Complaints to HDC involving District Health Boards

Report and Analysis for period 1 July to 31 December 2019

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Feedback
We welcome your feedback on this report. Please contact Léonie Walker at hdc@hdc.org.nz

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Commissioner's Foreword

I am pleased to present you with HDC's six monthly DHB complaint report detailing the trends in complaints received by HDC about DHBs between 1 July and 31 December 2019.

Firstly, I would like to acknowledge the contributions of everyone working in the health and disability sector in responding to the Covid-19 pandemic. An enormous amount of work has occurred in a short space of time, and exceptional commitment and care has been demonstrated across the sector by the many thousands of individuals who together make our system what it is. I appreciate that these are extraordinary times. Issues relating to COVID-19, unheralded in New Zealand in the time covered by this report, will be traversed in the next DHB report.

HDC received 471 complaints about DHB services between 1 July and 31 December 2019. This is a 7 percent increase on the average number of 440 complaints received over the previous four reporting periods. The trends in complaints remain similar to what has been seen in previous six-month periods, with surgery being the most common service type complained about and missed/incorrect/delayed diagnosis being the most common primary issue.

Access to services continues to be a prominent issue seen in complaints to HDC about DHB services, featuring in around a quarter of all complaints about DHBs. Inadequate prioritisation systems, where patients are not prioritised according to clinical risk, and poor communication with consumers, are a common feature of investigations by my Office into treatment delays

Currently hospitals across New Zealand are appropriately operating at different alert levels, with some freeing up hospital resources and deferring non-urgent care. As I noted in my letter to the Minister of Health of 16 April 2020 (available on our website at https://www.hdc.org.nz/media/5466/letter-to-minister-16-4-20.pdf), it is vital that all services, and particularly those that are deferring non-urgent procedures and referrals, are regularly reviewing their waiting lists to ensure that patients are being appropriately prioritised according to shifting acuity.

Every complaint is an opportunity to learn, and I trust that this report will continue to promote ongoing quality improvement.

Anthony Hill
Health and Disability Commissioner

National Data for all District Health Boards

1.0 Number of complaints received

1.1 Raw number of complaints received

In the period Jul-Dec 2019, HDC received 471[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

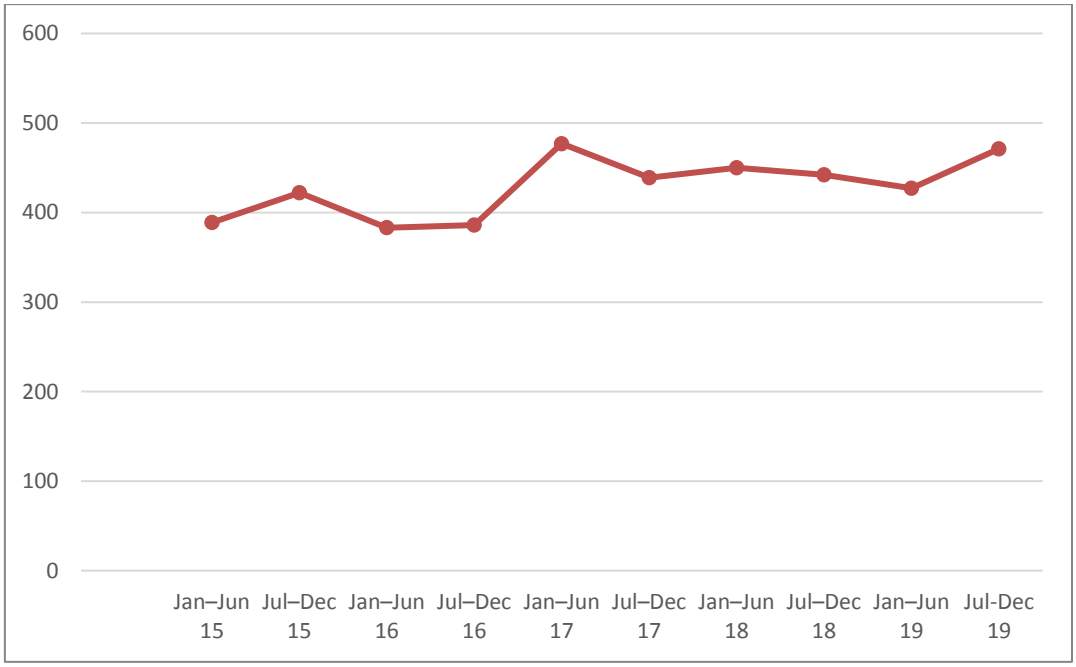
Table 1. Number of complaints received in the last five years

	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Average of last 4 6-month periods	Jul - Dec 19
Number of complaints	389	422	383	386	477	439	450	442	427	**440**	**471**

The total number of complaints received in Jul-Dec 2019 (471) shows a 7% increase over the average number of complaints received in the previous four periods.

