Complaints to HDC involving District Health Boards

Report and Analysis for period 1 January to 30 June 2020

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

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Contents

Commissioner's Foreword ii

National Data for all District Health Boards 1

1. How many complaints were received? 1
   1.1 Number of complaints received 1
   1.2 Rate of complaints received 2
2. Which DHB services were complained about? 4
   2.1 DHB service types complained about 4
3. What did people complain about? 7
   3.1 Primary issues identified in complaints 7
   3.2 All issues identified in complaints 10
   3.3 Primary issues by service type 13
4. What were the outcomes of the complaints closed? 14
   4.1 Number of complaints closed 14
   4.2 Outcomes of complaints closed 15
   4.3 Recommendations made to DHBs by HDC 16
5. Learning from complaints 17
   5.1 Informed consent for dementia patient 17
   5.2 Follow-up on incidental finding 18
   5.3 Failure to respect refusal of consent for treatment 19
   5.4 Delayed diagnosis of bladder cancer 20

Commissioner’s Foreword

Tēnā koutou

I am pleased to present you with HDC’s second six-monthly DHB complaint report for the 2019/2020 year. This report details the trends in complaints HDC received about DHBs between 1 January and 30 June 2020.

I took Office as the Health and Disability Commissioner on 7 September 2020. This has been an interesting and challenging time to join the organisation, with the effects of the COVID-19 pandemic still being felt in New Zealand, and particularly in the healthcare sector. The themes of this report include consumers’ concerns during the COVID-19 restrictions. First, I would like to acknowledge the huge pressure on the healthcare sector during the timeframe of this report. The high levels of resilience and agility displayed by the healthcare system in response to this unprecedented event have been impressive.

HDC is closely monitoring the trends that appear across complaints involving COVID-19 related issues. An outline of these issues for DHBs is detailed on page 12.

HDC received 392 complaints about DHB services between 1 January and 30 June 2020 — the lowest number of complaints received about DHBs since 2016. However, it should be noted that owing to COVID-19 restrictions there was a decline in inpatient discharges. When this decline in discharges was taken into account, HDC’s rate of complaints for January–June 2020 was similar to that seen in previous periods. This indicates that the decline in complaint numbers is at least partly attributable to COVID-19 restrictions and an associated decrease in health service activity.

Lack of access to services became the most commonly complained about primary issue for the first time in January–June 2020. Access for many was deferred during the COVID-19 restrictions, as people stayed away from health services and non-urgent care was postponed. A number of issues raised in complaints about COVID-19 centre on reduced access to care and delayed treatment, including reduced access to secondary and emergency health care. As the focus shifts to recovery, it is more important than ever to ensure that the system is operating in a consumer-centred way.

Every complaint is an opportunity to learn. HDC’s data is grounded in the consumer experience and reflects the issues that consumers care about most. As such, I hope these reports continue to promote quality improvement.

Whaowhia te kete mātauranga

Morag McDowell
Health and Disability Commissioner

National Data for all District Health Boards

1. How many complaints were received?

1.1 Number of complaints received

In the period Jan–Jun 2020, HDC received **392**[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

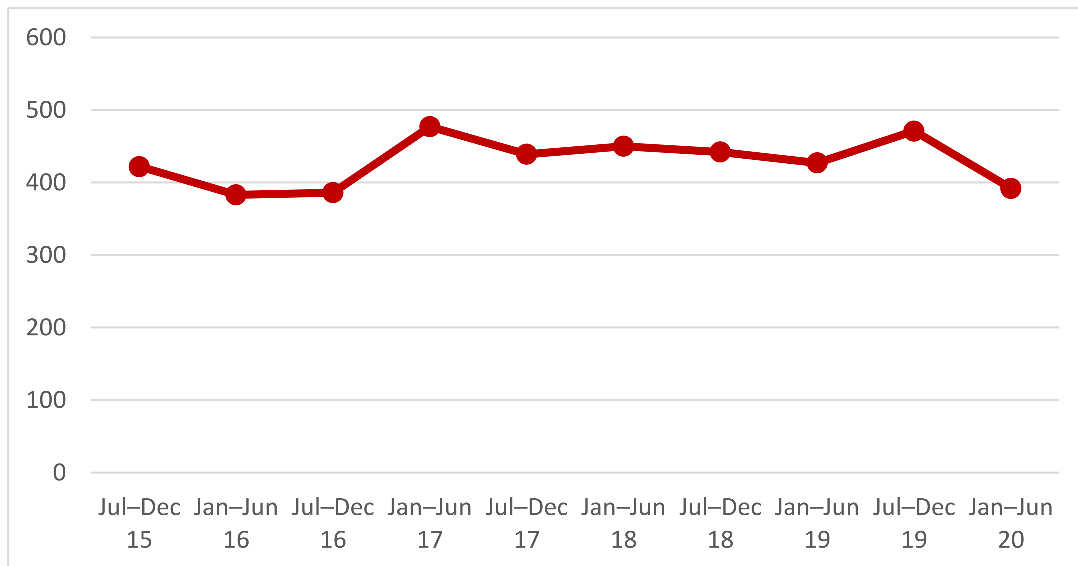
Table 1. Number of complaints received in the last five years

