

Complaints to HDC involving District Health Boards

Report and Analysis for period 1 January to 30 June 2016

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Commissioner's Foreword

I am pleased to present you with HDC's second six monthly DHB complaint report for the 2015/2016 year.

Complaints to HDC about DHBs decreased by 10% in the second half of 2015/2016. However, the trends in regards to the services and issues complained about are broadly consistent with what was seen in the first half of 2015/2016. Surgical services continued to be the most commonly complained about service type at DHBs, accounting for around 27% of all services complained about. A missed, delayed or incorrect diagnosis remained the most common primary issue complained about, being the primary issue for 15% of complaints about DHBs

What was notable to me, on reading this report, was the prominence of communication issues. 42% of consumers complaining about DHB services were concerned with how staff at the DHB had communicated with them. This is a timely reminder of the importance of consumer engagement and informed consumers. An engaged consumer is an empowered consumer. Clear, open and honest communication with consumers is vital to the principles of patient autonomy and informed consent.

Anthony Hill
Health and Disability Commissioner

National Data for all District Health Boards

1.0 Number of complaints received

1.1 Raw number of complaints received

In the period Jan–Jun 2016, HDC received a total of **383**¹ complaints about care provided by all District Health Boards. Numbers of complaints received in previous six month periods are reported in Table 1.

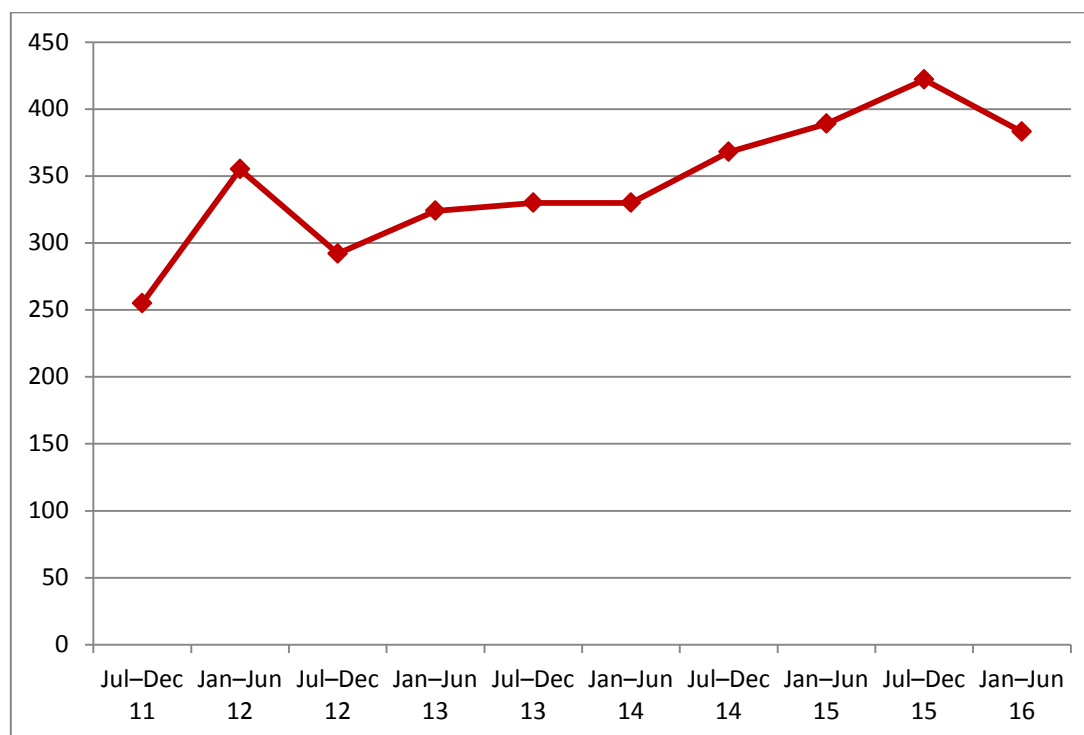
Table 1. Number of complaints received in last five financial years

	Jul– Dec 11	Jan– Jun 12	Jul– Dec 12	Jan– Jun 13	Jul– Dec 13	Jan– Jun 14	Jul– Dec 14	Jan– Jun 15	Jul– Dec 15	Average of last 4 6-month periods	Jan– Jun 16
Number of complaints	255	355	292	324	330	330	368	389	422	377	383

The total number of complaints received in Jan–Jun 2016 (383) shows a very small increase over the average number of complaints received in the previous four periods, but a 10% decrease over the number of complaints received in the previous six month period.

