# Annual Report
## 2021 - 2022

Health Complaints Commissioner
Tasmania

# Health Complaints Commissioner

## Annual Report 2021-2022

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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 2021-2022.

Yours sincerely

Richard Connock
HEALTH COMPLAINTS COMMISSIONER

3 November 2022

# About this Report

This report describes the functions and operations of the Health Complaints Commissioner Tasmania for the year ending 30 June 2022.

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@healthcomplaints.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 2021-2022 reporting year.

## INTRODUCTION

The last financial year can be separated into two clear halves; before and after the re-opening of the Tasmanian borders to all mainland states on 15 December 2021. After nearly two years of relative safety from COVID-19, the hundreds of thousands of visitors to the state over summer caused waves of the Omicron variant to spread through the Tasmanian population in January and then March-April 2022.

By the end of the reporting year, at least a third of Tasmanians had been infected by the virus and in the region of 100 people had died[1]. This high level of COVID-19 transmission created significant stress on the resources of both public and private medical services. My Office was inundated with COVID-19 related enquiries and complaints for most of January, February and March as the high level of transmission resulted in confusion and distress in the community. A large proportion of these complaints raised issues about the enforcement of Public Health regulations and as such were referred to the dedicated Public Health complaints unit which was subsequently established.

Matters that were outside the ability of Public Health to resolve, such as the position taken by health providers in relation to the eligibility criteria for mask and vaccination exemptions, contributed to a large number of complaints about 'refusal to treat'. Given the often unique nature of each complaint, these were necessarily assessed on a case by case basis. In this regard issues of discrimination were frequently raised by complainants, which resulted in referrals to the Anti-Discrimination Commissioner.

In addition to this, health service providers, particularly the public hospitals, continued to struggle with the impact of illness due to the virus causing low staffing and high admissions well into the year. This situation necessarily impacted on the capacity of the Tasmanian Health Service to respond to complaints and participate in conciliation meetings.

[1] Public Health Tasmania: https://www.coronavirus.tas.gov.au/important-community-updates

To protect against COVID-19 spreading throughout the vulnerable prison population, increased safeguards were introduced by the Tasmanian Prison Service which resulted in a higher than normal number of lockdowns to address outbreaks and staff shortages due to illness. In turn, this situation created further barriers for prisoners in accessing health care. Complaints from inmates about this situation increased markedly throughout the last half of the financial year.

Because of the higher than normal volume of complaints this year, as mentioned above, and staff shortages due to illness and other reasons, at the end of the year there were 290 active cases carried forward. This was a significant increase on the 80 cases carried forward last year.

In relation to resourcing, I was reassured to receive a large increase in funding for the 2022/23 financial year. Nonetheless, the 2021/2022 reporting year was another challenging one for my Office.

## STAFFING

'Adjustment and change' has characterised the Health Team during this reporting period.

The most significant change has been the transition of my long term, and extremely dedicated Principal Officer to another role in my Office. After a lengthy absence, she transitioned to her current role of Senior Conciliation Officer on 8 March 2022, working part time from Launceston. The position of Principal Officer was subsequently advertised, and in May 2022 I appointed a new Principal Officer.

A new Senior Investigation Officer (SIO) commenced in the Office in July 2021, appointed to a 12 month contract at 0.8 FTE[2]. In March 2022 my 0.6 FTE, a very experienced SIO accepted a secondment to another agency. This position was subsequently extended to full time and was filled on a fixed term basis in April 2022. In light of the complexity of most health complaints, it goes without saying that when new staff are recruited there is a lag in productivity as their induction entails a dedicated training period of several months.

In the second half of the financial year, the Intake and Assessment position remained vacant for approximately four months due to illness. This contributed to a large backlog

[2] This appointment has recently been made permanent

in enquiries and complaints, which in turn contributed to the large number of cases carried forward.

Due to circumstances largely out of our control, for the last four months of the financial year my Office consisted of 2.6 full time equivalent staff.

## INCREASED RESOURCING

For many years we have been reporting on the importance of the role of this Office and its inability to properly perform its functions due to inadequate resourcing. We are very fortunate to have received funding to appoint another permanent Senior Investigation Officer and a fixed term Conciliation Officer for the 2022-23 period.

## CODE OF CONDUCT

As I reported last year, legislation was passed through the Tasmanian Parliament in 2018 to amend the Health Complaints Act to make provision for the implementation of a Code of Conduct for Health Care Workers. These amendments give me the power to investigate complaints about unregistered health care workers and, in cases where they are found to be in breach of the Code and representing a significant risk to the public, to issue prohibition orders preventing their continued practice.

These amendments have not yet been proclaimed. As I have previously reported, any complaints related to the Code would mean an added strain on resources that are already stretched. If a significant number are received, our resources will not be sufficient to deal with them even taking into account the additional funding. There will also need to be extensive modifications to our case management system to accommodate workflows related to the administration of the Code.

## LEGISLATIVE REVIEW

As reported last year, the Health Complaints Act is overdue for a review and update so that it better reflects the work the Office now carries out, in the 25 years since it was proclaimed. I have recently secured funding for work in this regard to be undertaken by a consultant and I plan for this to happen as soon as possible and to be completed by the end of the current financial year.

## CHARTER OF HEALTH RIGHTS

As I reported last year, one of the main functions of the Commissioner under the Act is to develop and review a Charter of Health Rights. The Tasmanian Charter of Health Rights was developed in 1998 but has not been reviewed since. Similar to the Health Complaints Act, a review process, which will require extensive consultation with stakeholders, will also be undertaken in the near future.

## OUTREACH AND EDUCATION

My OHCC staff continually provide information to both complainants and providers on how they can make and respond to complaints most effectively, however we have not yet undertaken any formal training in this regard.

In 2021 I participated in an information forum with Australian Health Practitioner Regulation Agency (AHPRA) representatives arranged on the initiative of Health Consumers Tasmania (HCT). More of these are planned for 2022/23.

