Complaints to HDC involving District Health Boards

Report and Analysis for period 1 July to 31 December 2021

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Commissioner's Foreword

Tēnā koutou

I am pleased to present my Office's analysis of complaints received about DHBs between 1 July and 31 December 2021. This is the last DHB complaint trend report and HDC is currently reviewing the format these reports will take going forward, but I would like to reassure you that we will continue to publish six-monthly trend reports into the future.

I know that the health and disability sector is currently under significant pressure with the challenges posed by the pandemic, increases in respiratory viruses and associated staffing shortages. I am consistently impressed by the dedication and agility of providers in these difficult circumstances.

The pressure the health and disability system is under can be seen in the rising volume of complaints to HDC, with HDC forecasting an unprecedented 25% increase in complaints in 2021/22. As can be seen from this report, complaints to HDC about DHBs also continue to rise. The 566 complaints received during July to December 2021 represent a 22% increase on the average number of complaints received previously.

The general trends in this report are consistent with previous reports. Surgery, mental health and medicine services remain the most commonly complained-about services, although there was a small increase in the proportion of complaints about medicine and emergency department services in July to December 2021. Communication continues to be the most common issue raised by complainants.

HDC has continued to closely monitor the issues raised in complaints related to COVID-19. An outline of the trends in COVID-19-related complaints for DHBs is provided on page 16. In July to December 2021, the majority of COVID-19-related complaints received related to vaccine issues. Concerns around visitor restrictions and delayed access to care also continued to be raised in complaints about DHBs.

Around a quarter of complaints to HDC about DHBs continue to relate to concerns regarding informed consent. Informed consent is at the heart of the Code and should be the foundation on which all services are provided. There can be no complacency around this. I was reminded of this as I read with concern, a study published in the *New Zealand Medical Journal* on 20 May, which found serious lapses in obtaining informed consent by medical students for sensitive examinations. We must all strive to do better in this respect.

I trust that these reports have been of assistance in understanding complaint patterns for your DHB and nationally. We welcome your feedback on these reports, and would be particularly interested in any feedback you have about complaint trend information that would be useful in the reformed system.

Ngā mihi nui

Morag McDowell
Health and Disability Commissioner

National Data for all District Health Boards

1. How many complaints were received?

1.1 Number of complaints received

In the period Jul–Dec 2021, HDC received **566**[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

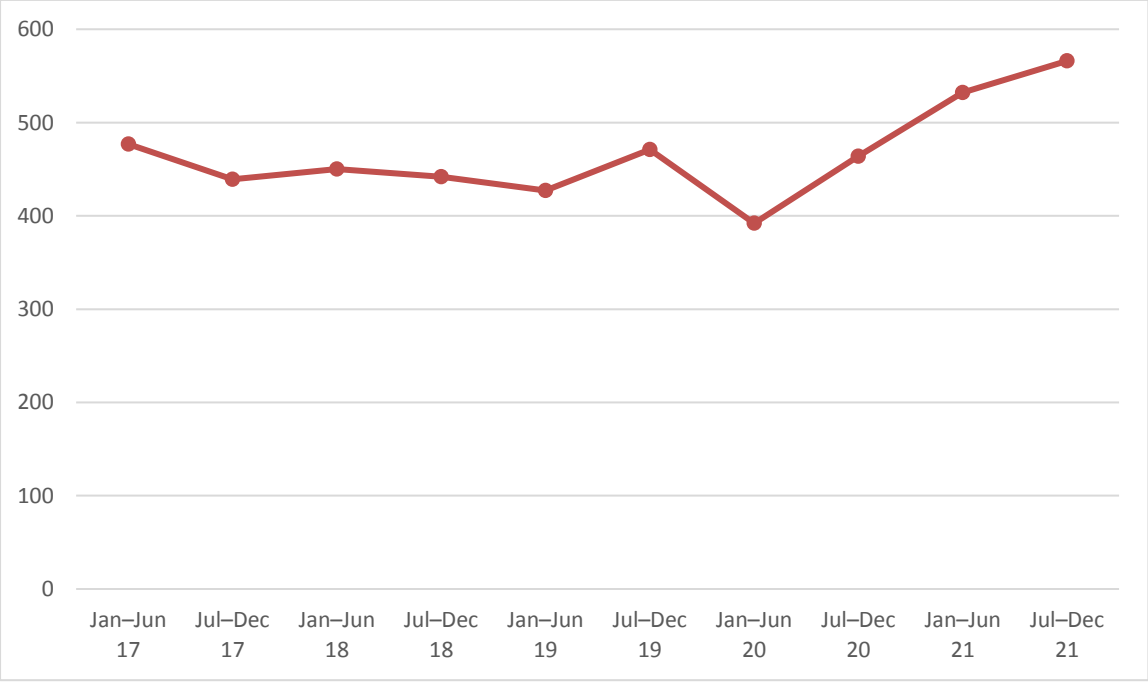
Table 1. Number of complaints received in the last five years

	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Jul–Dec 20	Jan–Jun 21	Average of last 4 periods	Jul–Dec 21
Number of complaints	477	439	450	442	427	471	392	464	**532**	**465**	**566**

The total number of complaints received in Jul–Dec 2021 (566) showed a 22% increase over the average number of complaints received in the previous four periods, and a 6% increase over the number of complaints received in the previous six-month period. The 566 complaints received in Jul–Dec 2021 is the highest number of complaints ever received about DHBs in a six-month period.

