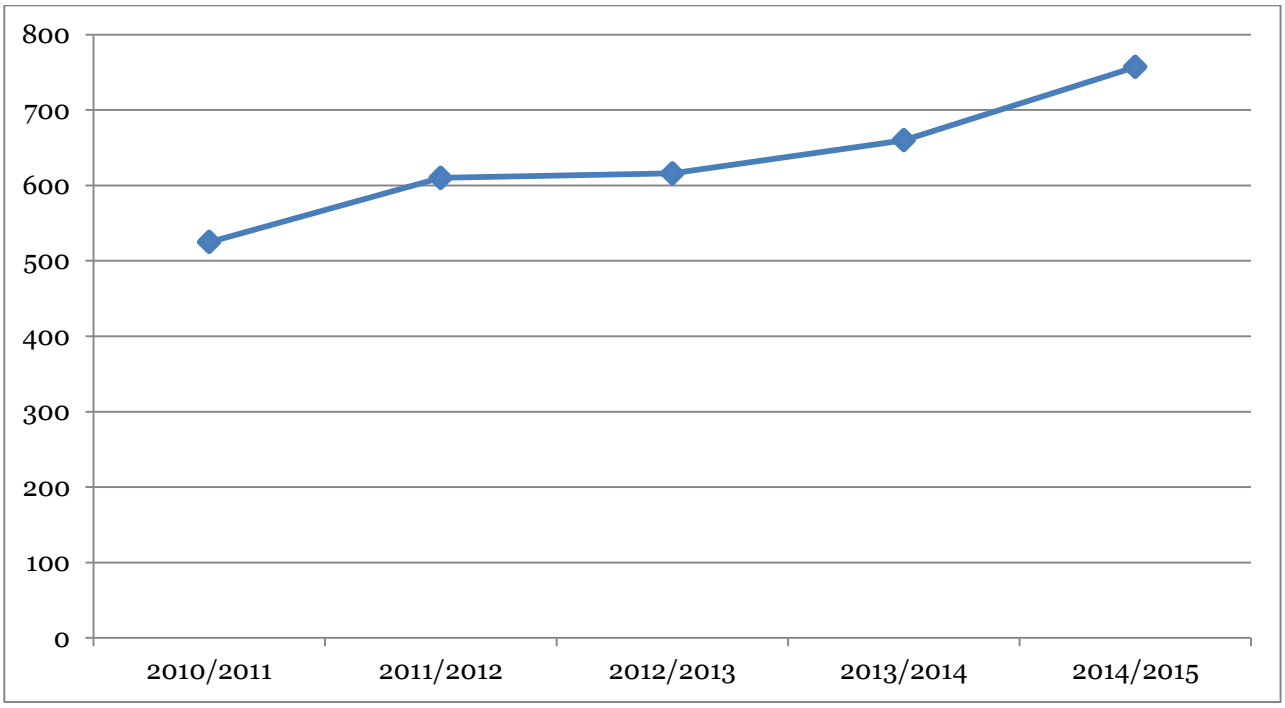
1. How many complaints were received?

1.1 Number of complaints received

In 2014/15, HDC received a total of **757** complaints about care provided by all DHBs. This equates to 40% of the total 1,880 complaints received by HDC that year.

The 757 complaints received in the 2014/15 year represents an increase of 15% over the 660 complaints received in 2013/14. As can be seen from Figure 1 below, DHB complaint numbers have been steadily increasing over the last five years. Analysis shows that this increase is statistically significant.[1]

Figure 1. Number of complaints received about DHBs



The number of complaints received about individual DHBs ranged from 8 complaints to 100 complaints. Large variability in complaint numbers is not unexpected given the similar variability in the size of populations served and number of services delivered by different DHBs.

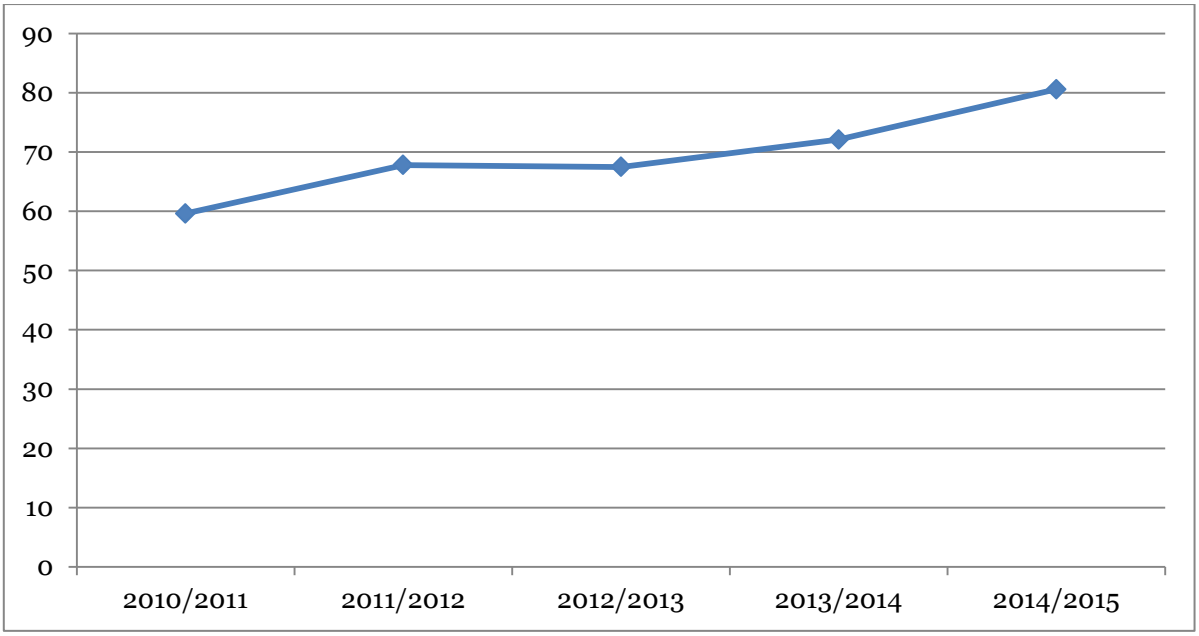
[1] There is a significant positive correlation between year and number of DHB complaints received ($r=0.92$, $p<.05$).

1.2 Rate of complaints received

Expressing complaints to HDC as a rate per 100,000 discharges allows more meaningful comparisons to be drawn between DHBs, and over time, enabling any trends to be better observed.

In the 2014/15 year, according to Ministry of Health data,[2] there were 939,510 discharges nationally. This equates to an overall rate of 81 complaints per 100,000 discharges across DHB services. This compares to an overall rate of 72 complaints per 100,000 discharges during 2013/14; an increase of 12%. As shown in Figure 2, the complaint rate per 100,000 discharges has increased steadily over the last five years. As for complaint numbers, analysis shows that this increase is statistically significant.[3]

Figure 2. Rate of complaints received about DHBs per 100,000 discharges



For individual DHBs, the rate of complaints received ranged from 54 complaints per 100,000 discharges to 144 complaints per 100,000 discharges.

However, while discharge data is useful for standardising DHB activity over time, it is less accurate when comparing DHBs against one another. This is because some services are excluded from the discharge data collected,[4] disproportionately affecting some DHBs more than others. In addition, discharge data does not take into account the particular services provided by a DHB or the nature of the population and geographical area served.

[2] Provisional as at the date of extraction, 14 August 2015.

[3] There is a significant positive correlation between year and rate of DHB complaints received ($r=.91$, $p<.05$).

[4] For example, the discharge data excludes short stay emergency department discharges, and patients attending outpatient units and clinics.

Why are complaint numbers increasing?

The increasing number of complaints being received by HDC about DHBs is reflective of an overall trend of sustained growth in complaint numbers to HDC. Over the last four years, the number of complaints to HDC has increased by 33%.

This increase must be interpreted with caution. HDC has no evidence to suggest that the increase in complaints relates to a decrease in the quality of services, by providers generally, or by DHBs in particular.

