

Complaints to the Health and Disability Commissioner involving District Health Boards

Report and Analysis for period 1 July 2016 to 30 June 2017

Feedback

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

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COMMISSIONER'S FOREWORD

I am pleased to present HDC's analysis of complaints involving district health boards (DHBs) for the 2016/2017 year. This report aims to provide the general public and providers with an understanding of the types of complaints HDC receives about DHB services and the learnings and positive changes that have been made as a result of these complaints.

DHB complaint trends have remained broadly consistent over the last four years. The issues of communication, missed or delayed diagnosis, inadequate treatment, inadequate assessments and inadequate coordination of care continue to be common themes in complaints about DHB services.

The 2016/2017 year marked the 20-year anniversary of the Code of Health and Disability Services Consumer's Rights (the Code). HDC's journey began in 1988 with the Cartwright Inquiry. In the report on the inquiry Dame Silvia Cartwright advocated for a system where the focus of attention shifted from the doctor to the patient. She emphasised that "health professionals need to listen to their patients, communicate with them, protect them, offer them the best healthcare within their resources and bravely confront colleagues if standards slip". I continue to promote such a consumer-centred system today, and as seen in this report, the themes of communication, consent, and culture continue to be themes in the complaints I receive.

The importance of culture and leadership continues to be a major theme in a number of investigations about DHB services completed by my Office. Deficiencies in culture can be seen in systems that do not support staff to work well together; not allowing them to foster good working relationships and clear lines of communication. It can be seen in the impact of hierarchy; in environments where junior staff do not feel able to speak up, or are not listened to when they do. It is also seen in instances where a culture of tolerance emerges; where sub-optimal practices become normalised, and not following policies and procedures becomes everyday practice. This is why I remain focused on promoting cultures that embody transparency, engagement and seamless service.

I trust that this report will continue to promote learning and ongoing quality improvement.

Anthony Hill
Health and Disability Commissioner

EXECUTIVE SUMMARY

In the 2016/17 year, HDC received 863 complaints involving DHBs. This was an increase of 7% compared to the number received in the previous year. The significant year-on-year increase in complaints about DHB services is consistent with increasing overall complaint numbers to HDC each year. The rate of complaints about DHB services is also increasing, with the 2016/17 rate of 89 complaints per 100,000 discharges being the highest to date.

Complaints were received in relation to a wide variety of DHB service types, with the most commonly complained about service types being surgical, mental health and general medicine services. The service types complained about in the 2016/17 year are broadly consistent with what was seen in complaints about DHBs in 2015/16.

Also consistent with complaint trends seen in previous years, doctors were the individual providers complained about most commonly within complaints about DHB services, with 86% of the individual providers identified in DHB complaints being doctors.

Missed, incorrect or delayed diagnosis was the primary issue of concern raised by the complainant in 15% of complaints. When all issues raised in complaints were considered, concerns about a failure to communicate effectively with the consumer were the most prevalent, followed by inadequate/inappropriate treatment. This is broadly consistent with complaint issue trends over the past three years.

The issues raised in complaints varied by the service type involved. Services with high diagnostic workloads, such as general medicine and emergency departments, commonly received more complaints primarily regarding missed, incorrect or delayed diagnoses. When all issues raised in complaints about each service type were analysed, general medicine and maternity services received a greater proportion of complaints involving inadequate coordination of care/treatment, while emergency department services received a greater proportion of complaints involving inadequate testing, and maternity and surgical services received a greater proportion of complaints regarding a delay in treatment. Mental health and general medicine services saw a greater proportion of complaints regarding communication with family than did other service types.

In the 2016/17 year, HDC closed 781 complaints about DHB services. This included the conclusion of 40 formal investigations. Around 27% of complaints were referred back to the DHB for resolution. In around 23% of cases, HDC recommended some kind of follow-up action or made educational comments designed to facilitate improvement in DHB services. The most common recommendation made by HDC to DHBs was that they provide evidence to HDC of the changes they had made in response to the issues raised by the complaint, followed by a review of their policies/procedures or implementation of new policies/procedures.

BACKGROUND

1. The Health and Disability Commissioner

HDC is an independent crown entity established under the Health and Disability Commissioner Act 1994 to promote and protect the rights of health and disability services consumers. The rights of consumers are set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code places corresponding obligations on all providers of health and disability services, including individual providers and organisational providers such as district health boards.

HDC promotes and protects the rights of consumers of health and disability services by:

- resolving complaints;
- improving quality and safety within the sector; and
- appropriately holding providers to account.

As such, HDC fulfils the critical role of independent watchdog for consumer rights within the sector.

Rights under the Code

1. The right to be treated with respect.
2. The right to freedom from discrimination, coercion, harassment and exploitation.
3. The right to dignity and independence.
4. The right to services of an appropriate standard.
5. The right to effective communication.
6. The right to be fully informed.
7. The right to make an informed choice and give informed consent.
8. The right to support.
9. Rights in respect of teaching or research.
10. The right to complain.

Anyone may make a complaint to HDC about a health or disability service that has been provided to a consumer. It is not uncommon for HDC to receive complaints from third parties, such as family members, friends, or other providers involved in the consumer's care. The Commissioner may also commence an investigation at his own initiative, even without having received a complaint, if he considers it appropriate to do so.

2. District Health Boards

There are 20 district health boards (DHBs) with responsibility for funding or providing a specified range of health and disability services on behalf of the government. Public hospitals, and other public health services, including various clinics and community-based services, are owned and funded by DHBs. Individual providers (for example, doctors and nurses) working in a DHB's facility are usually employed by that DHB.

3. This Report

This report describes the complaints HDC received and/or closed in relation to DHBs during the 2016/17 financial year.

Complaints about DHBs are of particular interest as DHBs are the largest organisational providers of health and disability services in this country. Approximately 40% of complaints received by HDC each year relate, at least in part, to DHB services.

The complaints are described both in terms of overall numbers and characteristics, as well as by reference to case studies. In terms of complaints received, the issues included in the analysis are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues can still provide a valuable insight into the consumer's experience of the services provided and the issues they care most about. Case studies are included to encourage readers to consider their own service provision and to ask "could that happen at my place" and, if so, what changes can be made to prevent it.

COMPLAINTS RECEIVED

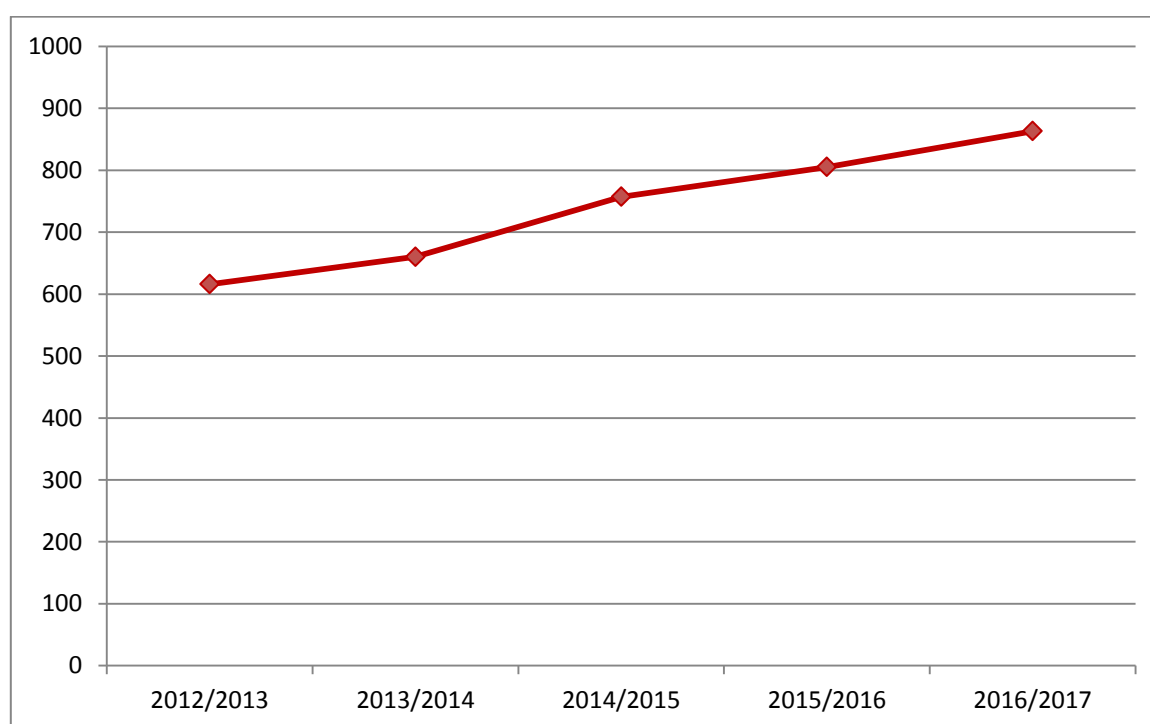
1. How many complaints were received?

