Complaints to HDC involving District Health Boards

Report and Analysis for period 1 January to 30 June 2021

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

Tēnā koutou

I am pleased to present my Office's latest complaint trend report for DHBs. This report details the trends in complaints HDC received about DHBs between 1 January and 30 June 2021.

At the outset I wish to acknowledge the ongoing work and commitment of health and disability service providers in responding to the pandemic, with all its pressures and stresses, while at the same time delivering core services and planning for upcoming reform. Ngā mihi nui.

There has been a significant increase in the number of complaints received in this period. The 532 complaints received were a 21% increase on the average volume of complaints, and were the highest number of complaints ever received about DHBs in a six-month period. However, it is important to note that this is generally in line with an overall increase in complaints to HDC. HDC experienced a 14% volume increase in 2020/21, and increases look set to continue with HDC receiving an unprecedented 43% increase in complaints in the first five months of 2021/22. There are likely many reasons for this, but recent increases seem to be particularly related to the COVID-19 pandemic and associated vaccine roll-out.

The general trends in this report are consistent with previous reports. Surgery and mental health remain the most commonly complained about services, and communication continues to be the most common issue raised by complainants.

I note that in 17% of complaints about DHBs, people continue to raise concerns about the DHB's complaints management process. In my view, the early resolution of complaints by providers, where appropriate, represents a win-win for both parties. It can increase effectiveness of quality improvement measures, and potentially reduces escalation to HDC. Our data tells us that the things that consumers need for effective complaint resolution are a timely response, acknowledgement of their concerns, commitment to preventative action, and above all to be heard — to have a voice.

Right 10 of the Code requires all providers to facilitate the fair, simple, speedy, and efficient resolution of complaints. I acknowledge that the current pressure the healthcare system is under, particularly in the context of rapidly changing circumstances, can place pressure on the time it takes to resolve complaints. In these circumstances, communication with people is particularly important, and complainants should be provided with regular progress updates and given reasons for any delays.

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

Morag McDowell
Health and Disability Commissioner

National Data for all District Health Boards

1. How many complaints were received?

1.1 Number of complaints received

In the period Jan–Jun 2021, HDC received **532**[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

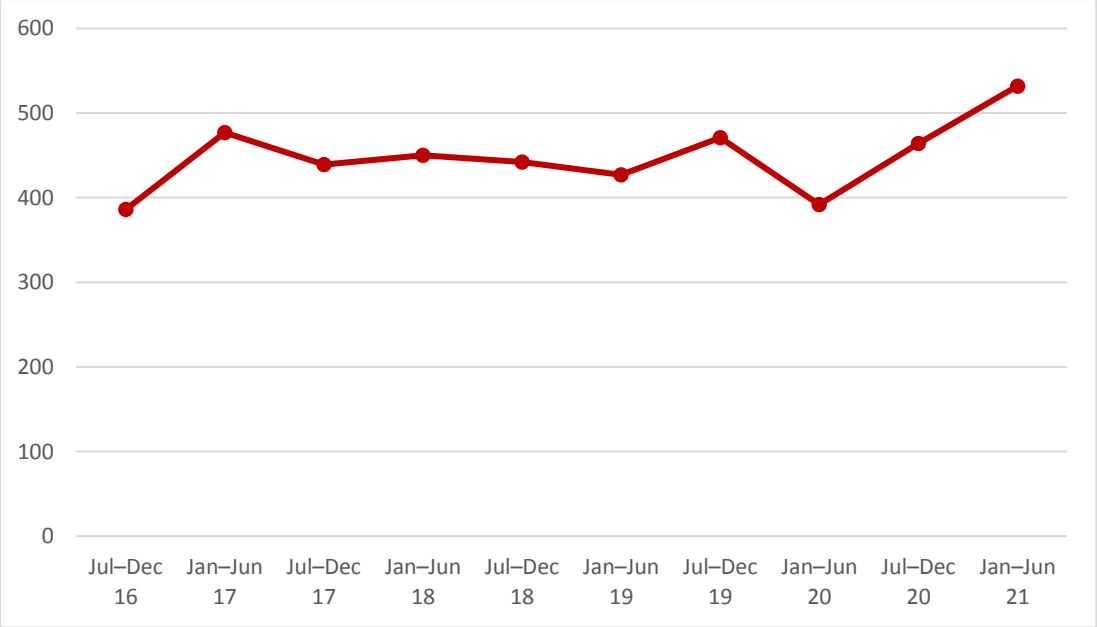
Table 1. Number of complaints received in the last five years

	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Jul–Dec 20	Average of last 4 6-month periods	Jan–Jun 21
Number of complaints	386	477	439	450	442	427	471	392	464	**438**	**532**

The total number of complaints received in Jan–Jun 2021 (532) shows a 21% increase over the average number of complaints received in the previous four periods, and is the highest number of complaints ever received about DHBs in a six-month period.

The number of complaints received in Jan–Jun 2021 and previous six-month periods is also displayed below in Figure 1.

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



[1] Provisional as of date of extraction (30 August 2021).

1.2 Rate of complaints received

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

Complaint rate calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (2 November 2021) and is likely incomplete; it will be updated in the next six-monthly report. It should be noted that this discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
532	**498,268**	**106.77**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan–Jun 2021 and previous six-month periods.

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

	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Jul–Dec 20[2]	Average of last 4 6-month periods	Jan–Jun 21
Rate per 100,000 discharges	78.79	99.08	88.23	93.80	88.47	87.97	92.92	90.35	92.00	**90.81**	**106.77**

The rate of complaints received during Jan–Jun 2021 (106.77) is 18% higher than the average rate of complaints received for the previous four periods, and is the highest rate of complaints ever received in a six-month period.

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

[2] The rate for Jul–Dec 2020 has been recalculated based on the most recent discharge data.

