Complaints to the Health and Disability Commissioner involving District Health Boards

Report and Analysis for the Period 1 July to 31 December 2018

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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

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

Citation: The Health and Disability Commissioner. 2019. *Complaints to the Health and Disability Commissioner involving District Health Boards: Report and Analysis for the period 1 July to 31 December 2018.*

Published in June 2019
by the Health and Disability Commissioner
PO Box 1791, Auckland 1140

This report is available on our website at www.hdc.org.nz

Contents

Commissioner's Foreword

I am pleased to present you with HDC's six-monthly DHB complaint report for July–December 2018. The report details the trends in complaints received by HDC about DHBs between 1 July and 31 December 2018.

The number of complaints received about DHBs in July–December 2018 is very similar to the average number of complaints received over the past four six-month periods. The trends detailed in the report also remain broadly consistent with the trends reported across previous periods. However, there has been a small increase in the proportion of complaints about mental health services, from 20% of all complaints about DHBs in previous periods to 25% in July–December 2018.

I note that for around 15% of complaints about DHBs, the complainant raised issues relating to the prescribing or administration of medication. In December 2018, I published a report detailing an analysis of complaints closed by my Office within a seven-year period where a medication error was found to have occurred. The aim of this report was to shed light on patterns regarding contributing factors that lead to medication error. The report also collates the lessons from the findings and from the case examples detailed in the report, in order to assist providers and organisations to recognise and address factors that contribute to medication errors. This report is available on our website.

The analysis found that around 22% of medication errors in the complaints data occurred in public hospitals. I was struck by the number of errors in which a failure to follow policies and procedures was a contributing factor. A failure by multiple staff to follow policies and procedures can point to a system that has allowed a culture of tolerance to emerge — where the suboptimal has become normal, and not following policies and procedures has become everyday practice. Organisational leaders must be alert to such issues, and ensure that staff are supported to do what is required of them, and that a culture is fostered where adherence to policies/procedures is "the way we do things around here".

Every complaint is an opportunity to learn. I encourage all providers when reading both the medication error report and this current report to consider, "Could this happen at my place?" and, if so, what changes could be made to prevent it.

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 2018, HDC received a total of **442**[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

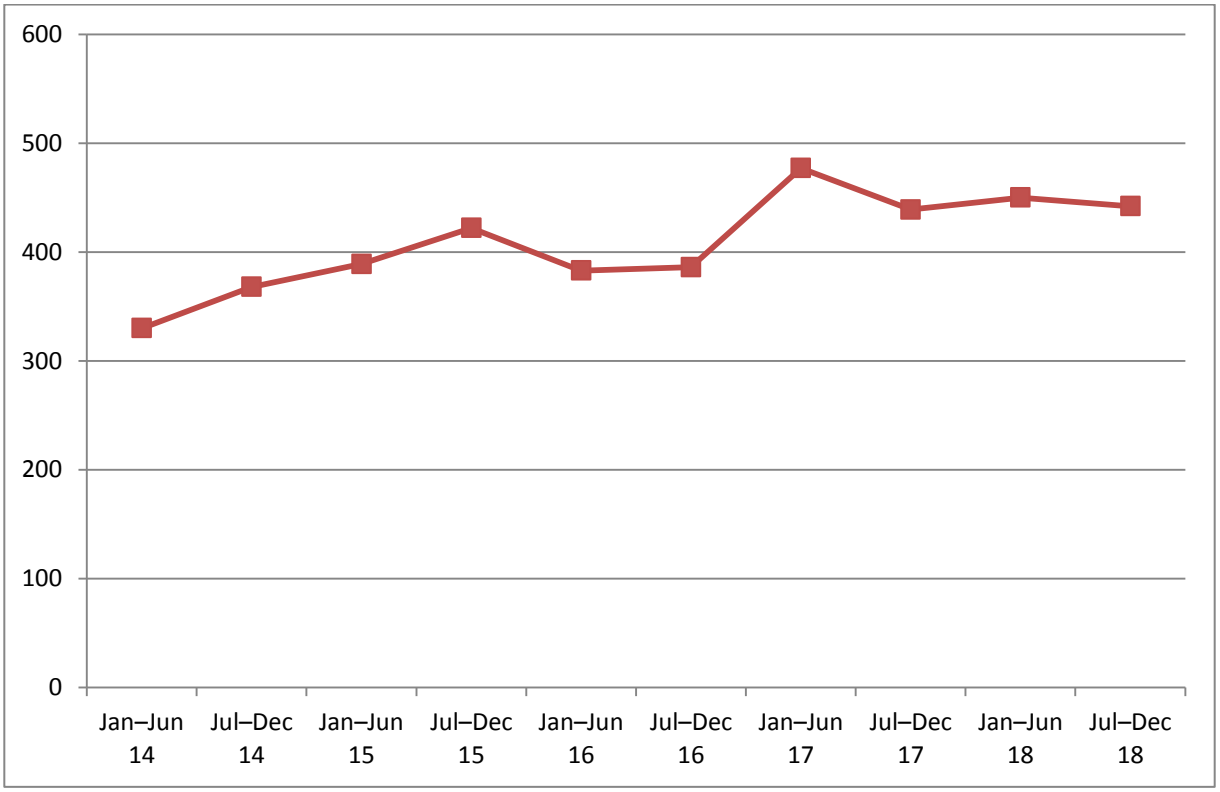
Table 1. Number of complaints received in the last five years

	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Average of last 4 6-month periods	Jul–Dec 18
Number of complaints	330	368	389	422	383	386	477	439	450	**438**	**442**

The total number of complaints received in Jul–Dec 2018 (442) shows a very small increase over the average number of complaints received in the previous four periods, but a very small decrease on the number of complaints received in Jan–Jun 2018.