The number of complaints received in Jan–Jun 2016 and previous six month periods are also displayed below in Figure 1.

Figure 1. Number of complaints received



¹ Provisional as of date of extraction (1 August 2016).

1.2 Rate of complaints received

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

Frequency calculations are made using discharge data provided by the Ministry of Health (provisional as at the date of extraction, 25 August 2016). It should be noted that this discharge data excludes short stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges during Jan–Jun 2016

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
383	470,202	81.45

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan–Jun 2016 and previous six month periods.

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

	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 14	Jul–Dec 15²	Average of last 4 6-month periods	Jan–Jun 16
Rate per 100,000 discharges	55.86	80.22	62.59	72.67	71.15	72.99	76.65	84.60	87.57	80.45	81.45

The rate of complaints received during Jan–Jun 2016 (81.45) shows a very small increase over the average rate of complaints received for the previous four periods, but a 7% decrease over the rate of complaints received in the previous six-month period.

Table 4 shows the number and rate of complaints received by HDC for each DHB³.

² The rate for Jul–Dec 2015 has been recalculated based on the most recent discharge data.

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

Table 4. Number and rate of complaints received for each DHB in Jan-Jun 2016

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	49	59564	82.26
Bay of Plenty	16	24159	66.23
Canterbury	45	54884	81.99
Capital and Coast	29	31772	91.28
Counties Manukau	45	50540	89.04
Hawke's Bay	7	16619	42.12
Hutt Valley	21	15832	132.64
Lakes	16	11526	138.82
MidCentral	20	15695	127.43
Nelson Marlborough	16	12088	132.36
Northland	13	19844	65.51
South Canterbury	7	5910	118.44
Southern	20	25833	77.42
Tairāwhiti	3	5143	58.33
Taranaki	8	12037	66.46
Waikato	30	45003	66.66
Wairarapa	6	3466	173.11
Waitemata	42	50886	82.54
West Coast	2	3438	58.17
Whanganui	6	5963	100.62

Notes on DHB's number and rate of complaints

It should be noted that a DHB's number and rate of complaints can vary considerably from one six month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six month period. For smaller DHBs, a very small absolute increase or decrease in 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 which may point to areas which require further attention.

It is also important to note that numbers of complaints received by HDC is not always a good proxy for quality of care provided and may instead, for example, be an indicator of the effectiveness of a DHB's complaint system or features of the consumer population in a particular area. Additionally, complaints received within a single 6 month period will, sometimes, relate to care provided within quite a different time period. From time to time, some DHBs may also be the subject of a number of complaints from a single complainant within one reporting period. This is important context that is taken into account by DHBs when considering their own complaint patterns.

2.0 Service types complained about

2.1 Service type category

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 383 complaints about DHBs, 401 services were complained about.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Alcohol and drug	7	1.7%
Anaesthetics/pain medicine	6	1.6%
Dental	5	1.2%
Diagnostics	6	1.6%
Disability services	3	0.7%
District nursing	5	1.2%
Emergency department (including paramedics)	49	12.2%
General medicine	71	17.7%
Cardiology	11	2.7%
Dermatology	1	0.2%
Endocrinology	3	0.7%
Gastroenterology	4	1.0%
Geriatric medicine	5	1.2%
Neurology	9	2.2%
Oncology	10	2.5%
Palliative care	4	1.0%
Renal/nephrology	2	0.5%
Respiratory	8	2.0%
Rheumatology	3	0.7%
Other/unspecified	11	2.7%
Hearing services	1	0.2%
Intensive care/critical care	3	0.7%
Maternity	29	7.2%
Mental health	91	22.7%
Occupational therapy	1	0.2%
Paediatrics (not surgical)	8	2.0%
Physiotherapy	1	0.2%
Rehabilitation services	2	0.5%
Sexual health	2	0.5%
Surgery	107	26.7%
Cardiothoracic	2	0.5%
General	24	6.0%
Gynaecology	22	5.5%
Neurosurgery	2	0.5%
Ophthalmology	6	1.5%
Orthopaedics	28	7.0%
Otolaryngology	7	1.7%
Plastic and Reconstructive	10	2.5%
Urology	5	1.2%
Unknown	1	0.2%
Other health service	4	1.0%
TOTAL	401	