1.1 Number of complaints received

In 2016/17, HDC received a total of **863**¹ complaints about care provided by all DHBs. This equates to 39% of the total 2,211 complaints received by HDC that year.

The 863 complaints received in the 2016/17 year represents an increase of 7% over the 805 complaints received in 2015/16. As can be seen from Figure 1 below, DHB complaint numbers have been steadily increasing over the last five years. Analysis shows that this increase is statistically significant.²

Figure 1. Number of complaints received about DHBs



In 2016/17 the number of complaints received about individual DHBs ranged from 7 complaints to 139 complaints. Large variability in complaint numbers is not unexpected given the similar variability in the size of populations served and number of services delivered by different DHBs.

¹ Provisional as of date of extraction, 25 August 2017.

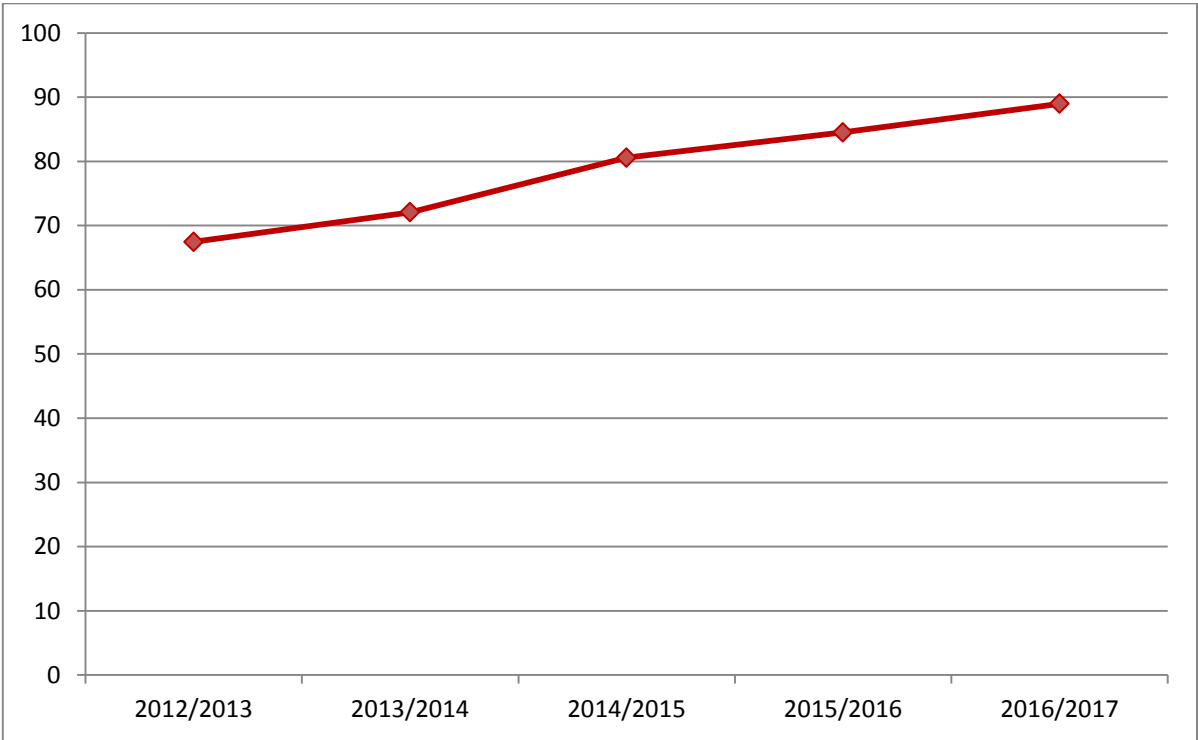
² There is a significant positive correlation between year and number of DHB complaints received ($r=0.99$, $p<.05$).

1.2 Rate of complaints received

Expressing complaints received by HDC about DHBs as a rate per 100,000 discharges allows more meaningful comparisons to be drawn between DHBs, and over time, enables any trends to be better observed.

In the 2016/17 year, according to Ministry of Health data,³ there were 970,992 discharges nationally. This equates to an overall rate of 89 complaints per 100,000 discharges across DHB services. This compares to an overall rate of 85 complaints per 100,000 discharges during 2015/16; an increase of 5%. As shown in Figure 2, the complaint rate per 100,000 discharges has increased steadily over the last five years. As with complaint numbers, analysis shows that this increase is statistically significant.⁴

Figure 2. Rate of complaints received about DHBs per 100,000 discharges



For individual DHBs, the rate of complaints received ranged from 54 complaints per 100,000 discharges to 130 complaints per 100,000 discharges.

However, while discharge data is useful for standardising DHB activity over time, it is less accurate when comparing DHBs against one another. This is because some services are excluded from the discharge data collected,⁵ disproportionately affecting some DHBs more than others. In addition, discharge data does not take into account the particular services provided by a DHB or the nature of the population and geographical area served.

³ Provisional as at the date of extraction, 25 October 2017.

⁴ There is a significant positive correlation between year and rate of DHB complaints received ($r=.98$, $p<.05$).

⁵For example, the discharge data excludes short stay emergency department discharges, and patients attending outpatient units and clinics.

Why are complaint numbers increasing?

The increasing number of complaints being received by HDC about DHBs is reflective of an overall trend of sustained growth in complaint numbers to HDC. Over the last five years, the number of complaints to HDC has increased by 37%.

This increase must be interpreted with caution. HDC has no evidence to suggest that the increase in complaints relates to a decrease in the quality of services, by providers generally, or by DHBs in particular.

The growth in complaint numbers is more likely to be due to the increasing profile of HDC, the improved accessibility of complaints processes due to advancing technology, and an increasing public knowledge of consumer rights. It may also reflect an increased willingness among consumers to complain about services received and increasing health care service activity.

HDC's increasing complaint load is not unique, but is consistent with a trend being observed in complaints agencies both around New Zealand and internationally. For example, in 2015/16 complaints to the New South Wales Health Care Complaint Commission and the Office of the Health Services Commissioner in Victoria rose by 15% and 28% respectively.

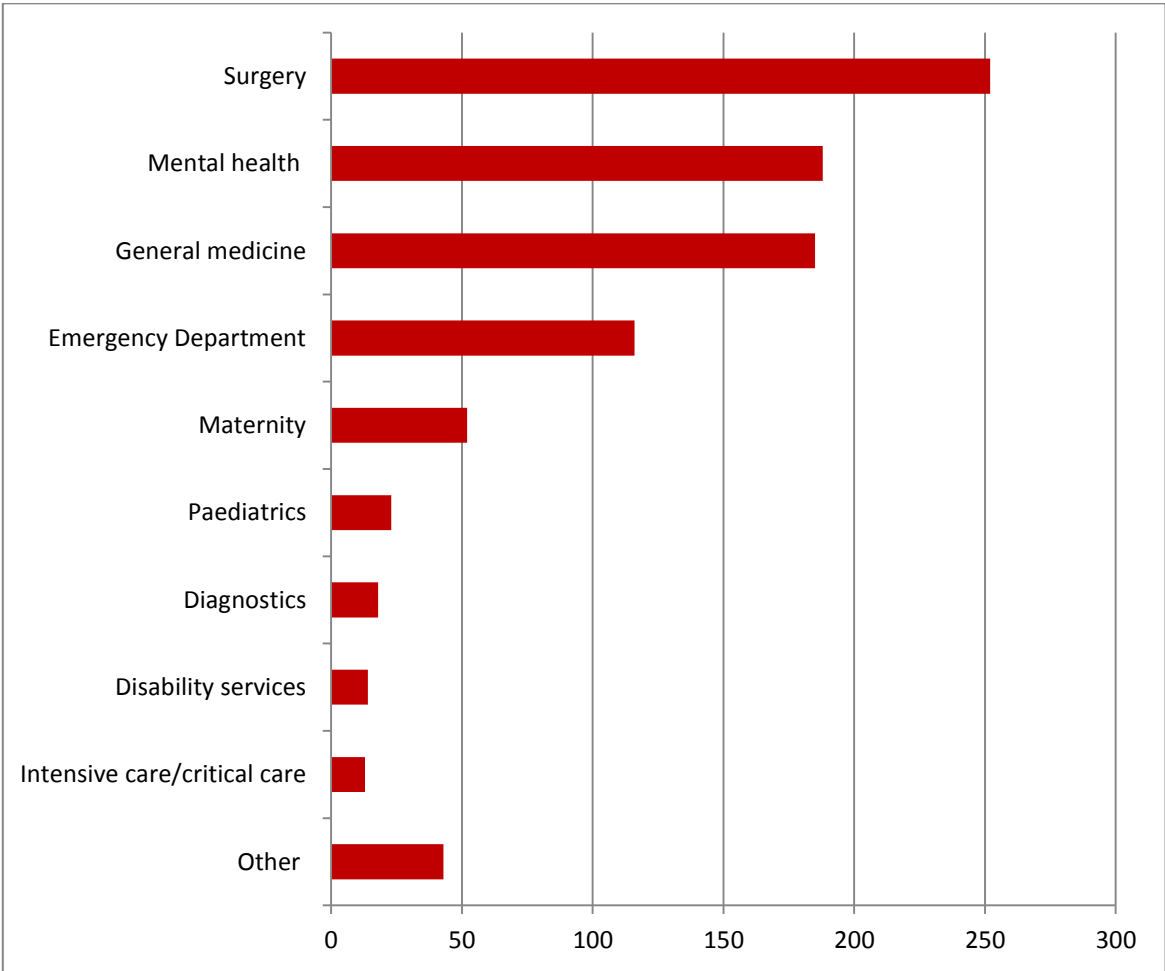
2. Which DHB services were complained about?