The growth in complaint numbers is more likely to be due to the increasing profile of HDC, the improved accessibility of complaints processes due to advancing technology, and an increasing public knowledge of consumer rights. It may also reflect an increased willingness among consumers to complain about services received.

HDC's increasing complaint load is not unique, but is consistent with a trend being observed in complaints agencies both around New Zealand and internationally. For example, in 2014/15 complaints to both the New South Wales Health Care Complaint Commission and the Office of the Health Services Commissioner in Victoria rose by around 10%.

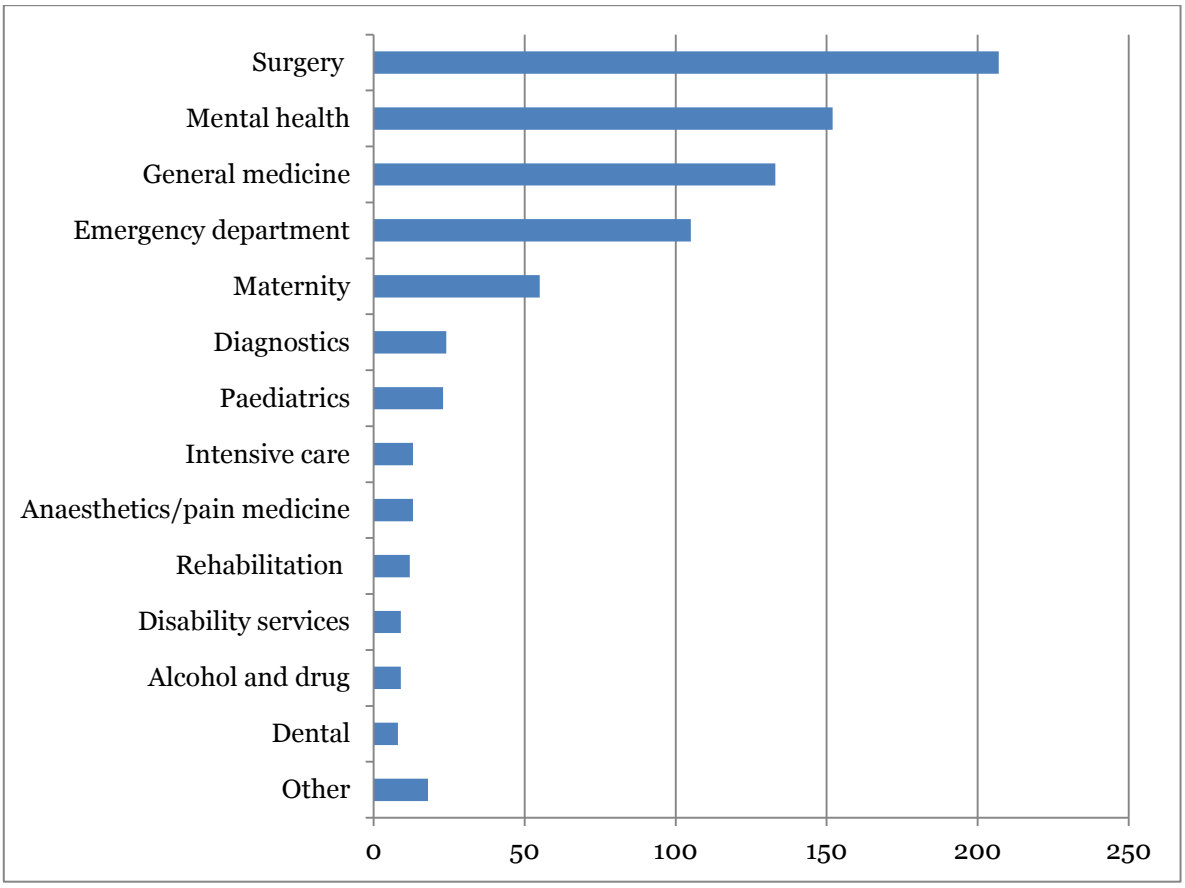
2. Which DHB services were complained about?

2.1 DHB service types complained about

DHBs operate a number of different services, both within hospitals and outside of hospitals, in clinics and in the community.

Complaints received by HDC in the 2014/15 year were spread across many of those service types, as shown in Figure 3 below, with the greatest proportion of complaints being about surgical services (27%), followed by mental health (19%), general medicine (17%), emergency departments (13%) and maternity services (7%).

Figure 3. DHB service types complained about



A more nuanced picture of service types complained about, including individual surgical and general medicine service categories, is provided in Table 1. Service types responsible for less than 1% of all complaints concerning DHBs are grouped together and classified as "other".

It should be noted that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 757 complaints about DHBs, 781 services have been complained about.

Table 1. DHB service types complained about

Service type	Number of services (%)
Alcohol and drug	**9(1)**
Anaesthetics/pain medicine	**13(2)**
Dental	**8(1)**
Diagnostics	**24(3)**
Disability services	**9(1)**
Emergency department (including paramedics)	**105 (13)**
General medicine	**133(17)**
Cardiology	10(1)
Gastroenterology	9(1)
Geriatric medicine	14(2)
Infectious diseases	4(0.5)
Neurology	18(2)
Oncology	21(3)
Palliative care	4(0.5)
Renal/nephrology	6(0.8)
Respiratory	8(1)
Rheumatology	5(0.6)
Other/unspecified	34(4)
Intensive care/critical care	**13(2)**
Maternity	**55(7)**
Mental health	**152(19)**
Paediatrics (not surgical)	**23(3)**
Rehabilitation services	**12(2)**
Surgery	**207(27)**
Cardiothoracic	7(0.9)
General	43(6)
Gynaecology	30(4)
Neurosurgery	6(0.8)
Ophthalmology	5(0.6)
Orthopaedics	66(8)
Otolaryngology	9(1)
Paediatric	5(0.6)
Plastic and reconstructive	4(0.5)
Urology	25(3)
Unknown/other	7(0.9)
Other health service	**18(2)**
TOTAL	**781**

Table 2 below, shows a yearly comparison of the proportion of complaints received for the most commonly complained about service types in 2014/15. As can be seen from this table, the most common service types complained about over the last two years have remained consistent. Therefore, although complaints about DHB services have increased overall in 2014/15, no one service seems to be responsible for this increase.

Table 2. Yearly comparison of the proportion of complaints received about the most commonly complained about service types in 2014/15

Service type	2014/15	2013/14
Surgery	**27%**	**26%**
Mental health	**19%**	**19%**
General medicine	**17%**	**19%**
Emergency department	**13%**	**13%**
Maternity	**7%**	**6%**
Surgery	**27%**	**26%**

Case study
Complaint about a general medicine service

A complaint was made to HDC regarding the care of a man in hospital. The man passed away in hospital, a day after his admission, from a heart attack.

The DHB advised HDC that it had undertaken a Serious Adverse Event Review (SAER) of the care provided to the man. Findings from the SAER indicated that there was a systemic failure both to detect and respond to the man's deterioration. These failures included: non appreciation of the significance of acute renal failure; a failure to record vital signs, calculate the Early Warning Score and initiate medical review as per protocol; a lack of documentation of urine output; and failure to complete the required care planning documentation.

The SAER made a number of recommendations arising from the failures identified in the man's care, including: undertaking revisions of the Early Warning Score Protocol, the care plan policy, the recognition and treatment of deteriorating and acute conditions course, and the use of fluid balance charts; and ensuring that night staff receive the same education updates as day staff. The DHB advised HDC that these recommendations had either been actioned or were in the process of being actioned, and that regular auditing of the use of the Early Warning Score within the Ward showed improved compliance by staff.

HDC's expert nursing advisor confirmed that the nursing care provided to the man was substandard in relation to assessment and monitoring, agreeing with the DHB that the delivery of timely medical intervention to the man was compromised by the lack of comprehensive assessment by the nurses involved. HDC's nursing advisor further advised that the DHB's SAER was very thorough and comprehensive, and that the recommendations and actions undertaken by the DHB in relation to this event were appropriate.