In May my Principal Officer provided an information session to Kingston U3A[3] on the role of my Office and how we could support their members in accessing our services. This presentation was well received and I will explore more outreach and training opportunities in the coming years.

## CONCILIATION

As mentioned earlier, a permanent, part time conciliation role was filled in March 2021. As at the end of the reporting year, although a number of complex matters are progressing though the conciliation process, none has been finalised.

## CASE MANAGEMENT SYSTEM

A major whole of office upgrade of the Resolve case management system was successfully completed in 2022. I have previously reported on the need to also upgrade Resolve as it relates specifically to Health Complaints, which was first introduced more than 12 years ago. We had planned to address this with an upgrade in early 2020 but 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, and also in the hope the legislative review foreshadowed above will be completed in the near future.

[3] University of the Third Age.

## 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 yet another challenging year.

The significant increase in funding which my office received in the reporting year and over the next two years will enable me to employ additional officers to ease the burden on existing staff and allow the office to broaden the scope of its work.

Unfortunately, personnel changes, vacancies and recruiting difficulties have led to something of a backlog of matters. I am confident, however, that once all positions have been filled, this backlog will be addressed.

# Office of the Health Complaints Commissioner

The *Health Complaints Act 1995* established the Office of the Health Complaints Commissioner (OHCC), which was first filled 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 as at 30 June 2022

| Position | Male | Female | Total |
|---|---|---|---|
| Commissioner | 0.2 | 0.0 | 0.2 |
| Principal Officer (Band 8) | 0.0 | 1.0 | 1.0 |
| Senior Conciliation Officer (Band7) | 0.0 | 0.6 | 0.6 |
| Senior Investigation Officer (Band 6) | 0.8 | 1.0 | 1.8 |
| Intake and Assessment Officer (Band 4) | 0.0 | 0.8 | 0.8 |
| Total | 1.0 | 3.4 | 4.4 |

# 2021-2022 At a glance

## SNAPSHOT

- 1310 approaches

### *Complaints opened*

- 769 complaints opened
- 498 complaints assessed within 45 days

### *Complaints closed*

- 631 complaints closed
- 122 complaints closed within three months

# 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 through 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.

For the purpose of the statistics which follow:

An ***enquiry*** is a case where a person or organisation is either seeking information from, or providing information to, the OHCC.

A ***complaint*** is a case where it is obvious that the person wants to make a complaint, rather than just seek or provide information, and where we undertake some form of assessment under the Act - even if that is only as to jurisdictional and threshold issues - or if we refer them to someone else.

A ***notification*** is a case where a person lodges a notification with AHPRA which, following consultation with this Office as to which is the preferred entity to deal with the matter, it is agreed that AHPRA should retain the matter.

## OVERALL CASE ACTIVITY

As set out in Table 2, when compared with overall case numbers last year, there was a marked increase in the number of cases received (23%), and a significant increase (263%) in the number of cases carried forward to the 2022/23 financial year.

Table 2 – Overall case activity

| Total cases | 2020-21 | 2021-22 | Variance |
|---|---|---|---|
| Cases carried forward | 131 | 80 | -39% |
| Cases received | 1,065 | 1,310 | 23% |
| Cases closed | 1,120 | 1,110 | -2% |
| Cases active | 80 | 290 | 263% |

## ENQUIRIES

Table 3 indicates a small reduction in the number of enquiries received (-6%) and a significant number of these were carried forward at the end of the reporting year. This is directly attributable to extensive staff absences in the first half of 2022.

Table 3 – Enquiry Activity

| Enquiries | 2020-21 | 2021-22 | Variance |
|---|---|---|---|
| Enquiries received | 573 | 541 | -6% |
| Enquiries closed | 580 | 469 | -19% |
| Enquiries active | 18 | 90 | 400% |

## COMPLAINTS

Table 4 indicates a very significant increase from last year in both the number of cases opened (75%) and the number of cases closed (29%) as complaints this reporting year. Again, the variation from last year's statistics is mostly attributable to the higher than normal number of complaints received in the reporting year and staffing shortages.

Table 4 – Complaint Activity

| Complaints* | 2020-21 | 2021-22 | Variance |
|---|---|---|---|
| Complaints carried forward | 71 | 62 | -13% |
| Complaints received | 440 | 769 | 75% |
| Complaints closed | 487 | 631 | 29% |
| Complaints active | 62 | 200 | 223% |

*Excludes complaints that start as notifications from AHPRA

## NOTIFICATIONS

The OHCC also receives notifications from AHPRA.

Table 5 - Notification Activity

| Notifications from AHPRA | 2020-21 | 2021-22 |
|---|---|---|
| Notifications carried forward | 1 | 0 |
| Notifications received | 52 | 57 |
| Notifications closed | 53 | 57 |
| Notifications Active at 30/6 | 0 | 0 |

# Who and what did people complain about?

## ISSUES RAISED

Consistent with previous reports the recurring issues raised in complaints relate to concerns about treatment, poor communication, access to services and failure to prescribe medication.

Table 6 – Common issues

| Issue | Number of complaints |
|---|---|
| Treatment | 382 |
| Communication and information | 149 |
| Access | 144 |
| Medication | 136 |
| Environment and facilities | 56 |
| Professional conduct | 47 |

## HEALTH SERVICE ORGANISATIONS

As in previous years, the main source of complaints about health organisations came from prisoners in the Tasmanian Prison Service (TPS) and related to Correctional Primary Health Services (CPHS). This was followed by complaints about public hospitals and then medical practices.

Table 7 - Complaints about Health Organisations

| Issue | Number of complaints |
|---|---|
| Correctional Primary Health | 262 |
| Public Hospitals | 132 |
| Medical Practices/Clinics | 84 |
| Private Hospitals | 17 |

## *Correctional Primary Health Services (CPHS)*

As in previous years, inmates contacted this Office directly through the prison's secure telephone system at no cost to them.