2.1 DHB service types complained about

DHBs operate a number of different services within hospitals, in clinics and in the community. It should be noted that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 864 complaints about DHBs, 904 services have been complained about.

Complaints received by HDC in the 2016/17 year were spread across many of those service types, as shown in Figure 3 below, with the greatest proportion of complaints being about surgical services (28%), followed by mental health (21%), general medicine (20%), emergency department (13%) and maternity services (6%).

Figure 3. DHB service types complained about



A more nuanced picture of service types complained about, including individual surgical and general medicine service categories, is provided in Table 1.

The most common surgical specialties complained about in 2016/17 were orthopaedics (8%) and general surgery (5%). This is broadly consistent with the surgical specialties complained about in 2015/16.

Table 1. DHB service types complained about

Service type	Number of services (%)
Alcohol and drug	4 (0.4)
Anaesthetics/pain medicine	7 (0.7)
Dental	6 (0.7)
Diagnostics	18 (2)
Disability services	14 (2)
District nursing	8 (0.9)
Emergency department	116 (13)
General medicine	185 (20)
Cardiology	26 (3)
Dermatology	2 (0.2)
Endocrinology	5 (0.6)
Gastroenterology	20 (2)
Geriatric medicine	13 (1)
Haematology	4 (0.4)
Hepatology	1 (0.1)
Infectious diseases	2 (0.2)
Neurology	31 (3)
Oncology	22 (2)
Palliative care	4 (0.4)
Renal/nephrology	9 (1)
Respiratory	8 (0.9)
Rheumatology	2 (0.2)
Other/unspecified	36 (4)
Hearing services	3 (0.3)
Intensive care/critical care	13 (1)
Maternity	52 (6)
Mental health	188 (21)
Paediatrics (not surgical)	23 (3)
Pharmacy	1 (0.1)
Rehabilitation services	4 (0.4)
Sexual health	2 (0.2)
Surgery	252 (28)
Cardiothoracic	5 (0.6)
General	47 (5)
Gynaecology	25 (3)
Neurosurgery	11 (1)
Ophthalmology	25 (3)
Orthopaedics	76 (8)
Otolaryngology	17 (2)
Paediatrics	2 (0.2)
Plastic and Reconstructive	15 (2)
Urology	17 (2)
Vascular	11 (1)
Unknown	1 (0.1)
Other health service	8 (0.9)
TOTAL	904

Table 2 below, shows a yearly comparison of the proportion of complaints received for the most commonly complained about service types. As can be seen from this table, the most common service types complained about over the last four years have remained broadly consistent, with general medicine showing a small increase in 2016/17. Therefore, although complaints about DHB services have increased overall in 2016/17, no one service type seems to be responsible for this increase.

Table 2. Yearly comparison of the proportion of complaints received about the most commonly complained about service types

Service type	2013/14	2014/15	2015/16	2016/17
Surgery	26%	27%	31%	28%
Mental health	19%	19%	21%	21%
General medicine	19%	17%	16%	20%
Emergency department	13%	13%	12%	13%
Maternity	6%	7%	6%	6%

Case study: Mental health (14HDC01390)

Police found Mr A wandering outside an airport, he appeared dazed and confused. Mr A was taken to the police station where he was seen by a consultant psychiatrist and a Duly Authorised Officer/social worker. The psychiatrist considered that Mr A was suffering from psychosis, possibly drug induced or associated with a mood disorder. The plan was to admit Mr A to a psychiatric inpatient unit.

Mr A was admitted directly to the ward, and placed on observations every 15 minutes. A second psychiatrist considered that Mr A was mentally disordered, and Mr A was given notice of a period of compulsory assessment and treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Mr A was reviewed by a consultant psychiatrist, who decided on a plan that included further assessment and monitoring for signs of withdrawal. She recorded a request that Mr A be reviewed by a registrar the following day (Saturday) and on Sunday if necessary. However, Mr A was not reviewed again by a psychiatrist during his admission. Later that day, a house officer conducted a physical examination of Mr A. The house officer recorded a history of substance abuse, chronic pain and anxiety, but made no risk assessment. On Saturday Mr A's mood appeared low, and he was subdued and kept to himself. He did not show signs or symptoms of withdrawal. The house officer reviewed him again, but did not request a review by the on-call psychiatrist or undertake a risk assessment.

On Sunday Mr A was visited by friends. When the friends left the ward, they spoke to the ward clerk and expressed concerns about Mr A. The ward clerk contacted Mr A's allocated nurse for the day, who met the friends to discuss their concerns. The nurse mentioned the conversation to another nurse and recorded it in the progress notes, but did not seek a medical review.

Early the next day, a psychiatric assistant saw Mr A standing by his open door acting unusually. About two hours later, Mr A was found unconscious in his room and sadly, he could not be resuscitated.

The Mental Health Commissioner considered that the DHB failed to provide services with reasonable care and skill to Mr A, in breach of Right 4(1) of the Code, in several respects:

- staff failed to arrange a psychiatric review of Mr A on the Saturday and Sunday;
- Mr A's risk was not assessed sufficiently following his admission;
- staff failed to respond adequately to his changing presentation;
- staff failed to monitor Mr A for signs of withdrawal after Saturday, as required by the plan made by the psychiatrist; and

- staff failed to respond adequately to the concerns expressed by Mr A's friends

The Mental Health Commissioner made several recommendations to the DHB, including that the DHB:

- report back to HDC on the implementation of recommendations set out in the DHB's corrective action plan;
- conduct audits of new standard operating procedures and policies and procedures, and provide HDC with the results of those audits and any service improvements that will be taken as a result of those audits;
- audit the use of risk assessment documentation for patients presenting with possible substance withdrawal, significant risks, or suicidal ideation, or who are receiving compulsory care under the MHA, to ensure that documentation meets professional standards;
- consider whether a registrar or consultant should attend the inpatient unit each day over the weekend and public holidays; and
- discuss psychiatrist input into inpatient care and treatment at weekends, public holidays and after hours at the next meeting of the Mental Health Clinical Directors of the DHBs

2.2 Professions of individual providers complained about

When people complain about services provided to them, they often complain about particular individuals involved in the provision of those services. The professions of the individual providers identified in complaints about DHB services are shown in Table 3 below.

Table 3. Professions of individual providers complained about in DHB complaints

Occupation	Number of individuals (%)
Doctors	152 (86)
Emergency medicine specialist	3 (2)
General surgeon	8 (5)
Internal medicine specialist	39 (22)
Medical officer	9 (5)
Neurosurgeon	4 (2)
Obstetrician/gynaecologist	13 (7)
Ophthalmologist	6 (3)
Orthopaedic surgeon	9 (5)
Otolaryngologist	5 (3)
Paediatrician	4 (2)
Plastic and reconstructive surgeon	4 (2)
Psychiatrist	16 (9)
Radiologist	4 (2)
Registrar	11 (6)
Urologist	6 (3)
Other	11 (6)
Other health providers	24 (14)
Midwife	6 (3)
Nurse	11 (6)
Other	7 (4)
TOTAL	176

The vast majority of the individual providers identified in DHB complaints received in the 2016/17 year were doctors. It is likely that doctors are more often seen by complainants as being responsible for the services provided and the outcomes of those services and are, therefore, more frequently viewed as individually responsible for any perceived shortcomings.

The most commonly identified individual provider occupations were internal medicine specialists (22%) and psychiatrists (9%). This is reflective of the fact that general medicine and mental health were two of the most commonly complained about service types, and is broadly consistent with what has been seen in previous years.

It should be noted that there are a number of factors that may account for the number of complaints about each specialty, such as the amount of patient contact that each specialty has, the clinical activities each specialty performs, and the characteristics of the population that each specialty serves.

Case study: Orthopaedic surgeon (15HDC00312)

Ms A underwent a discectomy carried out by an orthopaedic surgeon in order to alleviate her back pain. During surgery, the surgeon found a large amount of scar tissue and, despite using the appropriate clinical measures to identify the correct level of the spine to operate on, performed a discectomy on the incorrect level of Ms A's spine.

