

Complaints to HDC involving District Health Boards

National Report

Report and Analysis for period 1 January to 30 June 2015



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Commissioner's Foreword

I am pleased to present you with HDC's second six monthly DHB complaint report for the 2014/2015 year.

The trends within this report are broadly consistent with what was seen in the first half of 2014/2015. A missed, incorrect or delayed diagnosis continues to be the most common specific primary issue in complaints about DHB services, with it being the primary reason for around 20% of complaints. When we analyse all issues raised in complaints, communication continues to feature prominently; a failure to communicate effectively with the consumer was at issue in around 34% of complaints about DHB services.

Looking at the case reports presented in the "learning from complaints" section, we see that when things go wrong within DHB services, failings in teamwork are often implicated. Inadequate coordination of care is also often noted by consumers in their complaints about DHBs, with this being consistently at issue in around 20% of complaints in each six-month period. As I have noted previously, in any healthcare system, there are a series of layers of protections and people, which together operate to deliver seamless service to a patient. When any one or more of these layers do not operate optimally, the potential for that layer to provide protection, or deliver services, is compromised. Communication is key to providing this seamless service. Patients will often move from one part of the health care system to another, and back again, as they access the various services they need. It is essential that different units within the same system communicate well and that there is a safe and seamless system to ensure that the patient moves between the different providers and receives appropriate care at all stages.

I trust that this report will prove useful to you. I continue to welcome your feedback on how we can further improve the usefulness of these reports.

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 2015, HDC received a total of **389** complaints about care provided by all District Health Boards. Numbers of complaints received in previous six month periods are reported in Table 1.

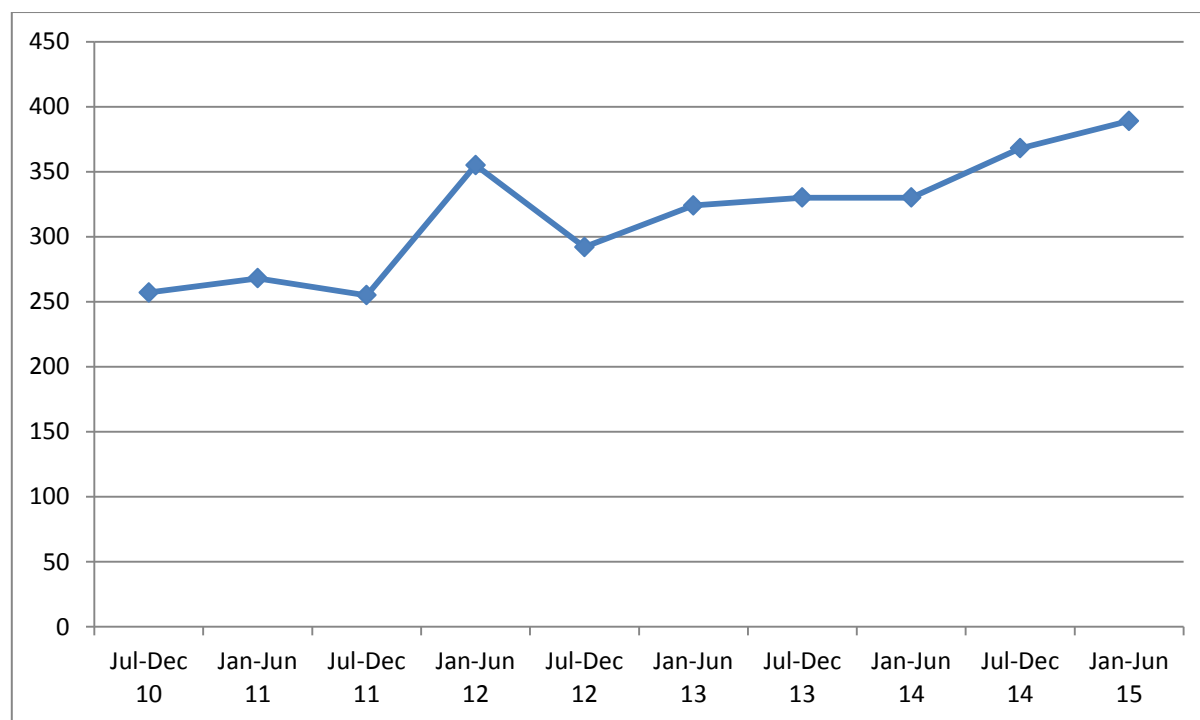
Table 1. Number of complaints received in last five financial years

	Jul– Dec 10	Jan– Jun 11	Jul– Dec 11	Jan– Jun 12	Jul– Dec 12	Jan– Jun 13	Jul– Dec 13	Jan– Jun 14	Jul– Dec 14	Average of last 4 6-month periods	Jan– Jun 15
Number of complaints	257	268	255	355	292	324	330	330	368	338	389

The total number of complaints received in Jan–Jun 2015 (389) shows an increase of 15% over the average number of complaints received in the previous four periods.

