Health Complaints Commissioner Tasmania

Annual Report 2018-19

Health Complaints Commissioner

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Letter to Parliament

To:

The Honourable President of the Legislative Council

and

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 2018-19.

Yours sincerely

Richard Connock
HEALTH COMPLAINTS COMMISSIONER

26 November 2019

About this Report

This report describes the functions and operations of the Health Complaints Commissioner Tasmania for the year ending 30 June 2019.

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 2018-19 reporting year.

Introduction

2018-19 was a year of positive action. Two positions which had been vacant for significant periods throughout the 2017/18 year were filled on a fixed term basis and as a result, very pleasing progress was made in reducing the backlog of complaints carried forward at the start of the year. The number of incoming complaints was similar to last year but with more staff available to deal with them, fewer cases have been carried forward.

We have also made progress rebuilding relationships following the restructuring of the THS and its Quality and Patient Safety Service (QPSS) in July 2018. Regular meetings have now been put in place between senior personnel at THS & HCC and individual case officers at the QPSS in the hope of simplifying and expediting responses. With the increase in staffing we were also able to undertake more conciliation meetings and although many of these cases remain open at the end of the reporting year, they provide a useful forum for building professional relationships with providers, both public and private which has a flow on benefit to complainants.

Steps are being taken to arrange a meeting with the Australian Health Practitioner Regulation Agency (AHPRA) with a view to improving the turnaround of complaints referred.

Despite ongoing challenges, which I mention in more detail below, 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 appear at the end of this report. Other examples will be published on our website.

Enquiry and Complaint Management

There was a 19% increase in the number of matters closed in enquiry this year while the number of complaints received remained static. The increase is in large part due to the recruitment of an Intake and Assessment Officer following a seven-month vacancy, with more matters being able to be addressed and resolved at enquiry level without the need to progress to a complaint. There was a significant increase in the number of complex cases received, being cases which raise serious clinical issues and which involve multiple parties who need to be consulted and managed.

Staffing

I have referred to the low staffing levels in the Health Complaints' team in previous reports. For significant periods throughout the last four years, these have been as low as 2.2 FTEs. I was pleased to recruit a Senior Investigation Officer (0.6 FTE) at the start of the year and as noted above an Intake and Assessment Officer for the last seven to eight months of the year. Unfortunately, these are only fixed term positions. I hope to fill the Intake and Assessment

position on a permanent basis in the coming weeks but disappointingly, I do not have the resourcing to fill the SIO position for more than two days a week.

Recruitment to these positions had notionally brought the health team up to 4.2 FTEs but absence due to illness and injury once again reduced the team to 3.6 for most of the year. This was still a significant improvement on the situation last year.

Low staff levels not only have an adverse impact on the time taken to resolve complaints but also, with a necessary focus on complaint resolution, they result in an inability to perform other functions prescribed by the Act. These include activities such as education about health rights, building complaint resolution capacity in providers, auditing improvements to health services, and conducting own motion investigations.

Delays

I have reported over the previous three reporting years on the time it can take to obtain responses from the THS. This followed the merger of the three separate Tasmanian Health Organisations in 2015 to form the THS and the centralisation of the Patient Safety Service (PSS) as a single state-wide service which resulted in the loss of experienced complaint managers in each region.

Following another 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 the time taken to provide responses. After a period of bedding down there appeared to be some improvement but the loss of experienced officers and numerous changes in personnel has once again resulted, in some cases, in significant delays obtaining meaningful responses.

We also continue to experienced significant delays in obtaining responses from AHPRA with whom we are required to consult with respect to all complaints received about registered practitioners.

Substantial delays finalising complaints are also encountered when compensation has been agreed during conciliation with THS and THS needs to take advice before finalising the matter.

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 also seriously adversely affect 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.

Ten Year Trend

Last year's report contained an analysis of complaint numbers over the preceding ten year period. That analysis demonstrated that complaint numbers had almost doubled over that time, with a corresponding decrease in staff levels by one-third (six FTEs to four FTEs), with significant periods with even fewer staff. The number of cases carried forward at the end of each year bears a direct correlation to the staffing levels at the time.

The main growth was in the number of simple cases with the number of complex and intermediate cases remaining reasonably static - although there was an increase in complex cases this reporting year. At times of low staff levels, with the need to deal with enquiries as they are received, and the legislative imperative to assess as many matters as quickly as possible, priority tends to be given to the more straightforward cases. The drawback is that a greater proportion of complex cases are carried forward than received.

This is particularly notable over the last five reporting years for reasons already stated.

Code of Conduct for Health Care Workers

At a meeting of the Commonwealth Parliamentary Standing Committee on Health in June 2013, Australia's Health Ministers agreed in principle to the establishment of a National Code of Conduct for Unregistered Health Care Workers (the Code), such as naturopaths, social workers and counsellors.

It was agreed at the Council of Australian Governments (COAG) Health Council meeting in April 2015 that this would proceed. Each State and Territory is responsible for enacting new, or amending existing legislation to give effect to the Code, which will be administered by the Health Complaints Entities in each jurisdiction.

At the time of writing, the situation in relation to Tasmanian legislation to implement the Code remains basically the same as last year; the amended Act has passed through Parliament but has not been proclaimed.

What exactly this change in the law will mean for the Office is not clear, but the work that will be involved will be different to what we presently do. The new work will carry a high degree of responsibility as the amended Act empowers my Office to make prohibition orders against unregistered practitioners. For example, it is not clear whether these orders will result from a process more in the nature of a prosecution than an investigation, but whatever the case, our processes will need to be rigorous enough to withstand a review process. Further, in the event of a breach of any order made, the matter would have to be prosecuted. Such a prosecution would need to be conducted by an appropriate agency, and existing staff will require additional training before entering into any part of that process.

It is not possible to say how many complaints we might receive but any will mean an added strain on resources that are already stretched. If a significant number are received, 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

With the changes in structure to the THS Quality and Patient Safety Service and a slight improvement on our own staffing levels, we were once again in a position to undertake and make inroads into the backlog of matters that had been assessed as suitable for conciliation but were awaiting attention. 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 five 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.

Five matters were referred to conciliation this year and nine were finalised. As at the end of the reporting year, there were 22 matters open in conciliation with an unacceptable average age of 600 days. Some of these cases had been progressed through the meeting stage during the year but delays, particularly in relation to complaints about THS where it is a requirement for it to seek legal advice before finalising a complaint, 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.

The Act was, at least in part, designed to provide an alternative avenue of redress to highly regulated, time consuming and expensive civil court proceedings. It was intended that the Office would develop procedures that emphasise conciliation rather than court-based litigation, which is becoming increasingly expensive and does not identify, address or attempt to remedy the underlying causes of concerns about health services. It was also intended to establish an accessible, structured complaints resolution system providing health consumers with a focus for complaints, and consistent procedures for assessing, resolving and following up those complaints.

Inadequate resourcing undermines these intentions 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.

Despite the well known therapeutic, restorative and financial benefits of resolving matters in this way, we may need to consider how many matters we refer to conciliation. I would be loath to do so as I consider that it would be contrary to the intentions and objects of the Act. It would also be contrary to the principles of open disclosure espoused by the Australian Commission on Safety and Quality in Health Care and recently adopted model litigant rules. Despite the best efforts of my staff, however, delays in finalising these matters result in consumers feeling that they have been led along and victimised yet again, concluding that the matters they raised in conciliation were not taken seriously after all. Failure to follow through and complete matters also leads to a significant waste of our resources.

Efficiencies

I have identified in my time as Commissioner that significant outcomes are being achieved by officers as a result of a protracted assessment period. I had initially been concerned that keeping matters open within this phase was contrary to the provisions of the Act which require the complaint to be assessed within a 45 day period. This can be extended to 90 days or longer when we are awaiting the receipt of information from third parties. The options after this are formal investigation, conciliation, referral or dismissal.