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

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



[1] Provisional as of date of extraction (8 March 2022).

1.2 Rate of complaints received

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

Complaint rate calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (16 May 2022) and may be incomplete. It should be noted that this discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics.

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

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
566	**482,394**	**117.33**

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

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

	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Jul–Dec 20	Jan–Jun 21[2]	Average of last 4 periods	Jul–Dec 21
Rate per 100,000 discharges	99.08	88.23	93.80	88.47	87.97	92.92	90.35	92.00	106.77	**95.51**	**117.33**

The rate of complaints received during Jul–Dec 2021 (117.33) is 23% higher than the average rate of complaints received for the previous four periods, and is the highest rate of complaints ever received in a six-month period.

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

[2] The rate for Jan-Jun 2021 has been recalculated based on the most recent discharge data.

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

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

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	86	57,922	148.47
Bay of Plenty	24	29,799	80.54
Canterbury	56	57,198	97.91
Capital and Coast	44	29,774	147.78
Counties Manukau	49	42,916	114.18
Hauora Tairāwhiti	10	5,577	179.31
Hawke's Bay	20	18,368	108.89
Hutt Valley	22	16,740	131.42
Lakes	13	12,304	105.66
MidCentral	29	15,605	185.84
Nelson Marlborough	18	12,449	144.59
Northland	21	22,821	92.02
South Canterbury	7	5,909	118.46
Southern	41	26,968	152.03
Taranaki	19	13,606	139.64
Waikato	49	49,329	99.33
Wairarapa	3	4,404	68.12
Waitematā	55	50,989	107.87
West Coast	9	2,855	315.24
Whanganui	13	6,861	189.48

Notes on DHB's number and rate of complaints

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

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

2. Who complained?

This section outlines the demographics of consumers in complaints to HDC about DHB services. The demographics of consumers is very similar to what was seen in the previous period and is similar to what is seen across all complaints to HDC.

2.1 Consumer gender

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

Table 5. Consumer gender

Consumer gender	Number of complaints	Proportion of complaints
Female	314	55%
Male	228	40%
Another gender	2	0.4%
Unknown/did not wish to answer	22	4%

2.2 Consumer age

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

Table 6. Consumer age

Consumer age	Number of complaints	Proportion of complaints
0 to 17 years	39	7%
18 to 24 years	23	4%
25 to 34 years	78	14%
35 to 49 years	114	20%
50 to 64 years	94	17%
65+ years	115	20%
Unknown/did not wish to answer	103	18%

2.3 Consumer ethnicity

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

Table 7. Consumer ethnicity

Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	73	13%
Pacific	14	2%
Middle Eastern/African/Latin American	15	3%
Asian	30	5%
Other European	30	5%
New Zealand European	254	45%
Unknown/did not wish to answer	150	26%

3. Which DHB services were complained about?

3.1 DHB service types complained about

Please note that some complaints involve more than one DHB and/or more than one service or hospital; therefore, although there were 566 complaints about DHBs, 604 services were complained about. Figure 2 below shows the most commonly complained about service types in Jul–Dec 2021. A more nuanced picture of service types complained about, including individual surgery and medicine services, is provided in Table 8.

Surgery (22%) services received the greatest number of complaints in Jul–Dec 2021, with orthopaedics (5%) being the surgical specialty most commonly complained about.

Other commonly complained about services included medicine (21%), mental health and addictions (20%), and emergency department (16%) services.

