Health Complaints Commissioner Tasmania

ANNUAL REPORT

2019-2020

Health Complaints Commissioner

Annual Report 2019-2020

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Letter to Parliament

The Honourable President of the Legislative Council
The Speaker of the House of Assembly

Pursuant to section 12 of the *Health Complaints Act 1995*, I present to the Parliament the annual report of the Health Complaints Commissioner for 2019-2020.

Yours sincerely

Richard Connock
HEALTH COMPLAINTS COMMISSIONER

3 November 2020

About this Report

This report describes the functions and operations of the Health Complaints Commissioner Tasmania for the year ending 30 June 2020.

It is available in print or electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with a disability. Requests should be directed to the Executive Officer at 1800 001 170 or Health.Complaints@ombudsman.tas.gov.au.

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From the Health Complaints Commissioner

This annual report is made pursuant to section 12 of the *Health Complaints Act 1995* (the Act), and details the work of my Office during the 2019-20 reporting year.

Introduction

It had been my hope in 2019-20 to continue the positive momentum of 2018-19 by: recruiting staff on a permanent basis to positions which had remained vacant for many years; seeking amendments to the *Health Complaints Act 1995* to help streamline processes; and continuing to build relationships with key stakeholders which had been re-established last year after several years of change within both the Tasmanian Health Service (THS) and the Australian Health Practitioner Regulation Agency (AHPRA).

Unfortunately, as with every other workplace in Tasmania, COVID-19 brought extra challenges to our work this year, over and above the long standing issues/problems noted below. The requirement to work remotely, in some case without access to office resources, recognition of the difficulties being faced by health service providers throughout these unprecedented times, and the inability to meet or speak with people necessary to progress complaints, all impacted on our complaint management as well as our ability to progress the initiatives foreshowed last year.

Despite this a number of difficult and highly complex cases which had been ongoing for a number of years were closed and a number of significant outcomes were achieved and improvements in the delivery of health services implemented over the reporting year because of the assessment and conciliation of complaints received by this Office.

Case summaries highlighting some of these improvements and the diversity and complexity of our work appear at the end of this report. Other examples will be published on our website.

Enquiry and Complaint Management

One of the consequences of COVID-19 has been a blurring in our statistics of the distinction between complaints and enquiries. The requirement to work from home without access to our case management system meant that cases that would normally have been recorded as complaints remained open as enquiries. This resulted in an increase in the number of matters being recorded as opened and closed as enquires and a decrease in the number of matters recorded as opened and closed as complaints compared with last year.

The end result however (when also combined with notifications from AHPRA) was a 8.6% increase in overall number of cases received compared with last year (904 to 982) and a 2.5% increase in the overall number of cases closed (972 to 997).

Staffing

Steps were taken at the beginning of the reporting year to address the historically low staffing levels in the Health Complaints' team, with fixed term appointees to a Senior Investigation Officer (0.6 FTE) and Intake and Assessment Officer last year being made permanent. Recruitment to these positions notionally brought the health team up to 4.4 FTEs, however long term absences of two members of the team, coupled with the inability to recruit and backfill positions during COVID-19 resulted once again in extensive periods where the team was reduced to just 3 FTEs.

Delays

I have reported over the previous four reporting years on the time it can take to obtain responses from the Tasmanian Health Service (THS). After a further restructure in July 2018 and the restoration of local consumer engagement officers in each region, I was hopeful that there would be a reduction in response times. I reported last year that after a period of bedding down there appeared to be some improvement but the loss of experienced officers and numerous changes in personnel resulted once again in significant delays in obtaining meaningful responses in some cases. Unfortunately this persisted throughout this reporting year, with delays in some cases of more than 12 months. I acknowledge that the impact of COVID-19 on THS and its staff members would have been enormous for the last four months of the reporting year and I am pleased to report that at the time of writing this report there appears to have been a marked improvement.

We continue to experience significant delays in obtaining responses from AHPRA with whom we are required to consult in relation to all complaints received about registered practitioners. During this period we are required to wait until AHPRA makes a decision as to whether they seek referral of the matter. We are unable to assess a complaint until this consultation process is complete. Unfortunately this resulted in a number of complaints, particularly from medical practitioners, about what they believe is a lack of activity on our part. We have taken steps to ensure the consultation process is clearly outlined to practitioners and to keep both providers and complainants updated as to progress.

We continue to experience substantial delays finalising complaints when compensation has been agreed during conciliation with THS and THS needs to take legal advice before finalising the matter. This has resulted in some matters that were capable of resolution in conciliation being litigated in any event.

As I have reported previously these delays result in valuable time, effort and resources being spent by members of my staff following up and re-familiarising themselves with the issues, as well as loss of momentum. They have a serious adverse effect on the parties to the complaint, not only the consumers and their families who are seeking answers but also the practitioners whose performance is being questioned. They also place an additional burden on my staff who have to deal with parties aggrieved by the delays.

I intend meeting with relevant stakeholders to address these issues in the coming months.

Code of Conduct for Health Care Workers

I have reported previously regarding the establishment and implementation of a National Code of Conduct for Unregistered Health Care Workers (the Code) such as naturopaths, social workers and counsellors. The code is to be administered by the Health Complaints Entities in each jurisdiction and, as reported last year, the Tasmanian legislation to implement the Code had passed through Parliament but has not been proclaimed. This situation has not changed.

As more interstate prohibition orders were brought to my attention it became apparent that due to the lack of a nationally consistent definition of a health service for the purposes of the code, I would not be able to enforce an interstate prohibition order in Tasmania in respect of a health service that does not fall within the Tasmanian definition. As interstate recognition was one of the main objectives this will require further amendment to the Act.

As previously reported it is not possible to say how many complaints we might receive relating to possible breaches of the code. The trend interstate indicates it will be high, but any will mean an added strain on resources that are already stretched; existing resources will not be sufficient to deal with them. There will also need to be extensive modifications to our case management system to accommodate workflows related to the administration of the Code.

I remain concerned that, without additional resources and funding, we will not be able to perform this new function adequately.

Conciliation

As noted last year we started to make inroads into the backlog of matters that had been assessed as suitable for conciliation but were awaiting attention. Unfortunately COVID-19 resulted in a cancelation of all face to face meetings and as such fewer matters have progressed.

Despite this 15 matters were referred to conciliation this year and 13 were finalised. As at the end of the reporting year, there were 20 matters open in conciliation with an average age

of 719 days. As I reported last year some of these cases had been progressed through the meeting stage during the year but the delays referred to, have meant that these cases have not been concluded in a timely manner. This has resulted in some complainants indicating increasing levels of frustration and the need to resort to litigation after all. This is extremely disappointing.

As I reported last year, Conciliation is the cornerstone of the OHCC process and when adequately resourced we were conducting more than 55 conciliations a year. The reduction in staffing and loss of two conciliators from the HCC team over the last six years has resulted in the conciliation load being carried solely by my Principal Officer in addition to her management duties. This is not sustainable, particularly when combined with other work she is required to undertake, particularly dealing with enquiries and assessments at times when staffing levels are low.

Inadequate resourcing undermines the objects and purpose of the Act and the role of the Commissioner because health service users are not always able to have their complaints and concerns dealt with and resolved in a timely and appropriate manner. There is a risk of the perception arising that government is not committed to this vital part of the Tasmanian health system, and good, affordable and timely outcomes for its users.

Efficiencies

In last year's report I foreshadowed that I would be seeking an amendment to the Health Complaints Act to create an additional stage, following assessment, as to jurisdictional and threshold issues, which would allow for further enquiries to be made about a complaint, to enable case officers to gather sufficient information and complete an informed analysis to found a decision as to whether the complaint should be referred, conciliated, investigated or dismissed. It would also provide an opportunity to explore outcomes without the need for formal referral to conciliation or investigation.

Currently this information gathering, analysis and informal resolution is occurring in a protracted assessment process but this is contrary to the provisions of the Act. Many of the significant outcomes reported later in this report are a consequence of this process. As I noted last year such a change would not necessarily result in cases being finalised more quickly but it would result in them being assessed in compliance with the legislation.

As foreshadowed I approached the Strategic Legislation and Policy of the Department of Justice, hoping to have the proposed amendment included in a Justice and Related (Miscellaneous Amendments) Bill, but it was considered too complex and of too broad a scope for that and would require separate consideration.

Case Management System

Data about our complaint activity is collected via our case management system. Preparation of this year's report has highlighted a number of areas where there could be improvement in the way in which cases are recorded and managed through this system. This system, and the workflows attached, were introduced more than 12 years ago. This predates both the National Registration and Accreditation Scheme and other changes in our assessment process. As such the configurations, workflows, stages and closure reasons are not capturing the work of the OHCC as clearly or effectively as it could. We had planned to address this with an upgrade in early 2020 however we have postponed this project in so far as it relates to the health complaints jurisdiction, pending further developments with the implementation of the Code of Conduct for unregistered practitioners, and also in the hope the amendment to the legislation foreshadowed above will be passed in the near future.

Conclusion

Once again, I would like to thank my Health Complaints staff for the quality of their work, for their dedication and professionalism and for sustaining their remarkable levels of activity over what has been a particularly challenging year. I am looking forward to a new year, and hopefully the progression a number of projects and initiatives which had been postponed.

Office of the Health Complaints Commissioner

The *Health Complaints Act 1995* established the Office of the Health Complaints Commissioner (OHCC) in 1997. The major functions of the Office are to:

- receive, assess and resolve complaints from health service users;
- assist health service providers in developing procedures to resolve complaints;
- encourage health service users to resolve complaints directly with health service providers; and
- identify and review issues arising out of complaints and suggest ways of improving health services.

