

Complaints to the Health and Disability Commissioner involving District Health Boards

Report and Analysis for the Period 1 January to 30 June 2018

Feedback

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

Authors

This report was prepared by Natasha Davidson (Senior Advisor – Research and Education).

Citation: The Health and Disability Commissioner. 2018. *Complaints to the Health and Disability Commissioner involving District Health Boards: Report and Analysis for the period 1 January to 30 June 2018*

Published in October 2018
by the Health and Disability Commissioner
PO Box 1791, Auckland 1140

©2018 The Health and Disability Commissioner

This report is available on our website at www.hdc.org.nz

Contents

Commissioner’s Foreword	i
National Data for all District Health Boards	1
1.0 Number of complaints received	1
1.1 Raw number of complaints received.....	1
1.2 Rate of complaints received	2
2.0 Service types complained about	4
2.1 Service type category	4
3.0 Issues complained about	6
3.1 Primary complaint issues.....	6
3.2 All complaint issues	9
3.3 Service type and primary issues	11
4.0 Complaints closed	12
4.1 Number of complaints closed.....	12
4.2 Outcomes of complaints closed	12
4.3 Recommendations made to DHBs following a complaint.....	14
5.0 Learning from complaints — HDC case reports	15

Commissioner's Foreword

I am pleased to present you with HDC's second six monthly DHB complaint report for the 2017/2018 year.

The trends in complaints about DHBs in January to June 2018 have remained broadly consistent with previous periods. Surgery, mental health and general medicine have remained the most commonly complained about service types at DHBs, and misdiagnosis was again the most commonly complained about primary issue. However, complaints regarding an unexpected treatment outcome became more prominent in January to June 2018, with this issue increasing from being the primary issue in around 8% of DHB complaints in previous periods to 12% in January to June 2018. This issue often relates to post-surgical complications, and can sometimes reflect the quality of information provided to the consumer around the risks and possible complications of surgery.

Over the last year, I have noted that inadequate follow-up of test result has been a feature of a number of investigations closed by this Office about DHBs¹. These cases are often contributed to by the lack of a clear, effective formalised system for the reporting and follow-up of test results. It is important that DHBs communicate their expectations around test result follow-up to staff clearly and that systems have a number of defences built into them to ensure that test results are actioned in a timely manner. Another issue I often see in these cases are inadequacies in electronic systems, including:

- incomplete rollout of electronic systems;
- lack of appropriate safeguards built into such systems;
- lack of clarity in policies and procedures around their use; and
- staff not being trained/competent in the use of electronic systems.

While I support the introduction of digital systems, it is important that these systems are fit-for purpose and the roll out and use of such systems are well planned, well designed, and subject to close scrutiny. Providers need to be trained appropriately on the use of these tools to ensure that they make the best use of the safety features and DHBs need to make their expectations regarding the use of such systems clear.

Anthony Hill
Health and Disability Commissioner

¹ 17HDC00316, 16HDC01980, 15HDC01289, 15HDC01204

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 2018, HDC received a total of 450² complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

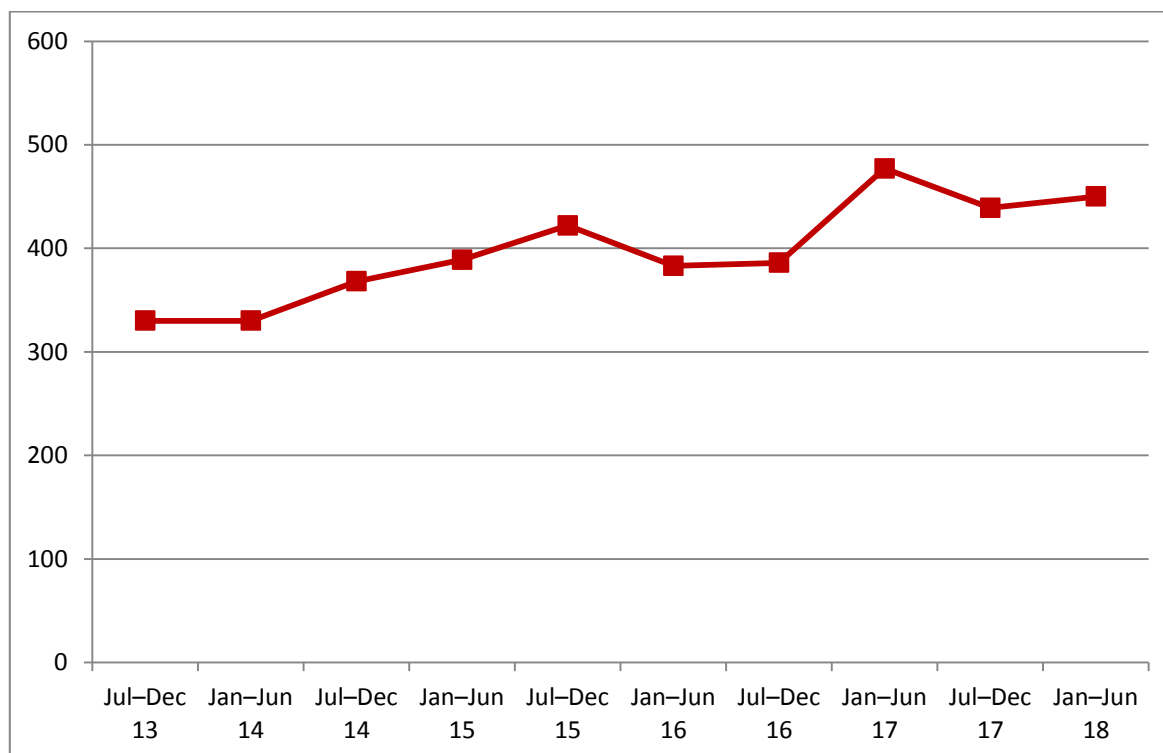
Table 1. Number of complaints received in the last five years