In many cases, however, because of the complexity of the issues and the number of parties needing to be consulted, it is almost impossible to obtain and consider all necessary information and consult with all necessary parties within the statutory time frame. I have concluded that there would be significant benefit in another option being developed, that is allowing for the making of preliminary inquiries.

I am able to do this in the Ombudsman jurisdiction. Pursuant to s 20A of the *Ombudsman Act 1978*, I may make any preliminary inquiries that I consider necessary for the purpose of ascertaining if a complaint should be investigated, and the principal officer of an agency is to provide me with any reasonable assistance necessary to enable me to make those inquires. Having done so, if appropriate the complaint can be resolved without proceeding to investigation. Most complaints in that jurisdiction are resolved at this level.

I am of the view that such a process, which allows officers to gather all the information they need to make an informed decision as to what if any further action is required, would see the informal resolution of significantly more Health Complaints. The process would still allow for outcomes to be achieved collaboratively without the need for the formality of an investigation. 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. I will be approaching the Department of Justice, which administers the Act, in this regard

We continue to resolve a significant number of matters informally at both the assessment and enquiry stage and to refer matters back to providers for an attempt at direct resolution with complainants.

We will also continue to work with our local AHPRA office to identify ways to expedite processes, and to meet with key stakeholders, particularly in the public hospital system, to explore the ways in which more timely responses can be delivered in both the assessment stage and when a matter has been referred to conciliation.

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 another very challenging year.

The 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 functions which go with these two separate appointments are delivered by the same Office, the Office of the Ombudsman and Health Complaints Commissioner.

Staff Profile

The staffing profile for the OHCC at the end of the reporting year was as follows:

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	1.4	1.4
Resolution Officer (Band 5)	0.0	1.0	1.0
Intake and Assessment Officer (Band 4)	0.0	1.0	1.0
TOTAL	**0.2**	**4.4**	**4.6**

2018-19 At a Glance

- A 14% increase in enquiries received
- A 34% increase in complaints closed
- 87% of complaints assessed within 90 days
- 77% of complaints closed within 6 months
- Only five cases referred to conciliation
- No cases referred to investigation
- 27% reduction in the number of open complaints at the end of the reporting year
- 41 AHPRA notifications received
- A number of significant improvements/outcomes from cases closed in assessment & conciliation
- 41 complaints recorded as resolved in assessment
- 133 cases recorded as resolved through quick resolution processes

Complaint and Enquiry Activity

Enquiries

A large number of enquiries are received each year, by telephone, email and in person. Enquiries are dealt with as they are received and represent a substantial workload.

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 and, if the enquiry does not fall within the jurisdiction of the OHCC, to facilitate referrals to other agencies.

Table 1 shows the number of matters opened and closed as enquiries during the reporting year, which is a significant increase over last year. As noted, this increase is most likely attributable to the recruitment of an Intake and Assessment Officer, following a seven-month vacancy, with more matters being able to be addressed and resolved at enquiry level without the need to progress to a complaint.

Table 1 – Enquiry Activity

Enquiries	2017-18	2018-19	Variance
Enquiries received	423	484	14%
Enquires closed	408	486	19%
Enquires active	37	23	-38%

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.

The Act requires that a complaint be made in writing. 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 2 shows a comparison of the number of complaints opened and closed during the last two reporting years. It also shows the number of matters carried forward at the beginning and end of each period. Table 2 indicates a 56% increase in the number of complaints carried forward from the previous reporting year. The number of new complaints remained almost static and there was a very pleasing 34% increase in the number of complaints closed.

This is the highest number of complaints closed in one year in more than ten years and, as a result, significant inroads have been made into what was becoming a growing backlog of

complaints. This progress is directly attributable to the appointment of a full time Intake and Assessment Officer and a 0.6 FTE Senior Investigation Officer. Regrettably, both these appointments are only for fixed terms and the number of active complaints carried forward into next year is still high.

Table 2 shows 114 active cases at the end of the reporting year. This is ten more than the actual calculations indicate. There are two possible reasons for this.

Firstly, 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.

Secondly, when a complaint is received without the necessary signed authority (as is the case with all online complaints) the start date for the complaint can be adjusted to the date on which the authority is received. Again, if this straddles two reporting years it is possible for the complaint to be counted in both years.

To avoid this anomaly in the future complaints that are split will assume a new start date and complaints received without the necessary authority will not be counted as complaints until the necessary authority is received.

Table 2 – Complaint Activity

Complaints	2017-18	2018-19	Variance
Complaints carried forward	100	156	56%
Complaints received	377	379	0%
Complaints closed	321	431	34%
Complaints active	156	114	-27%

Notifications

The OHCC also receives notifications from AHPRA. In past annual reports, notifications initially made to AHPRA in respect of matters that this Office & AHPRA are required to consult about under National Law have been classified and reported on separately from complaints. Although we previously indicated that complaints and notifications would be combined in future reporting, this has not yet occurred. We are, however, upgrading our case management system in early 2020 and will look to combining complaints and notifications as new workflows are developed. The number of notifications set out in Table 3 below are therefore in addition to the number of complaints received.

Table 3 indicates a 16% decrease in the number of notifications received from AHPRA this year compared with last year and a 76% increase in the number of notifications closed. The

improvement in closure rates is most likely attributable to an improved flow of information between HCC and AHPRA due to the availability of HCC staff to follow up in relation to these matters. We hope to re-establish a process of regular monthly meetings with AHPRA in order to maintain regular updates of the status of these cases. The number of active matters at the end of the year that will be carried forward into the next reporting year has reduced by 40%.

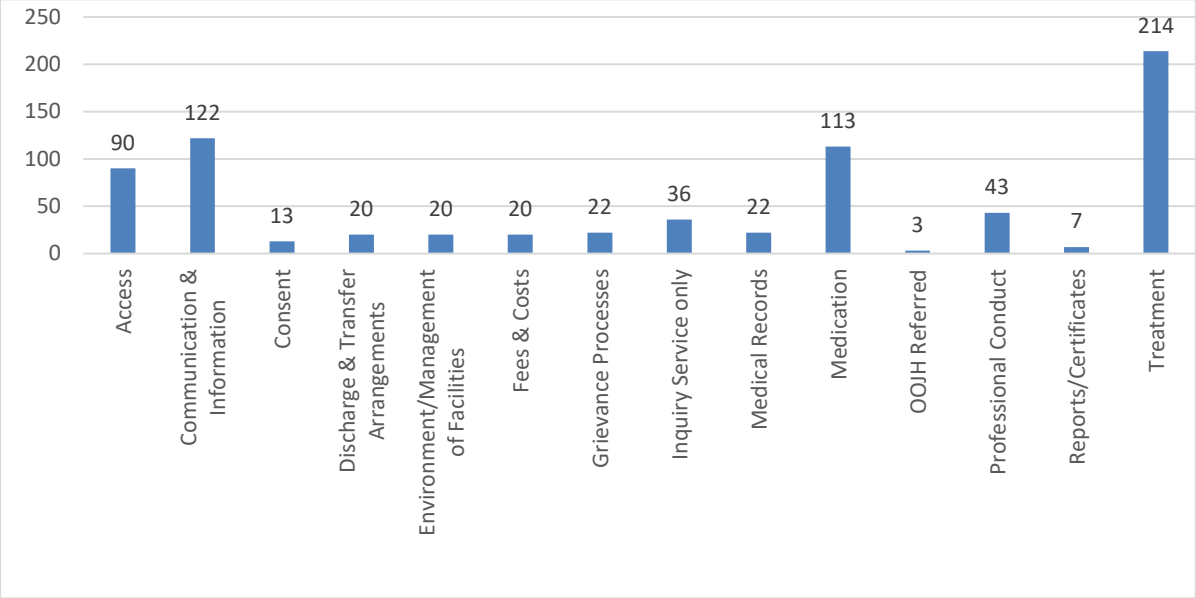
Table 3 - Notification Activity

Notifications from AHPRA	2017-18	2018-19	Variance
Notifications carried forward	16	35	+119%
Notifications received	49	41	-16%
Notifications closed	30	55	+76%
Notifications Active at 30/6	35	21	-40%

Who and What did People Complain About?