The Commissioner is an independent statutory officer who does not represent the interests of, nor act as an advocate for, either party to a complaint. The functions of the Commissioner are performed independently, impartially and in the public interest. It is not the role of the Commissioner to attribute fault or blame, but to seek improvements in the delivery of health services in Tasmania and, where possible, resolve complaints between the parties through conciliation.

It has been the practice since the commencement of the Act for the appointments of Ombudsman and Health Complaints Commissioner to be held by the same person. The same Office, the Office of the Ombudsman and Health Complaints Commissioner, delivers the functions which go with these two separate appointments.

Staff profile

Table 1- Staff profile

Position	Male	Female	Total
Commissioner	0.2	0.0	0.2
Principal Officer (Band 8)	0.0	1.0	1.0
Senior Investigation Officer (Band 6)	0.0	1.6	1.6
Resolution Officer (Band 5)	0.0	0.0	0.0
Intake and Assessment Officer (Band 4)	0.0	1.0	1.0
Total	0.2	3.6	3.8

2019-2020 At a glance

Snapshot

Cases closed

- 997 cases closed
- 73% closed in three months
- 65% cases finalised by quick resolution
- 13 cases resolved in conciliation

Cases opened

- 982 cases opened
- 82% assessed within 45 days
- 27% increase in enquiries
- 15 cases referred to conciliation

Results

Significant improvements and outcomes from cases closed in assessment and conciliation. Full details provided in 'Outcome from Complaints' on page 27.

Staffing

Staffing level at 30 June 2020 was 3.8 FTE.

Complaint and enquiry activity

Data collection

Data about our complaint activity is collected in our case management system. All cases received by the OHCC are initially recorded as enquiries. They then proceed though different workflows in the system, according to how they are managed, and data is collected at various points through those workflows. Cases are either closed as an enquiry or they progress to a complaint or notification.

In an attempt to avoid discrepancies reported in last year's annual report regarding the number of active complaints at the end of the reporting year, online complaints are now also recorded as enquiries and remain so until such time as the necessary authorities are received to enable the matter to be progressed.

COVID-19 impact

As a result of COVID-19, staff were required to work from home for the last three months of the reporting year. Lack of technology and the inability to access the case management system, and the workflows through which cases move, has created anomalies in this year's statistics with many cases that would normally have been taken though the complaint workflow being recorded and managed as enquiries.

Overall case activity

As the tables below show there was a marked increase in the number of matters recorded as opened and closed as an enquiry and a corresponding decrease in the number of matters recorded as opened and closed as a complaint. We have included an extra table (Table 2) has been included this year combining all cases. This demonstrates an overall increase of 9% in the number of cases opened and an overall increase of 3% in the number of cases closed.

The overall number of cases active at the end the reporting year was 17% less than the overall number of cases active at the end of the previous reporting year.

Table 2 – Overall case activity

Total cases	2018-19	2019-20	Variance
Cases carried forward	206	201	- 2%
Cases received	904	982	8.6%
Cases closed	972	997	2.6%
Cases active	158	131	-17%

Enquiries

A large number of cases are dealt with as enquiries each year. These are initiated by telephone, email or in person. Enquiries are dealt with as they are received and represent a substantial workload. Online complaints are also recorded as enquiries until such time as the necessary authorities are received to enable the matter to be progressed.

OHCC staff play a significant role in identifying the issues a potential complainant is concerned about and encouraging them to discuss their concerns directly with the health service provider involved. They will often take steps to assist parties to resolve the issues at this point. Usually enquires are finalised on the day or within a few days of being received. This was not the case this year with a large number of enquires remaining active and being carried forward at the end of the year.

Table 3 shows the number of matters opened and closed as enquiries during the reporting year. The table indicates a significant increase in the number of cases both opened and closed as an enquiry and a 161% increase in the number of enquiries active at the end of the year.

As noted above, these increases, particularly the increase in cases carried forward as an enquiry at the end of the year from 23 to 60, is directly attributable to cases remaining in the enquiry stage during the COVID-19 period rather than progressing through the workflows as they normally would and converting to a complaint.

Table 3 – Enquiry Activity

Enquiries	2018-19	2019-20	Variance
Enquiries received	484	616	27%
Enquiries closed	486	564	16%
Enquiries active	23	60	161%

Complaints

If a person has a grievance about a health service provider, and they have not been able to resolve their concerns directly with the provider or at the enquiry level, they are able to make a complaint.

When a complaint is received, OHCC staff contact both parties to identify and discuss the issues and, in appropriate cases, attempt to resolve those issues as quickly as possible by way of early resolution. Where this is not possible, the complaint proceeds to formal assessment.

Table 4 below shows a 27% decrease in the number of complaints carried forward from the previous reporting year and a 14% decrease in both the number of complaints received and the number of complaints closed. There is a 38% reduction in the number of complaints active at the end of the year but, as noted above, it is likely that this is due to matters not being progressed though the case management workflows and therefore not being converted from enquiries to complaints prior to the end of the reporting year.

As was the case last year, the number of active complaints reported in Table 3 this year is greater than the actual mathematical calculations indicate. There is a discrepancy this year of five cases. There were two reasons suggested for this last year. One related to the delay in receiving a signed authority in respect of an online complaint. This was remedied by retaining online complaints in the enquiry stage until receipt of the authority. This has in turn created the greater anomaly described above in relation to COVID-19. The other related to the splitting of complaints.

The Act provides that a complaint can be split, either as to parties or as to issues. An example of this is when a complaint is received about a hospital but it becomes necessary to open a separate complaint about a practitioner involved in the episode of care at that hospital because of the different trajectories the complaint can take – referral, investigation, or conciliation. If the complaint about the hospital is received in one reporting year and then split in the subsequent reporting year, the split complaint takes the date of the original complaint.

The discrepancy in the Table 4 carried forward calculations is most likely attributable to split complaints.

Table 4 – Complaint Activity

Complaints	2018-19	2019-20	Variance
Complaints carried forward	156	114	-27%
Complaints received	379	323	-14%
Complaints closed	431	371	-14%
Complaints active	114	71	-38%

*Excludes complaints that start as notifications from AHPRA

Notifications

The OHCC also receives notifications from AHPRA.

We have indicated in previous annual reports that, complaints and notifications would be combined in future reporting. This would be line with health complaint entities interstate. This practice has not yet occurred as the upgrade for to our case management system planned for early 2020, and the development of new workflows, has been postponed for the reasons set out earlier in this report.

The number of notifications set out in Table 5 below are therefore in addition to the number of complaints received.

Table 5 - Notification Activity

Notifications from AHPRA	2018-19	2019-20	Variance
Notifications carried forward	35	21	-40%
Notifications received	41	43	5%
Notifications closed	55	62	13%
Notifications Active at 30/6	21	1	-95%

Who and what did people complain about?

Issues raised

Consistent with previous reports the recurring issues raised in complaints relate to poor communication, inadequate care and treatment, and failure to prescribe medication.

Figure 1 – Common issues

Health Service Organisations

As in previous years, and as demonstrated in Table 25 – 'Complaints received about Health Organisations', the main source of complaints about health organisations came from prisoners in the Tasmanian Prison Service and related to Correctional Primary Health Services. This was followed by complaints about public hospitals and then medical practices.

Correctional Primary Health Services (CPHS)

In 2019/20, there was an 11% increase in the number of complaints about CPHS from 135 to 150. As in previous years, the main issue raised was failure to prescribe medication, the next was access to services.

Inmates are able to call this Office directly on a secure line on the prison's Arunta telephone system at no cost. Unlike complaints about THS and private providers which normally involve a single or 'one off' issue, prisoner complaints are more thematic and as such it is possible to consider the underlying causes.

Delays in accessing health care in prison

The OHCC routinely receives calls and written complaints from inmates alleging they have not been able to obtain an appointment with a medical officer within a reasonable timeframe. For some inmates, particularly those housed in the high and medium security sections of the Risdon Prison Complex, delays in obtaining medical care have been extensive and largely result from extensive lockdowns occasioned by TPS staff shortages.

In this situation, inmates are not able to be escorted by TPS staff to clinic appointments and backlogs for CPHS clinic appointments are created. Through the Arunta system, the OHCC is able to alert the CPHS to any urgent concerns raised by inmates.

Access to specialist appointments at the Royal Hobart Hospital (the RHH)

The OHCC received numerous complaints about delayed specialist outpatient appointments. During the height of COVID-19 restrictions, inmates were not able to be transported by the TPS to the RHH unless it was an urgent or emergency situation. This restriction has since been somewhat eased. Delays, however, were regularly occurring prior to COVID-19 due to TPS staffing issues and inmates were often unable to attend their scheduled specialist appointments. The CPHS and the RHH attempt to reschedule as soon as possible after a missed appointment.

Access to dental care

During the pandemic, dental clinics across Australia were obliged to deliver services at a restricted level to reduce the risk of infection. The prison dental clinic was further restricted to fortnightly visits and the wait list for the prison dental clinic has lengthened accordingly. As in the previous year, this situation is compounded when inmates cannot be taken to their scheduled appointments as a result of TPS staffing issues and lockdowns.

Prescribing medication

Complaints from inmates about medication issues, including the Opioid Replacement Therapy program, were frequently received by the OHCC. Most issues were related to the cessation or tapering of medications which the CPHS decided were not indicated. Other reasons included the contemporaneous use or trafficking of illicit substances by inmates.

This year the CPHS tightened its prescribing of some medications (particularly anti-psychotics) which had previously been prescribed for conditions that are not included in the approved product information document for that medication (see below).

