Complaints to the Health and Disability Commissioner involving District Health Boards

Report and Analysis for period 1 July 2015 to 30 June 2016

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

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COMMISSIONER'S FOREWORD

Welcome to HDC's analysis of complaints received involving District Health Boards for 2015/16. The aim of this report is to provide the general public and providers with an understanding of the for the types of complaints HDC receives about services run by DHBs and the positive changes that have been made to services as a result of these complaints.

This is the third such report published by HDC, and so analysis of changes that have occurred in DHB complaints over the past three years is now possible. DHB complaints trends have remained broadly consistent over the last three years. However, as you will see there has been an increase in the proportion of complaints in which complainants were concerned about the coordination of care/treatment, the examination/assessments conducted, and the way in which they were communicated with. I anticipate that over time, as we continue to publish these reports, the ability to conduct this time series analysis of complaint trends will prove to be of significant additional usefulness.

On reading this report I was struck again by the importance of doing the basics well. It is often in the ordinary where things go wrong and mistakes occur. The failure to do the basics well is a common theme in complaints to my Office. In the context of this report it can be seen in the failure to adequately communicate with the patient, to ask them the relevant questions about their medical history or their symptoms. Sometimes it can be seen in a failure of coordination of care, a failure to review the patient's notes or to ask questions of a colleague. Sometimes it can be seen in the decision to not undertake a physical examination where clinically indicated, other times in the failure to follow up on abnormal test results. The basics can be easily overlooked in the context of busyness and competing demands. This is why it is important to have systems in place and a team culture that supports providers to get these basics right.

I trust you will find this report of interest, and the changes made encouraging. It is my hope that those who read the report will, as a result, be empowered to be stronger partners in their own health care, and that it will assist DHBs to learn from complaints received about other DHBs, and to better understand how their own complaint patterns compare nationally.

Anthony Hill
Health and Disability Commissioner

EXECUTIVE SUMMARY

In the 2015/16 year, HDC received 805 complaints involving DHBs. This was an increase of 6% compared to the number received in the previous year. The significant year-on-year increase in complaints about DHB services is consistent with increasing overall complaint numbers to HDC each year.

The rate of complaints about DHB services is also increasing, with the 2015/16 rate of 85 complaints per 100,000 discharges being the highest to date.

Complaints were received in relation to a wide variety of DHB service types, with the most commonly complained about service types being surgical and mental health services. The service types complained about are broadly consistent with what was seen in complaints about DHBs in 2014/15.

Also consistent with complaint trends seen in previous years, doctors were the individual providers complained about most commonly within complaints about DHB services, with 77% of the individual providers identified in DHB complaints being doctors.

Missed, incorrect or delayed diagnosis was the primary issue of concern raised by the complainant in 16% of complaints. When all issues raised in complaints were considered, we found that concerns about inadequate/inappropriate treatment were the most prevalent, followed by a failure to communicate effectively with the consumer. This is broadly consistent with complaint issue trends over the past three years, although there has been an increase in the proportion of complaints involving inadequate coordination of care/treatment, inadequate/inappropriate examination/assessment and failure to communicate effectively with consumer. There was a decrease in the proportion of complaints involving an inadequate response to the consumer's complaint by the DHB in 2015/16.

The issues raised in complaints varied by the service type involved. Services with high diagnostic workloads, such as general medicine and emergency departments, commonly received more complaints primarily regarding missed, incorrect or delayed diagnoses. When all issues raised in complaints about each service type were analysed, general medicine and surgical services received a greater proportion of complaints involving inadequate coordination of care/treatment and emergency department services received a greater proportion of complaints involving inadequate testing. Maternity services received a greater proportion of complaints regarding a delay in treatment, and mental health services received a greater proportion of complaints regarding communication issues, than did other service types

In the 2015/16 year, HDC closed more complaints about DHBs than ever before. The 754 complaints closed this year was an increase of 9% over the number of complaints closed about DHBs in the previous year. This included the conclusion of 45 formal investigations. Around 19% of complaints were referred back to the DHB for resolution. In around 23% of cases, HDC recommended some kind of follow-up action or made educational comments designed to facilitate improvement in DHB services. The most common recommendation made by HDC to DHBs was that they review their policies/procedures, followed by the recommendation that the DHB conduct an audit, most often of policies/procedures and/or documentation.

BACKGROUND

1. The Health and Disability Commissioner

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

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

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

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

Rights under the Code

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

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

2. District Health Boards

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

3. This Report

This report describes the complaints HDC received and/or closed in relation to DHBs during the 2015/16 financial year.

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

The complaints are described both in terms of overall numbers and characteristics, as well as by reference to case studies. In terms of complaints received, the issues included in the analysis are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues can still provide a valuable insight into the consumer's experience of the services provided and the issues they care most about. Case studies are included to encourage readers to consider their own service provision and to ask "could that happen at my place" and, if so, what changes can be made to prevent it.

COMPLAINTS RECEIVED

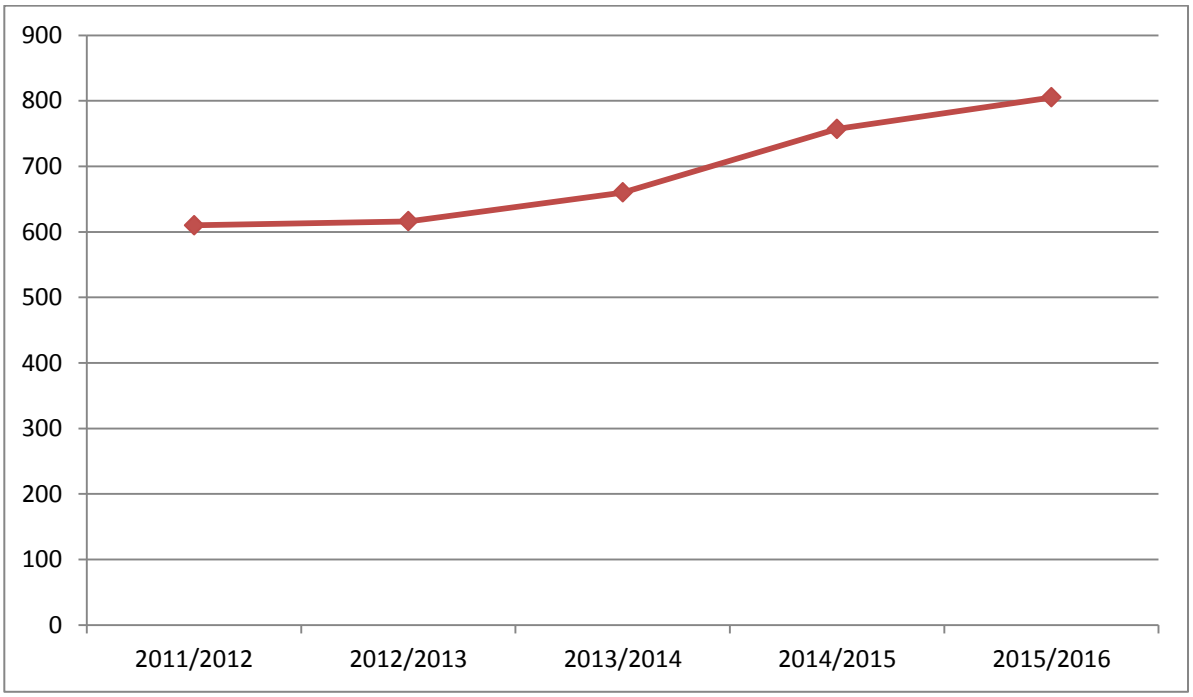
1. How many complaints were received?

1.1 Number of complaints received

In 2015/16, HDC received a total of **805**[1] complaints about care provided by all DHBs. This equates to 41% of the total 1,958 complaints received by HDC that year.

The 805 complaints received in the 2015/16 year represents an increase of 6% over the 757 complaints received in 2014/15. As can be seen from Figure 1 below, DHB complaint numbers have been steadily increasing over the last five years. Analysis shows that this increase is statistically significant.[2]

Figure 1. Number of complaints received about DHBs



In 2015/16 the number of complaints received about individual DHBs ranged from 2 complaints to 110 complaints. Large variability in complaint numbers is not unexpected given the similar variability in the size of populations served and number of services delivered by different DHBs.

[1] Provisional as of date of extraction, 1 August 2016.