During the reporting period there was a 33.7% increase (from 196 to 262) in the number of complaints received about CPHS compared with last year. The reasons for this significant increase in complaints are multifaceted but largely related to difficulties encountered by both staff and inmates in providing and accessing health services respectively during the numerous lockdowns due to both COVID-19 and TPS staff shortages. There was almost a 300% increase in 'access to treatment' complaints, the most common issue raised by inmates, consistent with the impact of the lockdowns.

Table 8 – Main issues arising from complaints about CPHS

| Issue | Number of issues |
|---|---|
| Treatment | 145 |
| Medication | 100 |
| Access | 72 |
| Communication and information | 18 |

## *Public Hospitals*

In line with previous years, public hospitals were the subject of the next highest number of complaints. There was a 76% increase in the number of complaints about public hospitals. The number of complaints received this year (132) was a significant increase on previous reporting years – for example there were 61 in 2018/19 and 75 in 20/21. As in previous years, the main issues raised in relation to hospitals were treatment and communication. There was no increase in the number of complaints received about mental health services, there were 18 in 2021 and the same number this year.

## *Medical Clinics*

There was also an increase in the number of complaints (from 36 to 84) about medical clinics. Recurring themes were concerns raised about mask and vaccination mandates. We also received a number of complaints relating to the termination of the therapeutic relationship as a consequence of alleged patient aggression.

### *Private Hospitals*

There was an increase of 113% in complaints about private hospitals – from eight last year to 17 this year). This increase was largely attributable to issues related to private hospitals managing and adapting to waves of COVID-19.

## INDIVIDUAL PROVIDERS

We received 143 complaints about individual health service providers this year. This is in addition to 57 notifications received from AHPRA. This is almost a 250% increase from last year when we received 41complaints and 52 notifications. The majority of complaints and notifications we received about individual providers related to medical practitioners. As noted in previous reports, this is attributable to there being more doctors than any other individual health providers who practice in their own right. Complaints about nurses for example are usually incorporated into complaints about hospitals. There was an increase in the number of complaints about medical practitioners received this year from 32 to 69.

# How were complaints and notifications resolved?

Table 9 - Reason for closure of complaints and notifications

| Reason closed | 2020-21 | 2021-22 |
|---|---|---|
| No further action following assessment | 452 | 608 |
| Referred to board pursuant to MoU[4] | 22 | 23 |
| Retained by board pursuant to MoU | 53 | 57 |
| Conciliation completed | 12 | 0 |
| Investigation (discontinued) | 1 | 0 |
| Total | 540 | 688 |

## ASSESSMENT

The majority of complaints received are closed following assessment. This was the case for 608 complaints closed this year. Table 10 at the end of this report provides more detail about the outcomes of assessment.

### *What is Assessment?*

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, but 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.

### *Preliminary Assessment*

The Act sets out a number of criteria to be satisfied before we can accept a complaint. If these criteria are not met, or if there is another organisation or person better equipped to deal with the complaint, then it is either dismissed or referred to the other entity as required.

[4] The Memorandum of Understanding between AHPRA and the Health Complaints Entities, see Referral to Registration Boards on page 16

This financial year 251 cases were dismissed following preliminary assessment. Of these, 233 were closed for failure to meet threshold issues or were withdrawn, and 18 were referred to another person or entity other than AHPRA. In some cases these referrals involved a facilitated referral back to the health service provider.

### *Quick Resolution*

Of the remaining cases, a further 274 were closed through our Quick Resolution pathway. 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 on the telephone and negotiating outcomes, such as a refund or waiver of fees or the provision of a service. Most cases about Correctional Primary Health Services fall into this category. These cases are recorded as having been closed in assessment on the basis that a reasonable explanation has been provided or that the complaint has been resolved.

### *Formal Assessment*

All remaining complaints, including those ultimately referred to AHPRA, conciliation or investigation, undergo a more formal assessment process. This involves making preliminary enquiries, including: obtaining formal written responses from the provider; receiving and reviewing medical records; identifying and reviewing relevant clinical standards; and, where necessary, consulting with AHPRA in relation to registered health practitioners involved in the episode of care.

Throughout this formal assessment process we continue to look for opportunities to resolve the complaint, and for possible improvements in the delivery of health services, without the need for referral to formal investigation or conciliation. In this reporting year, 83 complaints were closed following this assessment process on the basis that a reasonable explanation had been provided or that the complaint had been resolved.

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 enquiries and analysis to be undertaken, and resolution explored, without the need for referral to formal investigation or conciliation.

These cases are in effect "mini investigations" or informal conciliations and the closure reasons do not reflect the complexity or extent of the work undertaken. These cases represent a large percentage of the cases carried forward at the end of the reporting year.

## REFERRAL TO REGISTRATION BOARDS

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 the 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, the OHCC obtains information and undertakes preliminary enquiries sufficient to enable us to make a recommendation to AHPRA.

Similarly, when a notification is received by AHPRA, if the subject matter of the notification could form the basis of a complaint to the OHCC, AHPRA is required to notify and consult with the OHCC as to which entity should handle the matter. More often than not these notifications are retained by AHPRA.

## CONCILIATION

When there is an adverse outcome from an episode of care, 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.

In the last financial year my Office recruited a permanent part time (0.6FTE) conciliator in March. This effectively translated into conciliation services only being available for three months. As a result of this situation, although there are a number of complex complaints now progressing through the conciliation process, none have been completed this year.

