Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

HDC Complaint Data: Patterns and Predictions

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HDC Conference
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Learning from Complaints

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

- Individual complaints
- Patterns and trends

Safety and Quality

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

- Individuals
- Behaviours
- Systems

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Individuals (Doctors)

Study 1:
Complaints about Doctors

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- All complaints about doctors
- 7 year period: 2009-2015
- 3844 complaints, 4565 doctors
- 536-745 doctors complained about each year
- Coded each case for a range of complaint and doctor characteristics

Complaints about Doctors: Gender

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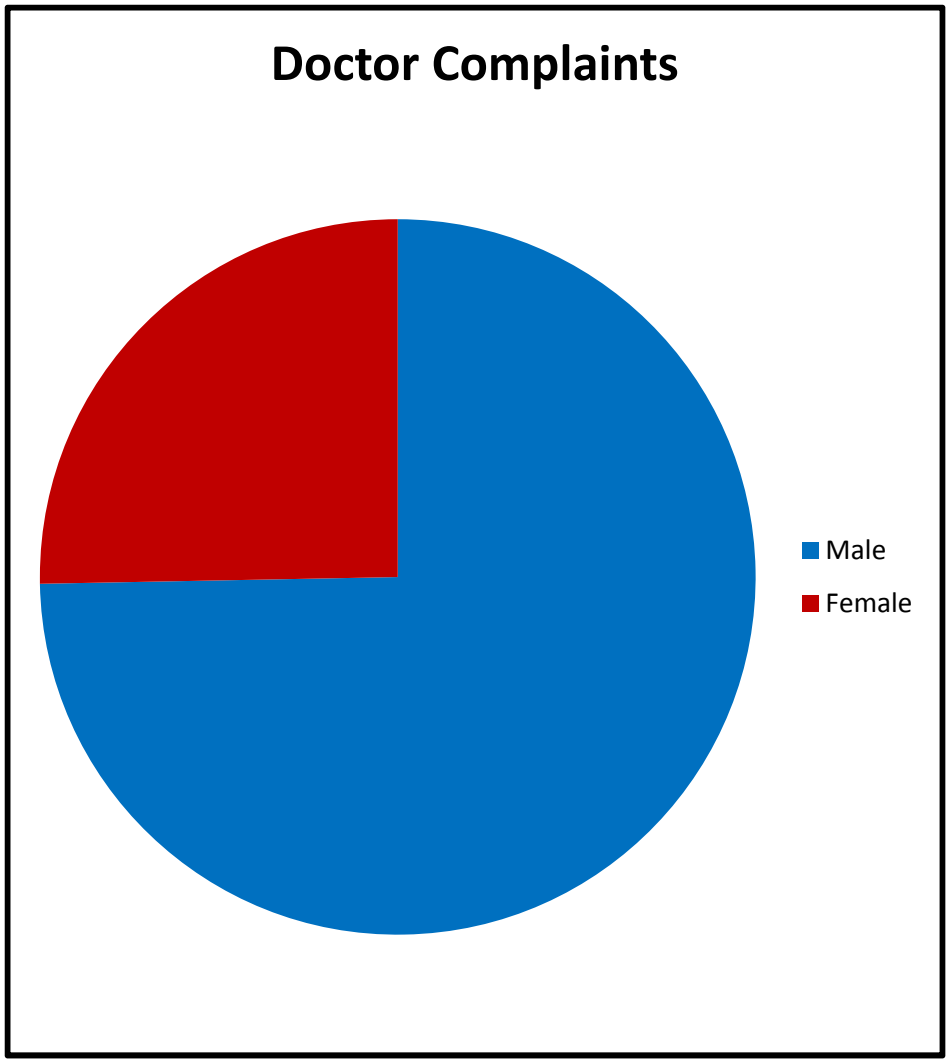