Surgical services (26.7%) received the greatest number of complaints in Jan-Jun 2016, with orthopaedics (7.0%), general surgery (6.0%) and gynaecology (5.5%) being the most commonly complained about surgical specialties. Other commonly complained about services included mental health (22.7%), general medicine (17.7%), emergency departments (12.2%) and maternity services (7.2%). This is broadly similar to what was seen last period.

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. Those complaint issues identified in only one complaint are classified as 'other'. The primary issues identified in complaints received in Jan–Jun 2016 are listed in Table 6.

The most common primary issue categories concerned care/treatment (57.2%), access/funding (12.3%), communication (10.2%) and consent/information (8.7%). Among these, the most common specific primary issues in complaints about DHBs were 'missed/incorrect/delayed diagnosis' (15.7%), 'inadequate/inappropriate clinical treatment' (8.6%), 'unexpected treatment outcome' (7.9%), 'lack of access to services' (6.0%), 'waiting list/prioritisation issue' (5.2%) and 'inadequate/inappropriate examination/assessment' (5.0%). This is broadly similar to what was seen in Jul-Dec 2015.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
<i>Access/Funding</i>	47	12.3%
Lack of access to services	23	6.0%
Lack of access to subsidies/funding	3	0.8%
Waiting list/prioritisation issue	20	5.2%
Other	1	
<i>Boundary violation</i>	3	0.8%
Inappropriate non-sexual relationship	2	0.5%
Inappropriate sexual physical contact	1	0.3%
<i>Care/Treatment</i>	219	57.2%
Delay in treatment	9	2.3%
Delayed/inadequate/inappropriate referral	8	2.1%
Inadequate coordination of care/treatment	8	2.1%
Inadequate/inappropriate clinical treatment	33	8.6%
Inadequate/inappropriate examination/assessment	19	5.0%
Inadequate/inappropriate follow-up	9	2.3%
Inadequate/inappropriate monitoring	4	1.0%
Inadequate/inappropriate non-clinical care	6	1.6%
Inadequate/inappropriate testing	2	0.5%
Inappropriate/delayed discharge/transfer	14	3.7%
Inappropriate withdrawal of treatment	5	1.3%
Missed/incorrect/delayed diagnosis	60	15.7%
Refusal to assist/attend	2	0.5%
Refusal to treat	5	1.3%
Rough/painful care or treatment	3	0.8%
Unexpected treatment outcome	30	7.9%
Other	2	
<i>Communication</i>	39	10.2%
Disrespectful manner/attitude	18	4.7%
Failure to communicate openly/honestly/effectively with consumer	11	2.9%
Failure to communicate openly/honestly/effectively with family	7	1.8%
Insensitive/inappropriate comments	3	0.8%
<i>Consent/Information</i>	33	8.7%
Consent not obtained/adequate	7	1.8%
Inadequate information provided regarding condition	3	0.8%
Inadequate information provided regarding treatment	3	0.8%
Issues with involuntary admission/treatment	18	4.7%
Other	2	
<i>Documentation</i>	5	1.3%
Delay/failure to disclose documentation	1	0.3%
Inadequate/inaccurate documentation	2	0.5%
Intentionally misleading/altered documentation	2	0.5%
<i>Facility issues</i>	7	1.8%
Waiting times	4	1.0%
Other	3	
<i>Medication</i>	15	3.9%

Primary issue in complaints	Number of complaints	Percentage
Inappropriate prescribing	9	2.3%
Prescribing error	2	0.5%
Refusal to prescribe/dispense/supply	4	1.0%
Reports/Certificates	2	0.5%
Inaccurate report/certificate	2	0.5%
Other professional conduct issues	8	2.1%
Assault	3	0.8%
Disrespectful behaviour	2	0.5%
Failure to disclose/properly manage a conflict of interest	1	0.2%
Threatening/bullying/harassing behaviour	2	0.5%
Other issues	5	
TOTAL	383	

Table 7 shows a comparison over time for the top five primary issues complained about. The top five primary issues in Jan–Jun 2016 are similar to primary issues reported in previous periods.