The Deputy Commissioner considered that the recommendations and actions taken by the DHB appropriately addressed the issues raised in this complaint, and so decided to take no further action on this complaint. However, the Deputy Commissioner asked the DHB to keep HDC updated on its progress in implementing the recommendations from the SAER, including that the DHB provide HDC with:

- a written copy of the DHB's apology to the man's family;
- a copy of the results of its most recent audit, and those taken every 6 months from then on, to ensure compliance with, and changes to, the Early Warning Score system;
- a copy of the results of its most recent audit of the care planning policy changes;

- a copy of the outcome of the review of the recognition and treatment of deteriorating and acute conditions course;
- an update on the education plan regarding the shift in the use of Fluid Balance Charts; and
- details of any action taken with staff involved in this event, including information regarding the performance reviews and additional training provided.

These recommendations have been met by the DHB.

2.2 Professions of individual providers complained about

When people complain about services provided to them, they often complain about particular individuals involved in the provision of those services. The professions of the individual providers identified in complaints about DHB services are shown in Table 3 below.

Table 3. Professions of individual providers complained about in DHB complaints

Occupation	Number of individuals (%)
Doctors	***227(78)***
Anaesthetist	5(2)
Emergency medicine specialist	10(3)
General surgeon	15(5)
House officer	5(2)
Internal medicine specialist	35(12)
Medical officer	4(1)
Neurosurgeon	3(1)
Obstetrician/gynaecologist	22(8)
Orthopaedic surgeon	23(8)
Otolaryngologist	3(1)
Paediatrician	7(2)
Plastic and reconstructive surgeon	3(1)
Psychiatrist	43(15)
Radiologist	6(2)
Registrar	19(7)
Urgent care specialist	4(1)
Urologist	9(3)
Other	11(4)
Other health providers	***65(22)***
Midwife	18(6)
Nurse	32(11)
Psychologist	3(1)
Social worker	3(1)
Other	9
TOTAL	**292**

Over three quarters of the individual providers identified in DHB complaints received in the 2014/15 year were doctors. Nurses and midwives were identified in 11% and 6% of complaints respectively. It is likely that doctors are more often seen by complainants as being responsible for the services provided and the outcomes of those services and are, therefore, more frequently viewed as individually responsible for any perceived shortcomings.

The most commonly identified individual provider occupations were psychiatrists (15%) and internal medicine specialists (12%). This is reflective of the fact that mental health and general medicine were two of the most commonly complained about service types.

A yearly comparison of the proportion of complaints received for the most commonly complained about individual providers in 2014/15 is displayed below in Table 4.

Table 4. Yearly comparison of the proportion of complaints received about the most commonly complained about individual providers in 2014/15

Occupation	2014/15	2013/14
Psychiatrist	**15%**	**9%**
Internal medicine specialist	**12%**	**12%**
Nurse	**11%**	**12%**
Obstetrician/gynaecologist	**8%**	**8%**
Orthopaedic surgeon	**8%**	**7%**

As can be seen from Table 4 above, the most common individual providers identified on DHB complaints has remained broadly consistent over the last two years. However, complaints about general surgeons in DHB complaints decreased in 2014/15 (from 12% to 5%), while complaints about psychiatrists increased (from 9% to 15%).

Case Study
Complaint about a psychiatrist working at a DHB

A man complained to HDC regarding the care provided to him by a psychiatrist working at a DHB. The man advised HDC that he felt that the psychiatrist had not listened to him and that the psychiatrist had made insensitive comments to him during consultations. The man also stated that he disagreed with parts of the psychiatrist's assessment of him.

The psychiatrist told HDC that he had not meant to offend the man and that the man may have misinterpreted what he said. The DHB advised HDC that they were happy to make any corrections to the assessments made that the man did not agree with.

The Deputy Commissioner decided to take no further action on this complaint, but did remind the psychiatrist of the importance of clear and effective communication and suggested that he reflect on the way in which he communicates with patients in the future.

3. What did people complain about?

3.1 Issues identified in complaints

Many complaints to HDC contain multiple issues of concern to the complainant. For the purposes of analysis, we identified the primary issue being complained about plus up to five additional complaint issues for each complaint received.

As shown in Table 5, we grouped the complaint issues into several categories. Among these categories, issues relating to care/treatment, communication, and access/funding were the most prevalent, appearing as the primary complaint category in 57%, 11% and 10% of complaints respectively. When separate complaint issues are considered, missed/incorrect/delayed diagnosis (17%), inadequate/inappropriate treatment (11%) and unexpected treatment outcome (6%) emerge as the most common primary complaint issues. This is broadly similar to what was seen last year, with the exception of access/funding issues which increased from being the primary complaint category for 7% of complaints in 2013/14 to 10% in 2014/15.

Case study
Missed/incorrect/delayed diagnosis

HDC received a complaint regarding the care a man received at a DHB, including the missed diagnosis of the man's spinal abscess and aortic abdominal aneurysm (AAA).

The DHB acknowledged that there were some shortcomings in the care they provided to the man. The DHB advised HDC that the man's various non-specific symptoms and findings confused the clinical picture and distracted from the incidental finding of an AAA.

HDC's clinical expert advisor advised that the DHB did not do enough to investigate the man's symptoms. The expert advisor stated that the clinicians involved in the man's care should have continued to explore differential diagnoses and then excluded these diagnoses through further investigation, rather than adopting the more narrow focus that they did. The expert was also critical of the standard of the clinicians' clinical documentation, saying that this poor standard of documentation made it challenging to understand the clinicians' diagnostic reasoning.

The Deputy Commissioner considered that there were important lessons for all clinicians to learn from the deficiencies identified in the case, and so she asked that the DHB ensure that the medical team present the complaint as an anonymised case study. It was recommended that this case study incorporate HDC's clinical expert's advice and comment on the standard of the clinical documentation and how this hampered clinical reasoning. The DHB subsequently met this recommendation.

On analysis of all issues identified in complaints about DHBs, the most common complaint issues were: inadequate/inappropriate treatment (40%), failure to communicate effectively with the consumer (34%), inadequate/inappropriate examination/assessment (27%), inadequate response to consumer's complaint by the DHB (24%), missed/incorrect/delayed diagnosis (24%), disrespectful manner/attitude (24%), and failure to communicate effectively with family (22%). Many complaints involved issues categorised as care/treatment, such as inadequate coordination of care/treatment, unexpected treatment outcome, inadequate/inappropriate testing, delay in treatment, inadequate/inappropriate follow-up and inappropriate/delayed discharge/transfer; each of these were mentioned in between 13% and 19% of complaints.

