# Complaints to HDC involving District Health Boards

## Report and Analysis for period 1 January to 30 June 2017

HDC

Health and Disability Commissioner

*Te Toihau Hauātanga, Hauātanga*

**Feedback**
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Citation: The Health and Disability Commissioner. 2017. *Complaints to the Health and Disability Commissioner involving District Health Boards: Report and Analysis for the period 1 January to 30 June 2017*

Published in October 2017
by the Health and Disability Commissioner
PO Box 1791, Auckland 1140

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# Commissioner's Foreword

I am pleased to present you with HDC's second six monthly DHB complaint report for the 2016/2017 year.

Complaints to HDC about DHBs increased by 24% in the second half of 2016/2017, with this being the largest number of complaints ever received by HDC about DHBs in a six-month period. This increase in complaints was, however, generally in line with the overall increase in complaints to HDC, with DHBs continuing to make up around 40% of all complaints received by HDC. The trends in complaints about DHBs in Jan-Jun 2017 have remained broadly consistent with previous periods. Surgery, general medicine and mental health have remained the most commonly complained about service types at DHBs, and misdiagnosis was again the most commonly complained about primary issue. Waiting list/prioritisation issues became the second most commonly complained about primary issue for DHBs for the first time in Jan-Jun 2017.

Almost a fifth of complaints about DHB services are complaints where the complainant first complained directly to the DHB, and then, considering the DHB's response to be inadequate, complained to HDC. All healthcare organisations should have a clear, visible and accessible complaints process that welcomes complaints from both consumers and staff. Individual staff should be encouraged to take personal responsibility for adopting a proactive and positive approach to dealing with and responding to complaints. Complaints should be reinforced as a learning opportunity to staff and as a chance to review and improve their practice.

One of HDC's strategic priorities for the 2016/2017 year was to work with DHBs to improve their complaints processes so that complaints are resolved at the lowest appropriate level. In line with this priority HDC continues to conduct complaint management workshops for DHBs. These workshops are targeted at front-line staff who deal with complaints as they happen. These workshops aim to increase the confidence of staff and their capability to resolve and learn from complaints. As complaint volumes continue to rise, I encourage all providers to consider how best to equip their staff to manage complaints well.

Anthony Hill
**Health and Disability Commissioner**

# National Data for all District Health Boards

## 1.0 Number of complaints received

### *1.1 Raw number of complaints received*

In the period Jan–Jun 2017, HDC received a total of **477**[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six month periods are reported in Table 1.

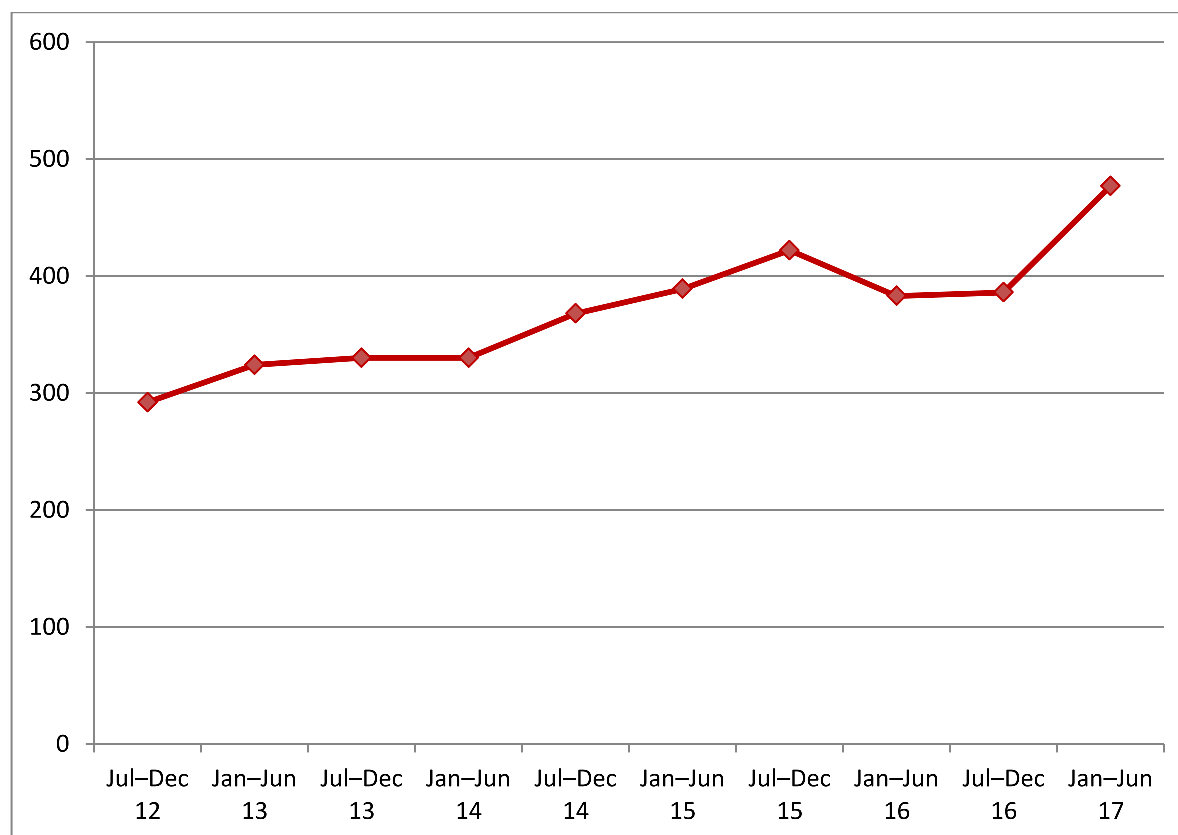
**Table 1.** Number of complaints received in the last five years

| | Jul–Dec 12 | Jan–Jun 13 | Jul–Dec 13 | Jan–Jun 14 | Jul–Dec 14 | Jan–Jun 15 | Jul–Dec 15 | Jan–Jun 16 | Jul–Dec 16 | Average of last 4 6-month periods | Jan–Jun 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Number of complaints** | 292 | 324 | 330 | 330 | 368 | 389 | 422 | 383 | 386 | **395** | **477** |

The total number of complaints received in Jan–Jun 2017 (477) shows an increase of 21% over the average number of complaints received in the previous four periods, and is the largest number of complaints ever received about DHBs in a six-month period.