	Jul– Dec 13	Jan– Jun 14	Jul– Dec 14	Jan– Jun 15	Jul– Dec 15	Jan– Jun 16	Jul– Dec 16	Jan– Jun 17	Jul– Dec 17	Average of last 4 6-month periods	Jan– Jun 18
Number of complaints	330	330	368	389	422	383	386	477	439	421	450

The total number of complaints received in Jan–Jun 2018 (450) shows an increase of 7% over the average number of complaints received in the previous four periods.

The number of complaints received in Jan–Jun 2018 and previous six-month periods are also displayed below in Figure 1.

Figure 1. Number of complaints received



² Provisional as of date of extraction (14 August 2018).

1.2 Rate of complaints received

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

Rate of complaints calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (14 September 2018) and is likely incomplete; it will be updated in the next six-monthly report. It should be noted that this discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges during Jan–Jun 2018

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
450	477,118	94.32

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan–Jun 2018 and previous six-month periods.

Table 3. Rate of complaints received in last five years

	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17³	Average of last 4 6-month periods	Jan–Jun 18
Rate per 100,000 discharges	71.15	72.99	76.65	84.60	87.57	81.44	78.79	99.08	88.23	86.89	94.32

The rate of complaints received during Jan–Jun 2018 (94.32) shows a 9% increase over 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.⁴

³ The rate for Jul–Dec 2017 has been recalculated based on the most recent discharge data.

⁴ 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 2018

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	67	60164	111.36
Bay of Plenty	23	25664	89.62
Canterbury	51	56445	90.35
Capital and Coast	45	29386	153.13
Counties Manukau	43	50666	84.87
Hawke's Bay	17	17390	97.76
Hutt Valley	16	15888	100.70
Lakes	13	11491	113.13
MidCentral	13	15013	86.59
Nelson Marlborough	13	9561	135.97
Northland	15	20635	72.69
South Canterbury	2	5935	33.70
Southern	36	26806	134.3
Tairāwhiti	6	5009	119.78
Taranaki	7	13177	53.12
Waikato	24	47618	50.40
Wairarapa	14	4366	320.66
Waitemata	48	51999	92.31
West Coast	7	3401	205.82
Whanganui	7	6504	107.63

Notes on DHB's number and rate of complaints

It should be noted that a DHB's number and rate of complaints can vary considerably from one six-month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six-month period. For smaller DHBs, a very small absolute increase or decrease in the number of complaints received can dramatically affect the rate of complaints. Accordingly, much of the value in this data lies in how it changes over time, as such analysis allows trends to emerge that may point to areas that require further attention.

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

2.0 Service types complained about

2.1 Service type category

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one hospital; therefore, although there were 450 complaints about DHBs, 472 services were complained about.

Surgical services (31.4%) received the greatest number of complaints in Jan–Jun 2018, with orthopaedics (8.1%) and general surgery (7.4%) being the surgical specialties most commonly complained about. Other commonly complained about services included mental health (21.2%), general medicine (16.3%), emergency departments (10.6%) and maternity services (6.8%). This is broadly similar to what has been seen in previous periods.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Aged care	2	0.4%
Alcohol and drug	3	0.6%
Anaesthetics/pain medicine	4	0.8%
Dental	3	0.6%
Diagnostics	16	3.4%
Disability services	8	1.7%
District nursing	3	0.6%
Emergency department	50	10.6%
General medicine	77	16.3%
Cardiology	8	1.7%
Dermatology	1	0.2%
Endocrinology	4	0.8%
Gastroenterology	7	1.5%
Geriatric medicine	9	1.9%
Haematology	1	0.2%
Infectious diseases	2	0.4%
Neurology	9	1.9%
Oncology	7	1.5%
Palliative care	1	0.2%
Renal/nephrology	2	0.4%
Respiratory	6	1.3%
Rheumatology	1	0.2%
Other/unspecified	19	4.0%
Hearing services	2	0.4%
Intensive care/critical care	4	0.8%
Maternity	32	6.8%
Mental health	100	21.2%
Paediatrics (not surgical)	12	2.5%
Rehabilitation services	5	1.1%
Surgery	148	31.4%
Cardiothoracic	1	0.2%
General	35	7.4%
Gynaecology	20	4.2%
Neurosurgery	7	1.5%
Ophthalmology	12	2.5%
Oral/Maxillofacial	1	0.2%
Orthopaedics	38	8.1%
Otolaryngology	14	3.0%
Plastic and Reconstructive	5	1.1%
Urology	11	2.3%
Vascular	3	0.6%
Unknown	1	0.2%
Other/unknown health service	3	0.6%
TOTAL	472	

