Complaints to HDC involving District Health Boards

Report and Analysis for period 1 July to 31 December 2014

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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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 2014.

The trends within this report continue to be consistent with those seen in previous reports. Over half of all complaints received in July to December 2014 about DHBs were primarily about care/treatment issues. The most prominent specific primary issue continues to be that of a missed, incorrect or delayed diagnosis, which was the primary issue in around 15% of complaints about DHBs. When we consider all issues raised in DHB complaints, we see that concerns about communication continue to feature in around a quarter of complaints, with failure to communicate effectively with the consumer showing an increase within this period as compared to last period. Communication is a key component of a consumer-centred culture. As I have noted previously, in the margins where we do not do well, culture often plays a part. It is seen in the failure to speak up, to raise a question, to make the connection, to listen – to patients, family, colleagues. That is why I am so focussed on cultures that empower people; cultures that embody transparency, engagement, and seamless services; cultures that put consumers at the centre of services.

I trust that this report will prove useful to you. I continue to welcome your feedback on how we can further improve the usefulness of these reports.

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 2014, HDC received a total of **368** complaints about care provided by all District Health Boards. Numbers of complaints received in previous six month periods are reported in Table 1.

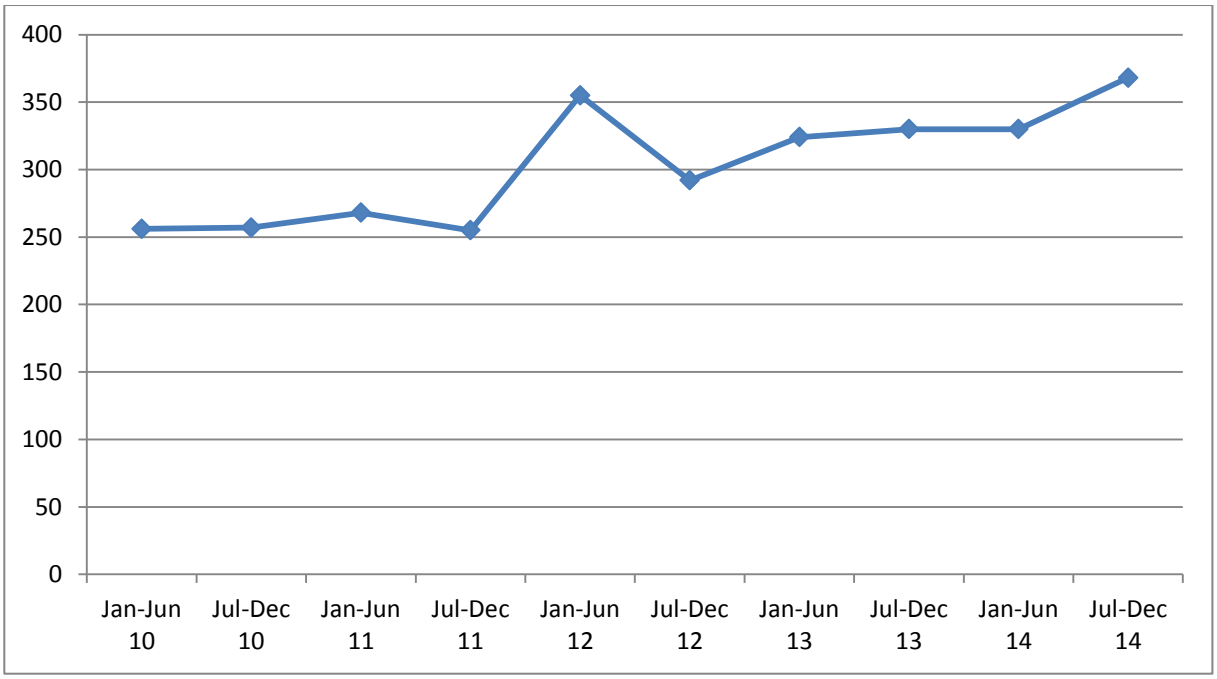
Table 1. Number of complaints received in last five years

	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Average of last 4 6-month periods	Jul–Dec 14
Number of complaints	256	257	268	255	355	292	324	330	330	**319**	**368**

The total for Jul–Dec 2014 (368) shows an increase of 15% over the average number of complaints received for the previous four periods.