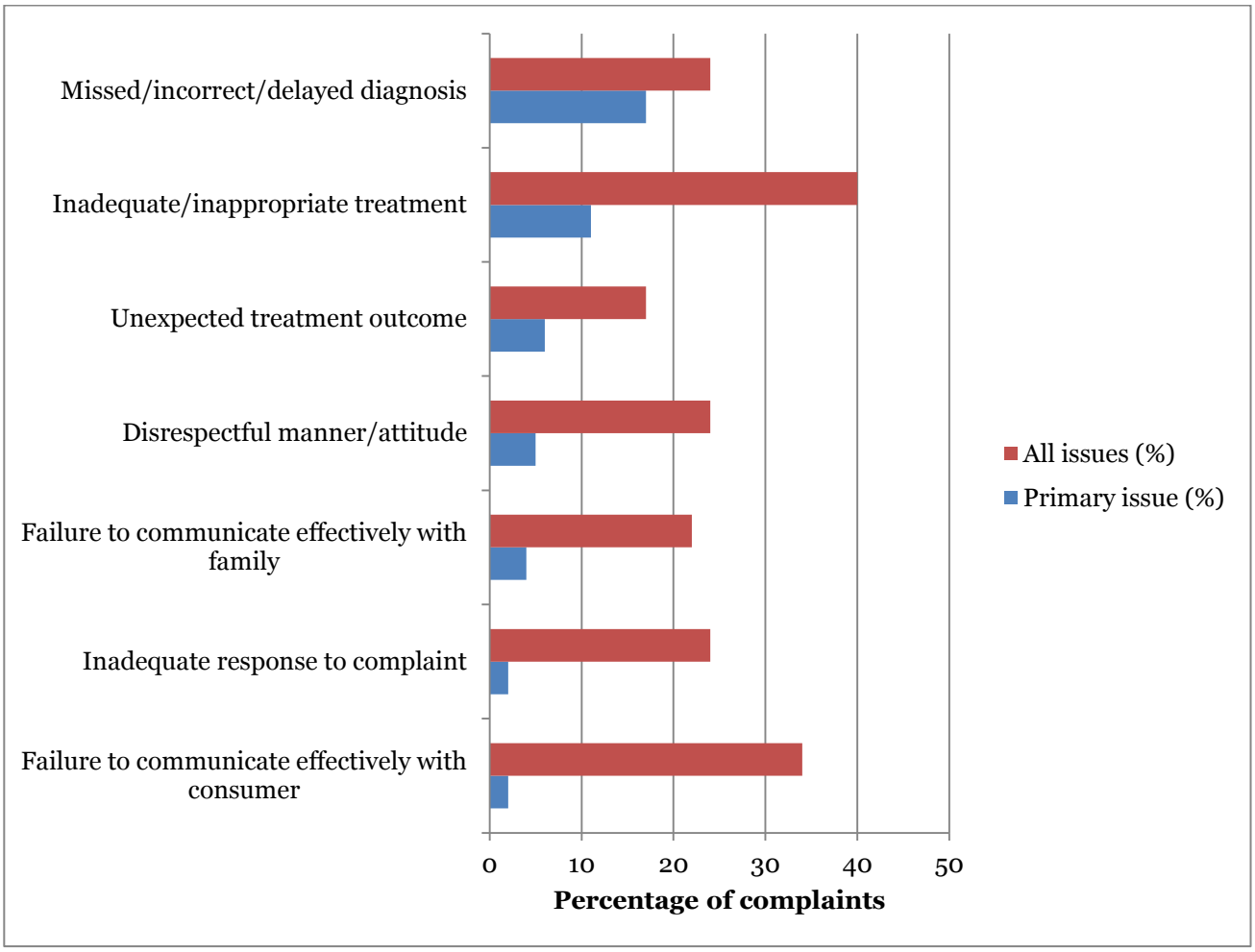
Table 5. Issues complained about in DHB complaints

Complaint issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Access/Funding	***73(10)***	
ACC compensation issue	1(0.1)	17(2)
Lack of access to services	32(4)	68(9)
Lack of access to subsidies/funding	6(0.8)	13(2)
Waiting list/prioritisation issue	34(4)	53(7)
Boundary violation	***2(0.3)***	
Inappropriate sexual communication	2(0.3)	4(0.5)
Inappropriate sexual physical contact	0	1(0.1)
Care/Treatment	***428(57)***	
Delay in treatment	13(2)	105(14)
Delayed/inadequate/inappropriate referral	9(1)	81(11)
Inadequate coordination of care or treatment	9(1)	143(19)
Inadequate/inappropriate clinical treatment	86(11)	300(40)
Inadequate/inappropriate examination/assessment	25(3)	202(27)
Inadequate/inappropriate follow-up	15(2)	102(13)
Inadequate/inappropriate monitoring	11(1)	62(8)
Inadequate/inappropriate non-clinical care	16(2)	71(9)
Inadequate/inappropriate testing	2(0.3)	114(15)
Inappropriate admission/failure to admit	3(0.4)	17(2)
Inappropriate/delayed discharge/transfer	25(3)	100(13)
Inappropriate withdrawal of treatment	10(1)	24(3)
Missed/incorrect/delayed diagnosis	130(17)	179(24)
Personal privacy not respected	1(0.1)	13(2)
Refusal to assist/attend	2(0.3)	33(4)
Refusal to treat	7(0.9)	29(4)
Rough/painful care or treatment	12(2)	45(6)
Unexpected treatment outcome	49(6)	125(17)
Unnecessary treatment/over-servicing	3(0.4)	9(1)
Communication	***86(11)***	
Disrespectful manner/attitude	36(5)	178(24)
Failure to accommodate cultural/language needs	3(0.4)	13(2)
Failure to communicate openly/honestly/effectively with consumer	16(2)	257(34)
Failure to communicate openly/honestly/effectively with family	28(4)	169(22)
Insensitive/inappropriate comments (not sexual)	3(0.4)	42(6)
Complaints process	***12(2)***	
Inadequate information provided regarding complaints process	0	3(0.4)
Inadequate response to complaint	12(2)	184(24)
Retaliation/discrimination as a result of a complaint	0	4(0.5)
Consent/Information	***64(8)***	
Coercion by provider to obtain consent	1(0.1)	4(0.5)
Consent not obtained/adequate	22(3)	47(6)
Failure to assess capacity to consent	0	10(1)
Inadequate information provided regarding adverse event	5(0.7)	20(3)
Inadequate information provided regarding condition	2(0.3)	39(5)
Inadequate information provided re fees/costs	2(0.3)	3(0.4)

Complaint issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Inadequate information provided re options	1(0.1)	14(2)
Inadequate information regarding results	4(0.5)	31(4)
Inadequate information provided regarding treatment	3(0.4)	54(7)
Incorrect/misleading information provided	2(0.3)	44(6)
Issues regarding consent when consumer not competent	3(0.4)	10(1)
Issues with involuntary admission/treatment	19(3)	24(3)
Documentation	***17(2)***	
Delay/failure to disclose documentation	3(0.4)	13(2)
Delay/failure to transfer documentation	0	8(1)
Inadequate/inaccurate documentation	11(1)	84(11)
Inappropriate maintenance/disposal of documentation	3(0.4)	8(1)
Facility issues	***18(2)***	
Accreditation standards/statutory obligations not met	0	2(0.3)
Cleanliness/hygiene issue	1(0.1)	10(1)
Failure to follow policies/procedures	0	19(3)
General safety issue for consumer in facility	6(0.8)	17(2)
Inadequate/inappropriate policies/procedures	1(0.1)	31(4)
Issue with sharing facility with other consumers	0	5(0.7)
Issue with quality of aids/equipment	1(0.1)	12(2)
Staffing/rostering/other HR issue	3(0.4)	27(4)
Waiting times	5(0.7)	21(3)
Other	1(0.1)	2(0.3)
Medication	***26(3)***	
Administration error	2(0.3)	9(1)
Inappropriate administration	1(0.1)	8(1)
Inappropriate prescribing	14(2)	57(8)
Inappropriate storage/security	1(0.1)	2(0.3)
Prescribing error	4(0.5)	8(1)
Refusal to prescribe/dispense/supply	4(0.5)	21(3)
Reports/Certificates	***7(0.9)***	
Inaccurate report/certificate	7(0.9)	24(3)
Refusal to complete report/certificate	0	6(0.8)
Training/supervision	***0***	
Delayed/inadequate/inappropriate handover	0	4(0.5)
Inadequate supervision/oversight	0	13(2)
Other professional conduct issues	***12(2)***	
Assault	1(0.1)	3(0.4)
Failure to disclose/properly manage a conflict of interest	1(0.1)	5(0.7)
Inappropriate collection/use/disclosure of information	6(0.8)	23(3)
Threatening/bullying/harassing behaviour	4(0.4)	10(1)
Other	0	7(0.9)
Disability-specific issues	***6(0.8)***	***15***
Other issues	***6(0.8)***	***27***
TOTAL	***757***	

Figure 4 details the seven most common complaint issues raised in complaints about DHBs received in the 2014/15 year. The blue bars show the percentage of cases in which the particular complaint issue was identified as the primary complaint issue, while the red bars show the percentage of cases in which the particular complaint issue was raised at all. As can be seen from the large difference in the size of the blue and red bars, communication-related complaint issues (disrespectful manner/attitude, and failure to communicate effectively with family or consumer) and inadequate response to complaint are present in a significant number of complaints, but are not often the primary issue raised.