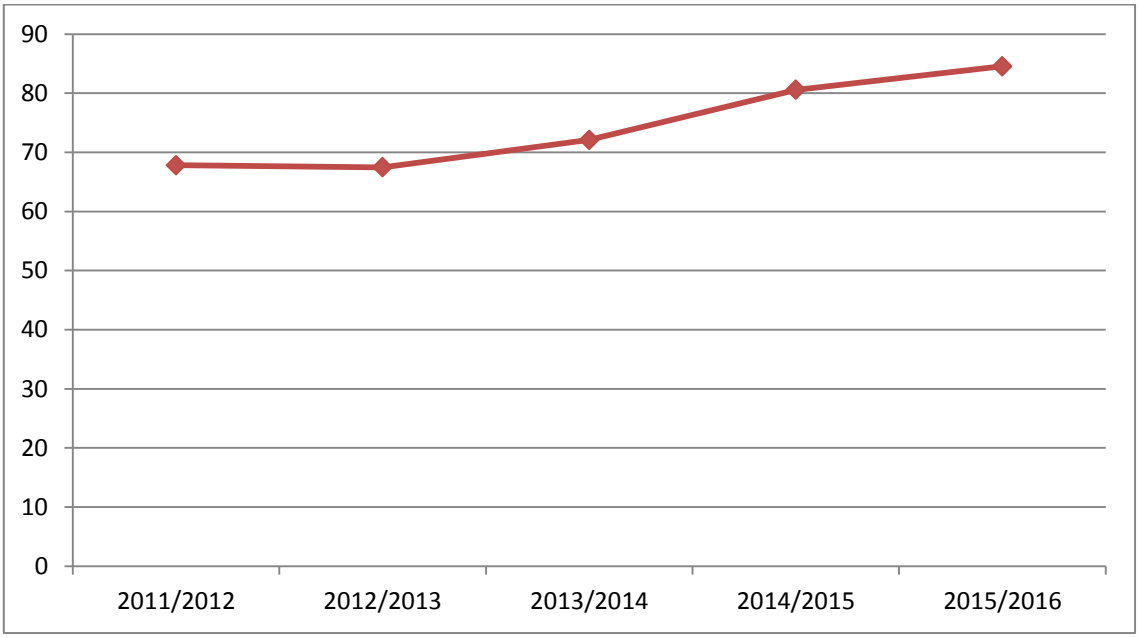
[2] There is a significant positive correlation between year and number of DHB complaints received ($r=0.92$, $p<.05$).

1.2 Rate of complaints received

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

In the 2015/16 year, according to Ministry of Health data,[3] there were 952,105 discharges nationally. This equates to an overall rate of 85 complaints per 100,000 discharges across DHB services. This compares to an overall rate of 81 complaints per 100,000 discharges during 2014/15; an increase of 5%. As shown in Figure 2, the complaint rate per 100,000 discharges has increased steadily over the last five years. As with complaint numbers, analysis shows that this increase is statistically significant.[4]

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



For individual DHBs, the rate of complaints received ranged from 28 complaints per 100,000 discharges to 165 complaints per 100,000 discharges.

However, while discharge data is useful for standardising DHB activity over time, it is less accurate when comparing DHBs against one another. This is because some services are excluded from the discharge data collected,[5] disproportionately affecting some DHBs more than others. In addition, discharge data does not take into account the particular services provided by a DHB or the nature of the population and geographical area served.

[3] Provisional as at the date of extraction, 25 August 2016.
[4] There is a significant positive correlation between year and rate of DHB complaints received ($r=.91$, $p<.05$).
[5] For example, the discharge data excludes short stay emergency department discharges, and patients attending outpatient units and clinics.

Why are complaint numbers increasing?

The increasing number of complaints being received by HDC about DHBs is reflective of an overall trend of sustained growth in complaint numbers to HDC. Over the last four years, the number of complaints to HDC has increased by 25%.

This increase must be interpreted with caution. HDC has no evidence to suggest that the increase in complaints relates to a decrease in the quality of services, by providers generally, or by DHBs in particular.

The growth in complaint numbers is more likely to be due to the increasing profile of HDC, the improved accessibility of complaints processes due to advancing technology, and an increasing public knowledge of consumer rights. It may also reflect an increased willingness among consumers to complain about services received.

HDC's increasing complaint load is not unique, but is consistent with a trend being observed in complaints agencies both around New Zealand and internationally. For example, in 2015/16 complaints to the New South Wales Health Care Complaint Commission and the Office of the Health Services Commissioner in Victoria rose by 15% and 28% respectively.

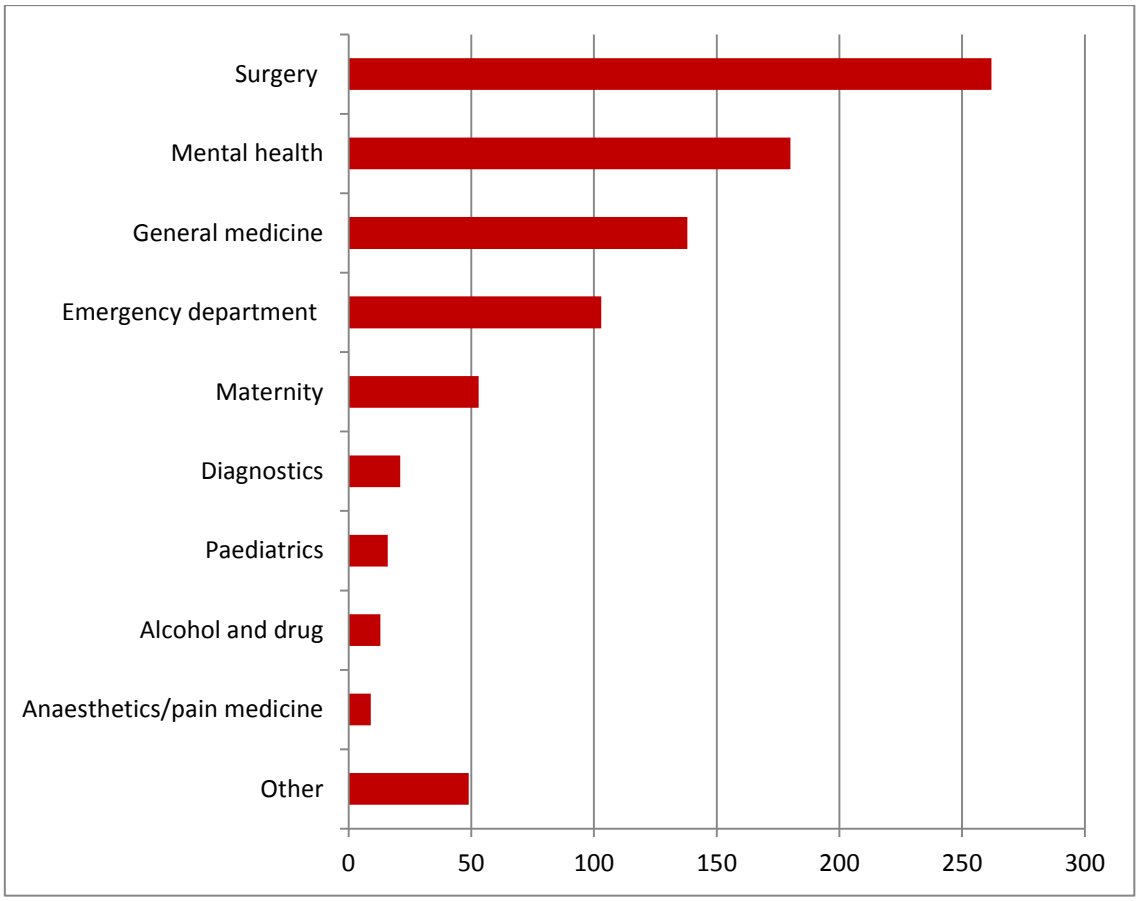
2. Which DHB services were complained about?

2.1 DHB service types complained about

DHBs operate a number of different services, both within hospitals and outside of hospitals, in clinics and in the community. It should be noted that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 805 complaints about DHBs, 844 services have been complained about.

Complaints received by HDC in the 2015/16 year were spread across many of those service types, as shown in Figure 3 below, with the greatest proportion of complaints being about surgical services (31%), followed by mental health (21%), general medicine (16%), emergency departments (12%) and maternity services (6%).

Figure 3. DHB service types complained about



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

The most common surgical specialties complained about in 2015/16 were orthopaedics (8%), general surgery (7%) and gynaecology (5%). This is consistent with the surgical specialties complained about in 2014/15.