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

Issues raised from closed complaints in 2018-19



Correctional Primary Health Services

As in previous years, the main source of complaints about prescribing came from prisoners in the Tasmanian Prison Service.

Inmates are able to call this Office directly on a secure line at no cost. Unlike complaints about THS and private providers which normally involve a single or 'one off" issue, prisoner complaints are more thematic.

Causes of complaints about the Correctional Primary Health Services (CPHS)

In 2018, there was a 12% increase in the number of complaints about CPHS from 120 to 135.

The main issue raised was failure to prescribe medication, but the next most common issues, and directly corresponding reason for the complaints were 'refusal to treat' and 'inadequate treatment.'

CPHS limitations in providing treatment to inmates

Another common reason for complaints by inmates was the delays many experienced in obtaining treatment for 'non-urgent issues'. This included accessing medical and other treatment services such as dental, optometry, surgical and cosmetic surgery. Current CPHS staffing levels, combined with the impact of prison lockdowns, often resulted in extensive delays in prisoners being able to access these services, usually considerably longer than the

time experienced to access these services in the community (that is, same day or next day appointments).

In summary, inmates routinely contact the OHCC to complain about issues arising from conditions that are largely attributable to the administration of the Tasmanian Prison Service (TPS), which fall outside the control of CPHS.

In the last 12 months, extensive 'lockdowns' have become commonplace at the State's prisons. Lockdowns can occur for a range of reasons but it appears that currently they are largely the result of staffing shortages. During lockdowns, CPHS is severely limited in its capacity to provide medical treatment to inmates. The opportunity to provide other, more limited services, such as dental and optometry is also lost.

Alcohol and Drug Services prior to and post release

The OHCC has received a number of complaints from inmates about the apparent failure of CPHS to liaise appropriately with Alcohol and Drug Services (ADS). These complaints tend to focus on the failure of CPHS to both ensure that ADS continues to provide inmates with access to the suboxone program following their release into the community, and to induct them into the program shortly before their release date.

The OHCC researched this apparent breakdown in communication between CPHS and ADS and learned that ADS currently has very limited resources to be able to manage the transition of inmates, either currently engaged on the suboxone program or in need of induction into it, into the community from prison. Issues relating to access to the suboxone program prior to and post release have therefore arisen due to ADS resourcing issues and not as a result of a failure on the part of CPHS to organise inmate access to the program before and following release.

Access to dental care

Dental services to the prison were doubled in November 2018. Despite this, access to dental care is still subject to a lengthy wait list. This is further compounded when inmates cannot be taken to their scheduled appointments due to TPS staffing issues and lockdowns.

Specialist clinic appointments

Inmates have complained about delays in attending appointment at specialist clinics at the Royal Hobart Hospital (RHH). Transport to and from the RHH is the responsibility of the TPS, not CPHS, and it appears that inmates have not been able to attend their scheduled appointments, again due to TPS staff shortages and lockdowns. CPHS is responsible for booking these appointments, and it appears that they attempt to reschedule appointments as soon as possible after they have been missed.

Tasmanian Health Service

In line with previous years, public hospitals were the subject of the next highest number of complaints. There was an 18% decrease in the number of complaints from 75 to 61 while the number of complaints about mental health services remained static at nine. As in previous years, the main issues raised in relation to hospitals were treatment and communication. As was the case last year, there were also a number of complaints about the THS internal complaint processes, both in terms of delay and adequacy of responses. The main issue in relation to mental health services was refusal to admit or treat.

Medical Clinics

There was a slight increase in the number of complaints about medical clinics from 27 to 30. Recurring themes were informed financial consent and billing practices.

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 decrease in the number of complaints received about medical practitioners this year from 71 to 56.

How Were Complaints Resolved?

Table 4 - Reason for Closure of Complaints and Notifications

Reason closed	2017-18	2018-19
No further action following Assessment	290	400
Referred to board pursuant to MOU	24	22
Retained by board pursuant to MOU *	30	55
Conciliation completed	5	9
Investigation completed	2	0
Total	**351**	**486**

*These cases started as notifications to AHPRA

Assessment

The majority of complaints received are closed following assessment. This was the case with 400 complaints closed this year.

As already referred to, 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 or dismissed. In this stage, responses are sought from providers, medical records are reviewed, expert opinions sought, consultation occurs with AHPRA, and attempts are made to resolve the complaint without the need for referral to formal investigation or conciliation.

The various reasons for closing a complaint in assessment are set out in Table 4. These reasons accord with the language of s25(5) of the Act, which stipulates the circumstances in which a complaint must be dismissed. Most of these relate to threshold issues, which result in a complaint being dismissed at an early stage in the assessment process. Approximately 6% of cases closed in assessment were closed due to threshold issues or due to the complaint being withdrawn.

Another 25% were closed through a quick resolution process, which involves obtaining information from the provider, or other entity, and sharing this with the complainant without the need for formal assessment. Most cases about Correctional Primary Health Services fall into this category.

A further 8% were referred to entities other than AHPRA, for example to the Aged Care Commissioner as described later in this report.

The remaining 40% of complaints, are subjected to the more protracted process described above and they are often closed on the basis that the complainant has been given a reasonable explanation about the incident that led to the complaint, or that the complaint has been resolved.

Although these cases tend to be the more complex ones, with multiple parties and issues, they are still recorded as having been 'dismissed'. This terminology is unfortunate, as it fails to convey the extent of the work undertaken during the assessment phase and the significant outcomes achieved from the assessment process. It is these cases and those closed in conciliation that account for the cases that take more than three months to resolve.

Examples of outcomes achieved from the assessment process appear later in this report, and examples of matters dealt with in assessment appear in the case study section at the end of this report and will be published on our website.

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 (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.

Table 4 indicates that in 2018-19 there were 77 cases either referred to or retained by a registration board pursuant to the MoU, of which 22 were referrals from this Office. We consulted with AHPRA in relation to an additional 19 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.

Some complaints received require attention from agencies other than registration boards. For example, complaints against aged care facilities might be referred to the Aged Care Complaints Commissioner, and complaints relating to mental health facilities might be referred to the Mental Health Official Visitor Scheme established under the *Mental Health Act 2013*. Cases about funding under the National Disability Insurance Scheme are referred to the National Disability Insurance Agency and cases raising concerns about Medicare fraud are referred to the Commonwealth Department of Health. Some complaints we receive concern subject matter already being considered by the Coroner and others are still undergoing investigation at a local level. These matters are generally closed in the assessment stage because, unlike referrals to registration boards, they do not generally require further consideration by this office. There were 30 such cases this year.

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 four years, the number of matters referred to and resolved within conciliation, however, has fallen dramatically. This followed the retirement of a part time conciliator and coincided with the need for the remaining conciliator (who is also the Principal Officer) to undertake additional management responsibilities as well completing assessments in the absence of adequate resourcing to recruit and retain investigation and resolution officers. For five years prior to this conciliation had been the cornerstone of the HCC complaint resolution process. 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.

Five matters were referred to conciliation this year and nine were closed. At the end of the reporting year there were 22 matters open in conciliation with an unacceptable average age of 600 days. Some of these cases had been progressed through the meeting stage during the year but delays, particularly in relation to complaints about THS, where it is required to obtain advice before finalising a complaint 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.