The number of complaints received in Jul–Dec 2018 and previous six-month periods are also displayed below in Figure 1.

Figure 1. Number of complaints received



[1] Provisional as of date of extraction (4 February 2019).

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 (11 April 2019) 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 2018

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
442	496,771	**88.97**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jul–Dec 2018 and previous six-month periods.

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

	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18[2]	Average of last 4 6-month periods	Jul–Dec 18
Rate per 100,000 discharges	72.99	76.65	84.60	87.57	81.44	78.79	99.08	88.23	93.80	**89.98**	**88.97**

The rate of complaints received during Jul–Dec 2018 (88.97) is very similar to 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 2018 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 2018

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	66	62366	105.83
Bay of Plenty	18	27024	66.61
Canterbury	39	56840	68.61
Capital and Coast	38	30297	125.42
Counties Manukau	39	51466	75.78
Hawke's Bay	10	18503	54.05
Hutt Valley	25	16909	147.85
Lakes	11	12469	88.22
MidCentral	15	15627	95.99
Nelson Marlborough	21	12496	168.05
Northland	16	20875	76.65
South Canterbury	5	6064	82.45
Southern	45	27813	161.79
Tairāwhiti	8	5462	146.47
Taranaki	2	13814	14.48
Waikato	39	50391	77.39
Wairarapa	9	4429	203.21
Waitemata	45	53695	83.81
West Coast	6	3300	181.82
Whanganui	2	6931	28.86

Notes on DHB's number and rate of complaints

It should be noted that a DHB's number and rate of complaints can vary considerably from one six-month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six-month period. 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 hospital; therefore, although there were 442 complaints about DHBs, 469 services were complained about.

Surgical services (30.1%) received the greatest number of complaints in Jul–Dec 2018, with general surgery (8.1%) and orthopaedics (7.7%) being the surgical specialties most commonly complained about. Other commonly complained about services included mental health (24.7%), medicine (15.1%) and emergency department (12.2%) services. This is broadly similar to what has been seen in previous periods, with the exception of mental health services, which increased from being responsible for around 20% of complaints about DHBs in previous periods to around 25% of complaints in Jul–Dec 2018.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Alcohol and drug	**8**	**1.7%**
Anaesthetics/pain medicine	**5**	**1.1%**
Dental	**4**	**0.9%**
Diagnostics	**9**	**1.9%**
Disability services	**10**	**2.1%**
District nursing	**2**	**0.4%**
Emergency department	**57**	**12.2%**
Intensive care/critical care	**2**	**0.4%**
Maternity	**16**	**3.4%**
Medicine	**71**	**15.1%**
General medicine	11	2.3%
Cardiology	10	2.1%
Dermatology	1	0.2%
Endocrinology	1	0.2%
Gastroenterology	10	2.1%
Geriatric medicine	2	0.4%
Haematology	2	0.4%
Neurology	10	2.1%
Oncology	3	0.6%
Palliative care	1	0.2%
Renal/nephrology	4	0.9%
Respiratory	4	0.9%
Other/unspecified	12	2.6%
Mental health	**116**	**24.7%**
Paediatrics (not surgical)	**17**	**3.6%**
Physiotherapy	**2**	**0.4%**
Rehabilitation services	**3**	**0.6%**
Surgery	**141**	**30.1%**
Cardiothoracic	4	0.9%
General	38	8.1%
Gynaecology	15	3.2%
Neurosurgery	3	0.7%
Ophthalmology	13	2.8%
Oral/Maxillofacial	3	0.6%
Orthopaedics	36	7.7%
Otolaryngology	5	1.1%
Paediatric	2	0.4%
Plastic and Reconstructive	7	1.5%
Urology	10	2.1%
Vascular	3	0.6%
Unknown	2	0.4%
Other/unknown health service	**6**	**1.3%**
TOTAL	**469**	