An MRI report completed after the surgery indicated that the surgery had not been performed on the correct level. Additionally, Ms A contacted the surgeon and advised that she was experiencing ongoing symptoms. The surgeon did not seek further advice from colleagues or the radiologist about interpretation of the MRI, and considered that clinical clarification with the aid of spinal steroid injections would be useful to resolve any uncertainty.

The surgeon did not advise Ms A that the MRI indicated it was possible he had operated on the incorrect level of her spine, and did not explain that the steroid injections he proposed were in order to check whether this was the case. The surgeon stated that he did not inform Ms A of this at the time because he wanted to confirm the situation clinically first.

The Commissioner considered that the surgeon took appropriate clinical measures prior to surgery to identify the appropriate spinal level on which to operate. However, it was clear from the relevant MRI scan that decompression of the correct level had not been performed. In the circumstances, including Ms A's ongoing symptoms, the surgeon should have sought further advice from colleagues and/or the radiologist about the interpretation of the scan at that stage. By failing to do so, the Commissioner found that the surgeon did not provide services to Ms A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner was highly critical that the surgeon failed to advise Ms A that the MRI report indicated that it was possible that he had operated on the wrong level of her spine, and that he intended to use steroid injections to seek further clarification in this regard. This was information that a reasonable consumer in Ms A's circumstances would need to receive to make an informed choice or give informed consent to proposed further treatment. Accordingly, the Commissioner found the surgeon in breach of Right 6(2) of the Code. Without this information, Ms A was unable to make an informed choice or give informed consent to the receipt of the steroid injections, and therefore the surgeon was also found in breach of Right 7(1) of the Code.

The Commissioner was critical of the DHB for not arranging a six weekly follow-up appointment for Ms A after the steroid injections. As a result of the follow-up appointment not being arranged, Ms A was subjected to further delay in her clinical situation being clarified.

The Commissioner recommended the surgeon consult with orthopaedic peers and consider adding additional screening to his clinical regimen, undertake a review of his process for providing consumers with information during the surgical consent process and postoperatively, and apologise to the woman.

3. What did people complain about?

3.1 Issues identified in complaints

Many complaints to HDC contain multiple issues of concern to the complainant. For the purposes of analysis, we identified the primary issue being complained about plus up to six additional complaint issues for each complaint received. It is important to note that this section details analyses of the issues raised by complainants in their complaints, rather than analyses of HDC's assessment of the issues raised. Inevitably, some of the complaint issues raised will have been found, on subsequent assessment, not to have been substantiated.

Primary complaint issues

As shown in Table 5, we grouped the complaint issues into several categories. Among these categories, issues relating to care/treatment (48%), access/funding (16%), communication (11%) and consent/information (10%) were the most prevalent. When separate complaint issues under each category are considered, missed/incorrect/delayed diagnosis (15%), unexpected treatment outcome (9%) and waiting list/prioritisation issue (8%) emerge as the most common primary complaint issues. This is broadly similar to what was seen last year. Complaints primarily about access/funding issues have steadily increased over the last four years from 7% in 2013/14 to 16% in 2016/17.

Case study: Missed/incorrect/delayed diagnosis (15HDC00268)

Mrs A presented to a public hospital's ED with a history of a cough and chest tightness. She was examined by a medical officer, Dr C, who gave her nebulisers, after which she improved. Dr C ordered a chest X-ray and did not note anything of concern. She diagnosed Mrs A with chronic obstructive pulmonary disease with acute asthma. Mrs A was discharged home with her care discharged back to her GP. Her discharge report did not mention a pending X-ray report.

Later that month, the formal radiologist's report was sent electronically to Dr C's inbox. In the report, the radiologist identified a mass and recommended a chest X-ray or CT scan in six weeks time.

Dr C reviewed the X-ray report in the memo tab of her inbox, but did not electronically acknowledge the results. Dr C went on leave the following day for ten days. She stated the X-ray results were not immediately urgent, and she considered it appropriate to action them on her return. Dr C assumed that the result would still be visible in the memo tab on her return, and was not aware that the memo would drop off from her view after 24 hours.

When Dr C returned from leave, Mrs A's chest X-ray results were no longer visible in the memo tab of Dr C's inbox, and Dr C did not recall the report. Mrs A did not receive the recommended follow-up X-ray or CT scan, and the X-ray results were not sent to her.

About 20 months after Mrs A's X-ray, she returned to the hospital having felt unwell for the last few days. A review of her electronic clinical history resulted in the discovery of the non-actioned X-ray report, which showed a mass on Mrs A's lung. Sadly Mrs A died two months later.

The DHB's investigation into these events found that its IT system allowed results to disappear from the view of the memo tab, once results were opened/viewed, after 24 hours regardless of whether they were acknowledged. All unattended and unacknowledged reports remained in the "unacknowledged work list". However, "the ED were unaware of this distinction in the functionality", and ED staff were using only the memo tab. There was no process at the hospital to ensure that reports or results were acknowledged within a certain length of time, and there was no warning system to alert clinicians to the existence of unacknowledged reports.

The Commissioner found that the DHB failed to have in place an appropriate system for the management and acknowledgement of test results. He noted, while a system was in place, clinicians

were not trained adequately to use that system. There was clearly widespread misunderstanding within the ED regarding the functionality of the IT system, which clinicians should have been able to rely on and use adequately. This failure resulted in Dr C not following up on Mrs A's report. In addition, the Commissioner considered that the DHB did not have in place an appropriate system to ensure that Mrs A's GP received the X-ray report, and did not have a process to ensure that reports or results did not go unacknowledged by clinicians. Accordingly, the Commissioner found that the DHB failed to provide Mrs A with services with appropriate care and skill, in breach of Right 4(1) of the Code.

The Commissioner was critical of Dr C for not putting in place any safety-netting strategies. However, overall, he considered it was reasonable for her to rely on the system in these circumstances.

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

- share a report regarding the outcome of its Electronic Acknowledgement Project (a project focusing on improving the systems and practices regarding unacknowledged results) with HDC and DHB Shared Services;
- provide HDC with an audit of four months of data regarding the time taken to acknowledge reports;
- consider having a warning system added to its electronic IT system to alert clinicians to the existence of unacknowledged results;
- arrange for an impartial IT expert with a medical background to examine its electronic management system to determine whether user warnings and updates need to be built in to the software and training sessions;
- provide a report to HDC regarding the actions taken in respect of the recommendations outlined in the DHB's Serious Adverse Event Report; and
- provide a written apology to Mrs A's family for its breach of the Code.

All complaint issues

On analysis of all issues identified in complaints about DHBs, the most common complaint categories were care/treatment (79%), communication (65%), consent/information (26%) and access/funding (24%). The most common specific complaint issues were: failure to communicate effectively with consumer (36%), inadequate/inappropriate treatment (33%), inadequate/inappropriate examination/assessment (23%), missed/incorrect/delayed diagnosis (22%), failure to communicate effectively with family (22%), delay in treatment (21%), inadequate coordination of care/treatment (21%) and disrespectful manner/attitude (20%).

Many complaints involved care/treatment issues, such as: unexpected treatment outcome; inadequate/inappropriate follow-up; inadequate/inappropriate testing; and inappropriate/delayed discharge/transfer, each of these were mentioned in between 12% and 14% of complaints.