	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Average of last 4 6-month periods	Jan–Jun 20
Number of complaints	422	383	386	477	439	450	442	427	471	**448**	**392**

The total number of complaints received in Jan–Jun 2020 (392) shows a 13% decrease over the average number of complaints received in the previous four periods, and is the lowest number of complaints received about DHBs since 2016. This decrease is, at least in part, attributable to COVID-19 restrictions and an associated decrease in health service activity. This is supported by the fact that when the decline in inpatient discharges is taken into account, HDC received a similar rate of complaints in Jan–Jun 2020 as seen in previous periods.

The number of complaints received in Jan–Jun 2020 and previous six-month periods is also displayed below in Figure 1.

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



[1] Provisional as of date of extraction (3 August 2020).

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.

Complaint rate calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (9 October 2020) and is likely incomplete; it will be updated in the next six-monthly report. It should be noted that this discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
392	**433,718**	**90.38**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan–Jun 2020 and previous six-month periods.

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

	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19[2]	Average of last 4 6-month periods	Jan–Jun 20
Rate per 100,000 discharges	87.57	81.44	78.79	99.08	88.23	93.80	88.47	87.97	92.92	**91.05**	**90.38**

The rate of complaints received during Jan–Jun 2020 (90.38) is very similar to the average rate of complaints received for the previous four periods.

Table 4 shows the number and rate of complaints received by HDC for each DHB.[3]

[2] The rate for Jul–Dec 2019 has been recalculated based on the most recent discharge data.

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

Table 4. Number and rate of complaints received for each DHB in Jan–Jun 2020

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	57	53476	106.59
Bay of Plenty	12	24187	49.61
Canterbury	47	50260	93.51
Capital and Coast	27	26186	103.11
Counties Manukau	38	44603	85.20
Hauora Tairāwhiti	4	4491	89.07
Hawke's Bay	9	15733	57.20
Hutt Valley	12	15128	79.32
Lakes	5	10492	47.66
MidCentral	21	13902	151.06
Nelson Marlborough	11	11471	95.89
Northland	20	18904	105.80
South Canterbury	7	5310	131.83
Southern	39	23290	167.45
Taranaki	11	12113	90.81
Waikato	20	44287	45.16
Wairarapa	2	3928	50.92
Waitematā	45	46799	96.16
West Coast	6	2830	212.01
Whanganui	8	6238	128.25

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. Further, for smaller DHBs, a very small absolute increase or decrease in the number of complaints received can dramatically affect the rate of complaints. Accordingly, much of the value in this data lies in how it changes over time, as such analysis allows trends to emerge that may point to areas that require further attention.

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

2. Which DHB services were complained about?

2.1 DHB service types complained about

Please note that some complaints involve more than one DHB and/or more than one service or hospital; therefore, although there were 392 complaints about DHBs, 409 services were complained about. Figure 2 below shows the most commonly complained about service types in Jan–Jun 2020. A more nuanced picture of service types complained about, including individual surgical and medicine service categories, is provided in Table 5.

Surgical services (31%) received the greatest number of complaints in Jan–Jun 2020, with general surgery (8%), orthopaedics (5%) and gynaecology (5%) being the surgical specialties most commonly complained about. This is similar to what was seen in the previous period, although complaints about orthopaedics decreased from 10% of all services complained about in Jul–Dec 2019 to 5% of services in Jan–Jun 2020.

Other commonly complained about services included mental health (22%), medicine (18%), and emergency department (11%) services.