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jan–Jun 2018 are listed in Table 6. It should be noted that the issues included are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues provide a valuable insight into the consumer’s experience of the services provided and the issues they care most about.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	80	17.8%
Lack of access to services	29	6.4%
Lack of access to subsidies/funding	3	0.7%
Waiting list/prioritisation issue	48	10.7%
Boundary violation	1	0.2%
Care/Treatment	214	47.6%
Delay in treatment	11	2.4%
Delayed/inadequate/inappropriate referral	3	0.7%
Inadequate coordination of care/treatment	7	1.6%
Inadequate/inappropriate clinical treatment	20	4.4%
Inadequate/inappropriate examination/assessment	10	2.2%
Inadequate/inappropriate follow-up	5	1.1%
Inadequate/inappropriate monitoring	5	1.1%
Inadequate/inappropriate non-clinical care	8	1.8%
Inadequate/inappropriate testing	1	0.2%
Inappropriate/delayed discharge/transfer	11	2.4%
Inappropriate withdrawal of treatment	3	0.7%
Missed/incorrect/delayed diagnosis	59	13.1%
Refusal to assist/attend	1	0.2%
Refusal to treat	9	2.0%
Rough/painful care or treatment	3	0.7%
Unexpected treatment outcome	54	12.0%
Unnecessary treatment/over-servicing	4	0.9%
Communication	38	8.4%
Disrespectful manner/attitude	12	2.7%
Failure to accommodate language/cultural needs	2	0.4%
Failure to communicate openly/honestly/effectively with consumer	7	1.6%
Failure to communicate openly/honestly/effectively with family	12	2.7%
Insensitive/inappropriate comments	5	1.1%
Complaints process	13	2.9%
Inadequate response to complaint	13	2.9%
Consent/Information	42	9.3%
Consent not obtained/adequate	10	2.2%
Inadequate information provided regarding adverse event	1	0.2%
Inadequate information provided regarding condition	4	0.9%
Inadequate information provided regarding fees/costs	2	0.4%
Inadequate information provided regarding results	2	0.4%

Primary issue in complaints	Number of complaints	Percentage
Inadequate information provided regarding treatment	4	0.9%
Issues regarding consent when consumer not competent	2	0.4%
Issues with involuntary admission/treatment	17	3.8%
Documentation	7	1.5%
Delay/failure to disclose documentation	1	0.2%
Inadequate/inaccurate documentation	6	1.3%
Facility issues	18	4.0%
General safety issue for consumer in facility	11	2.4%
Waiting times	2	0.4%
Other	5	1.1%
Medication	19	4.2%
Administration error	2	0.4%
Prescribing error	2	0.4%
Inappropriate administration	4	0.9%
Inappropriate prescribing	8	1.8%
Refusal to prescribe/dispense/supply	3	0.7%
Reports/Certificates	3	0.7%
Inaccurate report/certificate	3	0.7%
Other professional conduct issues	11	2.4%
Disrespectful behaviour	7	1.6%
Inappropriate collection/use/disclosure of information	4	0.9%
Disability-related issues	3	0.7%
Other issues	1	0.2%
TOTAL	450	

The most common primary issue categories were:

- Care/treatment (47.6%)
- Access/funding (17.8%)
- Consent/information (9.3%)
- Communication (8.4%)

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

- Missed/incorrect/delayed diagnosis (13.1%)
- Unexpected treatment outcome (12.0%)
- Waiting list/prioritisation issue (10.7%)
- Lack of access to services (6.4%)

Table 7 shows a comparison over time for the top five primary issues complained about. The top five primary issues have remained broadly consistent over time, with the exception of “unexpected treatment outcome” which increased from being the primary issue in around 8% of complaints in previous periods to 12% in Jan-Jun 2018, and “inadequate/inappropriate treatment” which decreased from being the primary issue in around 7-8% of complaints in previous periods to 4% in Jan-Jun 2018.

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

Top five primary issues in all complaints (%)							
Jul–Dec 16 n=386		Jan–Jun 17 n=477		Jul–Dec 17 n=439		Jan–Jun 18 n=450	
Misdiagnosis	15%	Misdiagnosis	15%	Misdiagnosis	12%	Misdiagnosis	13%
Unexpected treatment outcome	8%	Waiting list/ Prioritisation	10%	Waiting list/ prioritisation	10%	Unexpected treatment outcome	12%
Inadequate treatment	8%	Unexpected treatment outcome	9%	Unexpected treatment outcome	8%	Waiting list/ prioritisation	11%
Lack of access to services	8%	Inadequate treatment	6%	Inadequate treatment	7%	Lack of access to services	6%
Waiting list/ Prioritisation	7%	Lack of access to services	6%	Lack of access to services	6%	Inadequate treatment	4%