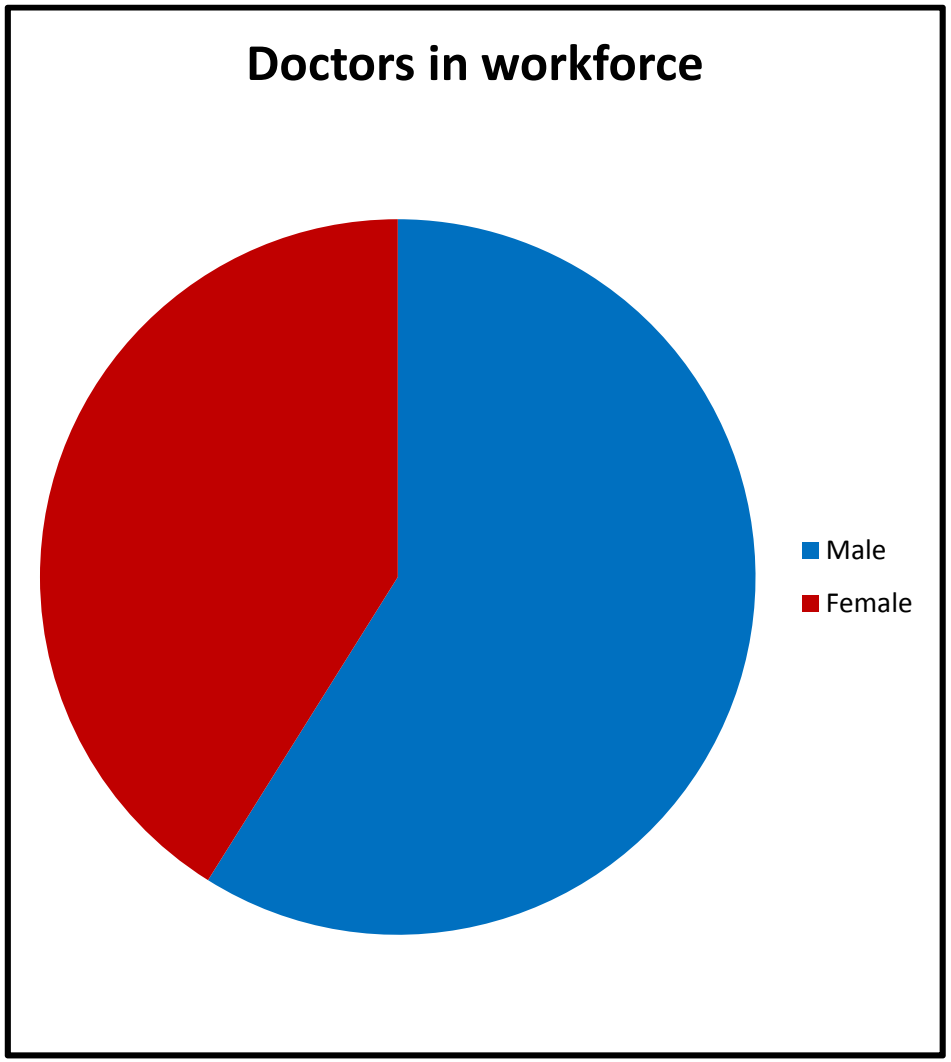

Complaints about Doctors: Specialty

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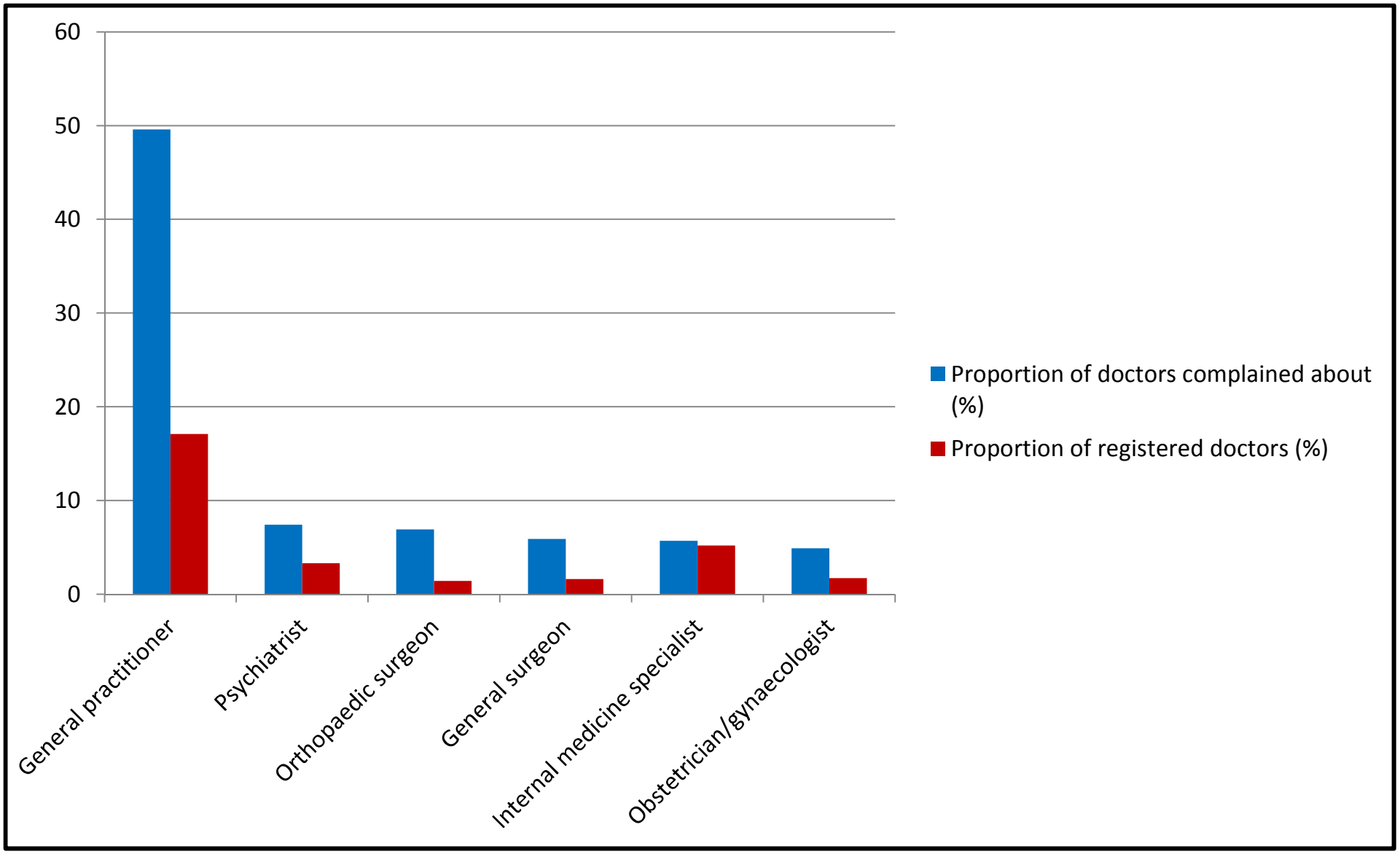

Complaints about Doctors: Scopes of practice

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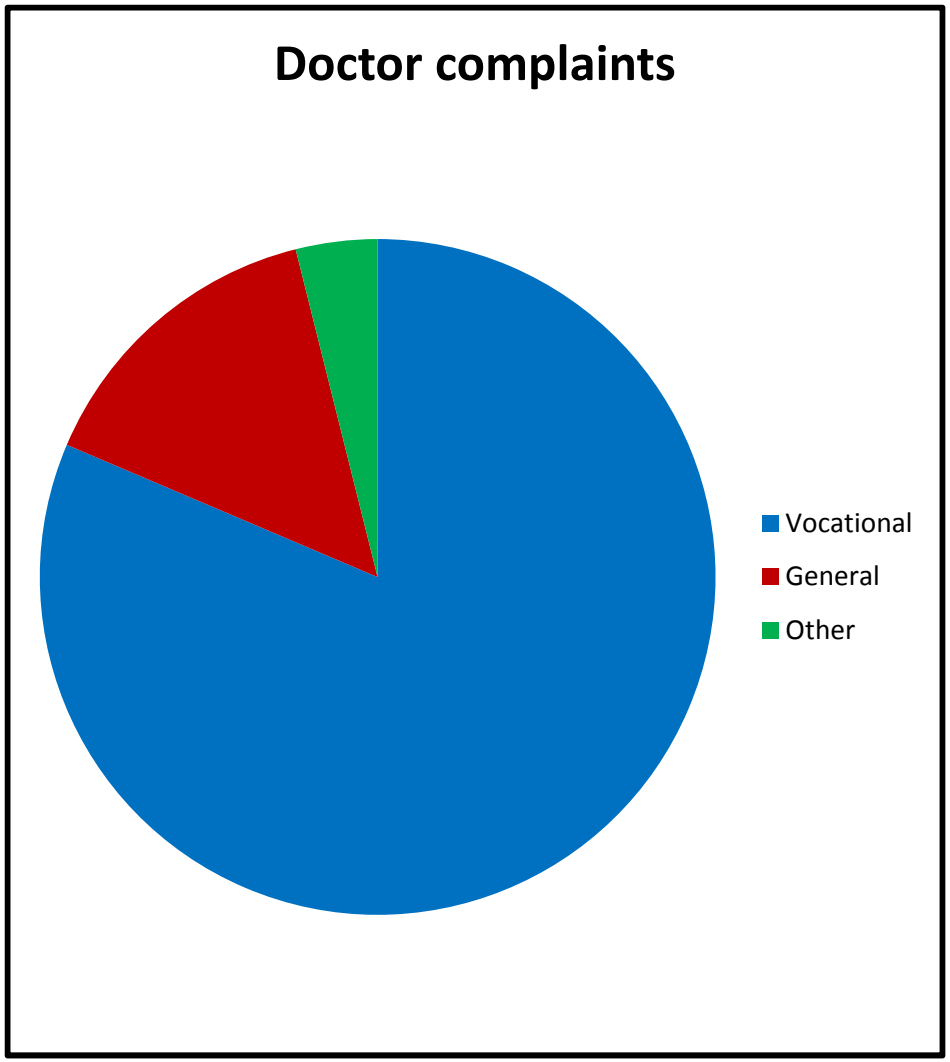