The number of complaints received in Jul-Dec 2019 and previous six-month periods are also displayed below in Figure 1.

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



[1] Provisional as of date of extraction (6 January 2020).

1.2 Rate of complaints received

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

Rate of complaints calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (27 February 2020) and is likely incomplete; it will be updated in the next six-monthly report. It should be noted that this discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges during Jul-Dec 2019

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
471	501,245	**93.96**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jul–Dec 2019 and previous six-month periods.

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

	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19[22]	Average of last 4 6-month periods	Jul-Dec 19
Rate per 100,000 discharges	84.60	87.57	81.44	78.79	99.08	88.23	93.80	88.47	87.97	**89.62**	**93.96**

The rate of complaints received during Jul-Dec 2019 (93.96) shows a 5% increase on the average rate of complaints received for the previous four periods.

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

[2] The rate for Jan-Jun 2019 has been recalculated based on the most recent discharge data.

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

Table 4. Number and rate of complaints received for each DHB in Jul-Dec 2019

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	57	63903	89.2
Bay of Plenty	19	28000	67.85
Canterbury	45	57118	78.78
Capital & Coast	41	30460	134.60
Counties Manukau	46	49360	93.19
Hauora Tairawhiti	5	5348	93.49
Hawke's Bay	18	18561	96.97
Hutt Valley	18	15611	115.3
Lakes	8	12624	63.37
MidCentral	24	16107	149
Nelson Marlborough	9	13380	67.26
Northland	12	21655	55.41
South Canterbury	7	6221	112.52
Southern	32	28039	114.12
Taranaki	19	14340	132.50
Waikato	43	51954	82.77
Wairarapa	7	4430	158.01
Waitemata	46	55283	83.2
West Coast	2	3257	61.41
Whanganui	12	6846	175.28

Notes on DHB's number and rate of complaints

It should be noted that the numbers above reflect complaints that may relate to different providers within one DHB or to providers in more than one DHB. These raw numbers are further refined for the individual DHB reports to remove duplicates and complaints withdrawn or out of jurisdiction of HDC. Please note; a DHB's number and rate of complaints can vary considerably from one six-month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six-month period. Further, for smaller DHBs, a very small absolute increase or decrease in the number of complaints received can dramatically affect the rate of complaints. Accordingly, much of the value in this data lies in how it changes over time, as such analysis allows trends to emerge that may point to areas that require further attention. It is also important to note that numbers of complaints received by HDC is not always a good proxy for quality of care provided, and may instead, for example, be an indicator of the effectiveness of a DHB's complaints system or features of the services provided by a particular DHB. Additionally, complaints received within a single six-month period will sometimes relate to care provided within quite a different time period. From time to time, some DHBs may also be the subject of a number of complaints from a single complainant within one reporting period. This is important context that is taken into account by DHBs when considering their own complaint patterns.

2.0 Service types complained about

2.1 Service type category

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one service or hospital; therefore, although there were 472 complaints about DHBs, 503 services were complained about.

Surgical services (31.2%) received the greatest number of complaints in Jul-Dec 2019, with orthopaedics (9.5%), general surgery (7.1%), and gynaecology (6.2%) being the surgical specialties most commonly complained about.

Other commonly complained about services included mental health (25%), medicine (16%) and emergency department (11%) services. This is broadly similar to what has been seen in previous periods.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Alcohol and drug	**5**	**1.0%**
Anaesthetics/pain medicine	**5**	**1.0%**
Diagnostics	**13**	**2.6%**
Disability	**13**	**2.6%**
District nursing	**2**	**0.4%**
Emergency Department	**57**	**11.2%**
Intensive/critical care	**5**	**1.0%**
Maternity	**24**	**4.7%**
Medicine	**82**	**16.2%**
Cardiology	4	0.8%
Dermatology	1	0.2%
Endocrinology	3	0.6%
Gastroenterology	11	2.2%
General	13	2.6%
Geriatric medicine	10	2.0%
Neurology	17	3.4%
Oncology	7	1.4%
Palliative care	2	0.4%
Renal/nephrology	2	0.4%
Respiratory	5	1.0%
Other/unspecified	7	1.4%
Mental health	**127**	**25.0%**
Paediatrics (not surgical)	**9**	**1.8%**
Physiotherapy	**2**	**0.4%**
Rehabilitation services	**2**	**0.4%**
Surgery	**157**	**31.0%**
Cardiothoracic	4	0.8%
General	36	7.1%
Gynaecology	22	4.3%
Neurosurgery	8	1.6%
Ophthalmology	5	1.0%
Oral/Maxillofacial	1	0.2%
Orthopaedics	48	9.5%
Otolaryngology	8	1.6%
Plastic and reconstructive	6	1.2%
Urology	11	2.2%
Vascular	4	0.8%
Other/unknown surgery	4	0.8%
TOTAL	**507**	

