

**Complaints to the
Health and Disability
Commissioner
involving
District Health Boards**

1 July 2013 to 30 June 2014



HEALTH & 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

Welcome to HDC's first full year analysis of complaints involving District Health Boards (DHBs). This report is designed to give readers a feel for the types of complaints HDC receives about services run by DHBs, how HDC has resolved those complaints, and the positive changes that have been made to services as a result.

The data and case studies contained in this report will allow DHBs themselves to learn from complaints received about other DHBs, and to better understand how their own complaint patterns compare nationally. Individual providers, such as doctors and nurses, who provide care in public hospitals, clinics, and as part of community-based services, should also find the report useful; as should the bodies responsible for the regulation of such individuals.

It is my hope that members of the general public who read the report will, as a result, be empowered to be stronger partners in their own health care. Such partnership is a key component of my vision to have "consumers at the centre of services". A consumer centred system is built on the concepts of engagement, seamless service, transparency, and a culture that focuses on the consumer. It is about engaging consumers by respecting, informing, involving and listening to them. It is also about doing the basics well: read the notes, ask the questions, and talk with the consumer. It's about a team environment where all clinicians will ask questions and raise concerns.

While this report, by its nature, highlights things that have gone wrong in the delivery of health or disability services, these cases represent only a very small proportion of the services that were delivered by DHBs during the year. In the vast majority of cases, health and disability services are delivered exceptionally well, by committed individuals in the context of well-run organisations.

However there are always things we can improve. Part of the value of complaints is their ability to shine a light on the areas where improvement is most needed. As you will see from this report, positive change and system improvement is a common outcome of complaints to HDC. In some cases, DHBs will have implemented changes before HDC becomes involved. In other cases, the HDC assessment or investigation is what leads to the issues being identified and remedied. In still other cases, HDC makes recommendations for change, which are followed up by feedback from the DHB about what has been done and, in some cases, audit of the effectiveness of such changes.

I trust you will find this report of interest, and the changes made encouraging. To the tens of thousands of you who provide outstanding care around this country every day, and to the hundreds of consumers who have shared your stories with us over the last year, I thank you for your contribution. It is a real privilege to share the journey with you.

Anthony Hill

Health and Disability Commissioner

EXECUTIVE SUMMARY

In the 2013/14 year, HDC received 660 complaints involving DHBs. This was an increase of 7% on the number received in the previous year. The significant year on year increase in complaints about DHB services is consistent with the pattern observed for all complaints to HDC.

The rate of complaints about DHB services is also increasing, with the 2013/14 rate of 72 complaints per 100,000 discharges the highest to date.

Complaints were received in relation to a wide variety of DHB service types, however, a quarter of all complaints concerned surgical services, and almost a fifth were about general medicine and mental health services respectively.

Doctors were the individual providers complained about most commonly within complaints about DHB services, with 75% of all complaints identifying them as responsible for at least some of the issues complained about.

Concern about a missed, incorrect or delayed diagnosis was the primary issue of concern raised by the complainant in 17% of cases. The second most prevalent primary issue of concern was inadequate or inappropriate treatment (14%). When all issues raised in complaints were considered (instead of just the primary issue), we found that concerns about inadequate or inappropriate treatment were the most prevalent (raised in 37% of complaints), and concerns about diagnosis were the second most prevalent (27%). Concerns about communication with the consumer, communication with the family, manner and attitude of the provider, and the adequacy of the DHB's response to the complaint, were all raised in around 20% of complaints. The issues raised in complaints varied by service type involved.

In the 2013/14 year, HDC closed more complaints concerning DHBs than ever before (691 complaints). This included the conclusion of 46 formal investigations. As well as formally investigating, HDC referred a number of complaints back to DHBs for resolution and to other agencies. In closing about a third of cases, HDC recommended some kind of follow up action or made educational comments designed to facilitate improvement in services. In the overwhelming majority of cases, HDC's recommendations are implemented by DHBs, leading to services becoming safer and of higher quality, to the benefit of all involved.

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 2013/14 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. 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

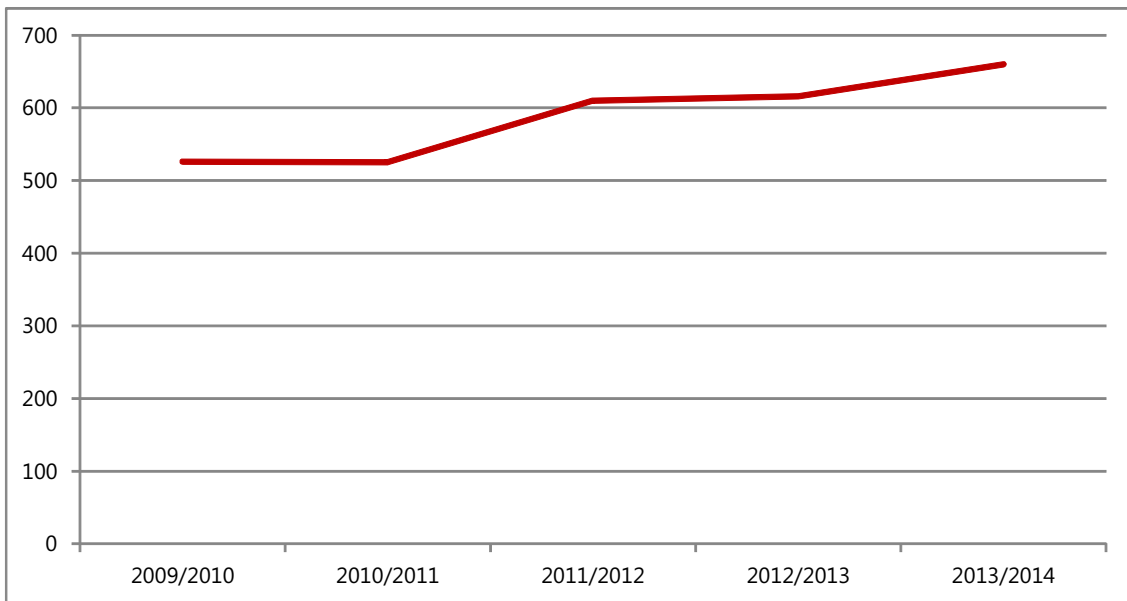
1. How many complaints were received?

