Complaints to HDC involving District Health Boards

Report and Analysis for period 1 July to 31 December 2016

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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

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

Citation: The Health and Disability Commissioner. 2017. *Complaints to the Health and Disability Commissioner involving District Health Boards: Report and Analysis for the period 1 July to 31 December 2016*

Published in March 2017 (Updated in May 2017)
by the Health and Disability Commissioner
PO Box 1791, Auckland 1140

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

Contents

Commissioner's Foreword ..... **ii**

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 **5**

3.1 Primary complaint issues 5

3.2 All complaint issues 7

3.3 Service type and primary issues 10

4.0 Complaints closed **11**

4.1 Number of complaints closed 11

4.2 Outcomes of complaints closed 11

4.3 Recommendations made to DHBs following a complaint 13

5.0 Learning from complaints — HDC case reports **14**

Commissioner's Foreword

I am pleased to present you with HDC's six monthly DHB complaint report for July-December 2016.

The number of complaints received about DHBs in July-December 2016 is very similar to the average number of complaints received over the past four six month periods. The trends reported remained broadly consistent with what has been seen in previous periods, with treatment and communication continuing to be the predominant issues in complaints.

I noted on reading this report that around a quarter of all complaints about DHBs involved issues of consent/information. Informed consent lies at the heart of the Code. Patient safety is improved when consumers are well informed. Well informed consumers are better able to comply with their treatment, better equipped to manage their condition, and are in a better position to recognise if an error is about to be made and to alert clinicians to these concerns. There is increasing evidence to suggest that involving patients in decision making has positive effects in terms of patient satisfaction, adherence to treatment and health outcomes.

The process of informed consent under the Code has three essential elements: effective communication between the parties; the provision of all of the necessary information to the consumer; and the consumer's freely given and competent consent. Consumers have a right to receive the information that a reasonable consumer in that consumer's circumstances would expect to receive. When consumers are considering their treatment options, this information includes an explanation of the options available, an assessment of the expected risks, side effects and benefits and costs of each option.

Additionally, 25% of complaints about DHBs involved access/funding issues, with 11% of complaints relating to prioritisation issues. It is the responsibility of District Health Boards to treat patients in a timely way, prioritise appropriately and provide patients with good information, particularly when waiting for resource constrained specialist procedures.

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 Jul–Dec 2016, HDC received a total of **386**[1] complaints about care provided by District Health Boards. Numbers of complaints received in previous six month periods are reported in Table 1.

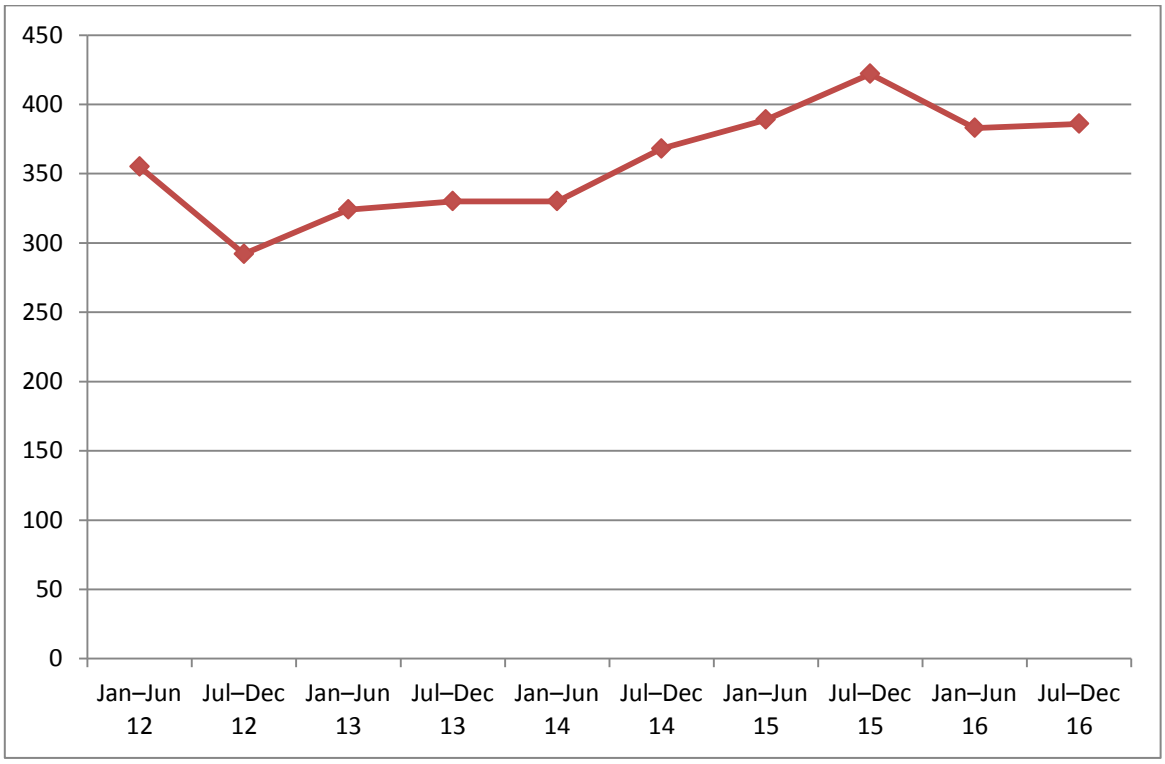
Table 1. Number of complaints received in last five years