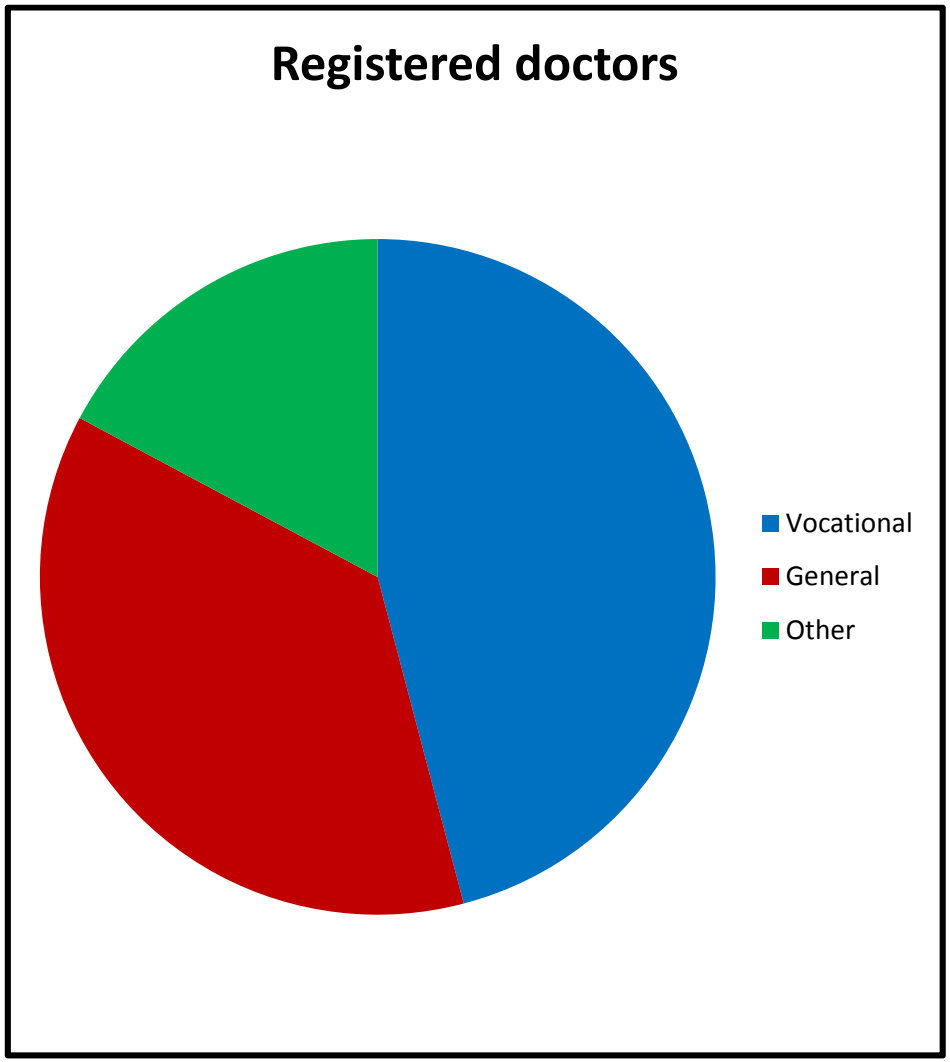

Complaints about Doctors:
International Medical Graduates

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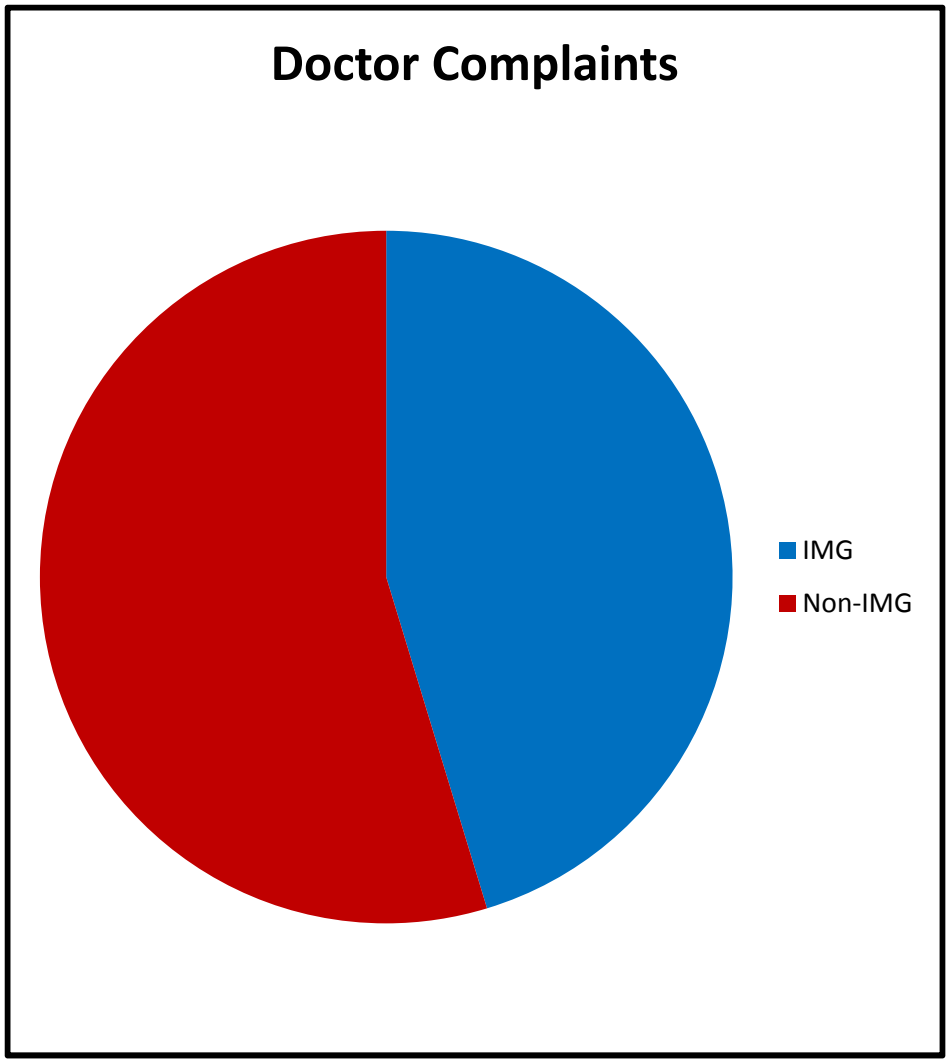