The number of complaints received in Jul–Dec 2014 and previous six month periods are also displayed below in Figure 1. The number of complaints received in Jul–Dec 2014 is the highest number of complaints about DHBs ever received in a six month period.

Figure 1. Number of complaints received



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, 11 March 2015).

Table 2. Rate of complaints received per 100,000 discharges during Jul–Dec 2014

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
368	477,859[1]	**77.01**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jul–Dec 2014 and previous six month periods.

Table 3. Rate of complaints received in last five years

	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14[2]	Average of last 4 6-month periods	Jul–Dec 14
Rate per 100,000 discharges	60.19	57.16	62.48	55.86	80.22	62.59	72.67	71.15	72.99	**69.85**	**77.01**

The rate of complaints received during Jul–Dec 2014 (77.01) shows a 10% increase over the average rate of complaints received for the previous four periods.

Table 4 shows the rate of complaints about DHBs received by HDC per 100,000 discharges for each DHB (not named[3]) relative to other DHBs for Jul–Dec 2014. Each DHB's complaint rate on Table 4 can be identified from its individual report.

All individual DHBs were subject to some complaints to HDC. As shown in Table 4, for individual DHBs, the rate of complaints received ranged from 41.65 complaints per 100,000 discharges to 146.20 complaints per 100,000 discharges as compared to the national rate of 77.01 complaints per 100,000 discharges. The raw number of complaints received about individual DHBs ranged from 3 complaints to 47 complaints.

[1] The total number of discharges excludes short stay emergency department discharges and patients attending outpatient units and clinics.

[2] The rate for Jan–Jun 2014 has been recalculated based on the most recent discharge data.

[3] Individual DHBs have not been named in this report given the small sample size and the short period covered (six months).

Table 4. Rate of complaints received per 100,000 discharges

DHB	Rate of complaints to HDC per 100,000 discharges	DHB	Rate of complaints to HDC per 100,000 discharges
DHB 1	41.65	DHB 11	81.02
DHB 2	44.05	DHB 12	87.98
DHB 3	51.26	DHB 13	111.39
DHB 4	54.92	DHB 14	115.77
DHB 5	55.82	DHB 15	115.79
DHB 6	67.62	DHB 16	118.57
DHB 7	75.80	DHB 17	121.61
DHB 8	78.00	DHB 18	132.16
DHB 9	78.58	DHB 19	142.35
DHB 10	80.39	DHB 20	146.20
		All DHBs	**77.01**

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 368 complaints about DHBs, 387 services were complained about.

The five service types with the greatest number of complaints were surgery (27.1%), mental health (20%), general medicine (19.1%), accident and emergency (9.5%) and maternity (6.7%). This is broadly similar to what was seen last period.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Accident and emergency (including paramedics)	**37**	**9.6%**
Aged care (long-term care facility)	**1**	**0.3%**
Alcohol and drug	**4**	**1.0%**
Anaesthetics/pain medicine	**5**	**1.3%**
Dental	**4**	**1.0%**
Diagnostics	**11**	**2.8%**
Disability services	**6**	**1.6%**
District nursing	**1**	**0.3%**
General medicine	**74**	**19.1%**
Cardiology	7	1.8%
Dermatology	1	0.3%
Endocrinology	1	0.3%
Gastroenterology	6	1.6%
Geriatric medicine	8	2.1%
Hepatology	1	0.3%
Infectious diseases	4	1.0%
Neurology	9	2.3%
Oncology	11	2.8%
Palliative care	3	0.8%
Renal/nephrology	1	0.3%
Respiratory	4	1.0%
Rheumatology	1	0.3%
Other/unspecified	17	4.4%
Hearing services	**1**	**0.3%**
Intensive care/critical care	**5**	**1.3%**
Maternity	**26**	**6.7%**
Mental health	**77**	**20.0%**
Paediatrics (not surgical)	**16**	**4.1%**
Rehabilitation services	**9**	**2.3%**
Surgery	**105**	**27.1%**
Cardiothoracic	4	1.0%
General	22	5.7%
Gynaecology	14	3.6%
Neurosurgery	5	1.3%
Ophthalmology	3	0.8%
Orthopaedics	30	7.8%
Otolaryngology	6	1.5%
Paediatric	2	0.5%
Plastic and Reconstructive	3	0.8%
Urology	15	3.9%
Vascular	1	0.3%
Vision/eye services (not surgical)	**1**	**0.3%**
Other health service	**2**	**0.5%**
Outside jurisdiction	**2**	**0.5%**
TOTAL	**387**	

