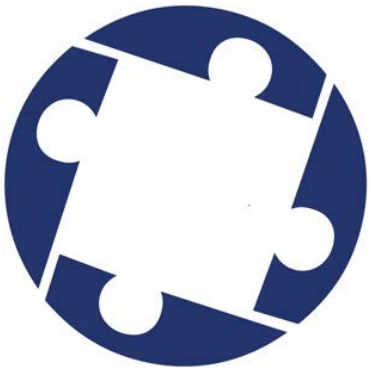

Health Complaints Commissioner Tasmania

Annual Report 2016/17

Health Complaints Commissioner

Annual Report 2016-17

Enquiries about this annual report should be directed to:

The Health Complaints Commissioner

Level 6, 86 Collins Street, Hobart, Tasmania 7000

Telephone: 1800 001 170

Facsimile: 03 6173 0231

Email: health.complaints@ombudsman.tas.gov.au

Website: www.healthcomplaints.tas.gov.au

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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 2016-17.

Yours sincerely

Richard Connock
HEALTH COMPLAINTS COMMISSIONER

22 November 2017

About this Report

This report describes the functions and operations of the Health Complaints Commissioner Tasmania for the year ending 30 June 2017.

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.

Contents

From the Health Complaints Commissioner 1

Statistics 1
Enquiry and Complaint Management 1
Staffing 2
Efficiencies 2
Conciliation 3
Australian Health Practitioner Regulation Agency 3
Strategic Plan 3
Code of Conduct for Health Care Workers 3
Systemic Improvements 4
Conclusion 4

The Office of the Health Complaints Commissioner 5

Staff profile 5

2016-17 Highlights 6

Complaint and Enquiry Activity 7

Enquiries 7
Complaints and Notifications 7

Who and what did people complain about 9

Correctional Primary Health Services 9
Tasmanian Health Service 9
Medical Clinics 9
Individual Providers 10

How were complaints resolved? 11

Assessment 11
Referral to Registration Boards and other entities 11
Conciliation 12
Investigations 12

Time taken to assess and finalise complaints 14

Time taken to assess complaints 14

Time taken to finalise complaints 15

Case Summaries 16

Enquiries 16

Wait-list times for specialist public health services 16

Informed financial consent 16

Fee for transfer of medical records 16

Lack of access to appointments and medication 16

Cases closed in Assessment 17

Home pharmacy review 17

Payment of rehabilitation services 17

Patient transport 17

Informed financial consent 17

Discharge from a mental health unit 17

Improvements in the care of children at a hospital 18

Standard of palliative care provided to patient by hospital 18

A missed diagnosis by a hospital 19

Delayed diagnosis of parasitic myositis 19

Cases closed following conciliation 19

Emergency department response to patient with suicidal ideation 19

Cases Closed Following Investigation 23

Was the health care provided to a mental health client adequate? 23

Was there a conflict of interest providing health care to the son of a mental health client? 23

Appendix 1 – Statistics 26

What did they complain about? 29

Issues by category 29

Who did they complain about? 35

Hospitals 36

Individual Providers 38

Tables

Table 1 – Enquiry Activity 7

Table 2 – Complaint Activity 7

Table 3 - AHPRA Notifications 8

Table 4 - Reason for Closure of Complaints and Notifications 11

Table 5 - Reasons for closure in Assessment Stage 26

Table 6 - Outcomes from Assessment 27

Table 7 - Outcomes from Conciliation 28

Table 8 - Access Issues 29

Table 9 - Communication and Information Issues 29

Table 10 – Consent Issues 30

Table 11 – Discharge and Transfer Arrangements 30

Table 12 – Environment / Management of Facilities Issues 30

Table 13 – Fees and Costs 31

Table 14 – Grievance Processes 31

Table 15 – Inquiry Service Issues 31

Table 16 – Medical Records 32

Table 17 – Medication Issues 32

Table 18 – Professional Conduct 33

Table 19 – Reports / Certificates 33

Table 20 – Treatment Issues 34

Table 21 – Complaints received about Health Organisations 35

Table 22 – Issues relating to Private Hospitals 36

Table 23 – Issues relating to Public Hospitals 37

Table 24 - Complaints to HCC received about Individual Providers 38

Table 25 – Complaints finalised over time 2011-12 to 2016-17 39

Graphs and Charts

Figure 1 - Time taken to assess complaints 14

Figure 2 – Time taken to finalise complaints 15

Figure 3 - Geographical location of complainants 28

From the Health Complaints Commissioner

This annual report is prepared under section 12 of the *Health Complaints Act 1995* (the Act), and details the work of my Office under the Act during 2016-17.

Statistics

These are the key statistics for the year:

- a 47% increase in enquiries received (377 in 2015-16 to 553 in 2016-17);
- a 45 % increase in enquires closed (382 in 2015-16 to 550 in 2016-17);
- a 3% reduction in complaints received (357 in 2015-16 to 348 in 2016-17);
- a 7% increase in complaints closed (344 in 2015-16 to 368 in 2016-17);
- 70 % of complaints finalised within three months;
- 11% of complaints assessed outside the required 90-day period;
- 13% of complaints took 12 months or more to finalise;
- a 13% increase in the number of complaints closed in assessment;
- a 12% decrease in the number of complaints closed in conciliation (24 to 21); and
- a 20% decrease in the number of complaints referred to conciliation (10 to 8).

Enquiry and Complaint Management

A large proportion of matters brought to our attention are resolved informally by members of my staff, in the enquiry stage. The number of matters closed in enquiry increased by 45% this year. Current reporting methods understate the amount of work performed and the outcomes achieved at this stage and we will be taking steps to capture and report this information in more detail in coming years.

The number of complaints received this year decreased by 3% (357 to 348). This is most likely attributable to the increased focus on resolving matters at the enquiry stage. A large proportion of the complaints received are complex with multiple parties needing to be consulted and managed.

Several years of growing complaint numbers and reduced staffing levels have resulted in a widening gap between opened and closed cases and an increase in the number of complaints carried forward from reporting year to reporting year. Although the figures for this year show an encouraging reversal of that trend, with more cases closed than opened, deeper analysis indicates that the cases carried forward at the end of the reporting year are the older, more complex cases rather than matters recently received.

Staffing

In previous reports I have referred to the low staffing levels in the Health Complaints' team. They reached their lowest (2.2 FTEs) in August 2015 following the retirement of a part time conciliator, the finalisation of a fixed term contract and the retirement of an Intake and Assessment Officer. We took steps throughout the 2015/16 year to address this and as at August 2016 the Health Complaints' team comprised 4.2 FTEs. There were 4.4 FTEs at the end of the reporting year.