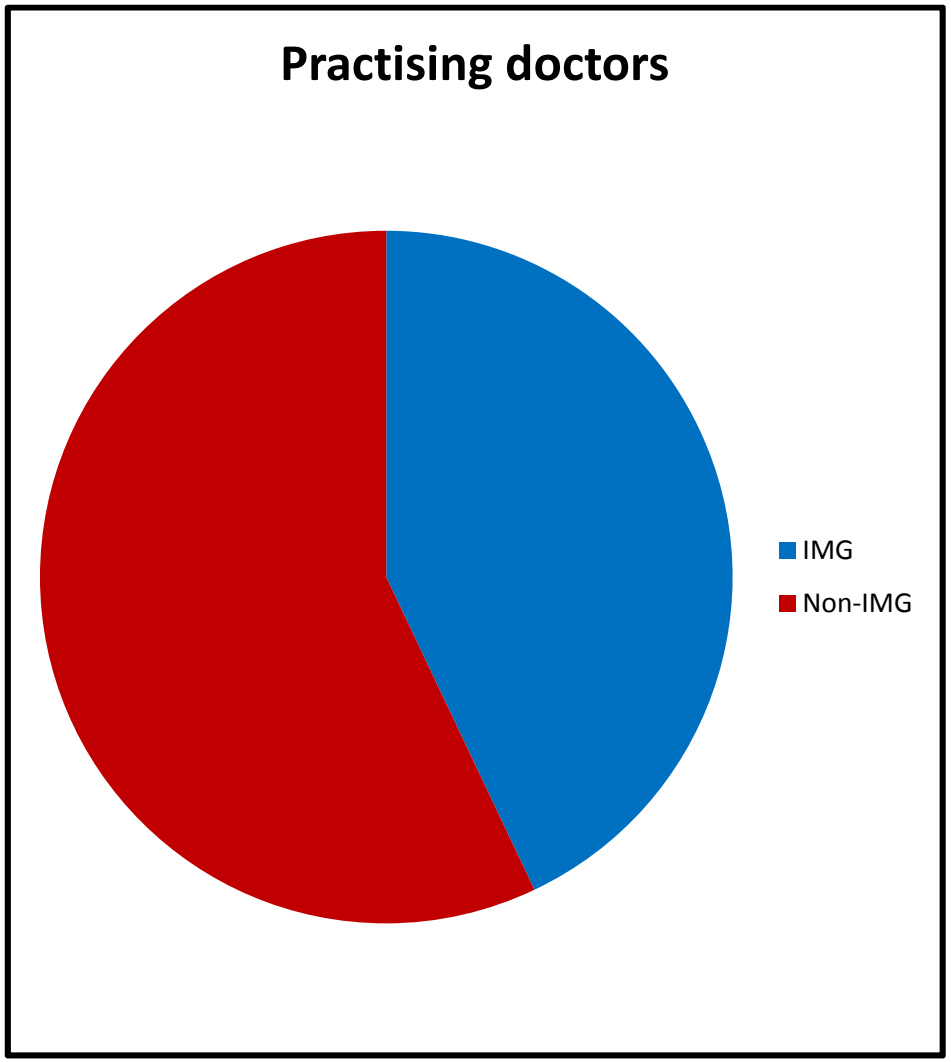

Complaints about Doctors: Incidence of complaints

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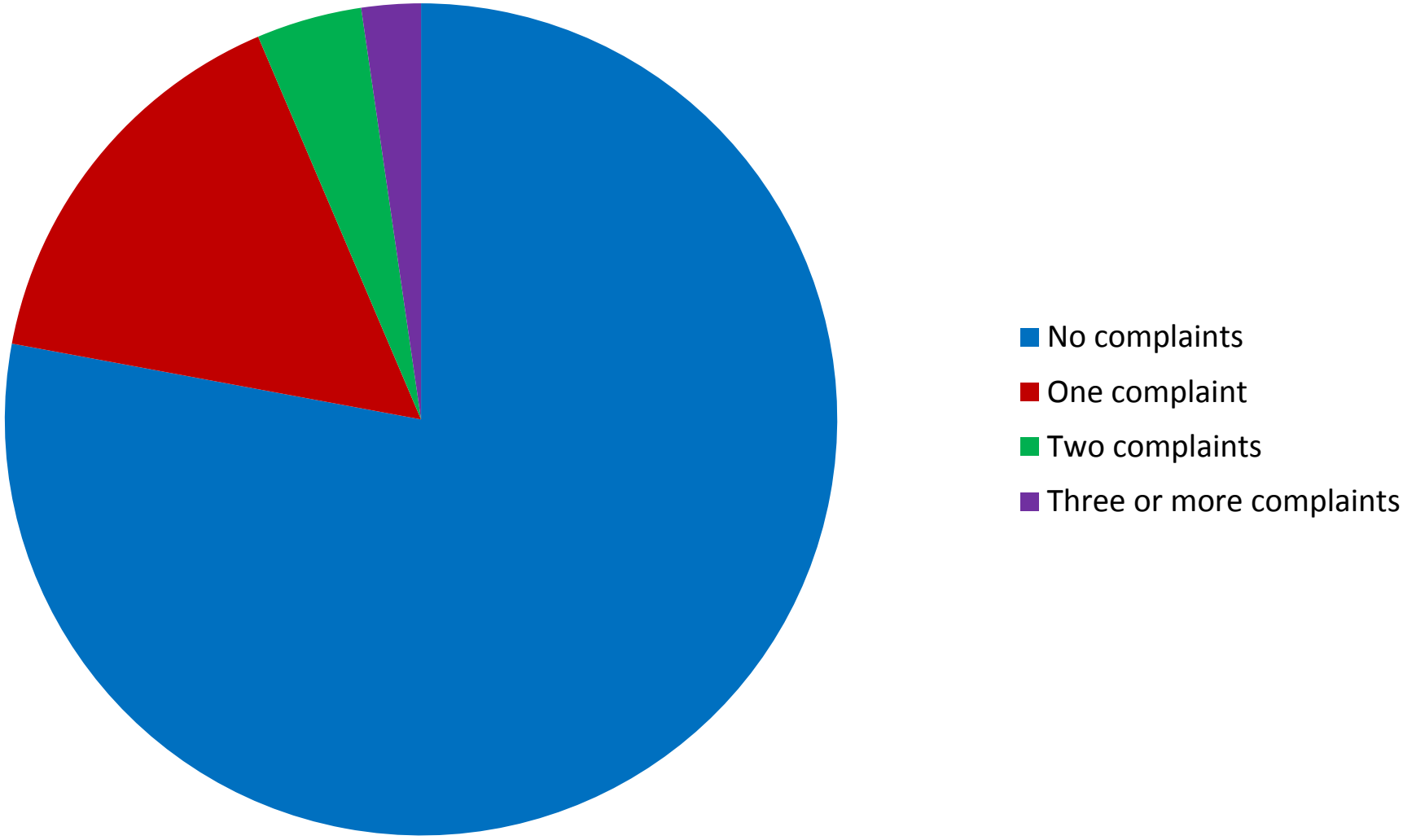