The number of complaints received in Jan–Jun 2015 and previous six month periods are also displayed below in Figure 1. The number of complaints received in Jan–Jun 2015 is the highest number of complaints about DHBs ever received in a six month period.

Figure 1. Number of complaints received



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.

Frequency calculations are made using discharge data provided by the Ministry of Health (provisional as at the date of extraction, 14 August 2015).

Table 2. Rate of complaints received per 100,000 discharges during Jan–Jun 2015

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
389	459,428 ¹	84.67

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan–Jun 2015 and previous six month periods.

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

	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14 ²	Average of last 4 6-month periods	Jan–Jun 15
Rate per 100,000 discharges	57.16	62.48	55.86	80.22	62.59	72.67	71.15	72.99	76.65	73.37	84.67

The rate of complaints received during Jan–Jun 2015 (84.67) shows a 15% increase over the average rate of complaints received for the previous four periods. The rate of complaints received in Jan–Jun 2015 is the highest rate of complaints about DHBs ever received in a six month period.

Table 4 shows the rate of complaints about DHBs received by HDC per 100,000 discharges for each DHB (not named³) relative to other DHBs for Jan–Jun 2015.

All individual DHBs were subject to some complaints to HDC. As shown in Table 4, for individual DHBs, the rate of complaints received ranged from 45.88 complaints per 100,000 discharges to 197.93 complaints per 100,000 discharges as compared to the national rate of 84.67 complaints per 100,000 discharges. The raw number of complaints received about individual DHBs ranged from 4 complaints to 53 complaints.

¹ The total number of discharges excludes short stay emergency department discharges and patients attending outpatient units and clinics.

² The rate for Jul–Dec 2014 has been recalculated based on the most recent discharge data.

³ Individual DHBs have not been named in this report given the small sample size and the short period covered (six months).

Table 4. Rate of complaints received per 100,000 discharges

DHB	Rate of complaints to HDC per 100,000 discharges	DHB	Rate of complaints to HDC per 100,000 discharges
DHB 1	45.88	DHB 11	104.14
DHB 2	57.06	DHB 12	108.42
DHB 3	63.93	DHB 13	112.47
DHB 4	67.13	DHB 14	123.79
DHB 5	72.47	DHB 15	124.07
DHB 6	72.97	DHB 16	124.15
DHB 7	77.01	DHB 17	137.65
DHB 8	86.38	DHB 18	138.79
DHB 9	93.65	DHB 19	144.74
DHB 10	97.09	DHB 20	197.93
		All DHBs	84.67

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 389 complaints about DHBs, 394 services were complained about.

The five service types with the greatest number of complaints were surgery (25.9%), mental health (19.0%), accident and emergency (17.3%) general medicine (15.0%), and maternity (7.4%). This is broadly similar to what was seen last period, with the exception of accident and emergency services, which saw an increase in complaints from 9.5% in Jul-Dec 2014 to 17.3% in Jan-Jun 2015.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Accident and emergency (including paramedics)	68	17.3%
Aged care (long-term care facility)	5	1.3%
Alcohol and drug	5	1.3%
Anaesthetics/pain medicine	8	2.0%
Dental	4	1.0%
Diagnostics	13	3.3%
Disability services	3	0.8%
District nursing	3	0.8%
General medicine	59	15.0%
Cardiology	3	0.8%
Gastroenterology	3	0.8%
Geriatric medicine	6	1.5%
Neurology	9	2.3%
Oncology	10	2.5%
Palliative care	1	0.3%
Renal/nephrology	5	1.3%
Respiratory	4	1.0%
Rheumatology	4	1.0%
Other/unspecified	14	3.6%
Hearing services	1	0.3%
Intensive care/critical care	8	2.0%
Maternity	29	7.4%
Mental health	75	19.0%
Paediatrics (not surgical)	7	1.8%
Rehabilitation services	3	0.8%
Surgery	102	25.9%
Cardiothoracic	3	0.8%
General	21	5.3%
Gynaecology	16	4.1%
Neurosurgery	1	0.3%
Ophthalmology	2	0.5%
Oral/Maxillofacial	1	0.3%
Orthopaedics	36	9.1%
Otolaryngology	3	0.8%
Paediatric	3	0.8%
Plastic and Reconstructive	1	0.3%
Urology	10	2.5%
Vascular	1	0.3%
Unknown	4	1.0%
Other health service	1	0.3%
TOTAL	394	

