Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Complaints to HDC involving Te Whatu Ora

Report and Analysis for period 1 January to 30 June 2022

Contents

Commissioner's Foreword

Tēnā koutou

I am pleased to present my Office's first complaint trend report for complaints made about Te Whatu Ora districts. This report outlines the trends in complaints received by HDC about districts between 1 January and 30 June 2022 and replaces previous reporting about DHB complaints. We are continuing to work on ensuring these reports support quality and safety in the new system, and would welcome any feedback you have.

HDC received 566 complaints about Te Whatu Ora districts in January to June 2022. This represents a 22% increase on the average number of complaints received, but is the same number of complaints as was received in the previous six month period.

The general trends in this report are consistent with past trends. Surgery, mental health & addictions, medicine and emergency department services remain the most commonly complained about services. Missed/delayed diagnosis continues to be the most common primary complaint issue raised by complainants.

HDC continued to receive a high number of COVID-19 related complaints in the first six months of 2022, and the profile of these complaints changed significantly with the advent of the Omicron outbreak and the significant pressure this placed on the health system. Complaints changed from being primarily related to the vaccine roll-out to being about the impact of COVID-19 on the health system. Almost 40% of district complaints related to COVID-19 were about reduced access and/or significant delays in care, as well as the impact reduced staffing had on consumers' experience of services. A number of complaints also related to COVID-19 related policies and protocols, most commonly concerns related to visitor restrictions.

I hope these reports assist in understanding the consumer experience and people's concerns. I know 2022 has been a particularly challenging year for the health and disability workforce. Ngā mihi for remaining committed to quality and safety and improving the consumer experience.

Morag McDowell
Health and Disability Commissioner

National data for Te Whatu Ora | Health New Zealand

1. Complaints received about Te Whatu Ora

1.1 Number of complaints received

In the period Jan–Jun 2022, HDC received 566[1] complaints about care provided by Te Whatu Ora| Health New Zealand (previously District Health Boards). This is the same number of complaints as was received in the previous six-month period, but is a 16% increase on the average number of complaints received over the past four six-month periods.

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

	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Jul–Dec 20	Jan–Jun 21	Jul–Dec 21	Average of last four periods	Jan–Jun 22
Number of complaints	439	450	442	427	471	392	464	532	566	**489**	**566**

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 and within regions over time, enabling any trends to be observed.

Complaint rate calculations are made using discharge data provided by Manatū Hauora | Ministry of Health. This data is provisional as at the date of extraction (20 October 2022) and may be incomplete. 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

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
566	453,671	124.76

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan–Jun 2022 and previous six-month periods.

[1] Provisional as of date of extraction (1 September 2022).

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

	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Jul–Dec 20	Jan–Jun 21	Jul–Dec 21	Average of last 4 periods	Jan–Jun 22
Rate per 100,000 discharges	93.80	88.47	87.97	92.92	90.35	92.00	106.77	117.33	**101.61**	**124.76**

The rate of complaints received during Jan–Jun 2022 (124.76) is 23% higher than the average rate of complaints received for the previous four periods, and is the highest rate of complaints ever received in a six-month period.

The number and rate of complaints received in Jan–Jun 2022 and previous six-month periods is displayed below in Figure 1.

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

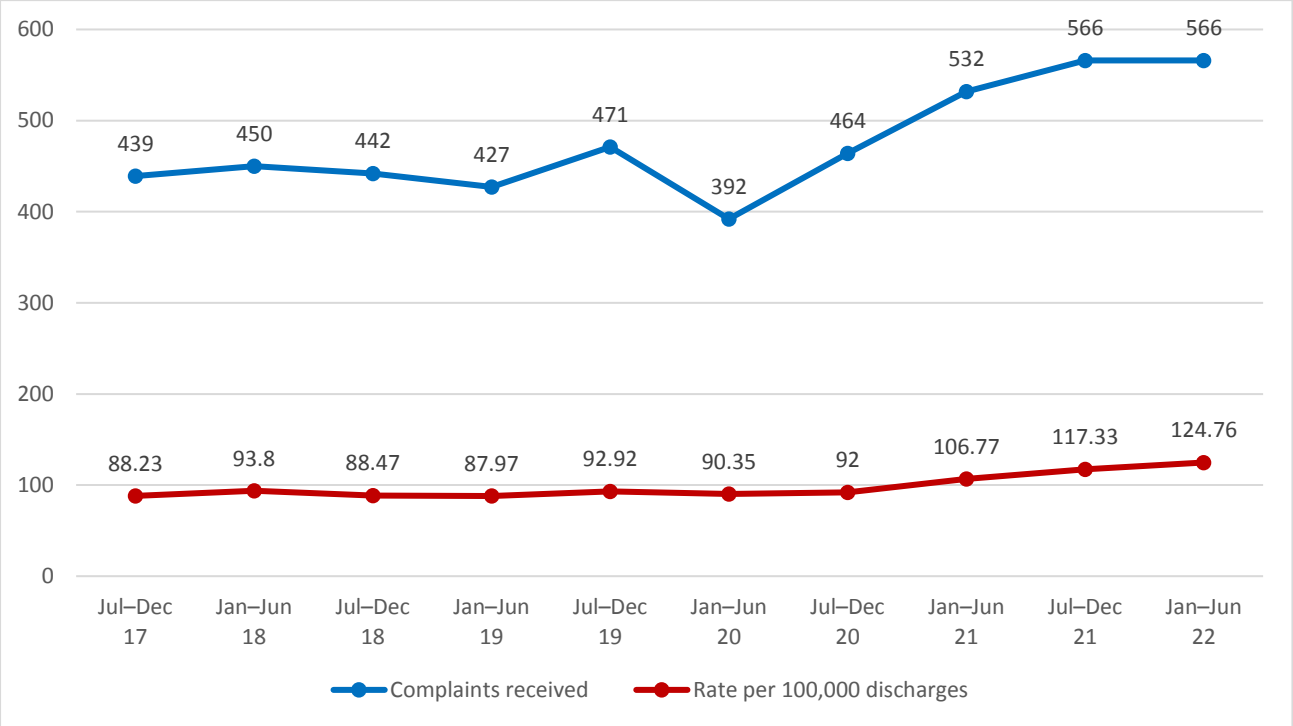


Table 4 shows the number and rate of complaints received by HDC for each Te Whatu Ora region and district.