Figure 4. Most common primary and all issues in complaints received



Case study

Inadequate response to complaint

A woman wrote to a DHB complaining about the time it was taking to process her referral, but her complaint was not acknowledged or acted on by the DHB. The woman then contacted the DHB's complaints centre with her concerns that she had not received a response to her complaint. In reply, the DHB wrote to the woman acknowledging the receipt of her complaint and advising her how to make a complaint. The woman then complained to HDC that her concerns had not been addressed by the DHB.

The DHB advised HDC that the woman's original complaint could not be located and as such, the DHB was unable to identify whether it had received this complaint. The DHB provided a response to the woman's second complaint over three months after receiving it. In its response the DHB apologised for the delay in responding to the woman's complaint, noting it was well outside its timeframes. The DHB told HDC that the delay in responding to the woman's second complaint could partly be explained by the need for two services to provide the woman with a response.

The Deputy Commissioner was critical that it had taken over three months for the DHB to respond to the woman's complaint, saying that the delay would have left the woman feeling unheard and had exacerbated her concerns about the management of her referral. The Deputy Commissioner wrote to the DHB to remind them of their obligations under Right 10 of the Code to keep consumers informed while their concerns are assessed. The Deputy Commissioner also suggested to the DHB that, in light of the problems coordinating the response to the woman's complaint between two services, it may be appropriate for it to consider formalising and documenting decisions of this nature when responding to complaints.

Table 6 details a yearly comparison of the most common issues raised in 2014/2015. Common complaint issues have remained broadly consistent over the last two years. However, inadequate/inappropriate examination/assessment has shown a large increase from 14% in 2013/14 to 27% in 2014/15. Failure to communicate effectively with consumer and inadequate response to complaint have also shown increases in 2014/15.

Table 6. Yearly comparison of the most common issues complained about in DHB complaints in 2014/15

Complaint issue	2014/15	2013/14
Inadequate/inappropriate treatment	**40%**	**37%**
Failure to communicate effectively with consumer	**34%**	**21%**
Inadequate/inappropriate examination/assessment	**27%**	**14%**
Inadequate response to complaint	**27%**	**20%**
Missed/incorrect/delayed diagnosis	**24%**	**27%**
Disrespectful manner/attitude	**24%**	**20%**

It is important to note that Table 5 and 6 and Figure 4 are analyses of the issues raised by complainants in their complaints, rather than analyses of HDC's assessment of the issues raised. Inevitably, some of the complaint issues raised will have been found, on subsequent assessment, not to have been substantiated.

Case study

Inadequate/inappropriate examination/assessment

HDC received a complaint about the care provided to an elderly woman by a number of providers, including a DHB, following a number of falls that took place over two months. The complainant was concerned that the woman's care was marked by a lack of adequate assessment and follow-up. In respect of the DHB, the complainant was particularly concerned about the lack of adequate cognitive assessments of the woman.

The DHB apologised to the woman and her family for the delays in completing a cognitive assessment. The DHB advised HDC that, after receiving the complaint, the DHB had undertaken an investigation and identified a number of areas that required improvement. While the DHB had carried out cognitive screening early on in the woman's care, the results were not acted on. The DHB also identified a number of missed opportunities where a comprehensive clinical assessment (InterRAI) could have been completed for the woman, but was not. The DHB made a number of changes as a result of the complaint, including: ensuring that staff were aware that when a patient scored below normal on a cognitive assessment, it is the responsibility of the staff member that undertook that assessment to discuss the results with the multi-disciplinary team; and reminding all staff that InterRAI assessments can be completed at any time, and are not dependent on the specific events taking place.

HDC's clinical expert advisor agreed with the DHB regarding the deficiencies they identified in their current assessment process, but considered that the DHB had taken appropriate remedial measures in response to these deficiencies.

The Deputy Commissioner considered the DHB's management of the woman's cognitive assessments to be a mild departure from expected standards. The Deputy Commissioner was concerned that as a result of the DHB's delay in undertaking a cognitive assessment, there was also considerable doubt as to whether the woman had the capacity to make decisions regarding her own welfare. The Deputy Commissioner acknowledged the areas for improvement identified by the DHB and asked the DHB to report back to HDC on the progress it had made with implementing those improvements, which the DHB has subsequently done.

3.2 Complaint issues by service type

Issues raised in complaints vary, at least to some degree, according to the DHB service type concerned. As shown in Table 7 below, diagnostic issues were most prevalent in complaints about services with high diagnostic workloads, with 38% of emergency department complaints and 23% of general medicine complaints being primarily about a missed/incorrect/delayed diagnosis.

This is broadly similar to what was seen last year, with the exception of surgical services for which access/funding issues became more prominent in 2014/15, with 13% of surgical complaints being primarily about a waiting list/prioritisation issue.

Primary issues in complaints about mental health services were quite distinct, with issues relating to involuntary admission/treatment being a prevalent primary issue, and failure to communicate effectively with family being the primary issue in 10% of complaints.

Table 7. Three most common primary issues in complaints by service type

Surgery n=207		Mental health n=152		General medicine n=133		Accident & emergency n=105		Maternity n=55	
Missed/ incorrect/ delayed diagnosis	14%	Inadequate/ inappropriate treatment	14%	Missed/ incorrect/ delayed diagnosis	23%	Missed/ incorrect/ delayed diagnosis	38%	Inadequate/ inappropriate treatment	24%
Waiting list/ prioritisation issue	13%	Issues with involuntary admission/ treatment	12%	Inadequate/ inappropriate treatment	8%	Inadequate/ inappropriate treatment	12%	Missed/ incorrect/ delayed diagnosis	16%
Unexpected treatment outcome	13%	Failure to communicate effectively with family	10%	Inadequate/ inappropriate care	8%	Disrespectful manner/ attitude	10%	Unexpected treatment outcome	15%

Case study

Surgical services and access/funding issues

A woman complained to HDC regarding the cancellation of her operation on the day of surgery.

The DHB advised HDC that the surgery had not gone ahead because the urologist was concerned that it would not reduce the woman's medical issues. The DHB noted that, in most circumstances, a pre-surgical appointment would be arranged for the day prior to any surgery, so that the nature and risks of the surgery could be discussed with the patient. However, in this case, no such appointment was scheduled. This meant that the urologist did not have an opportunity to discuss his concerns about the surgery with the woman.

The DHB noted that they had since written to the woman to apologise for any distress caused to her by the cancellation of her surgery. The woman subsequently expressed satisfaction with the urologist's decision not to proceed with the surgery.