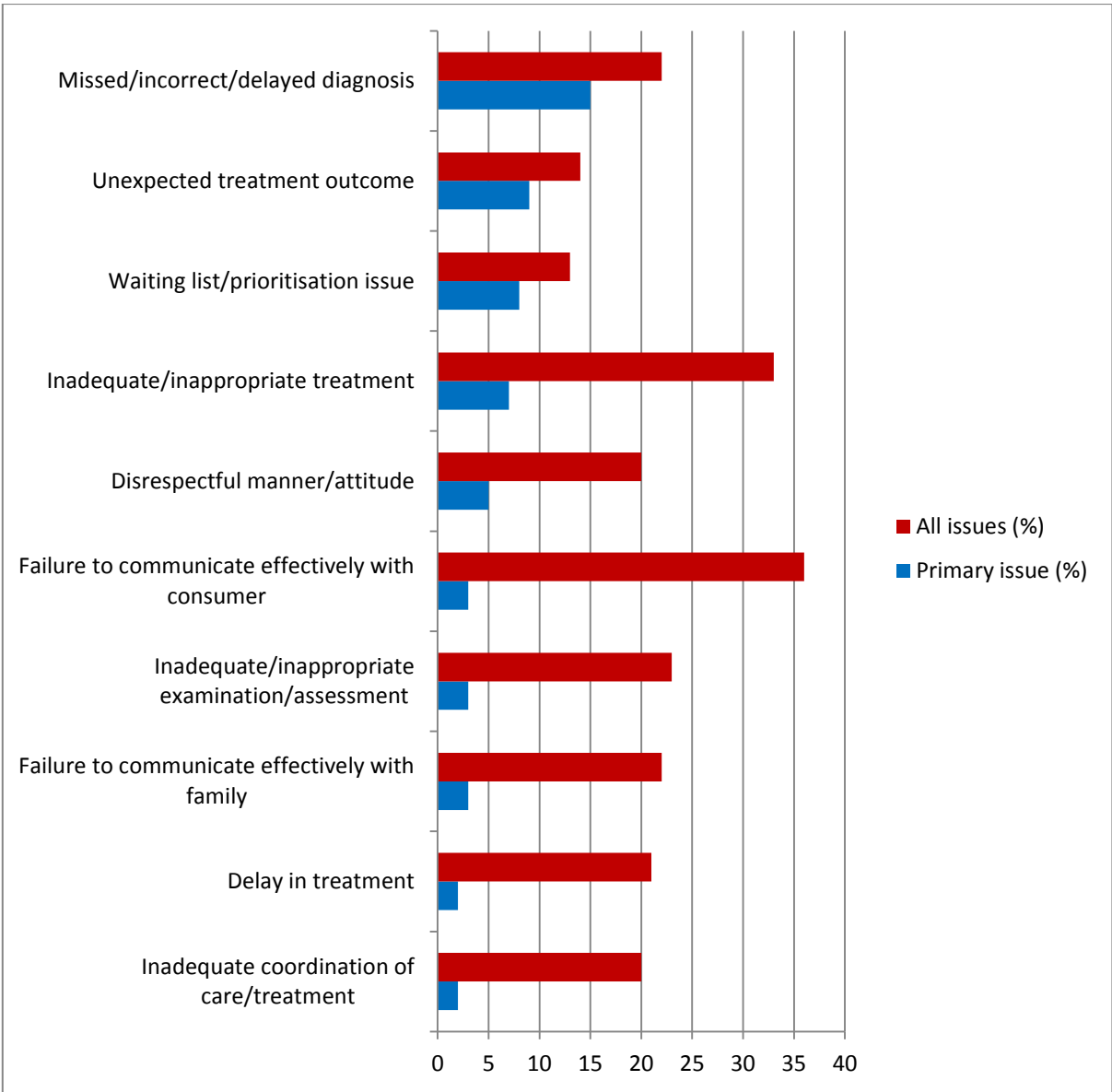
Table 5. Issues complained about in DHB complaints

Complaint issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
<i>Access/Funding</i>	<i>139 (16)</i>	<i>204 (24)</i>
ACC compensation issue	0	5 (0.6)
Lack of access to services	57 (7)	111 (13)
Lack of access to subsidies/funding	10 (1)	17 (2)
Waiting list/prioritisation issue	72 (8)	111 (13)
<i>Boundary violation</i>	<i>5 (0.6)</i>	<i>6 (0.7)</i>
Inappropriate non-sexual communication	1 (0.1)	2 (0.2)
Inappropriate sexual physical contact	2 (0.2)	2 (0.2)
Inappropriate non-sexual relationship	1 (0.1)	2 (0.2)
Inappropriate sexual relationship	1 (0.1)	1 (0.1)
<i>Care/Treatment</i>	<i>415 (48)</i>	<i>686 (79)</i>
Delay in treatment	16 (2)	179 (21)
Delayed/inadequate/inappropriate referral	4 (0.5)	48 (6)
Inadequate coordination of care or treatment	15 (2)	177 (21)
Inadequate/inappropriate clinical treatment	57 (7)	287 (33)
Inadequate/inappropriate examination/assessment	24 (3)	201 (23)
Inadequate/inappropriate follow-up	13 (2)	114 (13)
Inadequate/inappropriate monitoring	15 (2)	70 (8)
Inadequate/inappropriate non-clinical care	14 (2)	67 (8)
Inadequate/inappropriate testing	2 (0.2)	112 (13)
Inappropriate admission/failure to admit	3 (0.3)	23 (3)
Inappropriate/delayed discharge/transfer	27 (3)	106 (12)
Inappropriate withdrawal of treatment	6 (0.7)	29 (3)
Missed/incorrect/delayed diagnosis	126 (15)	188 (22)
Personal privacy not respected	2 (0.2)	9 (1)
Refusal to assist/attend	5 (0.6)	29 (3)
Refusal to treat	3 (0.3)	27 (3)
Rough/painful care or treatment	7 (0.8)	35 (4)
Unexpected treatment outcome	76 (9)	125 (14)
Unnecessary treatment/over-servicing	0	7 (0.8)
<i>Communication</i>	<i>96 (11)</i>	<i>564 (65)</i>
Disrespectful manner/attitude	39 (5)	171 (20)
Failure to accommodate cultural/language needs	0	19 (2)
Failure to communicate openly/honestly/effectively with consumer	29 (3)	311 (36)
Failure to communicate openly/honestly/effectively with family	24 (3)	189 (22)
Insensitive/inappropriate comments (not sexual)	4 (0.5)	28 (3)
<i>Complaints process</i>	<i>11 (1)</i>	<i>155 (18)</i>
Inadequate information provided regarding complaints process	0	3 (0.3)
Inadequate response to complaint	10 (1)	150 (17)
Retaliation/discrimination as a result of a complaint	1 (0.1)	4 (0.5)
<i>Consent/Information</i>	<i>87 (10)</i>	<i>224 (26)</i>
Coercion by provider to obtain consent	0	2 (0.2)
Consent not obtained/adequate	16 (2)	41 (5)
Inadequate information provided regarding adverse event	2 (0.2)	15 (2)
Inadequate information provided regarding condition	4 (0.5)	18 (2)
Inadequate information provided regarding fees/costs	2 (0.2)	2 (0.2)

Complaint issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Inadequate information provided regarding options	0	19 (2)
Inadequate information provided regarding provider	1 (0.1)	7 (0.8)
Inadequate information regarding results	3 (0.3)	16 (2)
Inadequate information provided regarding treatment	10 (1)	77 (9)
Incorrect/misleading information provided	3 (0.3)	27 (3)
Issues regarding consent when consumer not competent	1 (0.1)	2 (0.2)
Issues with involuntary admission/treatment	44 (5)	52 (6)
Other	1 (0.1)	3 (0.3)
Documentation	7 (0.8)	63 (7)
Delay/failure to disclose documentation	1 (0.1)	11 (1)
Delay/failure to transfer documentation	1 (0.1)	7 (0.8)
Inadequate/inaccurate documentation	5 (0.6)	44 (5)
Inappropriate maintenance/disposal of documentation	0	1 (0.1)
Intentionally misleading/altered documentation	0	2 (0.2)
Facility issues	30 (3)	171 (20)
Accreditation standards/statutory obligations not met	1 (0.1)	4 (0.5)
Cleanliness/hygiene issue	1 (0.1)	12 (1)
Failure to follow policies/procedures	2 (0.2)	17 (2)
General safety issue for consumer in facility	14 (2)	33 (4)
Inadequate/inappropriate policies/procedures	2 (0.2)	43 (5)
Issue with sharing facility with other consumers	2 (0.2)	14 (2)
Issue with quality of aids/equipment	1 (0.1)	10 (1)
Staffing/rostering/other HR issue	3 (0.3)	31 (4)
Waiting times	3 (0.3)	39 (5)
Other issue with physical environment	1 (0.1)	4 (0.5)
Medication	39 (5)	108 (13)
Administration error	5 (0.6)	15 (2)
Dispensing error	1 (0.1)	1 (0.1)
Inappropriate administration	7 (0.8)	16 (2)
Inappropriate prescribing	17 (2)	62 (7)
Refusal to prescribe/dispense/supply	9 (1)	17 (2)
Reports/Certificates	10 (1)	23 (3)
Inaccurate report/certificate	8 (0.9)	14 (2)
Refusal to complete report/certificate	2 (0.2)	9 (1)
Training/supervision	1 (0.1)	18 (2)
Delayed/inadequate/inappropriate handover	0	3 (0.3)
Inadequate supervision/oversight	1 (0.1)	16 (2)
Other professional conduct issues	20 (2)	63 (7)
Assault	2 (0.2)	3 (0.3)
Disrespectful behaviour	2 (0.2)	22 (3)
Failure to disclose/properly manage a conflict of interest	0	2 (0.2)
Inappropriate collection/use/disclosure of information	9 (1)	27 (3)
Threatening/bullying/harassing behaviour	1 (0.1)	1 (0.1)
Other	6 (0.7)	11 (1)
Disability-specific issues	1 (0.1)	7
Other issues	2 (0.2)	20
TOTAL	863	

Figure 4 details the ten most common complaint issues raised in complaints about DHBs received in the 2016/17 year. The blue bars show the percentage of cases in which the particular complaint issue was identified as the primary complaint issue, while the red bars show the percentage of cases in which the particular complaint issue was raised at all. As can be seen from the large difference in the size of the blue and red bars, communication-related complaint issues (disrespectful manner/attitude, and failure to communicate effectively with family or consumer), inadequate/inappropriate examination/assessment, delay in treatment and inadequate coordination of care/treatment are present in a significant number of complaints, but are not often the primary issue raised.