1.1 Number of complaints received

In 2013/14, HDC received a total of 660 complaints about care provided by all District Health Boards. This equates to 37% of the total 1,784 complaints received by HDC that year.

The 660 complaints received in the 2013/14 year represents an increase of 7% compared to the 616 complaints received in 2012/13. 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 5 complaints to 99 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.

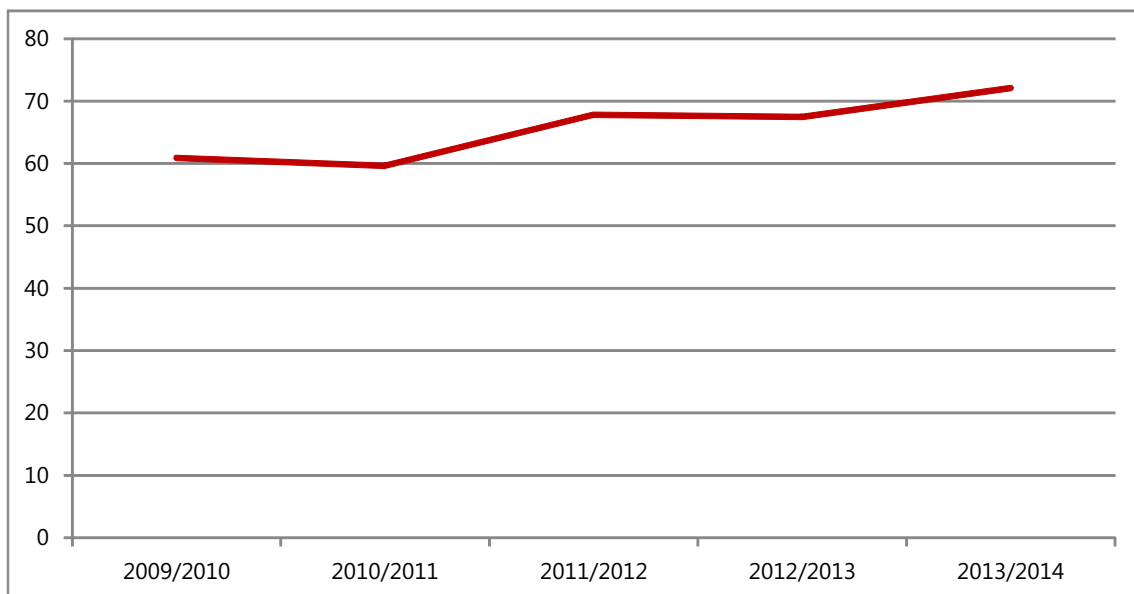
¹ There is a significant positive correlation between year and number of DHB complaints received ($r=0.95$, $p<.05$).

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, and enables any trends to be better observed.

In the 2013/14 year, according to Ministry of Health data,² there were 915,631 discharges nationally. This equates to an overall rate of 72 complaints per 100,000 discharges across DHB services. This compares to an overall rate of 67 complaints per 100,000 discharges during 2012/13; an increase of 7%. 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 32 complaints per 100,000 discharges to 159 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, 15 August 2014.

³ There is a significant positive correlation between year and rate of DHB complaints received ($r=.92$, $p<.05$).

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 27%.

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 knowledge among the public 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.

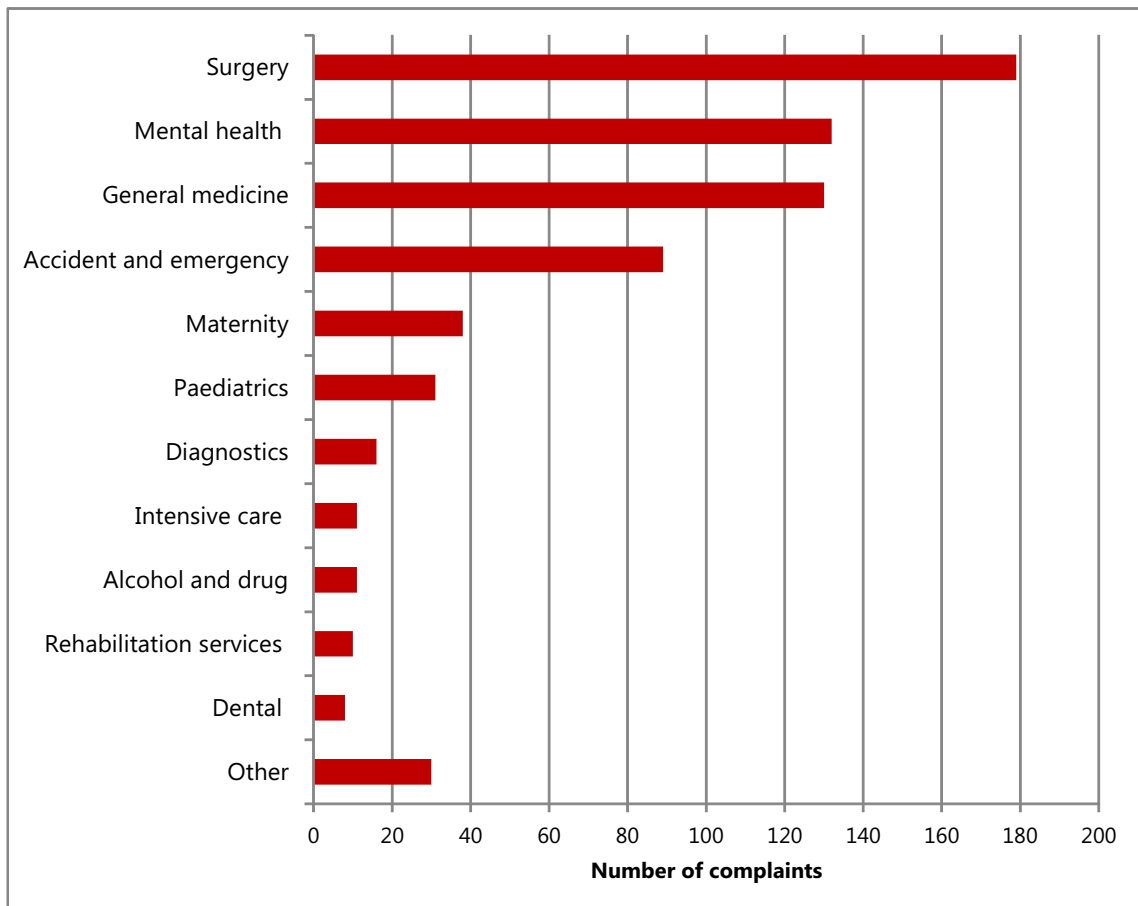
2. Which DHB services were complained about?