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. Those complaint issues listed in only one complaint are classified as 'other'. The primary issues identified in complaints received in Jan–Jun 2015 are listed in Table 6.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	32	8.2%
Lack of access to services	17	4.4%
Lack of access to subsidies/funding	2	0.5%
Waiting list/prioritisation issue	13	3.3%
Boundary violation	1	0.3%
Inappropriate sexual communication	1	0.3%
Care/Treatment	227	58.4%
Delay in treatment	8	2.1%
Delayed/inadequate/inappropriate referral	6	1.5%
Inadequate coordination of care/treatment	2	0.5%
Inadequate/inappropriate clinical treatment	47	12.1%
Inadequate/inappropriate examination/assessment	12	3.1%
Inadequate/inappropriate follow-up	11	2.8%
Inadequate/inappropriate monitoring	7	1.8%
Inadequate/inappropriate non-clinical care	4	1.0%
Inappropriate admission/failure to admit	2	0.5%
Inappropriate/delayed discharge/transfer	12	3.1%
Inappropriate withdrawal of treatment	5	1.3%
Missed/incorrect/delayed diagnosis	76	19.5%
Rough/painful care or treatment	7	1.8%
Unexpected treatment outcome	25	6.4%
Unnecessary treatment/over-servicing	2	0.5%
Other	1	0.3%
Communication	40	10.3%
Disrespectful manner/attitude	17	4.4%
Failure to communicate openly/honestly/effectively with consumer	8	2.1%
Failure to communicate openly/honestly/effectively with family	12	3.1%
Insensitive/inappropriate comments	2	0.5%
Other	1	0.3%
Complaints process	4	1.0%
Inadequate response to complaint	4	1.0%
Consent/Information	35	9.0%
Consent not obtained/adequate	13	3.3%
Inadequate information provided regarding adverse event	2	0.5%
Inadequate information provided regarding fees/costs	2	0.5%
Inadequate information provided regarding results	2	0.5%
Incorrect/misleading information provided	2	0.5%
Issues with involuntary admission/treatment	10	2.6%
Other	4	1.0%
Documentation	6	1.5%

Primary issue in complaints	Number of complaints	Percentage
Inadequate/inaccurate documentation	4	1.0%
Inappropriate maintenance/disposal of documentation	2	0.5%
Facility issues	12	3.1%
General safety issue for consumer in facility	5	1.3%
Waiting times	3	0.8%
Other	4	1.0%
Medication	15	3.9%
Inappropriate prescribing	8	2.1%
Prescribing error	2	0.5%
Refusal to prescribe/dispense/supply	2	0.5%
Other	3	0.8%
Reports/Certificates	3	0.8%
Inaccurate report/certificate	3	0.8%
Other professional conduct issues	8	2.1%
Inappropriate collection/use/disclosure of information	3	0.8%
Threatening/bullying/harassing behaviour	3	0.8%
Other	2	0.5%
Disability-specific issues	3	0.8%
Other issues	3	0.8%
TOTAL	389	

The most common primary issue categories concerned care/treatment (58.4%), communication (10.3%), consent/information (9.0%) and access/funding (8.2%). Among these, the most common specific primary issues in complaints about DHBs were 'missed/incorrect/delayed diagnosis' (76 complaints), 'inadequate/inappropriate clinical treatment' (47 complaints), 'unexpected treatment outcome' (25 complaints), 'disrespectful manner/attitude' (17 complaints) and 'lack of access to services' (17 complaints). This is broadly similar to what was seen in Jul-Dec 2014.

Table 7 shows a comparison over time for the top five primary issues complained about.

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

Top five primary issues in all complaints (%)							
Jul-Dec 13 n=330		Jan-Jun 14 n=330		Jul-Dec 14 n=368		Jan-Jun 15 n=389	
Misdiagnosis	17%	Misdiagnosis	17%	Misdiagnosis	15%	Misdiagnosis	20%
Inadequate treatment	17%	Inadequate treatment	11%	Inadequate treatment	11%	Inadequate treatment	12%
Disrespectful manner/attitude	5%	Disrespectful manner/attitude	6%	Unexpected treatment outcome	7%	Unexpected treatment outcome	6%
Inappropriate prescribing	4%	Unexpected treatment outcome	6%	Waiting list/prioritisation	6%	Disrespectful manner/attitude	4%
Lack of access to services	4%	Waiting list/prioritisation	5%	Disrespectful manner/attitude	5%	Lack of access to services	4%

The top five primary issues in Jan–Jun 2015 are similar to primary issues reported in previous periods. ‘Missed/incorrect/delayed diagnosis’ and ‘inadequate/inappropriate clinical treatment’ are consistently the most common primary issues across all periods.

