

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

**Report and Analysis for period 1 July 2017 to 30 June 2018**

**Feedback**

We welcome your feedback on this report. Please contact Natasha Davidson at [hdc@hdc.org.nz](mailto:hdc@hdc.org.nz)

**Authors**

This report was prepared by Natasha Davidson (Principal Advisor – Research and Education).

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# COMMISSIONER'S FOREWORD

I am pleased to present HDC's analysis of complaints received involving District Health Boards for the 2017/18 year. The aim of this report is to provide the general public and providers with an understanding of the types of complaints HDC receives about services run by DHBs and the positive changes that have been made to services as a result of these complaints.

DHB complaint trends have remained broadly consistent over the last five years. The most commonly complained about service types have continued to be surgery, mental health, general medicine and emergency department services. The most common issues complained about in relation to DHB services tend to be communication issues (in regards to communication with both consumers and their family), inadequate treatment, inadequate examinations/assessments, diagnostic issues and treatment delays.

I note that complaints regarding access issues, including waiting list management/prioritisation issues, make up around a quarter of all complaints received by my Office about DHBs. In 2017/18, I found two DHBs in breach of the Code for inadequate waiting-list management and the lack of an appropriate prioritisation system. One of these cases is detailed in this report and involved a young man with a family history of glaucoma, who experienced a six month delay in receiving a follow-up appointment at a DHB ophthalmology service. By the time the man was seen again, he had suffered vision loss in his right eye. The service lacked capacity, in that the clinic did not have enough appointments for the number of patients clinicians needed to see, and the DHB did not have a prioritisation system in place that focused on patients' clinical need. The case is an important reminder that at all times, and particularly when a system is under pressure, patient prioritisation must be a key focus so that the patients with the highest clinical priority are seen first. Additionally, these cases highlight the importance of providers taking proactive steps to assess, plan, adapt, and respond effectively to the foreseeable effects that new technologies and changing demographics will have on systems and demand.

As you will see as you read through this report, inadequate follow-up of test results and inadequate referral management has been a feature of a number of investigations closed by this Office in the past year. It is important that DHBs communicate clearly to staff their expectations around referral management and test result follow-up, and that their systems have a number of defences built into them to ensure that test results and referrals are actioned in a timely manner.

There is a person and whānau at the centre of every one of these complaints and it is important that we all take every opportunity to learn from these cases and reduce harm in future. I trust that this report will continue to promote ongoing quality improvement and learning for individuals, the organisations they work for, and the wider health system they work within.

Anthony Hill  
**Health and Disability Commissioner**

## EXECUTIVE SUMMARY

In the 2017/18 year, HDC received 889 complaints involving DHBs. This was a small increase of 3% on the number received in the previous year. These 889 complaints equate to a rate of 91 complaints per 100,000 discharges – a very small increase on the rate of complaints received in the previous year.

The complaints related to a wide variety of DHB service types, with the most commonly complained about service types being surgical, mental health, general medicine and emergency department services. The service types complained about have remained broadly consistent over the past five years.

Also consistent with complaint trends seen in previous years, doctors were the individual providers complained about most commonly, with 83% of the individual providers identified in DHB complaints being doctors.

Missed, incorrect or delayed diagnosis was the most common primary issue of concern, and was raised by the complainant as the primary issue in 13% of complaints. When all issues raised in complaints were considered, the most common complaint issues involved care/treatment and communication issues, followed by access issues and issues regarding the consent process and the information provided to consumers.

Issues complained about have remained broadly consistent over time. However, the proportion of complaints regarding a disrespectful manner/attitude and an inadequate response to the consumer's complaint by the DHB have decreased over the last five years.

The issues raised in complaints varied by the service type involved. Services with high diagnostic workloads, such as general medicine and emergency departments, commonly received more complaints primarily regarding missed, incorrect or delayed diagnoses. Primary issues in complaints about mental health services are quite distinct, with issues relating to involuntary admission/treatment and safety issues for consumers in inpatient units being common.

When all issues raised in complaints about each service type were analysed, general medicine and mental health services received a greater proportion of complaints involving communication with family than other service types, while emergency department services received a greater proportion of complaints involving inadequate examination/assessments, misdiagnosis and inadequate testing than did other service types. Surgical services received a greater proportion of complaints about a waiting list/prioritisation issue and maternity services received a greater proportion of complaints regarding a delay in treatment than other service types.

In the 2017/18 year, HDC closed 859 complaints about DHB services. This included the conclusion of 51 investigations. Around 21% of complaints were referred back to the DHB for resolution. In around 27% of cases, HDC made recommendations and/or educational comments designed to facilitate improvement in DHB services. The most common recommendation was that DHBs provide evidence to HDC of the changes they had made in response to the issues raised by the complaint, followed by a review of their policies/procedures or implementation of new policies/procedures. Staff training/education was also often recommended.

# BACKGROUND

## 1. The Health and Disability Commissioner

HDC is an independent crown entity established under the Health and Disability Commissioner Act 1994 to promote and protect the rights of health and disability services consumers. The rights of consumers are set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code places corresponding obligations on all providers of health and disability services, including individual providers and organisational providers such as district health boards.

HDC promotes and protects the rights of consumers of health and disability services by:

- resolving complaints;
- improving quality and safety within the sector; and
- appropriately holding providers to account.

As such, HDC fulfils the critical role of independent watchdog for consumer rights within the sector.

### **Rights under the Code**

1. The right to be treated with respect.
2. The right to freedom from discrimination, coercion, harassment and exploitation.
3. The right to dignity and independence.
4. The right to services of an appropriate standard.
5. The right to effective communication.
6. The right to be fully informed.
7. The right to make an informed choice and give informed consent.
8. The right to support.
9. Rights in respect of teaching or research.
10. The right to complain.

Anyone may make a complaint to HDC about a health or disability service that has been provided to a consumer. It is not uncommon for HDC to receive complaints from third parties, such as family members, friends, or other providers involved in the consumer's care. The Commissioner may also commence an investigation at his own initiative, even without having received a complaint, if he considers it appropriate to do so.

## **2. District Health Boards**

There are 20 district health boards (DHBs) with responsibility for funding or providing a specified range of health and disability services on behalf of the government. Public hospitals, and other public health services, including various clinics and community-based services, are owned and funded by DHBs. Individual providers (for example, doctors and nurses) working in a DHB's facility are usually employed by that DHB.

### **3. This Report**

This report describes the complaints HDC received and/or closed in relation to DHBs during the 2017/18 financial year.

Complaints about DHBs are of particular interest as DHBs are the largest organisational providers of health and disability services in New Zealand. Approximately 40% of complaints received by HDC each year relate, at least in part, to DHB services.

The complaints are described both in terms of overall numbers and characteristics, as well as by reference to case studies. In terms of complaints received, the issues included in the analysis are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues can still provide a valuable insight into the consumer's experience of the services provided and the issues they care most about.

Case studies are included to highlight the positive changes that have been made to services as a result of complaints about DHBs. Readers are encouraged to consider their own service provision when reading this report and to ask "could that happen at my place" and, if so, what changes can be made to prevent it?

# COMPLAINTS RECEIVED

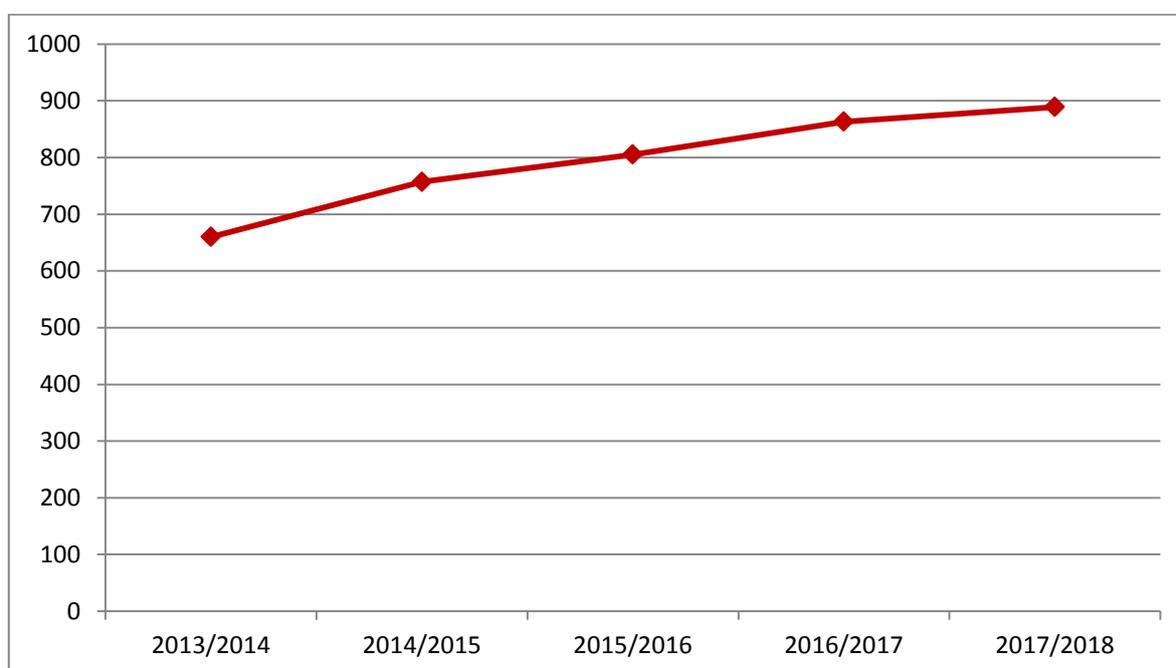
## 1. How many complaints were received?