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 2013/14 year were spread across many of those service types, as shown in Figure 3 below, with the greatest proportion of complaints being about surgery (26%), followed by mental health (19%), general medicine (19%), accident and emergency (13%) and maternity services (6%).

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".

Table 1. DHB service types complained about

Service type	Number of services (%)
Accident and emergency (including paramedics)	89 (13)
Alcohol and drug	11 (2)
Dental	8 (1)
Diagnostics	16 (2)
General medicine	130 (19)
Cardiology	13 (2)
Gastroenterology	8 (1)
Geriatric medicine	13 (2)
Neurology	13 (2)
Oncology	24 (4)
Respiratory	11 (2)
Other/unspecified	48 (7)
Intensive care/critical care	11 (2)
Maternity	38 (6)
Mental health	132 (19)
Paediatrics (not surgical)	31 (5)
Rehabilitation services	10 (1)
Surgery	179 (26)
Cardiothoracic	12 (2)
General	45 (7)
Gynaecology	21 (3)
Orthopaedics	60 (9)
Otolaryngology	7 (1)
Paediatrics	7 (1)
Urology	13 (2)
Vascular	3 (0.5)
Other	11 (2)
Other health service	30 (4)
TOTAL	685

It should be noted that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 660 complaints about DHBs, 685 services have been complained about.

Case study

Complaint about surgery

A man was admitted to a public hospital for removal of his left kidney and spleen, due to a cancerous growth. The man's pancreas was damaged during surgery, which caused peritonitis and led to pneumonia and cardiac arrest. The man's wife complained to HDC about a number of issues arising from his admission to the public hospital. Her complaint was largely about the lack of information provided about the man's condition, including that they were not informed about the damage to his pancreas until 12 days after surgery. She was also concerned about the length of time it took to treat the pancreatic damage, the manner of nurses involved in the man's care, and the standard of care he received during his recovery.

HDC sought a response to the complaint from the public hospital. As a result, the hospital undertook full, independent nursing and medical reviews into the man's care. While the reviews found that the standard of clinical care was generally appropriate, both reviews identified a significant lack of communication between medical staff and the man. The nursing review recommended that there be improvement to documentation, and that communication and explanations be recorded in patient notes going forward. The medical reviewer noted that he would have expected the man and his wife to have been contacted as soon as it was recognised that there was a pancreatic injury.

The DHB acknowledged that aspects of the care provided were unacceptable, and that their failing to adequately communicate with the man and his wife caused a considerable amount of distress. The DHB decided to draw up an action plan to address the recommendations outlined in both reviews. The DHB also expressed a wish to present the reviews to the couple, apologise directly, and ask for their input into service improvements.

The DHB was asked to provide HDC with a copy of the action plan once it had been drawn up, along with the minutes from any meetings held with the couple.

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 2 below.

Table 2. Professions of individual providers complained about in DHB complaints

Occupation	Number of individuals (%)
Doctors	184(75)
Anaesthetist	3(1)
Cardiothoracic surgeon	3(1)
Emergency medicine specialist	5(2)
General surgeon	30(12)
House officer	3(1)
Internal medicine specialist	30(12)
Medical officer	4(2)
Neurosurgeon	5(2)
Obstetrician/gynaecologist	20(8)
Ophthalmologist	5(2)
Orthopaedic surgeon	18(7)
Paediatric surgeon	3(1)
Paediatrician	8(3)
Psychiatrist	23(9)
Registrar	5(2)
Urgent care specialist	3(1)
Urologist	6(2)
Other	10(4)
Other health providers	59(24)
Midwife	16(7)
Nurse	30(12)
Psychologist	3(1)
Social worker	3(1)
Other	7(3)
Non-health providers	1(0.4)
TOTAL	244

Three quarters of the individual providers identified in DHB complaints received in the 2013/14 year were doctors. Nurses and midwives were identified in 12% and 7% 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.

Case study

Complaint about a nurse working at a DHB

A woman complained about a number of events that occurred during her admission to a public hospital. In particular, she alleged that:

- after she was advised she was to receive an enema, a nurse entered her ward room, abruptly told her to turn over, and roughly inserted the enema, causing pain, and that, despite the woman asking the nurse on a number of occasions to stop, the nurse continued;
- after the procedure the nurse told her to go “clean yourself up”, and did not offer support or help; and
- she overheard the nurse making derogatory comments about her and another patient.

HDC requested a response from the DHB, which acknowledged that shortly after the enema was inserted, the woman requested that the nurse stop. However, the nurse stated that much of the procedure had been completed at that point and so she elected to complete it. The nurse apologised to the woman that her experience of care was negative.

The DHB advised that, in response to the woman's concerns, the nurse would be given additional education regarding communication, with a particular focus on understanding informed consent.

The Deputy Commissioner decided not to formally investigate the complaint, but wrote instead to the Nursing Council and asked it to consider the appropriateness of the nurse's conduct. The Deputy Commissioner also asked the DHB to advise HDC of the steps taken in relation to the comments the woman said she overheard. The DHB advised HDC that all nursing staff had been reminded that no offensive comments would be tolerated at any level.

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 3, we grouped the complaint issues into several categories. Among these categories, issues relating to care/treatment, communication, and consent/information were most prevalent, appearing as the primary complaint category in 57%, 11% and 6% of complaints respectively. When separate complaint issues are considered, inadequate/inappropriate treatment (14%) and missed/incorrect/delayed diagnosis (17%) emerge as the most common primary complaint issues.

Case study

Consent not obtained/inadequate

A woman had a tubal ligation after an emergency Caesarean section. She complained to HDC that she was asked for consent to the tubal ligation when she was on the operating table, and after she had been medicated. She stated that assurances about her baby's health at the time unduly influenced her decision and that her husband had not been present. The woman told HDC that she regrets having had the tubal ligation.