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

**Figure 1.** Number of complaints received




[1] Provisional as of date of extraction (25 August 2017).

*1.2 Rate of complaints received*

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

Rate of complaints calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (25 October 2017) and is likely incomplete, it will be updated in the next 6-monthly report. It should be noted that this discharge data excludes short stay emergency department discharges and patients attending outpatient clinics.

**Table 2.** Rate of complaints received per 100,000 discharges during Jan–Jun 2017

| Number of complaints received | Total number of discharges | Rate per 100,000 discharges |
|---|---|---|
| 477 | 481,069 | **99.15** |

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

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

| | Jul–Dec 12 | Jan–Jun 13 | Jul–Dec 13 | Jan–Jun 14 | Jul–Dec 14 | Jan–Jun 15 | Jul–Dec 15 | Jan–Jun 16 | Jul–Dec 16[2] | Average of last 4 6-month periods | Jan–Jun 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Rate per 100,000 discharges** | 62.59 | 72.67 | 71.15 | 72.99 | 76.65 | 84.60 | 87.57 | 81.44 | 78.79 | **83.10** | **99.15** |

The rate of complaints received during Jan–Jun 2017 (99.15) shows a 19% increase over the average rate of complaints received for the previous four periods, and is the highest rate of complaints ever received about DHBs in a six-month period.

**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, with DHBs consistently making up around 40% of all complaints received by HDC.

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

The growth in complaint numbers is more likely to be due to the increasing profile of HDC, the improved accessibility of complaints processes due to advancing technology, and an increasing public knowledge of consumer rights. It may also reflect increasing health care service activity.

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] The rate for Jul–Dec 2016 has been recalculated based on the most recent discharge data.

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

**Table 4.** Number and rate of complaints received for each DHB in Jan-Jun 2017

| DHB | Number of complaints received | Number of discharges | Rate of complaints to HDC per 100,000 discharges |
|---|---|---|---|
| Auckland | 69 | 60,192 | 114.63 |
| Bay of Plenty | 16 | 25,810 | 61.99 |
| Canterbury | 52 | 56,513 | 92.01 |
| Capital and Coast | 49 | 31,022 | 157.95 |
| Counties Manukau | 41 | 50,911 | 80.53 |
| Hawke's Bay | 19 | 16,897 | 112.45 |
| Hutt Valley | 20 | 16,083 | 124.35 |
| Lakes | 11 | 11,674 | 94.23 |
| MidCentral | 26 | 15,359 | 169.28 |
| Nelson Marlborough | 17 | 12,145 | 139.98 |
| Northland | 13 | 20,341 | 63.91 |
| South Canterbury | 6 | 6,211 | 96.60 |
| Southern | 42 | 26,008 | 161.49 |
| Tairawhiti | 6 | 5,252 | 114.24 |
| Taranaki | 6 | 12,362 | 48.54 |
| Waikato | 40 | 47,567 | 84.09 |
| Wairarapa | 3 | 4,222 | 71.06 |
| Waitemata | 49 | 53,072 | 92.33 |
| West Coast | 5 | 3,229 | 154.85 |
| Whanganui | 5 | 6,199 | 80.66 |

**Notes on DHB's number and rate of complaints**

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

It is also important to note that numbers of complaints received by HDC is not always a good proxy for quality of care provided and may instead, for example, be an indicator of the effectiveness of a DHB's complaint system or features of the consumer population in a particular area. Additionally, complaints received within a single 6 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.

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

## 2.0 Service types complained about

### *2.1 Service type category*

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 477 complaints about DHBs, 497 services were complained about.

**Table 5.** Service types complained about

| Service type | Number of complaints | Percentage |
|---|---|---|
| **Alcohol and drug** | **3** | **0.6%** |
| **Anaesthetics/pain medicine** | **2** | **0.4%** |
| **Dental** | **5** | **1.0%** |
| **Diagnostics** | **17** | **3.4%** |
| **Disability services** | **7** | **1.4%** |
| **District nursing** | **4** | **0.8%** |
| **Emergency department** | **56** | **11.3%** |
| **General medicine** | **100** | **20.1%** |
| Cardiology | 13 | 2.6% |
| Dermatology | 1 | 0.2% |
| Endocrinology | 2 | 0.4% |
| Gastroenterology | 9 | 1.8% |
| Geriatric medicine | 9 | 1.8% |
| Haematology | 4 | 0.8% |
| Infectious diseases | 2 | 0.4% |
| Neurology | 18 | 3.6% |
| Oncology | 9 | 1.8% |
| Renal/nephrology | 5 | 1.0% |
| Respiratory | 7 | 1.4% |
| Rheumatology | 1 | 0.2% |
| Other/unspecified | 20 | 4.0% |
| **Hearing services** | **1** | **0.2%** |
| **Intensive care/critical care** | **8** | **1.6%** |
| **Maternity** | **27** | **5.4%** |
| **Mental health** | **98** | **19.7%** |
| **Paediatrics (not surgical)** | **10** | **2.0%** |
| **Pharmacy** | **1** | **0.2%** |
| **Rehabilitation services** | **2** | **0.4%** |
| **Surgery** | **150** | **30.2%** |
| Cardiothoracic | 3 | 0.6% |
| General | 24 | 4.8% |
| Gynaecology | 17 | 3.4% |
| Neurosurgery | 5 | 1.0% |
| Ophthalmology | 13 | 2.6% |
| Orthopaedics | 50 | 10.1% |
| Otolaryngology | 14 | 2.8% |
| Paediatrics | 2 | 0.4% |
| Plastic and Reconstructive | 8 | 1.6% |
| Urology | 7 | 1.4% |
| Vascular | 7 | 1.4% |
| **Other/unknown health service** | **6** | **1.2%** |
| **TOTAL** | **497** | |

Surgical services (30.2%) received the greatest number of complaints in Jan-Jun 2017, with orthopaedics (10.1%) being the most commonly complained about surgical specialty. Other commonly complained about services included general medicine (20.1%), mental health (19.7%), emergency departments (11.3%) and maternity services (5.4%). This is similar to what has been seen in previous periods.