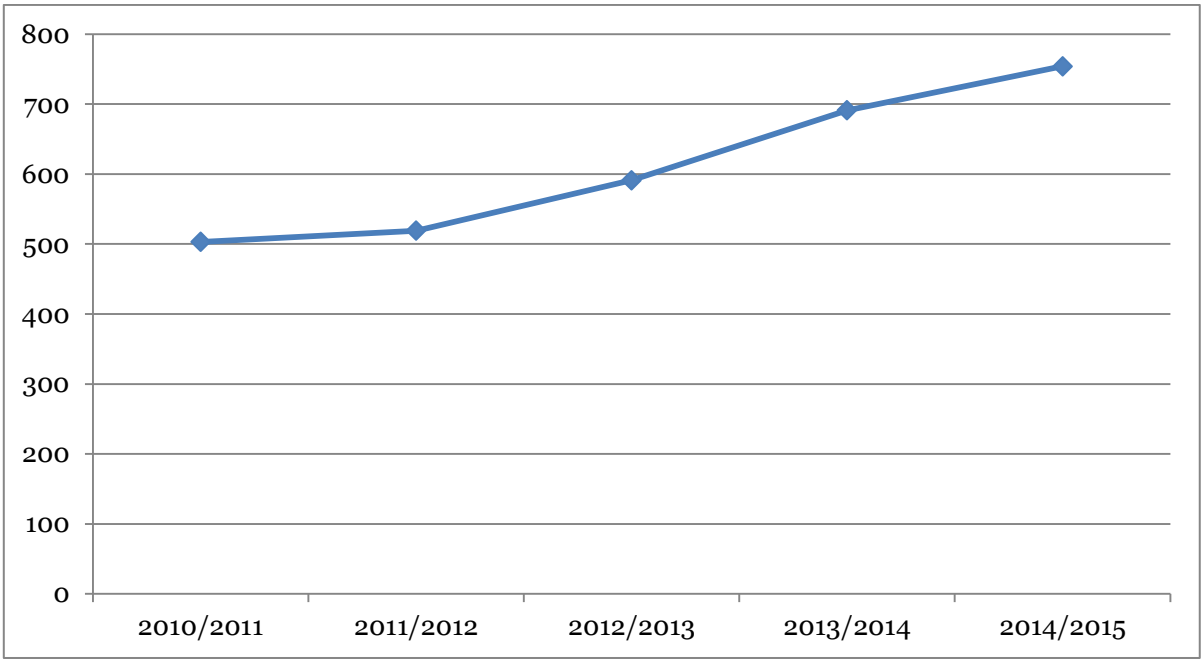
The Deputy Commissioner noted that surgery often entails emotional and physical preparation, and that the sudden cancellation of an operation can be very distressing on both levels. However, the Deputy Commissioner considered that the urologist's decision to delay the woman's surgery, pending further examination, was appropriate in the circumstances. The Deputy Commissioner decided to take no further action on this complaint, but asked the DHB to reflect on the fact that the sudden and unexpected change in plans had caught the woman off guard and left her feeling quite distressed, and to consider how the situation could have been handled differently. The Deputy Commissioner also asked the urologist to reflect on the woman's experience of the care he provided to her.

COMPLAINTS CLOSED

1. How many complaints were closed?

HDC closed **754** complaints involving DHBs in the 2014/15 year. This was an increase of 9% on the 691 complaints closed in 2013/14 and 100 more than was closed in 2012/13. As with complaints received, the number of complaints closed has been steadily increasing year on year for the last five financial years (see Figure 5 below).

Figure 5. Number of complaints closed in last five financial years



It should be noted that complaints may be received in one financial year and closed in the following financial year. This means that the number of complaints received will not correlate with the number of complaints closed.

2. What were the outcomes of the complaints closed?

2.1 Available resolution options

HDC has a number of options available for the resolution of complaints. These include referring the complaint to the Advocacy Service, to a professional body, or to another agency.

Case study
Referral to Advocacy Service

A woman complained to HDC about a venipuncture conducted by a nurse in a public hospital, which resulted in her suffering a nerve injury. The woman said that she had raised her concerns with the DHB, however she was not happy with their response.

HDC provided the woman with information on the Advocacy Service and asked whether she would be happy to work with an advocate. The woman indicated that she would like to work with an advocate, and so HDC referred her complaint to the Advocacy Service.

An advocate assisted the woman to write a detailed letter to the DHB raising her specific issues with the care provided to her and the DHB's response to her previous complaint. The DHB wrote to the woman offering an apology and detailing the changes that had been made as a result of her complaint. The woman told the advocate that she was happy with the DHB's response, saying that it was an improvement on their previous response because it provided a direct apology and outlined the education nursing staff would undertake to prevent a recurrence of the event.

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. 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.

Case study
Referral to DHB

A woman complained to HDC regarding the standard and coordination of care provided by a DHB in relation to her spinal injury. In particular, the woman was concerned that she had not been provided with a definitive diagnosis nor appropriate pain management, and that there had been delays in the provision of treatment.

The Deputy Commissioner referred the woman's complaint back to the DHB concerned, as she considered that the DHB was best placed to address the woman's concerns. The Deputy Commissioner asked the DHB to arrange a meeting with the woman to discuss her concerns.

The DHB advised HDC that a meeting had taken place between the woman and the DHB. At that meeting the DHB had explained the risks associated with the orthopaedic surgery proposed for the woman, and described how the surgery would proceed should it go ahead. At her request, the DHB referred the woman to orthopaedic services and pain management services for ongoing management. The woman reported that she was pleased with this outcome. The DHB advised the woman that the lines of communication would remain open to her, and gave her a specified contact person within the DHB as her first point of contact going forward.

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, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of formal investigation, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. This may happen, for example, where a DHB has carefully reviewed the case itself and no further value would be added by HDC investigating, or where another agency is reviewing, or has carefully reviewed the matter (for example, the Coroner, the Director-General of Health, or the District Inspector).

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. Often a decision to take no further action will be accompanied by an educational comment or recommendations designed to assist the provider in improving future services.

Case studies
No further action taken

Informed consent for a lumbar puncture

A woman made a complaint to HDC raising concerns about a lumbar puncture having been performed on her child without sedation. The woman considered that she had not provided consent for this procedure to be performed without sedation, stating that she had been informed by doctors that her child would be sedated.

The DHB advised HDC that sedation during a lumbar puncture is not standard practice for children and that the use of sedation would have confused the child's clinical picture. The DHB acknowledged that, although the procedure was reviewed with the woman, it did not clearly communicate to her that sedation is not routine and that the decision to sedate is made on a case by case basis. While the woman did consent to the procedure, the DHB appreciated that the options may not have been clearly presented in what was a stressful situation. The DHB further advised that it expected its staff to ensure that patients and families provide their full informed consent before any treatment is provided. To assist with this, the DHB was trialling a new sticker system to improve the process of procedure and consent documentation.

The Deputy Commissioner accepted that consent was given for the lumbar puncture to proceed, but she considered the DHB's failure to explain to the woman why sedation was not clinically indicated to be suboptimal. However, the Deputy Commissioner was satisfied with the steps the DHB had taken as a result of the complaint, and so decided to take no further action on the complaint. The Deputy Commissioner asked the DHB to provide HDC with a copy of their audit of the new sticker system that had been implemented at the DHB. This information was subsequently provided to HDC by the DHB.

Case studies
No further action taken

Care provided to a woman in labour

A complaint was made to HDC regarding a delay in proceeding to a Caesarean section during a woman's labour in a public hospital. The complainant was also concerned about inaccuracies in the clinical documentation of the woman's care, a lack of recorded observations during and after the labour, and the failure of midwives to recognise the woman's deteriorating condition.

The DHB's response and the clinical record confirmed that the care provided by the DHB was generally consistent with expected standards. There had been an appropriate response to the baby's slowed heartbeat and there was nothing in the woman's presentation that indicated a Caesarean section should have been considered earlier. The DHB did identify that there were some deficiencies in their documentation. The DHB also noted that, as part of their ongoing education process, education would be provided to staff regarding the deteriorating maternity patient.

Given the fact that the care provided by the DHB was of a generally reasonable standard, the Deputy Commissioner decided to take no further action on the complaint. However, the Deputy Commissioner took the opportunity to remind the DHB of the importance of maintaining a high standard of clinical documentation at all times and ensuring that a patient's clinical records are accurate and complete. The Deputy Commissioner also asked the DHB to provide HDC with evidence of the remedial actions that it had taken to ensure that such an incident did not occur again, and evidence that education regarding a deteriorating maternity patient had been undertaken. This information was subsequently provided by the DHB.

Where appropriate, the Commissioner may formally investigate a complaint. Once HDC has notified the parties that a complaint is to be investigated, the complaint is classified by HDC as a formal investigation, even though an alternative manner of resolution may subsequently be adopted. Notification of formal investigation generally indicates more serious or complex issues.

In appropriate cases, the Commissioner may decide to refer a provider who has been found in breach of the Code to the Director of Proceedings. The Director of Proceedings then makes an independent decision about whether to bring proceedings against the provider in either the Health Practitioners Disciplinary Tribunal (if the provider is an individual health practitioner) or in the Human Rights Review Tribunal. Referral to the Director of Proceedings only occurs in the most serious of cases, and referral of a DHB is relatively uncommon.