3.2 All complaint issues

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

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	111	24.7%
Lack of access to services	49	10.9%
Lack of access to subsidies/funding	8	1.8%
Waiting list/prioritisation issue	61	13.6%
Other	1	0.2%
Boundary violation	2	0.4%
Care/Treatment	357	79.3%
Delay in treatment	86	19.1%
Delayed/inadequate/inappropriate referral	7	1.6%
Inadequate coordination of care/treatment	71	15.8%
Inadequate/inappropriate clinical treatment	171	38.0%
Inadequate/inappropriate examination/assessment	119	26.4%
Inadequate/inappropriate follow-up	48	10.7%
Inadequate/inappropriate monitoring	31	6.9%
Inadequate/inappropriate non-clinical care	43	9.6%
Inadequate/inappropriate testing	48	10.7%
Inappropriate admission/failure to admit	11	2.4%
Inappropriate/delayed discharge/transfer	46	10.2%
Inappropriate withdrawal of treatment	3	0.7%
Missed/incorrect/delayed diagnosis	94	20.9%
Personal privacy not respected	2	0.4%
Refusal to assist/attend	13	2.9%
Refusal to treat	13	2.9%
Rough/painful care or treatment	20	4.4%
Unexpected treatment outcome	78	17.3%
Unnecessary treatment/over-servicing	10	2.2%
Communication	292	64.9%
Disrespectful manner/attitude	71	15.8%
Failure to accommodate language/cultural needs	4	0.9%
Failure to communicate openly/honestly/effectively with consumer	167	37.1%
Failure to communicate openly/honestly/effectively with family	103	22.9%
Insensitive/inappropriate comments	15	3.3%
Complaints process	68	15.1%
Inadequate response to complaint	68	15.1%
Consent/Information	102	22.7%
Consent not obtained/adequate	26	5.8%
Failure to assess capacity to consent	7	1.6%
Inadequate information provided regarding adverse event	7	1.6%
Inadequate information provided regarding condition	12	2.7%
Inadequate information provided regarding fees/costs	2	0.4%
Inadequate information provided regarding options	6	1.3%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding provider	3	0.7%
Inadequate information provided regarding results	10	2.2%
Inadequate information provided regarding treatment	26	5.8%
Incorrect/misleading information provided	12	2.7%
Issues regarding consent when consumer not competent	4	0.9%
Issues with involuntary admission/treatment	23	5.1%
Documentation	32	7.1%
Delay/failure to disclose documentation	7	1.6%
Inadequate/inaccurate documentation	24	5.3%
Intentionally misleading/altered documentation	1	0.2%
Facility issues	71	15.8%
Accreditation standards/statutory obligations not met	2	0.4%
Cleanliness/hygiene issue	6	1.3%
Failure to follow policies/procedures	2	0.4%
General safety issue for consumer in facility	12	2.7%
Inadequate/inappropriate policies/procedures	25	5.6%
Issue with quality of aids/equipment	12	2.7%
Issue with sharing facility with other consumers	6	1.3%
Staffing/rostering/other HR issue	7	1.6%
Waiting times	9	2.0%
Medication	44	9.8%
Administration error	4	0.9%
Prescribing error	4	0.9%
Inadequate storage/security	1	0.2%
Inappropriate administration	8	1.8%
Inappropriate prescribing	22	4.9%
Refusal to prescribe/dispense/supply	6	1.3%
Reports/Certificates	10	2.2%
Inaccurate report/certificate	7	1.6%
Refusal to complete report/certificate	3	0.7%
Teamwork/supervision	12	2.7%
Inadequate supervision/oversight	12	2.7%
Other professional conduct issues	23	5.1%
Disrespectful behaviour	10	2.2%
Inappropriate collection/use/disclosure of information	9	2.0%
Other	4	0.9%
Disability-related issues	9	
Other issues	7	

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

- Care/treatment (present for 79.3% of all complaints)
- Communication (present for 64.9% of all complaints)
- Access/funding (present for 24.7% of all complaints)
- Consent/information (present for 22.7% of all complaints).

The most common specific issues were:

- Inadequate/inappropriate clinical treatment (38.0%)
- Failure to communicate effectively with consumer (37.1%)
- Inadequate/inappropriate examination/ assessment (26.4%)
- Failure to communicate effectively with family (22.9%)
- Missed/incorrect/delayed diagnosis (20.9%)
- Delay in treatment (19.1%)
- Unexpected treatment outcome (17.3%)
- Disrespectful manner/attitude (15.8%)
- Inadequate coordination of care/treatment (15.8%)
- Inadequate response to the consumer’s complaint by the DHB (15.1%)

These issues are broadly similar to what was seen last period.

Also similar to the last six-month period, many complaints involved issues with a consumer’s care/treatment, including: “inadequate/ inappropriate testing”, “inadequate/inappropriate follow-up”, “inappropriate/delayed discharge/transfer” and “inadequate/inappropriate non-clinical care”. These issues were each present in around 10% of complaints.

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. However, compared to last period, access/prioritisation issues became more prominent for mental health services and less prominent for general medicine services.