Figure 2. Service types complained about

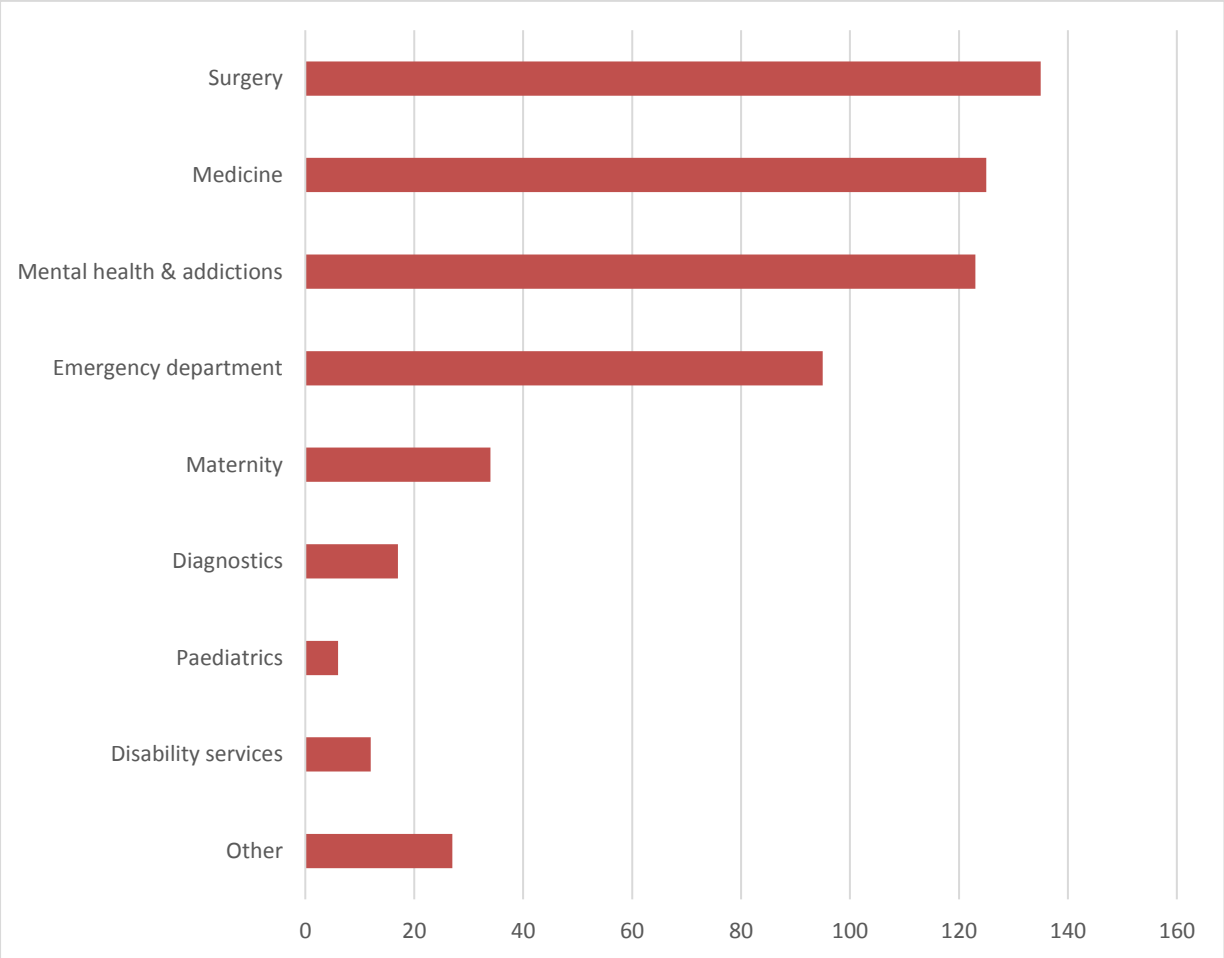


Table 6. Service types complained about

Service type	Number of complaints	Percentage
COVID-19 vaccination centre	**16**	**3%**
Dental	**2**	**0.3%**
Diagnostics	**17**	**3%**
Disability services	**12**	**2%**
District nursing	**5**	**0.8%**
Emergency department	**95**	**16%**
Intensive care/critical care	**2**	**0.3%**
Maternity	**34**	**6%**
Medicine	**125**	**21%**
General medicine	11	2%
Cardiology	16	3%
Dermatology	1	0.2%
Endocrinology	4	0.7%
Gastroenterology	19	3%
Geriatric medicine	7	1%
Haematology	5	0.8%
Infectious diseases	1	0.2%
Neurology	8	1%
Oncology	20	3%
Renal/nephrology	10	2%
Respiratory	3	0.5%
Rheumatology	4	0.7%
Other/unspecified	16	3%
Mental health and addiction	**123**	**20%**
Paediatrics (not surgical)	**6**	**1%**
Rehabilitation services	**5**	**0.8%**
Surgery	**135**	**22%**
Cardiothoracic	5	0.8%
General	23	4%
Gynaecology	25	4%
Neurosurgery	4	0.7%
Ophthalmology	7	0.8%
Oral/Maxillofacial	1	0.2%
Orthopaedics	33	5%
Otolaryngology	10	2%
Plastic and reconstructive	3	0.5%
Paediatric	4	0.7%
Urology	6	1%
Vascular	5	0.8%
Other/unknown	9	2%
Other/unknown health service	**27**	**4%**
TOTAL	**604**	

Table 7 below shows a comparison of the proportion of complaints received over time for the most commonly complained about service types.

Compared to what has been seen in previous periods, the proportion of complaints about medicine and emergency department services increased, while there was a small decrease in the proportion of complaints about surgery services in Jul–Dec 2021.

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

Service type	Jan–Jun 2019	Jul–Dec 2019	Jan–Jun 2020	Jul–Dec 2020	Jan–Jun 2021	Jul–Dec 2021
Surgery	31%	31%	31%	23%	26%	22%
Mental health and addictions	22%	25%	22%	24%	23%	20%
Medicine	18%	16%	18%	19%	16%	21%
Emergency department	12%	11%	11%	15%	12%	16%
Maternity	6%	5%	7%	5%	5%	5%

4. What did people complain about?

4.1 Primary issues identified in complaints

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

The most common primary issue categories were:

- Care/treatment (50%)
- Access/funding (10%)
- Communication (9%)
- Consent/information (9%)

The most common specific primary issues complained about were:

- Missed/incorrect/delayed diagnosis (10%)
- Inadequate/inappropriate treatment (6%)
- Lack of access to services (5%)
- Delay in treatment (5%)
- Inadequate non-clinical care (5%)