Table 1. DHB service types complained about

Service type	Number of services (%)
Aged care (long-term care)	**2 (0.2)**
Alcohol and drug	**13 (2)**
Anaesthetics/pain medicine	**9 (1)**
Dental	**6 (0.7)**
Diagnostics	**21 (2)**
Disability services	**6 (0.7)**
District nursing	**6 (0.7)**
Emergency department (including paramedics)	**103 (12)**
General medicine	**138 (16)**
Cardiology	23 (3)
Dermatology	5 (0.6)
Endocrinology	6 (0.7)
Gastroenterology	11 (1)
Geriatric medicine	13 (2)
Infectious diseases	3 (0.4)
Neurology	15 (2)
Oncology	19 (2)
Palliative care	6 (0.7)
Renal/nephrology	2 (0.2)
Respiratory	14 (2)
Rheumatology	3 (0.4)
Other/unspecified	18 (2)
Hearing services	**4 (0.5)**
Intensive care/critical care	**5 (0.6)**
Maternity	**53 (6)**
Mental health	**180 (21)**
Occupational therapy	**2 (0.2)**
Paediatrics (not surgical)	**16 (2)**
Rehabilitation services	**6 (0.7)**
Sexual health	**5 (0.6)**
Surgery	**262 (31)**
Cardiothoracic	11 (1)
General	60 (7)
Gynaecology	38 (5)
Neurosurgery	5 (0.6)
Ophthalmology	14 (2)
Oral/Maxillofacial	2 (0.2)
Orthopaedics	65 (8)
Otolaryngology	11 (1)
Paediatric	8 (0.9)
Plastic and reconstructive	19 (2)
Urology	24 (3)
Vascular	3 (0.4)
Unknown/other	2 (0.2)
Other health service	**7 (0.8)**
TOTAL	**844**

Table 2 below, shows a yearly comparison of the proportion of complaints received for the most commonly complained about service types. As can be seen from this table, the most common service types complained about over the last three years have remained broadly consistent, with surgery showing a small increase and general medicine a small decrease. Therefore, although complaints about DHB services have increased overall in 2015/16, no one service type seems to be responsible for this increase.

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

Service type	2013/14	2014/15	2015/16
Surgery	**26%**	**27%**	**31%**
Mental health	**19%**	**19%**	**21%**
General medicine	**19%**	**17%**	**16%**
Emergency department	**13%**	**13%**	**12%**
Maternity	**6%**	**7%**	**6%**

Case study: General medicine (14HDC01771)

Mrs A, a 51-year-old woman, was diagnosed with ovarian cancer. At that time she weighed 84kg. She was seen by an oncologist, Dr B, at a public hospital (DHB1), and agreed to receive chemotherapy, including carboplatin (a drug used to treat ovarian cancer).

As Mrs A did not live in DHB1's region, she travelled to her nearest public hospital's (DHB2) oncology clinic chemotherapy unit for her treatment. An oncologist from DHB1 attended this clinic twice a month.

The dose of carboplatin is based on an assessment of the level of the patient's kidney function. DHB1 uses a computer based calculator, the Aesculapius programme, which calculates the carboplatin dose based on the patient's weight and serum creatinine level. Mrs A's initial weight was 84kg and blood tests showed a creatinine level of 90mmol/L. At the time of Mrs A's treatment, the chemotherapy staff nurses documented a patient's height and weight only at the initial visit, and did not note their weight again. When a patient was seen in the oncology clinic, the oncologist noted the current weight in the clinical file, but as the Aesculapius programme was not readily available to the consultant while at DHB2, the input into the computer system depended on the oncologist entering the information when he or she returned to DHB1.

Mrs A's weight fluctuated, and a year later, her weight was 65.6kg and she had a creatinine level of 64mmol/L . A CT scan showed further disease progression and Dr B advised Mrs A to try single agent carboplatin treatment.

Dr B calculated Mrs A's first dose of single agent carboplatin. The Aesculapius prescription form shows that the calculation of the dose of 600mg was based on her original measurements, which were prepopulated into the Aesculapius programme (weight of 84kg and creatinine of 90mmol/L). Mrs A received this treatment and at her next consultation, Dr B recorded that the effect of the carboplatin seemed to be favourable. Four further doses of 600mg carboplatin were administered, at which stage carboplatin was discontinued because of myelosuppression.

A chemotherapy nurse then noticed that Mrs A had been receiving chemotherapy based on a weight of 84kg, some 20kg more than her actual weight of 65kg.

The Commissioner considered that the following systemic issues at DHB1 contributed to Mrs A receiving a dose of carboplatin calculated on the basis of incorrect measurements:

- Changes in patient information, on which prescriptions for chemotherapy treatment were based (such as weight and creatinine levels), could be recorded only in the chemotherapy treatment computer system at DHB1, where it was based, and not by oncologists working at off-site clinics.
- There were insufficient safeguards to identify the use of historic data, and whether the weight and creatinine levels on the day of delivery differed from that data. The oncologists were unable to update patient details remotely, and the patient's weight was not displayed prominently (or consistently) in the clinical file, which meant that it was not necessarily brought to the clinician's attention at clinic appointments.

Accordingly, the Commissioner found that DHB1 failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner was critical about the lack of systems in place at DHB2 to check that the data relied on was correct, prior to administering chemotherapy treatment. Criticism was also made about Dr B's failure to ensure that the calculations for treatment, which he signed off, were correct.

The Commissioner recommended that DHB1 provide HDC with a detailed report on the effectiveness of the changes made as a result of this case, including: how clinicians ability to access the Aesculapius programme remotely is affecting their service delivery; the results of a review of DHB1 and DHB2's models of service; and an assessment of the effectiveness of the changes made to its service delivery following the review. The Commissioner also recommended that Dr B report to HDC on how the ability to access the prescribing software remotely has affected his practice.

The Commissioner asked DHB2 that it provide HDC with a report on the effectiveness of the changes it had made, including: its new practice of weighing patients prior to treatment, and notifying a clinician at DHB1 if a discrepancy is detected against the script; the changes it had made to Aesculapius; and whether clinicians at its outreach clinics had adequate access to electronic databases, including the Aesculapius programme.

2.2 Professions of individual providers complained about

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

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

Occupation	Number of individuals (%)
Doctors	***243 (77)***
Anaesthetist	5 (2)
Cardiothoracic surgeon	3 (1)
General surgeon	25 (8)
House officer	3 (1)
Internal medicine specialist	31 (10)
Medical officer	7 (2)
Obstetrician/gynaecologist	30 (9)
Ophthalmologist	5 (2)
Orthopaedic surgeon	26 (8)
Otolaryngologist	6 (2)
Paediatrician	7 (2)
Plastic and reconstructive surgeon	8 (3)
Psychiatrist	39 (12)
Radiation oncologist	3 (1)
Radiologist	3 (1)
Registrar	20 (6)
Urologist	6 (2)
Other	16 (5)
Other health providers	***73 (23)***
Midwife	12 (4)
Nurse	36 (11)
Occupational therapist	3 (1)
Psychologist	8 (3)
Social worker	8 (3)
Other	6 (2)
TOTAL	**316**

Over three quarters of the individual providers identified in DHB complaints received in the 2015/16 year were doctors. It is likely that doctors are more often seen by complainants as being responsible for the services provided and the outcomes of those services and are, therefore, more frequently viewed as individually responsible for any perceived shortcomings.

The most commonly identified individual provider occupations were psychiatrists (12%), nurses (11%) and internal medicine specialists (10%). This is reflective of the fact that mental health and general medicine were two of the most commonly complained about service types.

A yearly comparison of the proportion of complaints received for the most commonly complained about individual providers in 2015/16 is displayed below in Table 4.

Table 4. Yearly comparison of the proportion of complaints received about the most commonly complained about individual providers in 2015/16

Occupation	2013/14	2014/15	2015/16
Psychiatrist	**9%**	**15%**	**12%**
Nurse	**12%**	**11%**	**11%**
Internal medicine specialist	**12%**	**12%**	**10%**
Obstetrician/gynaecologist	**8%**	**8%**	**9%**
Orthopaedic surgeon	**7%**	**8%**	**8%**

As can be seen from Table 4 above, the most common individual providers identified on DHB complaints has remained broadly consistent over the last three years.

Case study: Obstetrician/gynaecologist (13HDC01557)

Mrs B, a 46-year-old woman, consented to undergoing a total vaginal hysterectomy performed by obstetrician/gynaecologist, Dr A, at a public hospital. During the procedure, initial attempts by Dr A to open the Pouch of Douglas (the extension of the peritoneal cavity between the rectum and the posterior wall of the uterus) failed. Dr A then mistakenly identified Mrs B's bowel wall as the Pouch of Douglas and attempted to open it, causing a perforation to Mrs B's bowel.