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jul-Dec 2019 are listed in Table 6. It should be noted that the issues included are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues provide a valuable insight into the consumer's experience of the services provided and the issues they care about most.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/funding	**76**	**16.1%**
Lack of access to funding/subsidies	3	0.6%
Lack of access to services	36	7.6%
Waiting list/prioritisation issue	37	7.8%
Boundary violation	**2**	**0.4%**
Inappropriate sexual physical contact	2	0.4%
Care/treatment	**243**	**51.5%**
Delay in treatment	21	4.4%
Delayed/inadequate/inappropriate referral	3	0.6%
Inadequate coordination of care/treatment	7	1.5%
Inadequate/inappropriate care	4	0.8%
Inadequate/inappropriate clinical treatment	37	7.8%
Inadequate/inappropriate examination/assessment	17	3.6%
Inadequate/inappropriate follow-up	19	4.0%
Inadequate/inappropriate monitoring	1	0.2%
Inadequate/inappropriate testing	2	0.4%
Inappropriate withdrawal of treatment	5	1.1%
Inappropriate/delayed discharge/transfer	9	1.9%
Missed/incorrect/delayed diagnosis	66	14.0%
Refusal to treat	3	0.6%
Rough/painful care/treatment	4	0.8%
Unexpected treatment outcome	44	9.3%
Unnecessary treatment/over-servicing	1	0.2%
Communication	**36**	**7.6%**
Disrespectful manner/attitude	11	2.3%
Failure to accommodate language/cultural needs	4	0.8%
Failure to communicate effectively with consumer	14	3.0%
Failure to communicate effectively with family	7	1.5%
Complaints process	**3**	**0.6%**
Retaliation/discrimination as a result of a complaint	1	0.2%
Inadequate response to complaint	2	0.4%
Consent/information	**55**	**11.7%**
Coercion by provider to obtain consent	1	0.2%
Consent not obtained/adequate	23	4.9%

Inadequate information provided regarding adverse event	1	0.2%
Inadequate information provided regarding options	2	0.4%
Inadequate information provided regarding results	1	0.2%
Inadequate information provided regarding treatment	5	1.0%
Incorrect/misleading information provided	1	0.2%
Issues regarding consent when consumer not competent	1	0.2%
Issues with involuntary admission/treatment	20	4.2%
Disability-related issues	**4**	**0.8%**
Inadequate/inappropriate equipment provided	2	0.4%
Inadequate/inappropriate support provided	2	0.4%
Documentation	**7**	**1.5%**
Delay/failure to disclose documentation	1	0.2%
Inadequate/inaccurate documentation	6	1.2%
Facility	**7**	**1.5%**
General safety issue for consumer in facility	7	1.5%
Medication	**26**	**5.3%**
Administration error	5	1.1%
Inappropriate administration	2	0.4%
Inappropriate prescribing	13	2.5%
Prescribing error	1	0.2%
Refusal to prescribe/dispense/supply	5	1.1%
Report/Certificate	**7**	**1.5%**
Inaccurate report/certificate	7	1.5%
Professional conduct-related issues	**6**	**1.3%**
Disrespectful behaviour	2	0.4%
Inappropriate collection/use/disclosure of information	2	0.4%
Other	2	0.4%
TOTAL	**471**	

The most common primary issue categories were:

- Care/treatment (51.5%)
- Access/funding (16.1%)
- Consent/information (11.7%)
- Communication (7.6%)

The most common specific primary issues complained about were:

- Missed/incorrect/delayed diagnosis (14.0%)
- Unexpected treatment outcome (9.3%)
- Inadequate/inappropriate treatment (7.8%)
- Waiting list/prioritisation issue (7.8%)
- Lack of access to services (7.6%)

Table 7 shows a comparison over time for the top five primary issues complained about. These have remained broadly consistent.