Figure 4. Most common primary and all issues in complaints received



Case study: Delay in treatment (14HDC01215)

Mr A, a 78 year-old man, was admitted to an emergency department at a public hospital on a Friday morning, following a fall. On arrival, he was diagnosed with a displaced left neck of femur fracture. Mr A's clinical history included emphysema with alpha 1 antitrypsin deficiency (A1AD).

That afternoon Mr A was admitted to the orthopaedic service under the care of a consultant orthopaedic surgeon, Dr J. Dr J decided that an acute total hip joint replacement was appropriate. He anticipated that Mr A would have surgery the next morning. At 6pm, Dr J finished his period on call. A second consultant orthopaedic surgeon, Dr C, then commenced his weekend call.

At 8am on Saturday, Dr C decided that it would be preferable to wait until Monday to perform the hip replacement. Dr J said that the decision to defer was in part because of the higher acuity of other patients awaiting surgery. Dr C did not dictate a note recording his decision to delay, however he stated that medical and nursing staff present were aware of the decision, and Dr J had dictated a note to Mr A's GP. Mr A's care was returned to Dr J after the weekend. Dr C was not rostered on for Monday.

Later on Monday morning, and then again at 3pm, it was noted that Mr A was still awaiting theatre. In the early evening of Monday, Mr A was told that surgery would not proceed that day. Mr A had his total hip joint replacement surgery on Tuesday evening – four days post-admission. This was over double the optimal time frame (up to 48 hours) for such acute surgery.

On Wednesday morning, Mr A showed signs of deterioration. He did not make any sustained improvement, despite fluid resuscitation, and then deteriorated further. The DHB utilises an observation chart scoring system to help identify adult patients at risk of deterioration. It also has a policy which states that senior medical officers (SMOs) should be contacted when a patient under their care deteriorates suddenly. The score for Mr A increased on the Wednesday afternoon and evening, and a nursing entry the following morning indicated that the score overnight had fluctuated. While Mr A experienced a period of improvement in his observations during the day on Thursday, he had deteriorated again by 7pm. Despite Mr A's deterioration, while an orthopaedic registrar and a medical registrar were contacted at different times, SMO assistance was not sought.

At 10.30pm, Mr A had increasing shortness of breath, ongoing hypotension, and poor urinary output. Mr A's care was escalated to intensive care staff and then later, to the high dependency unit. He continued to receive treatment, but his condition deteriorated over time. Mr A was placed on a palliative care pathway and, sadly, he died.

The Commissioner considered that Mr A's case highlighted particular hospital systems issues that contributed to him receiving suboptimal care. In particular, the delay in carrying out the total hip joint replacement surgery was over double the optimal timeframe for such surgery, and then there was a failure by a number of staff to escalate Mr A's care appropriately to senior staff in accordance with DHB policy when Mr A deteriorated post-operatively. Accordingly, the Commissioner found that that the DHB failed to provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner was critical that Dr C did not document his rationale for the delay in surgery.

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

- Report to HDC on the effect of the key changes it had made to its services on acute orthopaedic waiting times and quality of patient care. These changes included dedicated orthopaedics operating theatres, an acute escalation process, orthopaedic subspecialising, and an integrated orthogeriatric service
- Conduct a scheduled audit of the standard of care provided to acute patients who have presented with a hip fracture, based on the Australian and New Zealand Guidelines for Hip Fracture Care, and report back to HDC on the results of this audit.
- Provide evidence to HDC of a further up-to-date audit of staff compliance with the

application of DHB policy, including the recognition of the deteriorating patient and the escalation of care to senior staff in the event of patient deterioration, with reference to the implementation of a national Early Warning Score observation chart in line with HQSC.

- Provide a written apology to Mr A's family.

Table 6 details a yearly comparison of the most common issues raised in 2016/17. Common complaint issues have remained broadly consistent over the last four years.

Table 6. Yearly comparison of the most common issues complained about in DHB complaints in 2015/16

Complaint issue	2013/14	2014/15	2015/16	2016/17
Failure to communicate effectively with consumer	21%	34%	38%	36%
Inadequate/inappropriate treatment	37%	40%	43%	33%
Inadequate/inappropriate examination/assessment	14%	27%	29%	23%
Missed/incorrect/delayed diagnosis	27%	24%	23%	22%
Failure to communicate effectively with family	21%	22%	24%	22%
Delay in treatment	15%	14%	18%	21%
Inadequate coordination of care/treatment	14%	19%	24%	21%
Disrespectful manner/attitude	20%	24%	25%	20%

Case study: Failure to communicate effectively with consumer (15HDC01036)

Mrs A, a woman in her thirties with a history of poorly controlled Type 1 diabetes mellitus, was pregnant for the third time. Mrs A was under the care of the DHB's Diabetes and Pregnancy Service (the Service). Despite her pregnancy being managed by the multidisciplinary "high risk" antenatal clinic, Mrs A had not been informed about the signs and symptoms of diabetic ketoacidosis (DKA), a serious complication of diabetes when the body produces high levels of ketones. Additionally, HDC's expert advisor considered that, in light of the high-risk nature of Mrs A's pregnancy, her diabetes during her pregnancy should have been monitored more closely than it was by the Service, and that increased personal contact by clinicians was warranted.

When she was 31 weeks pregnant, Mrs A presented at the hospital's emergency department (ED) with a headache, nausea and general illness. Mrs A was sent directly to the maternity unit without being triaged in ED. Mrs A told staff she had Type 1 diabetes mellitus and that she was under specialist obstetric and endocrinologist care. However, the Service was not advised of her admission.

Mrs A was given IV fluids and analgesia for her headache. There is no record of her urine having been checked for ketones following the administration of fluids. Her condition improved overnight with hydration, and Mrs A was discharged the following day despite poor glycaemic control and no inpatient assessment by the Service. Mrs A became unwell again and, in the early hours of the following morning, she re-presented to ED. Mrs A was seen by the ED registrar and the obstetric team, and a diagnosis of probable DKA was made. Given Mrs A's life-threatening condition, an emergency Caesarean section was performed and a still born infant was delivered. When Mrs A was discharged there was no record of consideration of the reasons why Mrs A developed DKA, and no guidance was provided at discharge on how to reduce the risk of recurrence.

The Commissioner found that the DHB failed to provide Mrs A with care of an appropriate standard in the following respects:

- the signs and symptoms that Mrs A might expect to experience should she be suffering from DKA were not adequately communicated to her;
- Mrs A's diabetes was not monitored sufficiently closely during the pregnancy, particularly through personal contact with clinicians;
- despite Mrs A telling hospital staff that she was a patient under specialist diabetes care, the Service was not contacted during her admission;
- various tests were not carried out during Mrs A's hospital admission, the management of her diabetes was not reviewed, and she was not assessed by a diabetes clinician prior to discharge;
- the discharge summary following her second admission, does not state why Mrs A developed DKA, and gives no guidance on how to reduce the risk of recurrence of DKA.

The Commissioner considered that the DHB team had sufficient information to provide Mrs A with appropriate care. However a series of judgement and communication failures meant that they did not do so. Accordingly the Commissioner found that the DHB failed to provide Mrs A with services with appropriate care and skill, in breach of Right 4(1) of the Code.

The Commissioner made a number of recommendations to the DHB, including that it provide an update to HDC on the actions it had taken following this complaint, including:

- a review of the staffing of the Service;
- a review of the physical layout and suitability of the Service, and an audit of the documentation of the care provided by the Service to pregnant women with diabetes;
- a report on the national gestational diabetes guidelines, once implemented;
- a copy of the patient information resource on diabetes management in pregnancy and the pregnancy-specific insulin infusion protocol, and any other relevant reviewed policies; and
- a report on the establishment of a preconception clinic.

The Commissioner also recommended that the DHB:

- undertake a consultation with other DHBs regarding the development of consistent glycaemic targets for pregnant women;
- include in any protocols developed a requirement that, in circumstances where a patient is receiving multidisciplinary care and is admitted to hospital, all disciplines are informed and involved in treatment decisions;
- give consideration to the development of a protocol to provide that, in cases where a woman's glycaemic control is poor, there is a regular review of the records by a doctor and limited contact by telephone and email;
- undertake a review of the diabetes assessment/education checklist to include DKA;
- undertake an investigation of the possibility of a system whereby the readings from BGL meters are downloaded electronically; and
- undertake a review of the protocol regarding DKA in the Service guidelines, with a view to adding the risks and precipitating causes, pregnancy-vomiting-hydration. Consider adding the recommendation that the blood sugar level is > 40mmol/L before referral to ICU.