The DHB advised HDC that the woman had been admitted to hospital two days before the Caesarean section and, on her admission, the possibility of a Caesarean section and the option of tubal ligation had been discussed with her. The woman signed two different consent forms; one of which was an agreement to sterilisation, and the other an agreement to Caesarean section and tubal ligation. The consent form documented that various risks associated with the tubal ligation had been discussed with the woman; however, the risk of regret was not discussed. The surgery was carried out by a different team of doctors from those who had initially obtained the woman's consent. Those doctors told HDC they had asked the woman whether she wished to proceed with the surgery but did not recall having had a specific discussion with her regarding the tubal ligation prior to commencing the surgery.

As a result of this complaint, the DHB now requires consent to be readdressed by the operating team before proceeding with tubal ligations, when the operating team is different from the team who obtained consent. The DHB is amending its consent form for sterilisation procedures to allow operating surgeons to annotate the form at the time consent is readdressed. The DHB provided HDC with the outcome of its audit of the new consent process, which showed 100% compliance with the new consent process for tubal ligation performed in conjunction with an emergency Caesarean section. As recommended by the Deputy Commissioner, the DHB also formally reminded staff undertaking tubal ligations in conjunction with a Caesarean section to ensure that they discuss the risk of regret with consumers and adequately document any such discussions in the clinical notes.

On analysis of all issues identified in complaints against DHBs, the most common complaint issues are inadequate/inappropriate treatment (37%), missed/incorrect/delayed diagnosis (27%), failure to communicate effectively with consumer (21%), failure to communicate effectively with family (21%), disrespectful manner/attitude (20%), and inadequate response to consumer's complaint by the DHB (20%). Many complaints involved issues categorised as care/treatment, such as inadequate assessment, delay in treatment, inadequate testing, inappropriate/delayed discharge/transfer, inadequate coordination of care or treatment, and unexpected treatment outcome; each of these were mentioned in around 14% of complaints.

Table 3. Issues complained about in DHB complaints

Primary issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Access/Funding	47(7)	
ACC compensation issue	0	17(3)
Lack of access to services	20(3)	63(10)
Lack of access to subsidies/funding	8(1)	15(2)
Waiting list/prioritisation issue	19(3)	41(6)
Boundary violation	9(1)	
Inappropriate non-sexual physical contact	0	2(0.3)
Inappropriate sexual physical contact	6(0.9)	7(1)
Inappropriate sexual relationship	3(0.5)	3(0.5)
Care/Treatment	378(57)	
Delay in treatment	12(2)	98(15)
Delayed/inadequate/inappropriate referral	18(3)	84(13)
Inadequate coordination of care or treatment	7(1)	91(14)
Inadequate/inappropriate clinical treatment	92(14)	242(37)
Inadequate/inappropriate examination/assessment	15(2)	95(14)
Inadequate/inappropriate follow-up	1(0.2)	36(6)
Inadequate/inappropriate monitoring	3(0.5)	28(4)
Inadequate/inappropriate non-clinical care	22(3)	64(10)
Inadequate/inappropriate testing	4(0.6)	97(15)
Inappropriate admission/failure to admit	1(0.2)	13(2)
Inappropriate/delayed discharge/transfer	26(4)	88(13)
Inappropriate withdrawal of treatment	2(0.3)	11(2)
Missed/incorrect/delayed diagnosis	113(17)	181(27)
Personal privacy not respected	1(0.2)	11(2)
Refusal to assist/attend	6(0.9)	46(7)
Refusal to treat	8(1.2)	25(4)
Rough/painful care or treatment	13(2)	40(6)
Unexpected treatment outcome	30(5)	99(15)
Unnecessary treatment/over-servicing	3(0.5)	15(2)
Other	1(0.2)	1(0.2)
Communication	72(11)	
Disrespectful manner/attitude	36(5)	132(20)
Failure to accommodate cultural/language needs	1(0.2)	16(2)
Failure to communicate openly/honestly/effectively with consumer	12(2)	137(21)
Failure to communicate openly/honestly/effectively with family	20(3)	136(21)
Insensitive/inappropriate comments (not sexual)	3(0.5)	52(8)
Complaints process	6(0.9)	
Inadequate response to complaint	4(0.6)	131(20)
Retaliation/discrimination as a result of a complaint	2(0.3)	4(0.6)
Consent/Information	53(8)	
Coercion by provider to obtain consent	0	4(0.6)
Consent not obtained/adequate	11(2)	37(6)
Failure to assess capacity to consent	1(0.2)	6(0.9)
Inadequate information provided regarding adverse event	1(0.2)	24(4)
Inadequate information provided regarding condition	4(0.6)	22(3)

Primary issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Inadequate information provided re fees/costs	1(0.2)	1(0.2)
Inadequate information provided re options	3(0.5)	12(2)
Inadequate information regarding results	1(0.2)	12(2)
Inadequate information provided regarding treatment	5(0.8)	41(6)
Incorrect/misleading information provided	1(0.2)	35(5)
Issues regarding consent when consumer not competent	5(0.8)	16(2)
Issues with involuntary admission/treatment	20(3)	25(4)
Documentation	12(2)	
Delay/failure to disclose documentation	2(0.3)	19(3)
Delay/failure to transfer documentation	2(0.3)	5(0.8)
Inadequate/inaccurate documentation	8(1.2)	59(9)
Facility issues	18(3)	
Cleanliness/hygiene issue	3(0.5)	15(2)
Failure to follow policies/procedures	0	19(3)
General safety issue for consumer in facility	2(0.3)	9(1)
Inadequate/inappropriate policies/procedures	1(0.2)	20(3)
Issue with sharing facility with other consumers	0	6(0.9)
Issue with quality of aids/equipment	3(0.5)	11(2)
Staffing/rostering/other HR issue	3(0.5)	14(2)
Waiting times	5(0.8)	16(2)
Other	1(0.2)	1(0.2)
Medication	35(5)	
Administration error	4(0.6)	12(2)
Inappropriate administration	2(0.3)	18(3)
Inappropriate dispensing	1(0.2)	2(0.3)
Inappropriate prescribing	18(3)	57(9)
Inappropriate supply	1(0.2)	1(0.2)
Prescribing error	3(0.5)	4(0.6)
Refusal to prescribe/dispense/supply	6(0.9)	28(4)
Reports/Certificates	8(1)	
Inaccurate report/certificate	8(1)	23(4)
Refusal to complete report/certificate	0	2(0.3)
Other professional conduct issues	14(2)	44
Other issues	8(1)	9
TOTAL	660	