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. Complaint issues listed in only one complaint are classified as ‘other’.

On analysis of all issues identified in complaints about DHBs, the five most common issues were ‘inadequate/inappropriate clinical treatment’ (39.3%), ‘failure to communicate effectively with consumer’ (33.7%), ‘inadequate/inappropriate examination/assessment’ (27.8%), ‘inadequate response to the consumer’s complaint by the DHB’ (26.7%), ‘missed/incorrect/delayed diagnosis’ (24.9%), ‘disrespectful manner/attitude’ (23.9%), and ‘failure to communicate effectively with family’ (21.9%). This is broadly similar to what was seen in Jul–Dec 2014.

Also similar to last period, many complaints involved issues with a consumer’s care/treatment, such as ‘inadequate coordination of care/treatment’ (18.3%), ‘unexpected treatment outcome’ (17.5%), ‘inadequate/inappropriate testing’ (17.0%), ‘inadequate/inappropriate follow-up’ (14.4%), ‘inadequate/delayed discharge/transfer’ (13.9%) and ‘delay in treatment’ (13.9%).

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
<i>Access/Funding</i>		
ACC compensation issue	3	0.8%
Lack of access to services	31	8.0%
Lack of access to subsidies/funding	7	1.8%
Waiting list/prioritisation issue	28	7.2%
<i>Boundary violation</i>		
Inappropriate sexual communication	3	0.8%
Inappropriate sexual physical contact	1	0.3%
<i>Care/Treatment</i>		
Delay in treatment	54	13.9%
Delayed/inadequate/inappropriate referral	43	11.1%
Inadequate coordination of care/treatment	71	18.3%
Inadequate/inappropriate clinical treatment	153	39.3%
Inadequate/inappropriate examination/assessment	108	27.8%
Inadequate/inappropriate follow-up	56	14.4%
Inadequate/inappropriate monitoring	37	9.5%
Inadequate/inappropriate non-clinical care	32	8.2%
Inadequate/inappropriate testing	66	17.0%
Inappropriate admission/failure to admit	11	2.8%
Inappropriate/delayed discharge/transfer	54	13.9%
Inappropriate withdrawal of treatment	13	3.3%
Missed/incorrect/delayed diagnosis	97	24.9%
Personal privacy not respected	4	1.0%
Refusal to assist/attend	15	3.9%
Refusal to treat	8	2.1%
Rough/painful care or treatment	25	6.4%
Unexpected treatment outcome	68	17.5%
Unnecessary treatment/over-servicing	8	2.1%
<i>Communication</i>		
Disrespectful manner/attitude	93	23.9%
Failure to accommodate cultural/language needs	6	1.5%
Failure to communicate openly/honestly/effectively with consumer	131	33.7%
Failure to communicate openly/honestly/effectively with family	85	21.9%
Insensitive/inappropriate comments	19	4.9%
<i>Complaints process</i>		
Inadequate response to complaint	104	26.7%
Other	3	
<i>Consent/Information</i>		
Consent not obtained/adequate	27	6.9%
Failure to assess capacity to consent	7	1.8%
Inadequate information provided regarding adverse event	11	2.8%
Inadequate information provided regarding condition	14	3.6%
Inadequate information provided regarding fees/costs	3	0.8%
Inadequate information provided regarding options	6	1.5%
Inadequate information provided regarding results	24	6.2%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding treatment	28	7.2%
Incorrect/misleading information provided	25	6.4%
Issues regarding consent when consumer not competent	5	1.3%
Issues with involuntary admission/treatment	13	3.3%
Other	3	
Documentation		
Delay/failure to disclose documentation	3	0.8%
Delay/failure to transfer documentation	3	0.8%
Inadequate/inaccurate documentation	36	9.3%
Inappropriate maintenance/disposal of documentation	3	0.8%
Other	1	
Facility issues		
Cleanliness/hygiene issue	5	1.3%
Failure to follow policies/procedures	13	3.3%
General safety issue for consumer in facility	12	3.1%
Inadequate/inappropriate policies/procedures	19	4.9%
Issue with quality of aids/equipment	9	2.3%
Staffing/rostering/other HR issue	11	2.8%
Waiting times	15	3.9%
Other	5	
Medication		
Administration error	5	1.3%
Inappropriate administration	6	1.5%
Inappropriate prescribing	33	8.5%
Prescribing error	4	1.0%
Refusal to prescribe/dispense/supply	8	2.1%
Other	1	
Reports/Certificates		
Inaccurate report/certificate	11	2.8%
Other	2	
Teamwork/Supervision		
Delayed/inadequate/inappropriate handover	4	1.0%
Inadequate supervision/oversight	4	1.0%
Other professional conduct issues		
Failure to disclose/properly manage a conflict of interest	4	1.0%
Inappropriate collection/use/disclosure of information	11	2.8%
Threatening/bullying/harassing behaviour	6	1.5%
Other	6	
Disability-specific issues	8	
Other issues	13	