Case studies
DHB found in breach of the Code

Supervision of a registrar during a labour and delivery

A woman went into labour at 40 weeks plus 9 days' gestation. Cardiotocography monitoring showed deep fetal heart rate declarations and the obstetrics registrar was called to review the woman. The registrar, who at the time of these events had only been working at the DHB for two weeks, reviewed the woman and immediately called the on-call obstetrics consultant. The doctors have different recollections of the telephone conversation, but both recall that the plan was to attempt a trial by forceps and, if unsuccessful, to proceed to a Caesarean section. The registrar understood that she was to carry out the procedures unsupervised, while the consultant understood that he was to attend.

The registrar proceeded with a trial of forceps delivery unsupervised, which was unsuccessful, and she then proceeded with the Caesarean section. While the consultant had arrived in the delivery suite at the time the above procedures were commenced, he was called to assist with another obstetric emergency first.

The registrar was unable to deliver the baby, as the baby's head was impacted in the pelvis. The consultant arrived shortly afterwards, and delivered the baby. The baby was born white and floppy with the umbilical cord wrapped around her neck. The baby was resuscitated and transferred to the Neonatal Intensive Care Unit, but sadly passed away.

The Commissioner found that the DHB breached the woman's rights under the Code because it failed to ensure that its staff were sufficiently supported and its policies followed. In particular, the DHB's policy for triaging obstetric emergencies and its senior medical officer cascade process were not followed and the registrar was not informed of the level of supervision she required.

The obstetrics consultant breached the Code for not appropriately supervising the registrar. The Commissioner noted that consultant oversight and input provides an important safety net, and, as the senior supervising clinician, the obstetrics consultant had a responsibility to ensure that his instructions were communicated clearly and were understood. The Commissioner also expressed concern about the time it took the consultant to arrive at the hospital after being called, and that he did not obtain an update on the woman's condition before attending another obstetric emergency.

The Commissioner was critical of the obstetrics registrar for proceeding with the delivery unsupervised and for not recognising that she was out of her depth. However, the registrar had not been informed of the DHB's credentialing and supervision requirements, and believed that the consultant had instructed her to proceed unsupervised. In addition, the clinical situation was worsening and there was no senior consultant available immediately. In the circumstances, the Commissioner did not find that the registrar breached the Code.

The DHB, registrar and consultant apologised to the woman and her husband. The Commissioner also made a number of recommendations to the DHB to help improve the quality of its services, including that it: review and update its policies to ensure that consultant attending times are outlined clearly and that staff are advised of these requirements; provide an education seminar on the cascade process to all obstetric consultants and associate charge midwives, including examples of when it is to be used; and develop a supervision of obstetric and gynaecology registrars policy, similar to the DHB's policy on 'Credentialing of Senior Medical Officers'. These recommendations have been met by the DHB.

Case studies
DHB found in breach of the Code

Assessment of a mental health patient found on floor

A man with a complex medical history, including bi-polar disorder, was admitted as a voluntary patient to a psychiatric hospital. The man's family were not informed of his transfer from his rest home to the hospital. The following evening, the man asked staff to take him back to his rest home. However, the man was kept at the hospital.

That night, there were two registered nurses (RNs) on duty. At 3.30am one of the RNs found the man on the floor, mostly naked, with his walker frame near the end of the bed. The man did not rouse to voice or gentle touch. The RN observed that he was breathing at a normal rate and rhythm and appeared to be asleep. The RN placed a blanket over the man to keep him warm and to maintain his dignity. Both RNs then observed and assessed the man, including his breathing colour, response, position and comfort. They made the decision to leave him, as it was not unusual to find patients sleeping on the floor in the hospital. The RNs did not consider that the man might have fallen.

The next day, following the morning shift handover, an RN checked on the man and said that he appeared to be asleep on the floor on his back, breathing regularly, that his colour was satisfactory, and there was no cause for concern. At approximately 1pm, the man was lifted into a chair by three RNs.

The RN in charge of the afternoon shift was told at handover that the man was still asleep as a result of over-sedation. The man's observations were taken and he was transferred into bed. He did not show any signs of responding to staff. The RN in charge called the duty house surgeon, who reviewed the man and rang an ambulance to transfer him to the public hospital. A large subdural haematoma was identified, but considered too extensive to treat. Sadly, the man died that evening.

The Deputy Commissioner found that the RNs who first found the man on the floor had breached the Code by failing to assess the man adequately. The Deputy Commissioner also found that an RN on the following morning shift had breached the Code by failing to review the man's notes correctly, failing to assess him adequately, and not responding to concerns raised by her colleagues.

The Deputy Commissioner found the DHB in breach of the Code as its staff failed to communicate with the man's family regarding admission to the psychiatric hospital, and should not have prevented the man from leaving the hospital due to his voluntary status and express wish to return to the rest home. Adverse comment was also made about the DHB's environment, culture, and failure to ensure that staff were familiar with policies and protocols.

The Deputy Commissioner recommended that a number of the RNs undertake further training on topics including: identifying levels of consciousness, identifying the deteriorating patient, and falls management. The Deputy Commissioner also made a number of recommendations to the DHB, including that it: audit the changes it had made since the man's death; provide evidence that all relevant staff at the hospital had been provided with training on patients' legal status, the involvement of family members, handovers, and the DHB's existing policies; consider whether they required a policy requiring that staff concerned about a patient's condition escalate their concerns to a senior clinician; review the on-call arrangements with psychiatrists on the weekends; review electronic patient management systems to ensure that staff have access to required information; audit documentation practices at the psychiatric hospital; and review the handover processes. The majority of these recommendations have been met by the DHB, while others are currently in the process of being implemented.

Case studies
DHB found in breach of the Code

Delayed antibiotics for patient with sepsis

A man, aged in his early 60s, experienced sudden severe back pain several weeks after having back and shoulder surgery. He was assessed in the emergency department (the ED) as having musculoskeletal back pain and he was discharged. The man re-presented four days later with back pain and dizziness. Investigations were undertaken and, following a review that morning, an emergency doctor queried whether the man had sepsis, and formulated a plan to administer the man antibiotics. The emergency doctor then discussed the man's presentation with the orthopaedic team, who asked to review the man before antibiotics were given. There was also a verbal understanding in the ED that antibiotics would be withheld until culture specimens had been obtained.

The man was reviewed that afternoon by an Intensive Care Senior Medical Officer (SMO) and an orthopaedic registrar, and the medical team. The medical team noted that the man was hypoxic and in acute renal failure. An MRI of the man's lumbar spine showed a large inflammatory mass and discitis. Intravenous antibiotics were not commenced until 7:15pm.

At 11:03pm the man was transferred to the orthopaedic ward, but he was transferred to the High Dependence Unit shortly afterwards due to respiratory distress. At 4:30am the man was transferred to the ICU. He developed multiple organ failure and died later that evening.

The Commissioner found that, although the man was promptly identified as having sepsis on his second presentation to ED, he should have received antibiotics soon after admission. There was a lack of clear understanding in the ED regarding when it was appropriate to withhold antibiotics and clinicians were reliant on an unwritten policy that did not provide guidance regarding unstable patients. There were missed opportunities for clinicians to recognise that because the man was unstable, antibiotics should not have been withheld.

The Commissioner also found that the delay in transferring the man to ICU was unacceptable. Although he was reviewed by multiple clinicians during his time in ED, no one individual identified that the seriousness of Mr A's condition required him to be admitted to ICU and advocated for this to occur. No single person had the full picture of the man's condition. The lack of effective communication among and across teams compromised the man's care.

The Commissioner found the DHB in breach of the Code for these failures of its staff. The DHB apologised to the man's family and made a number of changes to its practice to prevent a similar event from occurring. The Commissioner made further recommendations to the DHB including that it: report back to HDC on whether its treatment target for patients with probable severe sepsis had been reached; evaluate the effectiveness of its guidelines on withholding antibiotics for suspected spinal infections; and review the clarity of, and its compliance with, thresholds for undertaking critical event reviews. The majority of these recommendations have been met by the DHB, while others are currently in the process of being implemented.