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 2018 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	***80***	***18.1%***
ACC compensation issue	2	0.5%
Lack of access to services	40	9.0%
Lack of access to subsidies/funding	7	1.6%
Waiting list/prioritisation issue	31	7.0%
Boundary violation	***1***	***0.2%***
Care/Treatment	***203***	***45.9%***
Delay in treatment	9	2.0%
Delayed/inadequate/inappropriate referral	1	0.2%
Inadequate coordination of care/treatment	11	2.5%
Inadequate/inappropriate clinical treatment	25	5.7%
Inadequate/inappropriate examination/assessment	15	3.4%
Inadequate/inappropriate follow-up	11	2.5%
Inadequate/inappropriate monitoring	3	0.7%
Inadequate/inappropriate non-clinical care	4	0.9%
Inadequate/inappropriate testing	1	0.2%
Inappropriate admission/failure to admit	1	0.2%
Inappropriate/delayed discharge/transfer	9	2.0%
Inappropriate withdrawal of treatment	5	1.1%
Missed/incorrect/delayed diagnosis	60	13.6%
Refusal to assist/attend	1	0.2%
Refusal to treat	3	0.7%
Rough/painful care or treatment	3	0.7%
Unexpected treatment outcome	39	8.8%
Unnecessary treatment/over-servicing	2	0.5%
Communication	***38***	***8.6%***
Disrespectful manner/attitude	17	3.8%
Failure to communicate openly/honestly/effectively with consumer	15	3.4%
Failure to communicate openly/honestly/effectively with family	4	0.9%
Insensitive/inappropriate comments	2	0.5%
Complaints process	***6***	***1.4%***
Inadequate response to complaint	6	1.4%
Consent/Information	***53***	***12.0%***
Consent not obtained/adequate	15	3.4%
Inadequate information provided regarding adverse event	1	0.2%
Inadequate information provided regarding condition	1	0.2%

Primary issue in complaints	Number of complaints	Percentage
Inadequate information provided regarding fees/costs	2	0.5%
Inadequate information provided regarding options	1	0.2%
Inadequate information provided regarding provider	1	0.2%
Inadequate information provided regarding results	3	0.7%
Inadequate information provided regarding treatment	3	0.7%
Issues regarding consent when consumer not competent	3	0.7%
Issues with involuntary admission/treatment	23	5.2%
Documentation	***5***	***1.1%***
Delay/failure to disclose documentation	2	0.5%
Inadequate/inaccurate documentation	3	0.7%
Facility issues	***17***	***3.8%***
General safety issue for consumer in facility	10	2.3%
Inadequate/inappropriate policies/procedures	3	0.7%
Staffing/rostering/other HR issues	1	0.2%
Waiting times	2	0.5%
Other	1	0.2%
Medication	***24***	***5.4%***
Administration error	2	0.5%
Prescribing error	5	1.1%
Inappropriate administration	1	0.2%
Inappropriate prescribing	6	1.4%
Refusal to prescribe/dispense/supply	10	2.3%
Other professional conduct issues	***8***	***1.8%***
Disrespectful behaviour	1	0.2%
Inappropriate collection/use/disclosure of information	2	0.5%
Other	5	1.1%
Disability-related issues	***1***	**0.2%**
Other issues	***6***	***1.4%***
TOTAL	**442**	

The most common primary issue categories were:

- Care/treatment (45.9%)
- Access/funding (18.1%)
- Consent/information (12.0%)
- Communication (8.6%)

The most common specific primary issues complained about in complaints about DHBs were:

- Missed/incorrect/delayed diagnosis (13.6%)
- Lack of access to services (9.0%)
- Unexpected treatment outcome (8.8%)
- Waiting list/prioritisation issue (7.0%)
- Inadequate/inappropriate treatment (5.7%)

Table 7 shows a comparison over time for the top five primary issues complained about. The top five primary issues have remained broadly consistent over time. There was a small decrease in the

proportion of complaints primarily regarding an “unexpected treatment outcome” and a “waiting list/prioritisation issue” in Jul–Dec 2018, and a small increase in the proportion of complaints primarily regarding “lack of access to services”.

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 17 n=477		**Jul–Dec 17 n=439**		**Jan–Jun 18 n=450**		**Jul–Dec 18 n=442**	
Misdiagnosis	15%	Misdiagnosis	12%	Misdiagnosis	13%	Misdiagnosis	14%
Waiting list/ prioritisation	10%	Waiting list/ prioritisation	10%	Unexpected treatment outcome	12%	Lack of access to services	9%
Unexpected treatment outcome	9%	Unexpected treatment outcome	8%	Waiting list/ prioritisation	11%	Unexpected treatment outcome	9%
Inadequate treatment	6%	Inadequate treatment	7%	Lack of access to services	6%	Waiting list/ Prioritisation	7%
Lack of access to services	6%	Lack of access to services	6%	Inadequate treatment	4%	Inadequate treatment	6%