## 3.0 Issues complained about

### *3.1 Primary complaint issues*

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

**Table 6.** Primary issues complained about

| Primary issue in complaints | Number of complaints | Percentage |
|---|---|---|
| ***Access/Funding*** | ***80*** | ***16.8%*** |
| Lack of access to services | 28 | 5.9% |
| Lack of access to subsidies/funding | 5 | 1.0% |
| Waiting list/prioritisation issue | 47 | 9.9% |
| ***Boundary violation*** | ***2*** | ***0.4%*** |
| Inappropriate sexual physical contact | 1 | 0.2% |
| Inappropriate non-sexual relationship | 1 | 0.2% |
| ***Care/Treatment*** | ***233*** | ***48.8%*** |
| Delay in treatment | 9 | 1.9% |
| Delayed/inadequate/inappropriate referral | 3 | 0.6% |
| Inadequate coordination of care/treatment | 9 | 1.9% |
| Inadequate/inappropriate clinical treatment | 28 | 5.9% |
| Inadequate/inappropriate examination/assessment | 14 | 2.9% |
| Inadequate/inappropriate follow-up | 7 | 1.5% |
| Inadequate/inappropriate monitoring | 10 | 2.1% |
| Inadequate/inappropriate non-clinical care | 5 | 1.0% |
| Inadequate/inappropriate testing | 2 | 0.4% |
| Inappropriate admission/failure to admit | 3 | 0.6% |
| Inappropriate/delayed discharge/transfer | 13 | 2.7% |
| Inappropriate withdrawal of treatment | 3 | 0.6% |
| Missed/incorrect/delayed diagnosis | 70 | 14.7% |
| Personal privacy not respected | 1 | 0.2% |
| Refusal to assist/attend | 5 | 1.0% |
| Refusal to treat | 2 | 0.4% |
| Rough/painful care or treatment | 5 | 1.0% |
| Unexpected treatment outcome | 44 | 9.2% |
| ***Communication*** | ***47*** | ***9.9%*** |
| Disrespectful manner/attitude | 21 | 4.4% |
| Failure to communicate openly/honestly/effectively with consumer | 10 | 2.1% |
| Failure to communicate openly/honestly/effectively with family | 14 | 2.9% |
| Insensitive/inappropriate comments | 2 | 0.4% |
| ***Complaints process*** | ***5*** | ***1.0%*** |

| Primary issue in complaints | Number of complaints | Percentage |
|---|---|---|
| Inadequate response to complaint | 4 | 0.8% |
| Retaliation/discrimination as a result of a complaint | 1 | 0.2% |
| ***Consent/Information*** | ***55*** | ***11.5%*** |
| Consent not obtained/adequate | 10 | 2.1% |
| Inadequate information provided regarding adverse event | 2 | 0.4% |
| Inadequate information provided regarding condition | 4 | 0.8% |
| Inadequate information provided regarding fees/costs | 1 | 0.2% |
| Inadequate information provided regarding provider | 1 | 0.2% |
| Inadequate information provided regarding results | 2 | 0.4% |
| Inadequate information provided regarding treatment | 6 | 1.3% |
| Incorrect/misleading information provided | 2 | 0.4% |
| Issues with involuntary admission/treatment | 26 | 5.5% |
| Other | 1 | 0.2% |
| ***Documentation*** | ***5*** | ***1.0%*** |
| Delay/failure to disclose documentation | 1 | 0.2% |
| Inadequate/inaccurate documentation | 4 | 0.8% |
| ***Facility issues*** | ***15*** | ***3.1%*** |
| Accreditation/statutory obligations not met | 1 | 0.2% |
| Cleanliness/hygiene issue | 1 | 0.2% |
| Failure to follow policies/procedures | 2 | 0.4% |
| General safety issue for consumer in facility | 6 | 1.3% |
| Inadequate/inappropriate policies/procedures | 2 | 0.4% |
| Issue with sharing facility with other consumers | 1 | 0.2% |
| Staffing/rostering/other HR issue | 1 | 0.2% |
| Waiting times | 1 | 0.2% |
| ***Medication*** | ***20*** | ***4.2%*** |
| Administration error | 2 | 0.4% |
| Dispensing error | 1 | 0.2% |
| Inappropriate administration | 4 | 0.8% |
| Inappropriate prescribing | 9 | 1.9% |
| Refusal to prescribe/dispense/supply | 4 | 0.8% |
| ***Reports/Certificates*** | ***6*** | ***1.3%*** |
| Inaccurate report/certificate | 5 | 1.0% |
| Refusal to complete report/certificate | 1 | 0.2% |
| ***Other professional conduct issues*** | ***7*** | ***1.5%*** |
| Assault | 2 | 0.4% |
| Inappropriate collection/use/disclosure of information | 4 | 0.8% |
| Threatening/bullying/harassing behaviour | 1 | 0.2% |
| ***Other issues*** | ***2*** | ***0.4%*** |
| **TOTAL** | **477** | |

The most common primary issue categories concerned care/treatment (48.8%), access/funding (16.8%), consent/information (11.5%) and communication (9.9%). Among these, the most common specific primary issues in complaints about DHBs were 'missed/incorrect/delayed diagnosis' (14.7%), 'waiting list/prioritisation issue' (9.9%), 'unexpected treatment outcome' (9.2%), 'inadequate/inappropriate clinical treatment' (5.9%) and 'lack of access to services' (5.9%). This is broadly similar to what was seen last period.