### 1.1 Number of complaints received

In 2017/18, HDC received a total of **889**<sup>1</sup> complaints about care provided by all DHBs. This equates to 36% of the total 2,498 complaints received by HDC that year.

The 889 complaints received in the 2017/18 year represents an increase of 3% over the 863 complaints received in 2016/17. As can be seen from Figure 1 below, DHB complaint numbers have been steadily increasing over the last five years. This reflects an overall trend of growth in complaint numbers to HDC.

**Figure 1.** Number of complaints received about DHBs



In 2017/18 the number of complaints received about individual DHBs ranged from 7 complaints to 134 complaints. Large variability in complaint numbers is not unexpected given the similar variability in the size of populations served and number and type of services delivered by different DHBs.

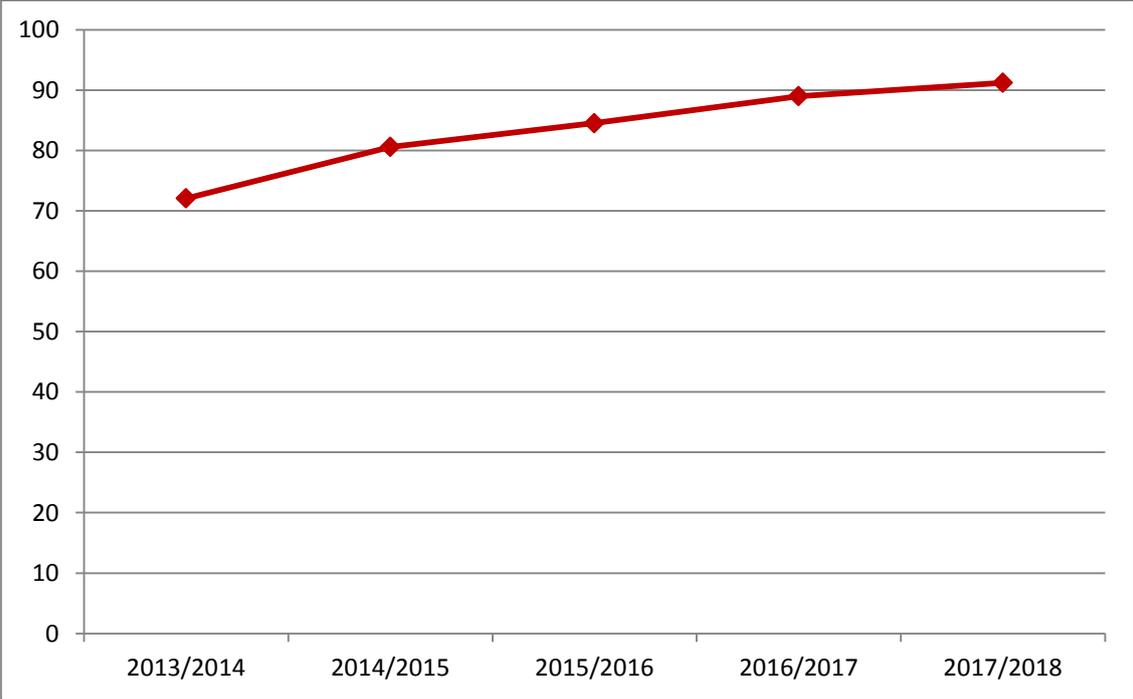
<sup>1</sup> Provisional as of date of extraction, 14 August 2018.

## 1.2 Rate of complaints received

Expressing complaints received by HDC about DHBs as a rate per 100,000 discharges allows more meaningful comparisons to be drawn between DHBs, and over time, enables any trends to be better observed.

In the 2017/18 year, according to Ministry of Health data,<sup>2</sup> there were 974,675 discharges nationally. This equates to an overall rate of 91 complaints per 100,000 discharges across DHB services. This is a very small increase on the overall rate of 89 complaints per 100,000 discharges received during 2016/17.

**Figure 2.** Rate of complaints received about DHBs per 100,000 discharges



For individual DHBs, the rate of complaints received ranged from 45 complaints per 100,000 discharges to 231 complaints per 100,000 discharges.

However, while discharge data is useful for standardising DHB activity over time, it is less accurate when comparing DHBs against one another. This is because some services are excluded from the discharge data collected,<sup>3</sup> disproportionately affecting some DHBs more than others. In addition, discharge data does not take into account the particular services provided by a DHB or the nature of the population and geographical area served.

<sup>2</sup> Provisional as at the date of extraction, 14 September 2018.

<sup>3</sup>For example, the discharge data excludes short stay emergency department discharges, and patients attending outpatient units and clinics.

## **Why are complaint numbers increasing?**

The increasing number of complaints being received by HDC about DHBs reflects an overall trend of sustained growth in complaint numbers to HDC. Over the last five years, the number of complaints to HDC has increased by 40%.

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 an increased willingness amongst consumers to complain about services received and 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. For example, in 2017/18 complaints to the New South Wales Health Care Complaint Commission and the Office of the Health Complaints Commissioner in Victoria increased by 12% and 13% respectively.

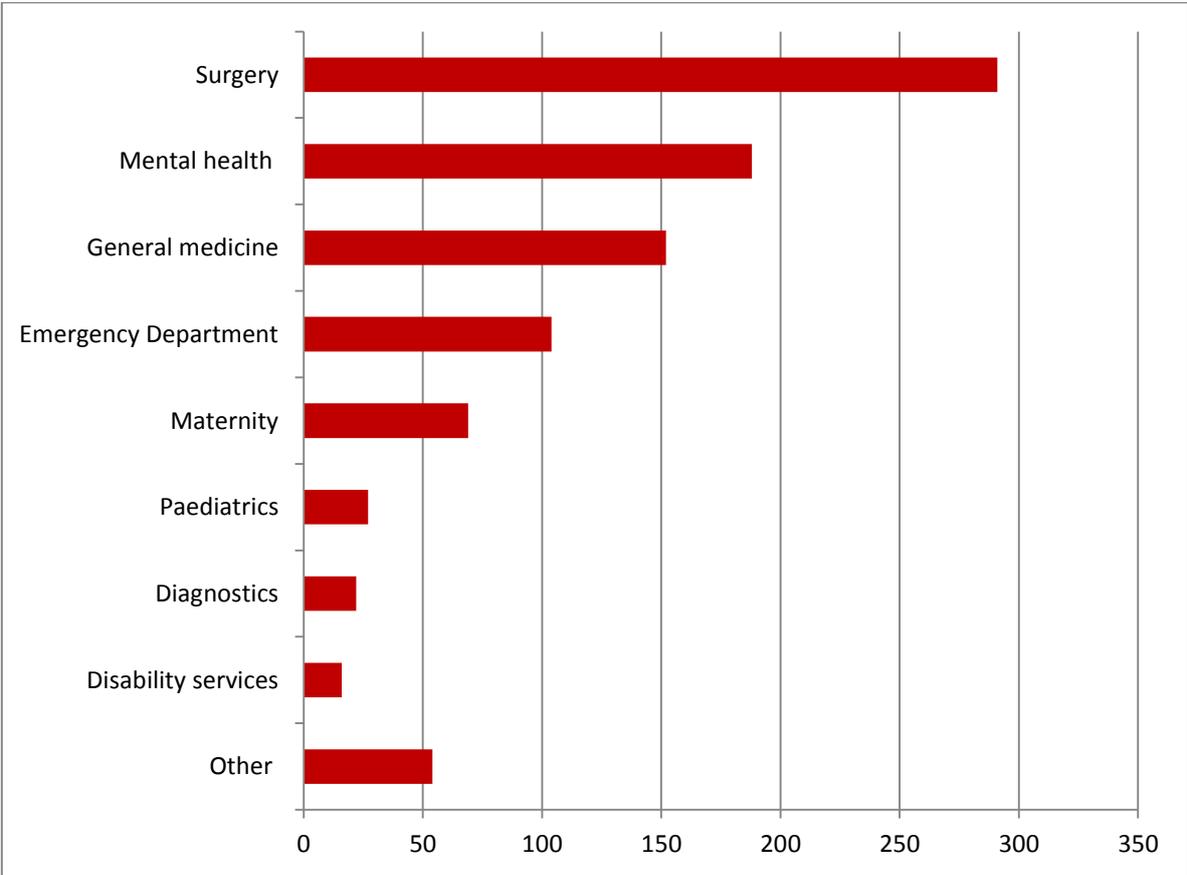
## 2. Which DHB services were complained about?