CPHS Developments in 2019/20

A new initiative to reduce the medication burden throughout the TPS

In May 2020, the CPHS commenced an initiative to cease the prescribing of the low dose antipsychotic medication Seroquel in the prison population. Seroquel had been historically widely prescribed 'off label' in the community and the prison as a sleep aid, and for behavioural regulation. It is also a highly trafficked drug in the prison system and the CPHS declared that it would no longer be prescribed unless clinically indicated.

Several inmates made complaints to the OHCC about the cessation of this medication without notice, which were forwarded to the CPHS. As a result of the complaints, the CPHS sent out a letter to all inmates who had had their medication ceased, explaining the rationale for cessation. Any inmate who considered that there was an ongoing need for the medication was given the opportunity to book into the mental health clinic for discussion about alternative, more appropriate prescribing.

Nonetheless, the OHCC received more complaints from inmates who alleged they had previously been diagnosed with a mental health condition which indicated the prescribing of Seroquel was appropriate. A small proportion of these inmates were successful in having the medication reinstated following a thorough review by the CPHS.

Improvements to the opioid substitution treatment program within the TPS

In June 2020 the CPHS commenced the transfer of all inmates currently on daily opioid substitution treatment ('the Suboxone program') onto monthly injections of depot buprenorphine, known by the brand name 'Buvidal'.

The Head of Department of the CPHS anticipated that inmates would have concerns about the introduction of Buvidal and would be contacting the OHCC in large numbers. To assist the OHCC staff manage the 'large number of potential complaints', the Head of Department organised an information session to explain the details and benefits of the planned transition to intravenous Buvidal to staff of the OHCC.

To date, the OHCC has not received any complaints from inmates who have been transitioned to Buvidal, a process that is ongoing. The Head of Department recently advised that there are eight established patients on the Buvidal program, four transitioning and 12 planned to start by the end of October. There are five Methadone clients for later transition and then more than100 inmates who will start on the program before the end of 2020.

Tasmanian Health Service

In line with previous years, public hospitals were the subject of the next highest number of complaints. There was a 29% decrease in the number of complaints from 61 to 43 while the number of complaints about mental health services increased from nine to ten. As in previous years, the main issues raised in relation to hospitals were treatment and communication.

Medical clinics

Table 25 indicates a decrease in the number of complaints about medical clinics from 30 to 22. Recurring themes were informed financial consent and billing practices. We also received a number of complaints relating to the administration of vaccinations.

Individual providers

Most complaints received about individual providers related to medical practitioners. As noted in previous reports, this is attributable to there being more doctors than other individual health providers who practice in their own right. Complaints about nurses for example are usually incorporated into complaints about hospitals. There was a significant decrease in the number of complaints about medical practitioners received this year from 56 to 21.

How were cases resolved?

Table 6 – Reason for closure of complaints and notifications

Reason closed	2018-19	2019-20
No further action following Assessment	400	333
Referred to board pursuant to MOU	22	24
Retained by board pursuant to MOU *	55	62
Conciliation completed	9	14
Total	486	433

*These cases started as notifications to AHPRA

Assessment

The majority of complaints received are closed following assessment. This was the case for 333 complaints closed this year.

Assessment is the stage under the Act at which a determination must be made as to whether a complaint should be referred to another entity, referred to conciliation, referred to investigation, a combination of any of these, or dismissed. This determination is meant to occur within 45 days of the complaint being received. This period can be extended to 90 days, or longer if the Commissioner is waiting for information. This is also the stage at which attempts are made at early resolution.

The various reasons for closing a complaint in assessment are set out in Table 8. These reasons accord with the language of s25(5) of the Act, which stipulates the circumstances in which a complaint must be dismissed. A number of these relate to threshold issues, which in most instances result in a complaint being dismissed at relatively early stage in the assessment process.

Of the cases closed following assessment, approximately 15% were closed due to threshold issues or due to the complaint being withdrawn. This is a significant increase over the previous year, and mostly attributable to an increase in the number of complaints being lodged by people without the necessary standing, such as on behalf of a deceased relative when they are not the executor, or purportedly on behalf of a relative who has capacity but does not consent to the complaint being made. We have also continued to take a strong position regarding the

need for complainants to attempt to resolve their concerns directly with a provider before making a complaint to us. In these cases we provide complainants with assistance as to how to frame their concerns in a way that might elicit the most favourable response.

A further 50% of the cases closed in assessment were closed having been resolved through our early resolution processes. These cases are managed as informally as possible and usually involve obtaining information from the provider, or other entity, and sharing this with the complainant. Alternatively they involve speaking with the parties and negotiating outcomes, such as a refund or waiver of fees or the provision of a service. These cases do not undergo a formal assessment as such but none the less have been attributed closure reasons set out in sections 25(5)(g) or(j) of the Act. Most cases about Correctional Primary Health Services fall into this category.

A number of cases require attention from agencies other than AHPRA, for example complaints about aged care facilities might be referred to the Aged Care Quality and Safety Commission, and complaints about disability services to the NDIS Quality and Safeguards Commission. Complaints relating to mental health facilities might be referred to the Mental Health Official Visitor Scheme established under the *Mental Health Act 2013*. We received a number of complaints this year from people seeking access to, or correction of, medical records and potential breaches of privacy. If these involved practitioners in the private sector they were referred to the Office of the Australian Information Commissioner. A further 9% of cases closed in assessment were closed having been referred to other agencies

All remaining complaints are subjected to a more formal assessment process during which responses are sought from providers, medical records are reviewed, expert opinions sought, consultation occurs with AHPRA, and further attempts are made to resolve the complaint without the need for referral to formal investigation or conciliation. Of the 333 complaints closed following assessment approximately 25% were subjected to this more protracted process.

These cases tend to be the more complex ones, with multiple parties and multiple issues and they are rarely assessed within the statutory timeframe. This is in part due to the time taken to receive responses from providers and other parties but also because of a conscious decision made several years ago to retain matters in assessment to enable extensive enquires and analysis to be undertaken, and resolution explored without the need for referral to formal investigation or conciliation.

As a consequence, very few formal investigations are undertaken and conciliation has been reserved only for cases involving significant harm and claims for compensation or complex communication issues.

This means that, although a large number of complaints are assessed and finalised within the statutory time limit, there are a significant number of complex matters that remain open in assessment for an extensive period of time. These cases are in effect "mini investigations" or informal conciliations but when they are finalised they are recorded as having been "dismissed" on the basis that a reasonable explanation was provided or the case was resolved. These closure reasons do not reflect the complexity or extent the work undertaken

Case studies at the end of this report highlight the complexity and significant outcomes that have been achieved through this protracted assessment process.

Referral to Registration Boards and other entities

The relationship between this Office and the national boards and AHPRA is governed by the *Health Practitioner Regulation National Law Act* 2009 (National Law). A Memorandum of Understanding (MoU) is in place between AHPRA and the various Health Complaints Entities, particularly with respect to the operation of s150 of the National Law.

When a complaint concerning a registered practitioner is made to OHCC, we are required to advise and consult with AHPRA as to whether any aspects of the complaint should be referred to AHPRA. Unless the issues raised are so serious as to require urgent referral to AHPRA, then as described in the MoU, OHCC obtains information and undertakes preliminary enquires sufficient to enable us to make a recommendation to AHPRA.

In some cases this is a simple process, for example if the complaint is about an individual practitioner and the only outcome being sought by the complainant is disciplinary action, then the complaint would be referred immediately.

Most complaints made to OHCC, however, are not seeking disciplinary action. Rather the person making the complaint is seeking an explanation, improvements to practice and procedure to make sure that it doesn't happen to anyone else and, in appropriate cases, an apology and compensation or other reparation such as refunds and waiver of fees.

If such complaints are referred outright to AHPRA because they raise possible concerns about a practitioner's conduct or performance then, the outcomes sought by the complainant are to a large extent lost. Particularly if they result in a decision by the relevant board to take no further action.

These cases therefore involve a significant amount of work on the part of the IOs. As described in relation to the complex cases closed in assessment, the information gathered and analysis undertaken is extensive and involves seeking responses from providers, reviewing medical records and formulating a recommendation. If the complaint is ultimately referred to

AHPRA the recorded closure reason is merely that it was referred. This is notwithstanding that the complainant in fact received the explanation and other outcomes they were seeking.

Table 6 indicates that in 2019-20 there were 86 cases either referred to or retained by a registration board pursuant to the MoU, of which 24 were referrals from this Office. We consulted with AHPRA in relation to an additional 12 practitioners who were not ultimately referred to a board. These additional consultations arose from complaints made about hospitals where a registered provider had been involved in the episode of care.

As discussed elsewhere in this report, the consultation process between this Office and AHPRA has a significant impact on the time taken to assess or progress complex complaints.

Conciliation

Most complainants want to understand what happened, and why it happened, and are often seeking an apology, ongoing care and/or compensation. They also want to know what can be done to prevent what happened to them happening to someone else. Conciliation under Part 5 of the Act is confidential and privileged, and provides a safe forum where the parties can have open and honest discussions about these issues.

In previous years, conciliation has been used extensively and with great success in resolving complaints and as a vehicle for exploring and bringing about systemic change.

Over the past six years, the number of matters referred to and resolved at conciliation has fallen dramatically following the retirement of a part time conciliator and the inability to recruit a replacement due to lack of resources. Prior to this conciliation had been the cornerstone of the HCC complaint resolution process with more than 55 conciliations per year being finalised in a timely manner. Not only were complaints resolved without the need for litigation, but also significant systemic improvements were achieved through collaboration between the parties, and relationships were restored.