Table 7 shows a comparison over time for the top five primary issues complained about. The top five primary issues have remained broadly consistent over time. However, 'waiting list/prioritisation issue' became the second most commonly complained about primary issue for the first time in Jan-Jun 2017.

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

| **Top five primary issues in all complaints** (%) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Jul–Dec 15 n=422** | | **Jan–Jun 16 n=381** | | **Jul–Dec 16 n=386** | | **Jan–Jun 17 n=477** | |
| Misdiagnosis | 16% | Misdiagnosis | 16% | Misdiagnosis | 15% | Misdiagnosis | 15% |
| Unexpected treatment outcome | 12% | Inadequate treatment | 9% | Unexpected treatment outcome | 8% | Waiting list/ prioritisation | 10% |
| Inadequate treatment | 9% | Unexpected treatment outcome | 8% | Inadequate treatment | 8% | Unexpected treatment outcome | 9% |
| Waiting list/ prioritisation | 7% | Lack of access to services | 6% | Lack of access to services | 8% | Inadequate treatment | 6% |
| Lack of access to services | 6% | Waiting list/ prioritisation | 5% | Waiting list/ prioritisation | 7% | Lack of access to services | 6% |

### *3.2 All complaint issues*

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

On analysis of all issues identified in complaints about DHBs, the most common complaint issue categories were care/treatment (present for 80.9% of all complaints), communication (present for 66.0% of all complaints), consent/information (present for 26.0% of all complaints) and access/funding (present for 22.2% of all complaints). The most common specific issues were 'failure to communicate effectively with consumer' (36.3%), 'inadequate/inappropriate clinical treatment' (34.8%) 'inadequate/inappropriate examination/assessment' (23.5%), 'failure to communicate effectively with family' (22.4%), 'missed/incorrect/delayed diagnosis' (22.0%), 'inadequate coordination of care/treatment' (21.8%), 'delay in treatment' (20.5%), 'disrespectful manner/attitude' (19.5%) and 'inadequate response to the consumer's complaint by the DHB' (17.4%). This is broadly similar to what was seen last period.

Also similar to the last six-month period, many complaints involved issues with a consumer's care/treatment, such as 'unexpected treatment outcome' (15.3%), 'inadequate/inappropriate testing' (13.8%), 'inadequate/inappropriate follow-up' (13.0%) and 'inappropriate/delayed discharge/transfer' (12.4%).

**Table 8.** All issues identified in complaints

| All issues in complaints | Number of complaints | Percentage |
|---|---|---|
| ***Access/Funding*** | ***106*** | ***22.2%*** |
| ACC compensation issue | 3 | 0.6% |
| Lack of access to services | 57 | 11.9% |
| Lack of access to subsidies/funding | 9 | 1.9% |
| Waiting list/prioritisation issue | 67 | 14.0% |
| ***Boundary violation*** | ***3*** | ***0.6%*** |
| ***Care/Treatment*** | ***386*** | ***80.9%*** |
| Delay in treatment | 98 | 20.5% |
| Delayed/inadequate/inappropriate referral | 33 | 6.9% |
| Inadequate coordination of care/treatment | 104 | 21.8% |
| Inadequate/inappropriate clinical treatment | 166 | 34.8% |
| Inadequate/inappropriate examination/assessment | 112 | 23.5% |
| Inadequate/inappropriate follow-up | 62 | 13.0% |
| Inadequate/inappropriate monitoring | 44 | 9.2% |
| Inadequate/inappropriate non-clinical care | 34 | 7.1% |
| Inadequate/inappropriate testing | 66 | 13.8% |
| Inappropriate admission/failure to admit | 16 | 3.4% |
| Inappropriate/delayed discharge/transfer | 59 | 12.4% |
| Inappropriate withdrawal of treatment | 11 | 2.3% |
| Missed/incorrect/delayed diagnosis | 105 | 22.0% |
| Personal privacy not respected | 1 | 0.2% |
| Refusal to assist/attend | 16 | 3.4% |
| Refusal to treat | 16 | 3.4% |
| Rough/painful care or treatment | 25 | 5.2% |
| Unexpected treatment outcome | 73 | 15.3% |
| Unnecessary treatment/over-servicing | 4 | 0.8% |
| ***Communication*** | ***315*** | ***66.0%*** |
| Disrespectful manner/attitude | 93 | 19.5% |
| Failure to accommodate cultural/language needs | 8 | 1.7% |
| Failure to communicate openly/honestly/effectively with consumer | 173 | 36.3% |
| Failure to communicate openly/honestly/effectively with family | 107 | 22.4% |
| Insensitive/inappropriate comments | 10 | 2.1% |
| ***Complaints process*** | ***84*** | ***17.6%*** |
| Inadequate response to complaint | 83 | 17.4% |
| Inadequate information provided re complaints process | 1 | 0.2% |
| Retaliation/discrimination as a result of a complaint | 1 | 0.2% |
| ***Consent/Information*** | ***124*** | ***26.0%*** |
| Consent not obtained/adequate | 26 | 5.5% |
| Failure to assess capacity to consent | 5 | 1.0% |
| Inadequate information provided regarding adverse event | 6 | 1.3% |
| Inadequate information provided regarding condition | 10 | 2.1% |
| Inadequate information provided regarding options | 13 | 2.7% |
| Inadequate information provided regarding provider | 4 | 0.8% |
| Inadequate information provided regarding results | 11 | 2.3% |
| Inadequate information provided regarding treatment | 41 | 8.6% |
| Incorrect/misleading information provided | 10 | 2.1% |