3.2 Complaint issues by service type

Issues raised in complaints vary, at least to some degree, according to the DHB service type concerned. As shown in Table 7 below, diagnostic issues were most prevalent in complaints about services with high diagnostic workloads, with 47% of emergency department complaints and 15% of general medicine complaints being primarily about a missed/incorrect/delayed diagnosis. Unexpected treatment outcome was prominent for surgical services, as this issue most often relates to post-surgical complications

These issues are broadly similar to what was seen last year. However, delay in treatment became a common primary issue for maternity services for the first time in 2016/17 and waiting list/prioritisation issue became a common issue for emergency department services for the first time.

Primary issues in complaints about mental health services were quite distinct, with issues relating to involuntary admission/treatment, inadequate examination/assessment and communication issues being common for this service.

Table 7. Most common primary issues in complaints by service type

Surgery n=252		Mental health n=188		General medicine n=185		Emergency department n=116		Maternity n=52	
Unexpected treatment outcome	23%	Issues with involuntary admission/treatment	24%	Missed/incorrect/delayed diagnosis	15%	Missed/incorrect/delayed diagnosis	47%	Inadequate/inappropriate treatment	15%
Waiting list/prioritisation issue	15%	Inadequate/inappropriate examination/assessment	9%	Inadequate/inappropriate treatment	9%	Disrespectful manner/attitude	10%	Missed/incorrect/delayed diagnosis	13%
Missed/incorrect/delayed diagnosis	12%	Failure to communicate effectively with consumer	5%	Lack of access to services	9%	Waiting list/prioritisation issue	5%	Delay in treatment	12%

Case study: Emergency department and a waiting list/prioritisation issue (15HDC01560)

Ms A, a university student, had been unwell for four days with flu-like symptoms. One night, she fainted twice. She hit her face and hurt her right thumb. Ms A was transported to a public hospital via ambulance and was triaged. Notes made by the ambulance officer and triage nurse record that she fainted twice and hit the side of her face, and was complaining of pain in her face and right thumb. The ambulance notes record that Ms A had a contusion on her left cheek bone.

Following triage, Ms A was examined by a senior house officer. The senior house officer said that he read the ambulance and triage documentation “too quickly” or, from the history Ms A gave him, was too focused on the fact that she might have a head injury, and he did not pick up that there could be a possible facial injury. The senior house officer recorded his impression as syncope (fainting) secondary to viral illness and dehydration. Ms A remained in hospital overnight for observation, and she was discharged the next morning. The senior house officer did not discuss Ms A’s case with a senior medical officer prior to discharge.

Ms A re-presented to the hospital that evening, as she felt unwell and thought something was wrong with her face. She spoke to a DHB staff member at the front desk of the Emergency Department (ED), but no triage was completed. No documentation exists for Ms A’s second presentation, except for a medical certificate issued by a medical officer. Subsequently, Ms A was diagnosed with facial fractures.

The Commissioner considered the DHB ought to have triaged Ms A when she re-presented to ED, and in not doing so, it failed to provide her with services with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner was also critical that there was no record of Ms A's second presentation (except for the medical certificate), and the DHB was unable to identify the staff member who spoke with Ms A.

The Commissioner was critical of the senior house officer for not picking up that there could be a possible facial injury, and for not discussing Ms A's case with a senior medical officer prior to discharge.

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

- provide HDC with an update on the implementation of its mentoring programme for junior staff;
- report to HDC on its review of the ED triage process;
- provide evidence to HDC of triage process training sessions being provided to triage and clerical staff; and
- provide a written apology to Ms A

As mentioned above, many complaints to HDC contain multiple issues of concern to the complainant. Table 8 below shows an analysis of the common complaint issues raised about each service type when all issues complained about are considered (rather than just the primary issue as in Table 7).

When all issues raised in complaints about each service type are analysed, it can be seen that communication issues feature prominently for all service types. However, again complaint issues do vary according to the service type complained about. General medicine and maternity services received a greater proportion of complaints involving inadequate coordination of care/treatment than other service types, while emergency department services received a greater proportion of complaints involving inadequate testing, and maternity and surgical services received a greater proportion of complaints regarding a delay in treatment. Mental health and general medicine services saw a greater proportion of complaints regarding communication with family than did other service types.

Table 8. Most common issues in complaints by service type

Surgery n=252		Mental health n=188		General medicine n=185		Emergency department n=116		Maternity n=52	
Failure to communicate effectively with consumer	44%	Failure to communicate effectively with consumer	34%	Failure to communicate effectively with consumer	35%	Missed/incorrect/delayed diagnosis	49%	Inadequate/inappropriate treatment	58%
Inadequate/inappropriate treatment	42%	Issues with involuntary admission/treatment	29%	Failure to communicate effectively with family	31%	Inadequate/inappropriate examination/assessment	37%	Failure to communicate effectively with consumer	48%
Unexpected treatment outcome	32%	Failure to communicate effectively with family	26%	Inadequate coordination of care/treatment	30%	Inadequate/inappropriate testing	33%	Delay in treatment	33%
Delay in treatment	27%	Inadequate/inappropriate examination/assessment	22%	Inadequate/inappropriate treatment	30%	Inadequate/inappropriate treatment	31%	Inadequate/inappropriate examination/assessment	31%
Missed/incorrect/delayed diagnosis	22%	Inadequate/inappropriate treatment	22%	Missed/incorrect/delayed diagnosis	26%	Failure to communicate effectively with consumer	29%	Unexpected treatment outcome & inadequate coordination of care/treatment	25% each

Case study: Inadequate coordination of care/treatment (15HDC00563)

Mr A was on long-term opioid substitution treatment under the care of the Addictions Service at a DHB. Mr A presented to the ED at his local hospital following a fall. Mr A was found to have multiple nodules on his lungs and a lesion on his liver. A consultant physician reviewed Mr A, recorded his impression of chronic liver disease, hypoxia with suspicions of malignancy, and abdominal lesions and nodes.

Three days later, Mr A contacted Mr C, an addiction clinician at the Addictions Service, and advised that he had been diagnosed with cancer of the liver. Mr C informed the manager at the Addictions Service, Ms D. The minutes from the Addictions Service's weekly meeting noted that Mr A was being investigated for liver cancer and was requesting to have his methadone increased when discharged from hospital. The hospital discharge summary referred to Mr A's "possible poor prognosis" and included a plan for outpatient follow-up and GP review of Mr A's abdominal pain and pain relief.

Mr A presented at the hospital a few weeks later, reporting shortness of breath and abdominal pain. Mr A's admission and pain were reported to Ms D. Mr A was discharged a few days later by house officer, Dr H, with a prescription for increased methadone intended for acute pain relief. Mr A was noted at the time to be in severe pain with a deteriorating clinical condition.

Mr A took the prescription to a pharmacy. Because of the change in methadone dose, the pharmacy called the Addictions Service. Dr B, an addiction specialist, contacted Dr H to clarify the prescription, and was advised that the methadone was prescribed to help with abdominal pain. Dr B advised that Dr H was unaware of the DHB policy on prescribing methadone for addiction services clients on discharge. Dr H cancelled the prescription. Dr B did not follow up on the prescription when he returned to work the next day.

Mr A was discussed at the next Addictions Service meeting, at which time it was noted that he was having an MRI that afternoon. The minutes note that Dr B was "reluctant to increase [Mr A's]

methadone, due to concern he is drug-seeking”.

Mr A underwent the MRI, but it could not be completed because he was unable to lie still owing to the pain. This information was relayed to Dr B by Mr C. Dr B said that this was the first indication he had that Mr A could be requiring methadone for clinical reasons rather than addiction. Responsibility for Mr A’s methadone prescribing was handed over to a palliative care specialist. Mr A was transferred to hospice care, and passed away shortly afterwards.

The Mental Health Commissioner stated that the DHB “failed to identify and/or address an overly cautious approach being taken to the management of interactions with Mr A”. The Mental Health Commissioner considered that there were a number of missed opportunities for communication about Mr A’s situation, his condition, and his pain relief requirements, as a result of service-based failures attributable to the DHB. Mr A did not receive the pain relief he should have been able to access, and accordingly, it was found that the DHB failed to provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code.

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

- develop a process for formal handover of Addictions Service clients when they move from outpatient to inpatient service and vice versa;
- develop, as part of the process above, a policy requiring hospital discharge summaries for Addictions Service clients to be emailed to the Addictions Service on discharge, and for all related contact between Addictions Service and other services to be documented;
- conduct an audit over a one-month period to ensure that all interactions with clients are recorded in the Addictions Service records and/or, if relevant, clinical records;
- review and revise, as necessary, the position descriptions for Addictions Service staff referred to within HDC’s report to ensure clarity of role expectations, professional development and support;
- conduct a random audit of the hospital’s discharge summaries to assess compliance with the requirement that hospital discharge summaries be sent to relevant GPs;
- provide refresher training for hospital staff on the “Methadone/Buprenorphine (with Naloxone) — Opioid Substitution Therapy for Treatment of Dependence (Addiction)” and “Pain Management — Adults” guidelines; and
- provide a written apology to Mr A’s family.