Outcomes from conciliation are set out in Table 10 in the appendix to this report. Of the thirteen cases closed:

- one case resulted in the actual payment of compensation;
- two cases were closed with the provider accepting liability to pay compensation and with an agreement to pay for any reports necessary to enable quantum to be determined - these were both highly complex cases where it was recognised that ongoing management and final negotiations should occur through the parties' legal representatives;

- five cases underwent extensive negotiations with the providers ultimately relying on a decisions by the relevant registration board to deny liability for the payment of compensation;

- three cases were resolved following face to face meetings at which the complainant had an opportunity to be heard and have their concerns acknowledged on the basis of an apology and explanation;

- two cases were resolved with a commitment from the providers to provide ongoing care; and

- five of the abovementioned cases resulted in significant quality improvements, including changes in policy or procedure.

In past years we have published case studies in relation to cases closed in conciliation. Due to the confidentiality provisions that attach to conciliation this has always been with the express permission of the parties involved. For a number of reasons this year case studies will not be published in this report. Some of the improvements are however set out later in the report.

Investigations

A decision was made some years ago that formal investigations would only be conducted into complaints which give rise to a matter of public interest, and that conciliation would be used more extensively. One of the reasons for this was that, in many cases, by the time the matter is brought to our attention, the provider has already engaged in a root cause analysis, and this has led to the identification and implementation of systemic changes necessary to prevent a recurrence of the subject incident. These outcomes are then shared with the complainant at conciliation.

The matters referred to investigation have tended to be those that affect vulnerable groups.

Time taken to assess and finalise complaints

Time taken to assess complaints

The Act requires that a complaint be assessed within 45 days. This can be extended to 90 days, and longer in some cases. There are a number of circumstances, described in past annual reports, and referred to earlier in this report, which are beyond our control and which have an impact on this Office's ability to meet these statutory periods.

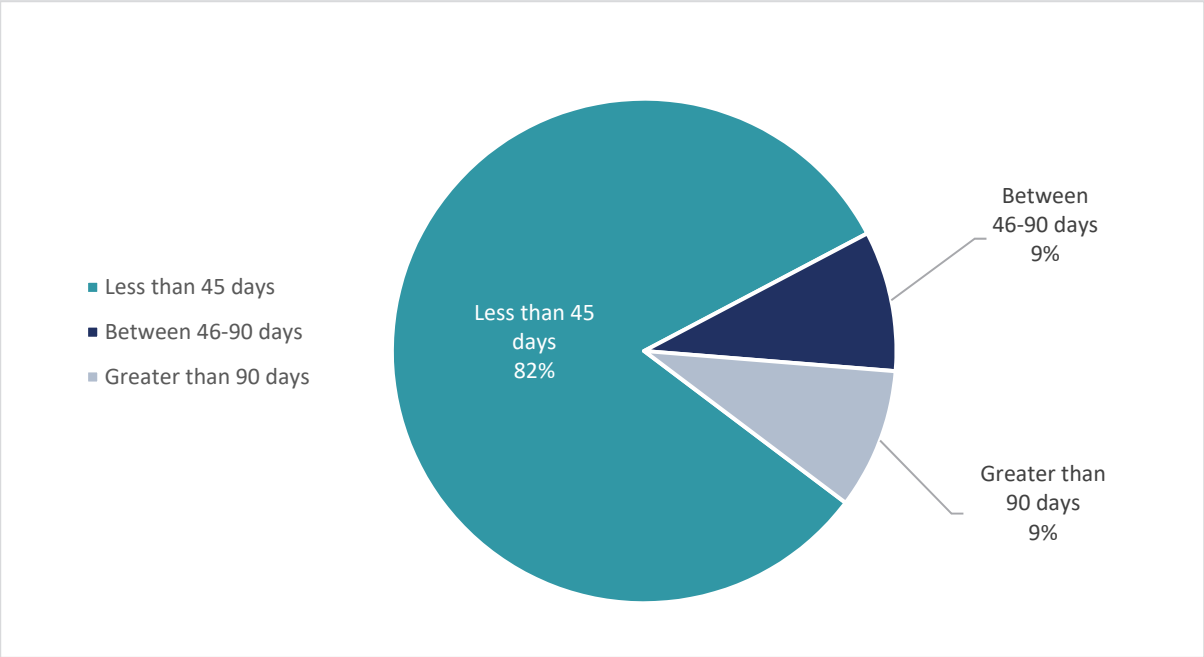
Once again, as reported last year, there were several instances in this reporting year of delays of more than six months in THS providing responses to complaints about public hospitals and other State funded services, and similar delays in receiving responses from AHPRA during the consultation process which occurs pursuant to the National Law and the MoU.

These delays not only have a deleterious effect on the parties to the complaint but also stifle momentum, and have an adverse impact on the management of the complaint by this Office.

An amendment to the Act came into effect in October 2015, which permits the assessment period to be extended if there is a delay in obtaining information requested by the Commissioner. Unfortunately, although this amendment has the potential to reduce our reported assessment times, it does not obviate the detrimental impact caused by the delays

As outlined earlier in this report another reason for complaints not being assessed within the statutory time frame is due to a conscious decision to retain matters in Assessment to gather information and negotiate outcomes rather than refer matters to the more resource intensive investigation or, in the absence of a dedicated conciliator, to conciliation. Again although this this decision delays the date of assessment it does not impact on the time taken to finalise the complaint.

Figure 2 – Time taken to assess complaints



Time taken to finalise complaints

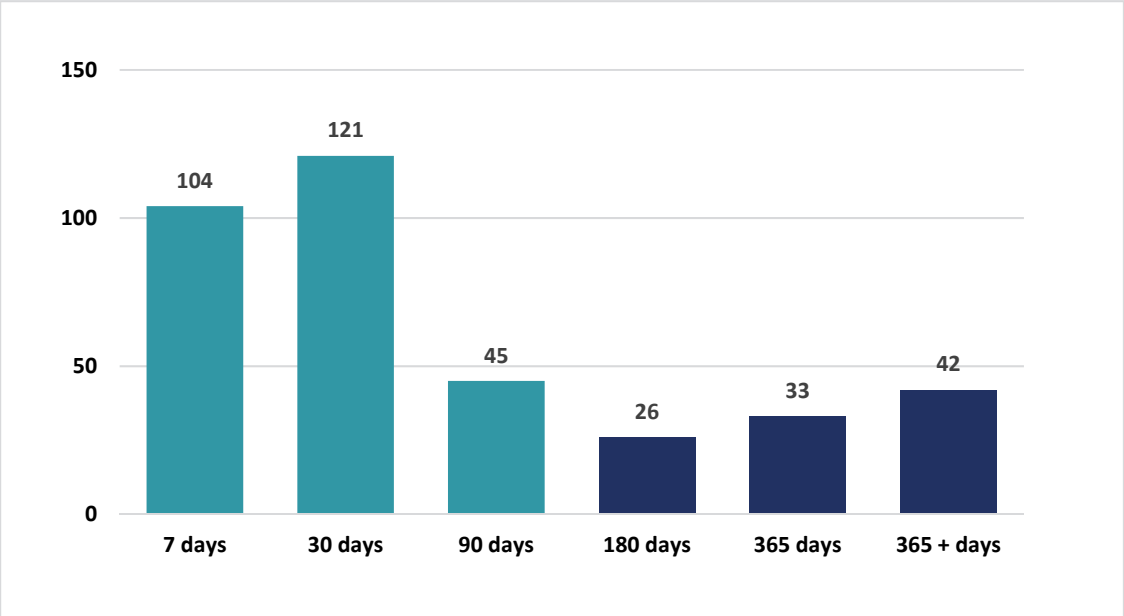
Table 7 below illustrates the time it takes to finalise complaints. As previously noted, the less complex complaints are generally resolved within three months and generally make up around 72% of all complaints received. The remaining 28% tend to be more complex.

The statistics for this year show an increase in the percentage of complaints taking more than 12 months to finalise. With the recruitment of an Intake and Assessment Officer and Senior Investigation Officer last year we were able to make inroads into the backlog of old complaints and at the end of that reporting year there were only 26 cases more than 300 days old.

Unfortunately with two staff members on extended leave for almost seven months and with the challenges presented by COVID-19, that number had almost doubled by the end of this reporting year with 51 of the 66 complaints carried forward being more than 300 days old. Of these, 20 remained open in assessment and a further 17 remained open in conciliation.

Another factor in relation to complaints about registered practitioners is the reluctance of those practitioners to engage in conciliation, particularly involving claims for compensation, until finalisation of any action against them by the relevant registration board. This results in cases remaining open pending the outcome of those proceedings and a delay over which this office, again, has no control. There were 14 matters older than 300 days awaiting the outcome of referral to AHPRA at the end of the reporting period.

Table 7 – Time taken to finalise complaints



Outcome from complaints

Quality improvements from Assessment Stage

Provider initiated improvements

Pharmacy

- Review and update of patient profiles in collaboration with General Practitioners and local clinics to ensure patient records are up to date.

- Cross-skilling of staff and sharing of jobs to ensure all staff are familiar with the requirements in each role.

General Practice

- Staff training - Improved education and training in immunisation, updated vaccination lists in each consulting room for staff to refer to and the employment of three additional nurse immunisers.

Specialist

- Improved practice processes in relation to written quotes in line with the Royal Australian College of Surgeons Position Paper Informed Financial Consent.

Public Hospital – Specialist Service

- Invitation for a consumer to be a consumer representative for a project to be undertaken in relation to the service, review of the service and education and training to all staff.

OHCC initiated improvements

Pharmacy

- Improved processes and further training for dispensing and high risk medications (drugs that have a heightened risk of causing significant patient harm).

