

Complaints to HDC involving District Health Boards

Report and Analysis for period 1 July to 31 December 2015

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Commissioner's Foreword

I am pleased to present you with HDC's six monthly DHB complaint report for the period July to December 2015.

Complaints to HDC about DHBs continue to increase; the 422 complaints received in Jul–Dec 2015 is the highest number of complaints about DHBs ever received in a six month period. The services and issues complained about remain similar to what we have seen in previous six month periods, with surgical services being the most commonly complained about service type at DHBs and a missed, incorrect or delayed diagnosis being the most common primary issue in complaints about DHBs.

Every complaint represents an opportunity to learn and improve the system. System improvement occurs in the majority of complaints that come to HDC, either in response to direct recommendations made by HDC, or through providers taking proactive steps in response to issues raised. The "Learning from Complaints" section of this report highlights four case studies where lessons were learnt and changes made in response to the complaint. This report also presents an opportunity for the sector to learn from the trends and themes that emerge in complaints to HDC. One of the primary reasons often cited by consumers for making a complaint is that they don't want the same thing to happen to somebody else.

I encourage all DHBs to ensure that they have an effective complaints management system which includes processes to ensure lessons are captured, and appropriate changes implemented and evaluated to prevent recurrence, and which allows for trends in complaint data to be monitored and evaluated.

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 2015, HDC received a total of **422¹** complaints about care provided by all District Health Boards. Numbers of complaints received in previous six month periods are reported in Table 1.

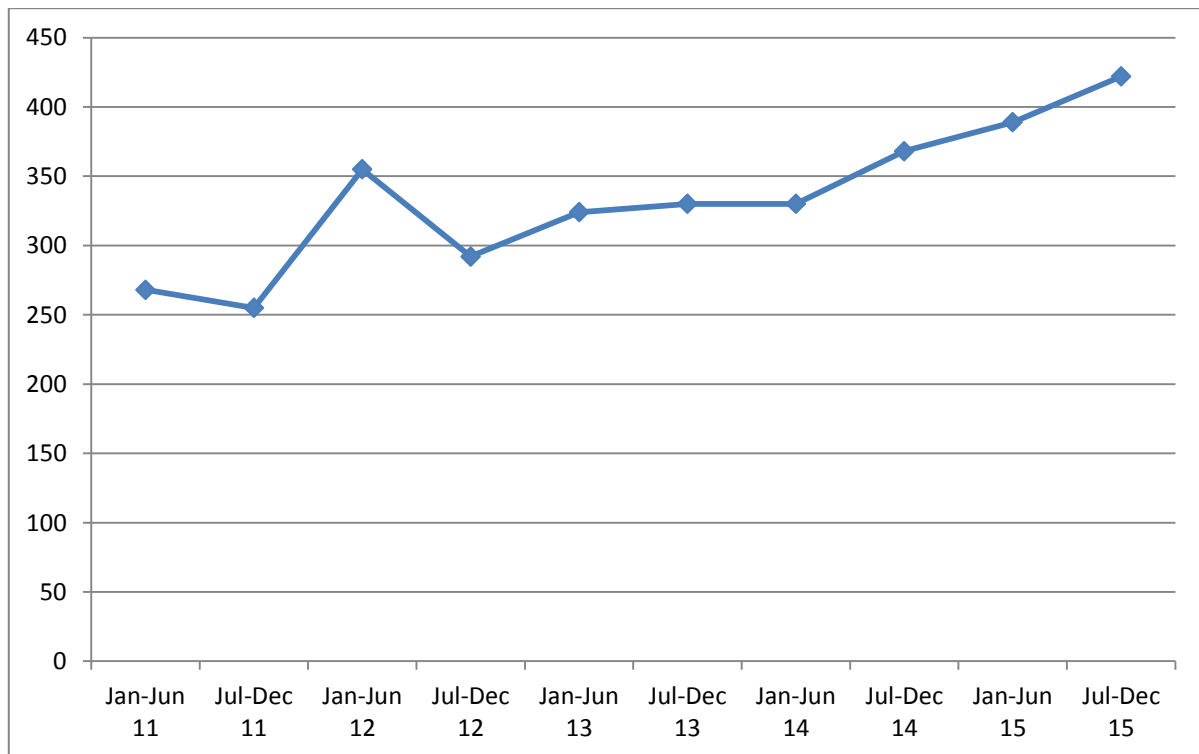
Table 1. Number of complaints received in last five years

	Jan– Jun 11	Jul– Dec 11	Jan– Jun 12	Jul– Dec 12	Jan– Jun 13	Jul– Dec 13	Jan– Jun 14	Jul– Dec 14	Jan– Jun 15	Average of last 4 6-month periods	Jul– Dec 15
Number of complaints	268	255	355	292	324	330	330	368	389	354	422

The total number of complaints received in Jul–Dec 2015 (422) shows an increase of 19% over the average number of complaints received in the previous four periods.