Dr A then stopped the procedure and sought assistance from her supervisor, Dr C. Dr C found that Mrs B had extensive adhesions of the uterus, tubes and ovaries and to the side and posterior walls of the pelvis. Due to the difficulties with the vaginal hysterectomy, the procedure was converted to an abdominal hysterectomy. Dr A contacted a general surgeon, Dr D, and requested his assistance with repairing the perforation of Mrs B's bowel. Dr D was unsure about being able to close the perforation entirely, so he decided to perform a loop colostomy. The abdominal hysterectomy was then completed.

Dr A and Mrs B have different recollections of what was discussed between them after the surgery. There is no record that Dr A told Mrs B that she had made an error during the surgery which resulted in her having perforated Mrs B's bowel.

The Commissioner considered that Dr A made several errors in this case, and was particularly critical of her lack of caution and failure to seek advice. When her initial attempts to open the Pouch of Douglas failed, Dr A persisted with the vaginal approach. She did not seek the advice of a senior colleague. She then mistook the anatomy and cut Mrs A's bowel.

Dr A's failure to seek advice and convert to an abdominal procedure earlier, together with her mistaken incision of incorrectly identified tissue amounted to a serious departure from expected standards and a failure to provide services to the woman with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner also considered that Dr A's poor standard of record-keeping departed from professional standards, and accordingly she breached Right 4(2) of the Code.

The Commissioner was also critical that while Dr A said that she was open and honest with Mrs B, it was more than a month before Mrs B understood what had happened to her during the surgery. The Commissioner considered that Dr A did not disclose the surgical error in a way that was adequately understood by Mrs B.

Dr A had been involved in prior adverse events at the Hospital and the Commissioner was critical of

the DHB's systems for identification and reporting of serious surgical events.

The Commissioner recommended that Dr A provide Mrs B with a written apology for the failures identified in his report. The Commissioner also recommended that should Dr A return to practise in New Zealand, the Medical Council of New Zealand undertake a review of her competence before issuing a practising certificate.

The Commissioner also made a number of recommendations to the DHB, including: that it consider introducing a separate credentialing process for advanced surgical procedures in addition to the standard Senior Medical Officer credentialing; and review its mechanisms for early identification and internal reporting of serious surgical morbidity.

3. What did people complain about?

3.1 Issues identified in complaints

Many complaints to HDC contain multiple issues of concern to the complainant. For the purposes of analysis, we identified the primary issue being complained about plus up to six additional complaint issues for each complaint received.

As shown in Table 5, we grouped the complaint issues into several categories. Among these categories, issues relating to care/treatment, access/funding and communication were the most prevalent, appearing as the primary complaint category in 56%, 13% and 10% of complaints respectively. When separate complaint issues are considered, missed/incorrect/delayed diagnosis (16%), unexpected treatment outcome (10%) and inadequate/inappropriate treatment (9%) emerge as the most common primary complaint issues. This is broadly similar to what was seen last year, with the exception of unexpected treatment outcome which increased from being the primary issue in 6% of complaints in 2014/15 to being the primary issue in 10% of complaints in 2015/16. Complaints primarily about access/funding issues have steadily increased over the last three years from 7% in 2013/14 to 13% in 2015/16.

Case study: Inadequate/inappropriate treatment (14HDC00766)

Mrs A, who had recently given birth to her first child, developed an abscess in her breast. Mrs A underwent surgery to have the abscess drained and was subsequently referred to the district nursing service for ongoing management of her wound. The wound was packed with a wound dressing called Aquacel rope. The end of the rope should remain outside the wound. However, when the district nurses visited, the end of the rope was not always visible. It was assumed that Mrs A had removed the rope herself, although she had not done so.

The wound was slow to heal, but there was no objective record of the dimensions of the wound. The district nurses made regular changes to the products being used to treat the wound, but the reasons for change of product were often not recorded. At times the district nurses relied on Mrs A contacting her GP for review rather than making contact for her.

When the wound was noted to have hypergranulated with an increased amount of green exude, Mrs A was told to see her GP to obtain a referral to the surgical team. During surgical excision of the wound a 5cm piece of Aquacel rope dressing was discovered.

The Commissioner was critical that the Aquacel rope was not used appropriately, the wound was not investigated adequately and Mrs A was not asked whether she had removed the dressings herself. In addition, the DHB wound assessment form was not designed to capture objective parameters that would indicate wound progress over time, and district nurses were not recording objective assessments of Mrs A's wound consistently. Accordingly the Commissioner found that the DHB had failed to ensure that services were provided to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner was also critical that the district nurses failed to work together effectively by: at times, relying on Mrs A to contact her GP rather than the district nurse contacting the GP directly; making regular changes to the products used without documenting the reason; and having no peer review and no recorded follow-up of the efficacy of the treatment provided. Accordingly, the Commissioner found that the DHB failed to ensure cooperation among providers to ensure quality and continuity of services to Mrs A, in breach of Right 4(5) of the Code.

Following this event the DHB undertook a review of policy, standard operating procedures and processes and implemented changes. The Commissioner recommended that the DHB: provide HDC

with a report confirming the implementation of changes, including evidence of the communication of these changes to staff; carry out an independent peer review of the quality of its District Nursing Service wound assessment and evaluation; and provide HDC with an update of progress regarding the possible introduction of electronic record-keeping within the District Nursing Service.

On analysis of all issues identified in complaints about DHBs, the most common complaint issues were: inadequate/inappropriate treatment (43%), failure to communicate effectively with the consumer (38%), inadequate/inappropriate examination/assessment (29%), disrespectful manner/attitude (25%), inadequate coordination of care/treatment (24%), failure to communicate effectively with family (24%), and missed/incorrect/delayed diagnosis (23%).

Many complaints involved issues categorised as care/treatment, such as: unexpected treatment outcome; delay in treatment; inadequate/inappropriate follow-up; inadequate/inappropriate testing; and inappropriate/delayed discharge/transfer, each of these were mentioned in between 17% and 19% of complaints.

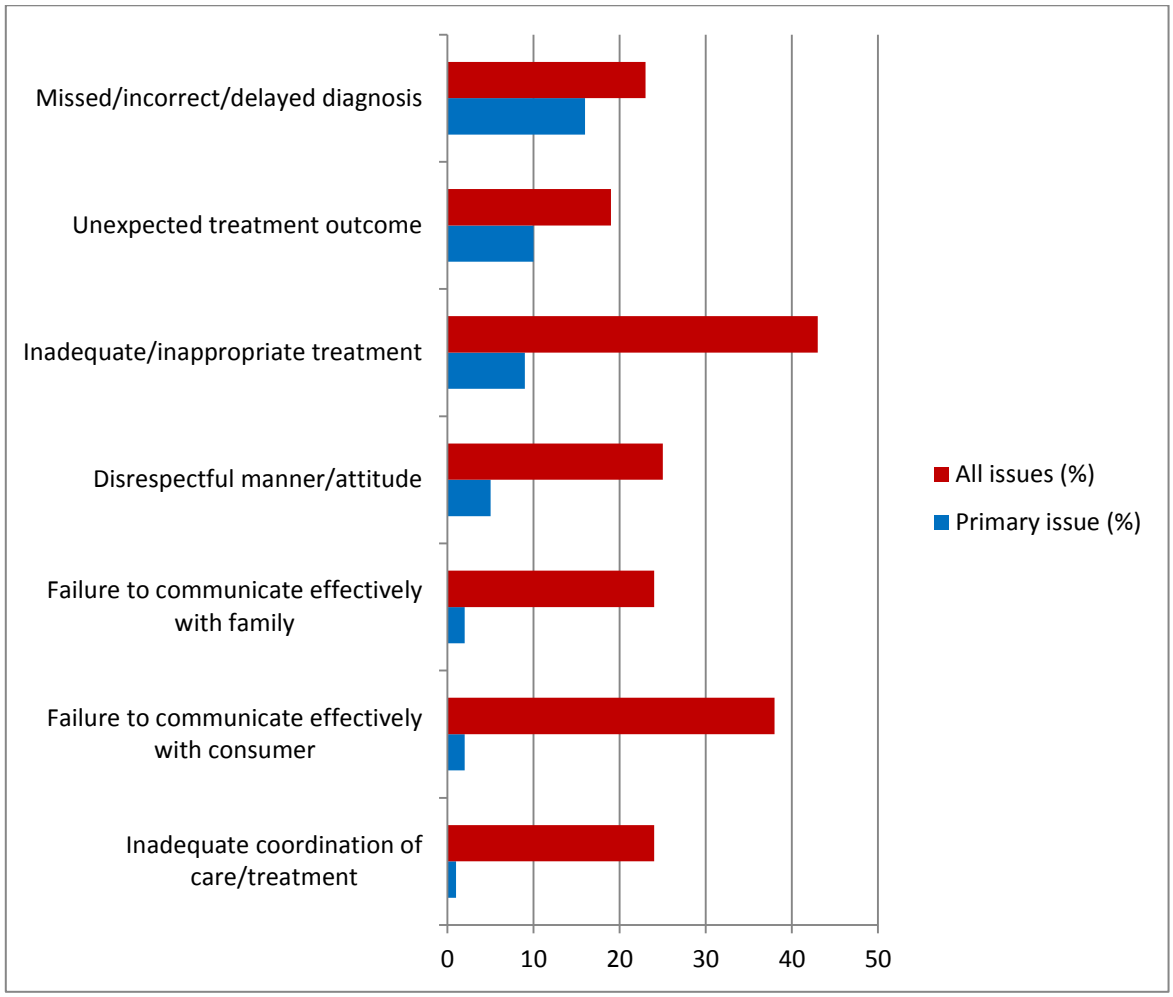
Table 5. Issues complained about in DHB complaints