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

Table 4. Number and rate of complaints received for each DHB in Jan–Jun 2021

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	83	62,507	132.79
Bay of Plenty	27	29,415	91.79
Canterbury	53	57,503	92.17
Capital and Coast	49	29,794	164.46
Counties Manukau	50	49,891	100.22
Hauora Tairāwhiti	10	5,387	185.63
Hawke's Bay	25	18,657	134.00
Hutt Valley	23	16,754	137.28
Lakes	10	12,629	79.18
MidCentral	16	15,715	101.81
Nelson Marlborough	13	13142	98.92
Northland	21	21,791	96.37
South Canterbury	5	6,046	82.70
Southern	39	27,173	143.52
Taranaki	10	14,555	68.70
Waikato	46	49,411	93.10
Wairarapa	12	4,611	260.25
Waitematā	43	54,202	79.33
West Coast	4	3,279	121.99
Whanganui	7	6,256	111.89

Notes on DHB's number and rate of complaints

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

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

2. Who complained?

2.1 Consumer gender

The gender of consumers in complaints to HDC about DHB services in Jan–Jun 2021 is detailed below.

Table 5. Consumer gender

Consumer gender	Number of complaints	Proportion of complaints
Female	311	58%
Male	210	39%
Another gender	9	2%
Unknown/did not wish to answer	2	0.4%

2.2 Consumer age

The age of consumers in complaints to HDC about DHB services in Jan–Jun 2021 is detailed below.

Table 6. Consumer age

Consumer age	Number of complaints	Proportion of complaints
0 to 17 years	32	6%
18 to 24 years	32	6%
25 to 34 years	71	13%
35 to 49 years	108	20%
50 to 64 years	69	13%
65+ years	118	22%
Unknown/did not wish to answer	102	19%

2.3 Consumer ethnicity

The ethnicity of consumers in complaints to HDC about DHB services in Jan–Jun 2021 is detailed below.

Table 7. Consumer ethnicity

Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	72	13%
Pacific	12	2%
Middle Eastern/African/Latin American	12	2%
Asian	47	9%
Other European	25	5%
New Zealand European	227	43%
Unknown/did not wish to answer	137	26%

3. Which DHB services were complained about?

3.1 DHB service types complained about

Please note that some complaints involve more than one DHB and/or more than one service or hospital; therefore, although there were 532 complaints about DHBs, 551 services were complained about. Figure 2 below shows the most commonly complained about service types in Jan–Jun 2021. A more nuanced picture of service types complained about, including individual surgery and medicine services, is provided in Table 8.

Surgery (26%) and mental health (23%) services received the greatest number of complaints in Jan–Jun 2021, with general surgery (7%) and orthopaedics (7%) being the surgical specialties most commonly complained about.

In Jul–Dec 2020 the proportion of complaints about surgery services dropped for the first time. Complaints about this service increased slightly in Jan–Jun 2021, but were still lower than the 30% seen previous to July 2020.

Other commonly complained about services included medicine (16%), and emergency department (12%) services.