Summary

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Increased risk of complaint:

- Males
- Particular specialities (e.g. general practitioners)
- Vocationally registered
- 21 – 30 years in practice

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Behaviours

Complaints about Doctors:
Issues complained about by specialty

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General practitioner	Psychiatrist	Orthopaedic surgeon	General surgeon	Internal medicine specialist	Obstetrician/ gynaecologist
Missed/ delayed diagnosis (37%)	Inadequate treatment (30%)	Inadequate treatment (40%)	Unexpected treatment outcome (58%)	Missed/ delayed diagnosis (38%)	Inadequate treatment (46%)
Inadequate treatment (34%)	Missed/ delayed diagnosis (25%)	Unexpected treatment outcome (40%)	Inadequate treatment (50%)	Disrespectful manner/ attitude (33%)	Unexpected treatment outcome (40%)
Inadequate examination/ assessment (32%)	Disrespectful manner/ attitude (23%)	Disrespectful manner/ attitude (32%)	Missed/ delayed diagnosis (28%)	Inadequate examination/ assessment (30%)	Failure to communicate effectively with consumer (29%)
Disrespectful manner/ attitude (32%)	Inadequate examination/ assessment (19%)	Inadequate examination/ assessment (28%)	Disrespectful manner/ attitude (26%)	Inadequate treatment (30%)	Disrespectful manner/ attitude (29%)
Delayed/ inadequate/ inappropriate referral (27%)	Inappropriate prescribing (17%)	Missed/ delayed diagnosis (28%)	Failure to communicate effectively with consumer (23%)	Failure to communicate effectively with consumer (21%)	Inadequate information provided re treatment (20%)
Failure to communicate effectively with consumer (16%)	Failure to communicate effectively with family (16%)	Failure to communicate effectively with consumer (25%)	Inadequate information provided re treatment (16%)	Inadequate testing (15%)	Missed/delayed diagnosis (20%)

General practitioner Delayed/inadequate/inappropriate referral

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- Mr A, who was overweight, a smoker, and had been diagnosed with diabetes, began experiencing coughing fits
- His GP, Dr B, prescribed antibiotics
- Mr A re-presented with further coughing fits, bleeding from the nose, and shortness of breath
- Dr B sent semi-urgent referral to DHB's respiratory service
- Referral letter contained little information

General practitioner Delayed/inadequate/inappropriate referral

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- Mr A returned to see Dr B after experiencing continual coughing
- GP documented that the man needed an urgent respiratory appointment
- GP said that he also sent a referral to the DHB for urgent specialist assistance.
- The DHB did not receive this referral
- Four days later, Mr A returned to see Dr B
- Dr B sent a new referral to the DHB for gastroenterology review

General practitioner Delayed/inadequate/inappropriate referral

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- DHB advised that an appointment had been booked
- Dr B assumed that appointment was for the specialist respiratory appointment
- DHB informed Mr A that he was booked in for respiratory testing on different date, but did not inform Dr B
- Approximately a week later, Mr A visited the Dr B again
- Dr B did not examine Mr A, but prescribed antibiotic
- Sadly, the next day, Mr A died

General practitioner Delayed/inadequate/inappropriate referral

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Findings – Dr B

Breaches of Rights 4(1) and 4(2)

- Failure to advocate appropriately for Mr A
- Failure to carry out the appropriate physical assessment of Mr A
- A pattern of inadequate documentation

"Providers must maintain clear lines of communication so that misunderstandings and incorrect assumptions are minimised. Co-operation and communication between providers involved in delivering co-ordinated health services are vital to ensure quality care."

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Behaviours and Systems

Study 2: Medication error

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- All closed complaints where medication error was found to have occurred
- 8 year period: 2009-2016
- 338 errors, 310 complaints
- Reviewed the original complaint letter, provider response, expert advice and decision letter
- Coded each case for: stage of medication process, type of error, setting of error, class of medication, contributing factors to error, and recommendations made by HDC