	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Average of last 4 6-month periods	Jul–Dec 16
Number of complaints	355	292	324	330	330	368	389	422	383	**391**	**386**

The total number of complaints received in Jul–Dec 2016 (386) shows a very small decrease over the average number of complaints received in the previous four periods, but a very small increase over the number of complaints received in the previous six month period.

The number of complaints received in Jul–Dec 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 (19 January 2017).

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. This data is provisional as at the date of extraction (11 April 2017[2]) and is likely incomplete, it will be updated in the next 6-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 Jul–Dec 2016

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
386	487,713	**79.14**

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

Table 3. Rate of complaints received in last five years

	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16[3]	Average of last 4 6-month periods	Jul–Dec 16
Rate per 100,000 discharges	80.22	62.59	72.67	71.15	72.99	76.65	84.60	87.57	81.44	**82.57**	**79.14**

The rate of complaints received during Jul–Dec 2016 (79.14) shows a very small decrease 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].

[2] The discharge data reported in this table was updated on 8 May 2017. Discharge data is updated as figures come to hand from DHBs, and is therefore likely incomplete. However, it was noted that the data, extracted in February 2017, was, for some DHBs, significantly more incomplete than it had been in previous periods, having a material effect on their complaint rates. Therefore, following the publication of this report in March 2017, the number of discharges and corresponding complaint rate was updated in May 2017.

[3] The rate for Jan–Jun 2016 has been recalculated based on the most recent discharge data.

[4] 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 Jul-Dec 2016[5]

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	70	61743	113.37
Bay of Plenty	17	25692	66.17
Canterbury	44	56597	77.74
Capital and Coast	31	32114	96.53
Counties Manukau	42	51839	81.02
Hawke's Bay	13	15971	81.40
Hutt Valley	8	16469	48.58
Lakes	13	11977	108.54
MidCentral	14	15360	91.15
Nelson Marlborough	15	12362	121.34
Northland	8	20462	39.10
South Canterbury	2	6076	32.92
Southern	20	27243	73.41
Tairawhiti	6	5365	111.84
Taranaki	12	12969	92.53
Waikato	44	47150	93.32
Wairarapa	5	4046	123.58
Waitemata	34	54642	62.22
West Coast	2	3301	60.59
Whanganui	5	6335	78.93

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 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.

[5] The discharge data reported in this table was updated on 8 May 2017. Discharge data is updated as figures come to hand from DHBs, and is therefore likely incomplete. However, it was noted that the data, extracted in February 2017, was, for some DHBs, significantly more incomplete than it had been in previous periods, having a material effect on their complaint rates. Therefore, following the publication of this report in March 2017, the discharge numbers and corresponding complaint rates for each DHB were updated in May 2017. Please note that this discharge data is provisional as of date of extraction, 11 April 2017.