Table 8. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***59***	***10%***
ACC compensation issue	3	0.5%
Lack of access to services	27	5%
Lack of access to subsidies/funding	4	0.7%
Waiting list/prioritisation issue	25	4%
Boundary violation	***7***	***1%***
Care/Treatment	***285***	***50%***
Delay in treatment	27	5%
Delayed/inadequate/inappropriate referral	11	2%
Inadequate coordination of care/treatment	20	4%
Inadequate/inappropriate clinical treatment	34	6%
Inadequate/inappropriate examination/assessment	25	4%
Inadequate/inappropriate follow-up	13	2%
Inadequate/inappropriate monitoring	8	2%
Inadequate/inappropriate non-clinical care	26	5%
Inadequate/inappropriate testing	4	0.7%
Inappropriate admission/failure to admit	3	0.5%
Inappropriate/delayed discharge/transfer	12	2%
Inappropriate withdrawal of treatment	6	1%
Missed/incorrect/delayed diagnosis	58	10%
Personal privacy not respected	4	0.7%
Refusal to treat	5	0.9%

Primary issue in complaints	Number of complaints	Percentage
Rough/painful care or treatment	6	1%
Unexpected treatment outcome	20	4%
Other care/treatment issue	3	0.2%
Communication	***52***	***9%***
Disrespectful manner/attitude	26	5%
Failure to accommodate cultural/language needs	3	0.5%
Failure to communicate openly/honestly/effectively with consumer	17	3%
Failure to communicate openly/honestly/effectively with family/whānau	6	1%
Complaints process	***5***	***0.9%***
Inadequate response to complaint	5	0.9%
Consent/Information	***51***	***9%***
Consent not obtained/adequate	13	2%
Inadequate information provided regarding adverse event	2	0.4%
Inadequate information provided regarding treatment	8	1%
Incorrect/misleading information provided	4	0.7%
Issues with involuntary admission/treatment	19	3%
Other consent/information issue	5	1%
Documentation	***15***	***3%***
Delay/failure to disclose documentation	5	1%
Inadequate/inaccurate documentation	4	0.7%
Other documentation issue	6	1%
Facility issues	***30***	***5%***
Cleanliness/hygiene issue	2	0.4%
Failure to follow procedures/policies	3	0.4%
General safety issue for consumer in facility	4	0.4%
Inadequate/inappropriate policies/procedures	7	1%
Waiting times	6	1%
Other	8	0.7%
Medication	***21***	***4%***
Administration error	4	0.7%
Inappropriate prescribing	5	1%
Prescribing error	2	0.4%
Refusal to prescribe/dispense/supply	7	1%
Other medication issue	3	0.7%
Professional conduct issues	***21***	***4%***
Disrespectful behaviour	4	0.7%
Inappropriate collection/use/disclosure of information	6	1%
Threatening/bullying/harassing behaviour	4	0.7%
Other professional conduct issues	7	1%
Other issues	***20***	***2%***
TOTAL	**566**	

Table 9 shows a comparison over time for the top five primary issues complained about. Compared to what has been seen in previous periods, there was a small decrease in complaints primarily related to an 'unexpected treatment outcome' in Jul–Dec 2021, and an increase in complaints primarily related to 'inadequate care' and a 'delay in treatment'.

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

Top five primary issues in all complaints (%)							
Jan–Jun 20 n=392		**Jul–Dec 20 n=464**		**Jan–Jun 21 n=532**		**Jul–Dec 21 n=566**	
Lack of access to services	12%	Misdiagnosis	13%	Misdiagnosis	11%	Misdiagnosis	10%
Misdiagnosis	10%	Lack of access to services	8%	Unexpected treatment outcome	8%	Inadequate treatment	6%
Unexpected treatment outcome	8%	Unexpected treatment outcome	7%	Lack of access to services	8%	Lack of access to services	5%
Waiting list/ prioritisation	7%	Waiting list/ prioritisation	7%	Waiting list/ prioritisation	6%	Delay in treatment	5%
Inadequate treatment	5%	Inadequate treatment	6%	Inadequate treatment	6%	Inadequate care	5%

4.2 All issues identified in complaints

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

Table 10. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	***119***	***21%***
ACC compensation issue	23	4%
Lack of access to services	60	11%
Lack of access to subsidies/funding	9	2%
Waiting list/prioritisation issue	49	8%
Boundary violation	***13***	***2%***
Care/Treatment	***445***	***78%***
Delay in treatment	121	21%
Delayed/inadequate/inappropriate referral	34	6%
Inadequate coordination of care/treatment	95	17%
Inadequate/inappropriate clinical treatment	90	16%
Inadequate/inappropriate examination/assessment	97	17%
Inadequate/inappropriate follow-up	73	13%
Inadequate/inappropriate monitoring	42	7%
Inadequate/inappropriate non-clinical care	64	11%
Inadequate/inappropriate testing	39	7%
Inappropriate admission/failure to admit	24	4%