Figure 2. Service types complained about

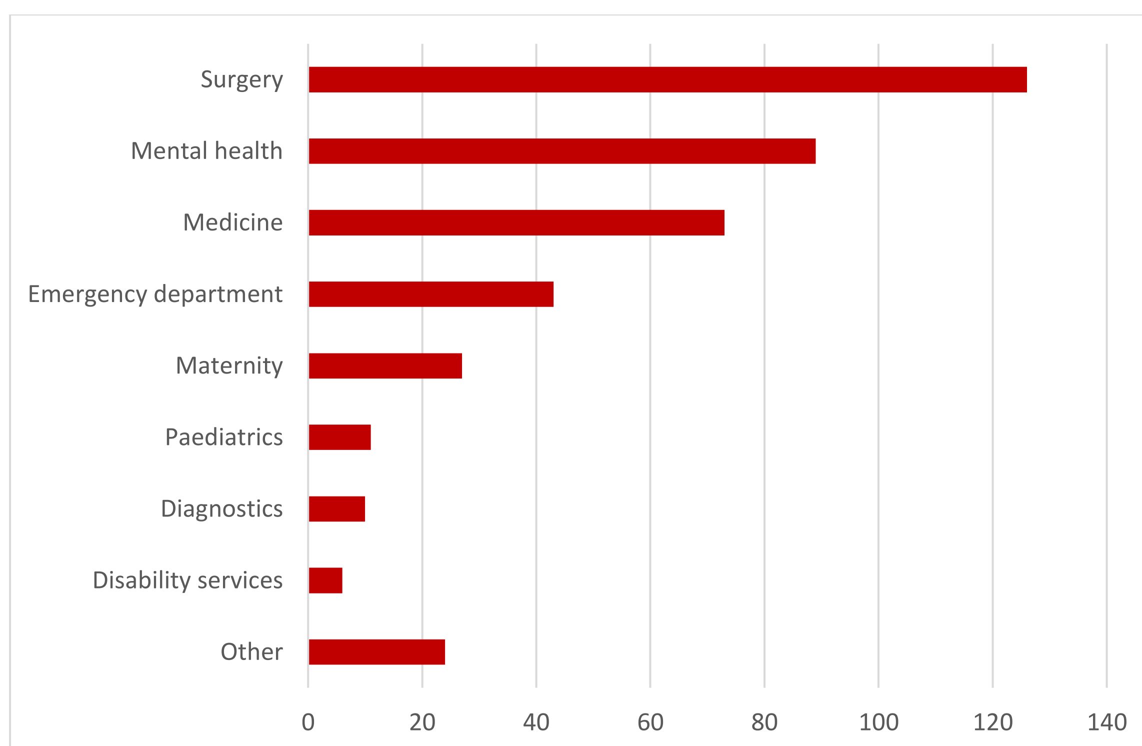


Table 5. Service types complained about

Service type	Number of complaints	Percentage
Alcohol and drug	**4**	**1.0%**
Dental	**5**	**1.2%**
Diagnostics	**10**	**2.4%**
Disability services	**6**	**1.5%**
District nursing	**2**	**0.5%**
Emergency department	**43**	**10.5%**
Intensive care/critical care	**3**	**0.7%**
Maternity	**27**	**6.6%**
Medicine	**73**	**17.8%**
General medicine	20	4.9%
Cardiology	7	1.7%
Endocrinology	2	0.5%
Gastroenterology	11	2.7%
Geriatric medicine	6	1.5%
Haematology	2	0.5%
Neurology	6	1.5%
Oncology	5	1.2%
Renal/nephrology	3	0.7%
Respiratory	4	1.0%
Rheumatology	2	0.5%
Other/unspecified	5	1.2%
Mental health	**89**	**21.8%**
Paediatrics (not surgical)	**11**	**2.7%**
Rehabilitation services	**2**	**0.5%**
Sexual health	**2**	**0.5%**
Surgery	**126**	**30.8%**
Cardiothoracic	7	1.7%
General	31	7.6%
Gynaecology	22	5.4%
Neurosurgery	5	1.2%
Ophthalmology	7	1.7%
Oral/Maxillofacial	3	0.7%
Orthopaedics	22	5.4%
Otolaryngology	8	2.0%
Paediatric	2	0.5%
Plastic and Reconstructive	3	0.7%
Urology	12	2.9%
Other/unknown	4	1.0%
Other/unknown health service	**6**	**1.5%**
TOTAL	**409**	

Table 6 below shows a comparison of the proportion of complaints received over time for the most commonly complained about service types. As can be seen from this table, the most common service types complained about over the last five six-month periods have remained broadly consistent.

Table 6. Comparison of the proportion of complaints received about the most commonly complained about service types

Service type	Jan–Jun 2018	Jul–Dec 2018	Jan–Jun 2019	Jul–Dec 2019	Jan–Jun 2020
Surgery	31%	30%	31%	31%	31%
Mental health	21%	25%	22%	25%	22%
General medicine	16%	15%	18%	16%	18%
Emergency department	11%	12%	12%	11%	11%
Maternity	7%	3%	6%	5%	7%

3. What did people complain about?

3.1 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 2020 are listed below in Table 7. It should be noted that the issues included are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues provide a valuable insight into the consumer's experience of the services provided and the issues they care about most.