The number of complaints received in Jul–Dec 2015 and previous six month periods are also displayed below in Figure 1. The number of complaints received in Jul–Dec 2015 is the highest number of complaints about DHBs ever received in a six month period.

Figure 1. Number of complaints received



¹ Provisional as of date of extraction (8 January 2016).

1.2 Rate of complaints received

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

Frequency calculations are made using discharge data provided by the Ministry of Health (provisional as at the date of extraction, 10 February 2016). It should be noted that this discharge data excludes short stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges during Jul–Dec 2015

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
422	476,413	88.58

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jul–Dec 2015 and previous six month periods.

Table 3. Rate of complaints received in last five years

	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 14 ²	Average of last 4 6-month periods	Jul–Dec 15
Rate per 100,000 discharges	62.48	55.86	80.22	62.59	72.67	71.15	72.99	76.65	84.60	76.35	88.58

The rate of complaints received during Jul–Dec 2015 (88.58) shows a 16% increase over the average rate of complaints received for the previous four periods. The rate of complaints received in Jul–Dec 2015 is the highest rate of complaints about DHBs ever received in a six month period.

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

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

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

Table 4. Number and rate of complaints received for each DHB in Jul-Dec 2015

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	61	60,058	101.57
Bay of Plenty	21	25,294	83.02
Canterbury	34	56,881	59.77
Capital and Coast	41	31,856	128.70
Counties Manukau	27	50,019	53.98
Hawke's Bay	9	15,520	57.99
Hutt Valley	16	15,871	100.81
Lakes	11	11,534	95.37
MidCentral	33	16,336	202.01
Nelson Marlborough	16	11,274	141.92
Northland	15	20,443	73.37
South Canterbury	6	5,957	100.72
Southern	33	27,232	121.18
Tairāwhiti	6	5,193	115.54
Taranaki	16	12,365	129.40
Waikato	52	45,970	113.12
Wairarapa	5	3,738	133.76
Waitemata	30	51,060	58.75
West Coast	0	3,569	00.00
Whanganui	9	6,243	144.16

Notes on DHB's number and rate of complaints

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

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

2.0 Service types complained about

2.1 Service type category

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 422 complaints about DHBs, 444 services were complained about.

The five service types with the greatest number of complaints were surgery (34.9%), mental health (20.0%), general medicine (15.1%), emergency departments (12.2%) and maternity (5.4%). This is broadly similar to what was seen last period, with the exception of surgical services, which saw an increase in complaints from 25.9% in Jan-Jun 2015 to 35.0% in Jul-Dec 2015. The most commonly complained about surgical specialties were orthopaedics (8.3%) and general surgery (8.1%).

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Aged care (long-term care facility)	2	0.5%
Alcohol and drug	6	1.4%
Anaesthetics/pain medicine	3	0.7%
Dental	1	0.2%
Diagnostics	15	3.4%
Disability services	3	0.7%
District nursing	1	0.2%
Emergency department (including paramedics)	54	12.1%
General medicine	67	15.1%
Cardiology	12	2.7%
Dermatology	4	0.9%
Endocrinology	3	0.7%
Gastroenterology	7	1.6%
Geriatric medicine	8	1.8%
Infectious diseases	3	0.7%
Neurology	6	1.4%
Oncology	9	2.0%
Palliative care	2	0.4%
Respiratory	6	1.4%
Other/unspecified	7	1.6%
Hearing services	3	0.7%
Intensive care/critical care	2	0.5%
Maternity	24	5.4%
Mental health	89	20.0%
Nutrition/dietetics	1	0.2%
Occupational therapy	1	0.2%
Paediatrics (not surgical)	8	1.8%
Rehabilitation services	4	0.9%
Sexual health	3	0.7%
Surgery	155	34.9%
Cardiothoracic	9	2.0%
General	36	8.1%
Gynaecology	16	3.6%
Neurosurgery	3	0.7%

Service type	Number of complaints	Percentage
Ophthalmology	8	1.8%
Oral/Maxillofacial	2	0.5%
Orthopaedics	37	8.3%
Otolaryngology	4	0.9%
Paediatric	8	1.8%
Plastic and Reconstructive	9	2.0%
Urology	19	4.3%
Vascular	3	0.7%
Unknown	1	0.2%
Other health service	2	0.5%
TOTAL	444	