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

Top five primary issues in all complaints (%)							
Jul–Dec 14 n=368		Jan–Jun 15 n=389		Jul–Dec 15 n=422		Jan–Jun 16 n=381	
Misdiagnosis	15%	Misdiagnosis	20%	Misdiagnosis	16%	Misdiagnosis	16%
Inadequate treatment	11%	Inadequate treatment	12%	Unexpected treatment outcome	12%	Inadequate treatment	9%
Unexpected treatment outcome	7%	Unexpected treatment outcome	6%	Inadequate treatment	9%	Unexpected treatment outcome	8%
Waiting list/prioritisation	6%	Disrespectful manner/attitude	4%	Waiting list/prioritisation	7%	Lack of access to services	6%
Disrespectful manner/attitude	5%	Lack of access to services	4%	Lack of access to services	6%	Waiting list/prioritisation	5%

3.2 All complaint issues

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

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
<i>Access/Funding</i>		
Lack of access to services	39	10.2%
Lack of access to subsidies/funding	8	2.1%
Waiting list/prioritisation issue	30	7.9%
Other	3	
<i>Boundary violation</i>		
Inappropriate non-sexual relationship	2	0.5%
Inappropriate sexual physical contact	2	0.5%
Other	1	0.3%
<i>Care/Treatment</i>		
Delay in treatment	66	17.2%
Delayed/inadequate/inappropriate referral	29	7.6%
Inadequate coordination of care/treatment	93	24.3%
Inadequate/inappropriate clinical treatment	145	37.9%
Inadequate/inappropriate examination/assessment	106	27.7%
Inadequate/inappropriate follow-up	60	15.7%
Inadequate/inappropriate monitoring	29	7.6%
Inadequate/inappropriate non-clinical care	29	7.6%
Inadequate/inappropriate testing	64	16.7%
Inappropriate admission/failure to admit	11	2.9%
Inappropriate/delayed discharge/transfer	64	16.7%
Inappropriate withdrawal of treatment	9	2.3%
Missed/incorrect/delayed diagnosis	81	21.2%
Personal privacy not respected	3	0.8%
Refusal to assist/attend	12	3.1%
Refusal to treat	15	3.9%
Rough/painful care or treatment	18	4.7%
Unexpected treatment outcome	63	16.4%
Unnecessary treatment/over-servicing	8	2.1%
<i>Communication</i>		
Disrespectful manner/attitude	81	21.1%
Failure to accommodate cultural/language needs	11	2.9%
Failure to communicate openly/honestly/effectively with consumer	161	42.0%
Failure to communicate openly/honestly/effectively with family	91	23.8%
Insensitive/inappropriate comments	26	6.8%
<i>Complaints process</i>		
Inadequate information provided regarding complaints process	4	1.0%
Inadequate response to complaint	72	18.8%
Retaliation/discrimination as a result of a complaint	4	1.0%
<i>Consent/Information</i>		
Consent not obtained/adequate	15	3.9%
Inadequate information provided regarding adverse event	10	2.6%
Inadequate information provided regarding condition	18	4.7%
Inadequate information provided regarding options	10	2.6%
Inadequate information provided regarding provider	7	1.8%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding results	8	2.1%
Inadequate information provided regarding treatment	41	10.7%
Incorrect/misleading information provided	10	2.6%
Issues with involuntary admission/treatment	19	5.0%
Other	5	
Documentation		
Delay/failure to disclose documentation	4	1.0%
Delay/failure to transfer documentation	2	0.5%
Inadequate/inaccurate documentation	22	5.7%
Inappropriate maintenance/disposal of documentation	3	0.8%
Intentionally misleading/altered documentation	3	0.8%
Facility issues		
Cleanliness/hygiene issue	7	1.8%
Failure to follow policies/procedures	7	1.8%
General safety issue for consumer in facility	6	1.6%
Inadequate/inappropriate policies/procedures	26	6.8%
Issue with quality of aids/equipment	3	0.8%
Staffing/rostering/other HR issue	16	4.2%
Waiting times	17	4.4%
Other	3	
Medication		
Administration error	3	0.8%
Inappropriate administration	5	1.3%
Inappropriate prescribing	25	6.5%
Prescribing error	4	1.0%
Refusal to prescribe/dispense/supply	14	3.7%
Other	2	
Reports/Certificates		
Inaccurate report/certificate	7	1.8%
Teamwork/supervision		
Delayed/inadequate/inappropriate handover	2	0.5%
Inadequate supervision/oversight	10	2.6%
Other professional conduct issues		
Assault	3	0.8%
Disrespectful behaviour	7	1.8%
Failure to disclose/properly manage a conflict of interest	2	0.5%
Inappropriate collection/use/disclosure of information	12	3.1%
Threatening/bullying/harassing behaviour	5	1.3%
Other	2	
Other issues	21	