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 last period.

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

Surgery n=102		Mental health n=75		General medicine n=59		Accident & emergency n=68		Maternity n=29	
Missed/incorrect/delayed diagnosis	14%	Inadequate/inappropriate treatment	20%	Missed/incorrect/delayed diagnosis	29%	Missed/incorrect/delayed diagnosis	38%	Missed/incorrect/delayed diagnosis	21%
Unexpected treatment outcome	13%	Issues with involuntary admission/treatment	12%	Unexpected treatment outcome	8%	Inadequate/inappropriate treatment	12%	Inadequate/inappropriate treatment	17%
Waiting list/prioritisation issue & Inadequate treatment	12% each	Inadequate assessment & Failure to communicate effectively with family	8% each	Inadequate treatment & Failure to communicate effectively with family	7% each	Disrespectful attitude/manner	9%	Unexpected treatment outcome	17%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **410⁴** complaints involving DHBs in the period Jan–Jun 2015. Table 10 shows the number of complaints closed in previous six month periods.

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

	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Average of last 4 6-month periods	Jan–Jun 15
Number of complaints closed	257	246	217	302	254	337	280	411	344	343	410

The total number of complaints closed for Jan–Jun 2015 shows an increase of 20% over the average of the last four six month periods.

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.

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 non-investigation. 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 2015 period, **6** DHBs had no investigations closed, **4** DHBs had one investigation closed, **5** DHBs had two investigations closed, **3** DHBs had three investigations closed and **2** DHBs had five investigations closed by HDC.

The manner of resolution and outcomes of all DHB complaints closed in Jan–Jun 2015 is shown in Table 11.

Table 11. Outcome for DHBs of complaints closed by complaint type⁵

Outcome for DHBs	Number of complaints closed
<i>Investigation</i>	33
Breach finding	17
No breach finding	2
No further action ⁶ with follow-up or educational comment	12
No further action	2
<i>Non-investigation</i>	355
No further action with follow-up or educational comment	86
Referred to Ministry of Health/Director-General of Health	1
Referred to District Inspector	6
Referred to DHB ⁷	82
Resolved between parties	1
Referred to Advocacy	11
No further action	160
Withdrawn	8
<i>Outside jurisdiction</i>	22
TOTAL	410

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 increasingly developed good systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

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 the current period. 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	31
Audit	38
Meeting with consumer/complainant	3
Presentation/discussion of complaint with others	8
Provision of information	30
Reflection	5
Review of policies/procedures	54
Training/professional development	32
Total	201

The most common recommendation made to DHBs was that they review their policies/procedures (54 recommendations). When audits were recommended, they were most commonly in relation to adherence to policies/procedures, followed by compliance with documentation requirements. Training/professional development was most often recommended in relation to clinical issues, documentation and communication.

5.0 Learning from complaints — HDC case reports

Delays in treatment in emergency department (13HDC00453)

Background

Mrs A, a 51 year old woman with multiple medical problems, experienced a sudden episode of shortness of breath and was taken to the Emergency Department (ED) of a public hospital.

Mrs A was triaged by a registered nurse (RN), RN D, as requiring treatment within 30 minutes. However, she was not reviewed by the ED registrar (Dr E) for over an hour. Dr E considered it likely that Mrs A had a chest infection, and requested a chest X-ray, blood tests and an ECG. The blood test results showed mildly raised potassium and troponin levels. Two hours after her initial review in the ED, Mrs A was referred to the medical team.

A general medical registrar, Dr I, reviewed Mrs A six hours later, while she was still in the ED. Dr I concluded that Mrs A was likely to be suffering from an exacerbation of her asthma/chronic obstructive pulmonary disease and planned repeat venous blood gas tests and a repeat ECG. Dr I performed an arterial blood gas test which showed an increased potassium level. However, Dr I decided to wait for the results of the venous blood gas test results before commencing treatment for the raised potassium level.