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 listed in only one complaint are classified as 'other'. The primary issues identified in complaints received in Jul–Dec 2014 are listed in Table 6.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***41***	***11.1%***
Lack of access to services	15	4.1%
Lack of access to subsidies/funding	4	1.1%
Waiting list/prioritisation issue	21	5.7%
Other	1	0.3%
Boundary violation	***1***	***0.3%***
Inappropriate sexual communication	1	0.3%
Care/Treatment	***201***	***54.6%***
Delay in treatment	5	1.4%
Delayed/inadequate/inappropriate referral	3	0.8%
Inadequate coordination of care/treatment	7	1.9%
Inadequate/inappropriate clinical treatment	39	10.6%
Inadequate/inappropriate examination/assessment	13	3.5%
Inadequate/inappropriate follow-up	4	1.1%
Inadequate/inappropriate monitoring	4	1.1%
Inadequate/inappropriate non-clinical care	12	3.3%
Inadequate/inappropriate testing	2	0.5%
Inappropriate/delayed discharge/transfer	13	3.5%
Inappropriate withdrawal of treatment	5	1.4%
Missed/incorrect/delayed diagnosis	54	14.8%
Refusal to treat	7	1.9%
Rough/painful care or treatment	5	1.4%
Unexpected treatment outcome	24	6.5%
Other	4	1.1%
Communication	***46***	***12.5%***
Disrespectful manner/attitude	19	5.2%
Failure to accommodate cultural/language needs	2	0.5%
Failure to communicate openly/honestly/effectively with consumer	8	2.2%
Failure to communicate openly/honestly/effectively with family	16	4.3%
Other	1	0.3%
Complaints process	***8***	***2.2%***
Inadequate response to complaint	8	2.2%
Consent/Information	***29***	***7.9%***
Consent not obtained/adequate	9	2.4%
Inadequate information provided regarding adverse event	3	0.8%
Inadequate information provided regarding condition	2	0.5%
Inadequate information provided regarding results	2	0.5%
Inadequate information provided regarding treatment	2	0.5%
Issues regarding consent when consumer not competent	2	0.5%
Issues with involuntary admission/treatment	9	2.4%

Primary issue in complaints	Number of complaints	Percentage
Documentation	***11***	***3.0%***
Delay/failure to disclose documentation	3	0.8%
Inadequate/inaccurate documentation	7	1.9%
Other	1	0.3%
Facility issues	***6***	***1.6%***
Staffing/rostering/other HR issue	2	0.5%
Waiting times	2	0.5%
Other	2	0.5%
Medication	***11***	***3.0%***
Inappropriate prescribing	6	1.6%
Prescribing error	2	0.5%
Refusal to prescribe/dispense/supply	2	0.5%
Other	1	0.3%
Reports/Certificates	***4***	***1.1%***
Inaccurate report/certificate	4	1.1%
Other professional conduct issues	***4***	***1.1%***
Inappropriate collection/use/disclosure of information	3	0.8%
Other	1	0.3%
Disability-specific issues	***3***	***0.8%***
Other issues	***3***	***0.8%***
TOTAL	***368***	

The most common primary issue categories in complaints concerned care/treatment (54.6%), communication (12.5%) and access/funding (11.1%). Among these, the most common specific primary issues in complaints about DHBs were 'missed/incorrect/delayed diagnosis' (54 complaints), 'inadequate/inappropriate clinical treatment' (39 complaints), 'unexpected treatment outcome' (24 complaints), 'waiting list/prioritisation issue' (21 complaints) and 'disrespectful manner/attitude' (19 complaints). This is broadly similar to what was seen in the previous six month period, with the exception of 'waiting list/prioritisation issue' which appears in the most common specific primary issues for the first time.