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 386 complaints about DHBs, 407 services were complained about.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Alcohol and drug	**1**	**0.2%**
Anaesthetics/pain medicine	**5**	**1.2%**
Dental	**1**	**0.2%**
Diagnostics	**1**	**0.2%**
Disability services	**7**	**1.7%**
District nursing	**4**	**1.0%**
Emergency department (including paramedics)	**60**	**14.7%**
General medicine	**85**	**20.9%**
Cardiology	13	3.2%
Dermatology	1	0.2%
Endocrinology	3	0.7%
Gastroenterology	11	2.7%
Geriatric medicine	4	1.0%
Hepatology	1	0.2%
Neurology	13	3.2%
Oncology	13	3.2%
Palliative care	4	1.0%
Renal/nephrology	4	1.0%
Respiratory	1	0.2%
Rheumatology	1	0.2%
Other/unspecified	16	3.9%
Hearing services	**2**	**0.5%**
Intensive care/critical care	**5**	**1.2%**
Maternity	**25**	**6.1%**
Mental health	**90**	**22.1%**
Paediatrics (not surgical)	**13**	**3.2%**
Rehabilitation services	**2**	**0.5%**
Sexual health	**2**	**0.5%**
Surgery	**102**	**25.1%**
Cardiothoracic	2	0.5%
General	23	5.7%
Gynaecology	8	2.0%
Neurosurgery	6	1.5%
Ophthalmology	12	2.9%
Orthopaedics	26	6.4%
Otolaryngology	3	0.7%
Plastic and Reconstructive	7	1.7%
Urology	10	2.5%
Vascular	4	1.0%
Unknown	1	0.2%
Other health service	**2**	**0.5%**
TOTAL	**407**	

Surgical services (25.1%) received the greatest number of complaints in Jul-Dec 2016, with orthopaedics (6.4%) and general surgery (5.7%) being the most commonly complained about surgical specialties. Other commonly complained about services included mental health (22.1%), general medicine (20.9%), emergency departments (14.7%) and maternity services (6.1%). This is 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. Categories with only one complaint have been grouped together and classified as 'other'. The primary issues identified in complaints received in Jul–Dec 2016 are listed in Table 6.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***59***	***15.3%***
Lack of access to services	29	7.5%
Lack of access to subsidies/funding	5	1.3%
Waiting list/prioritisation issue	25	6.5%
Boundary violation	***3***	***0.8%***
Inappropriate non-sexual communication	1	0.3%
Inappropriate sexual physical contact	1	0.3%
Inappropriate sexual relationship	1	0.3%
Care/Treatment	***182***	***47.2%***
Delay in treatment	7	1.8%
Delayed/inadequate/inappropriate referral	1	0.3%
Inadequate coordination of care/treatment	6	1.6%
Inadequate/inappropriate clinical treatment	29	7.5%
Inadequate/inappropriate examination/assessment	10	2.6%
Inadequate/inappropriate follow-up	6	1.6%
Inadequate/inappropriate monitoring	5	1.3%
Inadequate/inappropriate non-clinical care	9	2.3%
Inappropriate/delayed discharge/transfer	14	3.6%
Inappropriate withdrawal of treatment	3	0.8%
Missed/incorrect/delayed diagnosis	56	14.5%
Personal privacy not respected	1	0.3%
Refusal to treat	1	0.3%
Rough/painful care or treatment	2	0.5%
Unexpected treatment outcome	32	8.3%
Communication	***49***	***12.7%***
Disrespectful manner/attitude	18	4.7%
Failure to communicate openly/honestly/effectively with consumer	19	4.9%
Failure to communicate openly/honestly/effectively with family	10	2.6%
Insensitive/inappropriate comments	2	0.5%
Complaints process	***6***	***1.6%***
Inadequate response to complaint	6	1.6%
Consent/Information	***32***	***8.3%***
Consent not obtained/adequate	6	1.6%

Primary issue in complaints	Number of complaints	Percentage
Inadequate information provided regarding fees/costs	1	0.3%
Inadequate information provided regarding results	1	0.3%
Inadequate information provided regarding treatment	4	1.0%
Incorrect/misleading information provided	1	0.3%
Issues regarding consent when consumer not competent	1	0.3%
Issues with involuntary admission/treatment	18	4.7%
Documentation	***2***	***0.5%***
Delay/failure to transfer documentation	1	0.3%
Inadequate/inaccurate documentation	1	0.3%
Facility issues	***15***	***3.9%***
General safety issue for consumer in facility	8	2.1%
Issue with sharing facility with other consumers	1	0.3%
Issue with quality of aids/equipment	1	0.3%
Staffing/rostering/other HR issue	2	0.5%
Waiting times	2	0.5%
Other issue with physical environment	1	0.3%
Medication	***19***	***4.9%***
Administration error	3	0.8%
Inappropriate administration	3	0.8%
Inappropriate prescribing	8	2.1%
Refusal to prescribe/dispense/supply	5	1.3%
Reports/Certificates	***4***	***1.0%***
Inaccurate report/certificate	3	0.8%
Refusal to complete report/certificate	1	0.3%
Other professional conduct issues	***13***	***3.4%***
Disrespectful behaviour	2	0.5%
Inappropriate collection/use/disclosure of information	5	1.3%
Other	6	1.5%
Other issues	***2***	***0.5%***
TOTAL	**386**	

The most common primary issue categories concerned care/treatment (47.2%), access/funding (15.3%), communication (12.7%) and consent/information (8.3%). Among these, the most common specific primary issues in complaints about DHBs were 'missed/incorrect/delayed diagnosis' (14.5%), 'unexpected treatment outcome' (8.3%), 'inadequate/inappropriate clinical treatment' (7.5%), 'lack of access to services' (7.5%) and 'waiting list/prioritisation issue' (6.5%). This is similar to what was seen last period.