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. Those complaint issues identified in only one complaint are classified as 'other'. The primary issues identified in complaints received in Jul–Dec 2015 are listed in Table 6.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	61	14.4%
Lack of access to services	27	6.4%
Lack of access to subsidies/funding	3	0.7%
Waiting list/prioritisation issue	31	7.3%
Boundary violation	3	0.7%
Inappropriate sexual communication	2	0.5%
Inappropriate sexual physical contact	1	0.2%
Care/Treatment	229	54.3%
Delay in treatment	3	0.7%
Delayed/inadequate/inappropriate referral	3	0.7%
Inadequate coordination of care/treatment	2	0.5%
Inadequate/inappropriate clinical treatment	39	9.2%
Inadequate/inappropriate examination/assessment	13	3.1%
Inadequate/inappropriate follow-up	9	2.1%
Inadequate/inappropriate monitoring	8	1.9%
Inadequate/inappropriate non-clinical care	6	1.4%
Inadequate/inappropriate testing	1	0.2%
Inappropriate/delayed discharge/transfer	11	2.6%
Inappropriate withdrawal of treatment	2	0.5%
Missed/incorrect/delayed diagnosis	69	16.4%
Refusal to treat	4	0.9%
Rough/painful care or treatment	4	0.9%
Unexpected treatment outcome	50	11.8%
Unnecessary treatment/over-servicing	4	0.9%
Communication	43	10.2%
Disrespectful manner/attitude	21	5.0%
Failure to accommodate cultural/language needs	1	0.2%
Failure to communicate openly/honestly/effectively with consumer	9	2.1%
Failure to communicate openly/honestly/effectively with family	10	2.4%
Insensitive/inappropriate comments	2	0.5%
Complaints process	8	1.9%
Inadequate response to complaint	8	1.9%
Consent/Information	38	9.0%
Consent not obtained/adequate	7	1.7%
Inadequate information provided regarding adverse event	3	0.7%
Inadequate information provided regarding condition	4	0.9%
Inadequate information provided regarding fees/costs	2	0.5%
Inadequate information provided regarding results	3	0.7%
Inadequate information provided regarding treatment	2	0.5%

Primary issue in complaints	Number of complaints	Percentage
Incorrect/misleading information provided	2	0.5%
Issues with involuntary admission/treatment	13	3.1%
Other	2	0.5%
Documentation	5	1.2%
Delay/failure to disclose documentation	3	0.7%
Inadequate/inaccurate documentation	2	0.5%
Facility issues	7	1.7%
General safety issue for consumer in facility	4	0.9%
Issue in sharing facility with other consumers	1	0.2%
Waiting times	2	0.5%
Medication	15	3.6%
Administration error	2	0.5%
Inappropriate administration	3	0.7%
Inappropriate prescribing	5	1.2%
Prescribing error	2	0.5%
Refusal to prescribe/dispense/supply	3	0.7%
Reports/Certificates	5	1.2%
Inaccurate report/certificate	5	1.2%
Other professional conduct issues	9	2.1%
Assault	2	0.5%
Disrespectful behaviour	3	0.7%
Inappropriate collection/use/disclosure of information	4	0.9%
TOTAL	422	

The most common primary issue categories concerned care/treatment (54.3%), access/funding (14.4%), communication (10.2%) and consent/information (9.0%). Among these, the most common specific primary issues in complaints about DHBs were 'missed/incorrect/delayed diagnosis' (69 complaints), 'unexpected treatment outcome' (50 complaints), 'inadequate/inappropriate clinical treatment' (39 complaints), 'waiting list/prioritisation issue' (31 complaints) and 'lack of access to services' (27 complaints). This is broadly similar to what was seen in Jan-Jun 2015, with the exception of access/funding issues which were more prominent in Jul-Dec 2015 than in the Jan-Jun 2015 period (8.2%).

Table 7 shows a comparison over time for the top five primary issues complained about.

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

Top five primary issues in all complaints (%)							
Jan–Jun 14 n=330		Jul–Dec 14 n=368		Jan–Jun 15 n=389		Jul–Dec 15 n=424	
Misdiagnosis	17%	Misdiagnosis	15%	Misdiagnosis	20%	Misdiagnosis	16%
Inadequate treatment	11%	Inadequate treatment	11%	Inadequate treatment	12%	Unexpected treatment outcome	12%
Disrespectful manner/attitude	6%	Unexpected treatment outcome	7%	Unexpected treatment outcome	6%	Inadequate treatment	9%
Unexpected treatment outcome	6%	Waiting list/prioritisation	6%	Disrespectful manner/attitude	4%	Waiting list/prioritisation	7%
Waiting list/prioritisation	5%	Disrespectful manner/attitude	5%	Lack of access to services	4%	Lack of access to services	6%

The top five primary issues in Jul–Dec 2015 are similar to primary issues reported in previous periods. However, as mentioned above, access/funding issues have become more prominent in Jul-Dec 2015 as compared to previous periods. ‘Unexpected treatment outcome’ was also more prominent in Jul-Dec 2015, increasing from being the primary issue in around 6% of complaints in the last few six-month periods to 12% of complaints in Jul-Dec 2015.