Table 4. Number and rate of complaints received for each Te Whatu Ora region and district in Jan–Jun 2022

Region and district	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Northern North Island	**183**	**170,471**	**107.35**
Te Tai Tokerau	21	21,051	99.76
Waitematā	56	51,262	109.24
Te Toka Tumai Auckland	59	57,296	102.97
Counties Manukau	47	40,862	115.02
Te Manawa Taki	**110**	**100,919**	**108.99**
Waikato	51	45,524	112.03
Lakes	17	11,423	148.82
Hauora a Toi Bay of Plenty	23	26,466	86.90
Tairāwhiti	9	4,837	186.07
Taranaki	10	12,669	78.93
Central North Island	**128**	**84,193**	**152.03**
Te Pae Hauora o Ruahine o Tararua MidCentral	23	13,970	164.64
Whanganui	11	6,627	165.99
Capital, Coast and Hutt Valley	67	42,531	157.53
Te Matau a Māui Hawke's Bay	19	17,110	111.05
Wairarapa	8	3,955	202.28
Te Waipounamu	**145**	**98,090**	**147.82**
Waitaha Canterbury	64	53,802	118.95
Te Tai o Poutini West Coast	7	2,727	256.69
Nelson Marlborough	20	11,537	173.36
South Canterbury	9	5,797	155.25
Southern	45	24,227	185.74

Notes on region/district complaint number and rate of complaints

It should be noted that a district's number and rate of complaints can vary considerably from one six-month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six-month period. Further, for smaller districts, 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 the number of complaints received by HDC is not always a good proxy for quality of care provided, and can be impacted by a number of factors (e.g., features of the services provided by a particular district/region). 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 districts 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 regions when considering their own complaint patterns.

2. Who complained?

This section outlines the demographics of consumers in complaints to HDC about Te Whatu Ora services. The demographics of consumers is very similar to what was seen in the previous period.

2.1 Consumer gender

The gender of consumers in complaints to HDC about Te Whatu Ora services in Jan–Jun 2022 is detailed below.

Table 5. Consumer gender

Consumer gender	Number of complaints	Proportion of complaints
Female	343	61%
Male	215	38%
Unknown/did not wish to answer	8	1%

2.2 Consumer age

The age of consumers in complaints to HDC about Te Whatu Ora services in Jan–Jun 2022 is detailed below.

Table 6. Consumer age

Consumer age	Number of complaints	Proportion of complaints
0 to 17 years	43	8%
18 to 24 years	35	6%
25 to 34 years	89	16%
35 to 49 years	97	17%
50 to 64 years	108	19%
65+ years	132	23%
Unknown/did not wish to answer	62	11%

2.3 Consumer ethnicity

The ethnicity of consumers in complaints to HDC about Te Whatu Ora services in Jan–Jun 2022 is detailed below.

Table 7. Consumer ethnicity

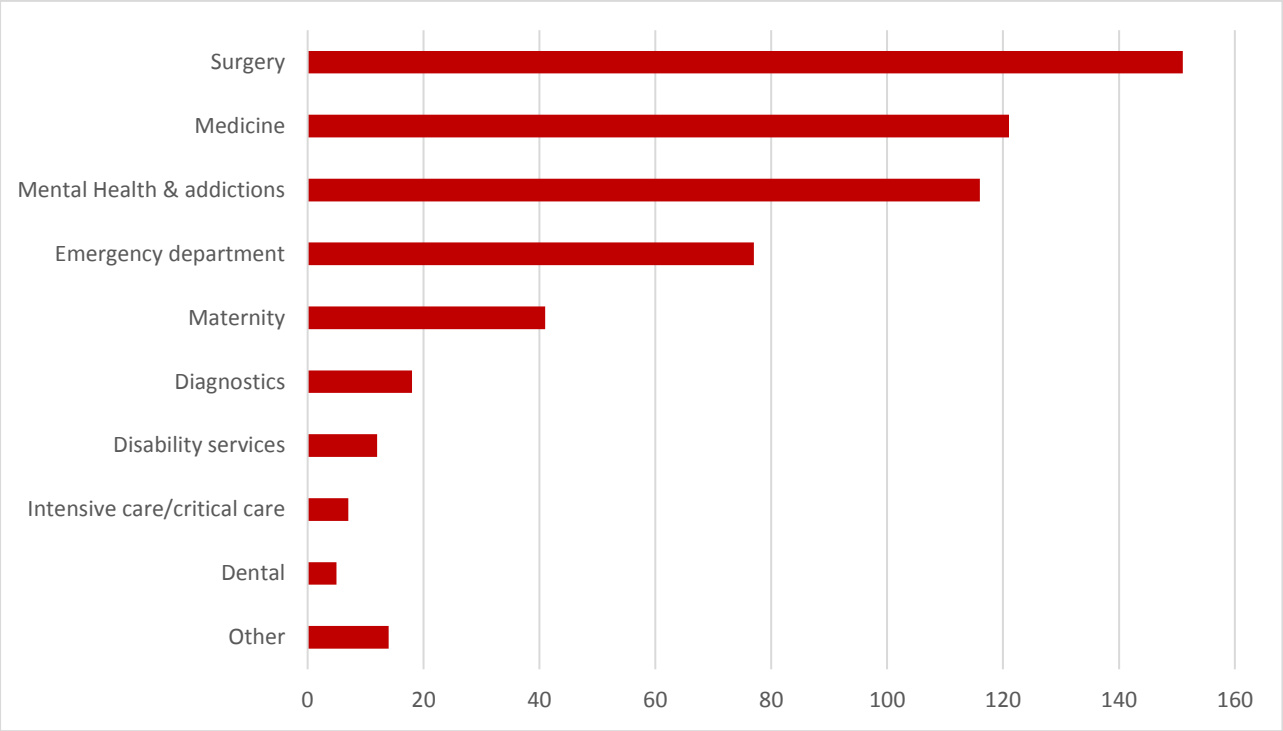
Consumer ethnicity	Number of complaints	Proportion of complaints
Māori	95	17%
Pacific	20	4%
Middle Eastern/African/Latin American	12	2%
Asian	31	5%
Other European	22	4%
New Zealand European	275	49%
Unknown/did not wish to answer	111	20%