| All issues in complaints | Number of complaints | Percentage |
|---|---|---|
| Issues with involuntary admission/treatment | 28 | 5.9% |
| Other | 3 | |
| ***Documentation*** | ***28*** | ***5.9%*** |
| Delay/failure to disclose documentation | 6 | 1.3% |
| Delay/failure to transfer documentation | 4 | 0.8% |
| Inadequate/inaccurate documentation | 18 | 3.8% |
| Intentionally misleading/altered documentation | 2 | 0.4% |
| ***Facility issues*** | ***94*** | ***19.7%*** |
| Accreditation/statutory obligations not met | 3 | 0.6% |
| Cleanliness/hygiene issue | 8 | 1.7% |
| Failure to follow policies/procedures | 9 | 1.9% |
| General safety issue for consumer in facility | 21 | 4.4% |
| Inadequate/inappropriate policies/procedures | 19 | 4.0% |
| Issue with quality of aids/equipment | 6 | 1.3% |
| Issue with sharing facility with other consumers | 9 | 1.9% |
| Staffing/rostering/other HR issue | 22 | 4.6% |
| Waiting times | 16 | 3.3% |
| ***Medication*** | ***60*** | ***12.6%*** |
| Administration error | 8 | 1.7% |
| Dispensing error | 1 | 0.2% |
| Inappropriate administration | 8 | 1.7% |
| Inappropriate prescribing | 37 | 7.8% |
| Refusal to prescribe/dispense/supply | 8 | 1.7% |
| ***Reports/Certificates*** | ***13*** | ***2.7%*** |
| Inaccurate report/certificate | 9 | 1.9% |
| Refusal to complete report/certificate | 4 | 0.8% |
| ***Teamwork/supervision*** | ***13*** | ***2.7%*** |
| Delayed/inadequate/inappropriate handover | 2 | 0.4% |
| Inadequate supervision/oversight | 11 | 2.3% |
| ***Other professional conduct issues*** | ***27*** | ***5.7%*** |
| Assault | 2 | 0.4% |
| Disrespectful behaviour | 11 | 2.3% |
| Inappropriate collection/use/disclosure of information | 13 | 2.7% |
| Other | 2 | |
| ***Other issues*** | ***16*** | |

### *3.3 Service type and primary issues*

Table 9 shows the top three primary issues in complaints concerning the most commonly complained about service types. This is broadly similar to what was seen in the last six-month period. However, waiting list/prioritisation issues became more prominent for general medicine and emergency department (complaints relating to the triage process) services in Jan-Jun 2017.

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

| **Surgery n=150** | | **General medicine n=100** | | **Mental health n=98** | | **Emergency department n=56** | | **Maternity n=27** | |
|---|---|---|---|---|---|---|---|---|---|
| Unexpected treatment outcome | 22% | Missed/ incorrect/ delayed diagnosis | 11% | Issues with involuntary admission/ treatment | 27% | Missed/ incorrect/ delayed diagnosis | 46% | Inadequate/ inappropriate treatment | 21% |
| Missed/ incorrect/ delayed diagnosis | 16% | Waiting list/ prioritisation issue | 9% | Inadequate examination/ assessment | 9% | Disrespectful manner/ attitude | 7% | Missed/ incorrect/ delayed diagnosis | 14% |
| Waiting list/ prioritisation issue | 15% | Inadequate/ inappropriate treatment | 8% | Waiting list/ prioritisation issue & Lack of access to services | 5% each | Waiting list/ prioritisation issue | 7% | Delay in treatment | 14% |

## 4.0 Complaints closed

### *4.1 Number of complaints closed*

HDC closed **465**[4] complaints involving DHBs in the period Jan–Jun 2017. Table 10 shows the number of complaints closed in previous six month periods.

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

| | Jul–Dec 12 | Jan–Jun 13 | Jul–Dec 13 | Jan–Jun 14 | Jul–Dec 14 | Jan–Jun 15 | Jul–Dec 15 | Jan–Jun 16 | Jul–Dec 16 | Average of last 4 6-month periods | Jan–Jul 17 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Number of complaints closed** | 254 | 337 | 280 | 411 | 344 | 410 | 365 | 482 | 316 | **393** | **465** |

### *4.2 Outcomes of complaints closed*

Complaints that are within HDC's jurisdiction are classified into two groups according to the manner of resolution — whether formal investigation or other resolution. Within each classification, there is a variety of possible outcomes. Once HDC has notified a DHB that a complaint concerning that DHB is to be investigated, the complaint remains classified as an investigation, even though an alternative manner of resolution may subsequently be adopted. Notification of investigation generally indicates more serious or complex issues.

In the Jan–Jun 2017 period, **4** DHBs had no investigations closed, **8** DHBs had one investigation closed, **2** DHBs had two investigations closed, **4** DHBs had three investigations closed, **1** DHB had four investigations closed and **1** DHB had six investigations closed by HDC.

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

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

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

| Outcome for DHBs | Number of complaints closed |
|---|---|
| ***Investigation*** | ***32*** |
| Breach finding | 16 |
| No further action with follow-up or educational comment | 7 |
| No further action | 5 |
| No breach finding | 4 |
| ***Other resolution following assessment*** | ***420*** |
| No further action[6] with follow-up or educational comment | 97 |
| Referred to Ministry of Health | 2 |
| Referred to Privacy Commissioner | 1 |
| Referred to District Inspector | 22 |
| Referred to DHB[7] | 104 |
| Referred to Advocacy | 68 |
| No further action | 121 |
| Withdrawn | 5 |
| ***Outside jurisdiction*** | ***13*** |
| **TOTAL** | **465** |

[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 which is listed highest in the table is included.