3.2 All complaint issues

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

On analysis of all issues identified in complaints about DHBs, the most common issues were ‘inadequate/inappropriate clinical treatment’ (47.4%), ‘failure to communicate effectively with consumer’ (34.6%), ‘inadequate/inappropriate examination/assessment’ (29.9%), ‘disrespectful manner/attitude’ (28.0%), ‘inadequate response to the consumer’s complaint by the DHB’ (25.1%), ‘missed/incorrect/delayed diagnosis’ (24.6%), ‘failure to communicate effectively with family’ (24.6%) and ‘inadequate coordination of care/treatment’ (24.4%). This is broadly similar to what was seen in Jan–Jun 2015.

Also similar to the last six-month period, many complaints involved issues with a consumer’s care/treatment, such as ‘unexpected treatment outcome’ (21.6%), ‘delay in treatment’ (18.7%) ‘inadequate/inappropriate follow-up’ (18.7%), ‘inappropriate/delayed discharge/transfer’ (17.3%) and ‘inadequate/inappropriate testing’ (16.6%).

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
<i>Access/Funding</i>		
ACC compensation issue	5	1.2%
Lack of access to services	48	11.3%
Lack of access to subsidies/funding	9	2.1%
Waiting list/prioritisation issue	59	14.0%
<i>Boundary violation</i>		
Inappropriate sexual communication	2	0.7%
Other	1	
<i>Care/Treatment</i>		
Delay in treatment	79	18.7%
Delayed/inadequate/inappropriate referral	47	11.1%
Inadequate coordination of care/treatment	103	24.4%
Inadequate/inappropriate clinical treatment	200	47.4%
Inadequate/inappropriate examination/assessment	126	29.9%
Inadequate/inappropriate follow-up	79	18.7%
Inadequate/inappropriate monitoring	33	7.8%
Inadequate/inappropriate non-clinical care	25	5.9%
Inadequate/inappropriate testing	70	16.6%
Inappropriate admission/failure to admit	3	0.7%
Inappropriate/delayed discharge/transfer	73	17.3%
Inappropriate withdrawal of treatment	9	2.1%
Missed/incorrect/delayed diagnosis	103	24.4%
Personal privacy not respected	4	0.9%
Refusal to assist/attend	4	0.9%
Refusal to treat	18	4.3%
Rough/painful care or treatment	19	4.5%
Unexpected treatment outcome	91	21.6%
Unnecessary treatment/over-servicing	11	2.6%
<i>Communication</i>		
Disrespectful manner/attitude	118	28.0%
Failure to accommodate cultural/language needs	5	1.2%
Failure to communicate openly/honestly/effectively with consumer	146	34.6%
Failure to communicate openly/honestly/effectively with family	104	24.6%
Insensitive/inappropriate comments	30	7.1%
<i>Complaints process</i>		
Inadequate information provided regarding complaints process	2	0.5%
Inadequate response to complaint	106	25.1%
Retaliation/discrimination as a result of a complaint	10	2.4%
<i>Consent/Information</i>		
Coercion by provider to obtain consent	4	0.9%
Consent not obtained/adequate	25	5.9%
Inadequate information provided regarding adverse event	15	3.5%
Inadequate information provided regarding condition	23	5.5%
Inadequate information provided regarding fees/costs	3	0.7%
Inadequate information provided regarding options	12	2.8%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding provider	5	1.2%
Inadequate information provided regarding results	16	3.8%
Inadequate information provided regarding treatment	39	9.2%
Incorrect/misleading information provided	20	4.7%
Issues with involuntary admission/treatment	14	3.3%
Issues regarding consent when consumer not competent	4	0.9%
Documentation		
Delay/failure to disclose documentation	6	1.4%
Inadequate/inaccurate documentation	29	6.9%
Facility issues		
Accreditation standards/statutory obligations not met	2	0.5%
Cleanliness/hygiene issues	11	2.6%
Failure to follow policies/procedures	5	1.2%
General safety issue for consumer in facility	11	2.6%
Inadequate/inappropriate policies/procedures	23	5.5%
Issue in sharing facility with other consumers	5	1.2%
Issue with quality of aids/equipment	10	2.4%
Staffing/rostering/other HR issue	15	3.5%
Waiting times	20	4.7%
Medication		
Administration error	3	0.7%
Inappropriate administration	4	0.9%
Inappropriate prescribing	18	4.3%
Prescribing error	5	1.2%
Refusal to prescribe/dispense/supply	9	2.1%
Reports/Certificates		
Inaccurate report/certificate	14	3.3%
Other professional conduct issues		
Assault	6	1.4%
Disrespectful behaviour	12	2.8%
Inappropriate collection/use/disclosure of information	10	2.4%
Qualifications issue/use of title(s)	2	0.5%
Threatening/bullying/harassing behaviour	6	1.4%
Other issue not regarding consumer	2	0.5%
Other	2	0.5%
Teamwork/supervision		
Inadequate supervision/oversight	8	1.9%
Disability-specific issues	5	
Other issues	18	

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, with the exception of access/funding issues which have appeared in the top three primary issues for mental health and general medicine for the first time. There has also been an increase in the number of surgical complaints relating primarily to an 'unexpected treatment outcome', with this increasing from being the primary issue in around 13% of surgical complaints in previous periods to being the primary issue in 28% of surgical complaints in Jul-Dec 2015.