On analysis of all issues identified in complaints about DHBs, the most common issues were 'failure to communicate effectively with consumer' (42.0%), 'inadequate/inappropriate clinical treatment' (37.9%) 'inadequate/inappropriate examination/assessment' (27.7%), 'inadequate coordination of care/treatment' (24.3%), 'failure to communicate effectively with family' (23.8%) 'disrespectful manner/attitude' (21.1%), 'missed/incorrect/delayed diagnosis' (21.2%), and 'inadequate response to the consumer's complaint by the DHB' (18.8%). This is broadly similar to what was seen in Jul-Dec 2015.

Also similar to the last six-month period, many complaints involved issues with a consumer's care/treatment, such as 'delay in treatment' (17.2%), 'inappropriate/delayed discharge/transfer' (16.7%), 'inadequate/inappropriate testing' (16.7%), 'unexpected treatment outcome' (16.4%) and 'inadequate/inappropriate follow-up' (15.7%).

3.3 Service type and primary issues

Table 9 shows the top three primary issues in complaints concerning the most commonly complained about service types. This is broadly similar to what was seen in the last six-month period.

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

Surgery n=107		Mental health n=91		General medicine n=71		Emergency department n=49		Maternity n=28	
Unexpected treatment outcome	23%	Issues with involuntary admission/treatment	24%	Missed/incorrect/delayed diagnosis	20%	Missed/incorrect/delayed diagnosis	33%	Missed/incorrect/delayed diagnosis	21%
Missed/incorrect/delayed diagnosis	14%	Inadequate examination/assessment	11%	Inadequate/inappropriate treatment	13%	Inadequate/inappropriate treatment	8%	Inadequate/inappropriate treatment	15%
Waiting list/prioritisation issue	12%	Missed/incorrect/delayed diagnosis	6%	Lack of access to services & inadequate coordination of care	6% each	Disrespectful manner/attitude	6%	Unexpected treatment outcome	11%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **482**⁴ complaints involving DHBs in the period Jan–Jun 2016. Table 10 shows the number of complaints closed in previous six month periods.

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

	Jul– Dec 11	Jan– Jun 12	Jul– Dec 12	Jan– Jun 13	Jul– Dec 13	Jan– Jun 14	Jul– Dec 14	Jan– Jun 15	Jul– Dec 15	Average of last 4 6-month periods	Jan– Jun 16
Number of complaints closed	217	302	254	337	280	411	344	410	365	383	482

The total number of complaints closed for Jan–Jun 2016 shows a 26% increase over the average of the last four six month periods.