The most common primary issue categories were:

- Care/treatment (43%)
- Access/funding (20%)
- Consent/information (11%)
- Communication (9%)

The most common specific primary issues complained about were:

- Lack of access to services (12%)
- Missed/incorrect/delayed diagnosis (10%)
- Unexpected treatment outcome (8%)
- Waiting list/prioritisation issue (7%)
- Inadequate/inappropriate treatment (5%)

Table 7. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***79***	***20.2%***
Lack of access to services	46	11.7%
Lack of access to subsidies/funding	4	1.0%
Waiting list/prioritisation issue	29	7.4%
Care/Treatment	***168***	***42.9%***
Delay in treatment	14	3.6%
Inadequate coordination of care/treatment	2	0.5%
Inadequate/inappropriate clinical treatment	18	4.6%
Inadequate/inappropriate examination/assessment	15	3.8%
Inadequate/inappropriate follow-up	12	3.1%
Inadequate/inappropriate monitoring	8	2.0%
Inadequate/inappropriate non-clinical care	6	1.5%
Inadequate/inappropriate testing	1	0.3%
Inappropriate admission/failure to admit	2	0.5%
Inappropriate/delayed discharge/transfer	14	3.6%
Inappropriate withdrawal of treatment	1	0.3%
Missed/incorrect/delayed diagnosis	40	10.2%
Refusal to treat	3	0.8%
Rough/painful care or treatment	1	0.3%
Unexpected treatment outcome	31	7.9%
Communication	***34***	***8.7%***
Disrespectful manner/attitude	10	2.6%

Primary issue in complaints	Number of complaints	Percentage
Failure to communicate openly/honestly/effectively with consumer	12	3.1%
Failure to communicate openly/honestly/effectively with family	10	2.6%
Insensitive/inappropriate comments	2	0.5%
Consent/Information	***44***	***11.2%***
Consent not obtained/adequate	16	4.1%
Inadequate information provided regarding condition	2	0.5%
Inadequate information provided regarding provider	1	0.3%
Inadequate information provided regarding results	2	0.5%
Inadequate information provided regarding treatment	4	1.0%
Incorrect/misleading information provided	2	0.5%
Issues regarding consent when consumer not competent	2	0.5%
Issues with involuntary admission/treatment	15	3.8%
Documentation	***3***	***0.8%***
Inadequate/inaccurate documentation	3	0.8%
Facility issues	***17***	***4.3%***
General safety issue for consumer in facility	8	2.0%
Inadequate/inappropriate policies/procedures	7	1.8%
Staffing/rostering/other HR issue	1	0.3%
Other	1	0.3%
Medication	***20***	***5.1%***
Administration error	1	0.3%
Inappropriate prescribing	11	2.8%
Prescribing error	1	0.3%
Refusal to prescribe/dispense/supply	7	1.8%
Reports/certificates	***5***	***1.3%***
Inaccurate report/certificate	3	0.7%
Refusal to complete report/certificate	2	0.5%
Other professional conduct issues	***14***	***3.6%***
Disrespectful behaviour	5	1.3%
Inappropriate collection/use/disclosure of information	7	1.8%
Other	2	0.5%
Disability-related issues	***2***	***0.5%***
Issues regarding right to support person	***4***	***1.0%***
Other	***2***	***0.5%***
TOTAL	**392**	

Table 8 shows a comparison over time for the top five primary issues complained about.

In Jan–Jun 2020, lack of access to services became the most commonly complained about primary issue for the first time, increasing from being the primary issue in around 7–8% of complaints received in previous periods to 12% of complaints in Jan–Jun 2020. This may be due to restricted access to many services during the COVID-19 emergency response.

Table 8. Top five primary issues in complaints received over the last four six-month periods

Top five primary issues in all complaints (%)							
Jul–Dec 18 n=442		**Jan–Jun 19 n=427**		**Jul–Dec 19 n=472**		**Jan–Jun 20 n=392**	
Misdiagnosis	14%	Misdiagnosis	16%	Misdiagnosis	14%	Lack of access to services	12%
Lack of access to services	9%	Waiting list/ prioritisation	12%	Unexpected treatment outcome	9%	Misdiagnosis	10%
Unexpected treatment outcome	9%	Unexpected treatment outcome	9%	Waiting list/ prioritisation	8%	Unexpected treatment outcome	8%
Waiting list/ Prioritisation	7%	Inadequate treatment	7%	Inadequate treatment	8%	Waiting list/ Prioritisation	7%
Inadequate treatment	6%	Lack of access to services	6%	Lack of access to services	8%	Inadequate treatment	5%

3.2 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. Table 9 includes these additional complaint issues, as well as the primary complaint issues, to show all issues identified in complaints received.

