

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

**Report and Analysis for the period 1 January to 30 June 2019**

**Feedback**

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

**Author**

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

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## Commissioner's Foreword

I am pleased to present you with HDC's second six monthly DHB complaint report for the 2018/2019 year. This report details the trends in complaints received by HDC about DHBs between 1 January and 30 June 2019.

HDC received 427 complaints about DHB services between January and June 2019. This is a small decrease on the average number of 452 complaints. 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 misdiagnosis being the most common primary issue.

However, I note that there has been a slight increase in the number of complaints received by HDC about mental health services in the 2018/19 year. Complaints about these services increased from 20% of complaints in previous years to 23% in 2018/19. There are a number of factors that could be contributing to this small increase. These include a mental health workforce under significant pressure, and greater public awareness of mental health and addiction issues and service challenges — with significant attention generated by the Government's Inquiry into Mental Health and Addiction.

There are a number of common issues identified by my Office on assessment of complaints about mental health and addiction services, including:

- Inadequate risk assessments.
- Inadequate discharge planning, including inadequate coordination between inpatient and community teams, inadequate follow-up and failure to adequately include the consumer and their family in discharge planning.
- Inadequate coordination of care between mental health and physical health services.
- Inadequate communication with family/whānau, particularly in regards to discharge planning and obtaining information from family in order to adequately complete risk assessments.
- Issues with management/treatment of co-existing disorders e.g. mental illness and addiction issues.
- Issues around the treatment of personality disorders and lack of psychologist input.
- Provision of emergency mental health care, including delays in crisis teams attending, the interface between mental health services and the emergency department and training provided to ED staff in regards to triage and treatment of mental health consumers.
- Issues regarding medication management by mental health care services for older persons, including a lack of communication with the consumer's Enduring Power of Attorney around such management.

A number of these issues reflect a lack of integrated, coordinated care – between community and inpatient teams, between mental health and addiction teams, between mental health and physical health services and between mental health and ED services. New Zealand's current mental health care model means that transitioning in and out of different mental health and addiction services is part of a consumer's journey. Additionally, many people with mental illness and/or addiction also have co-existing physical illnesses and multiple conditions, including co-existing substance use and mental health conditions. It is incumbent on mental health services to ensure they have robust systems in place to manage such complexity and ensure continuity of care and timely follow-up between themselves and the other providers involved in a consumer's journey.

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 Jan–Jun 2019, HDC received a total of **427<sup>1</sup>** complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

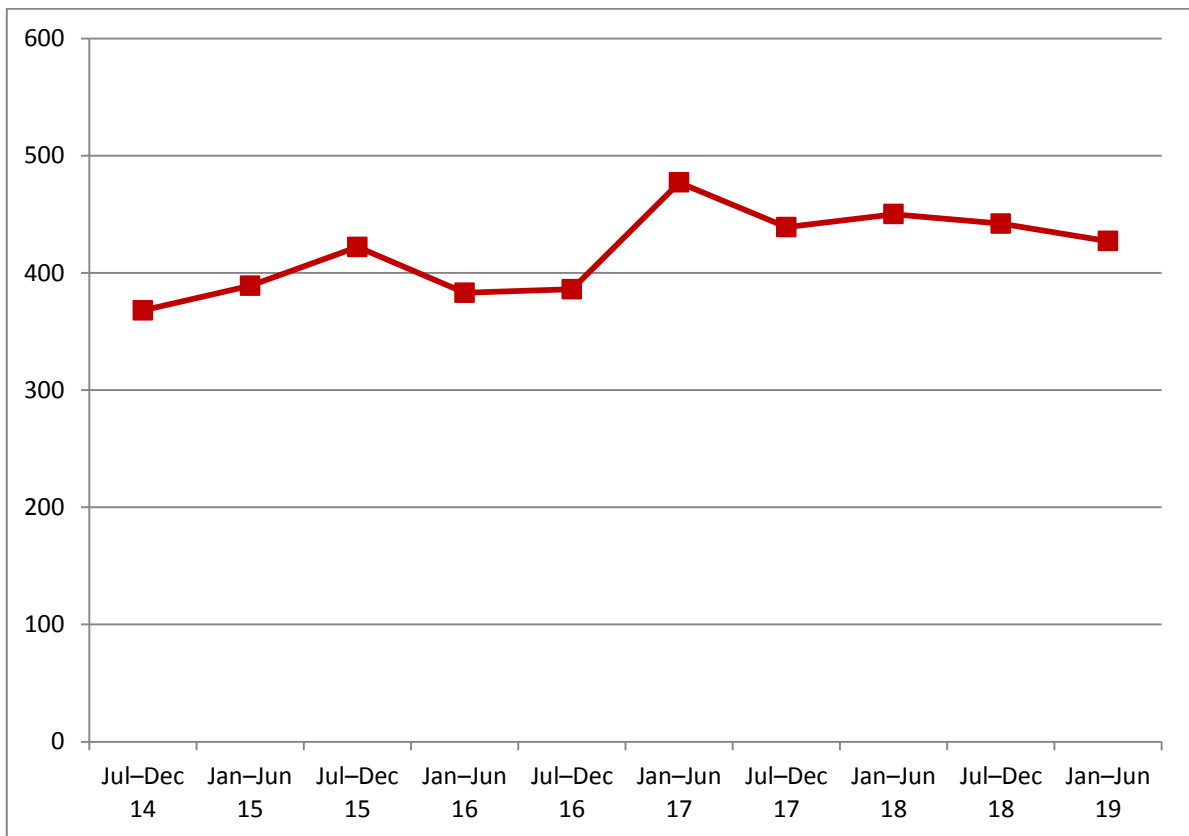
**Table 1.** Number of complaints received in the last five years