[6] The Commissioner has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of formal investigation, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. This may happen, for example, where a DHB has carefully reviewed the case itself and no further value would be added by HDC investigating, or where another agency is reviewing, or has carefully reviewed the matter (for example, the Coroner, the Director-General of Health, or a District Inspector). Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice.

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

### 4.3 Recommendations made to DHBs following a complaint

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

**Table 12.** Recommendations made to DHBs following a complaint

| Recommendation | Number of recommendations made |
|---|---|
| Apology | 22 |
| Audit | 28 |
| Meeting with consumer | 9 |
| Presentation/discussion of complaint with others | 17 |
| Provision of evidence of change to HDC | 48 |
| Reflection | 12 |
| Review/implementation of policies/procedures | 45 |
| Training/professional development | 32 |
| **Total** | **213** |

The most common recommendation made to DHBs was that they provide evidence to HDC of the changes they had made in response to the issues raised by the complaint (48 recommendations), followed by a review of their policies/procedures or implementation of new policies/procedures (45 recommendations). Audits were also often recommended (28 recommendations), this was most commonly in relation to ensuring that staff were following policies/procedures. When staff training was recommended this was most often in relation to clinical issues, followed by communication and documentation. On some occasions, HDC also recommended that an anonymised version of the complaint be used as a training tool for staff.

## 5.0 Learning from complaints — HDC case reports

### Care of pregnant woman with diabetic ketoacidosis (15HDC01036)

*Background*

Mrs A, a woman in her thirties with a history of poorly controlled Type 1 diabetes mellitus, was pregnant for the third time. Mrs A was under the care of the DHB's Diabetes and Pregnancy Service (the Service). Despite her pregnancy being managed by the multidisciplinary "high risk" antenatal clinic, Mrs A had not been informed about the signs and symptoms of diabetic ketoacidosis (DKA), a serious complication of diabetes when the body produces high levels of ketones. Additionally, HDC's expert advisor considered that, in light of the high-risk nature of Mrs A's pregnancy, her diabetes during her pregnancy should have been monitored more closely than it was by the Service, and that increased personal contact by clinicians was warranted.

When she was 31 weeks pregnant, Mrs A presented at the hospital's emergency department (ED) with a headache, nausea and general illness. Mrs A was sent directly to the maternity unit without being triaged in ED. Mrs A told staff she had Type 1 diabetes mellitus and that she was under specialist obstetric and endocrinologist care. However, the Service was not advised of her admission.

Mrs A was given IV fluids and analgesia for her headache. There is no record of her urine having been checked for ketones following the administration of fluids. Her condition improved overnight with hydration, and Mrs A was discharged the following day despite poor glycaemic control and no inpatient assessment by the Service. Mrs A became unwell again and, in the early hours of the following morning, she re-presented to ED. Mrs A was seen by the ED registrar and the obstetric team, and a diagnosis of probable DKA was made. Given Mrs A's life-threatening condition, an emergency Caesarean section was performed and a still born infant was delivered. When Mrs A was discharged there was no record of consideration of the reasons why Mrs A developed DKA, and no guidance was provided at discharge on how to reduce the risk of recurrence.

*Findings*

The Commissioner found that the DHB failed to provide Mrs A with care of an appropriate standard in the following respects:

- the signs and symptoms that Mrs A might expect to experience should she be suffering from DKA were not adequately communicated to her;
- Mrs A's diabetes was not monitored sufficiently closely during the pregnancy, particularly through personal contact with clinicians;
- despite Mrs A telling hospital staff that she was a patient under specialist diabetes care, the Service was not contacted during her admission;
- various tests were not carried out during Mrs A's hospital admission, the management of her diabetes was not reviewed, and she was not assessed by a diabetes clinician prior to discharge;
- the discharge summary following her second admission, does not state why Mrs A developed DKA, and gives no guidance on how to reduce the risk of recurrence of DKA.

The Commissioner considered that the DHB team had sufficient information to provide Mrs A with appropriate care. However a series of judgement and communication failures meant that they did not do so. Accordingly the Commissioner found that the DHB failed to provide Mrs A with services with appropriate care and skill, in breach of Right 4(1) of the Code.

*Recommendations*

The Commissioner made a number of recommendations to the DHB, including that it provide an update to HDC on the actions it had taken following this complaint, including:

- a review of the staffing of the Service;
- a review of the physical layout and suitability of the Service, and an audit of the documentation of the care provided by the Service to pregnant women with diabetes;
- a report on the national gestational diabetes guidelines, once implemented;
- a copy of the patient information resource on diabetes management in pregnancy and the pregnancy-specific insulin infusion protocol, and any other relevant reviewed policies; and
- a report on the establishment of a preconception clinic.

The Commissioner also recommended that the DHB:

- undertake a consultation with other DHBs regarding the development of consistent glycaemic targets for pregnant women;
- include in any protocols developed a requirement that, in circumstances where a patient is receiving multidisciplinary care and is admitted to hospital, all disciplines are informed and involved in treatment decisions;
- give consideration to the development of a protocol to provide that, in cases where a woman's glycaemic control is poor, there is a regular review of the records by a doctor and limited contact by telephone and email;
- undertake a review of the diabetes assessment/education checklist to include DKA;
- undertake an investigation of the possibility of a system whereby the readings from BGL meters are downloaded electronically; and
- undertake a review of the protocol regarding DKA in the Service guidelines, with a view to adding the risks and precipitating causes, pregnancy-vomiting-hydration. Consider adding the recommendation that the blood sugar level is > 40mmol/L before referral to ICU.

**Follow-up of X-ray results (15HDC00268)**

*Background*

Mrs A presented to a public hospital's ED with a history of a cough and chest tightness. She was examined by a medical officer, Dr C, who gave her nebulisers, after which she improved. Dr C ordered a chest X-ray and did not note anything of concern. She diagnosed Mrs A with chronic obstructive pulmonary disease with acute asthma. Mrs A was discharged home with her care discharged back to her GP. Her discharge report did not mention a pending X-ray report.