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

Top five primary issues in all complaints (%)							
Jan–Jun 18 n=450		**Jul–Dec 18 n=442**		**Jan–Jun 19 n=427**		**Jul–Dec 19 n=472**	
Misdiagnosis	13%	Misdiagnosis	14%	Misdiagnosis	16%	Misdiagnosis	14%
Unexpected treatment outcome	12%	Lack of access to services	9%	Waiting list/ prioritisation	12%	Unexpected treatment outcome	9%
Waiting list/ prioritisation	11%	Unexpected treatment outcome	9%	Unexpected treatment outcome	9%	Waiting list/ prioritisation	8%
Lack of access to services	6%	Waiting list/ Prioritisation	7%	Inadequate treatment	7%	Inadequate treatment	8%
Inadequate treatment	4%	Inadequate treatment	6%	Lack of access to services	6%	Lack of access to services	8%

3.2 All complaint issues

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

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	**116**	**24.6%**
Lack of access to services	55	11.6%
Lack of access to subsidies/funding	7	1.5%
Waiting list/prioritisation issue	56	11.9%
Boundary violation	**2**	**<1%**
Care/treatment	**401**	**84.9%**
Delay in treatment	90	19.1%
Delayed/inadequate/inappropriate referral	22	4.7%
Inadequate coordination of care/treatment	84	17.8%
Inadequate/inappropriate non-clinical care	30	6.3%
Inadequate/inappropriate clinical treatment	188	39.8%
Inadequate/inappropriate examination/assessment	127	26.9%
Inadequate/inappropriate follow-up	66	14.0%
Inadequate/inappropriate non-clinical care	4	<1%
Inadequate/inappropriate monitoring	31	6.6%
Inadequate/inappropriate testing	54	11.4%
Inappropriate admission/failure to admit	12	2.5%
Inappropriate/delayed discharge/transfer	62	13.1%
Inappropriate withdrawal of treatment	9	1.9%
Missed/incorrect/delayed diagnosis	90	19.1%
Personal privacy not respected	1	<1%
Refusal to assist/attend	6	1.2%
Refusal to treat	8	1.7%
Rough/painful care or treatment	15	3.2%
Unexpected treatment outcome	72	15.3%
Unnecessary treatment/over-servicing	3	<1%
Communication	**334**	**70.8%**
Disrespectful manner/attitude	82	17.4%
Failure to accommodate cultural/language needs	4	<1%
Failure to communicate openly/honestly/effectively with consumer	203	43.0%
Failure to communicate openly/honestly/effectively with family	107	22.7%
Complaints process	**79**	**16.7%**
Inadequate response to complaint	78	16.5%
Retaliation/discrimination as a result of a complaint	1	<1%
Consent/Information	**114**	**24.2%**
Consent not obtained/adequate	31	6.6%
Inadequate information provided regarding adverse event	8	1.7%
Inadequate information provided regarding condition	8	1.7%
Inadequate information provided regarding fees/costs	2	<1%
Inadequate information provided regarding options	15	3.2%
Inadequate information provided regarding provider	4	<1%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding results	6	1.2%
Inadequate information provided regarding treatment	35	7.4%
Incorrect/misleading information provided	6	1.2%
Issues with involuntary admission/treatment	24	5.1%
Issues with consent when consumer not competent	1	<1%
Coercion by provider to obtain consent	2	<1%
Documentation	**34**	**7.2%**
Delay/failure to disclose documentation	7	1.5%
Inadequate/inaccurate documentation	25	5.3%
Inappropriate maintenance/disposal of documentation	1	<1%
Intentionally misleading/altered documentation	3	<1%
Other	1	<1%
Facility issues	**52**	**11.0%**
Cleanliness/hygiene issue	3	<1%
Inadequate/inappropriate policies/procedures	12	2.5%
Failure to follow policies/procedures	8	1.7%
General safety issue for consumer in facility	11	2.3%
Issue with sharing facility with other consumers	3	<1%
Issue with quality of aids/equipment	5	<1%
Staffing/rostering/other HR issues	10	2.1%
Waiting times	5	<1.%
Medication	**57**	**12.1%**
Administration error	5	<1%
Inappropriate administration	2	<1%
Prescribing error	2	<1%
Inappropriate prescribing	34	7.2%
Refusal to prescribe/dispense/supply	9	1.7%
Reports/certificates	**11**	**2.3%**
Inaccurate report/certificate	11	2.3%
Other professional conduct issues	**18**	**3.8%**
Disability-related issues	**19**	**4.0%**
Other issues	**11**	**2.3%**

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

- Care/treatment (present for 85% of all complaints)
- Communication (present for 71% of all complaints)
- Access/funding (present for 25% of all complaints)
- Consent/information (present for 24% of all complaints).