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

Surgery n=148		Mental Health n=100		General medicine n=77		Emergency department n=50		Maternity n=32	
Unexpected treatment outcome	24%	Issues with involuntary admission/ Treatment	18%	Missed/ incorrect/ delayed diagnosis	18%	Missed/ incorrect/ delayed diagnosis	44%	Unexpected treatment outcome	22%
Waiting list/ prioritisation issue	20%	Lack of access to services	11%	Unexpected treatment outcome	10%	Refusal to treat	18%	Delay in treatment	9%
Missed/ incorrect/ delayed diagnosis	8%	Waiting list/ prioritisation issue	8%	Inadequate/ inappropriate treatment	8%	Waiting list/ prioritisation issue	6%	Inadequate/ inappropriate treatment	9%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **476**⁵ complaints involving DHBs in the period Jan–Jun 2018. Table 10 shows the number of complaints closed in previous six-month periods.

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

	Jul– Dec 13	Jan– Jun 14	Jul– Dec 14	Jan– Jun 15	Jul– Dec 15	Jan– Jun 16	Jul– Dec 16	Jan– Jun 17	Jul– Dec 17	Average of last 4 6-month periods	Jan– Jun 18
Number of complaints closed	280	411	344	410	365	482	316	465	383	412	476

4.2 Outcomes of complaints closed

Complaints that are within HDC’s jurisdiction are classified into two groups according to the manner of resolution — whether investigation or other resolution. Within each classification, there is a variety of possible outcomes. Notification of investigation generally indicates more serious issues.

In the Jan–Jun 2018 period, 6 DHBs had no investigations closed, 6 DHBs had one investigation closed, 1 DHB had two investigations closed, 1 DHB had three investigations closed, 2 DHBs had 4 investigations closed, 2 DHBs had 5 investigations closed, 1 DHB had 6 investigations closed and 1 DHB had 8 investigations closed by HDC.

The manner of resolution and outcomes of all complaints about DHBs closed in Jan–Jun 2018 is shown in Table 11.

⁵ 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 type⁶

Outcome for DHBs	Number of complaints closed
<i>Investigation</i>	38
Breach finding – referred to Director of Proceedings	3
Breach finding	18
No breach finding with recommendations or educational comment	13
No breach finding	4
<i>Other resolution following assessment</i>	432
No further action ⁷ with recommendations or educational comment	117
Referred to Ministry of Health	2
Referred to District Inspector	16
Referred to other agency	5
Referred to DHB ⁸	98
Referred to Advocacy	44
No further action	143
Withdrawn	7
<i>Outside jurisdiction</i>	6
TOTAL	476

⁶ 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.

⁷ The Commissioner has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. This may happen, for example, where a DHB has carefully reviewed the case itself and no further value would be added by HDC investigating, or where another agency is reviewing, or has carefully reviewed the matter (for example, the Coroner, the Director-General of Health, or a District Inspector). Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice.

⁸ In line with their responsibilities under the Code, DHBs have developed systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

4.3 Recommendations made to DHBs following a complaint

Regardless of whether or not a complaint has been investigated, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted upon. Table 12 shows the recommendations made to DHBs in complaints closed in Jan–Jun 2018. 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	23
Meeting with consumer	5
Presentation/discussion of complaint with others	14
Provision of evidence of change to HDC	65
Provision of information to consumer	2
Reflection	5
Review/implementation of policies/procedures	44
Training/professional development	35
Total	213

The most common recommendation made to DHBs was that they provide evidence to HDC of the changes they had made in response to the issues raised by the complaint (65 recommendations). Often, when HDC asks for this evidence, it is also recommended that the provider conducts a review of the effectiveness of the changes made. Conducting a review of their policies/procedures or implementing new policies/procedures (44 recommendations) and staff training (35 recommendations) were also often recommended. Staff training was most commonly recommended in relation to clinical issues. Where new policies/procedures have been introduced by providers following a complaint, HDC will often recommend an audit to ensure that staff are complying with these new policies/procedures.

5.0 Learning from complaints — HDC case reports

Delay in follow-up ophthalmology review (16HDC01010)

Background

A 20-year-old man presented to a DHB's Ophthalmology Service (the Service). The man had been referred urgently by a community optometrist and had a family history of glaucoma. He was prescribed eye drops and a follow-up review went ahead. Two months later, at a further scheduled appointment, the man was diagnosed with ocular hypertension. The consultant requested that the man be reviewed again in six months' time.

The man's follow-up appointment was delayed by six months. By this time, he had suffered vision loss in his right eye (which many clinicians subsequently attributed to the delay) and he required an urgent referral for management and surgery. In short, the man did not receive follow-up ophthalmology specialist care relating to his glaucoma management in line with the clinical time frames requested.

Findings

The Commissioner was mindful, as detailed in a thorough external review of the Service commissioned by the DHB, of a combination of factors that have driven rapidly increasing demand for ophthalmology services in New Zealand, including outpatient clinic time, over the last ten years. A key factor has been the introduction of very effective new therapies and treatment, which have resulted in consumers needing to see specialists for regular ongoing follow-up and/or treatment, fueling increased demand for ophthalmology services.