Complaint issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Access/Funding	***108 (13)***	
ACC compensation issue	0	7 (0.9)
Lack of access to services	50 (6)	87 (11)
Lack of access to subsidies/funding	7 (0.9)	18 (2)
Waiting list/prioritisation issue	51 (6)	89 (11)
Boundary violation	***6 (0.7)***	
Inappropriate non-sexual communication	0	2 (0.2)
Inappropriate sexual communication	2 (0.2)	2 (0.2)
Inappropriate sexual physical contact	2 (0.2)	2 (0.2)
Inappropriate non-sexual relationship	2 (0.2)	2 (0.2)
Care/Treatment	***447 (56)***	
Delay in treatment	12 (1)	145 (18)
Delayed/inadequate/inappropriate referral	11 (1)	76 (9)
Inadequate coordination of care or treatment	10 (1)	196 (24)
Inadequate/inappropriate clinical treatment	72 (9)	345 (43)
Inadequate/inappropriate examination/assessment	32 (4)	232 (29)
Inadequate/inappropriate follow-up	18 (2)	139 (17)
Inadequate/inappropriate monitoring	12 (1)	62 (8)
Inadequate/inappropriate non-clinical care	12 (1)	54 (7)
Inadequate/inappropriate testing	3 (0.4)	134 (17)
Inappropriate admission/failure to admit	1 (0.1)	14 (2)
Inappropriate/delayed discharge/transfer	25 (3)	137 (17)
Inappropriate withdrawal of treatment	7 (0.9)	18 (2)
Missed/incorrect/delayed diagnosis	129 (16)	184 (23)
Personal privacy not respected	0	7 (0.9)
Refusal to assist/attend	2 (0.2)	16 (2)
Refusal to treat	9 (1)	33 (4)
Rough/painful care or treatment	7 (0.9)	37 (5)
Unexpected treatment outcome	80 (10)	154 (19)
Unnecessary treatment/over-servicing	5 (0.6)	19 (2)
Communication	***82 (10)***	
Disrespectful manner/attitude	39 (5)	199 (25)
Failure to accommodate cultural/language needs	1 (0.1)	16 (2)
Failure to communicate openly/honestly/effectively with consumer	20 (2)	307 (38)
Failure to communicate openly/honestly/effectively with family	17 (2)	195 (24)
Insensitive/inappropriate comments (not sexual)	5 (0.6)	56 (7)
Complaints process	***9 (1)***	
Inadequate information provided regarding complaints process	0	6 (0.7)
Inadequate response to complaint	9 (1)	178 (22)
Retaliation/discrimination as a result of a complaint	0	14 (2)
Consent/Information	***71 (9)***	
Coercion by provider to obtain consent	1 (0.1)	6 (0.7)
Consent not obtained/adequate	14 (2)	40 (5)
Inadequate information provided regarding adverse event	3 (0.4)	25 (3)
Inadequate information provided regarding condition	7 (0.9)	41 (5)
Inadequate information provided regarding fees/costs	3 (0.4)	5 (0.6)

Complaint issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Inadequate information provided regarding options	0	22 (3)
Inadequate information provided regarding provider	0	12 (1)
Inadequate information regarding results	4 (0.5)	24 (3)
Inadequate information provided regarding treatment	5 (0.6)	80 (10)
Incorrect/misleading information provided	2 (0.2)	30 (4)
Issues regarding consent when consumer not competent	1 (0.1)	5 (0.6)
Issues with involuntary admission/treatment	31 (4)	33 (4)
Documentation	***10 (1)***	
Delay/failure to disclose documentation	4 (0.5)	10 (1)
Delay/failure to transfer documentation	0	2 (0.2)
Inadequate/inaccurate documentation	4 (0.5)	51 (6)
Inappropriate maintenance/disposal of documentation	0	3 (0.4)
Intentionally misleading/altered documentation	2 (0.2)	3 (0.4)
Facility issues	***14 (2)***	
Accreditation standards/statutory obligations not met	0	3 (0.4)
Cleanliness/hygiene issue	0	18 (2)
Failure to follow policies/procedures	0	12 (1)
General safety issue for consumer in facility	5 (0.6)	17 (2)
Inadequate/inappropriate policies/procedures	1 (0.1)	49 (6)
Issue with sharing facility with other consumers	1 (0.1)	6 (0.7)
Issue with quality of aids/equipment	0	13 (2)
Staffing/rostering/other HR issue	1 (0.1)	31 (4)
Waiting times	6 (0.7)	37 (5)
Medication	***30 (4)***	
Administration error	2 (0.2)	6 (0.7)
Inappropriate administration	3 (0.4)	9 (1)
Inappropriate prescribing	14 (2)	43 (5)
Prescribing error	4 (0.5)	9 (1)
Refusal to prescribe/dispense/supply	7 (0.9)	23 (3)
Reports/Certificates	***7 (0.9)***	
Inaccurate report/certificate	7 (0.9)	21 (3)
Training/supervision		
Delayed/inadequate/inappropriate handover	0	2 (0.2)
Inadequate supervision/oversight	0	18 (2)
Other professional conduct issues	***17 (2)***	
Assault	5 (0.6)	9 (1)
Disrespectful behaviour	5 (0.6)	19 (2)
Failure to disclose/properly manage a conflict of interest	1 (0.1)	2 (0.2)
Inappropriate collection/use/disclosure of information	4 (0.5)	22 (3)
Threatening/bullying/harassing behaviour	2 (0.2)	11 (1)
Other	0	8 (1)
Disability-specific issues	***4 (0.5)***	***14***
Other issues	***0***	***19***
TOTAL	***805***	

Figure 4 details the seven most common complaint issues raised in complaints about DHBs received in the 2015/16 year. The blue bars show the percentage of cases in which the particular complaint issue was identified as the primary complaint issue, while the red bars show the percentage of cases in which the particular complaint issue was raised at all. As can be seen from the large difference in the size of the blue and red bars, communication-related complaint issues (disrespectful manner/attitude, and failure to communicate effectively with family or consumer) and inadequate coordination of care/treatment are present in a significant number of complaints, but are not often the primary issue raised.

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



Case study: Failure to communicate openly/honestly/effectively with consumer (15HDC00100)

Ms A was referred to the emergency department (ED) of a public hospital by her GP with a suspected ankle fracture. On the referral letter, the GP noted that Ms A was allergic to several medications, including morphine. On arrival at the ED, Ms A completed an admission form on which she documented under "any medical alerts or allergies?" that she was allergic to morphine, codeine, penicillin, and erythromycin.

Ms A was seen by ED consultant, Dr C, who noted her history and her current medications and requested an X-ray. It was later documented in the nursing notes that Ms A was allergic to "penicillin, morphine, codeine, erythromycin".

Dr C noted that the X-ray showed no obvious fracture, but queried a Linsfranc fracture and requested orthopaedic review. Dr C then prescribed Ms A Severdol, which is the controlled drug morphine sulphate in tablet form, and discharged her home. Dr C did not ask Ms A whether she had any allergies, nor did he explain that Severdol was a form of morphine. Dr C also did not document his management or discharge plan.

Following Ms A's return home, but before she took the Sevredol, Ms A's mother, a registered nurse, noted that she had been prescribed morphine and contacted the ED.

The Commissioner noted that eliciting an adequate history is a basic medical skill and that information about the woman's allergy was easily available in the clinical records and could have been obtained directly from the woman. The Commissioner said that by failing to read the notes adequately and talk with his patient, Dr C missed several opportunities to ascertain Ms A's allergy status.