### 2.1 DHB service types complained about

DHBs operate a number of different services within hospitals, in clinics and in the community. It should be noted that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 889 complaints about DHBs, 923 services have been complained about.

Complaints received by HDC in the 2017/18 year were spread across many different service types, as shown in Figure 3 below, with the greatest proportion of complaints being about surgical services (32%), followed by mental health (20%), general medicine (16%), emergency department (11%) and maternity services (7%).

Figure 3. DHB service types complained about



A more nuanced picture of service types complained about, including individual surgical and general medicine service categories, is provided in Table 1.

The most common surgical specialties complained about in 2017/18 were orthopaedics (7%), general surgery (7%) and urology (5%). This is broadly consistent with the surgical specialties complained about in previous years, with the exception of urology services which increased from 2% of services complained about in 2016/17 to 5% in 2017/18.

**Table 1.** DHB service types complained about

<b>Service type</b>	<b>Number of services (%)</b>
<b>Aged care</b>	<b>4 (0.4)</b>
<b>Alcohol and drug</b>	<b>7 (0.8)</b>
<b>Anaesthetics/pain medicine</b>	<b>5 (0.5)</b>
<b>Dental</b>	<b>4 (0.4)</b>
<b>Diagnostics</b>	<b>22 (2)</b>
<b>Disability services</b>	<b>16 (2)</b>
<b>District nursing</b>	<b>5 (0.5)</b>
<b>Emergency department</b>	<b>104 (11)</b>
<b>General medicine</b>	<b>152 (16)</b>
Cardiology	23 (2)
Dermatology	1 (0.1)
Endocrinology	8 (0.9)
Gastroenterology	14 (2)
Geriatric medicine	19 (2)
Haematology	3 (0.3)
Infectious diseases	3 (0.3)
Neurology	18 (2)
Oncology	13 (1)
Palliative care	2 (0.2)
Renal/nephrology	3 (0.3)
Respiratory	9 (1)
Rheumatology	3 (0.3)
Other/unspecified	33 (4)
<b>Hearing services</b>	<b>3 (0.3)</b>
<b>Intensive care/critical care</b>	<b>6 (0.7)</b>
<b>Maternity</b>	<b>69 (7)</b>
<b>Mental health</b>	<b>188 (20)</b>
<b>Paediatrics (not surgical)</b>	<b>27 (3)</b>
<b>Rehabilitation services</b>	<b>6 (0.7)</b>
<b>Surgery</b>	<b>291 (32)</b>
Cardiothoracic	6 (0.7)
General	62 (7)
Gynaecology	35 (4)
Neurosurgery	12 (1)
Ophthalmology	27 (3)
Oral/Maxillofacial	1 (0.1)
Orthopaedics	69 (7)
Otolaryngology	19 (2)
Plastic and Reconstructive	10 (1)
Urology	42 (5)
Vascular	6 (0.7)
Unknown	2 (0.2)
<b>Other health service</b>	<b>14 (2)</b>
<b>TOTAL</b>	<b>923</b>

Table 2 below, shows a yearly comparison of the proportion of complaints received for the most commonly complained about service types. As can be seen from this table, the most common service types complained about over the last five years have remained broadly consistent, with general medicine showing a small decrease in 2017/18 as compared to the previous year.

**Table 2.** Yearly comparison of the proportion of complaints received about the most commonly complained about service types

Service type	2013/14	2014/15	2015/16	2016/17	2017/18
Surgery	26%	27%	31%	28%	32%
Mental health	19%	19%	21%	21%	20%
General medicine	19%	17%	16%	20%	16%
Emergency department	13%	13%	12%	13%	11%
Maternity	6%	7%	6%	6%	7%

### Case study: Emergency department (15HDC01723)

#### Management of shoulder dislocation

A man dislocated his shoulder in an accident and attended an emergency department. The man was triaged by a Registered Nurse who allocated him a triage category 3 (treatment within 30 minutes). His pain score and vital signs were not documented at triage. An X-ray was taken and pain relief was administered by nursing staff around one and a half hours after his arrival. A clinical nurse specialist attempted to reduce (relocate) the shoulder after the X-ray was reviewed, however this was discontinued due to pain.

The clinical nurse specialist attempted reduction on two further occasions after requesting intravenous opiate pain relief from the consultant. 25mcg IV fentanyl was administered before both of these reductions, but both were stopped at an early stage due to pain. The clinical nurse specialist then requested sedation from the consultant. After this was administered, the shoulder was reduced. A post reduction X-ray was taken to ensure the reduction had been successful. The man was discharged from the emergency department with a copy of his X-rays and notes and advised to follow up with his GP.

The day after discharge, the X-rays were reported on formally. The pre-reduction X-ray report stated that there was a 1 x 0.2mm bone fragment posterior to the humeral head on the lateral view, and the post-reduction X-ray report queried subtle deformities, and stated "if indicated this area can be better evaluated by CT." The consultant viewed and signed off the X-ray reports, noting no action was needed. These reports were not sent to the man and, as his GP's details were not recorded, the GP was not sent copies either.

#### Findings

The Commissioner was critical that the man's pain score and vital signs were not documented at triage, commenting that this impacted on his patient journey in ED. In particular, he considered it is more likely than not that his pain score was higher than 7/10 on arrival, given that subsequently it was found to be 9/10 on more than one occasion, and, accordingly, he should have been allocated a triage code 2. The Commissioner was also critical that there was no form of ongoing assessment between triage and formal review.

The Commissioner was also concerned that the man's pain was not managed adequately in ED, and that the IV opioid protocol was not used to provide him with adequate analgesia earlier in his

admission, given the extended amount of time he had to wait for formal review.

HDC's clinical advisor commented that there should have been a more detailed systematic assessment of the man's head, chest and abdomen documented and was critical that none of the DHB's staff undertook a secondary survey of him. The Commissioner was also concerned that the man's GP details were not recorded on the DHB's system meaning his pre- and post-reduction X-ray reports were not able to be copied to his GP.

The Commissioner found that these deficiencies indicated a pattern of poor care by staff, and systems issues, for which the DHB is responsible. For these reasons, it was held that the DHB did not provide the man with services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner was critical that the consultant did not inform the man of the abnormality seen on the X-ray, especially in light of the fact that the reports were not copied to his GP. This was information that a reasonable consumer in the man's circumstances would expect to receive, and by failing to provide this information the consultant breached Right 6(1)(f) of the Code.

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

- Provide HDC with an update on the improvements to triage assessment (including ensuring documentation of vital signs and accurate assessment and categorisation of patients).
- Provide HDC with evidence that the letter to patients advising them of additional X-ray results (where a condition or injury is identified on the X-ray report that was not seen at the time of their presentation to ED) is being used where appropriate.
- Consider providing triage nursing staff with appropriate training and authority to order X-rays.
- Provide training to ED nursing and medical staff on the use of the IV opioid protocol and the circumstances in which this should be implemented, and by whom.
- Remind ED reception staff of the importance of obtaining a patient's GP details.

These recommendations have been met.

## 2.2 Professions of individual providers complained about

When people complain about services provided to them, they often complain about particular individuals involved in the provision of those services. The professions of the individual providers identified in complaints about DHB services are shown in Table 3 below.

**Table 3.** Professions of individual providers complained about in DHB complaints

Occupation	Number of individuals (%)
<b>Doctors</b>	<b>171 (83)</b>
Emergency medicine specialist	3 (1)
General surgeon	17 (8)
Internal medicine specialist	21 (10)
Medical officer	11 (5)
Neurosurgeon	4 (2)
Obstetrician/gynaecologist	25 (12)
Ophthalmologist	7 (3)
Orthopaedic surgeon	13 (6)
Otolaryngologist	6 (3)
Psychiatrist	23 (11)
Registrar	20 (10)
Urologist	9 (4)
Other	12 (6)
<b>Other health providers</b>	<b>35 (17)</b>
Midwife	10 (5)
Nurse	13 (6)
Occupational therapist	3 (1)
Social worker	4 (2)
Other	5 (2)
<b>TOTAL</b>	<b>206</b>

The vast majority of the individual providers identified in DHB complaints received in the 2017/18 year were doctors. It is likely that doctors are more often seen by complainants as being responsible for the services provided and the outcomes of those services and are, therefore, more frequently viewed as individually responsible for any perceived shortcomings.

The most commonly identified individual provider occupations were obstetrician/gynaecologists (12%) and psychiatrists (11%).

It should be noted that there are a number of factors that may account for the number of complaints about each specialty, such as the amount of patient contact that each specialty has, the clinical activities each specialty performs, the characteristics of the population that each specialty serves and the degree to which an individual can be seen as responsible for the care provided.

## **Case study: Nurse (15HDC01330)**

### **Inadequate care provided to baby in hospital**

A seven-day-old baby was admitted to hospital with 11% weight loss since birth, jaundice, and reduced feeding. She was treated with phototherapy on the children's ward.

The baby's temperature spiked the following day. The consultant paediatrician ordered investigations to try to determine the cause, and decided to commence intravenous (IV) fluids and antibiotics. A junior paediatric registrar prescribed the antibiotics and IV fluids. The registrar prescribed IV fluids at a rate of 180ml/kg/day, which was higher than the amount recommended by the DHB's policy and other national guidelines.