Approximately two hours later, Dr I was called to assess Mrs A as she was complaining of chest pain. Dr I checked the repeat venous blood results which again showed a raised potassium level. Treatment was prescribed for this and Mrs A was given medication for her chest pain. Approximately ten minutes later, Mrs A suffered ventricular tachycardia and the emergency alarm was activated. However, Mrs A lost consciousness and cardiac output and sadly died.

Findings

The Commissioner held that the care provided to Mrs A was a serious departure from accepted standards, and that the DHB failed to meet its organisational duty to provide a safe healthcare environment for Mrs A. The Commissioner found that Mrs A was not monitored adequately by the nursing staff while she was in the ED, there were delays in her being assessed by the medical registrar, and the medical registrar's reaction to concerning changes in Mrs A's condition was inadequate. Therefore, the DHB failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Recommendations

The DHB instigated a number of changes in response to this case. The Commissioner also made a number of recommendations, including that the DHB:

- provide an apology to Mrs A's family for its breach of the Code;
- audit the effectiveness and level of compliance with its triage policy;
- provide HDC with the results of its 2013 and 2014 SSiED (shorter stays in emergency departments) health target compliance;
- conduct training for staff when clinical care guidelines were updated and provide refresher training on the updated clinical care guidelines on a regular basis;
- conduct a random audit of ED Resident Medical Officers' (RMOs) understanding of the RMO guidelines, in particular, the circumstances under which the RMO should notify the SMO (or senior registrar overnight);
- assess the changes made relating to ED length of stay and improvements to patient flow throughout the hospital;
- put in place a system where the laboratory immediately alerts the relevant department or requesting doctor of a critical result; and

- review the role of ED consultants to ensure that adequate supervision of junior doctors is occurring.

The DHB has met the majority of these recommendations, with others being due within three months of the date of the investigation report.

Care during labour of post-dates woman who had risk factors (13HDC00843)

Background

Ms A, who was pregnant with her third child, was admitted for an induction of labour (IOL) 10 days after her due date. She met with her LMC midwife (Ms C) and was then assessed by the on-call registrar (Dr B) who performed an artificial rupture of membranes. The baby was noted to be in a face presentation. Despite the face presentation, Ms C and Dr B considered that it was appropriate to augment the labour with Syntocinon. A short time later Ms C was unable to locate a fetal heart rate (FHR). The Syntocinon was turned off and Dr B was called. Dr B noted FHR decelerations and that the baby was now in an undeliverable brow presentation and a Caesarean section was necessary.

Prior to transfer to theatre the hospital midwives assisting in preparing Ms A again had difficulty detecting and recording the FHR. This was not adequately communicated within the team and the FHR was not monitored again on arrival in theatre. After the anaesthetist had inserted a spinal block Dr B realised that the FHR was not being monitored. Ms C then attempted to locate the FHR by auscultation with a hand held Doppler but was unable to locate it. Dr B performed an ultrasound scan and confirmed that no fetal heartbeat was present.

After discussion with the parents, Dr B made the decision to perform a Caesarean section. Sadly, the baby was stillborn.

Findings

The Commissioner found that it was clinically inappropriate, and also contrary to the DHB's policy, to commence Syntocinon in the circumstances and Dr B should have consulted with the on-call consultant before making that decision. Dr B was found in breach of Right 4(1) of the Code for not consulting with the on-call consultant, for making the decision to commence Syntocinon, for failing to reassess Ms A's uterine activity adequately and for failing to ensure monitoring of the FHR in the perioperative area. It was also held that Dr B breached Right 6(1)(b) of the Code for failing to provide Ms A with information about the option of performing a Caesarean section and the risks of Syntocinon before it was commenced. The Commissioner was critical of Dr B's failure to proceed with an emergency Caesarean section immediately when the fetal heartbeat was not detected.

The Commissioner was critical of Ms C's recommendation to commence Syntocinon. However, the Commissioner accepted that this was ultimately an obstetric decision and concluded that Ms C's involvement in the decision did not warrant a finding that she breached the Code.

The Commissioner had significant concerns about the individual and team failings in this case and found that the DHB failed to have a system in place that ensured policies and procedures were followed. The Commissioner stated that "policies and procedures are of little use unless they are accessible to staff and followed consistently. I am satisfied that the policies were available to staff. However, despite this I am concerned that the policies were not followed by both the registrar and the LMC midwife". The Commissioner further considered that the failure of any one staff member to initiate FHR monitoring upon arrival in the perioperative area was another example of staff failing to follow procedure. The Commissioner also found that staff failed to think critically and important information was not communicated effectively. Furthermore, it was held that the DHB must take some responsibility for Dr B's decision-making in this case. The Commissioner concluded that the DHB failed to provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Recommendations

In response to the Commissioner's recommendations, Dr B provided a written apology to Ms A and provided a report to HDC on the changes she had made to her practice with regard to communication in stressful situations. The Commissioner also made a number of recommendations to the DHB, including that the DHB:

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

These recommendations have been met by the DHB.