## 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. No cases were referred to Investigation this year.

# Time taken to assess and finalise complaints

## TIME TAKEN TO ASSESS COMPLAINTS

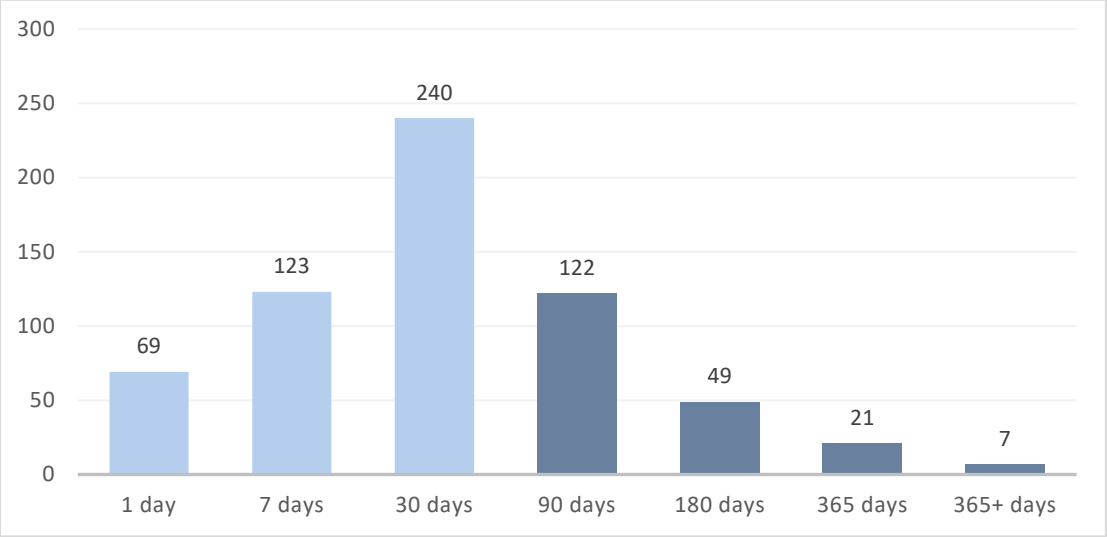
The Act requires that a complaint be assessed within 45 days. This can be extended to 90 days, and longer in some cases. There are a number of circumstances, described in past annual reports, and referred to earlier in this report, which are beyond our control and which have an impact on our ability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

In particular, as mentioned earlier, due to the spread of COVID-19 amongst healthcare workers resulting in staff shortages, we experienced significant delays in the THS providing responses to complaints about public hospitals and other State funded services.

## TIME TAKEN TO FINALISE COMPLAINTS

Figure 1 below illustrates the time it takes to finalise complaints. As previously noted, the less complex complaints were generally resolved within three months and made up around 86% of all complaints received. The remaining 14% tended to be more complex.

Figure 1 – Time taken to finalise complaints



# 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.

## COMPLAINTS RESOLVED IN ASSESSMENT

### *Improvements to mobile dental services provided in residential aged care facilities (RACF)*

This complaint demonstrates how the OHCC and AHPRA collaboratively manage complaints under the National Law.

Our Office received a serious complaint about an interstate mobile dental practice (the dental practice) from the Next of Kin of a resident of a residential aged care facility (RACF) raising concerns about possible over servicing and upselling of dental services provided to residents in a RACF. The complainant also raised concerns about the attitude and manner of the staff of the dental practice. The resident had a decision making disability and the complainant was her enduring guardian.

In particular, the complainant alleged that the resident had been given treatment without his consent (as her enduring guardian) and also that the treatment was unnecessary. He had also received an account for a much larger sum than that to which he had committed at the time of booking the appointment for the resident. After much consternation he had received a partial refund (for work which he believed had not been undertaken) from the dental practice. However, in order to obtain a full refund, he complained to the OHCC as the dental practice was unwilling to either address his concerns about the performance of the provider, or their billing and booking systems.

As required under the National Law we consulted with AHPRA who agreed to accept referral of the complaint about the performance of the practitioner. Following investigation by the Dental Board of Australia (the Board), conditions were imposed on the practitioner's registration.

The OHCC also made extensive inquiries with the dental practice and ultimately obtained a full refund, an apology and an explanation for the complainant. In regards to improvements, the dental practice agreed to implement a range of patient safeguards to protect residents from possible overservicing.

The systems improvements included the following:

- enhanced audits of dentists working remotely to assess compliance and the potential for over servicing;
- retaining a senior practitioner who randomly provides Peer Oversight of treatments and treatment plans and also oversees patient Next of Kin complaints; and
- amendments to the booking system such that the Next of Kin is now informed that conversations are being recorded and is given the opportunity to refuse this should they wish to.

The complainant was satisfied with the outcome of the complaint and felt relieved that the practitioner's performance had been considered by the Board and action had been taken. The systems improvements will hopefully contribute to the safety of vulnerable residents of RACFs, particularly those without decision making capacity.

### *Reinstatement of Patient Travel Assistance*

An aged pensioner raised concerns about the rejection of her application to receive transport assistance funding through the Patient Transport Assistance Scheme (PTAS) to subsidise the costs she incurred in travelling some 250 kilometres from her home to receive specialist treatment.

The funding had been ceased on the basis that the complainant should receive treatment from a specialist in her home town. However the complainant had previously experienced a negative outcome with that specialist and was unable to return as the relationship had broken down.

The OHCC requested a review of the decision by PTAS on the basis that they were acting in a manner that was inconsistent with the Charter of Health Rights.

PTAS undertook a review and the complainant's travel assistance funding was reinstated. As the complainant was a full pensioner, this financial outcome was very gratefully received.

### *Training provided to Emergency Department medical staff*

We received a complex complaint from a patient who had experienced a series of adverse events during a presentation (by ambulance) to the Emergency Department (ED) of a public hospital. In summary, the patient had received both an incorrect diagnosis and treatment during the episode of care due to the apparent failure of staff to take a thorough history from her and respond appropriately to the results of her CT scan.

During assessment of the matter the adverse events were forensically examined and the sources for the mistakes were established and ultimately relayed back to the hospital. In light of the significant negative impact of the experience on the complainant, and the importance of mitigating the risk of such a situation occurring again, we suggested that the complaint be utilised as the basis of some form of training or review process for ED staff. The Tasmanian Health Service subsequently advised our Office that the issues identified through the complaints process had been provided to the leadership teams and used to inform training for staff of the ED.

Additionally, we consulted with the Medical Board of Australia in relation to the performance of four practitioners. The Board made a determination of 'no further action' for all four practitioners on the basis that their performance did not represent a risk to the public.