The most common *specific* issues were:

- Failure to communicate effectively with consumer (43%)
- Inadequate/inappropriate clinical treatment (40%)
- Inadequate/inappropriate examination/assessment (27%)
- Failure to communicate effectively with family (23%)

- Missed/incorrect/delayed diagnosis (19%)
- Delay in treatment (19%)
- Inadequate coordination of care/treatment (18%)
- Inadequate response to complaint (17%)
- Disrespectful manner/attitude (17%)
- Unexpected treatment outcome (15%)

This is broadly similar to what was seen in the last six-month period. There was an increase in complaints about an inadequate response to the consumer's complaint by the DHB, from 10% in the previous reporting period to 17% in Jul-Dec 2019.

3.3 Service type and primary issue

Table 9 shows the top three primary issues in complaints concerning the most commonly complained about service types. This is broadly similar to what was seen in the last six-month period. However, there was an increase in the proportion of complaints regarding inadequate follow-up for mental health services and inadequate coordination of care/treatment for medicine services in Jul-Dec 2019.

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

Surgery n=157		**Mental health n=127**		**Medicine n=82**		**Emergency department n=57**	
Unexpected treatment outcome	23%	Issues with involuntary admission/ Treatment	15%	Missed/ incorrect/ delayed diagnosis	24%	Missed/ incorrect/ delayed diagnosis	32%
Waiting list/ prioritisation issue	16%	Inadequate treatment & inadequate follow-up	9%	Inadequate coordination of care/treatment	12%	Inadequate/ Inappropriate treatment	12%
Missed/ incorrect/ delayed diagnosis	13%	Inadequate/ inappropriate examination/ assessment	9%	Inadequate/ Inappropriate treatment	12%	Inadequate/ inappropriate examination/ assessment	7%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **423**[4] complaints involving DHBs in the period Jul-Dec 2019. Table 10 shows the number of complaints closed in previous six-month periods.

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

	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Average of last 4 6-month periods	Jul-Dec 19
Number of complaints closed	410	365	482	316	465	383	476	449	444	**438**	**423**

4.2 Outcomes of complaints closed

Complaints that are within HDC's jurisdiction are classified into two groups according to the manner of resolution — whether investigation or other resolution. Within each classification, there is a variety of possible outcomes. Notification of investigation generally indicates more serious issues.

In the Jul-Dec 2019 period, 4 DHBs had no investigations closed, 8 DHBs had one investigation closed, 2 DHBs had two investigations closed, 4 DHBs had three investigations closed, 1 DHB had four investigations closed and 1 DHB had five investigations closed.

The manner of resolution and outcomes of all complaints about DHBs closed in Jul-Dec 2019 is shown in Table 11.

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

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

Outcome for DHBs	Number of complaints closed
Investigation	***33***
Breach finding - Referred to Director of Proceedings	1
Breach finding	22
No breach finding - with adverse comment and recommendations	8
No breach finding	2
Other resolution following assessment	***389***
No further action[6]with recommendations or educational comment	71
Referred to District Inspector	13
Referred to other agency	7
Referred to DHB[7]	97
Referred to Advocacy	78
No further action	118
Withdrawn	5
Outside jurisdiction	***1***
TOTAL	**423**

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

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

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

4.3 Recommendations made to DHBs following a complaint

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

Table 12 shows the recommendations made to DHBs in complaints closed in Jul-Dec 2019. Please note that more than one recommendation may be made in relation to a single complaint.

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	25
Audit	20
Meeting with consumer	4
Presentation/discussion of complaint with others	14
Provision of evidence of change to HDC	37
Review/implementation of policies/procedures	37
Training/professional development	24
TOTAL	**161**

The most common recommendations made to DHBs was that they review or implement new policies and procedures (37 recommendations) and that they provide evidence to HDC of the changes they had made in response to the issues raised in the complaint (37 recommendations). 24 recommendations were made in relation to staff training – this was most often in regards to clinical issues identified in the complaint followed by training on policies and procedures, communication and documentation requirements.

5.0 Learning from complaints — HDC case reports

1) Cardiac anomaly not accounted for during surgery (17HDC00159)

Background

A 76 year old man had a cardiac anomaly whereby his right coronary artery (RCA) did not originate from the usual place in the heart, and it followed a different course to that of most people. A cardiothoracic surgeon performed surgery to replace the man's heart valve, but was unaware of the anomaly. During surgery, the surgeon placed a suture (stitch) through the man's RCA, and this caused poor right cardiac function. The man died following the surgery, and the surgical error was identified at autopsy.

Two weeks prior to the surgery, the man had an angiogram[8] performed by a cardiologist. The cardiologist documented the anomaly in the conclusion section of their report. The cardiologist did not complete a coronary diagram, as this was not a mandatory requirement at the DHB. The cardiologist handed over the case to another cardiologist to present for discussion at a combined cardiac meeting (CCM).