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	***108***	***24.4%***
ACC compensation issue	2	0.5%
Lack of access to services	52	11.8%
Lack of access to subsidies/funding	9	2.0%
Waiting list/prioritisation issue	50	11.3%
Boundary violation	***3***	***0.7%***
Care/Treatment	***341***	***77.1%***
Delay in treatment	81	18.3%
Delayed/inadequate/inappropriate referral	10	2.3%
Inadequate coordination of care/treatment	73	16.5%
Inadequate/inappropriate clinical treatment	150	33.9%
Inadequate/inappropriate examination/assessment	120	27.1%
Inadequate/inappropriate follow-up	50	11.3%
Inadequate/inappropriate monitoring	40	9.0%
Inadequate/inappropriate non-clinical care	33	7.5%
Inadequate/inappropriate testing	49	11.1%
Inappropriate admission/failure to admit	7	1.6%
Inappropriate/delayed discharge/transfer	50	11.3%
Inappropriate withdrawal of treatment	9	2.0%
Missed/incorrect/delayed diagnosis	85	19.2%
Personal privacy not respected	7	1.6%
Refusal to assist/attend	18	4.1%
Refusal to treat	14	3.2%
Rough/painful care or treatment	21	4.8%
Unexpected treatment outcome	61	13.8%
Unnecessary treatment/over-servicing	7	1.6%
Communication	***308***	***69.7%***
Disrespectful manner/attitude	79	17.9%
Failure to accommodate language/cultural needs	5	1.1%
Failure to communicate openly/honestly/effectively with consumer	164	37.1%
Failure to communicate openly/honestly/effectively with family	121	27.4%
Insensitive/inappropriate comments	7	1.6%
Complaints process	***71***	***16.1%***
Inadequate response to complaint	68	15.4%
Other	4	0.9%
Consent/Information	***111***	***25.1%***
Consent not obtained/adequate	28	6.3%
Failure to assess capacity to consent	1	0.2%
Inadequate information provided regarding adverse event	9	2.0%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding condition	13	2.9%
Inadequate information provided regarding fees/costs	2	0.5%
Inadequate information provided regarding options	6	1.4%
Inadequate information provided regarding provider	6	1.4%
Inadequate information provided regarding results	7	1.6%
Inadequate information provided regarding treatment	31	7.0%
Incorrect/misleading information provided	9	2.0%
Issues regarding consent when consumer not competent	4	0.9%
Issues with involuntary admission/treatment	23	5.2%
Documentation	***26***	***5.9%***
Delay/failure to disclose documentation	5	1.1%
Inadequate/inaccurate documentation	19	4.3%
Other	4	0.9%
Facility issues	***65***	***14.7%***
Accreditation standards/statutory obligations not met	2	0.5%
Cleanliness/hygiene issue	5	1.1%
Failure to follow policies/procedures	5	1.1%
General safety issue for consumer in facility	20	4.5%
Inadequate/inappropriate policies/procedures	19	4.3%
Issue with quality of aids/equipment	5	1.1%
Issue with sharing facility with other consumers	4	0.9%
Staffing/rostering/other HR issues	10	2.3%
Waiting times	6	1.4%
Other	2	0.5%
Medication	***68***	***15.4%***
Administration error	4	0.9%
Inadequate storage/security	2	0.5%
Inappropriate administration	8	1.8%
Inappropriate prescribing	35	7.9%
Prescribing error	6	1.4%
Refusal to prescribe/dispense/supply	18	4.1%
Reports/Certificates	***10***	***2.3%***
Inaccurate report/certificate	9	2.0%
Refusal to complete report/certificate	1	0.2%
Teamwork/supervision	***14***	***3.2%***
Delayed/inadequate/inappropriate handover	2	0.5%
Inadequate supervision/oversight	12	2.7%
Other professional conduct issues	***26***	***5.9%***
Disrespectful behaviour	9	2.0%
Inappropriate collection/use/disclosure of information	7	1.6%
Other	11	2.5%
Disability-related issues	***3***	
Other issues	***12***	

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

- Care/treatment (present for 77.1% of all complaints)
- Communication (present for 69.7% of all complaints)
- Consent/information (present for 25.1% of all complaints).
- Access/funding (present for 24.4% of all complaints)

The most common specific issues were:

- Failure to communicate effectively with consumer (37.1%)
- Inadequate/inappropriate clinical treatment (33.9%)
- Failure to communicate effectively with family (27.4%)
- Inadequate/inappropriate examination/assessment (27.1%)
- Missed/incorrect/delayed diagnosis (19.2%)
- Delay in treatment (18.3%)
- Disrespectful manner/attitude (17.9%)
- Inadequate coordination of care/treatment (16.5%)
- Inadequate response to the consumer's complaint by the DHB (15.4%)

These issues are broadly similar to what was seen last period.

3.3 Service type and primary issues

Table 9 shows the top three primary issues in complaints concerning the most commonly complained about service types. This is broadly similar to what was seen in the last six-month period, with the exception of "lack of access to services", which became more prominent for surgical services.

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

Surgery n=141		**Mental health n=116**		**Medicine n=71**		**Emergency department n=57**	
Unexpected treatment outcome	21%	Issues with involuntary admission/ Treatment	20%	Missed/ incorrect/ delayed diagnosis	15%	Missed/ incorrect/ delayed diagnosis	39%
Waiting list/ prioritisation issue	16%	Lack of access to services	10%	Lack of access to services	8%	Waiting list/ prioritisation issue	12%
Lack of access to services	16%	Inadequate/ inappropriate examination/ assessment	10%	Inadequate/ inappropriate treatment & inadequate coordination of care/treatment	7%	Disrespectful manner/attitude	11%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **449**[4] complaints involving DHBs in the period Jul–Dec 2018. 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 14	**Jul–Dec 14**	**Jan–Jun 15**	**Jul–Dec 15**	**Jan–Jun 16**	**Jul–Dec 16**	**Jan–Jun 17**	**Jul–Dec 17**	**Jan–Jun 18**	**Average of last 4 6-month periods**	**Jul–Dec 18**
Number of complaints closed	411	344	410	365	482	316	465	383	476	**410**	**449**

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 2018 period, 11 DHBs had no investigations closed, 8 DHBs had one investigation closed, and 1 DHB had three investigations closed.