Figure 2. Service types complained about

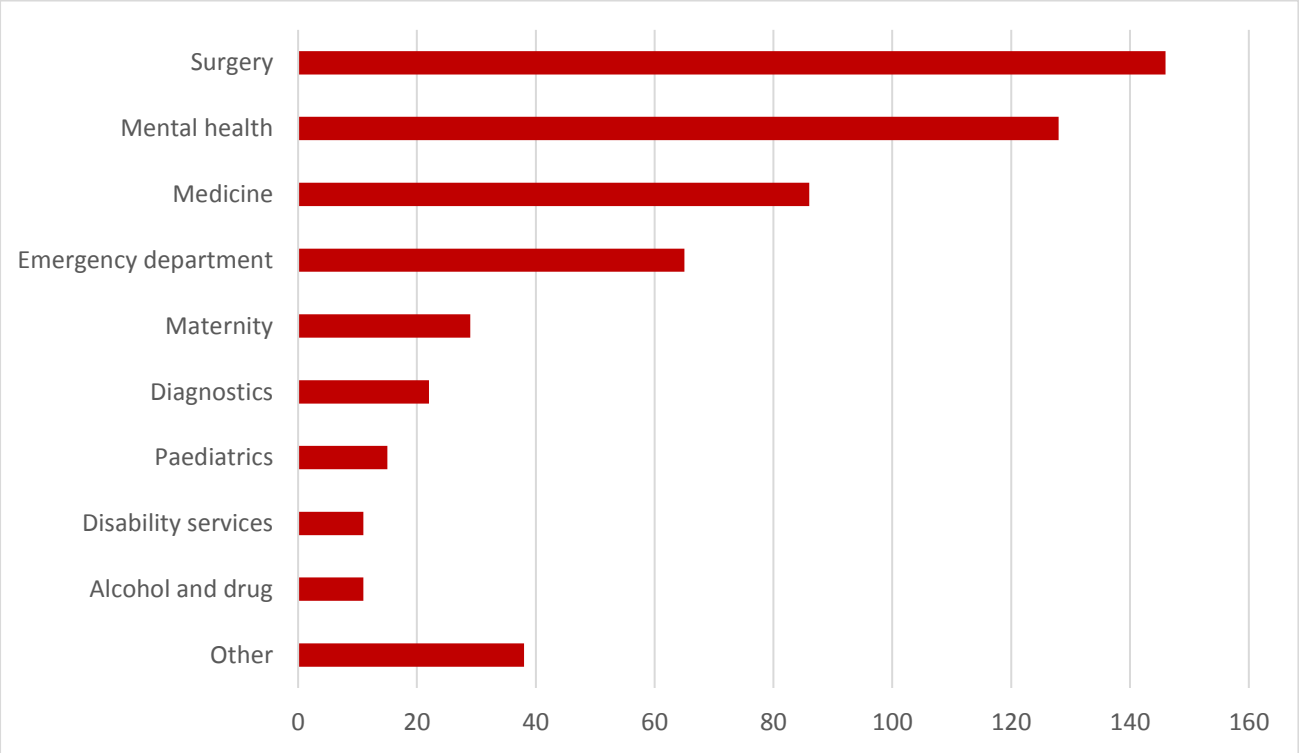


Table 6. Service types complained about

Service type	Number of complaints	Percentage
Alcohol and drug	**11**	**2.0%**
Anaesthetics/pain medicine	**3**	**0.5%**
COVID-19 vaccination centre	**6**	**1.1%**
Dental	**4**	**0.7%**
Diagnostics	**22**	**4.0%**
Disability services	**11**	**2.0%**
District nursing	**5**	**0.9%**
Emergency department	**65**	**11.8%**
Intensive care/critical care	**2**	**0.4%**
Maternity	**29**	**5.3%**
Medicine	**86**	**15.6%**
General medicine	19	3.4%
Cardiology	8	1.5%
Endocrinology	1	0.2%
Gastroenterology	18	3.3%
Geriatric medicine	5	0.9%
Haematology	1	0.2%
Neurology	9	1.6%
Oncology	9	1.6%
Renal/nephrology	2	0.4%
Respiratory	5	0.9%
Rheumatology	2	0.4%
Other/unspecified	7	1.3%
Mental health	**128**	**23.3%**
Paediatrics (not surgical)	**15**	**2.7%**
Rehabilitation services	**2**	**0.4%**
Sexual health	**2**	**0.4%**
Surgery	**146**	**26.5%**
Cardiothoracic	5	0.9%
General	40	7.3%
Gynaecology	21	3.8%
Neurosurgery	6	1.1%
Ophthalmology	7	1.3%
Oral/Maxillofacial	1	0.2%
Orthopaedics	37	6.7%
Otolaryngology	2	0.4%
Plastic and Reconstructive	11	2.0%
Urology	12	2.2%
Vascular	2	0.4%
Other/unknown	2	0.4%
Other/unknown health service	**14**	**2.5%**
TOTAL	**551**	

Table 7 below shows a comparison of the proportion of complaints received over time for the most commonly complained about service types. As can be seen from this table, complaints about surgical services started to decrease for the first time in Jul–Dec 2020.

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

Service type	Jan–Jun 2019	Jul–Dec 2019	Jan–Jun 2020	Jul–Dec 2020	Jan–Jun 2021
Surgery	31%	31%	31%	23%	26%
Mental health	22%	25%	22%	24%	23%
General medicine	18%	16%	18%	19%	16%
Emergency department	12%	11%	11%	15%	12%
Maternity	6%	5%	7%	5%	5%

4. What did people complain about?

4.1 Primary issues identified in complaints

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jan–Jun 2021 are listed below in Table 8. It should be noted that the issues included are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, they provide a valuable insight into consumers' experience of services provided and the issues they care about most.

The most common primary issue categories were:

- Care/treatment (48%)
- Access/funding (16%)
- Consent/information (11%)
- Communication (7%)

The most common specific primary issues complained about were:

- Missed/incorrect/delayed diagnosis (11%)
- Unexpected treatment outcome (8%)
- Lack of access to services (8%)
- Waiting list/prioritisation issue (6%)
- Inadequate/inappropriate treatment (6%)

This is very similar to what was seen in the previous six-month period.

Table 8. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***83***	***15.6%***
Lack of access to services	41	7.7%
Lack of access to subsidies/funding	8	1.5%
Waiting list/prioritisation issue	34	6.4%
Boundary violation	***2***	***0.4%***
Care/Treatment	***257***	***48.3%***
Delay in treatment	20	3.8%
Delayed/inadequate/inappropriate referral	2	0.4%
Inadequate coordination of care/treatment	9	1.7%
Inadequate/inappropriate clinical treatment	33	6.2%
Inadequate/inappropriate examination/assessment	19	3.6%
Inadequate/inappropriate follow-up	14	2.6%
Inadequate/inappropriate monitoring	10	1.9%
Inadequate/inappropriate non-clinical care	5	0.9%
Inadequate/inappropriate testing	1	0.2%
Inappropriate admission/failure to admit	4	0.7%
Inappropriate/delayed discharge/transfer	22	4.1%
Inappropriate withdrawal of treatment	3	0.6%
Missed/incorrect/delayed diagnosis	57	10.7%
Personal privacy not respected	1	0.2%
Refusal to assist/attend	4	0.7%
Refusal to treat	4	0.7%
Rough/painful care or treatment	5	0.9%
Unexpected treatment outcome	42	7.9%
Unnecessary treatment	2	0.4%
Communication	***38***	***7.1%***
Disrespectful manner/attitude	21	3.9%
Failure to accommodate cultural/language needs	1	0.2%
Failure to communicate openly/honestly/effectively with consumer	9	1.7%
Failure to communicate openly/honestly/effectively with family/whānau	7	1.3%
Complaints process	***2***	***0.4%***
Inadequate response to complaint	2	0.4%
Consent/Information	***56***	***10.5%***
Consent not obtained/adequate	18	3.4%
Failure to assess capacity to consent	1	0.2%
Inadequate information provided regarding adverse event	2	0.4%
Inadequate information provided regarding fees/costs	2	0.4%
Inadequate information provided regarding options	3	0.6%
Inadequate information provided regarding provider	1	0.2%
Inadequate information provided regarding results	1	0.2%
Inadequate information provided regarding treatment	4	0.7%
Issues with involuntary admission/treatment	24	4.5%
Documentation	***6***	***1.1%***
Inadequate/inaccurate documentation	4	0.7%

Primary issue in complaints	Number of complaints	Percentage
Inappropriate maintenance/disposal of documentation	2	0.4%
Facility issues	***26***	***4.9%***
Cleanliness/hygiene issue	2	0.4%
General safety issue for consumer in facility	15	2.8%
Inadequate/inappropriate policies/procedures	7	1.3%
Other	2	0.4%
Medication	***37***	***6.9%***
Administration error	7	1.3%
Inappropriate administration	3	0.6%
Inappropriate prescribing	18	3.4%
Prescribing error	2	0.4%
Refusal to prescribe/dispense/supply	7	1.3%
Reports/certificates	***6***	***1.1%***
Inaccurate report/certificate	6	1.1%
Professional conduct issues	***18***	***3.4%***
Disrespectful behaviour	6	1.1%
Inappropriate collection/use/disclosure of information	11	2.1%
Threatening/bullying/harassing behaviour	1	0.2%
Disability-related issues	***1***	***0.2%***
TOTAL	**532**	