Table 9. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	***105***	***26.8%***
Lack of access to services	60	15.3%
Lack of access to subsidies/funding	6	1.5%
Waiting list/prioritisation issue	45	11.5%
Care/Treatment	***281***	***71.7%***
Delay in treatment	93	23.7%
Delayed/inadequate/inappropriate referral	9	2.3%
Inadequate coordination of care/treatment	61	15.6%
Inadequate/inappropriate clinical treatment	91	23.2%
Inadequate/inappropriate examination/assessment	71	18.1%
Inadequate/inappropriate follow-up	63	16.1%
Inadequate/inappropriate monitoring	36	9.2%
Inadequate/inappropriate non-clinical care	23	5.9%
Inadequate/inappropriate testing	21	5.4%
Inappropriate admission/failure to admit	11	2.8%
Inappropriate/delayed discharge/transfer	43	11.0%
Inappropriate withdrawal of treatment	3	0.8%
Missed/incorrect/delayed diagnosis	54	13.8%
Refusal to assist/attend	7	1.8%
Refusal to treat	10	2.6%
Rough/painful care or treatment	11	2.8%
Unexpected treatment outcome	52	13.3%
Unnecessary treatment	3	0.8%
Communication	***243***	***62.0%***
Disrespectful manner/attitude	49	12.5%
Failure to accommodate cultural/language needs	11	2.8%
Failure to communicate openly/honestly/effectively with consumer	133	33.9%
Failure to communicate openly/honestly/effectively with family	86	21.9%
Insensitive/inappropriate comments	5	1.3%
Complaints process	***58***	***14.8%***
Inadequate response to complaint	54	13.8%
Retaliation/discrimination for making a complaint	4	1.0%
Consent/Information	***107***	***27.3%***
Consent not obtained/adequate	27	6.9%
Inadequate information provided regarding adverse event	7	1.8%
Inadequate information provided regarding condition	10	2.6%
Inadequate information provided regarding options	9	2.3%
Inadequate information provided regarding provider	11	2.8%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding results	12	3.1%
Inadequate information provided regarding treatment	33	8.4%
Incorrect/misleading information provided	6	1.5%
Issues regarding consent when consumer not competent	5	1.3%
Issues with involuntary admission/treatment	22	5.6%
Documentation	***19***	***4.8%***
Inadequate/inaccurate documentation	19	4.8%
Facility issues	***50***	***12.8%***
Cleanliness/hygiene issue	3	0.8%
Failure to follow policies/procedures	5	1.3%
General safety issue for consumer in facility	12	3.1%
Inadequate/inappropriate policies/procedures	22	5.6%
Issue with quality of aids/equipment	3	0.8%
Issue with sharing facility with other consumers	3	0.8%
Staffing/rostering/other HR issue	10	2.6%
Waiting times	4	1.0%
Other	3	0.8%
Medication	***51***	***13.0%***
Administration error	2	0.5%
Inappropriate administration	5	1.3%
Inappropriate prescribing	34	8.7%
Prescribing error	2	0.5%
Refusal to prescribe/dispense/supply	10	2.6%
Reports/certificates	***10***	***2.6%***
Inaccurate report/certificate	8	2.0%
Refusal to complete report/certificate	2	0.5%
Professional conduct issues	***25***	***6.4%***
Disrespectful behaviour	9	2.3%
Inappropriate collection/use/disclosure of information	13	3.3%
Other	4	1.0%
Teamwork/supervision	***6***	***1.5%***
Inadequate supervision	6	1.5%
Disability-related issues	***4***	***1.0%***
Issues regarding right to support person	***11***	***2.8%***
Other	***8***	

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

- Care/treatment (present for 72% of all complaints)
- Communication (present for 62% of all complaints)
- Consent/information (present for 27% of all complaints)
- Access/funding (present for 27% of all complaints)

The most common *specific* issues were:

- Failure to communicate effectively with consumer (34%)
- Delay in treatment (24%)
- Inadequate/inappropriate clinical treatment (23%)
- Failure to communicate effectively with family (22%)
- Inadequate/inappropriate examination/assessment (18%)
- Inadequate/inappropriate follow-up (16%)
- Inadequate coordination of care/treatment (16%)
- Lack of access to services (15%)
- Missed/incorrect/delayed diagnosis (14%)
- Inadequate response to complaint (14%)
- Unexpected treatment outcome (13%)

This is broadly similar to what was seen in the last period. However, delay in treatment became one of the top three issues complained about for the first time in Jan–Jun 2020, and there was a small increase in the number of complaints about inadequate/inappropriate follow-up.

Issues complained about in relation to COVID-19

HDC received 53 complaints about COVID-19 related issues at DHBs in Jan–Jun 2020. This represents 35% of all complaints about COVID-19 received by HDC during this time period.

The most common issues complained about for DHBs in regard to COVID-19 were:

- Lack of access to services/delayed treatment (49%)
- Policies regarding visitor restrictions/support people (19%)
- Access to testing for COVID-19 (15%)
- Inadequate/failure to follow infection control policies (9%)

3.3 Primary issues by service type

Table 10 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, lack of access to services became more prominent for surgical, mental health, and medicine services in Jan–Jun 2020. As noted above, this may be due, in part, to COVID-19 restrictions affecting the availability of some services.