3. Which Te Whatu Ora services were complained about?

3.1 Te Whatu Ora service types complained about

Please note that some complaints involve more than one Te Whatu Ora district and/or more than one service or hospital; therefore, although there were 566 complaints about Te Whatu Ora, 578 services were complained about. Figure 2 below shows the most commonly complained about service types in Jan–Jun 2022. A more nuanced picture of service types complained about, including individual surgery and medicine services, is provided in Table 8.

Figure 2. Service types complained about



Surgery (26%) received the greatest number of complaints in Jan–Jun 2022, with orthopaedics (6%) being the surgical specialty most commonly complained about.

Other commonly complained about services included medicine (21%), mental health and addictions (20%), and emergency department (13%) services.

Table 8. Service types complained about

Service type	Number of complaints	Percentage
Assisted dying	**3**	**Less than 1%**
Dental	**5**	**Less than 1%**
Diagnostics	**18**	**3%**
Disability services	**12**	**2%**
District nursing	**3**	**Less than 1%**
Emergency department	**77**	**13%**
Intensive care/critical care	**7**	**1%**
Maternity	**41**	**7%**
Medicine	**121**	**21%**
General medicine	15	3%
Cardiology	17	3%
Endocrinology	6	1%
Gastroenterology	8	1%
Geriatric medicine	11	2%
Neurology	14	2%
Oncology	13	2%
Palliative care	4	Less than 1%
Renal/nephrology	8	1%
Respiratory	4	Less than 1%
Rheumatology	4	Less than 1%
Other/unspecified	17	3%
Mental health and addiction	**116**	**20%**
Paediatrics (not surgical)	**4**	**Less than 1%**
Surgery	**151**	**26%**
Cardiothoracic	2	Less than 1%
General	41	7%
Gynaecology	30	5%
Neurosurgery	8	1%
Ophthalmology	9	2%
Orthopaedics	37	6%
Otolaryngology	7	1%
Plastic and reconstructive	2	Less than 1%
Paediatric	6	1%
Urology	7	1%
Other/unknown	2	Less than 1%
Other/unknown health service	**20**	**2%**
TOTAL	**578**	

Table 9 below shows a comparison of the proportion of complaints received over time for the most commonly complained about service types.

Table 9. Comparison of the proportion of complaints received about the most commonly complained about service types

Service type	Jul–Dec 2019	Jan–Jun 2020	Jul–Dec 2020	Jan–Jun 2021	Jul–Dec 2021	Jan–Jun 2022
Surgery	31%	31%	23%	26%	22%	26%
Mental health and addictions	25%	22%	24%	23%	20%	20%
Medicine	16%	18%	19%	16%	21%	21%
Emergency department	11%	11%	15%	12%	16%	13%
Maternity	5%	7%	5%	5%	5%	7%

4. What did people complain about?

4.1 Primary issues identified in complaints

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jan–Jun 2022 are listed below in Table 10. 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, they provide a valuable insight into consumers' experience of services provided and the issues they care about most.

The most common primary issue categories were:

- Care/treatment (53%)
- Access/funding (14%)
- Consent/information (11%)
- Communication (9%)

The most common specific primary issues complained about were:

- Missed/incorrect/delayed diagnosis (12%)
- Inadequate/inappropriate treatment (9%)
- Unexpected treatment outcome (8%)
- Lack of access to services (7%)
- Waiting list/prioritisation issue (6%)

Table 10. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	**76**	**13%**
Lack of access to services	39	7%
Lack of access to subsidies/funding	4	Less than 1%
Waiting list/prioritisation issue	33	6%
Boundary violation	**5**	**Less than 1%**
Care/Treatment	**296**	**52%**
Delay in treatment	24	4%
Delayed/inadequate/inappropriate referral	3	Less than 1%
Inadequate coordination of care/treatment	7	1%
Inadequate/inappropriate clinical treatment	53	9%
Inadequate/inappropriate examination/assessment	15	3%
Inadequate/inappropriate follow-up	13	2%
Inadequate/inappropriate monitoring	16	3%
Inadequate/inappropriate non-clinical care	9	2%
Inadequate/inappropriate testing	1	Less than 1%
Inappropriate admission/failure to admit	2	Less than 1%
Inappropriate/delayed discharge/transfer	20	4%
Inappropriate withdrawal of treatment	3	Less than 1%
Missed/incorrect/delayed diagnosis	67	12%
Refusal to assist/attend	2	Less than 1%
Refusal to treat	13	2%
Rough/painful care or treatment	3	Less than 1%
Unexpected treatment outcome	45	8%
Communication	**48**	**8%**
Disrespectful manner/attitude	28	5%
Failure to accommodate cultural/language needs	1	Less than 1%
Failure to communicate openly/honestly/effectively with consumer	11	2%
Failure to communicate openly/honestly/effectively with family/whānau	8	1%
Complaints process	**3**	**Less than 1%**
Consent/Information	**60**	**11%**
Consent not obtained/adequate	24	4%
Inadequate information provided regarding treatment	5	Less than 1%
Incorrect/misleading information provided	7	1%
Issues with involuntary admission/treatment	24	4%
Documentation	**8**	**1%**
Facility issues	**31**	**5%**
General safety issue for consumer in facility	11	2%
Inadequate/inappropriate policies/procedures	18	3%
Other	2	Less than 1%
Medication	**23**	**4%**
Inappropriate prescribing	15	2%
Refusal to prescribe/dispense/supply	5	Less than 1%

Other medication issue	3	Less than 1%
Professional conduct issues	**8**	**1%**
Disrespectful behaviour	4	Less than 1%
Inappropriate collection/use/disclosure of information	4	Less than 1%
Other issues	**8**	**1%**
TOTAL	**566**	

Table 11 shows a comparison over time for the most common primary issues complained about.