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.

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

Top five primary issues in all complaints (%)							
Jan–Jun 15 n=389		**Jul–Dec 15 n=422**		**Jan–Jun 16 n=381**		**Jul–Dec 16 n=386**	
Misdiagnosis	20%	Misdiagnosis	16%	Misdiagnosis	16%	Misdiagnosis	15%
Inadequate treatment	12%	Unexpected treatment outcome	12%	Inadequate treatment	9%	Unexpected treatment outcome	8%
Unexpected treatment outcome	6%	Inadequate treatment	9%	Unexpected treatment outcome	8%	Inadequate treatment	8%
Disrespectful manner/attitude	4%	Waiting list/ prioritisation	7%	Lack of access to services	6%	Lack of access to services	8%
Lack of access to services	4%	Lack of access to services	6%	Waiting list/ prioritisation	5%	Waiting list/ prioritisation	7%

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.

On analysis of all issues identified in complaints about DHBs, the most common complaint issue categories were care/treatment (present for 77.7% of all complaints), communication (present for 64.5% of all complaints), consent/information (present for 25.9% of all complaints) and access/funding (present for 25.4% of all complaints). The most common specific issues were 'failure to communicate effectively with consumer' (35.8%), 'inadequate/inappropriate clinical treatment' (31.3%) 'inadequate/inappropriate examination/assessment' (23.1%), 'missed/incorrect/delayed diagnosis' (21.5%), 'failure to communicate effectively with family' (21.2%), 'delay in treatment' (21.0%), 'disrespectful manner/attitude' (20.2%), 'inadequate coordination of care/treatment' (18.9%) and 'inadequate response to the consumer's complaint by the DHB' (17.4%). This is 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, such as 'inadequate/inappropriate follow-up' (13.5%), 'unexpected treatment outcome' (13.5%), 'inappropriate/delayed discharge/transfer' (12.2%), 'inadequate/inappropriate testing' (11.9%).