The case was discussed at the CCM of 10–20 clinicians, including the surgeon involved, to confirm the surgical plan. While two clinical documents referencing the anomaly were circulated to the attendees, and the angiogram images were viewed at the meeting, the anomaly was not discussed at the CCM. Following the CCM but ahead of surgery, three further clinical documents were prepared by clinicians other than the surgeon involved that referenced the anomalous RCA.

The surgeon confirmed that he reviewed the angiogram images and at least three of the clinical documents ahead of surgery, noting that his focus was on confirming the surgical plan from the CCM rather than making a rare diagnosis. Two anaesthetists subsequently confirmed that they were aware of the anomalous RCA during the surgery, but assumed that the surgical team were already aware of it, so did not discuss it during surgery.

Findings

The man's cardiac anomaly was known by multiple people and recorded in multiple places in the DHB's system. There were numerous missed opportunities for the information to be communicated to the surgeon, and these were contributed to by the fact that the DHB did not require completion of a coronary diagram ahead of surgery, and that the purpose of the CCM was not clear to its participants. Notwithstanding the surgeon's personal responsibility in this case, the DHB system failed to alert him to relevant and significant information about the man. Accordingly, the Commissioner found that the DHB did not provide services to the man with reasonable care and skill, in breach of Right 4(1) of the Code

The Commissioner considered there to have been significant failures in the care the cardiothoracic surgeon provided to the man. The surgeon did not: review the preoperative documentation comprehensively; interpret the angiogram images adequately; identify the RCA ostium during surgery or recognise that it was unusually large; administer antegrade cardioplegia; or document his operation findings adequately. Accordingly, the Commissioner found that the surgeon breached Right 4(1) of the Code.

[8] A procedure using X-ray imaging to visualise the heart's blood vessels.

Recommendations

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

- create terms of reference for the purpose and effect of the CCM;
- align a policy, regarding the completion of coronary diagrams ahead of cardiac surgery, with national practice;
- implement a system to ensure that letters or clinical reports finalised after the CCM but ahead of surgery are forwarded to a central repository to be inserted into the cardiothoracic surgery folder;
- provide in-house training regarding interpretation of angiogram images; ensure that it is clear to all surgery departments that it is expected that the operating surgeon will read all pertinent documentation ahead of surgery;
- provide a written apology to the man's family.

The Commissioner recommended that the surgeon undertake training on angiogram interpretation, and provide a written apology to the man's family. The Commissioner also recommended that the Medical Council of New Zealand consider whether a review of the surgeon's competence is warranted.

In summary,

The Commissioner commented; "*The whole team has a responsibility to ensure that relevant and significant information is shared amongst everyone in the operating theatre, and as this case has demonstrated, it is dangerous to make assumptions about what people already know. I encourage any surgical team member to speak up if there is any doubt in their mind about whether the surgeon knows about a key piece of information".*

2) Standard of urology services 17HDC02066,

Background
The Commissioner initiated an investigation of a DHB's urology service after it became apparent that there were lengthy delays in the assessment and treatment of patients, and consequently a substantial clinical risk. In the investigation the Commissioner addressed four individual cases. In each case he found the DHB to have breached the Code.

For one man, the time taken for him to receive treatment was almost double the target timeframe, which was compounded by a failure to keep him informed about a likely date for his surgery.

Another man had an unacceptable delay in receiving treatment. He was graded as priority 3 (expected to be seen within six weeks), but he was not seen until over five months after his initial referral. It was then a further seven weeks until his biopsy was performed, even though the booking form was marked urgent, with multiple circles and a star to emphasise the urgency.

A third patient, who was triaged "to be seen within 6 weeks", was offered a first specialist appointment more than four months after he was referred by a GP. Subsequently, the appointment was brought forward after his GP made a further referral noting the "high suspicion of cancer". In this case the Commissioner was also concerned about the DHB's communication with the man, in particular regarding information about managing his anticoagulation medication.

The fourth patient was booked for a flexible cystoscopy, an examination of the bladder using a fibre-optic tube. This was not performed until after a gynaecologist made an "urgent referral" six months later. In this case, the DHB was also found in breach of the Code for failures relating to its response when the woman complained.

Findings

Looking across the four cases, the Commissioner found there had been little planning for urology services in light of changing demographics, and referrals exceeded the DHB's capacity. The DHB did not have an effective system for managing patients who were waiting for urology services, and clinicians and the public came to expect delays, which became normalised. Many patients waited with no treatment and no information about when they would be treated.