As a result of the complaint process, the patient received an apology and a detailed explanation about what had caused the series of mishaps. Most importantly for the patient however, was the likelihood that health services were potentially improved through enhanced education and training for ED staff.

### *Compensation paid*

A patient complained about dental treatment received at a dental practice, alleging that they had experienced strong pain following the treatment; that they believed a tooth had been wrongly extracted; and that crowns fitted by the dentist were ill fitting and would damage their teeth. The patient was seeking an explanation and compensation to fund remedial work they believed was required.

The OHCC obtained a response to the concerns raised by the patient in which the dentist provided a detailed explanation of the treatment and disputed the allegations of unsatisfactory treatment. The OHCC formed the view that the evidence, which included medical records, tended to support the practitioner's version of events and was satisfied that the complaint did not support a finding that the dentist posed an unacceptable risk of harm to the public.

Although there was a dispute of fact between the patient and the provider, the latter agreed, without admission of liability, to resolve the complaint by way of a payment of $8000.00 to enable the patient to seek a further opinion and treatment if required.

### *Systemic change – Pathology test results policy and practise changes*

A patient complained about the policies and practises associated with regular pathology tests related to a renal condition. The patient complained that the health service provider refused to provide the pathology test results either directly to the patient or

to their treating specialist other than through the provider's records system, stating that this was the provider's policy.

The patient complained that the specialist was unable to access the results from outside the provider's location – for example when seeing patients at outside clinics. This had resulted in the patient attending a follow up appointment with their specialist, during which no test results were available to discuss.

The OHCC discussed the patient's concerns with the provider and obtained a detailed response in which the provider agreed to change its policy regarding pathology results. They committed to providing the pathology results to the patient and their treating specialist either directly or via the Personally Controlled Electronic Health Record system in future.

The complaint was closed on the basis that it had been resolved to the parties' satisfaction.

### *Referral of complaint to National Disability Insurance Scheme Quality and Safeguards Commission*

A registered health practitioner raised concerns that a health service provider working with a vulnerable client with disability may be engaging in health practice outside of the scope of their training and qualifications and may pose a risk of harm to the public. The complainant was concerned that the provider was misrepresenting their qualifications and expertise and was suggesting diagnoses without possessing an adequate understanding of the symptoms, diagnostic criteria and associated clinical and medical features of the client's conditions. The complainant was also concerned that the provider was designing a treatment plan for the client, despite not being qualified to design and administer interventions of this nature, and which were potentially harmful to the client.

The provider was not registered under the *Health Practitioner Regulation National Law* ('the National Law') as a health practitioner, however, the complainant believed that the provider was in effect performing the work of a health practitioner practicing in a profession regulated by the National Law.

The matter was referred initially to (AHPRA) but it advised that it was unlikely that the matter would be progressed through an investigation and/or to prosecution.

The issues raised in the complaint were also discussed with the National Disability Insurance Scheme Quality and Safeguards Commission ('NDIS QSC') and it was agreed that, while the complaint fell within the scope of matters that could be handled by the OHCC, the complaint was more appropriately dealt with by the NDIS QSC. This was

primarily because the NDIS QSC has powers to investigate and impose penalties, including banning workers or providers, de-registering providers and seeking civil penalties. The NDIS QSC also has the capacity to obtain, and if necessary, compel the provision of information about NDIS clients and people working or volunteering with NDIS clients.

### *Systemic change – Professional development for practitioners at a dental practice*

A patient raised concerns about dental treatment they received which they alleged resulted in the need for extensive remedial work.

The OHCC obtained a detailed response to the complaint from the provider. In the course of providing that response, the provider indicated that they had reflected on the circumstances of the complaint and consulted with senior dental specialists about whether, and how, the treatment might have been more appropriately and effectively delivered. As a result of this, the provider, who is also the owner of the practice, arranged for a specialist to deliver a training course to dentists at the practice. This education has assisted the practitioners to better understand and approach the complex work of the nature of that referred to in the complaint.

### *Improvements to monitoring of patients in the high dependency wards of a public hospital*

Family members of a patient on a general ward at a regional public hospital complained to staff about the sudden and serious deterioration of their relative when they were visiting him. This patient had spinal injuries and other complex health issues. The patient had been moved from the intensive care unit to a general ward which resulted in reduced emergency response monitoring. The patient had also been recently moved from one hospital to another by Ambulance, allegedly without a proper explanation to the family. The patient later died because of multiple and complex health issues.

Consultations and enquiries with the Coroner's Office and the Hospital commenced and a review was provided by the OHCC's Clinical Advice Committee.

During the complaint process, the Tasmanian Health Service (THS) apologised and provided explanations to the patient's family. Representatives of the THS met with the family to discuss their concerns. Additionally, the THS committed to the following improvements:

- additional funding to the Hospital;
- additional education and training in relation to quadriplegic patients and deteriorating patients and this education and training is to be documented;

- family members, patients and carers are able to contact the emergency response team;
- discussion of the learnings of this case with neurosurgical staff;
- the transfer of care from the intensive care unit to a high dependency ward rather than a ward, would be reviewed for optimal patient management; and
- that ambulance transfers are to be discussed and Ambulance Tasmania to provide their procedures to the family in future.

The patient's family was satisfied with the response from the THS.

### *Improvements in communication between a patient and health care provider due to effective health advocacy*

A complainant said that he is often in chronic pain and needs to attend a Community Health Clinic in the area where he lives. He said that he has a loud voice which is often mistaken for aggression. As a result, he felt as though he was not being adequately listened to when he raised his concerns during his weekly medical appointments with Clinic staff. He complained to both the OHCC and another agency, seeking an improvement in communication and treatment, as he had a need to continue to attend the Clinic.

This Office made enquiries with the Clinic, the other agency and advocates for the complainant in the process.

By letter, the Clinic apologised to the patient for not listening to his concerns and a consistent staff member was organised to see him. An agreement was also signed by the patient regarding his behaviour.