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

Surgery n=155		Mental health n=89		General medicine n=67		Emergency department n=54		Maternity n=24	
Unexpected treatment outcome	28%	Issues with involuntary admission/treatment	13%	Missed/incorrect/delayed diagnosis	16%	Missed/incorrect/delayed diagnosis	44%	Missed/incorrect/delayed diagnosis	25%
Waiting list/prioritisation issue	14%	Lack of access to services	11%	Lack of access to services & waiting list/prioritisation issue	9% each	Disrespectful manner/attitude	9%	Inadequate/inappropriate treatment	25%
Missed/incorrect/delayed diagnosis	13%	Inadequate examination/assessment	7%	Inadequate/inappropriate treatment	9%	Inadequate/inappropriate treatment	7%	Inadequate/Inappropriate monitoring	13%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **365**⁴ complaints involving DHBs in the period Jul–Dec 2015. 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 11	Jul– Dec 11	Jan– Jun 12	Jul– Dec 12	Jan– Jun 13	Jul– Dec 13	Jan– Jun 14	Jul– Dec 14	Jan– Jun 15	Average of last 4 6-month periods	Jul– Dec 15
Number of complaints closed	246	217	302	254	337	280	411	344	410	361	365

The total number of complaints closed for Jul–Dec 2015 shows a small increase over the average of the last four six month periods.

4.2 Outcomes of complaints closed

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

In the Jul–Dec 2015 period, **16** DHBs had no investigations closed, **2** DHBs had one investigation closed, **1** DHB had two investigations closed, and **1** DHB had three investigations closed by HDC.

The manner of resolution and outcomes of all DHB complaints closed in Jul–Dec 2015 is shown in Table 11.

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

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

Outcome for DHBs	Number of complaints closed
<i>Investigation</i>	7
Breach finding	3
No further action ⁶ with follow-up or educational comment	3
No further action	1
<i>Non-investigation</i>	342
No further action with follow-up or educational comment	64
Referred to Ministry of Health/Director-General of Health	1
Referred to Privacy Commissioner	1
Referred to District Inspector	10
Referred to DHB ⁷	95
Referred to Advocacy	16
No further action	148
Withdrawn	7
<i>Outside jurisdiction</i>	16
TOTAL	365

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

⁶ The Commissioner has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of formal investigation, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. This may happen, for example, where a DHB has carefully reviewed the case itself and no further value would be added by HDC investigating, or where another agency is reviewing, or has carefully reviewed the matter (for example, the Coroner, the Director-General of Health, or a District Inspector). Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice.

⁷ In line with their responsibilities under the Code, DHBs have increasingly developed good systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

4.3 Recommendations made to DHBs following a complaint

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

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	14
Audit	21
Meeting with consumer/complainant	2
Presentation/discussion of complaint with others	4
Provision of information to consumer	1
Provision of information to HDC	19
Reflection	2
Review of policies/procedures	22
Training/professional development	10
Total	95

The most common recommendation made to DHBs was that they review their policies/procedures (22 recommendations). When audits were recommended, they were most commonly in relation to adherence to policies/procedures, followed by compliance with documentation requirements. Training/professional development was most often recommended in relation to clinical issues, followed by communication.

5.0 Learning from complaints — HDC case reports

Administration of drug to consumer with known allergy (14HDC00157)

Background

Mrs A, an 80 year old woman, was admitted to hospital for a period of supportive rehabilitation following surgery for a hip fracture. Mrs A had previously experienced a severe adverse reaction to the antibiotic trimethoprim and wore a MedicAlert bracelet showing this.

The admitting house officer, Dr I, took a full medical history and recorded in the progress notes that Mrs A had numerous drug allergies. Dr I handwrote orange adverse reaction labels which he stuck to each page of the drug chart. In particular, the orange stickers stated: “Trimethoprim/Co-trimoxazole – toxic epidermal necrolysis”.

Two days later a registrar, Dr E, reviewed Mrs A for a suspected urinary tract infection. Dr E did not check the orange adverse reaction sticker and prescribed trimethoprim 1 x 300mg tablet to be given at night for five days. Dr E, while accepting that she made a “grievous error”, pointed to a number of systemic factors in the ward. In particular, she noted the large workload, high patient turnover, and the requirement to support and supervise junior staff, which made her vulnerable to omitting her standard check of the orange alert sticker.

That evening a nurse, RN F, administered Mrs A her first dose of trimethoprim 300mg. RN F advised that in her busyness she did not see the adverse reaction written on the adverse reaction sticker, and placed too much reliance on the fact that Mrs A would not be charted medications to which she was allergic. The following morning Mrs A was reviewed by a second registrar, Dr G, who identified that Mrs A had been given trimethoprim in error, stopped the prescription and advised nursing staff to observe Mrs A for signs suggesting an allergic reaction.