	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Average of last 4 6-month periods	Jan–Jun 19
<b>Number of complaints</b>	368	389	422	383	386	477	439	450	442	<b>452</b>	<b>427</b>

The total number of complaints received in Jan–Jun 2019 (427) shows a 6% decrease over the average number of complaints received in the previous four periods.

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

**Figure 1.** Number of complaints received



<sup>1</sup> Provisional as of date of extraction (22 August 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 (6 September 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 Jan–Jun 2019

<b>Number of complaints received</b>	<b>Total number of discharges</b>	<b>Rate per 100,000 discharges</b>
427	485,091	<b>88.02</b>

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

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

	<b>Jul–Dec 14</b>	<b>Jan–Jun 15</b>	<b>Jul–Dec 15</b>	<b>Jan–Jun 16</b>	<b>Jul–Dec 16</b>	<b>Jan–Jun 17</b>	<b>Jul–Dec 17</b>	<b>Jan–Jun 18</b>	<b>Jul–Dec 18<sup>2</sup></b>	<b>Average of last 4 6-month periods</b>	<b>Jan–Jun 19</b>
<b>Rate per 100,000 discharges</b>	76.65	84.60	87.57	81.44	78.79	99.08	88.23	93.80	88.47	<b>92.40</b>	<b>88.02</b>

The rate of complaints received during Jan–Jun 2019 (88.02) shows a 5% decrease on the average rate of complaints received for the previous four periods, and is very similar to the rate of complaints received in the previous period.

Table 4 shows the number and rate of complaints received by HDC for each DHB.<sup>3</sup>

<sup>2</sup> The rate for Jul–Dec 2018 has been recalculated based on the most recent discharge data.

<sup>3</sup> 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 Jan–Jun 2019

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	59	61,806	95.46
Bay of Plenty	20	26,136	76.52
Canterbury	40	58,032	68.93
Capital and Coast	45	29,089	154.70
Counties Manukau	39	50,029	77.95
Hawke's Bay	12	18,111	66.26
Hutt Valley	22	16,448	133.75
Lakes	9	11,512	78.18
MidCentral	23	15,086	152.46
Nelson Marlborough	16	12,514	127.86
Northland	10	20,108	49.73
South Canterbury	6	6,046	99.24
Southern	34	27,173	125.12
Tairāwhiti	3	5,297	56.64
Taranaki	10	13,163	75.97
Waikato	39	48,509	80.40
Wairarapa	4	4,100	97.56
Waitemata	36	52,355	68.76
West Coast	5	3,188	156.84
Whanganui	9	6,389	140.87

#### 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 427 complaints about DHBs, 452 services were complained about.

Surgical services (31.4%) received the greatest number of complaints in Jan–Jun 2019, with general surgery (8.0%), gynaecology (6.2%) and orthopaedics (5.8%) being the surgical specialties most commonly complained about. This is consistent with what has been seen in previous periods for surgical services, with the exception of gynaecology services which increased from being responsible for 3.2% of DHB services complained about in Jul–Dec 2018 to 6.2% of services in Jan–Jun 2019.

Other commonly complained about services included mental health (21.9%), medicine (17.7%) and emergency department (11.5%) 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
<b>Aged care</b>	<b>2</b>	<b>0.4%</b>
<b>Alcohol and drug</b>	<b>4</b>	<b>0.9%</b>
<b>Anaesthetics/pain medicine</b>	<b>3</b>	<b>0.7%</b>
<b>Dental</b>	<b>7</b>	<b>1.5%</b>
<b>Diagnostics</b>	<b>7</b>	<b>1.5%</b>
<b>Disability services</b>	<b>4</b>	<b>0.9%</b>
<b>District nursing</b>	<b>2</b>	<b>0.4%</b>
<b>Emergency department</b>	<b>52</b>	<b>11.5%</b>
<b>Intensive care/critical care</b>	<b>3</b>	<b>0.7%</b>
<b>Maternity</b>	<b>28</b>	<b>6.2%</b>
<b>Medicine</b>	<b>80</b>	<b>17.7%</b>
General medicine	15	3.3%
Cardiology	16	3.5%
Gastroenterology	10	2.2%
Geriatric medicine	8	1.8%
Haematology	3	0.7%
Neurology	8	1.8%
Oncology	9	2.0%
Palliative care	2	0.4%
Renal/nephrology	3	0.7%
Respiratory	3	0.7%
Other/unspecified	3	0.7%
<b>Mental health</b>	<b>99</b>	<b>21.9%</b>
<b>Paediatrics (not surgical)</b>	<b>11</b>	<b>2.4%</b>
<b>Rehabilitation services</b>	<b>4</b>	<b>0.9%</b>
<b>Surgery</b>	<b>142</b>	<b>31.4%</b>
Cardiothoracic	7	1.5%
General	36	8.0%
Gynaecology	28	6.2%
Neurosurgery	2	0.4%
Ophthalmology	9	2.0%
Orthopaedics	26	5.8%
Otolaryngology	7	1.5%
Paediatric	1	0.2%
Plastic and Reconstructive	12	2.7%
Urology	11	2.4%
Vascular	3	0.7%
<b>Other/unknown health service</b>	<b>4</b>	<b>0.9%</b>
<b>TOTAL</b>	<b>452</b>	