4.2 Outcomes of complaints closed

Complaints that are within HDC’s jurisdiction are classified into two groups according to the manner of resolution — whether formal investigation or non-investigation. Within each classification, there is a variety of possible outcomes. Once HDC has notified a DHB that a complaint concerning that DHB is to be investigated, the complaint remains classified as an investigation, even though an alternative manner of resolution may subsequently be adopted. Notification of investigation generally indicates more serious or complex issues.

In the Jan–Jun 2016 period, **6** DHBs had no investigations closed, **8** DHBs had one investigation closed, **5** DHBs had two investigations closed, and **1** DHB had four investigations closed by HDC.

The manner of resolution and outcomes of all DHB complaints closed in Jan–Jun 2016 is shown in Table 11.

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

Table 11. Outcome for DHBs of complaints closed by complaint type⁵

Outcome for DHBs	Number of complaints closed
<i>Investigation</i>	21
Breach finding	8
No further action ⁶ with follow-up or educational comment	8
No further action	2
No breach finding	3
<i>Non-investigation</i>	442
No further action with follow-up or educational comment	112
Referred to Privacy Commissioner	1
Referred to District Inspector	14
Referred to DHB ⁷	108
Referred to Advocacy	27
No further action	174
Withdrawn	6
<i>Outside jurisdiction</i>	19
TOTAL	482

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

⁶ The Commissioner has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or 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 a District Inspector). Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice.

⁷ 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.

4.3 Recommendations made to DHBs following a complaint

Regardless of whether or not a complaint has been investigated, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted upon. Table 12 shows the recommendations made to DHBs in complaints closed in the current period. Please note that more than one recommendation may be made in relation to a single complaint.

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	20
Audit	31
Presentation/discussion of complaint with others	14
Provision of information to other agency	3
Provision of information to HDC	36
Reflection	6
Review of policies/procedures	36
Training/professional development	28
Total	174

The most common recommendations made to DHBs were that they review their policies/procedures (36 recommendations) or that they provide information to HDC (36 recommendations). The provision of information to HDC was often in relation to HDC ensuring that DHBs had made the changes they reported that they would make in response to the complaint. When audits were recommended, they were most commonly in relation to adherence to policies/procedures, followed by compliance with documentation requirements. Training/professional development was most often recommended in relation to clinical issues, followed by documentation and communication.

5.0 Learning from complaints — HDC case reports

Assessment and treatment of young child with fever and respiratory symptoms (14HDC01187)

Background

Miss A, a nearly three year old child, had a cough and a runny nose which worsened over several days. On the fifth day, Miss A awoke with a fever shortly after midnight and her mother took her to the Emergency Department (ED) of 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. Miss A was assessed by two doctors, and following cooling techniques and the administration of paracetamol and ibuprofen, Miss A's temperature reduced to 37.4°C and her heart rate also reduced. Miss A was discharged home and her parents were instructed 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.

Miss A's condition worsened over the next two days – she was lethargic, slept frequently, and refused food, but continued to drink water. Her fever was managed with paracetamol and ibuprofen. On the second day, Miss A began to make wheezing noises when exhaling. Her wheezing worsened and her mother took her back to the ED at 9.14pm.

On arrival Miss A was triaged as category two (to be seen within 10 minutes). Miss A's temperature was 37.3°C, her heart rate was 170-175 beats per minute, and her respiratory rate was 44 breaths per minute. Miss A 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 transferred to a telehealth service. The mother 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.

Findings

The telehealth nurse 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 telehealth nurse 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. The DHB also failed to encourage a culture where staff felt comfortable questioning of 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"

Recommendations

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).

Use of tenecteplase for thrombolysis of stroke patient (13HDC01676)

Background

Mr A, a 77 year old man, presented to an ED of a regional hospital after suffering an ischaemic stroke. Upon medical review, a decision was made by a house officer (Dr B) in consultation with the consultant on call (Dr C), that Mr A was an appropriate candidate for thrombolysis.

Thrombolysis is the breakdown of blood clots using types of drugs called tissue plasminogen activator (tPA) drugs and can be used in patients who have suffered an ischaemic stroke or a heart attack. There are a number of risks associated with thrombolysis, including intracerebral haemorrhage (bleeding in the brain).