Table 10. Three most common primary issues in complaints by service type

Surgery n=126		Mental health n=89		Medicine n=73		Emergency department n=43	
Unexpected treatment outcome	20%	Issues with involuntary admission/ treatment	17%	Missed/ incorrect/ delayed diagnosis	21%	Missed/ incorrect/ delayed diagnosis	24%
Lack of access to services	15%	Lack of access to services	12%	Inadequate/ Inappropriate treatment	11%	Inadequate/ inappropriate examination/ assessment	10%
Waiting list/ prioritisation issue	12%	Inadequate/ inappropriate examination/ assessment	9%	Lack of access to services	11%	Waiting list/ prioritisation issue	10%

4. 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 is thorough and 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. These include referring the complaint to the Advocacy Service, to a professional body, or to another agency. HDC may also refer a complaint back to the provider to resolve directly. In line with their responsibilities under the Code, DHBs have increasingly developed good systems to address complaints in a timely and appropriate way. Where complaints are assessed as suitable for resolution between the parties, it is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

The Commissioner also has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances; 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. Often a decision to take no further action will 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 a DHB being found in breach of the Code. Notification of investigation generally indicates more serious issues.

4.1 Number of complaints closed

In the period Jan–Jun 2020, HDC closed **428**[4] complaints involving DHBs. Table 11 shows the number of complaints closed in previous six-month periods.

Table 11. Number of complaints about DHBs closed in the last five years

	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Jan–Jun 18	Jul–Dec 18	Jan–Jun 19	Jul–Dec 19	Average of last 4 6-month periods	Jan–Jun 20
Number of complaints closed	365	482	316	465	383	476	449	444	423	**448**	**428**

[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.

4.2 Outcomes of complaints closed

In the Jan–Jun 2020 period, seven DHBs had no investigations closed, three DHBs had one investigation closed, six DHBs had two investigations closed, one DHB had three investigations closed, two DHBs had four investigations closed, and one DHB had five investigations closed.

The manner of resolution and outcomes of all complaints about DHBs closed in Jan–Jun 2020 is shown in Table 12.

Table 12. Outcome for DHBs of complaints closed by complaint type[5]

Outcome for DHBs	Number of complaints closed
Investigation	***31***
Breach finding	19
No breach finding — with adverse comment and recommendations	7
No breach finding with recommendations	2
No breach finding	3
Other resolution following assessment	***395***
No further action with recommendations or educational comment	51
Referred to District Inspector	14
Referred to other agency	4
Referred to DHB	55
Referred to Advocacy	56
No further action	207
Withdrawn	8
Outside jurisdiction	***2***
TOTAL	**428**

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

4.3 Recommendations made to DHBs by HDC

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 13 shows the recommendations made to DHBs for complaints closed in Jan–Jun 2020. Please note that more than one recommendation may be made in relation to a single complaint.

Table 13. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	24
Audit	17
Evaluation of change	5
Meeting with consumer	2
Personal reflection	1
Presentation/discussion of complaint with others	9
Provision of evidence of change to HDC	14
Provision of information to consumer/complainant	1
Review/implementation of policies/procedures	25
Training/professional development	20
TOTAL	**118**

The most common recommendations made to DHBs were that they review or implement new policies and procedures (25 recommendations), apologise to the consumer/complainant (24 recommendations), and conduct staff training (20 recommendations). Recommendations for staff training were most often in regard to clinical issues identified in the complaint, followed by training on communication and documentation requirements.

5. Learning from complaints

5.1 Informed consent for dementia patient[6]

This case highlights the importance of providers being aware of consumers' legal status, and obtaining informed consent.

Background

An elderly woman with dementia was admitted to a mental health unit for assessment and treatment, as staff at her rest home were finding it increasingly difficult to manage her behaviour. The woman's daughter, who was her welfare guardian and the appropriate person to give consent on her behalf, opposed the admission. The DHB, however, considered that admission was the only practicable option. The Mental Health Commissioner commented that in this context, it would have been appropriate for DHB staff to consider the legal basis on which it was admitting the woman to the ward. The DHB acknowledged that the woman should have been treated under the Mental Health Act.

During her time in the unit, the woman was administered intramuscular (IM) lorazepam to restrain her, without informed consent from her daughter. Additionally, there was a lack of consistent engagement and regular timely meetings with the woman's family, and the woman's daughter was not given sufficient opportunity to provide input into her mother's treatment plan.

Findings

The Mental Health Commissioner noted that the woman's records frequently referred to the woman's daughter incorrectly as her enduring power of attorney. He commented that this mistake, together with poor communication with the woman's daughter, indicates that care was not taken to ascertain and understand the daughter's legal role. The Mental Health Commissioner emphasised that it is important that providers are aware of consumers' legal status, and sight and retain copies of the relevant documentation.

The Mental Health Commissioner found the DHB in breach of Right 7(1) of the Code for administering the woman IM lorazepam to restrain her without informed consent from her welfare guardian. He also found the DHB in breach of Right 6(2) of the Code for failing to consult the woman's welfare guardian prior to the use of IM lorazepam, and for failing to communicate with her adequately regarding her mother's care plan.