Within 24 hours Mrs A had peeling on her left inner thigh, like a burn, and both of her legs had developed blisters. Mrs A was admitted to intensive care with toxic epidermal necrolysis, a life threatening skin condition, resulting from the allergic reaction to the trimethoprim. Mrs A underwent surgery to remove damaged skin and dress her extensive lesions, but she sadly died a few days later.

Findings

The Commissioner considered that both Dr E and RN F missed several opportunities to establish Mrs A’s allergy status, including reading the notes, reviewing the drug chart, noting her MedicAlert bracelet, and asking Mrs A whether she had allergies. The Commissioner acknowledged that the ward was busy, but stated that it was Dr E’s responsibility to take the necessary steps to ensure that Mrs A was prescribed medication that was appropriate for her. The Commissioner also stated that RN F’s actions were a severe departure from accepted standards in relation to safe medication administration. Accordingly, both Dr E and RN F were found in breach of Right 4(1) of the Code.

The Commissioner’s expert advisor considered that there were several systemic issues in the ward in that the workload was high, there were concerns about staffing levels and skill mix, and the environment was confrontational. He stated: “the contribution of the work environment must not be underestimated as these errors are not made by bad doctors or nurses but by systems that fail to support the prescribers and dispensers”. The Commissioner found that the staff and systems at the DHB let Mrs A down and that the DHB failed to provide Mrs A with services with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner was also critical of suboptimal open disclosure and documentation at the DHB.

Recommendations

In accordance with the Commissioner’s recommendations, Dr E and RN F provided Mrs A’s family with a written apology. The Commissioner also recommended that the Nursing Council of New Zealand and the Medical Council of New Zealand consider whether a review of RN F’s and Dr E’s competence was warranted.

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

- provide a written apology to Mrs A's family for its breach of the Code;
- report to HDC on its involvement to date in the Health Quality and Safety Commission's National Medication Safety Programme;
- develop a policy requiring the routine checking of MedicAlert bracelets;
- report back to HDC on the recommendations outlined in its Root Cause Analysis (RCA), in particular its review of the workloads at the hospital and the measures it has instituted to identify and manage clinical risk and its review of the working environment and clinical governance of the ward;
- develop a process by which all staff are empowered to raise concerns about issues relating to patient safety, and the concerns are responded to and acted upon;
- develop a process to ensure that clinicians prescribing and administering medication are not interrupted or otherwise exposed to factors which increase errors; and
- review its policies and training on open disclosure.

These recommendations have been met by the DHB.

Delayed antibiotics for patient with sepsis (13HDC00343)

Background

Mr A, a 60 year old man, experienced sudden severe back pain several weeks after having back and shoulder surgery. He was assessed in the emergency care department (the ED) as having musculoskeletal back pain and he was discharged.

Mr A re-presented to the ED four days later with back pain and dizziness. He was assessed and found to have low blood pressure and an elevated heart rate. Blood samples were taken and X-rays were performed. At 11am, emergency care medical officer special scale (MOSS), Dr I, reviewed Mr A and queried whether Mr A had sepsis. Dr I planned to give Mr A antibiotics. However, Dr I discussed Mr A's presentation with the orthopaedic team, and they asked to review Mr A before antibiotics were given.

Mr A was reviewed that afternoon by an Intensive Care Unit (ICU) senior medical officer (SMO), Dr C, to determine whether Mr A was eligible for a trial of patients with sepsis that was being undertaken at the hospital. Dr C noted that Mr A's high INR (test of blood clotting) discounted him from the trial. Dr C felt that Mr A did not need ICU care, and noted that his blood pressure had improved.

That afternoon Mr A was also reviewed by an orthopaedic register and the medical team. The medical team noted that Mr A was hypoxic and in acute renal failure. An MRI of Mr A's lumbar spine showed a large inflammatory mass and discitis. Intravenous antibiotics were not commenced until 7:15pm.

At 11:03pm Mr A was transferred to the orthopaedic ward, but he was transferred to the High Dependency Unit shortly afterwards due to respiratory distress. At 4:30am Mr A was transferred to the ICU. He developed multiple organ failure and sadly died later that day.

Findings

The Commissioner found that although Mr A was promptly identified as having sepsis on his second presentation to ED, he should have received antibiotics soon after admission. There were missed opportunities for clinicians to recognise that because Mr A was unstable, antibiotics should not have been withheld. There was a lack of clear understanding in the ED regarding when it is appropriate to withhold antibiotics, and clinicians were reliant on an unwritten policy that did not provide guidance regarding unstable patients.