- All staff were instructed to review product literature about all critical drugs.

- Alerts were installed on the dispensing software so that messages automatically pop up saying, for example, 'once weekly only' (and also promotes the use of evidence based supplements).

- Additionally, posters containing information detailing drugs which have detrimental side effects if taken incorrectly, even over a short period of time were put up in areas where staff could see them.

General Practice

- Improved record keeping following a complaint about the failure of a general practitioner to properly diagnose a patient, it was revealed that the practitioner's record keeping was unsatisfactory and he was required to undertake further training.

- Greater awareness and tolerance of the impact of certain neurological disorders on some patients' communication ability and the barriers to healthcare which the disorder engendered.

- Greater awareness of the impact of the disorder on the communication skills of the patient and the barriers to healthcare which the disorder engendered.

- A general practice acknowledged that they lacked the capacity to manage communication with some patients with neurological disorders as a result of the assessment of a complaint from a patient with this form of disability.

- Practice staff were unaware of the impact of the disorder on the communication skills of the patient and the barriers to healthcare which the disorder engendered.

Hospitals/Facilities

- Improved policies and procedures to reduce the risks of adverse events for non-verbal in-patients with significant intellectual and physical disabilities.

- Improved communication systems to reduce the risk of referral for unnecessary invasive investigations requiring, for example, the insertion of an indwelling catheter.

- Improved communication with patients to avoid negative outcomes from insertion of intrauterine devices.

- Improved referrals for MRIs and orthopaedic clinic treatment for patients with fractures presenting to the emergency department.

- Improved access to training in communication skills and de-escalation techniques for staff to manage interactions with patients with neurological disorders.

- Improved monitoring of inmates prescribed medication to treat complex mental health disorders. .

Specialist Services

The Medical Advisory Committee within a specialist eye services clinic responded to a complaint by directing all staff to adopt new policies in regard to patients' privacy when completing forms that may be potentially misunderstood by patients.

Statewide Mental Health Services

- Mistakes rectified in their booking system that had resulted in patients being incorrectly discharged from the service.

- Administration staff received upskilling in maintaining privacy after a patient overheard a derogatory conversation.

Unregistered practitioners

A massage therapist developed insight into his lack of professional skills and decided to cease practice until he had completed a nationally accredited training program.

Registered Nurse

A registered nurse developed insight into her lack of professionalism when speaking with another registered nurse who was an in-patient.

Reimbursement of Costs

In addition we had four matters where the consumer was seeking reimbursement of costs and/or compensation as the only outcome to the complaint. These matters were resolved early without referral to conciliation. This outcome meant the matter was resolved quickly and to the satisfaction of all parties to the complaint. This is an increase from other years.

Improvements from cases closed in conciliation

- Review by the obstetrics and gynaecology quality and improvement working group in a public hospital to investigate and recommend strategies for improving the outcomes from perineal tears during child birth.

- Review and amendment of the screening and surveillance guidelines used by Child Health and Parenting Services (CHaPS) to include a focus not only on child development but also on growth.

- Implementation of a red flag system for referral for any growth chart anomalies or unusual measurements – such as growth plateaus or crossings of percentiles.

- Training to CHaPS staff in child growth and referral pathways and exploration of direct referrals in appropriate cases.

- Review and revision of protocols and guidelines for tilt table testing for post orthotic tachycardia syndrome (POTS) at a public hospital

- Education to clinicians on investigation and treatment of syncope including the use of tilt table tests.

- Education to staff in relation to alternate referral pathways for patients for autonomic function testing.

- Multi-professional obstetric training (PROMPT) in the effective management of obstetric emergencies.

- Ongoing audit, and inter professional training, in recognising and responding to clinically deteriorating patients.

Case Summaries

The following case summaries have been de-identified to protect the identity and privacy of the parties, and demonstrate the variety of matters we deal with.

Examples of cases resolved at Enquiry level

Information provided to complainant

An enquiry was received by this office from Mr T who was confused about his rights to access his pathology results from his general practice.

Mr T had been informed by the reception staff of the Practice that he needed to contact the relevant pathology laboratory to obtain his results. He believed this was incorrect.

Mr T wanted to lodge a complaint with the OHCC about the practice as he had previously been provided with his pathology results by it. OHCC staff provided Mr T with advice, published on the Commonwealth Health website, that a patient may request their pathology results from the treating practitioner at the time of consultation or directly from the relevant pathology laboratory. Mr T did not want to book a GP consultation to discuss or access his results and, as such, understood and accepted the advice provided by the Practice was correct. Though unhappy with the outcome, Mr T now understood the system for obtaining records.

Referred back for direct resolution

Sometimes complaints come to the OHCC before the complainant has attempted direct resolution of their concerns.

A person may not be aware that the *Health Complaints Act 1995* requires that they attempt to resolve a complaint with the health service provider before submitting a complaint to the OHCC. Without this step, the health provider may not be aware there is a problem. Importantly, the health provider is not afforded the opportunity to respond to the complaint and work towards resolution with the complainant, prior to a complaint being escalated.

An enquiry was received by this office from Ms G who had copied the OHCC into an email addressed to her health service provider in which she was complaining about an issue.

Ms G was contacted and advised that she was required to await a response from the provider. If she was not satisfied with the outcome of the direct resolution process, once it was finalised, Ms G was advised that she was welcome to recontact the OHCC to discuss her concerns

further. Ms G advised that she had not been aware of this requirement and that she would await the outcome of the complaint process she had already initiated with the health service provider.

Facilitated referral to provider

An enquiry was received from the parents of an adult male complaining about the care and treatment their son was receiving from a health service. The parents were advised of the legislated requirement to approach the health service provider in the first instance. This contact was facilitated by the OHCC and the provider was asked to follow up directly with the parents and their son.

The parents were further advised that if they remained dissatisfied with the outcome of that process, once it was finalised, they may recontact the OHCC. They were also advised that their son would need to lodge the complaint or provide his parents with his written authority to lodge a complaint with the OHCC on his behalf.

Changes to national prescribing guidelines for opioid medications

An enquiry was received by this office from Mr M who was upset that he had been refused a prescription for his regular opioid medications by a GP.

He was unaware that new national regulations were introduced on 1 June 2020 regarding prescribing opioid medications for both acute and chronic non-cancer related pain management. The new regulations, which include the requirement for a patient to be reviewed by a pain specialist or by another medical practitioner if opioids are required for a period exceeding 12 months, were explained to Mr M.

As Mr M was not aware of the new regulations associated with opioid prescribing he accepted the information and our suggestion that he seek further advice from his GP.

Advice provided about restrictions on prescribing

A number of enquiries were received about restrictions being placed on patients' access to Schedule 8 drugs. This class of drugs includes opioids and narcotic psychostimulants. They are heavily regulated under the *Tasmanian Poisons Act 1971* and the *Poisons Regulations 2008*. GPs are required to seek authority to prescribe these medications. The authorisation process is necessarily rigorous to protect public health, as these substances have potentially harmful side effects both in the short and long term. The Pharmaceutical Services Branch (PSB) of the Department of Health, Tasmania, is responsible for decisions regarding the authority to prescribe these medications for patients.

An enquiry was received from Mr B who was indignant that he had been asked by his GP to undertake a urine test to check his medication levels.

Mr B was unaware that, under legislation, his GP's application for the authority to prescribe his medication was assessed by the PSB and that the authority may include conditions. The legislation further allows the PSB to revoke his GP's authority or to vary the conditions at any time.

Mr B was advised that, should he wish to request a review of a decision, including that of the requirement to undergo urinalysis, he may submit an 'Application for Review' which is located on the PSB website. Mr B was also advised that, if he was not satisfied with the outcome of that review once it was finalised, he may wish to contact the Ombudsman Tasmania.

Access to health records in the private sector

Many enquiries are received from patients wanting to know if they are able to access their health records. Many simply want their medical records transferred from one GP Clinic to another when they change doctors. Another frequently asked question is if a GP Clinic can charge a fee for providing the records or transferring them to another practice.

Ms T asked for her records to be transferred from one clinic and was advised that she would need to pay a fee before this could be done.

Mrs T asked, "Can they do this? It is such a lot of money and they are our records."

Mrs T was advised that medical records are the property of the person who creates the record – in this case, the health service provider - not the patient. The *Privacy Act 1988* (Cth) gives the patient the authority to request access to the health information which a health service provider holds about them.

Further, Mrs T was advised that GP clinics can charge a fee for transfer of medical records, but this charge cannot be excessive or create a disadvantage for the patient.

Telehealth bulk billing during COVID-19

An enquiry was received by this office from Ms C regarding charges for a GP telehealth consultation which took place in March 2020.

Given the widely publicised information that telehealth appointments would be bulk billed, Ms C was surprised when she subsequently received a bill for the telehealth consultation.

The OHCC checked the timeframe referred to by Ms C and was able to advise that there had been a staged rollout of the bulk billing arrangements and that the temporary whole-of-population response, which started on 30 March 2020, unfortunately post-dated her appointment.

It was acknowledged that it was a difficult time of many rapid changes affecting all, including health practitioners and health service users. Ms C was advised that she may contact the Practice Manager of the GP Clinic if she was experiencing financial difficulties and request that they consider a discount or bulk billing in this instance.

Public health risk management during COVID-19?

An enquiry was received from Ms P who felt she had been a victim of discrimination as she had been required to wait outside the GP practice and to wear a mask during a GP appointment. It appears these requirements were imposed as Ms P's child was coughing while they were in the waiting area of the GP Clinic.