Complications following gallbladder removal (12HDC00779)

Background

Mr A, a 74 year old man who had multiple co-morbidities, presented to the Emergency Department (ED) of a public hospital with a sudden onset of right-sided back pain. Following a renal ultrasound that showed multiple gallstones, ED clinicians discharged him and referred him to the Surgical Outpatients Clinic for a possible cholecystectomy (surgical removal of the gallbladder).

A general surgeon, Dr D, reviewed Mr A and recommended he undergo an open cholecystectomy and incisional hernia repair. Mr A had a preoperative anaesthetic assessment, and the anaesthetist (Dr G) recommended that Mr A's planned surgery be delayed six months because of issues with his medication.

Mr A subsequently underwent treatment at the hospital for kidney stones, and presented to the ED with left-sided back pain. On the day of Mr A's surgery, Dr D discussed Mr A's recent medical history with him and the decision was made to proceed with surgery. However, Dr D did not document her discussion with Mr A.

Mr A underwent surgery, which was longer and more difficult than expected. Post-operatively Mr A was transferred to the Intensive Care Unit (ICU). During the next 24 hours Mr A's condition deteriorated. He was in pain, had low urine output, raised creatinine levels, ECG changes, and an increasingly distended abdomen. Mr A was treated by a number of doctors. At about midnight, a second general surgeon, Dr E, performed an exploratory laparotomy and repair of a jejunal perforation. However, Mr A continued to deteriorate and during the afternoon he was transferred to another hospital. Sadly, he died the following day.

Findings

Dr D did not record any of the discussions she had with Mr A about whether the gallstone-related pain he was experiencing, if any, was significant enough for him to undergo surgery in light of alternative management options, or the risks of surgery that were specific to him given his co-morbidities, including his increased risk of death. In the absence of any documented evidence that these issues were discussed, the Commissioner found that Dr D failed to provide Mr A with information a reasonable consumer in his position would have needed to make an informed choice about treatment, in breach of Right 6(2) of the Code, and that Dr D did not obtain Mr A's informed consent for surgery, in breach of Right 7(1). Dr D also demonstrated a lack of reasonable care and skill in deciding to perform surgery on Mr A seven months after her initial review of him, in circumstances where the planned surgery had been delayed, he had complex co-morbidities and had had medical treatment relevant to his condition in the intervening period. It was also found that Dr D's approach to Mr A's post-operative condition was insufficiently cautionary. In these respects Dr D

breached Right 4(1). In addition, Dr D's documentation fell below professional standards and, accordingly, she breached Right 4(2).

The Commissioner was also critical of the postoperative care provided to Mr A by Dr E and Dr G.

The Commissioner found that there was a lack of discernible leadership in the clinical team treating Mr A post-operatively. Although there were at least eight doctors involved in Mr A's care between his first and second operations, no one appeared to have taken ownership of his care. This lack of leadership meant that there was a lack of coordination in Mr A's care, and an absence of critical thinking in assessing the cause of his deteriorating condition. There was also a lack of support offered by senior doctors to junior doctors when they identified problems and discussed them with senior staff. The Commissioner concluded that this demonstrated a service level failure by the DHB to provide services with reasonable care and skill and accordingly, the DHB breached Right 4(1) of the Code. Furthermore, there was a pattern of sub-optimal documentation by the clinical staff treating Mr A post-operatively. For failing to ensure that staff met expected standards of documentation, the DHB was found in breach of Right 4(2). The Commissioner was critical of the DHB's post-operative process and consent to treatment process. The Commissioner also made comments about the DHB's Enhanced Recovery After Surgery (ERAS) protocol and about the DHB's communication with Mr A's family.

Recommendations

In accordance with the Commissioner's recommendations, Dr D provided an apology to Mr A's family for her breaches of the Code. The Commissioner also recommended that the Medical Council consider whether to undertake a review of Dr D's competence.

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

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

These recommendations are due to be completed by the DHB within three months of the date of the investigation report.

Assessment of a mental health patient found on floor (13HDC01375)

Background

Mr A, an elderly man with a complex medical history including a diagnosis of bipolar affective disorder, was admitted as a voluntary patient to a psychiatric hospital. Mr A's family were not informed of his transfer from his rest home to the hospital.