### 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 Jan–Jun 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
<b>Access/Funding</b>	<b>78</b>	<b>18.3%</b>
Lack of access to services	27	6.3%
Lack of access to subsidies/funding	2	0.5%
Waiting list/prioritisation issue	49	11.5%
<b>Boundary violation</b>	<b>3</b>	<b>0.7%</b>
<b>Care/Treatment</b>	<b>210</b>	<b>49.2%</b>
Delay in treatment	8	1.9%
Inadequate coordination of care/treatment	5	1.2%
Inadequate/inappropriate clinical treatment	30	7.0%
Inadequate/inappropriate examination/assessment	13	3.0%
Inadequate/inappropriate follow-up	8	1.9%
Inadequate/inappropriate monitoring	4	0.9%
Inadequate/inappropriate non-clinical care	10	2.3%
Inadequate/inappropriate testing	1	0.2%
Inappropriate/delayed discharge/transfer	11	2.6%
Inappropriate withdrawal of treatment	1	0.2%
Missed/incorrect/delayed diagnosis	68	15.9%
Refusal to assist/attend	3	0.7%
Refusal to treat	5	1.2%
Rough/painful care or treatment	4	0.9%
Unexpected treatment outcome	39	9.1%
<b>Communication</b>	<b>37</b>	<b>8.7%</b>
Disrespectful manner/attitude	17	4.0%
Failure to communicate openly/honestly/effectively with consumer	14	3.3%
Failure to communicate openly/honestly/effectively with family	6	1.4%
<b>Complaints process</b>	<b>3</b>	<b>0.7%</b>
Inadequate response to complaint	3	0.7%
<b>Consent/Information</b>	<b>38</b>	<b>8.9%</b>
Consent not obtained/adequate	12	2.8%
Inadequate information provided regarding condition	3	0.7%
Inadequate information provided regarding options	2	0.5%
Inadequate information provided regarding results	2	0.5%
Inadequate information provided regarding treatment	1	0.2%
Incorrect/misleading information provided	1	0.2%
Issues with involuntary admission/treatment	17	4.0%
<b>Documentation</b>	<b>5</b>	<b>1.2%</b>

<b>Primary issue in complaints</b>	<b>Number of complaints</b>	<b>Percentage</b>
Delay/failure to disclose documentation	2	0.5%
Inadequate/inaccurate documentation	2	0.5%
Inappropriate maintenance/disposal of documentation	1	0.2%
<b>Facility issues</b>	<b>14</b>	<b>3.3%</b>
General safety issue for consumer in facility	7	1.6%
Inadequate/inappropriate policies/procedures	4	0.9%
Issue with sharing facility with other consumers	1	0.2%
Waiting times	2	0.5%
<b>Medication</b>	<b>18</b>	<b>4.2%</b>
Administration error	2	0.5%
Inappropriate administration	1	0.2%
Inappropriate prescribing	10	2.3%
Refusal to prescribe/dispense/supply	5	1.2%
<b>Reports/certificates</b>	<b>6</b>	<b>1.4%</b>
Inaccurate report/certificate	6	1.4%
<b>Other professional conduct issues</b>	<b>12</b>	<b>2.8%</b>
Disrespectful behaviour	5	1.2%
Inappropriate collection/use/disclosure of information	5	1.2%
Other	2	0.5%
<b>Disability-related issues</b>	<b>1</b>	<b>0.2%</b>
<b>Other issues</b>	<b>2</b>	<b>0.5%</b>
<b>TOTAL</b>	<b>427</b>	

The most common primary issue categories were:

- Care/treatment (49.2%)
- Access/funding (18.3%)
- Consent/information (8.9%)
- Communication (8.7%)

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

- Missed/incorrect/delayed diagnosis (15.9%)
- Waiting list/prioritisation issue (11.5%)
- Unexpected treatment outcome (9.1%)
- Inadequate/inappropriate treatment (7.0%)
- Lack of access to services (6.3%)