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

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

Top five primary issues in all complaints (%)							
Jul–Dec 19 n=472		**Jan–Jun 20 n=392**		**Jul–Dec 20 n=464**		**Jul–Dec 20 n=464**	
Misdiagnosis	14%	Lack of access to services	12%	Misdiagnosis	13%	Misdiagnosis	11%
Unexpected treatment outcome	9%	Misdiagnosis	10%	Lack of access to services	8%	Unexpected treatment outcome	8%
Waiting list/ Prioritisation	8%	Unexpected treatment outcome	8%	Unexpected treatment outcome	7%	Lack of access to services	8%
Inadequate treatment	8%	Waiting list/ prioritisation	7%	Waiting list/ prioritisation	7%	Waiting list/ prioritisation	6%
Lack of access to services	8%	Inadequate treatment	5%	Inadequate treatment	6%	Inadequate treatment	6%

4.2 All issues identified in complaints

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

Table 10. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	***130***	***24.4%***
Lack of access to services	66	12.4%
Lack of access to subsidies/funding	12	2.2%
Waiting list/prioritisation issue	53	10.0%
Boundary violation	***2***	***0.4%***
Care/Treatment	***418***	***78.6%***
Delay in treatment	118	22.2%
Delayed/inadequate/inappropriate referral	21	3.9%
Inadequate coordination of care/treatment	98	18.4%
Inadequate/inappropriate clinical treatment	179	33.6%
Inadequate/inappropriate examination/assessment	148	27.8%
Inadequate/inappropriate follow-up	73	13.7%
Inadequate/inappropriate monitoring	53	10.0%
Inadequate/inappropriate non-clinical care	32	6.0%
Inadequate/inappropriate testing	58	10.9%
Inappropriate admission/failure to admit	11	2.1%
Inappropriate/delayed discharge/transfer	65	12.2%
Inappropriate withdrawal of treatment	7	1.3%
Missed/incorrect/delayed diagnosis	89	16.7%
Personal privacy not respected	5	0.9%
Refusal to assist/attend	9	1.7%
Refusal to treat	12	2.2%
Rough/painful care or treatment	18	3.4%
Unexpected treatment outcome	76	14.3%
Unnecessary treatment	6	1.1%
Communication	***360***	***67.7%***
Disrespectful manner/attitude	94	17.7%
Failure to accommodate cultural/language needs	13	2.4%
Failure to communicate openly/honestly/effectively with consumer	193	36.3%
Failure to communicate openly/honestly/effectively with family/whānau	113	21.2%
Complaints process	***95***	***17.9%***
Inadequate response to complaint	92	17.3%
Retaliation/discrimination as a result of a complaint	3	0.6%
Consent/Information	***131***	***24.6%***
Consent not obtained/adequate	38	7.1%
Failure to assess capacity to consent	2	0.4%
Inadequate information provided regarding adverse event	21	3.9%
Inadequate information provided regarding fees/costs	3	0.6%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding condition	2	0.4%
Inadequate information provided regarding options	19	3.6%
Inadequate information provided regarding provider	8	1.5%
Inadequate information provided regarding results	5	0.9%
Inadequate information provided regarding treatment	40	7.5%
Incorrect/misleading information provided	9	1.7%
Issues with involuntary admission/treatment	30	5.6%
Documentation	***34***	***6.4%***
Delay/failure to disclose documentation	4	0.7%
Delay/failure to transfer documentation	12	2.2%
Inadequate/inaccurate documentation	16	3.0%
Inappropriate maintenance/disposal of documentation	2	0.4%
Facility issues	***87***	***16.3%***
Accreditation/statutory obligations not met	2	0.4%
Cleanliness/hygiene issue	9	1.7%
Failure to follow policies/procedures	10	1.9%
General safety issue for consumer in facility	34	6.4%
Inadequate/inappropriate policies/procedures	31	5.8%
Issue with quality of aids/equipment	5	0.9%
Issue with sharing facility with other consumers	3	0.6%
Staffing/rostering/other HR issue	5	0.9%
Other	2	0.4%
Medication	***79***	***14.8%***
Administration error	9	1.7%
Inappropriate administration	9	1.7%
Inappropriate prescribing	49	9.2%
Prescribing error	3	0.6%
Refusal to prescribe/dispense/supply	12	2.2%
Reports/certificates	***9***	***1.7%***
Inaccurate report/certificate	9	1.7%
Teamwork/supervision	***7***	1.3%
Inadequate supervision/oversight	7	1.3%
Professional conduct issues	***38***	***7.1%***
Disrespectful behaviour	11	2.1%
Inappropriate collection/use/disclosure of information	21	3.9%
Other	6	1.1%
Disability-related issues	***5***	
Other	***21***	

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

- Care/treatment (present for 79% of all complaints)
- Communication (present for 68% of all complaints)
- Consent/information (present for 25% of all complaints)
- Access/funding (present for 24% of all complaints)

The most common *specific* issues were:

- Failure to communicate effectively with consumer (36%)
- Inadequate/inappropriate clinical treatment (34%)
- Inadequate/inappropriate examination/assessment (28%)
- Delay in treatment (22%)
- Failure to communicate effectively with family/whānau (21%)
- Inadequate coordination of care/treatment (19%)
- Disrespectful manner/attitude (18%)
- Inadequate response to complaint (17%)
- Missed/incorrect/delayed diagnosis (17%)

This is broadly similar to what was seen in the last period.