Unfortunately, early in the reporting year my Principal Officer (who is also my chief conciliator) suffered an injury and was absent on leave for much of the year with the remaining 3.2 members of the team making a commendable effort to keep up with the steady flow of enquiries and complaints.

Low staff levels have not only had an adverse impact on the time taken to resolve complaints but also, with a necessary focus on complaint resolution, they have resulted in an inability to perform other functions prescribed under the Act, such as education on health rights, building complaint resolution capacity within providers and improving, and auditing improvements to health services.

Efficiencies

We continue to search for efficiencies. We are currently undertaking a review of our processes in an attempt to identify strategies that will increase our ability to undertake these important functions referred to above. This in itself should result in better responses and complaint management by providers and a reduction in the number of matters requiring our assistance to resolve.

We are already resolving an increasing number of matters informally at the enquiry stage and referring matters back to providers for an attempt at direct resolution with complainants. We have identified that a key problem area is the process involved in consulting with registration boards pursuant to the *Health Practitioner Regulation National Law Act 2009* (National Law) and the Memorandum of Understanding (MOU) between the Australian Health Practitioner Regulation Agency (AHPRA) and Health Complaints Entities. We plan to work with our local AHPRA office during the coming months to identify ways to expedite this process.

We reported last year that considerable time and effort is expended following up providers for responses, particularly in relation to complaints about public hospitals. We started meeting with key stakeholders to explore ways in which more timely responses could be provided in both assessment and conciliation but major restructuring in the

Patient Safety Service of the Tasmanian Health Service during the reporting year meant that this process has been somewhat delayed.

Conciliation

Only eight matters were referred to conciliation this year. This was due to a concerted effort being made to resolve complaints within a prolonged assessment process in response to the absence of my chief conciliator. It also provided an opportunity to reduce the backlog of conciliation matters reported last year with 21 matters closed and only eleven carried forward at the end of this reporting year.

We are still experiencing significant delays in the scheduling of meetings with public hospitals due to the unavailability of necessary representatives. There are also continued delays in the time taken by public hospitals to respond to requests for compensation, which as reported in previous years appears, at least in part, to be a consequence of the stringent controls placed on public hospitals' access to the Tasmanian Risk Management Fund.

Australian Health Practitioner Regulation Agency

The consultation process between this Office and AHPRA pursuant to the requirements of National Law has been described in detail in earlier annual reports.

As noted earlier, a review of our efficiencies indicates that this process causes delays within this Office. In the previous reporting year a National decision-making matrix between AHPRA and the various Health Complaint Entities was developed. This was not adopted in Tasmania as it was considered that a more individualised approach would better meet the parallel roles of resolving a complaint between the parties and protecting the public - not just the latter. We plan to work with the local AHPRA representatives in the coming year to identify any aspects of the consultation process that can be refined and still meet these dual roles.

Strategic Plan

A new Strategic Plan, covering the whole of the office, is being developed and implemented. The aim of the plan is to promote the advancement of the office over the next three years. More information in this regard is contained in my Annual Report as Ombudsman.

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.

Implementation of the Code has been the subject of discussion at Health Complaints Commissioners' meetings and teleconferences. A working group, including representatives from all States and Territories and the Victorian Health and Human Services Department, has convened for monthly teleconferences to co-ordinate the consistent implementation of the Code across jurisdictions. This will involve a common framework for the collection and reporting of data and for annual performance reporting to the COAG Health Council, and the development of nationally consistent explanatory materials to support the implementation.

It is anticipated that a significant amount of work will be required in 2017-2018 to deal with amendments to the Tasmanian Health Complaints Act.

Systemic Improvements

A number of significant improvements in the delivery of health services have been identified or implemented over the reporting year as a result of actions taken by health providers, either on their own initiative or as a result of the assessment and conciliation of complaints received by this Office. Case summaries highlighting some of these appear at the end of this report. Other examples will be published on our website.

In appropriate cases, where improvements have been identified through our processes, we disseminate relevant information to other organisations and health care providers both intra and interstate so that the broader community will continue to benefit from the work we do. I would like to thank the healthcare providers we have worked with for their continued commitment towards improving the delivery of services in 2016-17.

Conclusion

I would like to thank my Health Complaints' staff for the quality of their work, for their dedication, and for sustaining their remarkable levels of activity over yet another very challenging year.

The Office of the Health Complaints Commissioner

The Office of the Health Complaints Commissioner (OHCC) was established in 1997 by the *Health Complaints Act 1995*. The major functions undertaken by 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 carried out 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 Health Complaints' division of OHCC as 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	1.2	1.2
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**	**4.2**	**4.4**

2016-17 Highlights

- 553 enquiries received
- 348 complaints received
- 40 AHPRA notifications received
- 941 total approaches
- 89% of complaints assessed within 90 days
- 95 complaints recorded as resolved in assessment
- 79% of complaints closed within 6 months
- A 47% increase in enquiries received
- A 3% decrease in complaints received
- A 7% increase in complaints closed
- A 13% increase in the number of matters closed in assessment
- A 57% decrease in cases referred to conciliation
- 21 cases closed in conciliation
- 3 investigations completed

Complaint and Enquiry Activity

Enquiries

Enquiries which do not develop into a written complaint represent a substantial workload for this Office. Table 1 shows the number of matters opened and closed as an enquiry during the reporting year and indicates that there was a significant increase in the number of matters dealt with in this way this year compared with last year. With more and more emphasis being placed on resolving matters as quickly and informally as possible, steps will be taken to capture and report on outcomes from enquiries in more detail in coming years.

Table 1 – Enquiry Activity

Enquiries	**2015-16**	**2016-17**	**Variance**
Enquiries received	**377**	**553**	**47%**
Enquires closed	**382**	**550**	**44%**
Enquires active	**-**	**21**	**-**

Complaints and Notifications

Table 2 – Complaint Activity

Complaints	**2015-16**	**2016-17**	**Variance**
Complaints carried forward	107	120	12%
Complaints received	357	348	-3%
Complaints closed	344	368	7%
Complaints active	120	100	-17%

Table 3 - AHPRA Notifications

Notifications from AHPRA	2015-16	2016-17	Variance
Notifications carried forward	-	26	-
Notifications received	43	41	5%
Notifications closed	47	51	11%
Notifications Active at 30/6	26	16	-38%

In past annual reports, notifications initially made to AHPRA (in respect of which this Office & AHPRA are required to consult under National Law) have been classified and reported on separately from complaints. Historically we have referred to these as "section 57 matters" which is a reference to a now obsolete provision in the Act. In future, notifications from AHPRA will be recorded as complaints and the outcomes noted as having been dealt with pursuant to the MOU with AHPRA.