Case study

Inadequate/inappropriate treatment

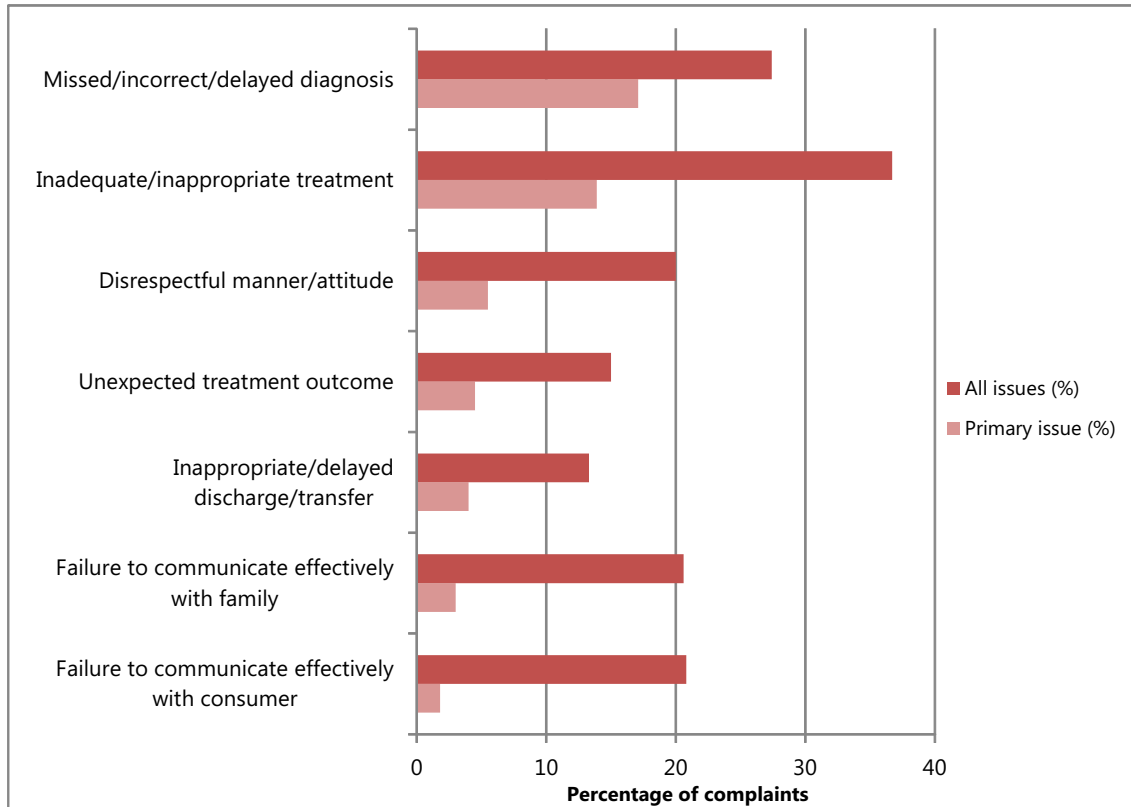
A woman was admitted to hospital in labour, however progress was slow and the decision was made to deliver the baby by Caesarean section. The anaesthetist conducted an "ice test" to check the woman's sensation, and she said she could feel that the ice was quite cold. However, the anaesthetist advised the obstetrician that she could begin the surgery. When the obstetrician entered the peritoneal cavity, the woman complained of pain but the anaesthetist assured the obstetrician that she could continue with the surgery. When the obstetrician attempted to deliver the baby the woman complained of pain and began lifting both her knees. The anaesthetist told the woman that she was feeling pressure rather than pain. He said that she could not have any more pain relief unless they "put her under", which would not be good for the baby. After the delivery, the woman continued to complain of pain while the obstetrician sutured the incision. The anaesthetist declined to administer extra pain relief.

The Commissioner found the anaesthetist breached the Code by failing to ensure that the anaesthesia/analgesia was adequate during the operation, and because the information provided to the woman fell seriously short of accepted standards. The anaesthetist was referred to the Director of Proceedings due to the severity of his breach of the Code. The obstetrician was also found in breach of the Code for not ensuring that appropriate analgesia was administered once the obstetrician became aware of the woman's pain.

The DHB was not found in breach of the Code but the Commissioner recommended that the DHB review the orientation of locum staff and audit the implementation and effectiveness of its policies and protocols for epidural anaesthesia. The Commissioner noted that he had "previously commented on the need for clinicians to advocate on behalf of patients, and for institutional providers to normalise a culture where such actions are accepted and expected". The Commissioner recommended that the DHB include information in its training that the practice of asking questions and the reporting of concerns is expected and accepted from all members of the multidisciplinary team.

Figure 4 details the seven most common complaint issues raised in complaints about DHBs received in the 2013/14 year. The light red bars show the percentage of cases in which the particular complaint issue was identified as the primary complaint issue, while the dark 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 light and dark red bars, communication-related complaint issues (disrespectful manner/attitude, and failure to communicate effectively with family or consumer) 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

Failure to communicate effectively with family

A father took his two week old daughter to the ED of a public hospital because she had an unusually high temperature. He complained that although he was told his daughter would need a blood test, IV line and a lumbar puncture, he was not provided with any information about those procedures. Multiple attempts were required to obtain intravenous access and lumbar puncture, which caused the daughter stress and pain.

The DHB acknowledged in its response to HDC that the daughter's care in ED was unnecessarily traumatic because of the lack of adequate explanation provided to her father. The DHB advised that it expects staff to fully inform parents about procedures and the impact of those on their child. The DHB apologised to the father, and reminded staff of the importance of providing adequate information to families. The DHB also advised HDC that it had recently started using the AI²DET tool to assist staff in communicating with parents and whanau before delivering care, and that this tool provides a more structured format for communication and documentation.

It is important to note that Table 3 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.

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 4 below, diagnostic issues were most prevalent in complaints about services with high diagnostic workloads (general medicine, accident and emergency and maternity), with 33% of accident and emergency complaints being primarily about missed/incorrect/delayed diagnosis. In surgical services, diagnostic issues came second to inadequate/inappropriate treatment issues, and were followed closely by complaints concerning unexpected treatment outcomes.

Primary issues in complaints about mental health services were quite distinct, with issues relating to involuntary admission/treatment being the most prevalent primary issue, and failure to communicate effectively with family being the primary issue in 9% of complaints.