Issues complained about in relation to COVID-19

HDC received 29 complaints about COVID-19-related issues at DHBs in Jan–Jun 2021. This represents 36% of all complaints about COVID-19 received by HDC during this time period, and is a decrease on the 44 COVID-19-related complaints received in Jul–Dec 2020.

The most common issues complained about for DHBs in regard to COVID-19 in Jan–Jun 2021 were:

- Lack of access to services/delayed treatment (24%)
- Vaccine-related issues (primarily issues regarding access to the vaccine and manner of staff at vaccine centres) (24%)
- Testing-related issues (primarily delays in receiving results and manner of staff at testing centres) (17%)

COVID-19 vaccine-related issues appeared for the first time in Jan–Jun 2021.

4.3 Primary issues by service type

Table 11 shows the top three primary issues in complaints concerning the most commonly complained about service types.

This is broadly similar to what was seen in previous periods. However, inappropriate/delayed discharge/transfer appeared in the top issues for medicine services for the first time. This issue often relates to complaints about inadequate discharge planning.

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

Surgery n=145		Mental health n=128		Medicine n=86		Emergency department n=65	
Unexpected treatment outcome	19%	Issues with involuntary admission/ treatment	19%	Missed/ incorrect/ delayed diagnosis	10%	Missed/ incorrect/ delayed diagnosis	34%
Lack of access to services	12%	General safety issue for consumer in facility	12%	Unexpected treatment outcome	9%	Disrespectful manner/ attitude	9%
Inadequate/ inappropriate treatment	10%	Lack of access to services	9%	Inappropriate/ delayed discharge/ transfer	8%	Waiting list management/ prioritisation	8%

5. What were the outcomes of the complaints closed?

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

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

The Commissioner also has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances; a more appropriate outcome can be achieved in a more flexible and timely way than by means of investigation; or the matters that are the subject of the complaint have been, are being, or will be, addressed appropriately by other means. Often a decision to take no further action will be accompanied by an educational comment or recommendations designed to assist the provider to improve services in future.

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

5.1 Number of complaints closed

In the period Jan–Jun 2021, HDC closed **478**[4] complaints involving DHBs. Table 12 shows the number of complaints closed in previous six-month periods.

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

	Jul–Dec 16	**Jan–Jun 17**	**Jul–Dec 17**	**Jan–Jun 18**	**Jul–Dec 18**	**Jan–Jun 19**	**Jul–Dec 19**	**Jan–Jun 20**	**Jul–Dec 20**	**Average of last 4 6-month periods**	**Jan–Jun 21**
Number of complaints closed	316	465	383	476	449	444	423	428	390	**421**	**478**

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

5.2 Outcomes of complaints closed

In the Jan–Jun 2021 period, 5 DHBs had no investigations closed, 8 DHBs had one investigation closed, 5 DHBs had two investigations closed, 1 DHB had three investigations closed, and 1 DHB had four investigations closed.

The manner of resolution and outcomes of all complaints about DHBs closed in Jan–Jun 2021 is shown in Table 13.

Table 13. Outcome for DHBs of complaints closed by complaint type[5]

Outcome for DHBs	Number of complaints closed
Investigation	***23***
Breach finding — referred to Director of Proceedings	3
Breach finding	11
No breach finding with adverse comment and recommendations	2
No breach finding with recommendations	6
No further action	1
Other resolution following assessment	***455***
No further action with recommendations or educational comment	61
Referred to District Inspector	22
Referred to other agency	3
Referred to DHB	106
Referred to Advocacy	93
No further action	164
Withdrawn	6
TOTAL	**478**

5.3 Recommendations made to DHBs by HDC

Regardless of whether or not a complaint has been investigated, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted upon.

Table 14 shows the recommendations made to DHBs for complaints closed in Jan–Jun 2021. Please note that more than one recommendation may be made in relation to a single complaint.

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

Table 14. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	19
Audit	15
Evaluation of change	12
Meeting with consumer/complainant	3
Presentation/discussion of complaint and improvements with others	14
Provision of evidence of change to HDC	28
Review/implementation of policies/procedures	32
Training/professional development	24
TOTAL	**147**

The most common recommendations made to DHBs were that they: review or implement new policies and procedures (32 recommendations); provide evidence of change made in response to the complaint to HDC (28 recommendations); conduct staff training (24 recommendations); and apologise to the consumer/complainant (19 recommendations). Recommendations for staff training were most often in regard to clinical issues identified in the complaint, followed by training on new policies/procedures. Often HDC will ask the DHB to use an anonymised version of the complaint as the basis for the training.

6. Learning from complaints

6.1 Emergency department care of girl with septic arthritis[6]

This case reflects a number of themes seen in HDC complaints around the management of recurrent presentations to ED, including the need to think critically with regard to the wider clinical picture, the importance of robust triage processes, and the importance of SMO review in the context of multiple presentations with worsening symptoms.

Background
A girl aged in her teens presented to the ED of a public hospital complaining of intense pain in her right knee and leg. She was unable to sleep or weight-bear on her right knee, and was experiencing chills and vomiting. She had not experienced an injury prior to developing this pain. She was seen by a triage nurse, who did not document the nausea and chills or record any vital signs. The girl was then seen by a clinical nurse specialist, who diagnosed her with a knee sprain/strain and gave soft tissue injury advice. The girl was discharged home, and although she was told to follow up with her GP, she was not given specific advice about returning to ED.

The pain in the girl's knee increased that evening, despite pain relief, and spread to her shin. She decided to return to ED. The triage nurse documented the girl's pain, but did not record her vital signs. While waiting to be seen by the ED registrar, the girl was given morphine for her pain. The registrar reviewed the girl's notes but did not see that she had been given morphine, and he assumed in error that she had been given codeine. Following his assessment, the registrar diagnosed her with a meniscal injury and sent her home with written advice to see a physiotherapist if her pain did not settle.