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding	***98***	***25.4%***
ACC compensation issue	2	0.5%
Lack of access to services	54	14.0%
Lack of access to subsidies/funding	8	2.1%
Waiting list/prioritisation issue	44	11.4%
Boundary violation	***3***	***0.8%***
Inappropriate non-sexual communication	1	0.3%
Inappropriate sexual physical contact	1	0.3%
Inappropriate sexual relationship	1	0.3%
Care/Treatment	***300***	***77.7%***
Delay in treatment	81	21.0%
Delayed/inadequate/inappropriate referral	15	3.9%
Inadequate coordination of care/treatment	73	18.9%
Inadequate/inappropriate clinical treatment	121	31.3%
Inadequate/inappropriate examination/assessment	89	23.1%
Inadequate/inappropriate follow-up	52	13.5%
Inadequate/inappropriate monitoring	26	6.7%
Inadequate/inappropriate non-clinical care	33	8.5%
Inadequate/inappropriate testing	46	11.9%
Inappropriate admission/failure to admit	7	1.8%
Inappropriate/delayed discharge/transfer	47	12.2%
Inappropriate withdrawal of treatment	18	4.7%
Missed/incorrect/delayed diagnosis	83	21.5%
Personal privacy not respected	8	2.1%
Refusal to assist/attend	13	3.4%
Refusal to treat	11	2.8%
Rough/painful care or treatment	10	2.6%
Unexpected treatment outcome	52	13.5%
Unnecessary treatment/over-servicing	3	0.8%
Communication	***249***	***64.5%***
Disrespectful manner/attitude	78	20.2%
Failure to accommodate cultural/language needs	11	2.8%
Failure to communicate openly/honestly/effectively with consumer	138	35.8%
Failure to communicate openly/honestly/effectively with family	82	21.2%
Insensitive/inappropriate comments	18	4.7%
Complaints process	***71***	***18.4%***
Inadequate information provided regarding complaints process	2	0.5%
Inadequate response to complaint	67	17.4%
Retaliation/discrimination as a result of a complaint	3	0.8%
Consent/Information	***100***	***25.9%***
Coercion by provider to obtain consent	2	0.5%
Consent not obtained/adequate	15	3.9%
Inadequate information provided regarding adverse event	9	2.3%
Inadequate information provided regarding condition	8	2.1%
Inadequate information provided regarding fees/costs	1	0.3%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding options	6	1.6%
Inadequate information provided regarding provider	3	0.8%
Inadequate information provided regarding results	5	1.3%
Inadequate information provided regarding treatment	36	9.3%
Incorrect/misleading information provided	17	4.4%
Issues regarding consent when consumer not competent	2	0.5%
Issues with involuntary admission/treatment	24	6.2%
Documentation	***35***	***9.1%***
Delay/failure to disclose documentation	5	1.3%
Delay/failure to transfer documentation	3	0.8%
Inadequate/inaccurate documentation	26	6.7%
Inappropriate maintenance/disposal of documentation	1	0.3%
Facility issues	***77***	***19.9%***
Accreditation standards/statutory obligations not met	1	0.3%
Cleanliness/hygiene issue	4	1.0%
Failure to follow policies/procedures	8	2.1%
Inadequate/inappropriate policies/procedures	24	6.2%
General safety issue for consumer in facility	12	3.1%
Issue with sharing facility with other consumers	5	1.3%
Issue with quality of aids/equipment	4	1.0%
Staffing/rostering/other HR issue	9	2.3%
Waiting times	17	4.4%
Other issue with physical environment	4	1.0%
Medication	***48***	***12.4%***
Administration error	7	1.8%
Inappropriate administration	8	2.1%
Inappropriate prescribing	25	6.5%
Refusal to prescribe/dispense/supply	9	2.3%
Reports/Certificates	***10***	***2.6%***
Inaccurate report/certificate	5	1.3%
Refusal to complete report/certificate	5	1.3%
Teamwork/supervision	***5***	***1.3%***
Delayed/inadequate/inappropriate handover	1	0.3%
Inadequate supervision/oversight	5	1.3%
Other professional conduct issues	***36***	***9.3%***
Assault	1	0.3%
Disrespectful behaviour	11	2.8%
Failure to disclose/properly manage conflict of interest	2	0.5%
Inappropriate collection/use/disclosure of information	14	3.6%
Threatening/bullying harassing behaviour	1	0.3%
Other	9	2.3%
Other issues	***12***	

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, access/funding issues became more prominent for surgical services in Jul-Dec 2016 and misdiagnosis became more prominent for emergency department services.

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

Surgery n=102		**Mental health n=90**		**General medicine n=85**		**Emergency department n=60**		**Maternity n=25**	
Unexpected treatment outcome	24%	Issues with involuntary admission/ treatment	21%	Missed/ incorrect/ delayed diagnosis	20%	Missed/ incorrect/ delayed diagnosis	48%	Missed/ incorrect/ delayed diagnosis	12%
Lack of access to services	16%	Inadequate examination/ assessment	9%	Inadequate/ inappropriate treatment	11%	Disrespectful manner/ attitude	13%	Inadequate/ inappropriate treatment	8%
Waiting list/ prioritisation issue	14%	Failure to communicate effectively with consumer	5%	Lack of access to service	11%	Inadequate/ inappropriate treatment	5%	Unexpected treatment outcome	8%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **316**[6] complaints involving DHBs in the period Jul–Dec 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 years

	Jan–Jun 12	**Jul–Dec 12**	**Jan–Jun 13**	**Jul–Dec 13**	**Jan–Jun 14**	**Jul–Dec 14**	**Jan–Jun 15**	**Jul–Dec 15**	**Jan–Jun 16**	**Average of last 4 6-month periods**	**Jul–Dec 16**
Number of complaints closed	302	254	337	280	411	344	410	365	482	**400**	**316**

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 other resolution. 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 Jul–Dec 2016 period, **14** DHBs had no investigations closed, **4** DHBs had one investigation closed and **2** DHBs had two investigations closed by HDC.

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

[6] 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 type[7]

Outcome for DHBs	Number of complaints closed
Investigation	***8***
Breach finding	3
No further action[8] with follow-up or educational comment	3
No further action	1
No breach finding	1
Other resolution following assessment	***291***
No further action with follow-up or educational comment	52
Referred to Ministry of Health	1
Referred to District Inspector	5
Referred to DHB[9]	103
Referred to Advocacy	45
No further action	72
Withdrawn	13
Outside jurisdiction	***17***
TOTAL	**316**

[7] 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.

[8] 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.