Table 7 shows a comparison over time for the top five primary issue categories complained about. Please note that, due to the introduction of new categories, comparisons over time have limitations.

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

Top five primary issues in all complaints (%)							
Jan–Jun 13 n=324		**Jul–Dec 13 n=330**		**Jan–Jun 14 n=330**		**Jul–Dec 14 n=368**	
Treatment	57%	Treatment	55%	Treatment	60%	Treatment	55%
Communication	15%	Communication	12%	Communication	10%	Communication	13%
Access/Funding	9%	Consent/ Information	9%	Access/Funding	9%	Access/funding	11%
Consent/ Information	8%	Medication	7%	Consent/ Information	7%	Consent/ Information	8%
Medication and Professional conduct	3% each	Access/Funding	6%	Medication	4%	Medication and Documentation	3% each

The top five categories of primary issues in Jul–Dec 2014 are similar to primary issues reported in previous periods. Treatment and communication are consistently the most common primary issues across all periods.

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 listed in only one complaint are classified as 'other'.

On analysis of all issues identified in complaints about DHBs, the five most common issues were 'inadequate/inappropriate clinical treatment' (39.9%), 'failure to communicate effectively with consumer' (34.2%), 'inadequate/inappropriate examination/assessment' (25.5%), 'disrespectful manner/attitude' (23.1%), 'failure to communicate effectively with family' (22.8%), 'missed/incorrect/delayed diagnosis' (22.3%), and 'inadequate response to the consumer's complaint by a DHB' (21.7**%**). This is broadly similar to what was seen in Jan–Jun 2014, with 'inadequate/inappropriate examination/assessment' increasing from being an issue in 17.3% of complaints to being mentioned in 25.5% of complaints received during Jul–Dec 2014, and 'failure to communicate effectively with consumer' increasing from being mentioned in 27.6% of complaints last period to being an issue in 34.2% of complaints in this period. 'Missed/incorrect/delayed diagnosis', on the other hand, decreased from being an issue in 28.2% of complaints in Jan–Jun 2014 to being mentioned in 22.3% of complaints made during this period.

Also similar to last period, many complaints involved issues with a consumer's care/treatment, such as 'inadequate coordination of care/treatment' (19.6%), 'unexpected treatment outcome' (15.5%), 'delay in treatment' (13.9%), and 'inadequate/inappropriate testing' (13.0%).

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding		
ACC compensation issue	14	3.8%
Lack of access to services	37	10.1%
Lack of access to subsidies/funding	6	1.6%
Waiting list/prioritisation issue	25	6.8%
Boundary violation		
Inappropriate sexual communication	1	0.3%
Care/Treatment		
Delay in treatment	51	13.9%
Delayed/inadequate/inappropriate referral	38	10.3%
Inadequate coordination of care/treatment	72	19.6%
Inadequate/inappropriate clinical treatment	147	39.9%
Inadequate/inappropriate examination/assessment	94	25.5%
Inadequate/inappropriate follow-up	46	12.5%
Inadequate/inappropriate monitoring	25	6.8%
Inadequate/inappropriate non-clinical care	39	10.6%
Inadequate/inappropriate testing	48	13.0%
Inappropriate admission/failure to admit	6	1.6%
Inappropriate/delayed discharge/transfer	46	12.5%
Inappropriate withdrawal of treatment	11	3.0%
Missed/incorrect/delayed diagnosis	82	22.3%
Personal privacy not respected	9	2.4%
Refusal to assist/attend	18	4.9%
Refusal to treat	21	5.7%
Rough/painful care or treatment	20	5.4%
Unexpected treatment outcome	57	15.5%
Other	1	
Communication		
Disrespectful manner/attitude	85	23.1%
Failure to accommodate cultural/language needs	7	1.9%
Failure to communicate openly/honestly/effectively with consumer	126	34.2%
Failure to communicate openly/honestly/effectively with family	84	22.8%
Insensitive/inappropriate comments	23	6.3%
Complaints process		
Inadequate response to complaint	80	21.7%
Other	4	
Consent/Information		
Coercion by provider to obtain consent	3	0.8%
Consent not obtained/adequate	20	5.4%
Failure to assess capacity to consent	3	0.8%
Inadequate information provided regarding adverse event	9	2.4%
Inadequate information provided regarding condition	25	6.8%
Inadequate information provided regarding options	8	2.2%
Inadequate information provided regarding results	7	1.9%
Inadequate information provided regarding treatment	26	7.1%