The Commissioner commented that provider accountability is not removed by the existence of such systemic pressures. A key improvement that all DHBs and the Ministry of Health must make, now and in the future, is to assess, plan, adapt, and respond effectively to the foreseeable effects that new technologies will have on systems and demand.

At the time of the man's care, the Service lacked capacity, in that the clinics did not have enough appointments for the number of patients clinicians had to see. In the context of resource constraint, prioritisation schemes become vital in ensuring those patients at greatest risk are seen first. However, the Service lacked an appropriate prioritisation system.

The pressure on the Service was contributed to by an insufficient response by senior management at the DHB to growing demands for ophthalmology services over many years. Management at the DHB failed to communicate effectively with its clinical staff and act on valid concerns raised by senior clinicians, and to ensure that a system was in place that effectively managed and prioritised patients waiting for follow-up specialist ophthalmology care. Additionally, to some degree, a culture of tolerance emerged and delays became normalised. As a result, the DHB tolerated a situation that put patients at risk.

The DHB failed to arrange a timely follow-up appointment because it did not have a prioritisation system that focused on patients' clinical need. Instead it relied on administration staff who lacked training and clear guidance to prioritise appropriately. Despite concerns being raised with the DHB, it did not recognise the clinical risk created by the lack of capacity at the Service, and did not take action to rectify the situation after an earlier serious event review in relation to a similar matter had raised associated concerns. In addition, there were missed opportunities for the DHB to rectify the delay in the follow-up appointment. The DHB did not provide the man services with reasonable care and skill and, accordingly, was found in breach of Right 4(1) of the Code.

Recommendations

The Commissioner made a number of detailed recommendations to the DHB, including that it provide HDC with a detailed update report on the steps taken to carry out the recommendations of an external review of the Service and those arising out of the DHB's own reviews with specific reference to:

- An independent evaluation of the systems in place to identify and prioritise overdue ophthalmology patients. This should include the use of clinically driven patient acuity scores so that patients with higher acuities are prioritised and patients identified as specifically high risk do not have appointments delayed, and patients who self-identify with severe pain or sudden loss of vision are booked for urgent review.
- A quantitative and qualitative audit of the management of Ophthalmology Service referrals and follow-ups, to be certain that tracking systems are in place so that all referrals are responded to in a timely manner
- The proactive steps taken to build departmental capacity, responsiveness, and adaptability, including regular accurate measurement and reporting of demand and capacity, using objective agreed criteria that account for actual and projected increases in demand, as well as details regarding:
 - Training and implementation of nursing staff and ancillary and non-specialist staff to remove inefficiency associated with lower priority tasks.
 - The effectiveness of the department's relocation to enhanced physical space.
 - Recruitment of ophthalmologists, optometrists, orthoptists, and ophthalmology staff.
- Details of the redefined roles and responsibilities of those involved in the management of the Ophthalmology Service.
- Routine telephone access to clinical staff so that DHB Ophthalmology Service patients can contact the Eye Department readily, speak to an appropriately trained person when clinical concerns are raised, receive an appropriate response, and have this recorded in their clinical notes.
- Shared learning:
 - Use of regular forums involving ophthalmology departmental staff and management staff, to include discussion and planning to assist development of treatment protocols in the context of an ageing population.
 - Confirmation that the external review report was discussed with all other DHBs via their Chief Medical Officers, to ensure that any patient risk arising from similar circumstances is identified and controlled.
- The Ophthalmology Service and its facilities undergoing regular credentialling, as occurs in most DHBs.
- A further update on how the Ophthalmology Backlog Programme project has been established across the DHB, involving its weekly stakeholder updates to track and monitor progress toward zero patients waiting beyond clinically appropriate timeframes.

The Commissioner also made recommendations to the Ministry of Health, including that it:

- Establish systems to identify worthwhile major new healthcare technologies, such as the advent of Avastin therapy, in the future, so that adequate planning and funding responses can occur in a timely way, and report to HDC on progress towards the development of those systems

- Update HDC on the progress it has made towards addressing the other national improvement recommendations made by the external review, including a national discussion on ophthalmology priorities (such as that initiated with RANZCO), and national reporting of overdue eye appointment statistics.

Management of incidental finding of rectal lymph nodes (17HDC00316)

Background

A 72-year-old man presented to the Emergency Department (ED) of a public hospital after falling approximately three metres. He sustained injuries to his left hip and left side of his chest. A senior ED consultant ordered an urgent CT scan of the chest, abdomen, and pelvis.

When reporting on urgent CT scans, a preliminary acute report was issued to help determine the immediate care of the patient (a “sticky note”). The sticky note mechanism is an immediate, rough tool to assist clinicians to proceed with treatment of the patient and to answer the immediate clinical questions. The case is then fully reported – usually within 24 hours. The ED acted on the reporting radiologist’s sticky note, which did not mention an incidental finding of rectal lymph nodes. The man was treated with pain relief and transferred to the surgical ward for ongoing care.