All issues in complaints	Number of complaints	Percentage
Inappropriate/delayed discharge/transfer	34	6%
Inappropriate withdrawal of treatment	13	2%
Missed/incorrect/delayed diagnosis	104	18%
Personal privacy not respected	14	2%
Refusal to assist/attend	13	2%
Refusal to treat	16	3%
Rough/painful care or treatment	26	6%
Unexpected treatment outcome	54	9%
Other care/treatment issue	4	0.7%
Communication	***349***	***61%***
Disrespectful manner/attitude	103	18%
Failure to accommodate cultural/language needs	23	4%
Failure to communicate openly/honestly/effectively with consumer	218	38%
Failure to communicate openly/honestly/effectively with family/whānau	84	15%
Insensitive/inappropriate comments	24	4%
Other communication issue	9	2%
Complaints process	***73***	***13%***
Inadequate information regarding complaints process	5	1%
Inadequate response to complaint	63	11%
Retaliation/discrimination as a result of a complaint	4	0.7%
Other complaint process issue	2	0.4%
Consent/Information	***146***	***26%***
Coercion by provider to obtain consent	8	1%
Consent not obtained/adequate	24	4%
Failure to assess capacity to consent	4	0.7%
Incorrect/misleading information provided	8	1%
Inadequate information provided regarding adverse event	9	2%
Inadequate information provided regarding condition	15	3%
Inadequate information provided regarding options	7	1%
Inadequate information provided regarding results	5	1%
Inadequate information provided regarding treatment	38	7%
Issues regarding consent when consumer not competent	3	0.5%
Issues with involuntary admission/treatment	39	7%
Other consent/information issue	7	1%
Documentation	***62***	***11%***
Delay/failure to disclose documentation	16	3%
Delay/failure to transfer documentation	4	0.7%
Inadequate/inaccurate documentation	32	6%
Intentionally misleading/altered documentation	6	1%
Other documentation issue	7	1%
Facility issues	***102***	***18%***
Cleanliness/hygiene issue	4	0.7%
Failure to follow procedures/policies	14	2%
General safety issue for consumer in facility	12	2%

All issues in complaints	Number of complaints	Percentage
Inadequate/inappropriate policies/procedures	31	5%
Issues with quality of aids or equipment	4	0.7%
Issues with sharing facility with other consumers	8	1%
Staff/rostering/other HR issue	15	3%
Waiting times	20	3%
Other facility issue	17	0.4%
Medication	***66***	***12%***
Administration error	8	1%
Inappropriate administration	12	2%
Inappropriate prescribing	12	2%
Prescribing error	4	0.4%
Refusal to prescribe/dispense/supply	14	2%
Other medication issue	16	3%
Professional conduct issues	***56***	***9%***
Disrespectful behaviour	13	2%
Inappropriate collection/use/disclosure of information	12	2%
Threatening/bullying/harassing behaviour	14	2%
Other professional conduct issue regarding consumer	20	3%
Other issue	***43***	

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

- Care/treatment (present for 78% of all complaints)
- Communication (present for 61% of all complaints)
- Consent/information (present for 24% of all complaints)
- Access/funding (present for 21% of all complaints)

The most common *specific* issues were:

- Failure to communicate effectively with consumer (38%)
- Delay in treatment (21%)
- Missed/incorrect/delayed diagnosis (18%)
- Disrespectful manner/attitude (18%)
- Inadequate/inappropriate examination/assessment (17%)
- Inadequate coordination of care/treatment (17%)
- Inadequate/inappropriate clinical treatment (16%)
- Failure to communicate openly/honestly/effectively with family/whānau (15%)

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

Issues complained about in relation to COVID-19

HDC received 72 complaints about COVID-19-related issues at DHBs in Jul–Dec 2021. This represents 16% of all complaints about COVID-19 received by HDC during this time period, and is an increase on the 29 COVID-19-related complaints received in Jan–Jun 2021.

The majority of these complaints were about vaccine-related issues (53%), including concerns regarding: health professional's manner towards people who were unvaccinated, delayed access to vaccinations and vaccine administration procedures.

Other issues raised in relation to COVID-19 included:

- Concerns regarding COVID-19 policies/procedures – 30% (including visitor restrictions, infection control policies and policies regarding mask wearing)
- Impact on the health and disability system – 14% (including delayed treatment and standard of care during restrictions)

4.3 Primary issues by service type

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

This is broadly similar to what was seen in previous periods. However, compared to the previous period, waiting list/prioritisation issue increased for surgical services.

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

Surgery		Mental health & addictions		Medicine		Emergency department	
Waiting list/ prioritisation issue	20%	Issues with involuntary admission/ treatment	31%	Missed/ incorrect/ delayed diagnosis	27%	Missed/ incorrect/ delayed diagnosis	19%
Inadequate/ inappropriate treatment	16%	Inadequate/ inappropriate examination/ assessment	13%	Inadequate/ inappropriate treatment	13%	Delay in treatment	14%
Delay in treatment AND Misdiagnosis	12%	Lack of access to services	13%	Inadequate/ inappropriate treatment	10%	Inadequate/ inappropriate examination/ assessment	12%

5. What were the outcomes of the complaints closed?

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

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

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

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

5.1 Number of complaints closed

In the period Jul–Dec 2021, HDC closed **330**[4] complaints involving DHBs. Table 12 shows the number of complaints closed in previous six-month periods.

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

	Jan–Jun 17	**Jul–Dec 17**	**Jan–Jun 18**	**Jul–Dec 18**	**Jan–Jun 19**	**Jul–Dec 19**	**Jan–Jun 20**	**Jul–Dec 20**	**Jan–Jun 21**	**Average of last 4 periods**	**Jul–Dec 21**
Number of complaints closed	465	383	476	449	444	423	428	390	478	**430**	**330**

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

5.2 Outcomes of complaints closed

In the Jul–Dec 2021 period, 11 DHBs had no investigations closed, 7 DHBs had one investigation closed, 2 DHBs had two investigations closed, and 1 DHB had five investigations closed.