All issues in complaints	Number of complaints	Percentage
Incorrect/misleading information provided	19	5.2%
Issues regarding consent when consumer not competent	5	1.4%
Issues with involuntary admission/treatment	11	3.0%
Other	1	
Documentation		
Delay/failure to disclose documentation	10	2.7%
Delay/failure to transfer documentation	5	1.4%
Inadequate/inaccurate documentation	48	13.0%
Inappropriate maintenance/disposal of documentation	5	1.4%
Other	1	
Facility issues		
Cleanliness/hygiene issues	5	1.4%
Failure to follow policies/procedures	6	1.6%
General safety issue for consumer in facility	5	1.4%
Inadequate/inappropriate policies/procedures	12	3.3%
Issue with quality of aids/equipment	3	0.8%
Issue with sharing facility with other consumers	4	1.1%
Staffing/rostering/other HR issue	16	4.3%
Waiting times	6	1.6%
Other	2	
Fees/costs		
Cost of treatment	2	0.5%
Medication		
Administration error	4	1.1%
Inappropriate prescribing	24	6.5%
Prescribing error	4	1.1%
Refusal to prescribe/dispense/supply	13	3.5%
Other	3	
Reports/Certificates		
Inaccurate report/certificate	13	3.5%
Other	3	
Training/Supervision		
Inadequate supervision/oversight	9	2.4%
Other professional conduct issues		
Inappropriate collection/use/disclosure of information	12	3.3%
Other	6	
Disability-specific issues	***7***	
Other issues	***11***	

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 last period, with the exception of surgery services, where 'waiting list/prioritisation issue' has become the most common primary issue for the first time.

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

Surgery n=105		**Mental health n=77**		**General medicine n=74**		**Accident & emergency n=37**		**Maternity n=26**	
Waiting list/ prioritisation	16%	Issues with involuntary admission/ treatment	12%	Missed/ incorrect/ delayed diagnosis	16%	Missed/ incorrect/ delayed diagnosis	38%	Inadequate/ inappropriate treatment	31%
Unexpected treatment outcome	12%	Failure to communicate effectively with family	9%	Inadequate/ inappropriate care	11%	Inadequate/ inappropriate treatment	14%	Missed/ incorrect/ delayed diagnosis	12%
Misdiagnosis and inadequate treatment	11% each	Inadequate/ inappropriate treatment	8%	Inadequate/ inappropriate treatment	8%	Disrespectful attitude/ manner	11%	Unexpected treatment outcome	12%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **344**[4] complaints involving DHBs in the period Jul–Dec 2014. 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 10	**Jul–Dec 10**	**Jan–Jun 11**	**Jul–Dec 11**	**Jan–Jun 12**	**Jul–Dec 12**	**Jan–Jun 13**	**Jul–Dec 13**	**Jan–Jun 14**	**Average of last 4 6-month periods**	**Jul–Dec 14**
Number of complaints closed	262	257	246	217	302	254	337	280	411	**321**	**344**

The total number of complaints closed for Jul–Dec 2014 shows an increase of 7% over the average of the last four six month periods.

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

4.2 Outcomes of complaints closed

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 2014 period, **10** DHBs had no investigations closed, **6** DHBs had one investigation closed, and **4** DHBs had two investigations closed by HDC.