In response to this case, the Commissioner stated that "It is essential that providers assess, plan, adapt, and respond effectively to the foreseeable effects that changing demographics in their population will have on systems and demand … In the context of constrained resources, appropriate waiting list and appointment management systems are vital to managing risk. Having mechanisms to monitor wait times and make these transparent to both the public and to referrers is essential. Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand."

The investigation also found that relationships within the DHB had become strained, and there was a lack of willingness to work together to find solutions. The Commissioner noted that the report highlighted the importance of collaborative and mutually accountable relationships between management and clinicians.

Recommendations
The Commissioner acknowledged the work undertaken by the DHB in the last two years to address the challenges faced by its urology service and noted that HDC would continue to monitor progress.

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

- An independent evaluation of the systems currently in place to prioritise urology patients
- Audits of the management of urology service referrals
- A review of mechanisms for monitoring wait times and making this information transparent
- A report to HDC on steps to build capacity of the department
- Making clinical staff routinely available to urology patients by telephone
- Arranging ongoing shared learning, including with other DHBs, in response to this case
- Regular credentialing for the urology service and its facilities
- Regular updates to HDC on implementation of recommendations from a separate external review
- A review of the DHB's complaints management processes

The Commissioner also recommended that the Ministry of Health consider a national discussion of urology service priorities and reporting of overdue urology appointment statistics.

Summary

In summary, The Commissioner noted that "*it is essential that providers assess, plan, adapt, and respond effectively to the foreseeable effects that changing demographics in their population will have on systems and demand. In the context of resource constraint, appropriate waiting list and appointment management systems are vital to managing risk. With increasing demand, capacity needs to be monitored. Having mechanisms to monitor wait times and make these transparent to both the public and to referrers is essential. Organisations also need to consider initiatives such as different models of care to reduce the gap between capacity and demand".*

3) Monitoring of man with cardiac issues 16HDC01028

A 68 year old man was admitted to the emergency department (ED) of a public hospital with chest discomfort.

Blood tests and an electrocardiogram (ECG) showed that he had suffered a non-ST elevation myocardial infarction (NSTEMI) (a heart attack). The next day, the man was admitted to a general medical ward, where he was monitored via remote cardiac monitoring, and commenced on anticoagulation and antiplatelet (blood-thinning) medications. The man suffered a fall during his time on the ward.

A number of issues were identified in the man's care in regards to communication between providers, medication administration, escalation of concerns and fall management, including:

- The medication administered was recorded inaccurately in MedChart; software issues contributed to this.
- The patient was left alone in the bathroom despite having recently been administered GTN sprays.
- Task Manager was used inappropriately to notify medical staff of clinical issues.
- Nursing staff failed to follow up Task Manager messages with the medical staff.
- There was poor clinical judgement by the overnight house officer, who decided not to review the patient despite his chest tightness and having required GTN sprays, and later having experienced a fall.
- The house officer did not look at the patient notes before deciding not to review him.
- Documentation was poor, including the overnight house officer not recording his decision not to review.
- There was poor communication between staff about the fall, particularly at the nursing and medical handovers.
- There is evidence that it was not uncommon practice for doctors not to document in the notes when they had attended patients.
- Nursing staff did not notify the house officer of the subsequent discovery of a head injury following the fall.
- There was no flag or warning system to identify patients on antiplatelet/ anticoagulation therapy, including in the DHB's electronic falls form.
- There was a lack of critical thinking by nursing staff, who continued to administer blood-thinning medication, and stopped neurological observations despite being told that he might have hit his head.
- There is no evidence that a falls assessment was undertaken following GTN use or after his fall.
- There was no face-to-face handover to the medical team from the night house officer.
- The nursing notes were not reviewed by the medical team during morning rounds.
- It appears that the knock to the head was not relayed verbally to the afternoon staff during the nursing handover.
- The nursing notes were not always reviewed by the incoming nursing staff.
- Additional medication would have been available when he was in palliative care, but the nurse was not aware of this.