Sometime later, the patient advised this Office that there had been an improvement in communication since he changed his health advocate. He stated that this person manages his issues more effectively and this has improved relationships between him and the health provider as a consequence.

### *Capacity to manage one's affairs, impact of an assessment on hospital fees*

The Next of Kin of a patient complained to the OHCC about a bill she had received for *nursing home type care fees* charged for a lengthy public hospital admission of her family member.

The patient was admitted as an acute care patient to a public hospital and discharged some three weeks later. At the time, the complainant, who lived interstate, was in the process of securing nursing home care in the area for the patient. The patient was

readmitted to the Hospital some two weeks after being discharged, again as an acute care patient.

The *Health (Fees) Regulations 2017* provides that after 35 days of care, with no further acute care required, *nursing home type care fees* apply to a patient's admissions. Approximately a week after his second admission, the patient's health had improved and he was medically assessed as having sufficient capacity to manage his affairs. He agreed to pay the *nursing home type patient care fees* when his time as an acute patient expired, in the event that a nursing home in the area would not become available. He signed an agreement to that effect. At the time, the complainant was not the patient's guardian and nor was she the patient's donee of a power of attorney.

Thirty five days later, the fees were rendered because the patient was still in hospital as a nursing home vacancy had not been available. He and the complainant received a bill. The complainant complained that she was not liable for the fees as they would not have occurred if a nursing home was found and secondly, that the patient was not capable of looking after himself and was therefore an acute care patient. The complainant also complained about communication issues between her and the Hospital.

This Office sought a response from the Tasmanian Health Service (THS) to the issues raised by the complainant about the fees payable.

The hospital apologised to the complainant regarding communication breakdowns and in relation to her understanding regarding the appropriateness of the patient's care and discharge planning. The THS provided explanations and noted the importance of keeping the patient and family informed. The THS also advised that the fee had been triggered following 35 days after the *second* admission and had not included the first admission which should have been the protocol. It was also explained that the patient had been charged less for the hospital stay than residential care would have normally cost him.

However, the THS held that the nursing home type patient fees applied as the patient had sufficient capacity, as assessed, to manage his affairs when he agreed to pay for the care. As the OHCC is not empowered to consider a financial dispute against a health provider in the circumstances, the complainant was referred for legal advice.

### *Concerns about swollen legs to be investigated further*

An inmate of the women's prison sought assistance regarding the time of day at which she was administered a medication. She claimed that when she received the medication in the afternoon it caused swelling in her legs which did not occur if she was administered the medication in the morning.

Enquiries were made by this Office to Correctional Primary Health who advised that whilst dosing cannot be scheduled to a fixed time, an ultrasound for the inmate was organised to find out what exactly was causing her legs to swell. The inmate was satisfied that her concerns were met and that her health issues were to be investigated in the process.

### *Migraine Treatment Improvements*

Concerns were raised with this Office about a 'migraine treatment information sheet' given to patients by a health provider. The complainant alleged that the lack of clarity about dosing of non-prescription medication to treat his migraine headache conveyed in the information sheet had contributed to him incorrectly taking a large dose of a medication which possibly caused him harm.

The OHCC requested that the provider review and rectify the information sheet to reduce the risk of such an adverse event occurring again.

The provider subsequently advised the OHCC that as a result of our enquiries, he had ceased using the information sheet and his practice is now to give individual written information to his patients about any non-prescription medications suggested, including instructions to follow the maximum daily doses and limits of use given on the box to avoid confusion.

# Appendix 1 – Statistics

Table 10 - Reasons for Closure

| Reason | 2020-21 | 2021-22 |
|---|---|---|
| Dismiss - Section 25 (5) (a) Complainant not a person entitled under s22 | 6 | 10 |
| Dismiss - Section 25 (5) (b) Complaint does not disclose a subject matter referred to in s23 | 13 | 29 |
| Dismiss - Section 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago | 9 | 10 |
| Dismiss - Section 25 (5) (d) Complainant has not attempted direct resolution | 61 | 168 |
| Dismiss - Section 25 (5) (e) Issues adjudicated by court or tribunal | 0 | 2 |
| Dismiss - Section 25 (5) (g) Complainant has been given reasonable explanation and information | 259 | 231 |
| Dismiss - Section 25 (5) (h) The complaint lacks substance | 0 | 8 |
| Dismiss - Section 25 (5) (i) The complaint is frivolous, vexatious or not made in good faith | 5 | 0 |
| Dismiss - Section 25 (5) (j) Complaint has been resolved | 44 | 112 |
| Dismiss – Section 25 (7) Complainant has failed to provide information under s24 | 0 | 1 |
| Section 30 (1) The complaint has been withdrawn in writing | 8 | 12 |
| Other | 2 | 3 |
| Out of Jurisdiction | 0 | 4 |
| Section 25 (1) (a) Complaint referred to the Ombudsman or another person | 45 | 18 |
| Referred to AHPRA pursuant to MoU | 22 | 23 |
| Retained by AHPRA pursuant to MoU | 53 | 57 |
| Closed in Conciliation | 12 | 0 |
| Closed in Investigation (investigation discontinued) | 1 | 0 |
| Total | 540 | 688 |