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

<b>Top five primary issues in all complaints (%)</b>							
<b>Jul–Dec 17 n=439</b>		<b>Jan–Jun 18 n=450</b>		<b>Jul–Dec 18 n=442</b>		<b>Jan–Jun 19 n=427</b>	
Misdiagnosis	12%	Misdiagnosis	13%	Misdiagnosis	14%	Misdiagnosis	16%
Waiting list/ prioritisation	10%	Unexpected treatment outcome	12%	Lack of access to services	9%	Waiting list/ prioritisation	12%
Unexpected treatment outcome	8%	Waiting list/ prioritisation	11%	Unexpected treatment outcome	9%	Unexpected treatment outcome	9%
Inadequate treatment	7%	Lack of access to services	6%	Waiting list/ Prioritisation	7%	Inadequate treatment	7%
Lack of access to services	6%	Inadequate treatment	4%	Inadequate treatment	6%	Lack of access to services	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
<b>Access/Funding</b>	<b>108</b>	<b>25.3%</b>
Lack of access to services	43	10.1%
Lack of access to subsidies/funding	4	0.9%
Waiting list/prioritisation issue	63	14.8%
<b>Boundary violation</b>	<b>3</b>	<b>0.7%</b>
<b>Care/Treatment</b>	<b>330</b>	<b>77.3%</b>
Delay in treatment	70	16.4%
Delayed/inadequate/inappropriate referral	8	1.9%
Inadequate coordination of care/treatment	62	14.5%
Inadequate/inappropriate clinical treatment	147	34.4%
Inadequate/inappropriate examination/assessment	113	26.5%
Inadequate/inappropriate follow-up	52	12.2%
Inadequate/inappropriate monitoring	35	8.2%
Inadequate/inappropriate non-clinical care	37	8.7%
Inadequate/inappropriate testing	60	14.1%
Inappropriate admission/failure to admit	7	1.6%
Inappropriate/delayed discharge/transfer	43	10.1%
Inappropriate withdrawal of treatment	5	1.2%
Missed/incorrect/delayed diagnosis	94	22.0%
Personal privacy not respected	1	0.2%
Refusal to assist/attend	11	2.6%
Refusal to treat	8	1.9%
Rough/painful care or treatment	25	5.9%
Unexpected treatment outcome	63	14.8%
Unnecessary treatment/over-servicing	4	0.9%
<b>Communication</b>	<b>288</b>	<b>67.4%</b>
Disrespectful manner/attitude	67	15.7%
Failure to accommodate cultural/language needs	2	0.5%
Failure to communicate openly/honestly/effectively with consumer	167	39.1%
Failure to communicate openly/honestly/effectively with family	89	20.8%
Insensitive/inappropriate comments	8	1.9%
<b>Complaints process</b>	<b>45</b>	<b>10.5%</b>
Inadequate response to complaint	42	9.8%
Retaliation/discrimination as a result of a complaint	3	0.7%
<b>Consent/Information</b>	<b>90</b>	<b>21.1%</b>
Consent not obtained/adequate	19	4.4%
Inadequate information provided regarding adverse event	10	2.3%
Inadequate information provided regarding condition	16	3.7%
Inadequate information provided regarding options	13	3.0%

<b>All issues in complaints</b>	<b>Number of complaints</b>	<b>Percentage</b>
Inadequate information provided regarding provider	3	0.7%
Inadequate information provided regarding results	10	2.3%
Inadequate information provided regarding treatment	17	4.0%
Incorrect/misleading information provided	10	2.3%
Issues with involuntary admission/treatment	18	4.2%
<b>Documentation</b>	<b>22</b>	<b>5.2%</b>
Delay/failure to disclose documentation	7	1.6%
Delay/failure to transfer documentation	1	0.2%
Inadequate/inaccurate documentation	12	2.8%
Inappropriate maintenance/disposal of documentation	1	0.2%
Intentionally misleading/altered documentation	3	0.7%
<b>Facility issues</b>	<b>61</b>	<b>14.3%</b>
Accreditation standards/statutory obligations not met	2	0.5%
Cleanliness/hygiene issue	4	0.9%
Failure to follow policies/procedures	8	1.9%
General safety issue for consumer in facility	10	2.3%
Inadequate/inappropriate policies/procedures	19	4.4%
Issue with sharing facility with other consumers	5	1.2%
Issue with quality of aids/equipment	6	1.4%
Staffing/rostering/other HR issues	7	1.6%
Waiting times	7	1.6%
Other	1	0.2%
<b>Medication</b>	<b>41</b>	<b>9.6%</b>
Administration error	2	0.5%
Inappropriate administration	8	1.9%
Inappropriate prescribing	25	5.9%
Refusal to prescribe/dispense/supply	8	1.9%
<b>Reports/certificates</b>	<b>16</b>	<b>3.7%</b>
Inaccurate report/certificate	15	3.5%
Refusal to complete report/certificate	1	0.2%
<b>Teamwork/supervision</b>	<b>7</b>	<b>1.6%</b>
Delayed/inadequate/inappropriate handover	4	0.9%
Inadequate supervision/oversight	3	0.7%
<b>Other professional conduct issues</b>	<b>34</b>	<b>8.0%</b>
Disrespectful behaviour	15	3.5%
Inappropriate collection/use/disclosure of information	16	3.7%
Other	6	1.4%
<b>Disability-related issues</b>	<b>2</b>	
<b>Other issues</b>	<b>9</b>	



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

- Care/treatment (present for 77.3% of all complaints)
- Communication (present for 67.4% of all complaints)
- Access/funding (present for 25.3% of all complaints)
- Consent/information (present for 21.1% of all complaints).