Later that month, the formal radiologist's report was sent electronically to Dr C's inbox. In the report, the radiologist identified a mass and recommended a chest X-ray or CT scan in six weeks time.

Dr C reviewed the X-ray report in the memo tab of her inbox, but did not electronically acknowledge the results. Dr C went on leave the following day for ten days. She stated the X-ray results were not immediately urgent, and she considered it appropriate to action them on her return. Dr C assumed that the result would still be visible in the memo tab on her return, and was not aware that the memo would drop off from her view after 24 hours.

When Dr C returned from leave, Mrs A's chest X-ray results were no longer visible in the memo tab of Dr C's inbox, and Dr C did not recall the report. Mrs A did not receive the recommended follow-up X-ray or CT scan, and the X-ray results were not sent to her.

About 20 months after Mrs A's X-ray, she returned to the hospital having felt unwell for the last few days. A review of her electronic clinical history resulted in the discovery of the non-actioned X-ray report, which showed a mass on Mrs A's lung. Sadly Mrs A died two months later.

The DHB's investigation into these events found that its IT system allowed results to disappear from the view of the memo tab, once results were opened/viewed, after 24 hours regardless of whether they were acknowledged. All unattended and unacknowledged reports remained in the "unacknowledged work list". However, "the ED were unaware of this distinction in the functionality", and ED staff were using only the memo tab. There was no process at the hospital to ensure that reports or results were acknowledged within a certain length of time, and there was no warning system to alert clinicians to the existence of unacknowledged reports.

*Findings*

The Commissioner found that the DHB failed to have in place an appropriate system for the management and acknowledgement of test results. He noted, while a system was in place, clinicians were not trained adequately to use that system. There was clearly widespread misunderstanding within the ED regarding the functionality of the IT system, which clinicians should have been able to rely on and use adequately. This failure resulted in Dr C not following up on Mrs A's report. In addition, the Commissioner considered that the DHB did not have in place an appropriate system to ensure that Mrs A's GP received the X-ray report, and did not have a process to ensure that reports or results did not go unacknowledged by clinicians. Accordingly, the Commissioner found that the DHB failed to provide Mrs A with services with appropriate care and skill, in breach of Right 4(1) of the Code.

The Commissioner was critical of Dr C for not putting in place any safety-netting strategies. However, overall, he considered it was reasonable for her to rely on the system in these circumstances.

*Recommendations*

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

- share a report regarding the outcome of its Electronic Acknowledgement Project (a project focusing on improving the systems and practices regarding unacknowledged results) with HDC and DHB Shared Services;
- provide HDC with an audit of four months of data regarding the time taken to acknowledge reports;
- consider having a warning system added to its electronic IT system to alert clinicians to the existence of unacknowledged results;
- arrange for an impartial IT expert with a medical background to examine its electronic management system to determine whether user warnings and updates need to be built in to the software and training sessions;
- provide a report to HDC regarding the actions taken in respect of the recommendations outlined in the DHB's Serious Adverse Event Report; and
- provide a written apology to Mrs A's family for its breach of the Code.

**Access to pain relief for addictions service client (15HDC00563)**

*Background*

Mr A was on long-term opioid substitution treatment under the care of the Addictions Service at a DHB. Mr A presented to the ED at his local hospital following a fall. Mr A was found to have multiple nodules on his lungs and a lesion on his liver. A consultant physician reviewed Mr A, recorded his impression of chronic liver disease, hypoxia with suspicions of malignancy, and abdominal lesions and nodes.

Three days later, Mr A contacted Mr C, an addiction clinician at the Addictions Service, and advised that he had been diagnosed with cancer of the liver. Mr C informed the manager at the Addictions Service, Ms D. The minutes from the Addictions Service's weekly meeting noted that Mr A was being investigated for liver cancer and was requesting to have his methadone increased when discharged from hospital. The hospital discharge summary referred to Mr A's "possible poor prognosis" and included a plan for outpatient follow-up and GP review of Mr A's abdominal pain and pain relief.

Mr A presented at the hospital a few weeks later, reporting shortness of breath and abdominal pain. Mr A's admission and pain were reported to Ms D. Mr A was discharged a few days later by house officer, Dr H, with a prescription for increased methadone intended for acute pain relief. Mr A was noted at the time to be in severe pain with a deteriorating clinical condition.

Mr A took the prescription to a pharmacy. Because of the change in methadone dose, the pharmacy called the Addictions Service. Dr B, an addiction specialist, contacted Dr H to clarify the prescription, and was advised that the methadone was prescribed to help with abdominal pain. Dr B advised that Dr H was unaware of the DHB policy on prescribing methadone for addiction services clients on discharge. Dr H cancelled the prescription. Dr B did not follow up on the prescription when he returned to work the next day.

Mr A was discussed at the next Addictions Service meeting, at which time it was noted that he was having an MRI that afternoon. The minutes note that Dr B was "reluctant to increase [Mr A's] methadone, due to concern he is drug-seeking".

Mr A underwent the MRI, but it could not be completed because he was unable to lie still owing to the pain. This information was relayed to Dr B by Mr C. Dr B said that this was the first indication he had that Mr A could be requiring methadone for clinical reasons rather than addiction. Responsibility for Mr A's methadone prescribing was handed over to a palliative care specialist. Mr A was transferred to hospice care, and passed away shortly afterwards.

*Findings*

The Mental Health Commissioner stated that the DHB "failed to identify and/or address an overly cautious approach being taken to the management of interactions with Mr A". The Mental Health Commissioner considered that there were a number of missed opportunities for communication about Mr A's situation, his condition, and his pain relief requirements, as a result of service-based failures attributable to the DHB. Mr A did not receive the pain relief he should have been able to access, and accordingly, it was found that the DHB failed to provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code.