Findings

The cumulative effect of these failings was that overall care was of a very poor standard. Consequently, the Commissioner found that the DHB did not provide the man with care with reasonable care and skill in breach of Right 4(1) of the Code

Recommendations

The Commissioner recommended that the DHB:

- Undertake an evaluation of the impact of the interventions put in place following its Serious and Sentinel Event Analysis.
- Provide an update in relation to the remainder of the recommendations made in the Serious and Sentinel Event Analysis regarding what has yet to be implemented, and when this will take place — including, but not limited to, the recommendations in relation to the review of patient notes and the documentation of clinical decision-making to ensure appropriate communication.
- Undertake an audit for the last six months from the date of this report, to assess whether patients who were diagnosed with a non-ST elevation myocardial infarction were admitted to the CCU in line with recommended practice.
- Undertake an audit to assess the appropriateness or otherwise of the use of the electronic notification tool.
- Provide a report to HDC identifying whether clinical matters that normally require face-to-face discussion or a telephone conversation are being actioned adequately in this way, as opposed to via the electronic notification tool.
- Undertake a review of its communication tools to ensure accurate handover between shifts. As part of this review, the DHB is to consider whether it should introduce a system such as the ISBAR sticker format, in line with expert advice.
- Provide evidence of its new alert system(s) flagging patients who are receiving antiplatelet and anticoagulation medications.
- Develop training for new doctors on how to prioritise their tasks when on call

In summary,

The Commissioner noted: "*The system lost sight of the patient through this process. Attention to the most basic aspects of monitoring, assessment, communication, and critical thinking were noticeably absent. This is well below the standard expected of hospital-level care in New Zealand. While staff may have been busy, they had the opportunity to consider the care of this patient, and simply failed to do so adequately — this was a collective failure of the system and the people operating in it, not the fault of any one individual. Nonetheless, the patient's experience resulted from a pattern of poor care, which reflects a sobering collection of suboptimal features."*

4) Seclusion of a young woman 17HDC00410

A woman in her late teens was transferred from a psychiatric unit at a public hospital to a clinic under a compulsory in-patient treatment order pursuant to section 30 of the Mental Health (Compulsory Treatment and Assessment) Act 1992 (the MHA). Over the previous year, she had presented with a significantly depressed and anxious mood associated with repeated self-harm behaviours, suicidal thoughts, and suicide attempts.

At a later date, the woman left the clinic. She was found by the police and taken to a locked unit at a psychiatric hospital, where she was assessed by a psychiatrist. There was no bed available on the locked unit, so she was transferred to a secure unit under Police restraint, as she continued to struggle.

When the woman arrived at the secure unit her clothing was removed and she was not given a tear-resistant gown to wear. The woman was placed in a seclusion room. Overnight, the lights were left on. She was also not provided with a mattress or a pillow, and was left with only a tear-resistant blanket and a cardboard bedpan.

A "seclusion recording form" details that two-hourly assessments and 10-minute observations occurred. At 4.30am two nurses recorded an 8-hourly assessment. The room was entered at 8.00am to provide food and fluids and to assess the woman, and again at 9.35am to provide fluids. At 11.05am, the room was entered again, and the woman was provided with a gown. A mattress was placed in the room, and the woman was told that they were working towards moving her to the locked unit.

At 1pm, the room was entered to allow the clinic staff to assess the woman's mood and mental state. At 1.10pm, the seclusion was suspended, and at 2.00pm it was terminated and the woman was returned to the clinic.

Findings

A number of staff failed to comply with the DHB seclusion guideline and the Ministry of Health seclusion requirements, and with the accepted standard of care for nursing staff. The mental health commissioner noted that DHBs are responsible for ensuring that staff comply with their policies and provide care of an acceptable standard, and the DHB failed to do so in this case.

The Mental Health Commissioner was not able to make a finding that the denial of clothing and bedding was a punitive action or intended to humiliate the patient; however, these actions were considered unacceptable and unkind.

The Mental Health Commissioner found that the manner of seclusion, over a period of approximately 18 hours, including removing of the patient's clothes, not providing her with a mattress, pillow or gown, and not dimming the lights overnight, meant that the DHB failed to respect the woman's dignity and independence in breach of Right 3 of the Code.

Recommendations

The DHB agreed to provide a written apology to the woman.

The DHB also agreed to undertake the following steps, with input from a consumer advisor:

- Provide training to the psychiatric hospital's mental health staff on restraint, seclusion, and the Code of Rights.
- Review its restraint minimisation and seclusion guidelines to ensure that they provide sufficient guidance on seclusion practices in line with the current Ministry of Health guidelines and any guidance from the Health Quality & Safety Commission.

- Review the seclusion policy to provide specific guidance on what consumers should be provided with when placed in seclusion, including clothing and bedding.

HDC's clinical advisor commented: "*Sometimes mental health nurses are faced with the need to use restrictive practices such as committal, forced use of medication, restraint, and seclusion. However, even in such adverse circumstances care can be provided with sensitivity, respect, and dignity. Even under conditions of coercion consumers will appreciate attempts to provide care respectfully. Of all the learning that can be taken from this incident, the point that would make the most immediate impact on patients' experience of care is the simple provision of every day comforts.*"