Although it was usual practice for stroke thrombolysis to be administered in the Intensive Care Unit (ICU), Dr B decided to treat Mr A in the ED rather than the ICU. In addition, Dr B prescribed tenecteplase rather than alteplase. Both are tPA drugs but, in New Zealand, tenecteplase is used for treatment of a heart attack (myocardial infarction) rather than ischaemic stroke. Dr B prescribed tenecteplase because she understood from nursing staff that there was no alteplase available at the hospital and was aware of studies which supported the use of tenecteplase in stroke.

Dr B followed the New Zealand Formulary guidelines for the use of tenecteplase in heart attack. In doing so, she prescribed at least twice the dose of tenecteplase recommended for treatment of ischaemic stroke. In addition, Dr B did not prescribe the correct mode of administration for tenecteplase. Dr B did not discuss her prescription of tenecteplase or the fact that the drug was administered in ED rather than the ICU with Dr C.

Partway through the administration of tenecteplase, Dr B was informed that alteplase was available at the hospital in the ICU. She telephoned Dr C for advice about whether or not to continue the infusion, who advised that the infusion should continue. Following the infusion of tenecteplase Mr A initially showed signs of improvement, but a computed tomography (CT) scan showed that he had suffered a brain bleed (intracerebral haemorrhage). Mr A died a few days later.

The DHB's relevant policy titled "the Stroke Pathway" referred to alteplase in some places but did not explicitly specify alteplase as the tPA drug to be used in the case of stroke thrombolysis. In addition, "the Stroke Pathway" did not state that alteplase should be given only ICU. There was also confusion amongst nursing staff about the correct process for administering thrombolysis, and Dr B had not been oriented to "the Stroke Pathway" adequately.

Findings

The Commissioner acknowledged that Dr B was faced with time pressure, that she had never given thrombolysis treatment previously, that she was not orientated to the Stroke Pathway sufficiently, and that she was the only doctor working on site in the ED that night (and one of two doctors on site at the hospital). However advice from a senior colleague (Dr C) was available to Dr B over the telephone, and yet she made decisions to deviate from standard practice without seeking that person's advice. The Commissioner considered that Dr B made significant errors of judgement in failing to transfer Mr A to ICU, in deciding to prescribe tenecteplase to him at the dose and via the mode of administration that she did, and in failing to consult Dr C about the use of tenecteplase. For these failings, the Commissioner held that Dr B breached Right 4(1) of the Code.

The Commissioner was critical that Dr C did not appear to have provided Mr A or his wife with a timely and clear explanation of what had occurred. Open disclosure about the error and its potential consequences needed to occur, either to Mr A if he was competent, or to another appropriate person, in this case, his wife.

The Commissioner considered that the DHB did not fulfil its responsibility to ensure its staff had the right tools, including adequate policies and training, to provide stroke thrombolysis safely.

Accordingly, the DHB failed to provide Mr A with services of an appropriate standard, in breach of Right 4(1) of the Code.

Recommendations

The Commissioner was thoughtful that this was not the first time that he had considered a case involving confusion between the use of alteplase and tenecteplase for thrombolysis of stroke patients in circumstances where the relevant DHB's protocol did not clearly identify the relevant drug, and the consultant was not called for advice when she should have been (11HDC01434). The Commissioner commented that: "it is essential that these cases are used as learning opportunities, to prevent similar errors from occurring in other DHBs." Accordingly, the Commissioner recommended to the National DHB CMO Group that it take steps to ensure that all DHBs' policies/guidelines in relation to stroke thrombolysis are clear and consistent.

The Commissioner also made a number of recommendations to the DHB, including that it: provide HDC with the outcome of its audit regarding compliance with its updated Stroke Pathway and review the orientation training of junior and new staff to ensure they know how to access all medications within the DHB and who to contact with questions or queries.

Wound management by district nursing service (14HDC00766)

Background

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 on-going management of her wound. The wound was packed with a dressing called Aquacel rope. The end of the rope would remain outside the wound. However, when the end of the rope was not visible and it was assumed that Mrs A had removed the rope herself, this was not the case.