The most common specific issues were:

- Failure to communicate effectively with consumer (39.1%)
- Inadequate/inappropriate clinical treatment (34.4%)
- Inadequate/inappropriate examination/assessment (26.5%)
- Missed/incorrect/delayed diagnosis (22.0%)
- Failure to communicate effectively with family (20.8%)
- Delay in treatment (16.4%)
- Disrespectful manner/attitude (15.7%)
- Inadequate coordination of care/treatment (14.5%)
- Unexpected treatment outcome (14.8%)
- Waiting list/prioritisation issue (14.8%)

These issues are broadly similar to what was seen in the last six-month period. There was a small increase in the proportion of complaints involving a ‘waiting list/prioritisation issue’ from around 10-11% in previous periods to 15% in Jan–Jun 2019.

**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.

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

Surgery n=142		Mental health n=99		Medicine n=80		Emergency department n=52	
Unexpected treatment outcome	23%	Issues with involuntary admission/treatment	17%	Missed/incorrect/delayed diagnosis	21%	Missed/incorrect/delayed diagnosis	29%
Waiting list/prioritisation issue	21%	Lack of access to services	8%	Inadequate/inappropriate treatment	10%	Waiting list/prioritisation issue	12%
Missed/incorrect/delayed diagnosis	15%	Inadequate/inappropriate examination/assessment	8%	Waiting list/prioritisation issue	9%	Delay in treatment	10%

## 4.0 Complaints closed

### 4.1 Number of complaints closed

HDC closed **444**<sup>4</sup> complaints involving DHBs in the period Jan–Jun 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

	Jul– Dec 14	Jan– Jun 15	Jul– Dec 15	Jan– Jun 16	Jul– Dec 16	Jan– Jun 17	Jul– Dec 17	Jan– Jun 18	Jul– Dec 18	Average of last 4 6-month periods	Jan– Jun 19
<b>Number of complaints closed</b>	344	410	365	482	316	465	383	476	449	<b>443</b>	<b>444</b>

### 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 Jan–Jun 2019 period, 5 DHBs had no investigations closed, 8 DHBs had one investigation closed, 3 DHBs had two investigations closed, 2 DHB 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 Jan–Jun 2019 is shown in Table 11.

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<sup>4</sup> 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<sup>5</sup>

<b>Outcome for DHBs</b>	<b>Number of complaints closed</b>
<b><i>Investigation</i></b>	<b>28</b>
Breach finding — referred to Director of Proceedings	1
Breach finding	18
No breach finding with adverse comment and recommendations	7
No breach finding	2
<b><i>Other resolution following assessment</i></b>	<b>414</b>
No further action <sup>6</sup> with recommendations or educational comment	70
Referred to District Inspector	13
Referred to other agency	6
Referred to DHB <sup>7</sup>	105
Referred to the Advocacy Service	77
No further action	137
Withdrawn	6
<b><i>Outside jurisdiction</i></b>	<b>2</b>
<b>TOTAL</b>	<b>444</b>

#### 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 Jan–Jun 2019. Please note that more than one recommendation may be made in relation to a single complaint.

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> 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

<b>Recommendation</b>	<b>Number of recommendations made</b>
Apology	20
Audit	19
Meeting with consumer	6
Presentation/discussion of complaint with others	9
Provision of evidence of change to HDC	35
Reflection	5
Review/implementation of policies/procedures	34
Training/professional development	26
<b>Total</b>	<b>154</b>

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 (35 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 (34 recommendations) was also often recommended. 26 recommendations were made in relation to staff training – this was most often in regards to clinical issues identified in the case followed by training on documentation requirements.

## 5.0 Learning from complaints — HDC case reports

### Cultural care plan and psychiatric review of at-risk patient (16HDC00195)

#### *Background*

A Māori woman in her 40s had been a consumer of mental health services since the mid-1990s. She had been diagnosed with bipolar affective disorder. The woman had experienced several mental health admissions, including an admission under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA).

The woman's mother contacted the DHB's mental health emergency team (MHET) about her concerns for her daughter's mental health, and requested that her daughter be admitted under the MHA. A consultant psychiatrist undertook a psychiatric assessment of the woman, and concluded that hospital admission was not necessary and that she could be managed by the community mental health team. MHET made regular contact with the woman and her mother following this assessment.

The following month, the woman's mother told MHET that her daughter had hunting knives in her possession, which the mother had confiscated. She also reported that her daughter's highs and lows were more extreme. A short time later, the woman was taken into Police custody after harming a woman unknown to her.

#### *Findings*

HDC's clinical advisors were critical of a number of aspects of the woman's care, including:

- The level of engagement with the woman lacked elementary factors of Māori communication and care. Additionally, the advisor noted that the lack of a cultural care plan was a departure from accepted standards of care in the Māori mental health context.
- No structured plan was put in place to address the difficulty in engaging with the woman. HDC's clinical advisor noted that the difficulty in obtaining a thorough and complete team review of the woman pointed to a lack of structured ways to deal with complex cases.
- Reliance was placed on the woman's mother to monitor and evaluate the woman and initiate the MHA if she felt it necessary, and little support was offered to her.
- There was a lack of a clear leader in the woman's care planning. The specialist psychiatrist was especially absent from the planning overview.
- The woman's clinical notes had no comprehensive longitudinal view. There was also no acknowledgement of the differences in assessment by different individuals and/or at different visits and no attempt to understand these differences.