The manner of resolution and outcomes of all DHB complaints closed in Jul–Dec 2014 is shown in Table 11.

Table 11. Outcome for DHBs of complaints closed by complaint type[5]

Outcome for DHBs	Number of complaints closed
Investigation	***12***
Breach finding	4
No further action[6] with follow-up or educational comment	6
No further action	2
Non-investigation	***310***
No further action with follow-up or educational comment	67
Referred to District Inspector	4
Referred to DHB[7]	65
Resolved by DHB	1
Referred to Advocacy	23
No further action	141
Withdrawn	9
Outside jurisdiction	***22***
TOTAL	**344**

[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	17
Audit	24
Meeting with consumer/complainant	3
Reflection	7
Presentation/discussion of complaint with others	4
Provision of information	18
Review of policies/procedures	33
Training/professional development	16
Total	**122**

The most common recommendation made to DHBs was that they review their policies/procedures (33 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, documentation and communication.

5.0 Learning from complaints — HDC case reports

Assessment and monitoring of an elderly man with dementia (12HDC00630)

Background

Mr A, aged 87 years, had been suffering from worsening dementia. His son, Mr B, held an enduring power of attorney (EPOA) as to Mr A's personal care and welfare, but this had not been activated.

Mr A was admitted to a public hospital with blood-tinged urine. His prescribed medications were recorded in his notes, but Mr B advised the hospital pharmacist that Mr A was non-complaint with his medications. The hospital pharmacist therefore crossed out the medications and wrote in the progress notes that the medication had been stopped. However, Mr A was administered his prescribed medication during his admission (including aspirin).

During his admission, Mr A had an unwitnessed fall. Neurological observations were carried out on the day of the fall, but were then discontinued, despite the DHB's policy requiring on-going observations. Mr A's mental state deteriorated and he was later placed on observations every 15 minutes due to his disruptive behaviour and wandering.

Two days later the registered nurse (RN) caring for the man, RN C, failed to undertake a number of the required checks. RN C handed over his patients to a second RN before taking his meal break, but did not tell the second RN to check Mr A at 15 minute intervals, or when Mr A had last been checked. RN C returned an hour later and realised that Mr A was missing. RN C contacted Security, who understood from that conversation that Mr A had gone missing in the previous 10 minutes. CCTV footage later confirmed that Mr A had left the ward approximately two hours earlier.

A member of the public found Mr A at a bus stop and called an ambulance. He was then taken back to the hospital, where he was found to have a large bilateral subdural haematoma. A registrar discussed Mr A's poor prognosis with Mr B at the bedside, which Mr B felt was inappropriate. Mr A later died in hospital. Mr B was concerned that the administration of aspirin during Mr A's admission may have contributed to his death.

Findings

RN C was found in breach of Right 4(1) of the Code for not making all the required checks, failing to hand over Mr A's care adequately and failing to ascertain the correct information and convey it to Security after he discovered Mr A was missing.

The DHB was found in breach of Right 4(1) of the Code for failing to ensure that its staff carried out the required neurological observations following Mr A's fall and failing to take action as his condition deteriorated. The DHB also had no formal process for meal break handover of patients by nurses, visual handover was not required, and there was no structure in place to ensure that appropriate staff were present during meal breaks.

Adverse comments were made about the DHB's failure to clarify the medications Mr A was receiving in the community or whether the EPOA had been activated, and in relation to the DHB's communication with Mr A and Mr B.

Recommendations

The Deputy Commissioner made a number of recommendations to the DHB, including that the DHB provide Mr A's family with an apology. The DHB was also asked to arrange for an audit of the documentation practices in the general medical ward, review its handover processes and review the training of nursing staff in the medical division regarding the care of elderly patients with dementia. The DHB has complied with all of these recommendations.

Inappropriate prescription of narcotic medication (12HDC01608)

Background

Mr A, an elderly man with complex co-morbidities including chronic renal impairment, was admitted to hospital for the management of an acutely ischaemic leg. Mr A underwent an angioplasty and his pain was noted to have improved postoperatively. Mr A was reviewed by the surgical registrar, Dr C, and the decision was made to discharge Mr A home on either the Sunday or Monday.