[9] 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 Jul-Dec 2016. 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	5
Audit	10
Meeting with consumer	3
Presentation/discussion of complaint with others	9
Provision of information to HDC	24
Reflection	6
Review of policies/procedures	20
Training/professional development	5
Total	**82**

The most common recommendations made to DHBs were that they provide information to HDC (24 recommendations) and review their policies/procedures (20 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.

5.0 Learning from complaints — HDC case reports

Management of a man with oesophageal cancer (14HDC00294)

Background

Mr A, a 66 year old man, had previously been diagnosed with oesophageal cancer and had undergone chemotherapy, an Ivor Lewis oesophagogastrectomy procedure (surgery to remove the oesophagus and part of the stomach), and had a feeding tube inserted. Following surgery, Mr A was advised by the surgeon's registrar that there were no further treatment options if the cancer recurred, but that his GP could request a surveillance CT scan at the six to 12 month mark.

Approximately six months after surgery, Mr A's condition began to decline, and another 2 months later he attended an appointment with his GP to, among other things, request a CT scan. The GP sent a request for a scan to a public hospital, but did not provide any information about Mr A's symptoms or any assessment findings. Unfortunately the DHB did not action the referral, as it was misplaced. The DHB had no electronic system to flag that the referral letter had not been followed up after it had been entered into the Patient Management System (PIMS).

Around a month later, Mr A reported new symptoms to the GP, including a "sharp burn" at the back of his throat. At the request of Mr A, the GP re-sent the initial referral to the public hospital. The GP made no additions or alterations to the referral. As there was no indication of Mr A's declining health or of the urgency of the request, the referral letter was left for review by the surgeon when he returned from leave about a month later. On his return, the surgeon sent a request for the scan to look for "recurrent disease".

Mr A underwent the scan which showed oesophageal distension (indicative of recurrent disease). Further investigations showed a blockage in Mr A's abdomen, and accordingly Mr A was scheduled for a laparoscopy to attempt to unblock the digestive tract, and to confirm whether his cancer had returned. Prior to surgery, Mr A had signs of a chest infection and underlying acute lung disease.

An anaesthetist undertook a preoperative review of Mr A. There is no documentation of the anaesthetist's conversation with Mr A prior to surgery, however the anaesthetist indicated that he did not think he had discussed the risk of perioperative death with Mr A. Mr A underwent the laparoscopy, but the surgeon was unable to complete it, due to the distribution of the recurrent cancer. Sadly, Mr A did not regain consciousness following the procedure and he died.

Findings

The Commissioner considered that the GP did not provide sufficient information in the initial referral and neither did he proactively offer Mr A the option of private CT scanning or review by the surgeon in private at that stage. Furthermore, the GP did not provide updated information about Mr A's worsening symptoms when he re-sent the referral, and neither did he discuss the possibility of a private referral with Mr A or contact the hospital or the surgeon about the delay. Accordingly the Commissioner found that the GP failed to provide Mr A with services with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner was also critical that the GP did not have a conversation with Mr A about his symptoms, likely prognosis, and options available to him when he presented with symptoms that were consistent with the return of cancer.

In respect of the DHB, the Commissioner commented that "DHBs also owe patients a duty of care in handling referrals from GPs within the district and from other DHBs … A DHB must have robust systems for managing referrals so that the referred patients do not fall through the cracks in the system". The Commissioner considered that the DHB's process for management of referrals was inadequate, as Mr A's initial referral was not tracked sufficiently to ensure that triage occurred. Accordingly, the Commissioner found that the DHB failed to ensure the quality and continuity of services provided to Mr A, in Breach of Right 4(5) of the Code.

The Commissioner considered that the anaesthetist's documentation was inadequate in a number of areas, and found that he breached Right 4(2) of the Code for failing to keep clear and accurate

patient records in accordance with professional obligations. The Commissioner was also concerned that the anaesthetist indicated that he did not think that he discussed the risk of perioperative death (at or around the time of surgery) with Mr A.

The Commissioner was critical of the surgeon for an error in scheduling which meant that the Mr A was taken to theatre for surgery before it was realised that the surgeon was away and could not attend. The Commissioner was also concerned that after undertaking the Ivor Lewis procedure, the surgeon did not make more precise arrangements for follow-up. Furthermore, the Commissioner was critical of the surgeon for failing to document his discussion with Mr A regarding the risks and benefits of laparoscopic surgery.

Recommendations

The Commissioner made a number of recommendations to the GP around referrals and communication.