The following day, full reporting of the CT scan was entered into the information technology (IT) system at the hospital. This final report noted numerous enlarged meso-rectal lymph nodes and suggested endoscopic examination to rule out a rectal tumour. Several days later, the man was discharged from hospital. However, the final CT scan report was not sighted until eight months after discharge, when further investigation was initiated. The man was diagnosed with Stage IIIa squamous cell carcinoma of the anus, and underwent chemo-radiotherapy treatment and surgery.

At the time of these events, the IT system did not allow for electronic sign-off of test results. There was no alert system to notify a doctor that a result had arrived, nor was there a doctor-specific list of results to review. This meant that doctors could not look up all the results of tests or procedures they had ordered that day apart from proactively on an individual patient basis. The hospital acknowledged that this was a significant weakness in its system and, until this could be improved, there was no protection from recurrence.

A further complicating factor in this case was that there appeared to be a lack of clarity around who was responsible for following up and acting on the results of the CT scan once it was reported on. The ED consultant considered that clinical responsibility for the final CT report was handed over when the man was transferred to the surgical ward. However, the surgeon advised that as he was not the practitioner who ordered the CT scan, he did not receive a paper copy of the report and therefore, did not and would not have viewed the final CT scan report. There were no internal policies or procedures at the DHB relating to this issue.

Findings

The DHB had a weak IT system that did not allow for electronic sign-off, and it did not have a clear, effective, and formalised system in place for the reporting and following up of test results. This systems failure resulted in a number of opportunities being missed by clinicians to review and action the man’s final CT scan report, and a delayed diagnosis of squamous cell carcinoma of the anus.

In respect of this case the Commissioner commented that the basic system principle with respect to the follow-up of test results is clear — the person who orders the test must follow up, or know by whom and how in the system it will be. The Commissioner was concerned about the inconsistencies in clinicians’ understanding of how this principle applied at their hospital, stating that it was not acceptable that systems and clinicians lacked clarity on this.

The Commissioner found that the DHB did not provide services to the man with reasonable care and skill, and breached Right 4(1) of the Code.

The Commissioner was thoughtful about the use of the “sticky note” function in this case. He emphasised that this function is only a preliminary reporting tool that answers the immediate clinical question. It should not be relied on in place of the final report.

Recommendations

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

- Update HDC on the progress and effectiveness of its IT system upgrade, including the development of policies and procedures with respect to electronic sign-off of test results and radiology reports. This update should include evidence that the new system reliably captures all relevant data.
- Advise whether “sticky notes” are still being used under the new IT system, and what measures have been taken to ensure that they are used as a preliminary reporting tool only, and that the final reports are also reviewed.
- Audit, over a period of three months, the management of test results ordered at ED where patients have been transferred to another ward.
- Take steps to ensure that discharge summaries accurately reflect available final diagnostic reports, and report back to HDC on the steps that have been taken.
- Develop policies and procedures on the management of test results and radiology reports.

Delay in neurology review (16HDC00761)

Background

A 62-year-old man presented to an emergency department with sudden onset of left-sided weakness and twitching, and reported a week-long history of dizziness upon standing. A CT scan identified the possibility of a dural arteriovenous fistula, and the report recommended a neurological opinion.

The man was admitted to the general medicine ward with a working diagnosis of an ischaemic stroke the same day. The admitting medical registrar completed a handwritten neurology referral but it was erroneously sent using the process for outpatient referrals. There was nothing on the form to indicate that it was intended to be an inpatient referral. As a result, the referral was not triaged until three days later.

The man was noted to have left arm tremors, which progressed to intermittent twitching of the left leg. The consultant general physician maintained the working diagnosis of ischaemic stroke when he reviewed the man in the morning of the following day. Nursing notes throughout that day refer to twitching and “on and off restlessness” in the man’s left leg. On the third day of admission, another medical registrar queried in the notes whether the man’s ongoing left-sided weakness was caused by seizures. This possibility was raised again during the physiotherapy and occupational therapy review in the afternoon, but the matter was not escalated to the consultant general physician.

On the fourth day of admission, the medical registrar from the previous day noted that the man had yet to be seen by a neurologist, and made active enquiries about the referral. As a result of these enquiries, the man was reviewed by the visiting neurologist, who diagnosed focal status epilepticus. The man was commenced on intravenous anti-seizure medication, and his involuntary

movements improved. He was later transferred to another hospital, where he received further treatment.

Findings

There were deficiencies in the care provided, which constituted a pattern of poor care on a service level, for which the DHB was ultimately responsible:

- The admitting medical registrar did not make an acute referral to the neurology service following the abnormal CT scan result.
- The admitting medical registrar's non-urgent referral was erroneously sent to the outpatient clinic.
- The consultant general physician did not discuss the CT report with the neurology service on his ward round the day after admission, when the man had been experiencing ongoing involuntary twitching.
- Junior staff did not escalate concerns about the man's ongoing involuntary movements, and the consultant general physician did not enquire.

The Commissioner was most concerned by the lapses in communication within the general medicine team and the lack of safeguards in place to identify errors in the neurology referral process. These factors hindered the coordination of the man's care within the team and across specialities, and contributed to the delay in him receiving the neurological review he required. For the above reasons, the Commissioner considered that the DHB failed to provide services with reasonable care and skill to the man, in breach of Right 4(1) of the Code.