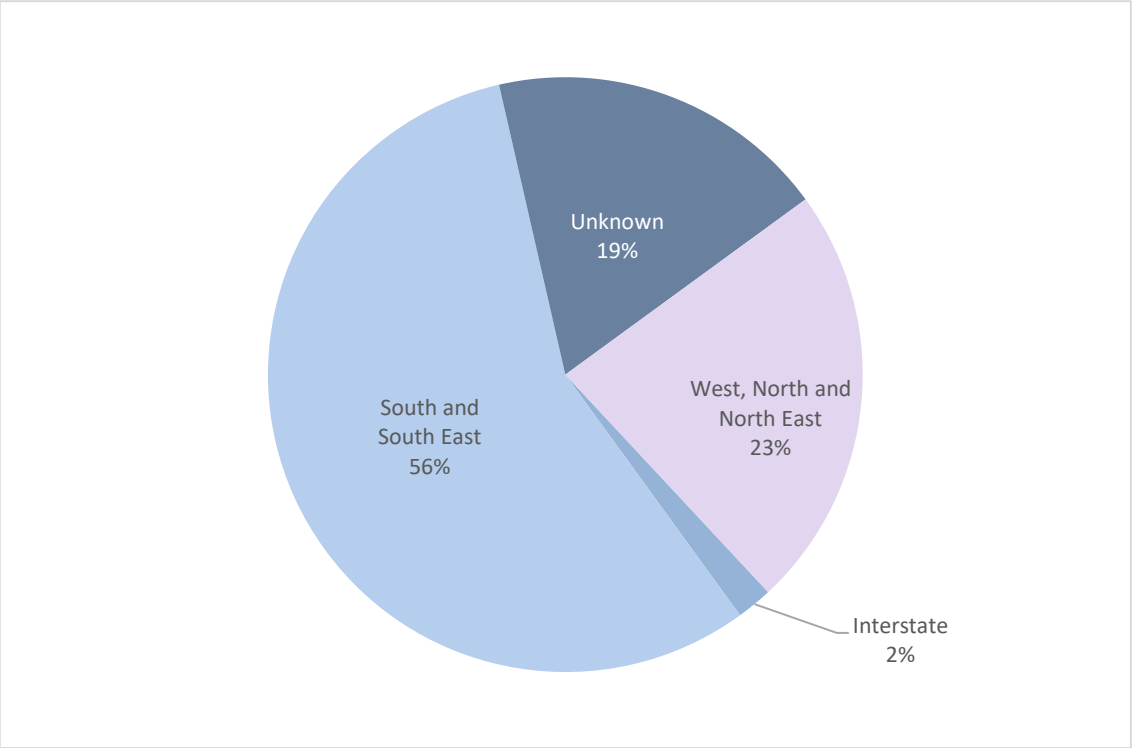
Outcomes achieved through the assessment process are set out in Table 11. These included apologies, provision of services, refunds of costs, and recommendations for, and the implementation of, quality improvements such as changes in policy or procedure. It should be noted that more than one outcome may 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 11 - Outcomes from cases closed in Assessment Stage

| Outcomes | 2020-21 | 2021-22 |
|---|---|---|
| Apology Given | 38 | 44 |
| Change in Policy | 10 | 10 |
| Change in Procedure | 14 | 9 |
| Compensation Received | 0 | 1 |
| Concern Registered | 149 | 213 |
| Declined/Referred | 6 | 17 |
| Dismissed (no other outcome) | 14 | 0 |
| Explanation Given | 177 | 204 |
| Fees/Costs - Refunded, waived or reduced | 7 | 11 |
| Information obtained | 257 | 267 |
| Quality Improvement | 14 | 22 |
| Service Obtained | 85 | 148 |
| Total | 771 | 949 |

Note: From 2020-2021 S25(1)(a) is no longer categorised as an outcome in assessment.

Figure 2 - Geographical location of complainants




## WHAT DID THEY COMPLAIN ABOUT?

### *Issues by category*

Table 12 - Summary of issues by category

| Issue | 2020-2021 | 2021-22 |
|---|---|---|
| Access | 166 | 144 |
| Communication and information | 124 | 149 |
| Consent | 19 | 18 |
| Discharge and transfer arrangements | 10 | 14 |
| Environment / Management of facilities | 31 | 56 |
| Fees and costs | 20 | 26 |
| Grievance processes | 21 | 16 |
| Inquiry service | 17 | 21 |
| Medical records | 8 | 16 |

| Issue | 2020-2021 | 2021-22 |
|---|---|---|
| Medication | 172 | 136 |
| Professional conduct | 27 | 47 |
| Reports / certificates | 20 | 23 |
| Treatment | 214 | 382 |
| Total | 849 | 1069 |

A breakdown of the issues arising from complaints closed in the reporting year is set out in Tables 13 to 25. It should be noted that a significant number of complaints involve more than one issue.

Table 13 - Access

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Access to facility | 2 | 5 |
| Access to subsidies | 3 | 1 |
| Refusal to admit or treat | 18 | 36 |
| Remoteness of service | 2 | 2 |
| Service availability | 122 | 80 |
| Waiting lists | 19 | 20 |
| Total | 166 | 144 |

Table 14 - Communication and Information

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Attitude/manner | 66 | 68 |
| Inadequate information provided | 25 | 42 |
| Incorrect/misleading information provided | 26 | 27 |
| Special needs not accommodated | 7 | 12 |
| Total | 124 | 149 |

Table 15 – Consent

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Consent not obtained or inadequate | 8 | 12 |
| Involuntary admission or treatment | 10 | 4 |
| Uninformed consent | 1 | 2 |
| Total | 19 | 18 |

Table 16 – Discharge and Transfer Arrangements

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Delay | 1 | 2 |
| Inadequate discharge | 7 | 9 |
| Mode of transport | 0 | 1 |
| Patient not reviewed | 2 | 2 |
| Total | 10 | 14 |

Table 17 – Environment / Management of Facilities

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Administrative processes | 20 | 44 |
| Cleanliness/hygiene of facility | 1 | 4 |
| Physical environment of facility | 7 | 7 |
| Staffing and rostering | 2 | 1 |
| Statutory obligations/accreditation standards not met | 1 | 0 |
| Total | 31 | 56 |

Table 18 – Fees and Costs

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Billing practices | 12 | 17 |
| Cost of treatment | 1 | 3 |
| Financial consent | 7 | 6 |
| Total | 20 | 26 |

Table 19 – Grievance Processes

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Inadequate/no response to complaint | 18 | 14 |
| Information about complaints procedures not provided | 3 | 1 |
| Reprisal/retaliation as a result of complaint lodged | 0 | 1 |
| Total | 21 | 16 |