Table 2 demonstrates a reduction in the number of complaints received, and an increase in the number of matters closed. Likewise, Table 3 shows a similar trend in relation to notifications from AHPRA. The result of this is an encouraging drop in the number of matters carried forward into the next reporting year.

On the face of it, if this trend continues the backlog of cases built up over years of low staffing levels should be disposed of in the next five years. The backlog consists of the more complex older cases.

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.

Correctional Primary Health Services

The source of complaints about prescribing was predominantly prisoners incarcerated in the Tasmanian Prison Service. There was a 40% increase in the number of complaints about Correctional Primary Health Services (from 101 to 141). Inmates are able to call this Office directly on a secure line at no cost. By far, the most common reason for (male) inmates to call was because they were seeking access to the suboxone opioid replacement program, or seeking access to stronger pain relief (males and females). To that end, the second most common and directly corresponding reason for complaint after 'access to the doctor', is for medication to be prescribed. It is possible that this increase was, at least partly, attributable to the smoke free status of Tasmanian prisons and the reduced access to the nicotine replacement therapy, with inmates seeking alternate solace in prescription medication.

Another common reason for complaints by inmates is that they want 'access to the doctor' in the same timeframe as they would in the community (same day or next day appointments), as well as other treatment services such as dental, optometry, surgery and cosmetic surgery.

Tasmanian Health Service

In line with previous years, and no doubt because of the sheer volume of patients attending, public hospitals were the subject of the next highest number of complaints. There was a pleasing 31% reduction in the number of these complaints (from 74-51) as well as a 54 % reduction (13 to 6) in the number of complaints received about mental health services. The main issues raised about public hospitals were treatment and communication. The main issue in relation to mental health services was refusal to admit or treat.

Medical Clinics

There was an increase in the number of complaints about medical clinics (26 to 31). A recurring theme related to 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 apart from nurses, with complaints about the latter mainly being incorporated into complaints about hospitals. There was a reduction in complaints received about medical practitioners this year from 60 to 52.

How were complaints resolved?

Table 4 - Reason for Closure of Complaints and Notifications

Reason closed	2015-16	2016-17
Assessed for no further action	290	329
Referred to board pursuant to MOU	26	15
Retained by board pursuant to MOU *	47	51
Conciliation completed	24	21
Investigation completed	4	3
Total	**391**	**419**

*These cases originated as notifications to AHPRA

Assessment

The majority of complaints received are closed following assessment. This was the case for 329 complaints closed this year. In the language of the Act, complaints closed following assessment are recorded as having been "dismissed" (as opposed to being referred to investigation, conciliation, a registration board, or elsewhere). 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.

The various reasons for closing a complaint in assessment are set out in Table 5. 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. The remaining two reasons, which account for 88% of all complaints dismissed in assessment during the reporting year, and which undergo a more protracted process, are that the complainant has been given a reasonable explanation about the incident that led to the complaint, or that the complaint has been resolved.

Referral to Registration Boards and other entities

The relationship between this Office and the national boards and AHPRA is governed both by the National Law and the Act. An MOU is in place between AHPRA and the various Health Complaints Entities to guide the interaction between those entities and AHPRA, particularly with respect to the operation of s150 of the National Law.

Table 4 indicates that in 2016-17 there were a total of 66 cases either referred to or retained by a registration board pursuant to the MOU of which 15 were referrals from this Office. However, during the reporting year we consulted in relation to an additional 33 matters that did not result in referral to a board. These additional consultations arose from complaints made about hospitals where a registered provider was involved in the episode of care. 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 1996* and now covered by the *Mental Health Act 2013*. Appropriate consultation occurs prior to referral. These matters are generally closed in the assessment stage because, unlike referrals to registration boards, they do not generally require further consideration by me. There were five 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 the same thing happening to someone else. Conciliation under Part 5 of the Act is confidential and privileged, and as such provides a safe forum where the parties can have open and honest discussions about these issues.

Only eight matters were referred to conciliation this year. This was attributable to the unexpected absence of my senior conciliator on personal leave for a significant part of the year as well as a conscious decision to retain matters in a prolonged assessment process and undertake informal negotiations at that stage. Although this avoids double handling of complaints it does have a detrimental effect on assessment times.

There were 21 cases closed in conciliation this year. Outcomes from conciliation are set out in Table 7 in the appendix. Of these cases, six resulted in the payment of compensation or waiver of fees, and seven resulted in significant quality improvements, including changes in policy or procedure. In a number of cases, the complainants' concerns were resolved by receiving further information or an explanation, in language they could understand, or simply by having those concerns acknowledged and receiving an apology.

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 process and identified and implemented whatever systemic changes are

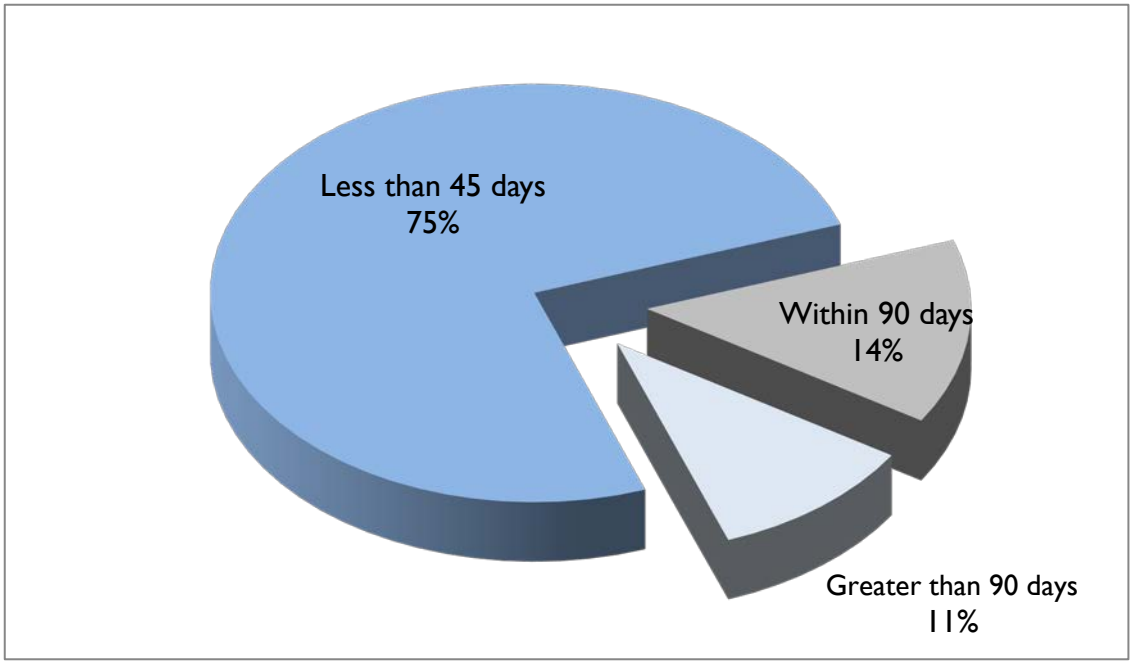
necessary to prevent a recurrence following the incident and these outcomes are then shared with the complainant within conciliation.