The manner of resolution and outcomes of all complaints about DHBs closed in Jul–Dec 2018 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	***11***
Breach finding — referred to Director of Proceedings	1
Breach finding	6
No breach finding with recommendations or educational comment	3
No breach finding	1
Other resolution following assessment	***429***
No further action[6] with recommendations or educational comment	88
Referred to Ministry of Health	7
Referred to District Inspector	19
Referred to other agency	1
Referred to DHB[7]	112
Referred to the Advocacy Service	63
No further action	135
Withdrawn	4
Outside jurisdiction	***9***
TOTAL	**449**

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 2018. Please note that more than one recommendation may be made in relation to a single complaint.

[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 expert 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.

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	11
Audit	11
Case review	5
Meeting with consumer	4
Presentation/discussion of complaint with others	7
Provision of evidence of change to HDC	29
Reflection	2
Review/implementation of policies/procedures	24
Training/professional development	15
Total	**108**

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 (29 recommendations). Often, when HDC asks for this evidence, it is also recommended that the provider conduct a review of the effectiveness of the changes made. Conducting a review of their policies/procedures or implementing new policies/procedures (24 recommendations) was also often recommended. 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.

5.0 Learning from complaints — HDC case reports

Delay in advising consumer of MRI scan results and arranging follow-up (16HDC01980)

Background
A woman saw an otolaryngologist (the surgeon) for significant right-sided hearing loss. The surgeon referred her for an MRI scan. The MRI scan was performed and the written report, which was available electronically later the same day, stated that a vestibular schwannoma[8] was seen. No action was taken in respect of these results at that time.

Nine months later, the MRI report results were discovered to be still "unacknowledged" in the electronic system after a project was undertaken to address the clinical risk of unacknowledged results. The surgeon was then alerted to the result and he arranged for the woman to be seen by another specialist. The surgeon did not contact the woman to advise her of the result. The woman was first made aware of the result when she was seen by the specialist a few months later. Subsequently, the woman underwent surgical removal of the tumour.

At the time of these events, the DHB was using both an electronic and a paper-based results system. The surgeon routinely used the paper-based system. While access logs show that he viewed the report the day after it was issued, the surgeon cannot recall this and said that he did not receive a paper copy of the woman's result and, accordingly, did not action it. At the time there was no requirement that clinicians acknowledge test results in the electronic system. When such a requirement was introduced, the new policy stated that every week a compliance summary report would be circulated to senior medical officers to inform them of their outstanding unacknowledged results. This did not occur in relation to the woman's MRI result.

Findings
The Commissioner stated that DHBs have a responsibility to have in place clear, effective, and formalised systems for the reporting and follow-up of test results, in order to enable their staff to action test results appropriately. The Commissioner was concerned by the lack of any formalised systems or processes in place around the reporting and follow-up of test results at the DHB at the time of these events. In particular, he noted that the electronic system was operating concurrently with the paper tracking system, and there were no requirements around the acknowledgement of test results. When such a requirement was introduced, the failure to send out a weekly compliance summary report to the surgeon after the implementation of the new policy contributed to the result not being picked up. As a result, the Commissioner found that the DHB did not provide services to the woman with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner was critical of the surgeon for the delay in arranging follow-up in a timely manner after the woman's MRI, and for the woman not having been advised of the results at the time, but considered that this was primarily a result of a lack of a clear, effective, and formalised system within the DHB and, therefore, was not solely attributable to the surgeon.

However, the Commissioner considered that the surgeon should have contacted the woman directly to inform her that she had a vestibular schwannoma once he was alerted to the MRI report being unacknowledged. In the Commissioner's view, after a nine-month delay a reasonable consumer in the woman's circumstances would want to receive the results as soon as possible, and be provided with an explanation for the delay. For failing to provide the woman with this information, the Commissioner found the surgeon in breach of Right 6(1) of the Code.

Recommendations
The Commissioner asked that the DHB provide his Office with a report detailing the findings of its most recent audit of the electronic medical records system in relation to acknowledgement of

[8] A benign tumour of the balance nerve.

electronic laboratory/radiology results, including the details of corrective actions taken in the event of any adverse findings. This recommendation was met.

Care of man with complex mental health issues (15HDC01279)

Background

A man with a history of mental health and alcohol dependence issues was admitted to a public hospital following an episode of self-harm. He was diagnosed with adjustment disorder, alcohol dependence, and likely antisocial personality disorder. He was treated as an outpatient after declining voluntary admission to the Acute Psychiatric Unit (APU). After being seen several times by the Triage Assessment and Crisis Team, he was referred by them to the Alcohol and Drug Service (AOD). His AOD keyworker drafted a personal crisis plan.