2.2 Manner of resolution and outcomes in complaints closed

The manner of resolution and outcomes for all DHB complaints closed in the 2014/15 year is shown in Table 8 below. It should be noted that outcomes are displayed in a descending order. If there is more than one outcome for a DHB upon resolution of a complaint, then only the outcome listed highest in the table is included.

Table 8. Outcome for DHBs of complaints closed

Outcome for DHB	Number of complaints
Investigation	***45***
Breach finding	21
No further action with follow-up or educational comment	18
No further action	4
No breach finding	2
Non-investigation	***665***
No further action with follow-up or educational comment	153
Referred to Ministry of Health	1
Referred to District Inspector	10
Referred to DHB	147
Resolved by between parties	2
Referred to Advocacy	34
No further action	301
Withdrawn	17
Outside jurisdiction	***44***
TOTAL	**754**

As can be seen from the table above, in the 2014/15 year, HDC concluded 45 formal investigations involving DHBs, 21 of which resulted in a finding that the DHB had breached the Code. The number of formal investigations concluded in respect of each individual DHB ranged from none to seven investigations. No DHBs were referred to the Director of Proceedings.

3. Recommendations made to DHBs following resolution of complaints

Regardless of whether or not a complaint has been investigated, or whether the DHB has been found in breach of the Code, the Commissioner may make recommendations to a DHB. HDC generally then follows up with the DHB to ensure that these recommendations have been acted on. Many such recommendations are described in the case studies included throughout this report.

Table 9 shows the recommendations made to DHBs in complaints closed in the 2014/15 year. Please note that more than one recommendation may be made in relation to a single complaint.

Table 9. Recommendations made to DHBs following a complaint

Type of recommendation	Number of recommendations made
Apology	48
Audit	62
Meeting with consumer/complainant	6
Presentation/discussion of complaint with others	12
Provision of information to HDC	48
Reflection	12
Review of policies/procedures	87
Training/professional development	48
Total	**323**

As can be seen from Table 9 above, the most common recommendation made to DHBs was that they review their policies/procedures (87 recommendations). Audits were also often recommended (62 recommendations). Audits were most commonly of policies/procedures followed by documentation. Training recommendations most frequently concerned communication, followed by clinical issues and documentation. Apologies were recommended on 48 occasions and feedback from complainants suggests that these were often highly valued.

In the vast majority of cases, recommendations made by HDC are implemented by all providers, including DHBs.

Case studies
Recommendations made by HDC

Recommendations arising from breach relating to inappropriate prescription of narcotic medication

On discharge from a public hospital, a registar provided a man with a prescription for Sevredol, despite the fact that his pain was already well managed and he had renal impairment. The man took the medication as prescribed and was later admitted to hospital and treated for opioid toxicity.

The Commissioner found that the registrar's failure to document a discharge plan and the decision to prescribe Sevredol, and its monitoring requirements, demonstrated a lack of caution that placed the man at unnecessary risk of harm, in breach of the Code. Adverse comment was made about a house officer's failure to critically question the prescription of Sevredol and the failure to complete any discharge documentation. The DHB was found in breach of the Code as, by failing to ensure adequate communication, documentation and coordination of care, the DHB failed to ensure that its staff provided services to the man with reasonable care and skill.

Following a recommendation by the Commissioner, the registrar and DHB provided the man's family with an apology for the shortcomings in the man's care. In accordance with the Commissioner's recommendations the DHB also:

- undertook monthly auditing of discharge summaries to ensure ongoing supervision and monitoring of staff in relation to compliance with its discharge policies;
- reviewed its current policies and procedures with regard to discharges, in particular weekend discharges, especially in relation to communication of discharge plans;
- provided a report to HDC on the outcome of its most recent audit of compliance with the Admission to Discharge plan and other aspects of discharge planning; and
- used the anonymised version of this report for educational purposes, highlighting in particular the concerns raised about culture communication and coordination of care.

Recommendations arising from breach relating to complications following gallbladder removal

A man was transferred to an intensive care unit following surgery for gallbladder removal. During the next 24 hours the man's condition deteriorated and he was treated by a number of doctors. However, the man continued to deteriorate and, sadly, he died the following day.

The risk of surgery was elevated for the man given his co-morbidities. The surgeon was found in breach of the Code for failing to provide the man with adequate information about his treatment options and the risks of surgery that were specific to him and therefore, for failing to obtain the man's informed consent for surgery. The surgeon was also found in breach of the Code for demonstrating a lack of reasonable care and skill in deciding to perform surgery on the man. The surgeon's approach to the man's post-operative condition was also found to be insufficiently cautionary. In addition, the surgeon's documentation fell below professional standards, in breach of the Code.

The Commissioner also found that there was a lack of discernible leadership, coordination and critical thinking in the clinical team who were treating the man post-operatively, and a lack of support offered by senior doctors to junior staff. This amounted to a service level failure by the DHB to provide services with reasonable care and skill, in breach of the Code. The DHB was also found in breach of the Code for failing to ensure that staff met expected standards of documentation.

Following a recommendation by the Commissioner, the surgeon and DHB apologised to the man's family for their breaches of the Code. The Commissioner also recommended that the Medical Council of New Zealand consider whether a review of the surgeon's competence was

warranted. The Commissioner made a number of recommendations to the DHB to improve the quality and safety of its services, including that it:

- review its processes for ensuring that pre-surgical patients are assessed in an appropriate and timely manner prior to surgery, especially in cases where surgery is unexpectedly delayed;
- provide a report to HDC on the actions it intended to take to ensure that all ICU/HDU patients have a senior lead clinician who takes ownership for managing the patient's care at all times;
- conduct an audit of clinical records to ensure that documentation by medical staff is being completed with sufficient detail;
- arrange an independent review of its Enhanced Recovery After Surgery protocol, and the manner in which it is implemented at the DHB;
- review its consent forms in light of the case;
- provide training to staff on the legal requirements of informed consent; and
- provide a report to the man's family on the changes it has made, and intends to make, to improve staff communication with patients and they families.

The majority of these recommendations have been met by the DHB, while others are currently in the process of being implemented.

Recommendations arising from breach relating to care during labour

Despite it being clinically inappropriate in the circumstances, a woman's labour was augmented with Syntocinon. The woman's uterus then became hyperstimulated and there were signs of fetal distress. The woman was transferred to theatre for a Caesarean section. The baby's fetal heart-rate (FHR) was not monitored on arrival to theatre. When FHR monitoring was re-commenced, no fetal heartbeat was present. Sadly, the baby was stillborn.

The Commissioner found the obstetric registrar in breach of the Code for failing to provide the woman with information about the option of performing a Caesarean section and the risks of Syntocinon before it was commenced. The registrar was also found in breach of the Code for not consulting with the on-call consultant before making the decision to commence Syntocinon, for making the decision to commence Syntocinon, and for failing to reassess to women's uterine activity adequately and to ensure monitoring of the FHR in the perioperative area.

The DHB was found in breach of the Code for failing to have a system in place that ensured its policies and procedures were being followed. The Commissioner held that staff failed to think critically, important information was not communicated effectively and that the DHB must accept some responsibility for the registrar's decision making.

In accordance with the Commissioner's recommendations, the registrar provided a written apology to the woman and provided a report to HDC on the changes she had made to her practice with regard to communication in stressful situations. The DHB implemented new policies in response to these events, and in response to the Commissioner recommendations, the DHB:

- carried out an audit of all malpresentation deliveries, assessing compliance with the new policy for consultant involvement;
- carried out an audit of all Caesarean sections performed on women who have been induced and proceed to Caesarean section, or have an emergency or acute Caesarean section, assessing compliance with the new policy for mandatory CTG monitoring in theatre; and
- developed and implemented training for staff communication when a senior person does not appreciate clinical concerns.