Table 11. Top five primary issues in complaints received over the last four six-month periods

Top five primary issues in all complaints (%)							
Jul–Dec 20 n=464		**Jan–Jun 21 n=532**		**Jul–Dec 21 n=566**		**Jan-Jun 22 n=566**	
Misdiagnosis	12%	Misdiagnosis	13%	Misdiagnosis	11%	Misdiagnosis	12%
Lack of access to services	10%	Unexpected treatment outcome	8%	Inadequate treatment	8%	Inadequate treatment	9%
Unexpected treatment outcome	8%	Lack of access to services	7%	Lack of access to services	8%	Unexpected treatment outcome	8%
Waiting list/ prioritisation	7%	Waiting list/ prioritisation	7%	Delay in treatment	6%	Lack of access to services	7%
Inadequate treatment	5%	Inadequate treatment	6%	Inadequate treatment	6%	Waiting list/ Prioritisation	5%

The most common primary issues complained about in regard to care provided to Māori consumers were:

- Inadequate/inappropriate clinical treatment — 14%
- Unexpected treatment outcome — 12%
- Missed/incorrect/delayed diagnosis — 10%
- Disrespectful manner/attitude — 7%

Māori raised issues around “inadequate treatment”, and “unexpected treatment outcome” and “disrespectful manner/communication” at a slightly higher rate than was seen across all population groups.

Complaints related to COVID-19

HDC received 129 complaints about COVID-19-related issues at districts in Jan–Jun 2022. This represents 23% of all complaints about COVID-19 received by HDC during this time period, and is an increase on the 72 COVID-19-related complaints received about districts in Jul–Dec 2021.

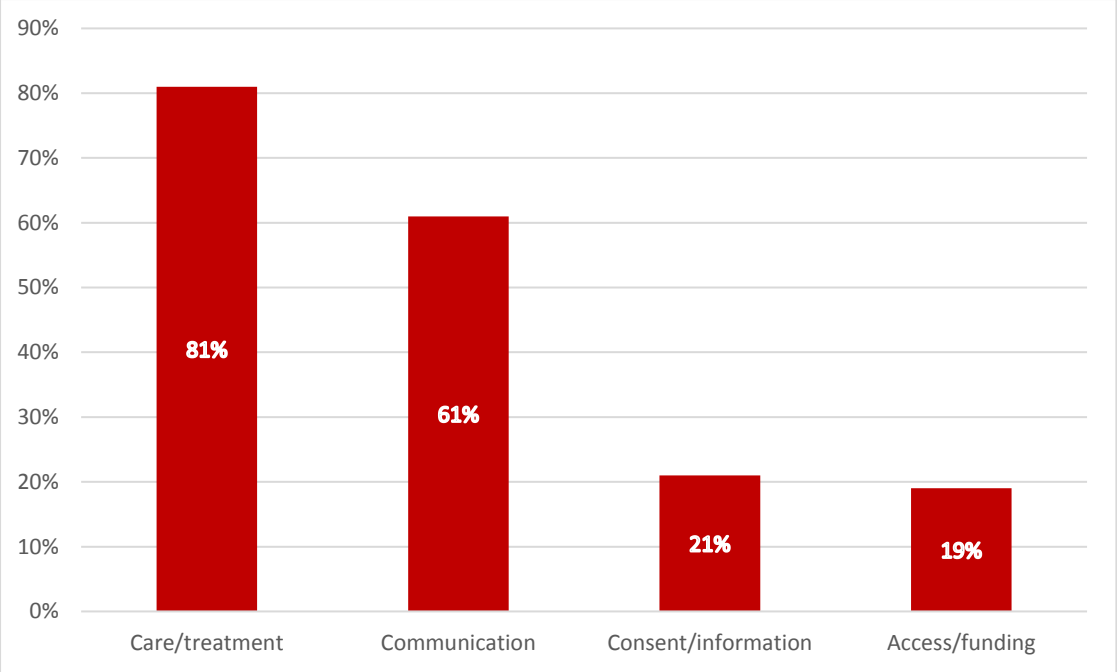
Complaints related to:

- Impact of COVID-19 on the health care system (e.g., delayed care, reduced staffing, etc.) — 39%
- COVID-19-related policies/procedures (primarily visitor restrictions, but also included concerns about mask requirements, vaccine mandates and other infection control policies) — 35%
- Vaccine-related issues (e.g., consent, adverse effects, administration procedure, etc.) — 12%
- Treatment of COVID-19 — 8%
- Testing-related issues (e.g., access to testing, delays in receiving results, etc.) — 5%

4.2 All issues identified in complaints

As well as the primary complaint issue, up to six additional complaint issues are identified for each complaint received by HDC. Figure 3 below shows the most common complaint issues when these additional complaint issues and primary complaint issues are considered. This is broadly similar to what has been seen in previous periods.

Figure 3. Most common complaint issues



4.3 Primary issues by service type

Table 12 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 previous periods. However, compared to the previous period there has been an increase in complaints about "unexpected treatment outcome" for surgical services.