Medication error:
Stage of medication process

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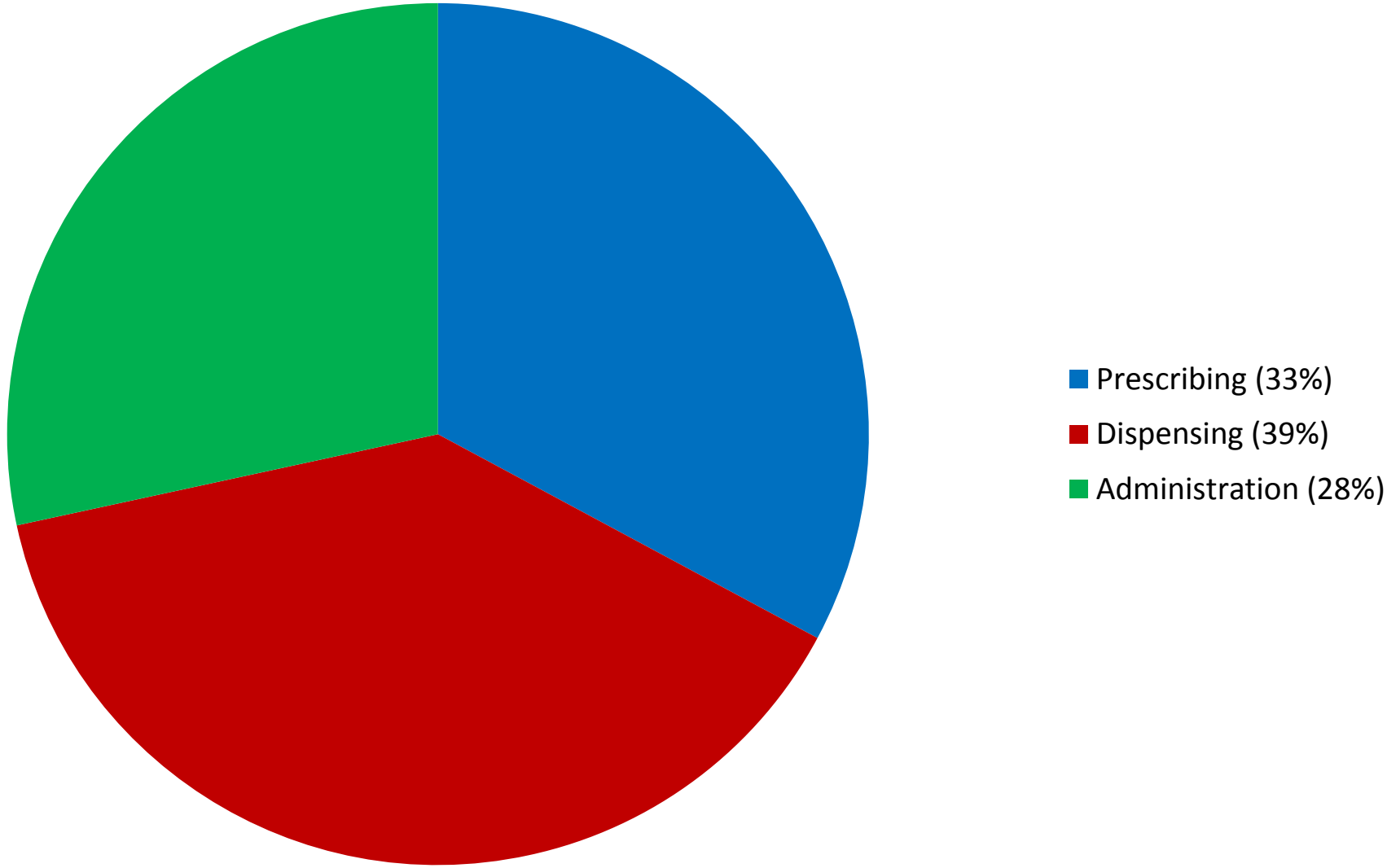

Medication error: Type of error

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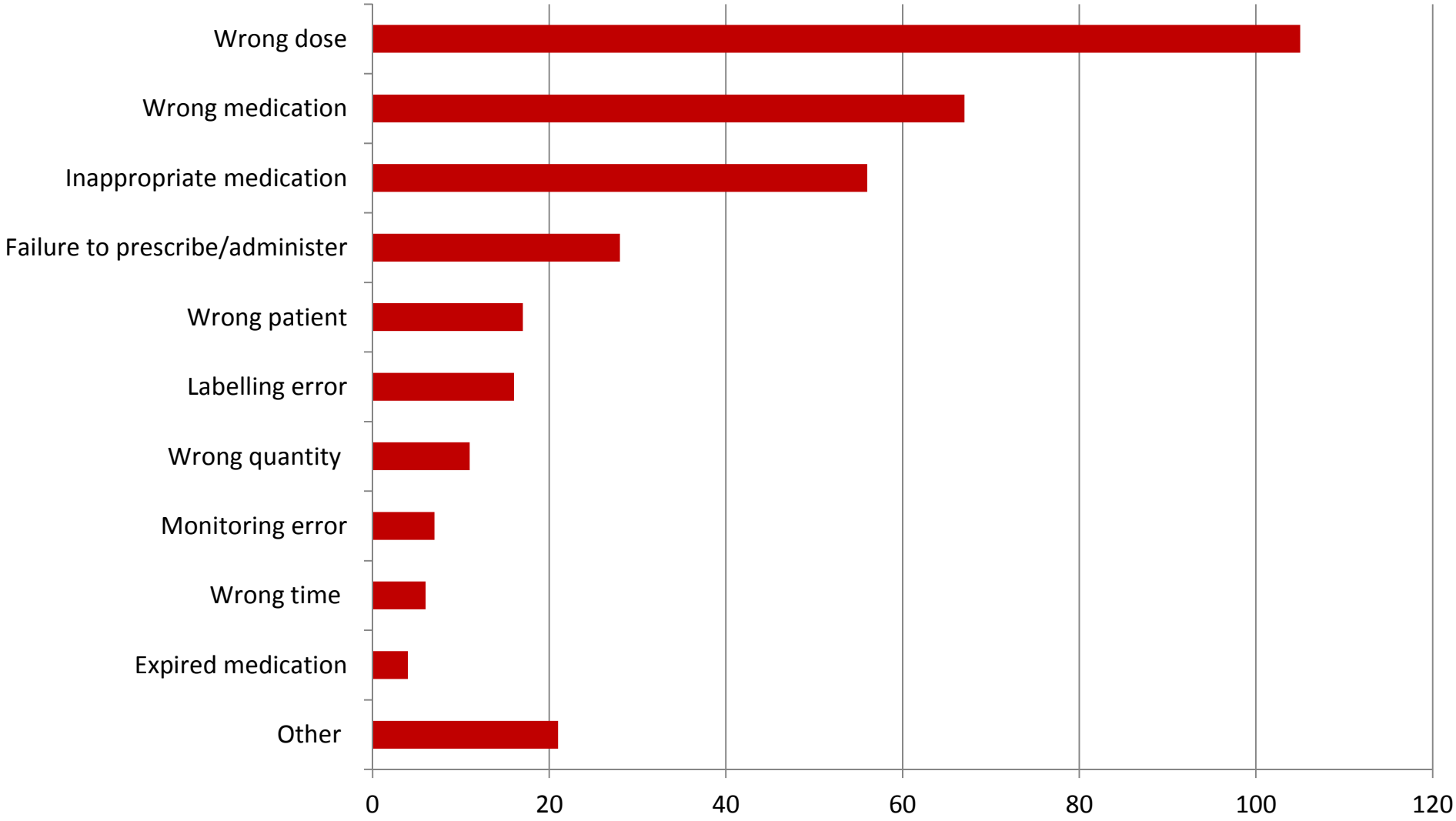

Medication error: Prescribing errors

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- Majority occurred in GP and public hospital settings
- Around half related to prescribing inappropriate medication
- Common contributing factors included:
  - Failure to obtain necessary information (60%)
  - Failure to act on information (32%)
  - Coordination of care issues (31%)
  - Issues with software system (28%)

Medication error: Dispensing errors

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- Almost all occurred in community pharmacy settings
- Majority relate to dispensing wrong medication or wrong strength of medication
- Common contributing factors included:
  - Failure to follow SOPs (78%)
  - Inadequate SOPs (34%)
  - Busyness (28%)
  - Medications with similar names (22%)

Medication error: Administration errors

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- Majority occurred in public hospital settings, followed by aged care and GP clinics
- Majority relate to administering wrong dose, a failure to administer or administering medication to wrong patient
- Common contributing factors included:
  - Failure to follow policies/procedures (55%)
  - Coordination of care issues (42%)
  - Busyness (32%)
  - Distractions/interruptions (19%)

Case Study: Medication error

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- Mrs A had experienced an adverse reaction to the antibiotic trimethoprim
- Was admitted to hospital for rehabilitation post-surgery
- Admitting house officer, Dr I, recorded in the progress notes: “NUMEROUS DRUG ALLERGIES → see chart.”
- Dr I labelled orange adverse reaction stickers with Mrs A’s medication allergies and reactions and stuck one to each page of the drug chart
- Registrar, Dr E, reviewed Mrs A and prescribed trimethoprim for a UTI.
- Dr E did not check the orange adverse reaction sticker.