The following month, the man called the Mental Health and Addiction Service (MHAS) Crisis Team number threatening self-harm, and was admitted to the APU. He was discharged two days later with a moderate to high risk of harm to self and/or others. The plan was for ongoing AOD follow-up.

Over the next few days the man sent two inappropriate texts to his AOD worker. He also told her that he had abused his prescription drugs but then retracted that statement. The keyworker discussed this statement with the psychiatrist who had assessed the man during his first admission to APU, and it was agreed that the man would remain at home, continue engaging with AOD, and call the Crisis Team if needed. After the second inappropriate text, the keyworker discussed the messages with the psychiatrist, who suggested that a formal complaint be made to the police and the keyworker's manager. The keyworker said that she was not told to complete an incident form.

A few days later, the man was voluntarily admitted to the APU following a call to the MHAS Crisis Team. During this admission he was visited by a friend, who offered to be a support person. On discharge, the nurse recorded that the man continued to be a moderate to high risk in the community for harm to himself and others. She noted that he had the Crisis Team number and a crisis plan. The crisis plan was the plan mentioned above — it had not been updated.

On the day of discharge, a Complex Case Conference was held to discuss the man's care. The keyworker then drafted a management plan. The case management plan included a plan that if the man made any threats of self-harm, the appointment would be cancelled immediately, the police would be contacted, and he would be discharged from the AOD. Four days after the conference, the man, accompanied by a support person, attended an appointment with the keyworker. During this appointment, the keyworker discussed the plan with him, and said that she still encouraged him to seek support if he felt suicidal. The man's support person said that the keyworker advised the man that she could not help him if he was going to continue to make suicidal threats.

Nine days later, the man sent the keyworker a text message stating that he wanted to die. When the keyworker called him, the man reported a number of stressors and stated that he did not want to live, although he denied any specific suicidal plans due to fear of the police being called. The keyworker stated that during this call the man requested discharge from AOD. Later that day, the keyworker visited the man and recorded that he had on-going suicidal ideation, was using an intoxicating substance, appeared depressed, and was expressing thoughts of hopelessness. She also recorded that the man expressed no interest in addressing his issues regarding alcohol and substance misuse, and no intention of attending appointments with her. She informed him that he would be discharged from AOD owing to his unwillingness to engage in the treatment being offered.

A psychiatrist (different from the psychiatrist referred to above) was informed of the visit and agreed that the man should be discharged from AOD. The management plan was updated that day, confirming that the man would be discharged owing to non-engagement with his treatment plan.

The keyworker presented the man's case at a multi-disciplinary team meeting at which the psychiatrist was present. The man was discharged from AOD. The risk assessment recorded that the man was at chronic risk of suicide, and noted the current factors that placed him at high risk to himself, including limited social support.

Some weeks later, the man was found dead at his home.

Findings

The Mental Health Commissioner was concerned that the DHB failed to have in place an accurate and up-to-date crisis plan for the man prior to his discharge following the second admission to APU. HDC's clinical advisor noted that there appeared to have been little development of the supports needed for his ongoing care in the community, when he had many ongoing stressors and his risk assessment was sitting on moderate to high for self-harm behaviours. She noted that there was heavy reliance on access to secondary health services and the police, and there was no inclusion of his support people, who had been identified as a contact for support. The Mental Health Commissioner stated that given the complexity of his case and his ongoing risk, it was important that the man's crisis plan was accurate and up to date, and appropriately reflected his needs.

The Mental Health Commissioner also considered that the Complex Case Conference Management Plan was inappropriate. He was particularly concerned that the plan prescribed discharge from AOD services in response to threats to self or others, and was also concerned that the plan was developed without the man's input and did not make reference to his support people. The Mental Health Commissioner was critical of the DHB for failing to have in place clear policies, procedures, or terms of reference for Complex Case Conferences that included clear processes and decision-making responsibilities and accountability. This lack of clarity meant that an inappropriate plan that focused on dictating the man's behaviour rather than supporting him, was able to be developed and communicated to him.

Finally, the Mental Health Commissioner was critical that the man's request for discharge was taken at face value, and that he was discharged from AOD without greater consideration of other ways to foster his engagement, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse. The Mental Health Commissioner was particularly concerned given that it followed the communication to the man of the punitively worded Complex Case Management Conference Plan discussed above.

The Mental Health Commissioner acknowledged that the man's needs were complex and that he required support from both mental health and addiction services, and that police support and intervention was at times required. However, the Mental Health Commissioner was concerned that towards the end of the man's care, emphasis appears to have been placed on dictating his behaviour, and support and guidance for staff were lacking. The Mental Health Commissioner considered that a more compassionate and consumer-focused approach could reasonably have been taken. For the failings noted above, the Mental Health Commissioner found that the DHB failed to provide services to the man with reasonable care and skill, in breach of Right 4(1) of the Code.