A couple of days later, the girl's mother called the ED as her daughter was in "terrible pain". However, the girl's mother found the ED staff unhelpful, and decided to take her daughter to an after-hours medical centre. The GP at the centre discussed the girl's case with the orthopaedic registrar at the public hospital, who advised that she return to ED for X-rays. The following morning, the girl returned to the ED. Her observations were recorded by the triage nurse and they were all in the normal range. The girl was reviewed by an ED registrar, who diagnosed Osgood-Schlatter disease, despite this diagnosis not being supported by the X-ray. The registrar discussed the girl's care with the SMO, but he did not tell the SMO that the girl was unable to sleep because of the pain and could not weight-bear. The girl was discharged with a sports medicine referral.

Over the next couple of days, the girl's mother made several calls to a telehealth service in regard to swelling in her daughter's knee, and was advised to take her back to ED. Later that day, the girl returned to ED via ambulance. She had red swollen knees, chest pain, an abnormally rapid heartbeat, and decreased oxygen saturations. Her care was escalated rapidly because of concerns that she had a severe bacterial infection and sepsis. Following surgery to drain her knees, she was transferred to the Intensive Care Unit and diagnosed with septic arthritis in both knees. The girl remained in hospital for several months and requires on-going rehabilitation.

Findings
Before the extent and nature of the girl's disease was identified, she presented to ED three times and, each time, she was sent home with a different incorrect diagnosis. The Commissioner accepted that the illness the girl had developed was rare and that the signs and symptoms may have been subtle, but considered that there were a number of short-comings in the care the girl received across the three ED presentations, specifically:

[6] Case 19HDC02034.

- At the first ED presentation:
  - The girl's nausea and chills were not documented by the triage nurse
  - Vital signs were not taken by the triage nurse
  - No safety-netting advice about when to return to ED was given
- At the second ED presentation:
  - Vital signs were not taken by the triage nurse
  - It was assumed that the girl had been given codeine in the ED, when actually she had been given morphine (despite the administration of morphine being recorded in the medication chart and notes)
  - There was a lack of recognition of the possibility of more serious pathology, and in particular there was a failure to question for infective symptoms in the presence of red flags (repeat presentation and increased pain severity)
- At the third ED presentation:
  - There was no documentation of infective symptoms
  - There was a lack of critical thinking regarding the wider clinical picture — a previously healthy teenager with an atraumatic presentation, increasing pain spreading to both knees, and an inability to weight bear. She was receiving strong analgesia, this was her third presentation in three days, and the X-ray and level of pain did not support the presumed diagnosis of Osgood-Schlatter disease
  - The SMO was not advised that the girl was unable to sleep with pain despite taking analgesics, and could not weight bear (red flag symptoms).

The Commissioner considered that the DHB was responsible for the inadequacies in the service provided, and therefore failed to provide services to the girl with reasonable care and skill, in breach of Right 4(1).

The Commissioner noted that the pressure on staff, in light of high patient acuity and staffing levels at the time, likely affected the quality of services the girl received.

Recommendations
The DHB advised that at the time of these events there was no system for automatic SMO review for patients with multiple re-presentations, and that its triage processes were not as robust as they could have been. The DHB made a number of changes to address these issues.

Bearing in mind these changes, the Commissioner made the following recommendations to the DHB:

- Using an anonymised version of this case, provide training to clinical staff on the importance of carrying out vital signs routinely on ED presentations unless it is clearly not clinically indicated, and of considering possible serious pathologies, particularly in the context of atraumatic pain
- Perform a random audit of ED presentations to confirm whether vital signs were performed where clinically indicated; discharge instructions included ED return criteria; and any recurrent presentations within 48 hours were reviewed in person by the SMO.
- Consider whether a review of its ED staffing levels is warranted.
- Provide a written apology to the girl and her family for the issues identified.

6.2 Failure of two DHBs caring for a premature baby[7]

This case highlights the critical importance of clear and effective communication systems between clinicians and DHBs, including processes that support robust discharge planning and transfer of information.

Background
A baby was born at DHB1 at 24 weeks' gestation. He was the second of twins and weighed 675g. The baby had a number of complications and was transferred to DHB2 owing to his extreme prematurity. Given his low birthweight, his prematurity, and the complications he experienced, the baby was at an increased risk of developing retinopathy of prematurity (ROP) — an abnormality in the growth of blood vessels in the eye, which if untreated can lead to retinal detachment and loss of vision. In order to be successful, treatment should occur when the baby is between 34 and 38 weeks old.

The baby was screened for ROP at DHB2 at 30 and 32 weeks. At 32 weeks, Stage 1 ROP was detected, and this finding was recorded in the Eye Book that was held at NICU, but was not recorded in the clinical notes. A plan was made for further ophthalmology review at 34 weeks. However, when the baby was 33 weeks old he was transferred back to DHB1. During transfer, a discharge letter was generated to assist with the handover of the baby's care from DHB2 to DHB1. Because the baby's ROP status was not documented in the clinical notes, it was not automatically included in the discharge letter.

The neonatal paediatrician at DHB2 called a paediatrician at DHB1 to discuss the baby's transfer. The neonatal paediatrician did not discuss the baby's ROP status or the timing for follow-up of the ROP examination. The neonatal paediatrician advised that the main focus during transfer was on maintaining a stable respiratory status and ensuring growth.

The baby was then admitted to DHB1. The receiving paediatrician wrote a management plan for the baby. The paediatrician noted that the documentation showed no indication that an ROP assessment was required urgently, but he was aware of the guidelines for the management of ROP, and he documented ROP follow-up as part of the management plan. However, the paediatrician did not arrange an ROP assessment.

The baby's father reported that a nurse at DHB2 had told him to "make sure they test his eyes", and that as a result he mentioned it numerous times to doctors and nurses at DHB1. One of these queries was documented. However, an ROP assessment was not arranged or undertaken.

When the baby was 39 weeks old, DHB1 considered that he was fit for discharge. Prior to discharge he was reviewed by a paediatrician, who recognised that ROP screening had not been undertaken. A referral asking for the baby to receive an assessment in 1–2 weeks' time was faxed to the referral centre. The baby was discharged home.