Case Study: Medication error

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- RN F administered the dose of trimethoprim 300mg that evening.
- Mrs A was reviewed by registrar Dr G the next morning.
- Dr G noted Mrs A's allergy to trimethoprim was written on her medication chart, stopped the medication and advised nursing staff to watch for signs of an allergic reaction
- Mrs A developed widespread truncal toxic epidermal necrolysis resulting from the allergic reaction to the trimethoprim and died

Case Study: Medication error

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Findings – Dr E

Breach of Right 4(1)

- Dr E failed to take the necessary steps to ensure that she prescribed medication to Mrs A that was appropriate for her and missed several opportunities to remind herself of Mrs A's allergy status.

Findings – RN F

Breach of Right 4(1)

- RN F had a number of opportunities to identify the medication error and failed to do so.
- RN F also failed to think critically and, instead, placed too much reliance on the fact that Mrs A would not be charted medication to which she was allergic.

Case Study: Medication error

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Findings – DHB

Breach of Right 4(1)

- **Systems and culture**
  - Several systemic issues in the ward in that the work load was high, there were concerns about staffing levels and skill mix, and the environment was confrontational.
  - Expert advisor noted:

    "The contribution of the work environment must not be underestimated as these errors are not made by bad doctors and nurses but by systems that fail to support the prescribers and dispensers."

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Systems

Systems

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- Modern medicine is most effective when it functions like a system:

> *"…diverse people working together to direct their specialised capabilities toward common goals for patients. They are coordinated by design."*
>
> A Gawande, "Pitcrews and cowboys" (2011)

Study 3: Complaints about DHBs

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- Provide DHBs with a complaint report every 6 months
- Publish an annual DHB complaint report
- Each DHB complaint coded for: service type, complaint issue, and complaint outcomes

DHB complaints:
Number received each year

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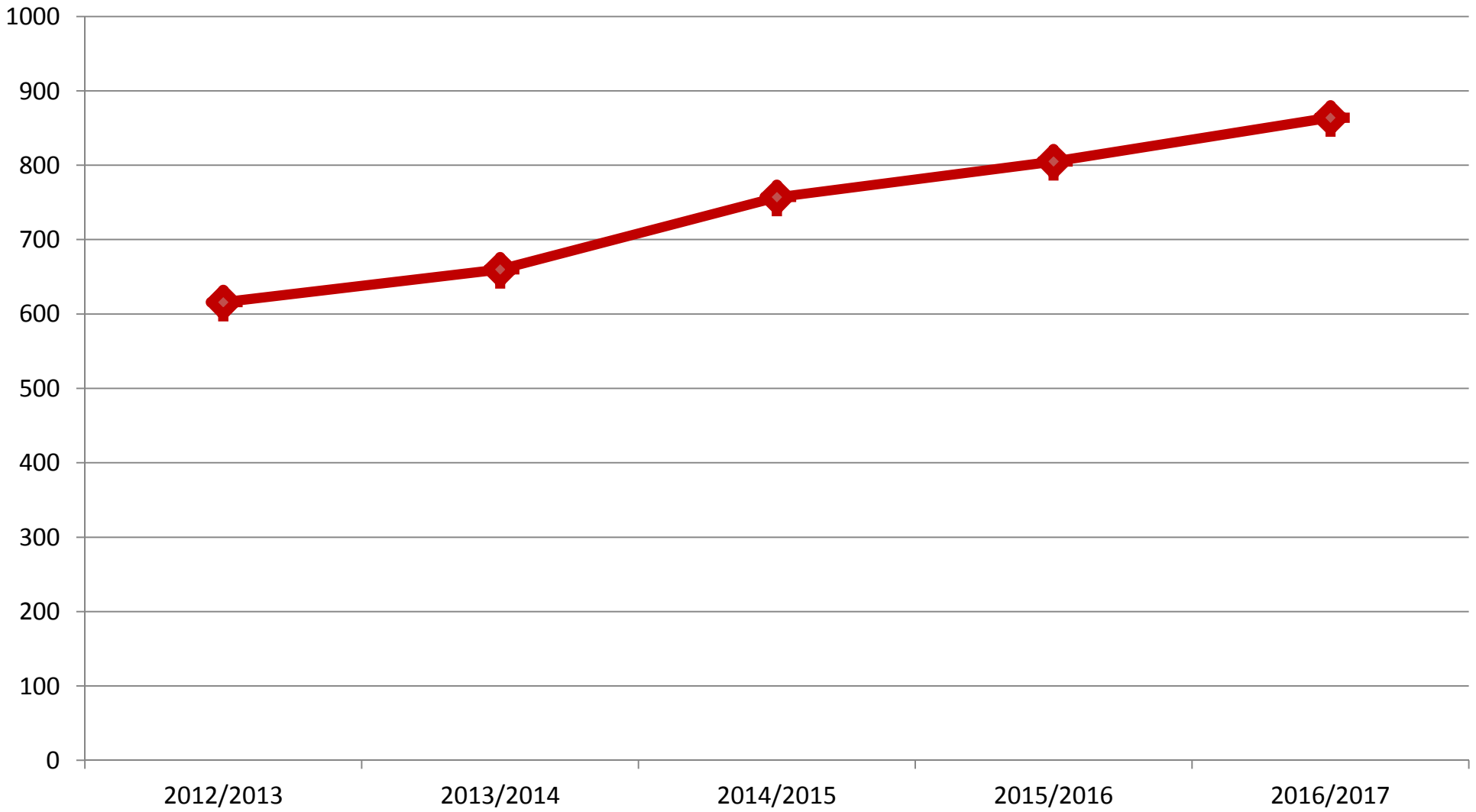