On Sunday morning, Dr C reviewed Mr A and changed his analgesic medication from fentanyl to Sevredol. However, Dr C did not document a discharge management plan or any details of the decision to prescribe Sevredol.

Later that day, the on-call surgical house officer, Dr D, was contacted by a nurse who requested that Dr D write a prescription for antibiotics and analgesia for Mr A so that he could be discharged. Dr D noted that Mr A had been prescribed Sevredol earlier that day by Dr C, so wrote a prescription for the same dose that had already been prescribed. Dr D did not complete the discharge documentation.

Mr A was then discharged and returned home. He took his medication as prescribed, including a total of five 10mg Sevredol tablets. The following morning Mr A was found unconscious by his daughter. He was later admitted to hospital and treated for opioid toxicity. Sadly, Mr A died a short time later.

Findings

Adverse comment was made that Dr C failed to critically assess the appropriateness of prescribing Sevredol to Mr A, given that his pain was already well-managed and he had renal impairment. The Commissioner found that having made the decision to prescribe such medication, Dr C should have proceeded with caution. The Commissioner also said that Dr C's failure to document a discharge plan and the decision to prescribe Sevredol and its monitoring requirements, demonstrated a lack of caution that placed Mr A at an unnecessary risk of harm. Accordingly, Dr C was found in breach of Right 4(4) of the Code.

Criticisms were made of aspects of the care Dr D provided, in particular the failure to critically question the prescription of Sevredol in a man who had renal impairment and the failure to complete any discharge documentation.

The DHB was found in breach of Right 4(1) of the Code for failing to ensure that its staff provided Mr A with an appropriate standard of care which had resulted from a sequence of poor communication and coordination of care, coupled with suboptimal documentation of the discharge plan.

Recommendations

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

- Undertake monthly monitoring of discharge summaries to ensure its on-going supervision and monitoring of staff in relation to compliance with its discharge policies.
- Review its current policies and procedures with regards to discharges, in particular weekend discharges, especially in relation to the communication of discharge plans.
- Provide a report to HDC on the outcome of its most recent audit of compliance with the Admission to Discharge Plan and other aspects of discharge planning.
- Use the anonymised version of this report for education purposes, highlighting in particular the concerns raised about culture, communication and coordination of care.

Supervision of a registrar during a labour and delivery (13HDC00093)

Background

Mrs A went into labour at 40 weeks plus 9 days' gestation. Cardiotocography monitoring showed deep fetal heart rate decelerations and the obstetrics registrar, Dr B, was called to review Mrs A. Dr B, who at the time of these events had only been working at the DHB for two weeks, reviewed Mrs A and immediately called the on-call obstetrics consultant, Dr C. The doctors have different

recollections of the telephone conversation, but both recall that the plan was to attempt a trial of forceps and, if unsuccessful, to proceed to a Caesarean section. Dr B understood that she was to carry out the procedures unsupervised, while Dr C understood that he was to attend.

Dr B proceeded with a trial of forceps delivery unsupervised, which was unsuccessful, and then she proceeded with the Caesarean section. While Dr C had arrived in the delivery suite at the time the above procedures were commenced, he was intercepted on his way to Mrs A by another obstetric emergency.

Dr B was unable to deliver Baby A as the baby's head was impacted in the pelvis. Dr C arrived shortly after, and delivered Baby A. Baby A was born white and floppy with the umbilical cord wrapped around her neck. Baby A was resuscitated and transferred to the Neonatal Intensive Care Unit, but sadly passed away.

Findings

The Commissioner found that the hospital policy for triaging obstetric emergencies and the senior medical officer cascade process was not followed. Furthermore, the orientation and induction of Dr B had not been appropriate, in that Dr B was unaware of the level of supervision she required. For not ensuring that its staff was sufficiently supported, and that its obstetrics policies and procedures were followed the DHB was found in breach of Right 4(1) of the Code.