Outcomes from conciliation are set out in Table 7 in the appendix to this report. Of the eight cases closed, one resulted in the payment of compensation, and four resulted in significant quality improvements, including changes in policy or procedure. In nearly all cases, the complainants' concerns were resolved by the provision of further information or an explanation in language they could understand, or simply by having those concerns acknowledged and receiving an apology.

Examples of outcomes in matters dealt with in conciliation appear in the list of outcomes set out later in this report. Examples of matters dealt with in conciliation appear in the case study section at the end of this report and will be published on our website.

Investigations

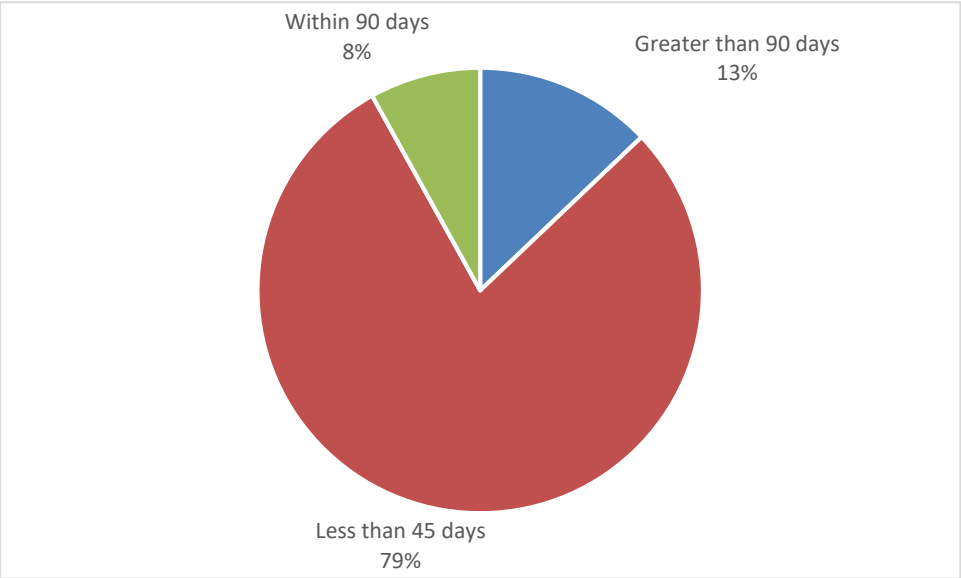
A decision was made some years ago that formal investigations would only be conducted into complaints which give rise to a matter of public interest, and that conciliation would be used more extensively. One of the reasons for this was that, in many cases, by the time the matter is brought to our attention, 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. There are currently two matters open in Investigation, which will be concluded in the next reporting year.

Time Taken to Assess and Finalise Complaints

Time taken to assess complaints

Figure 1 - 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 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.

Time Taken to Finalise Complaints

Figure 2 – Time taken to finalise complaints

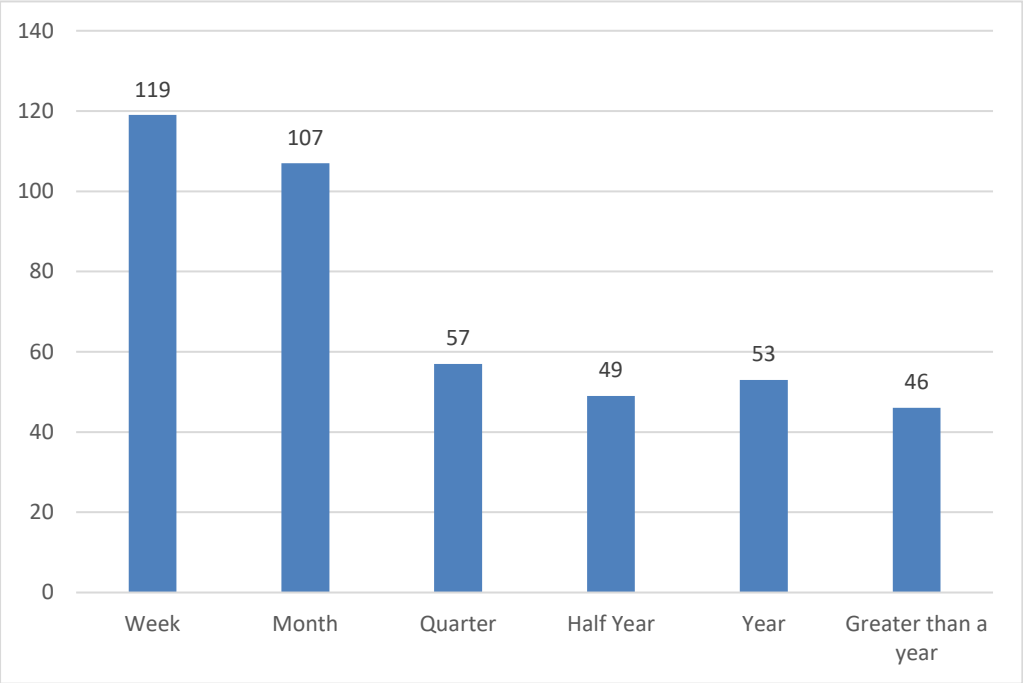


Figure 2 illustrates the time it takes to finalise the various types of complaints received. As previously noted, the less complex complaints are generally resolved within three months, and generally make up around 66% of all complaints received. The remaining 34% tend to be more complex.

In the last two years, we have reported an increase in the percentage of complaints taking more than 12 months to finalise (45 and 43 respectively). With the recruitment of an Intake and Assessment Officer and Senior Investigation Officer, we were able to make inroads into the backlog of old complaints and at the end of the reporting year, of the 114 cases carried forward, there were only 26 cases more than 300 days old. As noted above, most of these cases are matters that remain open in conciliation.

As reported above, the major factors affecting the time within which complaints are finalised are the increased complexity of complaints, decreased staffing levels, and delays and difficulty in receiving necessary advice and information from various sources.

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.

Outcome from Complaints

As noted earlier in this report significant improvements in the delivery of health services have been achieved from cases managed by OHCC during the reporting year. Examples of these are set out below.

Quality Improvements from Assessment

Improvements can be initiated by the providers or because of recommendations made by this Office. The following is a summary of improvements from the past year:

Provider Initiated Improvements

Mental Health Services - South

- Education and training for staff to develop and improve their clinical consultation techniques and debriefing (de-escalation) approaches.
- Psychiatrist continuing to engage in peer supervision.

Rural General Practice Providing Cover to a Rural Hospital

- Improved processes for complex patients in general practice to be reviewed by the same doctor where possible.
- Introduction of Goal of Care forms to ensure patients can outline their wishes at a time when they have capacity.

Correctional Primary Health Services

- Improved processes within Correctional Health for reviewing admission medication management.
- Pharmacy liaison, provision of patient medication information and medication change discussed with patients.

Dental Practice

- Implementation of a clear policy in relation to the non-refundable booking fee to ensure all patients are aware of this.
- Review of their privacy policy to ensure all patients receive a complete copy of their dental records if requested.

Disability Accommodation

- Establishment of a dedicated area for attending doctors, with computer, printer and server access, to record the consultation.
- Improved systems so that pathology and imaging requests can be generated and results accessed on site leading to increased efficiency.
- Improved systems for identifying each resident's guardian.

OHCC Initiated Improvements

General Practice – Wound Management

- Improved policies and procedures in place to support current wound management clinical guidelines including photography of wounds, after gaining the patient's informed consent.
- Development of appropriate photography storage practices.

Admission and Transfer Arrangements Between Facilities

- Improved processes for the discussion and recording of end of life decisions, not for resuscitation orders and appropriate discharge planning arrangements during patient admission.