The Commissioner found that by inappropriately prescribing Sevredol to someone with a known and well-documented allergy to that drug, Dr C failed to provide services to Ms A with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner was also critical of Dr C for failing to explain to Ms A that Sevredol is a form of morphine, and therefore failing to ensure that Ms A was provided with information that a reasonable consumer, in that consumer's circumstances, would expect to receive, in breach of Right 6(1) of the Code. As a consequence, the woman was unable to give her informed consent for this aspect of the treatment, and Dr C breached Right 7(1) of the Code.

The Commissioner also found Dr C in breach of Right 4(2) of the Code for failing to document his management or discharge plan, and, in particular, his prescription of Sevredol.

The Commissioner considered Dr C's failures to be individual clinical errors, and the DHB was not found to be vicariously liable for the Dr C's breaches of the Code.

The Commissioner recommended that Dr C undertake further training in elation to history taking in a clinical setting and safe prescribing practices. The Commissioner also required Dr C to apologise to Ms A.

The Commissioner recommended that the DHB share its learnings and actions it had taken in relation to prescribing controlled drugs and the maintenance of records with the National DHB Chief Medical Officer Group.

Table 6 details a yearly comparison of the most common issues raised in 2015/16. Common complaint issues have remained broadly consistent over the last three years. However, inadequate coordination of care/treatment became a common complaint issue for the first time in 2015/16, increasing from being present in 14% of complaints in 2013/14 to 24% of complaints in 2015/16. Inadequate/inappropriate examination/assessment has also shown a large increase over the last three years from 14% in 2013/14 to 29% in 2015/16, failure to communicate effectively with consumer has also increased steadily from 21% in 2013/14 to 38% in 2015/16. On the other hand, complaints involving an inadequate response to consumer's complaint by the DHB did not appear in the most common issues for the first time in 2015/16, decreasing from being present in 27% of complaints in 2014/15 to 22% of complaints in 2015/16.

Table 6. Yearly comparison of the most common issues complained about in DHB complaints in 2015/16

Complaint issue	2013/14	2014/15	2015/16
Inadequate/inappropriate treatment	**37%**	**40%**	**43%**
Failure to communicate effectively with consumer	**21%**	**34%**	**38%**
Inadequate/inappropriate examination/assessment	**14%**	**27%**	**29%**
Disrespectful manner/attitude	**20%**	**24%**	**25%**
Inadequate coordination of care/treatment	**14%**	**19%**	**24%**
Failure to communicate effectively with family	**21%**	**22%**	**24%**
Missed/incorrect/delayed diagnosis	**27%**	**24%**	**23%**

It is important to note that Table 5 and 6 and Figure 4 are analyses of the issues raised by complainants in their complaints, rather than analyses of HDC's assessment of the issues raised. Inevitably, some of the complaint issues raised will have been found, on subsequent assessment, not to have been substantiated.

Case study: Inadequate coordination of care/treatment (15HDC00111)

Mr A had a complex medical history, including cardiac issues and a strong family history of myocardial infarction (heart attack). Mr A presented to the Emergency Department (ED) of a public hospital for a mental health assessment and was discharged with a management plan. The following day, Mr A presented to the ED again after an incident of self harm. Mr A then had a cardiac event and was diagnosed with an ST-segment elevation myocardial infarction (STEMI). He was transferred to the intensive coronary care unit (ICCU) at another hospital.

Further investigations were undertaken and Mr A was considered to have Takotsubo cardiomyopathy. During his admission to ICCU, routine blood tests showed a very abnormal troponin T result (a highly specific marker for myocardial infarction or heart muscle cell death). However, Mr A's cardiologist, Dr E, was not aware that the test had been ordered and was not informed of the result. At the time of these events, the DHB required patients to be declared medically fit for discharge so that they could be nursed at the mental health facility.

The following day, Dr C reviewed Mr A and declared that he was medically fit for discharge. Mr A was transferred to the mental health facility. Mr A was to be observed every 10 minutes while in the mental health facility. The next morning Mr A was found deceased in his room. The mental health

facility confirmed that the 10-minute observations had been adhered to overnight.

The Coroner found that the direct cause of death was cardiac arrhythmia precipitated by recent myocardial infarction.

The Commissioner found that Mr A's discharge from the ICCU was inappropriate in the circumstances. The severity of the damage to Mr A's heart was not recognised and troponin T levels were not used to guide Mr A's further management. Accordingly the DHB failed to provide Mr A with services with reasonable care and skill in breach of Right 4(1) of the Code. The Commissioner also considered that the documentation in this case was suboptimal, in breach of Right 4(2) of the Code.

The Commissioner was critical that: the DHB process meant that Mr A needed to be declared fit for discharge from the ICCU before he could receive appropriate mental health care; DHB systems failed to alert Mr A's treating clinicians to his repeat troponin T test; and mental health facility staff were not made aware of the seriousness of Mr A's cardiac condition or risk of complications. He considered that the DHB processes meant that the providers involved in Mr A's care did not cooperate appropriately to ensure quality and continuity of services, in breach of Right 4(5) of the Code.

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

- provide HDC with a copy of the policy regarding the requirement of rise and satisfactory fall of troponin T levels prior to discharge from ICCU;
- finalise the policy requiring electronic sign-off of blood results;
- implement a system that requires the laboratory to alert the patient's treating clinical urgently when troponin T levels are abnormally high; and
- audit the rate of cross-referencing information about overnight observations in the mental health facility into the patient's clinical records;
- review ED polices regarding the management of at-risk patients; and
- review the terms of reference and/or guidelines related to the extended capacity of the Liaison Psychiatry service, and provide quarterly statistics to HDC regarding the use of the service in other settings, such as on medical wards.

3.2 Complaint issues by service type

Issues raised in complaints vary, at least to some degree, according to the DHB service type concerned. As shown in Table 7 below, diagnostic issues were most prevalent in complaints about services with high diagnostic workloads, with 39% of emergency department complaints and 18% of general medicine complaints being primarily about a missed/incorrect/delayed diagnosis. Unexpected treatment outcome was prominent for surgical services, as this issue most often relates to post-surgical complications

These issues are broadly similar to what was seen last year, with the exception of access/funding issues which became more prominent in 2015/16, with 13% of surgical complaints being primarily about a waiting list/prioritisation issue and 7% of mental health and general medicine complaints being primarily about a lack of access to services

Primary issues in complaints about mental health services were quite distinct, with issues relating to involuntary admission/treatment being a prevalent primary issue, and inadequate/inappropriate examination/assessment being the primary issue in 9% of complaints.

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

Surgery n=262		Mental health n=180		General medicine n=138		Emergency department n=103		Maternity n=53	
Unexpected treatment outcome	26%	Issues with involuntary admission/ treatment	18%	Missed/ incorrect/ delayed diagnosis	18%	Missed/ incorrect/ delayed diagnosis	39%	Missed/ incorrect/ delayed diagnosis	20%
Missed/ incorrect/ delayed diagnosis	13%	Inadequate/ inappropriate examination/ assessment	9%	Inadequate/ inappropriate treatment	11%	Inadequate/ inappropriate treatment	8%	Inadequate/ inappropriate treatment	19%
Waiting list/ prioritisation issue	13%	Lack of access to services	7%	Lack of access to services	7%	Disrespectful manner/ attitude	8%	Unexpected treatment outcome	11%

As mentioned above, many complaints to HDC contain multiple issues of concern to the complainant. Table 8 below shows an analysis of the common complaint issues raised about each service type when all issues complained about are considered (rather than just the primary issue as in Table 7).

When all issues raised in complaints about each service type are analysed, it can be seen that communication issues feature prominently for all service types. However, again complaint issues do vary according to the service type complained about, with general medicine and surgical services receiving a greater proportion of complaints involving inadequate coordination of care/treatment than other service types, while emergency department services received a greater proportion of complains involving inadequate testing and maternity received a greater proportion of complaints regarding a delay in treatment. Mental health services saw a greater proportion of complaints regarding communication issues than did other service types.

Table 8. Most common issues in complaints by service type

Surgery n=262		Mental health n=180		General medicine n=138		Emergency department n=103		Maternity n=53	
Inadequate/ inappropriate treatment	50%	Failure to communicate effectively with consumer	41%	Inadequate coordination of care/ treatment	38%	Inadequate/ inappropriate examination/ assessment	48%	Inadequate/ inappropriate treatment	57%
Failure to communicate effectively with consumer	43%	Inadequate/ inappropriate treatment	40%	Failure to communicate effectively with family	38%	Missed/ incorrect/ delayed diagnosis	42%	Failure to communicate effectively with consumer	51%
Unexpected treatment outcome	42%	Inadequate/ inappropriate examination/ assessment	30%	Inadequate/ inappropriate treatment	37%	Inadequate/ inappropriate treatment	40%	Unexpected treatment outcome	36%
Inadequate/ inappropriate examination/ assessment	29%	Failure to communicate effectively with family	27%	Missed/ incorrect/ delayed diagnosis	27%	Inadequate/ inappropriate testing	35%	Inadequate/ inappropriate examination/ assessment	32%
Inadequate coordination of care/ treatment	26%	Disrespectful manner/ attitude	23%	Failure to communicate effectively with consumer	25%	Failure to communicate effectively with consumer	34%	Delay in treatment	32%

Case study: Emergency department and an inadequate/inappropriate examination/assessment (14HDC01187)

Miss A, a nearly three year old child, had a cough and a runny nose. Her condition worsened over the next few days. On the fifth day, Miss A awoke with a fever shortly after midnight and her mother took her to the Emergency Department (ED) at a public hospital.