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

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

Outcome for DHBs	Number of complaints closed
Investigation	***14***
Breach finding — referred to Director of Proceedings	3
Breach finding	2
No breach finding with adverse comment and recommendations	2
No breach finding with recommendations	6
No breach finding	1
Other resolution following assessment	***316***
No further action with recommendations or educational comment	21
Referred to District Inspector	15
Referred to other agency	9
Referred to DHB	89
Referred to Advocacy	67
No further action	110
Withdrawn	5
TOTAL	**330**

5.3 Recommendations made to DHBs by HDC

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

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

Table 14. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	5
Audit	6
Meeting with consumer/complainant	3
Presentation/discussion of complaint and improvements with others	5
Provision of evidence of change to HDC/evaluation of change	10
Review/implementation of policies/procedures	16
Training/professional development	7
TOTAL	**52**

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

The most common recommendations made to DHBs were that they: review or implement new policies and procedures (16 recommendations); and provide evidence of change made in response to the complaint to HDC (10 recommendations). Review of policies/procedures often related to clinical issues identified in the complaints, consent procedures and staffing levels.

6. Learning from complaints

6.1 Communication and risk assessment in DHB maternity service[6]

This case highlights the importance of all team members having situational awareness of the evolving picture of a baby in distress, and knowing when to escalate care. The issues raised in this case are also indicative of the impact that delayed access to theatres and a lack of senior clinician oversight after hours can have on patient safety.

Background

A woman went into labour and was admitted to the hospital's primary birthing unit. The woman had previously been referred to specialist services owing to concerns about asymmetric fetal growth and high blood pressure. While her high BMI had been noted by specialist services, a recommendation was not made that she give birth in a specialist facility.

After a prolonged latent phase of labour, a cardiotocograph (CTG) was commenced to monitor the baby's heart rate. The CTG recorded two decelerations. A midwife undertook an assessment, and noted that no membranes could be felt and she was 4cm dilated. Following a discussion with the woman, her husband and the obstetric registrar, the woman was transferred to the specialist maternity facility for review and augmentation of labour.

The woman was reviewed by an obstetric registrar. The registrar noted that the CTG was abnormal, but she was reassured by clear liquor when she undertook an artificial rupture of membranes, and by a period of normal CTG activity. The registrar recommended Syntocinon augmentation to progress labour, and continuous fetal monitoring. A partogram (tool used to monitor labour and prevent prolonged/obstructed labour) was commenced.

Overnight, variable decelerations on the CTG continued to be seen and hospital staff continued to request reviews from the registrar. The registrar's impression was the CTG was abnormal, but was not in keeping with fetal hypoxia. The registrar increased Syntocinon to give the woman the best chance of a vaginal delivery.

At 3am the registrar reviewed the woman and Syntocinon was stopped shortly afterwards. The registrar documented that if the woman was no further dilated at 5.30am, she would be taken for a Caesarean section. At this time, the registrar had been called to perform a more urgent Caesarean section on another patient. The registrar told HDC that had this not been the case, she would have recommended the woman undergo a Caesarean section at 3am. The registrar did not consult the on-call consultant at this time.

The woman's CTG remained abnormal, and the midwife continued to escalate this to the registrar. At 6.20am, when the registrar left surgery, she reviewed the woman. A fetal scalp lactate was performed and was abnormal. A Caesarean section was recommended at 6.40am. The baby was born in poor condition. He was diagnosed with moderate neonatal encephalopathy, neonatal seizures and a stroke.

Findings

HDC's expert obstetric advisor considered that this case illustrates the problems of dysfunctional or obstructed, and therefore prolonged labour in a woman having her first baby, noting that this is more likely in patients with a high BMI. HDC's advisor commented that these circumstances should be well recognised by obstetricians and midwives alike, and anticipated and planned for, because the birth can become extremely complicated and risky with junior staff in an after-hours situation facing a

[6] Decision 20HDC00513

difficult surgery. He noted that systems issues, a culture of non-intervention, and an expectation that the labour was going to be normal may all have contributed to the late actions in this case.

The Deputy Commissioner was critical of the following aspects of care:

- There were missed opportunities for the woman's labour care to be provided in the specialist maternity facility from the outset;
- In the face of a persistently abnormal CTG in the context of the woman's risk factors and prolonged labour, there were missed opportunities to review the appropriateness of the woman's care;
- There was a lack of senior midwifery oversight after-hours (no particular midwife was employed in a position of overall responsibility and oversight);
- There should have been better documentation of the reasons for continuing labour despite the persistently abnormal CTG; and
- Earlier use of a partogram would have given additional context to the woman's prolonged labour.

In respect of these issues, the Deputy Commissioner considered that the DHB failed to provide services to the woman with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner also noted that the issues raised in this report indicate the impact that delayed access to theatres and a lack of senior clinician oversight after-hours can have on patient safety. These issues are seen in other complaints about regional obstetric units, and raise concerns about variation in care and geographical inequities in access to, and quality of, maternity services.

Recommendations

The Deputy Commissioner recommended that the DHB provide a written apology to the woman for the issues identified in this case, and provide an update on the progress of actions taken in response to the findings of the Serious Adverse Event Review, including:

- That "fresh eyes" interpretation of CTGs occurs every 2 hours, with overview of the whole CTG by the shift leader;
- That all clinicians involved in this case have undertaken fetal surveillance training in the last 12 months;
- That steps are taken to ensure that all women admitted to the birthing unit are admitted in compliance with the birthing unit policy; and
- That midwifery manager hours are increased to 24/7.