General Practice – Wide Excision of Lesion

- Development and implementation of guidelines for performing procedures on high risk elderly patients.

Public Hospital

- Improved recognition of conditions which have an impact on the delivery of health care, such as needle phobia.
- Improved processes for documenting alerts that affect the delivery of health care.

Private Hospital Bariatric Treatment

- Identification of the requirement for bariatric equipment on admission to the hospital.
- Improved processes to screen for, and strategies implemented to prevent, pressure injuries in accordance with best practice guidelines.

General Practice

- Improved systems to ensure the general practice medical records have been updated to indicate clearly where there is another patient with the same patient identifiers.
- Training for staff on patient identification.

Quality Improvements from Conciliation

It is important to note that the providers initiated some of the outcomes listed below prior to conciliation

Public Hospitals

- Review of guidelines and processes for seeking consent to non-coronial autopsies.
- Implementation of strategies to improve the patient / relative experience surrounding death in the Department of Critical Care Medicine including the introduction of the 'Care of the Dying Patient in DCCM' guideline.
- Relocation of the short stay surgical unit at a regional hospital resulting in availability of more staff.
- Reinstatement of the acute pain nurse position at a regional hospital to check patients' pain management.

Private Hospitals

- Improved complaint management processes.
- Improved reporting and awareness of clinical observations in the care of intravenous access devices and access sites.

General Practitioner

- Increased awareness of the potential for correspondence between health practitioners to cause distress if seen by the patient.

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.

Cases Closed in Enquiry

Friday afternoon emergency

While the OHCC is not a service that deals with crises, there are times when the timeliness of linking callers with relevant personnel is important. One Friday prior to a long weekend, a phone call was received from a family member of B, a patient who was hospitalised with a serious health condition. The family had a number of concerns about B's care and treatment. The family had attempted to speak with staff at the hospital about their concerns but felt they were not being heard. The family was upset and angry about the situation.

This Office made contact with the Tasmanian Health Service Quality and Patient Safety Service to ascertain who the family could speak to about their concerns. Arrangements were made for the relevant staff member to make contact with the family that same day.

The family member was advised of this and about the option to raise a complaint with this Office if, after working with THS staff to attempt to resolve the issues, they remained unsatisfied with the situation.

Educate and Empower

Educating and empowering people to attempt to resolve complaints direct with the health care provider is an important part of the work of this Office.

An enquiry was received from H, a person who had been unhappy with the service and treatment by a heath provider. H had spoken to the health provider at the time about the concerns and thought that the matter had been adequately resolved. Some months later, H received an invoice for services. She called the provider's reception to discuss what had transpired and what she thought had been resolved, seemingly to no avail.

During the phone call to this Office, a number of matters were discussed – how H would like to see the matter resolved along with how she could address the concerns direct with the provider. Given H's age, the Older Persons Legal Aid Service was also recommended as a source of advice. H decided to attempt resolution by sending a written complaint to the provider and would consider seeking legal advice if need be after that.

H contacted the Office to advise of a positive outcome to her written complaint to the provider. She said she appreciated the time spent discussing the issues, as she had been quite stressed by the situation. She advised that she had felt better about attempting to resolve the complaint direct with the provider after the phone call and advice received from this Office.

Accessibility issues at a GP Clinic

A patient of a medical centre, P, contacted us as he was concerned about access to and inside the medical centre he attends. P had not been able to raise the issues direct with the provider for a number of reasons.

This Office contacted the Practice Manager who advised that the new owners of the existing medical practice were aware of the reported accessibility issues. As new owners, their intention was to undertake a refurbishment that would take into account accessibility and in the interim, they would implement temporary arrangements regarding access.

P was advised of the planned and impending changes. He was also advised of other options, including making contact with the Practice Manager, if he felt there were ongoing concerns.

Multiple complex issues – not all falling within the jurisdiction of OHCC

There are times when a caller might have multiple complex issues of concern to them, not all of which fall within the jurisdiction of this Office. The caller may have tried contacting a number of different agencies seeking advice and assistance. One such caller, F, had a number of psychosocial issues which were having an impact on his life and he felt that the main agency providing support was not consulting or communicating effectively with him. Compounding this were pending changes in relation to funding for services and F's concern about the ongoing provision of support.

Contact was made with the agency, primarily in relation to the perceived lack of consultation and poor communication. The provider met with F to discuss these and other issues not within the jurisdiction of this Office. The provider acknowledged there had been some difficulties and mix ups in communication and that there was a need for ongoing communication with the service user to be clear. The provider advised that support would continue and that there would be ongoing consultation about planning. Further, a specific staff member was identified as a contact for F if he had future concerns or complaints.

Withdrawal of authority to prescribe S.8 medication – Pharmaceutical Services Branch

A complaint was received from M who was concerned about a General Practitioner not providing her with a prescription for a Schedule 8 medication.

Schedule 8 medications include opioids and narcotic psychostimulants. They are heavily regulated under the *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 known potentially harmful side effects both in the short and long term. The Pharmaceutical Services Branch (PSB) of the Department of Health and Human Services is the party responsible for decisions regarding the authority to prescribe these medications for patients.

M was advised that when a decision is made to withdraw the authority to prescribe, the affected party (the patient) is able to seek a review of that decision.

M was provided with the relevant information and forms required to seek a review. She was also advised that if she remained dissatisfied with the PSB after the request for review had been finalised, she could contact Ombudsman Tasmania.

Medical practice no longer offering bulk billing

T, a 79 year old pensioner, was charged a discounted standard consultation by a medical practice instead of being bulk billed, as he had been for the last 18 years. T advised that the practice had been privatised and its policy was now to offer discount fees for aged pensioners rather than bulk billing. T's main concern was the lack of adequate communication regarding the change in policy.

The Practice Manager was contacted and confirmed the policy and advised that the issue would be raised at the next practice meeting. The Practice Manager also advised that any patient could discuss financial hardship issues with the GP at the time of the consultation, the Practice Manager confirmed that should T choose to attend another medical practice, there would be no charge for transferring his records to that new practice.

The above advice was passed on to T, who elected to move to another practice. While a medical practice may charge a reasonable fee for the transfer of patients' records to another GP, in this case the fee was waived.

Unreasonable complaint

A telephone call was received from A who was unhappy at having been charged for a double appointment with a GP. She felt she had not been informed during the consultation that it was going overtime and therefore felt there was no informed financial consent.

In an attempt at early resolution of the concerns, contact was made with the Practice Manager. The Practice Manager provided further information; that it had been A's first visit to the medical practice, that the medical consultation had included a physical examination, diagnosis, referral for imaging and pathology, and more. Four issues were discussed at the consultation, including lifestyle issues, so the doctor could ensure that appropriate medication was prescribed. The length of the consultation was such that under Medicare it would have been listed as an Item D consultation, however A was charged for a lesser item.

This information was passed on to A. She remained unhappy with the situation, as it was different from the way she had been treated at her long standing medical clinic. A decided to think about the matter before progressing it further. She was advised that she was welcome to recontact to discuss further if she wished.

Cases Closed in Assessment

Delay in the provision of care and treatment

B complained about the care provided to her elderly father by a general practice, a hospital and the ambulance service. She alleged that the general practitioners, who also provide services at the hospital, should have transferred her father to the hospital earlier for investigation and treatment. B was also concerned about the delay on the part of the ambulance service in transferring her father to the general hospital.

We contacted the providers for responses to B's concerns and obtained medical records. The responses and medical records evidenced that B's father had been deteriorating for some time and he did not have capacity at the time to make decisions about his health. The medical records also showed there had been a significant delay in the ambulance transfer however, the following information was documented in the medical records:

- the attending medical practitioner considered the patient to be experiencing a life terminating event;
- there was no guardianship order in place;
- there was disagreement within the family as to whether B's father should be transferred or be treated palliatively at the regional hospital; and
- the ambulance Clinical Consultant requested the patient goals of care prior to considering transport so that the ambulance officers had clear goals on which to act in the event of a life terminating event during the transfer.