The matters referred to investigation have tended to be those that affect vulnerable groups. Three matters were closed in investigation this reporting year and all three related to services provided by mental health services. Summaries of these cases appear in the case summaries at the end of this report.

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, which have an impact on this Office's ability to meet these statutory time frames. These include delays in receiving responses and other information necessary to undertake an assessment from providers, and delays occasioned by the required consultation process with AHPRA, all of which are matters beyond our control.

An amendment to the Act, which was intended to address the difficulty, by providing that *if there is a delay in obtaining information requested by* [the Commissioner], *he or she may extend the period within which a decision must be made under* [s25(1)], came into effect on 13 October 2015. Modifications are required to our case management system to capture these delays before this amendment will have a positive bearing on our reported assessment times.

This reporting year only 11% of cases were assessed outside the 90-day period compared with 19% last year.

Time taken to finalise complaints

Figure 2 – Time taken to finalise complaints

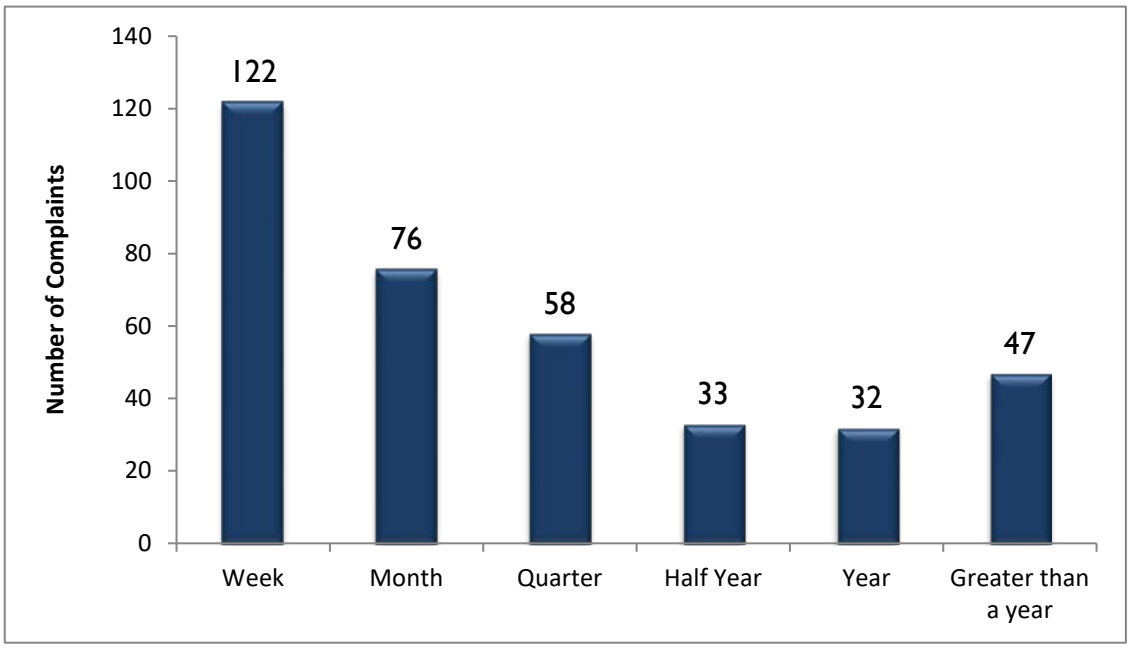


Figure 2 illustrates the time it takes to finalise the various types of complaints received. As previously noted, the less complex complaints are generally resolved within three months; these complaints generally make up around 65% of all complaints received. The remaining 35% tend to be more complex.

Although the statistics for this reporting year show a slight decrease in the percentage of complaints taking more than 12 months to finalise, it is to be noted that of the 100 complaints (excluding notifications) carried forward at the end of the reporting year, 45 were more than 300 days old. As reported last year 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 individuals to engage in conciliation, particularly involving claims for compensation, until finalisation of any action 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.

Yet another factor is the constant pressure to respond quickly to incoming enquiries, new complaints, AHPRA notifications and consultations in an attempt to meet statutory time limits.

We are always looking at ways to make processes more efficient to make the best use of the resources at our disposal.

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.

Enquiries

Wait-list times for specialist public health services

A complaint was received about wait-list times for specialist public health services. A person had been advised of a wait-list duration and felt that the information provided was incorrect. Information obtained by this Office demonstrated that the wait-list times that the person had been advised of, were less than the actual wait-list times for the respective specialist services involved. This Office was able to provide the person with the website link to the publically available information about wait-list times so that the patient could be better informed.

Informed financial consent

A complaint was received about a fee for a first time consultation that was booked online through a phone application. The person alleged that at no time was the fee made clear through the booking process, and was seeking a refund. This Office looked at the booking process via the app and found that the fee information was clear. There was no basis for the person to seek a refund.

Fee for transfer of medical records

A complaint was received about a fee being charged for the transfer of medical records from one practice to another. The patient alleged that the fee was excessive and had refused to pay. This Office explained to the patient that medical centres and GP practices are privately run businesses, and pursuant to Commonwealth Privacy Principles may charge a reasonable fee to cover the cost of providing information.

Lack of access to appointments and medication

A complaint was received claiming that a practitioner had refused to prescribe medication to a patient in relation to an alleged previous diagnosis, and had refused to make future appointments with the patient. On review of the medical records, this Office found that the patient did not have the diagnosis for which the medication was being sought and that the patient had engaged in abusive and threatening behaviour when attending medical appointments.

Cases closed in Assessment

Home pharmacy review

A patient was concerned that a GP had required her to have a review of her current medications by an in-house pharmacist which included looking at medications she already had at home and how they were stored. Following assessment of the complaint this Office suggested that in future, when recommending medication reviews, the GP explain to patients the purpose of the review, ensure they can ask questions and allow them to choose the pharmacist undertaking the review.