On arrival, Miss A had a cough, a temperature of 38.5°C (which soon increased to 39.3°C), and an increased heart rate. She was assessed by two doctors, and following cooling techniques and the administration of paracetamol and ibuprofen, her temperature reduced to 37.4°C and her heart rate also reduced. She was discharged home with the instruction to return if there were any concerns. The discharging doctor requested that the Paediatric Department call the family to follow-up but this did not occur.

Throughout the next two days Miss A was lethargic, slept frequently, refused food but continued to drink water. Her fever was managed with paracetamol and ibuprofen. On the second day, Miss A began to make a wheezing noise when exhaling. Her wheezing worsened and her mother took her back to the ED where they arrived at 9.14pm.

On arrival, Miss A was triaged as category 2 (to be seen within 10 minutes). Her temperature was 37.3°C, her heart rate was 170-175 beats per minute, and her respiratory rate was 44 breaths per minute. She was assessed by a house officer, Dr C, who discussed her presentation with the supervising consultant (Dr B). Dr B did not assess Miss A personally. Dr C recorded an impression of a viral illness, and Miss A was discharged home at 10:07pm. Dr C did not document any discharge information provided to Miss A's parents, and he did not request a follow-up telephone call from the Paediatric Department.

At 7am the following day, Miss A's temperature had increased to 40.2°C and her mother called the ED for advice. She was instead transferred to a telehealth service and spoke with a registered nurse (RN). Miss A's mother told the RN Miss A's temperature and that they had been to ED twice in two days. Miss A's breathing was audible to the RN throughout the call. The mother ended the call after 3 minutes and 12 seconds, before the RN had completed triage, telling the RN that she was "going to go". The RN did not call her back or contact the telehealth service's resource nurse for advice. At approximately 1pm Miss A stopped breathing. Her mother called an ambulance and Miss A was taken to the ED. Attempts to resuscitate her were unsuccessful.

The telehealth RN did not rule out all of the girl's relevant emergent symptoms, nor did he triage her clinical presentation within an acceptable timeframe, and therefore did not provide appropriate advice to her mother. Furthermore, he did not advise Miss A's mother to take Miss A back to ED or verify that she intended to do so, and he failed to take appropriate steps when Miss A's mother ended the call. For these reasons the Commissioner considered that the RN failed to provide services to Miss A with appropriate care and skill in breach of Right 4(1) of the Code.

The Commissioner considered that as the senior doctor supervising a house officer, and as the clinician with overall responsibility for Miss A's care, it was Dr B's duty to ensure that he had the relevant information about Miss A's condition before agreeing with the decision to discharge her. By approving Miss A's discharge home following her second presentation to ED without first taking sufficient steps to investigate the cause of her presenting symptoms, Dr B failed to provide Miss A with services with appropriate care and skill, in breach of Right 4(1) of the Code. The Commissioner was also critical of Dr C for discharging Miss A home without further investigation and for the quality of his documentation.

The Commissioner considered that there were service failures in the care provided to Miss A that were directly attributable to the DHB as the service operator, and that the failures exhibited a pattern of suboptimal care. DHB staff inappropriately discharged Miss A home following her second presentation to ED without first taking steps to consider her history and investigate the cause of her

presenting symptoms. Staff also failed, on two occasions, to provide adequate discharge information to Miss A's family. The Commissioner also considered that the DHB's system for paediatric follow-up was not sufficiently robust to ensure that follow-up would occur when requested. Additionally, the DHB failed to encourage a culture where staff felt comfortable questioning or challenging decisions and lacked a multi-disciplinary approach to Miss A's care. The Commissioner considered that the DHB team had sufficient information to provide Miss A with appropriate care, however, a series of judgement and communication failures meant that it did not do so. Accordingly, the Commissioner found that the DHB failed to provide services to the girl with reasonable care and skill, in breach of Right 4(1) of the Code.

In response to this case, the Commissioner commented that "Any individual in the clinical team should be able to ask questions or challenge decisions at any time, and it is important that employers such as DHBs encourage such a culture. Good support systems (including the safety net of vigilant senior nurses and readily available consultants) are also crucial"

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

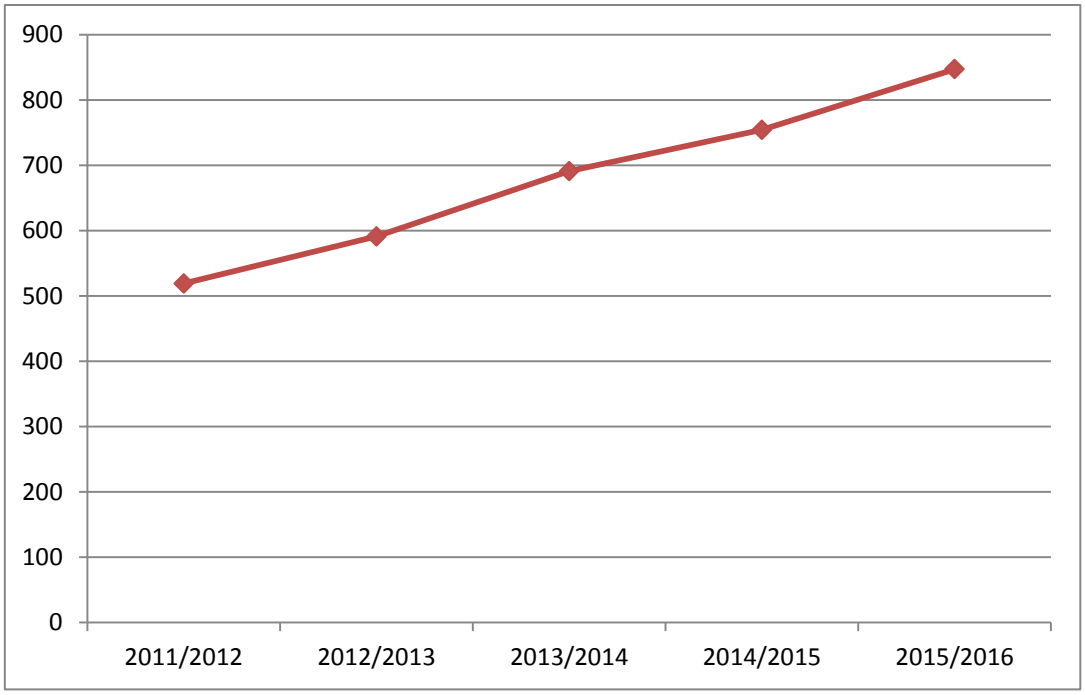
- conduct an audit of all unplanned re-presentations to ED, by patients under 5 years of age, within 48 hours of discharge, to measure compliance with: the requirement for assessment by a consultant or senior registrar prior to discharge, the requirement for nursing/medical consultation prior to discharge, and the requirement for a follow-up phone call from paediatric staff to families following referral;
- commission an independent review of senior/junior staff rostering to establish whether sufficient levels of supervision are available for junior staff working in ED;
- include in its training and induction for all staff, information that the practice at the DHB is that of asking questions and reporting of concerns is expected and accepted from all members of the multidisciplinary team;
- update HDC on the completion of outstanding recommendations from its Serious Adverse Event Review, and monitoring of ongoing changes made; and
- review its Memorandum of Understanding between the Emergency Department and Paediatric Department and its policy for transfer to the telehealth service (particularly whether specific instructions should be included to cover the circumstance where a person has been discharged from ED and advised to return if symptoms persist).

COMPLAINTS CLOSED

1. How many complaints were closed?

HDC closed **847** complaints involving DHBs in the 2015/16 year. This was an increase of 12% on the 754 complaints closed in 2014/15. As with complaints received, the number of complaints closed has been steadily increasing year on year for the last five financial years (see Figure 5 below).

Figure 5. Number of complaints closed about DHBs in last five financial years



It should be noted that complaints may be received in one financial year and closed in the following financial year. This means that the number of complaints received will not correlate with the number of complaints closed.