Table 20 – Inquiry Service

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Request for information - Health Service | 4 | 3 |
| Request for information - Other | 4 | 2 |
| Request for Information - Commission | 0 | 6 |
| Request for information - Complaint mechanisms | 9 | 10 |
| Total | 17 | 21 |

Table 21 – Medical Records

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Access to/transfer of records | 5 | 14 |
| Record keeping | 2 | 1 |
| Records management | 1 | 1 |
| Total | 8 | 16 |

Table 22 – Medication

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Administering medication | 4 | 9 |
| Dispensing medication | 3 | 4 |
| Prescribing medication | 164 | 122 |
| Supply/security/storage of medication | 1 | 1 |
| Total | 172 | 136 |

Table 23 - Professional Conduct

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Assault | 2 | 0 |
| Boundary violation | 1 | 3 |
| Competence | 9 | 13 |
| Discriminatory conduct | 0 | 10 |
| Emergency treatment not provided | 1 | 0 |
| Financial fraud | 3 | 1 |
| Illegal practice | 3 | 2 |
| Inappropriate disclosure of information | 8 | 14 |
| Misrepresentation of qualifications | 0 | 2 |
| Sexual misconduct | 0 | 2 |
| Total | 27 | 47 |

Table 24 – Reports/Certificates

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Accuracy of report/certificate | 7 | 5 |
| Cost of report/certificate | 1 | 0 |
| Refusal to provide report/certificate | 9 | 9 |
| Report written with inadequate or no consultation | 2 | 2 |
| Timeliness of report/certificate | 1 | 7 |
| Total | 20 | 23 |

Table 25 – Treatment

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Attendance | 0 | 1 |
| Coordination of treatment | 26 | 52 |
| Delay in treatment | 34 | 75 |
| Diagnosis | 24 | 27 |
| Excessive treatment | 2 | 6 |
| Experimental treatment | 1 | 1 |
| Inadequate care | 32 | 48 |
| Inadequate consultation | 9 | 10 |
| Inadequate prosthetic equipment | 4 | 4 |
| Inadequate treatment | 22 | 64 |
| Infection control | 1 | 1 |
| No/inappropriate referral | 7 | 11 |
| Rough and painful treatment | 6 | 6 |
| Unexpected treatment outcome/complications | 36 | 43 |
| Withdrawal of treatment | 2 | 15 |
| Wrong/inappropriate treatment | 8 | 18 |
| Total | 214 | 382 |

## WHO DID THEY COMPLAIN ABOUT?

Table 26 – Complaints received about Health Organisations

| Health Organisation | 2020-21 | 2021-22 |
|---|---|---|
| Aged Care | 1 | 6 |
| Ambulance | 2 | 7 |
| Community Health | 4 | 8 |
| Correctional Health | 196 | 262 |
| Dental Practices/Clinics | 4 | 10 |
| Department of Health (previously DHHS) | 14 | 28 |
| Diagnostic Services | 2 | 4 |
| Disability Services | 0 | 2 |
| Medical Practices/Clinics | 36 | 84 |
| Mental Health Services | 18 | 16 |
| Optometrist | 2 | 1 |
| Oral Health Services | 0 | 2 |
| Other | 11 | 29 |
| Pathology | 2 | 5 |
| Pharmacies | 5 | 8 |
| Private Hospitals | 8 | 17 |
| Public Hospitals | 75 | 132 |
| Total | 380 | 621 |

Table 27 – Issues Relating to Correctional Primary Health Service

| Issue | 2020-2021 | 2021-22 |
|---|---|---|
| Access | 116 | 72 |
| Communication & information | 13 | 18 |
| Consent | 1 | 0 |
| Discharge and transfer arrangements | 1 | 0 |
| Environment/management of facilities | 5 | 13 |
| Fees & Costs | 0 | 1 |
| Inquiry Service only | 2 | 2 |
| Medical records | 0 | 1 |
| Medication | 131 | 100 |
| Out of jurisdiction - Referred | 0 | 3 |
| Reports/certificates | 5 | 4 |
| Treatment | 49 | 145 |
| Total | 323 | 359 |

## *Hospitals*

Table 28 – Issues Relating to Private Hospitals

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Access | 0 | 1 |
| Communication & information | 8 | 7 |
| Consent | 1 | 0 |
| Discharge and transfer arrangements | 1 | 3 |
| Environment/management of facilities | 5 | 1 |
| Fees & costs | 1 | 3 |

| | | |
|---|---|---|
| Grievance processes | 4 | 0 |
| Medication | 3 | 0 |
| Medical Records | 0 | 1 |
| Professional conduct | 2 | 2 |
| Reports/Certificates | 0 | 1 |
| Treatment | 13 | 10 |
| Total | 38 | 29 |

Table 29 – Issues Relating to Public Hospitals

| Issue | 2020-21 | 2021-22 |
|---|---|---|
| Access | 23 | 20 |
| Communication & information | 30 | 38 |
| Consent | 5 | 6 |
| Discharge & transfer arrangements | 4 | 7 |
| Environment/management of facilities | 7 | 12 |
| Fees and costs | 5 | 3 |
| Grievance processes | 3 | 6 |
| Inquiry service only | 4 | 6 |
| Medical records | 0 | 4 |
| Medication | 9 | 7 |
| Out of jurisdiction - Referred | 0 | 2 |
| Professional conduct | 1 | 13 |
| Reports/certificates | 1 | 2 |
| Treatment | 44 | 98 |
| Total | 136 | 224 |

## *Individual Providers*

Table 30 - Complaints about Individual Providers

| Provider | 2020-21 | 2021-22 |
|---|---|---|
| Chiropractor | 0 | 2 |
| Dental | 5 | 9 |
| Exempt | 1 | 4 |
| Medical practitioner | 32 | 69 |
| Nurse | 2 | 3 |
| Other/unknown | 0 | 46 |
| Pharmacist | 0 | 6 |
| Podiatrist/Chiropodist | 0 | 1 |
| Psychologist | 1 | 3 |
| Total | 41 | 143 |