Payment of rehabilitation services

A person made a complaint that on discharge from a health facility a falls risk assessment was not carried out. The person subsequently had a fall and required rehabilitation services. After intervention by this Office, the health facility agreed to pay the cost of the rehabilitation services. A recommendation was made that falls risk assessments be available to prevent similar incidents occurring in the future. Currently the health facility is looking into implementing an assessment team to carry out falls risk assessments.

Patient transport

A complaint was made about a hospital transporting an inpatient by taxi for medical tests at another location. The patient felt that this was an undignified and inappropriate mode of transport. As a result of the complaint the hospital apologised to the patient and modified its transport policy.

Informed financial consent

A patient was given a quote for a dental check-up but, having attended an appointment for that purpose, received a bill for additional work. The patient advised that he was not informed of the additional costs before or during the consultation. As a result of the complaint the patient received a refund for the additional fees and the dental practice issued a reminder to its dentists of the importance of informing patients of costs before carrying out procedures.

Discharge from a mental health unit

A patient received treatment in a mental health unit following an attempted suicide. On discharge they travelled interstate to stay with family. A discharge summary was provided to the GP who had been caring for them in Tasmania but no attempts were made to follow up with the patient or provide information to their interstate treating team.

Research indicated that the first three months after a suicide attempt are critical in a person's recovery as they are at higher risk of a further attempt during that period. As a consequence of this complaint the mental health unit implemented a seven day

post-discharge follow up for any patient not referred to the Crisis Assessment and Treatment Team or for case management.

Improvements in the care of children at a hospital

A woman lodged a complaint raising concerns about her daughter's admission to a hospital.

She claimed there had been a lack of communication between the practitioners providing care to her daughter and a lack of communication between the nurses at handover. She cited examples of handover occurring on a paper towel. She also raised concerns about the physical environment of the hospital.

The hospital provided an apology to the woman and reassured her that her concerns were taken seriously. It advised that issues relating to the physical environment of the unit would be raised at a regular fortnightly meeting and the use of paper towels as a means of communication would be discussed with the nursing staff at the meeting, and would cease.

The complainant expressed her satisfaction with the response received from the hospital and was pleased to hear that improvements would be implemented based on her feedback.

Standard of palliative care provided to patient by hospital

A woman lodged a complaint about the standard of palliative care provided to her late brother.

She complained that her brother had a procedure which the family considered invasive and unnecessary for palliative care. Concerns were also raised about the infrequent repositioning provided and a lack of mouth care.

The complainant was also concerned that at the time of her brother's death, no support had been provided to the family members present.

The hospital provided this Office with an extensive list of the mandatory and voluntary education (current and future) provided to staff which directly addressed the issues raised in the complaint. The hospital also agreed to update its policy in respect of the procedures to be followed at the time of death such as viewing the deceased, counselling, debriefing and the provision of pastoral care for the family.

The complainant conveyed her appreciation for the help and assistance provided by this Office and found the efforts of the hospital to address her concerns reassuring and encouraging.

A missed diagnosis by a hospital

A young boy was taken to the emergency department of a hospital by his father, with a three day history of illness. After an abdominal x-ray the child was diagnosed with constipation and sent home. The father was advised to return if there were any concerns or change in the child's condition.

The following day the child was diagnosed at another hospital with pneumonia requiring admission and treatment. The father lodged a complaint alleging a failure to diagnose by the first hospital.

The hospital acknowledged that, against hospital policy, a junior doctor had signed off on the x-ray report, which had showed abnormal results and recommended further investigations, without discussing it with a senior staff member.

The hospital apologised for the distress and suffering caused to the child and his family and advised that a change in process had been implemented whereby all radiology reports are now copied to the senior clinician involved for review.

Delayed diagnosis of parasitic myositis

A man alleged that he had been misdiagnosed and received the incorrect treatment for a parasitic infection resulting in deterioration, septicaemia and delirium.

The practitioner concerned explained that there had been a delay in the diagnosis as no parasites were identified in the first muscle biopsy. The practitioner apologised and offered to meet with the complainant to discuss his concerns. The complainant declined this offer.

The case was presented at the American College of Rheumatology Annual Meeting in San Francisco to alert practitioners of the need to re-biopsy steroid resistant inflammatory myositis.

Cases closed following conciliation

Emergency department response to patient with suicidal ideation

A woman lodged a complaint about the adequacy of the care and treatment provided to her son at a hospital. Her son had rung the Mental Health Services Helpline due to agitation and suicidal ideation. He was encouraged to present to hospital for assessment. At presentation he told the triage nurse that he was feeling suicidal, however when he was seen by medical staff, he did not convey suicidal thoughts. A doctor assessed him as not actively suicidal and discharged him. Appointments were made for follow up care. He unfortunately took his own life shortly after discharge.

The matter was referred to conciliation which enabled the complainant to receive an explanation of the circumstances surrounding her son's death and to have her queries answered and concerns acknowledged. There was consensus that there were areas where the hospital could improve, one of which was the inability to access outpatient records.

A number of initiatives were subsequently outlined to improve the communication between inpatient and outpatient treating teams such as electronic discharge summaries and bi-weekly inpatient/community video conferences. The hospital also advised that the establishment of a single client information management system for Mental Health Services was a key priority.

Information provided to patient after an adverse outcome

During a biopsy of a lung tumour, a patient experienced severe pain in his back and the procedure was abandoned. Soon afterwards he experienced loss of feeling in his lower body and required admission to hospital followed by rehabilitation.

He made a complaint about the ongoing pain and difficulties he was suffering as a result of this and alleged that he was not able to see the doctor who performed the procedure or be provided with an explanation for what had caused the injury.

The hospital was not able to provide the complainant with a definitive diagnosis. The clinician involved advised this Office that he had spoken to the complainant on two occasions and felt he had provided sufficient explanation but was happy to meet with him to explain further.

At conciliation the man was able to recall the conversations he had with the clinician but could not remember the content of the conversations. It was agreed that the pain he had experienced may have prevented him from absorbing the information provided to him at the time.

Administration of antibiotics by community nursing

A man developed an infection after surgery. He was discharged home with an intravenous line in place for ongoing administration of antibiotics by community nursing. Hospital guidelines had been amended around that time specifying the preferred method of administration of antibiotics but community nursing had not been advised.

The man became unwell. Investigation undertaken by the hospital identified that the likely cause was the mode of administration of antibiotics by community nursing. The man's symptoms did not resolve.

The hospital offered to meet with him in conciliation where the complaint was resolved. The hospital advised that pharmacists are now allocated to hospital wards providing direct pharmacy input during a patient's stay and on discharge including clear instructions to patients and referred service providers regarding medication.