Adverse comment was made in relation to the DHB for:

- not effectively assimilating the man's care into a dual diagnosis understanding;
- the limited planning around early psychiatric input following the man's discharges;
- the lack of psychiatric input within the community;
- the lack of an apparent strengths-based approach;
- a lack of DHB policies in place to assist the keyworker in the performance of her role; and
- AOD policies that had deficiencies in the guidance they provided in relation to psychiatric involvement.

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

- Implement professional supervision for clinical staff working in the AOD Service.
- Assess its mental health and addiction services with reference to strengths-based practice to identify service improvements, and obtain input from family/whānau and consumer representatives in that assessment. The assessment should include consideration of consumer and family/whānau engagement in care planning and ensuring that implementation of improvements identified by the assessment can be monitored.
- Report on the findings and actions taken as a result of the DHB's independent review of the assessment, care, and treatment of clients with dual diagnosis, and implement professional supervision for clinical staff working in this area.
- Report on progress in implementing new terms of reference for Complex Case Conferences that set out, amongst other things, lines of responsibility for decision-making and requirements for minutes to be taken.
- Review policies and procedures in relation to boundary setting (including sexual safety for staff); professional supervision; incident reporting; discharge from the service; client engagement; and changing case workers, with reference to findings from this decision.
- Review the orientation of new staff to ensure that they are provided with training and appropriate supervision in relation to the above policies, including knowledge of escalation pathways when issues arise.

These recommendations have been met.

Adequacy and appropriateness of steps taken to ensure fitness to practice (15HDC01280)

Background
An overseas trained orthopaedic surgeon (the surgeon) applied for a job with a DHB. The recruitment policy at the DHB required at least two references, at least one of which needed to be from a previous manager (preferably the current or most recent manager). The DHB's credentialling checklist also required a written reference from colleagues within the last 12 months. When applying for the position, the surgeon had provided three written references from orthopaedic surgeons with whom he had worked overseas more than two years previously. The references alluded to communication difficulties, and noted concerns regarding demeanour and personality. Contrary to the recruitment policy, the surgeon was not asked to provide any references from his most recent workplace.

Another orthopaedic surgeon acted as the surgeon's supervisor. The DHB had no guidelines or policies in relation to supervision requirements, and relied on clinicians adhering to Medical Council of New Zealand supervision guidelines. The supervising surgeon advised HDC that he was not given enough time for supervision, and that in order to do the job properly he would have needed to drop clinical time.

During the surgeon's time at the DHB, complaints management was a manual process. An administrator received and acknowledged complaints before passing the complaint to the Service Manager or Business Manager for response. Three written complaints were received regarding the surgeon's manner of communication, personality, and demeanour. These complaints were dealt with in writing by the Business Manager, who reported discussing two of the responses with the surgeon. The supervising surgeon was not made aware of these complaints.

When a new Business Manager took over, she was not advised of any concerns regarding the surgeon. Further, the complaints database at the time did not name clinicians, and so an emerging pattern of concerns was not evident. No complaints were forwarded to the Human Resources Department, and the complaints policy did not provide guidance on situations where there were multiple complaints against one individual.

Two further patients complained. By this time, the surgeon was no longer under supervision. However, by this time the new Business Manager had identified that the surgeon was receiving more complaints than his orthopaedic colleagues, and this was raised with senior management.

One of the surgeon's colleagues then sent a formal letter of complaint to management stating that he would resign if his concerns regarding the surgeon were not dealt with. As a result, the Business Manager, Head of Surgery, and the Chief Medical Advisor decided that an external review of the surgeon's practice was required, and an extension to his contract was cancelled. The external review found that before moving to New Zealand the surgeon had received complaints while working overseas. The Head of Surgery and the Chief Medical Advisor, amongst others at the DHB, were aware of these complaints.

Findings

The DHB is subject to a legal duty to provide health services with reasonable care and skill. As part of this, the DHB has an obligation to take reasonable steps to ensure that its clinical staff are competent and fit to practise, in order to protect its patients. It has an obligation to select competent staff and monitor their continued competence, provide proper orientation and supervision of its staff, and establish systems necessary for the safe operation of its hospitals.

Additionally, DHBs should have a culture that supports safe care, identifies risks to patient safety promptly, and responds appropriately. There should be effective systems for clinical supervision, performance management, incident reporting, complaints management, and credentialling, together with traditional audits of morbidity and mortality within specialities. DHBs are responsible for ensuring that such systems are in place and that staff are supported to comply with them.

In relation to this case, HDC's advisor noted: "[T]hat an IMG locum tenens under MCNZ supervision could have five written complaints within three years and the supervisor, and head of department, not be notified or engaged in the management of those complaints represents a major departure from standard hospital management practice."

The Commissioner accepted this advice and considered that by failing to have in place appropriate systems relating to recruitment and complaints management, the DHB failed in its duty of care. This was evidenced by its lack of care in how it employed the surgeon, most notably by failing to secure a recent reference, and by failing to have in place adequate systems to identify an emerging pattern of concerns about the surgeon, and to enable the appropriate staff (including the surgeon's supervisor and head of department) to be aware of, and ultimately respond to, that emerging pattern. The Commissioner considered that by failing in this duty of care, the DHB failed to provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner made adverse comment in relation to the lack of guidelines or policies in place at the DHB at the time in relation to supervision; the failure to facilitate the supervision process by ensuring that enough time and resources were set aside for this to happen; and inadequacies in relation to the DHB's induction and orientation process.