Following assessment of the complaint, the following recommendations were made:

- complex patients should be reviewed by the same doctor if possible; and
- Goal of Care forms should be introduced to ensure patients outline their wishes at a time when they have capacity and these wishes can be adhered to.

Treatment in Accident and Emergency

R complained about the care provided to him at a public hospital emergency department when he attended with an acute mental health issue. R reported that he felt unheard, misunderstood, that his problem was not serious and the community mental health service did not follow up with him as he was told it would.

We contacted the provider for a response to R's concerns and obtained his medical records. The provider apologised for the delay in providing care and explained that emergency departments decide the order of patient treatment based on the degree of urgency rather than in the order that patients present; there were a large number of patients being treated and waiting for treatment at the time. The degree of urgency was reassessed when R threatened possible self harm. R discharged himself when informed that a bed was not available on the appropriate ward in the hospital. While he was told the community mental health service would contact him, a referral to the service had not been made.

As a result of this complaint, the hospital reviewed the process of referring patients to the community mental health service following their discharge from the emergency department. They also offered to meet with R to discuss the process.

Vaccination of children

J took her five and nine year old children to their general practitioner for a hepatitis A booster prior to travelling overseas. The practice nurse prepared the vaccine, which was checked by the general practitioner and administered by the nurse. The children were given an adult combined hepatitis A and typhoid vaccine. The error was identified when J questioned the fee for the immunisations. J was concerned about possible side effects to her children.

We contacted the practice manager for a response to J's concerns as well as a copy of relevant medical records and practice policies.

The general practitioner responded that: he had not detected that the nurse had drawn up the incorrect vaccination at the time; the consultation had been interrupted by a personal call from his wife; it was not his usual practice to take calls during consultations; and the vaccine error had reinforced the importance of maintaining this approach. He apologised to J and her husband, met with them to discuss their concerns and provided them with information about research available in the use of the combined vaccine in children.

As a result of the complaint the practice updated the vaccination lists in each consulting room to include the age recommendations in relation to the giving of each vaccine, the registered nurse involved completed online training and staff received further education in travel vaccinations.

Treatment in a public hospital following surgery

W complained about a number of individual practitioners and the care and treatment she received at a public hospital where she underwent surgery.

In response to the complaint, the hospital provided W with explanations and addressed her concerns about her treatment throughout her time at the hospital. When it became clear that the therapeutic relationship with her surgeon had broken down, W was referred to another surgeon.

A review of the care and treatment provided identified that some of the health practitioners involved in W's care may have adopted unhelpful communication styles, and there were difficulties attached to the communications by and with W generally. We were unable, however, to find any evidence that the treatment provided fell below an acceptable standard.

We recommended that the hospital consider training and education in relation to communication styles and the benefits of a collaborative approach to disease management.

Errors in dispensing procedures at an optometrist

Y raised concerns about dispensing errors made by the staff of an optometrist practice. He also complained about the inadequacy of the responses by the practice staff when he complained to them about the problems he had experienced with his new glasses.

Our Office obtained two responses to Y's complaint from the owners of the practice. They apologised to him and advised that, as a result of the issues he had raised in the complaint, they had implemented new procedures to ensure this situation does not occur for other customers in the future.

The procedures included a new system to routinely measure the vertical heights on all single vision lenses and the installation of a 'prescription calculator' to gauge the affect on the prescription of any height changes.

Pap smear screening improvements

V complained that her general practitioner had been insensitive and rough with her during her regular pap-smear examination, causing her to experience an unusual level of discomfort. When she raised her concerns with the GP she said, she felt belittled and humiliated by the response.

The GP provided a response, offering an apology and an undertaking to improve her practice for patients like V who have limited hip mobility by using a cervical pillow during the procedure.

We were also advised that there had been some confusion in the booking procedures on the day in question which resulted in a high level of stress for the GP. The general practice agreed to make improvements to its appointment booking system to ensure that longer appointments are always booked for patients requiring pap smears. This improvement allows the GP to take more time to carry out the procedure with the required level of sensitivity. The GP in this case was also able to review and reflect on the complaint, which would assist in improving future practice.

Assistance for hospital patients on the autism spectrum

A complaint was received from E, a patient diagnosed with agoraphobia associated with autism and post-traumatic stress disorder, which causes him to experience severe anxiety, often leading to panic attacks in public places such as hospital waiting rooms.

Prior to an appointment, E attempted to arrange with reception staff at a hospital outpatient's clinic to prevent an exacerbation of his panic disorder. In particular, he attempted to negotiate permission to wait in his car until he was required to attend for his appointment. This request was denied. E subsequently suffered a panic attack whilst in the waiting area and was unable to remain in the hospital and receive the post-operative review that he required. He was unable to obtain a satisfactory response from the health service to his concerns about this incident.

Following extensive consultation between this office and the health service, significant service improvements were achieved for patients with panic disorders and those with autism spectrum disorder. These included:

- enhanced administrative procedures to allow for SMS messaging to patients unable to wait in the waiting rooms;
- an upgrade to waiting room facilities in consultation with Autism Tasmania;
- provision of training by Autism Tasmania to hospital staff covering topics such as communication, recognising sensory perception differences, establishing autism-friendly environments and effective engagement with people on the autism spectrum; and
- improved training for security guards in managing patients with panic disorders.

Imposition of 'co-contribution fees' in a public hospital

An elderly patient, K, complained about the distress and confusion he had experienced because of the imposition of co-contribution fees during his wife's lengthy hospital admission.

In particular, K alleged that he had not been advised of changes in his wife's billing status from acute medical care to 'requiring nursing home type treatment', which resulted in a fee being charged for her admission. He believed the change in his wife's billing status had been invalid because, in his opinion, at that time she was still in need of acute medical care. Additionally, he felt that when he questioned hospital staff about the reasons for the imposition of the fee, they were not forthcoming with an explanation.

Our Office obtained an apology from the service for not responding to K's requests for an explanation of the fee imposition and the reasons for the change in his wife's care.

As a result of K's complaint we made two recommendations:

1. When a decision is made regarding a change to a patient's 'caretype', a face-to-face discussion should be held involving social work staff, the patient and caregivers. During this conversation, particular assistance should be provided to the patient or caregivers about both how to complete the necessary paperwork and to ensure that the reasons and implications for the change in 'caretype' are understood.

2. Where possible, the service responds in a timely and appropriate manner to all requests for further information about co-contribution payments.

Confusion about processes at a GP clinic

T complained to this Office that he had received contradictory information from different staff members of two linked general practices about the cost of a service and the process of conveying test results to patients. He had attempted to resolve his concerns with the practice without success.

We sought an explanation and clarification about the identified discrepancies from the practice manager who acknowledged that there had been inconsistencies in the practices' administrative processes. She committed to addressing these anomalies and to ensuring that every receptionist working at the practices had adequate training and education regarding billing practices and 'communication of test results' protocols.

Unintended Outcomes of a *Protected Meal Times Policy*

The family of a terminally ill patient at a regional hospital complained that they had experienced negative outcomes as a consequence of the *Protected Meal Times Policy* in operation at the facility. Additionally, they had not received a response to their concerns when they complained to the facility about the negative impact of the Policy.

In summary, the Policy required all visitors to depart the bedsides of a patient at meal times so that the patient could consume their meal without distraction. The intention of the policy was to improve the nutrition of patients and was originally designed to be flexible in its implementation.