Failure to respond to clinical deterioration

A woman lodged a complaint about staff at a hospital not listening to her when she reported increasing pain after surgery. Action was not taken by the hospital until blood tests confirmed that the patient was haemorrhaging and required urgent surgery.

A review of the records showed that the doctor who admitted the complainant and was the consultant in charge on the day of the operation did not see her for six days post

operatively. In addition, a number of relevant matters were omitted from the medical records which may have contributed to the delay in diagnosis and had an impact on continuity of care.

The practitioners involved were referred to the relevant registration boards who determined that a reasonable standard of care had been provided, but found that there was a systemic issue in relation to the 'chain of command' and overall responsibility for patient care. This issue was referred back to this Office.

The complaint had already been referred to conciliation and in that process, the complainant was able to tell the hospital that she had felt so unwell after surgery she thought she was going to die and was still suffering anxiety because of this. The hospital apologised to the complainant and acknowledged that she should have been listened to.

The hospital advised that a lot of work was being done to improve handover between staff and that the Australian Safety Standard for recognising and responding to clinical deterioration had been implemented, automatically triggering a medical review. The hospital also advised it was in the process of developing a family escalation program whereby family members concerned about a person's clinical status could initiate a review.

Following conciliation the hospital responded to the 'chain of command' issue and acknowledged that the admitting doctor is ultimately responsible for all patient care and for treatment provided by doctors under their supervision unless that care is formally transferred, with an appropriate handover. The hospital confirmed that it had moved to a team-led model of care with a registrar aligned to each team and led by a supervising consultant which provides for continuity of care.

The hospital advised that an extensive education and awareness program had been commenced. Consumer information posters had been placed in every ward, clinic and waiting room encouraging families, friends and carers to speak up if they have concerns about a patient, and advising that if dissatisfied with the response, they can seek a review and ultimately a clinical assessment by an independent clinician.

Explanation at conciliation for what went wrong

A man lodged a complaint following the death of his wife during an elective surgical procedure. The complainant said that he and his wife had not been warned of the heightened risk she faced due to her medical history and that she should have been discouraged from going ahead with the procedure. Her death was completely unexpected and the family was in shock.

The complainant was unaware of what caused his wife's death, and was concerned about the lack of communication from the hospital following her death.

At conciliation, a hospital representative advised that the normal process of open disclosure involved appointing an appropriate senior person in the hospital to offer support to both relatives and staff, however, it was acknowledged the the policy had clearly failed in this case.

The surgeon gave a detailed account of the procedure and said that the case had been assessed prior to surgery and it was determined that the risk involved in undergoing the procedure was significantly lower than not having it.

All parties found the prospect of conciliation confronting however they were all able to take advantage of the meeting to acknowledge the distress and grief experienced and to express that face to face.

The hospital has provided ongoing education to staff in relation to the open disclosure process.

Surgery riskier second time around

A woman lodged a complaint following her husband's death from a repeat surgical procedure.

Medical records were used during a conciliation meeting to explain the history of her husband's management in the 12 months prior to his death, the nature of the disease he had suffered from and what went wrong in theatre. It was explained to the complainant that the surgical procedure was riskier the second time around and carried a 10% mortality rate. The complainant was not aware of this and had not been present when this was explained to her husband at the time he was providing his consent for surgery.

It was identified that her husband's care plan was that he be kept in hospital prior to the repeat surgery but that he was discharged at his request to go home for a week. The complainant was glad to learn of this and agreed that he would have preferred to spend that time with family, in light of the heightened risk of the procedure which he chose not to share with her.

A personal apology was given to the complainant for her loss.

Complaint used as an educational tool by hospital

A woman lodged a complaint about the standard of post-operative care provided to her by a hospital.

During conciliation she was able to express how distressed the episode of care had left her and how this had caused her to lose confidence in the hospital.

The clinician that provided care to the complainant was able to respond to all the matters raised by her and undertook to provide feedback to another clinician involved in her care. The clinician issued a personal apology.

A representative of the hospital issued an apology for not communicating adequately following a complaint the complainant had made to the hospital.

The parties agreed that the complaint and conciliation (de-identified) would be used as an educational tool for clinical staff training.

Although the complainant was not persuaded that her post-operative care had been appropriately managed, she accepted the apologies made.

Cases Closed Following Investigation

Was the health care provided to a mental health client adequate?

A complaint was made by the sister of a deceased man who had long standing mental health issues.

Two months prior to his death, the sister made contact with Mental Health Services (MHS). The Crisis Assessment and Treatment Team (the Team) visited the man at home but was unable to make an assessment as he refused to open the door.

No further attempts were made to follow up and he was discharged from the service.

The following month, the sister made further contact with MHS. The Team made another home visit to him but there was no answer. They left a letter in the door requesting he make contact.

The Team became aware of a plan by another government agency to serve a legal notice on the man. The agency was willing to facilitate a formal assessment of the man by the Team. The Team discharged him from services until there was contact from the agency about serving the notice (which was to be in a fortnight's time).

Tragically the man was found deceased before that plan was able to be put into action.

I concluded that there was clearly a gap in the system which vulnerable people may slip through if they refuse to engage with services and an assessment is unable to be made. If a person's decision making capacity declines because of deteriorating mental health and that person refuses engagement with services, that person may miss out on mental health services that may prevent further decline.

MHS gave the following undertakings at the conclusion of the investigation:

- training would be provided to staff in respect to section 23 of the *Mental Health Act 2013* which enables a guardian, parent or support person to make application to a medical practitioner for an assessment order;

- this case will be used as a case study at a Clinical Lead meeting to examine options to ensure that a client is not discharged prior to an assessment being undertaken; and

- a memorandum will be issued to reinforce ongoing staff education and ensure that the outcomes of Clinical Lead meetings are communicated to staff.

Was there a conflict of interest providing health care to the son of a mental health client?

A client of the Older Persons Mental Health Team (the Team) raised concerns with the Team about her son's mental health. The Team formed the view that the son was placing a financial and emotional strain on his parents.

At the request of the parents, the Team organised for the son to undergo a psychiatric assessment

The son attended an appointment with the Team psychiatrist and he was diagnosed with schizophrenia.

The son disagreed with the diagnosis and obtained an independent psychiatric assessment. The independent psychiatrist disagreed with the diagnosis and reported that the son did not have any obvious symptoms of major mental illness.

The Team made an emergency application to the Guardianship and Administration Board (the Board) for the appointment of an administrator to make an application to Centrelink on the son's behalf for benefits.