Recommendations

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

- Provide training to all staff in the mental health unit on the Code of Rights, informed consent, enduring powers of attorney, welfare guardians, the Mental Health Act, restraint, and the interaction of respective decision-making rights;
- Conduct an audit of IM medication administration to ensure that informed consent had been obtained appropriately; and
- Provide an update on the efficacy of the changes it had made to its Older Adult Mental Health Service following this complaint.

[6] Case 17HDC00296.

5.2 Follow-up on incidental finding[7]

This case highlights the importance of communication between providers, and the need for adequate processes to ensure follow-up of incidental findings.

Background

A man in his fifties was taken by ambulance to the Emergency Department (ED) of a public hospital following an accident. A CT scan was performed, and an incidental finding of a lesion in the right upper lobe of the lung was reported, along with multiple spinal compression fractures. It was recommended that the man be seen by the respiratory team for an opinion on the lung lesion. The radiology registrar discussed the findings of the CT scan with the ED registrar.

The man was then admitted to the orthopaedic ward. During his admission, his care focused on the acute spinal injuries, and communication of the lung lesion finding did not occur when he was transferred between ED and orthopaedics.

At some point during his hospital stay the man's family were informed of the lesion verbally, and told that it needed to be followed up. However, it was not documented in his ED medical record or discharge summary, and no documentation of the issue was provided to the man or his family. The DHB acknowledged that communication of follow-up advice verbally was insufficient, given the stress of the multi-trauma situation. The man's GP was provided with a copy of the ED medical record and discharge summary, but was not notified of the lung lesion.

Nearly five months later, the man re-presented to the DHB with right-sided facial droop, right arm weakness, and slurred speech. CT scans revealed that a primary lesion in his right lung had metastasised to his brain. The man was diagnosed with metastasised lung cancer and, sadly, he passed away.

Findings

The former Commissioner commented that while he was mindful that the follow-up of incidental findings is a challenging issue worldwide, he considered that in this case there were a number of missed opportunities to take action. He noted that DHBs should have in place appropriate systems to facilitate the continuity of care for their patients as they move through the health system.

During his admission to hospital, the man was seen by many different doctors and was under the care of multiple hospital teams. Consequently, no single doctor took responsibility for the incidental finding, and communication of the finding did not make its way to the discharge summary or to the man's GP. This denied the man the opportunity for earlier diagnosis and treatment of his lung cancer. The former Commissioner found that the DHB failed to provide the man with coordination and continuity of care, in breach of Right 4(5) of the Code.

Recommendations

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

- Provide HDC with a copy of its new mandatory policy on incidental findings
- Create a package of educational material, including an anonymised version of this case, to be used throughout departmental teaching sessions and staff inductions to address the general standards of practice expected in relation to incidental findings, as well as specific systems that will help reduce the risk of such findings not being followed up.

[7] Case 19HDC00851.

- Undertake intermittent audits of the adequacy and observance of DHB policies relating to incidental findings that require action
- Provide HDC with an update on the changes made since this event and an analysis of the effectiveness of these changes, including:
  - the steps taken to ensure that findings that are not immediately related to orthopaedic injuries, but require follow-up, have a plan in place to ensure that they are acted on appropriately;
  - the rollout of its new electronic system that supports the delivery of co-ordinated care through creation and viewing of clinical notes, teams, and individual task management; and
  - the steps taken to enable Radiology electronic results to follow the patient from the ED to the inpatient team automatically.

5.3 Failure to respect refusal of consent for treatment[8]

This case highlights the need to ensure that a consumer's right to decide to refuse treatment is upheld, and that staff understand the relevance of consent issues and escalate pertinent consent information.

Background

A woman required surgery for suspected endometriosis. Surgical treatment of endometriosis usually requires removal of tissue by either surgical excision (cutting with surgical instruments), ablation (cutting and burning using an electrical probe), or a combination of both techniques. The woman reported that she had researched the various treatment options and told her obstetrician and gynaecologist that she did not want him to use ablation. She also told a junior doctor at a preoperative assessment that she did not consent to ablation, and the doctor had written the woman's refusal of ablation into her clinical notes. The operating surgeon advised that he does not recall the junior doctor informing him about the woman's refusal of ablation.

The obstetrician and gynaecologist did not read the woman's clinical notes before the surgery, and treated the woman using ablation.

Findings

The principle of informed consent is at the heart of the Code. The obstetrician and gynaecologist, as the treating practitioner, retained overall legal responsibility and accountability for the consent process. Ultimately, he performed a procedure on the woman to which she had not consented. The obstetrician and gynaecologist said that it was never his intention to disrespect the woman's choices in any way, and that he acted in her best interests. That is not the point. It is the consumer's right to decide, and, in the absence of an emergency or certain other legal requirements, clinical judgement regarding best interests does not apply.