The Commissioner also found that the delay in transferring Mr A to ICU was unacceptable. The Commissioner stated: “although he was reviewed by multiple clinicians during his time in ED, no one individual identified that the seriousness of Mr A’s condition required him to be admitted to ICU, and advocated for him for this to occur. No single person had the full picture of Mr A’s condition”

The Commissioner held that these failures were the result of systems and cultural issues at the hospital. Therefore, by not providing clear direction and guidance to its staff regarding withholding antibiotics, together with the failure of multiple clinicians to exercise critical thinking, the DHB did not provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner was also critical of the management of Mr A’s pain, the delay in managing his high INR and the DHB’s record keeping, including the fact that the DHB was unable to provide HDC with some of Mr A’s postoperative records.

Recommendations

In response to this complaint, the DHB apologised to Mr A’s family and made a number of changes to its practice to prevent a similar event from occurring. The Commissioner made further recommendations to the DHB, including that it:

- report back to HDC on whether the target, that 70% of patients with probable severe sepsis will have a door to antibiotic time of less than 60 minutes, had been reached;
- evaluate the effectiveness of its guidelines on withholding of antibiotics in suspected spinal infections and any other relevant guidelines and/policies;
- review its documentation management procedures to ensure safe storage and monitored access to documentation, and report back to HDC with any changes made; and

These recommendations have been met by the DHB.

Transfer of trauma patient (13HDC00046)

Background

Mr A, a 58-year old man, was involved in an accident and sustained multiple injuries. He was taken to hospital in a critical condition, and underwent multiple surgeries. Mr A spent time in the Intensive Care Unit (ICU) and was placed under the care of the DHB’s trauma service. On discharge from ICU, Mr A’s medications included 40mg Clexane, a medication which reduces the risk of deep vein thrombosis (DVT), once a day. Mr A was transferred to the surgical ward and encouraged to mobilise. Mr A made good progress and hospital staff decided to transfer him to a rehabilitation provider.

The DHB said it was advised by the rehabilitation provider that a doctor would admit the man on arrival. The rehabilitation provider said that at no stage did it indicate that the man would be admitted by a doctor. No medical staff were contracted to work at the rehabilitation provider at the time of Mr A’s transfer.

The final arrangements for Mr A’s discharge and transfer were made late on a Friday. Public hospital staff met with Mr and Mrs A prior to discharge. Three syringes of Clexane and a prescription for analgesia were given to Mrs A to take with them. DHB staff also met with the transfer flight nurse, but the details of this meeting were not documented by DHB staff. The flight nurse’s transport record does not refer to being advised of the Clexane regime.

The public hospital discharge summary did not refer to discharge medications or to the ongoing use of Clexane, and nor did it refer to supplementary documentation which outlined the discharge medications. At 8:15pm on Friday evening, Mr A arrived at the rehabilitation provider. He was not reviewed or admitted by a doctor on arrival.

The Clexane was not given to Mr A by the staff at the rehabilitation provider. Mr and Mrs A enquired why Mr A had not yet been given Clexane. A rehabilitation nurse then telephoned the public hospital for clarification but was given erroneous advice that Clexane was no longer needed.

For two days Mr A was given inadequate pain relief at the rehabilitation provider, as confusion had arisen for the rehabilitation nursing staff in the absence of information on the hospital discharge documentation.

Four days after arriving at the rehabilitation provider, Mr A developed chest pain and sadly died.

Findings

The Commissioner commented that having undergone a significant trauma, Mr A's transfer demanded co-operation and effective communication between all staff to ensure clarity and seamless co-ordination and continuity of services, and that did not occur in this case. The Commissioner found that Mr A's co-ordination and continuity of care was compromised for the following key reasons:

- the transfer by the DHB without obtaining verbal acceptance by a doctor from the rehabilitation provider was not in accordance with DHB policy;
- transfer documentation did not contain all the relevant and important clinical information;
- DHB staff did not ensure that there were clear written instructions passed on about Mr A's Clexane regime; and
- Mr A was transferred late on a Friday.

The Commissioner considered that this case is a salutary reminder of the importance of clear and accurate communication and documentation, stating that "clear communication and accurate documentation form two of the layers of protection that operate to deliver seamless care". The DHB was found in breach of Right 4(5) of the Code for failing to ensure adequate quality and continuity of services for Mr A.

The Commissioner found that the rehabilitation provider provided unclear direction to its staff about the requirements for admission and the timing of medical review. Therefore the rehabilitation provider failed to provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code. The Commissioner was also critical that, for approximately two days, Mr A had less analgesia than he needed.

Recommendations

The Commissioner made a number of recommendations to the rehabilitation provider, including that it report back to HDC on changes made to its processes and policies for admission, its process for communication of updates and changes to policy to staff, and its medication management system.