The son's care was transferred from the Team to the Hobart and Southern Districts Adult Community Mental Health Service (the Service). No immediate risks were identified. On the basis of the independent psychiatric assessment the Service informed the Board that it would not be supporting the application initiated by the Team.

The Board dismissed the application.

I concluded that although the Team had acted in good faith, it appeared that the motivation for assessing the son's mental health may have been concerns held by the Team about the welfare of his parents, rather than concerns about his welfare and his ability to make reasonable decisions about his financial affairs. It appeared that the Team was so focussed on achieving an outcome to benefit the son's parents that it lacked objectivity with regard to the son's best interests. I also concluded that there had been insufficient concern about whether there was a sound basis for the application by the Team to the Board.

MHS undertook to issue a memorandum to clinical staff informing them that client referrals that arise from circumstances similar to those of the client's son, must receive an independent assessment by a psychiatrist who is not influenced by an existing affiliation with other family members or friends. Further, that staff from the Board would be invited to provide education to MHS staff to ensure that the principles of the *Guardianship and Administration Act 1995* are correctly applied.

Investigation into the physical safety of patients at a mental health unit

A complaint was made to this Office by a man alleging that his wife had been sexually assaulted by another patient during her admission to a mental health facility.

There was concern that the complaint appeared to raise a number of broader systemic issues and it was determined that an own motion investigation would be undertaken into the facility focussing on the following issues:

- the number and nature of incidents that put at risk the physical safety of patients at the facility;

- the adequacy of the policies and procedures in place at the time of those incidents;

- the adequacy of supervision and managerial oversight in place at the time of those incidents; and

- the manner in which the facility investigates and responds to incidents that put at risk the physical safety of patients

All incident reports from the facility for the previous three year period were reviewed. It appeared that a number of recommendations for ongoing training and education, review of particular policies and procedures and audits, plus modifications to the physical environment were made in the incident reports. I was satisfied that all recommendations had been followed up and implemented.

I was concerned however, that following the incident which was the subject of a complaint to this Office, the practitioners involved in caring for the man's wife had been investigated internally, and conclusions were reached that policies and procedures may not have been followed. The facility did not however make a notification of this to the relevant registration board.

This Office brought this to the attention of the relevant board and an investigation by the board ensued. The board determined that the practitioners involved had practiced below the standard reasonably expected.

I therefore made a recommendation that consideration be given to whether a notification should be made to a registration board when there is evidence of a breach of standards by a registered health practitioner.

I also made a number of recommendations in relation to incorporating safeguards into current policy and guideline documents.

Appendix 1 – Statistics

Table 5 - Reasons for closure in Assessment Stage

Reason	2015-16	2016-17
Dismiss - Section 25 (5) (a) Complainant not a person entitled under s22	3	2
Dismiss - Section 25 (5) (b) Complaint does not disclose a subject matter referred to in s23	1	1
Dismiss - Section 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago	2	4
Dismiss - Section 25 (5) (d) Complainant has not attempted direct resolution	9	5
Dismiss - Section 25 (5) (e) Issues adjudicated by court or tribunal	1	2
Dismiss - Section 25 (5) (g) Complainant has been given reasonable explanation and information	157	196
Dismiss - Section 25 (5) (h) The complaint lacks substance	3	3
Dismiss - Section 25 (5) (i)	0	2
Dismiss - Section 25 (5) (j) Complaint has been resolved	70	95
Dismiss - Section 25 (7) Complainant has failed to provide information under s24	1	0
Other	15	8
Out of Jurisdiction	11	4
Section 25 (1) (a)Complaint referred to the Ombudsman or another person	9	5
Section 30 (1) The complaint has been withdrawn in writing	8	2
Total	**290**	**329**

Outcomes achieved through the assessment process included apologies, provision of services, refunds of costs, and recommendations for (and the implementation of) quality improvements such as changes in policy or procedure as set out in Table 6. It should be noted that more than one outcome may be achieved from one complaint. Examples of cases finalised in assessment appear in the case studies earlier in this report and are published on our website.

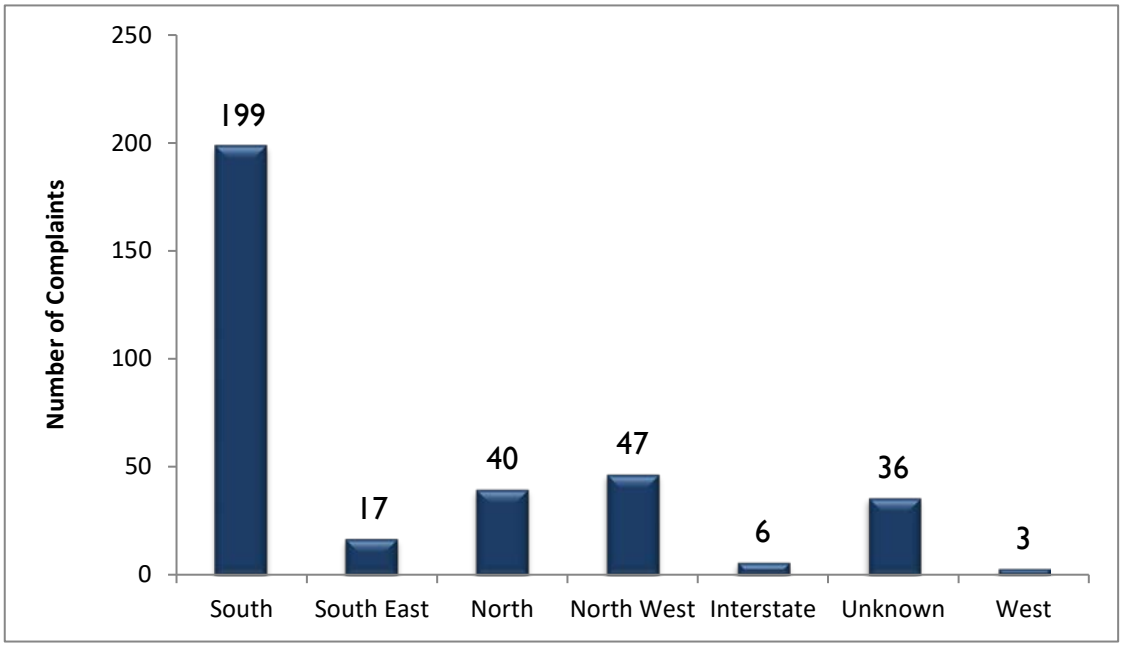
Table 6 - Outcomes from Assessment

Outcomes	**2015-16**	**2016-17**
Apology Given	31	43
Change in Policy	2	4
Change in Procedure	3	11
Compensation Received	1	1
Concern Registered	17	59
Explanation Given	159	243
Fees/Costs - Refunded, waived or reduced	11	9
Information obtained	31	41
Quality Improvement	8	25
Service Obtained	28	68
Total	**291**	**504**