The Mental Health Commissioner accepted that this was a complex case with several mitigating factors. Overall, however, he was of the view that the failings exhibited were systems issues for which the DHB was accountable.

The Mental Health Commissioner's fundamental concern was the lack of an adequate care plan, contributed to by the lack of psychiatric review over a protracted time. HDC's clinical advisor noted that the care offered "seemed to be of wait and see rather than a careful structured plan that sought to create engagement and the gathering of sufficient information to know the depth and severity of the illness effect". This was further compounded by the lack of an adequate cultural care plan. The Mental Health Commissioner found that the DHB failed to provide the woman with services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Mental Health Commissioner commented that "this decision highlights the importance of having a broader overall care plan for any consumer, which will require timely psychiatric oversight and should always take account of cultural needs."

Criticisms were also made of the psychiatrist for his inadequate documentation, and for failing to discuss the woman's mental health with her mother at the time of the psychiatric assessment.

#### *Recommendations*

The Mental Health Commissioner recommended that the DHB assess how its cultural and clinical care can be best coordinated and integrated, in collaboration with local Māori communities, and with input from consumer and family/whānau advisors. He also recommended that the DHB provide a further update to HDC in relation to the changes made since this complaint, and in relation to the outstanding recommendations made following the DHB's Serious Adverse Event Review.

### **Care of woman in labour with abnormal CTG (17HDC00384)**

#### *Background*

A woman pregnant with her second baby was admitted to a public hospital for a maternal and fetal check as her due date had passed. This included cardiotocography (CTG) monitoring (monitoring of the baby's heart rate). The woman had delivered her first baby by emergency lower segment Caesarean section owing to a failed forceps delivery. The woman was hoping for a vaginal birth this time.

When the CTG was commenced, the woman's lead maternity carer (LMC), a registered midwife, noted a variable fetal heart rate (FHR), no accelerations, and three late decelerations. She contacted the obstetrician who failed to recognise non-reassuring features of the CTG. The obstetrician reviewed the woman throughout the day. The obstetrician offered the woman a Caesarean section, which he recommended, or an induction of labour. The obstetrician accepts that he did not advise the woman that, in the circumstances of the abnormal CTG, a Caesarean section was the only appropriate course of action. He stated that he needed to consider the woman's "very strong preference".

CTG monitoring continued into the evening, and the obstetrician reviewed the woman one more time. Despite the fetal heart rate showing decelerations, the obstetrician carried out a Cook's catheter induction of labour. His plan was to stop CTG monitoring to allow the woman to mobilise, and for another CTG to be commenced at 10pm. The obstetrician went home after this, and said he asked to be called back at 10pm. This was not documented and he was not called. At handover, all four hospital-employed midwives working on the shift viewed the CTG and made a decision to discontinue the trace despite ongoing late decelerations. The decision was made because the CTG had not deteriorated and was no different from previous CTGs reviewed by the obstetrician.

In the early hours of the next morning, the core midwife recommenced CTG monitoring and documented that it was non-reassuring. After turning the woman on her left side to try and improve the CTG, the obstetrician was called in to review her. He arrived at 4am, and at 4.40am documented that there had been a prolonged period of reduced variability and that he had ruptured the woman's membranes and found meconium-stained liquor present. The obstetrician noted his plan to continue the CTG monitoring and to review the trace again in 15 to 30 minutes.

At 5.20am, the obstetrician decided to proceed to an emergency Caesarean section. The baby was delivered at 6.44am in poor condition, with no heartbeat and no respiratory effort, and immediate resuscitation was carried out. Later the baby was diagnosed with multiple co-morbidities and hypoxic ischaemic encephalopathy, and passed away.

### *Findings*

The Deputy Commissioner found that the obstetrician failed to provide services to the woman with reasonable care and skill by incorrectly interpreting the CTG when the woman was admitted, not recommending a Caesarean section as the only appropriate course of action and by proceeding with the induction of labour in the presence of an abnormal antenatal CTG, in breach of Right 4(1) of the Code

The Deputy Commissioner found the woman's care by the DHB concerning for a number of reasons. Over an extended period of time, four midwives failed to comply with RANZCOG guidelines, which had been adopted as policy by the DHB, in regards to CTG monitoring. Further, although the DHB advised that it had a CTG interpretation sticker in use, there is no evidence in the clinical notes that this was used by staff. Additionally, at no time during the women's admission did midwifery staff think critically about the woman's CTG, challenge the obstetrician's management plan or advocate for the woman. The DHB should have in place a system that ensures that staff are aware of and comply with its policies and procedures, and a culture that supports staff to voice concerns and ask questions.