The issues were discussed with Ms P and she was able to see that rather than being an issue of discrimination, the requests were in line with the Public Health protection guidelines for all during the COVID-19 pandemic. Following the time of that GP appointment, the majority of medical appointments were conducted via telehealth consultations to protect all patients, doctors and staff at GP Clinics.

Ms P was, nonetheless, advised how to raise a complaint with the Practice Manager of the GP Clinic.

Health practitioner ending the professional relationship

An enquiry was received by this office from Ms H who was distressed that she had been 'banned' from attending her regular general practice.

The practice had advised Ms H that they would no longer accept her as a patient and she believed they were failing in their duty of care to her.

We explained to Ms H about the obligations of general practitioners to their patients contained in the Medical Board of Australia's Code of Conduct in regard to her situation. The Code explains that medical practitioners have a duty of care to end a therapeutic relationship with a patient when they consider it has become ineffective or compromised in some way. Further, a medical practitioner is not obliged to provide treatment to a person in need, except in an emergency.

We advised Ms H of the GP's obligation to ensure that she is adequately informed of the decision and the requirement for the arrangements for her ongoing care to be facilitated,

including passing on relevant clinical information. This may involve the transfer of health records to her chosen new health practitioner.

Ms H was advised that she may express her concern to the Practice Manager of the Clinic and request that they continue to see her as a patient, however the Clinic is not obliged to do so.

Complaints resolved through Early Resolution

Under section 25 A of the Health Complaints Act, the OHCC is able to undertake resolution of complaints before proceeding to formal assessment processes. This course of action lends itself to the timely procurement of explanations, apologies and refunds on behalf of complainants with simple and genuine issues which do not require reviews of medical records or exchange of formal letters.

In certain cases we will also provide assistance to complainants to navigate other complaint mechanisms

Refund obtained

One such example was Mr J who, 12 months previously, had received upper and lower dentures from a dental prosthetist. He advised he had never been able to eat or talk whilst wearing his dentures as they were ill-fitting, uncomfortable and unsightly.

Mr J had been unable to resolve the situation with the provider. He contacted the OHCC to assist him to obtain a refund as he was now undertaking the process of obtaining new dentures from an alternative prosthetist.

With Mr J's permission, the OHCC contacted the prosthetist who immediately agreed, on return of the dentures, to refund Mr J his entire out of pocket expenses. In the space of five days, from submission of the complaint to finalisation, the complainant received a total refund of the cost of his dentures transferred to his bank account and he was able to pay for a new set of dentures.

Apology for attitude staff in a Pharmacy

A complaint was received by this office raising concerns about the attitude and manner of a Pharmacist, in particular the Pharmacist's behaviour towards a child with a developmental disability. The complainant, Ms G advised that she had felt demeaned and humiliated by the pharmacist when she visited the pharmacy seeking advice about a product and, as such she wanted an apology from the Pharmacist and a change in procedure.

There was a clear need to restore trust and appropriate service access, so the matter was identified as suitable for resolution through our 'Early Resolution' process, without resorting to formal correspondence.

Following a succession of emails and telephone calls between OHCC and the parties, the conflict was promptly resolved when the pharmacist apologised to Ms G for her poor behaviour and offered to meet her in person. In fact, the pharmacist had identified her divergence from best practice prior to being contacted by the OHCC.

Ms G advised that she was satisfied with the process and pleased to hear that the Pharmacist had realised that her behaviour had been unsatisfactory, was very sorry and had undertaken to change how she interacts with similar patrons. The Pharmacist also provided a follow up email response which was provided to Ms G who was happy with the swift resolution of her complaint and the positive outcomes.

Resident of a regional residential aged care facility during COVID-19

Calling from interstate, an anxious daughter contacted the OHCC with a range of concerns about the standard of care being provided to her mother in a regional residential aged care facility (RACF).

Due to COVID-19 restrictions, the family were not permitted to visit her to check on her situation. The daughter was fearful that her mother had been the victim of an assault and was not receiving appropriate trauma care.

The OHCC advised the daughter that complaints about the standard of services provided in an aged care facility were managed by the Aged Care Quality and Safety Commission (the ACQSC). The daughter felt unable to contact the ACQSC on her own. The OHCC agreed to help her.

We made a series of inquiries with all parties identified by the daughter and it was established that the ACQSC was already conducting an inquiry into the complaint, which had also become a criminal investigation.

The RACF acknowledged the serious nature of the complaint and explained how it had complied with all compulsory reporting obligations. The management of the RACF was keen to make contact with the daughter to discuss the situation and was willing to contract the services of an independent person, such as a social worker, to assist the family.

The OHCC obtained the daughter's consent to provide her details to the RACF management.

The OHCC explained the situation to the daughter and assisted her to make contact with the management and provided referrals to other advocacy agencies to assist her as well how to make contact with the ACQSC.

With regard to her mother's immediate needs, it eventuated that due to a communication breakdown within the family, the complainant was not receiving information that would have allayed her fears for her mother's safety. The OHCC was able to further reduce the daughter's concerns for her mother by establishing new lines of communication for her with the RACF management.

Complaints resolved in Assessment

The case studies below are examples of cases managed through our "extended/complex" assessment process. They demonstrate the value of matters being retained in assessment to undertake further enquires, analysis and negotiation without referral to more formal conciliation or investigation and prior to referral to AHPRA.

Vulnerable residents of a residential aged care facility

A complaint was received about the billing practices of an inter-state health service providing 'in-house' dental services to residents of a Tasmanian residential aged care facility, many of whom do not have decision-making capacity due to dementia and other illnesses. Prior to arriving in Tasmania, the dental service had made appointments with the guardians of the residents to carry out dental examinations for the fee of $35.00.

The complainant, who had been appointed enduring guardian of his wife, had initially requested that she undergo a dental examination only. However, during the 'examination' the dentist carried out a range of dental services without providing him, as her enduring guardian, the opportunity to consent to the services. He was then provided with a bill which he disputed on the grounds that his consent had not been given for the provision of the services.

The OHCC obtained responses to the allegations from the dentist and the health service for whom he worked, as well as the patient records.

The OHCC consulted with AHPRA who determined the practitioner's conduct appeared to be predatory in a financial context, and conditions were placed on his registration.

The complainant received a refund for most of the services for which they he not provided consent.

Given the vulnerable nature of the residents potentially affected by this behaviour, the OHCC continues its assessment of the issues that pertain to the organisation who employed the dentist. We are also attempting to obtain an entire refund for the complainant.

Monitoring medication in a prison environment

An inmate entered prison with a serious health condition. He was prescribed medication, (which required regular monitoring) to treat this condition, which continued during the term of his imprisonment.

Some 12 months into his sentence, the inmate complained to the OHCC that his medication had not been monitored appropriately by medical staff and he had subsequently developed a secondary condition, which he claimed was both irreversible and avoidable.

The regular assessment process of the inmate's complaint was followed. We obtained his medical records, responses from several practitioners, reviewed research about his condition and analysed best practice protocols.

OHCC subsequently consulted with the Medical Board of Australia about a practitioner involved in the episode of care and provided all the relevant information.

The Board requested referral of the complaint and subsequently concluded that the issues experienced by the inmate, whilst unfortunate, were largely attributable to systemic resourcing issues within the prison health service, rather than as a consequence of the decisions or actions of an individual practitioner.

As a result of the complaint, the OHCC made a range of recommendations to the prison health service aimed at improving medication review systems within the prison environment.

Unsafe dispensing procedures addressed and remedied

A customer of a large chemist chain outlet complained that he had experienced a number of errors in the dispensing of his medications. Some of these errors were very minor, but others were serious and had caused MJ to become very unwell.

The OHCC requested responses from the pharmacist to MJ's allegations, as well as the owner of the pharmacy.

Following consultation with AHPRA about the incident, the practitioner had conditions imposed on his registration by the Pharmacy Board of Australia such that he will be mentored by another registered pharmacist in relation to safe dispensing practices and systems, including relevant standards, guidelines, and legislation, and adequately counselling a patient.

In terms of improvements to make the pharmacy's dispensing practices safer for the public, the owner advised that he had made some significant improvements. He had alerted all pharmacy staff to the risks involved in dispensing the medication in question and had instructed all staff to review product literature about all critical drugs. He had put up posters, in strategic positions, which detailed drugs which have detrimental side effects if taken incorrectly, even over a short period of time.

The owner also implemented a further safety measure: the installation of alerts on his dispensing software. As a result of this new safety precaution an automated message pops up advising 'once weekly only' and promotes using Folic acid as an additional supplement whenever the medication in question was dispensed.

A misread x-ray leads to a quality improvement

Presenting to the emergency department in the early hours of the morning with a dislocated knee, an x-ray was carried out to investigate whether the patient had also incurred a fracture. The patient was told there was no evidence of a fracture established by the x-ray, and he was subsequently discharged into the care of his GP with a referral for a non-urgent MRI.

Some 12 months later, the patient complained to the OHCC that he considered his recovery had been unreasonably complicated and protracted and he was now facing reconstructive surgery as a result of the dislocation.

OHCC conducted an extensive analysis of the patient's emergency knee treatment and his rehabilitation, including the obtaining of responses from numerous practitioners and his GP. We also undertook an extensive review of his lengthy medical records and the 'best practice guidelines' for treatment of knee trauma.

Ultimately, we concluded that the patient's unsatisfactory recovery resulted from a delay in treatment resulting from a misreading of the results of his initial x-rays taken in the emergency department. The x-ray indicated the presence of lipohaemarthrosis (blood and fat in the joint following trauma) which was evidence of a 'hidden' fracture. Had this fracture been investigated and established earlier by urgent MRI and treated promptly, the patient may well have avoided the extensive complications he experienced.