Table 12. Three most common primary issues in complaints by service type

Surgery		Mental health & addictions		Medicine		Emergency department	
Unexpected treatment outcome	25%	Issues with involuntary admission/ treatment	18%	Missed/ incorrect/ delayed diagnosis	14%	Missed/ incorrect/ delayed diagnosis	28%
Waiting list/prioritisation issue	14%	Lack of access to services	9%	Inadequate/ inappropriate treatment	10%	Inadequate/ inappropriate treatment	13%
Lack of access to services	11%	Inadequate/ inappropriate treatment	7%	Lack of access to services	8%	Delay in treatment	11%

5. What were the outcomes of the complaints closed?

HDC is focused on fair and early resolution of complaints. Each complaint received by HDC is assessed carefully and resolved in the most appropriate manner, bearing in mind the issues raised and the evidence available. The assessment process can involve a number of steps, including

obtaining a response from the provider/s, seeking clinical advice, and asking for information from the consumer or other people.

A number of options are available to the Commissioner for the resolution of complaints. HDC may refer a complaint back to the provider or to the Advocacy Service to resolve directly with the consumer. In line with their responsibilities under the Code, providers have increasingly developed good systems to address complaints in a timely and appropriate way. Where complaints are assessed as suitable for resolution between the parties, it is often appropriate for HDC to refer a complaint to Te Whatu Ora to resolve with a requirement that it 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; a more appropriate outcome can be achieved in a more flexible and timely way than by means of investigation; or the matters that are the subject of the complaint have been, are being, or will be, addressed appropriately by other means. A decision to take no further action can be accompanied by an educational comment or recommendations designed to assist the provider to improve services in future.

Where appropriate, the Commissioner may investigate a complaint, which may result in Te Whatu Ora being found in breach of the Code. Notification of investigation generally indicates more serious issues.

5.1 Number of complaints closed

In the period Jan–Jun 2022, HDC closed 505[2] complaints involving Te Whatu Ora districts. Table 13 shows the number of complaints closed in previous six-month periods.

Table 13. Number of complaints closed about districts in the last five years

	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Jan–Jun 20	Jul–Dec 20	Jan–Jun 21	Jul–Dec 21	Average of last 4 periods	Jan–Jun 22
Number of complaints closed	383	476	449	444	423	428	390	478	330	**407**	**505**

5.2 Outcomes of complaints closed

The manner of resolution and outcomes of all complaints closed about Te Whatu Ora districts in Jan–Jun 2022 is shown in Table 14.

[2] 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 14. Outcome for districts of complaints closed by complaint type[3]

Outcome for Te Whatu Ora districts	Number of complaints closed
Investigation	***40***
Breach finding — referred to Director of Proceedings	3
Breach finding	18
No breach finding with adverse comment and recommendations	9
No breach finding with recommendations	5
No breach finding	3
Withdrawn	2
Other resolution following assessment	***465***
No further action with recommendations or educational comment	59
Referred to District Inspector	18
Referred to other agency	4
Referred to Te Whatu Ora	92
Referred to Advocacy	129
No further action	162
Withdrawn	1
TOTAL	**505**

5.3 Recommendations

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

Table 15 shows the recommendations made to Te Whatu Ora for complaints closed in Jan–Jun 2022. Please note that more than one recommendation may be made in relation to a single complaint.

Table 15. Recommendations made to districts following a complaint

Recommendation	Number of recommendations made
Apology	27
Audit	19
Presentation/discussion of complaint and improvements with others	18
Provision of evidence of change to HDC/evaluation of change	24
Review/implementation of policies/procedures	33
Training/professional development	32
TOTAL	**153**

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

The most common recommendations made in Jan–Jun 2022 were that the Te Whatu Ora district involved review/implement policies/procedures (33 recommendations) or that it provide further training to its staff (32 recommendations). Training was most often in relation to clinical issues, followed by communication and new policies/procedures. HDC also often suggests that an anonymised version of the complaint be presented to staff for educative purposes.

6. Learning from complaints

6.1 Informed consent to involvement of medical students[4]

This case highlights the expectation that the presence or involvement of students in sensitive examinations or procedures can take place only with unequivocal informed consent.

Background
A woman with a mild intellectual disability was accompanied by her mother to an appointment with an obstetrician & gynaecologist (the doctor). The doctor outlined the range of available contraceptive options, including a Mirena IUD. The woman's preference was for the Mirena to be inserted under a general anaesthetic.

The woman and her mother were clear that she did not consent to the presence of medical students, and that she had completed a form at the pre-assessment clinic refusing the presence of medical students. No such form could be found on her file. When the woman saw the doctor in the pre-assessment clinic, the subject of student involvement was not raised, and the "consent to students" section of the surgical consent form was not completed.

Prior to the procedure being undertaken, the doctor recognised that she had omitted to complete the checkbox on the consent form related to student involvement. The doctor therefore noted on the consent form that the presence of students needed "to be checked on admission", and that consent was to be confirmed. However, there is no evidence that anyone, including the doctor, acted on this alert or sought the woman's consent to student involvement.

The operation note states that the Mirena was inserted by a fifth-year medical student. There were also other medical students in the room as observers.

Findings
The Commissioner acknowledged the importance of medical education, but emphasised that there is a clear expectation that the presence or involvement of students in sensitive examinations or procedures can take place only with unequivocal informed consent, given the vulnerability of the person being examined. It is at the heart of patient-centred care.

The Commissioner considered that the woman was entitled to be notified about medical students' participation in her procedure, and concluded that the woman had earlier expressly refused it. While acknowledging that the woman's refusal appears not to have been known to the clinical team on the day of the procedure, consent was not otherwise obtained from her regarding the presence of medical students. The Commissioner found that by providing services involving teaching to the woman without first notifying her and obtaining her consent, the district breached Right 6(1)(d) and Right 7(1) of the Code.

The Commissioner also considered that the district's systems for obtaining consent were demonstrably lacking in that there were multiple forms at different stages of the process, and the "Time Out" processes were inadequate. Accordingly, the Commissioner found that the district failed to provide the woman with services with reasonable care and skill, in breach of Right 4(1) of the Code.