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 each change of product were often not recorded. At times, the district nurses relied on Mrs A contacting her GP for review rather than making the contact for her.

When the wound was noted to have hypergranulated with an increased amount of green exudate, 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, which had prevented the wound from healing.

The district nursing service's screening tool categorised patients according to complexity, but lacked the requirement for specific information that would indicate potential problems and the triage assessment lacked consideration of social or cultural factors that could impact on healing.

Findings

The Commissioner found that the Aquacel rope was not used appropriately and the wound was not investigated adequately. The Commissioner was critical that 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 for Mrs A's wound consistently. Accordingly, the DHB failed to ensure services were provided with reasonable care and skill in breach of Right 4(1) of the Code.

The Commissioner also considered that district nurses failed to work together effectively, in particular the Commissioner was critical that district nurses: relied on Mrs A to contact her GP; made regular changes to the products used without documenting the reason and had 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 care, in breach of Right 4(5) of the Code.

Recommendations

Following this event the DHB undertook a review of policy, standard operating procedures and process, and implemented changes. The Commissioner made a number of recommendations to the DHB, including that it:

- provide HDC with a report confirming the implementation of changes made following its reviews, including evidence of communication of these changes to staff and associated education provided;
- provide HDC with an update of progress regarding the possible introduction of electronic record-keeping with the District Nursing Service; and
- undertake an independent peer review of the quality of the District Nursing Service's wound assessment and evaluation, and the documentation thereof, for a random selection of patients cared for in the last six months.

Care of patient with a complex medical history (15HDC00111)

Background

Mr A had experienced cardiac issues and had a family history of myocardial infarction (heart attack). Mr A presented to the ED of a public hospital for a mental health assessment and was discharged with a management plan in place. 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 and transferred to the intensive coronary care unit (ICCU) at another hospital.

Further investigations were undertaken and Mr A was considered to have Takotsubo cardiomyopathy. Routine blood tests showed a very abnormal troponin T result, but Mr A's cardiologist was not aware that that test had been ordered and was not informed of the result. At the time, 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, the cardiologist reviewed Mr A and declared that he was medically fit for discharge. Mr A was transferred to the mental health facility where he was to be observed every ten minutes. The next morning Mr A was found deceased in his room. The mental health facility confirmed that the 10-minute observations were adhered to overnight. The Coroner found that the direct cause of death was cardiac arrhythmia and the antecedent cause was recent myocardial infarction.

Findings

The Commissioner held that Mr A's discharge from the ICCU was inappropriate in the circumstances. The severity of 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 Commissioner found that the DHB did not provide Mr A with services with reasonable care and skill in breach of Right 4(1) of the Code.

The Commissioner was critical that the DHB's process meant that Mr A needed to be declared fit for discharge from the ICCU before he could receive appropriate mental health care and that the DHB's systems failed to alert Mr A's treating clinicians to his repeat troponin T test, which had an abnormally high result. The Commissioner was also critical that mental health facility staff were not made aware of the seriousness of Mr A's cardiac condition or risk of complications. The Commissioner considered that the DHB's 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.

In relation to the lack of continuity of care in this case, the Commissioner commented: "It is unacceptable that Mr A was discharged from the ICCU 24 hours after his cardiac event. I am critical

that the decision to discharge Mr A was clearly influenced by a system where medical clearance was required in order for a patient to receive psychiatric care, despite the fact that a large number of patients suffer from both medical and mental illnesses. This process meant that staff were not able to coordinate to provide the most appropriate care for Mr A”

The documentation in this case was also suboptimal, particularly in relation to mental health facility staff observations of Mr A . Therefore, the Commissioner considered that he DHB failed to comply with legal standards, in breach of Right 4(2) of the Code.

Recommendations

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 on troponin T levels prior to discharge from the ICCU;
- implement a system that requires the laboratory to alert the patient’s treating clinician urgently when troponin T levels are abnormally high;
- over the period of one month, in the mental health facility, audit the rate of cross-referencing information about overnight observations into the patient’s clinical records (in cases where the patient has been subject to a formalised level of observations overnight); and
- review ED policies regarding the management of at-risk patients.