The Commissioner recommended that the DHB review the effectiveness of the following measures it implemented as a result of its internal review of this event:

- the criteria and process for follow-up of oesophagostomy;
- the plan for communication between cancer support nurses, GPs and specialists;
- the centralised referral process with regard to tracking and triaging of referrals; and
- the guidelines for management of communication regarding life-threatening events in the operating theatre.

The Commissioner also recommended that the anaesthetist undergo further training on record-keeping, and that the surgeon:

- review the effectiveness and appropriateness of his approach to follow-up;
- review the effectiveness of the written information provided to patients on discharge from hospital; and
- report to HDC on the implementation of his post-oesophagostomy treatment plan which he intends to provide to GPs when a patient is referred back into their care.

Management of a gynaecological patient (14HDC00991)

Background

Ms A was booked to have a laparoscopy, to remove an ovarian cyst, at a public hospital. This surgery was to be performed by obstetrician/gynaecologist, Dr C.

Ms A saw Dr C preoperatively, and consented to surgery. There is no documentation on file outlining that operative risks specific to Ms A were discussed with her. Dr C said that he discussed specific risks of surgery with Ms A and provided her with a leaflet. Ms A said that Dr C broadly discussed risk and that she could not recall whether any leaflet was provided to her.

Tumour marker blood test results (CA125) were ordered by Dr C, and a risk of malignancy index (RMI) was calculated in the afternoon following Dr C's consultation with Ms A. Dr C telephoned Ms A about the tumour marker result (which was negative). Dr C could not recall whether he discussed the RMI score (99). Ms A told HDC that he did not discuss it. The telephone call and RMI calculation were not documented.

The surgical procedure was complicated owing to adhesions. An operative injury to the bladder occurred, which was repaired by a urologist. Dr C handed over to a second obstetrician/gynaecologist, Dr B. Ms A had a difficult postoperative course. A senior house officer reviewed Ms A over the weekend, and: communicated the possibility of a ureter or bowel injury; instigated a number of investigations; and brought her concerns to the attention of Dr B, on three occasions.

Dr B reviewed Ms A. His impression was that, potentially, medication side effects explained her nausea. A differential diagnosis of bowel injury was made. Dr B did not order any investigations.

The senior house officer received the results of Ms A's blood cultures. They contained bacteria which had most likely come from the bowel. The senior house officer telephoned Dr B and discussed those results and Ms A's condition with him. Dr B did not review Ms A or arrange a surgical review. Ms A was later diagnosed with a bowel injury and referred to the surgical team.

Findings

The Commissioner considered that Dr C did not meet his obligations to keep clear and accurate clinical and surgical records, and accordingly failed to comply with professional standards, in breach of Right 4(2) of the Code.

The Commissioner was concerned that Dr C discussed the proposed surgery with Ms A without the knowledge of important clinical factors (the tumour marker result or the RMI calculation) that were relevant to a preoperative discussion. The Commissioner was also critical that Dr C did not appreciate, or think critically about, the potential surgical difficulties he might face given Ms A's history of extensive adhesive disease.

The Commissioner found that postoperatively there was a delay in Dr B recognising that Ms A might have a bowel injury, given that the possibility had been brought to his attention on more than one occasion. The Commissioner was particularly concerned that once the blood culture results were available to him, Dr B did not review Ms A or refer her for surgical review. Accordingly, Dr B failed to provide services to Ms A with reasonable care and skill, in breach of Right 4(1) of the Code.

In regards to the care provided by the DHB, the Commissioner commented that: "While individual clinicians need to be competent in their clinical assessment and management of patients, staff also need to be supported by systems that guide good decision-making and promote a culture of safety".

The Commissioner found that the DHB had overall responsibility for the deficiencies in the care experienced by Ms A. In addition: at the commencement of Dr C's employment, and at the time of Ms A's surgery, Dr C was not made aware of the RANZCOG guidelines pertaining to performing advanced operative laproscopy; the DHB's surgical consent form in use at the time had no space for the purpose of recording risks specific to the patient; and there were several administrative shortcomings identified in this case. Therefore, the Commissioner considered that the DHB failed to

ensure that Ms A was provided with services with reasonable care and skill, in breach of Right 4(1) of the Code.

Recommendations

The Commissioner recommended that Dr C: have an independent colleague review a random selection of his surgical consent forms from the last 12 months to report on whether specific surgical risks/concerns for each patient are written on the consent form; and that he provide HDC with a copy of the template used in his dictation in relation to information discussed in the consent process, to be dictated at the beginning of the operation note and also handwritten on the operation note.