The Deputy Commissioner was also critical of the staffing levels in the maternity unit at the time of these events. The obstetrician commented that the unit had a small number of obstetricians that had to provide 24-hour cover without support of middle-grade doctors or shift arrangements. He noted that obstetricians may sometimes be required to work excessive hours without collegial support. It is clear that the obstetrician would have benefited from greater collegial support and less onerous working hours. The DHB's workload measurement tool also indicated that the afternoon and night shift staff could have benefited from additional midwifery support. Additionally, in the evening, the obstetrician went home to sleep, and therefore, at handover, midwifery access to an obstetrician was limited. The Deputy Commissioner noted that as an employer, the DHB had a responsibility to ensure that obstetric and midwifery staff were supported appropriately to manage their workload.

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

The Deputy Commissioner commented: "This case highlights the importance of regular fetal surveillance updating for all staff and, in particular, that senior medical officers are encouraged and supported to self-reflect on whether or not they are fully up to date with all aspects of their core competencies."

### *Recommendations*

The Deputy Commissioner recommended that the DHB:

- Update HDC on the progress made in relation to increasing the number of employed obstetricians based at the hospital from three to four
- Consider developing local policies around intrapartum fetal surveillance in accordance with RANZCOG guidelines
- Consider implementing an updated CTG interpretation sticker and providing training on the use of that sticker
- Consider introducing mandatory fetal surveillance updating for all staff who work in maternity services
- Use this investigation (anonymously) as a case study to provide training for obstetric and midwifery staff. The training should include discussion on the importance of speaking up when staff are concerned about a clinical situation or plan of care.

## **Multiple presentations to ED before stroke diagnosis (17HDC00725)**

### *Background*

A woman was seen by her GP due to worsening neck pain, a pulsing noise in her head, and a persistent headache. Her GP referred her to the Emergency Department (ED) at a public hospital for further investigation. Over the next three days, the woman presented to the ED four times.

At the first visit, the woman was reviewed and discharged with treatment for an ear infection, neck pain, and a migraine.

The woman developed vertigo and vomiting, and presented to the ED for a second time. She was reviewed and her care was discussed with the ED consultants. She was referred to the Ear, Nose and Throat (ENT) service for investigation, in accordance with protocols for patients who present with vertigo. She was reviewed by two junior ENT doctors and diagnosed with otitis media with labyrinthitis (a viral infection that affects the inner ear) and migraine. No consultant review or CT scan was arranged, and she was discharged home.

At the third visit, an ED doctor discussed a CT scan with the admitting ENT registrar. The woman was referred to the ENT service for investigation, and seen by the ENT doctor who had examined her previously. Again, she was discharged with a diagnosis of vertigo caused by a middle ear infection. No CT scan was performed, and her presentation was not discussed with a consultant.

That evening the woman returned to the ED and was reviewed by a senior medical officer who ordered a CT scan. The scan revealed a vertebral artery dissection and acute and subacute bilateral cerebellar infarcts (two strokes).

### *Findings*

The Commissioner accepted his clinical advisor's advice and was satisfied that, overall, the standard of care provided by the ED was appropriate in the circumstances, noting that the woman's diagnosis was rare. Nonetheless he was thoughtful that when no firm diagnosis was made over several presentations with concerning symptoms that were not resolving, further critical thinking and diagnostic enquiry was not undertaken more actively.

The Commissioner found that the ENT care provided by the DHB was sub-optimal in several respects, including:

- The failure to offer the woman a CT scan of her head during her first and second ENT review;
- The failure by the junior doctor to discuss the woman's presentation with a consultant; and
- Inadequate communication which resulted in the ED doctor's recommendations for a CT scan not being adequately communicated to the ENT registrar.

The Commissioner was concerned that the ENT doctors failed to show critical thinking and make the necessary active diagnostic enquiries, despite the fact the woman was re-presenting with concerning unresolved symptoms. The Commissioner noted that this case demonstrates the significance of the patient's voice and the importance of listening to the patient's experience. The woman said that she told a doctor that her symptoms were not consistent with migraines she had experienced previously, and that she felt "unheard and brushed off". There was an opportunity to incorporate the woman's concerns into the analysis of her presentation, and he was critical that this did not occur.

Overall, the Commissioner was critical of the care provided by the ENT service at the DHB, and considered that this contributed to the delayed diagnosis of the woman's condition. In his view, these failings demonstrated a pattern of poor care by the DHB, in breach of Right 4(1) of the Code.



### *Recommendations*

The Commissioner recommended that the DHB report back to HDC confirming the procedures in place at the DHB to oversee and support junior registrars who are failing to satisfy the requirements of their clinical placements. He also recommended that the DHB use his report as a basis for training staff in the ED and ENT departments, and audit its compliance with the ENT guidelines to ensure that the escalation process is followed in situations where a consultant review is indicated.

The Commissioner asked the DHB to consider developing ED guidelines for situations when a junior doctor in the ED has a different diagnosis from the referring GP, and guidance for staff for situations where a patient with no definitive diagnosis re-presents to ED with concerning symptoms that have not resolved.