A registered nurse cared for the baby on the following evening shift. During the shift, the nurse administered the baby's antibiotics then recommenced the IV fluids. At about 8.30pm the IV monitor began to flash, saying that there was a "downward occlusion" (indicating a possible blockage or kink in the IV line). The nurse and a senior nurse investigated the line and the IV site but did not find any obvious issues. The nurse did not clearly document the issues she had with the IV line during the shift, nor did she hand these over to the following shift.

Another registered nurse took over the baby's care at 11.15pm for the night shift but did not review the baby for nearly two hours. At around 2.30am, the baby was due for her next antibiotics. The nurse said that there were no signs that the antibiotics had accidentally entered the surrounding tissue rather than the vein (no signs of phlebitis or tissue infiltration). During the administration of the antibiotic, the baby's mother noted a blister forming on the baby's arm, and the arm swelled immediately. The nurse stopped the antibiotic infusion and called for assistance. The baby was reviewed by a senior house officer and treated for an extravasation injury, meaning that the IV antibiotics had been accidentally administered into the tissue around the IV site.

The paediatric fluid balance charts from throughout the baby's hospital admission were not filled in regularly by staff in accordance with the DHB's "Fluid balance chart recording standards (Paediatric)" policy.

### Findings

The Deputy Commissioner considered that while the paediatric registrar's prescription of 180ml/kg/day was an individual clinical error, her orientation to the IV fluid guidelines used at the public hospital was inadequate. It was noted that it is not uncommon for junior staff to become confused with regard to fluid requirements for a neonate given the variation in both national and international guidelines, and the Deputy Commissioner was critical of the inadequate orientation and the lack of clear consensus on the guidelines to be followed at the DHB.

The Deputy Commissioner was also concerned that multiple staff reviewed the baby, but did not recognise that her IV fluid prescription was too high; and multiple staff did not fill in the baby's fluid balance chart in accordance with policy requirements. Accordingly, she found that the DHB failed to provide services to the baby with reasonable care and skill in breach of Right 4(1) of the Code.

The Deputy Commissioner considered that by failing to comply with the DHB's policy regarding hourly IV site monitoring and documentation; not documenting an accurate description of the issues she encountered or the actions she took in response to the IV pump alarm; and not handing over the issues she had with the IV pump to the following shift, the evening nurse breached Right 4(1) of the Code.

The Deputy Commissioner also found the night shift nurse in breach of Right 4(1) of the Code for failing to review the baby's IV site for two hours at the start of her shift, and for failing to fill in the

baby's fluid balance chart in accordance with policy requirements.

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

- Establish a clear consensus of which guidelines are to be followed when prescribing IV fluid to neonates.
- Provide HDC with the results of its six most recent monthly audits of IV access.
- Use this case as an anonymised case study during induction of nursing and medical staff to paediatric wards.
- Provide HDC with confirmation that actions taken to meet the recommendations of the DHB's internal investigation of this event are continuing.

The Deputy Commissioner recommended that the nurses undertake audits of their compliance with fluid balance recording standards.

These recommendations have been met.

## 3. What did people complain about?

### 3.1 Issues identified in complaints

Many complaints to HDC contain multiple issues of concern to the complainant. For the purposes of analysis, we identified the primary issue being complained about plus up to six additional complaint issues for each complaint received. It is important to note that this section details analyses of the issues raised by complainants in their complaints, rather than analyses of HDC's assessment of the issues raised. Inevitably, some of the complaint issues raised will have been found, on subsequent assessment, not to have been substantiated.

#### Primary complaint issues

As shown in Table 4, we grouped the complaint issues into several categories. Among these categories, issues relating to care/treatment (47%), access/funding (17%) and consent/information (11%) were the most prevalent. When separate complaint issues under each category are considered, the most common primary issues were:

- Missed/incorrect/delayed diagnosis (13%)
- Waiting list/prioritisation issue (10%)
- Unexpected treatment outcome (10%)
- Lack of access to services (6%)
- Inadequate/inappropriate treatment (6%)

This is broadly similar to what was seen last year.

#### **Case study: Waiting list/prioritisation issue (16HDC1010)**

##### **Delay in follow-up of ophthalmology review**

A 20-year old man, who had a family history of glaucoma, presented to the Ophthalmology Service of a DHB (the Service), having been referred urgently by a community optometrist. He was prescribed eye drops and a follow-up review went ahead the next week.

Two months later, the man was diagnosed with ocular hypertension. The consultant ophthalmologist requested that the man be reviewed again in six months' time. That follow-up appointment was delayed by six months despite the man telephoning the Service and correspondence being sent by his GP. By this time, the man had suffered vision loss in his right eye and required an urgent referral for management and surgery.

#### Findings

The Commissioner was mindful of a combination of factors that have driven rapidly increasing demand for ophthalmology services in New Zealand, including outpatient clinic time, over the last ten years. Key factors include changing demographics in the patient population and the introduction of very effective new therapies and treatment resulting in consumers needing to see specialists for regular ongoing follow-up and/or treatment. However, the Commissioner noted that provider accountability is not removed by the existence of such systemic pressures. A key improvement that all DHBs and the Ministry of Health must make, now and in the future, is to assess, plan, adapt, and respond effectively to the foreseeable effects that new technologies and changing demographics will have on systems and demand.

At the time of the man's care, the Service lacked capacity, in that the clinics did not have enough appointments for the number of patients clinicians had to see. The Commissioner was critical that the DHB failed to arrange a timely follow-up appointment because it did not have a prioritisation system that focused on patients' clinical need, and instead relied on administrative staff who lacked

training and clear guidance to prioritise appropriately. Despite concerns being raised with the DHB, it did not recognise the clinical risk created by the lack of capacity at the Service, and did not take action to rectify the situation after an earlier serious event review in relation to a similar matter had raised associated concerns. In addition, there were missed opportunities for the DHB to rectify the delay in the follow-up appointment. Accordingly, the Commissioner considered that the DHB did not provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).

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

Following on from the DHB's external review, and the ongoing work of DHBs and the Ministry of Health to address these issues, the Commissioner made a series of detailed recommendations requesting follow-up information and evidence of the effectiveness of corrective actions and strategies adopted from both the DHB and the Ministry of Health. These recommendations have been met.

### All complaint issues

On analysis of all issues identified in complaints about DHBs, the most common complaint categories were care/treatment (79%), communication (61%), access/funding (25%) and consent/information (24%).

The most common specific complaint issues were:

- Failure to communicate effectively with consumer (37%)
- Inadequate/inappropriate treatment (36%)
- Inadequate/inappropriate examination/assessment (24%)
- Missed/incorrect/delayed diagnosis (20%)
- Failure to communicate effectively with family (20%)
- Delay in treatment (20%)
- Disrespectful manner/attitude (16%)
- Inadequate response by DHB to complaint (16%)
- Unexpected treatment outcome (16%)
- Inadequate coordination of care/treatment (16%)

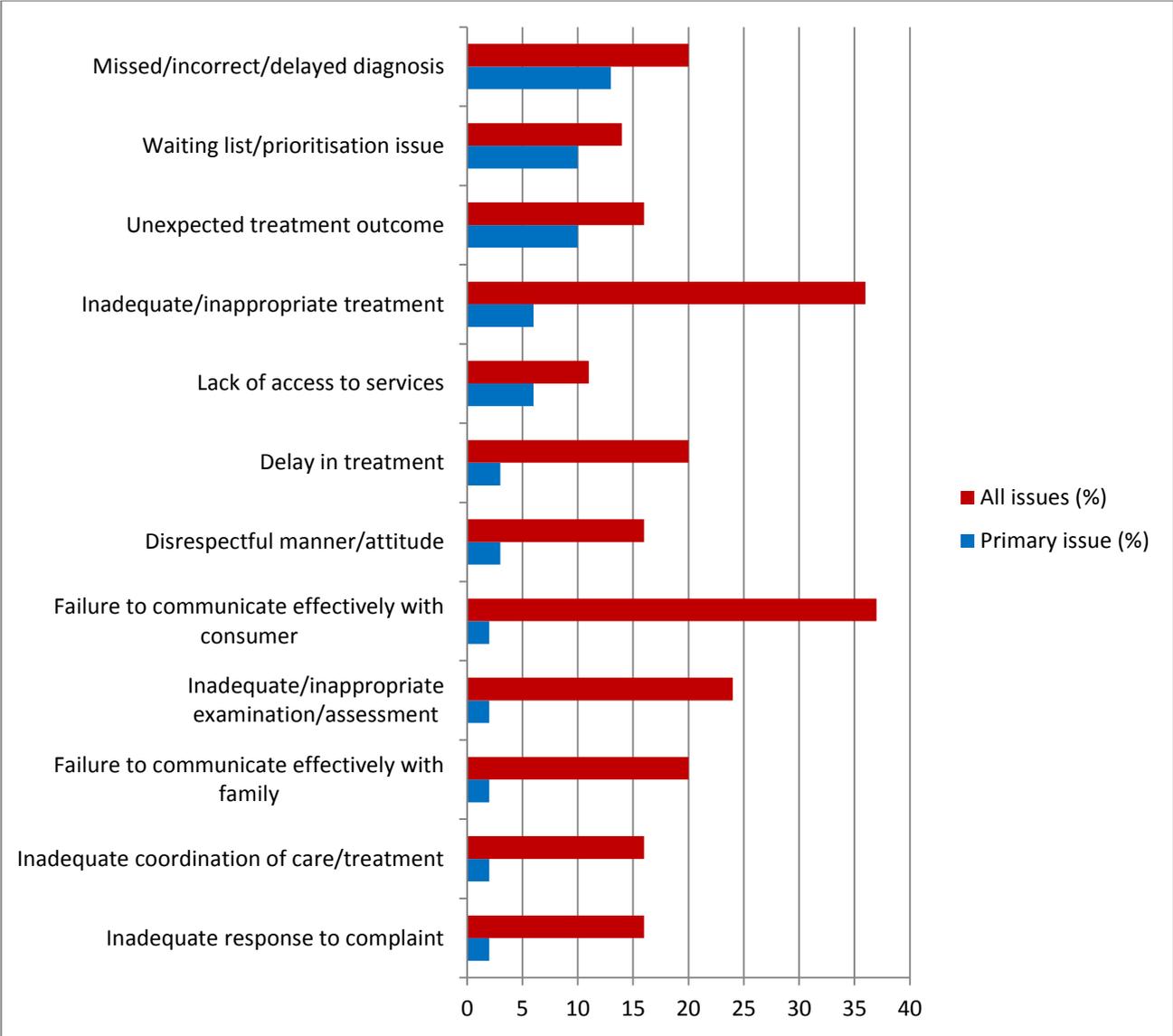
**Table 4.** Issues complained about in DHB complaints