Table 4. Three most common primary issues in complaints by service type

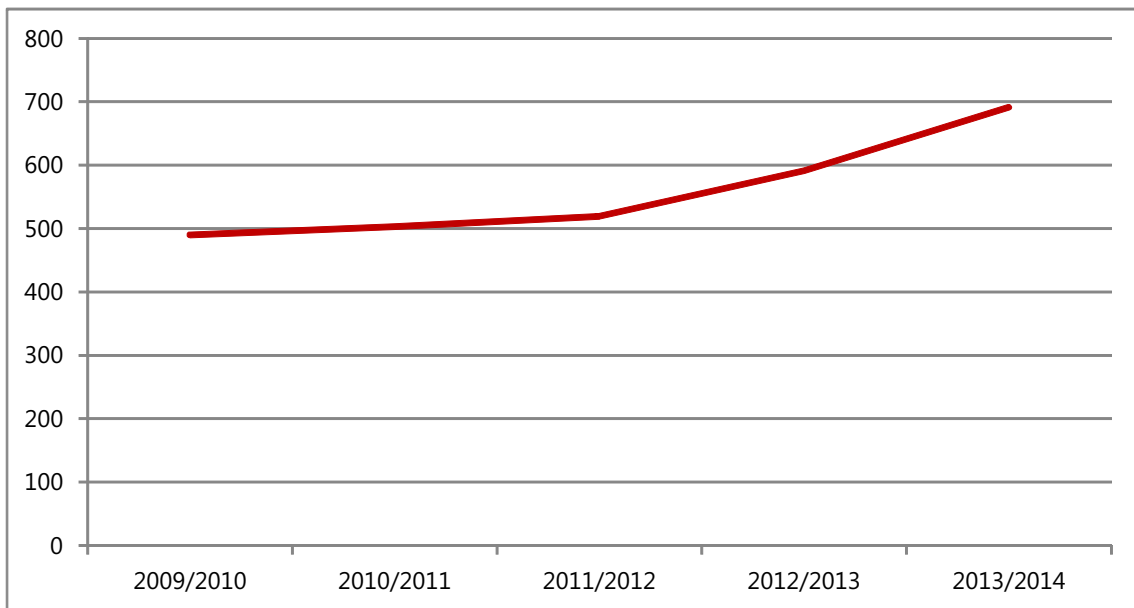
Surgery n=179		Mental health n=132		General medicine n=130		Accident & emergency n=89		Maternity n=38	
Inadequate/ inappropriate treatment	21%	Issues with involuntary admission/ treatment	14%	Missed/ incorrect/ delayed diagnosis	16%	Missed/ incorrect/ delayed diagnosis	33%	Missed/ incorrect/ delayed diagnosis	29%
Missed/ incorrect/ delayed diagnosis	18%	Failure to communicate effectively with family	9%	Inadequate/ inappropriate treatment	13%	Inadequate/ inappropriate treatment	13%	Inadequate/ inappropriate treatment	18%
Unexpected treatment outcome	14%	Inadequate/ inappropriate treatment	8%	Inadequate/ inappropriate care	8%	Inappropriate/ delayed discharge/ transfer	8%	Disrespectful manner/ attitude	11%

COMPLAINTS CLOSED

1. How many complaints were closed?

HDC closed 691 complaints involving DHBs in the 2013/14 year. This was an increase of 17% on the 591 complaints closed in 2012/13. As with complaints received, the number of complaints closed has been increasing year on year for the last five financial years (see Figure 5).

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 in her 20s, with a history of abusing dexamphetamine as a teenager, complained to HDC about the DHB's Community Mental Health Service. The woman had been put back on dexamphetamine but was then taken off it due to suspicions that she had been selling her pills. The woman did not find her new medication useful and denied selling her pills, or abusing her medication in any way. The woman reported to HDC that she felt that her past behaviour was being held against her.

The woman's complaint was referred to an advocate at the Advocacy Service. As a result, a resolution meeting was arranged between the DHB and the woman. The woman was satisfied with the actions agreed upon at the meeting and advised that she felt confident she would subsequently receive the support she sought.

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 preschooler had been seen by Dr A, a Paediatrician in the paediatric service of a DHB over a period of several years, in regard to developmental concerns. The boy's mother thought her son had more than just a language delay and made an appointment with Dr A. Following that appointment, the doctor called the mother and told her that her son did not have autism. Some time later, the boy's Group Special Education team suggested the mother take her son back to Dr A. The mother did so and told Dr A that she thought her son had autism. Dr A agreed and said that he had written to the mother following the earlier appointment to inform her that he had misinterpreted the results of his observations. The mother told HDC that she never received that letter. She complained to HDC as she was upset that such a diagnosis would be delivered in a letter and she also thought that a referral should have been made to other support services.

The Deputy Commissioner referred this complaint back to the DHB concerned as she considered the DHB was best placed to address the mother's concerns directly. Both the clinical director and Dr A apologised to the mother that she was not directly informed of her son's diagnosis and Dr A offered to assist the mother in accessing the child disability allowance. The mother reported she was happy with care provided by Dr A and would feel comfortable raising issues and concerns with him directly in future.

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 study

No further action taken

Inadequate response to complaint by DHB

A man underwent surgery at a public hospital for a rare squamous cell carcinoma in his mouth. Following surgery, he was transferred to a ward. Unfortunately, during the recovery period, the skin flap continued to swell, and it was decided that a further surgery would need to take place to explore the viability of the flap. Before the surgery commenced, and the man was being anaesthetised, his airway was unable to be supported and he suffered a cardiac arrest. He was stabilised and transferred to the Intensive Care Unit and further surgery was deferred. Sadly, he died three days later.

A Serious Event Review (SER) undertaken by the DHB found that there were:

- inconsistencies in the overall management and communication of tracheostomy care across the service;
- deficiencies in the monitoring and interpretation of flap treatment progression by the nursing team and junior medical teams; and
- anaesthetic difficulties on intubation and emergency response.

The DHB apologised for not meeting the required standard of communication with the man's wife and family when the man suffered the cardiac arrest. The DHB identified gaps in its head and neck service and produced appropriate remedial action to ensure that a comprehensive, well coordinated, and appropriate standard of care was provided to patients undergoing head and neck surgery.