The Deputy Commissioner also asked the DHB to update its definition of normal variability in its policy on fetal surveillance, and use this case as an anonymised case study for obstetric and midwifery staff.

The Deputy Commissioner highlighted her support of the work of the Neonatal Encephalopathy taskforce in implementing a nationally consistent multidisciplinary fetal heart monitoring training programme.

6.2 Lack of assessment and planning in acute mental health unit[7]

This case highlights some of the themes seen by HDC regarding risk assessment and planning in mental health units

Background
A man was transferred to a forensic mental health unit from prison, where he had been displaying agitated and aggressive behaviours. On admission to the unit, the man was assessed as being a high risk of harm to himself and others, and initially was managed in seclusion but was later transferred to the main ward. On day four of his admission, the man was provided with a razor which he subsequently used to self-harm.

Findings
The Deputy Commissioner considered that there was a lack of clear assessment and planning for the management of the man's risk and impulsive behaviours and, as a result, it is not clear whether important information about the man's level of risk was adequately communicated to nursing staff.

The Deputy Commissioner noted that for people who experience acute episodes of distress, relative risk of self-harm changes rapidly and frequently, as occurred in this case. She acknowledged that the district health board had a range of tools to assess and manage risk, but considered there was room for improvement in the way risk is communicated.

The Deputy Commissioner was also critical that razors were available on the unit, and that there was no policy to guide staff regarding access to them.

The Deputy Commissioner found that the DHB failed to provide services to the man with reasonable care and skill, in breach of Right 4(1).

Recommendations
Following recommendations made by the Deputy Commissioner resulting from this complaint, the DHB made a number of changes to support care planning across its mental health and addiction services, and introduced risk assessment tools for the assessment and management of its consumers.

The Deputy Commissioner also wrote to the Ministry of Health earlier this year to request support for the development of consistent risk management and safety planning protocols to replace the practice of risk prediction still being used in some services.

[7] Decision 19HDC01597

6.3 Inadequacies in reporting of scans before surgery[8]

This case highlights the importance of having guidelines and policies in place to facilitate careful, thorough, and timely reporting of preoperative imaging.

Background
A man was diagnosed with liver cancer and a decision was made to proceed with a liver resection to treat the cancer. He was reviewed by a hepatobiliary surgeon and an anaesthetist, who confirmed the man's suitability for a liver resection and placed him on the waitlist.

He was placed on DHB1 surgeon's list five days prior to surgery. The surgeon reviewed his case and discussed the need for updated imaging with the man's hepatologist. The man's hepatologist requested that a CT scan be undertaken at DHB2 (the man's domicile DHB). The referral form noted that the request was urgent as his surgery was scheduled for the following week.

DHB2 advised that when referrals are received, the normal process is that they are triaged, and the triage priority result is added prior to the referral going to the booking clerk. However, in this case, the referral was hand-delivered to the duty radiologist, who took the referral directly to the CT bookings clerk to expedite the process. The referral therefore skipped the normal process where the triage priority result is added prior to the referral going to the booking clerk, and an urgent tag was not added to the referral.

The man's CT scan was undertaken two days before his surgery. DHB2 loaded the images onto the DHB's picture archiving system and sent them to DHB1. DHB2 advised that it is standard practice to send images digitally and for the reports to be reviewed separately via the shared electronic record depository (Éclair).

The radiologist on duty over the weekend at DHB2 did not notice that the imaging needed to be reported on, likely because it was not tagged as urgent, and appeared on the radiology information system as a routine outpatient scan. The DHB advised that at this time, CT liver images were often left to be reported on by a radiologist who specialised in abdominal CT scans.

The images were not reviewed by a radiologist when received by DHB1, where imaging is transferred by a direct electronic mechanism to a radiology library. The process is the same whether or not the images are accompanied by a radiology report. At the time of these events, DHB1 did not have a policy or procedure that informed clinicians that any imaging that had not been reviewed at a multi-disciplinary meeting, or reported on by a radiologist, had to be reviewed by, or in conjunction with, a radiologist prior to surgery.

The images were reviewed by the hepatobiliary surgeon on the morning of the man's surgery. The surgeon concluded that a liver resection was still feasible. However, the imaging showed small lung nodules, indicating that the cancer had metastasised. This was not identified by the surgeon. Had the lung metastases been recognised prior to surgery, the operation would not have proceeded.

The CT scan was reported on by a radiologist at DHB2 the day after the surgery, and the man was diagnosed with prostate cancer with lung metastases.

Findings
The Deputy Commissioner was concerned that due to a series of failures by DHB1 the metastases were not identified prior to surgery. In particular: the need for CT chest imaging was not identified until five

[8] Decision 19HDC01944

days preoperatively; they did not have a system in place to ensure that the first scan was reported by a radiologist prior to surgery; and they did not have any policies or procedures in place to guide the surgeon's actions when he received imaging which had not been reported on. Accordingly, the Deputy Commissioner considered that DHB1 failed to provide services to the man with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner also made adverse comment about DHB2, as the process used to expedite the man's referral failed to identify that the request needed to be reported on urgently. This was a significant factor contributing to the man's metastatic lung disease not being identified until after the surgery had taken place.

Recommendations
The Deputy Commissioner recommended that the two DHBs each provide an apology to the man's family.