DHB complaints:
Service types complained about

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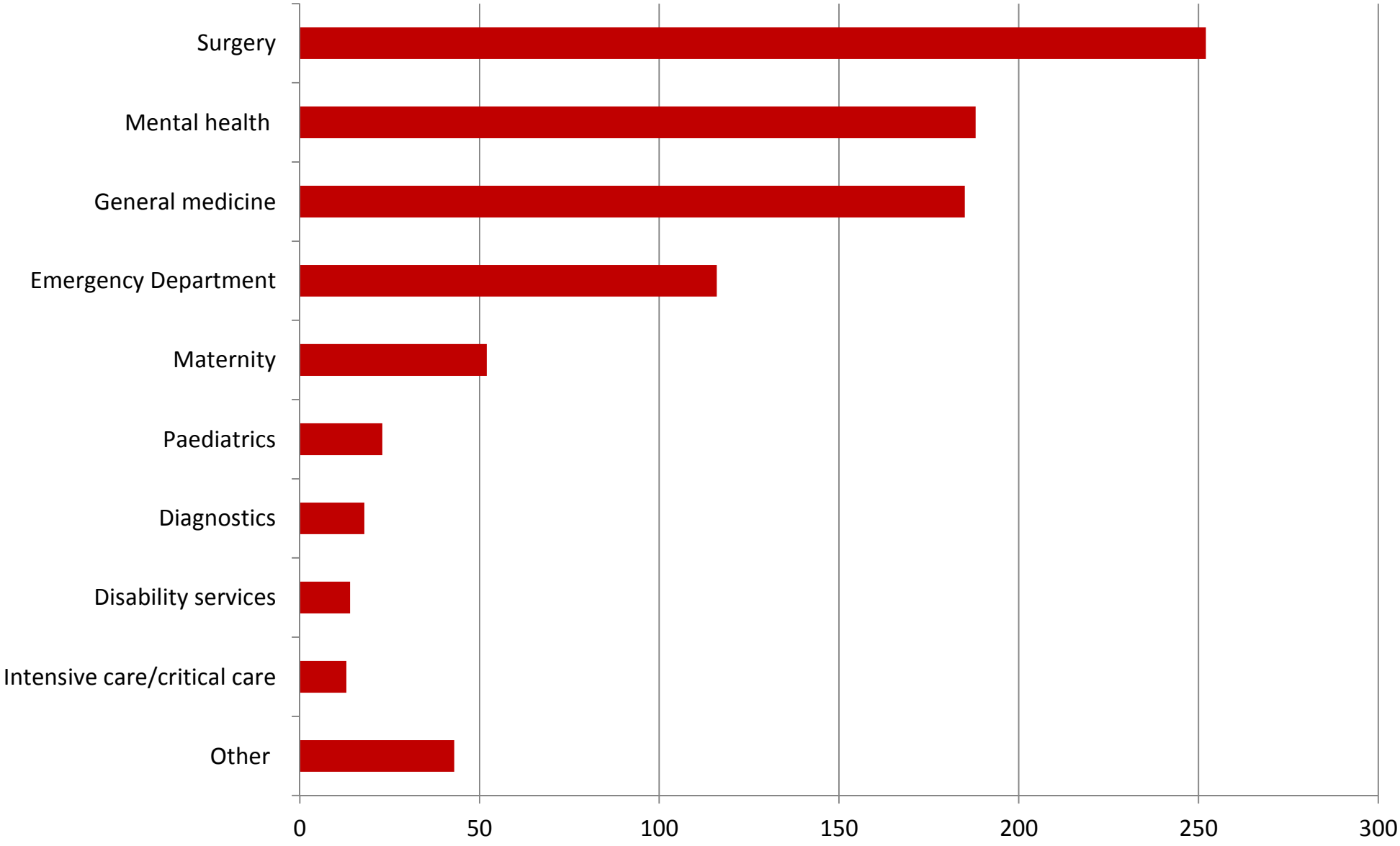

DHB complaints:

Issues complained about by service type

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Surgery n=252		Mental health n=188		General medicine n=185		Emergency department n=116		Maternity n=52	
Failure to communicate effectively with consumer	44%	Failure to communicate effectively with consumer	34%	Failure to communicate effectively with consumer	35%	Missed/ incorrect/ delayed diagnosis	49%	Inadequate/ inappropriate treatment	58%
Inadequate/ inappropriate treatment	42%	Issues with involuntary admission/ treatment	29%	Failure to communicate effectively with family	31%	Inadequate/ inappropriate examination/ assessment	37%	Failure to communicate effectively with consumer	48%
Unexpected treatment outcome	32%	Failure to communicate effectively with family	26%	Inadequate coordination of care/ treatment	30%	Inadequate/ inappropriate testing	33%	Delay in treatment	33%
Delay in treatment	27%	Inadequate/ inappropriate examination/ assessment	22%	Inadequate/ inappropriate treatment	30%	Inadequate/ inappropriate treatment	31%	Inadequate/ inappropriate examination/ assessment	31%
Missed/ incorrect/ delayed diagnosis	22%	Inadequate/ inappropriate treatment	22%	Missed/ incorrect/ delayed diagnosis	26%	Failure to communicate effectively with consumer	29%	Unexpected treatment outcome & inadequate coordination of care/treatment	25% each

DHB complaints: Common systems issues raised in complaints

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Issues	Percentage of complaints involving issue
Delay in treatment	21%
Inadequate coordination of care or treatment	20%
Inappropriate/delayed discharge/transfer	12%
Inadequate response to complaint	17%

DHB:
Coordination of care and inadequate communication

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- Mr A was on long-term opioid substitution treatment
- Presented to ED where a consultant physician recorded an impression of chronic liver disease, hypoxia with signs of malignancy, and abdominal lesions and nodes
- Mr A contacted an addiction clinician, Mr C, and advised he had been diagnosed with cancer of the liver
- The minutes from the Addiction Service's meeting noted that Mr A was requesting to have his methadone increased
- The hospital discharge summary referred to Mr A's "possible poor prognosis"

DHB:
Coordination of care and inadequate communication

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- Mr A was admitted to hospital with abdominal pain.
- Mr A was discharged by house officer, Dr H, with a prescription for increased methadone intended for acute pain relief
- The pharmacy contacted the Addictions Service, and an addiction specialist, Dr B, contacted Dr H to clarify the prescription.
- Dr H cancelled the prescription
- MRI could not be completed due to Mr A's pain. This information was relayed to Dr B
- Dr B advised this was the first indication he had that Mr A may be requiring methadone for clinical reasons, rather than addiction

DHB:
Coordination of care and inadequate communication

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Findings – DHB

Breach of Right 4(1)

- Number of missed opportunities for communication about Mr A's situation, his condition, and his pain relief medication, as a result of service-based failures attributable to the DHB
- Mr A did not receive the pain relief he should have been able to access

Improving safety and quality

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Individuals (doctors)

- Targeted interventions and training

Behaviours

- Understanding common themes and their causes

Systems

- Identifying and addressing systemic weaknesses

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