[4] Decision 20HDC01693

Recommendations
The Commissioner recommended that the district:

- Conduct an audit of cases within Obstetrics & Gynaecology in which students have observed or performed sensitive procedures, to check whether consent was given and recorded;
- Provide training to staff within Obstetrics & Gynaecology on informed consent, capacity, communication between clinicians, and the requirement to review clinical records; and
- Apologise to the woman in writing.

The Commissioner acknowledged that earlier this year a study was published in the *New Zealand Medical Journal* that showed serious lapses in obtaining informed consent for the involvement of medical students in sensitive examinations. Following the publication of the study in May 2022, the Commissioner wrote to all DHBs, medical schools and Te Whatu Ora to reinforce the message that informed consent must be sought for student involvement in sensitive examinations.

6.2 Assessment and action taken by an Emergency Department[5]

This case highlights the importance of critically assessing patients when they present to hospital on multiple occasions with the same symptoms within a relatively short period of time, particularly with little improvement. It also highlights the importance of communication, objectivity, and critically reflecting on biases when providing health services.

Background
A man in his thirties, of Māori descent, was diagnosed with otitis media (an infection of the middle ear) by a community health centre.

The man presented to the Emergency Department (ED) of a public hospital with a bacterial skin infection on his left foot, and was reviewed by the Senior House Officer (SHO). An incidental finding of discharge in his right ear, which had been present for two weeks, was noted. Following discussion with the Senior Medical Officer (SMO), the man was discharged with a referral to the Ear, Nose and Throat (ENT) service for follow-up. This referral was declined as it did not contain any clinical information indicating any degree of urgency.

A few weeks later, the man presented to ED with a four-week history of right ear pain, neck swelling and fever. He was seen by an SHO. The SHO noted that in the past the man had taken methamphetamine and cannabis, but had not taken those substances for six months. The man's blood tests indicated a significant infection. The SMO then reviewed the man and initiated the sepsis pathway. Antibiotics were commenced and a CT scan of his neck was undertaken, which showed an infection in the external ear. However, the middle ear could not be viewed on the scan and no further imaging was undertaken.

The man was then reviewed by an ENT specialist. The specialist understood that he was being asked to review a patient with a possible neck abscess, rather than for sepsis or a complicated ear infection. The specialist told HDC that the man was "in a state of great activity and euphoria" and was vague in responding to questions. The specialist documented his opinion that the man had otitis media/otitis externa, and recommended he be discharged with ear drops, antibiotics and a follow-up ENT appointment. The specialist stated that he saw no signs of sepsis, and no comments were made to him about possibly admitting the man.

The specialist reported that, based on the man's behaviour, he believed the man was experiencing acute methamphetamine intoxication. However, he did not discuss this with the man or his whānau. The specialist told HDC that he discussed the man's possible substance use with ED staff, but this is not documented. The man's family state that he was not intoxicated, and there is no documentation from ED staff that he was observed to be intoxicated.

The man was discharged from the ED and another ENT referral made. Later that evening (a Sunday), the ED Medical Director received a call from the laboratory, which advised that the man's blood cultures were positive for the bacteria *Streptococcus pyogenes* — a pathogen that can cause a variety of acute life-threatening infections. The discharge summary suggests that there was a delay of a few days before action was taken on these results.

The man re-presented to ED after being alerted to the abnormal results. The SMO noted that he was clinically well, and given his improvement he was discharged home with more intensive antibiotic treatment. The ED did not inform ENT of his positive blood cultures.

[5] Decision 19HDC01783

Around a month later, the man returned to ED with pain and discharge in his right ear, which had started the previous day. He was reviewed by an SHO and pus was noted in his right ear canal, and his eardrum was later confirmed to be perforated. The man's vital signs were abnormal. He was diagnosed with recurring otitis media, and discharged with antibiotics and an urgent ENT referral. At the time of the man's presentation there was no direct SMO supervision or experienced registrars in the ED, although there was an SMO on call. There is no record of the SHO discussing the man's presentation with an SMO.

A few weeks later, the man attended an outpatient appointment with the ENT specialist. The specialist found the man sleeping in the waiting room. The specialist believed the man's behaviour was a result of substance use. The specialist examined the man's ears. It was documented that the specialist reinforced to the man the importance of care of the ear and follow-up, and ear drops were prescribed and a CT scan arranged. The specialist recorded: "[T]he patient has obviously had very poor follow up with a significant history of substance abuse and methamphetamine use." There is no evidence that the specialist asked the man about his drug use or whether he had taken any substances.

The man's father had arranged to pick him up from the appointment, and the father told HDC that insensitive remarks were made by the ENT SMO about his son and drug use. The specialist stated that although he spoke about the man's drug use, he did not do so in the manner described by the father. The specialist said that he asked the man's father whether the family were aware that the man was using methamphetamines and doing very poorly.

The man collapsed at home three days later and was taken to ED by ambulance. CT imaging showed an abscess in the man's brain, arising from the temporal bone with associated fluid around the brain. Sadly, the man's condition continued to deteriorate despite intervention, and he died three days after his collapse at home.

Findings

Over the course of about two months, the man presented to the ED on four occasions with a recurring ear infection. There were a number of missed opportunities to investigate whether the man was experiencing complications. The clinicians involved failed to appreciate the significance of the man's repeated presentations and poorly resolving symptoms.

The Deputy Commissioner found that the district failed to provide care to the man with appropriate care and skill, in breach of Right 4(1) of the Code for the following reasons:

- CT head scans, including adequate views of the temporal and mastoid areas, were not undertaken.
- The follow-up of abnormal results policy for patients discharged from ED was insufficient in that it did not explicitly state timeframes and responsibilities, and there was poor follow-up of the man's positive blood cultures.
- There was an inadequate system for overnight SMO supervision in the ED — with the ability to call the SMO being limited to a small list of conditions, giving a strong impression that contacting SMOs is for urgent issues only and not for consultation. This resulted in a lack of SMO input into the man's care during one presentation to ED, and therefore a poor assessment being undertaken.