We made a suggestion to the hospital that a protocol be developed to urgently manage patients when lipohaemarthrosis is detected by x-ray.

As a result of this complaint, a new protocol was developed by the hospital for the early management of lipohaemarthrosis which mandated an Orthopaedic Department review in a timely way. This new protocol will ensure that patients with fractures are now subject to timely investigation and treatment from a team of hospital therapists, in accordance with best practice protocols and are not reliant on GP judgement alone.

Quality improvements in communication

A complaint about an unnecessary catheterisation procedure drew attention to the complex matrix of systems underpinning informed consent and communication in a hospital outpatient context, and the impact on care and treatment when these foundations become dysfunctional.

The OHCC made extensive inquiries into a complaint about a hospital practitioner who had attempted to undertake a procedure that necessitated the insertion of a urinary catheter (an IDC) prior to an outpatient investigatory procedure. The particular procedure had not been ordered for the patient by his specialist, therefore he had not required the catheterisation.

Our analysis of how this mistake had occurred revealed significant gaps in the communication systems between hospital departments, between the hospital and the patient, and between the individual practitioner and the patient.

To reduce the risk of this distressing situation ever occurring again, the hospital initiated a number of quality improvements to its communication systems both between departments and with patients. Additionally, the hospital revised the preparation guidelines provided to patients before the IDC.

The practitioner involved also received guidance in improving his communication skills following the obligatory consultation between the OHCC and the Medical Board of Australia.

Quality improvements for in-patients with disabilities

A major private hospital made a range of key quality improvements in the standard of care provided to patients with significant disabilities following a complaint from the family of a non-verbal patient who required 24 hour care. These included:

- a policy clarifying the decision-making processes and requirements for all staff in relation to 'sitters' and carers for high-needs patients and those with disabilities;

- a video and education program based on a patient's experience to enhance staff understandings of the experiences of a patient with an intellectual disability during an admission to the hospital;

- a training module about Person Centred Care for discussion at all staff orientations; and

- a new communication tool for non-verbal or confused patients which allows staff to get to know these patients by ascertaining what is important to them.

Additionally, a new administrative role was created to improve the hospital experience for patients with high-needs. These patients are now identified and managed prior to admission to allow for the implementation of strategies to deliver tailored resources, staff education and/or alternative care pathways.

Improving access to regional primary health care services

A regional primary health care practice was keen to upskill in 'working with patients with challenging behaviours' as a result of our assessment of a complaint from a patient with a neurological disorder. The details of the complaint indicated it was underpinned by a miscommunication between the patient and the practice staff.

During the resolution process, the OHCC invited the practice staff to view the patient's difficult behaviours as consistent with his disorder, rather than indicative of his intent to be vindictive or to cause harm. Further, we suggested that the practice utilise the event as a catalyst for both enhancing communication skills in de-escalation and improving its understanding of the barriers to accessing primary health care services faced by patients with intellectual and psychological disorders.

Prior to closure of the matter, the practice confirmed that it was committed to using the incident as an educational experience. Further, the practice made a decision to contact the peak body representing persons with the disability experienced by the patient with a view to undertaking upskilling in regards to working with patients who have been diagnosed with the subject condition.

Hospital committed to improving access for all patients

Unable to access an outpatient's clinic at her local hospital because of her mental health condition, Ms R complained to the OHCC.

The hospital was very receptive to investigating the issues raised by Ms R and compliant in adopting the improvements suggested by the OHCC to improve their service delivery to patients with a mental health disability.

To this end, the hospital made considerable efforts to improve its Consumer Rights and Engagement Policy by including information about the Australian Charter of Healthcare Rights. Posters with information about patients' rights were placed strategically across the hospital and information was shared with staff through weekly hospital newsletters.

An important outcome of the complaint was the provision of training in conflict resolution and personal safety training for all staff to better manage patient interactions. Security staff were also upskilled during 2020 in de-escalation and in other physical interventions, such as holding and escorting skills.

Unregistered practitioners and the National Code of Conduct

The OHCC receives complaints about health services provided by unregistered practitioners such as naturopaths and massage therapists.

Recent amendments to the *Health Complaints Act 1995* will, when proclaimed, adopt a National Code of Conduct for Health Care Workers (the Code) which will be applicable for all unregistered practitioners.

The Code sets out a list of minimum standards of conduct and practice for all unregistered health care workers who provide a health service. These amendments will also give the Commissioner the power to investigate possible breaches of the Code. If there is found to be a breach of the Code, and where the Commissioner is satisfied that a health care worker's continued practice presents a serious risk to public health and safety, he will be able to issue a prohibition order prohibiting the health care worker from providing those services in the future.

The Code has not yet been proclaimed, however, and the Commissioner continues to have no disciplinary powers under the Act.

When the OHCC received a complaint about the conduct of a massage therapist, we undertook our regular assessment process; requesting responses and records from the therapist, reviewing the best practice guidelines.

The practitioner's response, which included a number of concessions about his conduct and qualifications, was considered against the Standards defined in the not yet proclaimed Code. We advised the practitioner about the impending implementation of the Code and highlighted that, had it been proclaimed, the concerns raised by the complainant may have given rise to possible breaches of a number of the standards.

As a result of the assessment process, the massage therapist acknowledged that he did not possess the appropriate qualifications to advertise himself as a qualified therapist.

He ceased working as a massage therapist.

Dispensing Practices in a Pharmacy

A complaint was received about serious problems encountered with the dispensing of a Webster-pak by a pharmacy.

A response was obtained from the provider who explained that issues had arisen due to lack of education of staff and gaps in their dispensing procedures. The provider agreed to

undertake a number of improvements to its work practices to ensure the problem did not occur again, including the following:

- a review of internal procedures to ensure any pick up restrictions are clearly documented and recorded in the patient's dispensing history, Webster profile packing sheet and Webster-pak pick up sheet;

- all current patient profiles are completely up to date;

- contact was made with local general practitioners and clinics asking for information on any special restrictions that may be in place for mutual patients to ensure records are up to date; and

- cross-skilling and sharing of roles between staff in the pharmacy to ensure all staff are familiar with the requirements in each role.

The response and actions of the Pharmacy to the concerns raised was considered reasonable in the circumstances and sufficient to restore trust in the service for the complainant.

Immunisation practices in a Doctors Surgery

A complaint was received regarding the mistaken administration of adult doses of a vaccine to two children in a general practice setting.

The response from the general practitioner and the practice nurse revealed the mistake had occurred as a result of human error. AHPRA was notified in relation to both practitioners and following investigation no further action was taken in relation to the matter.

At the time of the incident the general practice had policies in place regarding the administration of vaccinations, but the complaint highlighted the need for tighter risk management regarding the processes surrounding the administration of vaccines.

As a result of the complaint process, the following systems' improvements were implemented in the practice to reduce the risk of a similar incident occurring:

- paper drug orders;

- in house education on vaccinations;

- updated vaccination lists in each consulting room;

- online training course for the registered nurse involved in the incident; and

- a further three Nurse Immuniser's have been employed.

This complaint is an example of the resolution process resulting in quality improvements designed to reduce the risk of an error occurring again. Additionally, the complaint highlighted the broader need for the reporting of vaccine errors to public health bodies to assist with quality assurance and training. This will be followed up with consideration given to confidentiality of matters.

Administration of Vaccination by General Practitioner

A complaint was received by this office from a complainant seeking compensation from a general practitioner for a debilitating condition allegedly acquired as a result of the incorrect administration of a vaccine.

The practitioner advised they had followed standard protocol in relation to the administration of the vaccination and there had been no deviation from their usual technique. The Medical Board of Australia sought referral of the matter, but following investigation it was determined that the care provided by the practitioner had been reasonable and no further action was required.

Despite the Board's finding, the practitioner made an ex gratia offer to pay a small amount of compensation to the complainant in exchange for a signed deed releasing the practitioner from all further liability in relation to the procedure. The complainant accepted the offer.

This complaint is an example of a matter being resolved prior to conciliation, through consideration of the complainant's desired outcome, and both parties willing to meet in the middle. This reduces the length of time and resources that are utilised in civil proceedings.

Appendix 1 – Statistics

Table 8 - Reasons for Closure in Assessment Stage

Reason	2018-19	2019-20
Dismiss - Section 25 (5) (a) Complainant not a person entitled under s22	2	10
Dismiss - Section 25 (5) (b) Complaint does not disclose a subject matter referred to in s23	5	8
Dismiss - Section 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago	1	2
Dismiss - Section 25 (5) (d) Complainant has not attempted direct resolution	19	23
Dismiss - Section 25 (5) (e) Issues adjudicated by court or tribunal	2	1
Dismiss - Section 25 (5) (g) Complainant has been given reasonable explanation and information	161	176
Dismiss - Section 25 (5) (h) The complaint lacks substance	7	7
Dismiss - Section 25 (5) (i) The complaint is frivolous, vexatious or not made in good faith	1	2
Dismiss - Section 25 (5) (j) Complaint has been resolved	41	62
Other	5	3
Out of Jurisdiction	4	2
Resolved	113	0[1]
Section 25 (1) (a) Complaint referred to the Ombudsman or another person	31	29
Section 30 (1) The complaint has been withdrawn in writing	8	7
Total	400	332

[1] No cases were recorded under this closure reason this reporting year. They were instead attributed closure reasons under s 25(5) (g) or s25 (5)(j)

Outcomes achieved through the assessment process as set out in Table 9 included apologies, provision of services, refunds of costs, and recommendations for, and the implementation of, quality improvements such as changes in policy or procedure. It should be noted that more than one outcome may result from one complaint. Examples of cases finalised in assessment appear in the case studies earlier in this report and are published on our website.