<b>Complaint issue</b>	<b>Number of complaints primarily about this issue (%)</b>	<b>Number of complaints involving this issue (%)</b>
<b><i>Access/Funding</i></b>	<b><i>153 (17)</i></b>	<b><i>223 (25)</i></b>
Lack of access to services	55 (6)	97 (11)
Lack of access to subsidies/funding	5 (0.6)	16 (2)
Waiting list/prioritisation issue	93 (10)	122 (14)
Other	0	2 (0.2)
<b><i>Boundary violation</i></b>	<b><i>2 (0.2)</i></b>	<b><i>4 (0.4)</i></b>
<b><i>Care/Treatment</i></b>	<b><i>422 (47)</i></b>	<b><i>699 (79)</i></b>
Delay in treatment	25 (3)	175 (20)
Delayed/inadequate/inappropriate referral	5 (0.6)	29 (3)
Inadequate coordination of care or treatment	16 (2)	143 (16)
Inadequate/inappropriate clinical treatment	49 (6)	318 (36)
Inadequate/inappropriate examination/assessment	20 (2)	217 (24)
Inadequate/inappropriate follow-up	9 (1)	92 (10)
Inadequate/inappropriate monitoring	14 (2)	67 (8)
Inadequate/inappropriate non-clinical care	19 (2)	70 (8)
Inadequate/inappropriate testing	2 (0.2)	82 (9)
Inappropriate admission/failure to admit	0	22 (2)
Inappropriate/delayed discharge/transfer	25 (3)	89 (10)
Inappropriate withdrawal of treatment	10 (1)	11 (1)
Missed/incorrect/delayed diagnosis	113 (13)	181 (20)
Personal privacy not respected	1 (0.1)	7 (0.8)
Refusal to assist/attend	1 (0.1)	24 (3)
Refusal to treat	14 (2)	23 (3)
Rough/painful care or treatment	6 (0.7)	40 (4)
Unexpected treatment outcome	89 (10)	144 (16)
Unnecessary treatment/over-servicing	4 (0.4)	15 (2)
<b><i>Communication</i></b>	<b><i>73 (8)</i></b>	<b><i>545 (61)</i></b>
Disrespectful manner/attitude	28 (3)	146 (16)
Failure to accommodate cultural/language needs	2 (0.2)	6 (0.7)
Failure to communicate openly/honestly/effectively with consumer	15 (2)	332 (37)
Failure to communicate openly/honestly/effectively with family	20 (2)	178 (20)
Insensitive/inappropriate comments (not sexual)	8 (0.9)	28 (3)
<b><i>Complaints process</i></b>	<b><i>15 (2)</i></b>	<b><i>146 (16)</i></b>
Inadequate response to complaint	15 (2)	145 (16)
Other	0	1 (0.1)
<b><i>Consent/Information</i></b>	<b><i>97 (11)</i></b>	<b><i>216 (24)</i></b>
Consent not obtained/adequate	19 (2)	53 (6)
Failure to assess capacity to consent	0	7 (0.8)
Inadequate information provided regarding adverse event	1 (0.1)	12 (1)
Inadequate information provided regarding condition	8 (0.9)	28 (3)
Inadequate information provided regarding fees/costs	5 (0.6)	7 (0.8)
Inadequate information provided regarding options	7 (0.8)	24 (3)
Inadequate information provided regarding provider	1 (0.1)	6 (0.7)
Inadequate information regarding results	4 (0.4)	16 (2)
Inadequate information provided regarding treatment	13 (1)	62 (7)
Incorrect/misleading information provided	1 (0.1)	23 (3)

<b>Complaint issue</b>	<b>Number of complaints primarily about this issue (%)</b>	<b>Number of complaints involving this issue (%)</b>
Issues regarding consent when consumer not competent	2 (0.2)	5 (0.6)
Issues with involuntary admission/treatment	36 (4)	43 (5)
Other	0	2 (0.2)
<b>Documentation</b>	<b>10 (1)</b>	<b>67 (8)</b>
Delay/failure to disclose documentation	1 (0.1)	9 (1)
Delay/failure to transfer documentation	0	2 (0.2)
Inadequate/inaccurate documentation	8 (0.9)	53 (6)
Intentionally misleading/altered documentation	1 (0.1)	4 (0.4)
<b>Facility issues</b>	<b>44 (5)</b>	<b>146 (16)</b>
Accreditation standards/statutory obligations not met	1 (0.1)	2 (0.2)
Cleanliness/hygiene issue	2 (0.2)	13 (1)
Failure to follow policies/procedures	0	7 (0.8)
General safety issue for consumer in facility	25 (3)	37 (4)
Inadequate/inappropriate policies/procedures	4 (0.4)	45 (5)
Issue with sharing facility with other consumers	1 (0.1)	14 (2)
Issue with quality of aids/equipment	1 (0.1)	19 (2)
Staffing/rostering/other HR issue	4 (0.4)	16 (2)
Waiting times	5 (0.6)	16 (2)
Other issue with physical environment	1 (0.1)	2 (0.2)
<b>Medication</b>	<b>38 (4)</b>	<b>89 (10)</b>
Administration error	3 (0.3)	9 (1)
Dispensing error	1 (0.1)	1 (0.1)
Prescribing error	2 (0.2)	4 (0.4)
Inappropriate administration	5 (0.6)	14 (2)
Inappropriate prescribing	19 (2)	45 (5)
Refusal to prescribe/dispense/supply	8 (0.9)	17 (2)
Other	0	2 (0.2)
<b>Reports/Certificates</b>	<b>6 (0.7)</b>	<b>16 (2)</b>
Inaccurate report/certificate	6 (0.7)	11 (1)
Refusal to complete report/certificate	0	5 (0.6)
<b>Training/supervision</b>	<b>0</b>	<b>20 (2)</b>
Inadequate supervision/oversight	0	20 (2)
<b>Other professional conduct issues</b>	<b>21 (2)</b>	<b>49 (6)</b>
Disrespectful behaviour	8 (0.9)	21 (2)
Inappropriate collection/use/disclosure of information	11 (1)	21 (2)
Threatening/bullying/harassing behaviour	0	5 (0.6)
Other	2 (0.1)	7 (0.8)
<b>Disability-specific issues</b>	<b>7 (0.8)</b>	<b>16 (2)</b>
<b>Other issues</b>	<b>1 (0.1)</b>	<b>20</b>
<b>TOTAL</b>	<b>889</b>	

Figure 4 details the twelve most common complaint issues raised in complaints about DHBs received in the 2017/18 year. The blue bars show the percentage of cases in which the particular complaint issue was identified as the primary issue, while the red bars show the percentage of cases in which the particular complaint issue was raised at all. As can be seen from the large difference in the size of the blue and red bars, communication-related complaint issues (disrespectful manner/attitude, and failure to communicate effectively with family or consumer), inadequate/inappropriate examination/assessment, delay in treatment, inadequate coordination of care/treatment, and inadequate response to complaint are present in a significant number of complaints, but are not often the primary issue raised.

**Figure 4.** Most common primary and all issues in complaints received



## Case study: Delay in treatment (16HDC00761)

### Delay in neurology review

A 62-year-old man presented to an emergency department with sudden onset of left-sided weakness and twitching, and reported a week-long history of dizziness upon standing. A CT scan report recommended a neurological opinion.