For this family, however, the Policy was stringently applied and resulted in a reduction of precious time with their very ill family member and precluded their ability to provide him with the physical assistance he required to eat his meals. Additionally, as the family lived a long distance from the hospital, their time with the patient was limited and unnecessarily reduced.

As a result of the complaint, the hospital carried out the following:

- a review of the evidenced based literature regarding the protected meal time interventions;
- a review of the current documented practice;
- observational audits of the practice at the hospital; and
- a review of feedback from frontline staff.

Following this review, the *Protected Meal Times* intervention was abandoned.

Extensive delays in obtaining a new prosthesis

Z, an amputee, complained about the length of time he had waited to obtain a replacement prosthetic device. He had been unable to walk during the time he waited for the new device.

In its response to the complaint, the orthotic provider acknowledged responsibility for failing to order the aid for Z in a timely manner. The service also acknowledged that Z should have been advised of this delay at the time and that the overall delay of five weeks between Z receiving the new aid and his first fitting appointment had been unacceptable.

The service provider committed to a number of undertakings to avoid a repeat of the situation experienced by Z, including:

- a review of its communication processes, particularly with regard to foreseeable delays and wait times;
- a review of the ordering system across state-wide services to see if this can be managed in a way that is less complex and which may assist in a more timely response; and
- to resolve issues with the relevant clinician in relation to the use of the particular device.

Case Closed Following Conciliation

Consent and complaint processes – poor communication

A woman complained, amongst other things, about the process for seeking consent to a non-coronial autopsy following her mother's death in hospital.

After her mother died, the woman and her father had spoken with a doctor at the hospital and had agreed to the hospital performing a partial autopsy. There was no suggestion that the hospital had done anything wrong, the autopsy was simply requested to enable doctors at the hospital to better understand the cause of death. The father subsequently signed a form consenting to the procedure.

Several weeks later, the family were shown a report describing a full autopsy. The daughter wrote to the hospital expressing her dismay and raising other issues that had arisen during the course of her mother's admission. She received a response from the hospital, which did not address these concerns. She made a complaint to this Office reiterating the matters she had raised with the hospital, and in addition pointing out that she had gone to considerable effort to raise the matters with the hospital in the hope that it would trigger an apology and bring about improvements. Instead, she considered the response glib and dismissive of her concerns, and furthermore suggested that her father had been at fault for signing the form without reading it.

The complaint was referred to conciliation. At conciliation, the hospital representatives acknowledged that the process for seeking consent to the autopsy had been far from ideal; it had involved two different doctors, one who spoke with the family and the other who asked the father to sign the form. They acknowledged that the father had every reason to believe that the form he was being asked to sign would reflect the discussion he had just had and that only a partial autopsy would be performed. They apologised profusely for the distress that had been caused and undertook to review the consent processes in relation to non-coronial autopsies. They also apologised that their initial response to the complaint had been inadequate.

The daughter advised that she and her father were very grateful for the opportunity to meet with hospital representatives and discuss their concerns. The daughter pointed out that had the hospital provided a more considered response at the outset, the matter would not have escalated.

Following the meeting, she wrote to this Office thanking us for our role in resolving the complaint. She advised that they had been very pleased with how the meeting went, particularly her father, as it had brought him some closure. She commented: *we appreciate the attendance, honesty and frankness of the [hospital] staff, and we understand the difficult circumstances that they find themselves in. We are pleased that our concerns appear to have been understood and taken on board.*

Acknowledgement and improved complaint processes

D complained about her experience in hospital following the birth of her daughter. This was her first child and the birth had been complicated. Her concern was that, despite her obstetrician recommending she spend an extra day in hospital, she had felt pressured by nursing staff to leave the hospital before she felt confident to manage at home.

D had provided feedback to the hospital and had received a response in which the hospital apologised that D's expectations not been met and explained that the nurse had been acting in her best interests.

D found the response defensive and disingenuous and made a complaint to this Office. She explained that her complaint was as much about the hospital complaint process as it was about the original incident. She explained that it had been difficult making the complaint in the first place but she had hoped that the hospital would acknowledge her experience, value her comments and take whatever steps were necessary to address the situation.

D clarified that she did not consider it was a question of whether her expectations had been met, but rather whether the nurse involved had behaved appropriately. She explained that her interaction on the day, instead of being supportive and encouraging to a new mother, had been confronting and distressing, as though she was on a 'mission to clear beds' rather than provide nursing care.

The complaint was resolved in conciliation. Representatives of the hospital met with D. They acknowledged, and apologised for, her experience. They assured her that they understood the vulnerabilities of a new mother and the importance of proper support at that time. They were very apologetic that this had not been the case for D. They advised that D's experience had been presented to staff at the hospital as an example of poor patient care. They also apologised that their initial response had not addressed D's concerns and advised that complaints were now being handled differently.

D advised that the meeting with the hospital representatives had helped resolve the issues for her. It had been very important for her to have her concerns acknowledged and to be reassured that what had happened was not acceptable.

Nursing care – the need to be heard

J made a complaint about the standard of nursing care she had received at a regional hospital following a surgical procedure. J was discharged home on the day of the procedure but returned four days later complaining of pain. She was admitted to the short stay surgical unit (SSMU) where she was administered pain relief and discharged home the following day. She returned to the hospital after a further four days, with increased pain, and was again admitted to the SSMU and administered pain relief. Ultimately, J underwent a CT scan, which indicated that she had experienced complications from her surgery and that her pain was not normal post-operative pain. She underwent a further procedure and her pain resolved.

J's complaint was not about the complications from the surgery, as these were a known risk, but that she did not feel that the nursing staff had taken her complaints of pain seriously and, consequently, had not provided her with assistance nor escalated her pain management issues to the necessary clinical staff. J reported being told that the ward was a mobilising ward and

she felt the expectation was that she should be doing things for herself. She described feeling a sense of isolation and helplessness and questioned whether she had been put on the wrong ward.

The complaint was resolved in conciliation. J met with representatives of the hospital who acknowledged and apologised for her experience. They explained that some of the issues that had arisen due to the location of the SSMU within the hospital and this had subsequently been changed. In addition, a position had been filled which would ensure patients' pain management issues were appropriately escalated.

J was grateful for the opportunity to meet with representatives from the hospital. She explained how important it was for her to be heard, as she had not felt heard during her admissions.

Appendix 1 – Statistics

Table 5 - Reasons for Closure in Assessment Stage

Reason	2017-18	2018-19
Dismiss - Section 25 (5) (a) Complainant not a person entitled under s22	7	2
Dismiss - Section 25 (5) (b) Complaint does not disclose a subject matter referred to in s23	6	5
Dismiss - Section 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago	1	1
Dismiss - Section 25 (5) (d) Complainant has not attempted direct resolution	9	19
Dismiss - Section 25 (5) (e) Issues adjudicated by court or tribunal	2	2
Dismiss - Section 25 (5) (g) Complainant has been given reasonable explanation and information	164	161
Dismiss - Section 25 (5) (h) The complaint lacks substance	4	7
Dismiss - Section 25 (5) (i) The complaint is frivolous, vexatious or not made in good faith	0	1
Dismiss - Section 25 (5) (j) Complaint has been resolved	65	41
Dismiss - Section 25 (7) Complainant has failed to provide information under s24	3	0
Other	4	5
Out of Jurisdiction	5	4
Resolved	0	113
Section 25 (1) (a) Complaint referred to the Ombudsman or another person	17	31
Section 30 (1) The complaint has been withdrawn in writing	3	8
Total	**290**	**400**

Outcomes achieved through the assessment process as set out in Table 6 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 6 - Outcomes from Assessment