The Deputy Commissioner was concerned that, having met with the DHB, the man's wife was left with unanswered questions and reported having felt isolated from the discussion, as she did not understand the content. The Deputy Commissioner considered that the DHB had not fully addressed all of the wife's concerns in its response. Therefore the Deputy Commissioner asked the DHB to arrange a further meeting with the man's wife to discuss any outstanding concerns and, during that meeting, to apologise to the man's wife in relation to their earlier communication with her. The Deputy Commissioner asked the DHB to report back on the outcome of the meeting and provide an update about one of the recommendations from the SER. These recommendations have been met by the DHB.

Case study

No further action taken

Alleged assault by nurse

A woman with a history of serious self-harm incidents and assaultive behaviour towards staff and co-clients became a care recipient under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and was admitted to a mental health facility. She had been assessed as needing a high level of health care. The woman was restrained by a nurse when she was found jumping from chairs in her bedroom. The woman required full floor restraint and was escorted to the soft room in the de-escalation area. The woman complained that she was assaulted by the nurse during the restraint, saying she was punched twice in the right ear, causing her ear to bleed.

The nurse denied the assault. The DHB undertook an internal review and concluded that the incident did not occur in the way alleged by the woman and that staff had acted appropriately. The woman's account about what had happened had included some inconsistencies.

The Ministry of Health had recently reviewed intellectual disability secure services including the facility concerned. Findings indicated that the one-on-one supervision regime was not adequate and that increased training was needed for staff.

The Deputy Commissioner considered that further action by HDC would not do anything to assist in confirming what happened in relation to the alleged assault, and made a decision to take no further action on the complaint. However, the Deputy Commissioner decided to follow up changes made at the DHB to ensure they were implemented and effective in addressing shortcomings identified by the Ministry of Health review. She wrote to the DHB highlighting the importance of supervision, adequate training of staff dealing with complex clients and ensuring incidents are reported appropriately. She also asked the DHB to provide to HDC a report on changes made in response to the Ministry's report.

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 study

DHB found in breach of the Code

Failure to follow-up chest x-ray results

A woman in her mid-sixties with a history of heavy smoking attended the Dental Unit of a public hospital for removal of all her teeth under general anaesthetic. At a pre-anaesthetic assessment a heart murmur was detected and an ECG showed sinus tachycardia. A chest x-ray the next day showed an abnormal opacity on the lung and the radiologist recommended a follow-up investigation. However, the request for the chest X-ray was not recorded, wording of the report was unclear and the process of "red flagging" the abnormal result was not followed. The x-ray result was automatically faxed to the Dental Unit where no-one sighted the results and they were not put on the woman's file.

A different anaesthetist checked the woman's medical history and notes from the pre-anaesthetic assessment prior to the operation but did not review the woman's heart murmur. There was no record that an x-ray had been requested. Surgery went ahead, and the woman was discharged home. A year later the woman was diagnosed with an inoperable carcinoma with metastases.

The Commissioner found that the failure to follow up the abnormality on the chest x-ray occurred in the context of serious organisational and systemic failures by the DHB. In particular, an effective and formalised system for reporting test results was not in place. It was held that the DHB breached the Code. The radiologist was also found to have breached the Code by failing to bring the abnormal result to the attention of clinicians caring for the woman, as was the second anaesthetist due to his failure to address the woman's heart murmur. The Commissioner also criticised the documentation of the first anaesthetist, but did not find that anaesthetist had breached the Code.

The Commissioner made detailed recommendations to the DHB, to be attended to as a matter of priority. In particular, he recommended that the anaesthetic department review and develop a formalised process governing follow-up of investigations ordered at pre-anaesthesia clinics. The Commissioner also recommended that the DHB provide an evaluative report on the effectiveness of all system changes implemented as result of the case. HDC has received a comprehensive report from the DHB setting out the changes made by the DHB in response to the complaint and the effectiveness of those changes.

Case study

DHB found in breach of the Code

Concentrated feeding and fluid balance assessment of baby

An 11 month-old child was admitted to a public hospital for management of on-going issues with vomiting and oral aversion, and poor weight gain. A treatment plan of concentrated feeding was developed. The baby responded well but then developed a rotavirus infection with increasing vomiting and diarrhoea. Over several days the baby's condition deteriorated until she collapsed and sadly died with hypernatremia and severe dehydration.

The Commissioner found that a number of service failures led to the baby receiving sub-optimal care and treatment in the period following her diagnosis with rotavirus. From a clinical perspective, the Commissioner considered that there was inadequate monitoring of the baby's fluid balance and weight, that clinicians should have considered whether to continue concentrated feeds given the diarrhoea, and that there was a failure to arrange medical review the night before the baby died.

The Commissioner found that poor communication within the multi-disciplinary team in regard to the rotavirus diagnosis led to missed opportunities for review of the treatment plan, and that this was a breach of the Code.

As a result of recommendations made by the Commissioner, the DHB has reviewed its nursing handover systems, the level of support and oversight available to junior doctors, and the content of paediatric fluid balance charts. The Commissioner also requested reports on the progress of the DHB's improvements, including the implementation of an Early Warning Score system and new gastroenteritis guidelines. These recommendations have been complied with.

Case study

DHB found in breach of the Code

Failure to provide information about infertility to young man prior to chemotherapy

When Mr A was 14 years old, he underwent a biopsy which indicated that he had Ewing sarcoma (cancer) of the pelvis. Mr A was admitted to hospital five days later for surgical treatment, to be followed by chemotherapy treatment.

On the morning of Mr A's first chemotherapy treatment, the on-call paediatric oncologist met with Mr A and his parents to discuss the treatment. The oncologist mentioned the potential impact of chemotherapy on fertility, but did not emphasise it. The discussion focused mainly on the potential adverse effects of the drugs to be used during the treatment. Mr A and his parents were provided with written information about the chemotherapy drugs, but those information sheets did not refer to the potential impact of chemotherapy on fertility. The DHB advised that, at the time of the events, the normal process was for fertility to be discussed with the patient by an adolescent nurse specialist as part of a checklist prior to chemotherapy starting. However, on the relevant date, the nurse specialist was on leave and there was no apparent system in place to ensure that the checklist was covered by someone else in the nurse specialist's absence.