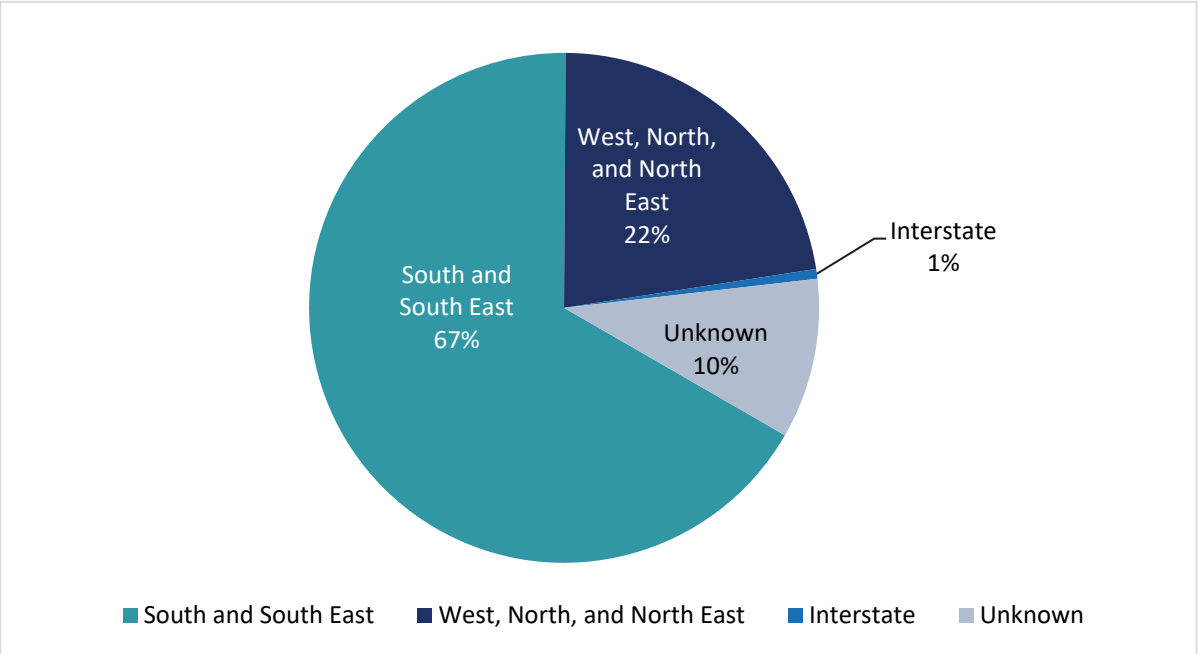
Table 9 - Outcomes from Assessment Stage

Outcomes	2018-19	2019-20
Apology Given	68	38
Change in Policy	20	11
Change in Procedure	25	15
Compensation Received	3	2
Concern Registered	179	82
Explanation Given	173	102
Fees/Costs - Refunded, waived or reduced	9	17
Information obtained	207	184
Quality Improvement	27	17
S25(1)(a) Referral to Registration Board or other person	0	32
Service Obtained	90	59
Total	854	559

Table 10 - Outcomes from Conciliation

Outcomes	2018-19	2019-20
Apology Given	8	7
Change in Policy	0	3
Change in Procedure	0	3
Compensation Received or agreed	2	3
Concern Registered	8	10
Explanation Given	7	14
Information obtained	3	11
Quality improvement	4	5
Service obtained	1	5
Total	37	61

Figure 3 - Geographical location of complainants



What did they complain about?

Issues by category

Table 11 - Summary of issues by category

Issue	2018-19	2019-20
Access	90	110
Communication and information	122	90
Consent	13	16
Discharge and transfer arrangements	20	8
Environment / Management of facilities	20	5
Fees and costs	20	21
Grievance processes	22	16
Inquiry service	36	29
Medical records	22	6
Medication	113	132
Professional conduct	43	24
Reports / certificates	7	16
Treatment	214	188
Total	745	661

A breakdown of the issues arising from complaints closed in the reporting year is set out in Tables 12 to 24. It should be noted that a significant number of complaints contain more than one issue.

Table 12 - Access

Issue	2018-19	2019-20
Access to facility	3	1
Access to subsidies	1	1
Refusal to admit or treat	7	5
Remoteness of service	1	0
Service availability	68	101
Waiting lists	10	2
Total	90	110

Table 13 - Communication and Information

Issue	2018-19	2019-20
Attitude/manner	51	46
Inadequate information provided	35	27
Incorrect/misleading information provided	28	13
Special needs not accommodated	8	4
Total	122	90

Table 14 – Consent

Issue	2018-19	2019-20
Consent not obtained or inadequate	8	8
Involuntary admission or treatment	2	3
Uninformed consent	3	5
Total	13	16

Table 15 – Discharge and Transfer Arrangements

Issue	2018-19	2019-20
Delay	4	1
Inadequate discharge	13	6
Mode of transport	2	1
Patient not reviewed	1	0
Total	20	8

Table 16 – Environment / Management of Facilities

Issue	2018-19	2019-20
Administrative processes	14	4
Cleanliness/hygiene of facility	1	1
Physical environment of facility	1	0
Staffing and rostering	1	0
Statutory obligations/accreditation standards not met	3	0
Total	20	5

Table 17 – Fees and Costs

Issue	2018-19	2019-20
Billing practices	15	12
Cost of treatment	0	3
Financial consent	5	6
Total	20	21

Table 18 – Grievance Processes

Issue	2018-19	2019-20
Inadequate/no response to complaint	20	14
Information about complaints procedures not provided	1	0
Reprisal/retaliation as a result of complaint lodged	1	2
Total	22	16

Table 19 – Inquiry Service

Issue	2018-19	2019-20
Request for information - Health Service	1	5
Request for information - Other	10	3
Request for Information - Commission	1	1
Request for information - Complaint mechanisms	21	20
Request review	3	0
Total	36	29

Table 20 – Medical Records

Issue	2018-19	2019-20
Access to/transfer of records	14	4
Record keeping	4	2
Records management	4	0
Total	22	6

Table 21 – Medication

Issue	2018-19	2019-20
Administering medication	12	8
Dispensing medication	3	8
Prescribing medication	96	116
Supply/security/storage of medication	2	0
Total	113	132

Table 22 – Professional Conduct

Issue	2018-19	2019-20
Assault	3	1
Competence	25	14
Discriminatory conduct	3	1
Emergency treatment not provided	1	0
Inappropriate disclosure of information	10	6
Sexual misconduct	1	2
Total	43	24

Table 23 – Reports/Certificates

Issue	2018-19	2019-20
Accuracy of report/certificate	2	6
Cost of report/certificate	0	1
Refusal to provide report/certificate	4	5
Report written with inadequate or no consultation	1	1
Timeliness of report/certificate	0	3
Total	7	16

Table 24 – Treatment

Issue	2018-19	2019-20
Coordination of treatment	17	18
Delay in treatment	23	15
Diagnosis	17	32
Excessive treatment	1	2
Experimental treatment	1	0
Inadequate care	44	28
Inadequate consultation	6	2
Inadequate prosthetic equipment	3	4
Inadequate treatment	39	24
Infection control	2	1
No/inappropriate referral	21	7
Rough and painful treatment	7	9
Unexpected treatment outcome/complications	24	41
Withdrawal of treatment	2	1
Wrong/inappropriate treatment	7	4
Total	214	188

Who did they complain about?

Table 25 – Complaints received about Health Organisations

Health Organisation	2018-19	2019-20
Aged Care	2	0
Ambulance	3	3
Community Health	5	0
Correctional Health	135	150
Dental Practices/Clinics	5	6
Department of Health (previously DHHS)	15	8
Diagnostic Services	0	1
Disability Services	2	2
Medical Practices/Clinics	30	22
Mental Health Services	9	10
Optometrist	2	2
Oral Health Services	1	2
Other	7	8
Pathology	0	2
Pharmacies	7	5
Private Hospitals	7	7
Public Hospitals	61	43
Total	291	274

Table 26 – Issues Relating to Correctional Primary Health Service

Issue	2019-20
Access	80
Communication & information	9
Environment/management of facilities	1
Inquiry Service only	3
Medical records	2
Medication	100
Professional conduct	1
Reports/certificates	3
Treatment	15
Total	214

Hospitals

Table 27 – Issues Relating to Private Hospitals

Issue	2018-19	2019-20
Access	0	2
Communication & information	6	1
Consent	1	0
Discharge and transfer arrangements	2	1
Environment/management of facilities	1	0
Fees & costs	1	1
Grievance processes	2	1
Medical records	1	0
Medication	1	1
Professional conduct	1	1
Treatment	15	7
Total	31	17

Table 28 – Issues Relating to Public Hospitals

Issue	2018-19	2019-20
Access	12	11
Communication & information	40	24
Consent	4	9
Discharge & transfer arrangements	11	4
Environment/management of facilities	3	0
Fees and costs	4	1
Grievance processes	10	3
Inquiry service only	3	5
Medical records	6	0
Medication	5	5
Professional conduct	11	4
Reports/certificates	0	2
Treatment	79	63
Total	188	131

Individual Providers

Table 29 - Complaints about Individual Providers

Provider	2018-19	2019-20
Chiropractor	2	0
Dental	7	9
Medical practitioner	56	21
Nurse	3	1
Optometrist	0	1
Other/unknown	11	12
Pharmacist	2	3
Psychologist	4	2
Total	85	49