### **Coordination of care for toddler with suspected non-accidental injury (16HDC00134)**

#### *Background*

A sixteen-month-old boy and his mother presented to the ED of a public hospital. The boy had not been weight-bearing on his left leg for approximately 36 hours. He was assessed by a number of ED staff, and an X-ray of his left leg was taken. No fracture was identified on the imaging, and the boy was transferred to the paediatric department, where further assessments were carried out and the X-ray re-reviewed. Again, no fracture was seen, and the boy was discharged home with analgesia and advice to return immediately if he deteriorated. There is no record in the clinical notes that non-accidental injury was considered specifically, but it was noted that the cause of injury was unknown. The paediatric consultant on this shift acknowledged that the clinical documentation for the presentation was incomplete, and attributed this to considerable pressure on the ward, with days being long and busy.

The boy and his mother re-presented to the paediatric department. In the context of a busy clinic, the paediatric consultant on this shift carried out a concise and focused assessment of the boy's left foot, and an X-ray of the foot was taken. No abnormalities were identified. The boy's presenting issue was documented as a deep soft tissue injury, and although the paediatric consultant considered inflicted injury, he acknowledged that this was not captured in the documentation. The boy was discharged home for monitoring and follow-up review in the paediatric ward if symptoms persisted.

Two days later the boy and his mother presented to the paediatric ward, and the boy was reviewed by a senior house officer. The paediatric consultant on this shift requested that the boy remain on the ward, and an orthopaedic opinion be sought. An orthopaedic registrar attended and recommended an MRI scan. The paediatric consultant advised that he attended the ward later that day with the intention of carrying out a child protection assessment. However, when he arrived on the ward, he was advised that the boy had gone home. An MRI scan was scheduled.

When the boy presented to the orthopaedic ward to undergo the MRI under general anaesthesia, a pre-anaesthetic checklist noted that he had a broken tooth. A Paediatric Nursing Assessment Form documented faded bruises on his right forehead and cheek, a missing tooth, and two black fingernails on the right hand. According to the nurses who assessed the boy, these findings were passed on to the house officer on duty. Following the MRI, a bone scan was recommended. However, because of the difficulty in arranging this, the boy was transferred to another hospital.

The paediatric team at the second hospital reviewed the boy, and a repeat X-ray of his left leg confirmed a diagnosis of a tibial spiral fracture. Additional injuries were also documented, including two black fingernails, two damaged fingernails, a missing left bottom incisor, bruises around the hips and chest, and a light pink discolouration over the right lower quadrant of the abdomen. Given this,

an Unexplained Injury Process was initiated. A Report of Concern was sent to Oranga Tamariki, and a referral made to the Child Protection Team. A skeletal survey was also planned.

The boy was flown back to the first hospital for the skeletal survey and, following this, was discharged. The paediatric consultant on call for this shift advised that the boy was discharged without her knowledge. In addition, although the findings of the skeletal survey were discussed and forwarded on to Oranga Tamariki on the day it was carried out, it was not formally reported on until much later.

The boy sustained further injuries following discharge, and was found deceased.

### *Findings*

The Commissioner noted that the boy's care demonstrates the challenges clinicians face when diagnosing non-accidental injuries. However, he considered these challenges could have been addressed by more rigorous analysis. The Commissioner commented that "in my view, the system that was meant to wrap around this boy had the information it needed to diagnose his fracture and non-accidental injuries earlier. However, a series of failings in assessment, communication, documentation, and coordination of care, and a failure to adhere to policies and procedures prevented this from occurring."

The Commissioner found the DHB in breach of Right 4(1) of the Code for failing to provide services to the boy with reasonable care and skill for the following reasons:

- The diagnosis of non-accidental injury was not considered adequately across multiple presentations to hospital, resulting in a delayed diagnosis. This was reflected in poor documentation of social history, cause of injury, and family violence screening.
- The important policies and procedures around family violence screening and non-accidental injury were not followed by numerous staff. Moreover, the DHB did not have robust systems in place to ensure that the policies could be followed.

The Commissioner found the DHB in breach of Right 4(5) for failing to ensure quality and continuity of services for the following reasons:

- The inadequate documentation led to an incomplete clinical picture being passed on from team to team, and this contributed to a delay in the boy's diagnosis.
- The boy's journey through the Paediatric, Orthopaedic, and Radiology teams was inadequate, and included two inappropriate discharges from hospital and delayed reporting of his skeletal survey.

The Commissioner referred the DHB to the Director of Proceedings who decided to institute a proceeding in the Human Rights Review Tribunal.

### *Recommendations*

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

- Advise HDC on the outcome of its review of medical staffing levels and rostering practices in the Paediatric and Radiology departments, and whether any improvements had occurred with respect to this.
- Carry out an audit on the standard of documentation of 50 child presentations to the hospital — in particular, the completion of family violence screening and social history. Additionally, carry out an audit on the reporting timeframes of paediatric skeletal surveys. Where the results of either of these audits do not reflect 100% compliance, the DHB should consider and advise HDC on what further improvements could be made to ensure compliance.

- Report back to HDC on the protocol being developed around hi-tech imaging requests for children under the age of 12 years.
- For the purpose of shared learning, disseminate the anonymised version of this report to clinical teams across all hospitals within the DHB, as well as on a national level at relevant meetings.

The Commissioner also recommended that the DHB continue to follow up with Oranga Tamariki and the New Zealand Police regarding a multi-agency meeting to discuss the findings from the DHB's serious adverse event report and the Commissioner's investigation report.