The man was admitted to the general medicine ward the same day with a working diagnosis of an ischaemic stroke. The admitting medical registrar completed a handwritten neurology referral but it was erroneously sent using the process for outpatient referrals. There was nothing on the form to indicate that it was intended to be an inpatient referral. As a result, the referral was not triaged until three days later.

The man was noted to have left arm tremors, which progressed to intermittent twitching of the left leg. The consultant general physician maintained the working diagnosis of ischaemic stroke when he reviewed the man in the morning of the following day. Nursing notes throughout that day refer to twitching and “on and off restlessness” in the man’s left leg. On the third day of admission, another medical registrar queried in the notes whether the man’s ongoing left-sided weakness was caused by seizures. This possibility was raised again during the physiotherapy and occupational therapy review in the afternoon, but the matter was not escalated to the consultant general physician.

On the fourth day of admission, the medical registrar from the previous day noted that the man had yet to be seen by a neurologist, and made active enquiries about the referral. As a result of these enquiries, the man was reviewed by the visiting neurologist, who diagnosed focal status epilepticus. The man was commenced on intravenous anti-seizure medication, and his involuntary movements improved. He was later transferred to another hospital, where he received further treatment.

### Findings

The Commissioner considered that there were deficiencies in the care provided, which constituted a pattern of poor care on a service level, for which the DHB was ultimately responsible:

- The admitting medical registrar did not make an acute referral to the neurology service following the abnormal CT scan result.
- The admitting medical registrar’s non-urgent referral was erroneously sent to the outpatient clinic.
- The consultant general physician did not discuss the CT report with the neurology service on his ward round the day after admission, when the man had been experiencing ongoing involuntary twitching.
- Junior staff did not escalate concerns about the man’s ongoing involuntary movements, and the consultant general physician did not enquire.

The Commissioner was most concerned by the lapses in communication within the general medicine team and the lack of safeguards in place to identify errors in the neurology referral process. These factors hindered the coordination of the man’s care within the team and across specialities, and contributed to the delay in him receiving the neurological review he required. For the above reasons, the Commissioner considered that the DHB failed to provide services with reasonable care and skill to the man, in breach of Right 4(1) of the Code.

The Commissioner recommended that the DHB:

- Conduct an audit of neurology referrals within the last three months to ensure that the correct process had been followed.

- Use this case as an anonymised case study for education on the importance of team communication.
- Update HDC on the implementation of its “TransforMED” project (a project which aims to ensure that time is set aside for subspecialists who participate in General Medicine to undertake a ward round daily on inpatients on their designated ward).

These recommendations have been met.

Table 5 compares the most common issues raised in 2017/18 with previous years. Common complaint issues have remained broadly consistent over the last five years. However, the proportion of complaints regarding ‘disrespectful manner/attitude’ and an inadequate response to the consumer’s complaint by the DHB have decreased over the last five years.

**Table 5.** Yearly comparison of the most common issues complained about in DHB complaints in 2017/18

<b>Complaint issue</b>	<b>2013/14</b>	<b>2014/15</b>	<b>2015/16</b>	<b>2016/17</b>	<b>2017/18</b>
<b>Failure to communicate effectively with consumer</b>	<b>21%</b>	<b>34%</b>	<b>38%</b>	<b>36%</b>	<b>37%</b>
<b>Inadequate/inappropriate treatment</b>	<b>37%</b>	<b>40%</b>	<b>43%</b>	<b>33%</b>	<b>36%</b>
<b>Inadequate/inappropriate examination/assessment</b>	<b>14%</b>	<b>27%</b>	<b>29%</b>	<b>23%</b>	<b>24%</b>
<b>Missed/incorrect/delayed diagnosis</b>	<b>27%</b>	<b>24%</b>	<b>23%</b>	<b>22%</b>	<b>20%</b>
<b>Failure to communicate effectively with family</b>	<b>21%</b>	<b>22%</b>	<b>24%</b>	<b>22%</b>	<b>20%</b>
<b>Delay in treatment</b>	<b>15%</b>	<b>14%</b>	<b>18%</b>	<b>21%</b>	<b>20%</b>
<b>Disrespectful manner/attitude</b>	<b>20%</b>	<b>24%</b>	<b>25%</b>	<b>20%</b>	<b>16%</b>
<b>Inadequate response to complaint</b>	<b>20%</b>	<b>24%</b>	<b>22%</b>	<b>17%</b>	<b>16%</b>
<b>Unexpected treatment outcome</b>	<b>15%</b>	<b>17%</b>	<b>19%</b>	<b>14%</b>	<b>16%</b>
<b>Inadequate coordination of care/treatment</b>	<b>14%</b>	<b>19%</b>	<b>24%</b>	<b>21%</b>	<b>16%</b>

## **Case study: Coordination of care/treatment (16HDC00460)**

### **Opioid treatment while on Methadone**

A woman with a complex medical history including chronic pain and substance dependence attended a methadone programme and also enrolled at a medical practice where she was prescribed dihydrocodeine (DHC) for her chronic pain. She failed to inform the GP that she was on the methadone programme for 16 months.

The GP contacted the methadone treatment service to discuss the woman's ongoing treatment, however although the service confirmed the woman was on the programme, no further advice about her treatment was provided. The GP continued to prescribe DHC regularly.

The methadone treatment service referred the woman to the pain clinic. However, the methadone treatment service stated that because the woman was an ACC client, the referral would have been sent to ACC for approval. It appears that this was not granted by ACC or followed up by the methadone treatment service.

The practice was contacted by Medicines Control who advised that a Restriction Notice in the woman's name had been issued and asked if the practice wished to be included as a prescriber on the Notice in conjunction with the methadone service.

There was confusion over extending the Restriction Notice. The practice thought it was authorised to prescribe DHC and that a plan to reduce the prescription would be forthcoming from the service. The practice continued to prescribe DHC to the woman until the service instructed the practice that all prescribing of DHC was to cease and any reduction would be managed by the service.

#### Findings

The Mental Health Commissioner was concerned that the standard of communication by the methadone treatment service with the medical practice was frequently ambiguous and inconsistent. He was critical of the methadone treatment service's failure to provide the medical practice with regular updates or to adequately discuss a treatment plan for the woman with the GP. Furthermore, he was critical that once the methadone treatment service became aware of the dual prescribing, there was not a timely, clear instruction from a senior member of the methadone treatment service team to the medical practice for an immediate cessation of prescribing. The Mental Health Commissioner also considered that the methadone treatment service's failure to follow up on the woman's referral to the pain clinic meant that she was unable to access the care she should have received.

As outlined above, the Mental Health Commissioner found there were a number of inadequacies in the coordination of the woman's care which were attributable to the DHB. Accordingly, he found the DHB in breach of Right 4(5) of the Code.

The Mental Health Commissioner also made adverse comment about the failure of the GP to determine beyond doubt if the medical practice could continue to prescribe the DHC and to clarify the reduction plan. Adverse comment was also made about a second GP at the medical practice prescribing 3 months supply of DHC for the woman when a smaller amount could have been prescribed due to the uncertainty of the prescribing responsibility.

The Mental Health Commissioner noted that the DHB had undertaken an external review of the methadone programme, and that the recommendations proposed as a result of this review have largely been implemented and continue to be reviewed, with the aim of providing a service that focuses on patient well-being, recovery, and harm minimisation. In light of these changes he

recommended that the DHB:

- Conduct a random audit of clients covering the past 12 months to ensure that a copy of the opioid substitution treatment assessment had been sent to the client’s GP, along with an update following the three-month and six-month review, and report back on the results of the audit, including any actions taken or planned to address any issues identified by the audit.
- Consider, in consultation with the Director of Mental Health and the Ministry of Health Medicines Control, the introduction of an alert to GPs on the clinical records system, and report back on its consideration.

These recommendations have been met.

### 3.2 Complaint issues by service type

Issues raised in complaints vary, at least to some degree, according to the DHB service type concerned. As shown in Table 6 below, diagnostic issues were most prevalent in complaints about services with high diagnostic workloads, with 40% of emergency department complaints and 14% of general medicine complaints being primarily about a missed/incorrect/delayed diagnosis. Unexpected treatment outcome was prominent for surgical services, as this issue most often relates to post-surgical complications.

These issues are broadly similar to what was seen last year. However, waiting list/prioritisation issues became more prominent for surgical and general medicine services and lack of access to services became more prominent for mental health services.

Primary issues in complaints about mental health services were quite distinct, with issues relating to involuntary admission/treatment and safety issues for consumers in inpatient units being common for this service. ‘General safety issue for consumer in facility’ became more prominent for mental health services in 2017/18 than has been seen in previous years.