The Commissioner stated that "consultant oversight and input provides an important safety net … as the senior supervising clinician, the obstetrics consultant had a responsibility to ensure that his instructions were communicated clearly and were understood". Accordingly, Dr C was found in breach of Right 4(1) of the Code for inappropriate supervision of Dr B. The Commissioner also expressed concern about the time it took Dr C to arrive at the hospital after being called and that he did not obtain an update on Mrs A's condition before attending the other obstetric emergency.

The Commissioner was critical of Dr B for proceeding with the delivery unsupervised and not recognising that she was out of her depth. However, Dr B had not been informed of the DHB's credentialing and supervision requirements, believed that Dr C had instructed her to proceed unsupervised; and the clinical situation was worsening and there was no senior consultant available immediately. In these circumstances, the Commissioner did not find Dr B in breach of the Code.

Recommendations

The DHB, Dr B and Dr C apologised to Mrs A and her husband. The Commissioner also made a number of recommendations to the DHB, including:

- Liaising with Mrs A and her husband in order to ascertain whether they would like to meet with the staff involved in Mrs A and Baby A's care in order to address the content of this report and arranging such a meeting if this is their wish.
- Review and update its policies to ensure that consultant attending times are outlined clearly and staff are advised of these requirements.
- The provision of an education seminar on calling categories, as per its 'Obstetrics Surgery/Procedures Triage' policy, including examples of when it is to be used, to all obstetric consultants and registrars.
- The provision of an education seminar on the cascade process, including examples of when it is to be used, to all obstetric consultants and associate charge midwives.
- The development of a supervision of obstetric and gynaecology registrars policy, similar to the DHB's 'Credentialing of Senior Medical Officers' (QLR-06).

These recommendations have been met by the DHB.

Monitoring of patient with pneumonia and documentation of care (**12HDC00548**)

Background

Mrs A was admitted to the critical care unit of a public hospital suffering from lower lobe pneumonia. While in the critical care unit Mrs A's health was variable. After several weeks, continuous monitoring, including ECG monitoring for heart rate, heart rhythm and respiratory rate, was stopped. It is not clear who made this decision and the decision was not documented in the notes. Only pulse oximetry, which monitored Mrs A's oxygen saturation via finger probe, remained in place. At times, Mrs A removed the finger probe.

Five days later, Mrs A was found to have suffered a cardiac arrest. She was not wearing her finger probe. The exact time of her arrest is unknown. Mrs A's family agreed that she was not for resuscitation. The day following her arrest she was taken off ventilation and she died the following day.

Findings

The Commissioner commented that adequate monitoring, together with vigilant staff, are core capabilities of intensive care units. Mrs A was in the critical care unit because she required intensive care, however, she was not monitored adequately and, as a result, her cardiac arrest was not noticed immediately. The Commissioner found that Mrs A should have been subject to continuous monitoring and the DHB should have in place robust guidelines to ensure that every patient is monitored appropriately while in the critical care unit. Therefore, the DHB was found in breach of Right 4(1) of the Code.

In addition, various aspects of Mrs A's care were not fully documented in the clinical notes, including her having removed her finger probe, decisions around when she was to be discharged to the ward, and, following her cardiac arrest, her treatment plan. The Commissioner considered that there was a pattern of suboptimal clinical documentation amongst multiple clinical staff, indicating a lax attitude towards documentation at the DHB. Therefore, the DHB was found in breach of Right 4(2) of the Code for failing to comply with legal standards.

Adverse comment was made in relation to the DHB's failure to mitigate the risk presented by Mrs A removing her finger probe.

Recommendations

The Commissioner recommended that the DHB review the Critical Care Unit Observations and Monitoring Guidelines and consider including a requirement that all patients must have appropriate monitoring until the patient is transferred to the ward. It was also recommended that the DHB carry out an audit of monitoring and documentation in that unit along with compliance with the modified Observations and Monitoring Guidelines. The DHB was asked to write a letter of apology to Mrs A's family that highlighted the changes the DHB had made since these events. The DHB has complied with all of these recommendations.