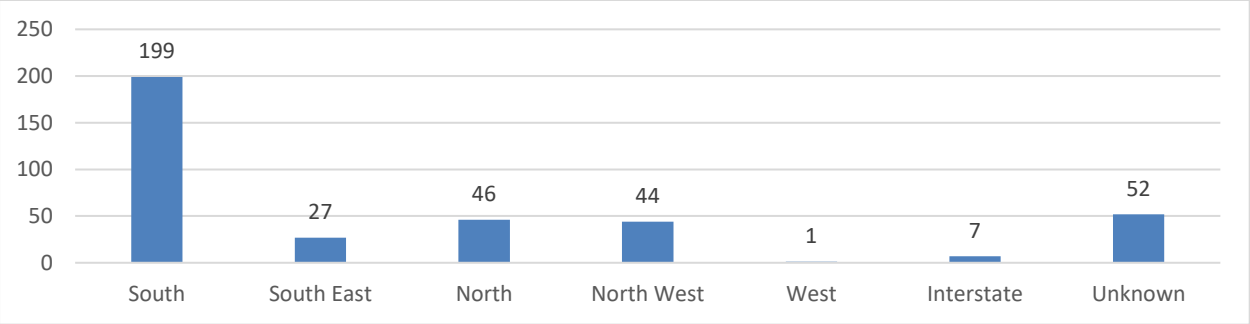
Outcomes	**2017-18**	**2018-19**
Apology Given	25	68
Change in Policy	7	20
Change in Procedure	5	25
Compensation Received	3	3
Concern Registered	61	179
Explanation Given	169	173
Fees/Costs - Refunded, waived or reduced	10	9
Information obtained	80	207
Quality Improvement	16	27
Service Obtained	59	90
Total	**435**	**854**

Table 7 - Outcomes from Conciliation

Outcomes	**2017-18**	**2018-19**
Apology Given	4	8
Compensation Received	1	2
Concern Registered	2	8
Explanation Given	5	7
Information obtained	2	3

Outcomes	2017-18	2018-19
Quality improvement	4	4
Service obtained	1	1
Total	**19**	**37**

Figure 3 - Geographical location of complainants



What did they complain about?

A breakdown of the issues arising from complaints closed in the reporting year is set out in Tables 8 to 20. It should be noted that a significant number of complaints contain more than one issue.

Issues by category

Table 8 - Access Issues

Issue	2017-18	2018-19
Access to facility	0	3
Access to subsidies	1	1
Refusal to admit or treat	31	7
Remoteness of service	0	1
Service availability	9	68
Waiting lists	5	10
Total	**46**	**90**

Table 9 - Communication and Information Issues

Issue	2017-18	2018-19
Attitude/manner	38	51
Inadequate information provided	27	35
Incorrect/misleading information provided	17	28
Special needs not accommodated	2	8
Total	**84**	**122**

Table 10 – Consent Issues

Issue	2017-18	2018-19
Consent not obtained or inadequate	4	8
Involuntary admission or treatment	2	2
Uninformed consent	1	3
Total	**7**	**13**

Table 11 – Discharge and Transfer Arrangements

Issue	2017-18	2018-19
Delay	3	4
Inadequate discharge	1	13
Mode of transport	3	2
Patient not reviewed	1	1
Total	**8**	**20**

Table 12 – Environment / Management of Facilities Issues

Issue	2017-18	2018-19
Administrative processes	7	14
Cleanliness/hygiene of facility	6	1
Physical environment of facility	7	1
Staffing and rostering	4	1
Statutory obligations/accreditation standards not met	1	3
Total	**25**	**20**

Table 13 – Fees and Costs

Issue	2017-18	2018-19
Billing practices	12	15
Cost of treatment	6	0
Financial consent	5	5
Total	**23**	**20**

Table 14 – Grievance Processes

Issue	2017-18	2018-19
Inadequate/no response to complaint	18	20
Information about complaints procedures not provided	1	1
Reprisal/retaliation as a result of complaint lodged	2	1
Total	**21**	**22**

Table 15 – Inquiry Service Issues

Issue	2017-18	2018-19
Request for information - Health Service	3	1
Request for information - Other	1	10
Request for Information - Commission	1	1
Request for information - Complaint mechanisms	3	21
Request review	0	3
Total	**8**	**36**

Table 16 – Medical Records

Issue	2017-18	2018-19
Access to/transfer of records	7	14
Record keeping	0	4
Records management	1	4
Total	**8**	**22**

Table 17 – Medication Issues

Issue	2017-18	2018-19
Administering medication	6	12
Dispensing medication	5	3
Prescribing medication	62	96
Supply/security/storage of medication	2	2
Total	**75**	**113**

Table 18 - OOJH Referred

Issue	2017-18	2018-19
Not specified	4	3
Total	**4**	**3**

Table 19 – Professional Conduct

Issue	2017-18	2018-19
Assault	0	3
Boundary violation	2	0
Competence	17	25
Discriminatory conduct	0	3
Emergency treatment not provided	1	1
Financial fraud	1	0
Impairment	1	0
Inappropriate disclosure of information	4	10
Misrepresentation of qualifications	1	0
Sexual misconduct	2	1
Total	**29**	**43**

Table 20 – Reports/Certificates

Issue	2017-18	2018-19
Accuracy of report/certificate	3	2
Refusal to provide report/certificate	4	4
Report written with inadequate or no consultation	0	1
Total	**7**	**7**

Table 21 – Treatment Issues

Issue	2017-18	2018-19
Coordination of treatment	11	17
Delay in treatment	33	23
Diagnosis	12	17
Excessive treatment	1	1
Experimental treatment	0	1
Inadequate care	56	44
Inadequate consultation	6	6
Inadequate prosthetic equipment	5	3
Inadequate treatment	41	39
Infection control	1	2
No/inappropriate referral	7	21
Rough and painful treatment	3	7
Unexpected treatment outcome/complications	22	24
Withdrawal of treatment	9	2
Wrong/inappropriate treatment	9	7
Total	**216**	**214**

Grand Total of Issues	**561**	**745**

Who did they complain about?

Table 22 – Complaints received about Health Organisations

Health Organisation	2017-18	2018-19
Aged Care	2	2
Ambulance	3	3
Community Health	3	5
Correctional Health	120	135
Dental	4	5
Department of Health & Human Services	6	15
Diagnostic Services	0	0
Disability Services	3	2
Medical Practices/Clinics	27	30
Mental Health	9	9
Optometrist	1	2
Oral Health Services	2	1
Other	9	7
Pathology	1	0
Pharmacy/Pharmaceutical	5	7
Private Hospitals	14	7
Public Hospitals	75	61
Total	**284**	**291**

Hospitals

Table 23 – Issues Relating to Private Hospitals

Issue	2017-18	2018-19
Access	1	0
Communication & information	5	6
Consent	0	1
Discharge and transfer arrangements	2	2
Environment/management of facilities	2	1
Fees & costs	6	1
Grievance processes	1	2
Medical records	0	1
Medication	0	1
Professional conduct	2	1
Treatment	12	15
Total	**31**	**31**

Table 24 – Issues Relating to Public Hospitals

Issue	2017-18	2018-19
Access	10	12
Communication & information	34	40
Consent	3	4
Discharge & transfer arrangements	4	11
Environment/management of facilities	5	3
Fees and costs	0	4
Grievance processes	9	10

Issue	2017-18	2018-19
Inquiry service only	0	3
Medical records	0	6
Medication	8	5
Professional conduct	5	11
Treatment	70	79
Total	**148**	**188**

Individual Providers

Table 25 - Complaints to HCC about Individual Providers

Provider	2017-18	2018-19
Chiropractor	0	2
Dental	7	7
Exempt	1	2
Medical practitioner	71	56
Nurse	0	3
Optometrist	1	0
Other/unknown	12	9
Pharmacist	0	2
Physiotherapist	1	0
Psychologist	0	4
Total	**93**	**85**