The Commissioner recommended that, in the event that Dr B wishes to return to New Zealand to practice, the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

The Commissioner made a number of recommendations to the DHB, asking it to provide HDC with a detailed update report on the progress and effectiveness of all steps taken by it to try and improve service as a result of this case, including:

- surveying new and existing employees in the Women's Health Surgical Service regarding their awareness of the RANZCOG guidelines for performing laproscopic procedures, and confirming that RMO and SMO orientation includes this information;

- reviewing complex cases from the last six months to confirm that SMOs regularly discuss complex cases at multidisciplinary meetings as a part of expected practice, and discuss general and specific operative risk with patients;

- providing HDC with a copy of the latest Women's Health Service policy addressing "Less Commonly Performed Gynaecology Procedures" re-emphasising the importance of guidelines for complex procedures;

- providing to HDC a copy of the amended Women's Health Service surgery surgical consent form showing that there is now space for adequate documentation of the proposed procedure and possible risks;

- providing results from the recent gynaecology surgery audit, benchmarking KPIs against comparably sized hospitals/DHBs;

- conducting a random review of clinical administration processes to ensure that a copy of all clinical information generated in the hospital service, and from external consultations, is placed in the clinical record; and

- conducting a review of administrative pathways in relation to complaints lodged with the DHB, to confirm that appropriate processes are followed and that all surgical clinicians are aware of that process.

The Commissioner also recommended that RANZCOG consider whether the wording of a relevant consensus statement concerning advanced operative laparoscopy requires revision.

Use of outdated measurements during chemotherapy treatment (14HDC01771)

Background

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

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

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

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

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

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

Findings

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

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

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

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

Recommendations

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

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

Prescription and dispensing of incorrect dose of medication to a child (15HDC01542)

Background

Miss A, aged two years and 11 months, experienced painful and difficult urination following bladder surgery. She was reviewed by a paediatric registrar at a public hospital who, after discussion with a senior colleague, prescribed her oxybutynin, which is indicated for the management of urinary urgency and incontinence. The paediatric registrar chose an appropriate dose of 2mg oxybutynin, but wrote "oxybutynin 20mg", three times daily for ten days, which was a ten times higher dose.

A pharmacist noticed that the oxybutynin dose seemed high but did not question it at the time. A second pharmacist delivered the medication to Miss A's mother, but did not discuss the medication with Miss A's mother.

After Miss A's mother gave her the prescribed dose of oxybutynin, Miss A experienced side effects and was taken to hospital. She was monitored and discharged later that day.

Findings

The Commissioner found that the first pharmacist failed to take steps to contact the prescriber when she noticed that the oxybutynin dose seemed high. She also failed to follow the pharmacy's Standard Operating Procedure (SOP) and sign the date stamp to indicate that she had dispensed and/or checked the prescription. The Commissioner held that that the pharmacist did not provide services in accordance with professional standards, and breached Right 4(2) of the Code. The Commissioner was also critical of the second pharmacist for not checking the prescription and missing the opportunity to check the appropriateness of the prescription at the time of delivery of medications to Miss A's mother. The Commissioner held that, in all the circumstances, the second pharmacist did not provide services with reasonable care and skill, and breached Right 4(1) of the Code. The Commissioner considered that non-compliance with the Dispensing Prescriptions SOP played a part in the girl receiving an inappropriate dose of oxybutynin. Accordingly, the pharmacy did not provide services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner held that it was the paediatric registrar's responsibility to ensure that she prescribed a clinically appropriate dose of oxybutynin. By failing to do so, she did not provide services to Miss A with reasonable care and skill, and accordingly, breached Right 4(1) of the Code.

Although the Commissioner was satisfied that the error in failing to prescribe a clinically appropriate dose of oxybutynin to Miss A was Dr C's alone, the Commissioner considered that, if electronic

prescribing had been available to Dr C at the DHB when she prescribed medication to Miss A, it could have minimised the risk of this error occurring. HDC's expert advisor commented that: "Digital systems are in their infancy in NZ. In the meantime, continuing education of clinical staff on manual prescribing with continuing innovation to mitigate risks is essential."

Recommendations

The Commissioner made recommendations to the pharmacy around compliance with its Dispensing Prescription SOP and using this case as case study for education purposes.

The Commissioner recommended that the DHB: provide feedback to HDC on the implementation of its new prescribing system; and use this case as an anonymised case study for education for paediatric medical staff.

The Commissioner also recommended that the Ministry of Health actively continue to support the rollout of electronic prescribing across New Zealand's DHBs in both inpatient and outpatient settings, and work with the sector to progress an integrated approach to medicines management.