The Deputy Commissioner recommended that DHB1:

- create and implement a policy that states that in the context of patients with cancer, any imaging that has not been reviewed by an MDM or reported on by a radiologist should be either reported on, or reviewed in conjunction with a radiologist, and documented prior to surgery;
- Create and implement a guideline that outlines the preoperative investigations that should be considered before hepatocellular carcinoma surgery, including the acceptable maximum time to have elapsed between the preoperative investigation and the date of surgery, and the creation of a safeguard to ensure that appropriate actions occur when the maximum time has elapsed.

6.4 Inadequate treatment of pulmonary embolism[9]

This case highlights the importance of creating a culture whereby junior staff are supported to escalate care after-hours

Background
A woman in her sixties presented to a medical centre with a five-day history of shortness of breath. Her blood pressure was high and blood tests showed significant heart strain, although an X-ray showed no evidence of heart failure. A pulmonary embolism (PE) – a blockage in the arteries in the lungs – was considered a possible cause of her symptoms. The medical centre administered a dose of Clexane (blood-thinning medication), and called an ambulance to transfer her to the Emergency Department.

When the woman arrived at ED she was assessed by a registrar who made a plan for the woman to undergo a CT scan of the pulmonary arteries before further review. The scan confirmed a large PE with evidence of right-sided heart strain.

An hour later she was reviewed by the admitting medical registrar for handover to the respiratory team. He noted that she had a PE severity Index of class IV and documented that this indicated an intermediate–high risk of mortality. The registrar also noted that she had an episode of light-headedness and faintness while in the ED. The registrar discussed her plan with on-call consultant. It was planned that thrombolysis would be considered if her blood pressure dropped or she went into shock.

At this time the ED was extremely busy and there were not enough inpatient beds to transfer patients from ED. Therefore, although the woman had been handed over to the respiratory team, she remained in ED while she waited for an inpatient bed to become available.

While in ED, the woman was monitored using an Early Warning Score. In the space of 20 minutes, the woman's EWS was 9 on three occasions and her blood pressure dropped, indicating that her case needed to be discussed with the on-call consultant. This did not occur. The woman was moved to the resuscitation bay, and her blood pressure continued to fluctuate. Saline was used in an attempt to raise her blood pressure. Documentation of care was poor, and although the notes indicate a registrar was involved in her care, the DHB could not verify which registrar was involved. On two occasions the woman's systolic blood pressure dropped below 90mmHG, indicating that thrombolysis should be considered (as directed by policy). However, thrombolysis was not considered.

While in the CCU the woman's EWS scores indicated that documented assessment was required, and although some assessments were undertaken they were not documented. The woman's systolic blood pressure was noted to be 90mmHG while she was in the CCU. The next morning, the woman suffered a cardiac arrest (due to the large PE) and died.

Findings
The Commissioner was concerned that staff considered it uncommon for an on-call consultant to be contacted overnight, and noted that the woman's care was not escalated when her EWS scores clearly indicated she was not improving and policies stipulated that escalation was warranted on a number of occasions. The Commissioner commented that DHBs have a responsibility to foster a culture that ensures junior staff are aware that they are able to escalate care to senior medical staff when necessary, that they can do so without concern, and that consultants are accessible and approachable.

[9] Case 20HDC00739.

While the Commissioner acknowledged the risks associated with thrombolysis, and the potential inexperience staff may have had with this therapy (possibly leading to a reluctance by staff to proceed with this course of action), there were multiple occasions during the woman's stay at the public hospital where opportunities for administering thrombolysis were missed. This inaction deprived the woman of the opportunity for potentially lifesaving treatment.

The Commissioner concluded that during the 17 hours the woman was in hospital, there were a number of missed opportunities for staff to exercise sound clinical judgement, assess her condition critically, escalate care to the responsible consultant, initiate thrombolysis when clinically indicated, and communicate with one another. Additionally, the documentation in this case fell well below accepted standards. Accordingly the Commissioner considered that the DHB failed to provide services to the woman with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner referred the DHB to the Director of Proceedings for the purposes of deciding whether any proceedings should be taken.

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

- Provide HDC with an update on its progress on the implementation of the Health Quality and Safety Commission's "Recognition and Response" programme;
- Use this investigation as an anonymous case study for the emergency medicine and respiratory medicine teams;
- Review the medical staffing levels at the hospital overnight to ensure that there is an adequate mix of skills and capacity to meet acuity of demand;
- Undertake an audit of the adequacy of clinical documentation within the public hospital;
- Consider the Health Quality & Safety Commission's resource on "Patient, Family and Whānau Escalation: Kōrero mai projects — what we know so far", and advise whether any continuous improvement projects could flow from the learnings in this investigation;
- Consider the Australasian College for Emergency Medicine's Statement on "Responsibility for Care in Emergency Departments" and use this to create its own guideline with regard to patients in ED awaiting inpatient beds;
- Consider developing a policy and process to allow for increased supervision of resident medical officers (especially house officers) during their first few weeks of a rotation;
- Promote awareness or develop a process or pathway for nurses to contact senior doctors directly in appropriate circumstances, such as a lack of response from house officers and registrars; and
- Provide training to its staff on: PE management; EWS and escalation from registrars to consultants; the recognition of critical illness and shock states; and medical documentation.

The Commissioner also asked the DHB to contact the woman's family to offer another meeting to discuss both the Clinical Incident Report and HDC's findings.