*Recommendations*

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

- develop a process for formal handover of Addictions Service clients when they move from outpatient to inpatient service and vice versa;
- develop, as part of the process above, a policy requiring hospital discharge summaries for Addictions Service clients to be emailed to the Addictions Service on discharge, and for all related contact between Addictions Service and other services to be documented;

- conduct an audit over a one-month period to ensure that all interactions with clients are recorded in the Addictions Service records and/or, if relevant, clinical records;

- review and revise, as necessary, the position descriptions for Addictions Service staff referred to within HDC's report to ensure clarity of role expectations, professional development and support;

- conduct a random audit of the hospital's discharge summaries to assess compliance with the requirement that hospital discharge summaries be sent to relevant GPs;

- provide refresher training for hospital staff on the "Methadone/Buprenorphine (with Naloxone) — Opioid Substitution Therapy for Treatment of Dependence (Addiction)" and "Pain Management — Adults" guidelines; and

- provide a written apology to Mr A's family.

**Care provided to man in hospital (15HDC01053)**

*Background*

Mr B, a 73 year old man, was admitted to the surgical ward of a public hospital with a four-week history of diarrhoea and abdominal pain. After two days, he was discharged and a plan was put in place for an urgent outpatient colonoscopy, to ensure that there was no significant bowel pathology. Surgical staff thought that his symptoms were caused by the medication he had been taking.

Less than a week later, Mr B was accepted by surgical registrar, Dr A, for review in the ED, as he had remained unwell following discharge. Unfortunately, owing to the busyness of the ED at the time, there was a delay of 35 minutes between Mr B's arrival at the ED and his triage.

A blood sample was requested by a registered nurse (RN) and she requested several routine blood tests, as well as a Troponin T test (an indicator for heart attack). No electrocardiogram (ECG) was carried out at that time by the RN. At the DHB, while it was usual practice for nurses to initiate blood tests in ED, nurses were not expected to inform medical staff specifically, and were not responsible for viewing or acting on the results (with medical staff responsible for this).

A Troponin T test result of 990 ng/L (abnormal, indicating heart damage) was processed and automatically released by the results system at 12.13pm, but Dr A was not advised of the result via telephone. Dr A was not aware that the RN had requested a Troponin T test.

Dr A discussed Mr B's case with medical registrar, Dr D, who agreed with Dr A's plan. Dr D agreed to review Mr B as soon as he was able to, but Dr D was very busy in the ED. Dr D advised that he had requested assistance from the back-up registrars, but the on-call medical consultant was busy in a cardiology clinic.

Dr A viewed Mr B's blood tests at 2.35pm, which indicated sepsis and heart damage, and spoke to Dr D again. Dr A stated that Dr D advised that he would review Mr B soon, although he was still very busy in the ED, and possibly admit him to the Coronary Care Unit. The DHB advised that there was a higher than usual number of presentations to the ED on that day, and that Dr D was responsible for six patients, in addition to Mr B. There was only one medical registrar allocated to the ED, medical wards, and surgical referrals during this time.

A decision was made to transfer Mr B to the surgical ward shortly before 3pm. However this was not discussed with Dr A. Due to the busyness of the ED, the transfer occurred without blood cultures having been taken, a catheter inserted, a catheter specimen of urine taken, a fluid balance chart commenced, stool cultures taken, or an ECG undertaken.

Dr D advised that, on hearing the Troponin T result, he immediately went to find Mr B, only to learn that he had been transferred to the surgical ward. Dr D then went to the surgical ward and began reviewing Mr B shortly before 3.30pm (approximately four and a half hours after medical review was

requested). Dr D's impression was NSTEMI (a type of heart attack) secondary to abdominal sepsis, and he put in place a detailed management plan. Antibiotic administration was also delayed.

Sadly, Mr B's condition deteriorated and he died at 5.17pm.

*Findings*

The Commissioner acknowledged that during Mr B's second admission, the ED was busier than usual which resulted in delays in triage, medical review and implementation of aspects of Dr A's management plan. However, the Commissioner was concerned that during Mr B's first admission, no medical or cardiologist input was sought, a source of infection was not considered, and no abdominal CT was carried out. The Commissioner was concerned that during Mr B's second admission:

- the DHB had two policies with differing criteria for escalation of test results to clinical staff by telephone and, in practice, neither of these were followed when dealing with Troponin T results. This meant that Mr B's high Troponin T result was not escalated to Dr A in a timely manner by telephone;
- the on-call consultant was not readily available for assisting when delays were experienced in medical review; and
- the DHB's practice regarding ward transfers did not reflect its policy, and, as a result, Mr B was transferred to a lower acuity ward without discussion with Dr A and required interventions being undertaken in order to meet the ED six-hour target.

The Commissioner found that the combination of these failings meant that the DHB failed to provide services with reasonable care and skill to Mr B, in breach of Right 4(1) of the Code.

*Recommendations*

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

- conduct an audit of the effectiveness of its new triage process in regard to the timeliness of triage and triage scoring;
- review its "Severe Sepsis Management Policy" and newly developed "Adult Sepsis Pathway", and conduct training for relevant staff on the "Adult Sepsis Pathway";
- develop a clear policy as to who has responsibility for following up test results ordered by ED RNs;
- consider implementing a system that requires the laboratory to alter the patient's treating clinician urgently when Troponin T results are abnormally high;
- review the hospital's "Emergency Department Standard Operating Procedure";
- develop a care escalation plan for the General Medicine team;
- review the role of the on-call consultant to ensure that adequate supervision of junior doctors is occurring;
- remind all staff working in ED that the transfer and location the patient is transferred to must be clinically appropriate; and
- provide a written apology to Mr B's family.