Recommendations

The Commissioner recommended that the DHB:

- Conduct an audit of neurology referrals within the last three months to ensure that the correct process has been followed.
- Use this case as an anonymised case study for education on the importance of team communication, and report back to HDC on this within three months of the date of this report.
- Update HDC on the implementation of its "TransforMED" project (a project which aims to ensure that time is set aside for subspecialists who participate in General Medicine to undertake a ward round daily on inpatients on their designated ward).

Delayed diagnosis of kidney problems in premature baby (15HDC00464)

Background

At 31 weeks' gestation, a woman had an ultrasound performed by a sonographer at a private radiology service. The reporting radiologist was working from a location remote from where the scan was performed. During the scan, the sonographer noticed that the fetal kidneys appeared dilated, and that the fetal bladder was full and not seen to empty. She recorded on the sonographer's worksheet: "Kidneys appear dilated ? rescan once born." She sent the images and worksheet to the radiologist, but did not discuss this case with him.

The radiologist wrote in the ultrasound report: "[B]ilateral fetal renal dilation (5mm). Fetal bladder appears somewhat overfilled. Bladder was not seen to empty during the study ... [P]ostnatal assessment is suggested." The actual findings of the scan were fluctuating renal pelvis measurements of 4.1mm to 9.5mm on the right and 5.1mm to 14mm on the left.

The baby was born at 32 weeks' gestation, and was admitted to the Neonatal Unit at a DHB. It was verbally reported to paediatric staff that an antenatal ultrasound had shown bilateral fetal renal dilation of 5mm, but a copy of the radiology report was not transferred from the mother's clinical records to the baby's records. A copy of the report was obtained from the private radiology service by the hospital, but not disseminated to paediatric staff, and paediatric staff did not request a copy.

Subsequently the baby developed oedema and had episodes of high blood pressure. Nursing staff were told that medical staff had no concerns and that they needed to give consistent feedback to the woman about this. A renal ultrasound was performed, and a diagnosis of posterior urethral valves (a condition where obstructing membranes in the posterior male urethra prevent normal urine flow from the bladder) was made. The baby was catheterised and transferred to another hospital, where he underwent posterior urethral valve ablation (surgery to remove the valve through the urethra).

At the time of these events, the DHB was testing a new electronic health record. This meant that staff were electronically recording in bullet or abbreviated form the clinical decisions made, but not necessarily the thinking behind those diagnoses or the alternative diagnoses considered. There was also a lack of clinical workstations, and it was difficult to enter data cot-side.

Findings

The Commissioner considered that the DHB responded appropriately to the reported antenatal ultrasound findings of bilateral fetal renal dilation of 5mm, and the care provided to the baby on the first four days of his life was appropriate. However, the DHB paediatric medical staff did not investigate the baby's worsening oedema and high blood pressure from day five of his life. The Commissioner was particularly concerned about these delays in investigation, given that the baby's parents repeatedly raised their concerns and requested earlier investigations. The Commissioner considered that this represented a lack of responsiveness and clinical judgement on the part of paediatric medical staff. Accordingly, the Commissioner found that the DHB did not provide care to the baby with reasonable care and skill in breach of Right 4(1) of the Code.

By not transferring a copy of the antenatal ultrasound report from the woman's clinical records to the baby's clinical records when he was born; not disseminating to relevant paediatric staff the copy of the report obtained from the private radiology service; and paediatric staff not requesting a copy of the report, the Commissioner considered that the DHB failed to ensure continuity of care and, therefore, breached Right 4(5) of the Code.

The Commissioner noted that there was a pattern of suboptimal documentation by multiple staff involved in the baby's care, and the environment in which the DHB staff were operating (with a new electronic system being tested, but insufficient equipment provided to use it properly) contributed considerably to the documentation failures in this case. Therefore, the Commissioner considered that

the DHB failed to provide services to the baby that complied with relevant standards, and thereby breached Right 4(2) of the Code.

The Commissioner was concerned that nursing staff were instructed to reassure the baby's parents that the baby was fine, and were told that the baby did not require multiple medical reviews in relation to his oedema. This was particularly concerning in light of the fact that the DHB's Root Cause Analysis (RCA) found that some nursing staff felt that they were not listened to. The Commissioner noted that it is important that medical staff work in partnership with nursing staff and take their views into consideration, and that the DHB should encourage a culture where it is acceptable to voice concerns and ask questions from any point in the hierarchy.

Recommendations

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

- Report back to HDC on the implementation of the recommendations arising from the RCA, including a review of current best practice for fetal/renal antenatal ultrasound scanning for renal abnormalities.
- Provide refresher training to all paediatric staff on the procedure for obtaining copies of external ultrasound reports, and remind all maternity staff of the importance of transferring relevant information from the mother's clinical records into the baby's clinical records.
- Undertake a qualitative audit to check for appropriate use of the electronic health record in the Neonatal Unit, obtain feedback from staff regarding any user issues and implement a mechanism for ensuring ongoing staff communication of issues.
- Provide a detailed update to HDC on progress toward additional clinical workstations being situated cot-side.