COMPLAINTS CLOSED

1. What were the outcomes of the complaints closed?

1.1 Available resolution options

HDC is focused on fair and early resolution of complaints. Each complaint received by HDC is assessed carefully and resolved in the most appropriate manner, bearing in mind the issues raised and the evidence available. The preliminary assessment process is thorough and can involve a number of steps, including obtaining a response from the provider/s, seeking expert advice and asking for input/information from the consumer or other persons.

At the conclusion of a preliminary assessment, there are a number of options available to the Commissioner for the resolution of complaints. These include referring the complaint to the Advocacy Service, to a professional body, or to another agency. HDC may also refer a complaint back to the provider to resolve directly. In line with their responsibilities under the Code, DHBs have increasingly developed good systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

The Commissioner also has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, 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. Often a decision to take no further action will be accompanied by an educational comment or recommendations designed to assist the provider in improving future services.

Where appropriate, the Commissioner may formally investigate a complaint. Once HDC has notified the parties that a complaint is to be investigated, the complaint is classified by HDC as a formal investigation, even though an alternative manner of resolution may subsequently be adopted. Notification of formal investigation generally indicates more serious or complex issues.

1.2 Manner of resolution and outcomes in complaints closed

The manner of resolution and outcomes for all DHB complaints closed in the 2016/17 year is shown in Table 9 below. It should be noted that outcomes are displayed in a descending order. If there is more than one outcome for a DHB upon resolution of a complaint, then only the outcome listed highest in the table is included.

Table 9. Outcome for DHBs of complaints closed

Outcome for DHB	Number of complaints
<i>Investigation</i>	<i>40</i>
Breach finding	19
No further action with follow-up or educational comment	10
No further action	6
No breach finding	5
<i>Other resolution following assessment</i>	<i>711</i>
No further action with follow-up or educational comment	149
Referred to Ministry of Health	3
Referred to Privacy Commissioner	1
Referred to District Inspector	27
Referred to DHB	207
Referred to Advocacy	113
No further action	193
Withdrawn	18
<i>Outside jurisdiction</i>	<i>30</i>
TOTAL	781

As can be seen from the table above, in the 2016/17 year, HDC concluded 40 formal investigations involving DHBs, 19 of which resulted in a finding that the DHB had breached the Code.

2. Recommendations made to DHBs following resolution of complaints

Regardless of whether or not a complaint has been investigated, or whether the DHB has been found in breach of the Code, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted on. Many such recommendations are described in the case studies included throughout this report.

Table 9 shows the recommendations made to DHBs in complaints closed in the 2016/17 year. Please note that more than one recommendation may be made in relation to a single complaint.

Table 9. Recommendations made to DHBs following a complaint

Type of recommendation	Number of recommendations made
Apology	27
Audit	38
Meeting with consumer/complainant	12
Presentation/discussion of complaint with others	26
Provision of evidence of change to HDC	72
Reflection	18
Review/implementation of policies/procedures	65
Training/professional development	37
Total	295

As can be seen from Table 9 above, 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 (72 recommendations), followed by a review of their policies/procedures or implementation of new policies/procedures (65 recommendations). Audits (38 recommendations) were most commonly in relation to staff adherence to policies/procedures. Recommendations related to staff training (37 recommendations) most frequently concerned training on clinical issues, followed by communication and documentation training. On some occasions, HDC also recommended that an anonymised version of the complaint be used as a training tool for staff (26 recommendations)

In almost all cases (99.6%), recommendations made by HDC are complied with by providers, including DHBs.

Case studies

Recommendations made by HDC to DHBs

Recommendations arising from breach relating to assessment and management of orthopaedic patient (14HDC00134)

A man who had a history of a large GI bleed secondary to use of non-steroidal anti-inflammatory drugs (NSAIDs) was referred to a public hospital for knee surgery. At the man's outpatient appointment and pre-admission clinic appointment, no staff reviewed his previous clinical records or documented his past history of a GI bleed. The anaesthetist on the day of surgery was not made aware of the history of a GI bleed, and postoperatively charted pain relief that included a NSAID. The man's surgeon went on leave, and no orthopaedic staff member was specified in the clinical record as being the responsible clinician. The man deteriorated post-operatively. Advice was not sought from senior clinicians, and Early Warning Score Protocols were not adhered to.

The Commissioner considered that there were a number of issues with the DHB's systems which contributed to a failure by the DHB to provide services to the man with reasonable care and skill, in breach of Right 4(1) of the Code. The DHB records system did not assist staff to facilitate effective review of patient history and significant patient comorbidities and the wording and nature of several of the questions on the DHB pre-assessment patient questionnaire may have been subject to misinterpretation. Postoperatively there was a lack of clarity about the person to whom oversight of the man's care had passed, staff did not adhere to Early Warning Score (EWS) protocols appropriately and escalation to senior staff did not occur appropriately.

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

- prepare or modify a policy or guidelines to clarify roles and responsibilities of staff and outline precisely when in the patient surgical pathway, and by whom, the patient's clinical history and records are to be reviewed and significant issues communicated;
- provide a detailed update in relation to its development of electronic patient records;
- implement an electronic alert process or system in the patient record for clear flagging of significant patient co-morbidities and clinical history;
- provide details of the steps taken to allow treating clinicians to re-check all patient hard copy records, electronic records and medications immediately prior to surgery; and
- detail mechanisms being pursued for ensuring appropriate medical response to an EWS trigger, and for ensuring that junior doctors are confident and supported to escalate concerns about deteriorating patients to their senior colleagues

Recommendations arising from breach relating to care of man in hospital (15HDC01053)

A man was accepted by a surgical registrar for review in the ED. Due to the busyness of the ED, there was a delay for triage. An abnormal Troponin T test result, indicating heart damage, was processed and automatically released by the results system, but the registrar was not advised of the result. The man was transferred to a surgical ward without important interventions being taken and without this being discussed with the registrar. Medical review and antibiotic administration were also delayed.

The Commissioner was concerned that during the man's admission:

- the DHB had two policies with differing criteria for escalation of test results to clinical staff by telephone and, in practice, neither of these were followed when dealing with Troponin T results. This meant that the man's high Troponin T result was not escalated to the registrar in a timely manner by telephone;
- the on-call consultant was not readily available for assisting when delays were experienced in

medical review; and

- the DHB's practice regarding ward transfers did not reflect its policy, and, as a result, the man was transferred to a lower acuity ward without discussion with the surgical registrar and required interventions being undertaken in order to meet the ED six-hour target.

The Commissioner found that the combination of these failings meant that the DHB failed to provide services with reasonable care and skill to Mr B, in breach of Right 4(1) of the Code.

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

- conduct an audit of the effectiveness of its new triage process in regard to the timeliness of triage and triage scoring;
- review its "Severe Sepsis Management Policy" and newly developed "Adult Sepsis Pathway", and conduct training for relevant staff on the "Adult Sepsis Pathway";
- develop a clear policy as to who has responsibility for following up test results ordered by ED RNs;
- consider implementing a system that requires the laboratory to alter the patient's treating clinician urgently when Troponin T results are abnormally high;
- develop a care escalation plan for the General Medicine team;
- review the role of the on-call consultant to ensure that adequate supervision of junior doctors is occurring; and
- remind all staff working in ED that the transfer and location the patient is transferred to must be clinically appropriate

Recommendations arising from breach relating to follow-up of test results in ED (15HDC01204)

An ED doctor ordered a chest X-ray for a man presenting to ED with a chronic cough, left-sided chest pain and shortness of breath. On discharge, the ED doctor told the man to follow up with his GP, but did not specify a timeframe for this. The discharge summary was sent to the man's GP. The chest X-ray report recommended a follow-up X-ray in 10-14 days' time. The ED doctor and the GP both received the report but neither took any action in respect of it.

The Commissioner found that the DHB did not have a clear, effective and formalised system in place for the reporting and following up of test results. The Commissioner stated that he would expect that such a system would include a policy requiring the clinician to instruct the patient leaving the ED to follow up any outstanding test result with an identified provider, normally his or her GP. The Commissioner held that the DHB did not provide services to the man with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner recommended that the DHB review its ED policy to ensure that there is a clear process for the handover of care from ED to GPs, including follow-up of tests and X-rays ordered in ED.

The Commissioner also recommended that the National CMO Group work to put in place clear practice guidelines regarding the interface between emergency departments and general practitioners in relation to follow-up of test results within all DHBs. The National CMO Group has undertaken to comply with this recommendation.