Table 7 - Outcomes from Conciliation

Outcomes	2015-16	2016-17
Apology Given	13	17
Compensation Received	4	6
Concern Registered	13	9
Explanation Given	23	20
Fees/Costs - Refunded, waived or reduced	1	0
Information obtained	2	3
Quality Improvement	16	7
Total	**72**	**62**

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	2015-16	2016-17
Access to facility	0	1
Access to subsidies	3	0
Refusal to admit or treat	30	34
Remoteness of service	0	0
Service availability	20	18
Waiting lists	8	23
Total	**61**	**76**

Table 9 - Communication and Information Issues

Issue	2015-16	2016-17
Attitude / Manner	45	44
Inadequate information provided	20	28
Incorrect / misleading information provided	9	17
Special needs not accommodated	1	3
Total	**75**	**92**

Table 10 – Consent Issues

Issue	2015-16	2016-17
Consent not obtained or inadequate	9	10
Involuntary admission or treatment	5	2
Uninformed consent	1	2
Total	**15**	**14**

Table 11 – Discharge and Transfer Arrangements

Issue	2015-16	2016-17
Delay	1	1
Inadequate discharge	2	6
Mode of transport	1	0
Patient not reviewed	0	1
Total	**4**	**8**

Table 12 – Environment / Management of Facilities Issues

Issue	2015-16	2016-17
Administrative processes	8	1
Cleanliness/hygiene of facility	1	2
Physical environment of facility	6	5
Staffing and rostering	2	2
Statutory obligations/accreditation standards not met	0	2
Total	**17**	**12**

Table 13 – Fees and Costs

Issue	2015-16	2016-17
Billing Practices	11	17
Cost of treatment	9	4
Financial consent	3	9
Total	**23**	**30**

Table 14 – Grievance Processes

Issue	2015-16	2016-17
Inadequate / no response to complaint	13	11
Information about complaints procedures	1	0
Reprisal / retaliation as a result of complaint lodged	0	1
Total	**14**	**12**

Table 15 – Inquiry Service Issues

Issue	2015-16	2016-17
Request for information – Health Service	1	1
Request for information - Other	1	1
Request for Information - Commission	2	0
Request for information – Complaint mechanisms	1	0
Total	**5**	**2**

Table 16 – Medical Records

Issue	2015-16	2016-17
Access to/transfer of records	12	9
Record keeping	1	2
Records management	1	2
Total	**14**	**13**

Table 17 – Medication Issues

Issue	2015-16	2016-17
Administering medication	13	13
Dispensing medication	11	10
Prescribing medication	23	42
Supply/security/storage of medication	3	1
Total	**50**	**66**

Table 18 – Professional Conduct

Issue	2015-16	2016-17
Annual declaration not completed	0	1
Assault	2	4
Boundary violation	2	3
Breach of condition	0	0
Competence	17	21
Discriminatory conduct	0	1
Emergency treatment not provided	0	0
Financial fraud	0	1
Illegal practice	1	2
Impairment	1	0
Inappropriate disclosure of information	6	6
Total	**29**	**39**

Table 19 – Reports / Certificates

Issue	2015-16	2016-17
Accuracy of report/certificate	2	2
Refusal to provide report/certificate	2	0
Report written with inadequate or no consultation	0	1
Timeliness of report/certificate	2	0
Total	**6**	**3**

Table 20 – Treatment Issues

Issue	2015-16	2016-17
Attendance	1	0
Coordination of treatment	4	4
Delay in treatment	39	51
Diagnosis	25	26
Excessive treatment	5	1
Inadequate care	34	56
Inadequate consultation	6	3
Inadequate prosthetic equipment	1	4
Inadequate treatment	48	52
Infection control	1	3
No/inappropriate referral	2	3
Public/Private election	0	1
Rough and painful treatment	10	5
Unexpected treatment outcome/complications	29	34
Withdrawal of treatment	17	14
Wrong/inappropriate treatment	19	19
Total	**241**	**276**
Grand Total	**554**	**643**

Who did they complain about?

Table 21 – Complaints received about Health Organisations

Health Organisation	2015-16	2016-17
Aged Care	1	3
Ambulance	5	1
Community Health	5	1
Correctional Health	101	141
Dental	5	4
Dept of Health & Human Services	6	4
Diagnostic Services	5	3
Disability Services	2	0
Medical Practices/Clinics	26	31
Mental Health	13	6
Optometrist	1	0
Oral Health Services	1	2
Other	6	4
Pathology	2	2
Pharmacy/Pharmaceutical	8	5
Private Hospitals	14	16
Public Hospitals	74	51
Total	**275**	**274**

Hospitals

Table 22 – Issues relating to Private Hospitals

Issue	**2015-16**	**2016-17**
Access	2	1
Communication & Information	3	3
Consent		1
Discharge and Transfer Arrangements	0	0
Environment/Management of Facilities	0	2
Fees & Costs	4	1
Grievance Processes	0	5
Medication	1	0
Professional Conduct	1	2
Treatment	9	11
Total	**20**	**26**

Table 23 – Issues relating to Public Hospitals

Issue	**2015-16**	**2016-17**
Access	12	10
Communication & Information	16	29
Consent	4	8
Discharge & Transfer Arrangements	3	6
Environment/Management of Facilities	7	8
Fees and Costs	0	2
Grievance Processes	4	4
Medical Records	1	0
Medication	5	7
Professional Conduct	7	8
Reports/Certificates	1	1
Treatment	57	85
Total	**117**	**168**

Individual Providers

Table 24 - Complaints to HCC received about Individual Providers

Provider	**2015-16**	**2016-17**
Chiropractor	0	0
Dental	8	6
Medical Practitioner	60	52
Medical Radiation Technologist	0	0
Nurse	2	1
Occupational Therapist	1	0
Optometrist	1	2
Other/Unknown	6	1
Pharmacist	1	2
Podiatrist / Chiropodist	0	0
Total	**79**	**64**

Table 25 – Complaints finalised over time 2011-12 to 2016-17

Time	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Week	13%	13%	15%	12%	26%	33%
Month	35%	32%	31%	36%	50%	54%
Quarter	55%	62%	72%	68%	69%	70%
Six months	71%	82%	84%	77%	77%	79%
12 months	81%	91%	91%	83%	86%	87%
More than 12 months	19%	9%	9%	17%	15%	13%