The following evening, Mr A was adamant that he was going back to his rest home and asked staff to take him there. However, Mr A was kept at the hospital.

Overnight, RN O and RN K were on duty. At 3.30am RN O heard water running in Mr A's room. On investigation, she found Mr A on the floor, mostly naked, with his walker frame near the end of the bed. Mr A did not rouse to voice or gentle touch. RN O observed that he was breathing at a normal rate and rhythm and appeared to be asleep. She placed a blanket over him to keep him warm and to maintain his dignity. Both RN O and RN K then observed and assessed Mr A, including his breathing, colour, response, position and comfort. They made the decision to leave him, as it was not unusual to find patients sleeping on the floor during the night. They did not consider the possibility that Mr A might have fallen.

The next day RN P volunteered to work with Mr A. Following the morning shift handover, RN P checked on Mr A and said that he appeared to be asleep on the floor on his back, breathing regularly, that his colour was satisfactory, and there was no cause for concern. At approximately 1pm, Mr A was lifted into a chair by RN P, RN J and RN R.

RN I, who was in charge of the afternoon shift, was told by RN P at handover that Mr A was still asleep as a result of over-sedation. RN I checked Mr A at RN P's request. When RN I touched Mr A she noticed that his body felt cold and that he looked very pale. RN I took Mr A's observations and he was transferred into bed. He did not show any signs of responding to staff. RN I called the duty house surgeon, who reviewed Mr A and rang an ambulance to transfer him to a public hospital. Following a CT scan, a large subdural bleed on the right side of his brain was identified but was considered too extensive to treat. Sadly, Mr A died that evening.

Findings

The Deputy Commissioner found that RN O and RN K failed to assess Mr A adequately when they found him on the floor, breaching Right 4(1) of the Code. RN P failed to review Mr A's notes correctly and also failed to assess him adequately, breaching Right 4(1) of the Code. The Deputy Commissioner was also critical of RN P's failure to respond to concerns about Mr A raised to her by her colleagues.

The Deputy Commissioner found that the DHB did not comply with legal standards and breached Right 4(2) of the Code for the failure of its staff to communicate with Mr A's family regarding his admission to hospital. It was also held that the DHB breached Right 7(7) as Mr A was prevented from leaving the hospital despite his voluntary status and express wish to return to his rest home. The Deputy Commissioner stated that the DHB failed to ensure continuity of care in this case, as there was no consultant oversight of the doses of Mr A's medications, and the documentation of his medical issues in his clinical records was inconsistent. Furthermore, because of the separate electronic patient information used by the public hospital and mental health services, the staff at the psychiatric hospital were not fully aware of Mr A's history. For this lack of continuity of care, the DHB breached Right 4(5) of the Code.

The Deputy Commissioner was also critical of the DHB regarding its environment, culture, and failure to ensure staff were familiar with policies and protocols. The nurses concerned in providing care to Mr A pointed to a number of challenges in the physical working environment, including the disestablishment of long established teams and new facilities. The Deputy Commissioner stated that there appeared to have been a lack of consideration by management of the possible effects that the break-up of long-established teams and an unfinished ward could have on staff performance, and the need for support. There also appeared to have been a culture within the psychiatric hospital at the time where the less experienced staff felt disempowered and unable to advocate for Mr A despite their concerns about his presentation.

Recommendations

In response to the Deputy Commissioner's recommendations, the DHB, RN K, RN O and RN P provided apologies to Mr A's family. It was also recommended that the Nursing Council of New Zealand consider undertaking a competence review of RN P if/when she recommenced practice as a registered nurse, and that RN K and RN O undertake further training on identifying levels of consciousness, identifying the deteriorating patient, and falls management.

A number of recommendations were also made to the DHB, including that the DHB:

- audit the changes implemented since Mr A's death;
- provide evidence that all relevant staff at the psychiatric hospital have been provided with training on patients' legal status, the involvement of family members in patient care, handovers including clarification as to the responsibilities for physical assessment and medical handover, and the DHB's existing policies;
- provide evidence of ongoing refresher updates of the training provided to staff;
- consider whether a policy requiring that staff concerned about a patient's condition escalate their concerns to a senior clinician as required;
- review the on-call arrangements with psychiatrists on the weekends to assess the effectiveness of the arrangements;
- review electronic patient information systems to ensure that staff have access to required information;
- conduct an audit of documentation practices at the psychiatric hospital; and
- review its handover processes.

These recommendations are due to be completed by the DHB within three months of the date of the investigation report.