The triaging ophthalmologist marked the referral as having insufficient information, and asked for it to be sent back to the paediatric department; however, accidentally it was sent to the baby's GP. The GP realised the error and sent it back to the DHB. The referral was returned to the paediatric department, but an ophthalmology appointment was not secured until ten days later. The baby was then aged 44 weeks and was outside the parameters for effective treatment of ROP. He was found to have suffered total retinal detachment in the right eye and partial detachment in the left eye.

Findings
The development of ROP was a known risk for the baby. Despite this, a number of administrative and communication failures meant that the baby was not screened and treated in the critical period

[7] Case 19HDC00239.

between 34 and 39 weeks. The systems at the two DHBs did not ensure that appropriate and timely ROP screening was undertaken. There were a number of occasions during the baby's admission at DHB1 and DHB2 when the failure to arrange follow-up ROP screening could have been rectified. The baby now has a lifelong disability that could have been prevented. This case highlights the devastating consequences of poor communication between clinicians and organisations, and the importance of implementing robust and effective screening systems for ROP, particularly at hospitals that may be less familiar with the condition and its management.

The Commissioner commented that when a baby is at risk of developing ROP, and care is to be transferred to another provider, it is especially important that systems are in place to ensure that all relevant information is captured by the discharging hospital and shared with the receiving hospital. She found that the system at DHB2 was not robust, and as a result the need for ongoing ROP screening was not communicated to DHB1. Accordingly, the Commissioner considered that DHB2 failed to ensure quality and continuity of services to the baby, in breach of Right 4(5) of the Code.

DHB1 recognised the need for ROP screening at admission and documented the family's query about eye tests for the baby. However, through a series of medical and administrative errors by multiple staff, DHB1 failed to screen the baby for ROP at the critical 34-week mark, or at any other time throughout his five-week admission. The DHB did not refer the baby for screening until the point of discharge from hospital, and even then there was no sense of urgency. Once the referral was eventually arranged, it was inappropriately rejected and misdirected. As a result, the baby was not screened for ROP until he was 44 weeks old — ten weeks after he was transferred to DHB1's care. Tragically, by that time it was too late for successful treatment.

In the Commissioner's view, this outcome could have been prevented if adequate mechanisms had been in place for ROP screening at DHB1. The series of errors indicate a system that lacked adequate safety-netting or clear protocols to ensure that babies did not fall through the cracks. The Commissioner found that DHB1 failed to provide the baby with services with reasonable care and skill, in breach of Right 4(1). The Commissioner referred DHB1 to the Director of Proceedings to consider whether any proceedings should be taken.

Recommendations
Following this event, DHB2 developed NICU discharge letter guidelines for generating electronic discharge letters that specifically refer to an ROP check for at-risk babies. DHB2 also implemented a process whereby all babies admitted to NICU are admitted under a named SMO, who is responsible for checking all results, letters, and documentation.

The Commissioner recommended that DHB2:

- Conduct an audit of its discharge letters for premature babies on transfer to another hospital, to ensure that ROP details were included.
- Institute a system to ensure that the staff member responsible for collating and printing a patient's discharge summary is reliably and easily identified.
- Ensure that the results of ROP screening are included in the clinical notes.
- Consider whether it is appropriate to have a specific person responsible for ROP screening within NICU.
- Provide a written apology to the baby and his family.

DHB1 told HDC that it had made a number of changes following the events in this complaint, including: reviewing the ROP procedure; ensuring that the clinical nurse manager co-ordinates ROP screening; implementing a process whereby a medical referral checklist is created for each baby on admission;

requiring a written referral and a specialist-to-specialist conversation for all ROP screening referrals; and launching Kōrero Mai (a process to support patient and whānau escalation of concerns) in the paediatric department.

In response to the Commissioner's recommendations, DHB 1 undertook audits of: ROP screening for all at-risk babies; the effectiveness and timeliness of ROP referral processing; and the adequacy of triaging for ROP. DHB1 also provided the baby and his family with an apology.

6.3 DHB failures lead to woman's hepatitis relapse[8]

This case highlights the importance of clarifying roles and responsibilities to enable continuity of care for a complex clinical picture, and of ensuring that patients are communicated with in a way that supports their understanding of the information given and allows them to be a partner in their care.

Background
A woman with lymphoma was under the care of a DHB's medical oncology service. She had a history of hepatitis B infection, which was monitored with six-monthly blood tests. Before commencing chemotherapy, the oncologist started the woman on the medication lamivudine to prevent her hepatitis from reactivating. The intention was for the woman to take lamivudine during chemotherapy and for one year following chemotherapy.

The woman recalls being told at her last chemotherapy oncology clinic that she did not need to take any more pills, and she was not given a prescription at the clinic.

At the completion of chemotherapy, the woman moved on to the radiation therapy component of her care. The problem list in her clinic letter stated: "Hepatitis B carrier, on lamivudine." However, there was no reference to lamivudine needing to be continued for one year after chemotherapy.

A toxicity review was planned with medical oncology, but the woman requested that this follow-up appointment be cancelled as she was undergoing radiotherapy and wanted to avoid duplication. The appointment was deferred for three months.

The woman came to the end of her latest prescription for lamivudine while under radiotherapy treatment. No further prescription was given, and it was the woman's understanding that she was on lamivudine only while undertaking chemotherapy. Accordingly, the planned one-year course after chemotherapy was not completed.

The woman was later admitted to hospital with deteriorating liver function secondary to hepatitis B reactivation. Subsequently, she underwent a liver transplant.

Findings
The system at the DHB did not support the co-ordination of care the woman required across a number of different teams. Issues identified included:

- A lack of clarity around roles and responsibilities, with no clinician seeing it as their primary responsibility to manage the prevention of hepatitis B reactivation once the woman had finished chemotherapy.

[8] Case 19HDC01210.