Recommendations
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 IMGs.

- Ensure that supervisors are aware of their responsibilities in regard 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 the 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 its 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.

Informed consent for the use of human products (16HDC00877)

Background
An orthopaedic surgeon (the operating surgeon) recommended that a man who had sustained a neck injury undergo an anterior cervical discectomy and fusion surgery. The operating surgeon did not recall the discussion, but said it was likely that he discussed using an allograft (using donated material) rather than harvesting an iliac crest (hip) graft from the man.

The man was seen by an orthopaedic medical officer for a pre-admission appointment. The man recalls being told that bone shavings would be taken from his hip and put between the vertebrae in his neck. The medical officer does not recall what he told the man, but said they he would have explained the operation in general terms but not the type of bone graft.

The operating surgeon saw the man again a few months later. The man said he was told that the damaged bone between his vertebrae would be repacked with bone from his hip, and his hip would be quite painful and he might have trouble sitting down after the operation.

On the day of surgery, another orthopaedic surgeon (the consenting surgeon) saw the man to obtain his informed consent to the surgery. This surgeon does not remember the conversation he had with the man, but said that he relied solely on the available medical records, and he consented the man for the procedure stated in the clinical records. The consenting surgeon said that there was no documented preoperative plan to use an allograft, and he was not aware that it was the operating surgeon's usual practice to use an allograft.

The man said that following the operation, he asked the consenting surgeon three times why his hip was not sore and, each time, the consenting surgeon "talked around the subject".

The man said that in the orthopaedic outpatient clinic a few months later, he asked the same questions about his hip bone, and the operating surgeon told him that no bone was taken from his hip, and bone from a dead person had been put in his neck. The operating surgeon did not record that the man had any concerns about the informed consent process.

Findings

The Commissioner considered that the operating surgeon failed to provide the man with sufficient information about the proposed treatment, which was information a reasonable consumer in that man's circumstances would expect to receive. Accordingly, the operating surgeon was found in breach of Right 6(1) of the Code. Further, the operating surgeon did not make it clear to other clinicians that an allograft was planned, and the consenting surgeon was unaware that it was the operating surgeon's usual practice to use an allograft. Consequently, the clinicians who saw the man were unable to provide the necessary information to him. The Commissioner considered that it was the operating surgeon's responsibility to ensure co-operation among providers to ensure quality and continuity of services, and that the operating surgeon failed to do so, in breach of Right 4(5) of the Code.

The Commissioner was also critical of the operating surgeon's documentation. The operating surgeon failed to record his intention to use an allograft, the information he gave to the man, and his conversations with the man regarding the man's concerns about informed consent and the plan to use an allograft. The Commissioner considered that because of these failures, the operating surgeon failed to comply with professional and legal standards, in breach of Right 4(2) of the Code.

The Commissioner considered that it was the consenting surgeon's responsibility to ascertain the planned procedure, so that he would be in a position to inform the man. As there was no information in the clinical records about the graft procedure to be undertaken, the consenting surgeon should have contacted the operating surgeon to clarify the plan before talking to the man. The consenting surgeon did not inform the man that donated material was intended to be used in his surgery, or discuss the other options available to him. That was information that a reasonable consumer in the man's circumstances would expect to receive, and without that information the man was not in a position to make an informed choice and give informed consent for the treatment provided. Accordingly, the consenting surgeon was found in breach of Right 6(1) and Right 7(1) of the Code.

The process at the DHB at that time was that it was not necessary to obtain consent for the use of donated material if the use of that material carried no risk. The Commissioner noted that the determination of what information must be provided to a patient is not an assessment of risk. The man had the right to choose between the available options. In order to make that choice, he required an explanation of the options, and the risks and benefits of each. A reasonable person in the man's circumstances would want to know whether the surgery would include a procedure on his hip, and whether or not the use of donated material was planned.

The Commissioner considered that providing services with reasonable care means operating a system that ensures that patients do not receive services unless they have been fully informed and have given consent to them. The DHB did not provide the man with information that a reasonable consumer would expect to receive and, accordingly, the Commissioner found the DHB in breach of Right 6(1)(b) of the Code.

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

- Provide HDC with a copy of its amended informed consent policy requiring explicit consent for the use of allograft material.

- Review its "Agreement to Treatment" form with a view to including a prompt for consent to the use of human products in all procedures where human products are used.

- Provide HDC with a copy of its amended "Agreement to Treatment" form that provides a space for the surgeon to counter-sign the consent stating that the patient has been informed appropriately if consent has been taken by another clinician.

- Review the consistency of the use of surgical checklists in orthopaedic surgery and report to HDC on the outcome, and the steps being taken to ensure full compliance if practice is found to be inconsistent.

The Commissioner recommended that the operating surgeon attend training courses on record-keeping and communication with patients and colleagues.

These recommendations have been met.