The Deputy Commissioner was critical of the ENT specialist for his communication with the man's father and for discussing his assumption that the man was using methamphetamine without clarifying

his suspicion with the man himself, or seeking to understand the interplay of the man's overall presentation.

In relation to speaking with whānau, the Deputy Commissioner reminded the ENT specialist of the Medical Council's statement on cultural safety, which stipulates that doctors should formulate treatment plans in partnership with patients that fit their cultural contexts and are balanced with the need to follow the best clinical pathway, and include the patient's whānau in their healthcare when appropriate.

Recommendations
The Deputy Commissioner recommended that the district:

- Provide a written apology to the man's whānau;
- Provide evidence of its amendment of ED SMO on-call policy and its review of the process for recalling patients to ED if they have positive blood cultures;
- Amend its ED follow-up policy for patients discharged from the ED with abnormal diagnostic results, to include timeframes in which the actions should occur;
- Develop clear guidelines for investigating and managing chronic otitis media, including details of when a CT head scan should be undertaken;
- Devise a protocol for managing suspected drug use; and provide training to all medical staff regarding expectations if drug use is suspected, including the provider's expectations in relation to documentation of conversations about suspected drug use between clinicians;
- Undertake an audit of positive blood cultures received by the ED in the last six months to identify whether timely follow-up occurred; and
- Provide evidence to HDC of the changes made as recommended in the critical systems analysis.

The Deputy Commissioner also recommended that the ENT specialist provide a written apology to the man's whānau; undertake self-directed learning on bias in healthcare; and reflect on his care in this case relating to his suspicion of drug use and the appropriate course of action, and his lack of documentation of discussions and observations, and provide HDC with his reflections and the changes made to his practice as a result.

6.3 Sharing clear information and risks about medication vital for informed choice and consent[6]

This case concerns a woman who became pregnant whilst taking Epilim (sodium valproate), which places the fetus at high risk of developing serious birth defects and can affect the way in which the child develops. The case reinforces the significance of the informed consent process, and highlights the importance of prescribing clinicians sharing with women clear information about the risks of taking Epilim with regard to pregnancy.

Background
A woman was referred to the District's mental health service by her GP. She was seen by a locum psychiatrist, who recorded her diagnosis as borderline personality disorder with a secondary differential diagnosis of Bipolar Affective Disorder Type 2. The psychiatrist commenced the woman on 200mg of Epilim in the morning and 500mg at night.

The psychiatrist's clinic letter addressed to the woman's GP contained no reference to any discussion with the woman regarding contraception or pregnancy planning in relation to Epilim. The psychiatrist told HDC that the woman agreed to a trial of Epilim after a full discussion of the risks and benefits of treatment, as well as alternative options. The psychiatrist could not recall whether she provided the woman with a medication safety information sheet about Epilim, but noted that it was her usual practice, and also that it was routine within the service for key workers to pass on this information.

The psychiatrist reviewed the woman again a few months later and noted that she was finding Epilim effective at regulating her emotions. The psychiatrist increased the dose to 900mg at night. There is no reference to discussion regarding contraception or pregnancy planning in relation to Epilim in the clinic letter to the GP from this appointment.

A second psychiatrist then reviewed the women and increased her dose to 1000mg and then 1200mg at night. Again there is no reference in the clinic letters to discussions around contraception or pregnancy. The second psychiatrist told HDC that it was her routine practice to discuss the side effects of Epilim in pregnancy and that she had this discussion with the woman.

The woman told HDC that none of the psychiatrists gave her written information about Epilim and pregnancy. She recalls being told that there were some risks regarding Epilim and pregnancy, but not what these were. She also recalled being provided with a pregnancy test by the second psychiatrist. The woman stated that there were no discussions about alternatives to Epilim.

Nearly 18 months following the initial consultation, the woman tested positive on a pregnancy test. The woman's GP reduced her Epilim dose to 1000mg at night, and sent an urgent referral to the District's obstetric service. A third psychiatrist reviewed the woman and advised slow weaning off Epilim to find the lowest effective dose — as the risk for congenital abnormality is dose dependent. The psychiatrist also increased the woman's folic acid dose. She recorded that the woman agreed with the plan and was aware of the risks and benefits. The woman was eventually weaned off Epilim completely during the pregnancy.

The woman attended an appointment with an obstetrician. The woman raised concerns with HDC that the obstetrician gave her incorrect information, telling her that there was a small increased risk of neural tube defects when taking Epilim, but no risk of cognitive or developmental delays. In a clinic

[6] Decision 19HDC00773

letter to the woman's midwife, the obstetrician wrote, "Epilim thought not to cause any cognitive issues". The obstetrician later apologised to the woman for this statement.

Findings

The Deputy Commissioner was not satisfied that the first psychiatrist who prescribed the woman Epilim provided her with information that a reasonable consumer in the woman's circumstances would expect to receive, including an explanation of the woman's options and the specific risks of Epilim in relation to pregnancy. The first psychiatrist was therefore found in breach of Right 6(1)(b) of the Code and Right 7(1) of the Code.

The Deputy Commissioner noted that the woman was of childbearing age, and this was the first occasion on which Epilim was being prescribed. As such, given the significant risks to the woman's child if she were to become pregnant, it was imperative that this information be discussed and a record made of the information provided.

The Deputy Commissioner was also critical of the obstetrician for providing incorrect information about the risks of Epilim, but noted that the primary responsibility for discussing the risks and benefits of Epilim lay with the prescribers — the mental health team.

An overarching factor that made it difficult to assess whether the standard of information provided to the woman about the risks of Epilim and pregnancy was adequate was the practice at the district of using the clinic letter from the psychiatrists to the GP as the record of assessment and treatment, rather than more fulsome clinical notes. The Deputy Commissioner was critical that this was the accepted practice at the District at the time.