2. What were the outcomes of the complaints closed?

2.1 Available resolution options

HDC has a number of options available for the resolution of complaints. These include referring the complaint to the Advocacy Service, to a professional body, or to another agency. HDC may also refer a complaint back to the provider to resolve directly. In line with their responsibilities under the Code, DHBs have increasingly developed good systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

The Commissioner also has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of formal investigation, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. 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 the 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 and, in many cases, expert clinical advice. Often a decision to take no further action will be accompanied by an educational comment or recommendations designed to assist the provider in improving future services.

Where appropriate, the Commissioner may formally investigate a complaint. Once HDC has notified the parties that a complaint is to be investigated, the complaint is classified by HDC as a formal investigation, even though an alternative manner of resolution may subsequently be adopted. Notification of formal investigation generally indicates more serious or complex issues.

In appropriate cases, the Commissioner may decide to refer a provider who has been found in breach of the Code to the Director of Proceedings. The Director of Proceedings then makes an independent decision about whether to bring proceedings against the provider in either the Health Practitioners Disciplinary Tribunal (if the provider is an individual health practitioner) or in the Human Rights Review Tribunal. Referral to the Director of Proceedings only occurs in the most serious of cases, and referral of a DHB is relatively uncommon.

2.2 Manner of resolution and outcomes in complaints closed

The manner of resolution and outcomes for all DHB complaints closed in the 2015/16 year is shown in Table 9 below. It should be noted that outcomes are displayed in a descending order. If there is more than one outcome for a DHB upon resolution of a complaint, then only the outcome listed highest in the table is included.

Table 9. Outcome for DHBs of complaints closed

Outcome for DHB	**Number of complaints**
Investigation	***28***
Breach finding	11
No further action with follow-up or educational comment	11
No further action	3
No breach finding	3
Other resolution following assessment	***784***
No further action with follow-up or educational comment	176
Referred to Ministry of Health	1
Referred to Privacy Commissioner	2
Referred to District Inspector	24
Referred to DHB	203
Referred to Advocacy	43
No further action	322
Withdrawn	13
Outside jurisdiction	***35***
TOTAL	***847***

As can be seen from the table above, in the 2015/16 year, HDC concluded 28 formal investigations involving DHBs, 11 of which resulted in a finding that the DHB had breached the Code. The number of formal investigations concluded in respect of each individual DHB ranged from none to five investigations. No DHBs were referred to the Director of Proceedings.

3. Recommendations made to DHBs following resolution of complaints

Regardless of whether or not a complaint has been investigated, or whether the DHB has been found in breach of the Code, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted on. Many such recommendations are described in the case studies included throughout this report.

Table 9 shows the recommendations made to DHBs in complaints closed in the 2015/16 year. Please note that more than one recommendation may be made in relation to a single complaint.

Table 9. Recommendations made to DHBs following a complaint

Type of recommendation	Number of recommendations made
Apology	34
Audit	52
Meeting with consumer/complainant	3
Presentation/discussion of complaint with others	18
Provision of information to other agency	3
Provision of information to HDC	55
Reflection	8
Review of policies/procedures	58
Training/professional development	38
Total	**269**

As can be seen from Table 9 above, the most common recommendation made to DHBs was that they review their policies/procedures (58 recommendations). The provision of information to HDC (55 recommendations) and audits were also often recommended (52 recommendations). The provision of information to HDC was often in relation to HDC ensuring that DHBs had made the changes they reported they would make in response to the complaint. Audits were most commonly of adherence to policies/procedures followed by compliance with documentation requirements. Training recommendations most frequently concerned clinical issues followed by communication and documentation. Apologies were recommended on 34 occasions and feedback from complainants suggests that these were often highly valued.

In the vast majority of cases, recommendations made by HDC are complied with by all providers, including DHBs.

Case studies
Recommendations made by HDC

Recommendations arising from breach relating to inappropriate use of tenecteplase for thrombolysis of stroke patient (13HDC01676)

A man presented to the emergency department (ED) after suffering an ischaemic stroke. Upon consultation with a consultant, the house officer decided that the man was an appropriate candidate for thrombolysis (clot busting). Although it was usual practice for stroke thrombolysis to be administered in the Intensive Care Unit, the house officer decided to treat the man in the ED. In addition, the house officer prescribed the man tenecteplase (used for heart attacks) rather than the expected alteplase (used for strokes). The house officer also prescribed the man at least twice the dose of tenecteplase recommended for treatment of an ischaemic stroke via an inappropriate mode of administration.

The Commissioner found that the house officer made significant errors in judgement in: failing to transfer the man to the ICU; deciding to prescribe tenecteplase to the man at the dose and via the mode of administration that she did; and failing to consult the consultant about the use of tenecteplase. The Commissioner was also critical of the steps the consultant took to openly disclose to the man what had happened.

The Commissioner considered that there were inadequacies in the DHB's Stroke Thrombolysis Pathway. In addition, there was evident confusion amongst nursing staff about the correct process for administering thrombolysis, and the house officer had not been orientated to the Stroke Thrombolysis Pathway adequately.

In accordance with the Commissioner's recommendations the DHB:

- provided HDC with the outcome of its audit regarding compliance with the updated Stroke Pathway;
- reviewed the orientation of junior and new staff to ensure they knew how to access all medications within the DHB and who to contact with questions or queries; and
- updated HDC regarding the changes it had made to its electronic reportable events system.

The Commissioner also recommended that the National DHB Chief Medical Officer group take steps to ensure that all DHB's policies/guidelines in relation to stroke thrombolysis are clear and consistent, including in relation to the appropriate medication, dose and mode of administration to use, and the level of supervision required.

Recommendations arising from breach relating to transfer of a trauma patient (13HDC00046)

A man underwent multiple surgeries after being involved in an accident in which he suffered significant trauma. The man's medications included Clexane (to reduce the risk of deep vein thrombosis). Hospital staff decided to transfer the man to a rehabilitation provider. The hospital discharge summary did not refer to discharge medications or the ongoing use of Clexane, and nor did it refer to supplementary documentation which outlined discharge medications. The Clexane was not given to the man by staff at the rehabilitation provider.

The Commissioner held that the coordination and continuity of the man's care was compromised for the following key reasons: the transfer by the DHB without obtaining verbal acceptance by a doctor from the rehabilitation provider was not in accordance with DHB policy; transfer documentation did not contain all the relevant and important clinical information; DHB staff did not ensure there were clear written instructions passed on about the man's Clexane regimen; and the man was transferred late on a Friday.

In accordance with the Commissioner's recommendations, the DHB:

- completed a random audit of Trauma Service discharge summaries for compliance with completion, accuracy, and the responsible medical team checking procedures instigated;
- reported to HDC on the outcome of the DHB's internal review of: criteria for transfer of major trauma patients to facilities with or without guaranteed and immediate medical back-up; policies for transfers occurring on Friday afternoons; and the process of critical information exchange between the hospital and the rehabilitation provider;
- reported to HDC on the tasking of surgical resident medical officers to cover the Trauma Service roster so that changes in staff are minimised and discharge processes are consistent; and
- reported to HDC on the effectiveness of the newly introduced transfer checklist for major trauma patients.

Recommendations arising from breach relating to monitoring during phenytoin infusion (13HDC00756)

A child was taken to the ED at a public hospital after suffering epileptic seizures. The child was prescribed intravenous (IV) phenytoin by a paediatric registrar. The paediatric registrar did not give specific instructions about how the child should be monitored during the infusion and she did not receive one-on-one monitoring. There is no record that the child was monitored during the infusion or that the IV site was checked. The child was transferred to another hospital for treatment of an extravasation injury.

The Commissioner considered that a number of factors led to the child receiving inadequate monitoring during the phenytoin infusion in the ED. The paediatric registrar did not give specific instructions about monitoring, and the DHB's policies did not specify that children receiving IV phenytoin infusions should have cardiac and blood pressure monitoring and be observed for signs of respiratory depression. There were also failures by staff to follow the policies that were in place. The Commissioner found that the care provided to the child also suffered because of staffing issues.

In response to the Commissioner recommendations, the DHB:

- reviewed its "Cannulation – Intravenous", "Phenytonin Intravenous – Adults Only" and "Handover" policies to ensure that those polices were adequate to guide safe and effective care and transfer of care between nurses;
- reviewed its current policies relation to phenytonin and IV medication administration/cannulation for adults and children to ensure that references to other policies were clear and accurate ;
- reviewed the systems it had in place for ensuring safe staffing in the ED; and
- used an anonymised version of this report as a basis for staff training at the hospital, focussing particularly on the deficiencies in care identified in this case.