**Table 6.** Most common primary issues in complaints by service type

Surgery total=291		Mental health total=188		General medicine total=152		Emergency department total=104		Maternity total=69	
Unexpected treatment outcome	22%	Issues with involuntary admission/ Treatment	19%	Missed/ incorrect/ delayed diagnosis	14%	Missed/ incorrect/ delayed diagnosis	40%	Inadequate/ inappropriate treatment	17%
Waiting list/ prioritisation issue	20%	General safety issue for consumer in facility	9%	Waiting list/ prioritisation issue	9%	Refusal to treat	13%	Unexpected treatment outcome	16%
Missed/ incorrect/ delayed diagnosis	9%	Lack of access to services	8%	Unexpected treatment outcome	7%	Waiting list/ prioritisation issue	8%	Inadequate/ inappropriate monitoring	10%

## **Case study: Emergency Department and a missed/incorrect/delayed diagnosis (17HDC00316)**

### **Management of incidental finding of rectal lymph nodes**

A 72-year-old man presented to the Emergency Department (ED) of a public hospital after falling approximately three metres. He sustained injuries to his left hip and left side of his chest. A senior ED consultant ordered an urgent CT scan of the chest, abdomen, and pelvis.

When reporting on urgent CT scans, a preliminary acute report was issued to help determine the immediate care of the patient (a “sticky note”). The sticky note mechanism is an immediate, rough tool to assist clinicians to proceed with treatment of the patient and to answer the immediate clinical questions. The case is then fully reported – usually within 24 hours. The ED acted on the reporting radiologist’s sticky note, which did not mention an incidental finding of rectal lymph nodes. The man was treated with pain relief and transferred to the surgical ward for ongoing care.

The following day, full reporting of the CT scan was entered into the information technology (IT) system at the hospital. This final report noted numerous enlarged meso-rectal lymph nodes and suggested endoscopic examination to rule out a rectal tumour. Several days later, the man was discharged from hospital. However, the final CT scan report was not sighted until eight months after discharge, when further investigation was initiated. The man was diagnosed with Stage IIIa squamous cell carcinoma of the anus, and underwent chemo-radiotherapy treatment and surgery.

At the time of these events, the IT system did not allow for electronic sign-off of test results. There was no alert system to notify a doctor that a result had arrived, nor was there a doctor-specific list of results to review. This meant that doctors could not look up all the results of tests or procedures they had ordered that day apart from proactively on an individual patient basis. The hospital acknowledged that this was a significant weakness in its system and, until this could be improved, there was no protection from recurrence.

A further complicating factor in this case was that there appeared to be a lack of clarity around who was responsible for following up and acting on the results of the CT scan once it was reported on. The ED consultant considered that clinical responsibility for the final CT report was handed over when the man was transferred to the surgical ward. However, the surgeon advised that as he was not the practitioner who ordered the CT scan, he did not receive a paper copy of the report and therefore, did not and would not have viewed the final CT scan report. There were no internal policies or procedures at the DHB relating to this issue.

### Findings

The DHB had a weak IT system that did not allow for electronic sign-off, and it did not have a clear, effective, and formalised system in place for the reporting and following up of test results. This systems failure resulted in a number of opportunities being missed by clinicians to review and action the man’s final CT scan report, and a delayed diagnosis of squamous cell carcinoma.

In respect of this case the Commissioner commented that the basic system principle with respect to the follow-up of test results is clear — the person who orders the test must follow up, or know by whom and how in the system it will be. The Commissioner was concerned about the inconsistencies in clinicians’ understanding of how this principle applied at their hospital, stating that it was not acceptable that systems and clinicians lacked clarity on this.

The Commissioner found that the DHB did not provide services to the man with reasonable care and skill, and breached Right 4(1) of the Code.

The Commissioner was thoughtful about the use of the “sticky note” function in this case. He emphasised that this function is only a preliminary reporting tool that answers the immediate clinical question. It should not be relied on in place of the final report.

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

- Update HDC on the progress and effectiveness of its IT system upgrade, including the development of policies and procedures with respect to electronic sign-off of test results and radiology reports. This update should include evidence that the new system reliably captures all relevant data.
- Advise whether “sticky notes” are still being used under the new IT system, and what measures have been taken to ensure that they are used as a preliminary reporting tool only, and that the final reports are also reviewed.
- Audit, over a period of three months, the management of test results ordered at ED where patients have been transferred to another ward.
- Take steps to ensure that discharge summaries accurately reflect available final diagnostic reports, and report back to HDC on the steps that have been taken.
- Develop policies and procedures on the management of test results and radiology reports.

As mentioned above, many complaints to HDC contain multiple issues of concern to the complainant. Table 7 below shows an analysis of the common complaint issues raised about each service type when all issues complained about are considered (rather than just the primary issue as in Table 7).

When all issues raised in complaints about each service type are analysed, it can be seen that communication issues feature prominently for all service types. However, again complaint issues do vary according to the service type complained about. General medicine and mental health services received a greater proportion of complaints involving communication with family than other service types, while emergency department services received a greater proportion of complaints involving inadequate examination/assessments, misdiagnosis and inadequate testing than did other service types. Surgical services received a greater proportion of complaints about a waiting list/prioritisation issue and maternity services received a greater proportion of complaints regarding a delay in treatment than other service types.

These issues are largely similar to what was seen last year for each service type, although complaints involving a waiting list/prioritisation issue became more prominent for surgical services in 2017/18.

**Table 7.** Most common issues in complaints by service type

Surgery total=291		Mental health total=188		General medicine total=152		Emergency department total=104		Maternity total=69	
Failure to communicate effectively with consumer	46%	Failure to communicate effectively with consumer	29%	Inadequate/inappropriate treatment	38%	Inadequate/inappropriate examination/assessment	52%	Failure to communicate effectively with consumer	55%
Inadequate/inappropriate treatment	44%	Failure to communicate effectively with family	27%	Failure to communicate effectively with family	35%	Missed/incorrect/delayed diagnosis	44%	Inadequate/inappropriate treatment	54%
Unexpected treatment outcome	30%	Inadequate/inappropriate treatment	25%	Failure to communicate effectively with consumer	33%	Failure to communicate effectively with consumer	36%	Delay in treatment	32%
Waiting list/prioritisation issue	21%	Issues with involuntary admission/treatment	23%	Missed/incorrect/delayed diagnosis	26%	Inadequate/inappropriate treatment	27%	Unexpected treatment outcome	29%
Inadequate/inappropriate examination/assessment	20%	Inadequate/inappropriate examination/assessment	22%	Inadequate/inappropriate examination/assessment	24%	Inadequate/inappropriate testing	25%	Inadequate/Inappropriate examination & inadequate/inappropriate monitoring	25% each

## Case study: General Medicine and communication issues (15HDC00937)

### Follow-up of clinically significant result

A woman went to a public hospital feeling unwell. She was transferred to the General Medical Service of the hospital with a suspected viral infection and an incidental finding of lower abdominal tenderness. She was placed under the care of a consultant general physician.

The consultant general physician ordered a priority ultrasound scan, and a query of ovarian cancer was listed in the “question to be answered” section of the scan request. The possibility of ovarian cancer was not discussed directly with the woman at the time due to her history of anxiety and depression.

The consultant general physician’s documented plan was to discharge the woman after the ultrasound scan had been performed, with a recommendation that she follow up with her GP if her symptoms did not settle. Contrary to the plan, however, the woman was discharged by a house officer prior to the scan being carried out. The scan was changed to an outpatient scan, and the request contained no specific reference to ovarian cancer and was given normal status. The request also did not indicate that the report was to be copied to the woman’s GP, although the discharge summary noted that her GP was to follow up on the result of the scan. The consultant general physician does not recall being made aware of these arrangements.

The woman’s outpatient scan noted a mass likely to be of ovarian origin, and recommended gynaecological referral and tumour marker correlation. Neither the woman nor her GP received a copy of the scan or a report relating to it. The ultrasound report was viewed and accepted electronically by the consultant general physician. The consultant general physician did not take any action in relation to the findings. Over a year later, the woman was found to have a large ovarian mass, and she was diagnosed with high-grade serous carcinoma of the ovary.

### Findings

The Commissioner was critical of the consultant general physician’s failure to inform the woman of his concerns about ovarian cancer when he decided to order an ultrasound initially, and, after viewing the scan result, his failure to inform the woman of her result. The Commissioner considered that this was information that a reasonable consumer in the woman’s circumstances would expect to receive, and by failing to provide this information the consultant general physician breached Right 6(1) of the Code.

The Commissioner noted that the basic premise, as stated in *Coles Medical Practice 2013*, is: “If you are responsible for conducting a clinical investigation you are also in charge of conducting follow up and keeping the patient informed.” The Commissioner found that, by not taking any follow-up action on the woman’s clinically significant test results, whether that be further investigations, or contacting her GP to ensure that someone was taking the follow-up action required, the consultant general physician failed to adhere to fundamental basic medical practice and breached Right 4(1) of the Code.

HDC’s clinical advisor noted that this case includes issues of communication, documentation, and oversight of resident medical officers. The Commissioner agreed that a mix of these issues were likely at play, and considered that a series of acts and omissions by DHB staff led to the woman receiving poorly coordinated care. In particular:

- The initial inpatient scan was changed without documented explanation to an outpatient scan, and from having priority status to having only normal status;
- The house officer completing the request for an outpatient scan did not request a copy of the scan to be directed to the woman’s GP, even though the discharge summary said that the GP was to follow up on the results. The concerns about ovarian cancer were not transcribed from

the inpatient scan request to the outpatient scan request;

- The woman was discharged contrary to the consultant general physician's documented plan in her clinical notes, without any documented explanation and without informing the consultant;
- There were no concerns about a possibility of ovarian cancer documented by the General Medical Service, other than on the in-patient scan request.