The day after Mr A's first chemotherapy treatment, a nurse mentioned fertility to Mr A and his parents when completing a routine checklist. Mr A's mother was upset when advised of the risk of infertility. The next day, the oncologist met with Mr A and his parents to discuss fertility and the option of storing a sperm sample. Part of this discussion took place in private with Mr A, without his parents being present.

The Commissioner acknowledged the efficient and appropriate clinical care Mr A received overall in relation to his management from the point of diagnosis to the commencement of his chemotherapy. However, the Commissioner was concerned about the information Mr A was provided. Prior to consenting to chemotherapy treatment, Mr A and his parents, who were his legal guardians at the time, were entitled to receive information about the risk of chemotherapy treatment in respect of fertility, and the option for banking sperm in light of that risk. The Commissioner was critical of the oncologist's failure to provide that information to Mr A prior to his first chemotherapy treatment, and his decision to, in the absence of Mr A's parents, discuss the option of Mr A providing a sperm sample.

The Commissioner found that the DHB breached the Code by failing to have adequate mechanisms in place at the time of these events to ensure the provision of fertility information and treatment options to consumers prior to them undertaking chemotherapy treatment.

The Commissioner noted that steps had been taken since that time to improve the provision of information about fertility to consumers in these circumstances. Those steps include a number of initiatives undertaken at the DHB, as well as the establishment of a national Fertility Preservation Working Group responsible for developing nationally agreed approaches to minimise the impact of cancer and cancer treatment on future fertility of people of any age (the National Guidelines). The Commissioner encouraged all providers working in the area to adopt the National Guidelines and ensure that future practice is improved. He also recommended that the DHB review its current policies, information sheets and practice with regard to discussions of infertility with patients undergoing chemotherapy. These recommendations have been complied with.

2.2 Manner of resolution and outcomes in complaints closed

The manner of resolution and outcomes for all DHB complaints closed in the 2013/14 year is shown in Table 5 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 5. Outcome for DHBs of complaints closed

Outcome for DHB	Number of complaints
Investigation	46
Breach finding	18
No further action with follow-up or educational comment	22
No further action	4
No breach	2
Non-investigation	619
No further action with follow-up or educational comment	168
Referred to Ministry of Health	2
Referred to District Inspector	15
Referred to DHB	130
Referred to Advocacy	49
No further action	238
Withdrawn	17
Outside jurisdiction	26
TOTAL	691

As can be seen from the table above, in the 2013/14 year, HDC concluded 46 formal investigations involving DHBs, 18 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 six 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 6 shows the recommendations made to DHBs in complaints closed in the 2013/14 year. Please note that more than one recommendation may be made in relation to a single complaint.

Table 6. Recommendations made to DHBs following a complaint

Type of recommendation	Number of recommendations made
Apology	49
Audit	53
Meeting with consumer/complainant	8
Personal reflection	8
Presentation/discussion of complaint with others	8
Provision of information	26
Review of policies/procedures	92
Training/Professional development	51
Total	295

As can be seen from the above table, the most common recommendation made to DHBs was that they review their policies/procedures (92 recommendations). Training/professional development was also often recommended (51 recommendations). Training recommendations most frequently concerned communication, followed by clinical issues and documentation. Audits were most commonly of policies/procedures followed by documentation. Apologies were recommended on 49 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 ED triage delay

A woman twice presented at a public hospital ED and both times experienced delays in being seen by a doctor. The Commissioner found the DHB in breach of the Code as the ED triage process was not implemented effectively on either occasion. The Commissioner made a number of recommendations to the DHB including that it:

- review its triage policy and the need for a triage assessment nurse to be allocated to the waiting room; and
- audit the effectiveness of changes it made to the systems operating in the ED, including its revised ED staffing levels, its triage categorisation process, the development of an Escalation Policy, and the introduction of a system to fast track lower acuity patients through the ED.

The DHB has complied with the recommendations and has made further improvements in the ED with a specific focus on patient safety and improvement in the flow of patients.

Recommendations arising from breach relating to an instrumental delivery

The Commissioner found an obstetric registrar in breach of the Code for proceeding to an instrumental delivery without recognising the complexity of a woman's presentation during labour. The Commissioner found the DHB in breach of the Code as systemic issues at the DHB had contributed to the registrar's failures. The Commissioner found that the DHB did not have a culture that sufficiently supported the registrar and that placed the onus on more junior staff to identify the limits of their expertise and ensure they were operating within safe and acceptable margins.

Subsequent to the complaint, the DHB implemented a new policy for mandatory consultant involvement in all mid-cavity and rotational instrumental deliveries, except where the registrar has been credentialed to undertake such deliveries without supervision.

In his report, the Commissioner recommended that the DHB:

- provide a written apology to the consumer for the shortcomings in her care;
- carry out an audit of all mid-cavity and rotational instrumental deliveries, assessing compliance with the DHB's new policy;
- provide a report to HDC on any adverse outcomes following mid-cavity or rotational instrumental deliveries since the incident that was the subject of the complaint; and
- communicate with all other DHBs in New Zealand to ensure that DHB policies in relation to the supervision of obstetrics registrars are consistent.

The DHB has complied with all of the recommendations.

Case study

Recommendations made by HDC

Recommendations arising from breach for failure to recognise decline in elderly patient

The Commissioner found a DHB in breach of the Code for failings in its care of an elderly woman, including failing to interpret and recognise the signs of a declining patient who was in pain, and failing to communicate appropriately with another provider about the arrangements for the woman's discharge. The Commissioner recommended that the DHB:

- develop clear and documented processes governing communication and handover between staff, and discharge/transfer of care from the DHB to aged care facilities;
- conduct a review of nursing staff's approach to, and use of, the Early Warning Score System, the Functional Independence Measure, and observational recordings;
- undertake a review of processes to identify and respond to signs of deterioration in adult patients and processes to audit staff compliance with the procedures;
- provide HDC with a copy of nursing staff orientation to the particular ward;
- update HDC on the outcome and results of the DHB review of falls management and strategies;
- provide HDC with an update on the effectiveness of the processes developed specific to the wards governing the timely examination by medical staff of patients who have had a fall;
- conduct a further audit regarding the expected frequency of medical reviews on the wards; and
- conduct a review of discharge summaries and evaluate the degree to which registrars and house surgeons are reviewing patients as being fit for discharge and recording that information in patients' clinical notes.

The DHB has complied with, or has advised HDC that it is currently putting in place processes to comply with, all of the recommendations.