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

- apologise to Mrs A for its breach of the Code;
- complete a random audit of Trauma Service discharge summaries for compliance with completion, accuracy, and the responsible medical team checking procedures instigated;
- report to HDC on the outcome of the DHB's internal review of the criteria for transfer of major trauma patients to facilities with or without guaranteed and immediate medical back-up, its policies for transfers occurring on Friday afternoons, and the process of critical information exchange between the hospital and the rehabilitation provider. This review should outline changes made to policy wording to ensure clarity about assigned responsibilities;
- report to HDC on the tasking of surgical RMOs to cover the Trauma Service roster so that changes to staff are minimised and discharge processes are clear and consistent; and
- report to HDC on the effectiveness of the newly introduced transfer checklist for major trauma patients.

These recommendations are due to be completed within three months of the date of this report.

Informed consent for use of haloperidol (13HDC01252)

Background

Mrs A, an 86 year old woman, was admitted to a public hospital for investigations into a medical condition. Mrs A had a complex medical history, including dementia. At the time of her admission Mrs A was noted to have had a recent fall, and was confused. Mrs A's daughter, Mrs B, had previously been appointed to be her Enduring Power of Attorney (EPOA) for personal care and welfare, although the EPOA had not been activated.

At hospital Mrs A was thought to have delirium in addition to cognitive impairment. Mrs B was advised that Mrs A's behaviour was disrupting the ward, and Mrs A was prescribed low dose haloperidol (an antipsychotic) to be administered two-hourly as required. Mrs A was not assessed to ascertain whether she was competent to consent to the proposed treatment, and there was no evidence of any discussion with Mrs A or Mrs B about the treatment.

Following Mrs A's discharge from hospital, Mrs A's GP stopped prescribing haloperidol. Mrs B considered that the haloperidol led to a deterioration in Mrs A's condition, in that prior to the hospital admission, Mrs A had been able to walk well without an aid, but following discharge she shuffled, took small steps, had a blank expression, and was unable to get in and out of bed by herself.

A short time later Mrs A was readmitted to hospital as she had not managed at home and was considered to have a severe risk of suffering falls. A cognitive assessment was not fully completed at admission. Mrs B requested that haloperidol not be administered to Mrs A; however it was administered without consent on five occasions when Mrs A was agitated or non-compliant with cares. The haloperidol was subsequently ceased and replaced with an alternative antipsychotic.

Findings

The Deputy Commissioner found that the hospital clinicians failed to be clear as to the legal basis on which haloperidol was being administered to Mrs A. There was a lack of consideration as to who was able to provide informed consent to the administration of haloperidol. As a result, appropriate steps were not taken regarding that administration, either in terms of consent from Mrs A herself if there were no reasonable grounds for believing she was incompetent, or if there were reasonable grounds for believing that she was incompetent, within the terms of Right 7(4) of the Code after appropriate consultation with Mrs B. Accordingly, the DHB was found in breach of Right 7(1) of the Code.

The Deputy Commissioner was also concerned that the use of haloperidol during Mrs A's second admission was unwise, and the issue of cessation of the haloperidol should have been discussed and considered earlier during that admission. Furthermore, the Deputy Commissioner considered the overall standard of communication between the DHB, Mrs A and Mrs B could have been much improved. It was also noted that the DHB should have updated Mrs B more regularly when she complained to them about Mrs A's care, as to the progress of that complaint.

The Deputy Commissioner also found that there was a pattern of suboptimal documentation by numerous DHB staff in this case. For example, there were no neurological examinations documented, there was no documentation that explained the rationale for the prescribing of haloperidol, the poor legibility of the records meant that the doctor who first prescribed the haloperidol could not be identified and assessment documentation was not fully completed at either admission. Accordingly the DHB was found in breach of Right 4(2) of the Code for failing to comply with legal standards.

Recommendations

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

- apologise to Mrs B for its breaches of the Code;
- review the medical ward admission processes;
- conduct an audit of a random selection of dementia patient admission notes from the last 12 months for compliance and completion of admission and cognitive assessment

documentation. This audit should include the recording of contact details for a liaising family member and any individuals holding EPOA for personal care and welfare, and clearly ascertaining whether the EPOA has been formally activated by medical certification before decisions were made regarding significant matters and the appropriate documents sighted by staff;

- update the DHB's Older Persons Health Specialist Service (OPHS) guidelines and the DHB policy on informed consent, and implement a process that ensures and records that pertinent patient information obtained on admission includes that of cognitive functioning and assessment of competency, and this is brought to the attention of the senior clinician with primary responsibility for the patient, and is included in the patient care plan;
- provide HDC with a copy of the general medical admission document, which now has a specific section prompting a neurological examination for patients with dementia and/or delirium;
- provide HDC with a copy of the "4 Questions Form" developed to improve communication with patients and their families by outlining basic information regarding the current working diagnosis and management plan, together with a copy of the revised Patient Admission Questionnaire, Risk Screening/Assessment and care plans now in use; and
- survey OPHS nursing staff regarding knowledge of how to access online and web-based procedures governing care of elderly patients with delirium or dementia.

These recommendations have been met by the DHB.