The Commissioner considered that these failings paint a picture of poorly coordinated and documented care, and found that the DHB failed to provide the woman with services with reasonable care and skill in breach of Right 4(1) of the Code.

The Commissioner recommended that the consultant general physician undertake a random audit of a selection of radiology test results received in the last three months to ensure that such test results have been followed up appropriately and communicated to his patients.

The Commissioner recommended that the DHB:

- Provide a report to HDC regarding the steps it has taken to facilitate systems to enable patients to receive a copy of their test results directly, including consideration that has been given regarding those patients without electronic access.
- Use this case as an anonymised case study for the education of staff, particularly around oversight of junior clinicians, communication and documentation.
- Provide a report to HDC regarding the status of recommendations made during its Root Cause Analysis of this event.

These recommendations have been met.

# COMPLAINTS CLOSED

## 1. What were the outcomes of the complaints closed?

### 1.1 Available resolution options

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 preliminary assessment process is thorough and 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.

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

The Commissioner also has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of 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. 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.

## 1.2 Manner of resolution and outcomes in complaints closed

The manner of resolution and outcomes for all DHB complaints closed in the 2017/18 year is shown in Table 8 below. It should be noted that outcomes are displayed in a descending order. If there is more than one outcome for a DHB upon resolution of a complaint, then only the outcome listed highest in the table is included.

**Table 8.** Outcome for DHBs of complaints closed

<b>Outcome for DHB</b>	<b>Number of complaints</b>
<b><i>Investigation</i></b>	<b><i>51</i></b>
Breach finding – referred to Director of Proceedings	3
Breach finding	22
No breach finding with follow-up or educational comment	19
No further action	1
No breach finding	6
<b><i>Other resolution following assessment</i></b>	<b><i>791</i></b>
No further action with follow-up or educational comment	187
Referred to Ministry of Health	7
Referred to District Inspector	30
Referred to other agency	10
Referred to DHB	179
Referred to Advocacy	109
No further action	251
Withdrawn	18
<b><i>Outside jurisdiction</i></b>	<b><i>17</i></b>
<b>TOTAL</b>	<b>859</b>

As can be seen from the table above, in the 2017/18 year, HDC concluded 51 formal investigations involving DHBs, 25 of which resulted in a finding that the DHB had breached the Code. Three investigations resulted in a DHB being referred to the Director of Proceedings for the purpose of deciding whether any legal proceedings should be taken in the HRRT and / or HPDT.

## 2. Recommendations made to DHBs following resolution of complaints

Regardless of whether or not a complaint has been investigated, or whether the DHB has been found in breach of the Code, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted on. Many such recommendations are described in the case studies included throughout this report. In almost all cases (98.9%), recommendations made by HDC are complied with by providers, including DHBs.

Table 9 shows the recommendations made to DHBs in complaints closed in the 2017/18 year. Please note that more than one recommendation may be made in relation to a single complaint.

**Table 9.** Recommendations made to DHBs following a complaint

Type of recommendation	Number of recommendations made
Apology	27
Audit	35
Meeting with consumer/complainant	5
Presentation/discussion of complaint with others	21
Provide evidence of change to HDC	96
Provide information to consumer/complainant	2
Reflection	13
Review/implement policies/procedures	79
Training/professional development	53
<b>Total</b>	<b>331</b>

As can be seen from Table 10 above, 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 (96 recommendations). Often, when HDC asks for this evidence, it is also recommended that the provider conducts a review of the effectiveness of the changes made. Conducting a review of their policies/procedures or implementing new policies/procedures (79 recommendations) and staff training (53 recommendations) were also often recommended. Staff training was most commonly recommended in relation to clinical issues. Where new policies/procedures have been introduced by providers following a complaint, HDC will often recommend an audit to ensure that staff are complying with these new policies/procedures.

## **Case studies**

### **HDC recommendations to DHBs**

#### **Recommendations arising from a breach of the Code relating to failures in coordinating the evaluation of the suitability of a woman and her donor for kidney transplant (14HDC00885)**

The Commissioner considered that the continuity of the woman's care was compromised owing to the fact that there were several points in the evaluative process for which one DHB was responsible where there was delay because of error, failure to follow agreed process in communicating with the regional transplant group, resource allocation or lack of clarity regarding roles. He therefore found this DHB in breach of Right 4(5) of the Code.

Three DHBs were involved in evaluating the suitability of the woman and her donor for a kidney transplant. The Commissioner considered that the woman's experience highlighted the difficulty in coordinating renal transplant services across multiple DHBs, and the need to clarify the responsibility of each clinical team. With this in mind, he recommended that the three DHBs involved in the woman's care collaborate in reviewing their system for sharing information regarding renal transplants. He specified that a policy should be agreed upon that includes: a clear method for seeking and providing advice; the form in which information is shared; the responsibility of each party; and timeframes wherever appropriate. He also asked that: where appropriate, template letters or documents be created or amended to align with the policy; and that a system be developed that provided for regular education/training to all relevant staff to ensure that the communication pathways are understood and that practices do not deviate from the policy over time.

The Commissioner made a number of recommendations to the DHB he found in breach of the Code, including that it:

- Update HDC on the changes it had put in place since the events of the case.
- Establish, with the assistance of other DHBs, clear guidelines for the evaluation of living donors, including: what circumstances are required for evaluations to begin prior to a recipient being accepted onto the deceased donor list; which tests will be completed prior to recipient acceptance; and guidelines around timeframes for completion of tests.
- Review staffing ratios to ensure that the needs of consumers can be met safely.

The Commissioner also recommended that another DHB involved in this case establish a system for providing clear and specific instructions at the outset regarding what is necessary for recipient evaluation in circumstances that deviate from the norm (such as dealing with complex and rare diseases), including where certain evaluations may not be required.

These recommendations have been met.

#### **Recommendations arising from a breach of the Code relating to an inadequate referrals system (15HDC01667, 16HDC00035, and 16HDC00328)**

The Commissioner found a DHB in breach of Right 4(1) of the Code for failures in their referrals system in regards to three consumers. The Commissioner considered that the three cases were concerning examples of information being available but not actioned appropriately within the DHB's system which had a direct impact on the timeliness of the consumers receiving appropriate care.

In response to recommendations made by the Commissioner, the DHB:

- Provided HDC with an update on its progress to move to a fully electronic internal referral system.
- Ensured that there was a clear procedure for ensuring that referrals, once received in the Patient Services Centre (PSC) are loaded onto the Patient Information Management System (PIMS) and actioned.
- Ensured that fundamental changes to key steps in policies are communicated across users.
- Moved away from a system that requires printing of the electronic referrals for grading (with the exception of radiology and maternity).

**Recommendations arising from a breach of the Code relating to failures in ensuring an overseas trained orthopaedic surgeon was fit to practise  
(15HDC01280)**

The Commissioner found that for failing to have in place appropriate systems relating to recruitment and complaints management, which amounted to a failure in its duty of care, a DHB failed to provide services with reasonable care and skill in breach of Right 4(1) of the Code. This was evidenced by its lack of care in how it employed the orthopaedic surgeon, most notably for failing to secure a recent reference, and by failing to have in place adequate systems to identify an emerging pattern of concerns, and to enable the appropriate staff to be aware of, and ultimately respond to, that emerging pattern.

The Commissioner was also critical of aspects of the DHB's supervision and monitoring process and its processes around induction and orientation.

The Commissioner asked the DHB to give consideration to the following actions and report back to HDC on the outcome of that consideration:

- Ensure that policies on recruitment are understood and followed, particularly in relation to the necessity of current referees, and of verbal reference checking – the content of which is fully documented.
- Review the position descriptions of the service manager and clinical leader to ensure that both parties understand their responsibilities in respect of recruitment of SMOs, and in particular in respect of international medical graduates (IMGs).
- Ensure that supervisors are aware of their responsibilities in regards to MCNZ's supervision requirements for IMG locum tenens. Particular care should be taken in respect of any pre-employment concerns such as those indicated in reference checking.
- Ensure that complaints regarding clinical staff are shared with relevant professional clinical leaders, who in turn should contribute to the response.
- Ensure that data regarding number of complaints by individual practitioners is monitored and, where there are more than two complaints in one year, or three in total, then consideration is given to further investigation and, as appropriate, performance management.
- Link complaints to adverse events in their incident reporting system, and provide reports to clinical leaders and management, who in turn should take joint responsibility for the review

and resultant actions.

- Consider a formal policy for annual performance appraisal/professional development for all SMOs, and develop a process whereby anonymous multisource feedback can be used in providing feedback about performance.
- Consider peer support/mentoring, independent of clinical supervision, for all IMGs in their first year of employment.
- Provide clinical leadership training for all clinicians in responsible roles.
- Consider performing yearly review of credentials for all IMG SMO appointments.

These recommendations have been met.