- The lack of a formal protocol for the prevention of hepatitis B reactivation in patients undergoing immunosuppressive therapy. A draft document was being followed informally, but this did not specify responsibilities for managing viral hepatitis prophylaxis.
- Medication prescribing in medical oncology was paper-based, which limited the accessibility and visibility of prescribing. The paper-based system also did not include prompts for when a patient required a new prescription.
- There was no clear plan to ensure that the woman stayed on lamivudine following chemotherapy.
- Insufficient information was provided to the woman regarding the risk of hepatitis B reactivation. The information provided was verbal only. She was not provided with appropriate information in a form that supported and reinforced her understanding, and she was not able to advocate for herself when the medication was stopped, and therefore was not empowered to be an active participant in her health and well-being.
- Her toxicity review was deferred, and no "end of treatment" summary was provided to the woman or her GP.

These systems issues meant that the stopping of lamivudine went unnoticed, and the woman's hepatitis B reactivated. Accordingly, the Commissioner found that the DHB failed to provide the woman with services with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner also considered that the DHB failed to ensure quality and continuity of services for the woman, in breach of Right 4(5) of the Code.

The woman in this case identified as Cook Island Māori, and the complainant raised issues regarding institutional racism, and that the experience of the woman aligned with the poorer outcomes experienced by Pacific peoples in New Zealand's health system. The DHB acknowledged that it had an obligation to do better for Māori and Pacific patients, who unquestionably experience inequitable health outcomes. The Commissioner agreed, and noted that the way in which the woman was communicated with failed to support her understanding of the care she was receiving, and did not allow her to be a partner in her own care.

Recommendations
Following this event, the DHB made a number of changes, including:

- Developing a new protocol on hepatitis B in patients with cancer, which clearly defines roles and responsibilities.
- Implementing an electronic care management system for medical oncology and haematology, which includes prompts for medication to be continued.
- Appointing a Māori health cancer nurse coordinator.
- Developing a written patient information sheet about the duration of prophylaxis treatment for hepatitis B.
- Ensuring that treatment summaries to GPs and patients include a clear delineation of the handover for high-risk patients to ensure that the patient knows who to contact if they have a problem, and the threshold for contacting their GP.

The Commissioner asked the DHB to apologise to the woman for the deficiencies identified, and to use an anonymised version of this case to encourage reflection and discussion during education sessions.

6.4 Woman's liver lesion not followed up[9]

This case highlights the vulnerabilities and complexities of test result follow-up for tests ordered in the ED, and the importance of building safety-nets into the system to ensure follow-up.

Background
A woman who had recently undergone a left femoral angiogram presented to the ED of a public hospital with left groin pain and swelling. Following an assessment, the ED doctor referred the woman for a CT angiogram of her left leg and abdomen to assess for a retroperitoneal (abdominal) bleed.

The radiologist who reported the CT scan noted a pseudoaneurysm in the left femoral artery, no significant bleeding, and a heterogeneous lesion within the right lobe of the liver. Regarding the liver lesion, the radiologist recommended comparison with prior imaging or "non-urgent dedicated liver imaging".

The radiologist called the ED doctor and provided an informal verbal report of his findings. The radiologist could not recall what he told the ED doctor, but stated that it was his usual practice to bring to the attention of the referring doctor all the findings listed in the conclusion of his report (where the liver lesion was detailed). The ED doctor reported that he was advised of the presence of the pseudoaneurysm, but felt it was unlikely that he was made aware of the liver lesion, as he had not documented it.

The ED doctor referred the woman to the vascular surgery team. He documented the presence of the pseudoaneurysm, but did not document the liver lesion. The ED doctor reviewed and accepted the CT report on the electronic system 27 hours after the woman had been transferred and admitted under another team. The electronic system showed that five other clinicians had also reviewed the report before the ED doctor had accepted it.

The woman was discharged home with a plan to undertake a procedure to treat the pseudoaneurysm. No further follow-up was arranged in relation to the liver lesion.

A few months later, the woman presented to ED with chest and abdominal pain, and a CT scan showed a liver mass. Unfortunately, she was diagnosed with inoperable cancer of the bile duct.

Findings
This case highlights vulnerabilities in a system where, despite apparently reasonable processes being in place, a woman's clearly identified liver lesion was not followed up in a timely manner.

HDC's expert advisors in this case highlighted the complexities of test result follow-up in the ED, with one stating: "[T]he practicalities of an ED SMO handing responsibility for following up a non-urgent finding to a surgical SMO in the early hours of the morning are problematic … [T]he realities of being a shift worker engaged in episodic acute care make it difficult to implement this consistently."

The Commissioner noted that although there was a clear responsibility for the ED doctor to delegate the follow-up of the test result to another clinician, there are obvious challenges in absolute compliance with this policy when taking into account a busy ED setting, and where the test results come in after a patient has been referred to another team. The Commissioner considered that redundancies need to be built into the system to ameliorate these challenges and associated risks.

It was the Commissioner's view that in a situation such as this, it could be reasonably expected that the receiving team would act as a safety-net and take responsibility for following up any unaddressed

[9] Case 19HDC01900.

test results. However, despite the woman being an inpatient for four days, and a number of staff reviewing the CT report, no one took steps to follow up the liver lesion. There was a collective failure to act on the reported abnormality.

The Commissioner found that fallibilities in the DHB's test result management system and the collective failure of several clinicians resulted in the woman not receiving services with reasonable care and skill, and so found the DHB in breach of Right 4(1) of the Code.

Recommendations
The Commissioner recommended that the DHB:

- Provide HDC with an update on its progress towards introducing a system to monitor abnormal radiology results for ED patients.
- Provide HDC with an update on its progress towards extending its procedure of radiologists notifying ordering clinicians of abnormal findings (including incidental findings) to include after-hours contracted radiologists.
- Consider introducing a mandatory review of all test results ordered during an episode of inpatient care prior to discharge, to ensure that any follow-up is actioned appropriately.