The obstetrician and gynaecologist failed to pay sufficient attention when the woman told him that she did not want to have ablation performed. The former Commissioner found that by treating the endometriosis with ablation when the woman had refused consent to ablation, the obstetrician and gynaecologist breached Right 7(7) of the Code. Additionally, the Commissioner found the obstetrician and gynaecologist in breach of Rights 4(1) and 4(2) of the Code for failing to read the woman's notes sufficiently before commencing surgery, and for the poor standard of his record-keeping in regard to discussions about consent.

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[8] Case 18HDC00131.

The former Commissioner also found the DHB in breach of the Code because the DHB's systems for informed consent did not provide adequate guidance to staff. In particular, he was concerned that:

- Staff were not clear about the relevance of consent discussions at the preoperative clinic
- The informed consent policy did not specify any requirement to escalate concerns beyond documenting the refusal
- There was no guidance for staff on the appropriate steps to escalate information pertinent to consent to the responsible clinician
- There was a lack of clarity and guidance for staff around reading the preoperative assessment

Recommendations

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

- Confirm to HDC the process for clinicians to follow at pre-assessment when important consent information obtained should be escalated to the clinician obtaining signed consent
- Provide HDC with a review of training provided to staff in relation to informed consent, and evidence that all medical staff in the women's health service have been trained in informed consent
- Clarify the expectation that an operating surgeon is responsible for reading the preoperative assessments
- Provide an update to HDC on the corrective actions it has undertaken as a result of this complaint

5.4 Delayed diagnosis of bladder cancer[9]

This case highlights the importance of having robust processes for sharing patient information so that appropriate treatment can be provided, and of ensuring that patients are treated with respect, even in circumstances in which workloads are high.

Background

A man's GP referred him to a urology clinic at a public hospital because he was experiencing pain while passing urine, difficulty with bladder control, and a frequent urge to urinate. The DHB contracts a specialist clinic to provide its urology outpatient services.

The referral letter from the man's GP mentioned issues including inflammation of the prostate gland, and the presence of blood and abnormal cells in the urine. The referral contained the man's medical history, and copies of four urine cytology reports, the results of which were all abnormal. These reports contained information regarding potential causes of the abnormal results, including the possibility of neoplasia. The referral was triaged as category 3 (to be seen within four months). The DHB told HDC that given the abnormal test results, the man should have been triaged as a higher priority and seen within four weeks.

When the man first saw the urologist, highly relevant information from this referral, including the cytology reports, was not made available to the urologist. The urologist did not conduct a thorough investigation of the man's symptoms or carry out imaging and urine analysis.

[9] Case 17HDC02166.

Over a year after the original referral, the man's symptoms had failed to resolve, and he returned to the urologist as a private patient. The specialist clinic did not identify the man's status accurately when he changed from a public to a private patient, and this resulted in confusion and miscommunication.

The man's pain worsened and his wife drove him to the public hospital's emergency department (ED). He was unable to manage the walk from the car to the ED, and, despite several requests by his wife for assistance from ED staff, he was left waiting in the car outside the ED in severe pain.

The man requested a referral to a different urologist, and was diagnosed with high-grade bladder cancer and carcinoma in situ.

Findings

The former Commissioner considered that the man's treatment by the DHB was very poor. Highly relevant information about his condition that was included in the referral was not available to the urologist when he first saw the man, owing to poor systems, and the specialist clinic did not identify the man's status accurately when he changed from a public to a private patient. He was at times treated discourteously and given inaccurate information. In particular, the Commissioner noted that he found it incomprehensible that the man was left outside ED in his car without pain relief or reassurance whilst waiting for a bed to become available.

DHBs have a responsibility for the actions of their staff, and an organisational duty to facilitate continuity of care. This includes ensuring that appropriate resources are available, and that all staff communicate effectively. It also requires that appropriate systems are in place to ensure that patients are triaged appropriately, necessary tests (and repeat tests) are undertaken, and patients are treated with respect, even in circumstances in which workloads are high.

The former Commissioner found that the DHB failed to treat the man with respect and failed to provide services to him with reasonable care and skill, in breach of Right 1(1) and Right 4(1) of the Code.

Recommendations

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

- Prepare an anonymised version of this case for the purpose of staff training, and arrange for the training to take place
- Conduct ongoing refresher training for its urology service staff with regard to communication and managing conflict between staff and patients and their relatives
- Consider whether a re-evaluation by a senior nurse of triaging of referrals is required as a precautionary measure
- Review the DHB's urology triaging codes/categories in light of the issues in this report
- Conduct an audit of the urology service to identify whether the priority level given to referrals correlates with the test results available at the time of referral
- Incorporate into the triage system the requirement for upper tract radiology to be obtained and reviewed for patients with microhaematuria
- Develop a policy on the information to be provided to private patients regarding their treatment options, and whether their investigations are to be made publicly or privately