The Deputy Commissioner was also critical that the District did not have a policy in place at the time relating to the prescribing of Epilim to women of childbearing age. She noted that in the absence of a clear set of guidelines for clinicians to follow consistently, particularly those who were working as locums, the District must bear some responsibility for the inadequacy of information given.

Recommendations

The significant effort invested by multiple organisations, including the District, to strengthen information sharing to ensure that information about Epilim and its risks in pregnancy are well known to prescribers and consumers was acknowledged.

The Deputy Commissioner made recommendations to improve the accessibility of information about Epilim, including recommending that:

- Relevant professional colleges circulate the Medsafe safety alert for Epilim to all their New Zealand members;
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) consider whether its Clinical Practice Guidelines for Mood Disorders (2020) are consistent with the 2019 Medsafe safety alert;
- Medsafe, ACC and HQSC work together to consider reproducing the current information book *Medicines for epilepsy, mental health, and pain can harm your unborn baby* in plain English, and in other languages, with a view to making this information as accessible as possible; and
- Relevant professional colleges communicate with their members HDC's recommendation that clinicians in New Zealand who prescribe Epilim to women of childbearing potential will do the following before commencing the medication:

i. Provide written information to their patients about the risks of Epilim and pregnancy;

ii. Discuss the risks and benefits of the medication, and the necessary precautions to mitigate the risks, and confirm that the patient has understood these; and

iii. Document in the clinical records that they have done i) and ii).

The Deputy Commissioner also recommended that the District share HDC's commentary about sparse note-keeping with its psychiatrists and report back to HDC on whether it has now developed and implemented a guidance document regarding the use of anti-seizure medications in women of childbearing age.

6.4 Robust systems vital to ensure patients are informed of the need for follow-up appointments[7]

This case concerns the delayed treatment of muscle-invasive bladder cancer. The complaint highlights the importance of robust administrative systems to ensure that important follow-up appointments are actioned.

Background
A man aged in his sixties presented to his GP regarding blood in his urine and other urinary symptoms. The GP referred the man to the District's urology service and arranged further testing. Cytology results showed a high-grade non-invasive tumour on the man's bladder. The GP updated the urology service referral with the cytology results, noting that there was now a high suspicion of cancer.

Three weeks later, the man saw a urologist to discuss the results and create a management plan. The urologist discussed with the man that a tumour had been identified on the right-hand lateral bladder wall that was thought likely to be carcinoma in situ. A further tumour was identified on the right-hand side of the bladder. The man signed a consent form for transurethral resection of the bladder tumour (TURBT).

The next month, the urologist performed the TURBT on the man in the day stay unit. Samples of the tumours were sent for analysis (histology). The urologist recorded that there would be a follow-up appointment in 2–3 weeks to discuss the histology report with the man.

The plan for a follow-up appointment was recorded by a registrar both in the handwritten clinical notes of the operation and in a dictated note on the day of the surgery. However, the dictated note was not typed and uploaded to the electronic record until a week later. The District stated that at the time, the day stay unit did not complete discharge summaries for patients who were discharged on the same day.

The man told HDC that he was advised that he would be followed up by the hospital within a few weeks, but he did not receive a discharge summary or information about the surgery following the operation. A registrar spoke with the man prior to his discharge, but he cannot recall the specific details of the conversation.

The District told HDC that despite the clear plan set out in the man's operation note following the surgery, the follow-up appointment with the urologist was never arranged. This was due to an error in the booking process for outpatient appointments. At the time of events, the urology secretary usually did a second check of the documentation prior to discharging the patient from the system. However, in the man's case, the operation note had yet to be added to the system, and there was no discharge summary from the day stay unit.

The man returned to the hospital two days after his procedure for a trial removal of his catheter. There is no record in the clinical notes of any discussion about a follow-up appointment in two to three weeks' time.

The man's histology was reported three days later, and indicated that his bladder tumours were cancerous and were likely to grow rapidly and spread. The man's histology results were to be discussed at the follow-up appointment, but this did not occur. The man told HDC that he assumed that he would be contacted if necessary and would receive an appointment card as he had done in the past.

[7] Decision 20HDC01960

The following year, the man presented to a medical centre with noticeable blood in his urine, and was later diagnosed with high-grade muscle-invasive bladder cancer for which he underwent chemotherapy.

Findings

The Deputy Commissioner was concerned that the District's outpatient booking system was not sufficiently robust to ensure that the man received a follow-up appointment within two to three weeks of his surgery. The follow-up plan was recorded contemporaneously by handwritten clinical note, but the District's system was unable to identify this information. In addition, had the urology service been in the practice of issuing discharge summaries at the time of these events, it is likely that the failure to book a follow-up appointment would not have occurred.

The Deputy Commissioner considered that by failing to arrange a follow-up appointment, the district failed to provide the man services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Deputy Commissioner was also critical that the man was not notified about his histology results, which contained serious findings of fast-spreading cancerous tumors, and considered this to be a systems failure. Had the follow-up appointment been booked by administrative staff, the man would have been informed of the results. The results of tumour biopsies was information that a reasonable consumer in the man's circumstances would expect to receive, and, accordingly, the district was found in breach of Right 6(1) of the Code.

Recommendations

The Deputy Commissioner recommended that the District:

- Provide a written apology to the man for the failings identified in the report;
- Outline the progress made in implementing discharge summaries for all day-stay patients;
- Monitor the new system implemented and automated in relation to referrals created in the electronic system, and consider further changes to ensure that patients are informed of the need for a follow-up appointment; and
- Consider what further improvements could be made to its systems to ensure that patients are informed and understand that they will need to return for a follow-up appointment when this is the case.

The Deputy Commissioner also asked Manatū Hauora to seek confirmation from Te Whatu Ora|Health New Zealand of the activities and expected outcomes under Te Pae Tata| New Zealand Health Plan that will improve electronic booking systems and administrative processes to improve patient outcome by reducing multiple handling of information.